AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 20th September, 2017, 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 P J Oakford (Chairman), Dr B Bowes (Vice-Chairman), Cllr S Aldridge, Dr F Armstrong, Mr I Ayres, Ms H Carpenter, Mr P B Carter, CBE, Dr S Chaudhuri, Ms F Cox, Ms P Davies, Dr S Dunn, Mr G K Gibbens, Cllr F Gooch, Mr R W Gough, Mr S Inett, Mr A Ireland, Dr N Kumta, Dr E Lunt, Dr T Martin, Mr S Perks, Mr A Scott-Clark, Ms A Singh, Dr R Stewart and Cllr P Watkins

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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 14 June 2017 (Pages 5 - 10)

To receive and agree the minutes of the last meeting

5 Health and Wellbeing Board - future direction and fitness for purpose (Pages 11 - 18)

To receive a report on the findings of the review undertaken by the Chairman into the fitness for purpose and future focus of the Board in light of the development of the Kent and Medway STP

6 NHS preparations for and response to winter in Kent 2017/18 (Pages 19 - 22)

To receive a briefing on the actions taken by the Health and Social Care system to prepare for and respond to winter

7 Pharmaceutical Needs Assessment (Pages 23 - 28)

To comment on and endorse the requirements for producing and publishing a Pharmaceutical Needs Assessment and to agree the recommendation to complete the required 60 day consultation prior to December 2017

8 Healthwatch Annual Report 2016/17 (Pages 29 - 46)

To note the Healthwatch Annual report 2016/17

9 Kent Health and Wellbeing Board Annual Report 2016-2017 (Pages 47 - 54)

To note the report

10 Kent Integration and Better Care Fund Plan 2017-2019 (Pages 55 - 134)

To note the report

11 0-25 Health and Wellbeing Board (Pages 135 - 142)

To note the minutes of the 0-25 Health and Wellbeing Board held on 28 March 2017

12 Minutes of the Local Health and Wellbeing Boards (Pages 143 - 184)

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

Ashford - 19 July 2017
Dartford, Gravesham and Swanley – 28 June 2017
Thanet – 20 July 2017
West Kent – 18 April 2017 and 20 June 2017

13 Date of Next Meeting - 22 November 2017

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)

John Lynch
Head of Democratic Services
03000 410466

Tuesday, 12 September 2017

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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, 14 June 2017.

PRESENT: Dr F Armstrong, Dr B Bowes, Ms P Davies, Mr G K Gibbens, Mr R W Gough, Mr S Inett, Mr A Ireland, Dr N Kumta, Dr S Lundy (Substitute for Dr S Dunn), Dr E Lunt, Dr T Martin, Mr P J Oakford, Mr A Scott-Clark and Dr R Stewart

ALSO PRESENT: Mr G Lymer

IN ATTENDANCE: Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

284. Apologies and Substitutes
(Item 1)

Apologies for absence had been received from Mr I Ayres, Ms H Carpenter, Mr P B Carter, Dr J Chaudhuri, Ms F Cox, Dr S Dunn, Cllr F Gooch, Mr S Perks, Cllr K Pugh and Cllr P Watkins.

Dr S Lundy was present as a substitute for Dr S Dunn.

285. Election of Chairman
(Item 2)

Dr B Bowes proposed and Mr G K Gibbens seconded that Mr P J Oakford be elected Chairman of the Board.

There being no other nominations, this was agreed without a vote, and Mr Oakford duly took the chair.

286. Election of Vice-Chairman
(Item 3)

Mr R W Gough proposed and Dr N Kumta seconded that Dr B Bowes be elected Vice-Chairman of the Board.

There being no other nominations, this was agreed without a vote.

287. Chairman's Welcome
(Item 4)

1. The Chairman thanked Mr Gough for his chairmanship of the Board over 6 years and the vast knowledge of the subject matter that he had built up over this time. A proud culmination of the work of the Board so far was the recent signing-off of the Kent and Medway Transformation Plan, and, with the advent of Sustainability and

Transformation Plans (STPs), the Board was now moving into a new era. This might be a good time to review the Board's work and direction and ask if it was still fit for purpose. Mr Oakford added that he planned to visit each member of the Board in turn to seek their views on the Board's future direction.

2. Mr Gibbens referred to a letter received from the Chief Executive of the East Kent Hospitals University Trust (EKHUFT) about the emergency transfer of some services from the Kent and Canterbury Hospital on 19 June, which had been tabled at the meeting and would be emailed to Board members. He referred to local residents' concerns about the proposals and highlighted the importance of the public being kept fully informed, despite the attendance at a recent public meeting to discuss the issue having been very low. He said it was vital that the transfer of services be as smooth as possible, and asked that the issue be reviewed at a future meeting of the Board. Dr Armstrong explained that the service transfer was to protect quality and clinical safety and that the issue was primarily one of workforce. Dr Lunt agreed and said that both primary and secondary care sectors were struggling nationally with workforce issues. Dr Kumta assured the Board that the Trust had not planned to be in a position to need to make such a transfer; it had done this as an emergency measure.

288. Declarations of Interest by Members in items on the agenda for this meeting
(Item 5)

There were no declarations of interest.

289. Minutes of the Meeting held on 22 March 2017
(Item 6)

RESOLVED that the minutes of the Board's meeting held on 22 March 2017 are correctly recorded and they be signed by the Chairman.

290. Revised Budget 2017-18 and Medium Term Financial Plan 2017 - 2
(Item 7A)

1. Mr Ireland introduced the report, which had been considered and its recommendations agreed by the County Council on 25 May 2017. He explained that a tour of local delivery boards would commence on 15 June and that, following consideration and comment by the Adult Social Care Cabinet Committee on 9 June 2017, two key decisions were about to be taken which would pass the benefit of the additional government funding to the care sector by extending contracts for a package of community support services, including domiciliary care and other homecare services.

2. Ms Davies reported that the issue had been discussed in detail at meetings of the CCGs' Accountable Officers. She added that it was important that the money be spent where it could close the gap in health inequalities, and she said providers were very willing to be part of joint working to find a solution. Mr Inett added that there had been engagement with all relevant groups, including the public. Mr Ireland commented that taking too long to decide how to spend the additional funding could mean there would be less time for it to have an impact before winter 2017/18 set in. As the additional funding was non-recurrent but would be phased over three years,

the County Council would need to be careful not to overcommit it. Ms Davies added that, to make best use of the money to support social care, services need to be integrated as far as possible.

3. RESOLVED that the information set out in the report, and given in response to comments and questions, be noted.

291. Better Care Fund 2016/17 Outturn and 2017/19 Plan
(Item 7B)

Mrs A Tidmarsh, Director, OPPD, and Miss M Goldsmith, Finance Business Partner, were in attendance for this item.

1. Mrs Tidmarsh introduced the report and explained the background and context to the request for the Chairman of the Health and Wellbeing Board to have delegated authority to approve the plan, given that it had to be agreed by CCGs and Accountable Officers, should the need arise in advance of the next meeting of the Board. Miss Goldsmith clarified that the funding listed at Table 2 in the report was 'flat cash' and was a combination of new and existing monies.

2. Dr Bowes and Mr Ireland agreed that the additional funding allocated for adult social care could be used as a driver for integration and that plans for spending it should now be made more specific.

3. RESOLVED that:-

a) the 2016/17 outturn position and the approach to developing the 2017/19 plan be noted; and

b) the Chairman of the Health and Wellbeing Board be given delegated authority to approve the plan, given that it had to be agreed by CCGs and Accountable Officers, should the need arise in advance of the next Health and Wellbeing Board.

292. Update on 'Your Life, Your Wellbeing' Pilots
(Item 8)

1. Mrs Tidmarsh presented a series of slides which set out phase 3 of the 'Your Life, Your Wellbeing' Transformation programme, the design phase, which would include pilot schemes and projects. An outline of and timetable for the latter was included. Mrs Tidmarsh responded to comments and questions from the Board, including the following:-

a) Ms Davies expressed concern about the timelines attached to the projects and commented that not much pilot activity was being proposed for East Kent. Mrs Tidmarsh explained that the stages of implementation were still becoming clear. Although most of the design work had indeed evolved in East Kent, it was expected that projects tried in one area could be rolled out across other areas;

b) Mr Inett welcomed the work set out in the report and Mrs Tidmarsh emphasised the links to the STP and local care services and the aim to establish a single point of access;

c) the Chairman asked why the timelines set out did not seem to include time for evaluation and Mrs Tidmarsh agreed that this element could be more clearly shown as part of the work stream;

d) Dr Kumta also welcomed the programme of projects set out and asked where and by whom the joint business case for the integrated "rehab" project would be signed off. Mrs Tidmarsh explained that, when ready, the joint business plan would be signed off by the County Council;

e) Dr Kumta asked how the local care projects would be delivered, and Mrs Tidmarsh explained that these would need to feed into both the local care STP and the local CCG; and

f) in response to a question about how roll-out would be effected across the county, Mrs Tidmarsh explained that the same process would be used as had been followed successfully before; roll-out would be straightforward if a single agency were involved, but in the case of integrated services, negotiation and joint agreement would be needed. Some services leant themselves to being delivered by a single agency, while other services required integration. Mr Ireland added that integration would allow much more to be delivered and would achieve better value for money. The STP included much useful detail of governance models which could be used to deliver integrated services. Dr Bowes undertook to raise this issue at a meeting of his Clinical Board on 15 June. Ms Davies added that, although there was a great appetite among CCGs to deliver integrated services, the different statuses of services (i.e. social care was means-tested while health care was free at point of delivery) would add complexity.

2. RESOLVED that the information set out in the presentation and given in response to comments and questions be noted, and the progress to date be welcomed.

293. Kent Health and Wellbeing Board Work Programme
(Item 9)

RESOLVED that the work programme be agreed, with the addition of the Pharmaceutical Needs Assessment to the agendas for September 2017 (for pre-consultation discussion) and March 2018 (for final sign-off).

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

RESOLVED that the minutes of local health and wellbeing boards, listed below, be noted:

Ashford – 26 April 2017
Canterbury and Coastal – 11 January 2017
Dartford, Gravesham and Swanley – 1 February 2017 and 12 April 2017

South Kent Coast – 24 January 2017 and 21 March 2017
Swale – 19 April 2017
Thanet – 9 March 2017 and 25 May 2017

295. Date of Next Meeting - 19 July 2017
(Item 11)

POST MEETING NOTE:
This meeting was subsequently cancelled as it was considered to be too soon following the 14 June meeting.

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From: Peter Oakford, Deputy Leader, Cabinet Member for Strategic Commissioning & Public Health and Chairman of the Kent Health and Wellbeing Board

David Whittle, Director Strategy, Policy, Relationships and Corporate Assurance

To: Health and Wellbeing Board – 20 September 2017

Subject: Health and Wellbeing Board – future direction and fitness for purpose

Classification: Unrestricted

Summary: This paper reports the findings of the review undertaken by the Chairman into the fitness for purpose and future focus of the Board in light of the development of the Kent and Medway STP.

Recommendations:

The Board is asked to:

a) **Note** findings of the review;
b) **Agree** that the Board should seek a role within the governance arrangements of the Kent and Medway STP;
c) **Agree** that the Chairman explore the creation of a joint Board with Medway Council to support the above recommendation.

1. Introduction:

1.1 At the last meeting of the Board it was agreed that the Chairman would undertake a review of the fitness for purpose and future direction of the Kent Health and Wellbeing Board (the Board) in light of the development of the Kent and Medway Sustainability and Transformation Plan (STP) and its impact. The Chairman agreed to visit/discuss the issue with each member of the Board to gauge their views and report back with findings and options. These visits/discussions took place throughout late July and August, and a list of those consulted is in Appendix A. This included current Board members, former Board members and other interested organisations/partners.

1.2 This report summarises the key issues raised during those discussions and sets out options for the Board to consider before agreeing next steps.

2. Background:

2.1 The Board is a formal committee of the County Council required by S.194 of the Health and Social Care Act 2012. The Board existed in shadow status from the summer of 2011, following Kent being given early implementer status by the Department of Health, and became fully operational on the 1st April 2013. The Act denotes the number of statutory members of the HWBB as:

- The Leader of the Council and/or their nominee
- Director of Adult Social Services for the local authority
- Director of Children's Services for the local authority
- Director of Public Health for the local authority
- A representative of the Local Healthwatch organisation
- A representative of each clinical commissioning group
- A general power of the local authority to appoint other persons as appropriate

2.2 S.197-199 establishes the Board as a forum for leaders from the local health and care system to jointly work to improve the health and well-being of the people in their area; reduce health inequalities, and promote the integration of services. It has a statutory duty to ensure the production of a joint strategic needs assessment and a joint health and wellbeing strategy, setting out priorities for local commissioning. It also needs to ensure the production of a Pharmaceutical Needs Assessment. These priorities then inform local authority and CCG commissioning plans.

2.3 Health and Wellbeing Boards have limited formal powers and were constituted as a partnership forum rather than an executive decision-making body, with executive authority for health and social care commissioning remaining with the CCG governing body or the local authority Cabinet. This reflects the intention of the Health and Social Care Act 2012 to create CCGs as the statutory vehicle for the commissioning of health services for their local population, and a clear statutory demarcation between commissioning and service provision within the health system. In only a limited number of examples, usually smaller unitary/metropolitan council area has a local authority Cabinet delegated executive decision-making authority to a Health and Wellbeing Board.

2.4 In Kent, the Board also created local Health and Wellbeing Boards (following Clinical Commissioning Group boundaries) as sub-committees of the main Board. This followed the Department of Health giving both the County Council and Dover District Council early implementer status in 2011 (although district councils held no formal role under the Act) and there was an appetite across CCGs and the District Councils for local Boards to support local planning, integration and engagement. It is worth noting that the other two-tier authorities given early implementer status (Hertfordshire & St Albans and Suffolk & Great Yarmouth) did not follow through to create a local Board structure. It was also agreed that three representatives from District Councils, nominated by the Kent Council Leaders group, would sit as members of the Board.

2.5 In March 2014, the Board also agreed to establish a Children's Health and Wellbeing Board as an informal working group reporting to the Board. The aim of the Children's Board is to ensure a clear link between the commissioning of children's services and the priorities set out in JSNA and the Health and Wellbeing Strategy as required under S.7 of the Children and Families Act 2014. It also supports the general duty on all partners for inter-agency cooperation to improve the welfare of children as set out in S.10 of the Children Act 2004.

2.6 It should be noted that while the statutory requirements as to membership and purpose of the Board is set out in the statute, there was an expectation from the Government that Health and Wellbeing Boards would develop beyond this limited statutory role as new partnership arrangements matured. As such, there is scope for variability in the focus and operation of the Board while still complying with the statutory limitations of the 2012 Act.

3. The development and focus of the Board

3.1 Many of those interviewed commented on the success of the previous Chairman in personally driving the development of the Board from the early implementer stage. In particular, there was a consensus that this had allowed members to forge cross-sector relationships that had not previously existed, and develop a pan-Kent view of the health and social care system. There was agreement that these 'softer' benefits should neither be underplayed nor lost in any reforms, as effective relationships across the different sectors are critical.

3.2 In particular, the advantage of the Board was particularly felt by clinical leads who found its broader consideration of health and well-being to be important. Discussions on the wider determinants of health such as social care, public health, housing, leisure etc. were seen as critical to supporting primary care, given the increasing demand for primary care can only be met through greater social prescribing and signposting to services provided by wider public services.

3.3 However, there was a broad degree of frustration from Board members regarding its limited role and in particular its lack of decision-making powers (beyond approving the JSNA, HWB

Strategy and PNA). There was agreement that this led to items being 'show and tell' narratives, where different partners in the system would inform other partners of their plans and strategies but with only limited reference to the wider pan-Kent issues, and limited scope for board members to influence those plans and activities. As such, members felt the Board wasn't adding value in the way it could or should do. Non-members interviewed expressed frustration that the influence of the Board wasn't felt across the wider health and social care system or the wider Kent public service landscape.

3.4 Some interviewees expressed the view that the Health and Wellbeing Board should be a mechanism for collectively holding the health and social care system to account for delivery. However, a counter view put forward by some was that as a committee of the County Council, which is meeting in public and with elected politicians as members, such collective peer challenge was unrealistic. They feel the Board is not a suitable forum for 'difficult discussions' on system performance, and that such conversations take place through better alternative forums.

3.5 There is consensus from all Board members that the emergence of the STP is a game changer. At a practical level, the STP governance arrangements and programme delivery are now driving the day-to-day activity of Board members, both CCG and KCC, as well as a requiring a significant degree of capacity and capability of the resources from their respective organisations. As a consequence, this is leading to meeting fatigue and prioritisation of effort more carefully. Given this, many Board members feel that they cannot prioritise engagement with the Health and Wellbeing Board while the STP is so resource intensive.

3.6 Moreover, in responding to the policy direction set by NHS England through the *Five Year Forward View,* the STP is blurring the demarcation between health commissioners and providers in favour of an integrated planning framework across the health and social care system. As such, the operating environment set for the Board through the 2012 Act is being radically transformed, even if the legal framework lags behind. It is felt that the Board must respond to this changing operating environment if it is to remain relevant.

3.7 There was broad agreement that it was the right time to review the role and fitness for the purpose of the Board. However, given the fluid nature of the health and social care system as a result of the STP, it was felt that any new arrangements would need to be revisited again in 18-24 months to ensure that they were still appropriate.

4. The role of the Board vis-à-vis the STP

4.1 Given the current prominence of the STP, there was agreement that its successful development and delivery is the short-term (1-2 years) priority for the health and social care system in Kent. There was also agreement that as a statutory committee with a remit covering health and social care, a membership drawn from across both sectors and a role in promoting integration, that the Board should play a significant role within the STP. There was also a strong view expressed by the majority of interviewees that if the HWBB were to have a more formal role within the STP, then it should be at a Kent and Medway geography, as this is the spatial scale of the STP. This would require the creation of a joint Health and Wellbeing Board between KCC and Medway Council.

4.2 The difficulty is that while there was a substantial degree of consensus that the Board *should* have a role within the STP, there was limited clarity about *what* that role should be and how it could be discharged in practice. Presuming that a joint Kent and Medway joint Board is possible, options put forward included:

a) **Strategic oversight:** Given national political and media interest in STP development, and the requirement of NHS England for all STPs to have local public and partner support, some interviewees suggested that the Board could have a strategic oversight role over STP development and delivery. As such, the Board might consider the STP a 'third pillar' of its responsibilities alongside the JSNA and the Health and Wellbeing Strategy. This was particularly

supported by those who expressed concern about the opaque and unclear accountability arrangements for the STP. However, it can be argued that given the number of STP updates considered by the Board already this year, it already acts as a form of strategic oversight. Moreover, this option is limited by the fact that even within the STP, there is no single decision-making authority and any proposals for change currently require sign off by each CCG governing body and, if necessary, local authority Cabinet. Without knowing what strategic oversight means beyond what the Board is already doing, this option risks the new joint Board with Medway merely becoming a talking shop sitting above the STP. Also, as some decisions emanating from the STP will likely be significant service changes, there is a risk that a 'strategic oversight' role duplicates the statutory role of Health Overview and Scrutiny Committees in considering service reconfiguration proposals.

b) **Act as the STP Programme Board:** Some suggested that given many members on the Board also sit on the STP Programme Board, the Health and Wellbeing Board could take on that responsibility. While possible, it needs to be remembered that there are organisations on the Programme Board that are not on the Health and Wellbeing Board, in particular, some health providers and other representative bodies (such as the Local Medical Committee). There is also the added complexity that the Programme Board is in the process of recruiting an independent Chairman, and is supported by external consultancy given the demands of the STP and the need for frequent Programme Board meetings. Transposing Programme Board responsibilities to a joint Health and Wellbeing Board is not straightforward.

c) **Work stream lead responsibility:** Another option suggested by a number of interviewees was that a joint Board should take a greater responsibility and accountability for the development of specific work streams within the STP, in particular, those work streams where local government and social care have a particular interest because of the potential impact on local authority social care and public health budgets, staffing and commissioning arrangements. The two work streams most frequently suggested where the 'Local Care' and 'Prevention'. It was broadly felt that while these were essential to the delivery of a new health and social care model, the STPs immediate focus on acute service sustainability meant they are not as prominent in the STP as they could be. It was felt that placing them under the auspices of a joint Board would give them the necessary ownership to be developed at a greater pace.

4.3 It was widely recognised that if there was an appetite for a greater role within the STP, then this would drive business and agenda in the short-term bar any continued statutory responsibilities for the JSNA, Strategy and Pharmaceutical Needs Assessment. This did raise some words of caution, particularly from clinicians, that the important focus on the wider determinants of health should not be lost given that post-STP, these issues will still be fundamental to dealing with future demand pressures.

4.4 Indeed, when asked what the Board should focus on if it were *not* able to integrate with the STP or form a joint Board with Medway, the majority of interviewees suggested that a sharper focus on the wider determinants of health, particularly on a smaller number of priorities identified through the forthcoming refresh of the Health and Wellbeing Strategy. This would, however, have to be achieved through fewer Board meetings as the resource demands of the STP would remain.

5. Membership

5.1 The issue of the membership of the Board was the area of least agreement amongst those interviewed. Whilst there was an acceptance that if the Board took on a formal role in the STP its membership would have to change to discharge that role, on the general principle of membership there was little agreement, and a general concern that changing the membership of the Board would change the nature of discussions and detrimentally impact on meeting management.

5.2 Although the Kent Board chose to establish itself as a board of commissioners, there are a number of examples of Health and Wellbeing Boards including health providers on the Board itself

(normally as non-voting members) or creating specific mechanisms to engage health providers. Some interviewees expressed support for inviting representatives from acute, primary and community providers in Kent onto the Board on the basis that the STP and wider policy agenda for health is removing the absolute demarcation between commissioning and provision, and there was no logic for the Board in keeping it. Others expressed sympathy for this view but were concerned about the practical implications of inviting more members onto a Board that already has a large membership.

5.3 Others thought that inviting providers onto the Board was not only impractical but would have unintended consequences. In particular, there was concern that a focus from providers on short-term delivery would skew discussions away from the strategic issues that is the remit of the Board. Unsurprisingly, the providers interviewed thought that they should be represented on the Board, as the Board is better served by having as much input from clinicians as possible, and provider organisations were more clinically focussed. In particular, they argued they would be able to support the delivery of the Boards objectives more directly by being members, and that the Board would provide an appropriate vehicle currently for providers to engage in strategic planning conversations.

5.4 The issue of broadening the membership to wider public service partners was also considered during interviews. Whilst it was felt that this would not be appropriate if the Board was focussed on a role within the STP, if focussed on wider determinants, there was general agreement that would be beneficial, although some concern as to the impact on the management of the meetings. The Police and Crime Commissioner would like to be included as a member of the Board, given the strong link between demand on police services and mental health.

5.5 Repeatedly throughout the review process, Board members thought a representative from the state education sector would be a positive step given the importance of schools, education and training to the future health and wellbeing of the population and reducing health inequalities. It was suggested that the Association of Kent Head teachers might be appropriate to become a member of the Board. Alongside education, the most frequently referenced wider public sector partner whom it was felt should be represented on the Board was housing. This representative could come from one of the housing associations operating in Kent or a representative from the Kent Housing Group, the officer group of district council housing officers that acts as a pan-Kent coordinating body.

6. Agenda planning and meeting management

6.1 Another issue that was frequently referenced by those interviewed were concerns about meeting management. In particular, numerous interviewees raised concerns that the Board frequently has too many agenda items to discharge, and that there was a tendency for the time available in meetings to be focussed on just a single (and often the first substantive) item, with other items having to effectively be rushed through without appropriate consideration.

6.2 It was generally recognised that this was a consequence of the Board having too greater scope and not focussing on more specific objectives and priorities. There has become a tendency to treat the Boards consideration of an item as a ‘tick box’ exercise that was adding unnecessary items to the agenda. Some health members felt that they had not done enough to support the local authority in developing an appropriate forward plan and ensure appropriate agendas were set for the Board.

7. Meeting arrangements

7.1 There was some concern about the meeting arrangements of the Board including the bi-monthly meeting schedule and timing the start of meetings in the early evenings. This is difficult for members who have to travel long distances home in the late evening from Maidstone. The meeting schedule necessary to support the STP has compounded this matter for some Board members.

7.2 The rationale for the evening meetings lies in the initial establishment of the Board at early implementer stage in 2011. At the time, clinical leads were combining their new CCG leadership roles with GP surgeries, and evening meetings were deemed the best way to allow clinical leads to attend. The bi-monthly meeting frequency was, again, set at early implementer stage as this was necessary to discharge the business of the Board. However, it is worth noting that the terms of reference for the Board only require it to meet quarterly.

8. Local Health and Wellbeing Boards

8.1 As noted in paragraph 2.4 the Board established local Health and Wellbeing Boards as a response to the concurrent early implementer status given to both KCC and Dover District Council in 2011. From the interviewees who had experience of local Boards (not all did) there were very mixed views about them. In some CCG areas the local Boards had found a niche role, and promoted wider engagement with partners at a local level, and as such were valued. In other areas, the Boards have fallen away and were no longer meeting. All respondents felt that the links between the main Board and the local Boards were weak, and the issue of lack of decision-making powers at the main Board was replicated in local Boards.

8.2 A number of respondents made the point that the future of local Boards couldn't be separated from the STP, as they also contributed to the feeling of meeting overload, but also because there is an emerging place based sub-structure for delivery of the STP. There is also widespread expectation that whatever new integrated health and social care arrangements might be created through the STP, these will have a local footprint (most likely through Accountable Care Systems) that would inevitably further challenge the purpose and role of local Boards.

8.3 It was broadly felt that trying to 'sort out' local Boards and bring them back to having some uniform, standardised role with stronger links back to the countywide Board would be both impractical and should not be an immediate priority given other pressures.

9. Children's Health and Wellbeing Board

9.1 Not all those interviewed as part of the review had experience of the Children's Health and Wellbeing Board. There was as mixed response about whether it should continue to sit as a informal subcommittee of the main Board. On the one hand, there was a strong view from some interviewees that if the aim of the Board was to impact on the wider determinants of health, such longitudinal change must start by a focus on children as part of the preventative agenda, and therefore children's issues should be a core focus of the main Board.

9.2 Conversely there was also a view put forward that the integration of health and children's social care in Kent is lagging behind the progress made in other areas of the country, and as such, a separate Children's Health and Wellbeing Board can provide a vehicle for progressing that agenda more quickly given it provides an appropriate, and specific, engagement vehicle. In the future, should the integration of children's health and social care progress, it was suggested that the Children's Board could exist as a decision-making committee in its own right. It was certainly felt by a number of interviewees that the current lack of a focus on children's issues in the STP made having a specific vehicle for engaging on children's issues necessary.

10. Discussion and next steps

10.1 If we accept that form should follow function, then the fundamental decision, from which other issues and decisions (e.g. membership, agenda planning, sub-board arrangements) will flow, is what role, if any, the Board should seek to have within the STP?

10.2 It is important to recognise that the Board cannot unilaterally decide to integrate itself into the STP governance arrangements. The STP is a separate entity. It is developing its own governance and support arrangements. As a change programme it needs to be flexible and adaptable to both

local and national requirements. Its membership is broader than the Board's. If the Board does feel it should have a role within the STP, this needs to be negotiated and there must be consensus about what the role is to be, and how it should be discharged.

10.3 Moreover, if the Board is to have a role in the STP, the consensus is that it must operate at a Kent and Medway. The Kent Board cannot do this unilaterally as it would require the creation of a Joint Health and Wellbeing Board between Medway Council and Kent County Council. Both Councils would formally have to agree, and Medway Council are under no requirement or obligation to do so. If Medway Council did agree, then the Kent Board would likely need to delegate much of its functions to the new joint Board for the period it is in place.

10.4 If Medway Council does not agree, then we should not expend time and resource seeking to persuade. Instead, we should default to the option identified in para 4.4 and on which there was broad agreement through the review, to refocus the Kent Board on the wider determinants of health, agree fewer specific and actionable objectives, and pare down the forward agenda and meeting requirements accordingly.

10.5 Initial conversations with Medway Council leadership have taken place about the appetite to create a joint Health and Wellbeing Board. Medway Council are willing to explore the creation of a joint Board, on a without prejudice basis, and KCC and Medway officers have been tasked to prepare reports on the options and practicalities for the operation of a joint Board, to be considered by both Councils' senior leadership later this month. An update on those discussions will be provided to the next Board meeting.

11. Recommendations:

11.1 The Board is asked to:

a) Note findings of the review;
b) Agree that the Board should seek a role within the governance arrangements of the Kent and Medway STP;
c) Agree to explore the creation of a joint Board with Medway Council to support the above recommendation.

Background Documents:

- Terms of reference and governance arrangements for the Kent Health and Wellbeing Board, Kent County Council, 28 March 2013 available at: https://democracy.kent.gov.uk/documents/s38976/Appendix%20A%20-%20Delivering%20Better%20Healthcare%20for%20Kent.pdf

Appendix:

- Appendix 1: Persons consulted as part of the review

REPORT AUTHOR:

David Whittle
Director of Strategy, Policy, Relationships and Corporate Assurance
Email: david.whittle@kent.gov.uk
Tel: 03000 416833

Appendix A: Interviewees as part of the review:

- Felicity Cox, Director Commissioning Operations South (South East), NHS England
- Dr Fiona Armstrong, Swale CCG Chair
- Dr Elizabeth Lunt, Clinical Chair for Dartford, Gravesham & Swanley CCG
- Patricia Davies, Accountable Officer, Dartford, Gravesham & Swanley CCG and Swale CCG
- Simon Perks, Accountable Officer, Ashford CCG and Canterbury & Coastal CCG
- Simon Dunn, Clinical Chair - Canterbury & Coastal CCG
- Dr Bob Bowes, Chair of West Kent CCG
- Dave Holman, Head of Mental Health Commissioning for West Kent CCG
- Ian Ayres, Accountable Officer – West Kent CCG
- Dr Tony Martin, Clinical Chair, Thanet CCG
- Dr Jonathan Bryant, Clinical Chair, South Kent Coast CCG
- Dr Joe Chaudhuri, Governing Body Member, South Kent Coast CCG
- Hazel Carpenter, Accountable Officer – South Kent Coast CCG and Thanet CCG
- Steve Inett, Chief Executive – Healthwatch
- Paul Bentley, Chief Executive, Kent Community Health Foundation Trust
- Dr. Mike Parks, Kent Local Medical Committee
- Dr. Gaurav Gupta, Kent Local Medical committee
- Matthew Scott, Kent Police and Crime Commissioner
- Cllr Paul Watkins, Leader of Dover District Council
- Cllr Fay Gooch, Deputy Leader, Maidstone Borough Council
- Cllr Ken Pugh, Swale Borough Council
- William Benson, Chief Executive, Tunbridge Wells District Council
- Roger Gough, Cabinet Member for Children, Young People and Education, KCC
- Andrew Ireland, Corporate Director - Social Care, Health and Wellbeing, KCC
- Graham Gibbens, Cabinet Member for Adult Social Care and Health, KCC
- Andrew Scott-Clark, Director for Public Health, KCC

NHS England

NHS preparations for and response to winter in Kent 2017/18

To: **Kent Health and Wellbeing Board**

From: **Ivor Duffy, Director of Assurance and Delivery, NHS England South (South East)**

Author: **Zara Beattie, Winter Resilience Lead, NHS England South (South East)**

Date: **23 August 2017**

1.0 Purpose

This report provides a briefing to the Kent Health and Wellbeing Board that describes the actions taken by the Health and Social Care system to prepare for and respond to winter.

2.0 Background

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

The key vehicle for winter Preparedness and Response activities are the Local A&E Delivery Boards that were established in 2016. Kent has four Local A&E Delivery Boards covering the Dartford Gravesham and Swanley; East Kent, West Kent and Medway and Swale. Kent County Council is a core member of each of these groups and is represented on them by an Executive Director.

3.0 Winter 2016/17 Debrief

During Winter 2016/17 weekly teleconferences were held with Local A&E Delivery Board leads to share good practice and assist with any immediate issues requiring escalation. An interim stocktake was held on 2 February 2017 to learn lessons from the management of and performance over the Christmas and New Year Bank holidays to implement any necessary improvements ready for the Easter 2017 Bank Holiday. A full Winter 2016/17 debrief was held with system leads on 9 May 2017. Key successes that have been continued for 2017/18 winter planning include:

1. Training for on-call teams particularly in effective teleconference management
2. GP Service provision within A&E
3. Flexibility of implementation of escalation beds and discharge to assess systems

Key lessons that have been incorporated into Winter 2017/18 plans include:

1. Demand and Capacity forecasting and planning process started earlier in the year, including early engagement with workforce
2. Implementing management systems for non-urgent prescribing
3. Automated real-time data collection available in some form across all Local A&E Delivery Boards.

4.0 Local A&E Delivery Board Assurance ahead of winter

NHS England set a clear expectation that all Local A&E Delivery Boards in Kent would have in place robust plans to deliver the urgent care standards and to ensure

that plans are in place to effectively manage winter pressures. Therefore ahead of winter 2017/18 NHS England South (South East) and NHS Improvement facilitated a dual assurance process, via self-assessment and peer review, which required Local A&E Delivery Boards to provide assurance that they have put in place preparations for the winter period. This included a review of the key actions being taken to improve on last year's plan, delivery of the national ten high impact interventions, the flu programme for staff and patients and work on Delayed Transfers of Care.

5.0 Surge Management Plans and Exercises

All Local A&E Delivery Boards have prepared Surge Management Plans that are aligned to the NHS England South Region Surge Management Framework which was agreed by the South Region Bipartite of NHS England and NHS Improvement. Plans have been updated to incorporate lessons from Winter 2016/17 and Easter Bank Holiday 2017. NHS England and NHS Improvement have also sent a Bipartite Gateway letter (Reference 06969) confirming the four national priorities for winter 2017/18 which have been incorporated into the Local A&E Delivery Boards Surge Management Plans.

NHS England South (South East) will ensure that each Local A&E Delivery Boards conduct a Surge Capacity exercise ahead of winter 2017-18. The Local A&E Delivery Boards' Surge Management plans will then be updated to ensure that these lessons are addressed.

6.0 Winter Communications

All Local A&E Delivery Boards are promoting the nationally led 'Stay Well This Winter' campaign, which is a joint initiative between NHS England and Public Health England. http://www.nhs.uk/staywell/

This campaign drives home key messages to the public which will take the pressure off frontline services. The messages ask the public to protect themselves as the cold weather sets in by staying warm, stocking up on prescription medicines or checking in on friends and neighbours to make sure they are keeping well and taking up the offer of a seasonal flu vaccination where eligible.

7.0 Seasonal Flu Vaccination

Outbreaks of flu can occur in health and social care settings, and, because flu is so contagious, staff, patents and residents are at risk of infection. As a result front-line healthcare workers are offered a flu vaccination. Local A&E Delivery Boards have put in place measures to maximise and monitor updates by eligible Health and Social Care staff.

The flu vaccination is also offered free of charge to people who are at risk, pregnant women, carers and some young children to ensure that they are protected against catching flu and developing serious complications. The continued support of KCC in promoting the uptake is recognized and welcomed.

8.0 Winter Response

NHS England South (South East) is operating a virtual winter resilience room between 1 October 2017 and 30 April 2018. The winter resilience room provides a focal point for winter briefings, escalation discussions and communications through

the winter. From here NHS England will provide oversight of the Local A&E Delivery Boards response to winter, monitor daily situation reports prepared by hospitals and community services organisations, prepare daily situation reports and briefings and facilitate system-wide requests for support where required.

9.0 Health and Wellbeing Boards and Better Care Fund Plans

Health and Wellbeing Boards have responsibility for signing off Better Care Fund plans, which for 2017-19 include a national condition around managing transfers of care. Local areas will have undertaken self-assessments against the 8 High Impact Change Model for managing transfers of care. Through the Better Care Fund systems were required to submit DToC (Delayed Transfers of Care) targets by Health and Wellbeing Board footprint, including for NHS, Social Care and jointly attributable delays. A national review of performance against the DToC targets is planned by the Department of Health in November 2017. The November review will cover 18/19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care.

10.0 Summary

- Local A&E Delivery Boards, of which KCC is an integral part, have taken steps to prepare the health and social care system to manage winter pressures.
- Individual Health and Social Care organisations and Local A&E Delivery Boards have Surge Management plans.
- These Surge Management plans will be tested by exercise and amended to take account of lessons identified ahead of the winter period.
- A strong national communications campaign is being supported and delivered locally. The NHS recognises and welcomes KCC's ongoing support to successfully deliver these important messages to the population of Kent.
- KCC and other partners' support in encouraging the uptake of seasonal flu vaccination is also welcomed.
- A robust system of winter reporting has been put in place to identify and respond to any challenges as they arise via the Winter Resilience Room
- In addition to the Surge Management Plans, all the members of Local A&E Delivery Boards have robust, well-rehearsed plans in place to manage the impact of emergencies that can result from severe weather, infectious disease outbreaks or industrial action.
- The Surge Management Plans are supported by the Urgent and Emergency Care work stream, Health and Wellbeing Boards and the Better Care Fund Plans.

Zara Beattie
Winter Resilience Lead
NHS England South (South East)

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From: Peter Oakford, Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health and Wellbeing Board

20 September 2017

Subject: Pharmaceutical Needs Assessment

Classification: Unrestricted

Previous Pathway: This is the first committee to consider this report

Future Pathway: None

Electoral Division: All

Summary:

This document sets out the statutory requirement for the Kent Health and Wellbeing Board to have developed and consulted upon a Pharmaceutical Needs Assessment (PNA). The first PNA was published in spring 2015 and this document needs to be renewed by April 2018. The accompanying paper details the background, what the implications are and details the organisational structure to oversee development and publication of the revised PNA

Recommendations:

The Health and Wellbeing Board is asked to:

1. NOTE the requirements for producing and publishing a Pharmaceutical Needs Assessment

2. AGREE to the consultation on the revised PNA for 60 days commencing in October 2017. The consultation document will be circulated to all Health and Wellbeing Board members at commencement of the consultation

1. Introduction

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

2. Purpose

2.1. The PNA enables NHS England to make decisions on future applications for NHS pharmaceutical services after 1 April 2018, and thus the PNA will need to be fit for purpose and continue to be maintained and up-to-date.

2.2. The purpose of this paper is two-fold:

- To bring this to the attention of the Kent County Council Health and Wellbeing Board members and ensure the Board is aware of the legislative requirements.

- To seek agreement of how we manage the process of undertaking the PNA and consulting on the revised Kent County Council PNA prior to publication in April 2018.

3. Background

3.1. The Health and Social Care Act 2012 transferred responsibility for developing and updating of Pharmaceutical Needs Assessment from Primary Care Trusts to Health and Wellbeing Boards (HWBs).If a person (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, a GP) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by NHS England locally. This process is known as market entry.

3.2. Market entry for NHS pharmaceutical services contracts has been evolving over the past number of years from a regulatory control system to a needs based system. Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services Regulations (“the 2013 Regulations”)), applications must now prove they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance selling (internet or mail order only) basis.

3.3. Pharmaceutical Services in relation to PNAs are defined as:

- "Essential services" which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service; i.e. the dispensing of medicines, promotion of healthy lifestyles and support for self-care;

- "Advanced services" which community pharmacy contractors can provide subject to accreditation as necessary – these are Medicines Use Reviews and the New Medicines Service for community pharmacists and Appliance Use reviews and the Stoma Customisation Service for dispensing appliance contractors;

- Locally commissioned services (known as enhanced services) commissioned by NHS England.

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

4. Scope

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

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

5. The use of the 2015 Kent County Council PNA

5.1. NHS England have informed the steering group that the 2015 PNA has been used to inform decision for planning applications for new pharmacies and to assist NHS England in making decisions on appeals.

5.2. The intention is to refresh the existing PNA for 2018-21 rather than re-writing the needs assessment. The data, including maps, will be updated and the section on new housing developments will be updated to consider the impact of large developments such as Ebbsfleet Garden City and Garden Village developments.

6. Consultation

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

These include:

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

Kent County Council will need to consult with the public more broadly as the users of pharmaceutical services.

6.2. The public consultation is required to last a minimum of 60 days.

7. Timeline

7.1. The Kent Health and Wellbeing Board are required to publish a PNA every 3 years

7.2. There is also a requirement to publish a revised assessment as soon as is reasonably practical after identifying a significant changes to the availability of pharmaceutical services since the publication of the last PNA. It is the responsibility of NHS England to provide these updates to Public Health in order to publish them

7.3. There is also a requirement to publish supplementary statements of change where it is considered a full new PNA is not necessary (e.g. the granting of a new pharmaceutical services contract).

7.4. The previous PNA was published in March 2015 and the 2018-21 PNA is due to be published in March 2018. .

7.5. The public consultation on the PNA takes 60 days and the intention is to consult on the 2018-21 PNA in October 2017.

8. Project organisational structure

8.1. The Kent County Council PNA Steering Group met on 4 July 2017 and agreed to consult on the 2018-21 PNA before the holiday season, in autumn 2017.

8.2. The membership of the PNA Steering group includes:.

- KCC Public Health – Deputy Director Public Health (Chair)
- KCC Pharmacy Advisor (Consultant Pharmacist)
- Kent Public Health Observatory (for mapping)
- NHS England Area Team representative
- KCC Engagement representative (for consultation)
- Kent Local Medical Committee (officer and dispensing GP representative)
- Kent Pharmaceutical Committee (officer and community pharmacist)
- Kent Local Pharmacy Network representative
- HealthWatch Kent
- CCG representative(s)

8.3. Terms of Reference have been agreed by the group, broadly the group's responsibility will be to agree the following:

- The final scope of the PNA
- Detailed timelines in order for the Health and Wellbeing Board to sign off the PNA for publication by March 2018.
- Geographical area at which PNA will make most sense to analyse (the Kent area is too broad, the last PNA analysed data at District level).
- Data set requirements to assess pharmaceutical need.
- How best to publish to enable NHS England to make decisions on pharmaceutical list market entry applications.
- How subsequent amendments are to be handled (a statutory requirement).

9. Recommendations

The Health and Wellbeing Board is asked to:

1. NOTE the requirements for producing and publishing a Pharmaceutical Needs Assessment

2. AGREE to the consultation on the revised PNA for 60 days commencing in October 2017. The consultation document will be circulated to all Health and Wellbeing Board members at commencement of the consultation

10. Background Documents

10.1. 2015 PNA can be found at: http://www.kpho.org.uk/health-intelligence/service-provision/pharmacy/pharmaceutical-needs-assessments

11. Contact Details

Report Author

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Relevant Director:

- Andrew Scott-Clark: Director of Public Health
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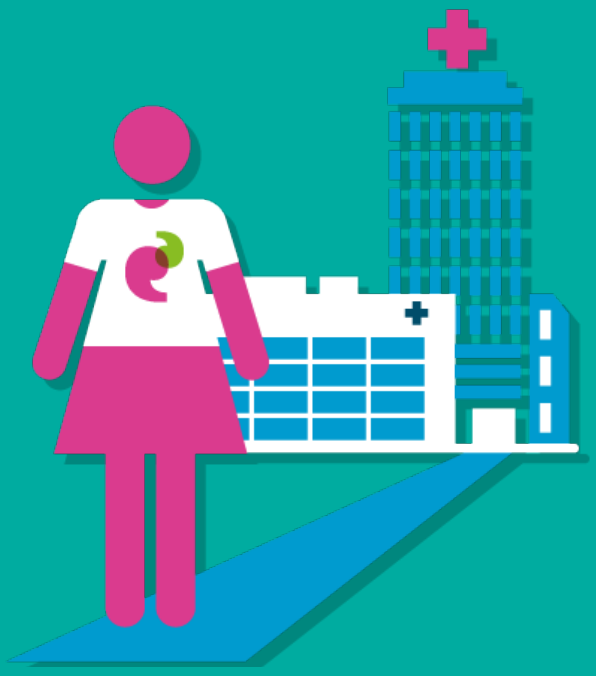
healthwatch Kent

Healthwatch Kent Annual Report 2016/17

Contents

Our vision, mission and values



Our vision

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

Our mission

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

Our values

- Open and transparent
- Volunteer led
- Objective and balanced

We achieve this by

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

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

Foreward from our Chief Executive

This year has been a time of great change.

Both the NHS and social care are under huge strain. Numbers of people needing services continue to increase every month; the money available for services continues to be reduced and we continue to face a critical lack of staff to meet the needs of patients and service users. All of these factors together mean that services must change and the health and social care system in Kent must work differently to ensure that this change can happen.

The role of Healthwatch Kent in this sea of change is to ensure patients and service users have a voice. You should not only be informed of potential changes but also be given the opportunity to get involved in constructive discussions about what those changes could or should look like.

Much of our year has been spent working to ensure you have a voice and a place to get involved with these changes. This journey will continue over the coming year and we would encourage you all to get involved if you can. This is the time to make your views heard.

In addition to this we have continued to focus on specific services and issues that we have heard about from the you including;

- We spoke to over 300 people about the Children & Adolescent Mental Health service. Our recommendations are part of the new service which will be rolled out in 2017
- We spoke to over 100 people about their experience of being discharged from hospital in North Kent. We have worked on a new patient leaflet explaining the discharge process which is currently being piloted with 20,000 patients
- Our report on changes to repeat prescriptions is being used to inform all 7 Clinical Commissiong Groups as they work to reduce the amount of money wasted on unwanted medicines
- Our findings about people's experience of autism services has been used as part of a national report highlighting the challenges that parents and young people with autism are facing

None of this would have been possible without the tireless enthusiasm and determination of our volunteers. We are very lucky to work with some incredible people who are involved in all aspects of our work from invaluable administrative support through to making decisions about our priorities.

This report gives you an insight into our work, but it you are interested in finding out more do please get in touch. We are always looking for people to get involved in any way they can so take a read and give us a call if you want more information.

You can reach us anytime on 0808 801 0102 or email info@healthwatchkent.co.uk

Steve Inett
Chief Executive, Healthwatch Kent

The year at a glance

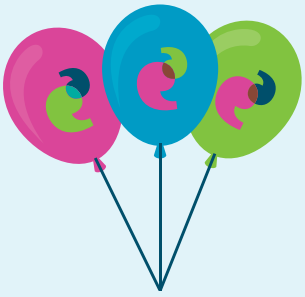
This year we've spoken to 2,467 people through our Helpline

We've spent hundreds of hours visiting community groups and proactively working with groups which are traditionally harder to reach such as Gypsy & Travellers

Our volunteers help us with everything from booking meetings to making decisions about our priorities and resources

We've visited 16 of our local services

We've met hundreds of local people through our work in communities



Our reports have tackled issues ranging from getting a GP appointment through to mental health patients being placed outside of Kent

What we do for you?

We exist to make health and care services work for the people who use them.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

Our role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work. We believe that asking people more about their experiences can identify issues that, if addressed, will make services better.

What do we do for you?

- Give you information about health and social care services.
- Signpost you to the correct place.
- Inform you about your rights as a patient and service user.
- Help you to understand how to make a complaint and what support is available.
- Record your experiences of services.
- Regularly analyse the themes and trends from what people have told us.
- Escalate serious concerns to the right people and follow up on the outcome.
- Respond to enquiries on our Freephone line within two working days.
- Meet as many people face to face as possible, in particular contacting groups who do not contact us by other means. To do this we will visit a different district council area each month and visits priority groups in that district.
- Be open and transparent in how we work.

What do we do for commissioners and providers?

- Work in a spirit of partnership, sharing information, informing you about work we are undertaking and supporting work that improves patient/service user experiences.
- Meet with you quarterly to discuss shared areas of concern and monitor an action plan made up of agreed issues, Healthwatch report recommendations and CQC findings.
- Act as a critical friend for consultations you undertake.

What do we offer our volunteers?

- Be clear about the requirements and expectations of you and be open with you if there are any concerns about how you carry out your role.
- Give you clear roles so you can understand your commitment and what you will achieve.
- Give you training and experience in working in health and social care at a strategic level.
- Reimburse your out of pocket expenses.
- Be appreciative of your time and efforts.

For the voluntary sector we offer:

- Regular monthly information shared with your key contact person, known as a Community Champion.
- Regular encouragement to share the experiences of your clients or members with us.
- A platform to raise the voice of your clients and members.
- Involve you in our public voice programme when we are in your area.
- Involve you in our projects where relevant.

District Councils

- Inform you when we are working in your area.
- Support councillors to share experiences of local residents.
- Keep you updated of the outcomes of our work.

To fulfil our other statutory roles we will:

- Use the outcome of escalations, projects and Enter & View visits to make recommendations to Healthwatch England / Care Quality Commission to conduct special reviews or investigations.
- Use the database designed for the Local Healthwatch network to provide Healthwatch England with the intelligence and insight it needs to enable it to perform effectively at a national level.
- Work with CQC and NHS improvements where there are significant concerns about an organisation.
- Continue to be effective participants of the Kent and local Health & Wellbeing Boards.
- Continue to be effective participants of the Kent Health Overview & Scrutiny Committee and escalate concerns to them.
- Contribute to the Pharmaceutical Needs Assessment and the Joint Strategic Needs Assessment
- Provide feedback on the quality accounts of providers annually.

How do we bring about change?

The answer is simple… By listening

We listen to people through a number of different ways:

- When people contact our Helpline directly
- By proactively visiting communities and groups especially those who are classed as seldom heard and may not share their feedback
- Through our regular Information stands at public places including libraries and hospital foyers
- By using our statutory powers to Enter & View any adult health or social care service and talk to patients and users about their experience
- On board our Healthwatch Big Bus which visited every Kent district in 2016

Through this work we have been able to listen to people from all ages from young to old. We've also heard from people who would be classed as 'seldom heard or vulnerable plus people who may not live within Kent but who use Kent's services.

Here's just a few examples of where we have been this year:

- Mental Health support groups
- Eastern European family liaison group
- Several Travellers sites
- Older People's Groups
- Pensioners Advice & Information Fair
- Rural Libraries
- Kent Physical Disability Forum
- Disability Groups
- BME Ladies' Coffee morning
- Young People's Transition Information Day
- Carers Forums
- Kent Mental Health Festival
- East Mencap Fun Day

What we've learnt from visiting services:

We've learnt so much from talking to people but here are a few snapshots

- Services do not currently work as efficiently or as joined up as they could be
- It's extremely confusing for people about how to complain about services
- If people cannot get an appointment from their GP, they are twice as likely to go to A&E
- Translation services within GP surgeries continues to be an issue
- People who require a complex level of care often stay in hospital much longer than they need to
- People are confused and fearful of changes to services. They want to understand what services will look like in the future
- People don't feel they are being engaged and involved in changes to services
- Autistic patients struggle to get the support they need
- The Children & Adolescent Mental health services continues to be an issue for patients and families

What difference have we made?

In our hospitals: Our trained volunteers have visited hospitals in North and West Kent talking to patients about being discharged. As a result, we have worked with Darent Valley Hospital to develop a new patient leaflet explaining the discharge process. This is currently being piloted with 20,000 patients. We have returned to visit Outpatient departments in East Kent and have seen improvements in waiting times and the way appointments are being handled. All our recommendations have been implemented. We've also visited Outpatients in West & North Kent and heard largely positive feedback. Improvements have been made to signage and the information included in appointment letters as a result of our visits.

In our Care Homes: We have escalated 11 cases of concern for patient safety to the Care Quality Commission and Kent County Council this year. All of our escalations have been investigated and in one instance the care home was prevented from accepting new residents until measures were put in place.

For mental health patients and carers: We've worked closely with our mental health trust to follow up on concerns we heard from patients being placed in beds outside of Kent. We're pleased to report that currently the numbers of patients has dropped significantly. There are currently 5 mental health patients in beds outside of Kent.

The recommendations from our report on the Children & Adolescent Mental Health service have all been included in the new specification for the contract. Our findings from Autistic patients was used as part of a national report by Healthwatch England.

Changes to our services: We monitor and where relevant scrutinise consultations that involve changes to our social care or health services in Kent. Through this work we have identified that organisations often don't engage with patients and service users enough prior to any public consultation. To address this we have created our Best Practice Guide to Pre-consultations to ensure all organisations are fully aware of their responsibilities. We are also setting up two new patient groups to support better engagement around the Sustainability & Transformation Plan (STP) and for Kent County Council.

GP services: We visited 3 GP surgeries in South Kent Coast and highlighted that patients aren't aware of online booking or extended opening times. We have written to all South Kent Coast GP practices to ask them how they plan to promote these services to patients.

Dentists: Following our detailed report into NHS dental services we have made a number of recommendations. We will be working on these with NHS England and the Local Dental Practitioners Network to make the changes. We have also created two new leaflets for the public clarifying issues around dental charges and how to find an NHS dentist.

Information & signposting service

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

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

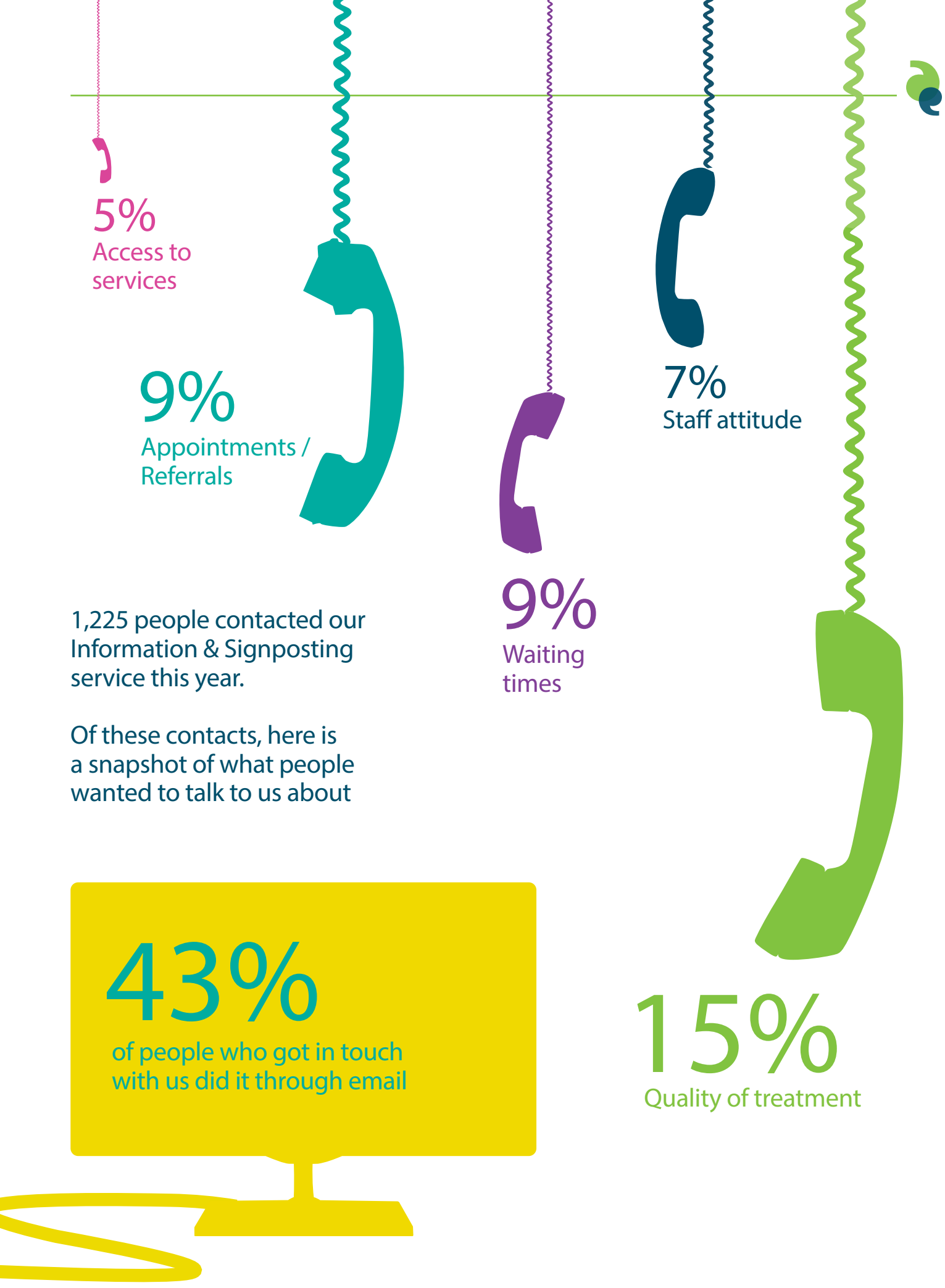
Although we can't give you advice or make specific recommendations, we can help you make an informed decision in finding the right health and social care service whether it is provided by the NHS, the Council, a voluntary or community organisation.

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

Call us for FREE on
0808 801 0102

Calls answered from
10am – 4pm every weekday

Messages welcome anytime and responded to within two working days.
Email us at info@healthwatchkent.co.uk or text 07525 861 639. Text 'Need BSL' for our British Sign Language Interpreter to contact you.



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

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

43%

of people who got in touch with us did it through email

Our Volunteers

Our volunteers are central to everything that we do. They are involved in every level from administration through to decision making.

Here's just a few examples of what our volunteers do for us:

- Hold regular sessions in Kent hospitals talking to patients about their experiences
- Represent Healthwatch at key meetings including all seven local Health & Well Being Boards ensuring that patient voice remains on the agenda
- Work with us to shape the workplan for the Kent Health & Well Being Board
- Visiting services as part of our Enter & View remit to talk to patients about their experiences
- Visiting community and seldom heard groups to understand their experiences of services
- Read, distil and analyse reports and information

Our Steering Group is made up of volunteers

They identify themes and trends for our future work

Together they agree our priorities and projects

They define and shape our project work and allocate resources

Our local Area Teams discuss and examine local issues

They work with local organisations and commissioners

They determine our local activity within each Clinical Commissioning Group area

They are made up entirely of volunteers

The year ahead?

Together with our volunteers, we have identified the following priorities based on what we have heard from the public.

This list is not exhaustive and we will continue to respond to issues brought to our attention during the year.

The Sustainability & Transformation Plan

We will continue to be actively involved in this. We have created and will Chair the new Patient & Public Advisory Group to drive forward better engagement and involvement with the public. We will also exercise our statutory responsibility to act as a critical friend to this process.

Health & Social Care Complaints

This continues to be an issue for people who contact our Helpline. We have recently reviewed organisations' websites in relation to complaints and we are planning a focus group of patients who will work directly with organisations to help them improve their service.

Hospital Discharge

We will be publishing a further report on patients who have a delayed discharge in North Kent.
Our report on Hospital Discharge in West Kent will also be published this year and we will embark on a new project to talk to patients in East Kent about their experiences.

Children & Young Peoples Services

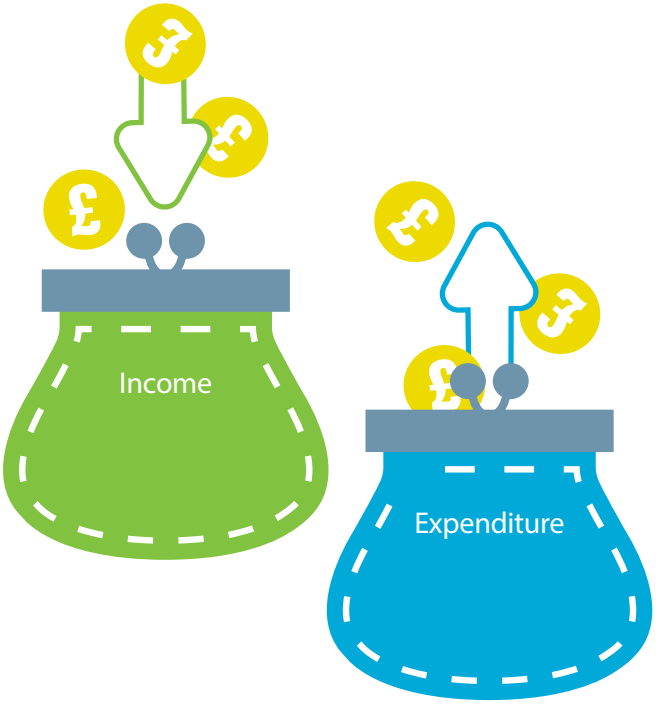
We are a founding member of the new NHS Youth Forum. The forum will ensure that organisations effectively engage with young people but in a co-ordinated and integrated way.

Finances

Table heading showing statement of activities for the year ending 31 March 2017

Income	
Funding recieved through local authority to deliver Healthwatch statutory activities	£666,270
Additional Income	£0
Total income	£666,270

Expenditure	
Operational costs	£240,789
Staffing costs	£327,760
Office costs	£23,805
Volunteer costs, expenses & training	£22,545
Total expenditure	£614,899
Balance brought forward	£51,371

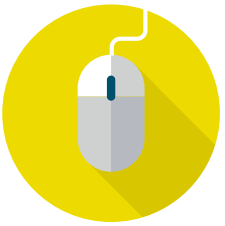


Your comment counts
We want to hear from you

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

By Telephone:
Healthwatch Kent
Freephone 0808 801 01 02

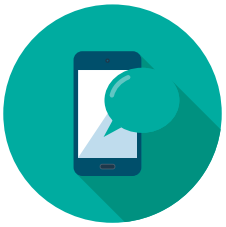
By Email:
Info@healthwatchkent.co.uk



Online:
www.healthwatchkent.co.uk

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

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



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

healthwatch Kent

Healthwatch Kent
Seabrooke House, Church St. Ashford, TN23 1RD
Tel 0808 801 0102
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/hwkent
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From: Peter Oakford – Chairman, Health and Wellbeing Board

To: Health and Wellbeing Board, 20 September 2017

Subject: Kent Health and Wellbeing Board Annual Report 2016-2017

Summary:

This is the annual report for the Kent Health and Wellbeing Board covering the period from April 2016 until March 2017. As a formal committee of Kent County Council the Board is required to provide assurance that it is meeting its statutory responsibilities.

Recommendation:

Members of the Kent Health and Wellbeing Board are asked to:

a) Note the contents of the report

1. Introduction and Current Context

1.1 This is the annual report of the Kent Health and Wellbeing Board (the Board) for 2016/17. Under its terms of reference the Board is required to produce an annual report detailing how it has met its statutory obligations and performed other important functions that fall within its terms of reference. The report is not intended to be a comprehensive review of the Health and Social Care system in Kent but focuses on the work of the Board itself. This report details the activity of the Board during the period **April 2016 to March 2017.**

1.2 During this year the Board was engaged with the Sustainability and Transformation Plan (STP) for Kent and Medway. The STP is a national initiative designed to have a significant impact on the progress of integration and it will influence all aspects of health and social care. It provides the current framework for health and social care policy discussion and has been the focus of leaders across health, public health, and social care for the past year and will continue to be an area of significant interest for the Board.

1.3 The Board will continue to have the same statutory responsibilities that it currently has. The challenge for the Board as it goes forward will be to continue to fulfil its statutory duties and operate meaningfully within a different planning and commissioning environment. It is worth noting that the Board, under its new Chair has decided to review whether it is still fit for purpose in its current form in light of the STP and emerging national policy. A report will be coming to the Board and any proposals for change reported to County Council in due course.

2. The Structure of the Kent Board and its Membership

2.1 The Kent Health and Wellbeing Board is a statutory body established by the Health and Social Care Act 2012 as a formal committee of Kent County Council (KCC), with the intention that it operate as a partnership board. The Kent Board has statutory representation from all the organisations that are responsible for the planning and commissioning of health and social care services in the county, along with Healthwatch. The Act specified a minimum membership that in Kent has been extended to include representatives of district councils, recognising we operate in a two tier authority area where district colleagues are critical partners.

2.2 The Kent Health and Wellbeing Board was chaired for the whole of 2016/17 by KCC Cabinet Member for Education and Health Reform, Roger Gough. It met 6 times between April 2015 and March 2016. A full list of agenda items considered at each meeting can be found at Appendix 1. The Board does not have any dedicated resources and is administered as a Committee of Kent County Council by Democratic Services, a Secretariat of KCC.

3. Substructures

3.1 Over time a number of subgroups have been established to assist the Kent Board for specific purposes. These are:

- Seven Local Health and Wellbeing Boards primarily supported by District Councils.
- The Kent Children's Health and Wellbeing Board that focusses on issues relevant to our children and young people.
- The Kent Health and Social Care Integration Pioneer Group that is responsible for delivering the NHS England Integration Pioneer Programme of which Kent was a founder member.
- The Better Care Fund Assurance Group that monitors the progress of the Better Care Fund plans developed to promote integration.

4. Statutory Responsibilities of the Board

4.1 Under the Health and Social Care Act 2012 the Kent Board has five responsibilities and in 2016/17 has successfully fulfilled its statutory requirements as described below:

A. To ensure that a Joint Strategic Needs Assessment (JSNA) that identifies the health priorities for the population is produced

Kent's JSNA is available here: http://www.kpho.org.uk/joint-strategic-needs-assessment.

4.2 Reports concerning the JSNA were received by the Board:
- Kent JSNA Overview Report for 2016 on 25 May 2016.
- An exception report was considered by the Board on 22 March 2017.

4.3 During the year a working group has been looking at how a "JSNA Plus" can be developed that will include trend analysis, predictive modelling and value

for money tools. This work is being carried forward with the current review of the Joint Health and Wellbeing Strategy.

B. To ensure that a Joint Health and Wellbeing Strategy, based on the Joint Strategic Needs Assessment is produced.

4.4 The strategy was published in 2014 and runs until the end of 2017. It is available here: http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/joint-health-and-wellbeing-strategy

4.5 The Board has continued to oversee the implementation of the strategy which has five outcomes and during 2016/17, the focus was on reporting against specific Outcomes

- Every child has the best start in life- report received 25 January 2017.
- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing- 20 July 2016.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support- 21 September 2016.
- People with mental health issues are supported to 'live well'- 20 July 2016
- People with dementia are assessed and treated earlier, and are supported to live well- 23 November 2016

4.6 On 23rd November 2016 the Board agreed to begin development of the next Joint Health and Wellbeing Strategy. The Board agreed that a strategy steering group would be formed which has met four times since November 2016. Some local engagement work has also taken place with representatives from the Voluntary sector and Healthwatch Volunteers. Work on the new strategy continues into 2017-18.

C. To ensure that the commissioning plans of the CCGs and Kent County Council (social care and public health) properly reflect the needs identified in the Joint Strategic Needs Assessment and the priorities within the Joint Health and Wellbeing Strategy.

4.7 The Health and Wellbeing Board received a report on 22 March 2017 which provided assurance that work carried out by Commissioners reflected the priorities of the current Joint Health and Wellbeing Strategy.

D. To ensure that a Pharmaceutical Needs Assessment is produced.

4.8 The main aim of the Kent Pharmaceutical Needs Assessment (PNA) is to describe the current pharmaceutical services in Kent, systematically identify any gaps/unmet needs and in consultation with stakeholders make recommendations on future development.

4.9 The Board approved the Kent's Pharmaceutical Needs Assessment on 18 March 2015 and it is available here: http://www.kpho.org.uk/health-intelligence/service-provision/pharmacy/pharmaceutical-needs-assessments

E. To promote the integration of health and social care

4.10 Sustainability and Transformation Plan (STP)

The Kent and Medway STP sets out the challenges that the health and social care system is facing. It also describes how New Models of Care are being developed to enable the whole system to be realigned to meet these challenges. The document is available here - http://kentandmedway.nhs.uk/

The Health and Wellbeing Board has been involved in the development of the STP and the Chair of the Board is a member of the Kent and Medway STP Programme Board. The Board has received regular reports on the STP – 25 May 2016, 21 September 2016 (with a special focus on Local Care), and 22 March 2017.

4.11 Better Care Fund (BCF)

The Better Care Fund is a driver for integration as it promotes the pooling of budgets and the development of joint initiatives by health and social care organisations designed to reduce demand for hospital services. In 2015/16 the national allocation for the Kent Better Care Fund was £101m. For 2016/17 this was increased to £105m. The Social Care Capital Grant has ceased and the Disabled Facilities Grant has been increased from £7.2m to £13.1m. While the BCF is a relatively small element of health and social care budgets in Kent, the Board is keen for it to be used efficiently and effectively and it received papers on the BCF on 25 May 2016 and 25 January 2017.

4.12 Pioneer Programme

The national Integrated Care and Support Pioneer Programme was launched in November 2013 to assist selected authorities to progress with their health and social care integration plans at pace and scale. As one of the original Integration Pioneer sites Kent established an Integration Pioneer Group as a sub-group of the Health and Wellbeing Board to coordinate the delivery of the objectives identified in the Kent Pioneer bid. The Integration Pioneer Programme and team continue to support the development of new models of delivery to support the STP.

Further information about the Kent and Medway Integration Care Pioneer can be found here: http://www.kent.gov.uk/about-the-council/strategies-and-policies/health-policies/kent-integration-pioneer

4.13 One Public Estate (OPE)

This programme is designed to facilitate and enable public sector bodies to work collaboratively on property and land matters. The Board considered how the Department of Health's Local Estate Strategy and the requirement to establish local estates forums might fit with wider collaboration and integration of service commissioning. A substantial amount of practical work in different localities has followed on from this and the Board received an update on 21 September 2016.

5 Endorsement, consideration and support

5.1 A number of issues that either have implications for the health and wellbeing of the population or are likely to impact on the health and social care system

have been presented to the Board for their consideration and endorsement. In 2015/16 these have included:

- Kent Environment Strategy – 20 July 2016
- Kent and Medway Crisis Care Concordat Annual Report – 20 July 2016.
- Healthwatch Kent Annual Report – 21 September 2016.
- Kent Safeguarding Children Board 2015/16 Annual Report – 23 November 2016.
- Kent Transformation Plan for Children, Young People and Young Adults' Mental Health and Wellbeing – 23 November 2016.
- Update from the Kent Drug and Alcohol Partnership – 25 January 2017.
- Kent and Medway Safeguarding Adults Board Annual Report 2015/16 – 25 January 2017.

6. Recommendation

Members of the Kent Health and Wellbeing Board are asked to:

i. Note the contents of the report.

Background Papers

Information on the Kent Health and Wellbeing Board, including meeting dates and meeting papers can be found here: https://democracy.kent.gov.uk/mgCommitteeDetails.aspx?ID=790

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Policy and Relationships Adviser (Health)
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Tristan Godfrey
Policy and Relationships Adviser (Health)
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APPENDIX 1

Substantive agenda items taken by the Kent Health and Wellbeing Board in 2016/17

25 May 2016

- Draft Sustainability and Transformation Plans - Presentation
- The Kent Better Care Fund
- Workforce Task and Finish Group - Final Report and Recommendations
- Addressing Obesity: Progress Report from Local Health and Wellbeing Boards
- Abridged Kent Joint Strategic Needs Assessment (JSNA) Overview Report 2016
- Forward work programme of the Board
- Minutes of the 0-25 Health and Wellbeing Board (Standing item)
- Minutes of the Local Health and Wellbeing Boards (Standing item)

20 July 2016

- Kent Environment Strategy
- Kent and Medway Crisis Care Concordat - Annual Report
- Review of Outcome 2 - Prevention of Ill-health

21 September 2016

- Outcome 3 of the Health and Wellbeing Strategy and Development of Out of Hospital Care
- One public estate/local estates update
- Draft Kent Health and Wellbeing Board Annual Report 2015-16
- Healthwatch Kent Annual Report

23 November 2016

- Kent Safeguarding Children Board - 2015/16 Annual Report
- Review of Outcome 5 – Dementia
- Developing a Joint Health and Wellbeing Strategy 2018-21
- Developing the Relationship between the Kent Health and Wellbeing Board and the VCS
- Kent Transformation Plan for Children, Young People and Young Adults' Mental Health and Wellbeing

25 January 2017

- Update from the Kent Drug and Alcohol Partnership
- Better Care Fund 2017/19
- Health and Wellbeing Strategy: Update Outcome 1. Every Child has the Best Start in Life.
- Update report on the Children's Integrated Commissioning Project

- Kent and Medway Safeguarding Adults Board – Annual Report 2015/16

22 March 2017

- Draft Joint Kent Health and Wellbeing Strategy 2018-23.
- Kent Health and Wellbeing Board Review of Commissioning Plans and STP Update.
- Kent Joint Strategic Needs Assessment Exception Report 2016/17.

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Kent Integration and Better Care Fund Plan 2017 – 2019

Owner: The Kent Health and Wellbeing Board

Date: 11 September 2017

Version No: 1

Contents

1. Introduction

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). The Kent plan for 2016/17 built on these early developments to support the implementation of the Kent and Medway Sustainability and Transformation plans (STP) and ensure a fully integrated system by 2020.

The plan for 2017–19 is to support delivery of the STP and the Local Care Model through the identified schemes and supported by existing governance arrangements. It identifies the roadmap to move forward with the ambition for existing schemes to be fully integrated by 2019.

"*The Kent and Medway health and care system is seeking to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting. More than that, the system will transform services to deliver proactive care, and ensure that support is focused on improving and promoting health and wellbeing, rather than care and support that is solely reactive to ill health and disease Core to the model is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and where appropriate the independent sector to deliver the right care, in the right place, at the right time*." Kent and Medway STP October 2016

(http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/20161021-Kent-and-Medway-STP-draft-as-submitted-ii.pdf)

This plan has been confirmed and agreed by:

Peter Oakford, Chairman Kent Health and Wellbeing Board

Anu Singh, Corporate Director Adult Social Care

Patricia Davies, Accountable Officer Dartford Gravesham Swanley / Swale CCGs

Hazel Carpenter, Accountable Officer Thanet / South Kent Coast CCGs

Simon Perks, Accountable Officer Ashford / Canterbury CCGs

Ian Ayres, Accountable Officer, West Kent CCG

2. The Kent Vision for Integrated Care

The Kent vision is clearly outlined in the draft STP and the Better Care Fund plan is seen as a key driver in delivering the model of Local Care. This is a collective commitment to fundamentally transform how and where we will support people to keep well and live well.

We will help people to understand that hospitals aren't always the best place to receive care. Clinical evidence shows us that many people, particularly frail older people, are often better cared for closer to home. The model will build a vibrant social, voluntary and community sector to support people to look after their health and wellbeing, connect with others, manage their long-term conditions and stay independent. We have initially focused on the development of Local Care for frail older people with complex needs using an example service user 'Dorothy' to bring the model to life:

Dorothy will no longer need to repeat her story over and over again to different professionals – key workers will help to co-ordinate care and support and ensure that her wishes and goals are at the heart of her care and wellbeing planning - She will have one number to call when she needs help, advice or support. She will be safe in her home free from harm and hazards. If she needs to see a specialist/expert wherever possible this will be done close to home. If she needs help urgently she'll be able to access 'rapid response' at home via a skilled professional who understands Dorothy's case and can assess her needs to get her the right support. This will help to stabilise the situation and hopefully avoid Dorothy going to hospital If she does need to go into hospital, Dorothy will be supported to get home as quickly as possible with the appropriate support so she will recover faster Dorothy will be supported to stay independent in her own home for as long as possible.

This model of care will be delivered through a designated Multi-Disciplinary Team (MDT) which will bring together staff from the health, social care, and voluntary sectors. - We will create and expand new roles in care coordination and care provision, including multi-skilled 'Generic Health and Social Care Workers', and advanced multi-skilled practitioner roles. These new roles will help to fuse health and social care duties and competencies, help to address recruitment and retention challenges and create exciting new career opportunities.

Over time, this model will help to support primary care resilience such that GPs will be better supported to care for their local communities. We also will see a reduction in pressure on large acute hospitals, helping us to provide effective and sustainable hospitals services into the future.

2.1 The Kent Context and Case for Change

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.

The Kent and Medway Case for Change states:
"*We all want health and social care services that can meet our needs now and in the future. The NHS in Kent and Medway, Kent County Council and Medway Council do their best to offer safe, compassionate and high-quality care. However, we face new challenges that mean we need to change the way we work to improve care and get better value for the money we have available. As our population grows, and more people live with long-term conditions, the demands on our services are changing and increasing. Services are not necessarily designed for todays or future needs, and it is becoming harder to keep up with rising costs. What's more we aren't making the most of opportunities to improve health and wellbeing, prevent illness and support people to manage existing conditions and stay independent*."
(http://kentandmedway.nhs.uk/wp-content/uploads/2017/04/Kent-Medway-Case-for-Change-UPDATED-APRIL-17.pdf)

Kent is also part of the National Integrated Care Pioneer programme: a partnership between the 7 CCGs, Adult Social Care, Kent Community Health Foundation Trust, Kent and Medway Partnership Trust for Mental Health, Hospital Trusts in Kent and district councils. The partnership also includes the independent and voluntary sector and Healthwatch. The aim of the Integrated Care Pioneer programme is to make Health and Social Care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

This is supported by the development of The Design and Learning Centre for Clinical and Social Innovation which is focused on working to reduce frailty, develop safe new services and transform the health and social care workforce by promoting independence and self-care. The centre provides the opportunity to innovate together and work as a network rather than in isolation. The Design and Learning Centre ultimately sets out to facilitate new ways of working by co-designing and evaluating sustainable solutions to meet the changing needs of a growing population.

3. Progress to date

The Local Care model for older people with complex needs is built around eight core components:

- **Care planning and navigation** – People will be supported to develop a personalised care and wellbeing plan. Dedicated professionals from a variety of health and social care backgrounds will co-ordinate the care and support from the rest of the MDT and the wider health, social care and voluntary sector.
- **Supporting people to improve their health and wellbeing** – Supporting people and carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention / engagement.
- **Healthy living environment** – Ensuring a healthy living environment to preserve long-term health & wellbeing (e.g. falls prevention, housing improvements and alterations).
- **Integrated health and social care multi-disciplinary team** – Providing person-centred, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have personalised care plans based on their needs.
- **Single point of access** – A number called by the person, the GP, community services and acute staff, or indeed any other professional, to support people with their care by gaining more efficient, coordinated access to services.
- **Rapid response** – The ability within an MDT to respond rapidly to people with complex needs who are experiencing urgent health or social care needs that left unattended would result in a hospital admission.
- **Discharge planning and reablement** – A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating and to support their recovery.
- **Access to expert opinion and timely access to diagnostics** – The ability for primary care professionals to access a specialist opinion in the community setting.

Significant progress has been made to date in delivering not only the aims of Local Care but the objectives of previous Better Care Fund plans, this includes:

- A multispecialty community provider (MCP) vanguard called “Encompass” has been developed to serve a population of approximately 170,000 people across Whitstable, Faversham, Canterbury, Ash and Sandwich. This consists of a federation of 16 GP practices working in partnership with all sections of the health and care system, including voluntary sector and patient groups.

- In Thanet, a Primary Care Home has been established to start building an integrated, Accountable Care Organisation (ACO) to improve care for frail older people and reduce demand. An integrated nursing team has been established to provide an enhanced frailty pathway and an acute response team has been created to provide a range of treatment and personal care support to keep people out of hospital.

- An integrated commissioning team has been established jointly by Dartford, Gravesham and Swanley, with Kent County Council for Children, this includes joint governance arrangements and full time posts.

- Ashford is piloting integration of Intermediate Care, provided by the Kent Community Health Foundation Trust (KCHFT), and Enablement, provided by Kent County Council (KCC). Through this pilot, it is becoming clear that reviewing cases jointly is very helpful in achieving better outcomes for the users of the service. It is also clear that there is duplication and that a more efficient use of skills and staff time can be achieved. The plan is to roll this out initially to East Kent first and then to the whole of Kent.

- Case Managers in Thanet and South Kent Coast are attending monthly MDTs in GP practices to manage risk and jointly agree pro-active management of people's needs.

- An integrated rehabilitation service is currently being co-developed by KCC, KCHFT and Virgin Care as part of the current phase of Transformation. This will be community based to respond to people in their own homes and support hospital discharge for those who require rehabilitation and enablement. This will be linked to the Discharge to Assess "home first" models across the county. In previous phases of transformation KCC have worked with hospitals to get people back to their own homes following a hospital discharge, using the ethos "Own home is best bed". KCC are part of integrated discharge teams in all hospitals in Kent, where Health and Social care are working together to get people back to their own homes. This has enabled the health and social care system to co-produce Discharge to Assess and Home First models to support people to leave hospital in a timely manner. KCC senior support for new model of care, with a multi-disciplinary discharge team, is based on Esther and Buurtzorg models.

- An alliance agreement in Learning Disability between 7 CCGs and KCC for integrated provision.

- An integrated mental health service covers secondary care health and social care. Also CCG commissioned mental health primary care that is integrated with KCC social care, Live Well Kent strategic partners.

- A Kent and Medway Transforming Care Board – currently developing integrated commissioning for the Transforming Care programme.

4. Evidence base and local priorities to support plan for integration

The Better Care Fund plan continues to be aligned to improving the following outcomes identified within the Health and Wellbeing Strategy:

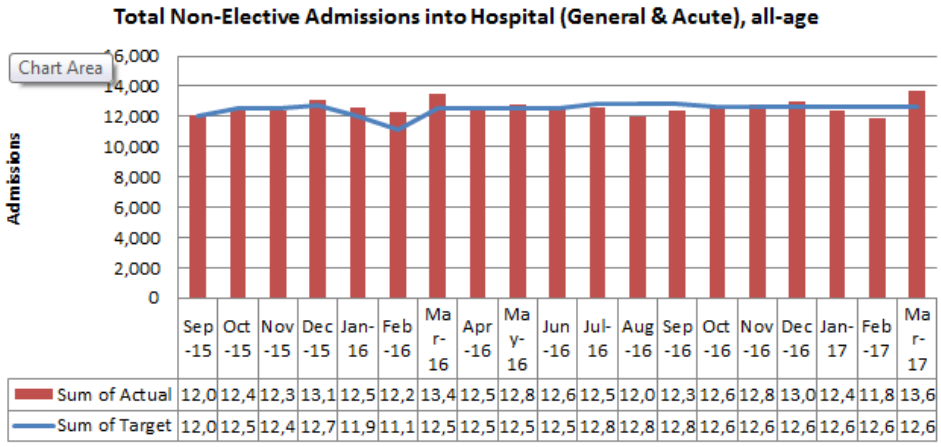
- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
- People with mental ill health issues are supported to live well.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

It is also a key driver in the ambition outlined in the Kent and Medway STP, to put local people at the heart of services, helping people to stay well and independent in their own homes and communities and avoid being admitted to hospital. It sets out how we want to:

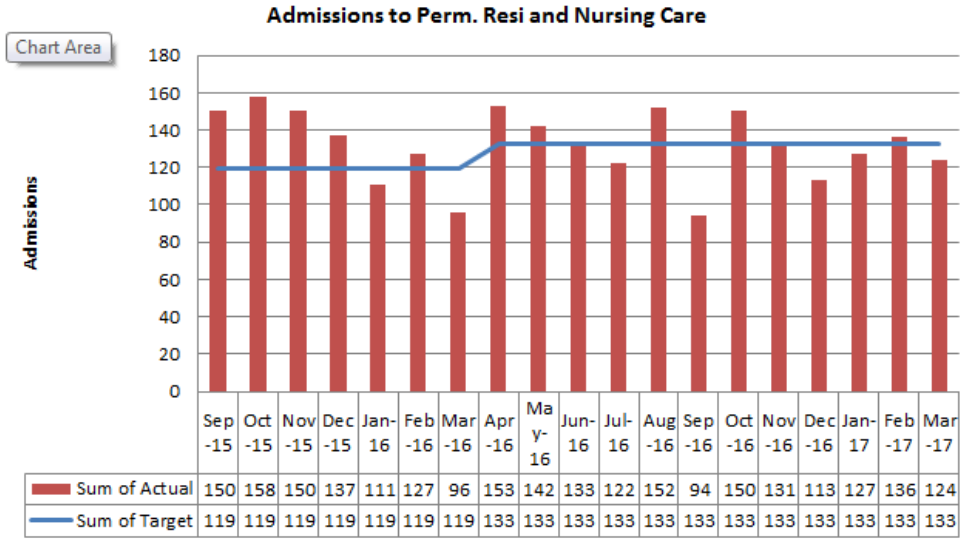
- improve the health and wellbeing of local people
- deliver high-quality, joined-up health and social care
- offer access to the right care and support in the right place, at the right time
- make sure NHS and social care staff are not under so much pressure that they can't deliver the caring ethos of the NHS and social care
- better meet people's needs within the funding we have available
- build health and care services that are sustainable for years to come.

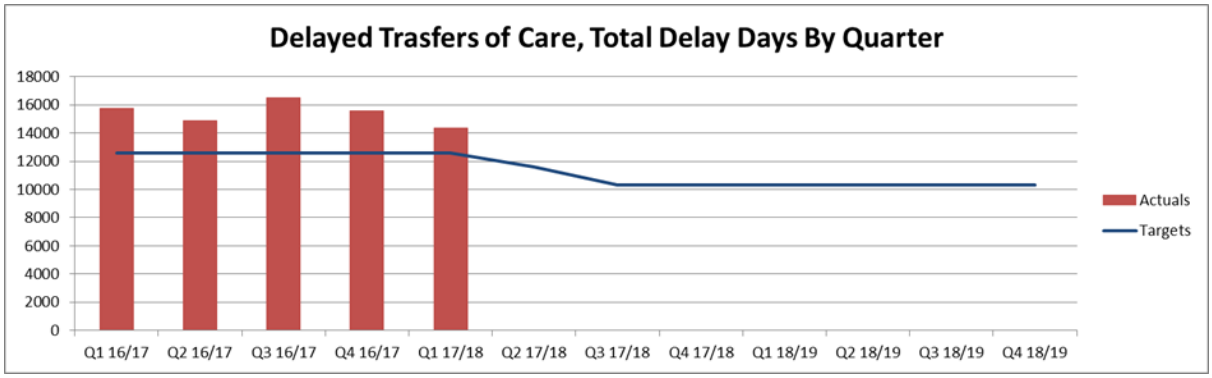
In 2016 Kent County Council published Your Life Your Wellbeing, which details the vision for Adult Social Care over the next 5 years. This is supported by a transformation programme aligned to the priorities in the STP and delivering elements of the Better Care Fund plan.

As part of the development for the 2017-19 BCF a review took place of existing schemes and their outcomes. This identified how schemes currently contribute to the national conditions, but also the Local Care Model.



	Sep -15	Oct -15	Nov -15	Dec -15	Jan-16	Feb -16	Mar-16	Apr -16	May-16	Jun -16	Jul-16	Aug -16	Sep -16	Oct -16	Nov -16	Dec -16	Jan-17	Feb -17	Mar-17
Sum of Actual	12,0	12,4	12,3	13,1	12,5	12,2	13,4	12,5	12,8	12,6	12,5	12,0	12,3	12,6	12,8	13,0	12,4	11,8	13,6
Sum of Target	12,0	12,5	12,4	12,7	11,9	11,1	12,5	12,5	12,5	12,5	12,8	12,8	12,8	12,6	12,6	12,6	12,6	12,6	12,6





This review has been used to inform the roadmap outlined in the plan and identify the key priority areas across Kent that align with local delivery:

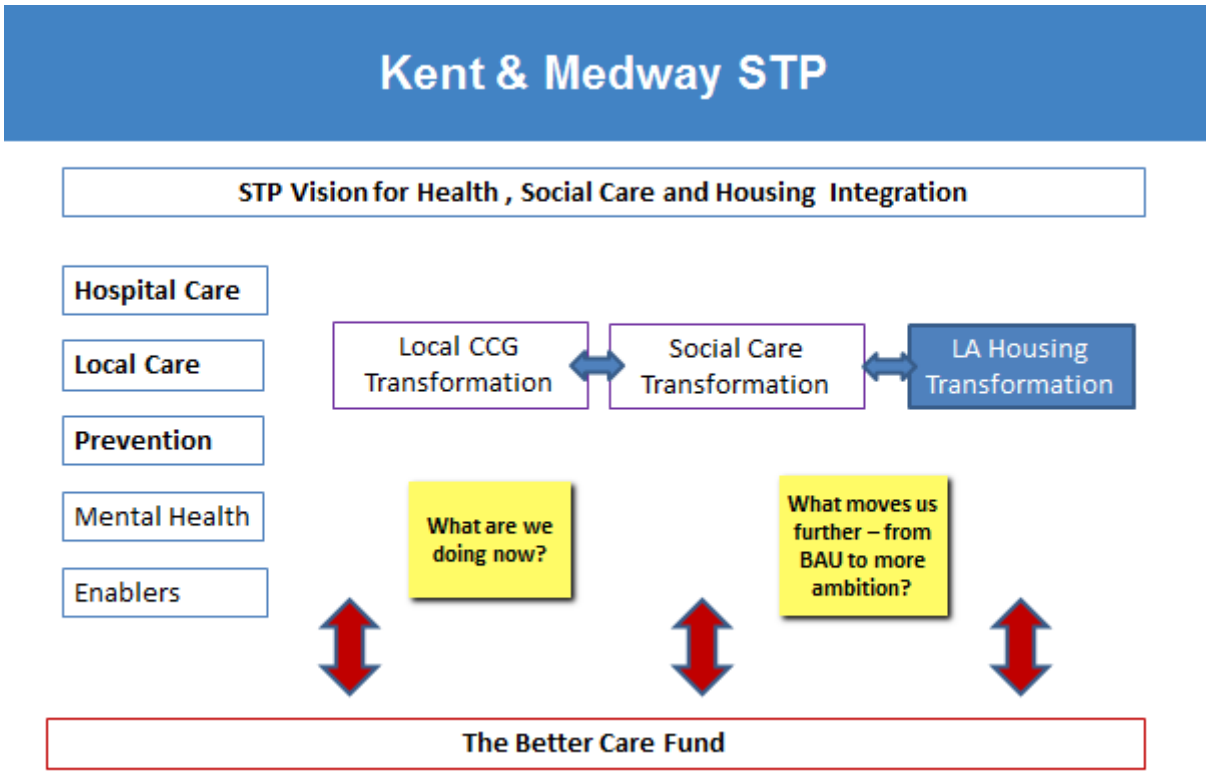
- Care Navigation
- Integrated Discharge Teams
- Discharge to Assess
- Joint Commissioning
- ICES
- Rapid Response / Reablement
- Intermediate Care Beds
- Carers Break
- Mental Health aftercare (Section 117)

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

- Joining up schemes and approaches across the STP footprint.
- The advantages of having a more integrated approach to commissioning and delivery. The road map identifies further opportunities to integrate functions to the benefit of both health and social care
- Development of the Care Navigation role to support people with non-medical needs and supporting integration with their communities.

5. The Better Care Fund plan

The Health and Wellbeing Board in January 2017 agreed the ambition of developing a BCF roadmap that supports delivery of the STP through ensuring alignment of key issues across Kent whilst supporting local delivery.



In broad terms the plans and how each of these areas will contribute to the required national conditions is outlined below. (The detail of spend for these schemes is in the attached planning template.)

The plan includes the aim to take existing areas of integrated work – such as ICES and intermediate care beds to incorporate them in to the BCF by 2019. Additional areas such as joint commissioning will not be delivered in 2017/18 but are ambitions for 2019, with the work required to design how these schemes will operate beginning now.

2017 – 2019 Schemes	**National conditions supported by the scheme**
Care Navigator	• NHS commissioned out of hospital services
IDT (hospital teams)	• Managing Transfers of Care
Discharge to Access	• Managing Transfers of Care
Joint Commissioning	• Plans jointly agreed
Integrated Community Equipment Service	• NHS commissioned out of hospital services

2017 – 2019 Schemes	National conditions supported by the scheme
Rapid Response / Reablement	• NHS commissioned out of hospital services
Intermediate Care Beds	• NHS commissioned out of hospital services
Carers Break (rolled from 16/17)	
OP Mental Health aftercare (Section 117)	• Managing Transfers of Care
Maintenance of Social Care	• Maintain provision of social care services
Disabled Facilities Grant	• NHS commissioned out of hospital services
Implementation of the Care Act	• Maintain provision of social care services
Carers support	• NHS commissioned out of hospital services
Delayed Transfers of Care – action plan	• NHS commissioned out of hospital services • Managing Transfers of Care

Further details of these schemes have been developed at a local level within scheme templates which outline strategic objectives, deliverables, linked metrics and risks and issues. For example within Care Navigation the objectives are:

To develop a joint Health and Social Care Navigation service based on learning from existing service of care navigation

- To develop a range of community based wellbeing services that will prevent or delay entry into formal health and social care systems by promoting individual wellbeing.
- To provide an easily accessible resource that both health and social care triage points can refer to.
- To refer people into community based resources.

With the outcomes of:

- Positive Patient Experience
- Increase in Patient Wellbeing
- Equity of Service
- Improved Integration of Community Services
- Reduction in Non-Elective Admissions in cohort

The partners in Kent have agreed that the additional social care funding will be used in line with the guidance issued:

- Sustainability of social care
- Market sustainability
- High Impact Changes in relation to Delayed Transfers of Care.

Use of the iBCF (across OP, LD, MH, PD) to improve social care market sustainability in care homes and community support includes wrap around support to care homes, leadership support, addressing shortfalls in the workforce, increasing capacity, identifying priority areas if risk of exiting the market and collectively working to improve quality across all client groups and access to loan equipment to support hospital discharge. It will also include investment in homecare and improving terms and conditions for the workforce and ensuring increases in wages direct to the worker. Alongside investment in other community support activity and voluntary sector support.

Money has also been agreed for training for the whole social care sector to target service gap and increased care home leadership training capacity facilitating discharges and follow up support for Home First, increasing flow.

The Disabled Facilities Grant is an important part of the BCF with the need to achieve improved independence, hospital discharge and the link with STP Local Care models such as community hubs. Joint Chief Executives agreed in March 2016 to a county wide review, resulting in recommendations for a transformation of the delivery of DFGs. The scope of the review was initially to work towards a more integrated model that could be implemented from 2018/19.

Further work is to take place in 2017/18 to develop this integrated model, but it has been agreed that the following can be included:

- DFGs
- Minor & Major Adaptations
- Handy Persons Schemes
- Hospital Discharge Schemes/support
- Telecare (assisted technology)
- Housing Assistance – low level inspection & referrals for repairs, heating and energy efficiency measures
- Advice Information & Support for accessing services outside the scope of the MDT/Hub

6. Risk

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.

Significant work has taken place across the development of the STP to ensure local transformation programmes align, therefore minimising risk to delivery. This includes the design and implementation of Your Life Your Wellbeing Phase 3 of Transformation for Adult Social Care. Understanding of the impacts of risk has been a key part of developing the 2017-19 BCF plan and is included in the planning templates used to inform this document.

The BCF Strategic Leads Group will have responsibility for monitoring risk and escalating issues as required to the Health and Wellbeing Board. However local level programmes will monitor, maintain and manage their own risks. Some key risks identified in the delivery plan are:

Risk	**Mitigating Actions**
Individual organisational timescales and pressures making system wider transformation difficult.	• Work collaboratively through the local governance and partnership arrangements.
Workforce issues with recruitment across all sectors	• Liaison with education providers required to support longer term delivery of workforce. • Integration of health and social care teams and use of technology to improve pathways and process releasing capacity.
Current national issues with availability of domiciliary care and reductions in the social care budgets.	• Additional social care funding and planning work with providers to create domiciliary care capacity. • New delivery models of domiciliary care explored (outcome based care) • Joint working with providers on workforce management.
<u>Integrated Community Equipment:</u> Failure to deliver equipment within the requested timescale may delay discharge or necessitate hospital admission or care placement unnecessarily. Failure to collect equipment in a timely manner may lead to clients and/or carers/families disposing of equipment therefore necessitating the purchase of replacement equipment. Failure to repair or service equipment within the scheduled frequency may put the user and/or carer at risk of injury.	• CCG reviews the performance indicators on a monthly basis as part of the contract and performance meetings, the quality of these indicators is scrutinised and wider system impact evaluated. • Kent wide operational and equipment review groups are in place to ensure patient pathways remain seamless and delays are reduced/addressed where necessary. • Good engagement with our partner organisations and senior provider leads which support areas of mitigation where appropriate.
<u>Care Navigation:</u> Lack of practice engagement leading to lower use of service Lack of consistency and equity across practices	• Concerted effort to ensure good understanding at co-design and planning phases, communication and engagement plan in place • Encourage GPs to be involved in developing the mode

7. National Conditions

7.1 National condition 1: jointly agreed plan

In January 2017 the Health and Wellbeing Board agreed the approach to developing the 2017-19 Better Care Fund plan. This included the creation of a BCF Strategic Leads Group to develop the plan and monitor its implementation.

The signatories to this Better Care Fund plan have agreed the approach outlined and further work has also taken place with Joint Chief Executives (as outlined in Section 6) on agreement for the Disabled Facilities Grant.

The partners in Kent have agreed that the additional social care funding will be used in line with the guidance issued:
- Sustainability of social care
- Market sustainability
- High Impact Changes in relation to Delayed Transfers of Care.

Kent County Council has consulted with NHS and other partners in relation to the iBCF proposals meeting with the Accountable Officers of the CCGs, all the Kent and Medway A&E Delivery and Improvement Boards (as requested by the CCGs) and these include NHS providers, the Kent Health and Wellbeing Board, social care provider forums and internal KCC member and officer committees.

7.2 National condition 2: social care maintenance

Significant work to transform social care services has taken place and work continues to deliver the Your Life Your Wellbeing strategy and implement the vision for Adult Social Care. This supports delivery of the Local Care Model within the STP and contributes significantly to the roadmap of increased integration by 2019.

Extensive work with the social care market has happened and KCC is issuing a new interim contract co-produced with providers as the first stage of market sustainability, moving in the next stage to a more Outcome Based Support contract. It is expected that this will improve the professionalisation of the workforce and increase recruitment and retention rates. Whilst addressed as two separate areas, both are linked and interdependent as, for instance, an effective Home Care service allows people to leave hospital quicker and safely.

£29.2m 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; £4.7m toward the provision of domiciliary care, £8.2m toward residential provision, £5.6m toward Enablement Services and £2.6m toward provision of Direct Payments to support service user's social care needs.

7.3 National condition 3: NHS commissioned out-of-hospital services

The BCF is designed to support the implementation of the Local Care Model Toolkit, with significant investment in out of hospital services. Full details of this can be found in CCG Operational Plans and the STP.

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

7.4 National Condition 4: Managing Transfers of Care

The High Impact Change model for managing transfers of care is being implemented as follows:

Early Discharge Planning: additional staffing to support social care activity in all hospitals at the front door for admission avoidance/integrated urgent care models and other staffing.

Systems to monitor Patient Flow: this will provide an integrated dashboard for monitoring activity and delays; it will also support a more effective panel process speeding up authorisations.

Integrated Discharge Team: additional staffing to support the Integrated Discharge Team pathway and OT Physio Support. All Acute Trusts have the intention to develop Integrated Discharge Teams and staff who will support the Home First pathways, but they are not all in place yet. This project will fully staff all the elements of the pathways and will make the IDTs and HF more effective across older people and adult mental health .

Home First/ Discharge to Assess / Trusted Assessors: additional investment in pathway, service commissioning to integrate the wider workforce, additional recruitment for enablement, Kent Recovery Service MH, technicians for adaptations and equipment across the sector. Home First is key to improving DTOC; this investment will provide a big increase in the HF capacity. It will also improve the follow up capacity of the enablement service and access to technicians for adaptations and equipment.

Seven Day Service: a single point of access to develop in line with Integrated Discharge Team/Home First pathways and additional professional mental health workers for the AMHP service.

Focus on Choice: working with Live Well Kent and KERS to do early engagement and link with individual in crisis to support them through admission and return home this should improve discharge to home rates for MH service users.

Improved integrated working with fewer discharges blocked through Choice issues.

Enhancing Health In Care Homes: increasing professional support (OT, Pharmacy) to care homes, reducing admissions from care homes and quicker

discharges. Additional dementia stepdown beds to improve flow for people with dementia and adult mental health.

8. Overview of funding contributions

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Kent	£14,387,024	£15,645,644
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Ashford	£775,304	£842,979
Canterbury	£1,017,727	£1,101,325
Dartford	£513,627	£558,301
Dover	£1,113,133	£1,203,366
Gravesham	£882,691	£961,866
Maidstone	£1,131,348	£1,230,870
Sevenoaks	£976,757	£1,064,336
Shepway	£1,138,882	£1,229,558
Swale	£2,182,185	£2,382,555
Thanet	£2,568,686	£2,794,932
Tonbridge and Malling	£1,007,235	£1,097,910
Tunbridge Wells	£1,079,451	£1,177,645
Total Minimum LA Contribution exc iBCF	**£14,387,024**	**£15,645,644**

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution	**£14,387,024**	**£15,645,644**

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Kent	£26,392,010	£35,018,901
Total iBCF Contribution	**£26,392,010**	**£35,018,901**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Ashford CCG	£7,324,821	£7,463,993
NHS Canterbury and Coastal CCG	£12,861,063	£13,105,423
NHS Dartford, Gravesham and Swanley CCG	£15,566,069	£15,861,824
NHS South Kent Coast CCG	£13,451,140	£13,706,711
NHS Swale CCG	£6,936,651	£7,068,448
NHS Thanet CCG	£9,810,694	£9,997,097

NHS West Kent CCG	£27,870,714	£28,400,258
Total Minimum CCG Contribution	**£93,821,153**	**£95,603,755**

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Swale CCG	£59,700	£59,700
NHS Dartford, Gravesham and Swanley CCG	£25,000	£25,000
Total Additional CCG Contribution	**£84,700**	**£84,700**

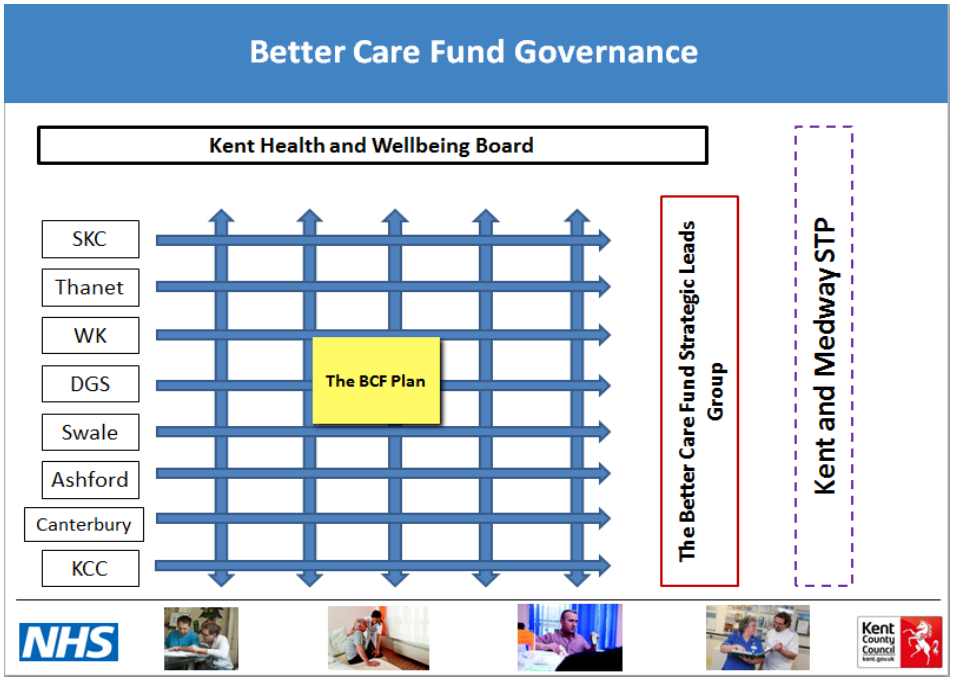
	2017/18	2018/19
Total BCF pooled budget	**£134,684,888**	**£146,353,000**

9. Programme Governance

The planning template identifies the detailed areas of spend for the Kent 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.

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.

To support the Board it was agreed to establish a new group of BCF Strategic Leads, comprising representatives from all CCGs and KCC. This group will meet bi-monthly to monitor delivery and implementation of the road map for 2019. This group will be supported by local implementation arrangements and existing STP governance.



10. National Metrics

Non Elective Admissions

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 17/18**	**Total 18/19**
HWB Non-Elective Admission Plan* Totals	**40,002**	**40,400**	**40,793**	**39,768**	**39,241**	**39,629**	**40,043**	**39,036**	**160,962**	**157,950**

Residential Admissions

The overall residential figure is reducing; the plan is to sustain this throughout 17/18 and 18/19.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	594.8	519.8	510.2	500.2
	Numerator	1,786	1,595	1,595	1,595
	Denominator	300,274	306,850	312,626	318,873

Reablement

Performance will begin to see the impact of Discharge to Assess programmes therefore the aim is to maintain the target at 85.9%. Note: The performance of this indicator is measured once a year, for people discharged within a specific 3 month period – this is as per the statutory return guidance. This means we will only be able to refresh the 16/17 position after March 2018.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	83.4%	85.9%	85.9%	85.9%
	Numerator	1,354	1,351	1,351	1,351
	Denominator	1,624	1,573	1,573	1,573

Delayed Transfers of Care

For this indicator we have replicated the national expectation target from the Department of Health that we are aiming to reach as of September 2017, with a plan to continue the performance into the last quarter of 17/18 and throughout 18/19.

		16-17 Actuals				17-18 plans				18-19 plans			
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	1304.4	1231.7	1368.1	1279.7	1179.7	952.7	848.9	841.3	841.3	841.3	841.3	834.1
	Numerator (total)	15,739	14,862	16,508	15,591	14,373	11,607	10,342	10,342	10,342	10,342	10,342	10,342
	Denominator	1,206,598	1,206,598	1,206,598	1,218,316	1,218,316	1,218,316	1,218,316	1,229,352	1,229,352	1,229,352	1,229,352	1,239,886

11. Delayed transfers of care (DTOC) plan

The DTOC plan is coordinated by the Health and Wellbeing Board and has Home First work streams in each of the four Health Economies across Kent (West, East, North and Swale). Partnership working takes place through the A&E Delivery Boards and associated work streams, working to the A&E improvement plans, linking with the developing STP in particular Hospital Care and Local Care. This includes Adult Social Care presenting High Impact areas at the A&E delivery boards to be considered alongside the A&E five priorities.

Examples within the action plan include:

- KCC hospital teams identify people who are not yet ready for discharge and track their treatment whilst in the Acute setting to support timely social care engagement at the point of medical optimisation. In most cases this is as part of an integrated discharge team.

- All Integrated Discharge Teams have voluntary sector presence and link to the community services.

- Home First and Discharge to Assess models are being developed across Kent supported by Governance linked to the A&E Delivery Boards. Adult Social care has aligned the Home First model with the Your Life Your Wellbeing Transformation Programme.

- MDTs, task and finish groups, health workshops e.g. Home First, Frailty Model, Stroke Services are attended by health and social care.

- Appropriate use of care navigators, telecare and the Esther and Buurtzorg models. Care Navigators are on site in the majority of the Acute Hospitals and active members of the IDT teams.

- Appropriate social care involvement in rapid improvement events, perfect discharge weeks, and locality work such as ART, Vanguard.

- KCC have invested in performance capacity to develop a social care urgent care dashboard approved by A&E delivery boards and submitted to form part of integrated dashboards.

- KCC work with transforming care in development of SHREWD capability for social care, which is used across Kent as an operational tool.

- KCC are part of the SE ADASS DTOC reporting framework.

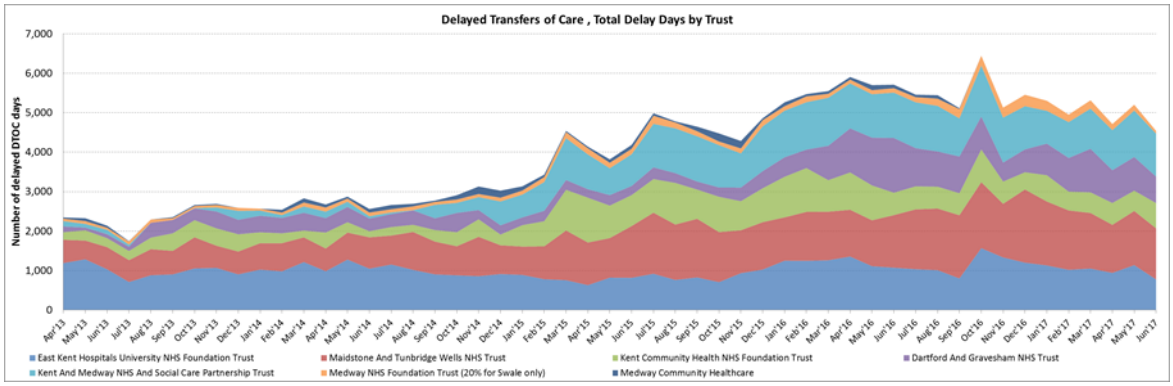
- KCC have a senior manager with responsibility for urgent care, supported by a county service manager operational lead. Transfers of Care are monitored daily and there is an escalation process in place. Where DTOC pressures occur there is a commissioning escalation process in place to resolve delays. As part of the iBCF reporting each hospital team leader has a DTOC target in terms of bed days and DTOC numbers.

- A Trusted Assessor Model is in place across social care where by Case Officers and Case Managers have been trained as community equipment assessors and assisted digital technology.

- KCC along with health partners are signed up to the wider trusted assessor role and will progress this as part of Home First when the tool kit / further guidance is issued. In East Kent and North Kent work has commenced with ECIP to start this.

- There are 4 integrated care centres across Kent. These units support admission avoidance and discharges from hospital and are included in the BCF plan for 17-19.

Recent data shows some improvement in DTOC, with local plans and targets being set to meet the national targets set for delayed transfers of care and sustain these in the second part of 17/18 and throughout 18/19. The development of an integrated urgent care dashboard will support the ability to measure impact of the action plan.



12. Kent Better Care Fund Plan Sign Off

The Kent Health and Wellbeing Board discussed the Better Care Fund Plan on 14 June 2017 and due to timescales delegated responsibility for formal sign off to the Chairman.

However the Kent Better Care Fund Plan will go before the Kent Health and Wellbeing Board on 20 September 2017, in addition to electronic circulation.

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Planning Template v.14.6b for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: Guidance

Overview

This template is to be read and used in conjunction with the BCF Policy Framework document and the BCF Planning Requirements document which provides the background and further details on the planning requirements for 2017-2019.

The purpose of this template is to collect the BCF planning information for each HWB which includes confirmation of National Conditions, specific funding requirements, scheme level financial information and planning metrics for the period 2017-2019.

This template should also be aligned to the BCF narrative plan documents for the BCF schemes being planned for 2017-2019 by the HWB.

Note on entering information into this template

1. Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:
Yellow: Data needs inputting in the cell
Blue: Pre-populated cell
2. All cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000
3. This template captures data for two years 2017-19

Data needs inputting in the cell

Pre-populated cell

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to tab)

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before submission for plan-assurance.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference (hyperlinked) for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

Summary (click to go to tab)

1. This sheet summarises the key planning information provided on the template to be used for review and plan-assurance.
2. Print guidance: By default this sheet has been set up to print across 4 pages, landscape mode and A4.

1. Cover (click to go to tab)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Please enter the following information on this sheet:
- Several area assurance contact roles have been pre-populated for you to fill in, please enter the name of that contact and their email address for use in resolving any queries regarding the return;
- Please add any further area contacts that you would wish to be included in official correspondence. Please include their job title, and their email address.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all 5 cells are green should the template be sent to england.bettercaresupport@nhs.net

2. HWB Funding Sources (click to go to tab)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2017-19. It will be pre-populated with the minimum CCG contributions to the BCF, the DFG allocations and the iBCF allocations. These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.

2. This sheet captures the various funding sources that contribute to the total BCF pool for the Local Area. The DFG, iBCF and CCG minimum funding streams are pre-populated and do not need re-entering.
Please enter the following information on this sheet:
- Additional contributions from Local Authorities or CCGs: as applicable are to be entered on this tab on the appropriate sections highlighted in "yellow".
- Additional Local Authority contributions: Please detail any additional Local Authority funding contributions by selecting the relevant authorities within the HWB and then entering the values of the contributions. Please use the comment boxes alongside to add any specific detail around this additional contribution.
- Additional CCG contributions: Please detail any additional CCG funding contributions by selecting the relevant CCGs. Please note, only contributions assigned to a CCG will be included in the 'Total Additional CCG Contribution' figure.
- Funding contributions narrative: Please enter any comments in the "Funding Contributions Narrative" field to offer any information that could be useful to further clarify or elaborate on the funding sources allocations entered including any assumptions that may have been made.
- Specific funding requirements: This section requests confirmation on the specific funding requirements for 2017-19. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for further details. These are mandatory conditions and will need to be confirmed through the planning assurance process. Please select "Yes" where the funding requirement can be confirmed as having been met, or "No" to indicate that the requirement is unconfirmed. Where "No" is selected as the status, please provide further detail in the comments box alongside to indicate the actions being taken or considered towards confirming the requirement.

3. HWB Expenditure Plan (click to go to tab)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to demonstrate how the national policy framework is being achieved.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme. In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this tab please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple lines.

2. Scheme Name:
- This is a free field. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.

4. Area of Spend:
- Please select the area of spend from the drop down list by considering the area of the health and social system which is most supported by investing in the scheme.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.

5. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme to the provider. If there is a single commissioner please select the option from the drop down list.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.

6. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list.
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines.

8. Scheme Duration:
- Please select the timeframe for which the scheme is planned for from the drop down list: whether 2017-18, 2018-19 or Both Years.

9. Expenditure (£) 2017-19:
- Please enter the planned spend for the scheme (Based on the duration of the scheme, please enter this information for 2017-18, 2018-19 or both)

This is the only detailed information on BCF schemes being collected centrally for 2017-19 but it is expected that detailed plans and narrative plans will continue to be developed locally and this information will be consistent across them.

4. HWB Metrics (click to go to tab)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2017-19. The BCF requires plans to be set for 4 nationally defined metrics.
This should build on planned and actual performance on these metrics in 2016-17.

1. Non-Elective Admissions (NEA) metric planning:

• The NEA plan totals are pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2017-19. This is to align with the wider CCG Ops planning for this metric
• If the BCF schemes are aiming for additional NEA reductions which are not already built into the CCG Operating Plan numbers for NEAs, please select “Yes” to the question “Are you planning on additional quarterly reductions”. This will make the cells in the table below editable. Please enter the additional quarterly planned NEA reductions for 2017-19 in these cells.
• Where an additional reduction in NEA activity is planned for through the BCF schemes, an option is provided to set out an associated NEA performance related contingency reserve arrangement (this is described in the Planning Requirements document). When opting to include this arrangement, please select “Yes” on the NEA cost question. This will enable any adjustments to be made to the NEA cost assumptions (just below) which are used to calculate the contingency reserve fund. Please add a reason for any adjustments made to the cost of NEA
• Further information on planning further reductions in Non-Elective Activity and associated contingency reserve arrangements is set out within the BCF Planning Requirements document.

2. Residential Admissions (RES) planning:

• This section requires inputting the information for the numerator of the measure.
• Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
• The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS 2014 based subnational population projections.
• The annual rate is then calculated and populated based on the entered information.
• Please add a commentary in the column alongside to provide any useful information in relation to how you have agreed this figure.

3. Reablement (REA) planning:

• This section requires inputting the information for the numerator and denominator of the measure.
• Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
• Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
• The annual proportion (%) Reablement measure will then be calculated and populated based on this information.
• Please add a commentary in the column alongside to provide any useful information in relation to how you have agreed this figure.

4. Delayed Transfers of Care (DToC) planning:

• Please refer to the BCF Planning Requirements 17/19 when completing this section.
• This section captures the planned Delayed Transfers Of Care (delayed days) metric for 2017/19
• Please input the delayed days figure for each quarter.
• The total delayed days and the quarterly rate is then calculated based on this entered information
• The denominator figure in row 95 is pre-populated (population - aged 18+, 2014 based SNPP). This figure is utilised to calculate the quarterly rate.
• Please add a commentary in the column alongside to provide any supporting or explanatory information in relation to how this metric has been planned.

5. National Conditions (click to go to tab)

This sheet requires the Health & Wellbeing Board to confirm whether the national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2017-19. Please refer to the BCF Policy Framework and BCF Planning Requirements docments for 2017-19 where the BCF national conditions are set out in full. Please answer as at the time of completion.
On this tab please enter the following information:

1. Confirmation status for 2017/18 and 2018/19:
For each national condition please use the 2017/18 column to select ‘Yes’ or ‘No’ to indicate whether there is a clear plan set out to meet the condition for 2017/18 and again for 2018/19. Selecting ‘Yes’ confirms meeting the National Condition for the Health and Well Being board as per the BCF Policy Framework and Planning Requirements for 17/19

2. Where the confirmation selected is ‘No’, please use the comments box alongside to indicate when it is expected that the condition will be met / agreed if it is not being currently. Please detail in the comments box issues and/or actions that are being taken to meet the condition, when it is expected that the condition will be met and any other supporting information.

CCG - HWB Mapping (click to go to tab)

The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity plans.

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Planning Template v.14.6b for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: Checklist

<< Link to the Guidance tab

Complete Template

1. Cover

	Cell Reference	Checker
Health and Well Being Board	C10	Yes
Completed by:	C13	Yes
E-mail:	C15	Yes
Contact number:	C17	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19	Yes
Area Assurance Contact Details	C22 : G31	Yes

Sheet Completed:	Yes

2. HWB Funding Sources

	Cell Reference	Checker
Are any additional LA Contributions being made on 2017/18? If yes please detail below	C35	Yes
Are any additional LA Contributions being made on 2018/19? If yes please detail below	D35	Yes
Local authority additional contribution:	B38 : B40	Yes
Gross Contribution (2017/18)	C41	Yes
Gross Contribution (2018/19)	D41	Yes
Comments (if required)	F38	N/A
Are any additional CCG Contributions being made on 2017/18? If yes please detail below;	C62	Yes
Are any additional CCG Contributions being made on 2018/19? If yes please detail below;	D62	Yes
Additional CCG Contribution:	B65	Yes
Gross Contribution (2017/18)	C65	Yes
Gross Contribution (2018/19)	D65	Yes
Comments (if required)	F65	N/A
Funding Sources Narrative	B83	N/A
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority? (2017/18)	C91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? (2017/18)	C93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? (2017/18)	C94	Yes
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? (2017/18)	C95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? (2017/18)	C96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? (2017/18)	C97	Yes
6. Is the iBCF grant included in the pooled BCF fund? (2017/18)	C98	Yes
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority? (2018/19)	D91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? (2018/19)	D93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? (2018/19)	D94	Yes
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? (2018/19)	D95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? (2018/19)	D96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? (2018/19)	D97	Yes
6. Is the iBCF grant included in the pooled BCF fund? (2018/19)	D98	Yes
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority? Comments	E91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? Comments	E93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? Comments	E94	Yes
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? Comments	E95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	E96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	E97	Yes
6. Is the iBCF grant included in the pooled BCF fund? Comments	E98	Yes

Sheet Completed:	Yes

3. HWB Expenditure Plan

	Cell Reference	Checker
Scheme ID	B18 : B267	Yes
Scheme Name	C18 : C267	Yes
Scheme Type (see table below for descriptions)	D18 : D267	Yes
Sub Types	E18 : E267	Yes
Please specify if 'Scheme Type' or 'Sub Type' is 'other'	F18 : F267	Yes
Area of Spend	G18 : G267	Yes
Please specify if 'Area of Spend' is 'other'	H18 : H267	Yes
Commissioner	I18 : I267	Yes
if Joint Commissioner % NHS	J18 : J267	Yes
if Joint Commissioner % LA	K18 : K267	Yes
Provider	L18 : L267	Yes
Source of Funding	M18 : M267	Yes
Scheme Duration	N18 : N267	Yes
2017/18 Expenditure (£000's)	O18 : O267	Yes
2018/19 Expenditure (£000's)	P18 : P267	Yes
New or Existing Scheme	Q18 : Q267	Yes

Sheet Completed:	Yes

4. HWB Metrics

	Cell Reference	Checker
4.1 - Are you planning on any additional quarterly reductions?	E18	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q1 (2017/18)	F20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q2 (2017/18)	G20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q3 (2017/18)	H20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q4 (2017/18)	I20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q1 (2018/19)	J20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q2 (2018/19)	K20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q3 (2018/19)	L20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q4 (2018/19)	M20	Yes
4.1 - Are you putting in place a local contingency fund agreement on NEA?	E24	Yes
4.1 - Cost of NEA (2017/18)	E30	Yes
4.1 - Cost of NEA (2018/19)	E31	Yes
4.1 - Comments (2017/18) (if required)	F30	N/A
4.1 - Comments (2018/19) (if required)	F31	N/A
4.2 - Residential Admissions : Numerator : Planned 17/18	H48	Yes
4.2 - Residential Admissions : Numerator : Planned 18/19	I48	Yes
4.2 - Comments (if required)	J47	N/A
4.3 - Reablement : Numerator : Planned 17/18	H57	Yes
4.3 - Reablement : Denominator : Planned 17/18	H58	Yes
4.3 - Reablement : Numerator : Planned 18/19	I57	Yes
4.3 - Reablement : Denominator : Planned 18/19	I58	Yes
4.3 - Comments (if required)	J56	N/A
4.4 - Delayed Transfers of Care : Planned Q1 17/18	I65	Yes
4.4 - Delayed Transfers of Care : Planned Q2 17/18	J65	Yes
4.4 - Delayed Transfers of Care : Planned Q3 17/18	K65	Yes
4.4 - Delayed Transfers of Care : Planned Q4 17/18	L65	Yes
4.4 - Delayed Transfers of Care : Planned Q1 18/19	M65	Yes
4.4 - Delayed Transfers of Care : Planned Q2 18/19	N65	Yes
4.4 - Delayed Transfers of Care : Planned Q3 18/19	O65	Yes
4.4 - Delayed Transfers of Care : Planned Q4 18/19	P65	Yes
4.4 - Comments (if required)	Q64	N/A

Sheet Completed:	Yes

5. National Conditions

	Cell Reference	Checker
1) Plans to be jointly agreed (2017/18)	C14	Yes
2) NHS contribution to adult social care is maintained in line with inflation (2017/18)	C15	Yes
3) Agreement to invest in NHS commissioned out of hospital services (2017/18)	C16	Yes
4) Managing transfers of care	C17	Yes
1) Plans to be jointly agreed (2018/19)	D14	Yes
2) NHS contribution to adult social care is maintained in line with inflation (2018/19)	D15	Yes
3) Agreement to invest in NHS commissioned out of hospital services (2018/19)	D16	Yes
4) Managing transfers of care	D17	Yes
1) Plans to be jointly agreed, Comments	E14	Yes
2) NHS contribution to adult social care is maintained in line with inflation, Comments	E15	Yes
3) Agreement to invest in NHS commissioned out of hospital services, Comments	E16	Yes
4) Managing transfers of care	E17	Yes

Sheet Completed:	Yes

Planning Template v.14.6b for BCF: due on 11/09/2017

Summary of Health and Well-Being Board 2017-19 Planning Template

Being Board:

Kent

Data Submission Period:

2017-19

Summary

<< Link to the Guidance tab

2. HWB Funding Sources

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution exc iBCF	£14,387,024	£15,645,644
Total iBCF Contribution	£26,392,010	£35,018,901
Total Minimum CCG Contribution	£93,821,153	£95,603,755
Total Additional CCG Contribution	£84,700	£84,700
Total BCF pooled budget	**£134,684,888**	**£146,353,000**

Specific Funding Requirements for 2017-19	2017/18 Response	2018/19 Response
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes
2. In areas with two tiers of local government:		
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?	No	No
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.	Yes	Yes
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes

3. HWB Expenditure Plan

Summary of BCF Expenditure (*)	2017/18 Expenditure	2018/19 Expenditure
Acute	£1,871,425	£1,906,648
Mental Health	£385,000	£392,000
Community Health	£35,704,976	£36,415,738
Continuing Care	£9,127,000	£9,300,475
Primary Care	£8,773,041	£8,938,431
Social Care	£74,465,445	£84,989,708
Other	£4,358,000	£4,410,000
Total	**£134,684,887**	**£146,353,000**

Summary of BCF Expenditure from Minimum CCG Contribution (***)	2017/18 Expenditure	2018/19 Expenditure
Acute	£1,871,425	£1,906,648
Mental Health	£385,000	£392,000
Community Health	£35,704,976	£36,415,738
Continuing Care	£9,127,000	£9,300,475
Primary Care	£8,688,341	£8,853,731
Social Care	£33,686,411	£34,325,163
Other	£4,358,000	£4,410,000
Total	**£93,821,153**	**£95,603,755**

→

Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool (**)	2017/18 Expenditure	2018/19 Expenditure
Mental Health	£385,000	£392,000
Community Health	£35,223,976	£35,925,738
Continuing Care	£9,127,000	£9,300,475
Primary Care	£8,688,341	£8,853,731
Social Care	£821,511	£837,163
Other	£4,358,000	£4,410,000
Total	**£58,603,828**	**£59,719,107**
NHS Commissioned OOH Ringfence	£26,661,311	£27,167,876

Additional NEA Reduction linked Contingency Fund	2017/18 Fund	2018/19 Fund
NEA metric linked contingency fund held from the ringfenced local allocation for NHS OOH spend	£0	£0

BCF Expenditure on Social Care from Minimum CCG Contribution	2016/17	2017/18	2018/19	
Minimum Mandated Expenditure on Social Care from the CCG minimum		£33,524,537	£34,161,503	
Planned Social Care expenditure from the CCG minimum	£32,935,000	£33,686,411	£34,325,163	
Annual % Uplift Planned		**2.3%**	**1.9%**	*Below minimum mandated uplift*
Minimum mandated uplift % (Based on inflation)		**1.79%**	**1.90%**	

4. HWB Metrics

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
Total HWB Planned Non-Elective Admissions	40,002	40,400	40,793	39,768	39,241	39,629	40,043	39,036	**160,962**	**157,950**
HWB Quarterly Additional Reduction Figure	0	0	0	0	0	0	0	0	**0**	**0**
HWB NEA Plan (after reduction)	40,002	40,400	40,793	39,768	39,241	39,629	40,043	39,036	**160,962**	**157,950**
Additional NEA reduction delivered through the BCF									**£0**	**£0**

4.2 Residential Admissions

		Planned 17/18	Planned 18/19
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	**Annual rate**	510	500

4.3 Reablement

		Planned 17/18	Planned 18/19
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	85.9%	85.9%

4.4 Delayed Transfers of Care

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	**Quarterly rate**	1,180	953	849	841	841	841	841	834

5. National Conditions

National Conditions For The BCF 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?
1) Plans to be jointly agreed	Yes	Yes
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes
4) Managing transfers of care	Yes	Yes

Footnotes

* **Summary of BCF Expenditure** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:
Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

** **Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool** is the sum of the amounts allocated to the 6 individual out of hospital 'areas of spend' that have been provided in tab 4. HWB Expenditure Plan, where;
Area of Spend = Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other (everything other than Acute)
Commissioner = CCG, NHS England or Joint (if joint we use the NHS% of the value)
Source of Funding = CCG Minimum Contribution

***Summary of BCF Expenditure from Minimum CCG contribution** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' form the minimum CCG contribution that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:
Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other
Source of Funding = CCG Minimum Contribution

Planning Template v.14.6b for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: 1. Cover Sheet

<< Link to the Guidance tab

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Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.

Health and Well Being Board	**Kent**
Completed by:	Jayne Urwin
E-Mail:	jayne.urwin@kent.gov.uk
Contact Number:	03000 416792
Who signed off the report on behalf of the Health and Well Being Board:	Mr. Peter Oakford

	Role:	Title and Name:	E-mail:
Area Assurance Contact Details*	Health and Wellbeing Board Chair	Mr. Peter Oakford - MEM	Peter.Oakford@kent.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Mr. Ian Aryes	i.ayres@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Mrs. Patricia Davies Mrs. Hazel Carpenter Mr. Simon Perks Mr. Ian Ayres	Patricia.Davies1@nhs.net hazelcarpenter@nhs.net simon.perks@nhs.net i.ayres@nhs.net
	Local Authority Chief Executive	Paul Carter	Paul.Carter-
	Local Authority Director of Adult Social Services (or equivalent)	Anu Singh	Anu.Singh@kent.gov.uk
	Better Care Fund Lead Official	Anne Tidmarsh	Anne.Tidmarsh@kent.gov.uk
	LA Section 151 officer	Mr. Andy Wood	Any.Wood@kent.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->			

***Only those identified will be addressed in official correspondence**

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete Template

	No. of questions answered
1. Cover	**6**
2. HWB Funding Sources	**31**
3. HWB Expenditure Plan	**16**
4. HWB Metrics	**31**
5. National Conditions	**12**

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Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 2. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Kent

Data Submission Period:

2017-19

2. HWB Funding Sources

<< Link to the Guidance tab

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Kent	£14,387,024	£15,645,644
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Ashford	£775,304	£842,979
Canterbury	£1,017,727	£1,101,325
Dartford	£513,627	£558,301
Dover	£1,113,133	£1,203,366
Gravesham	£882,691	£961,866
Maidstone	£1,131,348	£1,230,870
Sevenoaks	£976,757	£1,064,336
Shepway	£1,138,882	£1,229,558
Swale	£2,182,185	£2,382,555
Thanet	£2,568,686	£2,794,932
Tonbridge and Malling	£1,007,235	£1,097,910
Tunbridge Wells	£1,079,451	£1,177,645
Total Minimum LA Contribution exc iBCF	**£14,387,024**	**£15,645,644**

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution	**£14,387,024**	**£15,645,644**

Comments - please use this box clarify any specific uses or sources of funding

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Kent	£26,392,010	£35,018,901
Total iBCF Contribution	**£26,392,010**	**£35,018,901**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Ashford CCG	£7,324,821	£7,463,993
NHS Canterbury and Coastal CCG	£12,861,063	£13,105,423
NHS Dartford, Gravesham and Swanley CCG	£15,566,069	£15,861,824
NHS South Kent Coast CCG	£13,451,140	£13,706,711
NHS Swale CCG	£6,936,651	£7,068,448
NHS Thanet CCG	£9,810,694	£9,997,097
NHS West Kent CCG	£27,870,714	£28,400,258
Total Minimum CCG Contribution	**£93,821,153**	**£95,603,755**

Are any additional CCG Contributions being made in 2017/18 or 2018/19? If yes please detail below	Yes	Yes

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Swale CCG	£59,700	£59,700	Care Navigator
NHS Dartford, Gravesham and Swanley CCG	£25,000	£25,000	Care Navigator
Total Additional CCG Contribution	**£84,700**	**£84,700**	

	2017/18	2018/19
Total BCF pooled budget	**£134,684,888**	**£146,353,000**

Funding Contributions Narrative
Funding Contributions have been agreed by all partners

Specific funding requirements for 2017-19	Response	Response	If the selected response for either year is 'No', please detail in the comments box
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes	
2. In areas with two tiers of local government:			
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?	No	No	Additional adaptations to homes made by the Local Authority
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.	Yes	Yes	
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes	
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes	
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes	
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes	

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 3. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Kent

Data Submission Period:
2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£33,686,411	£34,325,163
Ringfenced NHS Commissioned OOH spend	£58,603,828	£59,719,107

Expenditure

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
1	Integrated Community Equipment Service (SKC)	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Community Health		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,177,000	£1,200,000	Existing
2	CHC integrated commissioning (SKC)	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Continuing Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£5,827,000	£5,938,000	New
3	Care Navigator/Age UK (SKC)	2. Care navigation / coordination	1. Care coordination		Primary Care		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£50,000	£51,000	New
4	Integrated long term conditions management MDT primary care teams (SKC)	12. Personalised healthcare at home	3. Other	Mental and Physical Health/Wellbeing	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£387,000	£394,000	Existing
5	Discharge to assess (SKC)	9. High Impact Change Model for Managing Transfer of Care	4. Home First/Discharge to Access		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£453,000	£462,000	Existing
6	Integrated Discharge Team (hospital teams) (SKC)	9. High Impact Change Model for Managing Transfer of Care	4. Home First/Discharge to Access		Acute		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£226,000	£230,000	Existing
7	Rapid Response - Pneumonia (SKC)	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£387,000	£394,000	New
8	Carers Support (SKC)	3. Carers services	1. Carer advice and support		Community Health		Local Authority			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£481,000	£490,000	Existing
9	BCF Hosting (SKC)	7. Enablers for integration	3. Programme management		Other	Programme Support	CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£7,000	£7,000	Existing
1	Integrated Community Equipment Service (THA)	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Community Health		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£822,000	£839,000	Existing
2	CHC integrated commissioning (THA)	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Continuing Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,275,000	£2,318,000	New
3	Care Navigator - Enhanced Frailty (THA)	2. Care navigation / coordination	1. Care coordination		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19			New
7	Rapid Response - Pneumonia (THA)	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£458,000	£467,755	New
7	Rapid Response - ART (THA)	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£273,000	£278,000	New
5	Discharge to assess (THA)	9. High Impact Change Model for Managing Transfer of Care	4. Home First/Discharge to Access		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£320,000	£326,000	Existing
6	Intergrated Discharge Team (hospital teams) (THA)	9. High Impact Change Model for Managing Transfer of Care	4. Home First/Discharge to Access		Acute		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£160,000	£163,000	Existing

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Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£33,686,411	£34,325,163
Ringfenced NHS Commissioned OOH spend	£58,603,828	£59,719,107

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10	Intermediate Care Beds - Westbrook House (THA)	11. Intermediate care services	2. Step up		Community Health		CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,161,000	£2,202,000	New
8	Carers Support (THA)	3. Carers services	1. Carer advice and support		Community Health		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£325,253	£331,000	Existing
9	BCF Hosting (THA)	7. Enablers for integration	3. Programme management		Other	Programme Support	CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£5,000	£5,000	Existing
4	Integrated Primary Care Teams (DGS)	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£3,848,000	£3,921,112	Existing
7	Crisis & Rapid Response Service (DGS)	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,229,000	£1,252,275	Existing
11	Support to Primary Care (DGS)	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,249,000	£1,272,731	Existing
8	Carers Breaks (DGS)	3. Carers services	1. Carer advice and support		Social Care		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£462,000	£470,778	Existing
12	End of Life Care (DGS)	14. Residential placements	6. Other	Hospice	Continuing Care		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,025,000	£1,044,475	Existing
1	Integrated Community Equipment Service (DGS)	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Community Health		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,469,000	£1,496,911	New
6	Integrated Discharge Team (DGS)	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Acute		CCG			NHS Acute Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£722,000	£735,718	Existing
3	Care Navigator (DGS)	2. Care navigation / coordination	1. Care coordination		Primary Care		CCG			Charity / Voluntary Sector	Additional CCG Contribution	Both 2017/18 and 2018/19	£25,000	£25,000	New
9	BCF Hosting (DGS)	7. Enablers for integration	3. Programme management		Other	Programme Support	CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£8,000	£8,000	Existing
3	Care Navigator (C&C)	2. Care navigation / coordination	1. Care coordination		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£3,128,000	£3,188,000	Existing
4	Integrated Primary Care Team (SWA)	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,753,341	£2,805,888	Existing
6	Integrated Discharge Team (SWA)	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Acute		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£763,425	£777,930	Existing
8	Carers Breaks (SWA)	3. Carers services	1. Carer advice and support		Social Care		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£256,511	£261,385	Existing
1	Integrated Community Equipment Service (SWA)	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Community Health		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£740,723	£754,797	New
3	Care Navigator (SWA)	2. Care navigation / coordination	1. Care coordination		Primary Care		CCG			Charity / Voluntary Sector	Additional CCG Contribution	Both 2017/18 and 2018/19	£59,700	£59,700	New
9	BCF Hosting (SWA)	7. Enablers for integration	3. Programme management		Other	Programme Support	CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£4,000	£4,000	Existing

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13	Care Act Implementation (KCC)	3. Carers services	2. Implementation of Care Act		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£3,608,000	£3,677,000	Existing
1	Integrated Community Equipment Service (KCC)	9. High Impact Change Model for Managing Transfer of Care	2. Other - Physical health / wellbeing		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£936,000	£954,000	New
14	District Facilities Grant	4. DFG - Adaptations			Social Care		Local Authority			Local Authority	Local Authority Contribution	Both 2017/18 and 2018/19	£14,387,024	£15,645,644	Existing
15	New Primary Care - Intermediate Care (WK)	10. Integrated care planning	2. Integrated care packages		Community Health		CCG			NHS Acute Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,588,000	£2,637,000	Existing
16	New Primary Care - Reablement Schemes (Physiotherapy) (WK)	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,037,000	£1,057,000	Existing
17	New Primary Care - Reablement Schemes (OT) (WK)	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£985,000	£1,004,000	Existing
18	New Primary Care - Reablement Schemes (Community Liaison) (WK)	10. Integrated care planning	2. Integrated care packages		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£377,000	£384,000	Existing

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1	Integrated Community Equipment Service (WK)	7. Enablers for integration	11. Other	Equipment	Community Health		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,574,000	£1,604,000	Existing
1	Integrated Community Equipment Service (WK)	7. Enablers for integration	11. Other	Equipment	Community Health		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£351,000	£358,000	Existing
19	New Primary Care - Health and Social Care Coordinators (WK)	10. Integrated care planning	2. Integrated care packages		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£542,000	£552,000	Existing
20	Self and Informal Care - Carer Funding (WK)	3. Carers services	1. Carer advice and support		Mental Health		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£385,000	£392,000	Existing
21	Self and Informal Care - End of Life Care (WK)	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,451,000	£1,479,000	Existing
22	Self and Informal Care - Elderly Care (WK)	3. Carers services	1. Carer advice and support		Social Care		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£103,000	£105,000	Existing
23	System Enablers - Information Systems (WK)	7. Enablers for integration	2. System IT Interoperability		Primary Care		CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£788,000	£803,000	Existing
9	BCF Hosting (WK)	7. Enablers for integration	3. Programme management		Other	Programme Support	CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£15,000	£15,000	Existing
24	New Primary Care - Community Hospitals (WK)	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£7,395,000	£7,535,000	Existing
25	Domiciliary Services (support for Social Care) (KCC)	6. Domiciliary care at home	1. Dom care packages		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£4,723,200	£4,812,000	Existing
26	Direct Payments (support for Social Care) (KCC)	6. Domiciliary care at home	3. Other	Direct Payments	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,610,000	£2,659,000	Existing
27	Enablement (support for Social Care) (KCC)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£5,600,400	£5,706,000	Existing
28	Residential Services (support for Social Care) (KCC)	14. Residential placements	4. Care home		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£8,180,300	£8,336,000	Existing
29	Nursing Services (support for Social Care) (KCC)	14. Residential placements	5. Nursing home		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£5,568,100	£5,674,000	Existing
30	24/7 Extended Working (KCC)	9. High Impact Change Model for Managing Transfer of Care	5. Seven-Day Services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,638,900	£1,670,000	Existing
3	Care Navigator (ASH)	2. Care navigation / coordination	1. Care coordination		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,635,000	£1,717,000	Existing
31	Home First (ASH)	9. High Impact Change Model for Managing Transfer of Care	4. Home First/Discharge to Access		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£602,000	£602,000	Existing
32	Frailty (ASH)	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Other	Covers Community Health and Primary Care	CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,558,000	£1,558,000	Existing
33	Integration (ASH)	2. Care navigation / coordination	1. Care coordination		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£541,000	£541,000	Existing

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34	Carers (ASH)	3. Carers services	1. Carer advice and support		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£303,000	£309,000	Existing
9	BCF Hosting (ASH)	7. Enablers for integration	3. Programme management		Other	Programme Support	CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£4,000	£4,000	Existing
35	HIC 1 - Early Discharge Planning (KCC)	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£308,000	£450,000	New
36	HIC 2 - Systems to Monitor Patient Flow (KCC)	9. High Impact Change Model for Managing Transfer of Care	2. Systems to Monitor Patient Flow		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£27,500	£10,000	New
37	HIC 3 - Multi-Disciplinary/Multi-Agency Discharge Teams (KCC)	9. High Impact Change Model for Managing Transfer of Care	3. Multi-Disciplinary/Multi-Agency Discharge		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£270,000	£360,000	New
38	HIC 4 - Home First/Discharge to Access (KCC)	9. High Impact Change Model for Managing Transfer of Care	4. Home First/Discharge to Access		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£6,296,136	£4,320,400	New
39	HIC 5 - Seven-Day Services (KCC)	9. High Impact Change Model for Managing Transfer of Care	5. Seven-Day Services		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£155,850	£207,800	New

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40	HIC 8 - Enhancing Health in Care Homes (KCC)	9. High Impact Change Model for Managing Transfer of Care	8. Enhancing Health in Care Homes		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£981,400	£1,295,200	New
41	Demography (KCC)	6. Domiciliary care at home	1. Dom care packages		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£1,000,000	£437,000	New
42	Integrated Commissioning (KCC)	7. Enablers for integration	10. Joint commissioning infrastructure		Social Care		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£2,000,000		New
43	Sustainability - Community (KCC)	6. Domiciliary care at home	3. Other	Various schemes to assure sustainability	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£8,751,009	£5,232,426	New
44	Sustainability - General (KCC)	16. Other		In-house development of complex need / provider	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£380,833	£510,700	New
45	Sustainability - Homes (KCC)	14. Residential placements	6. Other	Infrastructure support	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£1,195,051	£2,607,231	New
31	Home First (C&C)	9. High Impact Change Model for Managing Transfer of Care	4. Home First/Discharge to Access		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,253,000	£1,277,000	Existing
46	Meeting Future Demand and Cost Pressures of Adult Social Care (KCC)	16. Other		Meeting Future Demand and Cost Pressures of Adult Social	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£301,231	£17,525,144	New
32	Frailty (C&C)	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Other	Covers Community Health and Primary Care	CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,750,000	£2,802,000	Existing
33	Integration (C&C)	2. Care navigation / coordination	1. Care coordination		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£798,000	£813,000	Existing
34	Carers (C&C)	3. Carers services	1. Carer advice and support		Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£462,000	£471,000	Existing
9	BCF Hosting (C&C)	7. Enablers for integration	3. Programme management		Other	Programme Support	CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£7,000	£7,000	Existing
47	Demography (KCC)	14. Residential placements	2. Learning disability		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£1,400,000	£611,000	New
48	Demography (KCC)	16. Other		Equipment	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£500,000	£218,000	New
49	Demography (KCC)	14. Residential placements	4. Care home		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£500,000	£218,000	New
50	Demography (KCC)	14. Residential placements	5. Nursing home		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£500,000	£218,000	New
51	Demography (KCC)	14. Residential placements	1. Supported living		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£900,000	£393,000	New
52	Demography (KCC)	16. Other		Mental health	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£700,000	£306,000	New
53	Demography (KCC)	16. Other		Transforming Care	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£225,000	£99,000	New

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Link back to the top of the sheet >>

Scheme Type	Description	Sub type
1. Assistive Technologies	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	1. Telecare 2. Wellness services 3. Digital participation services 4. Other
2. Care navigation / coordination	A service to help people find their way to appropriate services and support and thus also support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. This is often as part of a multi-agency team which can be on line or use face to face care navigators for frail elderly, or dementia navigators etc. . This includes approaches like Single Point of Access (SPoA) and linking people to community assets.	1. Care coordination 2. Single Point of Access 3. Other
3. Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	1. Carer advice and support 2. Implementation of Care Act 3. Respite services 4. Other
4. DFG - Adaptations	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	
5. DFG - Other Housing	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
6. Domiciliary care at home	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	1. Dom care packages 2. Dom care workforce development 3. Other
7. Enablers for integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commisisioning infrastructure includes any personnel or teams that enable joint commissioning.	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Other
8. Healthcare services to Care Homes	Improve the availability and quality of primary and community health services delivered to care home residents. Support the Care Home workers to improve the delivery of non-essential healthcare skills. This includes provider led interventions in care homes and commissioning activities eg. joint commissioning/quality assurance for residential and nursing homes.	1. Other - Mental health / wellbeing 2. Other - Physical health / wellbeing 3. Other
9. High Impact Change Model for Managing Transfer of Care	The 8 changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system.	1. Early Discharge Planning 2. Systems to Monitor Patient Flow 3. Multi-Disciplinary/Multi-Agency Discharge Teams 4. Home First/Discharge to Access 5. Seven-Day Services 6. Trusted Assessors 7. Focus on Choice 8. Enhancing Health in Care Homes 9. Other
10. Integrated care planning	A co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	1. Care planning 2. Integrated care packages 3. Review teams (reviewing placements/packages) 4. Other

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	11. Intermediate care services		Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and delivered by a combination of professional groups. Services could include Step up/down, Reablement (restorative of self-care), Rapid response or crisis response including that for falls.									1. Step down 2. Step up 3. Rapid/Crisis Response 4. Reablement/Rehabilitation services 5. Other				
	12. Personalised healthcare at home		Schemes specifically designed to ensure that a person can continue to live at home through the provision of health related support at home. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term and end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in the Personalised Healthcare at Home scheme type.									1. Other - Mental health /wellbeing 2. Other - Physical health/wellbeing 3. Other				
	13. Primary prevention / Early Intervention		Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.									1. Social Prescribing 2. Other - Mental health /wellbeing 3. Other - Physical health/wellbeing 4. Other				
	14. Residential placements		Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.									1. Supported living 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Other				
	15. Wellbeing centres		Wellbeing centres provide a space to offer a range of support and activities that promote holistic wellbeing or to help people to access them elsewhere in the community or local area. They can typically be commissioned jointly and provided by the third sector.													
	16. Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.													

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Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 4. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:

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4. HWB Metrics

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4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 17/18**	**Total 18/19**
HWB Non-Elective Admission Plan* Totals	**40,002**	**40,400**	**40,793**	**39,768**	**39,241**	**39,629**	**40,043**	**39,036**	**160,962**	**157,950**

Are you planning on any additional quarterly reductions?	No

Please only record reductions where these are over and above existing or future CCG plans. HWBs are not required to attempt to align to changing CCG plans by recording reductions.

If yes, please complete HWB Quarterly Additional Reduction Figures

HWB Quarterly Additional Reduction										
HWB NEA Plan (after reduction)										
HWB Quarterly Plan Reduction %										

Are you putting in place a local contingency fund agreement on NEA?	No

	2017/18	2018/19
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/contingency fund **	£26,661,311	£27,167,876

Cost of NEA as used during 16/17***	£1,490	Please add the reason, for any adjustments to the cost of NEA for 17/18 or 18/19 in the cells below
Cost of NEA for 17/18 ***		
Cost of NEA for 18/19 ***		

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	**Total 17/18**
Additional NEA reduction delivered through BCF (2017/18)						
		Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 18/19**
Additional NEA reduction delivered through BCF (2018/19)						
HWB Plan Reduction % (2017/18)						
HWB Plan Reduction % (2018/19)						

The CCG Total Non-Elective Admission Plans are taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 10/07/2017

* This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

** Within the sum subject to the condition on NHS out of hospital commissioned services/contingency fund, for any local area putting in place a contingency fund for 2017/18 or 2018/19 as part of its BCF planning, we

*** Please use the following document and amend the cost if necessary: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	594.8	519.8	510.2	500.2	In 16/17 we placed 1760 people into residential and nursing care, this is 165 higher than the pre-populated figure for 16/17. Although the overall residential figure is reducing, this is due to the number of people ending a residential or nursing service, not because we are placing less.
	Numerator	1,786	1,595	1595	1595	
	Denominator	300,274	306,850	312,626	318,873	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	83.4%	85.9%	85.9%	85.9%	The performance of this indicator is measured once a year, for people discharged within a specific 3 month period – this is as per the statutory return guidance. We have explored doing this more frequently however, the resource needed to do this was too intensive. This means we will only be able to refresh the 16/17 position after March 2018
	Numerator	1,354	1,351	1,351	1,351	
	Denominator	1,624	1,573	1,573	1,573	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	1304.4	1231.7	1368.1	1279.7	1179.7	952.7	848.9	841.3	841.3	841.3	841.3	834.1	Based on the reductions required to achieve the Kent Target of 9.3 delayed days per 100,000 population by September 2017 (which is a total of 3,447.5 days for the month). They have been calculated by looking at the difference between the current position (from June'17 NHS data) and then dividing the total difference into the number of months between our current position and target position.
	Numerator (total)	15,739	14,862	16,508	15,591	14,373	11,607	10,342	10,342	10,342	10,342	10,342	10,342	
	Denominator	1,206,598	1,206,598	1,206,598	1,218,316	1,218,316	1,218,316	1,218,316	1,229,352	1,229,352	1,229,352	1,229,352	1,239,886	

Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a DTOC rate for these two Health and Well-Being Boards.

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 5. National Conditions

Selected Health and Well Being Board:

Kent

Data Submission Period:

2017-19

5. National Conditions

<< Link to the Guidance tab

National Conditions For The Better Care Fund 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?	If the selected response for either year is 'No', please detail in the comments box issues and/or actions that are being taken to meet the condition.
1) Plans to be jointly agreed	Yes	Yes	
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes	
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes	
4) Managing transfers of care	Yes	Yes	

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CCG to Health and Well-Being Board Mapping for 2017-19

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.2%	87.9%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	7.0%	8.5%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.3%	0.5%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.2%	3.0%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.0%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.0%	92.5%
E09000003	Barnet	07P	NHS Brent CCG	1.9%	1.7%
E09000003	Barnet	07R	NHS Camden CCG	0.9%	0.6%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	2.9%	2.4%
E09000003	Barnet	08D	NHS Haringey CCG	2.1%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.5%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.7%	98.3%
E06000022	Bath and North East Somerset	11H	NHS Bristol CCG	0.3%	0.8%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	12A	NHS South Gloucestershire CCG	0.0%	0.1%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.5%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.5%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.6%	8.8%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	91.9%	53.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.8%	24.3%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.0%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.4%	18.8%
E08000025	Birmingham	05P	NHS Solihull CCG	15.2%	3.0%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	89.0%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.6%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.7%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.5%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.4%	0.9%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000028 & E06000029	Bournemouth & Poole	11J	NHS Dorset CCG	45.9%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.6%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.1%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.1%	0.1%
E06000036	Bracknell Forest	11C	NHS Windsor, Ascot and Maidenhead CCG	1.8%	2.3%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.9%

E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.6%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	22.2%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.9%	57.9%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	02V	NHS Leeds North CCG	0.6%	0.2%
E08000032	Bradford	03C	NHS Leeds West CCG	1.7%	1.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.2%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.9%	86.5%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.9%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000005	Brent	08E	NHS Harrow CCG	5.8%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.5%	2.8%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.4%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.7%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.7%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.1%	1.3%
E09000006	Bromley	08A	NHS Greenwich CCG	1.5%	1.2%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.1%
E09000006	Bromley	08L	NHS Lewisham CCG	2.0%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Y	NHS Aylesbury Vale CCG	91.3%	35.3%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.0%	59.7%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E10000002	Buckinghamshire	10T	NHS Slough CCG	2.8%	0.8%
E10000002	Buckinghamshire	11C	NHS Windsor, Ascot and Maidenhead CCG	1.3%	0.4%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.1%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.7%	2.1%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.5%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.0%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.4%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.5%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%
E09000007	Camden	07R	NHS Camden CCG	84.0%	89.2%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.8%	4.8%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.3%	3.1%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.0%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.2%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.4%
E06000049	Cheshire East	04J	NHS North Derbyshire CCG	0.4%	0.3%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	05N	NHS Shropshire CCG	0.1%	0.0%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.5%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.3%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.7%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%

E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.1%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.3%	29.3%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.3%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.4%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	1.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	72.7%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.0%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.9%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.1%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	99P	NHS North, East, West Devon CCG	0.4%	0.6%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.2%	52.6%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.6%	46.1%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.4%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.4%	93.3%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.9%	2.8%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Morecambe Bay CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.2%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.1%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.0%	0.1%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.5%
E06000015	Derby	04R	NHS Southern Derbyshire CCG	50.0%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.0%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.4%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.3%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.0%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.2%	35.9%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.2%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.1%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.0%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	99P	NHS North, East, West Devon CCG	70.1%	80.6%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.5%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.4%	0.5%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%

E10000009	Dorset	11J	NHS Dorset CCG	52.5%	95.9%
E10000009	Dorset	11X	NHS Somerset CCG	0.6%	0.7%
E10000009	Dorset	11A	NHS West Hampshire CCG	2.0%	2.5%
E10000009	Dorset	99N	NHS Wiltshire CCG	0.8%	0.9%
E08000027	Dudley	13P	NHS Birmingham Crosscity CCG	0.3%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.8%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.7%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.8%	90.7%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.8%	3.0%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.8%	3.6%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.0%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.5%	8.1%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.5%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.1%	1.3%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.5%
E09000010	Enfield	07X	NHS Enfield CCG	95.4%	90.8%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.3%	11.6%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.7%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.6%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.6%
E10000012	Essex	08N	NHS Redbridge CCG	3.0%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.9%	97.9%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	12A	NHS South Gloucestershire CCG	0.3%	0.1%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.5%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.7%	89.7%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.2%	4.7%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.4%	94.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.6%
E09000012	Hackney	08H	NHS Islington CCG	4.4%	3.6%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.6%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	1.0%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.2%

E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.4%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.4%	87.7%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.1%	0.2%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.7%	0.0%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.6%	14.5%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	10M	NHS Newbury and District CCG	5.9%	0.5%
E10000014	Hampshire	10N	NHS North & West Reading CCG	0.9%	0.0%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.4%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	16.0%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.5%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.3%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.5%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.5%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08D	NHS Haringey CCG	87.8%	91.5%
E09000014	Haringey	08H	NHS Islington CCG	2.4%	2.0%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.2%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.4%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.5%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.5%	99.5%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.3%	2.8%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.4%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.1%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	10Y	NHS Aylesbury Vale CCG	0.4%	0.0%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	96.9%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.4%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.8%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.3%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	10H	NHS Chiltern CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.3%	1.9%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.9%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%

E09000018	Hounslow	07W	NHS Ealing CCG	5.7%	7.8%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.7%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	86.8%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.6%	3.9%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.6%	5.2%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.3%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.6%
E09000019	Islington	08H	NHS Islington CCG	89.4%	88.7%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.4%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.2%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.0%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.8%	93.1%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.2%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.2%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.0%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.2%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.3%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.5%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.6%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.9%	1.5%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.7%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.5%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.1%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.8%	0.5%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.9%	92.6%
E09000022	Lambeth	08R	NHS Merton CCG	1.1%	0.6%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.8%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.6%	3.8%

E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.0%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.3%	1.8%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01H	NHS Cumbria CCG	1.4%	0.6%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.5%	11.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	17.1%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	99.8%	12.9%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.1%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.0%	8.8%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.8%	0.2%
E08000035	Leeds	02W	NHS Bradford City CCG	0.6%	0.0%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.7%	0.3%
E08000035	Leeds	02V	NHS Leeds North CCG	96.4%	24.2%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.4%	31.7%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	43.0%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.3%	2.0%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.3%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.7%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.4%	39.9%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.5%	4.2%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.7%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.9%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.8%	92.4%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.8%	3.8%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.5%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	2.6%	0.6%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.2%	4.4%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.6%
E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.5%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.6%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.1%	1.6%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	94.0%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.1%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%

E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.6%
E09000024	Merton	08R	NHS Merton CCG	87.5%	81.1%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.2%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.1%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.6%	95.1%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.1%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.7%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.7%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.8%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	25.4%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.5%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.1%	1.4%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	97.2%	96.8%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	11H	NHS Bristol CCG	0.3%	0.6%
E06000024	North Somerset	11T	NHS North Somerset CCG	99.1%	97.7%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.0%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.4%	8.3%
E10000023	North Yorkshire	01H	NHS Cumbria CCG	1.2%	1.0%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.5%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.0%
E10000023	North Yorkshire	02V	NHS Leeds North CCG	3.0%	1.0%
E10000023	North Yorkshire	03G	NHS Leeds South and East CCG	0.5%	0.2%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.7%	18.7%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%

E10000021	Northamptonshire	10Y	NHS Aylesbury Vale CCG	0.1%	0.0%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.1%	9.7%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	1.9%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.2%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.2%	1.1%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	01H	NHS Cumbria CCG	0.0%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	1.0%	0.7%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.6%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	95.3%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.3%	1.2%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.3%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.6%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.0%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.0%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.5%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.4%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04R	NHS Southern Derbyshire CCG	0.6%	0.4%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.6%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.1%	1.8%
E10000025	Oxfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10M	NHS Newbury and District CCG	0.1%	0.0%
E10000025	Oxfordshire	10N	NHS North & West Reading CCG	2.0%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.3%	96.6%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.8%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.2%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.6%	36.2%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.8%	60.6%
E06000038	Reading	11D	NHS Wokingham CCG	3.1%	2.7%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	5.6%	3.8%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.5%	1.8%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.6%	88.7%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.4%	3.2%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.0%	1.0%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.4%	99.0%

E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.5%	1.4%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.5%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000005	Rochdale	00V	NHS Bury CCG	0.6%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.3%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.4%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.7%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	11.9%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.3%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.9%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	0.9%	2.2%
E08000006	Salford	01G	NHS Salford CCG	94.0%	94.8%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	3.0%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.0%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.8%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.9%	41.8%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	03Y	NHS Hardwick CCG	0.4%	0.0%
E08000019	Sheffield	04J	NHS North Derbyshire CCG	0.7%	0.3%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.3%	0.1%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.6%	99.2%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.6%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.5%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.1%	6.5%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E06000039	Slough	10T	NHS Slough CCG	96.6%	93.1%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	1.9%	6.2%
E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.4%	0.6%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05P	NHS Solihull CCG	83.6%	92.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.3%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11T	NHS North Somerset CCG	0.9%	0.3%
E10000027	Somerset	99P	NHS North, East, West Devon CCG	0.3%	0.5%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.0%

E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.6%	0.5%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	5.0%	8.9%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.1%	88.7%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.7%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.7%	4.6%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.4%
E09000028	Southwark	07R	NHS Camden CCG	0.4%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.2%	1.4%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.0%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.4%	88.7%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.1%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.0%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	13P	NHS Birmingham Crosscity CCG	0.5%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.0%	14.6%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	04J	NHS North Derbyshire CCG	0.7%	0.2%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.5%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.1%	23.7%
E10000028	Staffordshire	04R	NHS Southern Derbyshire CCG	0.5%	0.3%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.6%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.9%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.3%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.7%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	95.0%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.3%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.5%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.6%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.6%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.1%	97.0%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.4%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.4%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.1%

E10000030	Surrey	10G	NHS Bracknell and Ascot CCG	1.7%	0.2%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.2%	0.4%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	17.0%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.6%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.4%
E10000030	Surrey	08P	NHS Richmond CCG	0.6%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E10000030	Surrey	11C	NHS Windsor, Ascot and Maidenhead CCG	8.5%	1.1%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.4%	3.3%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.4%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.2%	98.3%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.4%
E08000008	Tameside	14L	NHS Manchester CCG	2.3%	5.9%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.7%	2.2%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.7%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.3%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.2%
E06000027	Torbay	99Q	NHS South Devon and Torbay CCG	48.9%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.4%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.1%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.5%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	6.9%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.6%	92.8%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	03G	NHS Leeds South and East CCG	1.0%	0.8%
E08000036	Wakefield	03C	NHS Leeds West CCG	0.1%	0.2%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.1%
E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.6%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.2%
E08000030	Walsall	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.1%	0.0%
E08000030	Walsall	05Y	NHS Walsall CCG	92.7%	90.6%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.3%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.2%	1.6%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.6%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.5%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.0%	3.2%
E09000032	Wandsworth	08R	NHS Merton CCG	2.9%	1.7%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.8%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	93.1%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.3%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	96.9%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.3%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.2%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.8%	0.2%
E10000031	Warwickshire	05P	NHS Solihull CCG	0.6%	0.3%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.2%	45.5%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.2%	66.4%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.3%	23.5%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	10W	NHS South Reading CCG	8.7%	7.5%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E06000037	West Berkshire	11D	NHS Wokingham CCG	0.1%	0.1%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.2%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.7%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	13.9%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.0%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	1.9%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	80.4%	71.2%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.4%	23.2%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.2%
E08000010	Wigan	01G	NHS Salford CCG	0.9%	0.7%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.3%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.7%	0.9%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.6%

E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.8%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.8%	0.2%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12A	NHS South Gloucestershire CCG	0.9%	0.5%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.2%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.8%
E06000040	Windsor and Maidenhead	10H	NHS Chiltern CCG	0.6%	1.2%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.1%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.6%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.1%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.3%	1.3%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	10G	NHS Bracknell and Ascot CCG	3.2%	2.6%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.2%	0.1%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E06000041	Wokingham	10W	NHS South Reading CCG	11.5%	9.5%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.6%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.5%	3.6%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.2%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.4%	0.5%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.5%	1.3%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.8%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	1.0%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.9%	27.9%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05P	NHS Solihull CCG	0.5%	0.2%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.1%	49.0%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.4%	18.7%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

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Minutes of the 0-25 Health and Wellbeing Board Meeting
28 March 2017
2.00pm – 4.15pm
Swale Room 1 Sessions House

Present:			
Andrew Ireland*	AI	-	Social Care Health & Wellbeing Corporate Director, KCC (Chair)
Peter Oakford*	PO		Cabinet member – Specialist Children's Services
Roger Gough	RG	-	Cabinet Member – Education & Health Reform, KCC
Karen Sharp*	KS		Head of Commissioning Public Health, KCC
Amanda Kenny	AK	-	Swale & DGS Clinical Commissioning Group Commissioner
Debbie Wade	DW	-	Representing Simon Thompson Head of Partnerships and Communities, Kent Police
Helen Cook	HC	-	Children's Commissioning Manager, KCC
Claire Winslade	CW	-	Interim Public Health Consultant , KCC
David Holman*	DH	-	West Kent Clinical Commissioning Group, Children's Lead
Penny Southern*	PSo	-	Director Disabled Children, Adults learning Disability and Mental health, Representing Penny Southern KCC
Sue Chandler	SC	-	South Kent Coastal CCG representing the LCPG Chairs
Philip Segurola*	PSe	-	Specialist Children's Services Director, KCC
Sarah Robson	SR	-	Representing Kent Housing Group Executive
Gill Rigg*	GR	-	Kent Children's Safeguarding Board Independent Chair
Patrick Leeson	PL	-	Education and Young People's Services Corporate Director, KCC
Julie Ely	JE	-	Head of SEN Assessment & Placement, KCC
Emily Silcock	ES	-	Headstart Analyst, KCC
Jo Tonkin	JT	-	Public Health Specialist, KCC
Alex Gamby*	AG	-	Head of Early Years and Child care
Jayne Hagues*	JH	-	District Partnership Manager - Shepway
* Present for part of the Meeting			

Apologies	
Jane O'Rourke	East Kent Clinical Commissioning Group Head of Children's Commissioning
Michael Thomas-Sam	Head of Strategy and Business Support
Stuart Collins	Director of Early Help, KCC
Mark Radford	Chief Executive Swale Borough Council
Matthew Scott	Kent Police Crime Commissioner
Sharon McLaughlin	Thanet District Manager Early Help and Preventative Services, KCC

1. Welcome & Introductions

1.1 The Chair welcomed everyone to the meeting and introductions were made.

2. Minutes from meeting held on 21 November 2016

2.1 The minutes were agreed as an accurate account.

2.2 All actions were noted as completed.

3. UASC Update – Andrew Ireland

3.1 The Chair provided a detailed update on UASC, highlighting the following:

- The number of new arrivals remains at a low level with the transfer scheme working well and where a client's transfer is delayed Kent starts the health check and assessment process on the taking authority's behalf.
- Kent is not expected to take any children under the Dublin Amendment unless they have family already in the county. Kent staff, continue to contribute with Home Office work supporting French authorities in the encampments with child assessments which helps to identify those who need to come to the UK.
- With regards those clients who came in within the first wave prior to the introduction of the transfer scheme are no longer eligible as a large number of these are 18+ and leaving care which in turn is now placing additional pressures on all public services including housing.

3.2 The Chair highlighted that concerns are already being voiced on what Mental Health support can be offered to this particular client group who have/may develop mental health issues like post-traumatic stress disorder (PTSD), and recommended that as part of the transformation programme it should look at building a future strategy in what support can be offered to this particular client group.

3.3 Members were assured that there have already been discussions around supporting these clients and agreed that the transformation programme should give some more thought to how this vulnerable client group with Mental health needs are supported in both the short and long-term. Action agreed: DH to raise at the next Mental Health Transformation meeting. **Action 1**

4. Item 6.5 – Emotional Health & Wellbeing CAMHS Transformation of Children and Young People's Mental Health Services – Dave Holman

4.1 The above report provided board members with an update on the progress and next steps in the redevelopment of Children and Young people's mental health services. The report highlighted key achievements including:

- Securing funding from national bodies to secure to fund additional programmes/studies
- Collaboration with CCGs and other strategic partners on the procurement of services.

4.2 The next steps include:

- Continue to work against NHS England's criteria to reform and develop Children and Young People's Mental Health services.
- Further develop a local, system wide leadership and ownership through revised governance arrangements which includes clear accountability for delivery across local health economies.
- Development of a robust system wide monitoring including risk register dashboard and evaluation framework which can be measured against NHS England's outcomes.

4.3 With regards to the procurement of services this is still on track with contract award scheduled for May 2017 with a four month mobilisation phase to the service live date of September 2017.

4.4 In addition to the above report members were also briefed on the re-procurement of Public Health's school nursing contract which has been divided into two lots:

- Primary
- Adolescent's Health and Wellbeing Service

Both contracts have been awarded to Kent Community Health Foundation Trust (KCHFT) with a formal communications of the award to be sent out in the near future. The services are currently in the mobilisation phase, structured across the age line.

4.5 As part of this new Adolescent's Emotional Mental Health service's design, it is both a universal and tier 2 level service and therefore it is anticipated that the HeadStart provision for children aged 10-16years could be embedded as part of the overall service offer.

4.6 Board members were also assured that to ensure governance around the Transformation programme the Transformation Board are required to provide an annual plan to demonstrate that all areas of the plan can be reported against.

4.7 In welcoming the progress made on the significant achievements made the group discussed what measures are being considered for those young people within primary care crisis groups or those in specialist hospital placements outside the county requiring support post discharge.

4.8 Actions agreed:

- JT to share the Transformation Board's governance structure with board members. **Action 2**
- DH to update plan on how links with primary care and the Winterbourne programme can be made. **Action 3**
- DH to provide an update report on the progress of the transformation programme and the annual report at the October meeting. **Action 4**

5. Item 5 Joint Reviews for Children aged 2 years (JR2); Update and Progress report – Alex Gamby

5.1 The above report provided members with an overview of the first two phases of the Thanet pilot for joint reviews for children aged 2 years. The key areas highlighted included:

- Development of four referral pathways that will determine the type of review that is undertaken.
- Positive engagement within Early Years settings requests for JR2 assessments especially for those who have missed their Health check reviews
- Positive response from parents on their involvement in providing a more holistic picture of the child's issues and needs.
- Strengthening the support mechanisms of the early years Local Inclusion Forum Team (LIFT).
- Development of a JR2 implementation toolkit.

- Health visitors are supportive of the reviews
- Challenges include:
    - Ensuring that there is adequate time to complete further reviews once the initial assessment has taken place
    - Maintaining delivery of JR2s when relevant Health practitioners are unavailable as this can create a backlog.
    - Work is under way to ensure greater effectiveness in communication strategies at a strategic level between Health and Early Years to share information in a timely manner
    - Countywide roll out – the development of a new service specification that includes the JR2 assessment.

5.2 In agreeing the recommendations for the continuation of the pilot's Phase II along with a final report at the Autumn meeting, Board members welcomed the proposal to ensure that there is a whole system model though which the workforce can identify speech/language needs.

5.3 Actions agreed:

- AG to present a final report at the October meeting. **Action 5**
- KS to add the communication strand to the pilot and share learning with the group. **Action 6**

6. **Item 4: Children Needs assessment – Claire Winslade**

6.1 Board members were provided with an overview of the progress made to the needs assessment outcomes resource pack highlighting the key benefits it will bring including:

- Maintaining an overview of the demographics and information about particular populations
- Using PHE child health profiles/indicator framework to a county level and reproducing where possible the most deprived family super output areas.
- Bespoke JSNAs and refreshing existing JSNAs
- Priority analysis – who's at risk
- Update with new child health priorities.

6.2 The group welcomed the progress made in developing the document's accessibility maintaining a balance between the amount of information contained in relation to what can be achieved. The next step will be ensuring that the data is used to inform service provision. Actions agreed:

- CW to bring a further update paper to the autumn meeting. **Action 7**
- PM to send out presentation slides. **Action 8**

7 Item 6.1: Healthy Child Programme: Local Maternity System and Maternity Needs Assessment – Amanda Kenny and Claire Winslade

7.1 The above report provided an update on the progress made on the local maternity system to plan and deliver the requirements of Better Births across Kent and Medway to reduce the numbers of still births and neonatal deaths. Action agreed: AK to send through the Terms of reference for the LMS group. **Action 9**

7.2 The Maternity needs assessment has been carried out with two main areas of focus:

- Up to date demographic information on women giving birth in Kent.
- Use of the Kent Integrated Dataset (KID) to analyse the impact of smoking, obesity and long term conditions on Kent mothers re service use and cost during pregnancy and the following six months post-delivery.

7.3 In noting the paper Board members agreed that the children's agenda across the priorities of the Sustainable Transformation Programme (STP) needs to be more prominent and better represented across this agenda especially as there is still no clarification on when funding will be available. Action agreed: STP and the profile of children will be an agenda item for the next meeting. **Action 10**

8 Item 6.2: Special Educational Needs and Disability (SEND) Update – Patrick Leeson

8.1 The above report gave an overview of the progress to date on the delivery of the SEND strategy and the key priorities for action to continue the revised strategy's implementation. The key areas highlighted were:

- Education
- Independence
- Access to employment and training

8.2 In endorsing and noting the progress in delivery of the revised strategy, Board members welcomed that the revision will have a forward focus in SEND provision especially in supporting those within the 16-25age group

8.3 Board members were provided with an overview of the further developments of the Lifespan transformation which has been developed to be in line with the strategy to support those with disability throughout their life. Actions agreed

- PS to raise with AI for this to be included as a future agenda item on the Social DMT with CCG accountable officers attending. **Action 11**
- PS to bring a report on Lifespan transformation to the next meeting. **Action 12**

9. Item 6.3: Children and Young People's Framework (CYPF) update – Helen Cook

9.1 The above paper is a performance report for December on the delivery of the framework's key indicators, highlighting the updates and changes following feedback from Local Children's Partnership Group (LCPG's).

9.2 In noting the paper Board members discussed the process undertaken on how grants are allocated and the assurances officers can evidence that the funding provided has been spent appropriately against performance and outcomes. The Chair was optimistic that the framework will deliver the outcomes and make a difference at a local level. Action agreed

- HC to provide a further report for the October meeting that looks at:
  - Monitoring
  - How outcomes are different
  - Demonstrate value for money. **Action13**

10 Item 6.4: Turning the curve presentation – Sue Chandler

10.1 The above presentation provided the group with an overview of the approach that the South Kent Coastal Local Children's Partnership Board has taken to reduce the numbers of self-harm hospital admissions.

10.2 Board members welcomed the work carried out and were advised that other LCPGs are also undertaking a similar approach to this indicator. Action agreed: PM to send out the presentation slides. **Action 14**

11 KCC transformation

11.1 The Chair gave assurance that it was business as usual whilst KCC continues with its transformation , with PL still leading on the SOR programme as part of this integration.

11.2 With regards to the Ofsted inspection, the outcome and recommendations from the inspection will be included as part of the transformation process. Action agreed: AI to share the Ofsted report and recommendations along with the supporting action plan with the board. **Action 15**

12. Any Other Business

12.1 None noted.

Next meeting:

19 July 2017 – Darent Room, Session House, 2.00pm – 4.00pm

Action List

Action Number	Action Required and By Whom	By When
	UASC update	
1	DH to raise with the Mental Health Transformation board on how this vulnerable client group with Mental health needs are supported in both the short and long-term.	**Next meeting**
	Item 6.5 – Emotional Health & Wellbeing CAMHS Transformation of Children and Young People's Mental Health Services	
2	JT to share the transformation Board's governance structure with board members.	**With minutes**
3	DH to update plan on how links with primary care and the Winterbourne programme can be made.	**Next meeting**
4	DH to provide an update report on the progress of the transformation programme and the annual report at the October meeting.	**October meeting**
	Joint Reviews for Children aged 2 years (JR2); Update and Progress report	
5	AG to present a final report at the October meeting.	**October meeting**
6	KS to add the communication strand to the pilot and share learning with the group.	**Next meeting**
	Children's needs assessment	
7	CW to bring a further update paper to the autumn meeting.	**October meeting**
8	PM to send out presentation slides	**30 March 2017**
	Healthy Child programme – LMS	
9	AK to send through the Terms of reference for the LMS group.	**With minutes**
10	AK to draft a letter on behalf of the group to NHS England regarding the need for a dedicated resource to support the implementation of Better Births.	**Next meeting**
	SEND update	
11	PSo to raise with AI for this to be included as a future agenda item on the Social DMT with CCG accountable officers attending.	**30 March 2017**
12	PSo to bring report on Lifespan transformation to the next meeting.	**July 2017**
	Children's & Young People Framework	
13	HC to provide a further report for the October meeting that looks at: o Monitoring o How outcomes are different o Demonstrate value for money.	**October 2017**
	Turning the curve presentation	
14	PM to send out the presentation slides.	**30 March 2017**
	KCC transformation	
15	AI to bring the Ofsted report and recommendations along with the supporting action plan will be shared with the board.	**October meeting**

Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **19th July 2017.**

Present:

Councillor Brad Bradford - Portfolio Holder for Highways, Wellbeing and Safety, ABC (Chairman)

Dr Navin Kumta – Clinical Lead and Chair, Ashford CCG (Vice-Chairman)
Geoff Lymer, Chairman of Health Reform and Public Health Cabinet Committee, KCC
Councillor Andrew Buchanan, Deputy Portfolio Holder for Highways, Wellbeing and Safety, ABC
Sheila Davison – Head of Health, Parking and Community Safety, ABC
Faiza Khan, Public Health, KCC
Neil Fisher – Head of Strategy and Planning, CCG
Karen Cook – Policy and Strategic Partnerships, KCC
Paul Kennedy, District Partnership Manager, KCC
John Bridle – HealthWatch
Sharon Williams – Head Of Housing, ABC
Alex Waller, Sports and Activity Project Officer, ABC
Will Train, Corporate Scrutiny and Overview Officer, ABC
Keith Fearon – Member Services Manager, ABC

Apologies:

Peter Oakford – Cabinet Member, KCC, Helen Anderson, Ashford Local Children's Partnership, Deborah Smith, Public Health, KCC, Tracey Kerly, Chief Executive, ABC, Christina Fuller, Head of Culture, ABC.

1 Notes of the Meeting of the Board held on 26 April 2017

The Board agreed that the notes were a correct record.

2 Update on the Kent Health and Wellbeing Board Meeting – 14 June 2017

2.1 Navin Kumta advised that the Minutes of the Kent Health and Wellbeing Board meeting held on 14th June 2017 could be accessed using the link provided under item 4 on the agenda. There were no specific actions to be addressed by the Ashford Health and Wellbeing Board.

3. Update on the Kent Joint Health and Wellbeing Strategy

3.1 The report asked the Board to comment on the updated priorities set out in a table within the report and on the proposed outcome measures that had emerged following engagement with stakeholders and officers since the last meeting.

3.2 Karen Cook advised that Mr Oakford had signalled his intention to review the membership of the Kent Board and therefore the strategy had been deferred to the November meeting of the Kent Board. She drew attention to the proposed themes set out in paragraph 3(b) of the report. Chris Morley advised that he was keen to talk off- line in terms of future collaboration.

3.3 In response to a comment, Karen Cook said that she would be happy to assist in ensuring alignment of Ashford's priorities with the overall Kent Strategy.

3.4 The Board were advised that public consultation on the Strategy will now take place in October.

Resolved:

That the report be received and noted.

4 Update on Ashford Health and Wellbeing Board Priorities

(a) Reducing Smoking Prevalence Final Report 2016/17

4.1 Faiza Khan introduced this item. She advised that good progress had been made in relation to smoking prevalence in pregnant women, vaping and the being undertaken by the One You Shop on smoking cessation. The Smoking Action Plan was on track and one of the next steps was to work with the William Harvey Hospital (WHH) and other acute trusts in Kent to ensure that the hospital sites are Smokefree. Neil Fisher clarified that smoking was already banned on those sites but the ban was not enforced. Faiza Khan said that she supported the suggestion of establishing cessation advisors at the WHH and also said that any initiative should start with the staff who currently smoked on the site. The Chairman advised that the same staff should not undertake the enforcement and prevention/education aspects. Chris Morley referred to the economic impact of reducing smoking in terms of the workforce and suggested that this be raised with the Federation of Small Businesses and the Institute of Directors. The Chairman offered to raise the subject with the local Chamber of Commerce.

4.2 In response to a question about the accuracy of smoking statistics, Faiza Khan explained the background as to how they were produced.

4.3 Paul Kennedy emphasised the need to focus attention on preventing children from starting to smoke in the first place and the potential involvement by the Local Children's Partnership Group.

Resolved:

The Board agreed that:

(i) the update and progress of the 2016/17 Action Plan be received and noted.

(ii) the recommendations as set out in the report be approved.

(iii) the Task and Finish Group deliver the recommendations in the report through an Action Plan for 2017/18.

(b) Healthy Weight Prevalence Final Report 2016/17

4.3 Faiza Khan drew attention to the progress report and referred to the need to understand the barriers faced by people who were not making use of existing schemes to assist in reducing weight. She drew attention to the proposed Healthy Weight Actions for 2017/18 as set out on page 26 of the report and sought the Boards approval to them.

4.4 Navin Kumta supported the message of increasing physical activity to help maintain a healthy weight and said that it was important that this be conveyed to families. He said that if the various initiatives were promoted people could make their own decisions about exercise and healthy eating. Chris Morley considered that it would be a relatively straightforward exercise for the Borough Council to perhaps consider organising events on the various Multi Use Games Areas in the Borough for activities linked to this initiative. Geoff Lymer highlighted the links between excess weight and alcohol consumption.

4.5 Sharon Williams said that the Borough Council could help in terms of promoting the initiative via its links to tenants of Council housing stock.

4.6 Sheila Davison suggested that the Task and Finish Group be asked to further develop the proposed Action Plan and identify specific activities for the next year.

Resolved:

The Board agreed that:

(i) the progress of the 2016/17 Action Plan be received and noted.

(ii) the Task and Finish Group be asked to review the Action Plan and bring back to the Board a yearlong programme of activities for approval.

(iii) the broad aims of the Action Plan for 2017/18 with activities to achieve the Kent Healthy Weight priorities as set out in the report be supported

(c) Priorities 2018-23

4.7 The report set out proposed priorities for the Ashford Health and Wellbeing Board for the period 2018-23.

4.8 Sheila Davison drew attention to paragraph 9 which set out the proposed priorities and advised that this was based on the recently published Health Profile health data with a focus on the comparison with National and South East Region data. Paragraph 12 of the report identified lead organisations for each of the priorities. Sharon Williams suggested that homelessness could be linked to a more generic priority for health and housing as there were linkages between the Single Transformation Plan and Disabled Facilities Grants. This priority could also give attention to the falls indicator.

4.9 In response to a comment about whether the broader issues of GCSE attainment and children in low income should be included as priorities, Sheila Davison highlighted that the Board is able to review progress against any of the indicators. She undertook to map the indicators set out in paragraph 8 to lead partners/groups where possible. Following further discussion the Board agreed priorities under four broad headings.

Resolved:

The Board agreed that:

(i) the four priorities for 2018-23 be Housing; Smoking; Obesity in children and excess weight in adults; and Diabetes.

(ii) the leads for the four priorities would be Ashford Borough Council for housing; Kent County Council (Public Health) for Smoking and Obesity/Excess Weight and the Clinical Commissioning Group for Diabetes.

(iii) the boarder indicators set out in paragraph 8 would be further examined and where possible be linked to lead partners/groups.

5 Update on Postural Stability and Falls Service in Ashford

5.1 Faiza Khan advised that this report had been produced for the Board arising from a request made at a previous meeting.

Resolved:

That the report be received and noted.

6 Sustainability and Transformation Plan (STP)

6.1 Neil Fisher gave a presentation on this this item. Also tabled at the meeting was a report entitled 'Service Models and Hurdle Criteria' which together with the presentation had been published on the Council's website under:- https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3166

6.2 Neil Fisher advised that it was intended to undertake full consultation on the proposals in early 2018. He also undertook to distribute copies of two reports which analysed early engagement survey results.

6.3 Sharon Williams referred to the problem of people being discharged from hospital and then presenting themselves to the Borough Council as homeless and asked whether it was possible in future to obtain specific information in advance of such patients being discharged. Neil Fisher considered that this was the type of issue which could be picked up by one of the three clusters proposed for the Ashford Borough area.

6.4 Chris Morley drew attention to the meeting on 26 July of the three Community Forums covering Ashford which would discuss how the proposed arrangements would work and he encouraged the Board and all elected Members to attend.

6.5 Neil Fisher said that he would produce an update report for each Board meeting and he also suggested that it would be helpful for the Ashford Clinical Providers to attend a future meeting.

Resolved

The Board agreed that:

(i) progress reports on the STP be presented to future Health and Wellbeing Board meetings.

(ii) the Ashford Clinical Providers be invited to attend a future meeting.

7 Partner Updates

(a) Clinical Commissioning Group

7.1 Update noted

(b) Kent County Council (Social Services)

7.2 Not provided

(c) Kent County Council (Public Health)

7.3 Update noted

(d) Ashford Borough Council

7.4 Sheila Davison advised that the 2018 National Wellbeing Symposium might be held in Ashford and she suggested that the Board may wish to use this as an opportunity to promote its work.

7.5 Alex Waller gave a brief presentation on the Beat the Streets which is a project that turns a town into a game where people earn points as they walk, cycle and run around. It involves players tapping a registered card on sensors placed at various locations in an area over a seven-week period. The aim was to improve health by participants walking, running or cycling between the given points. The cost for the Ashford urban area was estimated at £96k and for the whole borough would be £134k however there were match-funding opportunities available from Sport England. At this stage Alex Waller sought approval of the Board to submit an expression of interest.

7.6 The Chairman said that the game would give the Council and its partners an opportunity to plan routes between areas and it would also be open for schools to register and participate.

7.7 Neil Fisher advised that he was aware that East Sussex had introduced the game into their area.

The Board agreed that:

(i) the Beat the Streets game be supported in principle.

(ii) a report be submitted to the next meeting providing more information about the scheme including a timeline and comments about future sustainability.

(iii) a representative from the company that organizes the event and a local authority who have experience in operating the game be invited to attend the next meeting.

(e) Voluntary Sector

7.8 Not provided.

(f) Healthwatch

7.9 John Bridle advised that Healthwatch wished to engage with the public and other Groups in terms of feedback about local health and social care services. A report they had produced on travelers would be published shortly.

(g) Ashford Local Children's Partnership Group

7.10 Update noted.

8 Ashford Health and Wellbeing Board – Membership

8.1 The Board was asked to address the vacant KCC Officer and Voluntary Sector positions on the Board and subsequently the AHWB Lead Officer Group.

8.2 The Chairman considered that the Kent Association of Local Councils (Ashford Branch) should be invited to nominate a representative to join the Board.

8.3 The Board discussed the current lack of a representative of the Voluntary and Community Sector and considered that a way forward would be to invite a representative linked to specific items on the Forward Plan and involve them in the more focused work of the Board's Task Groups.

Resolved:

(i) The Board agreed that the Kent Association of Local Council's (Ashford Branch) be invited to nominate a representative to join the Board.

(ii) Voluntary and Community Sector representatives be invited to attend the Board in relations to specific items on the Forward Plan and where relevant to specific Task Groups.

9 Forward Plan

9.1 It was agreed that the following items would be on the agenda for the Board meeting on 18th October 2017.

- Ashford Local Children's Partnership Group update
- Beat the Streets
- Priorities 2018-2023 – Project Leads

9.2 In terms of the January meeting, the topics of Health and Housing and a possible presentation from Ashford Vineyard were added.

10 Dates of Future Meetings

10.1 The next meeting would be held on 18th October 2017.

10.2 Subsequent date:

17th January 2018

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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 28 June 2017.

PRESENT: Councillor Roger Gough (Chairman)
Councillor Mrs Ann D Allen MBE
Councillor David Turner
Sheri Green
Nick Moor
Melanie Norris

Also Present Hayley Brooks, Karen Cook, David Holman, Dr Sarah MacDermott, Theresa Oliver, Dr Manpinder Sahota, and Catherine Read.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Searles, Dr. Lunt, Graham Harris, Andrew Scott – Clarke, Sarah Kilkie, Lesley Bowles, Jo Pannell Allison Duggal and Terry Hall.

2. DECLARATIONS OF INTEREST

There were no declarations of interest received.

3. MINUTES

The minutes of the Dartford, Gravesham and Swanley Health and Wellbeing Board held on 12 April 2017 were agreed as a correct record of that meeting.

4. KENT COUNTY COUNCIL HEALTH AND WELLBEING BOARD

The Chairman updated the Board on the major issues discussed at the meeting of the Kent Health and Wellbeing board held on 14 June 2017.

Councillor Gough explained that the Kent Board had concentrated on the two major issues:

Adult Social Care, receiving two reports one relating to an update on the position of Social Care in Kent, which had focussed on ways to rebuild capacity for domiciliary care, and a second looking at the financial position of the Better Care Fund for 2016/17 and the approach being taken to plan for 2017/2019.

An update on the Your Life Your Wellbeing Pilots, which had been established (mostly) in east Kent and which it was now proposed to extend across the County later this year.

Councillor Gough also informed the Members that he had stepped down as Chairman of the Kent Board, his place being taken by Dr Peter Oakford, as his County remit had been amended.

5. URGENT ITEMS

The Chairman reported that there were no urgent issues for the Board to consider.

6. LOCAL CHILDREN'S PARTNERSHIP GROUPS: UPDATE REPORT

The Board received a presentation from Mr Nick Moor, KCC Head of Service (0 – 25) North, on work undertaken by the Local Children's Partnership Groups which focussed particularly on the 2017/18 Early Help and Preventative Services Grants process and awards for the Dartford, Gravesham and Swanley areas.

Mr Moor explained that the grants awarded were classified as Innovation Grants and were made on a one off basis to fund

- Innovations / pilots or pilot scheme, or;
- The development of new organisations which would contribute to the Council's strategic priorities.

He explained the grant aiding process to the Board and detailed the priorities and grants awarded by each of the three partnership groups.

It was noted that one of the groups which had received grant aid had subsequently ceased trading and that KCC were attempting to recover the funding amount from their administrators.

Mr Moor further reported that monitoring reports on the continuity and sustainability of the projects funded would be presented in future years.

The Board thanked Mr Moor for his presentation and agreed to note the report.

7. JOINT KENT HEALTH AND WELLBEING STRATEGY: 2018 - 2023

The Board received a draft of the Kent Joint Health and Wellbeing Strategy 2018-23 which had been discussed at the Kent Health and Wellbeing Board on 22nd March 2017.

The report, presented by Karen Cook - Policy and Relationships Adviser (Health), Kent County Council - outlined a strategy responding to a challenge set by commissioners to more effectively support the commissioning decision making process.

Having approved the draft Strategy the Kent HWB agreed, amongst other things that the Strategy be presented to local HWB for comment, especially relating to the priorities identified in Appendix 2 which relate to Health Priorities.

Having considered the draft report the Board welcomed the Strategy and the approach toward preventative intervention (especially Obesity) rather than curative work.

The Board also identified the following points as requiring refinement:

Priority 1 – a tighter definition of “Housing” in the Outcomes section

Priority 2 – the addition of “Sexual Health”, and “Earlier Identification of Sexual Abuse” in the Outcomes section

Priority 3 – a redefinition “Recovery from mental health problems” in the Outcomes section, and the introduction of a methodology to avoid target chasing.

Priority 4 - a tighter definition of “Housing” in the Outcomes section, to include care situations.

8. ADOLESCENT MENTAL HEALTH SERVICE.

The Board received a report on the process and outcome of the recent procurement exercise undertaken to commission specialist mental health care services for children and young people across Kent.

The contract was for a 5 year period with an option to extend for a further 2 years

It was noted that the current contract would expire in August 2017 and that it was essential that the new contract commence in September 2017.

Details of the selection criteria and the client consultation process were provided together with information relating to the suppliers that submitted applications for the contract.

The Board noted that the North East London Foundation Trust had provided the most satisfactory application and that they had been awarded the contract to commence in September 2017.

9. KENT HEADSTART

Ms Catherine Read presented to the Board a synopsis of the work of the HeadStart project in Gravesham.

HeadStart is a lottery funded pilot providing five years investment into work to improve young people's resilience and mental health.

The pilot aims to improve the mental well-being of at - risk 10 to 16 year-olds by developing

- the necessary local conditions to enable that strategy to become sustainable after a two year introductory period

- a more robust evidence-base around 'what works' in the area of mental well-being to be pro-actively shared beyond HeadStart with the aim of contributing to the national and local policy debate with those at risk of mental Health problems.

The HeadStart pilot works in four main areas, local schools; the home; through social media; and through the Community, and provides

- Kent's Resilience Approach and Quality Mark Resources and Support
- A Menu of Evidence Based Interventions
- A Common Measurement Framework which is accessible to two year groups.
- Workforce Development
- Domains Approach to Resilience, Mindfulness, Youth Mental Health First Aid.

It was noted that HeadStart was currently planned to be operated in four geographic regions in Kent,

a) Swale and Gravesham;
b) Ashford, Shepway, and Canterbury;
c) Thanet and Maidstone; and,
d) Tonbridge & Malling and Dover

which had been identified as most suitable for the pilot, and work is either underway or is planned in these regions.

In addition work on the establishment of a Resilience Hub is also underway.

The Board thanked Ms Read for her presentation and noted the information that she had provided.

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

There were no matters to consider.

11. INFORMATION EXCHANGE

There was no information to disseminate.

12. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS OF THE DGSHWB, AND FORWARD WORK PLAN.

The Board received and noted a report which set out the plan of work for the forthcoming year and identified outstanding issues that required attention.

The chairman undertook to pursue the matter of the establishment of the Obesity Working Group with the relevant Officers outside the meeting.

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 20 July 2017 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Councillor Lin Fairbrass (Chairman); Janine Collins (Kent County Council), Councillor Gibbens (Kent County Council), Clive Hart (Thanet Clinical Commissioning Group), Madeline Homer (Thanet District Council) and Ailsa Ogilvie (Thanet Clinical Commissioning Group)

In Attendance: Bob Porter

15. APPOINTMENT OF CHAIRMAN AND VICE CHAIRMAN FOR 2017/18

Clive Hart proposed, Councillor Gibbens seconded and members agreed that Councillor Lin Fairbrass be the chairman for the meeting and that the substantive chairman will be elected at the next scheduled meeting of the Board.

Councillor Fairbrass in the Chair.

16. APOLOGIES FOR ABSENCE

Apologies were received from the following:

Dr Martin;
Hazel Carpenter;
Sharon McLaughlin, substituted by Janine Collins;
Mark Lobban, has left KCC. The clerk was asked to check with KCC about the replacement.

17. DECLARATION OF INTEREST

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 25 May 2017.

19. HOUSING SITUATION IN THANET (IN GENERAL).

Bob Porter, Head of Housing at Thanet District Council gave a presentation on housing situation in the district. This was on the invitation of the Board. In his presentation Mr Porter made the following points:

- Transport infrastructure, tourism offer, cultural offer make private housing developers want to come to invest in Thanet;

- There has been a significant increase in house prices in the area and fastest increase in house values outside London;
- There are growing wage levels;
- The Council was consulting on the draft Local Plan;
- Policy position was to develop 17,000 houses with 30% of those being for social housing (taking into account viability factors);
- Inner circuit road network being planned to support new housing development;
- Council would need to deliver 1,000 per year, but currently 300 being developed annually;
- **Affordability**: There are more people on low income, making it unaffordable to buy a house;
- Average local income for households needs to increase at twice the county rate;

- **Homelessness:** There were 880 homelessness applications received by the council in 2016. One of the reasons for this is the termination of short leases by landlords who then re-let at a higher rate;
- There were more families in temporary accommodation than before;
- The number of rough sleepers has doubled in the last 12-24 months;
- Housing conditions: 11% of homes have a category 1 hazard. This means that such properties have a significant risk that impacts on an individual's life;
- It is estimated that £18.8 million would be required for repairs to these properties to remove the risk;
- **Housing conditions** have an impact on health and wellbeing of those affected (for example excess cold would lead to health problems especially for the elderly and children);
- Life expectancy in Cliftonville is 8 years below the England average;
- Delays in hospital discharges nationally increased by 33%;

- **Adaptations**: Council assists with adapting people's homes in order to promote independence through a £2.5m disabled facilities grants programme;;
- Council is working towards fulfilling its housing priorities as set out in the PowerPoint presentation which is attached the minutes. These include the following;
    - ❖ Improving access to supply of housing;
    - ❖ Wellbeing maintained safer homes across all tenures;
    - ❖ Increase services to prevent homelessness and increase housing options;
    - ❖ Improve health and wellbeing of residents and communities;

- Empty homes were being brought back to use;
- Council conducted property inspections to enforce standards;
- Selective licensing was also used to enforce standards;
- Fire safety measures were reviewed;
- Council prevented homelessness in about 300 cases per year;

In response to the presentation Board members made the following comments:

- Ailsa Ogilvie said that Thanet CCG would like to some joint working with TDC Housing on housing and hospital discharges;
- Madeline Homer said that the government could work with councils on improving housing for individuals in cases that relate to hospital discharges;
- Clive Hart said that frailty was an important factor that should be considered when assessing individuals who can access supported housing as relying on age restrictions (*e.g. for over 55s only*) could exclude some deserving individuals;
- Alisa Ogilvie would liaise with TDC Housing to explore joint working with Thanet CCG on housing and hospital discharges through the Better Care Funding activities;

Bob Porter further made the following comments:

- TDC Housing will approach Thanet CCG for input to the Housing Strategy that the council was currently reviewing;
- Supply of supported housing especially for young individuals living with learning difficulties was a major challenge;
- Information on supply of supported housing in the district will be provided at future meetings of the board.

Members noted the report.

20. EAST KENT DELIVERY BOARD UPDATE

Ailsa Ogilvie suggested and members agreed that the next update on the East Kent Delivery Board activities will focus mainly on Thanet.

21. AOB

Janine Collins gave a brief report on the funded projects that sit within the LCPG Subgroups, This included the following:

- Challenger Troop are running 2 programmes one for 8-12 yrs to build resilience and support Transition which will run in the October half term, the other a NEET programme for 16-19yrs.
- GAP Project are running activities for 11-16's in Broadstairs.
- Oasis project 'Just so you know' will be delivered in 5 schools, to Yr9 groups.
- Fegans are delivering a programme 'Parents Supporting Parents (PSP)'. They were also offering 1-1 support to vulnerable children.
- I Talk programme promoting resilience and wellbeing for 12-15 year olds will start in the next few weeks and will involve 15 youths.
- IMAGO SAFE Project is working within 5 schools.

Janine will provide the update to be circulated to all Board members after the meeting. The update document has also been attached to the minutes.

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Draft Minutes of West Kent Health and Wellbeing Board Meeting
18 April 201716.00 -18.00
Tonbridge & Malling Borough Council, Gibson Drive, Kings Hill, West Malling, Kent, ME19 4LZ

PRESENT:

Dr Bob Bowes (BB)	Chair, NHS West Kent Clinical Commissioning Group Governing Body (NHS WK CCG)
Adam Wickings (AW)	Joint Chief Operating Officer, NHS WKCCG
Alison Broom (AB)	Chief Executive, Maidstone Borough Council (MBC)
Lesley Bowles (LB)	Chief Officer Communities & Business, Sevenoaks District Council (SDC)
Tristan Godfrey (TG)	Policy & Relationship Adviser (Health), Kent County Council (KCC)
Gary Stevenson (GS)	Head of Street Scene, Tunbridge Wells Borough Council (TWBC)
Lynne Weatherly (Cllr LW)	Councillor, TWBC
Jane Heeley (JH)	Tonbridge & Malling Borough Council (TMBC)
Piers Montague (Cllr PM)	Councillor, TMBC
Penny Graham (PG)	Healthwatch Kent
Fay Gooch (Cllr FG)	Councillor, Deputy Leader, MBC

IN ATTENDANCE:

Karen Hardy (KH)	Specialist, KCC Public Health
Sarah Warren	Good Neighbours, Tunbridge Wells
Matt Roberts	Community Partnerships & Resilience Manager, MBC
Karen Sharp	Head of Public Health Commissioning, KCC
Sarah Ward	Health & Housing Officer, MBC
Helen Wolstenholme	TWBC
Yvonne Wilson (Minutes)	NHS WK CCG
Satnam Kaur	Chief Housing Officer, TMBC
Linda Hibbs	Private Sector Housing Manager, TWBC
Donna Crozier	Family Mosaic Housing Service
Gillian Shepherd – Coates	Age UK in West Kent
Janice Greenwood	Private Sector Housing Manager, TWBC
Emma Hanson	Head of Strategic Commissioning, Adult Community Support, KCC
Danny Hewis	Deputy CEO, Involve, Kent
Louise Fleet	Public Health Falls Prevention Instructor, Involve, Kent
Jenny Wilders	IMAGO
Linda Newby	Case Manager/Occupational Therapist, Adult Community Team, KCC
Alison Jankowski	Clinical Manager, Therapy, Assisted Discharge Service, Maidstone & Tunbridge Wells BHS Trust

Natalie Rennie	Frailty and Medical Commissioning Manager, HNS WK CCG
Dr George Noble	Community Geriatrician, Kent Community Health Foundation Trust (KCHFT)
Ken Scott	Older Person's Activist
Jane Miller	County Manager, Occupational Therapy and Reablement, KCC
Dr Chris Burke	GP Registrar, CLIC
GP Trainee	CLIC

1.	**Welcome and Introductions**	Action
1.1	Dr Bob Bowes welcomed all present to the meeting, in particular those attending for the special Workshop Session on Falls Prevention.	
1.2	Apologies were received from Gail Arnold, Julie Beilby (Substitute - Jane Heeley), Cllr Pat Bosley, Penny Southern, Cllr Roger Gough, Cllr Fran Wilson, Dr Caroline Jessel, Dr Tony Jones, Dr Andrew Roxburgh, Dr Sanjay Singh and Reg Middleton.	
1.3	Dr Bob Bowes extended thanks to Malti Varshney (Public Health Consultant) who had taken up a new role at NHS England and Mark Lemon who had recently retired from his role at KCC for their contributions to the work of the Health and Wellbeing Board.	
1.4	Dr Bowes welcomed the following new members to the Board: • Tristan Godfrey Policy & Relationships Adviser, KCC • Cllr Fay Gooch (Deputy Leader of MBC) attending on behalf of Fran Wilson who now formally takes a seat on the board ins place of Cllr Annabel Blackmore • Adam Wickings, NHS WK CCG Joint Chief Operating Officer • Cllr Piers Montague, Tonbridge & Malling Borough Council who now formally takes a seat on the board in place of Cllr Maria Heslop.	YW
2.	**Declaration of Disclosable Pecuniary Interests** There were none.	
3.	**Minutes of the Previous Meeting – 20 December 2016** The minutes of the previous meeting were agreed as a true record.	
4.	**Matters Arising**	
4.1	**Update: Implementing the Health and Wellbeing Board Annual Report Recommendations**	
4.1.1	Board Development Event 21 February 2017	Yvonne Wilson/Dr Bob

	Dr Bowes reported on the recent whole Board Development Event to review its effectiveness and consider ways of strengthening the impact and influence of the Board. Members were directed to the report of the event prepared by John Simmons the event facilitator. Attached as an Appendix t the minutes. Dr Bowes explained that going the meetings will have a different format: • fewer agenda items • more time to fully consider topics of concern • invitation to participate extended to a broader range of partners (including providers of services) who can add value to the Board's deliberations • 'workshop style' session • less focus on the West Kent Board operating in the same way as the Kent Board • greater emphasis on delivering outcomes	Bowes
4.1,2	Assurance Framework Report Dr Bowes drew members' attention to the short briefing (see Appendix providing further details on how the decisions on the Assurance Framework considered at the 20 December meeting were being progressed.	
5.	**Kent Health & Wellbeing Board Feedback**	
5.1	Dr Bowes provided the following feedback from the issues considered at the 22 March meeting of the Kent Health & Wellbeing Board:	
5.2	Health & Wellbeing Strategy	
5.2.1	A new Health & Wellbeing Strategy was being produced, format is a radical departure from previous strategies. Commissioners on the Kent Board have issued a challenge for a strategy that has the capability to more effectively support commissioning decision making within the context of current health and social care planning, including the Sustainability and Transformation Plan. Dr Bowes reported on the position taken at the Kent Board, that Health and social care commissioners believe the current Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy do not provide them with sufficiently detailed direction they need to inform their commissioning decisions and that the new approach would go a considerable way to remedying this.	
5.2.2	Work was underway to develop the analytical and modelling	

	capability across the health and social care system to support development of a JSNA Plus. This work will develop into a set of tools that enhance the work taking place in the STP to give commissioners a mutually agreed evidence base through which to test different commissioning scenarios and make more informed and targeted decisions.	
5.2.3	The strategy and presentation of dynamic systems modelling had been well received at the Health and Wellbeing Board which gave its approval for Phase 2 of the Dynamic System Modelling Project to be taken forward. KCC Public Health department will organise workshops for key analytics staff to become familiar with the software that underpins the model. Dr Bowes explained that this work will be followed by a workshop with commissioners to begin to test out the model and explore the questions commissioners are grappling with in their planning and decision making.	
5.3	**Joint Strategic Needs Assessment (JSNA) Plus**	
5.3.1	Dr Bowes reported that the refresh of Kent Joint Strategic Needs Assessment chapter summaries was completed in late 2016 and early 2017. Key issues highlighted in the JSNA worthy of mention, included: • increased migration into Kent, • ageing population • inequities in heath and care service access, leading to health inequalities	
	Review of Commissioning Plans	
5.4	Dr Bowes informed the WK HWB that the Kent HWB had reviewed the commissioning plans of the member in the light of the STP Local Care work stream, and that the issue of how extra funding for social care can be used to ease pressure on the acute sector was also discussed, and is likely to go back to June Kent HWB meeting for further consideration..	
6.	**Board Workshop Session** **Frail and Elderly People**	
6.1	See Minutes Appendix for details of the discussion and conclusions.	
7.	**Sustainability & Transformation Plan (STP): Challenges & Prospects**	
7.1	Dr Bowes updated the meeting on the recent developments with implementation of the Kent & Medway Sustainability and	

	Transformation Plan (STP) explaining that the 'Case For Change' document had been published. Dr Bowes identified the challenges for system leaders: • Stronger focus on prevention was required, to deliver population-wide interventions – further consideration should be given by the Board as to how it could get involved in helping develop good cross-sector partnerships • Recognition that long-term sustainable change was not possible with just a reliance on transforming acute sector services, changes were required across the health and social care system and in particular the development of local care (out of hospital) to deliver better care for more people is essential to this.	
7.2	AB asked whether WKCCG would now take steps to consider how local district and borough councils could be involved in the STP process, particularly as local authorities clearly had a positive role to play. Dr Bowes confirmed that steps would be taken to enable council partners to be involved in STP operational delivery matters.	BB/WKCCG
8.	**Health Improvement Model: Local Authority Devolution**	
8.1	Lesley Bowles (SDC) and Karen Sharp (KCC) delivered a joint presentation outlining the objectives underpinning the proposed changes for Public Health provision across West Kent. Ms Bowles explained that a West Kent Improvement Board had been set up in response to the Government's devolution agenda. Membership of the Integration Board included Leaders of the four Councils with meetings also attended by the three Chief Executives and KCC Officers. Ms Bowles reported that the individual sovereignty of the four councils would be retained and the purpose of the Integration Board was to: • Save money by taking out waste and duplication and • Develop structures that enable services to be co-commissioned, delegated or devolved	
8.2	Ms Bowles outlined the prospects for the West Kent Deal, which including a 'Ten Point Plan' for Enhancing the range of support on offer: • Hub model for integrated public health (preventative services) • Debt and housing advice extended to include healthy lifestyle referrals • Communication tools/campaigns • Making every contact count • Partnerships with GPs • Focus on Healthy Workplaces • Access new funding opportunities	

	• Strengthen and promote the environment as a vehicle for health improvement (open spaces, leisure and active travel • Policy review • Asset Mapping	
8.3	Ms Sharp explained the new pathway for Kent which has a clear vision for motivating change, supporting people to change and to maintain positive outcomes. Ms Sharp identified the advantages of the new model and outlined a range of developments across the three councils and prospects for joining up with other agendas.	
8.4	There was limited opportunity for depth discussion, though it was agreed that the work carried out so far, had not yet included a conversation with 'health' where there were a number of potential opportunities for collaboration, some of these were highlighted in the presentation, for example – links with the housing devolution agenda; offering support for healthy lifestyles from a range of locations which could be aligned to new GP Clusters. Dr Bowes thanked Ms Bowles and Ms Sharp for the informative presentation.	
8.5	It was agreed to identify key individuals in the health system who can facilitate discussion with Officers devising the strategy and implementation of the devolution agenda to consider: • Housing Devolution • Healthy lifestyles programme offer – premises/locality links with the Local Care Agenda • Alignment between West Kent Devolution and Local Care agenda ACTION: BB; LB; AB; KS; Gail Arnold, YW	
9.	**Any Other Business – Future Agenda Items**	
11.1	It was resolved that the Board will consider the following issues. The items suggested on the meeting agenda were agreed to be brought forward onto the Work Programme for the Health and Wellbeing Board.: Alcohol Related Harm : Task & Finish Group - A Proposal to the Board for a Sustainable Approach to Tackling Local Challenges June 2017 Tackling Obesity – Workshop Session June 2017 Community Asset Mapping Workshop Session - August 2017 Self-Care, Self - Management – Workshop Session August 2017 North Kent Pilot Children's Commissioning Model - Workshop Session October 2017	Chair/Yvonne Wilson

12.	**Date of Next Meeting** **20 June 2017 - Tonbridge & Malling Borough Council Offices, Gibson Drive, Kings Hill, West Malling, ME19 4LZ**	All
13.	**<u>West Kent Health & Wellbeing Board Meetings 2017 - 2018</u>:** • **15 August 2017** • **17 October 2017** • **19 December 2017 TBC** • **20 February 2018** • **17 April 2018**	All
	For any matters relating to the West Kent Health & Wellbeing Board, please contact: Yvonne Wilson, Health & Wellbeing Partnerships Officer NHS West Kent CCG Email: yvonne.wilson10@nhs.net Tel: 01732 375251	

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West Kent Health & Wellbeing Board Meeting 18 April 2017
Notes of the Workshop Session
Frail and Elderly People
Towards a Whole Systems Approach to Falls Prevention
From Current State to Ideal Status

Roundtable Discussion – Question (1)	Responses
How can we increase the number of people at risk of falling getting access to prevention?	• Identify who is at Risk of Falling - Be clear about what the data tells us – are the clients falling known to other services; what's their age; are they risk takers; who are they and how do we find them? Identify patients/residents who should be flagged up automatically in the system • Assemble Clear Facts - Are there opportunities for the profile of falls/falling to be raised by wider discussion/portrayal of issues more widely? • Enable the Targeting of resources in a 'joined up' way • Change the way the services are promoted/advertised (needs more 'popular appeal' to encourage the relevant segments of the target 'population group' who are often reluctant to ask for help) • Needs greater awareness of 'self-care', to encourage understanding of the potential for falling • Need wider and earlier education • Explore the opportunity for using private sector providers (who the population group might trust) to distribute prevention materials e.g., booklet or apps • Engagement needs to be meaningful and properly targeted - Care Navigators, Fire Service as a 'trusted brand' could be considered
	• Duration of the Postural Stability sessions are not adequate and they are likely 'not' offered in the most appropriate locations. Locally available services need to meet the needs of the local population (eg is transport adequate – can difficulties of the location be overcome? • There's a need to take messages about falls out to people in places where they meet and in a wide range of settings • Primary/Secondary interventions –different approaches needed (consider more flexibility in the existing programmes) • Need more education around 'staying active' as a prevention measure for later life for the *general* population (General Wellbeing Messages – need to highlight the Risk Of Falls) • Do we know enough about the kinds of Wellbeing Messages around Falling we need to

	develop that will have greater impact and spread better awareness • Identification of those at Risk; look at who can help identify those who might benefit, KFRS; Housing; Community Wardens; Voluntary Sector – particularly where contacts may be being made with those residents/clients and 'sign posting' might benefit • Need to explore the reasons for/responses to people's resistance to accepting support/help • Make 'staying active' something we embed in people's lives and a natural part of getting older and offer activities and opportunities to engage people and promote 'age-friendly' activities
	• Falls branding is likely 'off putting', - consideration to be given to what actions required if a client refuses a referral, what next, are there other strategies in place to help? • Recognition that a 'Falls Programme' is not for everyone – what about a DIY Falls Programme – Wii, yoga, Pilates? • Need to look at local housing conditions in a more systematic way (to address potential for slips, trips and falls), how are we managing accommodation risk assessment, might potential responses include a routine referral for a home safety audit by KFRS be established as an integral part of the Falls Pathway, or a general offer to residents over a certain age? • Consider whether there is a role for the Homes Improvement Agency (HIA)/Disabled Facilities Grants mechanism (DFG) and Community Wardens etc? • Do we know why people Drop Out of the Prevention Programmes?
	• Whole Community approach needed / One Size 'doesn't fit all' must be recognised and we must have different ways of reaching people • Can Health Checks highlight Risk Factors? • Generic messages – lighting; Rugs/carpets; Slow down/think; Pharmacists, Opticians, Hearing Centres, GP, Leisure Centres, Social Prescribing (Walking Football; Health Walks; (Grey Pound, doesn't need to be free….)
	• Consider promoting ways to stay active and happy by fun means, dancing; the arts • Could we have local hubs for addressing Falls, how might the Devolution discussions assist? • Develop better appreciation of what's available locally so we can offer via sign posting and ensure those accessing existing services and others are informed • Agree a strong Self-Care message and how we will share it to create Behaviour Change - Can we use 'younger people/children' to pass on the message and/or think of how to overcome the family/life-style challenges (much like messages around stopping smoking)?
	• Education & Awareness - Need clearer pathways and innovative approaches - Use Council Tax Bills to spread simple health messages/mobilise existing communications strategies and arrangements?

	• Services need to get out into the community/outreaching • Can the community, voluntary sector (CVS) help create better awareness? • Key areas – marketing should include engagement of older people in the design of messages • Link with and offer older people a whole range of activity programmes with a more holistic approach – Build in a programme of fun, social activities and exercise • Increase access to prevention • Robust falls risk assessment tool • Consider re-marketing of the services • ? Need for better education of the benefits?
Roundtable Discussion – Question (2)	
How can we make falling risk be part of Making Every Contact Count (MECC)	• MECC too prescriptive and the 'ask' of professionals is too rigid, needs to be done at the right time by the right people with the right skills. The training is too broad. • Locally available services needed to help needs to be met – as a result, careful consideration to be given to transport matters and ensure current difficulties of some of the service location issues be overcome? • Should the approach be about referring into the West Kent/other Lifestyle services/other professional services • Belief that older people may not be fully ready for discharge into community, there's often still the burden of acute illness at play (Do we know what proportion of the people who fall are ill/have no diagnosis?) • Client perceptions are crucial – often they are not fully aware of the risks and therefore we must ensure prevention messages and conversations are 'acceptable' • Remove Professional boundaries – help people be confident to hold MECC style conversations.
Other Points for Commissioners to Consider	• KCC are commissioning an 'Older Person's Offer' – this work fits into an 'early intervention' agenda/prevention agenda that they are seeking to procure – THERE MUST BE JOINING UP • There needs to be more 'joining up' across services and organisations including 'data sharing' • Data requirements - must be West Kent specific • Housing Design needs to take account of dwellings which suit a broader range of mobility needs including better access for all so there are fewer challenges for people with mobility issues
	• Need to consider developing 'frailty friendly' communities
	• Needs better investment in services • Holistic approach – different range of activities should be 'on offer and welcoming' • Commission Kent Sport Pilot – Indoor bowls and walking football

Summary of suggestions for actions which might strengthen the holistic falls pathway:

- Early action to help identify people at risk of falls e.g., by drawing on the role of a wider range of professionals and agencies
- Consider schemes which pro-actively targets specific vulnerable population groups (e.g., people on the Local Authority Sensory Impairment Register) for a home safety audit by the Fire Service
- Boost Effectiveness of the messages about Prevention, Staying Active, Proactive Planning for Older Age and Retirement
- Better appreciation of what an effective, integrated falls service looks like, fully integrated across agency/sectors
- Better understanding of the reasons for hospital attendances due to falls (e.g., trips; slips; medicines effects; self-neglect/hoarding and action to pre-empt these and tackle root causes)
- Commit to a joined up and fully integrated commissioning across the health, social and council care systems and services that reflects interventions which are complementary to the STP approach
- Develop a broad-based area – wide promotional campaign to highlight falls prevention where appropriate, linked to the 'One You' Campaign and a commitment to promote active citizenship and boost 'civil society'

Draft Minutes of West Kent Health and Wellbeing Board Meeting
20 June 2017 16.00 -18.00
Tonbridge & Malling Borough Council, Gibson Drive, Kings Hill, West Malling, Kent, ME19 4LZ

PRESENT:

Dr Bob Bowes (BB)	Chair, NHS West Kent Clinical Commissioning Group Governing Body (NHS WK CCG)
Alison Broom (AB)	Chief Executive, Maidstone Borough Council (MBC)
Roger Gough (RG)	Cabinet Member, Kent County Council (KCC), Vice Chair
Tony Jones (TJ)	GP Governing Body Member, NHS WK CCG
Andrew Roxburgh (AR)	GP Governing Body Member, NHS WK CCG
Gary Stevenson (GS)	Head of Street Scene, Tunbridge Wells Borough Council (TWBC)
Lynne Weatherly (Cllr LW)	Councillor, TWBC
Penny Graham (PG)	Healthwatch Kent

IN ATTENDANCE:

Sally Allen (SA)	Head of System-Wide Commissioning, NHS WK CCG
Alison Davis (AD)	Programme Co-ordinator, Youth Central CIC
Darren Lanes (DL)	Head of Leisure Services, Tonbridge & Malling Borough Council (TMBC
Martin Guyton (MG)	Chief Executive Officer, TM Active
Karen Hardy (KH)	Specialist, KCC Public Health
Jo Hulks (JH)	Healthy Weight Team Manager, Kent Community Health Trust
Paul Kirrage (PK)	Kent Healthy Business Manager
Val Miller (VM)	Specialist, KCC Public Health
Susan Reynolds	Specialist Midwife, Maidstone & Tunbridge Wells Hospital Trust
Matt Roberts (MR)	Community Partnerships & Resilience Manager, MBC
Sarah Richards (SR)	Healthy Lifestyles Coordinator, TWBC
Shona Slingo-Bass (SSB)	Specialist Midwife, Maidstone & Tunbridge Wells Hospital Trust
Anthony	Licensing Manager, TMBC
Anton Tavernier-Gustave	Healthy Lifestyles Manager
Kelly Webb (KW)	Community Safety Manager, SDC
Yvonne Wilson (Minutes)	NHS WK CCG

1.	**Welcome and Introductions**	Action
1.1	Dr Bob Bowes welcomed all present to the meeting, in particular those attending for the special Workshop Session on Healthy Weight and the item on addressing Alcohol-Related Harm.	
1.2	Apologies were received from Gail Arnold, Julie Beilby Penny Southern, Cllr Fay Gooch, Dr Caroline Jessel, Tristan Godfrey, Cllr Piers Montague, Dr Sanjay Singh and Reg Middleton. CI Dave Pate had also offered apologies as he was due to attend to present the report at item 7.	
1.3	Dr Bowes invited all present to introduce themselves prior to the item on Alcohol Related Harm as a number of Council Officers were attending specifically to offer their comments to the discussion.	
2.	**Declaration of Disclosable Pecuniary Interests** There were none.	
3.	**Minutes of the Previous Meeting – 18 April 2017** The minutes of the previous meeting were agreed as a true record.	
4.	**Election of Chair and Vice Chair**	
4.1	Bob Bowes reported that the Board was required to elect a Chair and Vice Chair for the period to 1 April 2018.	
4.2	Cllr Lynne Weatherly nominated Bob Bowes as Chair, seconded by Tony Jones. There were no objections and Dr Bowes was duly accepted as the Board Chair until April 2018.	
4.3	Bob Bowes nominated Cllr Roger Gough as Vice Chair, this was seconded by Alison Broom. There were no objections and Cllr Roger Gough was duly accepted as the Board Vice Chair until April 2018.	
5.	**Matters Arising**	
5.1	**Update: Progressing the Outcomes of the Falls Prevention Workshop HWB meeting18 April**	
5.1.1	Dr Bowes directed Board members to Appendix 2a, the notes of the Workshop Discussions attached to the minutes. Dr Bowes reported that the workshop notes and summary of the issues highlighted had been sent to commissioners of Falls Prevention services with a letter asking that the issues be reflected upon and taken into account whilst undertaking the commissioning of services. The service Commissioners were invited to attend the WK HWB meeting on 17	

	October to report formally to the Board on actions taken to address the concerns and outcomes from the Falls Prevention Workshop.	
5.1.2	Letters had been sent to the following: - KCC, Director of Public Health - Andrew Ireland, KCC, Corporate Director for Adult Social Care and Health - Barbara Cooper, KCC, Corporate Director for Environment - Dr Andrew Cameron, Clinical Lead for Frailty and Medical Commissioning - Rachel Parris, Commissioning Lead – Frailty & Medical Commissioning, HS WK CCG	
5.1.3	Dr Bowes explained that a group of officers from a range of agencies had met following the Falls Workshop to share information about current and future provision of the falls pathway in West Kent. Dr Bowes remarked that clarity was required around future KCC commissioning. Karen Hardy, KCC Public Health Specialist advised the meeting that Alison Duggall the Deputy Director for Public Health had been identified as the KCC strategic lead for Falls. Dr Bowes agreed to also send a letter to Alison Duggall.	Yvonne Wilson/Dr Bob Bowes
6.	**Kent Health & Wellbeing Board Feedback**	
6.1	Cllr Roger Gough reported on key business discussed at the recent Kent HWB meeting.	
6.2	Cllr Gough had stepped down as HWB to be replaced by Cllr Peter Oakford (KCC Deputy Leader). Dr Bob Bowes was re-elected and remains as Vice Chair of Kent HWB.	
6.3	Cllr Gough shared the highlights of the discussion on the proposed expenditure of additional funding for social care following the decision announced in the Chancellor's Budget Statement in March 2017. Cllr Gough reported that decisions had been taken to address certain 'market stresses' and structural measures to tackle Delayed Transfers Of Care.	
6.4	Cllr Gough informed the Board that a review of the Better Care Fund had been carried out. Extra resources for social care had been allocated by central government for the period up to 2019 – 2020.	
6.5	Cllr Gough reported on the presentation 'Your Life, Your Wellbeing' which set out the progress on a pilot in East Kent aligning health and social care. KCC were looking to the potential for rolling out the model across the County.	

7.	**Alcohol Task & Finish Group** A Proposal to the Board for a Sustainable Approach to Tackling Local Challenges	
7.1	Karen Hardy, Public Health Specialist introduced the report by briefly outlining the background context for the setting up of the Alcohol Related Harm Task & Finish Group which included a 'summit' in October 2015 and the development of a multi-agency Alcohol Misuse Action Plan to guide delivery of a range of interventions to address the problems across West Kent. Ms Hardy explained that CI Pate had written to identified stakeholders to secure their commitment to deliver interventions set out in the Action Plan with a positive response received.	
7.2	Ms Hardy explained that the Task Group had met over the last 18 months and agreed the priorities for West Kent, but that Public Health arrangements were currently under review as part of the Devolution discussions taking place between KCC and local councils. It was now felt that Community Safety Partnerships were best placed to take the lead role in co-ordinating future activities and monitoring progress.	
7.3	Ms Hardy explained that a brand new Kent Drug & Alcohol Strategy was due to be approved and recommended that the West Kent Alcohol Misuse Action Plan be updated to reflect local issues, the Kent-wide Strategy's five themes and be managed by the West Kent Community Safety Partnerships. Ms Hardy further recommended that an officer representing the Community Safety Partnerships be identified to ensure a reporting relationship to the WK HWB.	
7.4	Dr Bowes invited comments on the proposals outlined to the Board. The following issues and questions were highlighted in the discussion: • The accompanying Action Plan remained incomplete with gaps in the detail expressing the identification of measures of success for the actions described and timetable for delivery • Some Community Safety Unit Managers had not seen an updated version of the Action Plan (KW) • That at the summit in 2015, it was acknowledged that a range of organisations had different opportunities to intervene to support people experiencing difficulties with their alcohol use and the Board should ensure early intervention was being offered to prevent escalating problems (TJ) • Making Every Contact Count (MECC) was an integral part of all NHS Contracts and joint work was required with providers to look at ways help staff deliver brief interventions (BB) • Some of the Action Plan Targets are out of date and the document needs to be re-freshed (e.g., Alcohol required Zones no longer in place) (TMBC) • Suggestion that Outcomes Based Accountability Training	Action: BB/WKCCG

	might be a useful skill/discipline for the Task Groups to assist in target setting and outcomes (MR)	
7.5	**The Board agreed the following:**	
7.5.1	That the Action Plan should be updated and remain focussed on local priorities managed by the West Kent Community Safety Partnerships, with clear ambitions, target measures and outcomes identified.	x4 Community Safety Partnership Managers (CSPs)
7.5.2	The Draft Kent Alcohol and Drug Strategy Themes are included in and aligned fully with the West Kent Action Plan .	
7.5.3	The four Community Safety Partnership Managers to work together with KH to update the Action Plan and feed back to the WK HWB.	
7.5.4	That an officer representing the four Community Safety Partnerships be identified to feed back on progress to the WK HWB.	TBC
8.	**Board Workshop Session** Tackling Obesity: Towards a Whole Systems Approach to Healthy Weight Management, From Current State to Ideal Status	
8.1	The HWB Healthy Weight Champion, Cllr Lynne Weatherly introduced the Workshop Session and expressed her delight in the Task & Finish Group being given an opportunity to engage with a wider group of people/organisations beyond those represented on the Board about this important issue. Cllr Weather explained that there was a strong desire to ensure the Draft Strategic Action Plan truly reflects the contributions that the organisations and interest groups attending the Workshop can undoubtedly make, this will ensure the Board has a right to be confident there's the greatest benefit to residents across West Kent.	
8.2	Cllr Weatherly explained that the Task Group approach has been to identify high level priorities reflecting what research and evidence indicates are the most effective ways to reduce obesity. The Task Group fully acknowledged this as a very complex issue and is seeking the help of stakeholders to further develop and implement actions that will help deliver on the agreed priorities. Cllr Weatherly emphasised that it wants to make sure the Board is able to influence investment in activities and programmes that build on the strengths of individuals and communities and the relationships in our local communities. Cllr Weatherly also stressed the importance of ensuring activities suggested in the Action Plan are focused where there is the greatest capacity to benefit.	BB/WKCCG
8.3	Cllr Weatherly stated that she was particularly ly pleased to be able to welcome Specialist Midwives, Leisure Service Providers, Voluntary sector agencies, the West Kent Healthy Business Adviser and trainee	

	GPs. Cllr Weatherly introduced the four 'presentations which she explained were designed to help provide background and context about the scale of the challenge in West Kent, giving a better understanding of how the national and Kent-branded One You initiative can also help local ambitions around promoting steps to Healthy Weight and more active lifestyles. Val Miller, KCC Public Health Specialist and Sally Allen, Head of System-Wide Commissioning (NHS WK CCG) delivered the presentations.	
8.4	The following issues and observations were raised in discussion: • Draft Action Plan says nothing about being active and measures to promote encouraging people to move more (MG) • Case Studies about successful experiences of people being able to change their lives in a 'commercial' environment – helping open doors PHE study showed 1:6 premature deaths, lack of physical activity plays a part • Question about GPs recording weight; what may happen in the consultation when GPs mention weight issues; further analysis of the published data on GP recording of obesity (TJ, AR, BB) • One You – more than a campaign • Concern that interventions may not be reaching BME groups; young people • Need to recognise different agendas when dealing with weight management • One You already invited to CCG AGM and will hopefully be sharing experience of the approach in a GP surgery to encourage practices to take up the challenge of boosting awareness • New organisations in the voluntary sector struggle to get started, be seen as legitimate, effective and are an 'unknown quantity' despite seeking to reach out to engage young women. New charity working with young women – founder has personal experience of being very obese but now a healthier weight so considers there's value in being able to share understanding of dome of the issues (AD) Offer of a stall at CCG AGM (TJ) • Action Plan required for MECC (SA) • Need to ensure link up with the self-care agenda	Action: TJ WKCCG, AD
8.5	Cllr Weatherly encouraged attendees to fully participate in the important part of the agenda, the time for all to get involved in conversation about tackling obesity and promoting healthy weight.	
8.6	It was agreed to have the notes from the Workshop Session written up into an Appendix for review by the Task Group and further consideration by the Board at a future meeting.	YW, Task Group, WK HWB

9. 9.1	**Any Other Business – Future Agenda Items** It was resolved that the Board will consider the following issues at the August meeting: • Community Asset Mapping Workshop Session • Self-Care, Self - Management – Workshop Session	Chair/Yvonne Wilson
10.	**Date of Next Meeting** **15 August 2017 - Tonbridge & Malling Borough Council Offices, Gibson Drive, Kings Hill, West Malling, ME19 4LZ**	All
11.	**West Kent Health & Wellbeing Board Meetings 2017 - 2018:** • **17 October 2017** • **19 December 2017 TBC** • **20 February 2018** • **17 April 2018**	All
	For any matters relating to the West Kent Health & Wellbeing Board, please contact: Yvonne Wilson, Health & Wellbeing Partnerships Officer NHS West Kent CCG Email: yvonne.wilson10@nhs.net Tel: 01732 375251	

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West Kent Health & Wellbeing Board 20 June 2017 Healthy Weight Workshop Notes		
Who have we not taken in to account in developing the Action Plan?	How to work with other stakeholders to reduce prevalence?	What can commissioners do to better integrate services?
Specific target groups: • People with hypertension • People on specific care /treatment pathways (Musculo Skeletal) • People undergoing current assessment by physiotherapists • Young People • Commuter groups • Older People • BME Communities - Businesses are important contributors - Workplaces are important settings	- Audit outcomes in Primary Care - All promote One You - Better recognition of the role of the Voluntary Sector - Need to see information about 'area-based deprivation' overlaid onto GP Cluster maps (these show the groups of GPs who are planning to work together more collaboratively. Across West Kent there are 7 clusters). This will help with joining up healthy weight and health improvement agendas	Focus on ensuring appropriate advice, information and sign-posting is made available for: • People on specific care /treatment pathways (Musculo Skeletal) • People undergoing current assessment by physiotherapists - Work with different population groups to encourage their participation in the development of potential measures to promote healthy weight. - Recognise the role of the Voluntary/Community sector and the need to encourage communities to make better use of open spaces. - Help people make better use of web-based resources. - Commissioners to engage leisure service providers - Need to see information about 'area-based deprivation' overlaid onto GP Cluster maps (these show the groups of GPs who are planning to work together more collaboratively. Across West Kent there are 7 clusters). This will help with joining up healthy weight and health improvement agendas

Who have we not taken in to account in developing the Action Plan?	How to work with other stakeholders to reduce prevalence?	What can commissioners do to better integrate services?
- Target commissioning to those in most need/who could benefit most, e.g. deprivation, ethnicity, hard to reach groups, young people - Find the motivating factor for the targeted groups (it is not their first priority to lose weight if they have other bigger issues such as housing and employment) - Teach people related skills, e.g. cooking, nutrition, self-esteem - Out-reach to where people meet/gather, e.g. arts centres, healthy living centre, interest groups, schools, use community leaders (tackle industries such as care, shop staff and those in the building trades) - Improve promotion of healthy eating and local initiatives	- Use collective power of public sector to drive change in organisations and communities, e.g. start in-house and with contracted providers on weight management initiatives, put OneYou on email signatures - Public sector to stop short-termism – reduce focus on quick results and focus on longer term interventions and support - All to give the same message and sue the same data source and language - Stop normalising being overweight and obese : clear messaging about knowing your BMI and what is healthy weight - Sign-posting all services using a service directory via One You - Try to get workplace communities to make changes together	- Longer lead-in times for new services to establish themselves - Encourage links between services - Better inter-working between exercise and dietary services – reinforce the messages about the link between weight and exercise/moving more

Who have we not taken in to account in developing the Action Plan?	How to work with other stakeholders to reduce prevalence?	What can commissioners do to better integrate services?
- Young People and Peer Champions/Mentors use' Lancaster' Model/Approach - Men aged 35+ (via social networks) - Specific occupational groups (e.g., Taxi Drivers) - Businesses - Known Communities in Need - BME people - People with Learning Disabilities - More work with local people - Midwives and importance of Ante Natal period - Ensure consistent messages that encourage behavioural change	- Health in All Policies - Promote One You Website - Promote Social Prescribing - Use Make Every Contact Count (MECC) approach/principles – find ways to measure and monitor - Review content of Health Checks and Health MOTs - Asset Mapping – highlight work in known areas of deprivation - Use CCG development of 'Local Care' approach as vehicle for 'joined up' work with primary care workers, GPs and community sector - Greater emphasis on utilising the Kent Healthy Business Award - Better support for local workforce activities - Food Champions in Kent Community Health Trust	- Promote issue with contractors - Better emphasis on maternity services and links with the GP Clusters - Ensure consistent messages that encourage behavioural changes - Ensure focus on universal services - Ensure the issue has a strong focus in the Kent & Medway STP - One You should be an integral part of all relevant commissioning activity - Commissioners to communicate with one another to ensure Tier 2 – Tier 4 Pathway - Consider targeted commissioning of support and services - Need to ensure effective sign-posting

KEY MESSAGES from discussion:

1) All to promote One You

2) Access to service and support directory/sign-posting

3) Target communities and areas which would benefit most/work with local people and in communities

4) Commission for outcomes that have a direct effect on prevalence

5) Use the One You resources, tailor promotions and offer solutions too

6) Need to ensure links with the self-care agenda

7) Action Plan required for MECC – NHS WK CCG and providers

8) Draft Action Plan to include more about being active and should offer measures to promote encouraging people to move more

9) Consider specific ways of engaging Primary Care/GPs

10) How can we support innovation?