Ashford Health and Wellbeing Board

ASHFORD
BOROUGH COUNCIL

Notice of a meeting, to be held in Council Chamber, Civic Centre, Tannery Lane, Ashford, Kent TN23 1PL on Wednesday, the 23rd October 2013 at 12.00 noon

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Agenda

Page Nos.

1. **Welcome and Apologies**

2. **Declarations of Interest:-** To declare any interests which fall under the following categories, as explained on the attached document: 1

   a) Disclosable Pecuniary Interests (DPI)
   b) Other Significant Interests (OSI)
   c) Voluntary Announcements of Other Interests

   See Agenda Item 2 for further details – but please note this is an Ashford Borough Council document which members might nonetheless find helpful. It is understood that KCC will be issuing guidance to members on interests in the near future.

3. Notes of the Meeting of this Board held on the 24th July 2013

4. Revisions to terms of reference for CCG level health and wellbeing boards –Sheila Davison

5. Clinical Commissioning Group (CCG) – Priority Setting Engagement Event (verbal report) – Navin Kumpta

6 Update on the Integrated Commissioning Group – Dave Harris

7. Integrated Transformation Fund - KCC

8. The Public Health Resource and Programme for Ashford – Marion Gibbon

9. Public Health Contribution to the Kent Health and Wellbeing Strategy – Marion Gibbon

10. Kent SEND (Special Educational Needs and Disabilities) Strategy – Julie Ely and Martin Cunnington (to follow)

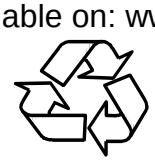
11. Items for the Forward Plan

12. Next Meeting – 22nd January 2014

Under the Council's Public Participation Scheme, members of the public can submit a petition, ask a question or speak concerning any item contained on this Agenda (Procedure Rule 9 Refers).

KRF/VS
15th October 2013

Queries concerning this agenda? Please contact Keith Fearon:
Telephone: 01233 330564 Email: keith.fearon@ashford.gov.uk
Agendas, Reports and Minutes are available on: www.ashford.gov.uk/committees



Declarations of Interest (see also "Advice to Members" below)

(a) **Disclosable Pecuniary Interests (DPI)** under the Localism Act 2011, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares a DPI in relation to any item will need to leave the meeting for that item (unless a relevant Dispensation has been granted).

(b) **Other Significant Interests (OSI)** under the Kent Code of Conduct as adopted by the Council on 19 July 2012, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares an OSI in relation to any item will need to leave the meeting before the debate and vote on that item (unless a relevant Dispensation has been granted). However, prior to leaving, the Member may address the Committee in the same way that a member of the public may do so.

(c) **Voluntary Announcements of Other Interests** not required to be disclosed under (a) and (b), i.e. announcements made for transparency reasons alone, such as:

- Membership of outside bodies that have made representations on agenda items, or
- Where a Member knows a person involved, but does not have a close association with that person, or
- Where an item would affect the well-being of a Member, relative, close associate, employer, etc. but not his/her financial position.

[Note: an effect on the financial position of a Member, relative, close associate, employer, etc; OR an application made by a Member, relative, close associate, employer, etc, would both probably constitute either an OSI or in some cases a DPI].

Advice to Members on Declarations of Interest:

(a) Government Guidance on DPI is available in DCLG's Guide for Councillors, at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/240134/Openness_and_transparency_on_personal_interests.pdf

plus the link sent out to Members at part of the Weekly Update email on the 3rd May 2013.

(b) The Kent Code of Conduct was adopted by the Full Council on 19 July 2012, and a copy can be found in the Constitution at http://www.ashford.gov.uk/part-5---codes-and-protocols

(c) If any Councillor has any doubt about the existence or nature of any DPI or OSI which he/she may have in any item on this agenda, he/she should seek advice from the Head of Legal and Democratic Services and Monitoring Officer or from other Solicitors in Legal and Democratic Services as early as possible, and in advance of the Meeting.

Ashford Health and Wellbeing Board

24th July 2013

1. **Introduction**

The Chairman opened the meeting and as there were some new faces around the table, he invited the members of the Board to introduce themselves and explain their respective roles.

Apologies:

John Bunnett – Chief Executive, ABC
Marion Gibbon – Public Health Representative, KCC
Mark Lemon – Policy & Strategic Relationships, KCC
Simon Perks – Accountable Officer, CCG

Present:

Cllr Michael Claughton – Chairman, Cabinet Member, ABC
Navin Kumta – Vice Chairman, Clinical Lead Ashford, CCG
Cllr Jenny Whittle – Cabinet Member, KCC
Sheila Davison – Public Health Representative, ABC
Dave Harris - Families and Social Services, KCC
Martin Harvey – Patient Participation Representative, Lay Member, CCG
Belinda King - Management Assistant, ABC
Jane Miller - Families and Social Services, KCC
Paula Parker – Families and Social Services Representative, KCC
Sue Sawyer – Volunteering Ashford
Penny Southern - Families and Social Services Lead, KCC
Debbie Smith – Public Health Representative, KCC
Danny Sheppard – Senior Member Services Officer, ABC

2. **Minutes of the Last Meeting held on 24th April 2013**

It was agreed that the Minutes were a correct record of the Meeting.

3. **Matters Arising**

Following discussion at the last meeting on the Terms of Reference of this Board, there had been a meeting with the Head of Legal & Democratic Services at ABC on the 12th June and there remained areas of concern about a number of issues including: - KCC/ABC Codes of Conduct; voting rights; disclosure of all categories of interest; substitution arrangements; public participation; and scrutiny and call-in arrangements. Details had been sent to Mark Lemon at KCC and it was fair to say that this was a 'work in progress'. It would be vitally important to get the Terms of Reference right.

On membership gaps, the Chairman said it would be advantageous to have a voluntary/community sector representative on board in a permanent capacity. Sue Sawyer from Volunteering Ashford was present at this meeting and, by October, it would be clear who the permanent representative would be going forward. A representative from Healthwatch was also being pursued.

In terms of the on-going circulation of agendas and production of the minutes of meetings, Hayley Curd had now left ABC and this would be taken on by either Keith Fearon or Danny Sheppard from ABC Member Services. In terms of the publication of agendas Danny Sheppard advised that this would generally be a minimum of five working days before meetings and members would be given advanced notice of the lead in time needed for reports.

The Chairman advised that starting with the next meeting in October future meetings would take place in public. It was important to be clear about the distinctions of 'meeting in public' as opposed to 'a public meeting' in that members of the public should not have their hopes raised that they could come along and raise any issues they wanted.

4. **Update on the Integrated Commissioning Group meetings and Commissioning Plan**

Paula Parker advised that the Integrated Commissioning Group (ICG) had met three times since April and were forming well as a group. They had considered and discussed the various plans and aligned them all into one document, agreeing the areas they wished to target. These three broad areas were: - family support; long term conditions; and healthy living, all centred on early diagnosis. These were three distinct areas but there was a considerable amount of overlap. There was now a need to align the services for the Ashford area and bring something back to this Group with a view to deciding what projects to take forward. A highlight report had been produced and Paula Parker endeavoured to make that available for circulation with the minutes.

Dave Harris gave a brief presentation on how the initial 171 priorities had been distilled down into 20 high level areas. The next area of work was to map existing services and do a gap assessment. It was agreed that it would be beneficial to re-circulate the full list of priorities sitting behind the document to members. The document they had produced was 'live' and open to input from members should they wish to add/amend anything.

Penny Southern asked if this same format was going to be used across the County as it would seem a good idea in terms of economies of

scale. Dave Harris said that colleagues were sharing what they were doing and all using the same tools. Consistency of language and terms would also be important to avoid confusion.

5. Kent Health and Wellbeing Board - Update

In the absence of Mark Lemon, Navin Kumta agreed to give a brief update on the topics for discussion at the last Kent Health and Wellbeing Board on the 17th July 2013. These included the Kent Befriending Scheme; Public Health Priorities; Health Inequalities (by area); and Fall Prevention.

With regard to addressing health inequalities, the distinction between people in certain areas and 'hard to reach' individuals was discussed. Debbie Smith said it was not strictly that people were 'hard to reach' rather that there were some individuals who did not want to be reached or listen to the messages that were being given. Just because somebody lived in a deprived area did not automatically mean that they had a higher chance of becoming ill, although resources did have to be directed to those areas most in need.

6. Themes for Future Meetings

The Chairman said that he was keen for this Board to work towards some kind of tangible end product. He had a particular concern about the issue of dementia as it had been made quite clear to him that there was a dearth of provision for mental health and in particular dementia prevention in this Borough and this was quite unusual. Whilst he accepted it may not be the right time to be making any firm proposals just yet, he considered it would be beneficial to work towards some sort of dementia day care centre in the Ashford Borough. There were potential options in terms of locations at Repton Community Centre or the St Stephens Walk Surgery.

Navin Kumta said he was concerned that a day centre purely for older people with dementia could be unnecessarily restrictive. He considered that a flexible, multi-functional day centre would be the preferable way forward. Sheila Davison further explained that a piece of land next to Repton Community Centre had been earmarked for health provision and it had been suggested that this could be some sort of joined up facility providing a mixture of services. There had been initial discussions with Michael Ridgwell, Director of Commissioning, NHS, who had explained that there was interest but the facility would have to be provided by a consortium of GPs. A further meeting was proposed and Board members discussed the various individuals and organisations that would need to be involved. Sheila Davison endeavoured to arrange this meeting fairly quickly.

Jane Miller explained that some work was going on in conjunction with Farrow Court and there would be some provision there, but it was noted that this would not be a specific facility as proposed.

In terms of future meetings Sheila Davison said that the Kent Health & Wellbeing Board meetings were themed around certain issues, and asked if this Board wished to do the same. The Chairman said he was happy with the way things were progressing at the moment and that as long as matters related to Ashford that was the key point.

7. Update on Children's Trust Boards and the Next Steps

Jenny Whittle explained that there were now 12 Children's Trust Boards operating in Kent, but with Health & Wellbeing Boards (HWBs) and Clinical Commissioning Groups emerging it would be important to get together and not have separate discussions on the same themes. The proposed way forward was for each HWB to establish a Children's Sub-Group to replace the Trusts, with the membership ultimately down to each Board. The emerging consensus was that the Chairs of those Sub-Groups would also sit on the local HWB. Task and Finish Sub-Groups would be able to tackle such issues as the effectiveness of the CAHMS contract, children's contracts with the KCHT, breastfeeding rates, teenage pregnancy and teenage obesity, without each HWB sitting around a table and discussing the same matters for hours on end. The new arrangements would start on the 1st October 2013 so it was therefore expected that the representative for the Children's Sub-Group would attend the next HWB meeting.

With regard to the on-going review of Children's Centres, Jenny Whittle explained that there was concern that the hardest to reach families still did not engage with the centres. There was a romantic notion attached to bricks and mortar buildings, but in her view it was more important to get the Health Visitors out where they were most needed and most likely to be used.

8. The Pioneer Bid

Paula Parker directed the Board's attention to the papers circulated with the Agenda and explained that Kent was bidding to be an Integration Pioneer as part of the Department of Health's Integration Pioneer Programme. This was focused on co-ordination of care for patients, service users and their families and working in partnerships that supported integrated commissioning and the provision of integrated services. Navin Kumta further explained that the bid was now with the Department for Health and 10 sites would be identified in September 2013 with a further 20 in the future. Paula Parker said that the bid was

likely to be something that the Kent HWB would focus on and the local HWBs would also have a role to play. It was suggested that James Lambert could be invited to the next ICG meeting to explain how the bid would be taken forward at a local level and that the bid should be included in Ashford's overall Integrated Commissioning Plan. The Chairman said that he would be interested in updates on the bid as it progressed. Penny Southern said it was worth pointing out that what was set out in the document was happening already and was not reliant on the bid to become an Integration Pioneer. The targets would be pursued regardless and the local HWBs would have a role to play.

9. **Dates of 2014 Meetings**

These were confirmed as 22nd January; 23rd April; 23rd July; and 22nd October 2014 - all at 12noon at the Civic Centre, Tannery Lane, Ashford.

10. **Date of the Next Meeting**

This was confirmed as Wednesday 23rd October 2013, at 12noon in Committee Room 1, Civic Centre, Tannery Lane, Ashford.

DS

By: Mark Lemon Strategic Business Advisor KCC

To: Ashford Health and Wellbeing Board

Date: 23 October 2013

Subject: Revisions to terms of reference for CCG level health and wellbeing boards

Classification: Unrestricted

For Discussion. The Ashford Health and Wellbeing Board is asked to discuss the amendments to the terms of reference and procedure rules set out in Appendix 1 of this report.

These amendments are yet to be formally agreed by all parties (including the CCGs) and are subject to approval by the Kent Health and Wellbeing Board.

Background

1. On 29 May 2013, the Kent Health and Wellbeing Board (HWB) resolved to establish a series of CCG level Health and Wellbeing Boards (local HWBs) to focus on the following key areas:

    - CCG level Integrated Commissioning Strategy and Plan
    - Ensure effective local engagement
    - Local monitoring of outcomes
    - Delivery of local projects

2. As sub-committees of a Kent County Council committee, the governance arrangements (e.g. terms of reference and declaration of pecuniary interests) are the same as those applied to any other County Council committee or sub-committee.

3. The terms of reference for the local HWBs were drafted to be as flexible and permissive as possible within the KCC governance arrangements.

4. The seven local HWBs based around CCG boundaries have all been set up and are meeting regularly. Some are still relatively new and have held preliminary meetings whilst others have been meeting for longer and are quite well established.

5. A number of issues have arisen relating to terms of reference and although none has been sufficiently serious to affect the business of the local HWBs it is important they are resolved.

6. The issues requiring clarification within the terms of reference are:

a) The status of district council officers as potential voting members of the and whether they would be bound by the Kent Code of Conduct requiring them to disclose pecuniary and other significant interests;

b) Arrangements for the completion and registration of disclosable pecuniary interests and resolving any potential conflicts of interest;

c) The flow of business between local HWBs and the HWB;

d) Representation of local HWBs at the HWB;

e) Public participation arrangements in meetings of local HWBs;

f) Scrutiny and Call-In arrangements for local HWBs.

g) Voting arrangements at local Health and Wellbeing Boards in the event of being unable to agree a consensus.

2. District Council Officers

2.1 The status of district council officers and dealing with potential conflicts of interest was discussed at the Kent Secretaries meeting held on 10 September 2013.

2.2 It is highly unusual to have officers and external partners voting on a council committee or sub-committee. The Health and Social Care Act 2012 established health and wellbeing boards as forums for collaborative local leadership and were to be different from ordinary local authority committees in a number of important areas. The Act requires that the Director of Adult Social Care, the Director of Children's Services and the Director of Public Health be members of the HWB. There are however no such officers at district/borough or city level. The predominant feeling of district, borough and city council officers is that they should be non-voting members of local HWBs.

2.3 It is therefore proposed that the terms of reference and procedure rules for local HWBs be amended to make it clear that district council officers are not voting members and as such are not subject to the Kent Code of Conduct for Members.

3. Arrangements for the completion and registration of disclosable pecuniary interests and resolving any potential conflicts of interest

3.1 The Register of Disclosable Pecuniary Interests is held by the KCC Monitoring Officer.

3.2 Kent County Council has written to all members of the local HWBs asking for Declarations of Pecuniary Interests forms to be completed. As

soon as forms are completed and received by Democratic Services they are published on the KCC website.

3.3 Work is underway to create links between the HWB web pages and district, borough and city councils' websites.

3.4 A guidance note on the Kent Code of Conduct for Members has been circulated to all members of local HWBs.

3.5 The nature of health and wellbeing boards may lead to conflicts of interest among members particularly in relation to the representatives from CCGs who are both providers and commissioners of services. As the local HWBs are sub-committees of the HWB, any conflicts of interest will be resolved in accordance with the Kent Code of Conduct for Members and with the advice of the Monitoring Officer.

4. The flow of business between local and county boards

4.1 The relationship between the local HWBs and the HWB continues to develop and common expectations about how business will flow need to be established. All local HWBs are keen to set out a work programme based on common themes and priorities linked to the needs of local population and most are looking to synchronise their business with that of the HWB.

4.2 A meeting of the chairs of all the local HWBs and the HWB is planned for later in the autumn.

4.3 A memorandum of understanding may be required but at this time no amendments are proposed to the terms of reference or procedure rules for the local HWBs.

5. Representation of local boards at the Kent Health and Wellbeing Board

5.1 Local HWBs are currently required to elect their representatives on the HWB from among those who already attend the HWB.

6. Public participation arrangements in meetings of local HWBs

6.1 The arrangements for district, borough and city council meetings vary with regard to the ability and rights of members of the public to participate in meetings. KCC's constitution allows very limited public participation at meetings. Among local HWBs there are different approaches to the involvement of the public in meetings, with some boards opting to invite contributions from the public in various ways, while others "meet in public" rather than have "public meetings".

6.2 As the local HWBs are sub-committees of the HWB, KCC's Constitution regarding formal arrangements for public participation at meetings prevails. There may, however, be times when it is appropriate to hear from members of the public or other local organisations about matters

being discussed and this is a matter for local discretion. Therefore no changes are proposed to the terms of reference or to the local HWBs' procedure rules.

7. Scrutiny and Call-In arrangements for local HWBs

7.1 Formal health scrutiny powers under the Health and Social Care Act 2012 are exercised by the Health Overview and Scrutiny Committee at Kent County Council. However, under the regulations, these powers do not automatically include scrutiny of the HWB or local HWBs. Any issues that arise will be dealt with in accordance with the Protocol for Overview and Scrutiny Inter-Authority Co-operation and the Protocol for the Health Overview and Scrutiny Committee in KCC's Constitution. The guiding principle for health scrutiny activity at county, district and borough level is that it seeks to be complementary and not unnecessarily duplicate work.

8. Voting arrangements

It is expected that wherever possible the local Health and Wellbeing Boards will conduct their business on the basis of reaching an agreed consensus. Currently it is also the case that the Boards have no delegated decision making powers and therefore are not able to take independent decisions that are binding upon their constituent organisations. Whilst it unlikely that voting will be necessary under present arrangements the process by which decisions can be made where consensus is not achieved needs to be in place in case circumstances change.

8.1 During the evolution of the local Boards across the County it has become evident that there are substantial differences between the Kent Board and the local Boards. For example the officer representation on the Kent Board is designated by regulation and applies to specific officer posts. These posts do not exist at district level and there are no direct equivalents. The Kent Board is based on local authority geography whereas the local boards follow CCG boundaries. This means there are local boards that include one district authority within their area whilst others contain up to four. At the Kent Board the principle of no one set of organisations being able to outvote any of the others (the House of Lords principle) can be relatively simply applied but this is not the case for all of the local boards given their various configurations, unless district council representation is considered "en bloc" in CCG areas with multiple districts.

8.2 There is no single solution that can easily reconcile the variation in membership of boards across the county. Whilst recognising that on some boards it will be less than ideal the simplest solution is the one proposed in the attached draft governance arrangements which gives each organisation – CCG, KCC, District Council and Healthwatch- one vote.

9. Conclusion

9.1 The local HWBs' terms of reference and procedure rules are attached at **Appendix 1** and for ease of reference include the amendments proposed in the paragraphs above.

9.2 These amendments are yet to be formally agreed by all parties (including the CCG's) and are subject to approval by the Kent Health and Wellbeing Board.

Recommendations

The Ashford Health and Wellbeing Board is asked to consider the amendments to the terms of reference and procedure rules set out in Appendix 1 of this report

Background Documents - none

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Appendix 1

Local Health and Wellbeing Boards

Governance Arrangements

The Kent Health and Wellbeing Board (HWB) leads and advises on work to improve the health and wellbeing of the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to:

- secure better health and wellbeing outcomes in Kent
- reduce health inequalities and
- ensure better quality of care for all patients and care users.

The HWB has a primary responsibility to make sure that health care services paid for by public monies are provided in a cost-effective manner. It is supported in this work by a series of sub-committees referred to as local Health and Wellbeing Boards (local HWBs).

As sub-committees of a Kent County Council committee, the governance arrangements (e.g. terms of reference and declarations of disclosable pecuniary interests) are the same as those applied to any other County Council committee or sub-committee.

At this time no decision has been taken to delegate any decision making responsibilities to the local HWBs. Instead they will be asked to make recommendations to both the HWB and their partner bodies. This position may change in the future.

Role of the local Health and Wellbeing Boards

The local HWBs will lead and advise on:

- the development of a CCG level Integrated Commissioning Strategy and Plan;
- ensure effective local engagement;
- monitor local outcomes.

They will focus on improving the health and wellbeing of the people living in their CCG area through joined up commissioning across the NHS, social care, district councils, public health and other services (that the HWB agrees are directly related to health and wellbeing), in order to secure better health and wellbeing outcomes in their area and better quality of care for all patients and care users.

Terms of Reference:

The local HWBs will:

1. Be appointed as sub-committees of the Kent Health and Wellbeing Board (a committee of Kent County Council);

2. Develop a CCG level Integrated Commissioning Strategy and Plan, based on the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and partners Commissioning Plans. This will be approved by the Kent Health and Wellbeing Board;

3. Consider the totality of the resources in the CCG area for health and wellbeing and consider how and where investment in health improvement and prevention services could (overall) improve the health and wellbeing of local residents;

4. Work with existing partnership arrangements, e.g. children's commissioning, safeguarding and community safety, to ensure that the most appropriate mechanism is used to deliver service improvement in health, care and health inequalities;

5. Endorse and promote joint arrangements where agreed and appropriate; including the use of pooled budgets for joint commissioning (s.75), the development of appropriate partnership agreements for service integration, and the associated financial protocols and monitoring arrangements, making full use of the powers identified in all relevant NHS and local government legislation;

6. Undertake monitoring of local outcomes;

7. Ensure effective local engagement on health and care issues, using existing engagement mechanisms where necessary and linking in to any county level engagement work where established;

8. Develop a local Communication and Engagement Strategy to ensure clear lines of communication/consultation with residents, County Council, Neighbourhood Forums and Patient/Public Networks;

9. Provide advice (as and when requested) to the Kent Health and Wellbeing Board on local service reconfigurations that may be subject to referral to the Kent County Council Health Overview and Scrutiny Committee (HOSC) or the Secretary of State on resolution by KCC HOSC;

10. Be the focal point for joint working in the CCG area to ensure facilities and accessibility, in order to enhance service integration;

11. Report to the Kent Health and Wellbeing Board on an annual basis on its activity and progress against the milestones set out in the Integrated Commissioning Strategy and any established work plan;

12. Responsible for overseeing local project resource to facilitate local pathway redesign, as appropriate;

13. Provide recommendations on how and where investment, resources and improvements can be made within the CCG area;

14. Identify how to make the best use of the flexibilities at the Board's disposal, such as devolved/pooled budgets.

Membership:
The local HWBs have similar membership to that of the Kent Health and Wellbeing Board. Typically membership is as follows:

- District/Borough/City Council Leader/Senior Member
- District/Borough/City Council senior officers (non-voting)
- Kent County Council Cabinet Member or Deputy Cabinet Member
- Kent County Council Families and Social Care Corporate Director (or his nominee)
- Kent County Council Public Health Consultant
- CCG Senior Officer
- CCG GPs
- Healthwatch representative
- Chair of the Children's Operational Group (when appointed)
- Other representatives as identified and agreed by the local HWB, e.g. voluntary sector

Changes to membership of the local HWBs will not need to be notified to the Kent HWB.

In addition to the core membership, other people can be invited by the Chairman to attend the meeting to present as and when required.

All meetings will be held in public.

The Chairman will be elected by the local HWB.

Local Health and Wellbeing Boards

Procedure Rules

1. **Conduct.**
   Members of local HWBs are required to subscribe to and comply with the Kent County Council Code of Conduct for Members. Non-elected members of local HWBs (e.g. GPs) will be co-opted members and, as such, are also covered by the Kent Code of Conduct for Members for any business they conduct as a member of the local HWB. Council officer representatives will be non-voting members and as such not subject to the Kent Code of Conduct for Members.

2. **Declaration of Disclosable Pecuniary Interests.**
   Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the HWB and any sub-committee of it. A register of disclosable pecuniary interests is held by the Clerk to the HWB, but HWB members do not have to leave the meeting once a disclosable pecuniary interest is declared, however they cannot have a vote on that matter.

3. **Frequency of Meetings.**
   Local HWBs meet at least quarterly. The date, time and venue of meetings is fixed in advance by the local HWB.

4. **Meeting Administration.**
   - Local HWB meetings are advertised and held in public and administered by the nominated District/Borough/City Council.
   - Local HWBs may consider matters submitted to them by local partners.
   - The administering Council publishes and gives at least five clear working days' notice in writing to each member of every ordinary meeting of the local HWB, to include any agenda of the business to be transacted at the meeting.
   - Papers for each local HWB meeting are sent out at least five clear working days in advance.
   - Late papers may be sent out or tabled only in exceptional circumstances and with the agreement of the chairman.
   - Local HWBs hold meetings in private session only in accordance with the Access to Information Procedure Rules and the Local Government Act 1972 (as amended)
   - Local HWB meetings will be webcast where the facilities are in place.
   - The Chairman's decision on all procedural matters is final.

5. **Meeting Administration of Sub Committees**.
   Local HWBs are administered by a District/Borough/City Council in each area. They will be subject to the provisions stated in these Procedure Rules.

6. **Special Meetings.**
   The Chairman may convene special meetings of a local HWB at short notice to consider matters of urgency. The notice convening such meetings shall

state the particular business to be transacted and no other business will be transacted at such meeting.

The Chairman is required to convene a special meeting of a local HWB if they are in receipt of a written requisition to do so signed by no less than three members of the local HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within five clear working days of the Chairman's receipt of the requisition.

7. Minutes.

Minutes of all local HWB meetings are prepared recording:

- the names of all members present at a meeting and of those in attendance;
- apologies;
- declarations of Disclosable Pecuniary Interests and Other Significant Interests
- details of all proceedings, decisions and resolutions of the meeting.

Minutes are circulated to each member before the next meeting, when they are submitted for approval by the local HWB and are signed by the Chairman.

8. Agenda.

The agenda for each meeting normally includes:

- Minutes of the previous meeting for approval and signing;
- Declarations of Disclosable Pecuniary Interests and Other Significant Interests
- Reports seeking a decision from the local HWB;
- Any item which a member of the local HWB wishes included on the agenda, provided it is relevant to the terms of reference of the local HWB and notice has been give to the Clerk at least nine working days before the meeting.

The Chairman may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. He must state these reasons at the meeting and the Clerk shall record them in the minutes.

9. Chairman and Vice Chairman's Term of Office.

The Chairman will be elected by the local HWB. The Chairman and Vice Chairman's term of office terminates on 1 April each year, when they are either reappointed or replaced by another member, according to the decision of the local HWB, at the first meeting of the local HWB succeeding that date.

10 Membership

Members will usually comprise:

- District/Borough/City Council Leader/Senior Member
- District/Borough/City Council senior officers (non-voting)
- Kent County Council Cabinet Member or Deputy Cabinet Member
- Kent County Council Families and Social Care Corporate Director (or his nominee)
- Kent County Council Public Health Consultant
- CCG Senior Officer
- CCG GPs
- Healthwatch representative
- Chair of the Children's Operational Group (when appointed)
- Other representatives as identified and agreed by the local HWB, e.g. voluntary sector

Council officers will be non-voting members of the boards.

The process for nomination of members and named substitutes is a matter for each nominating organisation.

11. Absence of Members and of the Chairman.

If a member is unable to attend a meeting, a named substitute may attend in their absence, subject to them being of sufficient seniority to agree and discharge decisions of the Board within and for their own organisation.

The Clerk of the meeting should be notified of any absence and/or substitution at least five working days prior to the meeting.

The Chairman presides at local HWB meetings if they are present. In their absence the Vice-Chairman presides. If both are absent, the local HWB appoints from amongst its members an Acting Chairman for the meeting in question.

12. Voting.

Local HWBs should operate on a consensus basis. Where consensus cannot be achieved, the subject matter is put to a vote. Local HWBs decide all such matters by a simple majority of the members present based on the principle of one organisation one vote. In the case of an equality of votes, the Chairman shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chairman.

13. Quorum.

A third of voting members form a quorum for local HWB meetings. No business requiring a decision shall be transacted at any meeting of the local HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman either suspends business until a quorum is re-established or declares the meeting at an end.

14. Adjournments.

By the decision of the Chairman, or by the decision of a majority of those members present, meetings of local HWBs may be adjourned at any time

to be reconvened at any other day, hour and place, as the local HWB decides.

15. Order at Meetings.

At all meetings of local HWBs, it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. They decide all questions of order that may arise.

16. Suspension/disqualification of Members.

At the discretion of the Chairman any body with a representative on a local HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive meetings without good reason or without the prior consent of the Chairman.

Ashford Integrated Commissioning Group (ICG) Highlight Report

Period (Qtr): Q3 Oct – Dec '13

Report author: Dave Harris

MONTHLY/QUARTERLY R/A/G STATUS 2013

Q1 Apr – June '13	Q2 July – Sept '13	Q3 Oct – Dec '13	Q4 Jan – Mar '14
Green	Green	Amber	

Targets / Performance / Milestones:

- **Collect and collate stakeholder commissioning priorities**

  These were collected from the following stakeholders to provide a broad foundation with which to start to define priorities for Ashford based on the local strategic needs assessment:

  - *Ashford Borough Council*
  - *Ashford Clinical Commissioning Group*
  - *Ashford Housing Framework*
  - *Ashford Supporting Families Programme*
  - *Community Health & Wellbeing Group*
  - *Community Safety Partnership*
  - *Kent County Council*
  - *Public Health*

- **Discover commonalities within the priorities**

  The priorities from the above stakeholders were then compared for commonalities to reduce duplication and evidence aligned strategic areas.

- **Establish shared key areas of local need**

  Following discussion at the Ashford Integrated Commissioning Group, the following broad key areas of local need were defined, based on the local strategic needs assessment and the experience of the stakeholders within the group:

  - *Family Support*

Achievements / actions completed:

- **Collection of commissioning priorities from each of the stakeholder organisations involved in the Ashford Integrated Commissioning Group.**

  These were collected from the following stakeholders to provide a broad foundation with which to start to define priorities for Ashford:

  - Kent County Council (KCC) – Families and Social Care, Public Health etc.
  - Ashford Borough Council (ABC) – Housing, Environmental Health, Community Safety, Planning etc.
  - Ashford Clinical Commissioning Group (CCG)

  Throughout this process, the Ashford ICG ensured that the local Integrated Commissioning Plans also considered national and countywide priorities, including but not limited to the following:

  - Kent's Health Inequalities Action Plan - MIND THE GAP Building bridges to better health for all
  - Winterbourne View – Programme of Action
  - Caldicott Information Governance Review
  - What Matters Forum - Quality Assurance Action Plan
  - Falls Prevention
  - 2013 Mid-Staffordshire NHS Francis Report

- **Three local priority areas have been defined: Supporting Families, Long Term Conditions and Healthy Living**

- *Long Term Conditions*
- *Healthy Living*

Each of the commissioning priorities were reviewed and filtered to those aligned against these agreed areas of locally focussed need.

- **Match commissioning priorities to key areas**

The remaining priorities were then matched against the following key commissioning areas:

- End of Life Care
- Long Term Care & Support – Sustained & Ongoing
- Prevention & Self Care
- Short Term Care & Support – Goal Oriented

This was to ensure county wide consistency across each of the Integrated Commissioning Plans in line with the Integrated Commissioning Toolkit.

- **Agree on shared commissioning objectives**

Following further discussion at the Integrated Commissioning Group around the three locally areas of focus, Supporting Families, Long Term Conditions and Healthy Living, it was decided that the main commissioning objectives for services in Ashford delivering in these areas would be as follows:

- Early Diagnosis and Intervention, including awareness raising and information sharing to promote choice and control

- **Map existing services**

Each stakeholder within the Integrated Commissioning Group to map the existing services they current provide or fund within Ashford District. Venn Diagram to be created.

Discussion took place over several Integrated Commissioning Group meetings to look at the themes and trends that were coming from the shared commissioning priorities list.

After some debate these it was agreed that the group would focus on the three local priority areas of Supporting Families, Long Term Conditions and Healthy Living. It was also agreed these broad themes would need to be further broken down into more targeted areas.

- **Key local objectives agreed of Early Diagnosis and Intervention were set**

Following the agreeing of the broad themes as stated above, the next task of the group was to identify key local objective that could be applied to each identified area.

Following a good deal of discussion, it was agreed that there was currently a gap within each area in supporting early diagnosis and intervention. This was unanimously agreed to be a key local objective in improving supporting and improving diagnosis rates as well and providing early intervention and appropriate needs-led levels of support for each individual.

- **Applying the local objectives to the 199 commissioning priorities set by the group reduced the number to 20**

The original commissioning priorities list comprised of 171 individual items and following considerations from the Ashford Health and Wellbeing Board and further input from the Integrated Commissioning Group, this number eventually rose to 199 commissioning priorities across the stakeholder organisations represented within the Group.

When these priorities were filtered against the agreed local priority areas of Supporting Families, Long Term Conditions and Healthy Living and then by the local objectives of Early Diagnosis and Intervention, the priorities list reduced to a more manageable 25.

- **The broad local priority areas were re-fined to Behavioural and Emotional Need, Dementia and Eating**

Disorders with a focus on Obesity.

Having a reduced number of commissioning priorities to focus on, the Group were able to more clearly refine the key areas from Supporting Families, Long Term Conditions and Healthy Living down to the more focused areas of Behavioural and Emotional Need, Dementia and Eating Disorders with a particular focus on Obesity, a condition that affects almost 25% of the Ashford population.

- **Service Map and associated Venn Diagram now directly links to the Commissioning Priorities List.**

  Using the Commissioning Priorities List as a starting point, a service area was applied to each of the 199 priorities. These services were then mapped against each of the stakeholder organisations forming the ICG:

  - Kent County Council (KCC) – Families and Social Care, Public Health etc.
  - Ashford Borough Council (ABC) – Housing, Environmental Health, Community Safety, Planning etc.
  - Ashford Clinical Commissioning Group (CCG)

  Following this mapping exercise the ICG were able to produce a Venn Diagram that graphically illustrated how some these service areas overlapped the remit and scope of the three key organisations, KCC, ABC and the Ashford CCG.

  The Venn Diagram shows 18 service areas that cross-cut all three organisations, most importantly these include the 3 agreed local priority areas of Behavioural and Emotional Need, Dementia and Eating Disorders.

- **Sub Groups have now been formed for each of the local priority areas**

  It has been agreed by the Ashford ICG that a sub group be formed for each of the local priority areas with a member from each of the stakeholder organisations taking a lead as follows:

Sub Groups	Priority Area	Lead
	Dementia	Kent County Council
	Behavioural and Emotional Needs	Ashford Borough Council
	Eating Disorders / Obesity	Ashford Clinical Commissioning Group

Membership of these groups will be agreed and circulated prior to the next AICG meeting on 27th November 2013. Each group will then develop outcomes and objectives for each priority area.

Next Steps

- **Complete the linking of the AICG priorities to the MIND THE GAP equalities action plan.**

  AICG members to complete the mapping of the priorities list to the national MIND THE GAP equalities action plan for each of their stakeholder organisations.

- **Sub groups to be formed for each of the AICG priority areas – Eating Disorders/Obesity, Dementia and CAMHS/ASD promoting early diagnosis and intervention.**

  A representative from KCC, ABC and CCG to lead each group and carry out a service gap analysis of current provision including associated costs, service user profile and usage including pathway.

- **Further define objectives and produce associated outcomes**

  Having defined the Areas of focus and the local commissioning objectives to be applied to each, it is now the task of the Sub Groups to further define the objectives and produce associated outcomes and expectations.

New or outstanding risks:

- **These to be discussed by each stakeholder partner within the Integrated Commissioning Group and will become a standard agenda point for review and update of this report.**

  AICG Risk

  Changes in AICG membership can result in regular revisions of the Priorities and can delay forward movement.

  This did lead to the priorities list being revised several times and growing significantly from 171 to the current 199 items.

  Priority Definitions

  During the original task action of listing and collating the commissioning priorities from each of the stakeholder organisations into a single list, it became apparent that some of the items listed referred too specifically to individual services rather than a higher level strategic priority as intended and needed to be reworked.

  The AICG needs to be mindful of this going forward as the focus of some discussions can become too narrow.

	Priorities crossed referenced by JSNA The AICG need to ensure that any priorities agreed are cross referenced with the local Joint Strategic Needs Assessment.

From: Mark Lemon Strategic Business Advisor KCC

To: Ashford Health and Wellbeing Board 23 October 2013

Subject: The Integration Transformation Fund

Classification: Unrestricted

Summary:

The £ 3.8 bn Integration Transformation Fund (ITF) announced by the Government dramatically accelerates the timescale for achieving the integration of health and social care services. Government expectations are that a fully integrated system should be in place by 2018 based on actions identified to start in 2014-15 and begin significant delivery in 2015-16. The funding consists of a number of existing components as well as new allocations from CCG budgets.

Plans to spend the funding must be agreed by statutory Health and Wellbeing Boards who must assume responsibility for monitoring the achievement of the targets required, agree contingency plans for re-allocating funding if targets are missed, and be satisfied that providers, especially acute hospital trusts, have been effectively engaged in the planning process.

Recommendations:

Ashford Health and Wellbeing Baord is asked to:

(i) Acknowledge the timescales involved for the preparations of the Kent plan for the Integration Transformation Fund

(ii) Recognise the need to align integration activity with the requirements of delivering through the ITF in Kent.

1. Introduction

The Integration Transformation Fund was announced in the Comprehensive Spending Review It follows the NHS “Call to action” that identified a £ 30 bn shortfall in NHS funding in 2020 unless action to manage demand is taken. This has also spawned the integrated care “Pioneer Programme”.

The funding is described as “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”

Funding will be awarded to local plans, based on a statutory Health and Wellbeing Board footprint and with Boards as the leaders for implementation. Health and Wellbeing Boards will need to agree plans to spend the money to deliver agreed outcomes.

Plans will also need to take account of the implications for the acute sector of service transformation and set out arrangements for the redeployment of funding within the system if outcomes are not reached.

There will need to be some oversight and ministerial sign off of plans but it is intended that this be “light touch”.

The funding is a pooled budget, not a transfer, and local authorities and the NHS are equal partners. It is not necessarily confined to social care and other LA functions may be relevant. It is expected that the funding will be allocated under s256 arrangements.

A great deal of effort is already being devoted to furthering integration across Kent and there is a sound basis to build upon. The Integration Transformation Fund seriously increases the pace and the scale at which these developments need to deliver. The government expects “that each area moves to a wholly integrated approach to health and care by 2018” (Refreshing the Mandate to NHS England: 2014 – 2015 Consultation)

2. ITF Funding components

Half the ITF funding will come from existing commitments:

- £1.9bn of existing funding continued from 14/15 – this is money already allocated across the NHS and social care to support integration and including:

- £300m of CCG re-ablement funding

- £130m of CCG carers' break funding

- £900m existing transfer from health to social care plus £200m for the joint fund

- c. £350m in capital grants from government departments including £220 m of Disabled Facilities Grant

Whilst it is not expected that these components will be diverted into funding other services the implication is that the plan associated with spending the ITF must show how each of these elements will contribute to the overall aim of achieving integrated services by 2018.

There is an additional element of £1.9 bn from NHS allocations which includes funding to cover demographic pressures in adult social care and some costs associated with the Care Bill.

Of this £1bn has been designated as “at risk money”. This will be paid dependent upon performance with particular reference to taking pressure off the acute sector and improving patient experience. If not paid the funding will revert to the general NHS budget. The “at risk” funding will be split over the 15/16 financial year:

£0.5 bn at start of 15/16 dependent upon performance in 14/15

£0.5 bn at end of 15/16 dependent upon performance in 15/16

This £1.9 bn contribution from core CCG budgets equates to £10m from an “average” CCG.

3. Conditions of the full ITF

The ITF will be a pooled budget that can be deployed locally on social care and health, subject to the following national conditions which will need to be demonstrated in the plans:

- joint agreement between local authorities and the NHS through the Kent Health and Wellbeing Board.
- protection for social care services (not spending)
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health)
- ensure a joint approach to assessments and care planning
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached
- agreement on the consequential impact of changes in the acute sector.

4. Timetable

Money is for 1 year with no guarantee of repeat funding. There will be a general election and a further Comprehensive Spending Review in 2015. Funding is to establish practice that can be incorporated into allocation of base budgets in following years.

Further guidance and support will be issued in the Autumn to enable consideration within CCG commissioning plans for 14/15 with more events and engagement planned over the Autumn

However guidance states: “we think it is essential that CCGs and local authorities build momentum in 2014/15 using the additional £200 mil due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and 2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter”.

5. Key Messages

- This will only work if services are redesigned to move activity from the acute sector to the community and primary care.

- Successful implementation of plans may lead to significant hospital reconfiguration. Potential impact on providers (acute trusts) needs to be part of the planning process. Changes to service that are not properly planned could potentially destabilise providers. This led to emphasis being placed on involvement of providers with an urgent need to revisit how they engage with the commissioners and the Kent Health and Wellbeing Board.

- This is urgent – get on with it. There are early wins to be had regarding winter pressures and in any event Boards need to start building momentum towards 14/15.

6. Outcome measures

Measures to determine progress and success have not yet been established. The general view is that any outcome measures should be taken from existing outcome frameworks and should not generate extra data collection for new indicators.

Some new measures may be necessary to demonstrate how issues such as better data sharing based on use of the NHS number have progressed

7. Timetable and Alignment with Local Government and NHS Planning Process

Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans

- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)

- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows

- The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:

- August to October: Initial local planning discussions and further work nationally to define conditions etc

- November/December NHS Planning Framework issued

- December to January: Completion of Plans

- March: Plans assured

8. National next steps

NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds

- Conditions, including definitions, metrics and application

- Risk-sharing arrangements

- Assurance arrangements for plans

- Analytical support e.g. shared financial planning tools and benchmarking data packs.

9. Other Issues

Analysis from Greater Manchester highlighted the scale of the issue. Their advice is that partners should agree how much money needs to move across sectors in the system. Their calculation was that Greater Manchester needed to transfer £250m worth of activity from acute to community and primary care which translated into a potential 25% of hospital activity. There was concern whether existing systems such as HR and finance can cope with the required shift of resources and personnel around the system at this scale. Greater Manchester's experience also demonstrated the need for robust financial modelling and the need to "develop investable propositions".

10. Kent Workforce

Locally some discussions have already been held about how workforce planning needs to respond to the challenge posed by the integration agenda, including representatives from social care and KCHT. These discussions have led to the following summary for the Board:

The health and social care economy is reliant on the right staff and multi-professional teams being available at the right time, in the right place to deliver the right care and service. As we face the challenge of ensuring our services are sustainable for the future, meeting the need for improving outcomes and experience of patients whilst making best use of the public pound, a key factor in delivery will be workforce availability. This workforce stretches from carers through volunteers and on to registered health and social care professionals. How will HWBB commissioning partners be assured that the necessary workforce, with the right skills and competencies for future models of health and social care is being developed?

Health Education England (HEE) is the national NHS and social care body responsible for the education and development of the health workforce. The local presence of HEE is HE Kent Surrey Sussex who have a local partnership arrangements in Kent and Medway. The HEE work with their local membership of health providers and education institutes to ensure there are comprehensive workforce strategies and plans in place so that resources are appropriately focused. In order for providers to have detailed and deliverable workforce plans they need to have a clear strategic steer as to the future services to be commissioned. There is clearly a potential role for the Kent HWBB partners to clearly describe the strategy for service change and development into the future in a way that enables HEKSS to respond.

The pioneer bid for integration provides an ideal and clear opportunity to test the new governance, roles and responsibilities with a focus on delivery. The Kent HWBB should consider how it adequately describes the future service strategy in a way that the Local Partnership group, chaired by Marion Dinwoodie can consider how they provide assurance to the Kent HWBB that plans are in place to implement the necessary changes in workforce that this may require. It is recommended that the Local partnership Board be asked to set out how local partners will develop the workforce to meet the requirements of the bid.

11. Issues for the Kent Health and Well Being Board

The Integration Transformation Fund raises a number of issues for the Health and Wellbeing Boards across Kent apart from the pace and scale of the changes required. The level of involvement in the planning process, oversight of effectiveness and responsibility to redeploy resources if plans are unsuccessful brings the Kent Board closer to being a joint-commissioning body and the group that manages risk within the wider system. The need to engage the acute trusts and others emphasises the importance of ongoing discussions about how to involve providers with the business of the Board.

In delivering the requirements of the Integration Transformation Fund it will be important that we bring all relevant resources to bear and there are a number of existing initiatives that can be deployed:

The Pioneer programme derived from the current bid could provide a focus for delivery of the plan

The local Health and Wellbeing Boards with their associated Integrated Commissioning Groups will be an essential element in developing plans.

The Board may wish to consider other ways the planning and delivery of the Integration Transformation Fund may be supported in Kent. In particular the Board will need to be assured that it can address the following questions.

What processes and mechanisms do we need to establish to deliver the ITF in Kent ?

Does the Pioneer Programme provide the vehicle for delivery ?

What will be the involvement and responsibility of local Health and Wellbeing Boards including the local Integrated Commissioning Groups ?

How will providers, especially the hospital trusts, be engaged ?

Are local support systems including those for finance and Human Resources robust enough to deal with the scale of change within the system ?

How will the pooled funding be managed ?

Who will write the plan?

12. Considerations for the Ashford Health and Wellbeing Board

Integration of services and commissioning between the NHS and social care has been a priority for a long time and a great deal is already being done across the county to achieve this. The requirements of the Integration Transformation Fund mean that these initiatives must now be considered and evaluated within the context of the plans associated with the fund in order to achieve the agreed outcomes.

Local Health and Wellbeing Boards and their subgroups such as the Integrated Commissioning Groups will need to be part of the overall plan and implementation associated with the ITF.

Recommendations:

The Ashford Health and Wellbeing Board is asked to:

(i) Acknowledge the timescales involved for the preparations of the Kent plan for the Integration Transformation Fund

(ii) Recognise the need to align integration activity with the requirements of delivering through the ITF in Kent.

13. Background Documents:

None

14. Contact details

Report Author

Mark Lemon, Strategic Business Advisor, email: Mark.Lemon@kent.gov.uk

To: Ashford Health and Wellbeing Board
From: Marion Gibbon: Public Health Consultant & PH Lead for Ashford CCG
Title: The Public Health Resource and Programme for Ashford Health and Wellbeing Board
Author: Marion Gibbon (KCC), Wendy Jeffries (KCC), Abi Mogridge (KCHT)

Date: 4th October 2013

1. Introduction:

This paper describes the commissioning resource that Public Health Kent (now part of Kent County Council) are responsible for and provides a brief description of this resource currently serving Ashford. The paper does not include public health programmes that are outside of this allocation that are running in Ashford H&WBB. Under new commissioning arrangements public health will also be provided from the National Commissioning Board and via Public Health England. These programmes will not be covered in this paper.

2. Public Health in Kent County Council

After the Health and Social Care Act was passed and from April 1st 2013, top tier Local Authorities have become responsible for a number of functions that were previously performed by the Primary Care Trusts in England.

From April 1st 2013 Kent County Council has become responsible for:

- planning services based on assessing needs of local populations
- securing services that meet these needs
- monitoring and evaluating the quality of care provided

In most cases these services are not isolated from complex and integrated clinical and social care pathways and will in future be aligned closely with district councils, Clinical Commissioning Groups and the National Commissioning Board.
The place where this work will be effectively commissioned in partnership and monitored and evaluated will be the local district and CCG level Health and Wellbeing Boards e.g Ashford H&WBB.

The overall current public health budget that has transferred to Kent County Council is approximately £42.1 million and 40% (£17.6 million is allocated via commissioning to Kent Community Health Trust in block contract). Staffing costs account for £4 million approximately (9%) and 30% of the budget commissions drug and alcohol services via Kent Drug and Alcohol Team. This leaves £8.2 million of funds that must be allocated to deliver the Public Health Outcomes Framework. The outcomes framework for public health concentrates on increasing life expectancy and reducing the gap in life expectancy between communities. The programmes are currently commissioned and delivered pan-Kent in order to maximise efficiency and retain the integrity of services.

The reason why 40% of the budget is commissioned from KCHT is historical as before 2010 the KCHT service was part of the Kent PCT Public Health Teams.
Under new commissioning arrangements at the KCC and alongside Health and Wellbeing Boards Locally, these arrangements will be scrutinised and aligned.

3. Health Improvement Services that KCC are responsible for the following programmes:

1	Children's health	Healthy Child programme for school-aged children including school nursing	4 million
2	Sexual Health	Contraception over and above the GP contract Testing and treatment of sexually transmitted infections (excluding HIV treatment) Sexual health advice, prevention and promotion.	13 million
3	Public Mental Health	Mental health promotion, mental illness prevention and suicide prevention	100k & block contract
4	Physical activity	Local programmes to address inactivity and other interventions to promote physical activity. The Healthy Club	300k & block contract
5	Obesity programmes	Local programmes to prevent and address obesity e.g. National Childhood Measurement Programme and Weight Management Services	2 million & block contract KCHT
6	Drugs misuse	Drugs misuse services, prevention and treatment	10 million combined
7	Alcohol misuse	Alcohol misuse services, prevention and treatment	
8	Tobacco control	Local activity, including stop smoking services, prevention activity, enforcement and communication activity	2.61 million
9	Nutrition	Locally led initiatives	351k & block contract

10	NHS Health check programme	Assessment and lifestyle interventions	2.41 million
11	Reducing and preventing birth defects	Population level interventions to reduce and prevent birth defects (with Public Health England)	Block contract and PHE
12	Health at work	Any local initiatives on work place health	None specified
13	Dental public health	Epidemiology, dental screening and oral health improvement, including water fluoridation (subject to consultation)	132k
14	Accidental injury prevention	Local initiatives such as falls prevention services	None specified
15	Seasonal mortality	Local initiatives such to reduce seasonal deaths	315k

4. Public Health Provision in Ashford

4.1 Healthy Weight:

Fresh Start (Adult)

The healthy lifestyles service consists of a team of people who can support people who want to change their lifestyles. The healthy weight team help their clients lose weight and make long-term changes to their lifestyle.

Using British Heart Foundation guidelines, Fresh Start is delivered by your local pharmacy adviser and involves a weekly appointment to discuss your personal weight loss plan. The programme focuses on, and includes advice and support on, health eating, physical activity, recipes and meal ideas, beating the cravings and much more. It's a free service.

It consists of 12 one-to-one appointments, over three months, with a Fresh Start adviser in a local venue. The sessions will be tailored to your needs.

For a full list of venues and address details, please phone 0800 849 4000 (option two)

Health Walks (Adult)

Ashford

Walking for Fitness
Day: Mondays
Date: Ongoing
Location: Conningbrook Hotel Car Park, Canterbury Road, Kennington, Ashford, TN24 9QR
Time: 9.30am for 9.45am start
Length: Approx 90 mins
Contact: Sally 01233 626597.

Smarden Charter Hall
Day: Mondays
Date: Ongoing
Location: Smarden Charter Hall, Chessenden Lane, Smarden, Ashford TN27 8NF
Time: 10am for 10.15am start
Length: Approx 40 to 60 mins
Contact: 0800 849 4000 option 6.

Learning Disability Forum
Day: Mondays
Date: Ongoing
Location: Victoria Park, Ashford TN23
Time: 10.15am for 10.30am start
Length: Approx 60 mins
Contact: 0800 849 4000 option 6.
For people with learning disabilities only, referral required. Wheelchair friendly.

Walk & Talk Tenterden
Day: Tuesdays
Date: Ongoing
Location: St Andrew's Catholic Church, 47 Ashford Road, Tenterden, TN30 6LL
Time: 10.30am for 10.45am start
Length: Approx 90 mins
Contact: Janet 01580 762526.
Dogs on leads welcome.

Hamstreet Surgery
Day: Wednesdays
Date: Ongoing
Location: Hamstreet Surgery, Ruckinge Road, Hamstreet, Ashford, TN26 2NJ
Time: 1pm for 1.15pm start
Length: Approx 45 to 60 mins
Contact: 0800 849 4000 option 6.

Wittersham Walkers
Day: Wednesdays
Date: Ongoing
Location: St John the Baptist Church, Wittersham, TN30 7EA
Time: 10am for 10.15am start
Length: Approx 60 mins
Contact: Yvonne 07944 183798.
Dogs on leads welcome.

New Hayesbank Surgery
Day: Wednesdays
Date: Ongoing
Location: New Hayesbank Surgery, Bybrook, Kennington, TN24 9JZ
Time: 9.30am for 9.45am start
Length: Approx 60 to 75 mins
Contact: 0800 849 4000 option 6.

Ashford Library
Day: Thursdays
Date: Ongoing
Location: Ashford Library, Ashford Gateway Plus, Church Road, Ashford, TN23 1AS
Time: 10.30am for 10.45am start
Length: Approx 60 mins
Contact: 0800 849 4000 option 6.
Dogs on leads welcome.

Tenterden Trekkers
Day: Fridays
Date: Ongoing
Location: Zion Baptist Church, High Street, Tenterden, TN30 6BB
Time: 10am for 10.15am start
Length: Approx 60 mins
Contact: 0800 849 4000 option 6.

Singleton Environment Centre
Day: Fridays
Date: Ongoing
Location: Singleton Environment Centre, Wesley School Road, Singleton, Ashford TN23 5LW
Time: 9.30am for 9.45am start
Length: Approx 75 to 90 mins (Two walk options available)
Contact: 0800 849 4000 option 6.

Shadoxhurst Weekend Walk
Day: Saturdays
Date: Ongoing
Location: Kings Head Car Park, Woodchurch Road, Shadoxhurst, Ashford, TN26 1LQ
Time: 9.45am for 10am
Length: Approx 90 mins
Contact: 0800 849 4000 option 6 or Kathryn 01233 732883.

Charing Surgery
Mondays:
Time: 9.50am for 10am start
Length: Approx 60 mins (around three miles)
Intermediate: Easy pace but a bit quicker than beginners.

Tuesdays:
Time: 10.20am for 10.30am start
Length: Approx 35 to 40 mins (around one mile)
Beginners: Not too far or too fast. No hills or stiles. Great for new starters or those who walk with a stick.

Thursdays:
Time: 2.20pm for 2.30pm start
Length: Approx 90 mins (around four miles)
Harder walks: Incorporates footpaths, hills and stiles.

Walk your way to health

Gentle stroll, shorter distance

Brisk walk, slightly further distance

Faster pace, longer distance or rough ground

Please note the colour symbols are meant as a guide only. All walks may vary slightly. Please ring the contact details for each walk for more information or future dates.

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Exercise Referral

This scheme helps people, aged 16-years-old or over, to make long-term lifestyle changes and take responsibility for their own health. It consists of a 12-week tailored exercise programme. Exercise programmes will be based on the reason for referral, health status and personal preferences. Classes include: Active for Life, Aqua for Life, gym programmes, yoga, pilates and swimming.

There are currently 6 exercise referral sites, with a total of 718 accessing the scheme from January to present, 74% of those referred had a BMI greater than 25.

Change 4 Life Clubs (Children)

Part of Health and Wellbeing Services, the Healthy Weight Team support families to make changes for a healthier future. We believe that healthy kids are happy kids and if families are ready to make some changes, we are here to help.

The free Change 4 Life clubs are for all families with children aged 7-11 who want to eat well, move more and live longer. The club includes fun games, activities and interactive

sessions on the eatwell plate, 5 a day, the importance of being active and why our bodies need energy.

It lasts an hour and a half each week for 5 sessions and is based on the Change4Life messages.

Following the club, families can become members of the online Healthy Club. So they can keep up-to-date with what is going on in their local area, helping to provide with motivation for a healthier lifestyle.

For more information please phone 0800 849 4000 (option five)

Ready, Steady, GO! (Children)
Part of the services provided by the Healthy Weight Team, this is a comprehensive and targeted weight management programme consisting of physical activity, nutrition and behaviour change for children aged from seven to 11-years-old who are above the 91st centile and for families to encourage long-term lifestyle changes.

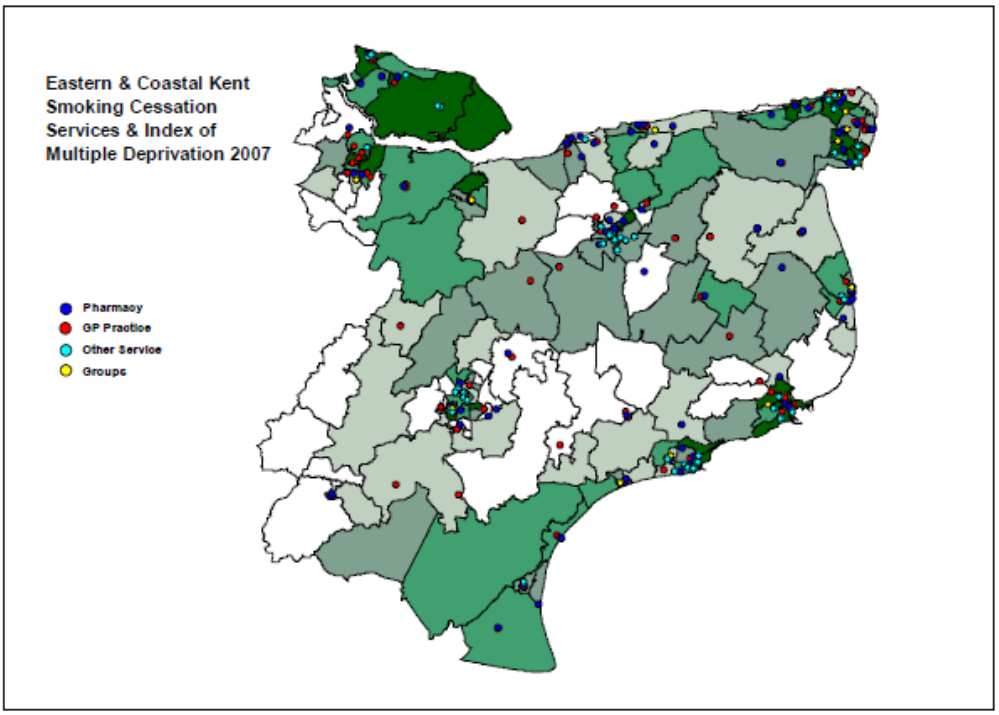
This programme runs over 18 weeks and provides continual support to families that register. There is a pre-programme assessment and this if followed by fun and interactive information sessions about healthy eating and physical activity. Practical sessions include cook and eat and a supermarket tour, as well as continuing learning to encourage and help families to make small, healthy changes. The sessions are free.

For more information please phone 0800 849 4000 (option five)

The Healthy Club
The Healthy Club which is a virtual club to help the people of Kent improve their health and wellbeing has just been launched. A future development of this resource will be to provide local focused information for health, social care and community pharmacy staff to enable them to sign-post their clients to activities that support their health and well-being. Are there suggestions on how this resource can be improved? The web address is www.healthyclub.nhs.uk

4.2 Stop- smoking:
The stop smoking service has a Kent wide target of over 9000 quits, the target for Kent is not currently being met.

In Ashford there are 17 GP surgeries (2 have satelites) and 17 community pharmacies that offer support for people to stop smoking.



The stop smoking service includes Quit Clubs, rolling groups, drop-ins, phone advice, one-to-one counselling and web-based interventions across a variety of venues including hospitals, GP surgeries, pharmacies, community centres, supermarkets, libraries, children's centres and workplaces.

The core team within the Stop smoking service delivered the following quits in Ashford over the last three years:

4.3 Children and Young people H&W service:
Is a specialist health improvement service, working to national guidance such as the Healthy Child and Healthy Schools programmes. We work to give children the best start in life and endeavour to ensure they are safe, healthy, happy and able to make most of their abilities.

Healthy eating, physical activity and support for emotional health and wellbeing are crucial to healthy growth and development. Learning how to take responsibility for your own and others' health and wellbeing needs to start early.

They support managers, teachers and support staff of schools and other settings to ensure the places where children and young people grow, play and learn promote healthy behaviour. We work to make sure there is easy access to healthy options and quality personal social and health education (PSHE), which nurtures understanding of health issues and gives the skills to manage risks and take control over lifestyle choices.

They provide advice, training, resources and support materials on policy and curriculum development, teaching and learning, support services and strategies to involve the whole school community to identify, plan for and monitor improved outcomes.

Ashford has **96% of 54 schools** that have achieved Healthy School status and **48%** of those are engaged with the Healthy Schools Enhancement Program supporting primary and special schools with Healthy Weight , Healthy Lifestyles and secondary schools with Adolescent Risk Taking, including a focus on Healthy Relationships and Sex Education, Emotional and Mental Health.

4.4 Health Trainer service:
In Ashford area there are 5 Health Trainer (HT) host sites and health trainers are employed for a total of 45 hours per week.

Health Trainers work in various areas of deprivation e.g Gateways, children's centres and libraries. (after review of Q1 data it indicates that all clients seen were registered with a GP and therefore, the HT service has not supported anyone to register with a GP.

Some positive points from the recent HT report are as follows:

- over 50% of the clients seen in Quarter 1 were from quintile 1-2 which shows that the health trainers are reaching their target group
- 35 people reported achieving or part achieving their goal (71.4%)
- 12 people reported they did not achieve their goal (24.4%)
- 2 people had not completed.
- One of the health trainers are delivering weight management support within Ashford which is linked to the Fresh Start Programme offered by the weight management team. This HT is also offering group support and there are currently 5 people involved in this.

A recent evaluation report stated that a large percentage of clients were not registered with a GP and the HT enabled the patients to obtain preventative and generic appropriate care. *Please see my comments above*

4.5 Health Checks:
KCHT have been commissioned to provide the NHS Health Check programme in Ashford since April 2013.

All GP Practices in Ashford are signed to deliver NHS Health Checks to their eligible population. In quarter 1, 2131 people received their invitation to a check and 700 people took up the opportunity to receive one at their GP practice.

KCHT are developing an outreach programme in partnership with their Health Trainer service to target certain population which are at high risk of cardiovascular disease due to their lifestyle choices or ethnic background.

4.6 Healthy Living Pharmacies
The HLP framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and help to reduce health inequalities. HLP status will be a future requirement for Public Health services commissioned via community Pharmacy.

There are two accredited Healthy Living Pharmacy in Ashford CCG locality, one based at Charing Surgery and also Kamsons in Bank Street, Ashford. Both Pharmacies passed the accreditation process with no conditions that must be met and are now part of the new Kent HLP network.

4.7 Sexual Health

KCC Update on current position:

KCC are currently making arrangement to go out to tender on sexual services. This follows a detailed review of current services which provided opportunity for users and stakeholders, including GPs, to be involved in:

- a questionnaire via survey monkey
- focus groups
- telephone interviews

In addition we have conducted a GP Nexplanon audit and audits of the pharmacy emergency hormonal contraception programme.

KCC will be hosting a meet the market event 22nd October re: the tendering of sexual health services at Sessions House, Maidstone. Interested organisations can register their attendance via the link below.

https://www.kentbusinessportal.org.uk/procontract/supplier.nsf/frm_opportunity?openForm&opp_id=OPP-HIS-KENT-9A5K8J&contract_id=CONTRACT-KENT-9A5K33&org_id=ORG-KENT-8YKEYH&from=

My colleagues in the public health business team will be inviting stakeholders and requesting clinical representatives from clinical commissioning groups to support us in the tendering and procurement process.

National chlamydia screening programme (15 -24 yr olds) There has been change to one component of this programme, that is, change to the providers of the laboratory service for the National Chlamydia Screening Programme in Kent. The contract was awarded to one provider, Source Bioscience which commenced on August 1st.

Engagement with the clinical leads for the coordination of the NCSP locally has been key to supporting us with the planning and mobilisation of this contract. This service requires GP practices to directly post all screens for this programme. The forms to be completed are different to those previously used. Females can opt to do a vaginal swab or provide a urine sample and males a urine sample.

The address for returns which are pre printed and pre paid on the boxes is:

Source BioScience, 1 Orchard Place, Nottingham Business Park, Nottingham, NG8 6PX

All results from this screening programme are provided by the chlamydia screening office to your patients.

Chlamydia screening in the general population

The system and processes you have remain unchanged.

Long acting reversible contraception (LARC)

The LARC enhanced service for contraception has been reviewed with GP and local medical council support. A service agreement with KCC will be issued in the next few months following change to faculty training, expected to be announced in November. A training programme for updating competency and accreditation amongst GPs is being planned.

GP practices in Ashford signed up to the LARC enhanced service:

- ✓ Hamstreet surgery
- ✓ Hollington surgery
- ✓ Ivy court surgery
- ✓ Kingsnorth medical centre
- ✓ New Hayesbank surgery
- ✓ Sellindge surgery
- ✓ Singleton surgery
- ✓ St Stephens medical centre
- ✓ The Charing surgery
- ✓ The Willesborough health centre
- ✓ Woodchurch
- ✓ Wye surgery

Provision of services by Kent Community Health Trust

The Sexual Health Service has transformed and is now provided in a Hub and Spoke model with the Hubs offering level 3 GUM and Contraception and the Spokes offering a full range of contraception and asymptomatic screening.

The Hub in Ashford is at the recently refurbished Vicarage Lane Health Centre and by November 2013 it is anticipated that this will provide a fully integrated GUM and contraception one stop sexual health service for Ashford. Currently the Hub is open 4 days a week and offers a range of contraception and asymptomatic screening and the GUM services are provided at the William Harvey Hospital three times a week.
The service is in discussion with a termination provider to explore the provision of medical termination from the Hub.

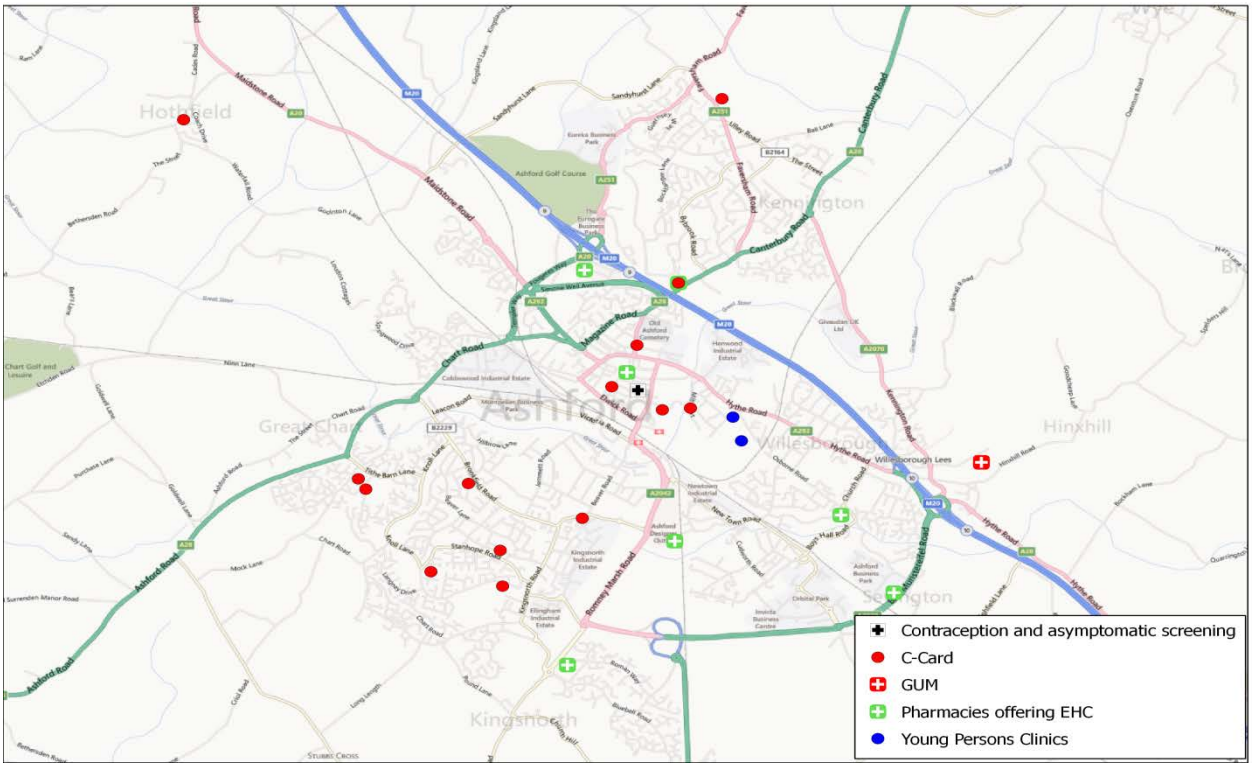
Whilst commissioned by Specialist Commissioning HIV services are integral to the GUM services and clinics are provided in Ashford at WHH, Thanet at QEQM, Sheppey at the SMH and Folkestone at the RVH.

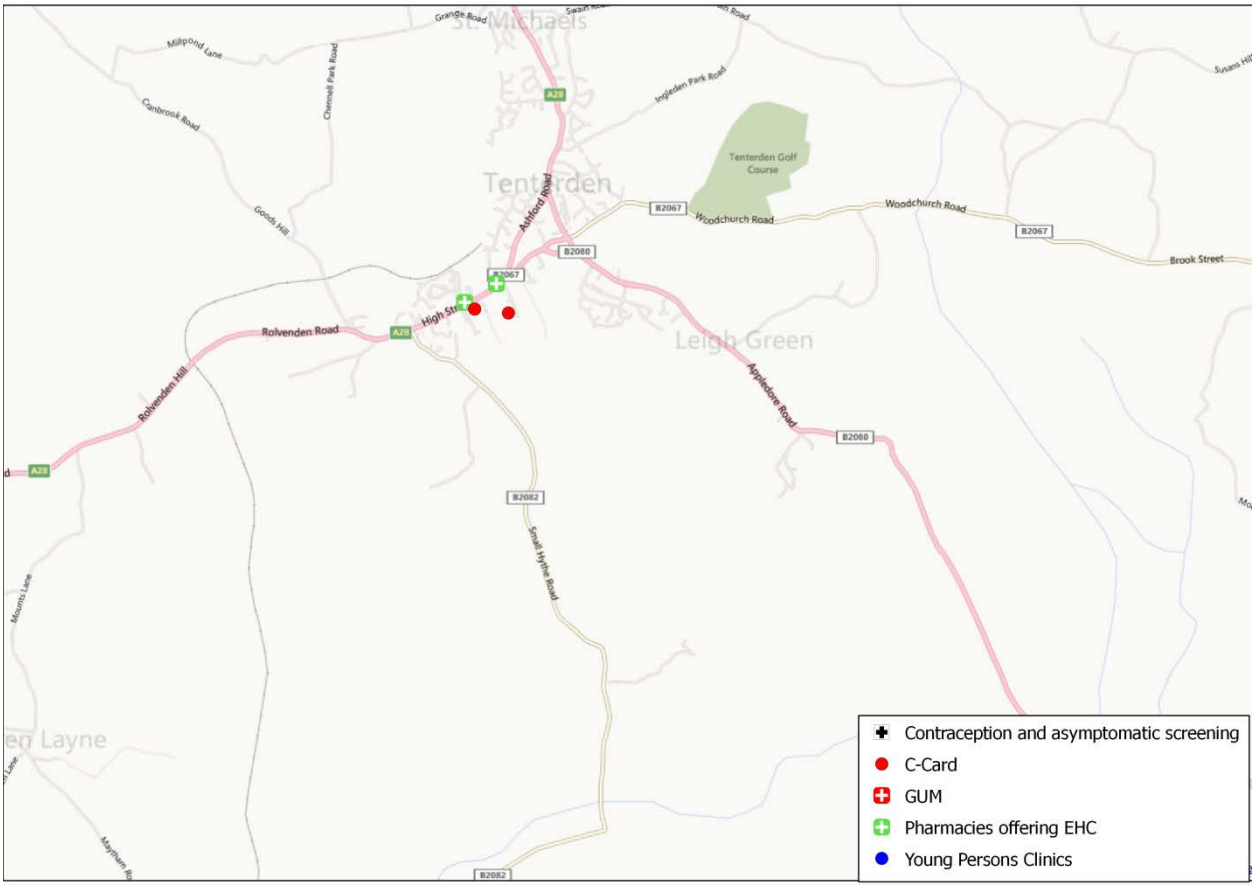
The sexual health service offers a specialist and universal service and is consultant led employing a range of staff from clinical nurse specialists to specifically trained health care assistants. They provide sexual health young people's services which include specific clinics in health and non-health settings, sexual health outreach nurses, chlamydia screening, teenage pregnancy prevention services and behaviour change interventions.

The service operates a Kent wide free condom scheme called the C Card and in Ashford there are 60 outlets for condoms. They have a website www.kentsexualhealth.nhs.uk and an App which signposts to the free condom sites. GPs can refer to outreach nurses and are encouraged to directly provide the C Card condom scheme and Chlamydia screening.

The service has a strong training arm and is the main provider of sexual health training for GPs and secondary care staff as well as providing training to non-health professionals on basic issues such as teenage pregnancy and condom use.

Map of sexual health clinics


Contraception and asymptomatic screening
C-Card
GUM
Pharmacies offering EHC
Young Persons Clinics


Contraception and asymptomatic screening
C-Card
GUM
Pharmacies offering EHC
Young Persons Clinics

4.8 Drug and Alcohol Services

The funding for Drug and Alcohol services are geared more towards Drug Detox but recent changes in policy have enabled funding to also be used for Alcohol needs – however quality and targets for Drug Treatment still have to be met.
Plans to commission A&E liaison nurses are being progressed.

Brief Interventions for Alcohol are also provided via Pharmacy and by Health Trainers.

Making the Kent Joint Health and Wellbeing Strategy a local strategy for Ashford

The 12-month strategy is a starting point for a partnership approach to improve health and care services whilst reducing health inequalities.

Good health and wellbeing is fundamental to living a full and productive life. Although Ashford has a good overall standard of health and wellbeing, this hides some poorer health and differences in life expectancy.

The purpose of this document is to give an overview and to focus on the issues we need to tackle together.

Our Mission and Values

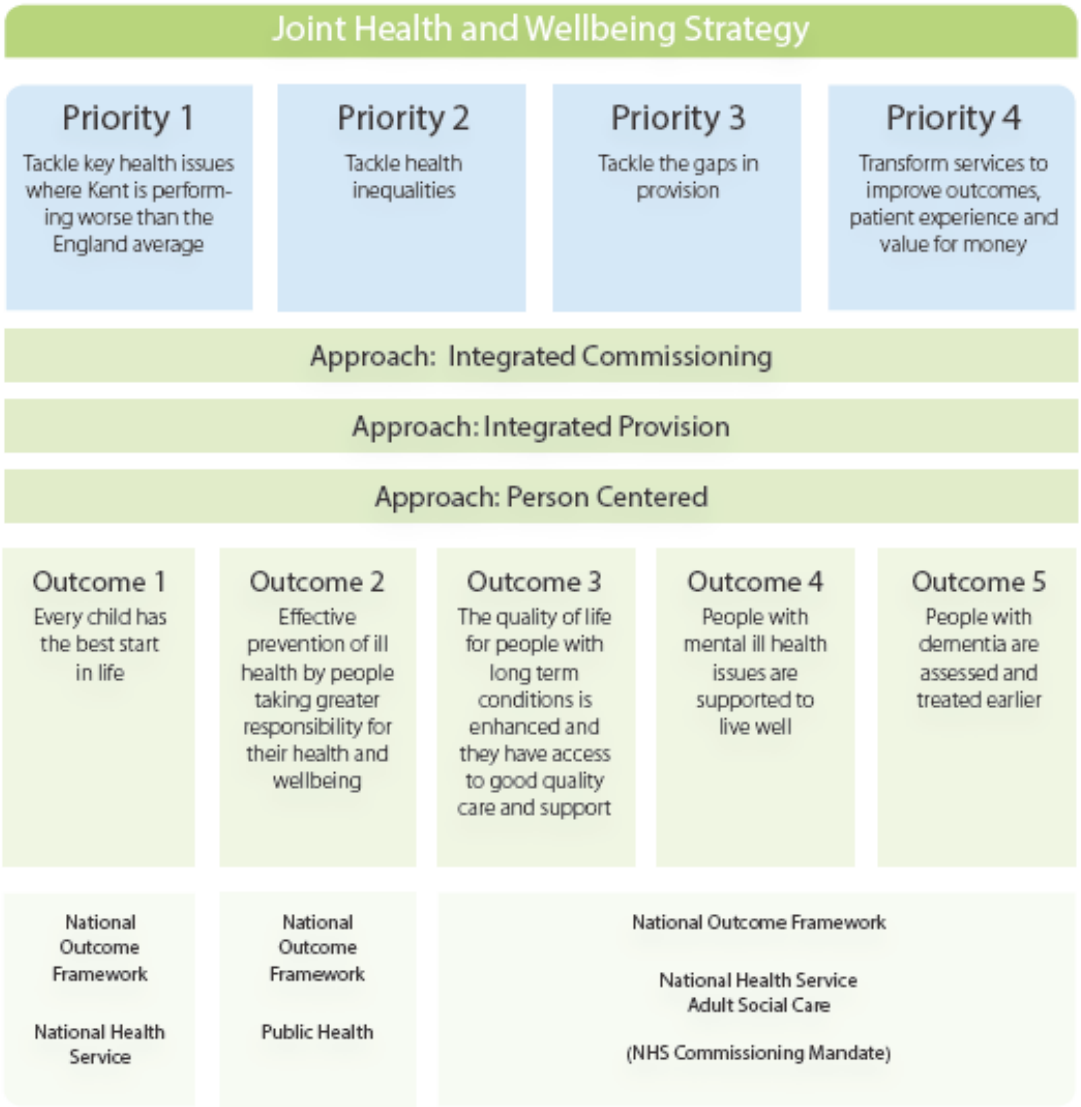
Our Mission for Ashford Health and Wellbeing Board is:
To improve the health and well-being of the population of Ashford by successfully engaging local GPs and working in partnership with patients, Ashford Borough Council, Public Health and other key stakeholders, to develop plans to improve outcomes.

Our values are:

Listen: listening to people, being responsive and ensuring their thoughts and needs shape the commissioning decisions and striving to ensure all patients have the best possible experience of services.
Collaborate: Best care is delivered when working together – clinicians, patients, stakeholders and all sections of the community.
Be open to change: As the needs of people and patients change we need to ensure considerations of high quality and value for money are paramount.
Be realistic about the challenge ahead: We know that with the increasing demands on services there will be a need to deliver sustainable services within the limits of financial resources.

The following diagram (See Figure 1) illustrates the key elements of the Kent Joint Health and Wellbeing Strategy.

Figure – Key Elements of Kent Joint Health and Wellbeing Strategy



Challenges that we face

Many factors affect our health and wellbeing; our environment, living conditions, genetic factors, economic circumstances, how we interact with our local community and the choices we make about our lifestyles.

The evidence base

This document is based on data and evidence in the Kent Joint Strategic Needs Assessment, the Ashford Borough Health Profile (2011), The Kent health Inequalities Action Plan

Joint Strategic Needs Assessment
www.kmpho.nhs.uk/jsna

Ashford Health Profile 2011
Ashford Health Profile 2011

Kent Health Inequalities Action Plan: Mind the Gap
Mind the Gap

The joint Strategic Needs Assessment identified the following key priorities that need to be addressed:

- Improving the health of children in early years
- Improving lifestyle choices
- Preventing ill health and preventing existing health conditions from getting worse
- Shifting care closer to home and out of the hospital
- Tackling health inequalities

Demographic pressures and health inequalities

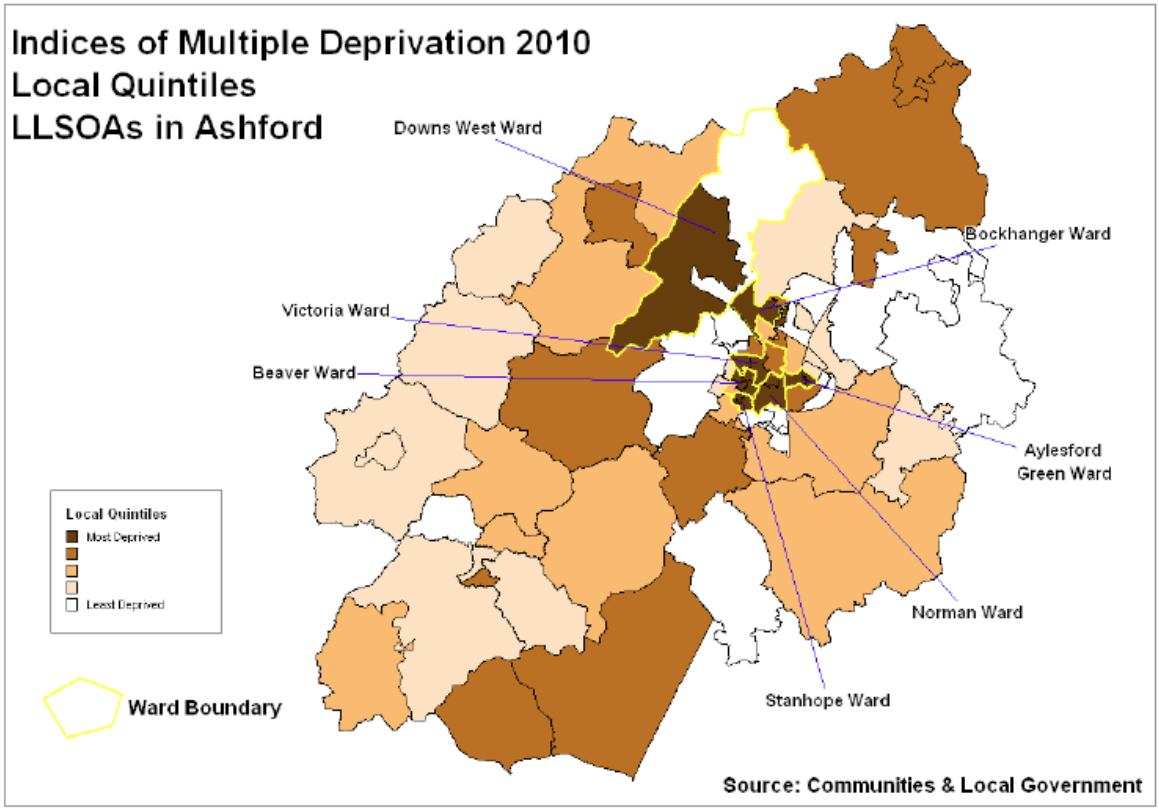
Ashford ranks I98 out f 326 in terms of the English Indices of Deprivation

Table - Rank for Kent Districts

Authority	ID 2010 score	National rank (out of 326)	South East Rank (out of 67)	KCC rank (out of 12)
Thanet	28.47	49	2	1
Shepway	23.53	97	8	2
Swale	23.48	99	9	3
Dover	20.69	127	13	4
Gravesham	19.46	142	17	5
Canterbury	16.71	175	24	6
Dartford	16.71	175	24	7
Ashford	15.31	198	27	8
Maidstone	13.85	217	28	9
Tunbridge Wells	11.99	249	32	10
Tonbridge and Malling	10.49	268	37	11
Sevenoaks	10.49	276	40	12

Source: Indices of Deprivation 2010, Communities and Local Government
Based on average of LSOA scores
A rank of 1 is the most deprived

Figure – Ashford ward IMD 2010

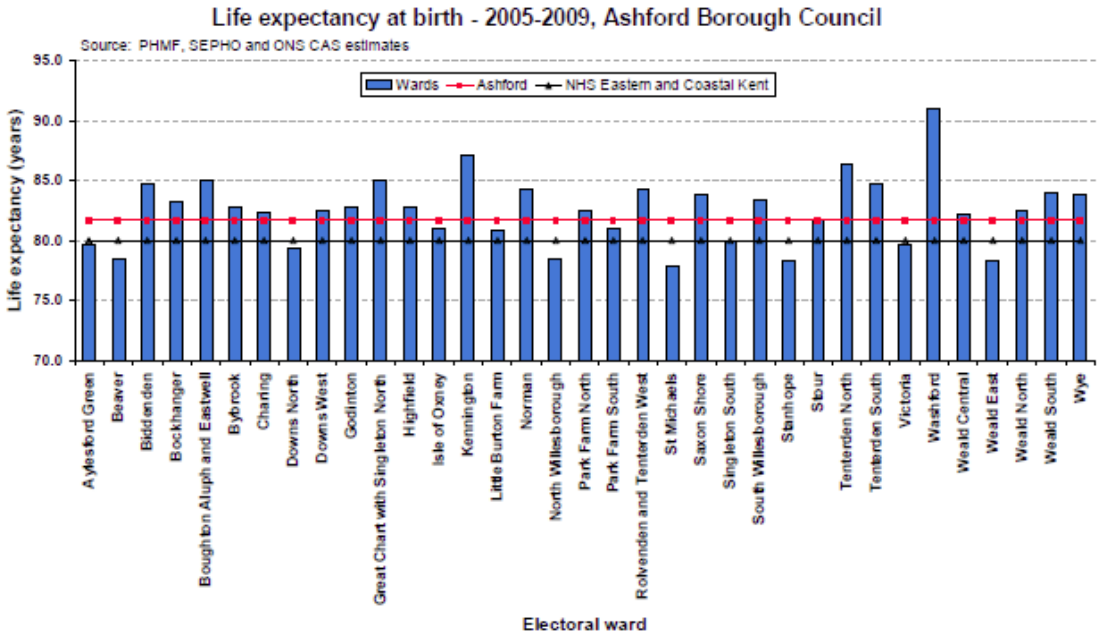


All of the seven wards in Ashford that are identified as being the most deprived are also the most deprived in the health and disability domain.

Life expectancy

The average life expectancy in Ashford is 81.6 with females having a higher life expectancy at 82.9 compared to males at 80.3.

Figure – Life expectancy at Birth

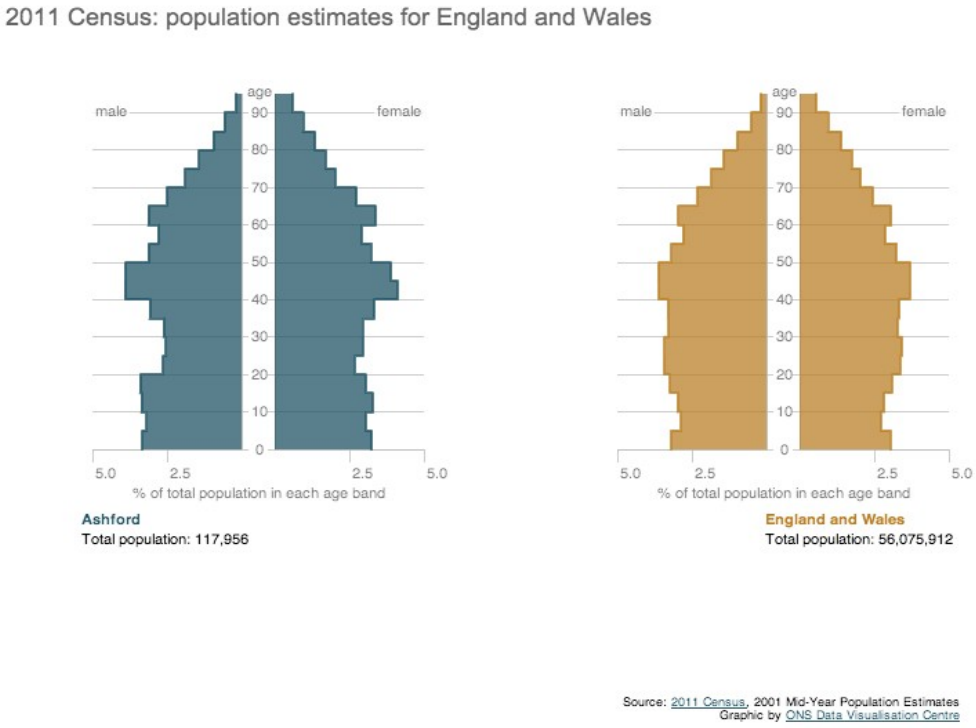


The graph above illustrates the pooled life expectancy at birth for electoral wards in Ashford. The lowest life expectancy figures are in the wards of St Michaels and Weald East, with the highest figures in Washford. The difference in the number of years between the highest and lowest life expectancy at birth is 13.1 years.

Age profile

The resident population of Ashford comprises approximately 117,956
In comparison to the national profile, Ashford has a higher percentage of 14 yr olds, a smaller proportion of 15-35 yr olds with the majority aged between 35 and 50 yrs. There is also a higher proportion of over 60 yr olds than the national average.

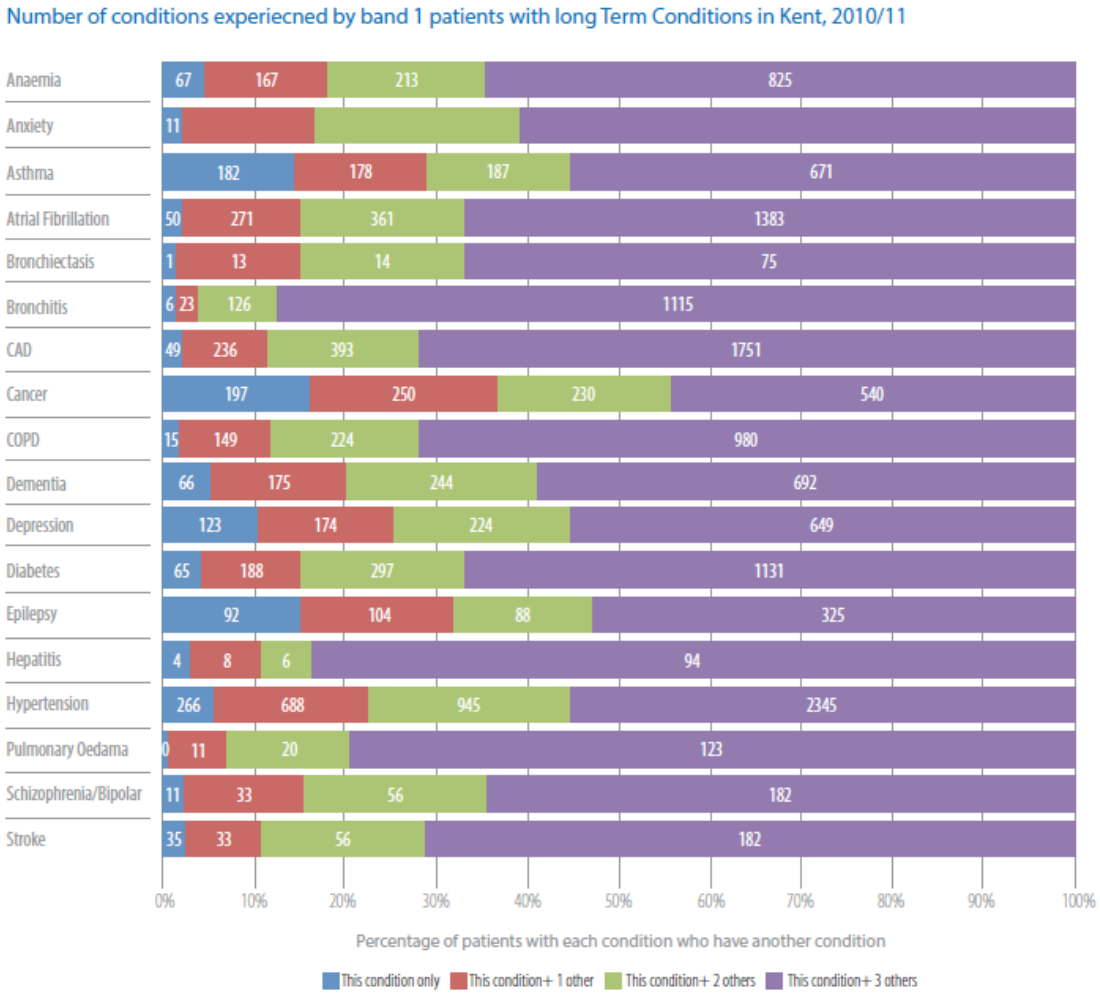
Figure – Ashford age profile



70% of Kent residents describe themselves as being in good health but 16.5% of Kent's population live with a limiting long-term illness, and in most cases they have multiple long-term conditions (See Figure 5). There needs to be a shift from treating individual illnesses to treating the whole person.

Figure - Risk profile for Kent population in Band 1

The graph below shows that the top 0.5% (Band 1) of the Kent population who have been identified as having the highest risk of re-hospitalisation are patients who have at least 3 or more long term conditions, indicating that multi morbidity is the norm, not the exception. For example, only 5% of patients with dementia had only dementia, and only 1% of patients with COPD had only COPD.



Health Summary for Ashford

The areas where Ashford is better than England Average are:

- Less deprivation
- Lower proportion of children in poverty
- Lower levels of violent crime
- Lower levels of long-term unemployment
- Less hospital stays for self-harm
- Lower levels of early deaths
- Better life expectancy in males and females

The areas where Ashford needs to do better are:

- Statutory homelessness

- Educational attainment
- Smoking in pregnancy
- Breastfeeding initiation
- Obese adults
- Levels of physical activity

To improve people's long term health we have to improve healthy lifestyles; encourage healthy eating, address the challenges of an ageing population; give every child the best start in life and enhance the quality of life of people with long-term health conditions, including mental health and dementia.

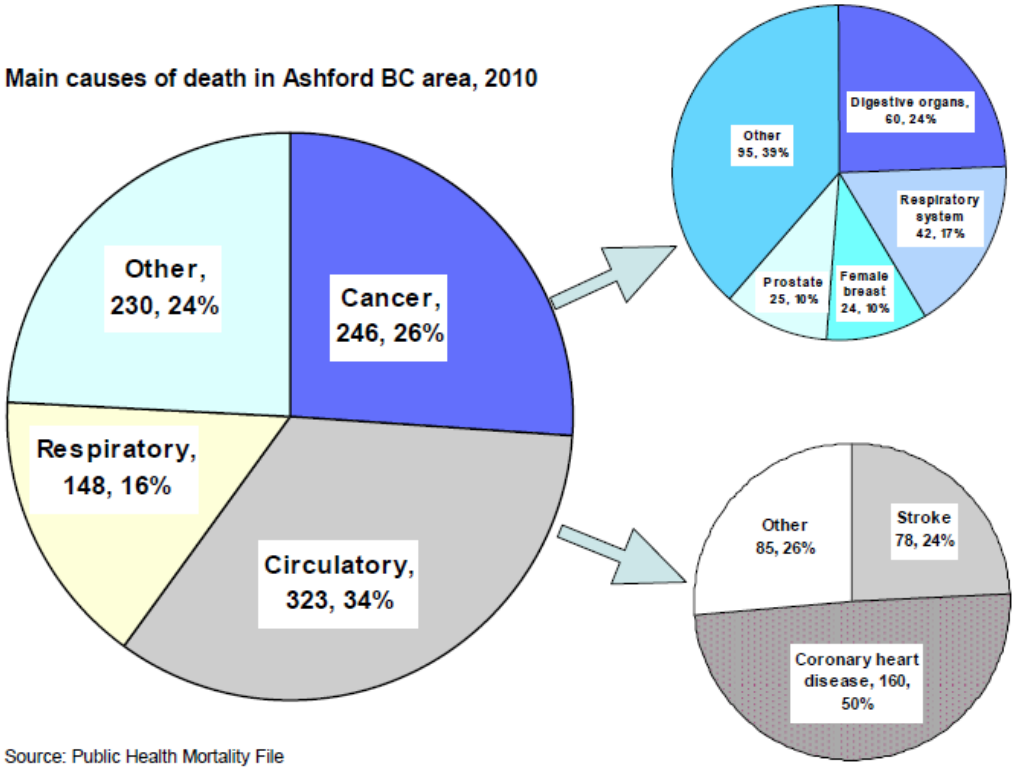
We will need a real focus on differences in outcomes. There needs to be greater effort focused on the wards with the greatest deprivation as these are also the wards with the poorest health outcomes. This will require us thinking how to improve the knowledge of local people about different diseases and how to prevent them, for example by encouraging more people to get active and eat healthily. Healthier choices need to become easier choices to make.

We will also need to address the wider determinants of ill health such as lifestyle, access to services, employment status and housing conditions. If these are tackled successfully they will have a significant long-term impact on the health of the people of Ashford.

Preventable deaths

The pie chart (See Figure 6) illustrates the main four causes of death in Ashford in 2010. These remain largely unchanged. Taking a more proactive approach to health and care can reduce all of these health conditions.

Figure – Main causes of death in Ashford



To promote healthier lives for everyone in the borough of Ashford we will need to prioritise the areas we are doing less well.

- Tackle statutory homelessness, educational attainment, smoking in pregnancy, breastfeeding initiation, and adult obesity and physical activity levels
- Tackle health inequalities to improve health in the seven worst wards. This will mean looking at the gaps in provision in these areas and focusing on preventative work.

Our priorities will be delivered through the following approaches

- Integrated commissioning, leading to
- Integrated provision that is focused around the person

Outcome 1

Every child has the best start in life

Several of the areas where Ashford needs to do better will lead to improvements in outcome 1. These are:

- Statutory homelessness
- Educational attainment
- Smoking in pregnancy
- Breastfeeding initiation
- Improving levels of physical activity

What are our priorities for action?

Public health has commissioning intentions for:

- Tackling smoking in pregnancy
- Improving breastfeeding initiation
- Improving levels of physical activity

Reducing prevalence of smoking in pregnancy

a) An audit of Smoking at Time of Delivery (SATOD) activity is about to start. This will consider accuracy of data and self-reporting.

b) Redesign pathways and interventions with midwifery and cessation services including the roll out and continuing evaluation in Kent of the successful “Babyclear” programme.

c) Current costs to NHS in Kent of smoking in pregnancy by NICE modelling are estimated to be £2,486,875 pa.

Breastfeeding support is being commissioned as the prevalence of breastfeeding is a key area where Kent is under-performing against national statistics and it is therefore proposed to increase support services, focussing on key Districts and wards. For Ashford this will be an important priority.

The Healthy Club is contributing to efforts in improving the physical activity of individuals, families and children. The website supports the setting of objectives for individuals, families, and schools and enables tracking of success. There are further developments in the provision of information for professionals and information on the different activities available at a local level.

How will we measure our success?

We will initially see an increase in the prevalence of smoking at time of delivery as the reporting improves. In the longer term it is hoped that a focus

on smoking during pregnancy will lead to a decrease in the prevalence of smoking at time of delivery in Ashford.

An improvement in the prevalence of breastfeeding and its continuation amongst mothers in Ashford.

An increase in the numbers of people signed up to the Healthy Club and improvements in their rates of physical activity. It is hoped that this will also lead to decreased obesity levels.

Outcome 2

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

Public health support to this agenda:

The main area that Ashford needs to improve in this area is adult obesity. Adult obesity levels can be improved through licence regulation of fast food outlets. The main focus of the work of public health in this area is through the commissioning of tier 3 weight management services. Continuing to give support to the healthy weight programmes and health improvement services provided by Kent Community Health Trust.

Public health is currently undertaking a review of adult healthy weight services across Kent. A care pathway has been developed that needs to be implemented in a systematic and consistent way. Historically, healthy weight services have differed and there are distinct variations between the approach across West Kent and East Kent. Once the review is completed it will enable an aligned and co-ordinated approach to be developed and commissioned.

A business plan for increasing the number of outdoor gyms across Kent has been agreed. Ashford has been proposed as one of the boroughs where an outdoor gym will take place.

The Healthy Living Pharmacy Programme is being invested in and rolled out across the county. Community pharmacists will be empowered to tackle the prevention of ill-health and health improvement agenda with their clients. This programme will give them the tools to tackle, helping people to quit smoking, supporting people to have NHS health checks, making referrals to other services and providing support for sexual health issues.

More funding is being allocated to health trainers particularly in West Kent which has been under-funded in the past. Public health will be funding the health trainer strand that focuses on helping people to improve their lifestyles leading to the prevention of ill-health and facilitating people to take greater responsibility for their health and well-being.

Tobacco control and supporting people to quit will have increased funding. The strategy recognises the importance of helping smokers to quit but places emphasis on prevalence rates that will incorporate how to prevent young people taking up smoking, as well as teenage quit rates.

Other priorities in the public health outcomes framework will require action on tobacco use to be achieved. These include reducing rates of cardiovascular disease, cancer and respiratory disease as well as the overarching indicators of reducing inequalities in life expectancy and healthy life expectancy. Prioritising tobacco control programmes can therefore also contribute to the QIPP agenda.

Historically Kent has concentrated investment in services to help adults quit smoking. These have achieved significant success - last year (11/12) the Stop Smoking Services in Kent helped 9,314 people quit smoking at a cost of c. £3.3 million. However the agenda is now much wider and Kent has developed a Tobacco Control Strategy (Towards a Smokefree Generation) that addresses the use of tobacco across the Life-Course[1] and provides a coherent programme of interventions that address the local priorities for Kent. Critically we need to reduce the number of children that start smoking. The Kent strategy has a clear emphasis on engaging and empowering young people to avoid smoking.

Two programmes of work are currently being recommended nationally to address workplaces, the National Public Health Responsibility Deal and the Liverpool Workplace Health and Wellbeing Charter, which can be adapted and renamed locally. Public health is proposing a pilot for a workplace health and wellbeing project through commissioning district Councils and getting engagement with businesses through Environmental Health Officers and Food Safety Officers.

Kent County Council Business Engagement is also looking to develop a single point of access and one conversation with businesses to collate all initiatives and present them on a single website. The proposed Kent Healthy Business Award will provide an overarching framework that support business improvement and self-assess against national advice and guidelines and plan improvements. Themes that can be addressed include:

- Leadership
- Attendance management
- Health and safety
- Mental health and wellbeing
- Smoking
- Physical activity
- Healthy eating

1 Marmot (2010) Fair Society, Healthy Lives (The Marmot Review) 2010 www.ucl.ac.uk/marmotreview

- Alcohol and substance misuse

How will we measure success?

- Improvements in life-expectancy
- Reduction in mortality
- Reduction in smoking prevalence
- Increased levels of physical activity

Outcome 3

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

We know that the population of Ashford is ageing and living longer adding to the significant financial and demand pressures; we will need to focus not just on adding years to life, but life to years. The support that public health give to this agenda is through the co-commissioning of health trainers who will support people with complex health needs to improve their lifestyles and lessen their reliance on secondary care services.

Commissioning of long-term conditions (LTC) is not effective because patients with multiple morbidities are not accounted for, but represent significant burden on hospital services including A&E. This requires a radical shift in the way it delivers care. Integrated care is increasingly being seen as part of the solution.

The national LTC model of care endorses 3 key principles, all of which needs to be implemented at pace and scale by CCGs to transform care services:

- Population risk stratification to identify patients with the highest risk of crises for multidisciplinary case management. Public health has been working with the KMHIS who run the local version of the King's Fund Model to use and apply risk stratification towards transforming integrated commissioning. Details of the analysis are located here www.kmpho.nhs.uk/jsna including a bespoke profile for Ashford CCG. Public health is also currently leading the local implementation of the Year of Care programme, of which Kent is now one of 8 early implementer sites nationally. Work is currently underway with CCGs to test-proof a new currency / tariff which will lead to formation of integrated health and social care risk adjusted capitation budgets
- Care coordination through functionally integrated generic care teams at a practice / neighbourhood level comprising all relevant health and social agencies to provide joined up and personalised services. This is now a Direct Enhanced Service for primary care introduced by NHS England. Public Health has been supporting the Kent Health and Social Care

Integration Programme, which, over the last two years has implemented mainstream proactive multidisciplinary team working to enable anticipatory care planning targeted at patients at future risk of crisis and rehospitalisation.

- Empowering patients to maximise self-care, self-management and choice, through access to their medical records, co-production of their care plan leading to delivery of coordinated interventions and targeted care. Public health provides valuable support through the co-commissioning of health trainers who will support people with complex health needs to improve their lifestyles and lessen their reliance on secondary care services by signposting them to services already available in the community provided by the third/voluntary sector particularly in the areas for falls prevention, dementia support for carers and end of life. It is currently exploring with adult social care to understand synergies between health trainers and care navigators and opportunities for joint commissioning of both services.

Success will be measured by a number of key milestones and outcomes*)*:

Structure

- Creation of new commissioning contracting models to mainstream national LTC Model of care approach
- Formation of virtual neighbourhood practice based integrated teams through the HASCIP, particularly involving, community health, mental health, social care and hospital specialists.
- Concomitant transformation of health and social service capacities (eg. reduction of hospital beds) to ensure sustain new integrated care model approach

Process

- Increase in primary care based targeted MDT meetings and case conferences as recommended by the national DES.
- Increase in number of anticipatory care plans using prescribed format agreed by HASCIP which will describe definitive community based measures for crisis prevention and crisis resolution.

Outcomes

If the LTC model of care is implemented at pace and scale, targeted towards the top 5% of at risk population identified proactively through risk stratification, roughly speaking, it is expected:

- A reduction of up to 25% of unscheduled admissions and > 30% non-elective bed days
- Reduction in hospital mortality by about ~10%

Outcome 4

People with mental ill health issues are supported to 'live well'

Public Health is working with other directorates in KCC, local partners and the public to prevent mental illness and promote positive mental health. *Live it Well* Kent's mental health and wellbeing strategy gives priority to promoting wellbeing as a cost effective preventative intervention to keep people well. The wellbeing approach focuses on holistic wellbeing and emphasises strengths and abilities and offers a positive alternative to illness and disability.

What are our priorities for action?

Public health is investing in areas of greatest need and will be campaigning using the six dimensions of the Wheel of Wellbeing (Body, Mind, Spirit, People, Place and Planet) developed by the South London and Maudsley NHS Foundation Trust.

The themes of this work follow:

- Asset based community development
- Wellbeing in communities
- Campaigns
- Training and suicide prevention

There will be 12 interventions - the first nine of which - are being funded by Public Health

1. Resilience and asset mapping research
2. MindFull pilot for schools
3. Wellbeing campaign resources
4. Workforce wellbeing support
5. Live-it-well website
6. Men's sheds
7. Community care and resilience wellbeing hubs in libraries
8. Young people asset mapping
9. Mental health awareness training
10. Community development programmes
11. Parenting – families and schools support
12. Tackling isolation in priority communities

How will we measure success?

A reduction in suicide
Increased reported wellbeing

Increased access to IAPT services

Outcome 5

People with dementia are assessed and treated earlier

The number of people with dementia is expected to treble nationally in the next 30 years. Currently the average QOF prevalence rate for dementia in Kent is 37% as of 2011 estimates, still far below the expected prevalence of 1.2% based on national rates. In Ashford CCG the QOF prevalence is 30% equating to approximately 455 people. The Protecting Older People Prevention Information system suggests there should be almost 1700 people with dementia by 2015. Any targets for improving diagnosis rates should be developed based on these estimates.

Research suggests that dementia is rarely seen in patients as a single long -term condition and usually accompanied by other co morbidities. In Kent, the top 0.5% of high-risk population showed only 5% of patients with dementia had only dementia (shown in diagram above).

While a number of multi agency initiatives are currently underway to improve diagnosis rates for dementia, Public Health suggests that this outcome be linked with outcome 3. Implementation of the LTC model of care will also support this by way of identifying and assessing persons at risk through an MDT approach. The rationale behind this is that, in light of emerging rise and importance of multiple morbidities, the at risk population for dementia i.e. Complex frail elderly > 65 yrs will be also at risk for falls and fractures and end of life and therefore a multidisciplinary approach to assessment and management is required.

Kent SEND Strategy a local response to a national challenge

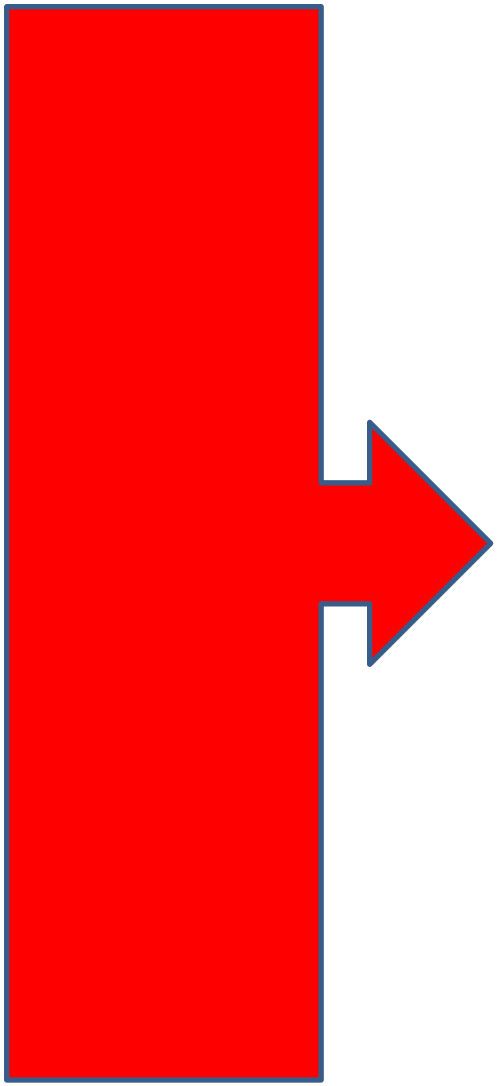
Ashford Health & Wellbeing Board

23rd October 2013

Martin Cunnington & Julie Ely

Meeting the challenge

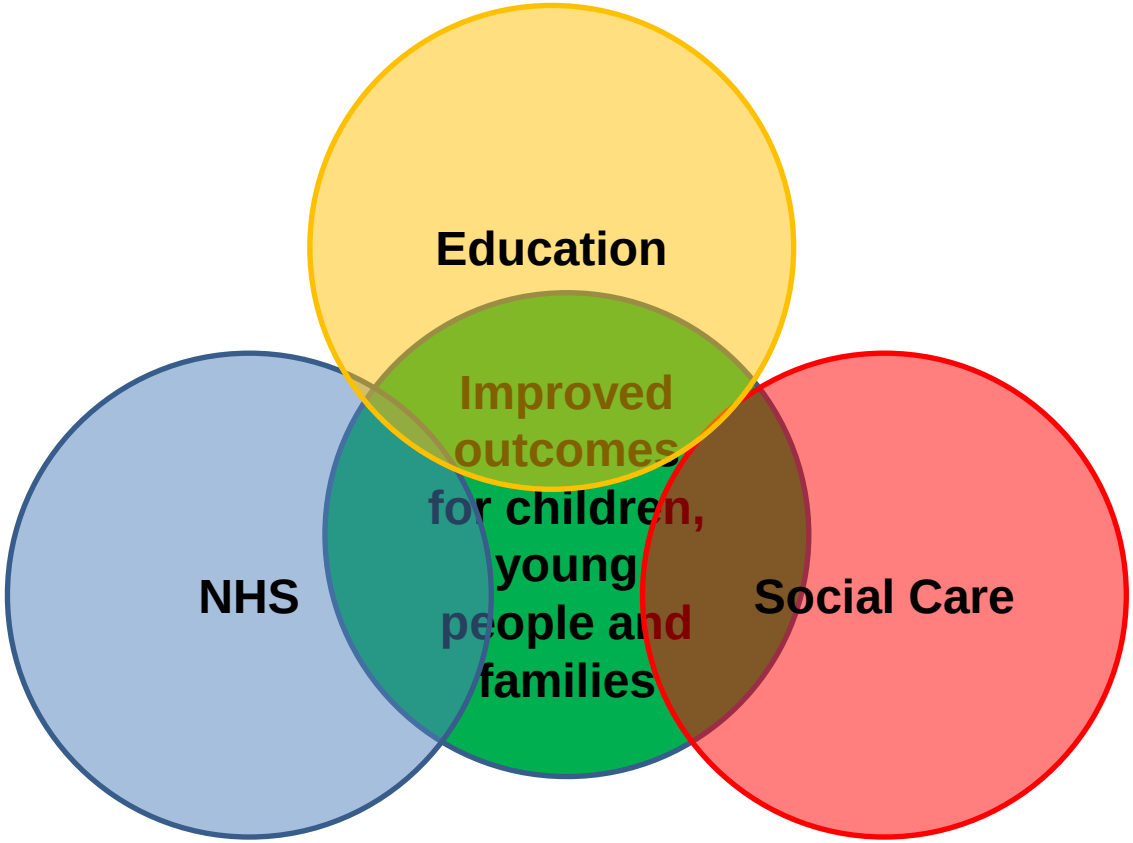
- Everyone Counts: Planning for Patients 2013/14
- Govt response to CYP Health Outcomes Forum Report
- Revised NHS Constitution
- Revised NHS & Public Health Outcomes Frameworks
- Draft Children & Families Bill
- Draft Care & Support Bill



Improved outcomes for children, young people and their families

Bringing initiatives together

We can view the needs of a child and family through different lenses or we can work on themes that unite us..



Or we can work on the themes that unite us

Common themes

- Whole system change linked to personalisation.
- Joint commissioning.
- Integrated services and integrated assessment and planning.
- Personal budgets.
- Improved information, transparency and accountability.
- Workforce training and development.
- Improved data and key performance indicators.

Co-production

“We must ensure patients’ and their families’ voices are heard and used to help us develop the insight to improve outcomes and guarantee no community is left behind or disadvantaged. We want to make the NHS the best customer service in the world and throughout the NHS, we must all strive to design and deliver care based on the needs and choices of each individual patient”.

Sir David Nicholson, Everyone Counts: Planning for Patients 2013/14

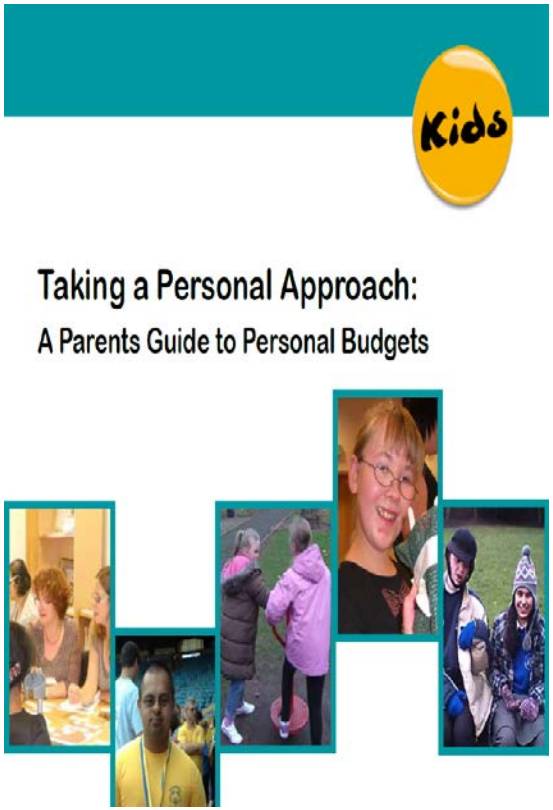
Co-production

SE7 definition of co-production

"Co-production happens when all team members together agree outcomes, co-produce recommendations, plans, actions and materials as a collective. It is an approach which builds upon meaningful participation and assumes effective consultation and information sharing…Parent carers are not just there to illustrate the experience of service users, but rather to take responsibility to help shape future experiences and be an active part of delivering the solutions".

Britton & Taylor (2013): Co-production with parent carers the SE7 experience. SE7 SEND Pathfinder.

Making It Personal



Products:

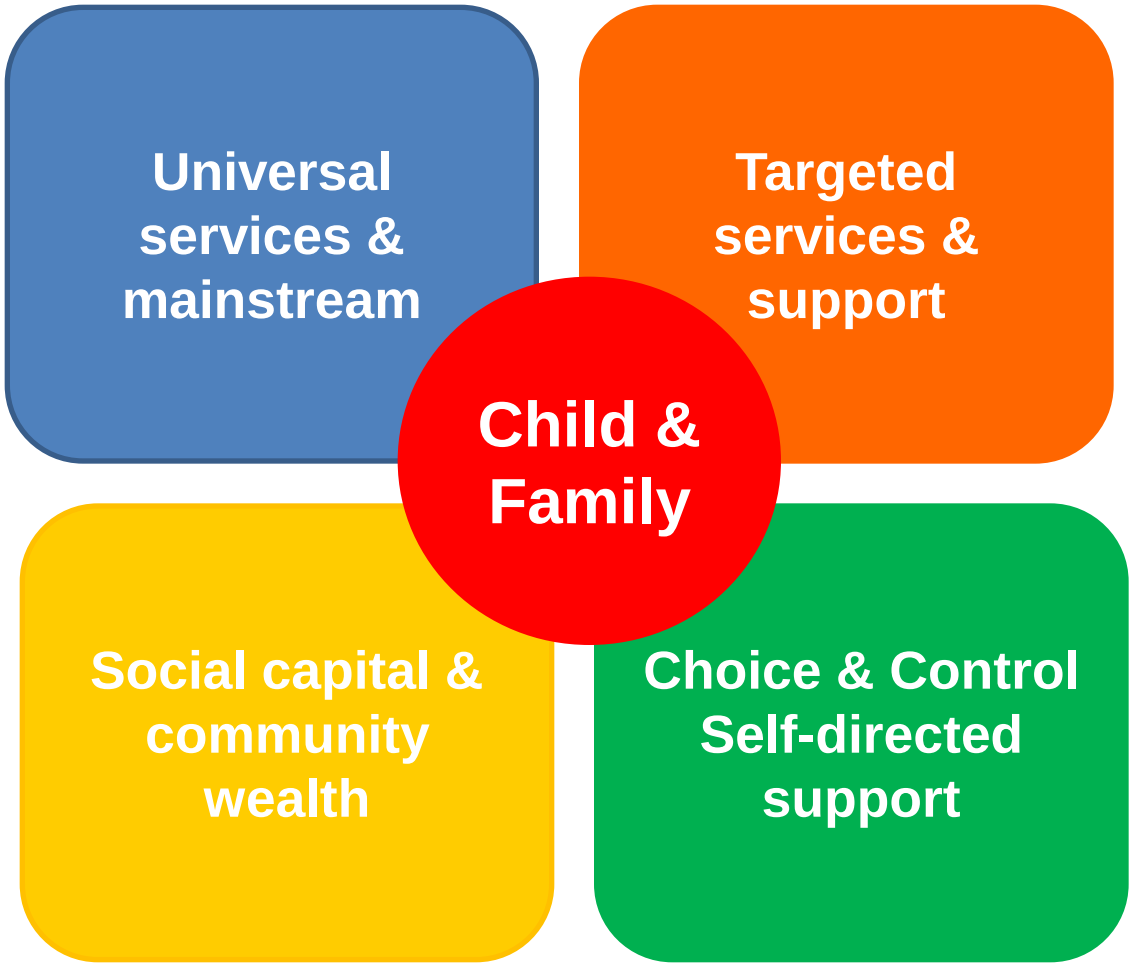
- Parents Guide to PBs
- Case studies
- E learning
- Commissioners guidance

- http://www.kids.org.uk

Commissioning levels

- Individual level commissioning
  - Parents and young people
  - Co-production between parents and young people and lead professionals and/or social workers
- Operational/community level commissioning
  - Focus on localities and or care groups / care pathways
  - CCG, District Council or County Council level
- Strategic commissioning
  - Set strategic direction with strategic plan, agree pace of change, allocate resources, manage whole system performance, well governed, cyclical, seasonal

Personalisation & Promoting choice and control



The local offer

- Local offer aligned to the new joint commissioning duty.
- Web based tool that creates a snap shot in time.
- Opportunity to innovate.
- Organic process that changes over time.
- Improved information, transparency and accountability

Kent SEND Strategy

Aims

1. improve the educational, health and emotional wellbeing outcomes

2. better integrated assessment and joint commissioning to deliver single education, health and care plans

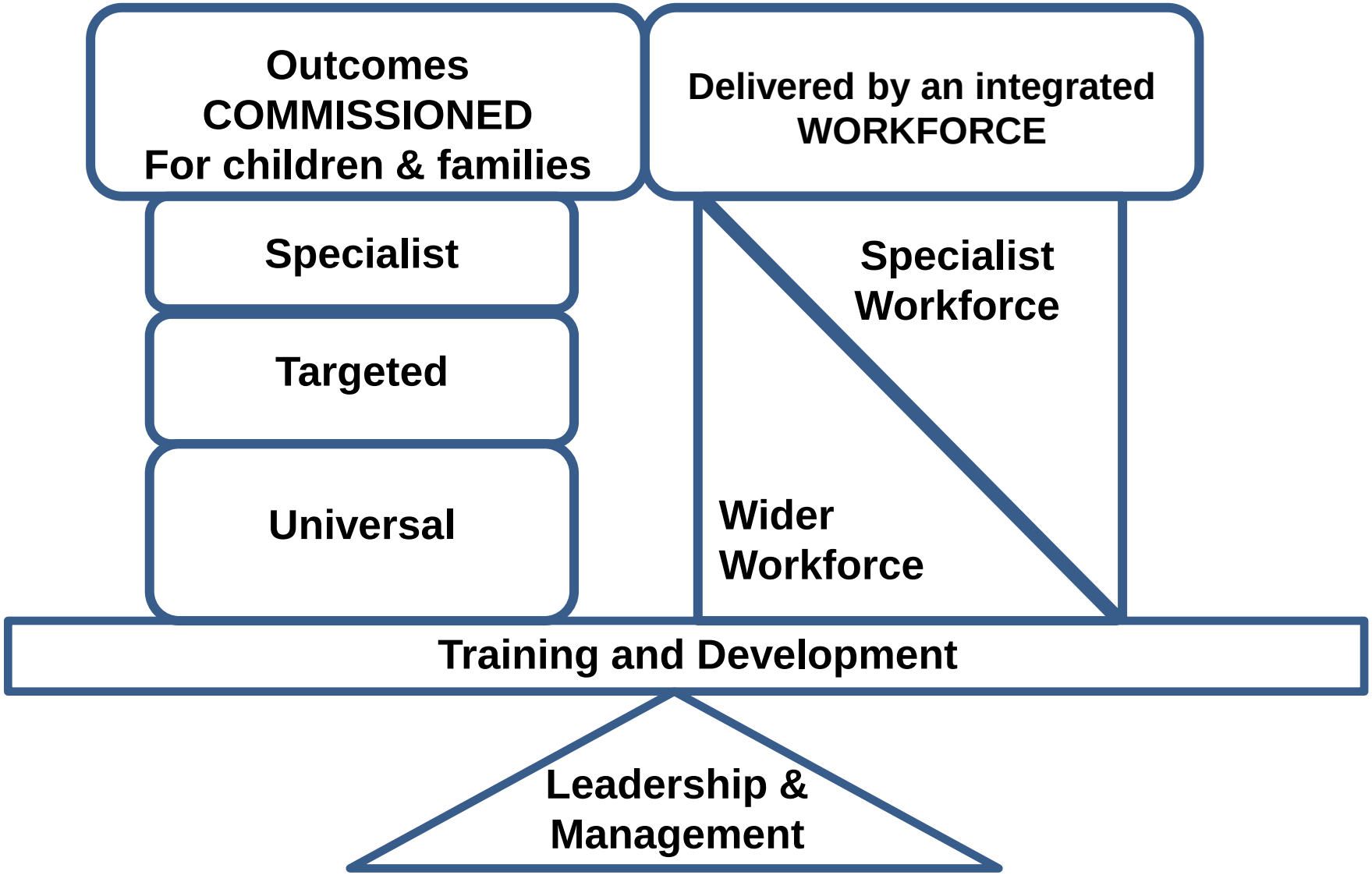
3. develop the range of social care, health and education providers and encourage a mixed economy

Kent SEND Strategy

Priorities

- Better progress & closing the achievement gap
- Parental engagement
- Multi-agency planning by autumn 2014
- Therapies, CAMHS and nursing
- Effective use of our resources
- Quality and capacity of schools
- Broadest range of providers to increase parents choice
- Personalised budgets where appropriate
- Early intervention

Whole system approaches to meeting current & future demand



Core principles for integrated working

“The provision of integrated services around the needs of patients occurs when the right values and behaviours are allowed to prevail and there is a will to do something different. We need to move beyond arguing for integration to making it happen.”

Professor Steve Field, NHS Future Forum

Core principles for integrated working

- No decision about me, without me.
- Tell my story once.
- Parent carers / young people and professionals both have active roles to play in the assessment of need, identification and implementation of the shared goals.
- Shared goals that a team around a child / family can work on.
- Shared understanding of key working functions.

Core principles for integrated working

- Clear and accessible information that is available to parent carers and young people early in the process.
- Shared values.
- Open and transparent process.
- Joint workforce training and development, with parent carers empowered to deliver key aspects of the training programme jointly with professionals.
- The training offered to professionals linked to a particular child / young person should also be delivered to the parent carers.