Ashford Health and Wellbeing Board

ASHFORD
BOROUGH COUNCIL

Notice of a meeting, to be held in Committee Room No. 2 (Bad Münstereifel Room), Civic Centre, Tannery Lane, Ashford, Kent TN23 1PL on Wednesday, the 22nd January 2014 at 12.00 noon

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Agenda

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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/AEH
14th January 2014

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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, with revisions adopted on 17.10.13, 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

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **23rd October 2013.**

Present:

Councillor Michael Claughton – Chairman, Cabinet Member, ABC;
Navin Kumta – Vice-Chairman, Clinical Lead, Ashford CCG

John Bunnett – Chief Executive, ABC
Penny Southern - Families and Social Services Lead, KCC
Paula Parker – Families and Social Services Representative
Marion Gibbon – Public Health Representative, KCC
Sheila Davison – Public Health Representative, ABC
Neil Fisher – Head of Strategy and Planning, Ashford CCG
Jane Miller – Families and Social Services, KCC
Dave Harris – Families and Social Services, KCC
Steve Inett – HealthWatch Representative
Martin Harvey – Patient Participation Representative, Lay Member CCG
Keith Fearon – Member Services and Scrutiny Manager, ABC
Belinda King – Management Assistant, ABC
Martin Cunnington – Interim Associate Partner (Children's and Maternity Services KMCS) (for item 9 only)
Julie Ely – Head of Special Needs, KCC (for item No 9.only)

Apologies:

Cllr. Jenny Whittle, KCC
Mark Lemon, Policy and Strategic Relationships, KCC

1 Introduction

1.1 The Chairman welcomed all those present and the member of the public and advised that this was the first open meeting of the Board.

2 Notes of the Meeting of the Board held on the 24th July 2013

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

3 Revisions to Terms of Reference for CCG Level Health and Wellbeing Boards

3.1 The report set out the proposed amendments to the Terms of Reference and Procedure Rules of the Board which were still to be formally agreed by all parties and subject to final approval by the Kent Health and Wellbeing Board.

3.2 The Chairman referred to the comment in paragraph 3.4 and advised that the statement was incorrect in that the guidance on the Kent Code of Conduct for Members had not been circulated.

3.3 Sheila Davison advised that the report had been produced by Mark Lemon of Kent County Council and she then took the Board through the report noting in particular the following:-

- Officers would not act as voting members.
- The meeting of all Chairs of all Local HWBs' on 3rd December 2013 would be attended by Sheila Davison as the Chairman was unavailable on that day.
- Navin Kumta attended the Kent Health and Wellbeing Board as the representative for the Ashford Health and Wellbeing Board.
- Although the Kent County Council's Constitution did not permit public participation, local discretion could apply and therefore the Ashford Borough Council Scheme of Public Participation would be used.
- The voting arrangements would be on the basis of one vote per organization, i.e. KCC/ABC/CCG and HealthWatch. The Board did not have decision making powers and therefore it was expected that the business would be conducted on the basis of consensus.

The Board agreed the report.

4 Clinical Commissioning Group (CCG) – Priority Setting Engagement Event

4.1 Navin Kumta gave a verbal introduction to the report and advised that the third planning session had looked at establishing the priorities for 2014/15.

4.2 Neil Fisher further explained that the ideas put forward by providers and member practitioners had been discussed with the aim of establishing a priority and a clear steer on the overall outcome of the priorities. These included a revision of outpatient services; increasing one stop facilities; further advice and guidance prior to discharge; dementia and in particular out of hours support; the mental health services such as dealing with eating disorders; and all age ADHD (Attention Deficit Hyperactivity Disorder) services. Neil Fisher further explained that the area of children's services' objectives examined included support for looked after and disabled children. The next step would be to work up a full business case for each of the objectives for inclusion in the annual commissioning plan. The target deadline to complete all this work was before Christmas 2013.

The Board received and noted the report.

5 Update on the Integrated Commissioning Group

5.1 Included within the Agenda papers was the Integrated Commissioning Group's (IIG) Highlight Report for the quarter 3 period, October to December 2013.

5.2 Dave Harris explained that in May representatives from Kent County Council, Ashford Borough Council and the Clinical Commissioning Group had met to discuss commissioning priorities. These had been examined and refined and three priorities had been established covering:-

a) Dementia with Kent County Council as lead;
b) Behavioural and emotional needs with the Ashford Clinical Commissioning Group as lead; and
c) Eating disorders/obesity with Ashford Borough Council as the lead.

5.3 Three sub-groups had been established and would feed back into the commissioning process.

5.4 Neil Fisher explained that in terms of Dementia it was recognised that there were a large number of people being treated for Dementia but had not had a clinical diagnosis. Therefore at this stage it was difficult to estimate how many Dementia sufferers would be identified and therefore what level of funding was needed to be allocated to support it. John Bunnett considered it was important that the CCG responded to the needs assessment as it related to Ashford and not just the whole of Kent and it was these areas of work that the Borough Council would wish to progress. He asked whether the CCG worked with the schools on the issue of obesity. Paula Parker confirmed that schools were represented on the sub-group and a report would be brought back to the next meeting setting out a plan as to how the priority could be tackled. Navin Kumta also explained that the Chairman of the Children's Trust Board sat on the main Health and Wellbeing Board and said it might be useful for the January meeting of this Board to have an update on the Children's Trust Board. John Bunnett considered that there was a need to reconcile the early initiatives which could be picked up now rather than wait until next year and make the schools aware sooner rather than later. Dave Harris also clarified that in terms of Dementia work this would be centred on increasing independence by helping to keep the person in the home environment rather than moving to direct care.

The Board received and noted the report.

6 The Integration Transformation Fund

6.1 The report advised that the £3.8bn Integration Transformation Fund (ITF) announced by the Government dramatically accelerated the timescales for achieving the integration of health and social care services. Government expectations were that a fully integrated system should be in place by 2018

and be based on actions identified to start in 2014-2015 with the beginning of significant delivery in 2015-2016. Plans to spend the funding had to be agreed by the statutory Health and Wellbeing Board who assumed responsibility for monitoring the achievements of the targets required; agreed contingency plans for reallocating funding if targets were missed; and be satisfied that providers, especially acute Hospital Trusts, had been effectively engaged in the planning process. Paula Parker took the Board through the report and explained that in paragraph 2 the ITF funding components were set out.

The Board:

i) acknowledged the timescales involved in the preparations of the Kent Plan and the Integrated Transformation Fund.

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

7 The Public Health Resource and Programme for Ashford

7.1 In accordance with Procedural Rule 9, Annie Jeffrey, a member of the public, attended and said she had a question relating to mental health provision in Ashford. She explained that she was a member of the East Kent Carers Council and also Chair of Charing PPG. She said that acute mental health services in Ashford were in crisis and completely unacceptable as was the rest of Kent and Medway. She asked why did the Arundel Unit at the William Harvey Hospital remain empty when there were no available beds and patients were being transported all over the country because these wards were closed. It had been acknowledged that due to data errors these wards should never have been closed in the first place. Annie Jeffrey also said that patients were being ferried around Kent which was an issue for the Police who were often accompanying the patients. Local in-patient provision was essential for service users in Ashford to keep contact with family and friends as many mental health patients ended up homeless, in prison or dead. She said that if the William Harvey Hospital closed there would be a public outcry which in her view indicated that when it came to mental health it did not seem to matter. In conclusion she said that services were going backwards with high suicide and readmission rates and commented that there was a duty of care but asked where was the care?

7.2 Marion Gibbon explained that the Board was looking at this from a public health prevention perspective and said the cases referred to by the speaker related to those persons who needed acute care.

7.3 Navin Kumta said this had been discussed at the CCG in September and the view had been that the priority should be providing support for mental health issues as a community based service. He said that the Arundel Ward was not appropriate as it was a mixed ward and was not integrated with other

services. With the aim to provide more support in the community, work would be undertaken with Kent County Council and the Carer's Service. In terms of available data he said it was not possible to assess the impact for Ashford. He accepted that in terms of the time lag there was a delay in community service providing support, and it was proving difficult to catch up in terms of the provision. He stressed that there was no new money available and if more resources were to be placed within the mental health arena this would have to be drawn from elsewhere within the current budgets.

7.4 The Chairman also explained that there would be an item on the next agenda of the Board in January to discuss this in more detail. Steve Inett explained the role of HealthWatch and said that he would examine the evidence put forward by Annie Jeffrey.

7.5 Marion Gibbon then introduced the report she had produced for the Board which described the commissioning resource that Public Health Kent, which was part of Kent County Council, were responsible for. It also provided a brief description of the resource currently serving Ashford.

7.6 In response to a question from the Chairman, Marion Gibbon explained that the practitioners who would be assisting in terms of the healthy weight initiative were nutritionists and also were experienced in dealing with behavioural change. Penny Southern explained that there would be a Performance Framework produced for each of the other outcomes which would be colour coded in terms of overall level of performance. She further explained it was important that targets were correct in terms of the initiatives for Ashford.

7.7 John Bunnett asked what steps could the Borough Council take to influence the outcomes and how could it feed into the process. Marion Gibbon explained that work on producing the Ashford Health Profile was on-going, and it was hoped to produce a draft of the document in the next few weeks.

7.8 Navin Kumta commented on whether it was possible to try and regulate the number of fast food outlets within the area.

7.9 In terms of planning and licensing matters John Bunnett highlighted the national as well as local perspective. Neil Fisher said that one of the major changes in terms of smoking reduction related to Government legislation which had banned smoking in public places.

The Board received and noted the report.

8 Making the Kent Joint Health and Wellbeing Strategy a Local Strategy for Ashford

8.1 The report explained that the twelve months strategy was a starting point for a partnership approach to improve health and care services whilst reducing health inequalities. The report gave an overview and focused on the issues

that needed to be tackled. Set out within the report were links to the Ashford Health Profile 2011 and the 'Kent Health Inequalities Action Plan: Mind the Gap' document. Marion Gibbon explained that the health profile showed the Indices of Multiple Deprivation 2010 for the wards in the Ashford Borough area. Marion Gibbon drew particular attention to the health summary for Ashford set out on page 51 of the Agenda, which showed areas where Ashford was better than the England average and areas where Ashford needed to do better.

The Board noted the report.

9 Kent SEND (Special Educational Needs and Disabilities) Strategy

9.1 The Board received a presentation by Martin Cunnington, Interim Associate Partner (Children's and Maternity Services) KMCS and Julie Ely who was Head of Special Needs at Kent County Council on the above strategy. A copy of the slides used for the Powerpoint presentation had been loaded onto the Agenda page of Ashford Borough Council https://secure.ashford.gov.uk/cgi-bin/committee/index.cfm?fuseaction=doctrack.details&ItemID=1640

9.2 In response to a comment about language issues within schools Martin Cunnington explained that in the 0-5 age group up to 50% of children in Ashford had language needs and therefore, for example, it was important to encourage parents to read to their children.

9.3 Penny Southern also commented that issues raised within the strategy were small in terms of numbers when compared to issues such as cancer and dementia.

9.10 In conclusion the Chairman thanked Martin Cunnington and Julie Ely for their presentation.

10 Items for the Forward Plan

10.1 The following items were suggested for the agenda for the next meeting:-

- Mental Health
- Commissioning Plan
- William Harvey Hospital – Strategy
- Update on Children's Trust Board

11 Next Meeting

11.1 The next meeting would be held on Wednesday 22nd January 2014.

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Ashford Clinical Commissioning Group

Agenda Item 4

Partnership working towards delivering outcome 4 of the Kent Health and Wellbeing Strategy- People with Mental Ill Health Issues are supported to 'Live Well'.

Summary: To provide a joint update on progress for the Ashford Health and Wellbeing Board on the Kent Joint Health and Well Being Strategy - Outcome 4 - mental health, People with mental ill health issues are supported to live well.

Date: January 2014
Classification: Unrestricted

The 12-month HWB strategy is the starting point for a long term partnership approach to improve health and care services whilst reducing health inequalities in Kent by strengthening partnership working between councils and healthcare commissioning groups.

Progress towards Kent Joint Health and Well Being Strategy- Outcome 4, in Ashford.

Annually £8.25 million is invested in secondary care adult mental health services and £1 million in primary care in Ashford CCG which is delivered through the Kent wide integrated strategy (Live it Well) for mental health and wellbeing of people in Kent.

The three key drivers for the next three years are increased personalisation, partnership working and better use of primary care. Personalisation will see more people in charge of their care plans, fundamentally changing the relationships between service users and mental health staff. Primary care has a key role to play in mental health services; over 90%of people with mental health problems are treated exclusively within primary care. By moving resources such as mental health social care staff into primary care, we will help people earlier, before mental health problems become too difficult to manage. We should see the following happen: early recognition of mental ill health will be increased, ensuring that patients and their families can access support at the appropriate time, improving their quality of life; improved access to community support and early intervention services will see an increase in people reporting an improvement in their own mental ill health and wellbeing and the stigma of mental ill health will be reduced.

Outcome 4 of the Kent HWB strategy Mental Health - People with mental ill health issues are supported to live well, identified seven key outcomes.

1. Promote independence and ensure the right care and support is available to prevent crisis
2. Lessen the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services
3. Ensure that all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours
4. Improve awareness raising and access to good quality information
5. Work with the voluntary sector, other providers, carers and families to reduce the social isolation of people with mental health issues
6. Ensure we have robust audit processes around mental health e.g. suicide prevention
7. Use the Safeguarding Vulnerable Adults competency framework to evidence that all staff that come into contact with vulnerable adults are competent to do so.

The success of the outcomes to be measured by:

1. Improving rates of recognition and diagnosis in Kent and get people into the right services when they need them
2. Promoting independence and ensuring the right care and support is available to prevent crisis
3. Awareness raising and access to good quality information
4. Ensuring more people with mental ill health are recovering
5. Ensuring more people with mental ill health have good physical health
6. Ensuring more people with mental ill health have a positive experience of care and support
7. Ensuring more people with mental ill health are supported in employment and/or education
8. Working with the voluntary sector, other provider, carers and families to reduce the social isolation of people with mental health issues
9. Ensuring we have robust audit processes around mental health e.g. suicide prevention.

The Kent JSNA 2010 states that at any time in Kent there are approximately 160,000 people suffering from common Mental Health issues, 60,000 people with severe Mental Health issues and 12,000 with severe mental illness such as schizophrenia and bi-polar conditions.

The overarching strategic context for the delivery of Mental Health services in Kent is set by:

- The NHS Outcomes Framework
- No Health Without Mental Health
- The Kent Health & Wellbeing Strategy 2012/2013
- The Live it Well Strategy

In order to ensure that there are a range of services to meet individual needs, Statutory Services including Clinical Commissioning Groups (CCG), Families and Social Care (FSC) and Public Health (PH) need to work in partnership with the voluntary and independent sector to improve Mental Health and Wellbeing.

Progress during 2013/14 towards Outcome 4 of the Kent Health and Wellbeing Strategy - measures of success.

1. *Improving rates of recognition and diagnosis in Kent and get people into the right services when they need them*

Primary care psychological talking therapy is available through GP or self-referral. 1,466 people completed treatment for the full year 2012/13 in Ashford compared to 957 in the first half of 13/14 an increase of 30%. There is now an improved choice of providers under Any Qualified Provider and waiting times for treatment are within 28 days.

Primary Care Psychological Therapy Quarter 1-2 2013/14 Estimated need Ashford = 11160	**Actual Q1-Q2 13/14**	**Target Q2 13 /14**
Referrals	1848	1247
Entered treatment	1041	998
Completed treatment	957	698
% Recovered	56%	50%
% off sick pay	9%	5%
% of need entered treatment	18.6%	17.9%

Early intervention services in Ashford accepted 13 new cases during Q1-Q2 2013/14.

Mental Health Matters helpline is available 24 hours a day 365 days a year. People feeling distressed, anxious or depressed are able to call the Mental Health Matters helpline on 0800 107 0160 any time. Support workers use counselling skills to provide confidential emotional support and guidance and have details of local and national support services. There were nearly 4000 calls made to the helpline in the first half of 2012/13, up 47% from 2010/11.

PbR (Payment by Results) for Mental health requires that 95% of all people have a HoNOS (Health of the nation outcome scale). This is then used to assign people to a care pathway which best suits their needs. Service users have to be assessed and reviewed regularly in accordance with NICE guidance. PbR forms the basis of improving quality of care compared to traditional block contract arrangements.

Number of people in PbR cluster Ashford CCG	November 2013
1, 2, and 3 (primary care)	1052
4, 8 and 10 (shorter term planned care)	341
7, 11 and 12 (stable long term conditions shared with primary care)	149
6, 13, 16 and 17 (stable long term conditions complex needs)	45
5, 14 and 15 (urgent care)	66
18 - 21 (dementia)	521

2. *Promoting independence and ensuring the right care and support is available to prevent crisis*

Primary care mental health workers is a pilot project providing specialist care to people with stable long term mental health conditions who would otherwise be in need of secondary care services. The project is delivered within the GP community setting which provides the opportunity to:

- Increase identification and management of the full range of adult mental health conditions in primary care, including where this is secondary to a physical long term health condition.
- Ensure patients get to the right mental health service, sooner.
- Increase the capacity of primary care to safely and effectively manage stable long-term mental health conditions.
- Improve service quality and outcomes for people with mental ill-health, based on recovery principles.
- Ensure primary care plays a lead role in the management of the Payment by Results system in mental health services.
- Help to achieve system wide change and efficiency savings through the delivery of QIPP.

Crisis cards are now issued to all service users by KMPT which includes the information they need to quickly access care in a crisis.

Community Link Workers work closely with GPs to help identify practical solutions to issues such as housing, access to benefit and employment. The scheme is due to be evaluated by March 2014.

Crisis Home Treatment services provide interventions and support to treat people in their own homes and prevent admission to acute inpatient hospitals unless required.

A range of supported accommodation has been developed over the last five years, to meet individual need in conjunction with KCC District and Borough Housing Partners. Through working together we have seen an additional 215 units of new supported accommodation across Kent. Everyone needs a stable roof over their head, in order to keep or find a job, build a social network, or participate in a range of other opportunities. Loss of accommodation is most likely to happen to the more vulnerable or disadvantaged members of our society.

Safeguarding Coordinators have been appointed to support with safeguarding practice, record keeping and data quality. The coordinators also provide training, induction and carry out regular audits to assist with performance management and learning from experience.

3. Awareness raising and access to good quality information

www.liveitwell.org.uk is a website developed in partnership between health and social care to provide the public and clinicians with help to maintain their wellbeing and quickly find support and information when needed. During April- September 2013 11,304 people visited the Live it Well website compared to 1,445 in the same period 2010. A customised search facility enables people to find the information that is most relevant to their needs.

"The Live it Library" is a collaborative project between Live It Well (KCC), KMPT and Rethink Mental Illness. People who have experienced or are experiencing Mental Health issues share their stories in film online. Over thirty videos of experts by experience challenge stigma, promote understanding, offer hope and enable people to speak honestly about their experiences.

4. Ensuring more people with mental ill health are recovering

Primary Care Psychological therapy measures the outcomes of all people who enter treatment. During the first half of 2013/14 there was a 50% increase in the number of people who moved to recovery to 511 people in Ashford CGG area. Recovery rates in Ashford are much higher than the England average of 46% at 56%.

Recovery-orientated services aim to support people to build lives for themselves with an emphasis on self-directed care, choice and control. Commissioners are working with providers to support people to build lives for themselves with an emphasis on hope, control and opportunity. The Implementing Recovery programme provides tools for people to assess how well they are doing and take steps to become more recovery-orientated. In secondary care services a CQUIN scheme (Commissioning for Quality and Innovation) incentives KMPT (Kent and Medway Partnership Trust) to collect and measure both patient reported outcome scores (the recovery star) and clinician outcome scores (HoNOS). From the 1st October 2013 every new service user in secondary care will have a personal care plan including a crisis plan and will have had greater involvement in the agreement of their care plan. By the end of 2013/14 there will be better information than ever before on how many people have progressed towards the aims they have agreed themselves in their personal care plans.

5. Ensuring more people with mental ill health have good physical health

People with a severe mental illness die up to 20 years younger than their peers in the UK. (Chang et al., 2011; Brown et al., 2010). The mortality rate among people with a severe mental illness aged 18-74 is three times higher than that of the general population (HSCIC, 2012).

Primary Care mental health workers, in addition to psychological support also provide weight management support, smoking cessation and support towards reducing drug and alcohol abuse.

Monitoring of physical health in secondary care services has improved but more work is still required to improve the communication between secondary and primary care. 100% of inpatients receive a physical health check in mental health acute wards. In Community mental health services only 33% of people were recorded as having had a physical health check in Q1. This is expected to be at 90% by the end of 2013/14. Whilst the figures would appear to be low, this is an improvement from previous years when data on physical health checks was not collected.

The integration of physical health into decisions about prescribing and monitoring of medication has improved as evidenced in the results of the 2012/13 CQC community survey.

6. *Ensuring more people with mental ill health have a positive experience of care and support*

Psychiatric liaison services work within Acute General Hospital emergency departments to improve the experience of people who require support for mental health needs and improve their experience. There has been a 20% reduction in the number of people known to mental health services who present at Acute General Hospital emergency departments.

A patient experience measurement exercise has been funded by CQUIN and has surveyed four times as many people as the national CQC survey within secondary care mental health services. The results will be available in December 2013 and will result in action plans to improve patient experience in those areas identified by patients as needing improvement.

Patient experience in talking therapy treatments is an outcome measure making up part of the tariff for talking therapy treatment. Every person is asked if the treatment met their needs and helped with their situation.

Advocacy services provide time limited and focused advocacy interventions and enable empower service users to develop confidence and skills in dealing with issues, protect the rights of service users by working with other agencies and give support at Care Planning meetings and reviews. Rethink provided a statutory IMHA (Independent Mental Health Advocacy) service under the Mental Health Act 8 times; and 12 further episodes of advocacy to people with mental health problems in the Ashford area.

7. *Ensuring more people with mental ill health are supported in employment and/or education*

Employment projects are commissioned as a joint strategy between Kent County Council and the CCG. Both contribute to the overall funding and the performance management of the projects is undertaken by Kent County Council on behalf of both KCC and the CCG's. Projects include vocational profiling, occupational action plans, skills development and work placements. Training is provided to enhance confidence and the ability to build workplace relationships. Service Users are supported to use community based opportunities in finding work and work with local employers to find work placements. Shaw Trust worked with 65

people and helped 23 people into sustained employment (defined as being for 13 weeks or more).

8. *Working with the voluntary sector, other provider, carers and families to reduce the social isolation of people with mental health issues*

Families and Social Care and Ashford CCG received £454,489 funding from KCC in the Ashford area in 2013/14.

Informal community services deliver services to reduce social isolation through community services and user forums to facilitate engagement. MCCH and Ashford and Tenterden Umbrella provided informal support to 1,019 people with mental health problems on a regular basis, both in centre activities and a wide range of activities out in the local community.

User forums Speakup CIC held fortnightly meetings with 22 mental health service users and facilitated 20 episodes of service user participation in decision-making meetings with professionals and commissioners to present a service user perspective and to take part in service evaluations.

Carers Support funded by KCC hold regular meetings of carers and support individual carers on a range of issues that they face, provide carer training and support programmes to build capacity in carers to participate at all relevant levels, collect carer's views by a range of means and identify gaps in service facilitate carers participation in decision making forums.

Rethink Community Support within the BME community provided informal support to 27 people with mental health problems on a regular basis, both in centre activities and activities out in the local community. Carers Services within the BME community provided support to over 27 carer's of people with mental health problems as well as carer's receiving help with a carer's break.

9. Ensuring we have robust audit processes around mental health e.g. suicide prevention

Suicide rates in Kent are slightly lower compared to England a new national suicide strategy was published in 2012 with a stronger emphasis on public mental health and supporting families than previous strategies. Suicide prevention report attached.

Finance and Local performance

Ashford Clinical Commissioning Group

- Primary care psychological talking therapy- £1. million
- Secondary care mental health services - £8.2 million

Kent County Council Investment (Kent-wide)

Kent County Council spends £24.1 million on Mental Health services across Kent. £9.4 million relate to a Section 75 Partnership Agreement which is in place between Kent County Council and Kent and Medway NHS and Social Care Partnership Trust. £9.8million is spent on community services including supporting service users in residential care. **Kent Public Health (alongside FSC)** provides £750k.

Tripartite arrangements between CCGs public health and social care now deliver an additional half a million pounds of funding across Kent for primary care community link workers who support people in primary care with their social care needs.

Ashford has set up a Mental Health Local Performance Meeting to look at service delivery issues that have been raised in local community engagement forums where this is impacting a more responsive system for clients to be assessed and receive a service. The CCG is supported by one GP clinical lead who is increasingly involved in the redesign of mental health services.

Whilst the HWB Strategy Outcome 4 for mental health focuses very much on service provision for those who already have a mental health problem, the 'Live it Well' strategy sets out the need to address mental health and wellbeing in a joined up way and make improvements for those with common mental health problems.

The Marmot Review looked at strategies for reducing health inequalities and concluded that 'focusing solely on the most disadvantaged will not reduce health inequalities sufficiently". It advised on both universal and targeted solutions to build individual and community resilience, with a particular focus on groups at increased risk of developing mental health problems such as people with long term physical health conditions, older people, pregnant women or new mothers who are socially isolated and people who are unemployed or in poor housing.

It is likely therefore that a targeted psychological and social approach in Ashford for those most at risk of developing a mental health problem and using the leadership and authority of the HWB partnership to drive forward together will have more of an impact on prevention, early detection, resilience and wellbeing.

Conclusion

There is a strong moral and economic case to tackle the challenge that mental health problems pose for the people of Ashford. There is also evidence of the effectiveness of strategies and the practical steps that can be taken to reduce the prevalence of mental ill health to promote well-being and build resilience.

Whilst it is important to improve pathways for people with mental illness (HWB Strategy Outcome 4) it is as equally important to address mental wellbeing and resilience so to improve the lives of more people in Ashford (Live it well). This will also enhance the other work to address health inequalities and improve physical health. (No health without mental health.)

Recommendations

The recommendation is to hold an East Kent summit for mental health to bring together the key leaders and decision makers from the partner organisations represented on the HWB Board to:

- Consider and understand the Joint Strategic Needs Assessment and Assets (JSNA) for Ashford including those most at risk of developing mental health problems.

- Set the strategic direction for mental health and well-being in Ashford and open up new ways for a mental health and well-being focus across all services and departments.
- Agree target groups and the actions required so frontline staff can make every contact count.

The HWB Board is asked to approve the proposal to host a mental health summit for East Kent in February 2014.

The Health & Wellbeing Board is asked to note the continuing progress towards the Health and Wellbeing strategy and the development of local resources to support it.

Ashford Clinical Commissioning Group

Agenda Item 5

Strategic Commissioning Plan

April 2014- March 2019

(Incl. Operational Plan April 2014-March 2016)

v0.4

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A note from the Chair

The NHS has changed, with responsibility for planning and paying for local health services being transferred from Primary Care Trusts (PCT) to Clinical Commissioning Groups (CCGs). We have thought long and hard about how we can use these reforms to improve the health of the community we serve, by capitalising on our knowledge and understanding of the local population. We have concluded that there are two key components to ensuring that Ashford Clinical Commissioning Group (CCG) achieves its objective – putting patients at the centre of our decisions, and working in partnership with other agencies, such as the borough council and Public Health.

Ashford Clinical Commissioning Group (ACCG) has a membership of 15 practices covering the whole of the Ashford district and is led by local GPs and senior healthcare managers. We inherited a local NHS which offers good services, in good facilities and delivers good outcomes for most people, but is often uncoordinated and this means that the right things for patients are not always the easiest things to do. We will continue to work with residents and organisations, including Kent County Council, Ashford Borough Council, providers of health and social care, and the voluntary and community sector.

The aim of our Strategic Commissioning Plan is to tell the end-to-end story about how we will move from assessing the needs of our population to delivering services that will drive improvements in health outcomes. This document also sets out how ACCG will inform and involve residents, partners, health and social care professionals, and voluntary and community sector groups to ensure we champion their needs, and ensure their thoughts shape our decisions.

Some of the decisions we will have to make this year and next will be tough, but we know that together with local doctors, nurses, NHS staff and you, our patients and our public, we can make a real difference to the quality of services you receive and the NHS is able to offer. In all we do, we want to ensure patients are involved and can have their say. In establishing our channels for engaging the public we are taking the best of the past and incorporating it into exciting new engagement models, including using new technologies to help us create a social movement for improved healthcare.

Within the Ashford area I believe will have a healthcare partnership to be proud of, and I look forward to continuing the progress we have already begun to make.

We want a health economy that is sustainable for the future with primary and community care services working closer together, along with voluntary organisations and other independent sector organisations able to forge common goals for improving the health and well-being of local people and communities

- Increased elective productivity through provision of "Right care, first time, right place"
- Integrated 24/7 urgent care system across all sectors
- Reduced acute ambulatory care sensitive emergency admissions
- Improved maternity experience particularly early pregnancy
- Reduce the number of suicides
- Personalised care and independent living for patients with long term needs
- Enable patient-centric care to be delivered in the most appropriate setting

Planned Care
- Transform Outpatient Services
- Revised outcome based Orthopaedic Pathways

Urgent Care
- Falls Prevention
- Integrated Urgent Care Centre
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- Out-Of-Hours GP Service
- Improved discharge planning

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- Improved Early Pregnancy Unit
- Multi-agency intensive support team model for children with severe challenging behaviour

Mental Health
- All Age ADHD and Eating Disorder Services
- Personality Disorder Peer Support
- Crisis support

Long Term Conditions
- Community Geriatrician Service
- Integrated Diabetes Pathway
- Personal Health Budgets
- Earlier diagnosis of dementia

Governance
- Health and Wellbeing Board
- Programme Boards
- Federation meetings
- Monthly review of programme or project progress at CCG Clinical Strategy and Investment Committee meetings
- Identified Leads CCG for specific projects

Success Criteria
- Primary and community care services will work closer together, along with voluntary organisations and other independent sector organisations reducing the time people currently spend waiting for a service.
- We will see less acute admissions and reduced length of stay.
- We will see more people remaining in their own homes and a reduction in the proportion of the population living in care homes.
- More people will be living independently following reablement/intermediate care

Values and Principles
- People are supported to live in their own homes or communities.
- We have a workforce with skills to deliver integrated care.
- Our integrated teams respond rapidly to people at risk of admission
- Carers are be supported and have access to services as appropriate.
- We will have systematised self-care so that people can to manage their own health and social care needs

Introduction

Background and Context

Our Vision

Our Values

Background and Context

The Health and Social Care Act (2012) gave more power and responsibility to front-line professionals to commission safe, high-quality and compassionate care and to make decisions about the use of resources through Clinical Commissioning Groups. This comes at a time when, across England, the NHS must continue its QIPP programme to deliver £30bn of savings by 2020. We have started to build a track record of delivering change and have established a strong partnership approach in our local health and social care economy

This means that 2014-16 will be another challenging period for the NHS and your CCG will be taking to support delivery of the improvements and standards set out in the NHS Constitution (DH 2012), the NHS Mandate (DH 2012) and the NHS Outcomes Framework (DH 2012).

In support of the 2014/16 planning and delivery process ACCG has produced this document to:

- Provide the context in which ACCG operates
- Communicate our plan to our patients and local population
- Mobilise commissioners, providers, partners, voluntary organisations and members around a common set of objectives and plans
- Provide assurance on how we will deliver what ACCG aims to achieve

The document and content within it is generated from, amongst other inputs, demographic information, performance data, national guidance and recent health inquiries. However, one of our most important sources of information is that which our patients and public provide us directly. We have used a number of stakeholder events, feedback given to our practices and our formalised patient participation groups to inform this plan and we will continue to refine and update our plans based on what our patients and public are telling us.

We believe that these steps will deliver ambitious improvements to the local NHS in line with the needs of local people as set out in our Joint Strategic Needs Assessment (2012) and Joint Health & Wellbeing Strategy (2012) as well as against the 5 Domains of the NHS Outcomes Framework:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm

This plan is owned and sponsored by our governing body and member practices and represents our commissioning and delivery intentions.

Our Vision

Our vision and goals within our plan have not been developed in isolation and reflect the broader strategic context in which we operate as a statutory body. There are a number of external factors and influences, plus national requirements on which we are mandated to deliver. These can be broadly encapsulated in the following analysis.

Political	Economic
• National policy implementation • Changing NHS landscape • Secretary of States mandate • Public Health Transition • Legislative changes • Regulatory bodies • Market development • NHS England • Healthwatch • Health & Wellbeing Board • Professional preferences and resistance	• Financial sustainability • Financial Accountability • QIPP Challenge • Financial climate • Patient choice • NHS Cooperation and Competition • • Foundation Trust pipeline
Social	**Technological**
• Health inequalities • Deprivation factors • Equity of Access • Lifestyle choices • Ethical decisions • Protected characteristics	• NICE guidance • Evidence based decisions • IMT providers and suppliers • Emerging technology • Introduction of new drugs • Use of social media and internet

ACCG worked on our mission, vision and strategic priorities as it went through its authorisation process to become a statutory commissioning body. They were arrived at through consultation with our patients, members and Governing Body. They are also aligned to, and informed by, the Kent Health and Wellbeing Strategy.

"A Healthcare Partnership to be proud of"

To improve the health and well-being of the population of Ashford by successfully engaging local GPs to lead our work and working in partnership with patients, Ashford Borough Council, Public Health and other key stakeholders, to develop plans to improve outcomes.

By 2018/19 we want to achieve a health economy that is sustainable for the future. We want care that crosses the boundaries between primary, community, hospital and social care. Our vision is of primary and community care services working closer together, along with voluntary organisations and other independent sector organisations able to forge common goals for improving the health and well-being of local people and communities.

We aim:

1. To deliver the 'right care, in the right place at the right time by the right person' to the individual that needs it.
2. To reduce the pressure on the acute hospitals by ensuring the right services are available and accessible for people when it is required.
3. Wherever possible, to support people to stay well in their own homes and communities.
4. To support people to take more responsibility for their own health and well- being.
5. To get the best possible outcomes within the resources we have available.

What will we have done to achieve vision and aims?

- People will be supported to live in their own homes or communities.
- Access to an excellent General Practice service which, along with the range of community services, proactively seeks to keep people well and healthy in the community but, when appropriately required, can access secondary care services.
- We will have reduced pressure on the acute services.
- We will have integrated our professional teams to have new workforce with skills to deliver integrated care.
- We will have a rapid response integrated team whose task is to respond to people at risk of admission to hospital or residential or nursing home care where indications are that, with some immediate intensive input and support, such admissions can be avoided.
- We will have a joint accommodation strategy, with appropriate range of accommodation available with care for vulnerable adults needing accommodation and care input, including those with dementia, learning or other disability or with mental health needs unable to remain in their home such as extra care housing. Extra care provides the security of having your own home as well as the availability of having care on site.
- Carers will be supported and have access to services as appropriate.
- Easier access to information, advice and guidance will be available.
- We will have improved access to services through single points of access.
- Care will be available locally.

- We will have systematised self-care so that people with long term conditions can do more to manage their own health and social care needs to prevent deterioration and overreliance on services.
- We will have improved access to a wide range of assistive technology, telecare and telemedicine to complement person based support, offer reassurance and protection and support independence to support people in the community.
- We will have improved integrated IT systems to improve patient / service user care, underpinned by personal health records that can be accessed by the individual.
- We will have improved access to equipment when it is assessed to be required.
- We will have a 7 day a week support services available for those who require it.
- We will have continued to ensure services available are of a high quality
- We will be open and transparent so people will be able to have a dialogue about services available and what might be required locally.
- Access to good transport services.

How are we going to do it?

- We will design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of hospital and care home admissions.
- We will work together to support care homes.
- We will work together to identify people who may require intensive support at home before they go into crisis.
- We will review community services provision within health and social care.
- We will provide intermediate and reablement care to reable people back to a level of independence that meets their need.
- We will commission services to support people in their own homes.
- We will develop an Integrated Urgent Care/Long term conditions Service/centre model.
- We will develop 7 day a week working across all partners.
- We will develop easier access to services.
- We will develop a falls service.
- We will develop an integrated IT system.
- We will improve access to of assistive technology.
- We will develop a joint accommodation strategy.
- We will develop support for carers.

- We will develop access to transport for vulnerable people who need it to prevent social isolation and access medical appointments.

How will we know we have achieved success?

- Primary and community care services will be working closer together, along with voluntary organisations and other independent sector organisations.
- People will get the 'right care, in the right place at the right time by the right person'. We will measure the success of this by measuring if there has been a reduction in the time people currently spend waiting for a service.
- Pressure on the acute hospitals will reduced, we will see less acute admissions and reduced length of stay.
- We will see more people remaining in their own homes and a reduction in care home admissions taking into account the increase in population.
- More people will be living independently following reablement/intermediate care.

Our Values

- **Listen.** listening to patients, being responsive and ensuring their thoughts and needs shape the CCG's commissioning decisions and striving to ensure all patients have the best possible experience of the NHS.

- **Collaborate.** Best healthcare is delivered when working together – clinicians, patients, stakeholders and all sections of the community. The CCG will work as one with its stakeholders within the locality and CCGs across east Kent so that we become recognised as a confident organisation that listens, learns and delivers.

- **Be open to change.** As the needs of patients change and new treatments develop the CCG will strive to make sure it always commissions high quality and value for money services.

- **Be realistic about the challenge ahead.** The CCG knows that with the increasing demands on services it needs to deliver sustainable services within the limits of its financial resources. The CCG will be open and honest with all its patients and stakeholders and work closely with them to prioritise our commissioning decisions.

- **Good corporate governance.** Ashford CCG is committed to ensuring that it is effective at understanding the business, can articulate and oversee the delivery of a strong strategic vision, deliver an improved patient experience and is able to demonstrate robust financial control.

- **Respect and dignity.** We value each person as an individual, respect their aspirations, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

- **Commitment to quality of care.** We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

- **Compassion.** We respond with humanity and kindness to each person and give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked.

- **Improving lives.** We strive to improve health and well-being and people's experiences of the NHS. We value excellence and professionalism wherever we find it.

- **Working together for patients.** We strive to improve health and well-being and people's experiences of the NHS. We value excellence and professionalism wherever we find it.

- **Wide Clinical Engagement.** We believe that all clinicians have a part to play in the design and delivery of health services. We will ensure that the experience and knowledge of all clinicians, and best evidence, is used to drive our organisation and decision making.

- **Services close to patient.** Patients want services as close to home as possible. We will listen to patients and strive to commission more community / primary care focused services.

Working with… **Local GPs**

Detail to follow

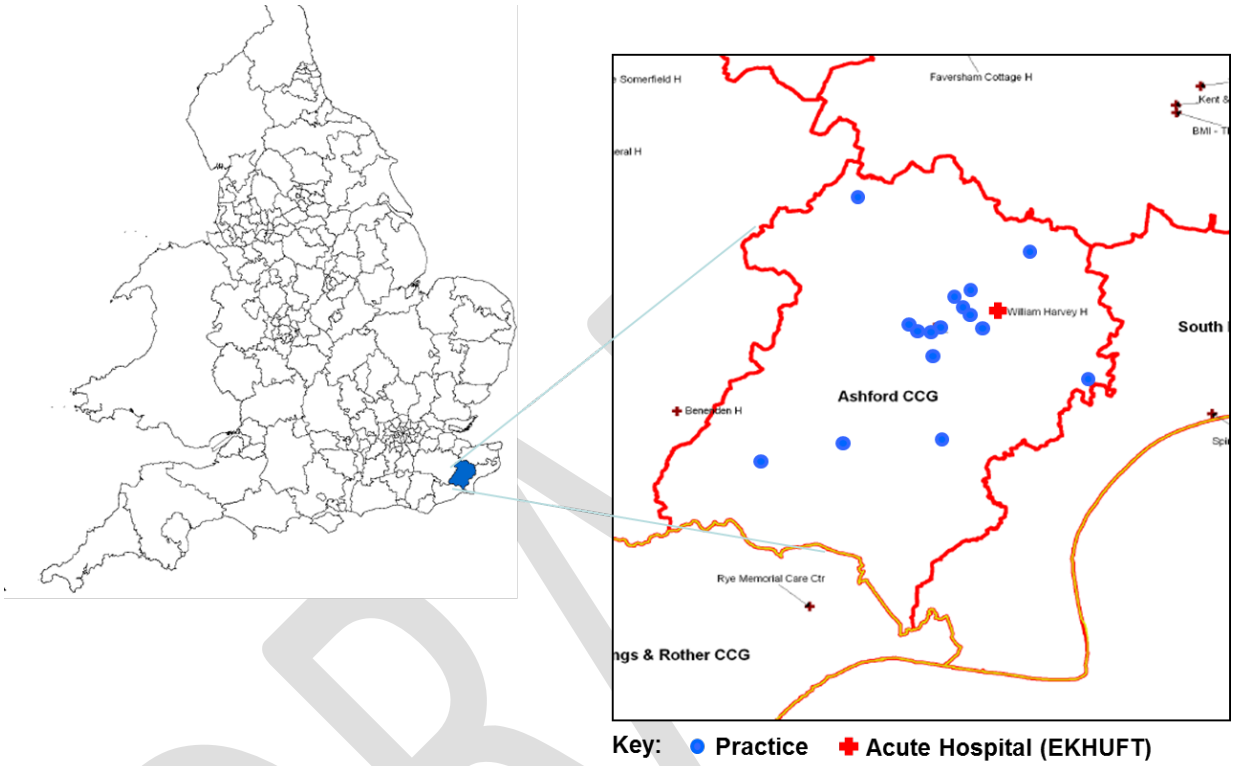
Joint Strategic Needs Assessment

SUMMARY – OUR POPULATION HEALTH CHALLENGES	
Inequalities	The average life expectancy in Ashford is 83.4 years for females compared to males at 80.7 The lowest life expectancy figures are in the wards of St Michaels and Weald East and Weald North, with the highest figures in Park Farm North and Washford. The difference in the number of years between the highest and lowest life expectancy at birth is 15.7 years.
Population	The resident population of Ashford comprises approximately 120,116 (ONS, mid-year estimates 2012). In comparison to England, Ashford has a considerably smaller proportion of 20 to 34 year olds and a larger proportion of 40-49 and 60+ year olds. The distribution of the Ashford CCG population can be classified as a "constrictive" pyramid, meaning that there are lower numbers of young people and larger numbers in the age ranges between 40 and 69. This type of age structure is often referred to as the "ageing population time bomb". The shift in age structure towards older people with a simultaneous reduction in working-aged adults has implications on future pensions, provision of health and social care and economic growth.
Cause of Death	Circulatory Disease is now the main cause of death (34% of deaths), followed by Cancer (26%), and respiratory disease (15%).
Lifestyles	Smoking leads to cardiovascular disease, respiratory disease and cancer. NICE highlight that smoking is the "leading cause of health inequalities in the UK today and the principal reason for inequalities in death rates between rich and poor." In Ashford, almost 35% of people in the most deprived wards are smokers which compares to less than 20% in more affluent wards. The prevalence of adult obesity has been mapped across electoral wards in Ashford. The wards with the highest prevalence (estimated to be between 26% and 30%) are Beaver, Stanhope, Norman and Aylesford Green. All these four wards are found in the south of Ashford town and have a relatively high level of deprivation.
Long-Term Conditions	There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having more than two conditions.
Mental health	Age specific adult mental health rates are seen to correlate with areas of deprivation, with high rates seen in Stanhope, Beaver, Norman, South Willesborough, Aylesford Green and Victoria Wards. Lowest rates are seem in Weald North.
Dementia	Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65.

The information in this section provides the geographical, socio-economical, regulatory and financial context in which NHS Ashford CCG will commission services in 2013/14. It directly informs what NHS Ashford CCG will prioritise within the context of limited resources.

Location

The geographical area covered by NHS Ashford Clinical Commissioning Group is fully coterminous with Ashford Borough Council:



Key High-Level Data

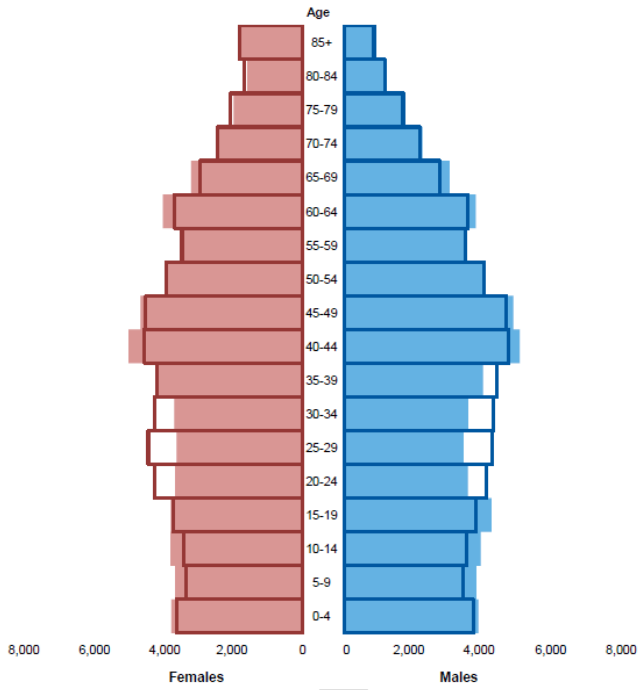
Below are some high-level data points which are relevant to this CCG and its commissioning activity:

Data Point	Data
Registered patient population:	122,000
Number of GP practices:	15
Neighbouring CCGs	4
Acute Hospital	1
Commissioning budget:	£134.5M

High-level demographic information

The chart below shows the number of people registered with this CCG's practices by sex and 5-year age band. The darker outline shows the profile of England's population.

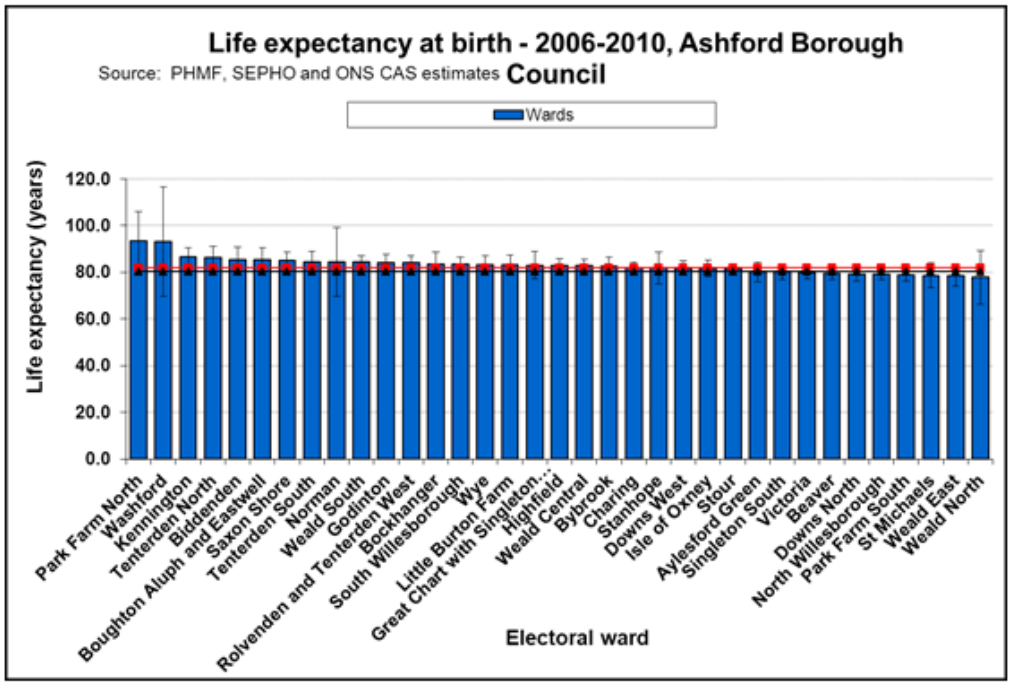
Compared to the rest of England, Ashford has a higher than average population between the ages of 5-14, 40-49 and 60-69. Alongside the importance of health promotion and prevention for the younger generation ACCG must also plan for a 16% rise in 65+ age groups.



More generally, the town of Ashford is set to double in size over the next 25 years. As new housing developments emerge, ACCG will work with Ashford Borough Council to ensure that these new populations benefit from high quality, local integrated health and social care services.

Life Expectancy

Compared to the eastern and coastal Kent average (the line in black), the average life expectancy for Ashford (the line in red) is high i.e. 80 vs 82:

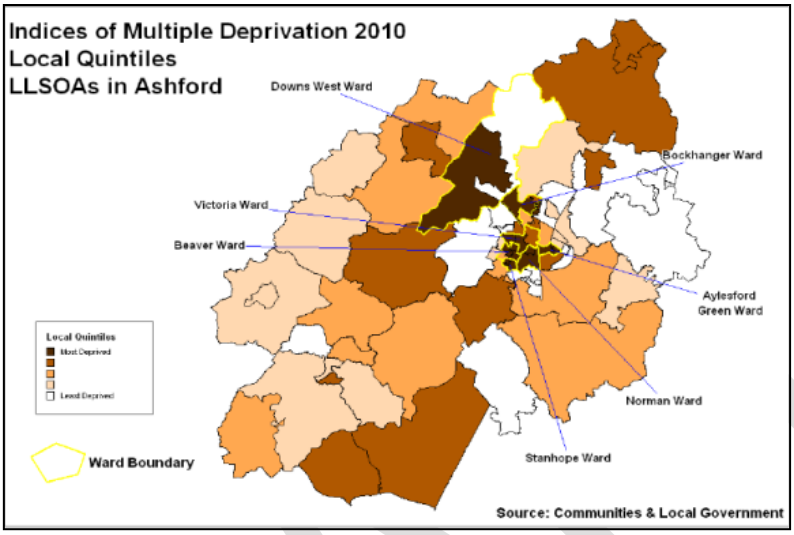


However, whilst ACCG is proud of its current health outcomes it recognises it will need to work hard to maintain the health status and clinical effectiveness of its population particularly with the

expected growth in the 65+ population. Additionally, whilst the life expectancy is higher than local averages, Ashford also contains the biggest variation in life expectancy across its wards in Kent and Medway. All of our project and programmes must therefore include, as an objective, the targeting of those communities which do not benefit from the outcomes that the majority of our population currently experience. This includes educative elements across all of our projects and programmes.

Deprivation

Whilst the ACCG benefits from relatively good health outcomes and life expectancy it does include some relatively deprived wards denoted by the dark brown areas on the map below.



The 20% most deprived areas of Ashford are in the central and southern parts of the town (Stanhope, Aylesford Green, Norman, and Beaver), although the village of Hothfield in the Downs West ward and Bockhanger were also in the worst quintile for deprivation.

Inequalities in health are primarily a socio-economic relationship. The poorer people are, the greater the likelihood of early onset disability and chronic disease and shorter life span. In contrast, those who are of high status have expectations of a much greater disability free life span and of a good old age.

People with low socio-economic status are at greater risk of behaviours causing ill health. They will have higher smoking rates, have a poorer diet, have less opportunity to take part in social activities, have poor mental health. Whilst it is undeniable that individual behaviour is a significant driver of ill health, it is wrong to attribute all causes of premature poor health and early death to personal behaviour. If such behaviour was eliminated, people with the lowest socio-economic status would certainly live longer, but would continue to die prematurely relative to the mainstream society.

Addressing health inequalities as a strategic response requires CCGs to commit to partnership working with other statutory agencies whose capacity to address the wider determinants of health is core to their purpose. Accordingly ACCG must support the actions of Public Health working with local authorities to address the root causes of disadvantage through the Kent Health Inequalities Strategy and more locally through the work of Ashford's local Health and Wellbeing Board. All pathways must include education as a key step to mitigate the risk of individual's behaviours affecting their health.

Performance in 2013/14

DETAIL

Our Plans

Developing Our Plans
Improving Quality and Outcomes
NHS Constitution
Improvement Interventions
Delivery, Efficiency and Risk Assessment

Working with… **Key Providers**

Detail to follow

Developing our plans

This Strategic Commissioning Plan and the component projects are the product of our ambition to continually improve the quality and patient experience of local health care services.

They build on our experience and robust information and analysis and have been developed in partnership with key partners including Social Care, local Government, our patients, carers and Public Health colleagues.

During the course of the year we have engaged all 22 of our member practices, exploring local needs and inequalities (supported by Public Health). We have also engaged with the public we service, to shape our work plans and set local priorities the outputs of which are summarised in this document.

We are also fully engaged with our Health and Wellbeing Board who have endorsed our vision and plans and the journey they will take the local health and social care system on.

However we recognise that this plan and the projects it sets out, only represent a snapshot in time. It will constantly evolve as we, and our clinical community analyse our system, benchmark our performance, study best-practice and design local services which will deliver a high quality and sustainable NHS for our population.

Improving Quality and Outcomes

We know that we must drive improvements in line with the ambitions set out in the NHS Outcomes Framework and have already identified specific actions against each of the 5 Domains related to quality and safety, these are set out below.

1	**Preventing people from dying prematurely**

DETAIL TO FOLLOW

2	**Enhancing quality of life for people with long-term conditions**

DETAIL TO FOLLOW

3	**Helping people to recover from episodes of ill health or following injury**

DETAIL TO FOLLOW

4	**Ensuring that people have a positive experience of care**

DETAIL TO FOLLOW

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

DETAIL TO FOLLOW

To achieve the expectations outlined in the domains, NHS England has distilled them into specific measurable ambitions which are critical indicators of success and against which we will track the progress of our plans:

- Securing additional years of life for the people of England with treatable mental and physical health conditions.
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

NHS Constitution

The NHS Constitution identifies a range of standards to which patients are entitled and which we are committed to deliver. We have set out these areas below. We know that to fully deliver services which meet the expectations of local people and their rights as set out within the NHS Constitution; we will have to focus through our work plans.

Referral To Treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%
A&E waits
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%
Cancer waits – 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls
Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%

NHS Constitution support measures

Mixed Sex Accommodation Breaches
Minimise breaches
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%
Referral To Treatment waiting times for non-urgent consultant-led treatment
Zero tolerance of over 52 week waiters
A&E waits
No waits from decision to admit to admission (trolley waits) over 12 hours
Cancelled Operations
No urgent operation to be cancelled for a 2nd time
Ambulance Handovers
All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

Improvement Interventions

There is no lack of ambition to deliver the right outcomes for our patients and the wider population but we recognise the unprecedented scale of the challenge that faces the NHS nationally and locally. However, we believe that our developing plans give us the building blocks for a sustainable health economy in east Kent.

We have sufficient evidence for us to adopt radical change across Planned and Unscheduled Care, and that we can, and will, drive improvements in medicines use and by working in partnership with our members, improve Primary Care infrastructure, workforce and services for patients.

We are confident that we are doing the right things for both patient care and for the delivery of a sustainable, viable and vibrant health economy, where we will actively seek and support opportunities for integrated care and integration between health and social care.

We are convinced that maintaining and driving the types of improvement to the quality of services set out in this plan will drive the productivity which delivers long term sustainability.

In 2014-2016 our main work streams are…

- **Urgent Care** – Defined as "the range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis." People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.

  Many patients, through better preventative care, should not need to access urgent care services. In addition patients often experience issues in identifying the best urgent care option to suit their needs. In addition, once they access urgent care services they may find it difficult to be discharged quickly and effectively due to sub-optimal integration of care services.

- **Long Term Conditions** - There are around 15 million people in England with at least one long term condition – a condition that cannot be cured but can be managed through medication and/or therapy. Numbers are expected to rise due to an ageing population and certain lifestyle choices that people make. National guidance has, to date, specifically focused on the need to:
  - Risk profile patients
  - Integrate health and social care teams
  - Systematise supported self-care

  The CCG has made good progress in these areas but recognises the work to do to fully implement and optimise these processes. This work is reflected in the 2014/16 objectives and projects which are complemented by specific, required interventions for certain long term conditions.

- **Maternity Children and Young People - The** Child Health and Maternity commissioning agenda is complex and there are a number of issues and characteristics that require a significantly different approach to other commissioning areas. This includes the requirement to deliver against key statutory responsibilities and work in partnership with local authorities, police and other agencies to improve outcomes for children, young people and their families.

- **Planned Care -** Planned care refers to services where the patient has a pre-arranged appointment. This includes things like being referred by your GP to see a physiotherapist or consultant or being sent for diagnostic tests such as an X-Ray.

  The CCG is committed to working with the organisations who provide planned care services to improve care and to look at different ways of ensuring high quality services that are centred on the patient and are available as close to their home as possible.

- **Mental Health -** Mental health is about how we think, feel and behave. One in four people in the UK has a mental health problem at some point during their lives, which can affect their daily life, relationships or physical health. Mental health disorders take many different forms and affect people in different ways. There is no single cause of mental health problems and the reasons why they develop are complex. Some mental health problems are more common in certain people. For example, women are more likely than men to have anxiety disorders and depression. Drug and alcohol addictions are more common in men, and men are also more likely to commit suicide.

Summaries of each projects provided as an annex

Efficiency and Risk Assessment

This section provides a summary of the efficiencies planned in 2014-16 together the determined level of risk associated with them. All risk has been assessed using the NHS Sustainability Model (NHS Institute for Innovation and Improvement).

Portfolio	Value	Sustainability	Risk Rating	Adjusted Risk Value
Urgent Care	£			£
Planned Care	£			£
Long Term Conditions	£			£
Maternity, Children and Young People	£			£
Prescribing	£			£
Corporate	£			£
Totals	**£**			**£**

Addressing Health Inequalities

Integrated Working with CCGs
Fair Society, Healthy Lives
Kent Health and Wellbeing Strategy
Ashford Health and Wellbeing Board
Better Care Fund
NHS England

Working with… **Public Health Kent**

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, including Public Health.

Locally services include:

- **Children's health** - Healthy Child programme for school-aged children including school nursing
- **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.
- **Public Health Mental Health** - Mental health promotion, mental illness prevention and suicide prevention
- **Physical activity** - Local programmes to address inactivity and other interventions to promote physical activity. The Healthy Club
- **Obesity programmes** - Local programmes to prevent and address obesity e.g. National Childhood Measurement Programme and Weight Management Services
- **Drugs and Alcohol misuse** – including, prevention and treatment
- **Tobacco control** - Local activity, including stop smoking services, prevention activity, enforcement and communication activity
- **Reducing and preventing birth defects** - Population level interventions to reduce and prevent birth defects (with Public Health England)
- **Accidental injury prevention** - Local initiatives such as falls prevention services

Working across CCGs

In some instances, CCGs need to work together to create a bigger footprint as a "unit of planning" in order to effectively commission some of the services for which they are responsible, but also to share risk safely, transfer skills and secure commissioning support. The CCGs in east Kent have agreed to collaborate in a range of areas where working together will;

- **Support Clinical Improvement –** through consistent, evidence based pathway development and effective and consistent performance management
- **Drive greater efficiency –** by ensuring leverage with providers; keeping transaction costs low; and sharing (potentially scarce) expertise and capacity
- **Provide greater resilience –** by managing financial risks together; improving risk management and sustaining more effective business continuity arrangements

A range of initiatives have been agreed which will ensure that CCGs are able to work together across east Kent to both deliver transformation in areas where a greater critical mass must be achieved to make change sustainable and where wider approaches are key levers to improvements in individual CCGs.

As illustrated in the diagram below the projects will be planned and delivered at either an East Kent-level, as joint projects with Canterbury and Coastal CCG or as a local project only to serve Ashford's needs:

Fair Society, Healthy Lives

The Marmot Review, published in 2010, highlighted that people with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – "it should become the main focus". Consider one measure of social position: education. People with university degrees have better health and longer lives than those without.

Dahlgren and Whitehead (1991) talk of the layers of influence on health. They describe a social ecological theory to health. They attempt to map the relationship between the individual, their environment and disease. It still stands as the most effective illustration of health determinants and continues to inform the work to of those concerned with understanding and reducing the health inequality gap.

The first layer includes structural factors: housing, working conditions, access to services and provision of essential facilities. The next layer is social and community influences, which provide mutual support for members of the community in unfavourable conditions. But they can also provide no support or have a negative effect. The final layer is personal behaviour and ways of living that can promote or damage health. –e.g. choice to smoke or not-Individuals are affected by friendship patterns and the norms of their community. Individuals are at the centre with a set of fixed genes. It is worth noting that it is the surrounding influences on health that can be modified, those of structural factors, social and community factors and finally lifestyle choices.

Delivering change which will have the greatest impact on health and social care, and the policy objectives set out in the Marmot Review, therefore requires action by central and local government, the NHS, the third and private sectors and community groups. In this section we reflect on the plans of our partners across the public sector.

Kent Health and Wellbeing Strategy

Good health and wellbeing is fundamental to living a full and productive life. Overall Kent has a good standard of health and wellbeing, but this hides some significant areas of poor health and a wide gap in life expectancy (15 years between the healthiest and least healthy wards in Kent). The overarching Joint Health and Wellbeing Strategy (JHWS) aims to identify the health and social care outcomes that we want to achieve for the people of Kent. The document sets out the challenges we all face, what we are going to do to address them and what we hope to see as a result.

The vision in Kent is to deliver better quality care, improve health outcomes, improve the public's experience of health and social care services and ensure that the individual is at the heart of everything we do.

The JHWS is based on data and evidence in the Kent Joint Strategic Needs Assessment (mentioned previously), the Kent Health Profile 2012, the Kent Health Inequalities Plan plus additional guidance from the Department of Health.

Kent ranks 102 out of 152 county and unitary authorities in the English Indices of Deprivation 2010 (ID2010). This places Kent within England's least deprived third of authorities as a rank of one indicates the most deprived area. However, there are areas within Kent that do fall within the 20% most deprived in England. Overall, Kent suffers the most from barriers to housing and services deprivation and suffers the least from health deprivation and disabilities. 70% of Kent residents describe themselves as being in good health and 16.5% of Kent's population live with a limiting long term illness. Kent's ageing population will place significant pressures on health and social care services.

The strategy takes into account the health and wellbeing challenges facing Kent and the difficult financial situation for public services. It is important we look across organisations in Kent and consider how we may change the way we work together so that we can improve the health and wellbeing of every person in Kent. The Health and Wellbeing Board will champion and work hard on behalf of the residents of Kent to ensure we make these improvements.

We also believe it is important that local communities have a greater role in shaping and influencing services and improving health and well-being in communities. This will be supported by the role of democratically elected members and our local Health Watch (patient representation is an integral part of the Health and Wellbeing Board). Not only do we think this will help us tailor services to meet the needs of local people we also understand the value of community in improving the health and well-being of residents.

Partnership working on health and wellbeing issues is not new in Kent. We have a long history of doing so; the recent establishment of the Kent Health and Wellbeing Board which includes a Health Watch representative, Council representatives and Health representatives will enable even closer working.

This joint health and wellbeing strategy is a new opportunity for the health and wellbeing board members to explore together the local issues that we have not managed to tackle on our own. It sets out collectively what the greatest issues are for the local community, based on evidence in our Joint Strategic Needs Assessment, how we will work together to deliver the agreed priorities and what outcomes we intend to be achieved.

The Health and Wellbeing Strategy informs the Ashford CCG commissioning plans enabling us to focus on the needs of service users and communities, tackle factors that impact on health and wellbeing across service boundaries and influence local services beyond health and care to make a real impact on the wider determinants of health (e.g. employment, housing and environment).

From these Priorities and Approaches come 5 key Outcomes against which we will measure our success in improving the health of the people of Kent. These key outcomes are:

Every Child has the best start in life - Over the next 3 years we would hope to see an increase in breast feeding take up. We would also like to see targeted support on healthy eating in families leading to an increase in healthy weight levels. There will also be an increase in MMR take up and additional Health Visitors who will support families with young children.

People are taking greater responsibility for their health and wellbeing - This is designed to promote a continued increase in people accessing treatment for drug and alcohol problems; fewer alcohol related admissions to hospital; an increase in people quitting smoking and staying smoke free and more people supported to manage their own conditions.

The quality of life for people with long term conditions is enhanced and they have access to good quality care and support - More patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reduce number of times patients have to repeat information to professionals (Tell us Once); see a 15% reduction in A&E admissions; a 20% reduction in emergency admissions and a 14% reduction in elective admissions. More importantly this will lead to a 45% reduction in the rates of people dying earlier than expected.

People with mental ill health are supported to live well - Early diagnosis of mental ill health will be increased, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support and early intervention services will see an increase in people reporting an improvement in their own mental ill health and wellbeing. The stigma of mental ill health will be reduced.

People with dementia are assessed and treated earlier - Early diagnosis of Dementia will become the norm, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support including housing, supported housing options and dementia friendly communities will lead to patients being able to stay within their own communities for longer. GPs and other health and care staff will be able to have the appropriate conversations with patients and their families about end of life care.

Ashford Health and Wellbeing Board

The Ashford Health and Wellbeing Board brings together the statutory and voluntary organisations which are involved in healthcare, social care and public health to champion the delivery of better, more efficient and integrated services in the area. It is a forum where partners can share their respective objectives, performance requirements and proposed plans with a view to identifying areas of mutual interest and support. Although formally a sub-committee of the Kent board, the local board is closer to local citizens/patients and has a more detailed insight into their needs and preferences which therefore complements the county-wide overview and is able to inform and influence County priorities and actions

The Board can review spending plans and priorities of the constituent partners e.g. public health, district and county council and CCG and their contribution to health and wellbeing and informs priority setting, commissioning decisions and the planning process

Better Care Fund

The 'Better Care Fund' (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. Whilst the fund itself does not address the financial pressures faced by local authorities and CCGs, it can act as a catalyst for developing a new shared approach to delivering services and setting priorities.

The BCF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The BCF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the BCF as a significant catalyst for change. The BCF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings.

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

- plans to be jointly agreed;
- 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; and
- agreement on the consequential impact of changes in the acute sector.

Local Health and Wellbeing Boards will sign off the plans, which will have been agreed between the local authority and CCGs. The HWB is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

Delivering Harm Free Care

CQUINS
Quality Monitoring
Hospital Acquired Infections
Never Events
Whistleblowing
Safeguarding

Working with… **Kent Police**

One in four people experience a mental health problem at any one time. For the police, this often means that of the victims, suspects, and witnesses they deal with on a daily basis, many will be experiencing mental health difficulties. The police may be first on the scene of a person in a mental health crisis therefore assisting police officers to be able to identify people with mental ill health from the very first point of contact - and getting them the right care - can play a critical role in improving health outcomes and response.

The mental health street triage pilot provides an immediate joint screening assessment aimed at adults aged 18 who have presented in a place to which the public have access, who have been reported via the Police, whose presentation suggests a mental health crisis or those individuals who are known to mental health services who require a welfare check.

The anticipated benefits of this scheme are:

- Reduction in the use of Section 136 of the mental health act
- Improve response to those in mental health crisis
- Improve user experience when in mental health crisis
- Improved outcomes for the individual including timely access to services (primary and secondary care)
- Improved understanding of Mental Health within the Police force

CQUINS
DETAIL TO FOLLOW

Quality Monitoring
DETAIL TO FOLLOW

Hospital Acquired Infections
DETAIL TO FOLLOW

Never Events
DETAIL TO FOLLOW

Whistleblowing
DETAIL TO FOLLOW

Safeguarding
DETAIL TO FOLLOW

Finance

Allocation Assumptions
2 Year Financial Plan
Expenditure Assumptions

Working with… **Community Safety Partnerships**

The local Community Safety Partnerships undertook a strategic assessment which involved reviewing performance data from the partner agencies.

They have identified the areas where they will focus for the year ahead and having considered the priority areas of Kent's Police and Crime Commissioner, as well as the Kent Community Safety Agreement, the Partnerships have agreed to focus on the following priority areas during the coming year.

- **Acquisitive Crime** - To enable people living, working and studying in the district to do so without risk of being a victim of theft.
- **Anti-Social Behaviour** - To improve the quality of life for people within the locality.
- **Domestic Abuse** - Improve the health and wellbeing of families and individuals subject to and at risk from domestic violence.
- **Road Safety** - To make the roads of the district safer for road users.
- **Substance Misuse** - To improve the safety and wellbeing of people vulnerable to substance misuse.
- **Violent Crime** - Improve the safety of people within the district who are vulnerable to injury through violence

Allocation Assumptions

The CCG is currently assuming a 20% move towards the new allocations formula. Although it is not known how much this will actually equate to, due to speed of implementation, it is felt that planning at this level is appropriately risk averse.

2 Year Financial Plan

Set out below is the expected allocation and expenditure for 2014/15 and 2015/16.

	2014/2015	2015/2016
Final 13/14 Allocation	£130,093,000	£129,880,403
Less Non Recurrent Allocations	-£1,434,000	
2% Allocation Growth	£2,573,180	£2,467,728
CCG Funding for ITF	-£385,977	-£3,896,412
Assumption on Pace of Change for Allocations	-£965,800	-£965,800
Recurrent Baseline	£129,880,403	£127,485,919
Return of Surplus	£1,345,400	£1,342,358
£25 per head Running costs	£3,010,000	£2,709,000
Total Non-Recurrent Allocation	£134,235,803	£131,537,277
13/14 Forecast	£130,802,779	£128,037,703
Full Year Effect Issues (inc recurrent QIPP)	-£453,156	-£1,610,192
Non-Recurrent Spend	-£589,170	£0
Cost Pressures	£1,148,603	£1,174,633
1.5% Population Growth	£1,917,186	£1,920,566
1.6% Reduction in Tariff	-£2,044,999	-£2,048,603
QIPP	-£6,440,769	-£3,436,665
CQuin Impact	£844,718	£844,718
Expected 14/15 Programme Spend	£125,185,192	£124,882,158
£25 per head Running Costs	£3,010,000	£2,709,000
1.5% Non-Recurrent Transition Funding	£2,013,537	£1,315,373
1% Further Funding for ITF	£1,342,358	£0
1% Contingency	£1,342,358	£1,315,373
1% Surplus Requirement	£1,342,358	£1,315,373
Total Spend	£134,235,803	£131,537,277

Expenditure Assumptions

The start point for the planning is the 13/14 forecast out-turn position. The CCG is on target to make its surplus but has had to use all of the 1% contingency and the 2% strategic change funding to support this position. This is due to a number of factors including those within and external to the CCGs control. 13/14 QIPP delivery has not been as expected, a major contributor to the current position. For some areas of expenditure, for example prescribing despite QIPP delivery the position has been adversely affected by changes in Category M pricing and other factors.

The Full Year effect adjustments include both QIPP investment and savings expected to continue from the 13/14 financial year.

The adjustment for non-recurrent funding reflects the fact that the CCG will no longer receive is reablement funding. As reablement funding has been used to deliver a number of joint projects across the health economy a resultant cost pressure has been included in the plan to reflect the need for a proportion of this funding going forward.

Cost pressures include growth allocated to those areas recognised in the planning guidelines as expecting price inflation. Additionally the CCG is undertaking significant developments across some of the larger East Kent contracts moving to payment based on real usage rather than fair share to allow better commissioning decision making. Finally a significant cost pressure determined nationally is the move Payment by Results for mental health although these values are yet to be finalised.

Population Growth is expected to be at 1.5% and tariff has been reduced as advised in the guidance.

The total QIPP amount included in the plan equates to £7.0m, comprised of £0.3m schemes to be continued and £6.7m of new commissioning plans. This equates to 5.3% of the total budget. In 13/14 the 3% planned level of QIPP was recognised as significantly challenging and one of the highest plans in the region. The CCG recognises that the level of QIPP in the 14/15 plan exceeds this by 2.3% and represents a significant challenge that can only be delivered through fundamental changes in delivery of healthcare across providers, that is facilitated by utilisation of all contracting options available to commissioners.

The creation of the ITF fund included in the 2014/15 plans is assumed as a cost to the CCG, with no financial benefit in year through reductions in activity in the acute setting, this will need to be discussed with our Social Care Partners.

The plan also assumes that there will be 1.5% strategic funding available and a further 1% for the ITF (described below). As required the plan also assumes 1% contingency and 1% surplus. No additional funding has been assumed at this time for savings in primary care and any quality premium.

Running costs will be at the expected level of £25 per head of population.

The challenge is further compounded in 2015/16 as the full impact of the ITF is included and the expected resource growth reduces. However, in year 2 of the two year plan a number of the more substantial integrated service models will be implemented or part implemented, thus generating the major change needed to sustainably move the CCG to an affordable baseline.

The challenge therefore for the CCG is to deliver the very challenging significant QIPP target in 2014/15 before the large integrated system changes impact in 2015/16.

Delivering The Plan

Delivery Architecture
Patient and Public Involvement
Contractual and Performance Management
Decommissioning and Disinvestment
Equality and Diversity

Working with… **Kent Fire and Rescue Service**

A combination of factors can significantly increase the risk of an older person suffering a house fire and often decreases their chances of survival. A vulnerable person is someone who is at higher risk of death or injury in a fire, quite often because of mobility issues, or some other physical or psychological reason. Kent Fire and Rescue Service (KFRS) have a team of highly professional personnel who work closely with social services, mental health teams, local authorities, housing associations and the police to put intervention measures in place, often at very short notice.

KFRS offer a detailed home safety visit and have the following items available:

- Fire retardant bedding packs
- Fire retardant blankets
- Alarms suitable for those with hearing and visual problems
- Cooker switches
- Fire retardant sprays
- Letterbox sealing
- Ashtrays (if you have concerns over someone falling asleep whilst smoking, or for disabled people)
- Natural gas and carbon monoxide alarms.
- Falls assessments

Delivery Architecture

To ensure that Ashford CCG remains focused on delivery of its plans throughout 2014/16 and beyond it will implement the following tracking mechanisms.

- Monthly review of project progress at operational team meetings, run by the Head of Commissioning Delivery
- Monthly meetings between the Clinical Programme Lead and Commissioners
- Monthly review of programme or project progress at CCG clinical strategy committee meetings
- Monthly review of how the CCG is doing against its Quality Premium indicators

Where possible, the benefits of each project should be tracked to monitor its effectiveness in achieving its objectives. The aforementioned fora will be used to check whether benefits have been realised. If they have not been realised, a decision will be taken about whether the project continues or is adapted.

Conflict of Interest

The CCG takes conflicts of interest very seriously. Ashford's constitution details how conflicts of interest will be managed but in summary:

Declarations of interest are published on the Ashford CCG website: www.ashfordccgnhs.uk

Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the Group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Head of Corporate Services.

The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

Patient and Public Involvement

A communication and engagement strategy document has been developed to set out how Ashford CCG will inform and involve residents, partners, health and social care professionals, voluntary and community sector groups to ensure that specific health care needs that have been identified in the Joint Strategic Needs Assessment are addressed. This document is to be found on the website:

www.ashfordccg.nhs.uk/

In summary though, our main means of engaging patients and public include:

Means of Engaging Patients and Public	Detail
Patient participation groups (PPGs)	Ashford's CCGs practices have a patient participation group. Representatives from the CCG attend these group meetings to listen and act on patient views. Ashford Patient Participation Group also attends (in a non-voting capacity) the CCG Governing Body
Public reference group (PRG)	Consists of a representative from the PPGs as well as representatives from key groups and organisations.
Ashford Health Network	Ashford CCG is looking to set up a virtual group of patients, members of the public and voluntary organisations who help make decisions about local health services.
Ashford Health magazine	Free quarterly health promotion magazine available online. To receive a hard copy of the magazine patients/public are able complete a form and send back using a freepost address. These are available in surgeries and other community venues.
Governing Body meetings	These are now held in public where people can contribute to the meeting agenda.
Healthwatch Kent	Healthwatch Kent will be run by a consortium of 'Kent and Medway Citizens Advice' (KAMCA), 'Voluntary Action within Kent' and 'Activmob'. The consortium aims to excel at providing advice and information to the public, supporting the voluntary sector, and engaging with the public in new and innovative ways. C&C CCG is looking forward to working with Healthwatch Kent as it continues to emerge in 2013.
@AshfordHealth	Twitter account for Ashford CCG with latest news, tips and advice for Ashford's local community

Complaints and Compliments

Most medical care and treatment goes well, but things occasionally go wrong, and people may want to complain. They may want to make positive comments on the care and services that they or their family have received. These comments are just as important because they tell NHS organisations which factors are contributing to a good experience for patients.

We welcome complaints as a valuable means of receiving feedback on the services we commission for the people of Ashford and also on the way we go about our business. The CCG aims to use information gathered from complaints as a means of improving services and the effectiveness of the

organisations. We seek to identify learning points that can be translated into positive action, and where necessary provide redress to set right any injustice that may have occurred.

Personal information may be anonymised for the purposes of monitoring the complaints process or improving service quality. The purposes for which identifiable information will be used is strictly for the processing of the complaint. This may include passing relevant information to a service provider in order that they can provide appropriate responses and comments on the circumstances set out in the complaint.

Patients and service users are encouraged to express complaints, concerns and views both positive and negative about the treatment and services they receive, in the knowledge that:

- they will be taken seriously
- they will receive a speedy and effective response by a member of staff appropriately qualified and trained to respond
- appropriate action will be taken
- lessons will be learnt and disseminated to staff accordingly
- there will be no adverse effects on their care or that of their families

We are committed to dealing with all complaints fairly and impartially and to providing a high quality service to complainants.

Complaints received by NHS Ashford CCG are investigated by Kent and Medway Commissioning Support (KMCS). KMCS is hosted by NHS England, and provides a number of administrative functions including managing the complaints process. This may involve accessing your case records and disclosing relevant information to the CCG in order that we can discharge our duties to you under the NHS Complaints Regulations.

Freedom of Information (FoI)

The Freedom of Information Act 2000 (FOIA) came into force on 1 January 2005, and gives the public and other organisations the right of access to information held by NHS Ashford CCG. We are committed to openness and transparency in the conduct of all our business.

The Freedom of Information Act 2000 recognises that, gives the public and other organisations have the right to know how public services such as the NHS make their operational decisions and how public money is used. The Act gives anyone a general right to request access to see official information held by public authorities. The Act reflects a national policy to shift from a culture of confidentiality to one of openness, where information is routinely available, subject to certain exemptions, to anyone who wishes to see it.

Freedom of Information (FOI) requests are processed by Kent and Medway Commissioning Support (KMCS) on our behalf and we maintain a disclosure log on information that has already been published which is available through our website to download. However, if someone is unable to find what they are looking for on the publication scheme, then a written request should be sent to:

Freedom of Information Team
Kent House - 4th Floor
81 Station Road
Ashford
Kent
TN23 1PP
Email: foi@nhs.net

Contractual and Performance Management

There has been an increased focus on provider performance management in 2013/14 and this will continue into 2014/16.

Our approach to management of the Hospital contract will focus around improving patient outcomes whilst achieving National Targets – for example 18 and 52 week referral to treatment times and ensuring compliance with all cancer waiting standards.

For community services we are one year through a two year contract and we will focus on establishing service lines within the scope of the vast community contract which can be independently monitored as part of the contracting process. For example, establishing a baseline for community nursing services and ensuring that for the money we spend we are getting enough nursing services.

The Mental Health contract will be moving from a Kent Wide commissioning arrangement to an East Kent contract to enable us to focus more closely on delivery of appropriate care for patients within this area. There will also be progress towards payment by results tariffs for Mental Health over the coming year moving us from historic block arrangements to a cost per case mechanism for payment.

There are 130 contracts which the CCG is a party to and we are undertaking a plan for systematically ensuring all of these are up to date and are properly monitored in relation to outcomes for patients but also to ensure appropriate amounts of activity are undertaken for the best possible value. The majority of the contracts are small but important services which contribute to the overall strategy outlined in this document of ensuring we can provide the most appropriate care setting.

The overarching approach to developing contracts for 2014-15 the CCG has taken account of:

- Improvement in Care of Patients especially the frail elderly,
- Avoidance of duplication and achievement of timeliness of care,
- The need to work within the funding available.

CQUIN payments

All NHS contracts must include a Commissioning for Quality and Innovation (CQUIN) payment which is a payment of 2.5% of contract value over the contract baseline which is payable as an incentive for innovative working.

For 2014-2016 the CCG has identified areas to start making the change. It is likely that quality payments will be made to providers through the strategic use of the CQUIN arrangements covering the following areas:

- Chronic Obstructive Pulmonary Disorders (COPD)
- Diabetes
- Heart Failure
- Dementia

These quality payments will be linked to whole system outcome and process measures wherever possible. This will require providers to work together to drive change. Quality payments will not be made where one provider is successful but overall patient care does not improve. So we will attempt to put the same measurements into all contracts for the next year to ensure that the Hospital works with Community services or that Mental Health and Acute services are aligned and properly incentivised to deliver the best outcomes for the patients.

Decommissioning and Disinvestment

To ensure that limited resources are consistently directed to the highest priority areas the CCG have identified the need to develop a Decommissioning and Disinvestment Plan that sets out the agreed principles for decommissioning services to allow funds to be redirected where appropriate. There is a need to ensure that when approval has been given to decommission, or disinvest from, a service a clearly defined process is followed, with clear lines of accountability and responsibility.

> ***Decommissioning:*** *This relates to the withdrawal of funding from a provider organisation where the service is subsequently re-commissioned in a different format.*
>
> ***Disinvestment:*** *This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.*

In some circumstances there will be the need to re-commission part of the service or a modified service to ensure that there are no gaps in healthcare delivery.

The following points will be considered when making the decision to decommission a service.

- The patient experience and health need must be paramount and gaps in service provision minimised once the service ceases.
- The potential destabilising effect on other organisations e.g. third sector, of a decision to decommission/disinvest should be considered.

Equality and Diversity

We fully recognise the importance of the Public Sector Equality Duty (PSED) and have already developed our Equality and Diversity Strategy which includes our equality objectives, set in line with the four Equality Delivery System (DH Toolkit) goals. These are detailed below:

Goal	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways 1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly 1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all 1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds 2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment 2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised 2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and	The NHS should Increase the diversity and quality of the working lives of the paid and	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades

Goal	Narrative	Outcome
well-supported staff	non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately 3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all 3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.) 3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond 4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination 4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes

We will review these annually and ensure our staff are supported to commission services which ensure equality of access to services and that meet the needs of our diverse population.

Education, Research and Innovation

Innovation Forum
Innovation Challenge Events
Clinical Leadership in Commissioning for GP Trainees

Working with… **NHS England**

Detail to follow

Innovation Forum

The NHS is currently faced with quality, efficiency and demand challenges on a scale that has never been seen before. Organisations across the NHS have already made significant progress in reducing delays, improving quality, and giving patients access to new services and technologies. However, in order to respond effectively to the scale of the current challenge, all parts of the health and care system will need to collaborate to apply innovative approaches to the problems they face.

Innovation, Health and Wealth (DH, 2011) defines innovation as:

> *"An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied"*

This gives clinical commissioners the dual role of championing the adoption of innovation and best practice seen elsewhere, alongside seeking to generate new ideas and ways to apply new opportunities creatively.

In recognition of this, NHS organisations now have a "duty to innovate". The commitment to champion innovation was included as part of the CCG authorisation process.

Together with Canterbury and Coastal CCG we have established an Innovation, through which we can:

- Generate new ideas
- Learn about best practice opportunities
- Agree new ways to address complex priority areas

The objectives of doing this are to:

- Accelerate the identification, adoption and diffusion of innovations that will improve patient outcomes and service quality in areas that the CCG defines as priorities
- Embed innovation into the CCGs' commissioning cycles
- Build an innovation climate within the CCGs and partner organisations
- Link with other organisations involved in health and care (commissioners and providers) so that they can also embed innovation and innovation projects in their business planning processes

The Innovation Forum brings together senior CCG decision makers along with agreed relevant external input from the academic community, technology industry and health and social care stakeholders. Participants are asked in advance to consider specific questions or focus areas, and to identify relevant information, research or case studies based on their own experience or areas of work. This also involves considering how existing practice or tools could be applied differently or in other areas. The aim of the Innovation Forum is not to carry out an in-depth review of opportunities, but to consider how they might impact on the health challenges that the group prioritises.

Innovation Challenge Events

Twice yearly an Innovation Challenge event will be run, bringing together a wider group of people to learn about opportunities in a particular area and consider how they will be applied for local people. Each Innovation Challenge event will have its own objectives, which will vary according on the questions being posed, however events will have a number of objectives in common:

Learn and challenge	Generate ideas
• Increase understanding of the presenting issue from different perspectives • Hear about alternative solutions (or components of solutions) from providers and users • Learn about what has worked – and what hasn't – in other areas • Consider why the approach in place locally does not fully meet the needs of service users	• Consider how new approaches or tools would impact the presenting issue • Discuss how existing tools (new or already in use in the area) could be improved • Review what could be done differently to address gaps in services • Learn from how other organisations or industries are addressing similar challenges • Probe the ideas considered: do they fully address the presenting issue or is there a way to enhance them further?
Agree actions	**Synthesise solutions**
• Agree what should be taken forward and how • Define specific actions and owners • Understand what inputs are required to make each action happen • Ensure clarity over who's leading on different solution areas • Confirm expectations of stakeholders	• Identify groups of linked opportunities • Prioritise the ideas raised • Gauge interest and consensus from different stakeholders • Gain stakeholder commitment to being involved in developing the opportunity from idea/pilot to broader diffusion

The first Innovation Challenge Day was held in April, focussing on Dementia. Working with the Young Foundation, the event was attended by commissioners and provider organisations, local authority, third sector organisations, universities, and technology firms.

Our aim was to think differently and hear different things about ways to support people with dementia. Speakers presented on their innovative tools or services supporting different aspects of dementia care. Small group discussion to help review, understand or prioritise the innovative ideas presented. Participants were asked to identify ways in which they would take back the ideas generated and use them to influence change in their own organisations.

It is important to differentiate between an Innovation Challenge event and a patient co-design or consultation event. People who use services should be involved to raise their alternative perspectives of services and their ideas about what could make them better, as well as ensuring that the group understands the potential impact of opportunities. However, Innovation Challenge events should be focused on opportunities to deliver transformational change benefiting a large number of people, rather than redesigning elements of specific services in detail. A project initiated at an Innovation Challenge event could lead to a number of other engagement events during the development and delivery period.

Clinical Leadership in Commissioning for GP Trainees

The GP Clinical Leadership in Commissioning (CLIC) rotation is an innovative or integrative GP training post (ITP). ITPs and have been used for a number of years, and have been a feature of many areas in Kent, Surrey and Sussex. Educationally, they are an extension of the educational placement for trainees that are a regular part of the GP placement (such as attending an outpatient clinic, community clinic, or public health department). Previously, they have consisted of a combination of GP Trainer employed and hosted posts, or part placement (and employment) in a GP Training Practice and part placement in a hospital or community clinic post.

The commissioning rotation comprises 5 clinical sessions within a GP practice and 2 days within the commissioning setting. Most trainees will work on a Wednesday and Thursday within the commissioning component of the rotation, with the other five clinical sessions in GP. Mandatory sessions are structured with experts in areas of commissioning or workshops which relate to key aspects of leadership development. Each trainee is allocated a commissioning project which they work on alongside the CCG commissioning team.

Trainees are expected to demonstrate evidence of learning, teaching and team working as part of RCGP curriculum requirements and personal professional development. In this placement the trainees are invited to present to their supervisors and peers at the end of the 4m placement.

Project Summaries

Transformation of Outpatient Services	**Planned Care**
Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • TBA Key Changes • Pre-Referral Advice and Guidance Service • One-Stop Clinics • Improved Triage High Level Benefit Assessment For patients • Appropriate referral to the right clinician • Management of their condition by local clinicians • Reduced attendances in acute settings For GPs • Education resource • Reduces redirection/rejected referrals • Reduction in overall referrals For provider • Only those patients that need to be in clinic are seen • More diagnostic tests, where appropriate, can be completed prior to referral • Improves RTT timelines where redirection of referrals has added delays in the past For CCG's • Confidence that referrals to secondary care are appropriate • Potential for savings where patients are not referred and managed in primary/community care Key Risks • Potential for provider to miscode response and therefore output data maybe of questionable quality • Percentage of referrals avoided provides minimal savings • Engagement with GPs

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead	Dr M Davies	**Managerial Leads**	Paula Smith Sue Luff Felix Robinson
Key Partners	East Kent Hospitals University NHS Foundation Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Dermatology	Planned Care

Description

Strategic Fit

- TBA

Evidence Base

- TBA

Key Changes

- Prime contractor will be responsible for developing and implementing an integrated and coordinated programme of Dermatology care
- Services will be commissioned on the basis of "outcome" rather than separate services for each condition.

High Level Benefit Assessment

- Reducing fragmentation in the patient pathway.
- Reducing confusion for GPs with regard to where to refer.
- The patient being seen by the right clinician in the right place first time.
- Ensuring the right investigations is undertaken.
- Creating efficiencies and financial savings.
- Better clinical effectiveness and increase quality of service.
- Monitoring based on outcomes.
- Supports education in primary care.

Key Risks

- Conflicts of interest from current providers engaged within the Task and Finish Group
- Destabilisation of the Trusts Cancer services
- Inability to procure a new service by October.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

Project Accountability			
Clinical Lead		**Managerial Lead**	
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	February 2014	Service Review	
	March 2014	Redesign	
	October 2014	Implement changes	
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Macula Oedema	**Planned Care**

Description

Strategic Fit

- TBA

Evidence Base

- NICE Technology Appraisal Guidance
- Diabetic Macular Oedema (DMO; TA274)
- Wet Age-Related Macular Degeneration (WAMD; TA155)

Key Changes

- A hub and spoke type service model to provide patients with community monitoring facilities and a central acute site(s) for the treatment/drug administration

High Level Benefit Assessment

- Patients would not need to attend acute hospital sites for every appointment.
- Patients seen in a timely fashion and impact on their vision is minimised
- Improved delivery of high quality and value for money monitoring service that will also provide the maintenance a patient requires between injections
- Improved access and choice
- Delivers greater consistency of treatments
- Equity of services across the localities which enhances patient experience and reduces wait times

Key Risks

- Fragmentation of service
- Patients confused where their next treatment will be provided
- Community provider monitoring patients fails to identify developing problems
- Agreed tariff too low to be viable & attract providers

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	
Key Partners	East Kent Hospitals University NHS Foundation Trust Local Optometrist Committee Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Integrated Urgent Care Centre	**Urgent Care**

Description

Evidence Base

- East Kent Integrated Care Pilot 2009
- ECIST review of the Urgent Care System 2010
- Clinical Systems Model for Integrated Urgent Care and Long Term Conditions 2012
- Kings Fund review of Urgent and Emergency Care NHS South of England 2013.

Key Changes

- a clinician to clinician discussion via a 24/7 'Care Co-ordination' Centre;
- enhanced GP out of hours service to replicate what is provided in hours;
- enhanced input to review and treat patients within care homes, reducing the need to access acute hospital services;
- robust decision making skills through the use of jointly developed 'decision support or assessment' tools;
- consistently responsive and reliable service 24/7;
- integration of the out of hours service with other care providers;
- clear discharge processes from urgent care to planned or primary care, to maintain capacity within the system; and
- proactive case management.
-

High Level Benefit Assessment

- Provide a rapid multi-disciplinary assessment of patients quickly
- Provide rapid access to a range of services that will ensure that patients are managed seamlessly and are better supported to cope within their local community. This service will to prevent a significant cohort of patients from having to attend hospital , improve recovery following an event and ensure that patients retain independence.

Key Risks

- Quality / complaints
- Human resources / organisational development / staffing / competence
- Adverse publicity / reputation

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Alastair Martin
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Ambulatory Care Pathways	**Urgent Care**

Description

Evidence Base

- The Royal College of Physicians – Acute Medicine Task Force & endorsed by the College of Emergency Medicine, 2012
- NHS Elect – Directory of Ambulatory Emergency Care for Adults 2012
- Kings Fund – Managing Urgent and Emergency Activity 2012

Key Changes

- TBA

High Level Benefit Assessment

- Improved access to timely assessment, diagnosis and treatment for patients with Ambulatory conditions
- Ability to manage patients within own care setting
- Promotes self-management of chronic conditions
- Increased patient satisfaction
- Integrated service across all providers
- Supports development of Integrated Urgent Care System and Community Review
- Reduced urgent care admissions

Key Risks

- TBA

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Sue Luff
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Dementia Out Of Hours Crisis Support	**Long Term Conditions**

Description

Strategic Fit

- Dementia has been identified as a priority for the Kent HWB as well as the CCG. The business supports the desire to deliver care as close to home as possible.
- The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy, 2009 and the Prime Ministers Dementia Challenge, 2012.

Evidence Base

-

Key Changes

- The proposal is to develop existing community services
- This enhanced service would provide an out of hours response for both older people with functional problems as well as people with dementia
- The service would be available to both patients known to the secondary mental health services and new referrals and would deliver a service to individuals in their own homes, including care homes
- The service will be targeted at those patients requiring an urgent response from mental health services and those patients who needs may require a joint response between community nursing and mental health services because a physical problem has enhanced their level of confusion.

High Level Benefit Assessment

- Enable older people to remain in their own home (which could be a care home) at times of crisis.
- Avoid unnecessary hospital attendances and admissions.
- Facilitate hospital discharge

Key Risks

- Inability recruit to additional posts will impact on service delivery
- Service does not ultimately deliver savings.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Linda Caldwell
Key Partners	Kent and Medway Partnership Trust Local CCGs		
Delivery in 2014-16			
Key Measures	Reduction in admission to acute hospital beds		
	Time of referral to the service.		
Key Milestones	January 2014	Undertake modelling to identify hours service needed.	
	February 2014	Agree activity and KPIs for inclusion in KMPT contract	
	Mid February 2014	Advertise for posts	
	May 2014	Service fully implemented	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Pulmonary Rehabilitation Service	**Long Term Conditions**

Description

Strategic Fit

- TBA

Evidence Base

- TBA

Key Changes

- Increase capacity in the Pulmonary Rehabilitation Service
- Encourage and facilitate patient self-management exercise groups
- Ensure consistency in acute sites operate across East Kent

High Level Benefit Assessment

- Reduced duplication and meet existing gaps in provision – clear patient pathway
- Reduced unnecessary appointments by improving patient self-management
- Equitable service across East Kent
- Closer working relationships between the acute trust and community clinicians
- Accurate Asthma and COPD registers, and achievement of respiratory QoF points

Key Risks

- TBA

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Kim Eaglestone
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Memory Assessment	**Long Term Conditions**
Description	Strategic Fit • The provision of early diagnosis for people with dementia is identified as an objective in the National Dementia Strategy 2009 • Prime Minister's Dementia Challenge, 2012 which sets a target diagnosis rate of 66% by 2015 (against expected prevalence). Evidence Base • The proposal is based on NICE guidelines. Key Changes • The pathway envisages in future that the majority of people with dementia will be reviewed and monitored in primary care. • Dementia screening should be undertaken in primary care to exclude other reasons for the cognitive impairment • Magnetic resonance imaging (MRI) is suggested as the preferred modality to assist with early diagnosis and detect subcortical vascular changes; the suggestion would be that the scan should be ordered in primary care. High Level Benefit Assessment • Care closer to home by increasing the assessment and treatment available in primary care. • A more multi-disciplinary approach to patients will also help to support the integration of services • Free up capacity in the memory assessment service for those people who need more specialist input Key Risks • Redesign of pathway does not increase capacity in memory assessment services leading to delays in assessment. • Future modelling of local tariffs and activity indicate current budget is insufficient. • Prescribing will continue to be a cost pressure unless appropriate agreements are reached.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Linda Caldwell
Key Partners	Kent and Medway Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures	Reduction in admission to acute hospital beds		
	Time of referral to the service.		
Key Milestones	January 2014	Review additional data, e.g. scanning data, number of referrals converted to diagnosis.	
	February 2014	Second workshop for dementia leads	
	Mid February 2014	Agree specification for cluster 18	
	April 2014	Initial evaluation of Cantabmobile pilot	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Personal Health Budgets	**Long Term Conditions**

Description

Strategic Fit

- From 1st April 2014 everyone eligible for NHS Continuing Healthcare funding will have a right to ask for a personal health budget
- children in receipt of NHS Continuing Healthcare funding will be affected by the requirement to provide integrated Education, Health and Social Care plans from September 2014

Evidence Base

The final national evaluation of the personal health budget pilot programme was released in May 2013. The key findings of the evaluation were:

- 72.6% of budget holders reported their budget having a positive impact on their independence
- 67.9% reported a positive impact on being supported with dignity and respect
- 67.7% reported a positive impact on being in control of their support
- 63.9% reported a positive impact on their mental wellbeing
- 59.4% of personal health budget holders reported their budget having a positive impact on the long-term condition for which they held the budget

Key Changes

- Implement a robust governance system aligned with the national framework for adults eligible for continuing healthcare
- Implement a robust governance system for assessment and planning linked to the SE7 SEN and Disabled Children Pathfinder and the establishment of the new Education, Health and Care Plans.
- Implement a multi-agency joint commissioning approach to the provision and monitoring of a personal budget.

High Level Benefit Assessment

Benefits to budget holders and carers

- Greater choice and control
- Improved alignment with patients personal life and circumstances

Wider system benefits

- Greater transparency in the allocation of NHS funds
- Greater integration
- Greater innovation and service development

Key Risks

- Section 75 agreement not completed by April 2014
- Inability to recruit broker resources
- Unable to agree clinical quality monitoring and support with existing providers

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	Treating and caring for people in a safe environment and protecting them from avoidable harm

Project Accountability			
Clinical Lead		**Managerial Lead**	Maria Reynolds
Key Partners	Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	Mar 2014	Completion of Section 75 agreement	
	Jul 2014	Broker recruitment and training completed	
	Aug 2014	Development and approval of joint assessment processes for children with SEN and Disabilities	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Admiral Nursing	**Long Term Conditions**
Description	Strategic Fit • Dementia has been identified as a priority for the Kent HWB as well as the CCG. • The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy 2009 and the Prime Ministers Dementia Challenge 2012. Evidence Base • NICE QS30 Supporting people to live well with Dementia. Quality Standard 30 (NICE 2012) • NICE CG42 Dementia Support people with dementia and their carers in health & social care (NICE 2005) Key Changes • The existing Admiral Nurse be integrated into the Neighbourhood Care Teams • The service will need to develop stronger working links with Age UK (who currently hold the contract for Dementia Café in Canterbury). • The service will need to link with and harness the expertise, of the link worker aligned to practices to ensure need is identified and referrals made early on. The link worker will also be pivotal in supporting education with regard criteria amongst health professionals. • A combination of clinic and home visit approach is explored and adopted to create capacity, utilising existing voluntary sector accommodation where appropriate (Age UK etc.) • Improve links with carers rapid response and other jointly commissioned services i.e. Crossroads crisis service. High Level Benefit Assessment • Reduced admissions due to carer breakdown Sue Gratton link to crisis service development. (*Patient Safety, Duty Quality, Patient Experience, Prevention)* • Reduced carer admissions • Improved access for carers/families to support them in caring role. • Integrated working between Neighbourhood Care Teams/admiral nursing/voluntary sector • Capacity for service to educate other professionals. • Link to action plan for Dementia Key Risks • TBA

NHS Outcomes Framework				
1	**2**	**3**	**4**	**5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Lisa Barclay
Key Partners	Kent Community Health NHS Trust Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Expansion of Neighbourhood Care Team	**Long Term Conditions**
Description	Strategic Fit • Dementia has been identified as a priority for the Kent HWB as well as the CCG. • The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy 2009 and the Prime Ministers Dementia Challenge 2012. Evidence Base • Neighbourhood Care Team was implemented in February 2013, A&E attendance and admission avoidance achieved in line with plans Key Changes • Make the current H&SCC roles substantive within NCT, recognising the role functions as a central point of access and service navigation for practices. • Review measurement of savings and test cost assumptions on patient cohort where admission avoidance achieved. • Increase the H&SCC roles to cover Sunday between 10-2pm • Extend current NCT team cover for long term conditions, to allow service cover until 8pm at night (currently 5pm), with an on call service being available for care homes 8-8, Mon-Sun • Improve working relationships between Discharge Referral Service and community care to reduce LoS • Encourage use of integrated team through H&SCC, by Out of Hours GP Provider. • Embed use of Share My Care across EKHUFT/KCHT/IC24 and SECAmb to reduce A&E attendances and admissions. High Level Benefit Assessment • Continue to reduce A&E attendances in 65+ age group – absorb growth in population attendances • Improve provider integration Key Risks • TBA

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Lisa Barclay
Key Partners	Kent Community Health NHS Trust Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Falls Strategy	**Long Term Conditions**
Description	Strategic Fit • Kent has an aging population, the over 65 population is expected to rise by at least 15% over the next 5 years (more than 20% for over 85 years). Evidence Base • One in three people aged 65+ will fall each year and one in two people aged 80+ will fall each year (NHS Confederation, April 2012) • Falls account for approx. 10 to 25% of ambulance callout (NHS Confederation). • NICE and National Service Framework (NSF) for older people recommend the prompt delivery of multifactorial assessment and interventions Key Changes • Screening of adults who are at a higher risk of falls • Integrated multi-disciplinary assessment for the secondary prevention of • falls and fractures • Use of standardised Multifactorial Falls Assessment and Evaluation tool • across Kent • Availability of community based postural stability exercise classes • Follow on community support for on-going maintenance closer to home High Level Benefit Assessment • Improve access to services • Reduce hospital admissions related to falls by preventing the patient from having a second fall • To reduce the number of health and social care activity related to falls and fracture in older people • Improve patient experience of services • Improve outcomes for patients Key Risks • Public Health timescales for the training and delivery of Postural Stability Instructors may not align with the delivery of the integrated pathway.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	
Key Partners	Kent Community Health NHS Trust Kent County Council Local CCGs Kent Fire and Rescue Service		
Delivery in 2014-16			
Key Measures			
Key Milestones	February 2013	Multi-agency workshop	
	March 2014	Agree new service & service specification	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Cardiology	Long Term Conditions
Description	Strategic Fit • Kent Health and Wellbeing Strategy • Joint Strategic Needs Assessment Evidence Base • TBA Key Changes • Review all of the existing services • Develop an integrated service model • Services commissioned on the basis of "outcome" rather than separate services for each condition • Care delivered in a community setting • Clear and responsive referral routes into secondary care services. High Level Benefit Assessment • Reducing fragmentation in the patient pathway. • Reducing confusion for GPs with regard to where to refer. • Ensuring the patients areseen by the right clinician in the right place first time. • Creating efficiencies and financial savings, providing value for money against existing services • Better clinical effectiveness and increase quality of service. • To improve health outcomes through earlier diagnosis and treatment of common cardiology conditions • To reduce the number of referrals, so far as clinically appropriate, to secondary care • To establish a robust communication mechanism between all parties providing and receiving the service. Key Risks • KCHT may not wish to support the continuation of the GPwSI service on an interim basis • Lack of data on the GPwSI service to review effectiveness • Clinicians ability to dedicate time to the Task and Finish Groups

NHS Outcomes Framework				
1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Community Equipment Loan Store	**Long Term Conditions**
Description	Strategic Fit • TBA Evidence Base • TBA Key Changes • Integrated tender and procurement approach and process for a single Kent wide provider for the Community Loan Equipment Service • Predicted cost pressures for 2014/15 are addressed as part of the KCHT block contract negotiations • in-year improvements to the current Community Equipment Loan Store (CELS) Service provided by KCHT by introducing 7 day working High Level Benefit Assessment • TBA Key Risks • TBA

NHS Outcomes Framework				
1	**2**	**3**	**4**	**5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Kim Eaglestone
Key Partners	Kent County Council Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Confidential Inquiry into the Deaths of People with Learning Disabilities (CIPOLD)	**Learning Disabilities**

Description	Strategic Fit • CIPOLD was commissioned in 2010 as recommended by Sir Jonathan Michael in the 2008 report Healthcare for all • In response to CIPOLD Kent held a workshop which found that there is scope to implement some of the recommendations locally Evidence Base • CIPOLD provides the evidence that people with learning disabilities do not have equal access to good healthcare. Key Changes • Mandatory Mental Capacity Act Training for all healthcare providers in Primary and secondary care should be demonstrated as being completed on an annual basis. • Continue to provide LD training which meets LD DES criteria on an Annual Basis during PLT sessions. • Improve links with outside LAs who place people in Kent through Care Management to reduce inequalities in health due to lack of system communication – GPs to flag people from out of Kent with their Liaison Nurse to follow up • Invest in Community Speech & Language in order to reduce hospital admissions due to Dysphagia complications (separate Kent wide Dysphagia business case). • Address or support Kent wide investigation and review into inequality in access to and use of specialist equipment between CCGs with Kent wide solutions. High Level Benefit Assessment • TBA Key Risks • TBA

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Sue Gratton
Key Partners	Kent and Medway Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Winterbourne Joint Plan	**Learning Disabilities**

Description

Strategic Fit

- The *Winterbourne Concordat: Programme of Action* (DH 2012)

Evidence Base

- The *Winterbourne Concordat: Programme of Action* (DH 2012)

Key Changes

- Agree a personal plan for each individual that is inappropriately placed in CCG or NHS England commissioned learning disability or autism in-patient services and put the plans into action so that all individuals receive personalised care and support in the community no later than 1 June 2014
- Put in place a locally agreed joint plan for high quality care and support services by April 2014, which accords with the model of good care to ensure that a new generation of inpatients do not take the place of people currently in hospital.

High Level Benefit Assessment

- People with learning disability and autism who have complex mental health or behaviour problems will experience more integrated care and support in the community
- There will be improved multi-disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions
- There will be reduced reliance on the use of high cost in-patient services
- Clinical consultancy and support would be available for other professionals in mainstream services to enable them to make reasonable adjustments.
- The service would meet key requirements of national policy and guidance.

Key Risks

- Lack of funding from NHSE Specialised Commissioning renders commissioning recommendations unaffordable for CCGs and Local Authority
- June 2014 deadline for discharges of current in-patients not met due to requirement to undertake procurement process for new services

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Sue Gratton
Key Partners	Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	Completed	Identify current in-patients for discharge	
	February 2014	Details of each patients support and accommodation needs	
	March 2014	Consult on new care pathway and models of care	
	April 2014	Final Joint Plan	
	June 2014	All current in-patients discharged or agreed discharge plan / procurement being implemented.	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Autistic Spectrum Conditions Diagnostic Assessment Service	**Learning Disabilities**

Description

Strategic Fit

- It was identified in 2010 that there was no clear diagnostic or care pathway for adults with high functioning autism and Asperger's syndrome in Kent
- The current capacity of the service is 60 diagnostic assessments a year, and the waiting list as of July was 280 patients

Evidence Base

- NICE quality standards

Key Changes

- Increase capacity for assessment service

High Level Benefit Assessment

- The backlog of people waiting for diagnostic assessment will be addressed
- There will be improved multi-disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions
- Formal diagnosis ensures individuals are not referred to inappropriate health, social care and community and voluntary services.
- Carers and families will have a greater understanding of autism as a result of the development of this service.
- The service would meet key requirements of national policy and guidance.

Key Risks

- A legal challenge that the CCG and Local Authority has not met the requirements of the Autism Act to provide easy access to assessment and diagnosis.
- Risk that current level of referrals may not be a true representation of future demand for service – the prevalence data suggests referrals could continue to increase
- Risk that current provider cannot sustain current service which may pre-empt closure of the current service.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	Treating and caring for people in a safe environment and protecting them from avoidable harm

Project Accountability			
Clinical Lead		**Managerial Lead**	Sue Gratton
Key Partners	Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Transformation of ADHD Service	**Mental Health**

Description

Strategic Fit

- Kent Health and Wellbeing Strategy

Evidence Base

- NICE Clinical Guidance for ADHD 2008
- Joint Strategic Needs Assessment

Key Changes

- Implement protocols around prescribing, shared care and transition
- Provide an integrated, all age, service

High Level Benefit Assessment

For patients

- clear pathway
- access to a comprehensive treatment programme
- access to services in primary care

For GPs

- Shared care and prescribing protocol
- Access to specialist service for advice

Key Risks

- GPs unwilling to sign up to an ADHD shared care and prescribing protocol
- Lack of engagement and buy in to the transformation of services from stakeholders particularly at the early stages of the children's pathway

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davies
Key Partners	Kent and Medway Partnership Trust Sussex Partnership NHS Trust East Kent Hospitals University NHS Foundation Trust Medway NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	March 2014	Determine the level of service required	
	June 2014	Service design (including prescribing arrangements)	
	September 2014	Development of shared care and prescribing protocol	
	March 2015	Procurement process and implementation of new service	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Personality Disorders Service	**Mental Health**
Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • NICE guidelines for Borderline Personality Disorder Key Changes • TBA High Level Benefit Assessment • *TBA* Key Risks • No increase in current PD service provision – no decrease in current pressures placed by PD patients on A&E, primary care, acute and secondary mental health services

NHS Outcomes Framework				
1	**2**	**3**	**4**	**5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davies
Key Partners	Kent and Medway Partnership Trust MEGAN CIC Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	February 2014	Contract variation to be agreed with KMPT, contract and service level agreement to be drawn up with MEGAN CIC	
	April 2014	Commencement of service	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Eating Disorders Service	**Mental Health**
Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • NICE guidelines for Borderline Personality Disorder Key Changes • TBA High Level Benefit Assessment • To improve the condition of patients with eating difficulties or disorders, whereby they are able to maintain their physical and psychological health either with no or less specialist assistance • To improve the nutritional health of patients with eating difficulties or disorders • A reduction in subjective distress of patients • To liaise with secondary and tertiary care providers to provide appropriate and timely care for patients identified as needing more intensive treatment or admission Key Risks • Derogation of funds from NHSE to CCGs – no agreement in place between CCGs regarding fair share of funding and resources

NHS Outcomes Framework				
1	**2**	**3**	**4**	**5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davies
Key Partners	Kent and Medway Partnership Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Transformational of Urgent Care for Children and Young People	**Child Health and Maternity**

Description

Strategic Fit

- Kent Health and Wellbeing Strategy

Evidence Base

- DH and DfE, Improving Children and Young People's Health Outcomes – a system wide response (2013)
- RCGP in partnership with RCPCH and RCN, Commissioning a good child health service (2013)
- Standards for children and young people in emergency care settings (2012)
- NHS Institute for Innovation and Improvement, Focus on: Children and Young People Emergency and Urgent Care (2010)

Key Changes

- New urgent and emergency care clinical network for children and young people
- Use of assistive technology
- Working with Public Health and the School Nursing Service to deliver key messages in schools.
- Develop lesson plans for use in schools around PSHE.

High Level Benefit Assessment

- Parents have an increased level of awareness and confidence in being able to support their children with common illnesses which may require urgent or emergency care.
- Children and young people, where it is clinically safe are treated and supported outside of hospital in their local community.
- Reduction in A&E attendances.
- Reduction in 0 LOS non elective emergency admissions

Key Risks

- Destabilisation of services
- Lack of engagement
- Services not streamlined
- Efficiencies and quality not meeting expectations

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Martin Cunnington
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Kent County Council Sussex Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Early Pregnancy Assessment Unit	**Child Health and Maternity**

Description

Strategic Fit

- Kent Health and Wellbeing Strategy
- Kent's Children and Young People's plan 'Every Day Matters'
- Kent Health Inequalities Action Plan "Mind the Gap"

Evidence Base

- NICE Guidelines for Ectopic pregnancy and miscarriage

Key Changes

- Ensure pathways are transparent, equitable and clearly communicated
- Single Point of Access (SPA) led by a clinician who will feed into primary care and OOH services that link to the A&E pathways.
- Improved access to scanning appointments, or explore having a scanner available in primary care

High Level Benefit Assessment

- Ensure the right care is given at the right time, at the right place and by the right professional
- Deliver the best, proactive care to prevent avoidable complications and interventions. Supporting the reduction of adverse outcomes of pregnancy
- Enable and empower women and GPs to use appropriate access routes to the services
- Improve transparency and accuracy of coding to result in more efficient use of resources
- Continued reduction of A&E attendances – improve pathways and reduce activity though this route

Key Risks

- Destabilisation of services
- Lack of engagement
- Projected benefits are not fully realised.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davies
Key Partners	East Kent Hospitals University NHS Foundation Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	September 2014	Research and understand best practice	
	December 2014	Redesign EPAU pathway	
	September 2015	Implement new EPAU pathway	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Multi-agency whole system approach for supporting disabled children and young people with challenging behaviour	**Child Health and Maternity**

Description

Strategic Fit

- Kent Health and Wellbeing Strategy

Evidence Base

- Department of Health's Report into Winterbourne View
- Children and Families Bill
- Kent Sufficiency Strategy (2013)

Key Changes

- A new multi-agency integrated pathway involving professionals working at universal, targeted, specialist and highly specialist levels Integrated assessments and care planning process aligned to the new Education Health and Care plans

High Level Benefit Assessment

- Children and young people are able to remain living at home with their families.
- Children and young people are educated in a Kent school.
- Children and young people are able to maintain or develop friendships and access local community services.
- Families feel safe in their own home.
- Families feel confident in managing their son or daughter's challenging behaviour and are able to participate in everyday activities.

Key Risks

- Delay in recruiting the right staff with the right level of training and experience.
- Unable to agree contract variation to support the implementation of the transformation programme.
- Decision by any partner not to invest in this transformation programme.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Project Accountability			
Clinical Lead	Dr D Grice	**Managerial Lead**	Martin Cunnington
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent County Council Sussex Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	June 2014	Baseline data and scope of the evaluation agreed.	
	September 2014	New outcome measures and KPIs included in a range of contracts and a central data collection system agreed.	
	December 2014	Remodelling and training within CAMHS, social care and education to implement new integrated pathway across universal, targeted and specialist services	
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

Health and Wellbeing in Planning – Ashford's emerging local plan – Agenda Item No.6

The National Planning policy framework makes clear that planning should address sustainable development on three fronts – Economic, Social, and Environmental. More specifically, the NPPF requires that:

"Local planning authorities should work with public health leads and health organisations to understand and take account of the health status and needs of the local population (such as for sports, recreation and places of worship), including expected future changes, and any information about relevant barriers to improving health and well-being". (NPPF: Para 171)

In many ways planning authorities have sought to deliver this outcome as part of achieving 'sustainable development', ensuring that access to local facilities and services is central to the spatial strategy - and where it's not, ensuring that additional or improved facilities can be supplied. If anything, LPAs have often gone further than this, and considered health and well-being in a much wider context, with the theme also being addressed as part of economic or environmental policies. However the new requirement in the NPPF requires LPAs to articulate how health and wellbeing can, and will, be delivered through planning.

Traditionally, Health and Wellbeing is achieved in planning in three ways;

- The overall spatial strategy – encouraging cycling, walking, sustainable spatial allocation of development
- The management of new development – good design, environmental mitigation, on-site facilities, the use of land
- Delivering additional infrastructure or facilitating additional services – contributions to new community facilities, developing the critical mass for better bus services.

It is important for service providers to consider all avenues to help implement health and wellbeing, not simply the investment side.

The overall Spatial Strategy

The adopted core strategy (2008) sought to increase accessibility to key services through increasing public transport, walking and cycling provision, as well as the provision of new facilities where possible (particularly in the strategic development sites). While this will remain the ambition of the council, the reduction in public sector funding – particularly the revenue funding available to key service providers – will require a more considered look at existing capacity rather than rely on the provision of new facilities.

An early piece of work being developed with Kent County Council is to 'map' the provision of key services and facilities, and to identify areas with either existing capacity or where improved provision could be accommodated with the greatest cost effectiveness. This approach is mutually beneficial to the council and service providers, as it should be noted that while the council may be able to safeguard land for facilities, or even secure some funding for capital investment – the revenue implications of operating services will be borne on service providers.

With impending cuts to revenue funding, service providers should see the process of developing the spatial strategy as an opportunity to revitalise existing services rather than solely provide new capacity, such as the potential opportunities to co-locate services (and redevelop existing assets).

The management of new development

Implementing improvements to health and wellbeing can be achieved through development management policies, such as the restrictions on 'bad neighbour uses,' restrictions on takeaways, or the allocation of sites to be reserved for park land. While implementing such policies does not have a 'cost' on the council or service providers as such, they nonetheless require justification. The council will look to all stakeholders to provide assistance, and evidence, for the justification of such policies.

With regards to more specific site policies, the NPPF champions sustainable development and calls on LPAs to seek "secure high quality design and a good standard of amenity for all existing and future occupants of land and buildings". However, the NPPF also introduces a relatively new requirement - to demonstrate 'whole plan' viability:

"Pursuing sustainable development requires careful attention to viability and costs in plan-making and decision-taking. Plans should be deliverable. Therefore, the sites and the scale of development identified in the plan should not be subject to such a scale of obligations and policy burdens that their ability to be developed viably is threatened". (NPPF: Para 173)

In short, the provision of enhanced design, or the requirement for a developer to provide a new facility, must be balanced against economic viability –LPAs are to make 'hard choices' on what it will ask of development. This includes the 'cost' of introducing the Community Infrastructure Levy, which must be set at a rate that is largely affordable to most development. For Larger, more viable sites, the council will still be able to use the Section 106 mechanism to secure on-site infrastructure. It is therefore likely that LPAs will be more able to accommodate the requests of service providers if specific solutions are identified as part of site policies, rather than such projects competing for funding via CIL.

For example, the provision of health care facilities may be best achieved through a developer supplying as part of their proposal a building at ‘peppercorn’ rent. – which would have a nominal cost on the developer. This is not only limited to infrastructure. The council also has the opportunity to encourage developers to use local labour or local suppliers – which would provide good opportunities for apprenticeships (a similar agreement is being progressed as part of the Chilmington Green proposal).

Delivering additional infrastructure or facilitating additional services

Inevitably, some new services and infrastructure will have to be supplied. Initial work undertaken to scope potential CIL revenue in the Borough indicates that CIL alone will not be able to meet the borough’s infrastructure requirements. While the council has not set its CIL expenditure priorities, it is likely that requests for funding from CIL will be more successful if projects lever additional funding from other sources, or indeed demonstrate an ability to actually reduce costs to the public sector over the longer term.

Due to the limitations of CIL revenue, service providers should engage early with the council to develop proposals that are affordable and represent value for money to the public. The council may be able to secure funding from other sources, or identify an opportunity to deliver components through S106. It may also be the case that the council does not have the funding to deliver the preferred option, but could deliver a partial option in the interim. In short, active engagement with the council on the outcomes sought and the planning of facilities is far more likely to arrive at a solution that is of benefit to the local community

Key thoughts

- Local Planning Policies have traditionally sought to deliver the same health and wellbeing objectives as those promoted by service providers and stakeholders. However, coordination between the two has not always been sympathetic, and sometimes too ad hoc. How and when do stakeholders envisage their involvement?

- There is no one-size-fits-all solution. The model of delivery of a particular service in Ashford may differ from those in other parts of the UK, and so may the way in which those needs are met through the planning system. What are the emerging models of delivery?

- Direct financial contributions to service provision from development will be limited – can the local plan assist in a more innovative way? Can the local plan assist with ‘making the case’ for service providers to access funding from

other sources? Is behavioural change the key? How can this be put effectively into policy?

- Some issues will require cross-boundary coordination; some will be local or even development specific. What are the key strategic issues? What issues can be addressed at what level and what stage of the planning process?

Moving forward: Key stages in the local plan preparation - where do stakeholders feel their objectives are best served?

- Defining capacity constraints and opportunities
- Developing the spatial strategy and site allocations
- Drafting of core thematic policies
- Drafting of 'Development Management' and 'Site Allocation' policies
- Infrastructure Delivery Plan
- Monitoring

ASHFORD HEALTH AND WELL-BEING BOARD: REPORT FROM THE VOLUNTARY SECTOR REPRESENTATIVE - Agenda Item No.8

Representation

In December, CASE Kent, the voluntary and community sector infrastructure body which covers the Ashford area, nominated people from the voluntary sector locally to represent the sector on the boards of local statutory bodies.

Tracy Dighton, of Ashford Counselling Service, is the representative on the Ashford Health and Wellbeing Board; Anne Puttick and Shirley Leslie of CRUSE are the representatives on the Health and Social Care Integration Steering Project. There is no representative of the sector on the Ashford Clinical Commissioning Group (CCG). However, Martin Harvey, the lay representative on this group will work with the sector and provide a route for liaison.

CASEKent and Ashford Volunteer Centre have created a steering group to take forward engagement with the statutory sector. The representatives listed above will work as part of this group. The group has met twice.

Determining the needs of the sector

CASEKent has developed a survey, which will be circulated as widely as possible within the sector, to map the organisations who work alongside the statutory sector organisations. It considers the size and scope of the organisations and the services they provide and the impact of their services on beneficiaries.

The responses will be used to generate a report which will highlight key issues for beneficiaries and the local voluntary sector's priorities for working with the statutory sector. The report will consider its findings in light of the four priority themes identified by Ashford CCG: dementia, healthy minds (young people), managing chronic conditions and admission avoidance schemes. It will highlight 3-4 case studies of organisations working with people in some of these groups. It will provide examples to illustrate good relationships between the two sectors and outline cases where commissioning has worked well, including bringing in ideas from elsewhere in the county and the rest of the UK. The aim is to provide clarity on what support the local voluntary sector needs from the statutory sector using the case studies as illustrations of practice that could be applied across the sector.

The group is working to a deadline of mid March for completing the report.

Tracy Dighton, General Manager of Ashford Counselling Service, through the offices of CASE Kent.

Better Care Fund **Agenda Item 10**

Draft Planning Guidance

NHS England Board Paper

David Nicholson

The draft NHSE Board paper on Planning Guidance for the NHS has today been released. It runs to over 80 pages in total. It contains a great deal more detail about the Better Care Fund, principally in Annex I, but also referenced throughout the document. As ever the devil will be in the detail but there is some important new information that is evident from a first reading.

The BCF is given a high degree of prominence throughout the document and is highlighted as one of 5 major components of the CCG's planning for 14/15 and beyond. (Part 2 para 15) along with the Strategic Plan (5 year plan), the Operational Plan (2 year plan), the Financial Plan and the Direct Commissioning Plan. The BCF is recognised as a part of the Strategic Plan but must also "be capable of being extracted as a stand-alone plan" (Annex I Para 24)

Apart from the Strategic Plan it requires the engagement of the greatest number of stakeholders (Pt2 Para 30) in Patient and Carers, Healthwatch, Local Authority, NHS England (Area Team), Public Health England, Monitor and the NTDA and it is the only part of the plan required to be assured by ministers as well as NHS England.

The Strategic Plan will be evaluated against the 6 characteristics of a sustainable system and the Operational Plan against the 5 year vision. The BCF will need to demonstrate how it is driven by the Strategic Plan (Pt 1 para 81).

The need for an agreed and shared risk register detailing what will happen if outcomes are not achieved is reinforced (Pt1 Para 28) and it is stressed that all providers including social care, housing and other related services must be engaged. (Pt1 para 29).

The wider document also includes references to other parts of the planning process that may have a bearing on the BCF and the planning for it.

As part of the wider Call to Action the BCF will have to contribute to the overall reduction in hospital emergency activity of c. 15% with significant progress towards this in 14/15 (Pt 1 para 18).

The cumulative effect of all the required efficiency savings and provision for the BCF is estimated to be 9% for CCGs over the 2 years 14/15 and 15/16 (with greater impact in 15/16). (Pt 2 para 56)

There will be a focus in 14/15 on people aged 75 years and over with practices to be funded at a rate of £5 per head of practice population, to avoid acute admissions. These initiatives should be "complementary" to those of the BCF with the implication that they should not be

funded through it. This payment to practices can also include initiatives to integrate primary care and community services more effectively when this will deliver fewer admissions of over 75's. (Pt1 paras 34-37).

In addition CCGs will be required to increase the "non-recurrent" set aside of their budgets to 2.5% with 1% to be allocated to a "transformation fund" focussing on actions to prepare for the introduction of the BCF in 15/16 (Pt2 para 82) including support for disinvestment in services (Pt1 para 30)

"This transformation fund is intended to be used at a local health economy level by commissioners working together to develop and implement plans for change, focusing in particular on any actions required to prepare for the introduction of the Better Care Fund".

The guidance has much to say about integration of services including:

"Each integrated care model will look different depending on the community served but is likely to include the following features:

• senior clinicians (within a team) taking full responsibility for people with multiple long-term conditions;

• full responsibility lasting from presentation to episodic care, including personalised care planning for those who would benefit; and

• co-ordination of care including lifestyle support and advice, social care, general practice care and hospital episode co-management." (Pt 1 para 39)

For the 5% of patients with multiple and often complex needs the modern model of integrated care will include a senior clinician being responsible for active co-ordination of the full range of support that these people need from lifestyle help to acute care including primary and social care. (Pt 1 para 33).

More specifically about the BCF there is a deal of new detail.

It is reiterated that the BCF plan must reflect the priorities of the Health and Wellbeing Strategy (Pt2 para 10).

The timeline has changed and been clarified.

The Health and Wellbeing Board must agree a first cut of the BCF plan for submission on or before the 14th February 2014 for initial assurance. Final plans subject to any required amendment to be submitted on or before the 4th April (in line with CCG planning cycle). (Pt 2 para 24).

The performance metrics have been confirmed.

The national criteria for the funds are reaffirmed:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends.
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes in the acute sector

(Annex I para 31)

Performance indicators are confirmed as:

• admissions to residential and care homes

• effectiveness of reablement

• delayed transfers of care

• avoidable emergency admissions and

• patient / service user experience. (Annex 1 para 36)

In addition local areas should include a locally agreed measure (Annex I para 41) which needs to be able to be baselined in 14/15. Suggestions from the key Outcomes Frameworks are given (Annex I para 42) and criteria for choosing any others are listed (Annex I para 43).

Guidance on setting the appropriate level of ambition for each indicator is given (Annex I para 45-47) along with criteria for the Health and Wellbeing Board to judge this by (Annex I para 50).

Payment for Performance

The PfP element has also been more clearly defined.

For April 15 £250 mil will be paid against progress in 14/15 against 4 of the national criteria:

- Protection for Adult Social Services

- 7 day services to facilitate hospital discharge and prevent unnecessary admissions
- Agreement on impact on acute providers
- Accountable lead professional for integrated packages of care

A further £250 mil will be paid against 3 of the performance metrics:

- Delayed Transfers of Care
- Avoidable Emergency Admissions
- Patient/User Experience

And the locally agreed indicator (Annex I para 33)

Not all the measures and indicators are included because they may only be collected annually (care home admissions and re-ablement statistics) or they may still be in preparation (Annex I para 39).

The proposal to re-allocate money if targets are not achieved has been revised partially. This sanction will not be used in 15/16 and will be considered further for the future (Annex I para 52).

If 70% of each indicator's outcomes are achieved the "held back" funding will be available to fund the agreed contingency plan. (Annex I para 53)

If less than 70% success is achieved a recovery plan will need to be implemented alongside support from a peer reviews and NHS England. (Annex I para 54).

A thinly veiled warning against target chasing to the detriment of quality of patient care is given (Annex I para 37).

The budgetary arrangements have been clarified more.

Nationally £135 mil will be linked to the "range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill." (Annex I para 10).

The fund will be pooled between CCGs and the upper tier local authority under "s756" which I don't think exists and is probably a misprint for s75 or possibly s256.

It will be routed through NHS England. (Annex I para 11).

The position of Disabled Facilities Grant is clarified further.

The DFG element of the BCF will be paid to upper tier authorities but the responsibilities of the housing authorities will remain. (Annex 1 para 15). In Upper Tier areas the DFG element

will therefore need to be transferred to district councils in a “timely” manner in order for it to be able to be used “in year”. (Annex 1 para 16). Legislation will be needed to ensure that local authorities not party to the pooled budget arrangements (ie districts) can be paid through it. (Annex 1 para 14). The amount of the DFG element will be based on the formula used in 14/15. (Annex 1 para 20).

More no doubt to follow.

Mark Lemon

Strategic Business Advisor

18/12/13

Paper NHSE121304

BOARD PAPER - NHS ENGLAND

Title: Draft planning guidance

Clearance: Paul Baumann, Chief Financial Officer; Dame Barbara Hakin, Deputy Chief Executive and Chief Operating Officer

Purpose of paper:

- This paper presents draft planning guidance for commissioners. The guidance will be entitled 'Everyone Counts', building on the planning guidance we published in 2012.
- The first part of the paper describes our ambition for the NHS over the years ahead, including our determination to focus on outcomes for patients. It describes a series of changes to the way health services are delivered that we consider are required to deliver improved outcomes within the resources that will be available to the NHS.
- The second part of the paper sets out the steps we expect commissioners to take in order to achieve the ambitions identified. It explains that we are asking commissioners to develop 5 year strategic plans (for 2014/15 to 2018/19) and 2 year operating plans (for 2014/15 to 2015/16)
- To note: the table in paragraph 6 of the second section identifies the key elements we expect to be included in strategic and operational plans. This will be augmented to include specific features that we would expect to be addressed in plans that will be used in the assurance of plans in due course.

Actions required by Board Members:

- The Board is asked to approve the planning guidance for publication.

Foreword

NHS England is a new organisation. We were established in 2011 but only took on our full powers in April 2013. Put simply, our role is to invest the £96 billion we receive from the government each year to deliver great outcomes for our patients.

We have been established as an independent organisation, at arms-length from government. Each year the government gives us a mandate[1] setting out its ambitions for the NHS. This details the outcomes that the government wants us to achieve for patients, but gives us the flexibility to determine *how* to deliver the mandate through our own direct commissioning and through Clinical Commissioning Groups. Delivering the mandate is central to our work but we also are determined to go further.

Our vision and purpose flow from the single idea that we exist to ensure ***high quality care for all, now and for future generations***. We want everyone to have greater control over their health and wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving.

Our work is underpinned by the following values:

- We prioritise patients in every decision we take.
- We listen and learn.
- We are evidence-based.
- We are open and transparent.
- We are inclusive.
- We strive for improvement.

Significant advances have already been made as a consequence of last year's planning guidance. Now for the next phase.

This planning guidance sets out how we propose that the NHS budget is invested so as to drive continuous improvement and to make ***high quality care for all, now and for future generations*** into a reality:

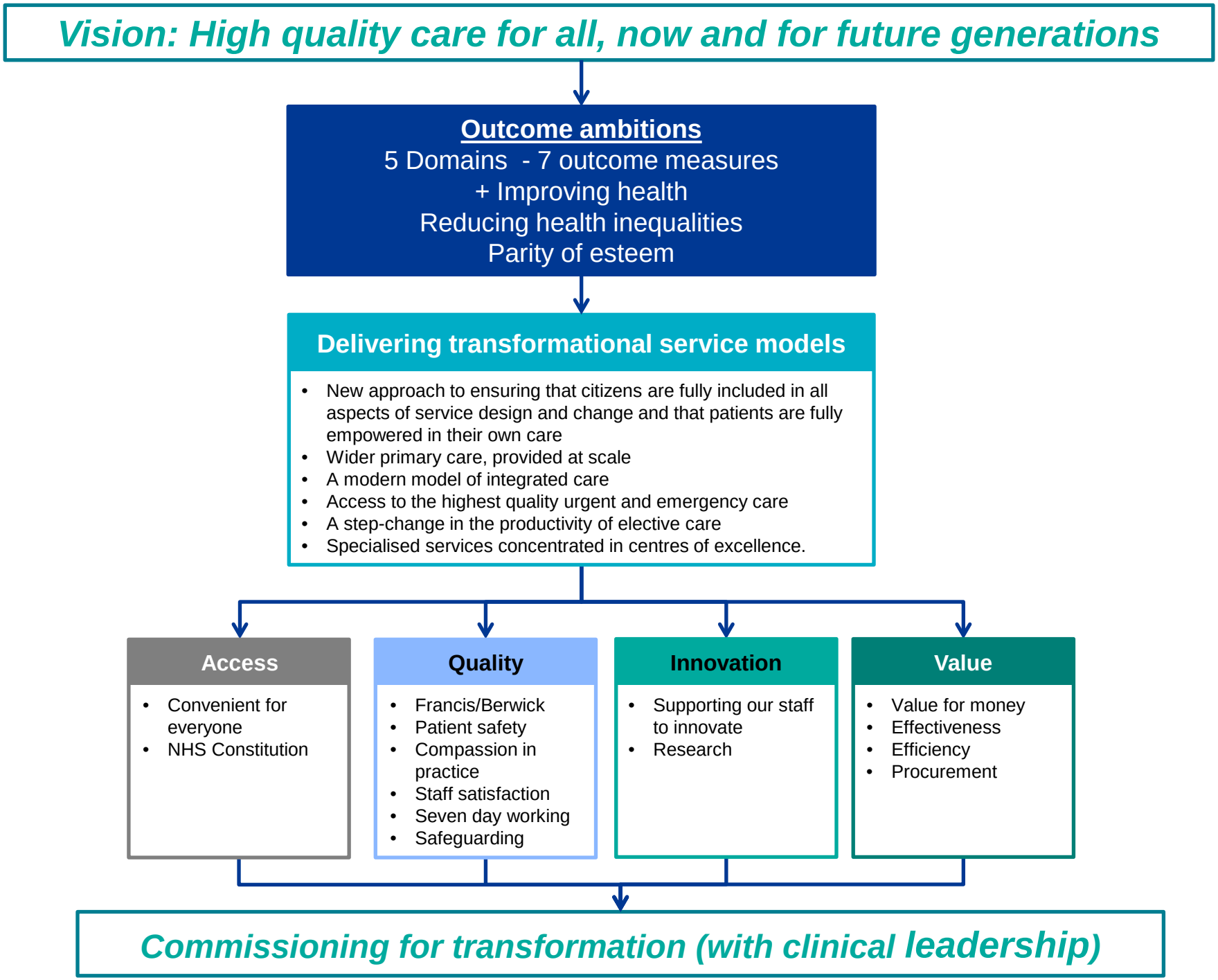
- **High quality care.** We will be driven by quality in all we do. No longer can we accept minimum standards as good enough – our patients rightly expect the best possible service.

[1] https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

- High quality care **for all.** We need to ensure that access to all services is on an equal footing whether the patient's need is for mental or physical help and support. We must put the greatest effort in providing care for the most vulnerable and excluded in society.
- High quality care for all, **now.** But high quality is not just an aspiration. The NHS provides high quality care, often to the highest standards of anywhere in the world, but we need to spread excellence more widely. We have to learn from the best and get better at sharing good practice rapidly across the NHS.
- High quality care for all, now **and for future generations.** We are investing not just for today but for the future. We have a responsibility to ensure that the NHS is on as strong a footing as possible, capable of remaining focused on quality through the significant economic challenges ahead. There is great urgency to plan strategically to start making the changes that are required to deliver models of care that will be sustainable in the longer term.

That is why this planning guidance is bold in asking commissioners to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care for all, now and for future generations.

Sir David Nicholson
Chief Executive


Vision: High quality care for all, now and for future generations
Outcome ambitions
5 Domains - 7 outcome measures
+ Improving health
Reducing health inequalities
Parity of esteem
Delivering transformational service models
New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
Wider primary care, provided at scale
A modern model of integrated care
Access to the highest quality urgent and emergency care
A step-change in the productivity of elective care
Specialised services concentrated in centres of excellence.
Access
Convenient for everyone
NHS Constitution
Quality
Francis/Berwick
Patient safety
Compassion in practice
Staff satisfaction
Seven day working
Safeguarding
Innovation
Supporting our staff to innovate
Research
Value
Value for money
Effectiveness
Efficiency
Procurement
Commissioning for transformation (with clinical leadership)

Part 1: Our ambition

High quality care for all, now and for future generations

1. People consistently tell us that what they want from the NHS and the wider care system is great outcomes. They tell us that they want services to be available when they need them, offered in a way which is convenient for them, that using services should be a good experience and that their needs must be met. They want to be helped to stay well and get the best treatment when they are ill. That is why NHS England wants the delivery of outcomes to be the central focus of our work.

2. Put simply, the outcome of care or a treatment is the impact it has on a patient - on their symptoms and on their ability to live the life they want to live. An outcomes-based approach means focusing less on *what is done* for patients, and more on the *results* of what is done. It means focusing on how well patients feel after treatment and that they stay well, whether suffering from physical or mental ill-health.

3. Our aspiration is to develop an NHS that delivers great outcomes, now and for future generations. That means, reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services and supporting local leaders to go even further to tailor care to their citizens' needs.

4. This document builds on the great work done last year in response to *Everyone Counts: Planning for Patients 2013/14*[1]. Part 1 focuses on the outcomes we want for patients and describes our bold ambitions to deliver them. It describes the emerging findings from our strategy, which lead us to six new models of care which together will deliver the transformational change needed if the NHS is to deliver improving outcomes at a time of increasing need, unprecedented new treatment options and economic restraint. In our role as leaders of the commissioning system we emphasise where our focus will lie – delivering the government's mandate to us and going beyond that to secure even better care. It concludes by reaffirming our commitment to a clinically led commissioning system with CCGs as local leaders. NHS England is also a local commissioner and throughout we recognise our dual role – a local commissioning partner as well as the coordinator and leader of a commissioning system on which better health and better care depends.

5. Part 2 of this document outlines the planning process and details of the plan which needs to be produced. The first chapter provides an overview of the fundamental planning considerations for all plans, outlines the strategic

[1] http://www.england.nhs.uk/wp-content/uploads/2012/12/everyonecounts-planning.pdf

enablers, describes how plans will be submitted and assured and provides an overview of the support available for the process. Subsequent chapters describe in more detail the content of plans and the core financial allocations and assumptions which must underpin them.

6. Last year we made five offers:

   - NHS services, seven days a week
   - More transparency, more choice
   - Listening to patients and increasing their participation
   - Better data, informed commissioning, driving improved outcomes
   - Higher standards, safer care

7. These offers represented what we then saw as the key enablers of change. They were identified early in NHS England's life when we had not begun the work on our emerging strategy. We consider that these early choices have stood the test of time and are still key as the basis for the next stage of development and can now be accommodated in the broader context of our strategic thinking. High standards of quality are still at the heart of everything we do and 7 day services, a key driver of quality, is now moving from aspiration to reality. This year's guidance describes the further progress we want to see on these as well as describing in the next level of detail how transparency and more widely available information empowers citizens and patients and helps them make the best choices for their services and their care.

8. Much of the basis for the government's mandate to us is the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see:

   - We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.
   - We want to make sure that those people with long-term conditions including those with mental illnesses get the **best possible quality of life**.
   - We want to ensure patients are able to **recover quickly** and successfully from episodes of ill-health or following an injury.
   - We want to ensure patients have a **great experience** of all their care.
   - We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

9. Our ambitions will always be focused on delivering the outcomes in these five domains.

10. However, it is vital that we translate these outcomes into specific measurable ambitions which we believe are critical indicators of success and against which we can track our progress. Working with clinicians and staff in NHS England, in CCGs and with key stakeholders we have defined seven specific ambitions:

    - Securing additional years of life for the people of England with treatable mental and physical health conditions.
    - Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
    - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
    - Increasing the proportion of older people living independently at home following discharge from hospital.
    - Increasing the number of people having a positive experience of hospital care.
    - Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
    - Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

11. Additionally, there are three more key measures that are vitally important and on which we expect to see significant focus and rapid improvements.

12. The first is **improving health,** which must have just as much focus as treating illness. At national level we will work closely with Public Health England to create the best environment for all localities. At a local level all stakeholders will address these issues through Health and Wellbeing Boards. We need to ensure that the key elements of Commissioning for Prevention are delivered and that every contact really does count in taking the opportunity to promote a healthy environment and healthy lifestyles. Everyone must make sure they work with all partners so that all those things which affect the broader determinants of health are addressed.

13. And as we strive to improve outcomes, we must place special emphasis on **reducing health inequalities**. We need to ensure that the most vulnerable in our society get better care and better services, often through integration, in order to bring an acceleration in improvement in their health outcomes.

14. We are absolutely committed to moving towards **parity of esteem,** making sure that we are just as focused on improving mental as physical health and

that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get the best care for their physical health problems.

15. This is our ambition for the NHS and the wider care system - not only delivering the key elements in the government's mandate but also going beyond those ambitions in our national thinking and unleashing the power of local systems to deliver the ambitions of their population. This will not be a task for the NHS alone. CCGs, as the local leaders of the NHS supported by Commissioning Support Units, NHS England, and all NHS providers, will need to work closely with all the key partners on the Health and Wellbeing Boards. It will be vital that NHS commissioners work closely with Local Authorities, who have such an important part to play in securing the broader determinants of health as well as delivering high quality social care services, and Healthwatch who can really ensure the patient perspective is paramount.

16. Working together we can make the biggest difference, ensuring great outcomes for everyone delivered through convenient services, under strong financial discipline, with enthusiastic and committed staff, described by the 6Cs[2], truly empowering patients and citizens and making everyone's lives better, both now and for future generations.

Delivering Transformational Change

17. Delivering our long-term ambitions will require a change in the way health services are delivered. People are living longer and our ability to treat and help to manage conditions that were previously life-threatening is improving all the time. With this has come a change in what can be delivered safely, effectively and efficiently in different settings. Patients can be cared for in their own homes, supported by experienced clinicians and technology which enables them to monitor their condition and get expert help to manage it. The result is that patients who would previously have needed hospital treatment can now stay at home.

18. That is why in July 2013, NHS England along with our national partners launched *A Call to Action*[3] which set out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. Put starkly, we need to find ways to raise the quality of care for all in our communities to the best international standards while closing a potential funding gap of around £30 billion by 2020/21. This was a call for creativity, innovation and transformation. It will require a significant shift in activity and resource from the hospital sector to the community. The funding and

[2] http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf
[3] http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

implementation of the Better Care Fund has the potential to improve sustainability and raise quality, including by reducing emergency admissions - hospital emergency activity will have to reduce by around 15 per cent. CCGs will need to make significant progress towards this during 2014/15.

19. The response to this Call to Action has been impressive. Over 250 local events involving clinicians, patients and public have been held to debate the future shape of services. Nationally, we have opened up discussion on the future of those services NHS England commissions with Calls to Action on general practice, community pharmacy and specialised services. And we have brought together patients, public and clinical and managerial experts in a series of events to share the best analysis and thinking on prevention, mental health and parity of esteem, and future landscape for providers, learning from the best in class in the world. In parallel, the development of integration pioneers and the ministerial focuses on vulnerable older people have been strong influences on the Call to Action.

20. There is a good degree of consistency in the themes emerging. The strongest message is that citizens must be at the centre of all our planning; and their interests and aspirations must be the organising principles for the future of health and care.

21. Taking this principle as our starting point, we know that different, identifiable groups within our population have different needs; and that the way services organise themselves to respond has a direct impact on outcomes and best use of resources. For many years, local health systems in this country and overseas have tested and developed new services for some groups covering some services. NHS England believes it is now time to draw out the lessons and propose a direction of service development, based on meeting the needs of whole populations, to be applied consistently across the country.

22. That means identifying the models of care that will apply in five years' time and determining the steps needed to realise that vision. NHS England has identified that any high quality, sustainable health and care system in England will have the following six characteristics in five years:

    - **A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.**
    - **Wider primary care, provided at scale.**
    - **A modern model of integrated care.**
    - **Access to the highest quality urgent and emergency care.**
    - **A step-change in the productivity of elective care.**

- **Specialised services concentrated in centres of excellence.**

Citizen inclusion and empowerment

23. We know that citizens want to be fully engaged in making positive choices about their own health and lifestyles; participating in the shaping and development of health and care services; well served by access to transparent and accessible data and advice about health and services; and able to choose which health services they can use and how to access them. We know that the public want a much greater say in how health services are organised, and we know that patients and their carers want much more say in how their personal care is delivered. We also know that patients and the public want much more and better information about how they can stay well or help to manage their own illness and to have information that is of high quality and readily accessible about different services and different treatments so that they can make informed choices about what will be the best for them. Empowered in this way, citizens and patients become co-providers of and active participants in health care.

i.) Listening to Patients' views

24. We need to make sure that public, patient and carer voices are at the centre of our healthcare services from planning to delivery. We also want commissioners to be informed by insightful methods of listening to those who use and care about services. The extension of the Friends and Family Test to maternity services in October 2013 and, from the end of December 2014, to GP practices will enhance the information that patients can use to make choices, for example such as for their maternity care. The Friends and Family Test provides real time feedback on the quality of services and gives front line staff a powerful incentive to make practical and timely improvements to the services they provide. The Friends and Family Test is being extended to community and mental health services by December 2014, and the rest of NHS services by end March 2015. There are two duties for NHS commissioners to support better patient and public participation. The first requires commissioners to ensure patients and carers are able to participate in planning, managing and making decisions about their care and treatment through the services they commission. The second requires the effective participation of the public in the commissioning process itself, so that services reflect the needs of local people. We have set out our approach to supporting CCGs with these important duties in *Transforming Participation in Health and Care*[4]. The stronger role for user voice within services will also be

[4] http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

strengthened through the roll-out of Personal Health Budgets from April 2014. CCGs will be able to offer Personal Health Budgets, including as a Direct Payment, to all patients who may benefit; and NHS Continuing Healthcare patients will have a right to have a Personal Health Budget from October 2014. In addition, we will expand existing programmes of patient reported outcome measurement to give patients and carers the greatest ability to manage and share data on their own care.

ii.) Delivering Better Care through the Digital Revolution

25. Changes in technology and the way we communicate have made vast differences to everyone's lives. We need to ensure that the NHS harnesses the use of this to deliver better care and to make it more convenient for patients. For example, we expect all people with a long-term condition to have a personalised care plan which is accessible, available electronically and linked to their GP health record, and that conforms to the best-practice standards that we will be developing. That will mean they receive safer care and don't need to repeat their details at every new contact. Greater access to web tools like NHS Choices and the creation of a digital 'front door' will help transform the way patients, their families and carers access information about NHS services and will provide self-management materials and information to further empower them to manage their own condition. Greater use of telehealth and telecare will also be important in supporting people with long-term conditions to manage their own health and care. We are committed to ensuring that nobody is left behind as we give patients and citizens greater control. For this reason, we have launched a major health literacy programme with the Tinder Foundation which will help 100,000 people each year learn how to use the Internet for health benefit and Care Connect, a programme to test how telephone and social media channels can improve public participation.

iii.) Transparency and Sharing Data

26. For too long the NHS has been unable to share the information patients need to understand their condition and make choices about the best treatment for them and where and how they receive it. We are determined to make apparent the different clinical outcome that different treatments, organisations and individual specialists achieve. Consultant level activity and clinical outcomes data for ten surgical specialties have now been published. This gives patients and citizens, as well as their commissioners and clinicians, enhanced access to data and information. We plan to extend this so that data from all appropriate NHS funded national clinical audits is made available before 2020. This will continue to provide vital insight for both patients and

healthcare professionals about the care that is provided and lead to improvements in quality.

27. We also know that effectively collecting, sharing and interpreting data is fundamental to the transformation we need to deliver. The steps we have already taken include the promotion of a single set of data and data transmission standards to facilitate a nationwide exchange of health information. Called ***care.data*** this will safely and securely join up existing clinical data sets, held securely within the Health and Social Care Information Centre, and extend and expand them so that they provide the data that commissioners need to support the delivery of high quality care and improved outcomes. Offering the opportunity for patients to access their own health information also forms part of this ground breaking work. These opportunities need to be factored into commissioner plans. By the summer of 2014 we anticipate that data in at least 5 per cent of GP practices will be linked to hospital data. By the end of March 2015 this will have increased to 90 per cent. We expect strategic plans to set out when 100 per cent coverage will be completed.

28. *Everyone Counts: Planning for Patients 2013/14* set out the expectation of universal adoption of the NHS number as the primary identifier by all providers. However, a significant number of providers are still not compliant. Such behaviour can have a detrimental impact on patient outcomes as it hinders the effective flow of information between primary and secondary care. Working with EHI Intelligence we have developed the Clinical Digital Maturity Index (CDMI) which will allow us to identify the scale of digitisation in each provider, including use of the NHS number. As a first step, we shall work with CCGs to secure immediate improvement from those providers who are in the bottom quartile of digitisation. Following that, our intention is to consider the possibility of introducing a range of increasingly stringent sanctions on providers, from contractual fines through to the withdrawal of contracts.

29. The 2014/15 GMS contract will help empower patients by enabling practices to register patients from outside traditional catchment areas, thereby creating greater patient choice. It introduces a new requirement for practices to promote and offer all patients the ability to book appointments online, order repeat prescriptions online and access their medical notes online. NHS England will develop metrics to identify the number of practices with access to online services.

30. The 2014/15 GMS contract introduces a new requirement for GP practices to upload information about medicines, allergies and adverse reactions onto the Summary Care Record. Commissioners should encourage out-of-hours, NHS111 and A&E providers to access this information to improve quality and

outcomes. The contract also requires that practices use the NHS number as the primary identifier for all clinical correspondence from April 2014 and use electronic systems to transfer patient records between practices.

Wider primary care, provided at scale

31. For those patients with a moderate mental or physical long-term condition (about 20 per cent of the population): access to all the support and care they need from wider primary care, provided at scale. This will mean access to a broader range of services in primary care, in their own homes and in their communities, centred on a much more pivotal and expanded role for general practice to co-ordinate and deliver comprehensive care in collaboration with community services and expert clinicians.

i.)Transforming primary care services

32. Our strategic framework for commissioning of general practice services, to be published in 2014, will set out the action we are taking at national level to support commissioners in developing joint strategies for primary care as part of their five year strategic plans. One of our key aims is to enable general practice, community pharmacy and other primary care services to play a much stronger role, at the heart of a more integrated system of community-based services, in improving health outcomes. It is clear from the Call to Action that there is a widespread appetite for developing new models of primary care that provide more proactive, holistic and responsive services for local communities, particularly for frail older people and those with complex health needs; play a stronger role care in preventing ill-health; involve patients and carers more fully in managing their health; and ensure consistently high quality of care. NHS England and CCGs have a joint responsibility to drive up all aspects of quality in primary care services.

33. There is a growing consensus that this will mean enabling general practice to work at greater scale and in closer collaboration with other health and care organisations, whilst retaining personal continuity of care and strong links with local communities. NHS England will create the strategic framework for this approach and work with CCGs to stimulate new models of care and in developing innovative forms of commissioning and contracting to support these new models.

A modern model of integrated care

For the 5 per cent of patients with multiple, often complex, mental or physical long-term conditions, often compounded by being elderly and perhaps frail,

we need **a modern model of integrated care** with a senior clinician taking responsibility (through a personal relationship) for active co-ordination of the full range of support from lifestyle help to acute care.

i.) Ensuring tailored care for vulnerable and older people

34. The government has determined that there will be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. Our expectation is that similar arrangements will apply to increasing numbers of people with long-term conditions in future years.

35. CCGs will be expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice. Practice plans should be complementary to initiatives through the Better Care Fund.

36. In some instances, practices may propose that this new funding be used to commission new general practice services that go beyond what is required in the GP contract and the new enhanced service. We will make arrangements for NHS England to be involved under these circumstances in order to help identify the contractual arrangements and help provide appropriate oversight and governance. In other instances, practices may propose that this money be invested in other community services to secure integration with primary care provision. Practices should have the confidence that, where these initial investment plans successfully reduce emergency admissions, it will be possible to maintain and potentially increase this investment on a recurrent basis.

37. In addition, CCGs will need to demonstrate how individual practices can have as much influence as they need over the commissioning of associated community services, community nursing especially district nursing and end of life care, so that their accountable GPs can discharge their responsibilities and so as to ensure that these services are co-ordinated with the services provided by the practice itself and provide integrated care for patients.

38. The 2014/15 General Medical Services (GMS) contract will support more proactive, integrated and personalised care, through:

- ensuring that all people aged 75 and over have a named, accountable GP who is responsible for overseeing their care;
- introducing more systematic arrangements for risk profiling and proactive care management, under the supervision of a named GP, for patients with the most complex health and care needs; and
- giving GP practices more specific responsibilities for helping monitor the quality of out-of-hours services for their patients and supporting more integrated working with out-of-hours services.

ii.) Care integrated around the patient

39. Delivering care in a way which is integrated around the individual patient is essential to a new way of working which truly puts the patient at the heart of what we do. Our early focus will be the integration of care around the most frail, often elderly patients but it will be important for all those who receive complex care. This may mean integration across health and social care and across different elements of NHS care. It may mean integrating specific services or integrated provider organisations. It may mean integrated commissioning between CCGs and NHS England and Local Authorities. But what matters is that patients experience holistic care which is joined up and is a single tailored package for them. Each integrated care model will look different depending on the community served but is likely to include the following features:
    - senior clinicians (within a team) taking full responsibility for people with multiple long-term conditions;
    - full responsibility lasting from presentation to episodic care, including personalised care planning for those who would benefit; and
    - co-ordination of care including lifestyle support and advice, social care, general practice care and hospital episode co-management.

40. With CCGs assuming responsibility for Special Educational Needs commissioning from September 2014, they will need to work closely with local authorities and schools to meet the wider pledge for better health outcomes for children and young people.

41. We have also begun to shift our focus from treating the consequences of poor care to the causes of preventing poor care. The £3.8 billion Better Care Fund that comes into operation in 2015/16 is aimed at supporting the integration of health and social care. The fund is an opportunity for local services to transform and improve the lives of the people that need it most. The fund will be available in 2015 but the planning has already started across the country. We expect commissioners to include in their plans their vision for how health and social care services work together to provide better support at home and

earlier treatment in the community to prevent people needing emergency care in hospital or care homes. All CCGs must include in their plans the actions they will take in 2014/15 to mitigate against the impact of the Better Care Fund in 2015/16 in order to fulfil their duty to commission sustainable services for patients.

Access to the highest quality urgent and emergency care

42. For all citizens, access to the highest quality urgent and emergency care. The report on the first phase *Urgent and Emergency Care review* [5] sets out an exciting vision for how we deliver NHS services in a way that complements modern day lifestyles and preferences. It suggests that the quality of urgent and emergency care would be enhanced if as many patients were treated as close to home as possible and if networks were established, with major specialised services offered in between 40 and 70 major emergency centres, supported by emergency centres and urgent care facilities.

43. The review will take some time to implement. Meanwhile, there are immediate issues around planning for seasonal variation, emergency situations and times of varying demand.

44. NHS 111 services will be a key component of the urgent care service. NHS 111 services will be rolled out to cover the whole of England. In addition, NHS England and CCGs will produce a new service specification for 111 to support the future commissioning of a comprehensive and high quality service.

45. We expect to see local resilience planning, led through the Urgent Care Working Groups (UCWGs), to be a continuous process with preparations simply continuing on from this winter to lead us into next winter. UCWGs should refresh their membership and ensure that all relevant stakeholders are involved at an appropriately senior level when the full group convenes. We recognise that a smaller core group will be needed to support day to day activities. It is essential that GP practices and out-of-hours providers, as well as all those who deliver other community and mental health services are fully involved. UCWGs must also engage effectively with local independent and voluntary sector providers, and we are developing a framework to support UCWGs in doing this. UCWGs should agree an appropriate mechanism for providers such as ambulance trusts, who will relate to many UCWGs to engage with them all effectively, e.g. through lead commissioning arrangements. It is similarly equally important that all local CCGs whose

[5] http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

patients use the acute trust at the centre of urgent care plans have a mechanism for full engagement through the lead CCG.

46. We expect UCWGs will build on their plans for 2013/14 in the spring and will have a fully refreshed set of plans before summer 2014. NHS England working NHS TDA, Monitor and partners in local government, will assess the effectiveness of each UCWG and, for those where there are concerns, will oversee the necessary changes required to ensure that these groups are well led, and can play a comprehensive and effective role in the management of urgent care, especially during the winter, in 2014/15. In particular, we expect UCWGs to be the vehicle for reaching agreement on the investment plans to be funded by the retained 70 per cent from the application of the marginal rate rule. Prior to any contracts being in place there must be absolute transparency about the use of this money to reduce pressures on A&E departments over the winter and that the acute trust must be satisfied that the plans for the use of that money addresses their needs.

A step-change in the productivity of elective care

47. For people who need episodic, elective care, access to services must be designed and managed from start to finish to remove error maximise quality, and achieve major step-change in the productivity of elective care. We expect to see centres that can deliver high quality treatment, treating adequate numbers, to be expert with the availability of modern equipment. If we are going to transform out of hospital care and look to concentrate specialised services in fewer sites then we need to review how we deliver routine planned admissions for patients for less complex treatments. International comparisons suggest that, as well as quality improvements there are significant productivity gains to be made if we can change our model of delivering elective care – giving us the opportunity to treat even more patients.

Specialised services concentrated in centres of excellence

48. For those who need them, specialised services for less common disorders need to be concentrated in centres of excellence where we know that the highest quality can be delivered. Maximising quality, effectiveness and efficiency means working at volume and connecting actively to research and teaching. Specialised services are currently being delivered out of too many sites, with too much variety in quality and at too high a cost in some places. Through NHS England's direct commissioning we shall be looking to reduce significantly the number of centres providing NHS specialised services, require standards of care to be applied consistently across England and maximise synergy from research and learning. Our strategy for specialised

services is still in the early stages of development but we can foresee a concentration of expertise in some 15 to 30 centres for most aspects of specialised care. Academic Health Science Centres will play an important role as the focus for many of these.

49. These characteristics of a high-performing health system will not need to be delivered in the same way everywhere. Local communities need to come together to determine the best way to deliver services for patients. For example, integrated care models for the 5 per cent of our population with greatest need could be developed out of existing NHS Trusts or NHS Foundation Trusts, out of extended primary care built on general practice, or through new offers. The outcome is what matters rather than the process or organisational form. NHS England wants local partners to determine the delivery vehicle which best suits local geographies and capabilities.

Maintaining the focus on essentials

50. There are a number of essential elements that will apply to all of the characteristics of every successful and sustainable health economy:

    - quality;
    - access;
    - innovation; and
    - value for money.

51. We expect to see how a specific focus will be maintained on each of these in local plans in a way which clearly demonstrates how they will be implemented to drive up outcomes for patients and local communities.

Quality

52. In everything we do, quality as effectiveness, experience and safety must be the central theme. All NHS commissioners must put quality at the centre of all their discussions with providers. The lessons from the Francis Report, Winterbourne View and the Berwick Report are that quality is as much about our behaviours and attitudes to patients as human beings as it is about the transactions we need to make to ensure services improve. There are three non-negotiable items that we expect to be part of every relationship between a commissioner and provider:

- The *Francis Report*[6] into the systemic failings at the Mid Staffordshire NHS Foundation Trust provides us all with important learning to ensure we expect and deliver the best possible care for our patients. NHS England supports the government's response set out in *Hard Truths*[7]. The National Quality Board's *How to ensure the right people, with the right skills, are in the right place at the right time*[8] sets out an approach to improving nursing, midwifery and care staffing for the benefit of patients. Getting the right staff with the right skills to care for our patients all the time is not something that can be mandated or secured nationally. Providers and commissioners, working together in partnership, listening to their staff and patients, are responsible for making these expectations a reality.

- *Transforming Care: A national response to Winterbourne View Hospital*[9] set out the basis on which CCGs, Local Authorities and our specialised commissioning should work together to implement the core specification. This describes the core principles that must be present in all education, health and social care services for children, young people, adults and older people with learning disabilities and/or autism who either display, or are at risk of displaying, behaviour that challenges.

- Further to the government's response to the *Berwick review into patient safety*[10] CCGs are expected to take an active part in their local patient safety improvement collaborative and address how their commissioning can support local improvement. Commissioners should ensure they have systems in place to satisfy themselves that the providers they commission services from are effectively reporting and learning from safety incidents and implementing patient safety alert actions in a timely manner.

53. To ensure local autonomy and flexibility in how NHS organisations plan and deliver service re-designs, plans need to demonstrate robust evidence against four tests, which are that there should be:
    - support from clinical commissioners;
    - clarity on the clinical evidence base;
    - robust patient and public engagement; and
    - support for patient choice.

[6] http://www.midstaffspublicinquiry.com
[7] https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response
[8] http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
[10] https://www.gov.uk/government/publications/berwick-review-into-patient-safety

54. A number of vital aspects of quality need to be considered:

i.) Patient safety

55. Knowing that they will be safe in our care is of paramount importance to patients. We are introducing a number of approaches to improve patient safety and reduce avoidable harm:
    - Regional and Area Team Quality Surveillance Groups to provide a wealth of evidence and intelligence to support early intervention when issues develop;
    - a new Patient Safety Alerting System to identify safety issues early;
    - continued zero tolerance of MRSA bloodstream infections with continued focus on reducing *Clostridium difficile* infections;
    - we will set up and support the Patient Safety and Collaborative Programme to create a comprehensive, effective and sustainable collaborative improvement system that underpins a culture of continual learning and patient safety improvement; and
    - we will create new Safety Thermometers for mental health care, medicines and maternity.

56. From January 2014 the Care Quality Commission (CQC) will provide definitive quality ratings on all providers of NHS services. Commissioners are expected to take prompt action with al providers that are judged by the CQC as "require improvement" or "inadequate". The CQC has committed to sharing information with commissioners through its Intelligent Monitoring and we expect commissioners to inform the CQC if they believe a provider might have quality or risk issues. Where feasible, NHS England will use the quality standards used by the CQC in its quality judgements.

57. We also need commissioners to be more proactive in responding to complaints and concerns expressed by patients, the public and NHS staff whether expressed through whistleblowing or other means. CCGs should have a strong and collaborative working relationship with its local HealthWatch so that issues of concern can be dealt with early.

ii.) Compassion in Practice

58. *Compassion in Practice*[11], the national nursing, midwifery and care giving vision and strategy, provides a challenge for commissioners to support providers through the adoption of the 6Cs: care, compassion, competence,

[11] http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

communication, courage and commitment. The 6Cs now have wide acceptance and reach throughout the nursing, midwifery and care staff workforce in the NHS across England in order to address six areas of action.

- help people to stay independent, maximising well-being and improving health outcomes;
- work with people to provide a positive experience of care;
- deliver high quality care and measure impact;
- build and strengthen leadership;
- ensure the right staff, with the right skills in the right place; and
- support a positive staff experience.

59. Each area of action has an implementation plan with national, local and individual actions. This is a nursing, midwifery and care staff strategy which is being delivered by the NHS healthcare system with national bodies and regulators leading on a range of initiatives. CCGs are asked to ensure that the local areas of action within the Compassion in Practice implementation plans are reflected in the services they commission.

iii.) Staff satisfaction

60. Staff satisfaction is an important indicator of quality. There is good evidence that happy, well-motivated staff deliver better care and their patients have better outcomes. NHS staff work very hard often under great pressure and we must ensure that we work with all providers of NHS services to make it possible for them to do the best job they can. We must ensure that clinical leadership in front line teams flourishes and drives innovation and better care. The results of the staff survey and, as it comes on stream, the staff Friends and Family Test should be used when considering the quality of services being provided.

iv.) Seven Day Working

61. The NHS Services, Seven Days a Week Forum, chaired by the National Medical Director, has reported to NHS England on how NHS services can be improved to provide a more responsive and patient centred service across the seven day week. The Forum was asked to focus, as a first stage, on urgent and emergency care services and their supporting diagnostic services. The Forum's review points to significant variation in outcomes for patients admitted to hospital at the weekend across the NHS. This variation is seen in mortality rates, patient experience, length of stay and re-admission rates.

62. There is no 'one size fits all' answer to introducing seven day urgent and emergency care services. Local solutions will need to be found. We shall

work with HEE on the workforce implications of transforming services. The Forum has developed a set of operational standards describing the standard of urgent and emergency care that all patients should expect to receive seven days a week. The standards have been developed through extensive engagement with stakeholders, and include a comprehensive supporting evidence base. Local contracts for 2014/15 should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section and a local CQUIN should be considered, based on the clinical standard for time from arrival to initial consultant assessment.

63. Consideration is being given to how data and information on the extent to which the clinical standards are being delivered, and the provision of seven day services, can be published in an accessible format that lends itself to comparisons.

v.) Safeguarding

64. The safeguarding of all those who are vulnerable is an enormous obligation for all of us who work in the NHS and partner agencies. There is still much to do to ensure this happens. In March 2013, NHS England published the *Safeguarding Vulnerable People in the Reformed NHS, Accountability and Assurance Framework*[12]. The Framework provides a clear set of principles and guidance to ensure the new system delivers improved outcomes for children and vulnerable adults. A strategic national steering group has been established to ensure the framework is embedded and provides a national forum to enable safeguarding leaders in NHS England to implement cross governmental policy. A number of key priorities are emerging which include, policies to prevent child sexual exploitation, female genital mutilation, sexual violence, domestic abuse and implementation of national legislation and policies relating to vulnerable children and adults.

65. Demonstrating how safeguarding duties will be discharged needs to be reflected in all local plans and NHS England will seek continuous assurance on this important issue.

Access to services - Convenient for Everyone

66. Good access to services is absolutely central to delivering better outcomes. Difficulty with access denies patients the services they need. Services should be available quickly and at a time and location which is convenient. Disadvantaged and minority groups need specifically tailored services which suit their circumstances or they will simply not be accessible to them. There

[12] http://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf

are many minority groups who will struggle to get the care they need if they are expected simply to fit in with what works for the majority.

67. Our patients have consistently told us how important it is that they don't have to wait for treatment. They tell us that waiting can be the most distressing part of their illness. And we know that waiting can make clinical outcomes worse and can even make services unsafe. We also know that our services can only improve outcomes for patients if they are available to them, and they receive those services quickly, when they need them, and in a way which is convenient for them and fits with their daily lives.

68. The NHS Constitution identifies a range of standards to which patients are entitled and which NHS England has committed to deliver. Every local plan will need to identify both how they will make services generally accessible but also how they will specifically deliver the standards in the constitution.

69. During 2014/15, we will also oversee pilots designed to extend access to general practice services and stimulate innovative ways of providing primary care services, supported by the Prime Minister's £50 million challenge fund. There will be at least nine pilots covering around half a million patients and testing new ways of providing evening and weekend access, making greater use of email and phone consultations, joining up urgent care and out-of-hours care, and providing a range of other flexibilities in how citizens access services.

Driving Change through Innovation

i.) Supporting our staff to innovate

70. NHS England is committed to innovation to deliver significant improvements in quality and efficiency in the NHS. In 2013/14 we introduced a Regional Innovation Fund to support and promote the adoption of innovation and the spread of best practice across the NHS. We will be looking to facilitate fresh perspectives or partnerships, bringing in different types of expertise or capacity to support the adoption of current innovations or the development of new ideas.

ii.) Research

71. Research and evaluation across the whole patient pathway including with partners in local government and Public Health England will contribute to improving outcomes and spreading innovation and economic growth. A marker of quality within NHS organisations is those with research activity able

to demonstrate evidence of improved patient outcomes and health service delivery. Commissioners should actively seek out research opportunities, understand where research is taking place within the providers with whom they contract and support that activity wherever possible through their commissioning decisions.

Value for money, effectiveness and efficiency

72. All of this, of course must be delivered against the backdrop of ensuring that patients and citizens get the very best out of every pound that is spent and that all parts of the system play their part in delivering better care within their allocated resource.

73. We have already set out that there is a potential funding gap of around £30 billion by 2020/21. Plans need to be explicit on how they will close this gap in a local context without any diminution in the quality of services provided to patients. NHS England does not underestimate the scale of this task and will do all in our power to support local health communities to take the decisions they need to transform services. We shall review our funding mechanisms so that they are truly supportive of improving outcomes.

74. In helping to deliver value for money for the taxpayer, commissioners and providers should support the implementation of *Better Procurement, Better Value, Better Care*[13]. This is a procurement development programme which includes an ambitious package of measures to help the NHS save £1.5 billion to £2 billion through improved procurement whilst supporting economic growth by improving access of opportunity for small and medium enterprises and ensuring the NHS is transparent in all its commercial relationships and procurement information.

75. It is absolutely critical that value for money drives commissioning so that our patients can be assured that the best possible quality of care is secured for every pound spent on their behalf.

Leading the Way through Commissioning

76. Last year's guidance identified stronger commissioning as a key theme for driving change. This section has set out those things which local

13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226835/procurement_development_programme_for_NHS.pdf

commissioners need to include in their plans which will deliver the change they want to see. CCGs and NHS England, supported by CSUs, must work as a coordinated whole and with other non-NHS commissioners of care.

77. Our commitment to clinical commissioning remains as strong, ensuring that commissioning decisions are firmly based on clinicians' close relationships with their patients and their understanding of clinical processes.

78. In this first section of the document we have:
    - reiterated the five domains of the outcomes we want to deliver for our patients;
    - translated those into a set of practical measurable ambitions which describe the progress we want to see in delivering the outcomes;
    - identified a further three measures which are vital that we deliver;
    - signalled six patterns of service, emerging from our early Call to Action work, which we believe will be necessary to deliver the transformation we need; and
    - identified four essential elements for the delivery of services.

79. It is now for local communities and all those who commission or deliver care to them to create the robust plans which will be their roadmap to better outcomes for their citizens. CCGs as the local leaders of health commissioning will take the lead in working with all key stakeholders, especially Local Authorities to develop those plans. NHS England will be alongside them in this planning as co-commissioners and in providing support and oversight. Health and Wellbeing Boards will be a key forum for agreeing plans with all stakeholders and accounting to the local community that these plans meet their needs and are delivered. In some instances, CCGs will work together to create a bigger footprint as their unit of planning. In all instances CCGs will need to work with their neighbours to ensure that each plan demonstrates how services delivered across a broader geography, such as ambulance services or specialised services are commissioned and delivered consistently and cohesively. They will need to demonstrate how they deliver all the aspects of the government's mandate to the commissioning system. They will need to take account of NHS England's ambitions and steers on strategic approach. They will need to include their own ambitions for the things their citizens tell them will meet their needs. This approach will allow us to articulate and quantify what we are aiming to achieve for the patients and communities we serve, locally and nationally. The scale of our ambitions will be determined by how bold we, and the communities we serve, are prepared to be and by how well we collaborate with partner organisations,

particularly local government and the voluntary and community sector. Outcomes based commissioning is now fundamental to our approach and will maximise health gain for the citizens of England and value for money for the tax payers.

80. Plans must be owned locally and driven by local needs. Unlike previous years this document is not prescriptive in how CCGs achieve this ambition nor does it attempt to apportion to individual CCGs specific targets across a host of areas where our collective action will need to deliver and exceed the government's mandate. It makes the assumption that individual patches will want to go even further in delivering the best for their citizens. NHS England does, however, have a key role in assuring that all plans are sufficiently robust, that they will collectively deliver our commitments and that all citizens across England are supported by equally high quality services. We also need to make sure the commissioning system is effective and efficient and that local flexibility does not translate into inefficiency or duplicated effort.

81. Part 2 of this guidance sets out in greater detail our expectations of these plans, but most importantly it creates the framework for planning which will help everyone to deliver. We expect each local system to follow to use this framework and the associated tools to make the right changes happen. These five year strategic plans are the starting point for the whole planning process. Operational plans will be judged for their consistency with movement towards the five year visions. Each strategic plan needs to be tested against the six characteristics of a sustainable health and care system ensuring that it reflects the needs of local citizens, the conclusions of local Call to Action conversations and informed by modelling tools such as Any town. The two year operational plans and the local approach to the Better Care Fund will need to demonstrate how they are driven by the strategic plan. Further detail on our approach is set out in Part 2 of this guidance.

82. Part 2 also identifies the range of support which is on offer.

83. We shall use these characteristics to support and test the development of the five year strategic plans for local systems and nationally commissioned services.

84. Nationally, NHS England will organise and prioritise our work to support a move in this strategic direction. There are an important set of changes in day to day practice which will support these patterns of care as well as a set of enablers we need to resolve nationally to give local systems the freedom to innovate. As the Call to Action work draws to a conclusion in the spring/early summer 2014, we shall be working with national health and local government partners to identify the further financial, regulatory, leadership and workforce

development enablers which will accelerate the move towards high quality, sustainable health and care systems across the country. We expect the strategic vision work locally to be open and inclusive, involving patients, citizens and providers as well as commissioning partners on Health and Wellbeing Boards. We will harness the very best of what new technologies and new ways of working now offer to the changing needs of local populations and groups, relentlessly focusing on improving outcomes. This will be brought together into a compelling description of the local care delivery system that local health and social care communities want to build, and a clear and credible local plan to get there.

Part 2: How we are going to achieve these ambitions

1. This part 2 of the guidance is structured to provide an overview of the planning process and details of the plans which need to be produced. It comprises four sections:
   - The Strategic and Operational Planning process – provides an overview of the fundamental planning considerations for all plans, outlines the strategic enablers, describes how plans will be submitted and assured and provides an overview of the support available for the process.
   - Strategic, Operational and Financial Planning – provides a high level overview of the structure and requirements of the 3 plans and sets out the financial allocations and core financial planning assumptions for planning.
   - Direct Commissioning – provides an overview of planning for direct commissioning and the associated financial planning assumptions.
   - Better Care Fund – provides an overview of Better Care Fund planning and the funding for integrated care.

The Strategic and Operational Planning Process

A new approach to planning

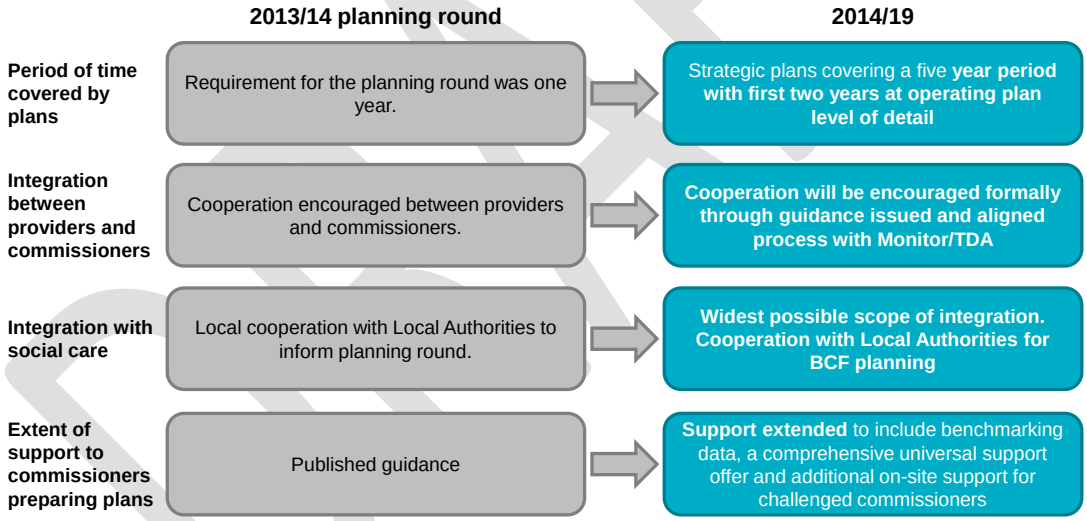
2. NHS planning has in the past been successful in supporting the delivery of annual incremental improvement. However, the NHS is facing an unprecedented challenge. We are committed to transforming outcomes for patients and to playing our role in minimising inequalities within and between communities. *A Call to Action* forecasts a financial gap of around £30 billion by 2020/21 and the affordability challenges in 2014/15 and 2015/16 are real and urgent.

3. Therefore, we now need to take a longer term view of the planning of services to reflect the step changes required to tackle these unprecedented challenges. The planning process has changed to address this:
   - Stretching local ambitions for outcomes should be developed against each of the outcomes ambitions set out in Part 1 paragraph 9 of this guidance, along with credible and costed plans to deliver them.
   - Through this guidance we are setting out a challenge for commissioners to plan for the transformation of services on a five year basis. Each commissioner's five year plan must drive its decisions to ensure its providers are best placed to deliver high quality and sustainable services for patients, and in particular we would expect to see alignment with the six service models outlined in Part 1.
   - Each five year plan should include the first two years of operational delivery in detail so that patients, their carers and other key stakeholders

can be satisfied that progress is being made against the longer term goals and the service transformation needed to realise them.

- As set out in Part 1 paragraph 17, plans must be explicit in dealing with the financial gap and contain appropriate risk and mitigation strategies.
- The planning process and timeline have been aligned with our national partners, including NHS commissioners, Monitor, the NHS Trust Development Agency, the Local Government Association and Health Education England.
- In addition to completing a complete set of plans for their own organisation, CCGs have been asked to choose their own footprint for strategic health and social care planning. This may involve working as part of a larger 'Unit of Planning' to enable wider issues which affect more than one commissioner to be dealt with at scale.
- a stratified support programme has been put in place to support the new planning process.

How has planning changed from previous years?



4. Both short-term transactional change and long-term transformation need to be guided by an explicit model of change and to be supported by a strong research and evidence base. The NHS Change Model[1] has been created to support the NHS to adopt a shared approach to leading change and transformation. Developed with hundreds of our senior leaders, clinicians, commissioners, providers and improvement activists and supported by a robust evidence base, the NHS Change Model brings together collective improvement knowledge and experience from across the NHS. Application of the eight components of change brings together improvement in a systematic

[1] http://www.changemodel.nhs.uk

and sustainable way, and we would expect to see this approach reflected in local strategic and operational plans.

Planning fundamentals

5. Strategic and operational plans must be explicit in dealing with local ambitions for outcomes within funding available. They should also be developed based on some fundamental planning principles. Plans should be:
   - bold and ambitious;
   - developed in partnership with providers and local authorities; and
   - locally led.

6. Each strategic and operational plan must explicitly set out in detail the approach to delivering the following fundamentals, the five year ambition and the plans for the first two years to move towards the long-term ambition.

		Fundamental	Key features to address in plans
1	Outcomes	Delivery across the five domains and seven outcome measures	TBC
2		Improving health	TBC
3		Reducing health inequalities	TBC
4		Parity of esteem	TBC
5	Patient services	New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	TBC
6		Wider primary care, provided at scale	TBC
7		A modern model of integrated care	TBC
8		Access to the highest quality urgent and emergency care	TBC
9		A step-change in the productivity of elective care	TBC
10		Specialised services concentrated in centres of excellence.	TBC
11	Access	Convenient access for everyone	TBC
12		Meeting the NHS Constitutional standards	TBC
13	Quality	Safety, effectiveness and patient experience	TBC
14		Response to Francis and Berwick	TBC
15		Patient safety	TBC
16		Compassion in practice	TBC

		Fundamental	Key features to address in plans
17		Staff satisfaction	TBC
18		Seven day working	TBC
19		Safeguarding	TBC
20	Constitutional commitments		TBC
21	Innovation and research		TBC
22	Delivering value	Financial resilience; delivering value for money for taxpayers and patients and procurement	TBC

Improving outcomes

7. *Part 1 paragraph 10 of* this guidance sets out our seven ambitions which the NHS is striving to achieve for the people of England.

8. The seven outcomes ambitions are set out in Annex A of this document, together with the measures that CCGs should use in planning. NHS England Area Teams should use the same measures, where relevant to their commissioning responsibilities, with further measures also included in Annexes D-G of this guidance.

Joint working and involvement

9. NHS England is working closely with Monitor and the NHS Trust Development Authority to ensure plans are sustainable and deliverable across commissioning and provision in local health economies. For plans to be deliverable, we are committed to ensuring that one organisation's plan does not put another's at risk or generate behaviours that work against patients' interests.

10. Plans need to reflect local priorities, as determined by each Health and Wellbeing Strategy, with the assumption that local discussions will resolve any differences. We expect commissioners and providers to cooperate in planning, and to be able to explain any differences in their plans. The assurance processes described later in this section will have a particular focus on localities where there are significant differences in plans.

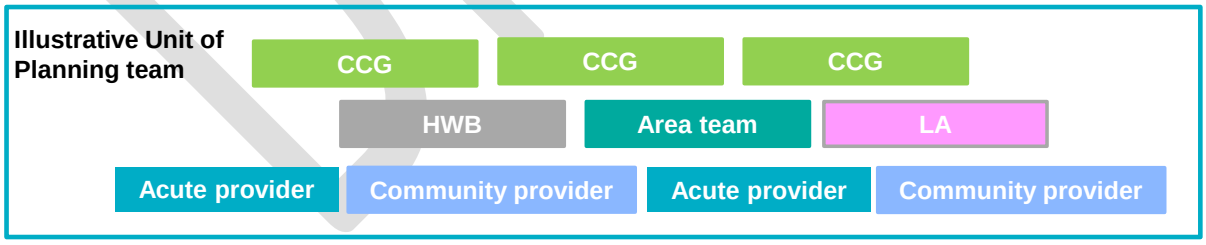
11. *A Call to Action* has reinforced the need for active and on-going participation with local communities and the people within them. These participation activities need to be demonstrably central to every five year strategic plan.

Aligned planning across health economies

12. Each CCG is accountable for developing a Strategic, Operational and Financial plan. To enable wider and more strategic health economy planning, all CCGs will work in close collaboration with relevant Area Teams, providers and local authorities and where appropriate they may also choose to join with neighbouring CCGs in a larger 'Unit of Planning' to aggregate plans, ensure that the strategies align in a holistic way and maximise the value for money from the planning resources and support at their disposal.

13. Where CCGs choose to associate to form a 'Unit of Planning' they should consider the following principles:
    - each CCG to belong to one unit only;
    - the Unit has been locally agreed and has clear clinical ownership and leadership;
    - it is based on existing health economies that reflect patient flows across Health and Wellbeing Board areas and local provider footprints with no CCG to be split across boundaries;
    - it has sufficient scale to deliver geography wide clinical improvements;
    - it enables the pooling of resources to reduce the risk associated with large investments;
    - it does not cut across existing locally agreed collaboration agreements;
    - engagement has been secured from Local Authorities; and
    - engagement has been secured from the Local Education and Training Board (LETB).

14. The diagram below demonstrates the potential components of a unit of planning.



15. Commissioner plans need to be submitted on the templates issued alongside this guidance. There are five templates:
    - Strategic plan;
    - Operational plan;
    - Financial plan;
    - Direct Commissioning plan; and
    - Better Care Fund.

16. Broader Strategic Plans constructed by Units of Planning will be a consolidation of individual organisations' Strategic plans.

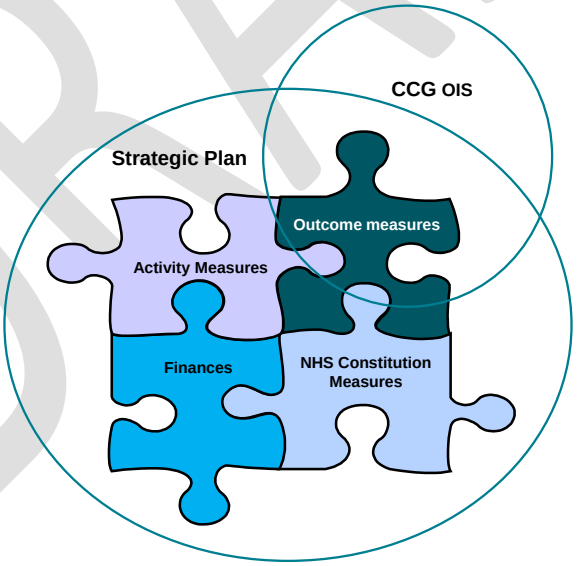
17. The Better Care Fund plan is developed at Health and Wellbeing Board level. This will mean that in some cases more than one CCG will be involved in the development of this plan.

18. Further details on plans for Better Care Fund are included in Annex I of this guidance.

19. NHS England's plans for directly commissioned services may not always fit neatly to a single Unit of Planning, so Area Teams will ensure their plans dovetail into all relevant Units of Planning. Similarly, on some occasions a provider's plan may need to be reflected in more than one Unit of Planning and when that happens, commissioners need to be satisfied that they are sighted on the totality of the Trust's plan.

Balancing plans

20. It is important that plans are balanced and aligned across the respective strategic, operational and financial elements illustrated below.



21. The CCG Outcomes Indicators Set[2] (CCG OIS) should be used by CCGs as a tool to understand trends in outcomes and to help them identify potential priorities for improvement and for inclusion in plans. Not all outcomes will be relevant for every plan. CCGs and NHS England may wish to refer to

[2] http://www.england.nhs.uk/ccg-ois/

indicators in the CCG OIS to help them gain a rounded picture of local outcomes as part of the assurance process.

22. NHS England will look to ensure that plans are consistent across primary, secondary and specialist care (i.e. that CCG and Area Team plans are aligned). We will work with Monitor and the NHS Trust Development Authority to develop a shared view about the recovery action that might be required where health economies are demonstrating pressure to such an extent that the quality of services provided to patients may be at risk of deterioration.

23. The operational plans must demonstrate that the strategic plan is the driving force behind transformational change. The operational plans should contain outcomes and relevant local metrics which show the journey towards the tangible achievement of the overarching strategy.

Planning timetable

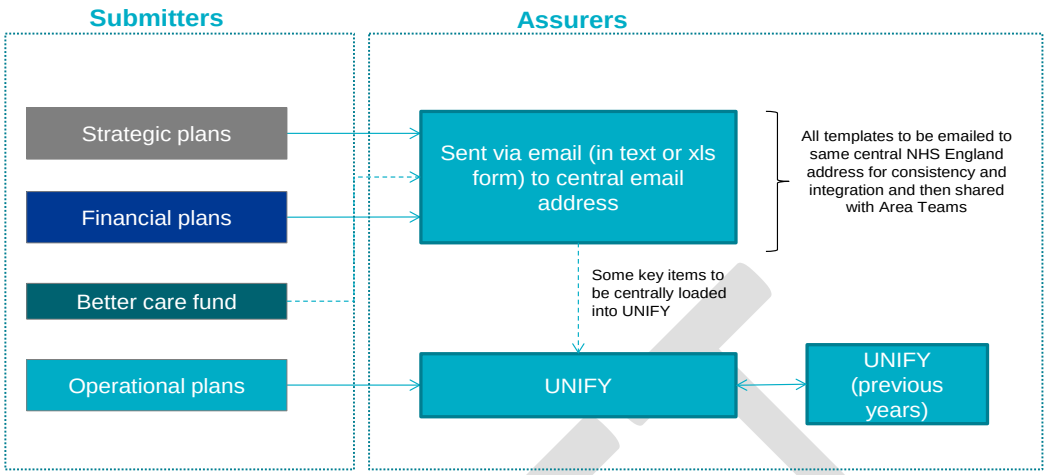
24. This guidance is issued at the same time as our allocations to commissioners. The planning timetable is detailed below. It will be challenging for everyone; but it is important that we lay strong foundations for delivery during what will be a testing time for all NHS organisations:

Activity	Deadline
First submission of plans	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Reconciliation process with NHS TDA and Monitor	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year operational plans and draft 5 year strategic plan	4 April 2014
Submission of final 5 year strategic plans • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

25. We will work closely with Monitor, NHS Trust Development Authority and Health Education England throughout this process to provide feedback to CCGs and providers and to ensure alignment and deliverability. This will be an iterative process as providers respond to commissioner plans.

Plan submission

26. The diagram below illustrates the submission process.



27. The central email address for strategic and financial plan submission is: NHSCB.financialperformance@nhs.net

Assurance of plans

28. Plan assurance should address the scale of ambition and plans for implementation of the planning fundamentals set out in paragraph 6 of this part 2, in the two and five year time horizons.

29. To maximise opportunities for mutual assurance across all health and social care services and minimise complexity, we will adopt the following principles for the rest of the assurance process:
    - Assurance of the overall strategic plan will be at Unit of Planning level, including engagement with patients and public in the local community;
    - Operational plans will be assured at CCG/ Health and Wellbeing Board level and at Area Team level for NHS England's directly commissioned services;
    - Area Teams to lead the assurance of CCG plans;
    - Regional Teams manage the assurance of Direct Commissioning plans;
    - Area Teams to assure the overall consolidated commissioning position and strength of local partnerships;
    - Area Teams and CCGs to ensure mutual assurance of Direct Commissioning plans, with escalation by exception; and
    - Boards and governing bodies should satisfy themselves that the outcomes or recommendations of the plan assurance process have been appropriately addressed prior to plan sign off.

30. The lead responsibilities for plan production and assurance are shown below.

Assurance and production of plans

Plan	Produced by…	Engaged	Triangulation	Formal assurance
	Responsible for driving development, completing & submitting plan	***Contribute to plan development***	***Responsible for ensuring that their work triangulates with plan***	***Responsible for providing formal assurance of plan***
Strategic	Unit of Planning	• Patients & carers • Healthwatch • CCG • Provider • HWB • Local Authority • NHS England Area Team • Health Education England • Local Education and Training Board (LETB)	• CCG • Provider • HWB • Local Authority • Area Teams	NHS England Regional Team
Operational	CCG	• Provider • Local Authority (contracts with community / social care providers)	• Provider • HWB • Local Authority • Unit of Planning	NHS England Area Team
Financial	CCG	• Provider • Local Authority (contracts with community / social care providers)	• Provider • HWB • Local Authority • Unit of Planning	NHS England Area Team

Plan	Produced by…	Engaged	Triangulation	Formal assurance
Provider	Provider	• CCG • Local Authority (depending on provider type)	• CCG • HWB • Local Authority • NHS England Area Teams • Unit of Planning	Monitor NHS Trust Development Agency
Better Care Fund	HWB	• Patients and carers • Healthwatch • Local Authority • NHS England Area Teams • PHE • Monitor • NTDA	• CCGs • Provider • Units of Planning	Ministers HWB NHS England Area Team LGA
Direct Commissioning	NHS England Area Team	• NHS England Regional Team • Provider	• Provider • CCG	NHS England Regional Team

31. The NHS England national support centre will support regions and areas throughout the process, providing challenge and advice through a series of checkpoint meetings.

32. The review and triangulation of plans will include:
    - the finances to secure delivery of the output objectives and adherence to the requirements outlined in the planning guidance;
    - ensuring the finances and activity projections are supported by reasonable & deliverable planning assumptions including level of assumed QIPP delivery and underlying activity growth;
    - triangulation of finance and activity;
    - coherence with the other planning and output assumptions; and
    - testing the strength of local relationships, which are key to ensuring delivery.

On-going assurance

33. NHS England has published assurance frameworks for both CCGs[3] and our direct commissioning[4] functions. These are integral to our approach to assurance of plans. In line with the principles set out in the assurance frameworks, discussions will take place on the basis of six consistent assurance domains.

34. Assurance will be informed by robust and diverse sources of evidence, underpinned by a developmental and supportive approach. Where delivery concerns are identified, improvement actions will be agreed. NHS England has broad powers available through legislation to ensure that these improvements are made. This guidance sets out the expectations for NHS commissioners, and the assurance process will be an important way of ensuring that both NHS England and CCGs are mutually accountable for delivering the improvements we want to see delivered.

Overview of Planning Support

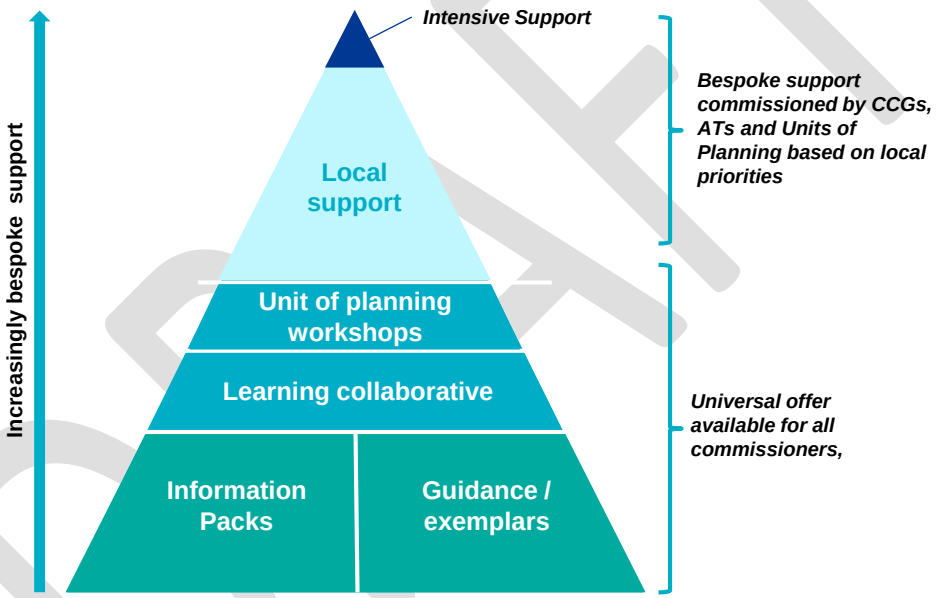
35. The support package that we will provide puts these requirements at the centre of the development and delivery of five year strategic plans. It has been developed in consultation with commissioners in CCGs and Area Teams and will be made available for commissioners to draw on where needed. A detailed communication on support will be published by the end of December.

36. The support programme includes:

[3] http://www.england.nhs.uk/wp-content/uploads/2013/11/ccg-ass-frmwrk.pdf
[4] http://www.england.nhs.uk/wp-content/uploads/2013/11/dc-ass-frmwrk.pdf

- universal, nationally developed tools, including information packs, exemplars and Strategic Planning Workshops that will bring together local partners to support them in agreeing their approach and priorities in developing and delivering aligned strategic plans.
- bespoke support based around ten key specifications;
- an intensive support package for economies with deep financial and/or quality issues, developed and owned jointly by NHS England, NHS Trust Development Agency, Monitor and the Local Government Association; and
- support to a number of Health and Wellbeing Boards aligned and interwoven across both the universal and bespoke elements of support.

37. The diagram below shows the support package which will be made available to support the planning process.



Universal support package

38. The universal support package, available to all commissioners, will include:
    - **Practical support on participation -** Our interactive web based *Transforming Participation in Health and Care* tool already provides advice, good practice, evidence and case studies on approaches to good public participation. This will be supplemented by resources that will be made available through Commissioning Support Units (CSU) aimed at engaging local communities in developing and commissioning services that meet their needs, and using insight and market research techniques to better understand those needs. The expectation is that local and regional voluntary sector organisations will work to make certain that public participation reaches all parts of local communities. There should

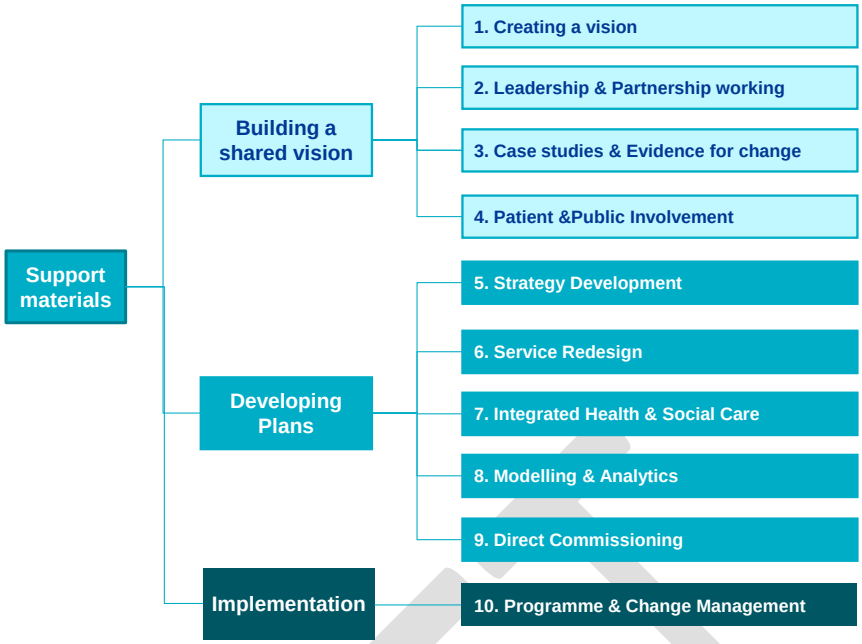
be particular focus on seeking and achieving input from communities which have traditionally not provided sufficient input into NHS decision-making.

- **Any town health system and Better Care Fund models -** To support CCGs in preparing plans, the Any town health system will be published in January. The Better Care Fund modelling tool enables HWBs to model high level integration interventions.
- **Data packages -** data and analysis packs showing the local opportunities for improvement and relative performance e.g. Commissioning for Value packs released in October.
- **Strategic planning workshops -** Local workshops designed to kick-start the planning process and build local relationships to create a joint vision and prepare for planning submissions. They will provide practical and technical advice about translating a strategy into a financial and operating plan and will support joint ways of working through advice on creating local governance arrangements aimed at galvanising action and initiating stakeholder discussions.
- **Learning collaborative -** This will support the spread and adoption of learning, best practice and technical expertise. We are planning to create a programme of webinars and learning events on key topics across three broad areas of: best practice sharing; strategic planning by injecting thought leadership and support for the technical aspects of planning and delivery.

Tailored local support to meet local challenges

39. The local support offer will be available to CCGs, Area Teams and Units of Planning that would benefit from additional more bespoke support in key areas.

40. Ten different specifications have been identified, which relate to the three main areas of planning activity: Building a shared vision for health and social care across multiple partners in the Unit of Planning; development of plans which deliver that vision; and implementation of plans.

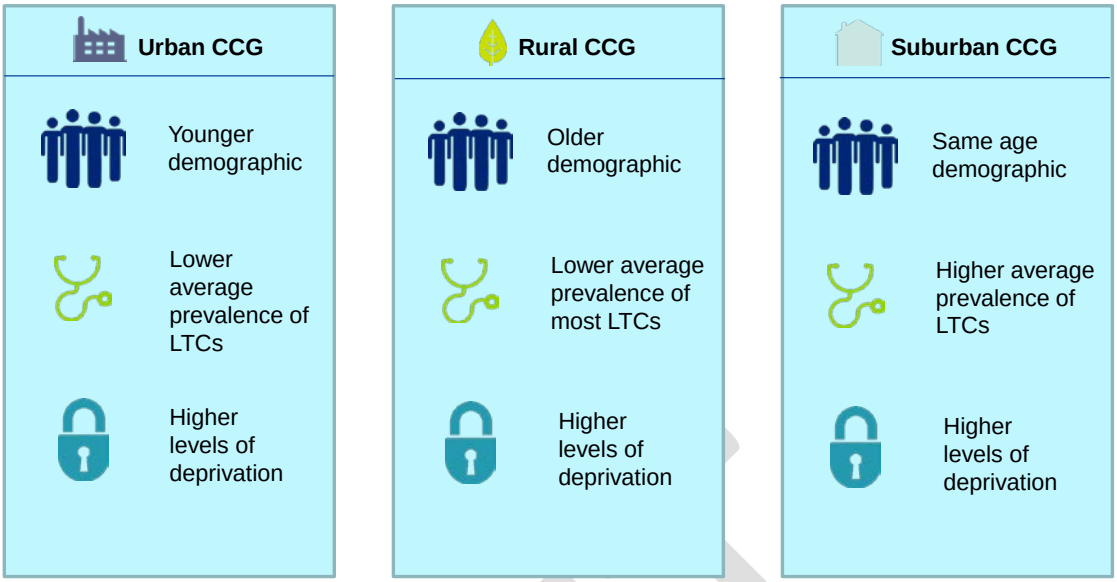


Any town health system

41. Any town health system is a resource designed to help local areas identify potential improvements to service delivery, and enable them to understand what the quality and financial impacts of those improvements may be. The tool provides case studies and analysis of a number of interventions that could be applied in a local health economy to achieve improved clinical outcomes and financial performance. It shows how CCGs could achieve financial balance over the strategic period covered.

42. A number of 'High Impact Interventions' have been fully impact assessed and included in the report. Twelve 'Early Adopter Interventions' are also included – these have not been impact assessed to the same specification as the 'High Impact Interventions', but are innovative, cutting edge ideas which may be promising.

43. To help understand the impact different interventions will have in different settings, three scenario CCGs have been created: Urban CCG, Suburban CCG and Rural CCG. There is a version of Any town for each scenario CCG. Local areas are, therefore, able to understand how each intervention might affect performance in an area that is demographically similar to their own.


Urban CCG
Younger demographic
Lower average prevalence of LTCs
Higher levels of deprivation
Rural CCG
Older demographic
Lower average prevalence of most LTCs
Higher levels of deprivation
Suburban CCG
Same age demographic
Higher average prevalence of LTCs
Higher levels of deprivation

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1. Strategic, Operational and Financial Planning

Strategic Plan Overview

44. Each strategic plan needs to have the ownership and buy-in of the whole local health economy and reflect a joint vision for the area and the road map required to attain this. All organisations should be satisfied that the plan will support the delivery of improvements for patients and service users. The plan should be short, focused and describe to those outside the system what the system plans to achieve in a way that informs and engages.

45. It is essential for these plans to be at the forefront of the planning process; they set the vision, ambitions and framework against which operational and financial planning will be determined.

46. Plans should be clear on proposed future activity levels, referenced to historical trends and future service proposals. The plans must demonstrate a clear link between activity and finances.

47. The strategic plan will require the creation of a:
    - System narrative ‘plan on a page’; and
    - Organisation specific key highlights.

48. Details regarding the content of the Strategic Plan template can be found in Annex J.

Operational Plan Overview

49. The operational plan will include the key operational metrics needed to support the assurance of, and measure performance against, strategic plans. The plan will be structured around the four headings:
    - Outcomes;
    - NHS Constitution;
    - Activity; and
    - Better Care Fund.

50. Details regarding the content of the Operational Plan template can be found in Annex J.

The Financial Plan Overview

51. The financial plan will provide the detailed financial breakdown of each plan. It will include the key financial metrics to support the assurance of, and measure performance against, strategic plans. It will require information under the following headings:

- Revenue resource limit;
- Planning assumptions;
- Financial plan detail 14/15-18/19;
- QIPP 14/15-18/19;
- Risk;
- Investment;
- Statement of financial position;
- Cash;
- Capital; and
- Contract value 14/15-18/19.

52. Details regarding the content of the Financial Plan template can be found in Annex J.

Financial allocations and the efficiency challenge

53. The 2014/15 and 2015/16 income allocated to CCGs and direct commissioning has been published alongside this guidance. More detail on these allocations can be found at (DN: add link: Notification of allocations).

54. The funding objectives contained within the Mandate require NHS England to run a transparent allocation process to ensure “equal access for equal need”. The 2012 Health & Social Care Act also requires NHS England to have regard to reducing inequalities in access to and outcomes from healthcare. Consequently, the intention is to implement an approach to allocation of funding that has regard for population on a per capita basis and takes into account both inequalities and the impact of an ageing population on demand for healthcare.

55. For clinical commissioning groups, NHS England has adopted a revised funding formula recommended by the Advisory Committee on Resource Allocation. For direct commissioners of primary care, NHS England is adopting a new funding formula which aims to allocate primary care funding based on need. Adjustments are made to both formulae to reflect the need to address unmet or inappropriately met need, particularly relating to our most deprived communities. Funds for specialised commissioning, health & justice and armed forces in 2014/15 and 2015/16 will continue to be allocated on a national basis and the investment made by NHS England in public health will be budgeted on a programme basis.

56. The implication of the distribution of resources is a differing level of efficiency challenge in 2014/15 and 2015/16 by commissioner. In 2014/15, specialised commissioning remains the area with the most challenging efficiency requirement. In 2015/16, with the introduction of the Better Care Fund, CCGs

face a more significant efficiency challenge. Over the two years the efficiency challenge for both CCGs and specialised commissioning is similar at approximately 9%, including the provider efficiency deflator.

57. To support commissioners to manage this challenge over the two year period we propose to prioritise access to drawdown of surpluses from prior years for specialist commissioning in the first year and CCGs in the second year.

58. For 2016/17 to 2018/19 commissioners as a whole should assume a continuity of the current allocations policy, although firm decisions on allocations beyond 2015/16 have not yet been taken at this stage. For subsequent years, assuming allocations keep pace with estimated GDP growth, commissioners could assume the following average growth in allocated income.

2016/17	2017/18	2018/19
1.8%	1.7%	1.7%

59. Continuity of the current policy would mean that CCGs and primary care commissioners would continue to move towards target on the basis of the trajectory set in 2014/15 and 2015/16.

60. From 2014/15 commissioners will be required to count the use of provisions as a utilisation of their allocated resource, in line with HM Treasury accounting rules.

Programme and administrative costs

61. Income is allocated separately for programme and administrative costs. Expenditure against these allocations will be monitored separately. Commissioners are asked to ensure that plans are in place to ensure administrative costs are not overspent. Underspends on administrative costs may be spent on programme costs.

62. The commissioning sector will receive a reduction in administrative costs over the first two years of the planning period, 2014/15 and 2015/16 (DN: to be updated following decision by the Board on the two options for distribution of running costs from the allocations discussion). Commissioners should assume that running costs remain flat in cash terms for years 3 to 5 of the planning period.

Financial planning assumptions

63. Published alongside this planning guidance is the Call to Action technical paper. This sets out the key financial and activity assumptions that underpin the £30bn challenge and details additional work undertaken over the subsequent period to further refine these projections (DN: add link to Call to Action technical paper).

64. The core financial planning assumptions for CCGs to use are shown in the following table. More detail is included in subsequent paragraphs.

CCGs		
Demographic growth	Local determination using age profiled population projections.	
Non-demographic growth	Local determination based on historic analysis and evidence.	
Tariff changes	See below.	
Price inflation - prescribing	Local determination - expected to be in a range of 4% to 7% per annum increase.	
Price inflation – continuing health care	Local determination - expected to be in a range of 2% to 5% per annum increase.	
Business rules	**2014/15** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2.5% non-recurrent spend (including 1% for transformation).	**2015/16-2018/19** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 1% non-recurrent spend • Better Care Fund spend as notified separately.

65. Surpluses and deficits accumulated at 31 March 2014 and subsequent years will be carried forward into the following financial years. Commissioners are asked to include proposals for access to historical surpluses, if required, in their plans. The plans will be assessed with reference to the impact on outcomes and subject to the maximum drawdown available. The maximum expected level of the national surplus drawdown will be finalised with the Department of Health and HM Treasury.

66. The National Tariff for 2014/15 was published jointly by NHS England and Monitor on 17th December. The tariff prices are generally the 2013/14 prices

rolled forward and adjusted for inflation and efficiency. The cost uplift for 2014/15 is 2.5% and the efficiency requirement is 4%, giving an overall adjustment to tariff prices of (1.5)%. This should be also the starting point for adjustments to the price for services without a national price.

67. For emergency admissions, commissioners should budget for all admissions at 100 per cent of the tariff. They should only pay 30 per cent for emergency admissions over the 2008/9 baseline with the 70 per cent to be invested in relevant demand management schemes. Full details of the operation of these rules are set out in the 2014/15 National Tariff Payment System [DN supply reference]. Commissioners need to engage with relevant providers with input from Urgent Care Working Groups when developing plans for the investment of the 70 per cent balance. These plans should be published on the commissioner's website and shared with all relevant stakeholders. The tariff document also contains details of the specific circumstances in which baselines should be adjusted, e.g. for service change

68. NHS England and Monitor are currently developing a medium term pricing strategy for 2015/16 and beyond. As set out in our joint consultation in May, we will be considering how best to develop an approach to pricing that supports improved outcomes and in particular more integrated services for patients. As part of our work we will consider the case for implementing new currencies and contracting models, and whether a more segmented approach to pricing is more appropriate. Consequently, for 2015/16 and beyond, commissioners should assume continuity of current pricing policy. Where appropriate, they should also consider the scope to use the local flexibilities introduced in 2014/15, specifically regarding local pricing variations where they are in the best interests of patients.

69. Commissioners should plan on the basis that the "net" level of provider efficiency delivered remains relatively constant over the five year period. (DN: may need to add 'in recent years "net" provider efficiency has delivered 2% with the difference between this amount and the 4% efficiency factor set in tariff attributable to additional income generated by providers" – to be confirmed with Monitor). Indicative tariff assumptions to use for future years are shown in the following table (DN: TBC with Monitor)

Tariff assumptions					
	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Secondary Care health cost inflation	2.3%	2.2%	3.0%	3.4%	3.4%

Provider sector efficiency	4.0%	4.0%	4.0%	4.0%	4.0%
Tariff uplift	-1.7%	-1.8%	-1.0%	-0.6%	-0.6%

Strategic Enablers

The NHS standard contract

70. The NHS standard contract remains the form of contract which commissioners must use for all contracts for clinical services, other than primary care. It can be found at (DN: reference link to standard contract).

71. After a significant re-drafting for 2013/14, the 2014/15 contract will retain the same structure and much of the same detailed content, allowing commissioners and providers to become familiar with using it in practice.

72. There will be significantly greater flexibility for commissioners to determine the duration of the contract they wish to offer, within the framework of national guidelines and regulations on procurement, choice and competition. The standard contract enables innovative contracting models such as the prime provider approach; with increased flexibility on contract duration, together with new tariff flexibilities (Local Payment Variations). Commissioners will be equipped with the tools to enable longer-term, transformational, outcomes-based commissioning approaches.

73. The framework of sanctions within the standard contract has been reviewed in depth, with significant input from stakeholders. The contract for 2014/15 will contain a more consistent and proportionate set of sanctions. We expect commissioners to enforce the standard terms of the contract, including the application of sanctions.

74. An online system for completing the NHS standard contract (the eContract) was made available in February 2013 and an improved, more robust system will be available for use for 2014/15. The eContract approach has significant benefits, for instance in enabling the tailoring of contract content to reflect the specific range of services being commissioned. We strongly encourage CCGs and CSUs to use the eContract during the 2014/15 contracting round. NHS England anticipates that use of the eContract approach will become the norm for directly commissioned services in 2014/15.

75. We expect commissioners to ensure that robust, good value contracts are signed by 28 February 2014.

76. A strategic review of pricing and incentives is underway as part of the Call to Action work. It has the aim of developing a fully integrated set of arrangements which support the emerging strategic priorities and provide the flexibility to implement the new service models which will be required. Arrangements for 2014/15, described below, aim to preserve stability in the short term while providing sufficient local flexibility to enable innovation to flourish.

The Quality Premium: rewarding commissioners

77. The measures to be used to determine the Quality Premium paid to CCGs in 2015/16 on the basis of performance during 2014/15 align with our outcomes ambitions and reflect local decision-making with Health and Wellbeing Boards. NHS England will publish the full methodology to be used for calculation of the Quality Premium in December 2013.

Commissioning for Quality and Innovation (CQUIN)

78. A CQUIN scheme will be in place for 2014/15. The key aim is to secure improvements in the quality of services and better outcomes for patients. Providers will be able to earn up to 2.5% of their annual contract outturn, excluding any income for high costs drugs and devices excluded from national prices.

79. One fifth of the CQUIN scheme will be for achievement of national improvement goals, as follows:
    - Friends and Family Test – where commissioners will be empowered to incentivise high performing providers;
    - Improvement against the NHS Safety Thermometer, particularly pressure sores;
    - Improving dementia and delirium care, including sustained improvement in Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR); and
    - Improving diagnosis in mental health – providers will be rewarded for better assessing and treating the mental and physical needs of their service users.

80. Following three years of funding through the national CQUIN scheme, the VTE CQUIN scheme will not be in place for 2014/15. Providers will be expected to continue to improve their management of VTE risk and any deterioration in risk assessment from current performance will result in a contract sanction being applied.

81. NHS England will publish separate guidance on the 2014/15 CQUIN scheme in December 2013, including detailed descriptions of the mandated national

indicators and guidance on developing local CQUIN indicators and setting improvement trajectories, along with a list of quality assured indicators for optional use.

Non recurrent funds

82. As in previous years, commissioning organisations are required to set aside some of their funding for non-recurrent expenditure. Recognising the need to accelerate efficiencies in 2014/15 both to prepare for the challenges in 2015/16 and to create funding for service change, we have increased the level of non-recurrent expenditure in 2014/15 to 2.5%. Of the total 2.5%, commissioners are asked to plan for 1% of this spend to be applied to transformation of local services. This transformation fund is intended to be used at a local health economy level by commissioners working together to develop and implement plans for change, focusing in particular on any actions required to prepare for the introduction of the Better Care Fund.

2. NHS England Direct Commissioning

Direct Commissioning Overview

83. NHS England has statutory responsibilities to commission services for patients across five areas:
    - primary, medical, dental, pharmacy and optical services and secondary care dental services;
    - specialised services;
    - public health section 7A services;
    - services for members of the Armed Forces and their families; and
    - services for people in the justice system.

84. In planning for the delivery for those services, NHS England's Area Teams will ensure they are aligned with CCG commissioning plans. The approach we will adopt is that each Area Team with responsibility for one or more of the above areas will:
    - develop a strategic plan for that service within which there will be greater granularity on the first two years;
    - ensure that each of those strategic plans is visible within relevant Units of Planning;
    - work with CCGs and other local partners to ensure a consistent and coordinated approach across the commissioning of all NHS services and related social care provision; and
    - ensure services are planned on the basis of affordability and securing the best possible outcome for patients.

85. The approach will be nationally consistent to deliver quantifiable improvements for patients within principles of:
    - equity of offer;
    - equity of access; and
    - equity of outcome.

Content of plans

86. NHS England's Area Teams will produce strategic and operational plans for the services they commission on the same basis as CCGs. For each of the five areas of NHS England's commissioning responsibilities, Area Teams will:
    - set out a five year strategic plan for how that service will improve within available resources, including dealing with any structural deficit;
    - include more granular detail for the first two years; and
    - use the measures in the Annexes D-G to identify improvement.

87. For each aspect of our commissioning, the objectives we expect to be achieved are set out below and should be read alongside the measures to be included in plans as set out in Annexes A to G of this guidance.

88. Details regarding the content of the Direct Commissioning Plan template can be found in Annex J.

Financial planning assumptions

89. The core financial planning assumptions for direct commissioning are set out below.

Direct commissioning excluding public health		
Demographic growth	Primary care: Local determination based on resident population in line with crude population projections. Other: Local determination using age profiled population projections for population covered by Area Teams.	
Non-demographic growth	Local determination based on historic analysis and evidence.	
Tariff changes	See below.	
Primary care cost increase	[TBD]	
Business rules	**2014/15** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2.5% non-recurrent spend.	**2015/16-2018/19** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2% non-recurrent spend.
Public health		
Demographic growth	Local determination using age profiled population projections for population covered by Area Teams.	
Business rules	• Minimum 0.5% contingency • 0% cumulative surplus carry forward • 0% underlying surplus • 0% non-recurrent spend.	

4 Better Care Fund Planning

Better Care Fund Overview

90. The Better Care Fund plan requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled Better Care Fund budget will be implemented to facilitate closer working between health and social care services.

91. Joint plans should be approved through the relevant local Health and Wellbeing Board and be agreed between all local CCGs and the Upper Tier Local Authority. Health and social care providers should also be closely involved in plan development.

92. The plan should demonstrate clearly how it meets all of the national Better Care Fund conditions, include details of the expected outcomes and benefits of the schemes involved, and confirm how the associated risks to existing NHS services will be managed. The measures we expect CCGs to use in considering the quality of the impact of the Better Care Fund are in Annex I, along with additional supporting information on developing BCF plans.

Funding for integrated care

93. In 2014/15, £1,100m will transfer to Local Authorities for social care to benefit health, using the same formula as 2013/14. This will be transacted through a central Section 256 transfer. In 2015-16, this funding will be part of the pooled Better Care Fund; while it will continue to be allocated to areas on the same basis as in previous years, the funding will be distributed through CCG allocations. For example, if a local authority consists of two equal sized CCGs and it received £10m from the s256 transfer in 2014/15, in 2015/16 the area will still receive £10m of the £1,100m, but it will be divided between the two CCGs' allocations. CCGs will be required to pass this funding to the Better Care Fund pooled budget along with the funding from core CCG allocations, discussed below.

94. From 2015/16, the Better Care Fund will also include a £1.9bn contribution from core CCG funding, over and above the existing £300m reablement funding and £130m carers' breaks which will also be pooled in the Better Care Fund. Core CCG funding going to the pooled Better Care Fund will be allocated based upon the CCG allocation formula. Additional contributions to the Better Care Fund from local authorities, in the form of social care capital grants and the disabled facilities grants, will continue to be allocated to them by central government on the same basis as for 2014/15.

95. Each Health and Wellbeing Board will receive a notification of its share of the pooled fund for 2014/15 and 2015/16, based on the aggregate of these allocation mechanisms. The allocation letter (DN: add link) specifies the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and, in part, on achieving specified goals in 2015/16.

Annex A: Outcomes measures

Outcome ambition	Measure to be used	Quality Premium measure	Support measure(s)
1. Securing additional years of life for the people of England with treatable mental and physical health conditions.	Potential years of life lost from conditions considered amenable to healthcare – a rate generated by number of amenable deaths divided by the population of the area.	Improvement to be locally set and no less than 3.2%. CCGs should focus on improving in areas of deprivation in developing their plans for reducing mortality.	None
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.	Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).	IAPT roll-out: i. achieve 15% for CCGs below that level ii. Additional locally set improvement for those over 15% or near 15%.	• Increase dementia diagnosis rate to 67 per cent by March 2015. • Achieve the IAPT recovery rate of 50%.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	A rate comprised of: • Unplanned hospitalisation for chronic ambulatory care sensitive conditions. • Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. • Emergency admissions for acute conditions that should not usually require hospital admission. • Emergency admissions for children with lower respiratory tract infections.	As per outcome measure	None
4. Increasing the proportion of older people living independently at home following discharge from	No indicator available at CCG level. CCGs and Area Teams will not be expected to set a quantitative level	None	A level of ambition needs to be established at Health and Wellbeing Board level on the *Proportion of older people*

Outcome ambition	Measure to be used	Quality Premium measure	Support measure(s)
hospital.	of ambition for this outcome. However, they will be expected to set out how they will improve outcomes on this ambition in their five year strategic plans.		*(65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services.*
5. Increasing the number of people having a positive experience of hospital care.	Patient experience of inpatient care.	Friends and Family Test: specific actions to improve low scores.	None
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Composite indicator comprised of (i) GP services, (ii) GP Out of Hours.	None	None
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	Hospital deaths attributable to problems in care. This indicator is in development.	Improving the reporting of medication errors.	• MRSA zero tolerance • *Clostridium difficile* reduction

All CCG OIS measures are available for planning: http://www.england.nhs.uk/ccg-ois/

Annex B: NHS Constitution measures

Referral To Treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%
A&E waits
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%
Cancer waits – 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls
Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%

NHS Constitution support measures

Mixed Sex Accommodation Breaches
Minimise breaches
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%
Referral To Treatment waiting times for non-urgent consultant-led treatment
Zero tolerance of over 52 week waiters
A&E waits
No waits from decision to admit to admission (trolley waits) over 12 hours
Cancelled Operations
No urgent operation to be cancelled for a 2nd time
Ambulance Handovers
All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

Annex C: Activity measures

Elective
Elective – ordinary admissions FFCEs
Elective – day cases FFCEs
Non elective
Non Elective admissions FFCEs
Outpatients
All first outpatient attendances in general and acute specialties
All subsequent outpatient attendances in general and acute specialties
A&E
A&E attendances – Type 1
A&E attendances – Total all types
Referrals
GP written referrals from GPs for a first outpatient appointment in general and acute specialties
Other referrals for a first outpatient appointment in general and acute specialties
First outpatient attendances following GP referral in general and acute specialties

Annex D: Primary care measures

Medical
Patient satisfaction
Satisfaction with the quality of consultation at the GP practice
Satisfaction with the overall care received at the surgery
Satisfaction with accessing primary care
Referrals
Proportion of new cancer cases referred using 2 week wait pathway
Vaccinations
Flu vaccinations – at risk coverage
Mental health
Identifying the prevalence of depression compared to estimated model

Dental
Access
% Patients seen – 24 month measure
Activity
Number of course of treatments per 100,000 population
Patient experience
GPPS % Positive experience

General Ophthalmic Services
Activity
Total number of sight tests / per 100,000 population
Quality and Innovation
%of tints per voucher
% of repairs per voucher and % of replacements per voucher
% of prisms per voucher

Annex E: Specialised services measures

Referrals
% of all NHS England patients receiving treatment within 18 wks of referral
Diagnostics
% of NHS England patients waiting 6 weeks or more for diagnostic tests

Annex F: Public health section 7A services measures

Vaccinations
Population vaccination coverage - Dtap / IPV / Hib (1 year old)
Population vaccination coverage – MenC
Population vaccination coverage – PCV
Population vaccination coverage - Dtap / IPV / Hib (2 years old)
Population vaccination coverage - PCV booster
Population vaccination coverage - Hib / MenC booster (2 years old)
Population vaccination coverage - MMR for one dose (2 years old)
Population vaccination coverage - MMR for one dose (5 years old)
Population vaccination coverage - MMR for two doses (5 years old)
Population vaccination coverage - Hib / Men C booster (5 years)
Population vaccination coverage - Hepatitis B (1 year old)
Population vaccination coverage - Hepatitis B (2 years old)
Population vaccination coverage – HPV
Population vaccination coverage – PPV
Population vaccination coverage - Flu (aged 65+)
Population vaccination coverage - Flu (at risk individuals)
Screening
% of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result
% of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella leading to a conclusive result
% of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report
% of babies registered within the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe
% of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes – well babies, all programmes – NICU babies) or 5 weeks corrected age (community programmes – well babies)
% of babies eligible for the newborn physical examination who were tested within 72 hours of birth
% of those offered screening for diabetic eye screening who attend a digital screening event
Abdominal Aortic Aneurysm (AAA) KPI
Breast cancer screening coverage % of eligible women screened adequately within the previous 3 years on 31st March

Cervical cancer screening coverage % of eligible women screened adequately within the previous 3.5 or 5.5 years (according to age) on 31st March
Bowel Cancer screening - uptake and coverage over 2.5 years
Family health services
No. of FTE Health Visitors

Annex G: Health and Justice measures

Health commissioned services
Deliver chronic disease care to the same standard of process and outcomes as is required by the National Service Frameworks for: Diabetes, CHD and Long Term Conditions and Mental Health and a QOF score is available
Access and waiting time
Access and waiting time
Learning disabilities
% of identified patients with a learning disability have an annual health check
Mental health
% of all prisoners returning to prison from any other Mental Health facility following treatment under the Mental Health Act (including section 3, 47, 48) are accompanied by a 117 aftercare programme

Annex H: Direct Commissioning Supporting Information

Primary, medical, dental, pharmacy and optical services and secondary care dental services

1. There are two central objectives to our commissioning:
   - to develop more integrated out-of-hospital services that help people stay healthy and provide proactive, coordinated support, particularly for people with long-term conditions; and
   - for our Area Teams, CCGs and Local Professional Networks to work collaboratively with local communities to develop joint strategies for commissioning primary care and wider community services, based on patient and public insight. These should be part of an integrated strategy for out-of-hospital care.

2. Local strategic plans should include specific actions to support development of general practice services in ways that reflect the six key characteristics of high-quality care set out in our general practice *A Call to Action* as follows:
   - proactive coordination of care, particularly for people with long-term conditions and more complex health and care problems;
   - holistic care: addressing people's physical health needs, mental health needs and social care needs in the round;
   - ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances;
   - preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and wellbeing;
   - involving patients and carers more fully in managing their own health and care; and
   - ensuring consistently high quality of care: effectiveness, safety and patient experience.

3. Area Teams should also work with their Local Professional Networks and, where appropriate, CCGs to develop equivalent commissioning strategies for dental care, community pharmacy care and eye care services, again as part of an integrated out-of-hospital strategy.

Primary Care Support services

4. NHS England is responsible for primary care support (PCS) services (also known as family health services or FHS). NHS England wants all practitioners to have access to a standard range of modern, efficient and effective PCS/FHS services which meet their needs.

5. The range of PCS/FHS services provided to primary care providers currently varies from area to area. Figures from November 2012 indicated that their costs also varied from around 80p to £2.70 per head of population. NHS England wants to reduce the PCS/FHS budget from £100 million in 2013/14 to £60 million in 2014/15, although any cost reduction must be in the context of delivering safe, high quality and effective services at all times.

6. NHS England will progress work through 2013 into 2014 to achieve a safe transition in PCS services. Efficiencies will be created by:
   - having a standard specification for core PCS/FHS services that will be funded by NHS England;
   - achieving 'best practice' levels of quality and cost across all services;
   - providing services from fewer sites;
   - making more and better use of technology; and
   - changing some of the ways services are delivered.

Specialised services

7. As part of *A Call to Action*, NHS England is developing a five year strategy for specialised services. This will address the service specific objectives for the next five years, overarching strategic objectives for the provision of a system of specialised health care as a whole and the impact of co-dependency between service areas.

8. The published commissioning intentions for 2014-2016 commit NHS England to a six strand strategic commissioning approach:

   i. Ensuring consistent access to the effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.
   ii. A clinical sustainability programme with all providers focused on quality and value through:
      - achieving and maintaining compliance with full service specifications, and making changes to service provision where there is no realistic prospect of standards being met;
      - refreshing and focusing Commissioning for Quality and Innovation (CQUIN) schemes to directly contribute to improving outcomes with challenging, but achievable goals; and
      - providing transparency in service quality through the continued development of service level quality dashboards and improvements in data flows.
   iii. An associated financial sustainability programme with all providers, focused on better value through a two year programme of productivity and efficiency improvement.

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

v. Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients, in particular services and care pathways to include a prime contractor model and co-commissioning with CCGs.

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

9. In their plans we expect NHS England's Area Teams to address any structural deficit from 2013/14. Cost growth will need to be constrained, greater consistency of provision secured and the quality of services maintained or improved.

Public health section 7A services

10. It is our objective to ensure the effective commissioning of certain public health services: immunisation and screening programmes, children's public health services from pregnancy to age five, child health information systems, public health for people in places of detention, and sexual assault services.

11. We will continue the effective implementation of the section 7A agreement, of which there are two overarching ambitions:
    - to increase the pace of change for the full implementation of the national service specifications; and
    - to set performance 'floors' to address unacceptably low performance by local providers.

12. NHS England's Area Teams will implement the specific changes from 2014/15, in line with these ambitions:
    - new trajectories for roll out of the Family Nurse Partnership and the Health Visitor Programmes;
    - a revised specification for Pneumococcal Vaccination;
    - introduction of HPV testing in women with mild/borderline changes in their cervical screening;
    - revised performance baselines for bowel and diabetic eye screening;
    - extension of the bowel screening programme for men and women up to 75;
    - a minor change to the service specification for seasonal flu;
    - a meningitis C catch up programme for university entrants;
    - continuation of a time limited MMR campaign for people over 16 and a catch-up campaign for teenagers;

- continuation of the temporary programme for pertussis for pregnant women;
- implementation of DNA testing for sickle cell and thalassemia screening;
- a shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds; and
- a number of developments for Sexual Assault Referral Centres to develop the service and make it more equitable.

13. We intend to extend flu vaccinations to all children over time. When fully implemented this will be the largest single immunisation programme that has yet been introduced. The extent to which the programme can be rolled out in 2014/15 and the expected uptake rates have not yet been agreed. They remain subject to an assessment of NHS England's commissioning capacity, and the development of robust workforce models for delivery of the programme, which will be completed in early 2014. These will be confirmed through a variation to the section 7A agreement. Prior to this planned variation, the proposed section 7A agreement for 2014/15 confirms that NHS England shares the ambition to offer vaccines to all children between 2 and 4 years old and as many secondary school aged children as possible in 2014/15.

Services for members of the Armed Forces and their families

14. We want to see the following achieved:
    - that the commissioning of services is organised in such a way as to provide the best possible patient outcomes and avoid any geographical or organisational variation;
    - to continue to embed the single operating model as described in Securing Excellence for Armed Forces and their Families;
    - full implementation of the Armed Forces Covenant Commitment;
    - to work in partnership with the Ministry of Defence (DMS Personnel and Recovery) commissioning healthcare in line with the Armed Forces National Partnership Agreement; and
    - to collaborate with CCGs to ensure services are locally integrated and to develop strong Armed Forces networks across England.

Services for people in the justice system

15. We will continue the implementation of the single operating framework and commissioning intentions (developed jointly with National Offender Management Service, Public Health England, Youth Justice Board, Home Office Immigration Enforcement and Police Custody Healthcare) in a range of Justice services settings:
    - Prisons;

- Young Offender Institutes;
- Secure Children's Homes;
- Immigration and Removal Centres;
- Police Custody Suites; and
- Court Liaison Services.

16. Specifically our priorities from 2014/15 are:
    - to ensure that commissioning is informed by an up-to-date health needs assessment, taking account of the reconfiguration of the custodial estate, including the creation of Resettlement Prisons;
    - to support sustainable recovery from addiction to drugs and alcohol and improved mental health services;
    - promotion of continuity of care from custody to community and between establishments, working closely with Probation Services, Local Authorities and CCGs;
    - development of a full understanding of the healthcare needs of children and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs;
    - continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme; and
    - to ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.

Annex I: Better Care Fund measures and information

Better Care Fund Measures

Transfers
Delayed transfers of care
Admissions
Emergency admissions
Admissions to residential and nursing care
Reablement
Effectiveness of reablement

What is included in the Better Care Fund and what does it cover?

1. The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

2. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

3. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care “pioneers” initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

What is included in the Better Care Fund and what does it cover?

4. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £859m transfer already planned from the NHS to adult social care, a further £241m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.

5. The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	**2015/16**
A further £241m transfer from the NHS to adult social care, in addition to the £859m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

6. For 2014/15 there are no additional conditions attached to the £859m transfer already announced, but NHS England will only pay out the additional £241m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund.

7. In 2014/15 there are no new requirements for pooling of budgets. The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance [5] from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

   - *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

- *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*

- *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

- *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

8. Councils should use the additional £241m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.

9. The £3.8bn Fund includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement

10. It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.

    i. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.

ii. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

What will be the statutory framework for the Fund?

11. In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 756 joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

12. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

13. DH will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.

14. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003. This will ensure that the Disabled Facilities Grant (DFG) can be included in the Fund

15. The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

16. Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the

[6] Sec 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets.

DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.

17. DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

How will local Fund allocations be determined?

18. Councils will receive their detailed funding allocations in the normal way. NHS allocations will be two-year allocations for 2014/15 and 2015/16 to enable more effective planning.

19. In 2014/15 the existing £859m s.256 transfer to councils for adult social care to benefit health, and the additional £241m, will continue to be distributed using the social care relative needs formula (RNF).

20. The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

21. The announcement of the two-year CCG allocations, communicated to CCGs and councils alongside this planning guidance, includes the Fund allocations in 2015/16. In 2014/15, the additional £241m will be transferred directly from NHS England to councils along with the rest of the adult social care transfer. The local authority and CCGs in each Health and Wellbeing Board area will receive a notification of their share of the pooled fund for 2014/15 and 2015/16 based on the aggregate of the allocation mechanisms. The allocation letter also specifies the amount that is included in the payment-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

22. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

23. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the Fund?

24. Each statutory Health and Wellbeing Board will sign off the plan for its constituent councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.

25. Where a unit of planning chosen by a CCG for its strategic and operational plan is not consistent with the boundaries of the Health and Wellbeing Board, or Boards, with which it works, it will be necessary for the CCG to reconcile the Better Care Fund element of its plan to the Health and Wellbeing Board level. NHS England will support CCGs in this position to ensure that plans are properly aligned.

26. The specific priorities and performance goals in the plan are clearly a matter for each locality but it will be valuable to be able to:
    - aggregate the ambitions set for the Fund across all Health and Wellbeing Boards;
    - assure that the national conditions have been achieved; and
    - understand the performance goals and payment regimes that have been agreed in each area.

27. To assist Health and Wellbeing Boards we have developed a template which we expect everyone to use in developing, agreeing and publishing their Better Care Plan. This is attached as a separate Word document and Excel spread sheet [DN – check this please]. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the Fund.

28. As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).

29. CCGs and councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Provider, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing

models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. It will be important to work closely with Local Education and Training Boards and the market shaping functions of councils, as well as with providers themselves, on the workforce implications to ensure that there is a consistent approach to workforce planning for both providers and commissioners.

30. CCGs and councils should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for all local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

What are the National Conditions?

31. The Spending Round established six national conditions for access to the Fund:

National Condition	Definition
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.

National Condition	Definition
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans should not have a negative impact on the level and quality of mental health services.

How will Councils and CCGs be rewarded for meeting goals?

32. The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.

33. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

34. The performance payment arrangements are summarised in the table below:

When	Payment for performance amount	Paid for
April 2015	£250m	Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions

		at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and three of the national metrics: • delayed transfers of care; • avoidable emergency admissions; and • patient / service user experience
October 2015	£500m	Further progress against all of the national and local metrics.

National and Local Metrics

35. Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

36. The national metrics underpinning the Fund will be:
    - admissions to residential and care homes;
    - effectiveness of reablement;
    - delayed transfers of care;
    - avoidable emergency admissions; and
    - patient / service user experience.

37. The measures are the best available but do have shortcomings. Local plans will need to ensure that they are applied sensitively and do not adversely affect decisions on the care of individual patients and service users.

38. Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

39. Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two of these metrics, on admissions to residential and care homes and the effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

Metric	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential and care homes	N/A	Apr 2014 - Mar 2015
Effectiveness of reablement	N/A	Apr 2014 - Mar 2015
Delayed transfers of care	Apr – Dec 2014	Jan - Jun 2015
Avoidable emergency admissions	Apr – Sept 2014	Oct 2014 – Mar 2015
Patient / service user experience	Details TBC	Details TBC

40. For the metric on patient / service user experience, no single measure of the experience of integrated care is currently available, as opposed to quality of health care or social care alone. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime, further details will be provided shortly on how patient / service user experience should be measured specifically for the purpose of the Fund.

41. In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

42. A menu of possible local metrics selected from the NHS, Adult Social Care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health services living independently with or without support
1D	Carer-reported quality of life
Public Health Outcomes Framework	

1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as “inactive”
2.24i	Injuries due to falls in people aged 65 and over

43. Local areas must either select one of the metrics from this menu, or agree a local alternative. Any alternative chosen must meet the following criteria:
    - it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
    - data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
    - it comes from an established, reliable (ideally published) source;
    - timely data is available, in line with requirements for pay for performance;
    - the achievement of the locally set level of ambition is suitably challenging; and
    - it creates the right incentives.

44. Each metric will be of equal value for the payment for performance element of the Fund.

45. Local areas should set an appropriate level of ambition for improvement against each of the national indicators, and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.

46. In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:
    - having a clear baseline against which to compare future performance;
    - understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
    - ensuring that any seasonality in the performance is taken in to account; and
    - ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

47. In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to be set such that it rewards a small improvement that is purely an artefact of variation in the underlying dataset.

How will plans be assured?

48. Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

49. To maximise our collective capacity to achieve these outcomes and deliver sustainable services the NHS and local government will have a shared approach to supporting local areas and assuring plans.

50. The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

51. The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers. The key elements of the overall assurance process are as follows:
    - Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).
    - If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA.
    - NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.
    - This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG, HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may

be resolved, either through provision of additional support or escalation to Ministers.

- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.
- Ministers will give the final sign-off to plans and the release of performance related funds.

What will be the consequences of failure to achieve improvement?

52. Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

53. If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.

54. If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.

55. If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

56. If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.

57. Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

When should plans be submitted?

58. Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by **14 February 2014**, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.

59. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

Annex J: Template Contents

Content of the Strategic Plan

[DN: content (and template) needs alignment with Part 1 content]

Segment	Covering:	Supported by:
System vision	A statement describing what the desired state would be for the health economy in 2018/19 – this should ideally describe the health system rather than an individual organisation view.	Stakeholder sign up Individual organisation visions
Integration	A statement describing the aims and objectives for integrated health and social care, as part of the overall system vision, explaining how use of the Better Care Fund will secure improved outcomes in health and care in the area.	Sign up from local authority and Health and Wellbeing Board
Quality Improvement	• Across the seven ambitions identified in Part 1 of this guidance, what levels of improvement does the health economy plan for?	Detailed metrics in the operational template for years 1 and 2
	• What other local quality improvement plans are in place and how do these align with the local strategic needs assessments?	Sign up from key stakeholders such as Health and Wellbeing Boards
Sustainability	In five years, what are the health economy goals for sustainability, including reference to financial position, activity levels, other resources and points of service delivery? This work should reference the 'do nothing' gap calculated for the system by 2018/19 that aligns to the challenges identified in *A Call to Action* and include risk-based model scenarios.	Detailed activity and financial metrics in the finance template.
Improvement interventions	To achieve the desired end state what are the key improvement interventions planned at an organisational level and how will these deliver the quality and sustainability outcomes required?	Contract expectations included in the financial template
Governance overview	A summary of the governance processes in place to oversee the delivery of the plans, including high level description of what success looks like and who is responsible for measuring it.	
Key values and principles	A summary of the agreed values and principles that underpin the system wide working required to deliver the vision.	

Content of Operational Plan

Segment	Covering:	Further detail:
Outcomes	Improvement against the measures to support the seven outcome ambitions: • Trajectory for *Clostridium difficile* reduction. • Trajectory for dementia diagnosis. • Trajectory for IAPT coverage and recovery. • Trajectory for seven outcome ambition measures. • Trajectory for Quality Premium measures (where different from seven outcome ambitions).	Measures set out in Annex A.
NHS Constitution	Self-certification of the delivery of all NHS Constitution rights and pledges.	Measures set out in Annex B.
Activity	Trajectories for: • Elective FFCEs. • Non elective FFCEs. • Outpatient attendances. • A&E attendances. • Referrals	Measures set out in Annex C.
Better Care Fund	Improvement against the agreed BCF measures.	Measures set out in Annex H.

Content of Financial Plan

Segment	Covering:
Financial plan summary	An overview of the financial plan.
Revenue resource limit	Detail of recurrent and non-recurrent allocations expected to be received. A
Planning assumptions	Provider efficiency, inflation, activity growth (demographic and non-demographic), contingency, headroom.
Financial plan detail 14/15-18/19	Financial plan for each of the next five years (2014/15 and 2015/16 at a higher level of detail). Planned income and expenditure for each service type (acute, MH, community).
QIPP 14/15-18/19	Detail of financial impact of QIPP schemes for each of the next five years with profile for the first two years.
Risk	Details and valuation of identified risks over each of the next five years (2014/15 and 2015/16 at a higher level of detail). Details of mitigation strategies including anticipated funding.

Segment	Covering:
Investment	Details of planned investment over each of the next five years including use of headroom.
Statement of financial position	Detail assets, liabilities and taxpayers' equity for each of the next two years.
Cash	Breakdown of receipts and payments over each of the next two years.
Capital	Planned capital expenditure by scheme for each of the next five years.
Contract value 14/15-18/19	Details of forecast spend on current contracts for 13/14 and anticipated contract value for each of the next five years.

Content of Direct Commissioning Financial Plan

	Segment	Covering:
	Area Team Summary	Summary of the financial plan for all directly commissioned services for Area Team.
For each Directly Commissioned service	Financial plan summary	An overview of the financial plan for each area of direct commissioning.
	Resource allocations	Details of allocation for service for each of the next five years.
	Assumptions	Provider efficiency, inflation, activity growth (demographic and non-demographic) – assumptions for each of the next five years.
	Financial Plan Detail	Financial plan for each of the next five years (2014/15 and 2015/16 at a higher level of detail).
	QIPP	Detail of financial impact of QIPP schemes for each of the next five years and saving profile for each of the next two years (2014/15 and 2015/16 at a higher level of detail).
	Investment	Details of planned investment over each of the next five years (2014/15 and 2015/16 at a higher level of detail).
	NR proposals	Proposals for non-recurrent funding over each of the next five years.
	Risk	Details and valuation of identified risks over each of the next five years. Details of mitigation strategies and funding required (2014/15 and 2015/16 at a higher level of detail).
	Contract value 14/15-18/19	Details of forecast spend on current contracts for 13/14 and anticipated contract value for each of the next five years.

Table X: Content of Direct Commissioning Operational Plan: NHS England commissioning improvement measures

Segment	Covering:	Supported by:
1. Improvement Measures	Improvement against the measures identified for area of Direct commissioning.	Measures set out in Annexes D-G
2. NHS Constitution	Self-certification of the delivery of all relevant NHS Constitution rights and pledges.	Measures set out in Annex B.
3. Activity	Trajectories for relevant activity measures for direct commissioning area	Measures set out in Annex C.

2013

Kent County Council

Dr Anne Imkampe,
Public Health Registrar

ASHFORD HEALTH PROFILE

A health profile of the population that is covered by the Ashford Clinical Commissioning Group.

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Many thanks to:

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CONTENTS

EXECUTIVE SUMMARY

Changes or additions to the Ashford Health Profile Report from 2011 are highlighted.

Demographics

1. Ashford's population is ageing due to lower birth rates and higher life expectancy over the past few decades. This is a universal problem that many developed countries currently face. The implications for health services are: increasing need for health and social care for elderly people at home or in care homes, requiring more staff and more funding.

2. There is a large difference in life expectancy between electoral wards within Ashford and this is a strong indicator for the existence of health inequalities. CCGs need to ensure that access to NHS care is equitable across different groups.

Community

3. **Pupils in Ashford have a lower rate achieving GCSEs including English and Mathematics than pupils in England overall**. Evidence has shown that Sure Start children centres have positive effects on children abilities and visits should be encouraged. Healthy schools programmes have helped to promote good learning environments and need continued support.

4. **Homelessness in Ashford is high and homeless people have disproportionately more health problems than the general population**. Hospital services are used more frequently. Health needs of homeless people are currently not met and access to primary care and prevention programmes needs to improve.

Lifestyle

5. People living in deprived areas consume less fruit and vegetables. Public health programmes to encourage healthy eating have been rolled out in Ashford and should continue. NICE guidance suggests that small programmes targeted at high risk groups and longer interventions with a sound theoretical basis are most effective.

6. Adult obesity is a particular problem in Ashford. NICE recommends a combined approach, addressing diet and exercise. Group interventions are superior to individual interventions. Public Health interventions to reduce weight available for adult Ashford residents mainly consist of 1:1 appointments and commissioners may want to consider installing group level interventions in addition.

7. Smoking prevalence is highest in people from routine and manual occupations. NICE recommends a harm-reduction approach to reduce smoking prevalence which promotes cutting down and reducing cigarette consumption for those not able to stop abruptly. The use of licensed nicotine-containing products should be encouraged. The programme is expected to be rolled out in Kent in 2014.

Inequalities by population group

8. Young people:

    - Childhood obesity is a significant problem with rates of around 19% in Ashford. A variety of Public Health Programmes are currently running focusing on weight reduction in children. Support for these programmes

should continue together with monitoring that the correct target groups are reached.

- Teenage pregnancy rates have been falling but are high in areas of high deprivation. Effective interventions include school-based SRE (sex and relationship education) linked to contraceptive services and Youth Development Programmes. SRE is currently provided within the Healthy Schools Programmes. Initiatives like HOUSE for young people, started in 2011, also offer advice and aim to reach high risk groups.

9. Maternity:

    - **Smoking during pregnancy is a problem in Ashford with rates significantly higher than the England average.** NICE has published guidance on this topic and suggests cognitive behaviour therapy, motivational interviewing, structured self-help and support from NHS Stop Smoking Services. CO testing by midwifes is recommended and all staff (midwifes, smoking advisors, etc) should have appropriate training and know to ask questions in a way that women speak openly about their smoking status.

    - **Breast feeding initiation rates in Ashford are low.** It is important to educate women on the positive effects of breastfeeding, either in group sessions or 1:1. Promotions delivered over both the ante- and postnatal period have been shown to be beneficial.

10. Older people

    - **Rates of hip fractures are high in some electoral wards in Ashford.** Access to Falls Prevention Services for elderly residents needs to be ensured with a focus on wards with high hip fracture prevalence.

Use of Health Services

11. Emergency admissions in Ashford are comparatively lower than in the rest of Kent. It is important that commissioners are aware of what types of admissions are avoidable and how to prevent them. Encouraging self-management of people with Long Term Conditions and good access to primary care including out-of-hours are important.

12. Vaccination uptake rates in Ashford practices are good with most reaching the WHO target of 95% or more.

13. **Not all practices in Ashford are achieving national targets in screening uptake and inequalities in uptake by deprivation quintile have been shown.** Practices serving more deprived populations may need to be more active to increase uptake. Efforts should be made to encourage attendance in those who have never participated in screening and economic barriers should be reduced. Healthcare professionals could use reminder systems such as tagged notes.

Long Term Conditions

14. Long Term Conditions are expected to increase as the population structure gets increasingly older. **There are large variations in prevalence by GP practice suggesting a risk of under diagnosis in some population groups.** Case finding is important in order to target prevention programmes to the appropriate population groups.

15. The focus for people with long term conditions should be on self-care but with appropriate services and equipment available to support patients and their carers.

Ashford's plans for expansion

16. The **population in Ashford is expected to grow rapidly** over the next few years as a number of new developments are in the planning stage. Public health issues are: i) to ensure good access to primary care with enough capacity to include new residents in preventative health programmes; ii) to encourage physical activity and design new built areas with community spaces, safe roads and cycle lanes; and iii) to promote healthy eating by making fresh food available locally and give space for own produce/community gardens.
    A careful design of new developments will encourage the development of social cohesion and have positive influences on people with mental health problems.

1 INTRODUCTION

1.1 HEALTH AND SOCIAL CARE ACT

Clinical Commissioning Groups (CCGs) were set up under the Health and Social Care Act 2012 and became functional on 1st April 2013. CCGs have responsibilities to commissioning health services for the local area. Duties of CCGs are specified in the Health and Social Care Act and include the duty to

(a) Reduce inequalities between patients with respect to their ability to access health services, and
(b) Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

1.2 INEQUALITIES IN HEALTH

The review on health inequalities in England published by Michael Marmot in 2010: "Fair Society, Healthy Lives" gives the key message that "the fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair…Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole society."

In the report recommendations it is highlighted that "reducing health inequalities will require action on six policy objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups."

Under the NHS reconfiguration, CCGs work closely together with local hospitals, Public Health and the Local Authority. Reducing health inequalities in society is a joint effort and concerns not just health service provision but includes the physical, social and economic environment.

1.3 THE ROLE OF CCGS

With the duty of reducing inequalities in health in the local population, one focus for commissioners should be, in line with Michael Marmots recommendations, on ill-health prevention.

1.3.1 PRIMARY PREVENTION

Illness is often preventable and differences in health behaviour are a major contributing factor to inequalities in health. It is important to invest into preventative programmes such as healthy nutrition advice, exercise classes, stop smoking support, falls prevention etc. The delivery of prevention programmes needs to be equitable so that no population groups are disadvantaged in access and outcomes.

1.3.2 SECONDARY PREVENTION

A number of screening programmes have been rolled out over recent years in order to detect and treat disease at an early stage, therefore reducing the demand on resources at more advanced stages and improve outcomes. Some cancers are curable when detected early and complications of cardiovascular disease and diabetes can be avoided when timely treatment and health advice is given.

It is important to further promote active case finding through health checks and screening programmes and to raise awareness of early disease symptoms within the population so that disease presentation is at an early stage.

1.3.3 TERTIARY PREVENTION

Long term conditions are a concern with much pressure on health care systems. Frequent use of health services are an indication that individuals are often not supported sufficiently in the community. Investments should be made into support programmes that help people with disabilities to cope with their illness, to gain higher degrees of independence and to improve quality of life.

1.4 AIM OF THIS REPORT

This report on the Ashford Health Profile has two main tasks:

1. To report characteristics of the population within the Ashford CCG, highlighting specific needs for CCGs to incorporate in commissioning decisions and future planning.
2. To show changes that have occurred since the last health profile was undertaken in 2011.

2 METHODS

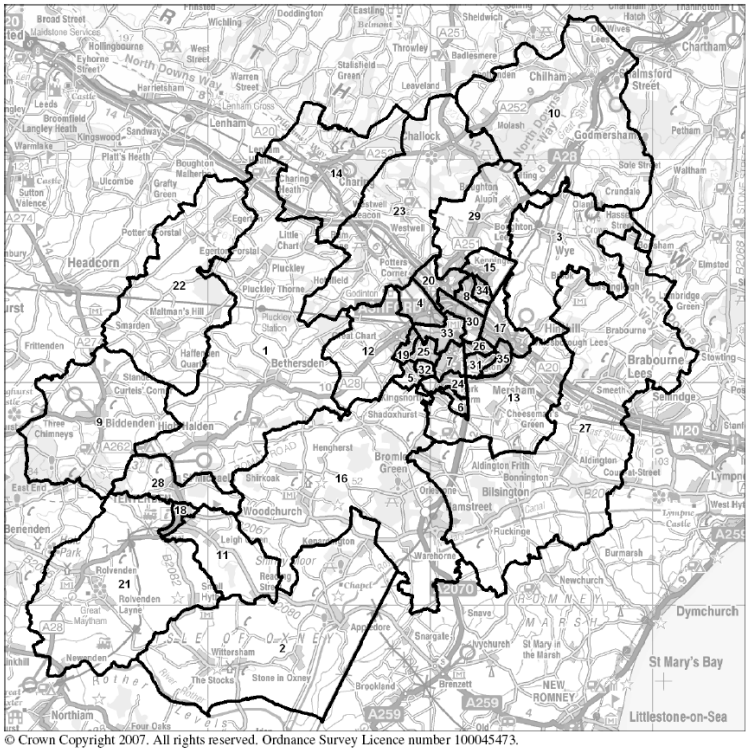
Information was collected from the Kent & Medway Public Health Observatory, the Network of Public Health Observatories (APHO) website, now part of Public Health England, from the Health & Social Care Information Centre website (NCHOD) and from the Office for National Statistics (ONS).

3 DEMOGRAPHICS

3.1 GEOGRAPHY

There are seven Clinical Commissioning Groups (CCGs) in Kent: (i) Ashford, (ii) Canterbury & Coastal, (iii) Dartford, Gravesham & Swanley, (iv) South Kent Coast, (v) Swale, (vi) Thanet and (vii) West Kent. Ashford CCG boundaries are based on Ashford LA electoral wards (Figure 1), but two wards (Biddenden and Weald North) are covered by West Kent CCG and one ward (Downs North) is covered by Canterbury CCG (Figure 2). There are 16 GP practices in the Ashford CCG area, distributed as seen in Figure 3.

Key to Electoral Wards in Ashford LA



No.	Ward Name	No.	Ward Name
1	Weald Central	19	Singleton South
2	Isle of Oxney	20	Bockhanger
3	Wye	21	Rolvenden and Tenterden West
4	Godinton	22	Weald North
5	Washford	23	Downs West
6	Park Farm South	24	Park Farm North
7	Norman	25	Beaver
8	Bybrook	26	Aylesford Green
9	Biddenden	27	Saxon Shore
10	Downs North	28	St. Michaels
11	Tenterden South	29	Boughton Aluph and Eastwell
12	Great Chart With Singleton North	30	Stour
13	Weald East	31	South Willesborough
14	Charing	32	Stanhope
15	Kennington	33	Victoria
16	Weald South	34	Little Burton Farm
17	North Willesborough	35	Highfield
18	Tenterden North		

Figure 1: Electoral Wards in Ashford LA

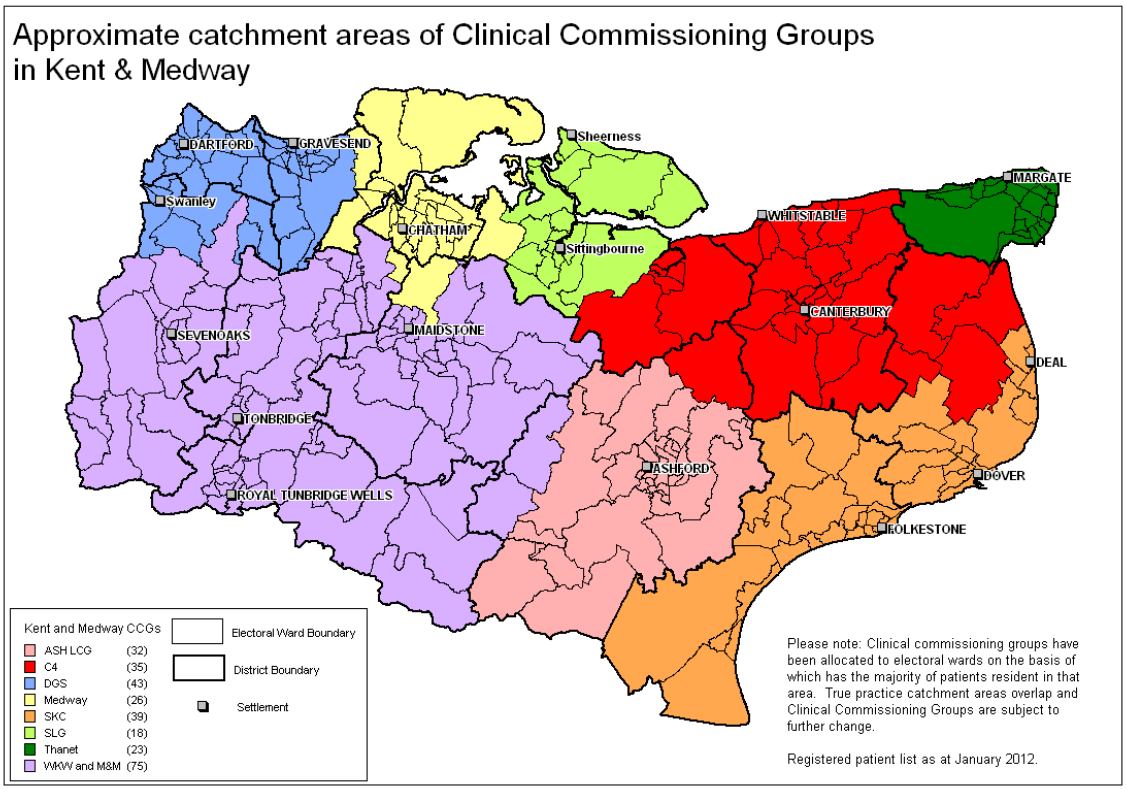
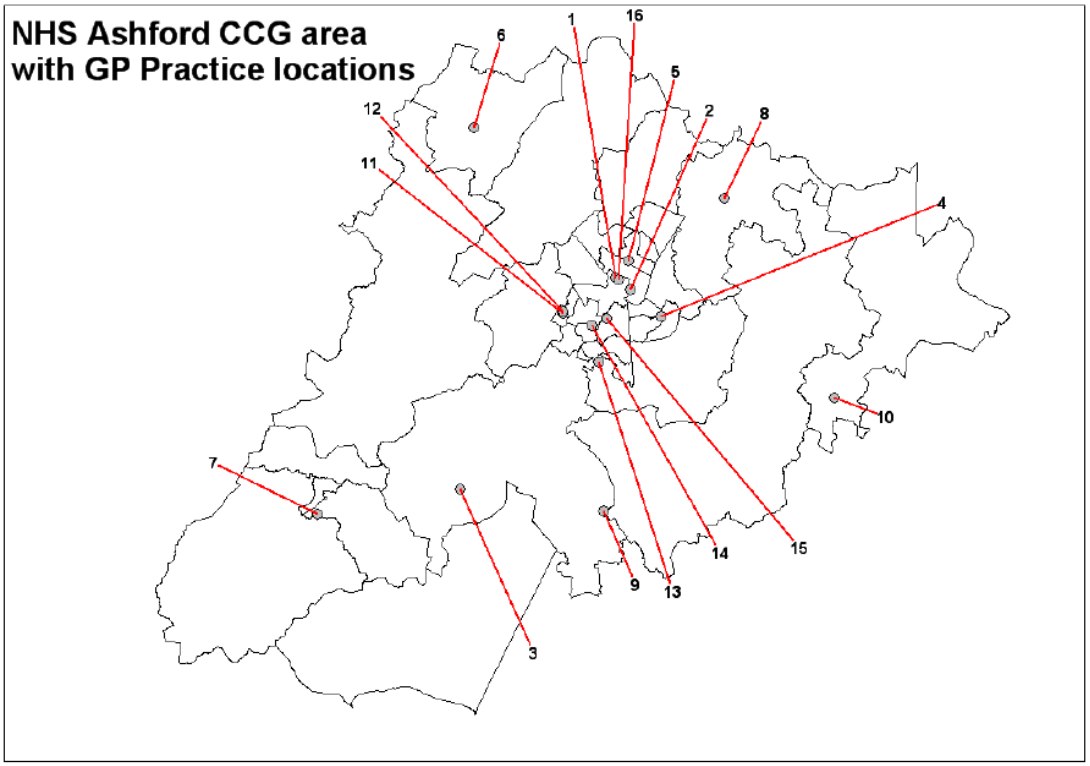


Figure 2: Clinical Commissioning Groups catchment areas



Key	Practice	Practice name
1	G82049	Dr Mohammed Y I
2	G82050	Sydenham House Medical Centre
3	G82053	Dr Busk C M A & Partner
4	G82080	Dr Cooney J A F & Partners
5	G82087	Dr Diu R S & Partners
6	G82094	The Charing Surgery
7	G82114	Dr Lloyd-Smith A R & Partners
8	G82142	Dr Waller R & Partners
9	G82186	Dr Lai A K T &| Partner
10	G82658	Dr Del Bianco G & Partner
11	G82688	Dr Setty M V S
12	G82712	Dr Thomas A
13	G82730	Dr Kelly J C & Partners
14	G82735	St Stephens Health Centre
15	G82748	Dr Fernandes M A A
16	G82788	Dr Pinnock R G

Figure 3: GP practice locations in Ashford

3.2 POPULATION SIZE AND STRUCTURE

3.2.1 CURRENT POPULATION

The 16 GP practices within the Ashford CCG serve a population of 120,116 (ONS, mid-year estimates 2012). The population pyramid shows graphically the distribution of age groups in a population. The distribution of the Ashford CCG population can be classified as a "constrictive" pyramid, meaning that there are lower numbers of young people and larger numbers in the age ranges between 40 and 69. This type of age structure is often referred to as the "ageing population time bomb". The shift in age structure towards older people with a simultaneous reduction in working-aged adults has implications on future pensions, provision of health and social care and economic growth.

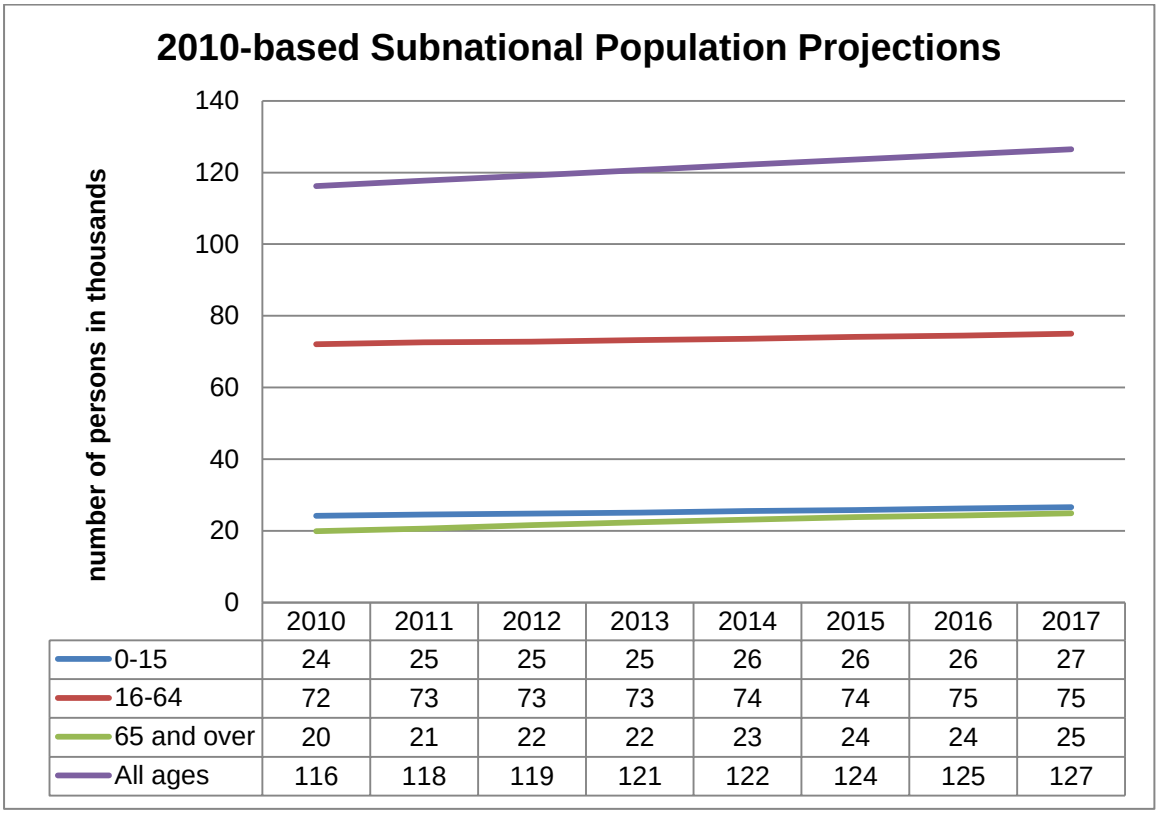
In comparison to England, Ashford has a considerably smaller proportion of 20 to 34 year olds and a larger proportion of 40-49 and 60+ year olds.

Figure 4: Population pyramid for Ashford CCG

3.2.2 POPULATION PROJECTIONS

Population projections are carried out by the Office for National Statistics (ONS) for the whole of the UK and also for regions and Local Authorities. Future population size and structure is calculated based on future trends in fertility, mortality and migration.

The population in Ashford is predicted to increase over the next few years with the largest percentage increase expected in the 65+ year age group (20,000 in 2010 to 25,000 in 2017 = 25%).

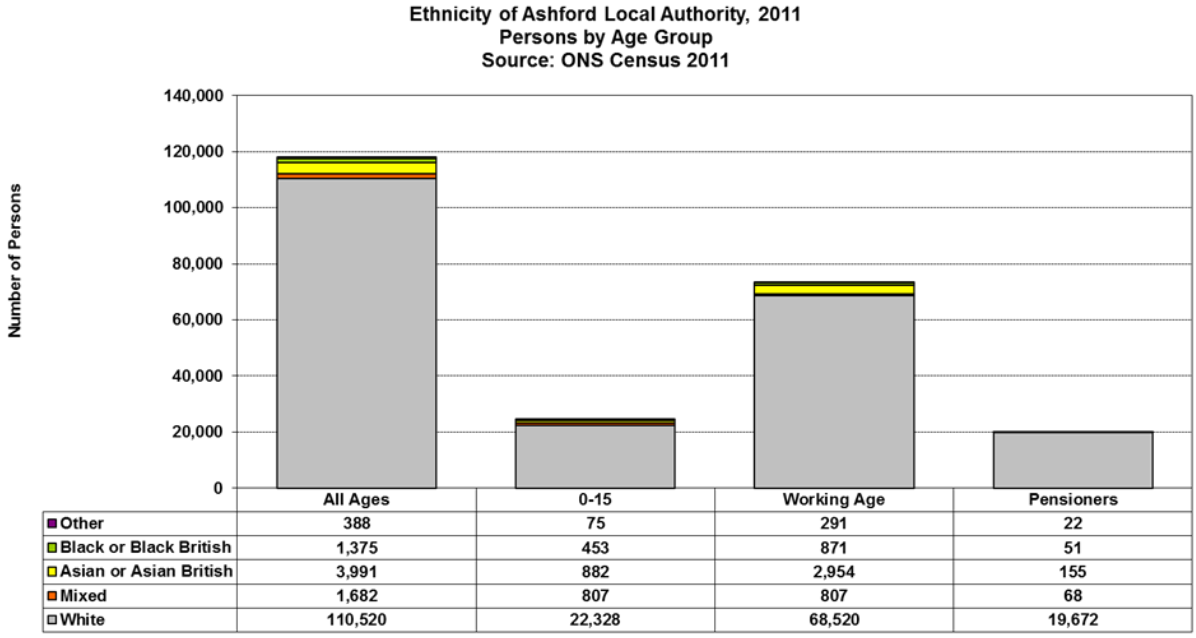


	2010	2011	2012	2013	2014	2015	2016	2017
0-15	24	25	25	25	26	26	26	27
16-64	72	73	73	73	74	74	75	75
65 and over	20	21	22	22	23	24	24	25
All ages	116	118	119	121	122	124	125	127

Figure 5: Population projections for Ashford LA

3.3 ETHNICITY

The ethnic majority in Ashford is White British (estimated 110,520 people compared to 7,436 people in BME groups). The highest percentage of BME groups is in those of working age (9.0%) and the lowest percentage is in pensioners (1.5%).

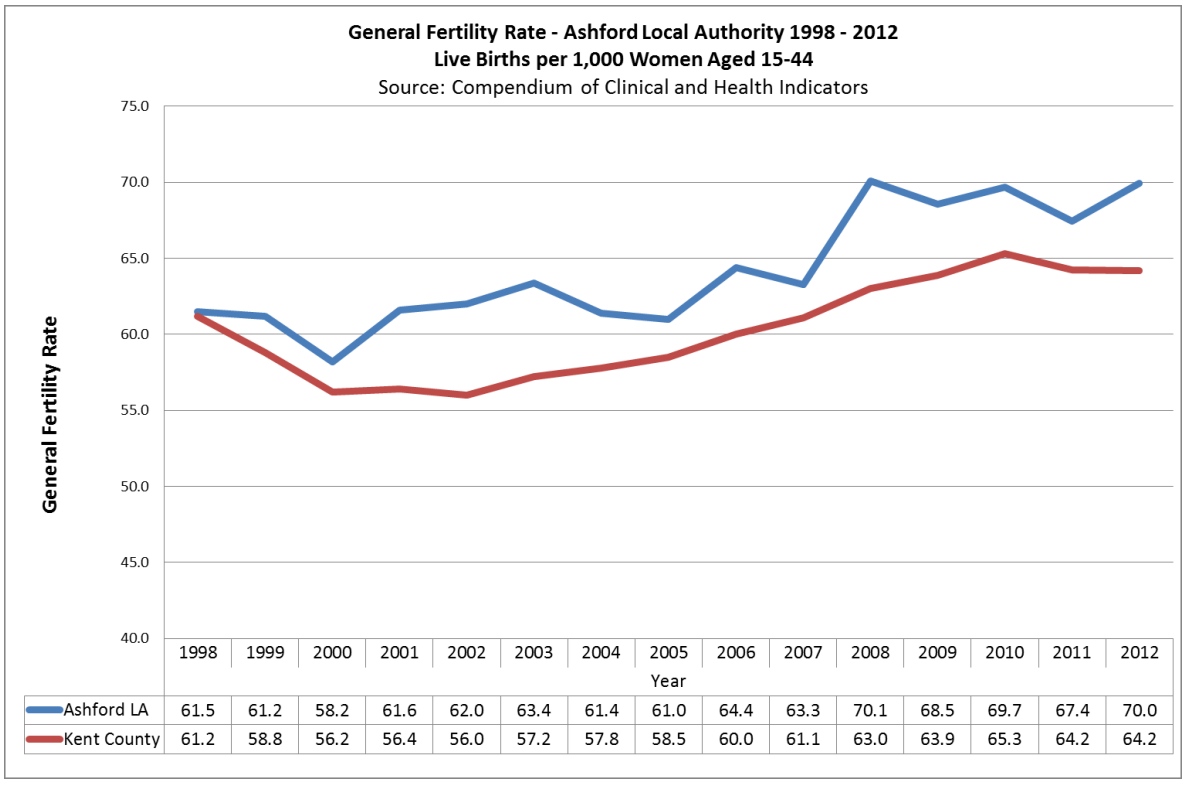


	All Ages	0-15	Working Age	Pensioners
Other	388	75	291	22
Black or Black British	1,375	453	871	51
Asian or Asian British	3,991	882	2,954	155
Mixed	1,682	807	807	68
White	110,520	22,328	68,520	19,672

Figure 6: Black and Minority Ethnic Groups in Ashford by age group

3.4 FERTILITY

The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15-44 per year. In Ashford, the GFR has increased from 2000 to 2008 but seems fairly stable at around 70/1000 live births per year from 2008 onwards (Figure 7). The GFR in Kent overall is lower than the Ashford rate.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Ashford LA	61.5	61.2	58.2	61.6	62.0	63.4	61.4	61.0	64.4	63.3	70.1	68.5	69.7	67.4	70.0
Kent County	61.2	58.8	56.2	56.4	56.0	57.2	57.8	58.5	60.0	61.1	63.0	63.9	65.3	64.2	64.2

Figure 7: General Fertility Rate over time for Ashford LA

The highest GFRs are found in the electoral wards of Stanhope, Singleton South and South Willesborough. Lowest rates are in Saxon Shore, St Michaels and Charing (Figure 8).

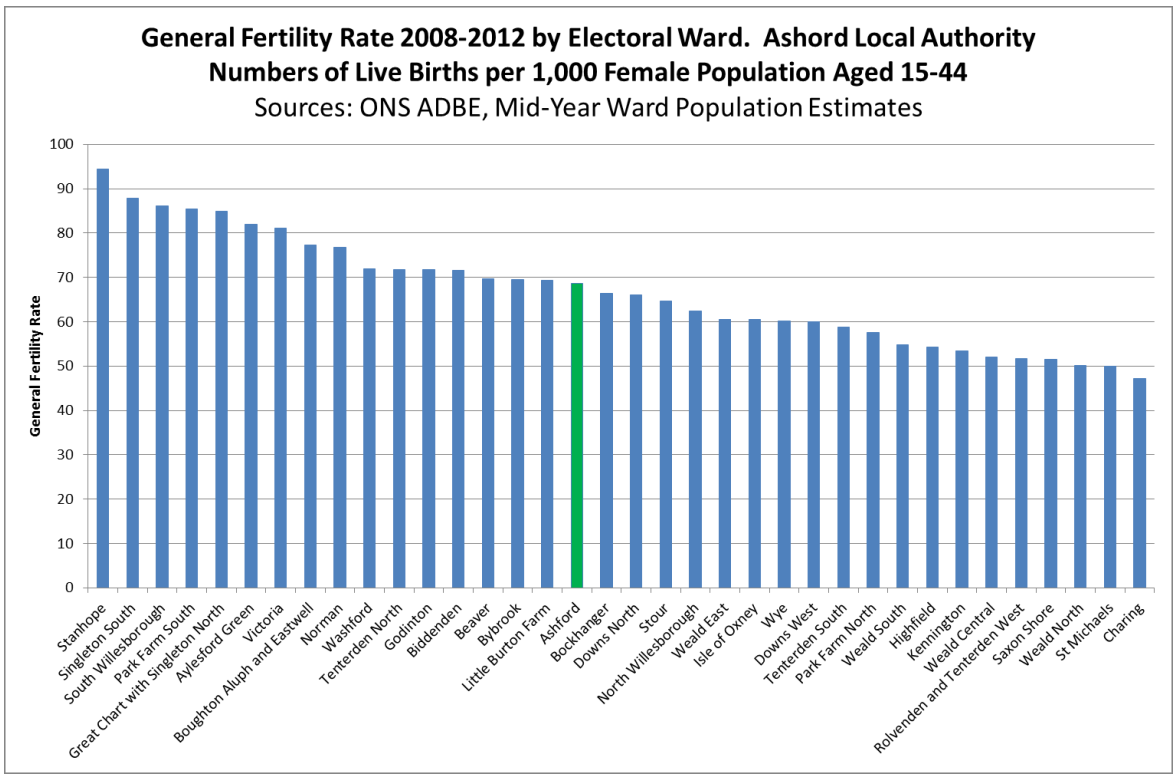


Figure 8: General Fertility Rate by electoral ward in Ashford LA

3.5 LIFE EXPECTANCY

Life expectancy can be defined as a “median” survival time in years from birth or a given age, meaning the number of years until 50% of a certain age-group has died. Life expectancy has generally improved over the last decades but improvements have been shown to vary by socio-economic group.

In Ashford, life expectancy ranges from 93.5 years in Park Farm North to 77.8 years in Weald North (Figure 9).

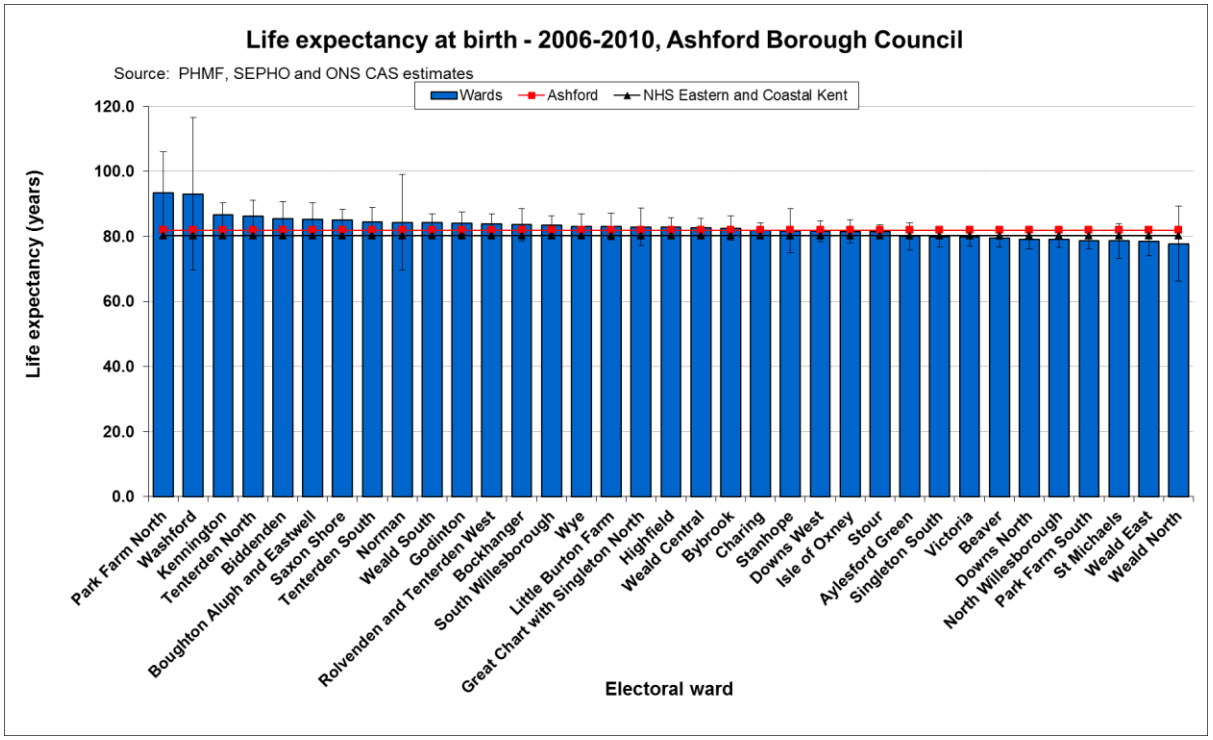
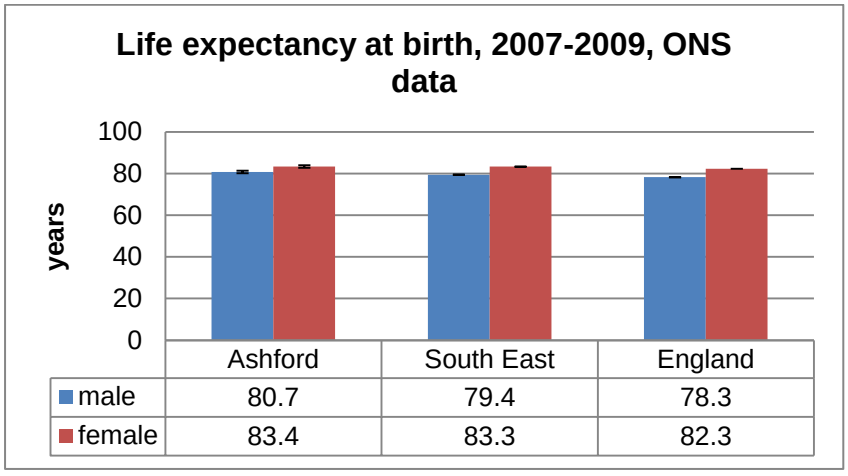


Figure 9: Life expectancy at birth by electoral ward for Ashford LA

Average life expectancy in Ashford is comparable to life expectancy in the South East and in England (Figure 10).



	Ashford	South East	England
male	80.7	79.4	78.3
female	83.4	83.3	82.3

Figure 10: Ashford LA life expectancy in comparison to the South East and England

3.6 INFANT MORTALITY

Infant mortality is defined as the number of deaths in infants, aged one year and younger, per 1,000 live births. It is seen as a key indicator of the overall health of a society because the majority of these deaths are preventable.

The infant mortality rate for Ashford was 3.2 deaths per 1,000 live births in 2009-2011 (pooled data). This compares to 4.4 deaths/1,000 in England and 3.5 deaths/1,000 in the South East Coast area (Figure 11).

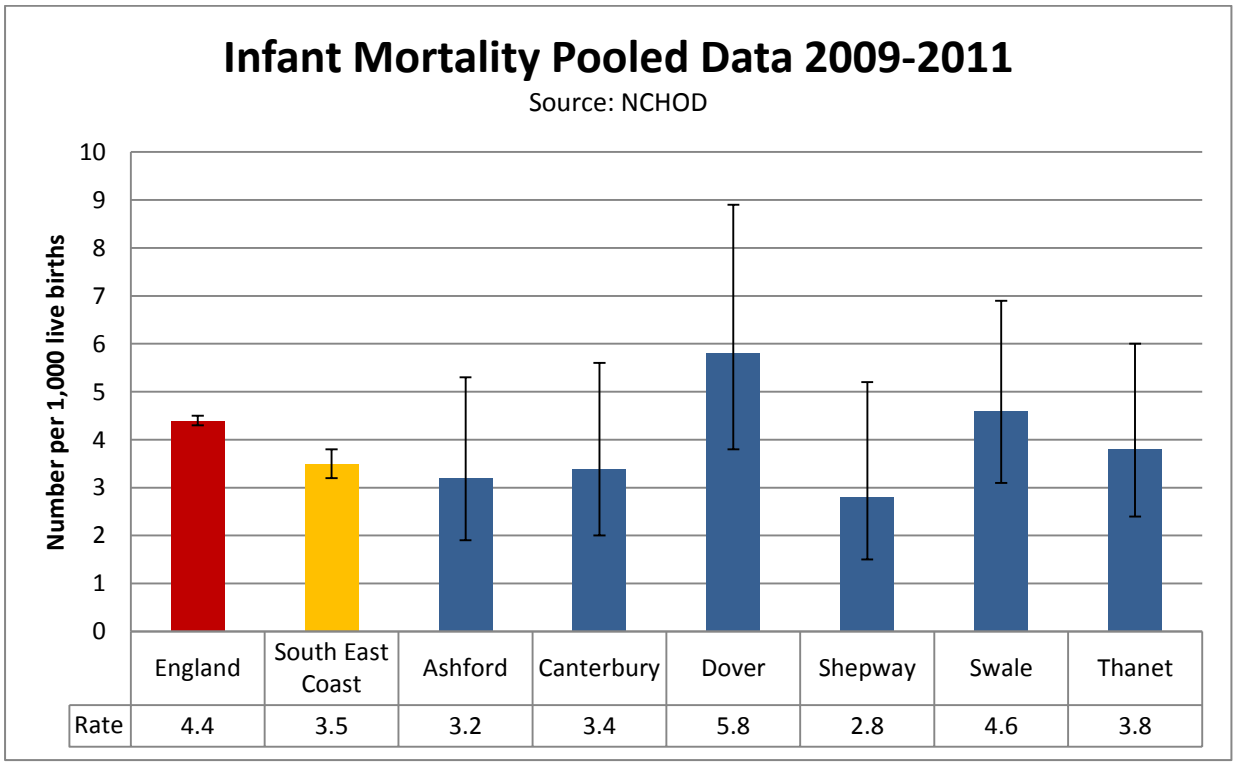
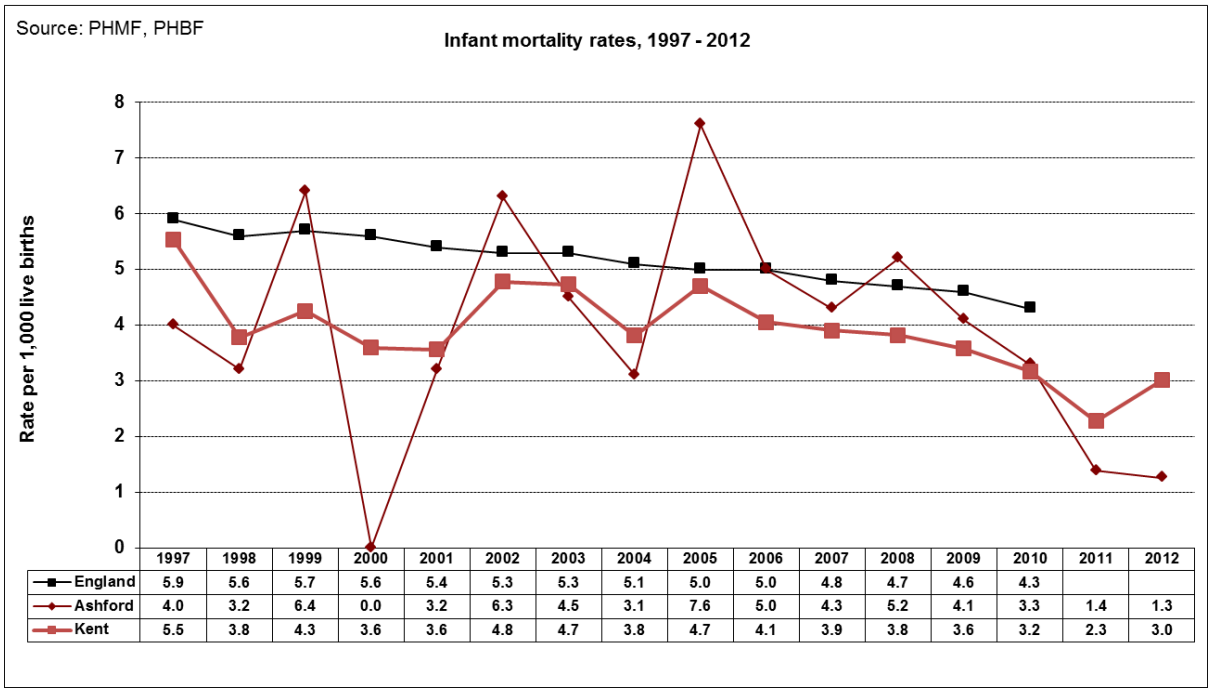


Figure 11: Infant mortality rates in Ashford compared to areas in Kent and nationally

Overall, infant mortality rates have been decreasing continuously over time, in Ashford as well as nationally (Figure 12).



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
England	5.9	5.6	5.7	5.6	5.4	5.3	5.3	5.1	5.0	5.0	4.8	4.7	4.6	4.3		
Ashford	4.0	3.2	6.4	0.0	3.2	6.3	4.5	3.1	7.6	5.0	4.3	5.2	4.1	3.3	1.4	1.3
Kent	5.5	3.8	4.3	3.6	3.6	4.8	4.7	3.8	4.7	4.1	3.9	3.8	3.6	3.2	2.3	3.0

Figure 12: Infant mortality rates over time in Ashford, Kent and England

3.7 MORTALITY CAUSES

The main cause of death in Ashford is from circulatory causes, followed by cancer and then respiratory disease.

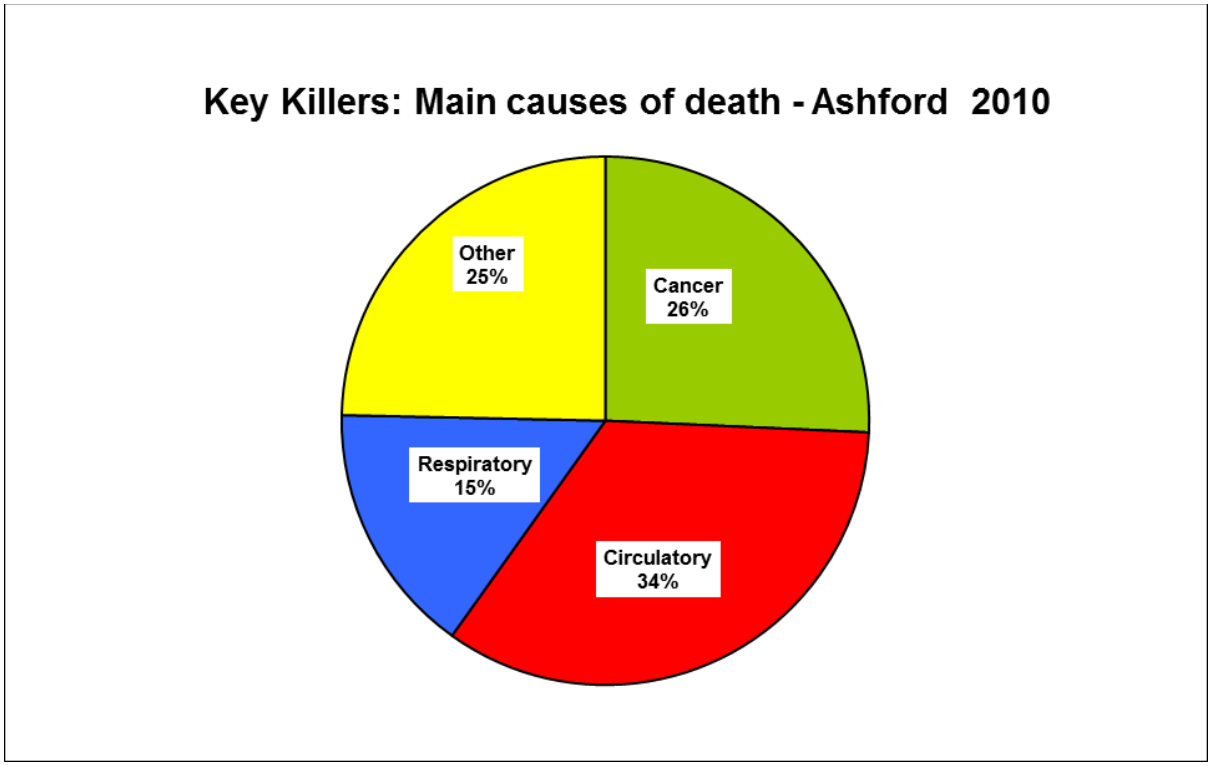
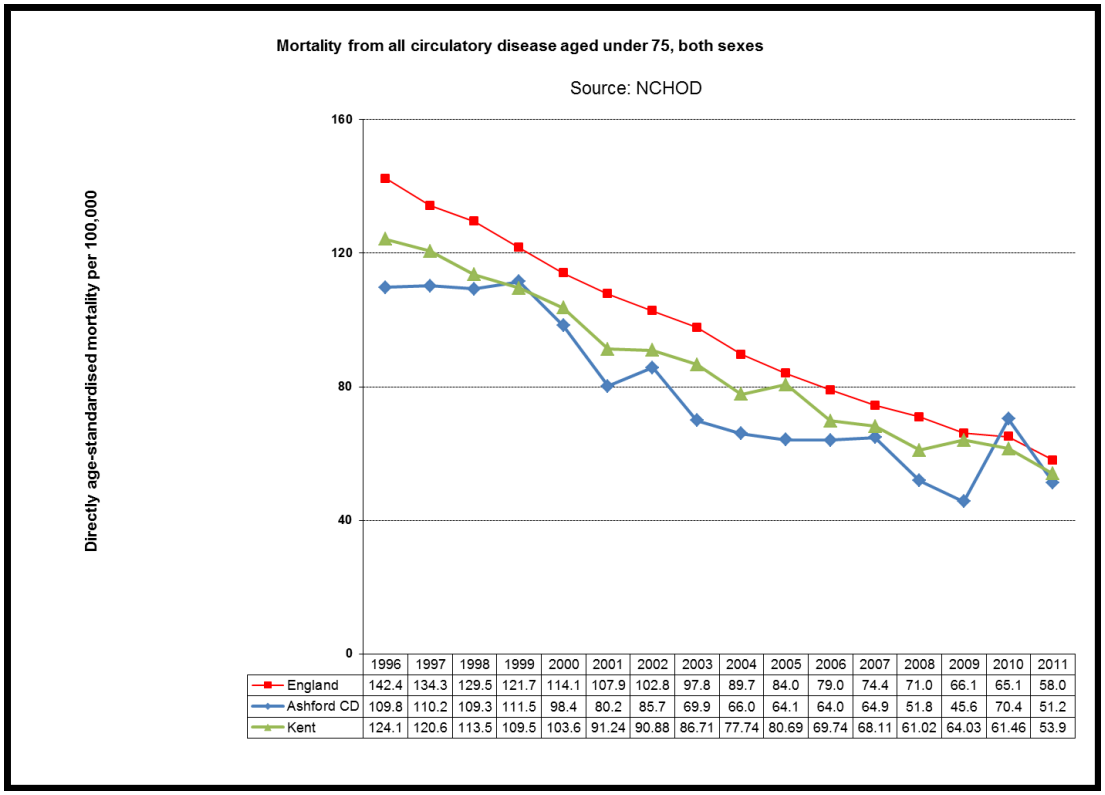


Figure 13: Causes of death, Ashford

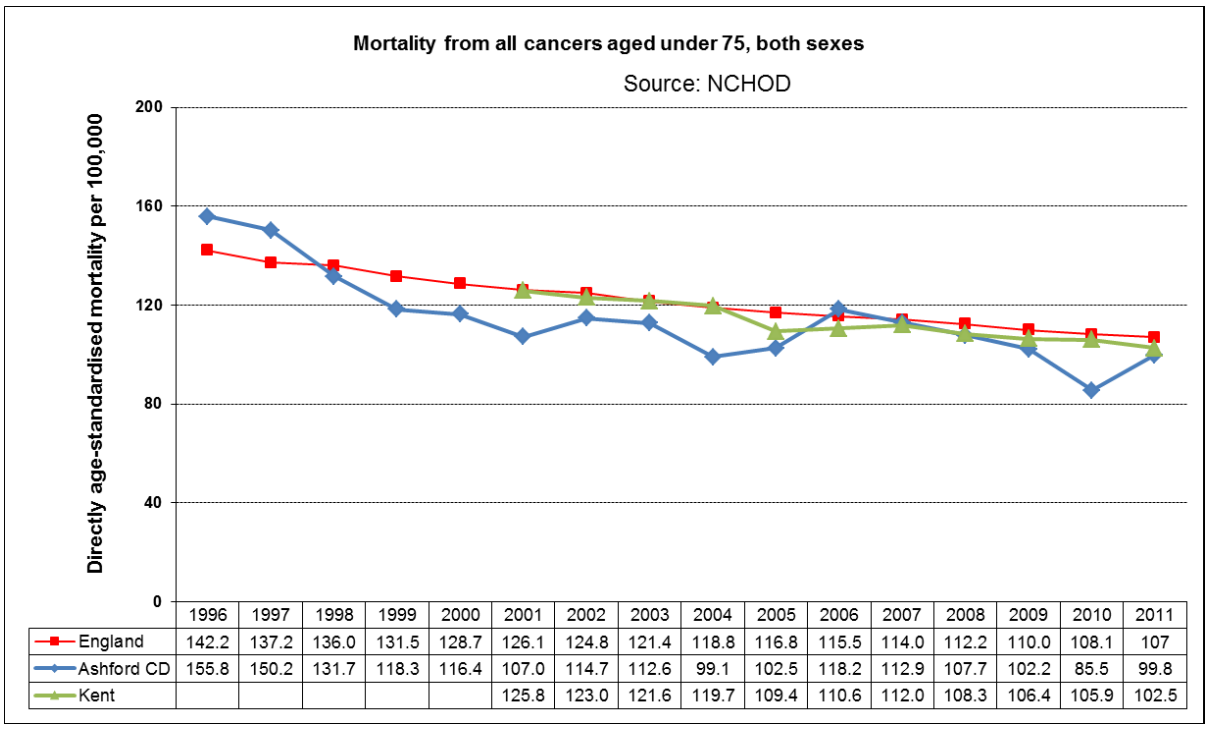
Death from circulatory disease has been decreasing steadily in Ashford from about 110/100,000 deaths in 1996 to 51/100,000 deaths in 2011. This trend is seen across England.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
England	142.4	134.3	129.5	121.7	114.1	107.9	102.8	97.8	89.7	84.0	79.0	74.4	71.0	66.1	65.1	58.0
Ashford CD	109.8	110.2	109.3	111.5	98.4	80.2	85.7	69.9	66.0	64.1	64.0	64.9	51.8	45.6	70.4	51.2
Kent	124.1	120.6	113.5	109.5	103.6	91.24	90.88	86.71	77.74	80.69	69.74	68.11	61.02	64.03	61.46	53.9

Figure 14: Mortality from circulatory disease over time

Mortality from cancer has also decreased, from 156/100,000 deaths in 1996 to 100/100,000 deaths in 2011. Again, a similar trend is observed for the whole of England.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
England	142.2	137.2	136.0	131.5	128.7	126.1	124.8	121.4	118.8	116.8	115.5	114.0	112.2	110.0	108.1	107
Ashford CD	155.8	150.2	131.7	118.3	116.4	107.0	114.7	112.6	99.1	102.5	118.2	112.9	107.7	102.2	85.5	99.8
Kent						125.8	123.0	121.6	119.7	109.4	110.6	112.0	108.3	106.4	105.9	102.5

Figure 15: Mortality from cancer over time

Public Health Interventions and Recommendations:

- Ashford has an "ageing" population structure and population projections predict further population increases disproportionately in older age groups over the next years. This has implication on the provision of health care and social care at home or in care homes with increasing needs for staff and funding in the future. Plans need to be in place on how the demand will be met.

- The General Fertility Rate (GFR) has been stable and similar to the England average over the last few years. There are, however, geographical pockets within Ashford where GFRs are high: Stanhope Ward, Singleton South Ward and South Willesborough Ward. There will be a higher demand for maternity services, health visitors and nurseries/schools in these areas.

- Life expectancy in Ashford is similar to national figures but the maximum gap between electoral wards is over 15 years difference. This is a strong indicator for the existence of health inequalities. Kent County Council has published an action plan: MIND THE GAP that includes strategies and targets to reduce inequalities in Kent[1]. CCGs need to ensure that access to NHS care is equitable across different groups: "*Emphasis on reducing inequalities should be focused on delivering screening and prevention programmes including Health Checks, immunisations, early diagnosis and reducing the burden of Long Term Conditions to the right populations not just those that present themselves*."

- The main cause of death in Ashford is from circulatory disease, followed by cancer and respiratory disease. Mortality from circulatory disease and from cancer has been decreasing since 1996. This is an encouraging observation and the aim should be to maintain this trend of reducing avoidable deaths. Equitable access to relevant prevention programmes needs monitoring, particularly stop smoking services, cancer screening programmes and NHS health checks.

[1] http://www.kmpho.nhs.uk/easysiteweb/getresource.axd?assetid=228636&type=0&servicetype=1

4 COMMUNITY

4.1 DEPRIVATION

Deprivation is presented based on national quintiles of the Index of Multiple Deprivation (IMD) 2010 by Lower Super Output Area (LSOA). LSOAs are small geographical areas of relatively even size (around 1,500 people). There are 32,482 of these areas in England. The Index of Multiple Deprivation is derived from seven distinct domains: Income Deprivation, Employment Deprivation, Health Deprivation and Disability, Education Skills and Training Deprivation, Barriers to Housing and Services, Living Environment Deprivation, and Crime. Using appropriate weights, measures from these domains are combined which allows each geographical area in England to be ranked according to deprivation experienced.

The graph shows the England deprivation quintiles and in comparison the percentage of the population of each deprivation quintile living in the local area.

In Ashford, over 75% of people live in the middle three quintiles with 20% living in the most affluent quintile and only 5% in the most deprived quintile.

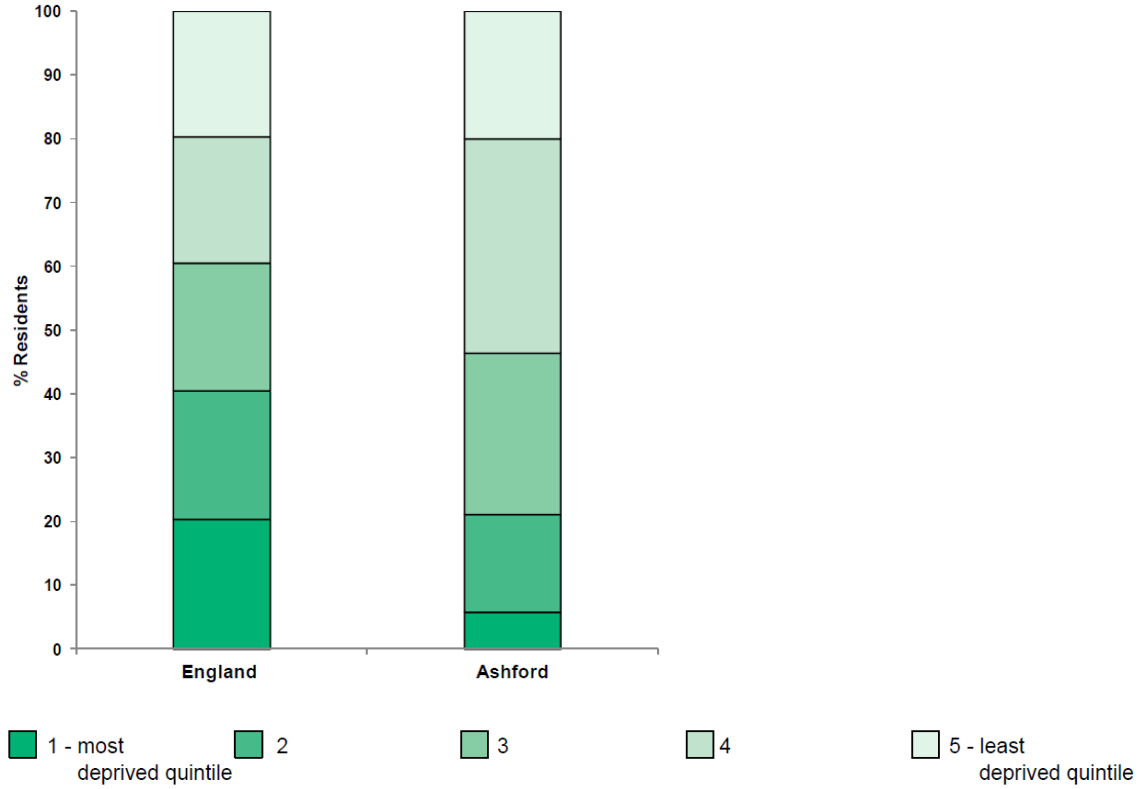


Figure 16: Deprivation quintiles in Ashford, 2013

Geographically, the most deprived areas in Ashford are: Stanhope Ward, Beaver Ward, Victoria Ward, Downs West Ward, Bockhanger Ward, Aylesford Green Ward and Norman Ward (Figure 17)

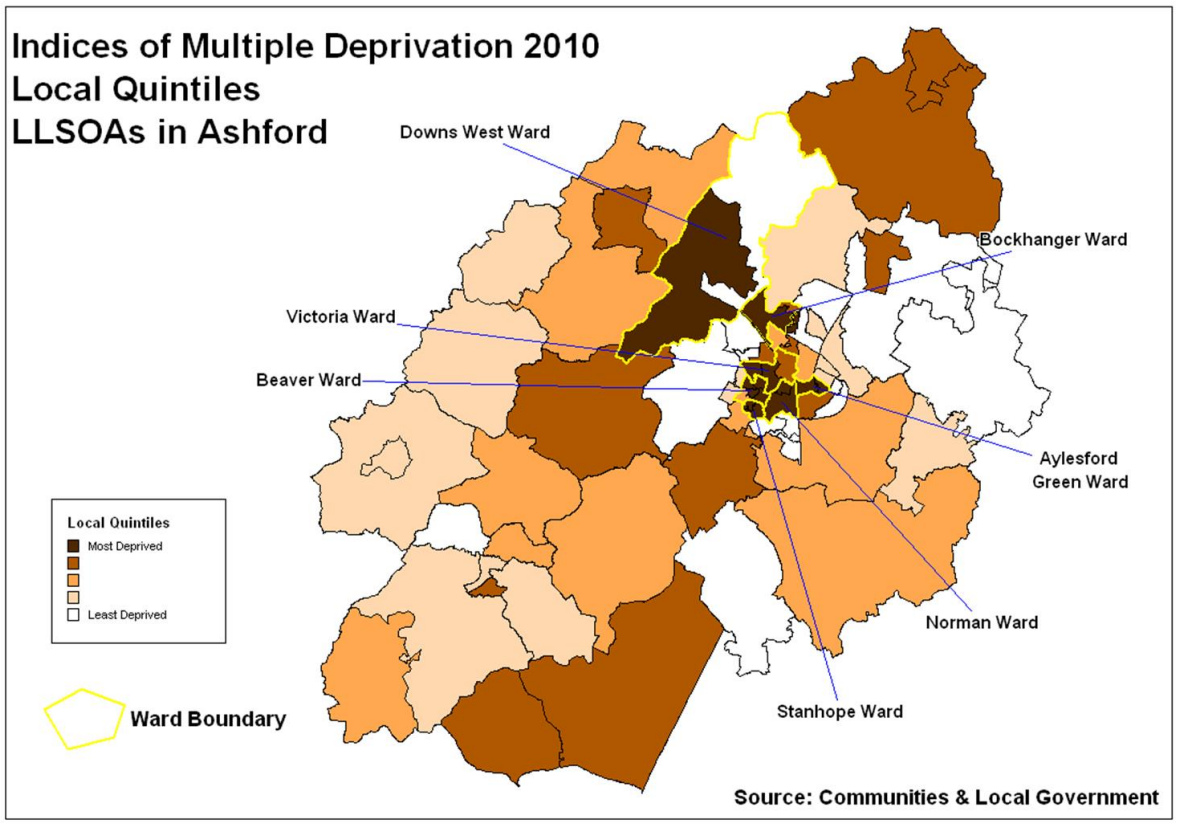


Figure 17: Deprivation in Ashford by electoral ward

The yellow lines demarcate those wards in Ashford within which most deprivation is experienced.

Deprivation is linked to overall health and life expectancy. This is illustrated in Figure 18, which was published in the Michael Marmot review: “Fair Society, Healthy Lives”. Awareness of where the local areas of high deprivation are, is essential in order to know where need is greatest. Areas of higher deprivation will require more resources and investments for an overall reduction in inequalities in health.

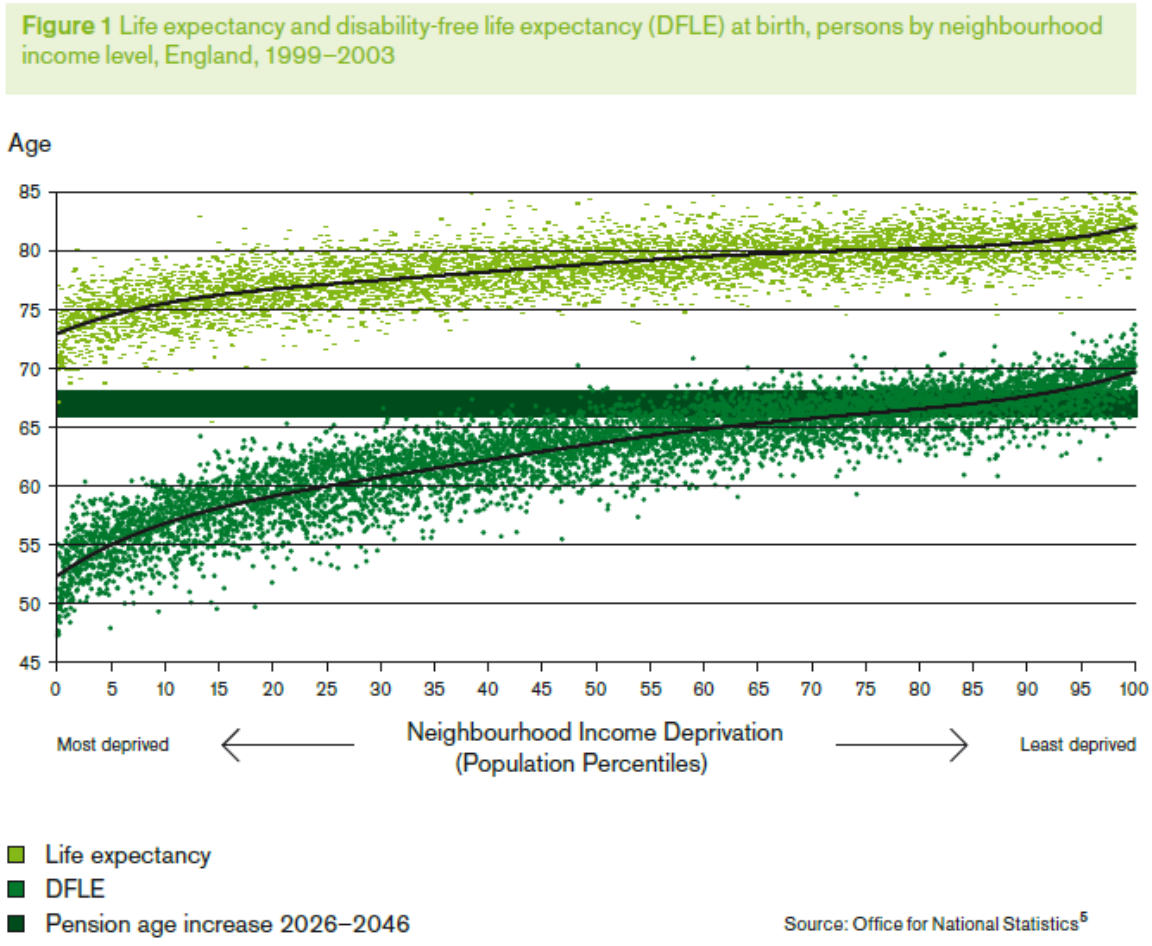


Figure 18: Relationship between deprivation and health/life expectancy

4.2 INCOME DEPRIVATION

Workers in Kent and the South East generally have a higher median income than workers in England as a whole (Figure 19). Within Kent, earnings are highest in Canterbury, followed by Ashford.

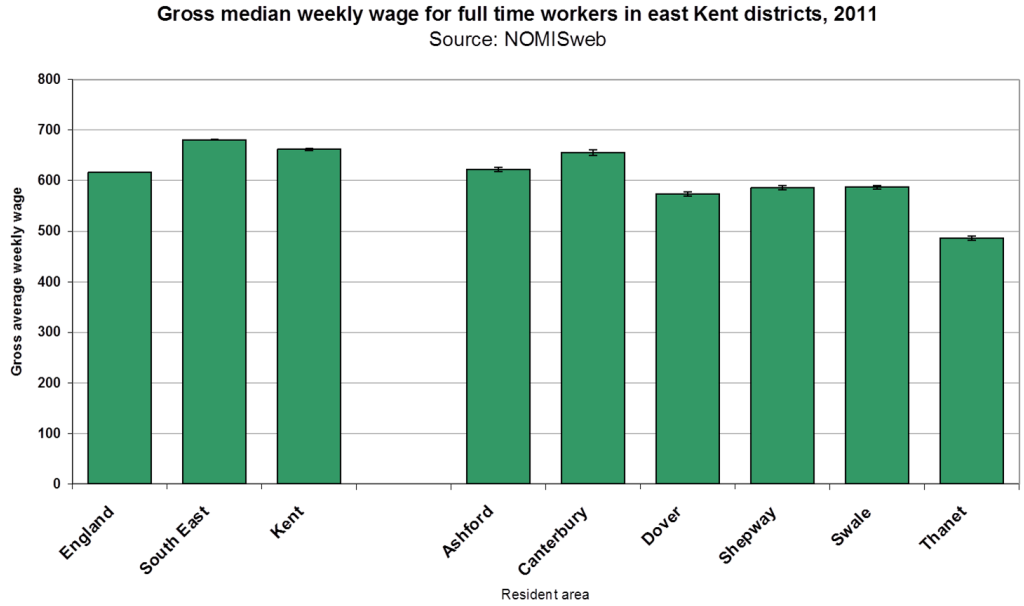


Figure 19: Income for full time workers in areas of Kent, compared to England

Still, there are pockets of income deprivation within Ashford and these are mainly in workers who live in Stanhope Ward, Beaver Ward, Victoria Ward, Charing Ward, Downs West Ward, Wye Ward, Bockhanger Ward, Aylesford Green Ward and Norman Ward (Figure 20).

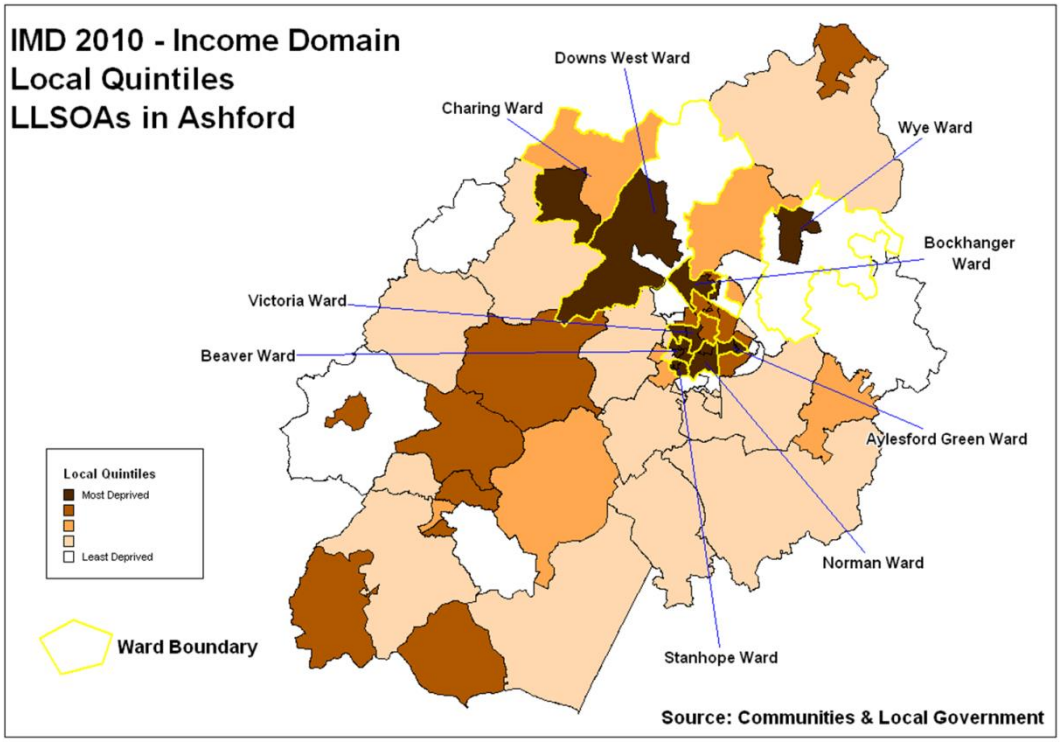


Figure 20: Income deprivation in Ashford by electoral ward

4.3 EMPLOYMENT DEPRIVATION

The unemployment rate in Ashford was 2.8% (number of resident population 16-64 years) in 2011 and this was below the Kent average of 3.1% and below the rate for England at 3.7% (Figure 21).

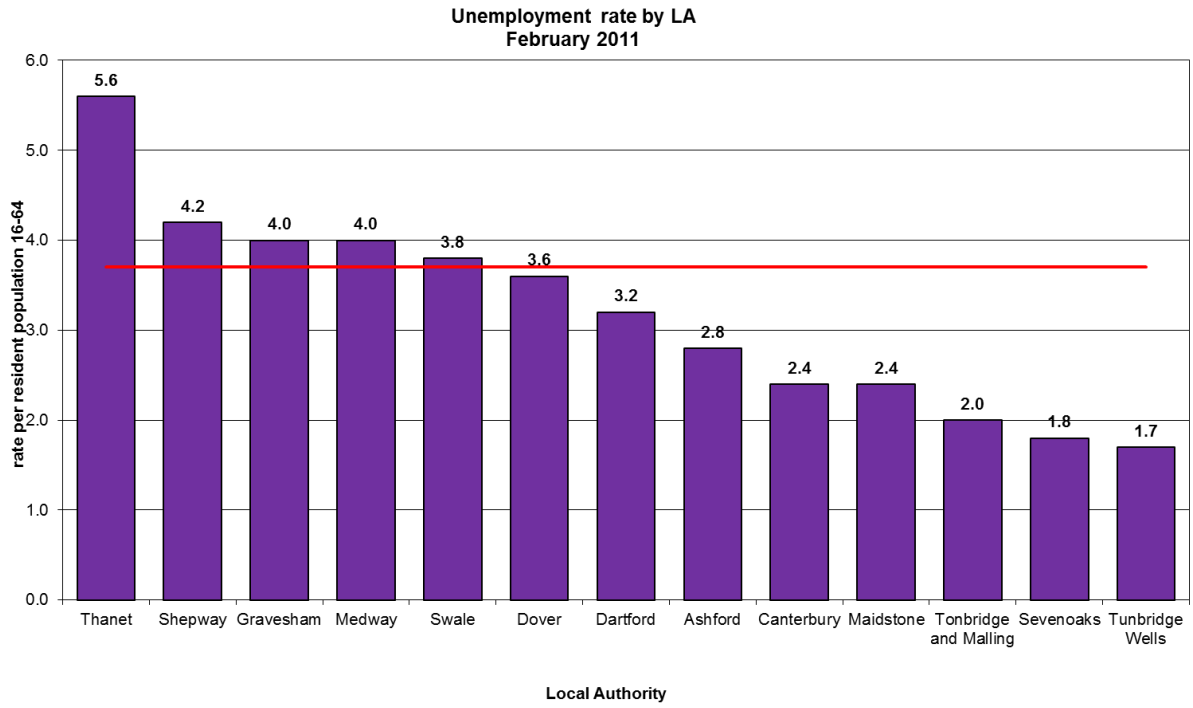


Figure 21: Unemployment rates in Kent Local Authorities compared to England

Wards with highest employment deprivation in Ashford are: Stanhope Ward, Beaver Ward, Victoria Ward, Godington Ward, Charing Ward, Downs West Ward, Bockhanger Ward, Aylesford Green Ward and Norman Ward (Figure 22).

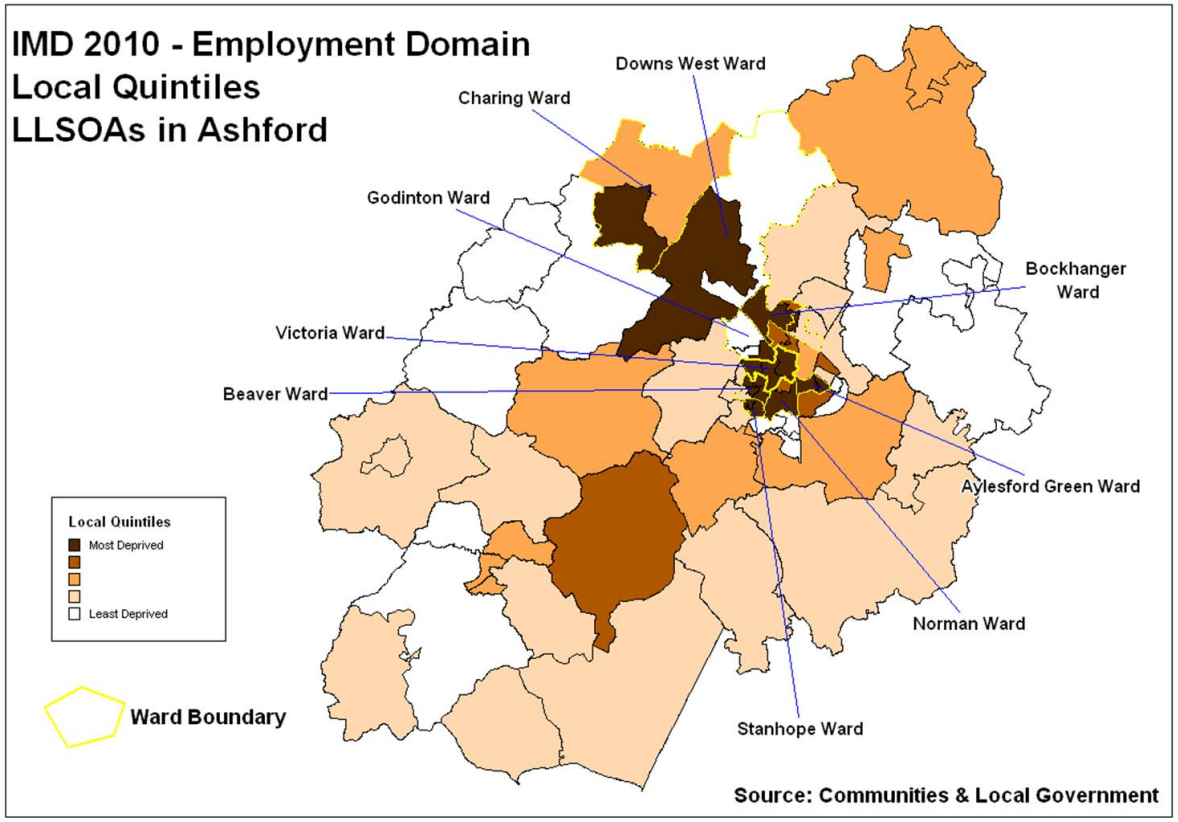
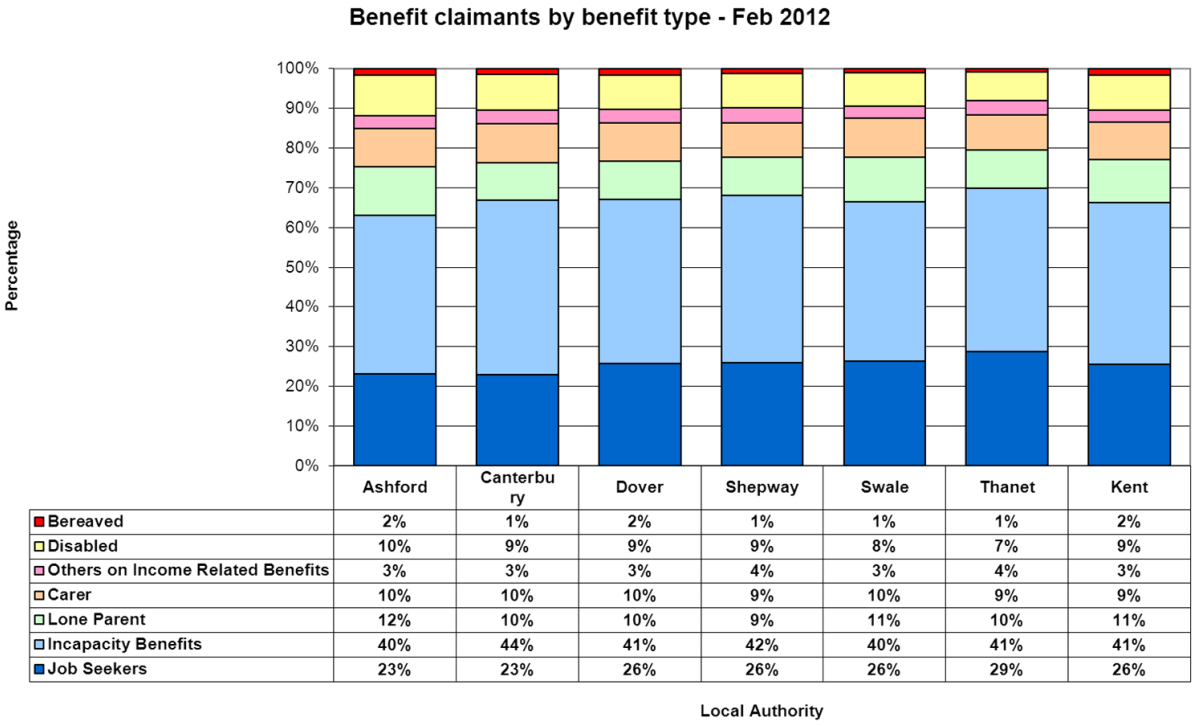


Figure 22: Employment deprivation in Ashford by electoral ward

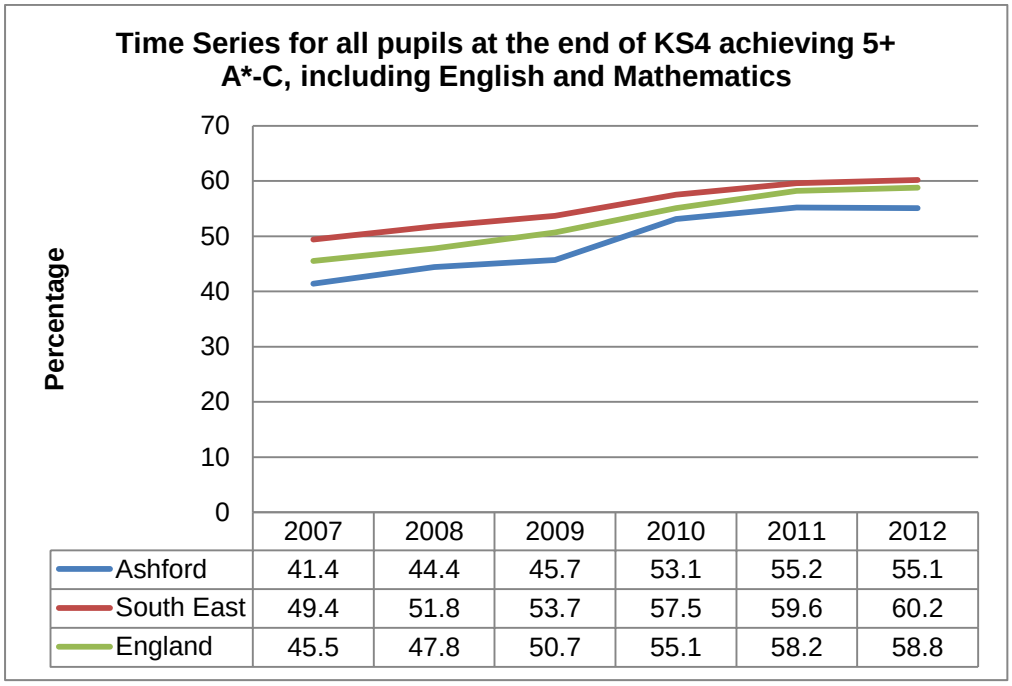
Of those who claim benefits, the majority of people claim for Incapacity Benefits, followed by Job Seekers Allowances. Less people claim for Lone Parent, Carer or Disabled Benefits (Figure 23). This distribution is similar to figures in Kent overall.



	Ashford	Canterbury	Dover	Shepway	Swale	Thanet	Kent
Bereaved	2%	1%	2%	1%	1%	1%	2%
Disabled	10%	9%	9%	9%	8%	7%	9%
Others on Income Related Benefits	3%	3%	3%	4%	3%	4%	3%
Carer	10%	10%	10%	9%	10%	9%	9%
Lone Parent	12%	10%	10%	9%	11%	10%	11%
Incapacity Benefits	40%	44%	41%	42%	40%	41%	41%
Job Seekers	23%	23%	26%	26%	26%	29%	26%

Figure 23: Benefit claims by type in South East Kent Local Authorities and Kent overall

Levels of GCSE attainment in Ashford have improved over time: from 41.4% in 2007 to 55.1% in 2012. The same trend can be seen in the South East and in England overall. Percentages of pupils achieving GCSEs including English and Mathematics were lower in Kent than in the South East or England.



	2007	2008	2009	2010	2011	2012
Ashford	41.4	44.4	45.7	53.1	55.2	55.1
South East	49.4	51.8	53.7	57.5	59.6	60.2
England	45.5	47.8	50.7	55.1	58.2	58.8

Figure 24: GCSE attainment over time, Ashford compared to South East Region and England. Data source: ONS

The areas with highest deprivation on the Education, Skills and Training Domain are shown in Figure 25 and comprise Stanhope Ward, Beaver Ward, Victoria Ward, Downs West Ward, Bockhanger Ward, Bybrook Ward, Aylesford Green Ward and Norman Ward.

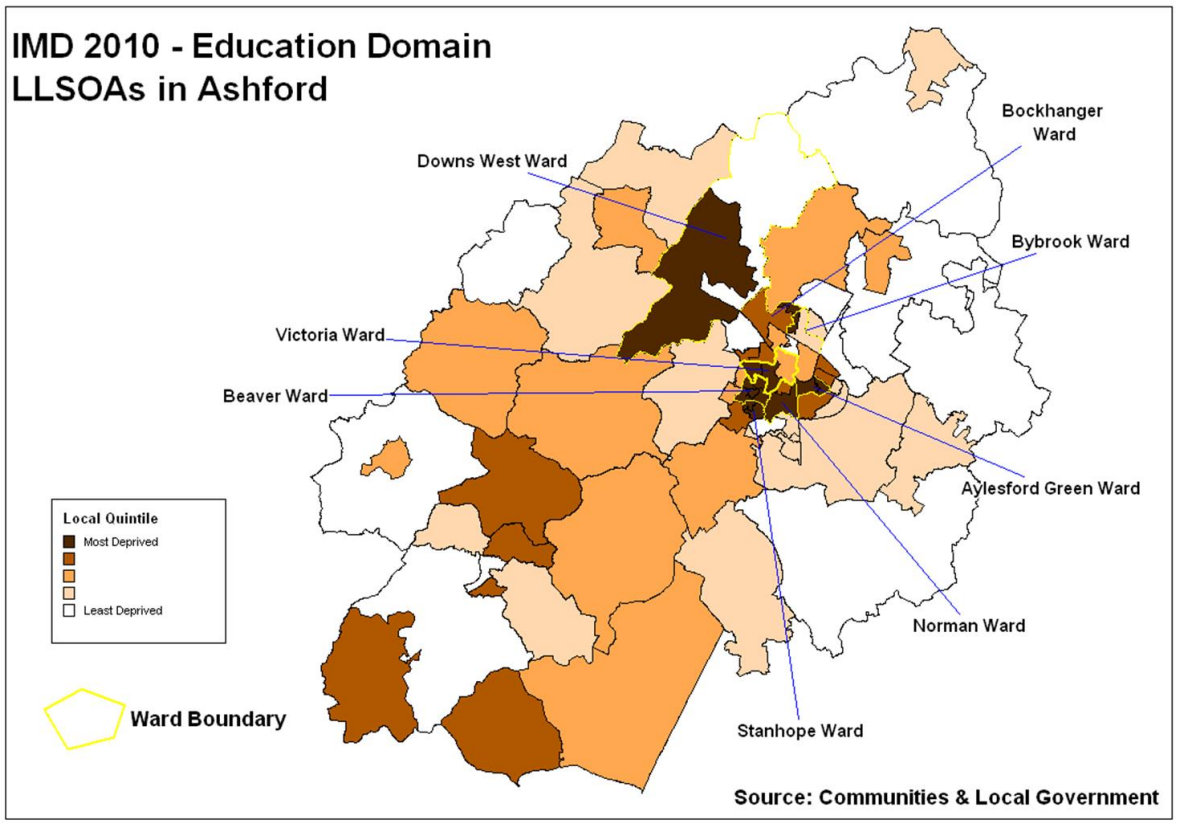


Figure 25: Educational deprivation in Ashford by electoral ward

Education and qualifications are important as achievements in this domain for children and teenagers have direct impact on later employment, income, housing and ultimately health and life expectancy. Lower educational achievements have been strongly linked to deprivation.[2] There are multiple reasons for this. Material deprivation may prevent parents to supply educational resources for their children. Ill health, family stress or low levels of parental education also play a role.

[2] http://skyeward.org.uk/resources/DCSF-Deprivation%20and%20Education.pdf

4.5 BARRIERS TO HOUSING AND SERVICES

This deprivation domain measures physical and financial accessibility of housing and key local services.

Barriers to Housing:

Household overcrowding: proportion of households which are judged to have insufficient space to meet the household's need

Homelessness: the rate of acceptances for housing assistance under the homelessness provisions of housing legislation

Housing affordability: proportion of households under 35 unable to afford owner-occupation

Geographical Barriers to Services:

Road distance to closest GP surgery

Road distance to closest food shop

Road distance to closest primary school

Road distance to closest post office

The deprivation picture for this domain appears reversed to the maps of the previous domains, with areas outside Ashford town experiencing more deprivation (Figure 26). This may be explained with house prices being higher in more rural areas and larger distances to facilities such as GP surgeries, food shops, schools and post offices.

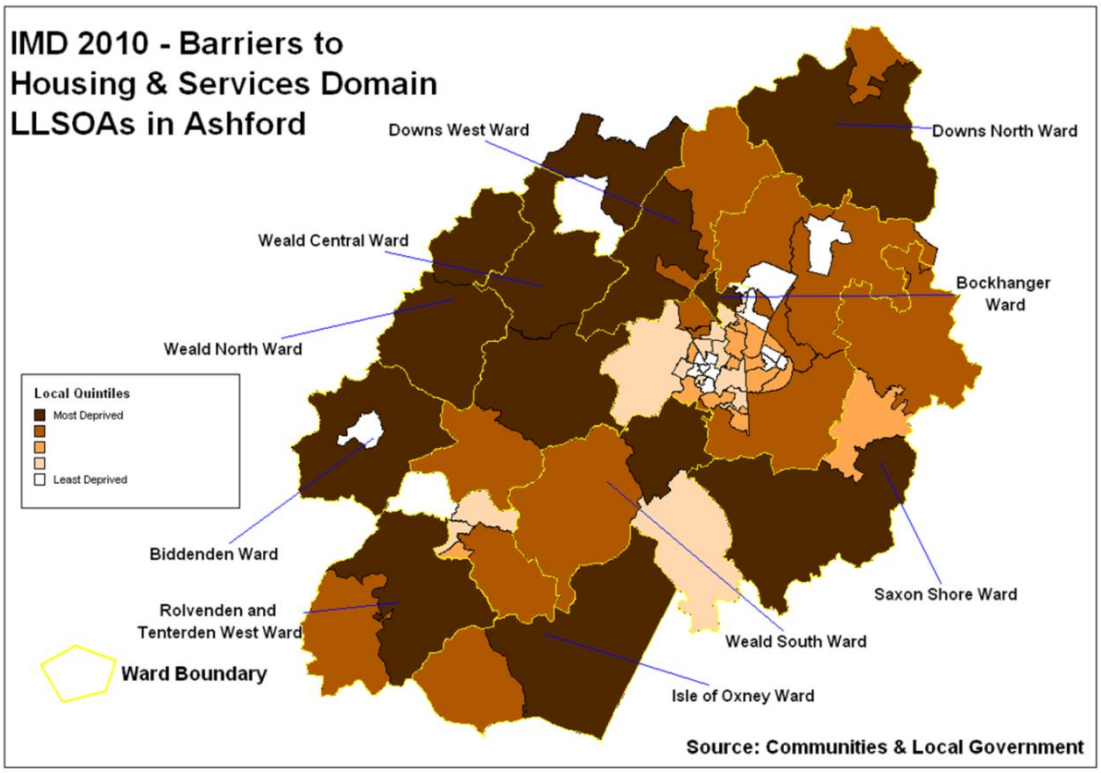
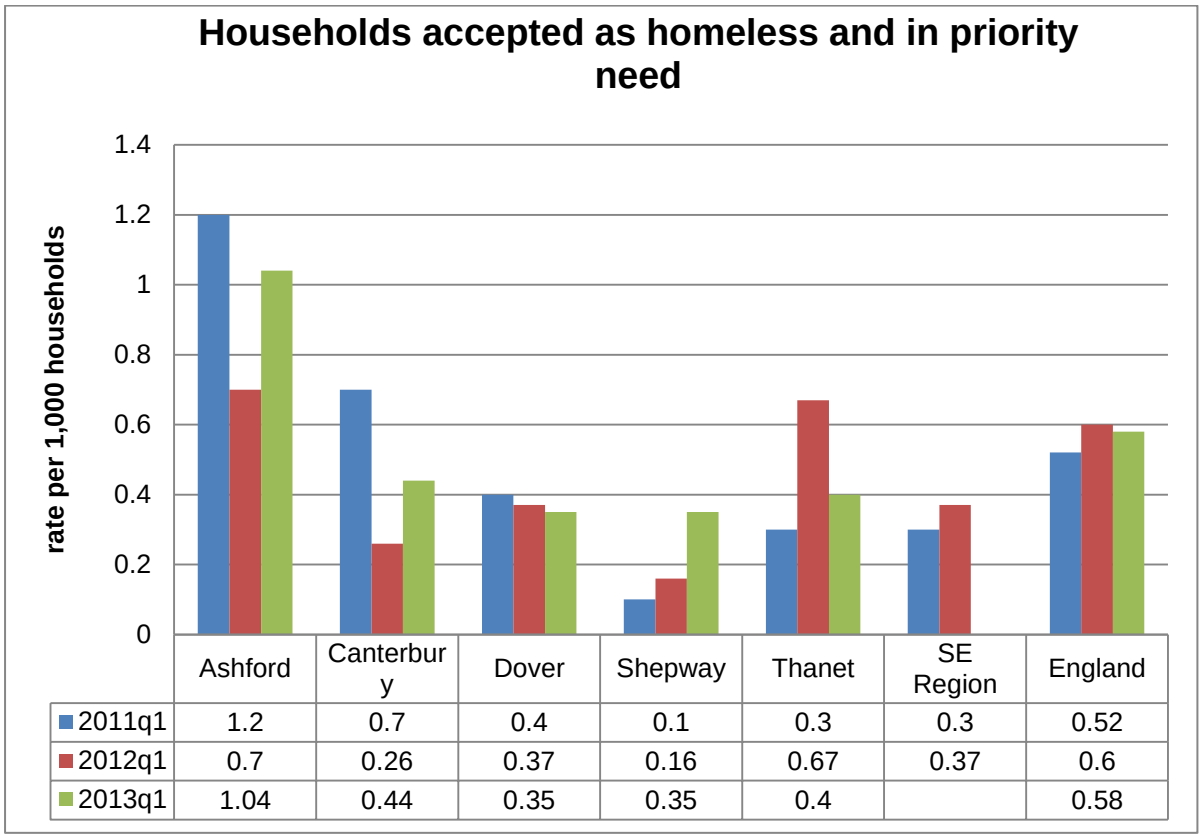


Figure 26: Housing and Services deprivation in Ashford by electoral ward

Homelessness in Ashford is high. Homeless people are not just those “sleeping rough” but include people to whom a homelessness duty has been accepted by a local authority. These are, for example, people who are threatened with the loss of, or are unable to continue with, their current accommodation.

The rates in Ashford are the highest in the Kent area.



	Ashford	Canterbury	Dover	Shepway	Thanet	SE Region	England
2011q1	1.2	0.7	0.4	0.1	0.3	0.3	0.52
2012q1	0.7	0.26	0.37	0.16	0.67	0.37	0.6
2013q1	1.04	0.44	0.35	0.35	0.4		0.58

Figure 27: Homelessness in Ashford compared to the South East and England. Data source: Kent County Council

Health issues associated with homelessness are described in a national audit conducted by “Homeless Link” in 2010[3]:

Over 700 homeless people from across England have contributed to the audit.

Homeless people have high levels of physical health needs. Most commonly reported were chest pain and breathing problems, joint and muscular pain and problems with eye sight, exceeding levels in the general population. 70% of clients had mental health needs and reported feeling often stressed, anxious and depressive. 77% of homeless people smoke which compares to 21% in the general population. Diets were poor and only few consumed fruit and vegetables regularly.

Homeless people used hospital services at a disproportionate rate and in the audit it was demonstrated that 80% of clients had seen a GP within the last 6 months but, additionally, 40% had been to A&E during the same time period.

Apart from the Local Authority duty to advise those assessed as homeless, more support is needed. GP’s are often the first point of contact for health problems but A&E attendance

[3] http://homeless.org.uk/sites/default/files/Health%20Audit%20Findings_National%20evidence.pdf

rates are still high. Any prevention and screening programmes that are rolled out locally or nationally, should reach homeless people and extra effort may be needed to ensure equitable access. Working together with charitable organisations for the homeless may help to reach this population group.

Public Health Interventions and Recommendations:

- In Ashford, only 5% of people live in the most deprived national quintile. The most deprived areas are: Stanhope Ward, Beaver Ward, Victoria Ward, Downs West Ward, Bockhanger Ward, Aylesford Green Ward and Norman Ward. There should be a focus on these areas that access to services is equitable.

- Pupils in Ashford have a lower rate achieving GCSEs including English and Mathematics than pupils in England overall. This may have implications on later achievements in terms of employment, income and ultimately health and wellbeing. A link between deprivation and educational attainment has been demonstrated.
    - A government initiated strategy was the initiation of Sure Start children centres in 1998, established mainly in deprived areas. Although initial evaluations of the programme's effectiveness were disappointing, more recent evaluations were able to demonstrate positive effects including an improvement in the home learning environment[4]. Attendance of activities in children centres should therefore be promoted for families with young children under 5.
    - Health is an important issue for educational attainment. Healthy Schools programmes have been rolled out countrywide and in Ashford, 96% of 54 schools have achieved Healthy School Status. This means that criteria concerning health and physical activity are being achieved. "*A healthy School promotes the health and well-being of its pupils and staff through a well-planned, taught curriculum in a physical and emotional environment that promotes learning and healthy lifestyle choices*."[5]
    - Government funding is available for schools in areas of highest social disadvantage to offer extended services to children and their parents (extended schools programme[6]). There is some evidence that this programme impacts positively on pupils' attainment and performance[7].

- Homelessness in Ashford is high. Homeless people are vulnerable and have disproportionately more health problems than the general population. Hospital services are used more frequently. The homeless link charity has expressed concerns that health needs of homeless people are currently not met and that commissioners need to ensure that homeless people are recognised. Access is an important issue and they write: "*Many homeless people arrive at health services with acute health problems that could have been addressed earlier on. Preventative services including screening and immunisation must be more routinely accessible. Personalised, flexible services must be accessible at a primary care level: it is unacceptable for these services to exclude patients on the basis of having no permanent address*."[8]

[4] http://www.ness.bbk.ac.uk/impact/documents/RB067.pdf
[5] http://www.salisbury.anglican.org/resources-library/schools/schools-every-child-matters/be-healthy
[6] http://www.salisbury.anglican.org/resources-library/schools/schools-every-child-matters/be-healthy
[7] http://www.teachingexpertise.com/articles/evaluation-of-the-full-service-extended-schools-initiative-3080
[8] http://homeless.org.uk/sites/default/files/hl_health-vision-paper_Jan2012.pdf

5 LIFESTYLE

5.1 HEALTHY EATING

“Fruit and vegetables are important components of a healthy diet and their sufficient daily consumption could help prevent major diseases, such as cardiovascular diseases and certain cancers… 1.7 million (2.8%) of deaths worldwide are attributable to low fruit and vegetable consumption...The WHO recommends a minimum of 400g of fruit and vegetables per day.”[9]

In Ashford, there is geographical variation in the consumption of fruit and vegetables, with people in more deprived wards eating less than the recommended levels. Less than 15% of people in Beaver Ward, Stanhope Ward and Washford Ward have a high enough consumption of fruit and vegetables that will help protecting from chronic diseases.

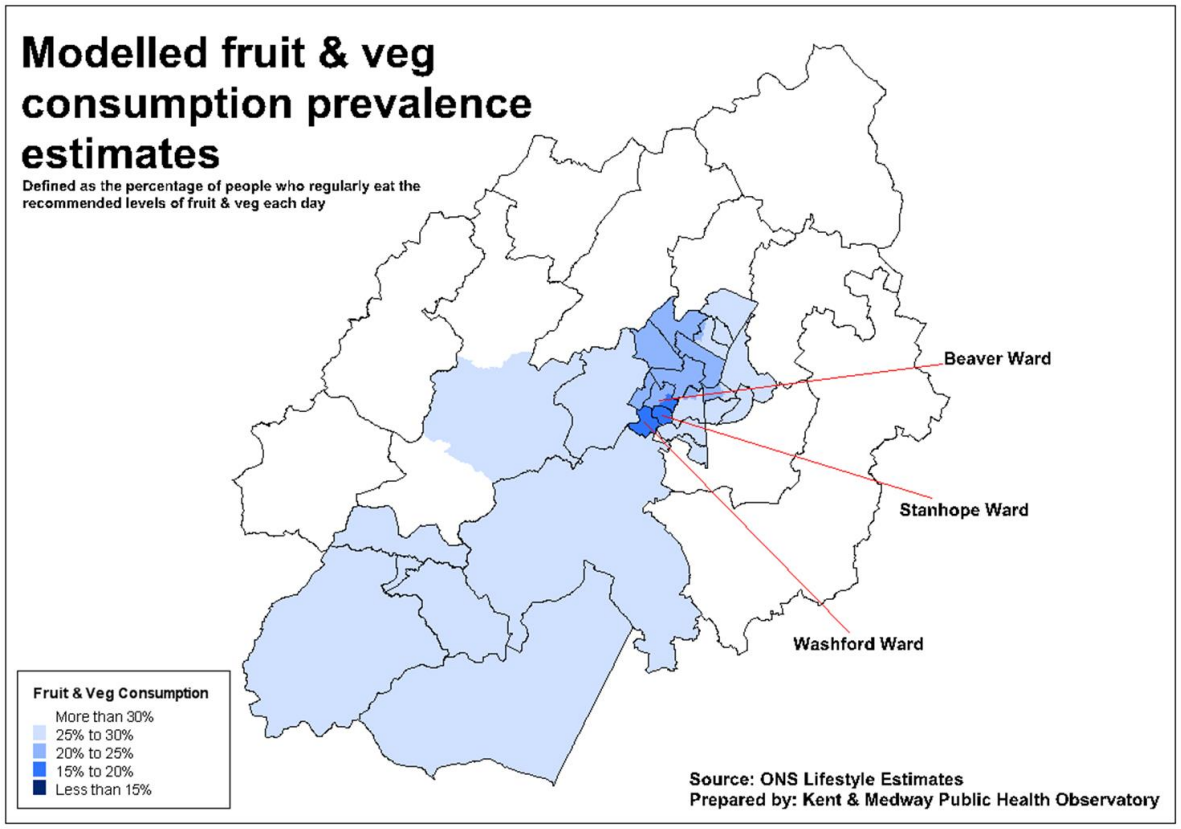


Figure 28: Fruit and Vegetables consumption prevalence in Ashford by electoral ward

[9] http://www.who.int/dietphysicalactivity/fruit/en/

5.2 OBESITY

Obesity is associated with ill health and can lead to cardiovascular disease, diabetes, cancer, osteoarthritis, indigestion, gallstones and obstructive sleep apnoea. Life expectancy is reduced in people who are obese.

Obesity is one of the leading preventable causes of death worldwide.

Obesity prevalence in Ashford is higher in high deprivation areas, with 25-30% of the population being classified as obese. Obesity, however, is not confined to areas of high deprivation. Figure 29 shows that in most other electoral wards the percentage of people being obese is also high, with 20-25%.

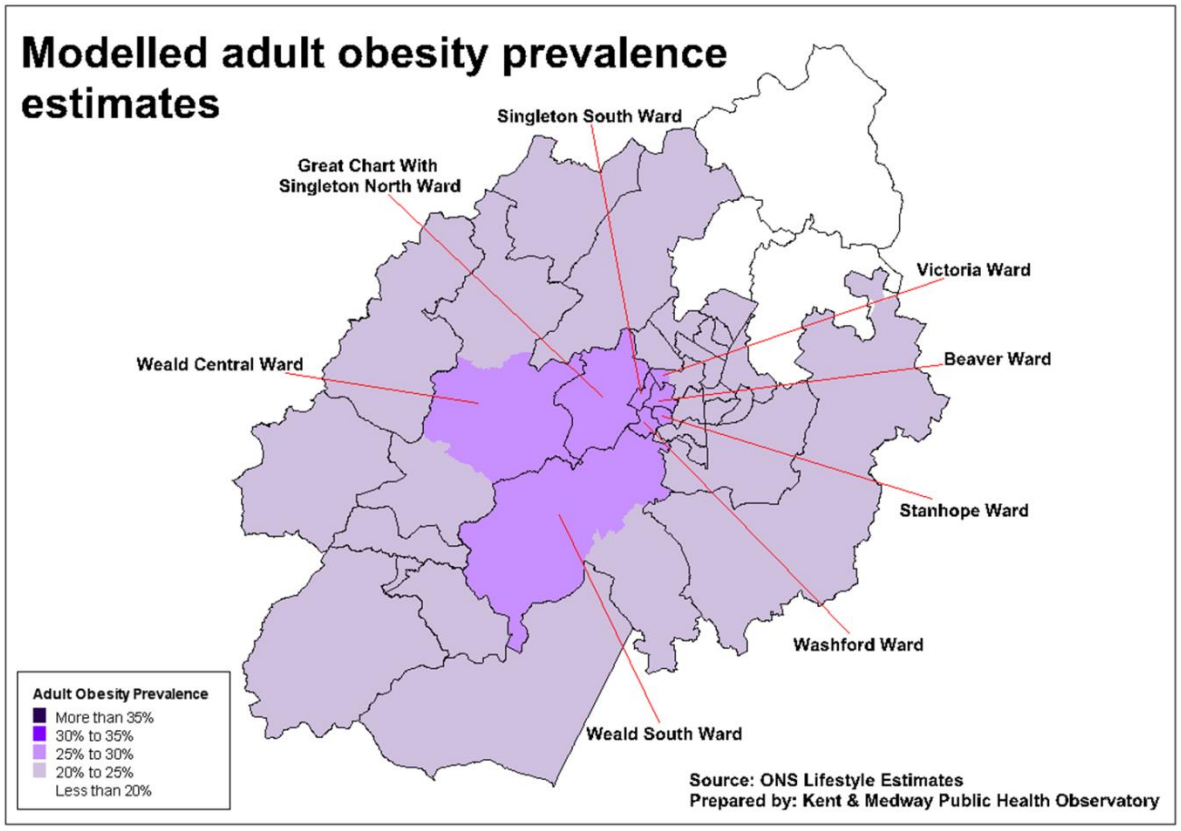


Figure 29: Obesity prevalence in Ashford by electoral ward

The percentage of obese people in the Ashford is with 27% significantly worse than the English average of 24.2% (Figure 30).

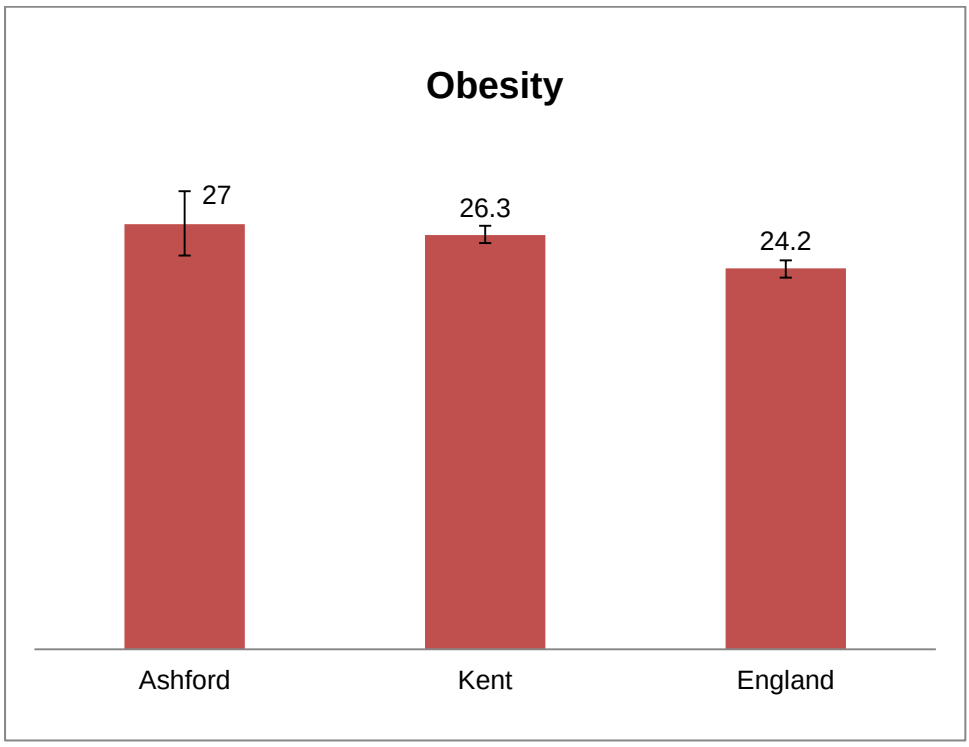


Figure 30: Obesity as a percentage of population aged 16 years and over. Data source: APHO

5.3 EXERCISE

The report “Start Active, Stay Active”, published by the Department of Health in 2011[10], highlights the importance of physical activity and gives guidelines for different age groups. Lack of physical exercise shortens life expectancy and is associated with diseases such as coronary heart disease, type 2 diabetes, and breast and colon cancers. Regular exercise protects from disease, improves quality of life and delivers cost savings for health and social care services.

Recommended exercise for adults (19-64 years): 150 minutes of moderate intensity activity in bouts of 10 minutes or more or alternatively 75 minutes of vigorous intensity activity spread across a week.

In Ashford, 54.5% of the population exercise at the recommended level and this is close to the national average of 56%.

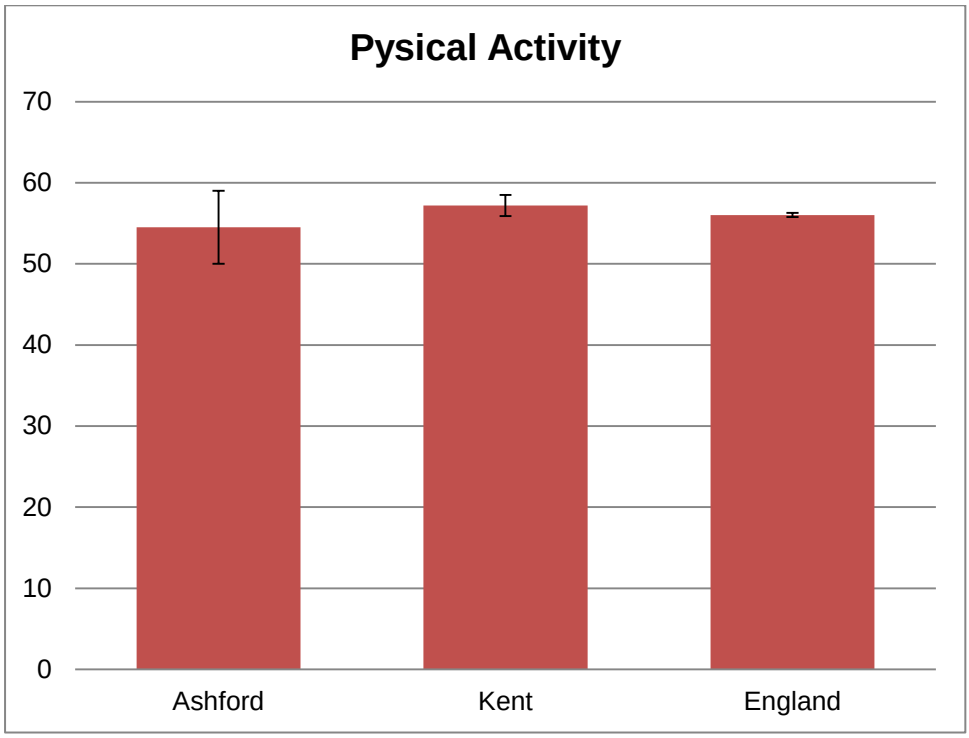


Figure 31: Percentage of population aged 16 and over who participate in recommended levels of physical activity (data Jan 2012 – Jan 2013). Data source: APHO

[10]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

5.4 SMOKING

Smoking leads to cardiovascular disease, respiratory disease and cancer. It is the single most preventable cause of death worldwide.

It is the "leading cause of health inequalities in the UK today and the principal reason for inequalities in death rates between rich and poor."[11]

In Ashford, almost 35% of people in the most deprived quintile are smokers which compares to less than 20% in the least deprived quintile.

Smoking prevalence is highest in Beaver Ward, Stanhope Ward and Washford Ward with over 35%.

Overall, smoking rates in Ashford are similar to the South East Region and to England rates.

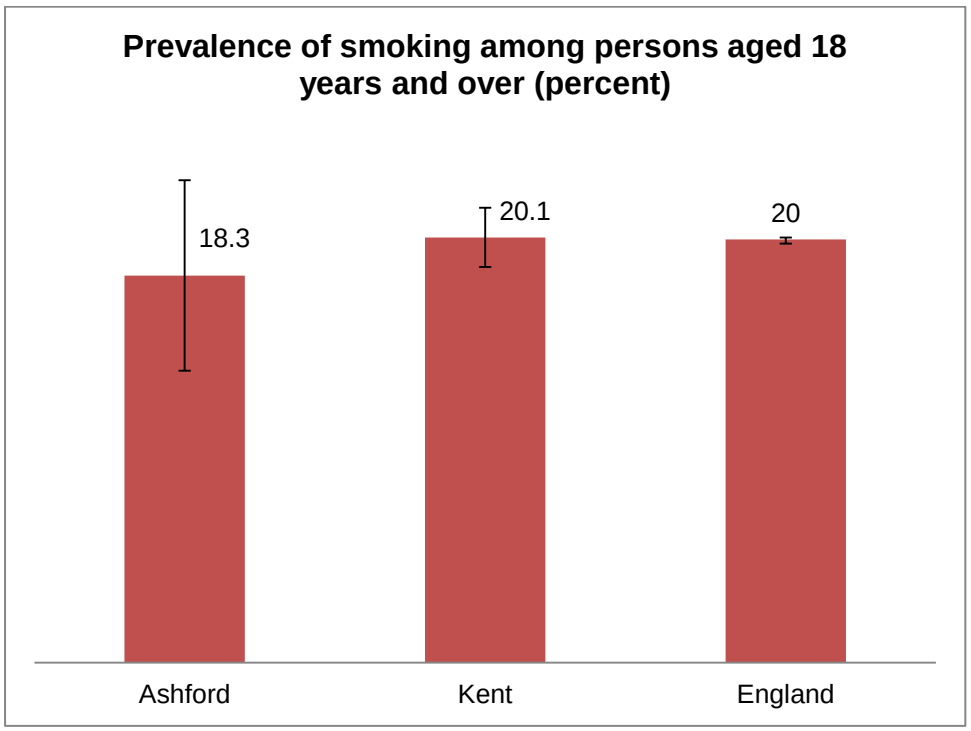


Figure 32: Smoking prevalence. Years 2011-12. Data source: www.tobaccoprofiles.info

5.5 ALCOHOL

Excessive use of alcohol has great impacts on health which range from accidents and injuries to violence, liver disease, pancreatitis and cancers.

Alcohol-attributable mortality in Ashford in 2010 was 17/100,000 for men and 10/100,000 for women.

[11] http://www.nice.org.uk/niceMedia/pdf/Smoking_and_public_health_V6.pdf

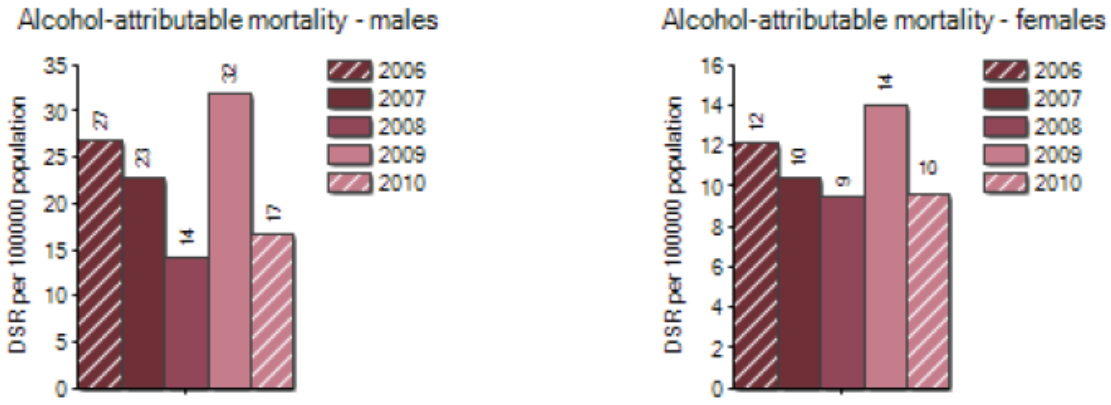


Figure 33: Alcohol-attributable mortality. Data source: North West Public Health Observatory.

The figures for women were comparable to the national average. The alcohol-attributable mortality for men was significantly lower than the England average (Figure 34).

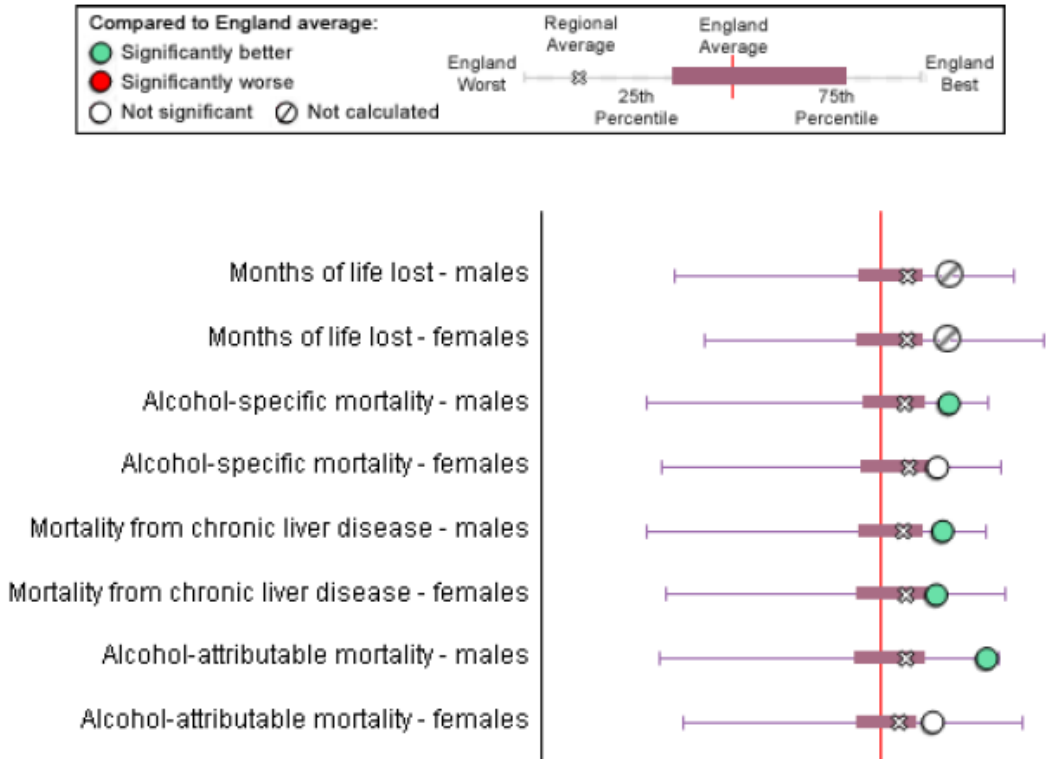


Figure 34: Alcohol consumption and Mortality in comparison to England average. Data source: North West Public Health Observatory.

A rising alcohol-attributable hospital admission rate for men and women, however, is of concern (Figure 35).

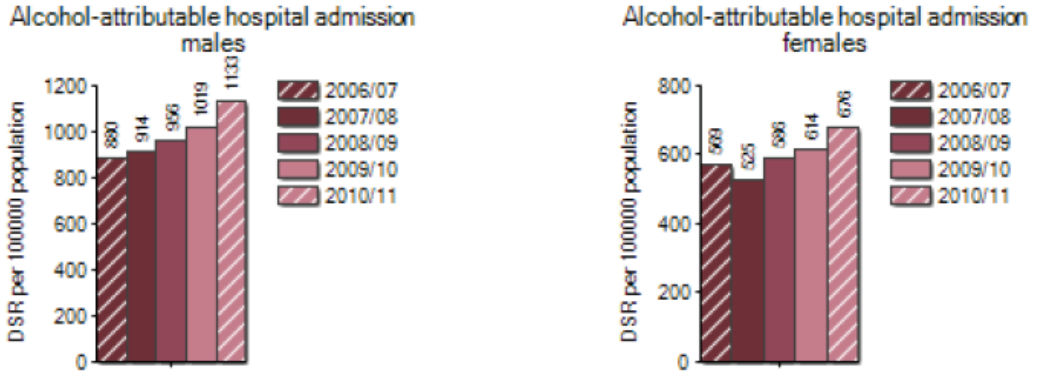


Figure 35: Alcohol-attributable hospital admission rates in Ashford. Source: North West Public Health Observatory

Public Health Interventions and Recommendations:

- People who live in more deprived wards consume less fruit and vegetables. The highest percentage of people with insufficient fruit and vegetable intake live in Beaver Ward, Stanhope Ward and Washford Ward. Public Health Programmes currently commissioned for Ashford give information on healthy nutrition to various population groups. Examples of programmes are: 'Healthy Weight: Fresh Start'; 'Change4Life Clubs'; 'Ready, Steady, GO' and the 'Children and Young people Health and Wellbeing service'. It needs to be monitored that services reach populations in high deprivation areas. NICE published a review on the most effective interventions to promote healthy eating and found the following characteristics important: small programmes, targeted at high risk groups and longer, more intensive interventions with a sound theoretical basis.[12]

- Obesity is a leading preventable cause of death worldwide. The percentage of obese people is with 27% in Ashford significantly higher than the national average of 24.2%. NICE looked at the effectiveness of various interventions for obesity and presented evidence that behavioural interventions are successful at inducing weight loss and that group interventions are superior to individual interventions[13];[14]. Diets were found to be beneficial and better than exercise alone and a combined approach is preferable. Very low Calorie Diets were unable to maintain weight loss over the longer term. A range of health promotion services are available to Ashford residents that encourage healthy eating, physical activity and weight loss. 'Healthy Weight: Fresh Start' is a programme for adults entailing 1:1 appointments with an advisor over three months. Health Trainers are available and give advice and support for taking up healthy life styles, primarily targeting populations from deprived backgrounds. Commissioners may want to consider installing group level interventions in addition, as these could be more (cost) effective according to recommendations from the NICE review.

- Physical activity protects from coronary heart disease and cancer. Levels of physical activity in Ashford are close to the national average with 54.5% of people exercising to recommended levels. Public Health Programmes commissioned for Ashford encouraging physical activity that are not part of a multi–component programme are: 'Health Walks' and 'Exercise Referral Schemes' for people over 16.
    - According to NICE recommendations[15], there is insufficient evidence for the effectiveness of Exercise Referral Schemes and it should only be used as part of a research study.
    - NICE does recommend opportunistic advice to inactive adults identified by primary care practitioners. This should include individually tailored guidance with written information and follow up appointments. The effectiveness should be monitored with a focus on whether it is helping people from disadvantaged groups.

- 35% of people in the most deprived quintile in Ashford are smokers (mainly in Beaver Ward, Stanhope Ward and Washford Ward) which compares to less than 20% in the least deprived quintile. Stop smoking services in Kent have a target of over 9000 quits county wide but this is not currently being met. NICE guidance recommends a "harm-reduction approach to smoking" to reach groups with a high smoking

[12] http://www.nice.org.uk/niceMedia/documents/healthpromo_eatgenpop.pdf
[13] http://www.nice.org.uk/nicemedia/live/11000/56354/56354.pdf
[14] http://www.noo.org.uk/uploads/doc/vid_5189_Adult_weight_management_Final_220210.pdf
[15] http://www.nice.org.uk/nicemedia/pdf/PH002_physical_activity.pdf

prevalence[16]. This consists of cutting down on smoking before setting a quit date, supported by the use of licensed nicotine-containing products. The programme should be commissioned for Kent next year (2014).

- Alcohol-attributable mortality in Ashford is comparable to rates in England for women and significantly better than rates in England for men. These figures are encouraging. Hospital admission rates for alcohol-related reasons are, however, increasing and efforts need to focus on reversing this trend. Drug and alcohol services are available in Ashford; however, these reach individuals that are actively seeking help. The extent of alcohol consumption is often hidden. There are various tools available to carry out screening for alcohol abuse in primary care[17]. This would help detect complications early and offer appropriate help. There is limited evidence but some suggestion that screening and brief advice at primary care level will result in savings to healthcare costs in the long run[18].

[16] http://publications.nice.org.uk/tobacco-harm-reduction-approaches-to-smoking-ph45
[17] http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?ID=12000008520
[18] http://www.nice.org.uk/nicemedia/live/13001/49071/49071.pdf

6 INEQUALITIES BY POPULATION GROUP

6.1 YOUNG PEOPLE

6.1.1 POVERTY

Poverty in childhood is associated with lower life expectancy. Children are more likely to be born with low birth weight, to suffer illness, to have a low education and later in life a low income job. This often leads to a vicious circle with more children born into poverty.

The percentage of children living in poverty in Ashford is lower than in Kent or in England.

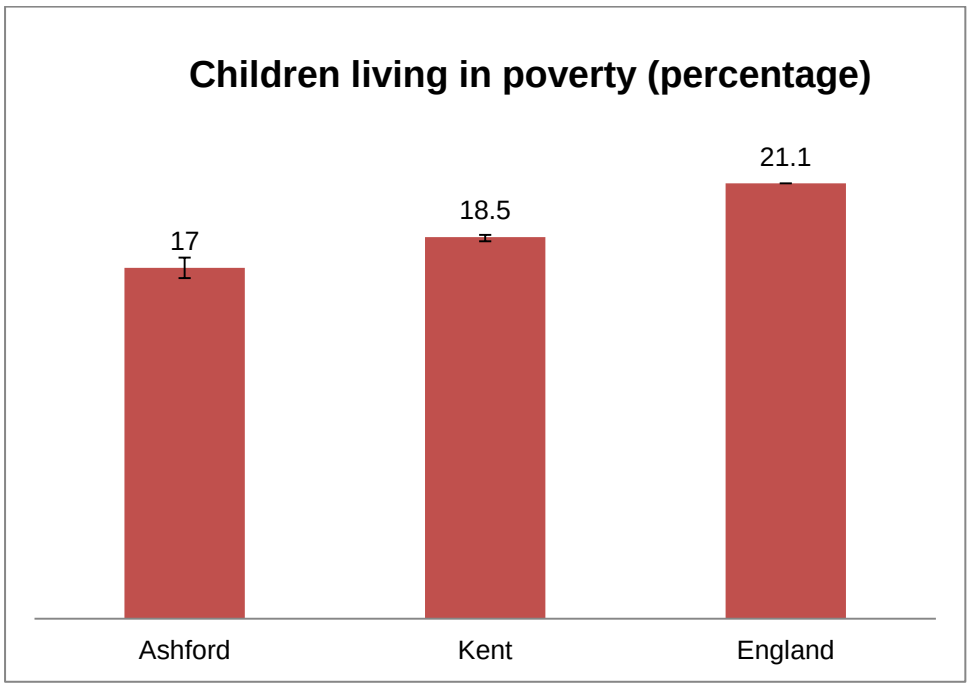


Figure 36: Percentage of children in poverty as compared to the number of child benefit claims, aged 16 and over (2010). Source: APHO data.

There are, however, areas within the Ashford CCG where a high proportion of children live in income deprived families. These areas are found in Stanhope Ward, Tenterden South Ward, Beaver Ward, Charing Ward, Downs West Ward, Bockhanger Ward, Wye Ward, Stour Ward, Victoria Ward, Aylesford Green Ward and Norman Ward (Figure 37).

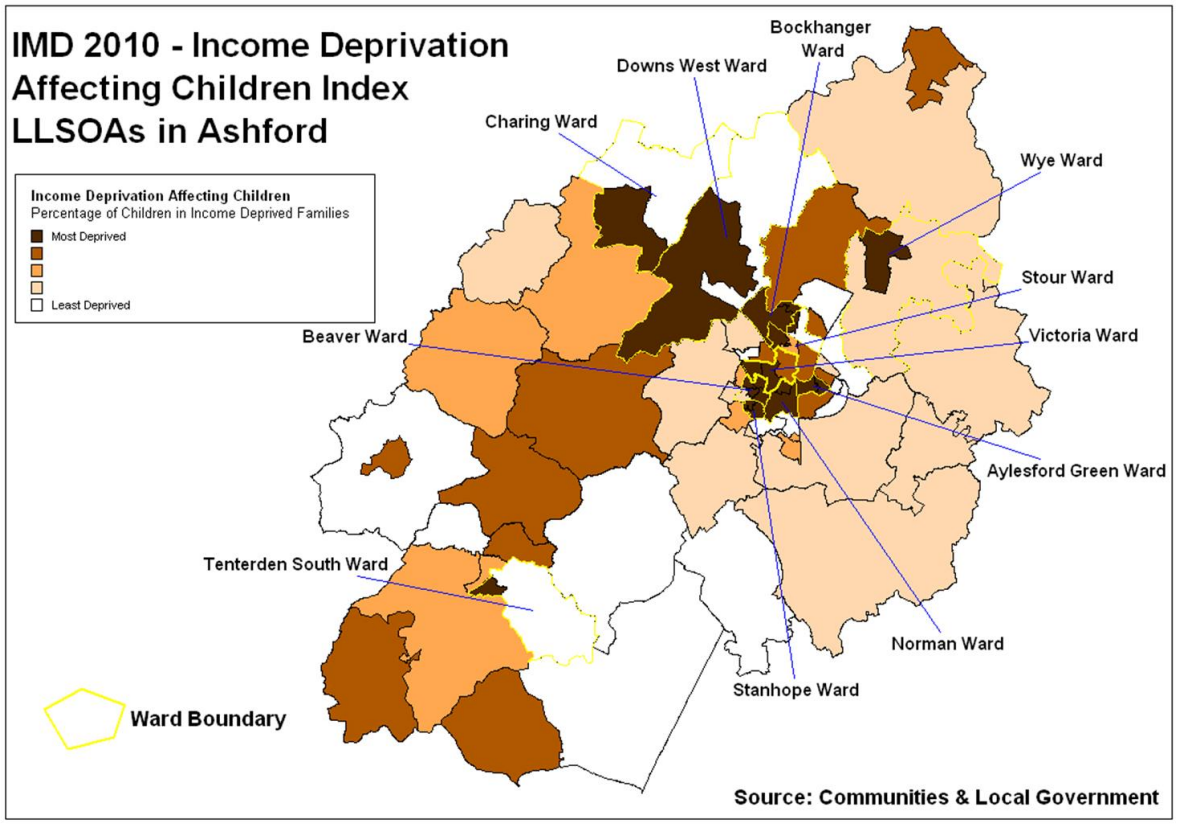


Figure 37: Income deprivation affecting children in Ashford by electoral ward

6.1.2 CHILDHOOD OBESITY

The prevalence of childhood obesity has increased over the last decades and this trend is alarming. Not all obese children go on to be obese in adulthood but the increasing trends of obesity suggest an association with increasingly unhealthy life styles: calorie rich food intake and lack of physical activity. A lifestyle adopted in childhood is likely to continue into adulthood and unhealthy lifestyles may be passed on to future generations.

In Ashford and also nationally, childhood obesity is a significant problem, with almost 20% of children in year 6 being classified as obese, Figure 38.

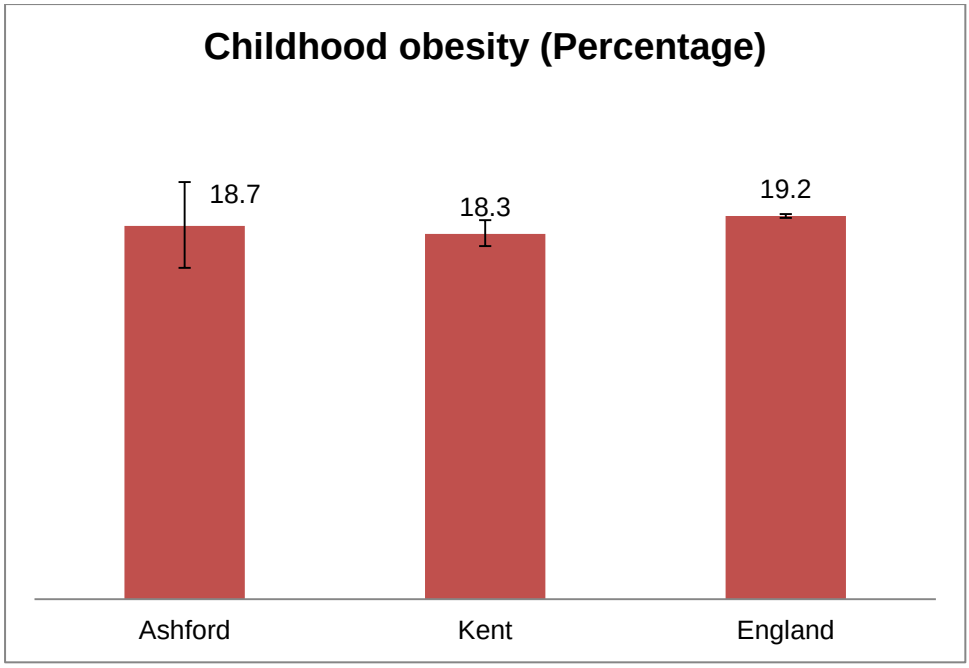


Figure 38: Obesity in children aged 10-11 (year 6). Data source: APHO

In some areas of Ashford, childhood obesity rates are over 25% including Weald South Ward, Isle of Oxney Ward, Weald North, Bockhanger, Kennington and South Willesborough.

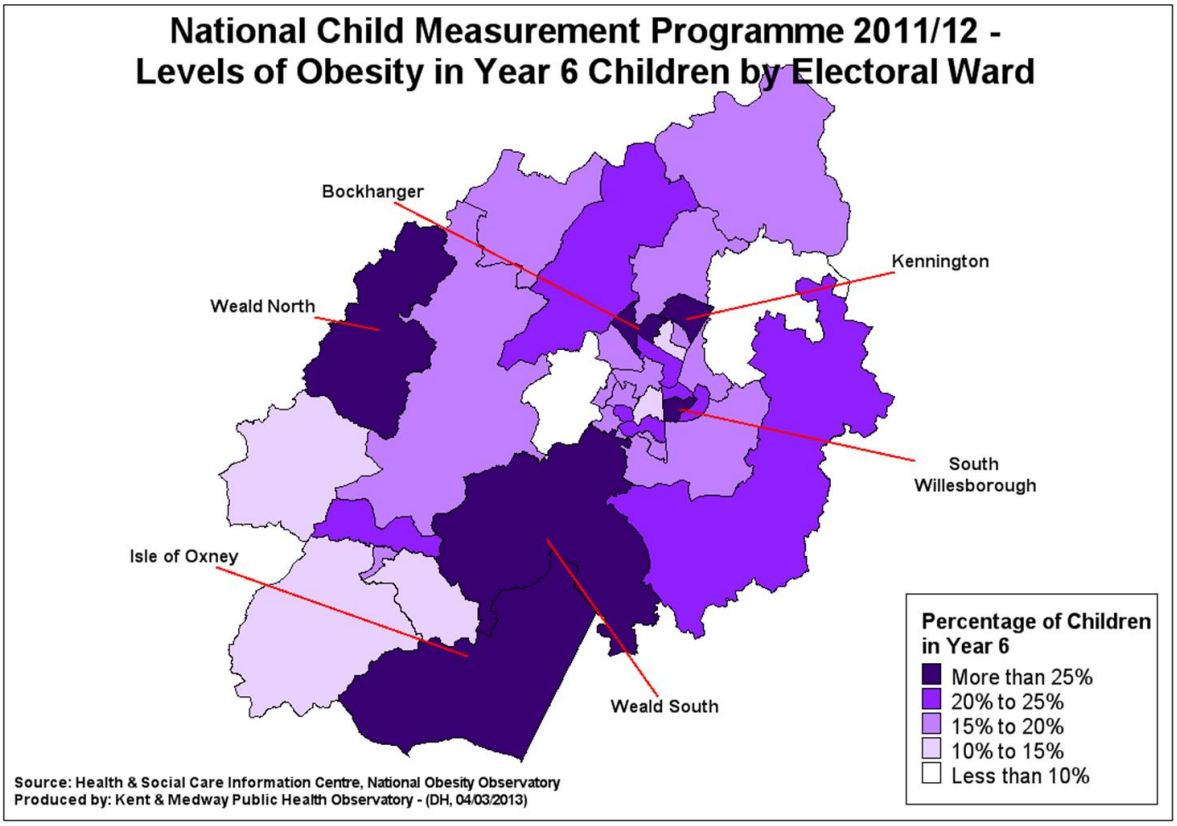


Figure 39: Childhood obesity (Year 6) by electoral ward

6.2 MATERNITY

6.2.1 TEENAGE PREGNANCY

"Teenage pregnancy is an important public health issue: it is common, largely preventable and associated with negative sequelae, both for teenagers who become pregnant and for their children. Compared with babies of older mothers, those born to teenagers are more likely to have lower birth weights, increased infant mortality, an increased risk of hospital admission in early childhood, less supportive home environments, poorer cognitive development and, if female, a higher risk of becoming pregnant themselves as teenagers. Teenaged mothers more often than other teenagers are socially isolated, have mental health problems, and have fewer educational and employment opportunities."[19]

The teenage conception rate in Ashford has decreased over time. With 37.3/1,000 in 2008-10, it is comparable to the England rate but lies significantly above the rate for the South East which is 30.5/1,000 (Figure 40).

Figure 40: Teenage Conceptions – Under 18 Conception Rate, 2008-10. Source: APHO, interactive atlas.

Teenage Conception Rates in Ashford are highest in Stanhope Ward, Victoria Ward, Bockhanger Ward, North Willesborough Ward, Aylesford Green Ward, South Willesborough Ward, Norman Ward and Park Farm North Ward, with 50 – 100/1,000.

[19] Donald B. Langville: Teenage pregnancy: trends, contributing factors and the physician's role. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1867841/

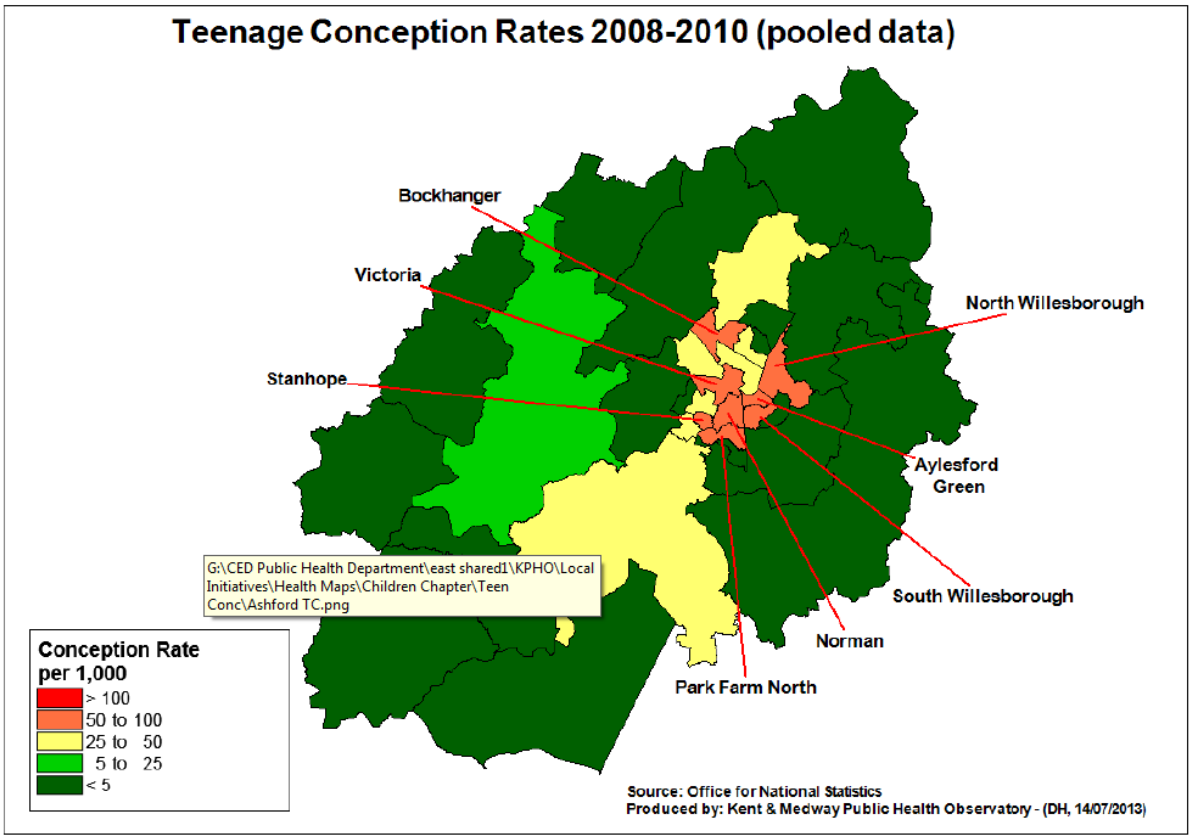


Figure 41: Teenage conception rates in Ashford by electoral ward

6.2.2 SMOKING IN PREGNANCY

"Smoking during pregnancy is associated with many fetal and neo-natal problems such as low birthweight, pre-term delivery, placenta damage, miscarriage and sudden-infant-death syndrome. It can also be the cause of respiratory problems such as chest infections and can aggravate asthma in young children."[20]

In Ashford, smoking in pregnancy is a significant problem with over 18% of mothers smoking at the time of delivery – a rate significantly higher than the rate in the South East or England (Figure 42).

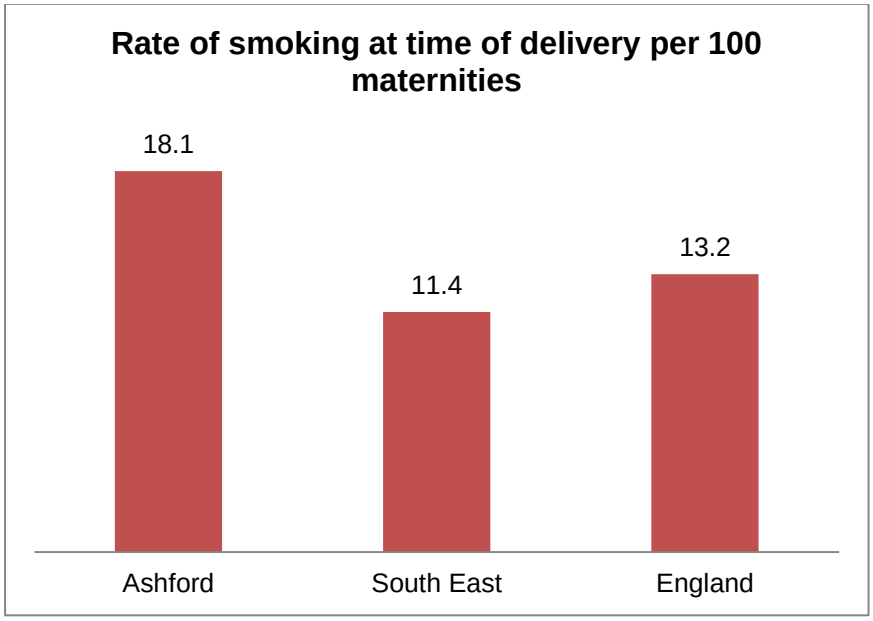


Figure 42: Smoking at time of delivery. Years 2011-12. Data source: www.tobaccoprofiles.info

[20] NICE: http://www.nice.org.uk/nicemedia/documents/smoking_and_pregnancy.pdf

6.2.3 BREAST FEEDING

The WHO recommends exclusive breastfeeding up to 6 months of age[21]:

- Breast milk gives infants all the nutrients they need and antibodies that help protect them
- In the long term, breast fed infants are less likely to become obese and to develop type-2 diabetes
- For mothers, it reduces the risk of breast and ovarian cancer

In Ashford, exclusive breast feeding rates at 6-8 weeks are lower than in Kent and Medway. Lowest breast feeding rates are seen in the most deprived population groups (Figure 43).

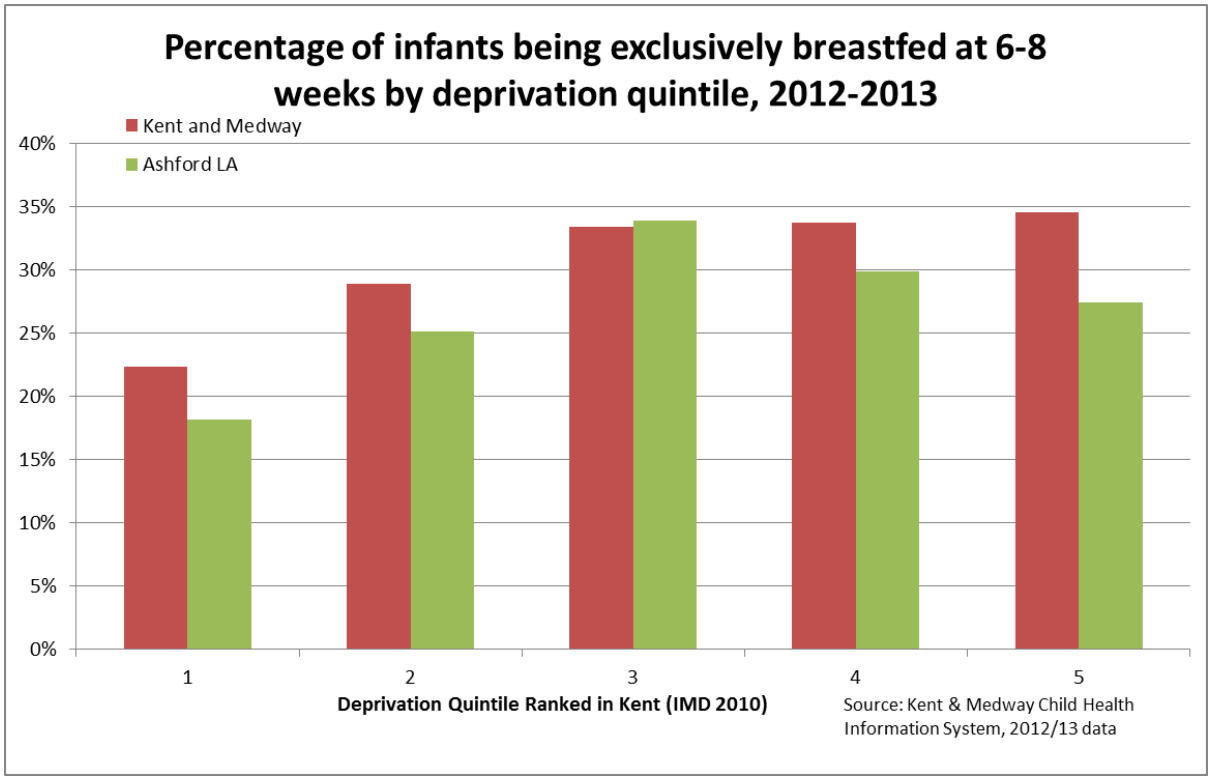


Figure 43: Exclusive breastfeeding at 6-8 weeks by deprivation quintile.

[21] http://www.who.int/features/factfiles/breastfeeding/en/index.html

Breast feeding initiation was with 71.7% significantly lower in Ashford compared to Kent (73.1%) or England (74.8%)

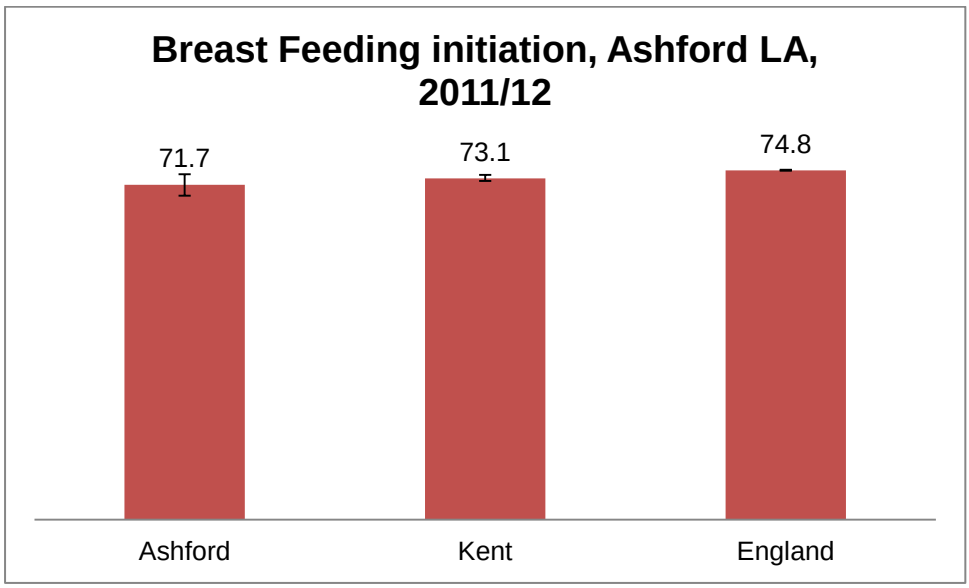


Figure 44: Breast feeding initiation. Data source: APHO.

6.3 OLDER PEOPLE

6.3.1 POVERTY

Many elderly people in the UK live in poverty and this has direct effects on health. As they are already vulnerable due to old age, low living standards with poor housing and insufficient heating during the winter will contribute to ill health. Access to services will be more difficult due to transport and mobility issues.

Income deprivation affecting older people in Ashford is illustrated in Figure 45. A number of electoral wards are considered to be within the most deprived national quintile and this includes almost the whole of central Ashford, with the surrounding wards Downs West, Wye and Biddenden.

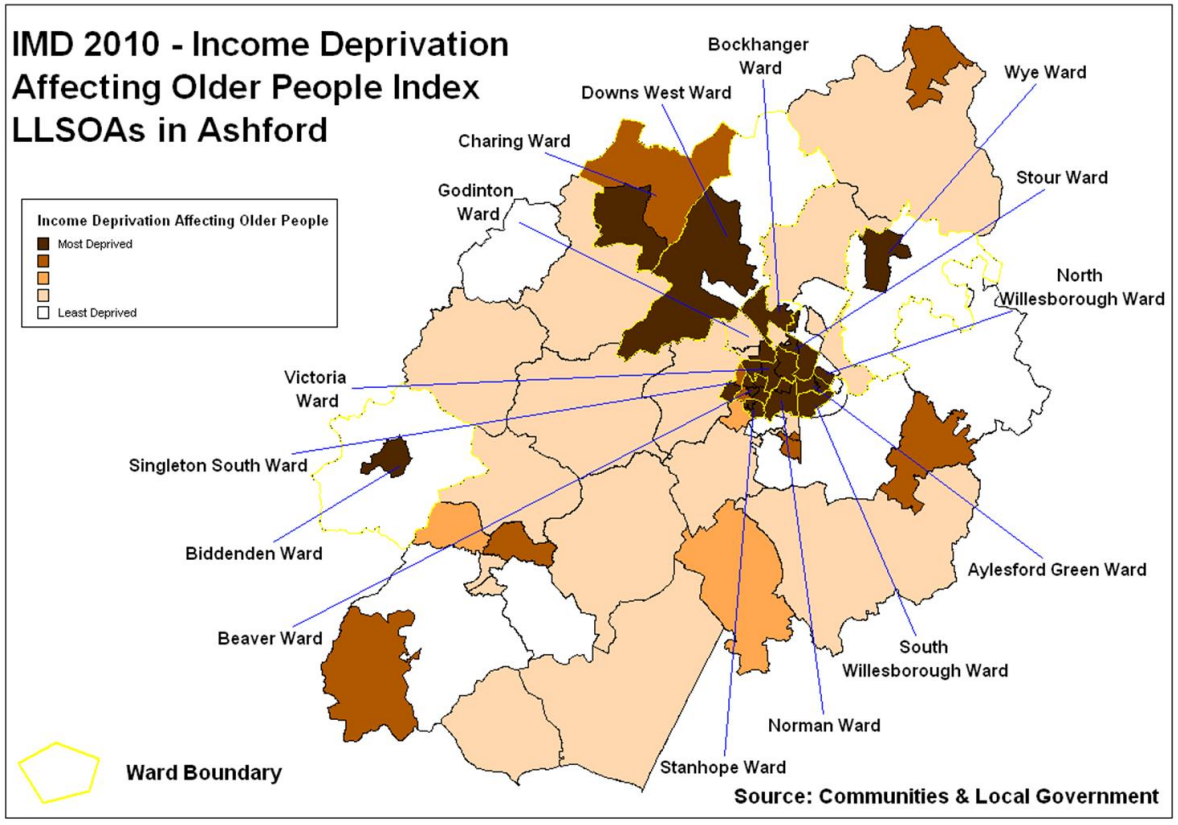


Figure 45: Income deprivation affecting older people in Ashford by electoral ward

6.3.2 FALLS AND FRACTURES

“Every year, over 500,000 older people attend UK Emergency Departments following a fall and 200,000 suffer fractures due to osteoporosis. Falls and fractures in the over-65s account for over 4 million bed days per year in England alone, at an estimated cost of £2 billion. Falls

and fractures often lead to disability and loss of independence, and are the leading cause of accidental death in this age group."[22]

This was part of a press release of the Royal College of Physicians in 2011, after a National Audit of Falls and Bone Health in Older People reported, that "there is unacceptable variation in the quality of NHS services for care and prevention of falls and fractures". Well-designed services can help prevent falls and it is important to respond and provide further services to elderly people when they first present with fractures.

The rate of hip fractures in the over 65 year olds in Ashford corresponds to rates in Kent and England (Figure 46).

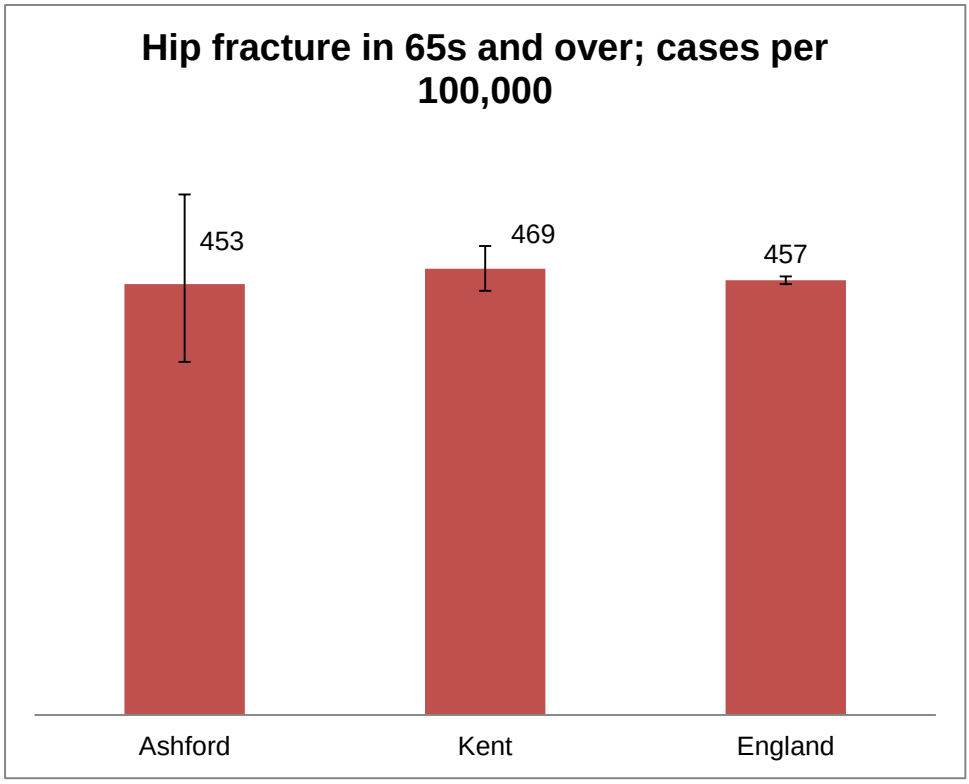


Figure 46: Hip fractures in the elderly. Years 2011-12. Data source: APHO.

Emergency admission rates for hip or shaft of femur fractures are highest for people who live in Singleton South Ward, Godington Ward, South Willesborough Ward and Park Farm South Ward (Figure 47). Services in these areas may need reviewing to see if rates of falls can be reduced in these wards.

[22] http://www.rcplondon.ac.uk/press-releases/nhs-services-falls-and-fractures-older-people-are-inadequate-finds-national-clinical-

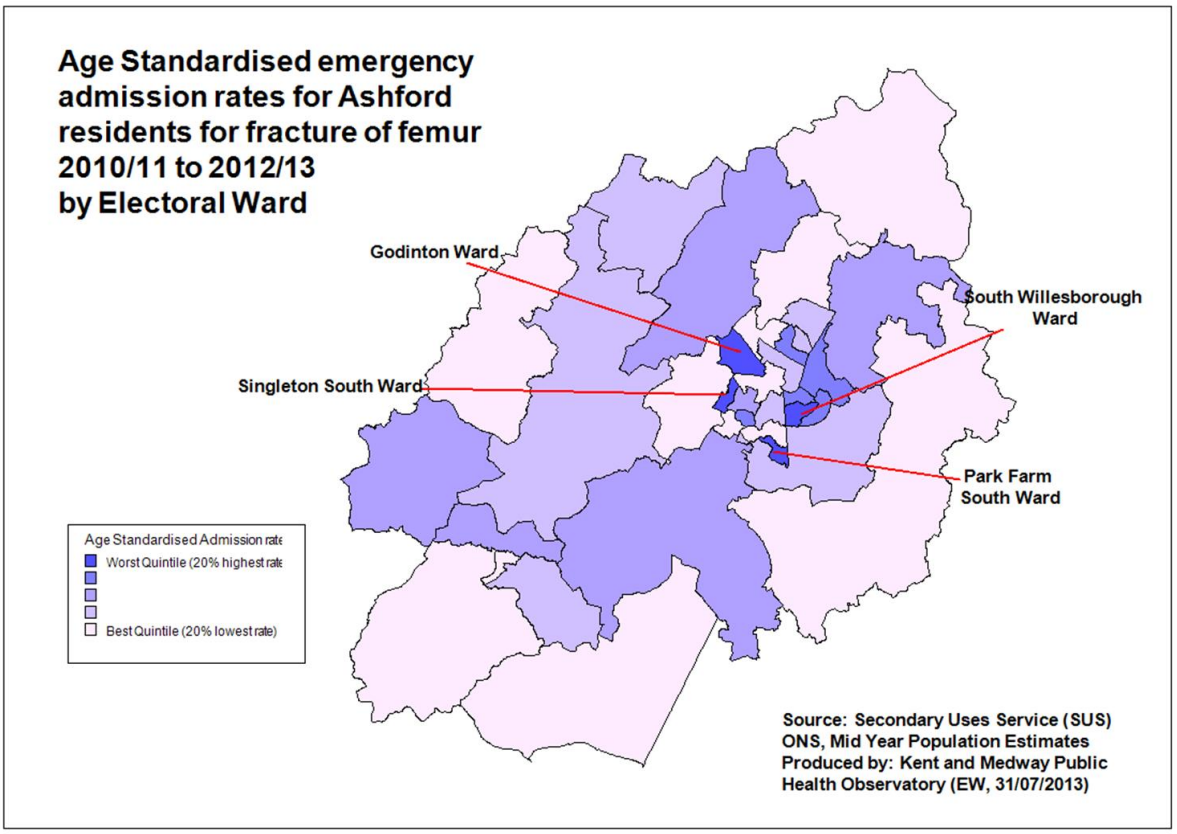


Figure 47: Emergency admission rates for femur fractures in Ashford by electoral ward

Public Health Interventions and Recommendations:

- Childhood obesity is a problem with rates of around 19% in Ashford (similar to rates in England). NICE recommends a combination approach consisting of education and goal setting about healthy eating and physical activity that should be tailored to individual circumstances and preferences. Important is appropriate training of those who deliver interventions including the use of motivational and counselling techniques[23]. There are a variety of Public Health programmes currently being commissioned in the Ashford area that focus on reducing obesity in children: 'Ready, Steady, GO!' – a targeted weight management programme for children aged 7-11; 'Change4 Life Clubs' support families with children aged 7-11 to make healthy lifestyle changes and following the sessions there is the opportunity to become members of the online Healthy Club; 'Healthy Schools' programmes help children of school age to adopt a healthy lifestyle. There should be future evaluations on the effectiveness of these programmes and monitoring of equitable access.

- The teenage pregnancy rate has been decreasing but there are still high rates (50-100/1,000) in some wards within Ashford: Stanhope Ward, Victoria Ward, Bockhanger Ward, North Willesborough Ward, Aylesford Green Ward, South Willesborough Ward, Norman Ward and Park Farm North Ward. The Health Development Agency, Teenage Pregnancy Unit, has published an overview on the research evidence of the effectiveness of interventions to bring down teenage pregnancy rates.
    - There is good evidence that school-based SRE (sex and relationship education) linked to contraceptive services can have an impact on reduction of pregnancy rates.
    - There is good evidence that contraceptive services with the following characteristics are beneficial: long-term provision, clear messages focusing on high risk groups' trained staff, respecting confidentiality of young people, joint-up with other services aimed at preventing pregnancy.
    - There is good evidence that including parents in information and prevention programmes is effective.
    - Youth development programmes have been shown to be most promising. They combine multiple approaches consisting of self-esteem building, voluntary work, educational support, vocational preparation, healthcare, sports, art activities and SRE.
    - Evidence of any impact of condom distribution schemes is not clear.

  In Ashford, school-based SRE is provided within the Healthy Schools programmes. There is also a Kent wide free condom scheme, called C Card with 60 outlets in Ashford and a website www.kentsexualhealth.nhs.uk with further information and a telephone helpline. The initiative HOUSE opened in Ashford in 2011 and offers a place for 13-19 year olds to "hang out". They are offered a range of activities and also advice on sexual health, drugs, relationships etc. These schemes are important for the aim of reducing the teenage pregnancy rates further and it needs to be ensured that the right target groups are reached.

[23] http://www.nice.org.uk/nicemedia/live/11000/30365/30365.pdf

- Smoking during pregnancy is a significant problem in Ashford. NICE has published guidance on quitting smoking in pregnancy and following childbirth.
    - Interventions shown to be effective are: cognitive behaviour therapy; motivational interviewing; structured self-help and support from NHS Stop Smoking Services.
    - Primary Care practitioners need to be aware that some pregnant women find it difficult to admit to smoking because of the pressure resulting. NICE therefore recommends a CO test done by a midwife at the booking appointment. Limitations of this test and interpretation of results are recognised.
    - Every pregnant woman who smokes or has recently stopped (within previous 2 weeks) should be given information on the risks and be offered a referral to the Stop Smoking service.
    - Commissioners should ensure that all staff (midwifes, smoking advisors etc.) have appropriate training and know how to ask questions in a way that women speak openly, know how to use a CO monitor and know which services to offer to this specific group.

- Breast feeding initiation rates are lower in Ashford than in Kent or England. It is important to encourage breast feeding as this has positive health effects on mother and baby. Some evidence on the effectiveness of different interventions to increase breastfeeding was published by the Health Development Agency[24]:
    - Education on breastfeeding is beneficial: not so much the distribution of leaflets alone but educational group sessions can be effective among low income groups and 1:1 educational programmes were effective for women who planned to bottle-feed.
    - Promotions delivered over both the ante- and postnatal period had a positive effect.
    - Within the health service, there is some limited evidence that training of staff, employment of a breastfeeding consultant and more home-like rooms in the hospital were effective in the USA among low income women.
    - Social support at home by midwifes for socially disadvantaged women has not shown any benefits over usual care
    - Peer support programmes were not effective for women who decided to bottle-feed.
    - Media campaigns help improving attitudes towards breastfeeding

- Rates of hip fractures in the elderly in Ashford are comparable to England but are high in the wards Singleton South, Godington, South Willesborough and Park Farm South. NICE recommends the following[25]:
    - Older people aged over 65 in contact with healthcare professionals should routinely be asked whether they have fallen in the past year.
    - Any people at risk should be offered a multifactorial falls risk assessment = referral to a specialist falls service.
    - Any people at risk should be considered for multifactorial interventions, which could include strength and balance training, home hazard assessment, vision assessment, medication review.

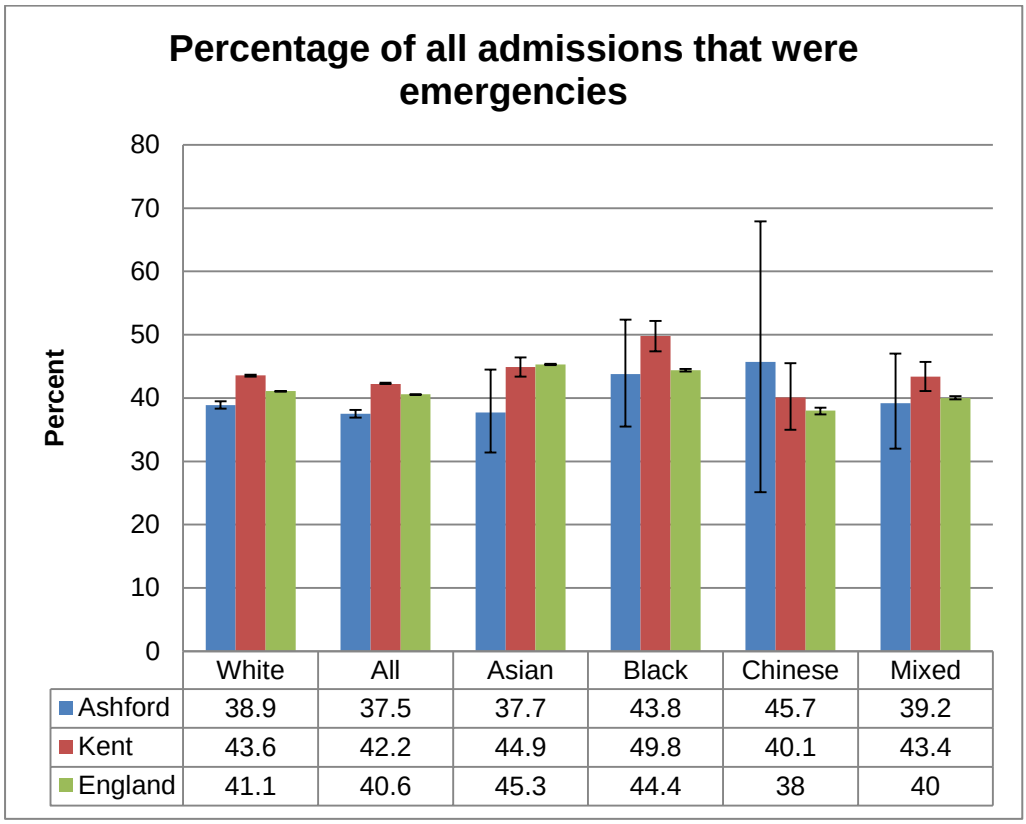
  The Kent Community Health Trust is providing a Falls Prevention Service for East Kent. Access and uptake of these services, in particular for elderly people living in the above wards, should be reviewed and referrals made appropriately.

[24] http://www.nice.org.uk/nicemedia/documents/breastfeeding_summary.pdf
[25] http://www.nice.org.uk/nicemedia/live/14181/64088/64088.pdf

7 USE OF HEALTH SERVICES

7.1 EMERGENCY A&E ADMISSIONS

The percentage of emergency admissions in Ashford during 2011-12 was with 37.7% significantly lower than rates in Kent (42.2%) and England (40.6%), Figure 48.



	White	All	Asian	Black	Chinese	Mixed
Ashford	38.9	37.5	37.7	43.8	45.7	39.2
Kent	43.6	42.2	44.9	49.8	40.1	43.4
England	41.1	40.6	45.3	44.4	38	40

Figure 48: Percentage of emergency hospital admissions. Years 2011-12. Data source: APHO

Ethnic minorities, with Black people in particular, had a higher rate of emergency admissions.

7.2 VACCINATION UPTAKE

Vaccination saves lives. The WHO estimates that vaccination prevents about 2.5 million deaths worldwide each year. Primarily, the aim of vaccination is to protect the individual that receives the vaccine but at the same time, vaccinated people are less likely to be a source of infection to others. The more people are vaccinated in a population, the less likely are unvaccinated people to be infected. It is thought that at about 95% immunity in a population the risk of infection for non-immune people is eliminated and this is called herd immunity.

Therefore, practices should aim at vaccination coverage of about 95% in their population, according to WHO targets.

The tables below show vaccine uptake by practice and it shows that most practices reach a target of 95% and above for most childhood vaccinations.

Ashford LA: 12/13 GP Practice Level Vaccinations 01/04/12-31/03/13
Source: Child Health Computer

Key	WHO Targets
	95% and above
	90.0%-94.99%
	<90%

G code	Practice Name	CCG	LA	Up to 1st birthday			Up to 2nd birthday primaries				Up to 2nd birthday boosters	
				DTap/IPV/ Hib	Men C	Pneu	DTap/IPV/ Hib	MMR 1	Men C	Pneu	Hib/MenC	Pneu
PCT				95.6	95.2	95.4	97.6	94.7	96.7	97.7	94.7	95.6
LA				97.1	96.4	96.9	98.5	95.6	97.7	98.7	96.4	97.1
G82049	Hollington Surgery	Ashford CCG	Ashford	97.8	97.8	97.8	100.0	97.9	100.0	100.0	100.0	100.0
G82050	Sydenham House	Ashford CCG	Ashford	98.4	97.8	98.4	98.9	94.4	98.3	99.4	96.1	97.8
G82053	Woodchurch Surgery	Ashford CCG	Ashford	83.3	83.3	83.3	96.2	96.2	96.2	96.2	96.2	96.2
G82080	Willesborough Health Centre	Ashford CCG	Ashford	97.6	97.6	97.6	100.0	98.2	98.8	99.4	98.2	98.8
G82087	New Hayesbank Surgery	Ashford CCG	Ashford	98.4	97.9	98.4	99.4	98.3	98.3	98.9	98.3	98.9
G82094	Charing Medical Partnership	Ashford CCG	Ashford	100.0	96.0	97.3	95.7	92.8	94.2	95.7	95.7	95.7
G82114	Ivy Court Surgery	Ashford CCG	Ashford	98.3	97.4	98.3	97.0	92.5	97.0	97.7	94.7	95.5
G82142	Wye Surgery	Ashford CCG	Ashford	96.8	96.8	96.8	96.6	93.1	95.4	97.7	93.1	95.4
G82186	Hamstreet Surgery	Ashford CCG	Ashford	98.6	97.3	97.3	100.0	97.0	100.0	100.0	97.0	97.0
G82658	Sellindge Surgery	Ashford CCG	Ashford	100.0	100.0	100.0	100.0	98.0	100.0	100.0	100.0	100.0
G82688	Singleton Surgery	Ashford CCG	Ashford	96.6	93.2	94.9	100.0	98.0	98.0	100.0	98.0	100.0
G82712	Singleton Medical Centre	Ashford CCG	Ashford	95.1	95.1	95.1	98.0	98.0	95.9	98.0	98.0	98.0
G82730	Kingsnorth Medical Practice	Ashford CCG	Ashford	96.4	96.4	97.8	100.0	94.2	99.3	100.0	97.1	96.4
G82735	St Stephens Health Centre	Ashford CCG	Ashford	93.8	93.2	93.8	97.5	97.5	96.9	98.1	95.7	97.5
G82748	Musgrove Park Medical Centre	Ashford CCG	Ashford	96.2	96.2	96.2	95.6	89.0	94.5	96.7	91.2	90.1

Figure 49: Vaccination coverage by GP practice up to second birthday

Ashford LA: 12/13 GP Practice Level Vaccinations 01/04/12-31/03/13
Source: Child Health Computer

Key	WHO Targets
	95% and above
	90.0%-94.99%
	<90%

G code	Practice Name	CCG	LA	Up to 5th birthday primaries				Up to 5th birthday boosters				Up to 14th birthday
				Dtap/IPV/ Hib	MMR 1	Men C	Pneu	DTPP	MMR 2	Hib/Men C	Pneu	Rubella
PCT				97.4	95.8	94.8	95.9	93.9	92.0	94.5	92.5	83.7
LA				97.9	96.8	95.6	96.7	94.9	93.5	95.8	94.9	81.0
G82049	Hollington Surgery	Ashford CCG	Ashford	100.0	97.4	97.4	100.0	100.0	97.4	97.4	100.0	75.0
G82050	Sydenham House	Ashford CCG	Ashford	97.4	96.9	96.9	97.4	95.4	93.4	96.4	97.4	90.4
G82053	Woodchurch Surgery	Ashford CCG	Ashford	100.0	100.0	97.2	100.0	100.0	100.0	97.2	100.0	84.2
G82080	Willesborough Health Centre	Ashford CCG	Ashford	98.9	97.7	93.1	94.9	94.3	94.3	95.4	92.6	81.3
G82087	New Hayesbank Surgery	Ashford CCG	Ashford	97.9	97.9	94.1	96.3	95.7	95.7	95.7	95.7	84.6
G82094	Charing Medical Partnership	Ashford CCG	Ashford	98.9	91.3	98.9	97.8	93.5	89.1	95.7	92.4	83.3
G82114	Ivy Court Surgery	Ashford CCG	Ashford	96.7	95.9	95.1	95.9	90.2	87.8	94.3	95.1	80.9
G82142	Wye Surgery	Ashford CCG	Ashford	98.9	97.9	96.8	96.8	96.8	94.7	97.9	94.7	82.5
G82186	Hamstreet Surgery	Ashford CCG	Ashford	98.8	96.5	97.7	98.8	96.5	91.9	97.7	94.2	86.7
G82658	Sellindge Surgery	Ashford CCG	Ashford	96.1	94.1	88.2	92.2	90.2	90.2	90.2	90.2	95.5
G82688	Singleton Surgery	Ashford CCG	Ashford	96.1	96.1	96.1	96.1	94.1	94.1	96.1	94.1	84.2
G82712	Singleton Medical Centre	Ashford CCG	Ashford	96.5	96.5	96.5	96.5	96.5	96.5	96.5	94.7	76.2
G82730	Kingsnorth Medical Practice	Ashford CCG	Ashford	99.4	100.0	98.2	99.4	98.2	97.0	97.6	98.8	79.3
G82735	St Stephens Health Centre	Ashford CCG	Ashford	97.2	97.2	95.9	95.9	95.2	95.2	94.5	93.8	66.7
G82748	Musgrove Park Medical Centre	Ashford CCG	Ashford	95.3	93.0	91.9	94.2	88.4	86.0	93.0	88.4	55.6

Figure 50: Vaccination coverage by GP practice, up to 14th birthday

7.3 SCREENING UPTAKE

Cancer screening uptake is essential to increase the proportion of cancers diagnosed at an early stage. There is variation in uptake for different population sub-groups and it has been observed that uptake is lower in deprived communities[26].

[26] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2790712/pdf/6605391a.pdf

The national target for breast screening uptake is >70%. Most practices within Ashford CCG have been achieving this target, Table 1

Breast Screening, percentage positive uptake, by practice, three years ending 31 March 2012

GP Code	GP Name	Eligible Practice Population	Number screened	% Uptake
G82735	South Ashford Medics	483	292	60.46%
G82748	Musgrove Park	415	257	61.93%
G82688	Dr Setty M V S & Partner	265	195	73.58%
G82049	Hollington Surgery	319	238	74.61%
G82186	Hamstreet Surgery	878	661	75.28%
G82712	Dr Thomas A	245	187	76.33%
G82142	Wye Surgery	969	744	76.78%
G82050	Sydenham House Medical Centre	1298	1011	77.89%
G82730	Dr Kelly J C & Partners	842	657	78.03%
G82087	New Hayesbank Surgery	1463	1147	78.40%
G82094	The Charing Surgery	1059	835	78.85%
G82080	The Willesborough Medical Ctr	1283	1012	78.88%
G82114	Ivy Court Surgery	1977	1638	82.85%
G82053	Front Road Surgery	463	386	83.37%
Ashford LA		11959	9260	77.43%
Kent and Medway		186431	145953	78.29%

Source: PCIS

Table 1: Breast Cancer Screening uptake

Figure 51 illustrates breast screening uptake by deprivation quintile of the area where practices are located. The figure shows that uptake is worst in patient populations that are registered with a GP practice situated in highly deprived areas. These are practices that have been unable to reach the national uptake target for breast cancer.

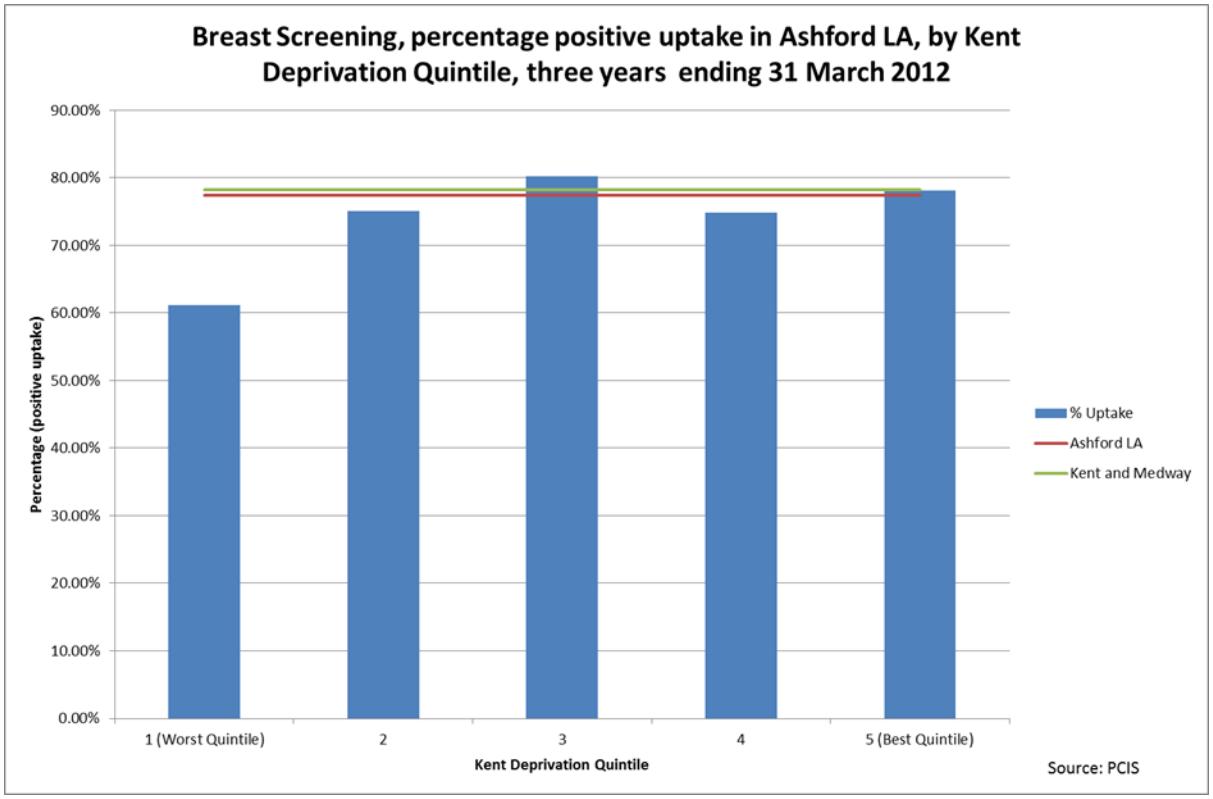


Figure 51: Breast Cancer Screening uptake in Ashford by practice location deprivation quintile

The national target for Bowel Screening uptake is at 60%. Table 52 shows that only half of the practices in the Ashford area have achieved this target.

Bowel Screening percentage positive uptake by practice, 2012/2013

GP Code	GP Name	Number Invited	Number adequately screened	% Uptake
G82748	Musgrove Park Medical Centre	282	129	45.74%
G82049	Hollington Surgery	236	119	50.42%
G82735	St Stephens Health Centre	298	153	51.34%
G82688	Singleton Surgery	143	76	53.15%
G82712	Singleton Medical Centre	117	64	54.70%
G82050	Sydenham House	800	454	56.75%
G82080	Willesborough Health Ctr.	741	427	57.62%
G82094	Charing Surgery	700	425	60.71%
G82730	Kingsnorth Medical Practice	469	290	61.83%
G82142	Wye Surgery	576	362	62.85%
G82053	Woodchurch Surgery	325	206	63.38%
G82087	New Hayesbank Surgery	907	580	63.95%
G82186	Hamstreet Surgery	553	354	64.01%
G82114	Ivy Court	1204	790	65.61%
Ashford LA		**7351**	**4429**	**60.25%**
Kent and Medway		**57785**	**34190**	**59.18%**

Source : PCIS

Table 2: Bowel Cancer Screening uptake

In Figure 52 it is demonstrated that, similar to breast cancer, practices situated in the most deprived areas of Ashford have the worst uptake rates and have not been able to achieve the national target of 60%. Uptake in practices located in areas within the 4th deprivation quintile also had low uptake rates. These are two practices in Singleton that are covering for populations living in very deprived areas of Ashford.

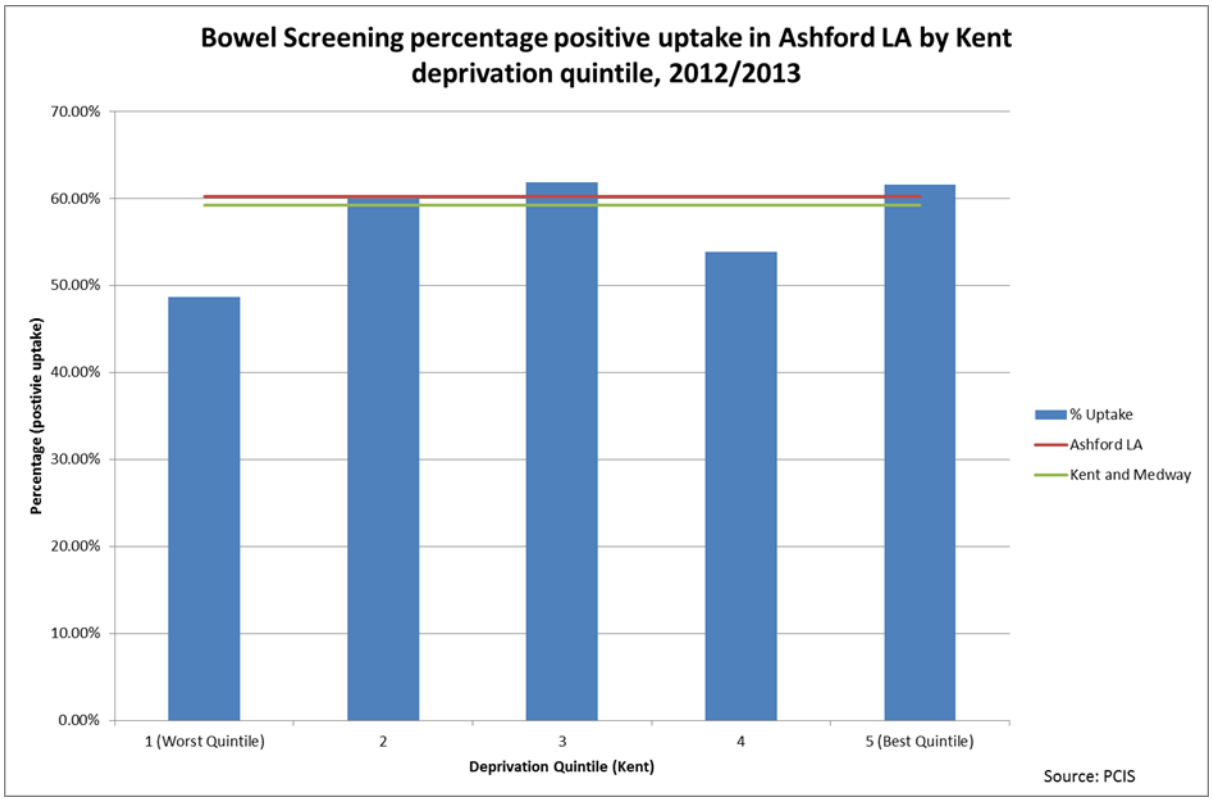


Figure 52: Bowel Cancer Screening uptake in Ashford by practice location deprivation quintile

The national target for the uptake of cervical screening is 80%. Table 3 shows that 6/14 practices (43%) are not achieving this goal.

Cervical Screening, percentage positive uptake, by practice, 5 years ending 30 September 2013

GP Code	GP Name	Eligible Practice Population	Number Screened	% Uptake
G82049	Hollington Surgery	808	618	76.49%
G82050	Sydenham House Medical Centre	3156	2493	78.99%
G82053	Front Road Surgery	783	656	83.78%
G82080	The Willesborough Medical Ctr	3126	2542	81.32%
G82087	New Hayesbank Surgery	4018	3220	80.14%
G82094	The Charing Surgery	2083	1722	82.67%
G82114	Ivy Court Surgery	3173	2530	79.74%
G82142	Wye Surgery	1963	1652	84.16%
G82186	Hamstreet Surgery	1617	1332	82.37%
G82688	Singleton Surgery	955	744	77.91%
G82712	Dr Thomas A	826	670	81.11%
G82730	Kingsnorth Medical Practice	2777	2470	88.94%
G82735	South Ashford Medics	1988	1477	74.30%
G82748	Musgrove Park	1590	1095	68.87%
Ashford LA		**28863**	**23221**	**80.45%**
Kent and Medway		**428450**	**344879**	**80.49%**

Source: PCIS

Table 3: Cervical Cancer Screening uptake

As in other cancer screening programmes, figure 53 shows that uptake for cervical screening is lowest in practices situated in highly deprived areas within Ashford and the target of 80% uptake is not achieved in these practices.

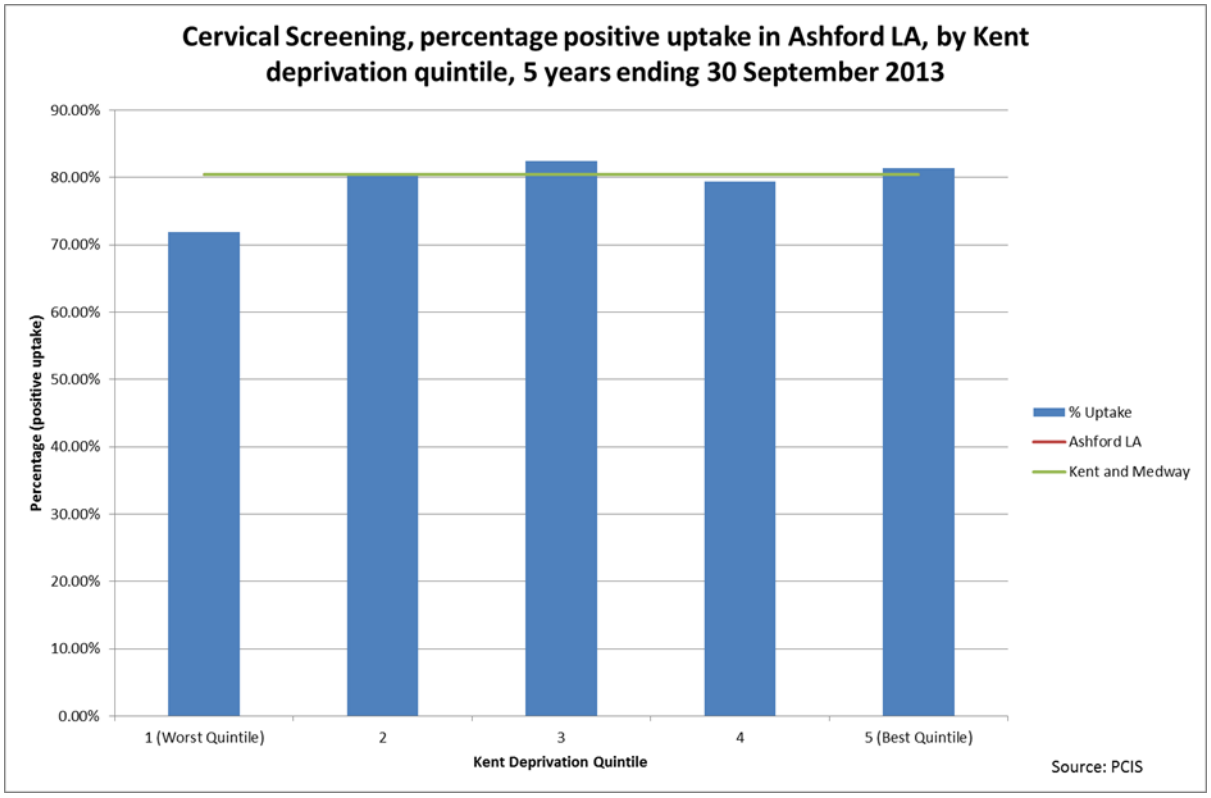


Figure 53: Cervical Cancer Screening uptake in Ashford by practice location deprivation quintile

Overall, there is an uptake of 80.98% for diabetic retinopathy screening in Ashford. This is in line with the national target of 80%. Only 6/14 practices (43%), however, have achieved this target individually and uptake in the majority of practices is less than 80%.

Diabetic Eye Screening, Percentage Positive Uptake, by practice, 2011/12

GP Code	GP Name	Eligible Practice Population	Number Screened	% Uptake
G82049	Hollington Surgery	164	117	71.34%
G82050	Sydenham House Medical Centre	590	464	78.64%
G82053	Front Road Surgery	177	153	86.44%
G82080	The Willesborough Medical Ctr	579	471	81.35%
G82087	New Hayesbank Surgery	595	558	93.78%
G82094	The Charing Surgery	368	295	80.16%
G82114	Ivy Court Surgery	694	553	79.68%
G82142	Wye Surgery	285	233	81.75%
G82186	Hamstreet Surgery	308	235	76.30%
G82688	Dr Setty M V S & Partner	133	90	67.67%
G82712	Dr Thomas A	115	87	75.65%
G82730	Dr Kelly J C & Partners	310	266	85.81%
G82735	South Ashford Medics	283	208	73.50%
G82748	Musgrove Park	205	162	79.02%
Ashford LA		**4806**	**3892**	**80.98%**
Kent and Medway		**77137**	**62018**	**80.40%**

Source: QoF, EKHUFT

Table 4: Diabetic Eye Screening uptake

Public Health Interventions and Recommendations:

- Emergency admissions in Ashford are comparatively lower than in the rest of Kent. This is a positive finding and the trend should be maintained. The King's fund has looked into the effectiveness of interventions that may decrease emergency admissions and stated the following key points[27]:
    - At highest risk for emergency admissions are people living in socio-economic deprivation (including older age, area of residence, morbidity, ethnicity). Commissioners should consider the impact when designing policy around admission rates.
    - Commissioners need to be clear about what admissions are avoidable and how these should be coded and measured.
    - Self-management among people with long-term conditions should be increased. There is evidence that this is particularly effective in patients with COPD and asthma.
    - Quality of primary care is important: continuity of care with a family doctor and out-of –hours primary care arrangements.
- Vaccination uptake rates in Ashford practices are good with most reaching the WHO target of 95% or more. Only few practices in the Ashford area have uptake rates of less than 90% for some vaccinations. Recommendations published by NICE to reduce differences in uptake include[28]:
    - Improve access: extending clinic times; children are seen promptly; clinics are child- and family-friendly
    - Ensure that enough appointments are available
    - Send out tailored invitations and tailored reminders and give out tailored information
    - Give opportunities to discuss concerns
    - Consider home visits to those who have not responded and offer giving vaccinations there and then
    - Check immunisation status of children at every appropriate opportunity
    - Ensure that staff is appropriately trained including communication skills and ability to answer questions
    - School nursing teams should check vaccination status
- Not all practices in Ashford are achieving national targets in screening uptake and inequalities in uptake by deprivation quintile have been shown. Practices serving more deprived populations may need to be more active to increase uptake and reach national screening targets. A systematic review was published by the NHS Centre for Reviews and Dissemination, looking at interventions aiming to increase screening uptake and they make the following recommendations[29]:
    - Efforts should focus on identifying and encouraging attendance among those who have never participated in screening.
    - Current UK practice is to use invitation letters and/or appointments and this is supported by good evidence.
    - Telephone counselling to discuss barriers to screening could be considered.
    - Reducing economic barriers (e.g. free postage or transportation costs) can increase uptake and may be appropriate for specific groups.
    - Healthcare professionals can be prompted either to perform or to recommend screening tests by using reminder systems such as tagged notes.

    Any attempts to increase the uptake of screening should be accompanied by initiatives to increase informed uptake.

[27] http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010_0.pdf
[28] http://www.nice.org.uk/nicemedia/live/12247/45497/45497.pdf
[29] http://www.hta.ac.uk/pdfexecs/summ414.pdf

8 LONG TERM CONDITIONS

Long term conditions (LTCs) are expected to increase as the overall population is ageing because of lower birth rates and longer life expectancy. There will be more demand on health care and emergency hospital admissions may increase as many elderly people are diagnosed with one or more LTCs.

8.1 CORONARY HEART DISEASE

Coronary Heart Disease (CHD) is one of the main causes of death in Ashford and Figure 54 shows prevalence by GP practice in relation to the regional and national average. Prevalence in Ashford is just over 3% and this is slightly lower than the England average. There is great variation between practices. The highest prevalence is in Front Road Surgery with over 5% and the lowest are Practice Dr Setty and South Ashford Medics with less than 2%.

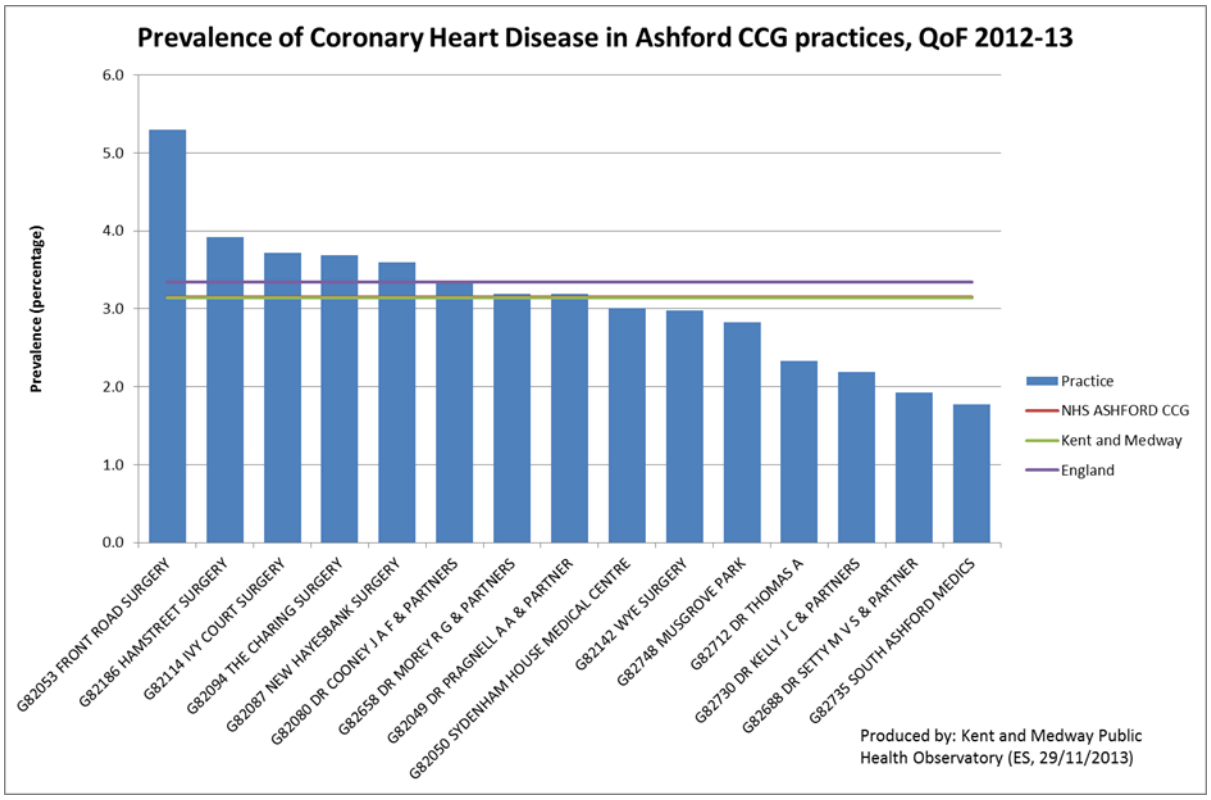


Figure 54: CHD prevalence by GP practice in Ashford compared to regional and national average

Figure 55 shows the emergency admissions presented by GP practice with a green dot showing the cancer prevalence of individual practices.

In 2012/13, the emergency admission rate for CHD in Ashford was between 2-2.5/1,000 registered patients. Practices with high admission rates compared to individual practice prevalence are: Hamstreet Surgery, Willesborough Medical Centre and Hollington Surgery.

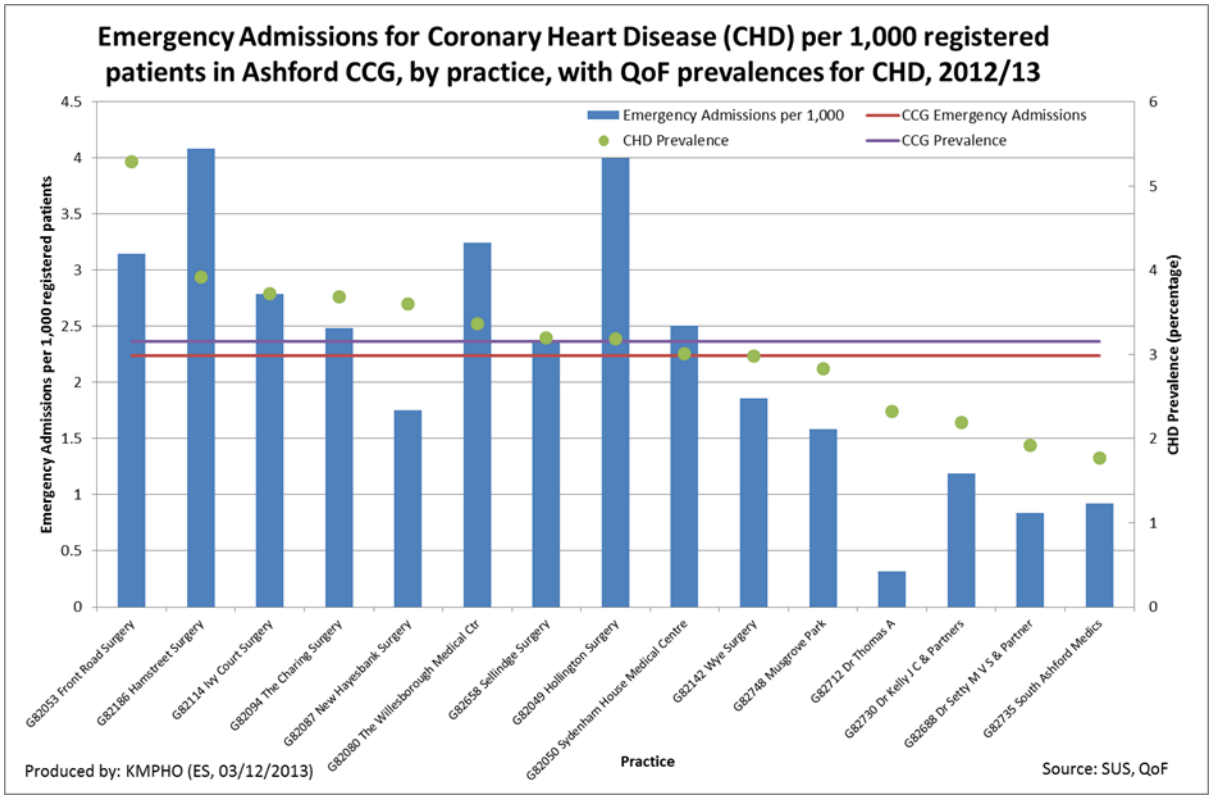


Figure 55: Emergency admissions for CHD by GP practice compared with CHD prevalence

8.2 DIABETES

Diabetes prevalence is around 6% in Ashford, very similar to the England national rate (Figure 56). Variation between practices ranges from over 7% in New Hayesbank Surgery to just over 4% in Practice Dr Kelly & Partners. There is a lower than average prevalence in a further four practices: Practice Dr Setty, South Ashford Medics, Practice Dr Thomas and Wye Surgery.

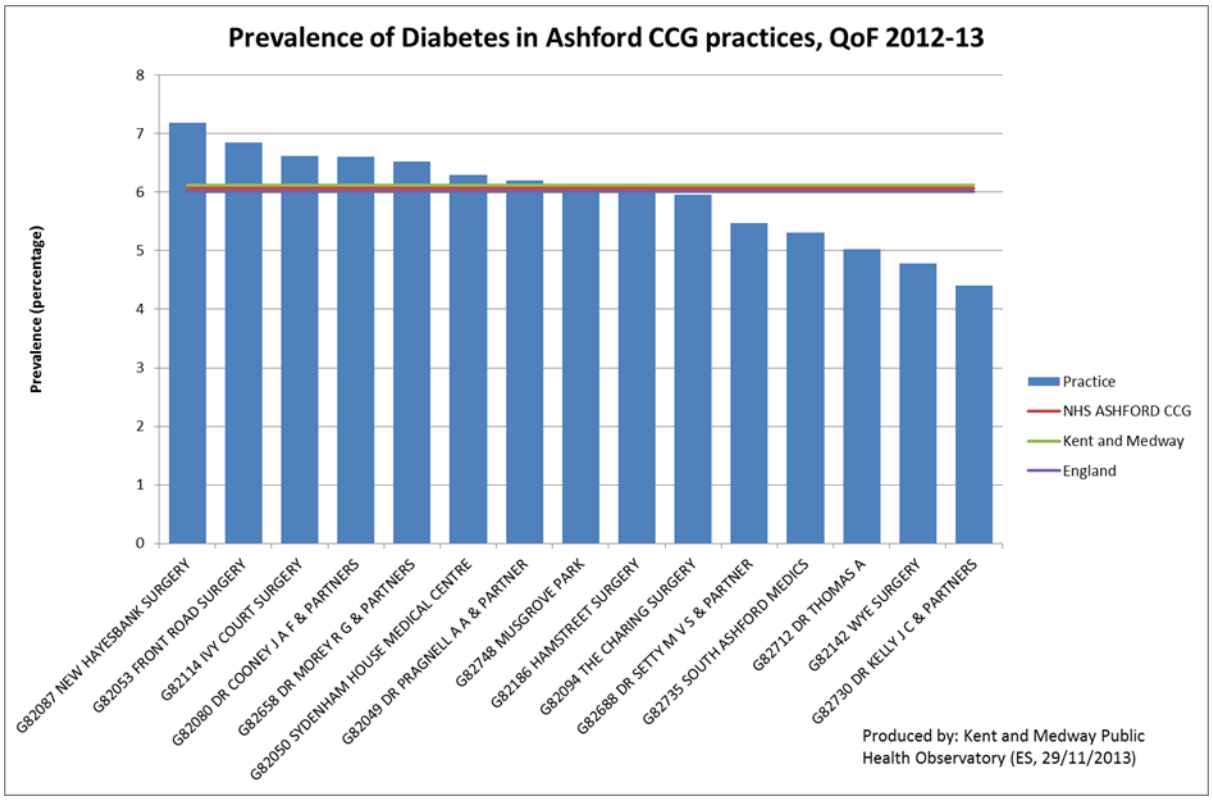


Figure 56: Diabetes prevalence by GP practice in Ashford compared to regional and national average

Emergency admissions for diabetes are quite low with less than 0.6/1,000 registered patients. Two practices had relatively high admission rates compared to their diabetes prevalence: Sydenham House Medical Centre and Practice Dr Setty.

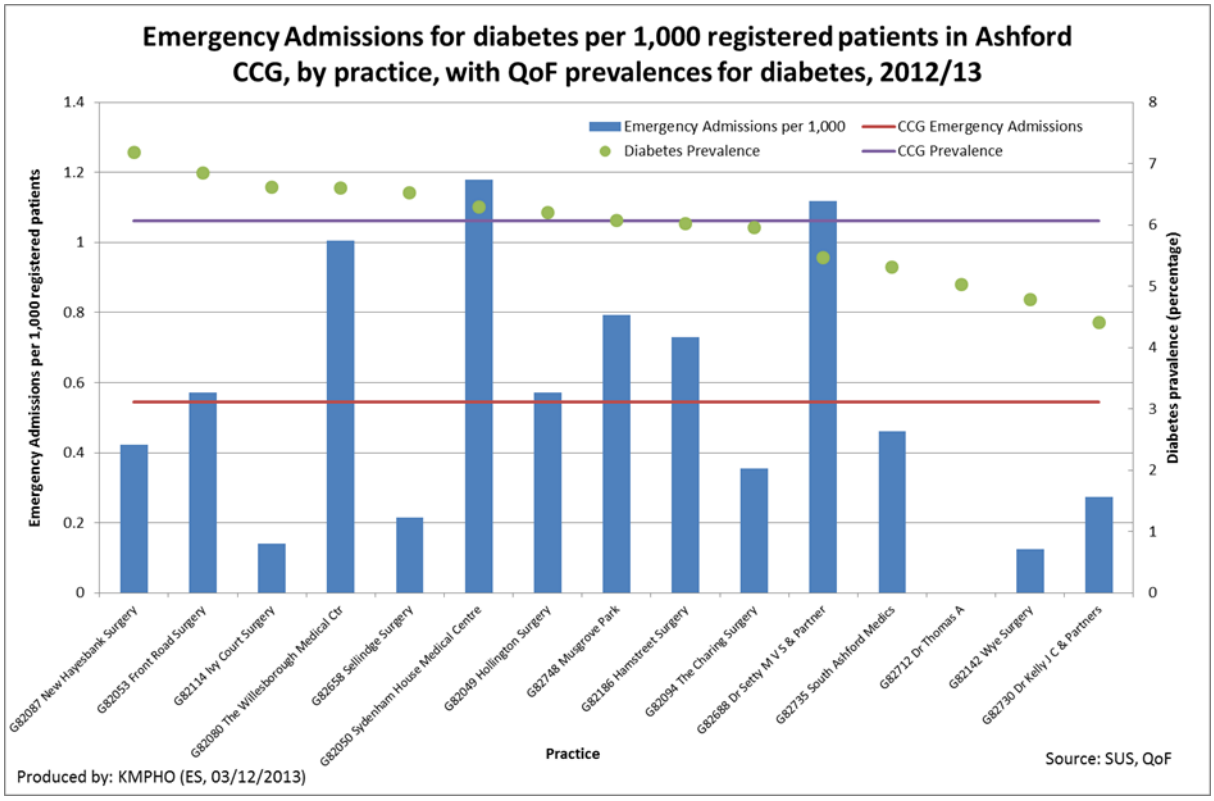


Figure 57: Emergency admissions for diabetes by GP practice compared with diabetes prevalence

8.3 CANCER

Figure 58 shows the prevalence of cancer in Ashford by GP practice. The national average is just under 2%, the average in Ashford just over 2%. The variation in prevalence between practices is large, ranging from less than 1% to over 3%. This fact raises concerns of cancers being undiagnosed in some population groups. Screening uptake was lowest in the practices: St Stephens Health Centre, Singleton Surgery, Musgrove Park Surgery and Hollington Surgery. All these surgeries have cancer prevalence rates below the regional and national average.

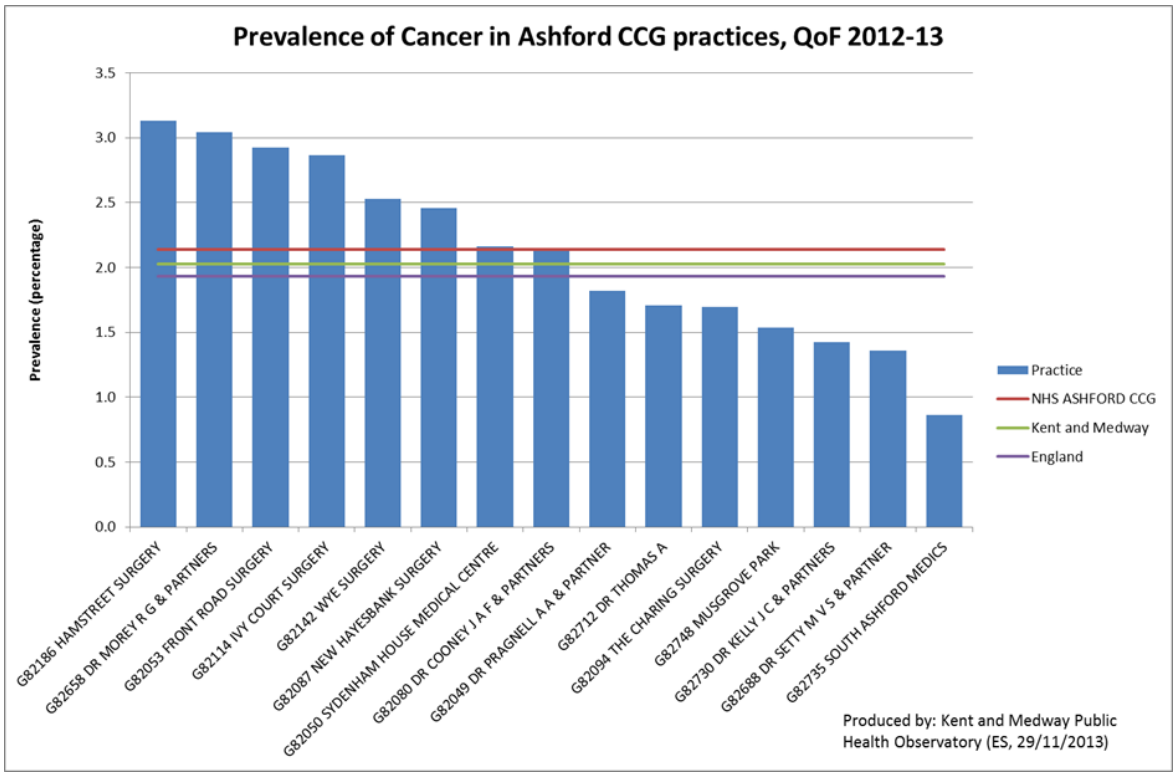


Figure 58: Cancer prevalence by GP practice in Ashford compared to regional and national average

There were, on average, about 1.2/1000 emergency hospital admissions for cancer in Ashford in 2012/13. Practices with a high admission to prevalence ratio are: South Ashford Medics, Dr Setty and Partners, The Charing Surgery and Hollington Surgery (Figure 59).

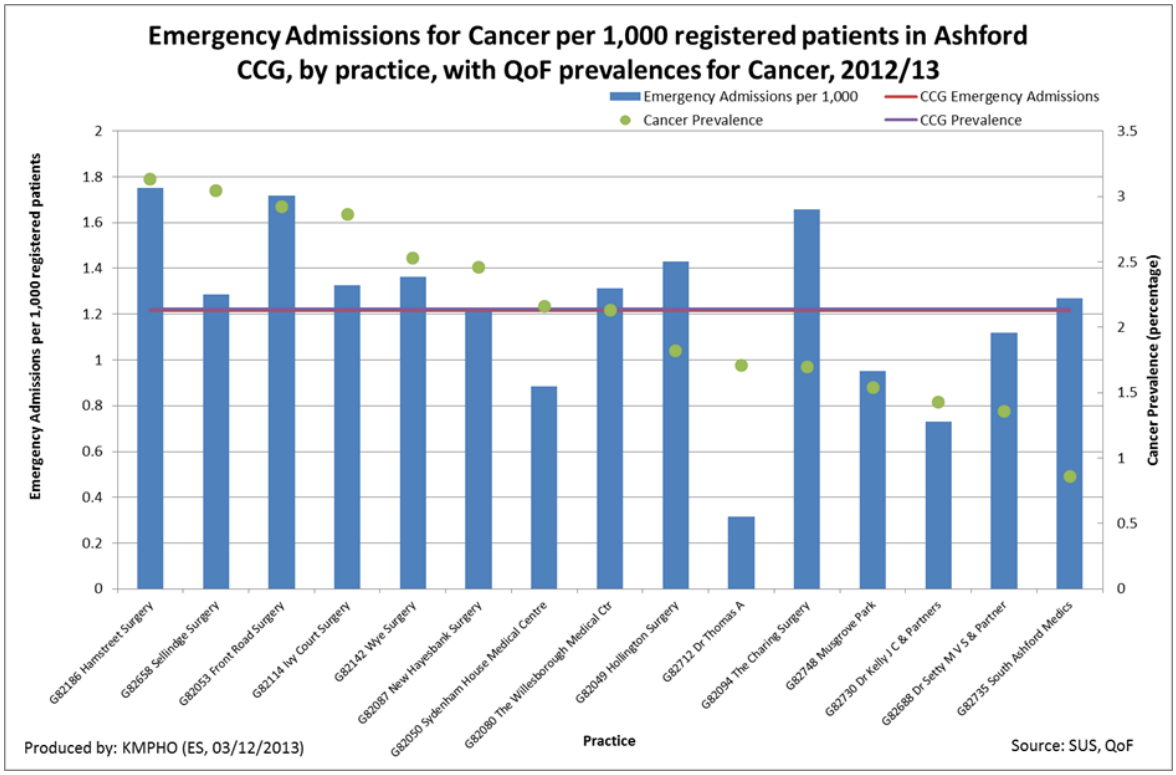


Figure 59: Emergency admissions for cancer by GP practice compared with cancer prevalence

8.4 ASTHMA

The prevalence of asthma in Ashford is less than 6% which is lower than the England average of around 6%.

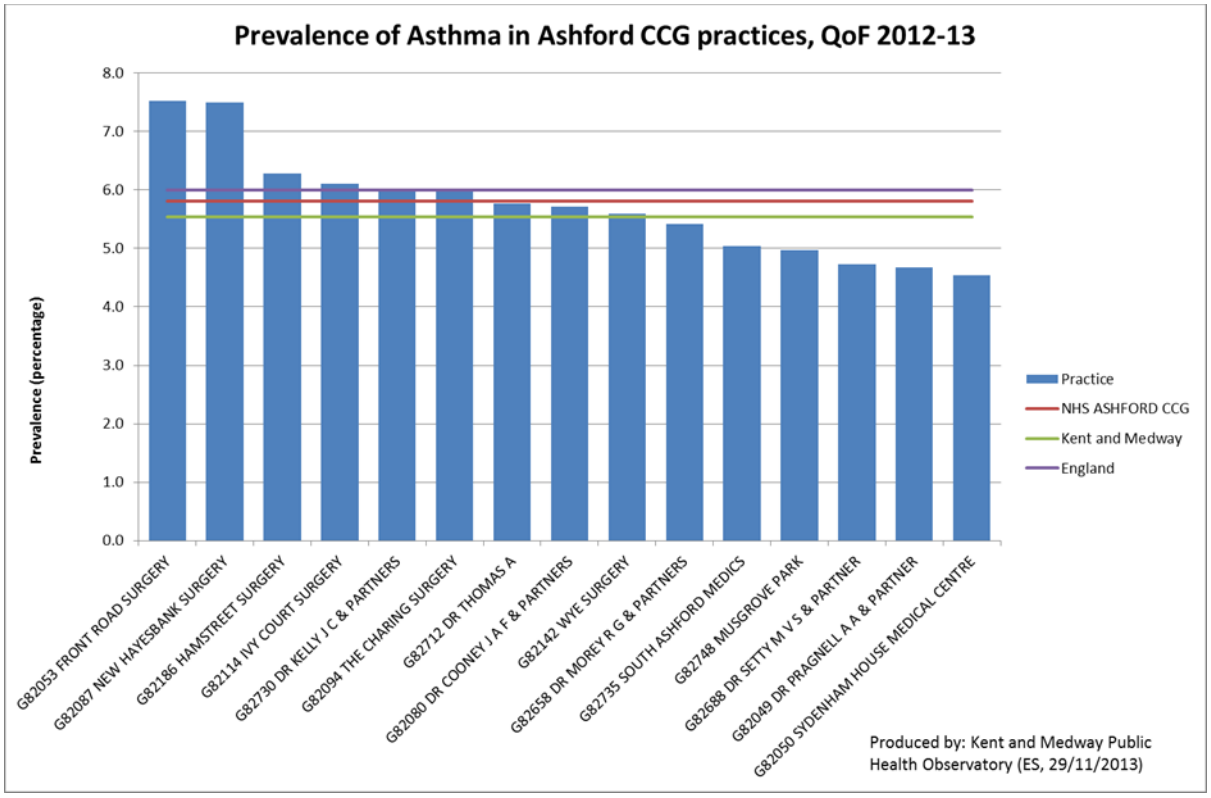


Figure 60: Asthma prevalence by GP practice in Ashford compared to regional and national average

In 2012/13 there were on average just over 0.6/1,000 emergency admissions for asthma in Ashford (Figure 61). Patients registered with South Ashford Medics had a high rate of emergency admissions (over 1,8/1,000), not explained by prevalence of asthma in their practice population.

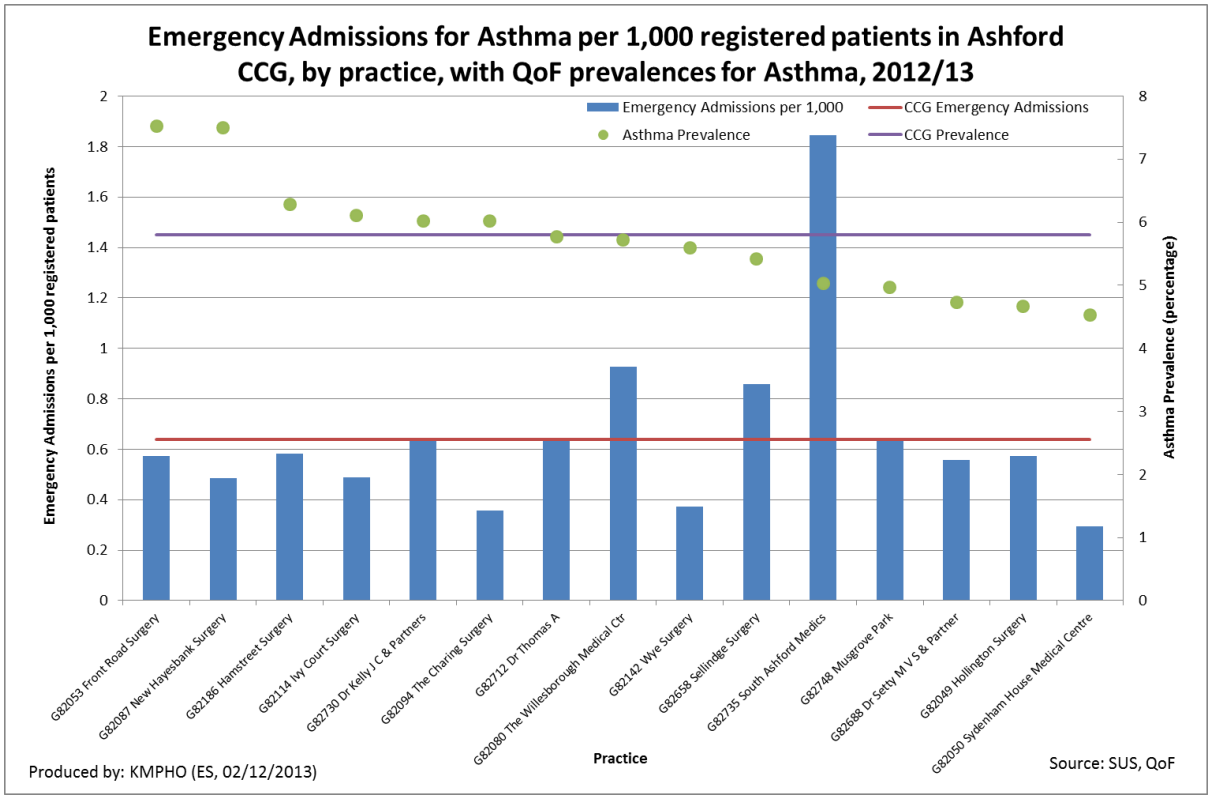


Figure 61: Emergency admissions for asthma by GP practice compared with asthma prevalence

8.5 COPD

The prevalence of COPD lies between 1.5 and 2% in Ashford, similar to rates in England (Figure 62). The prevalence is slightly higher at over 2% in the patient population of Front Road Surgery and Practice Dr Pragnell & Partner. Lower prevalence of COPD of less than 1,5% is seen in the practice population of Sydenham House Medical Centre and Practice Dr Thomas.

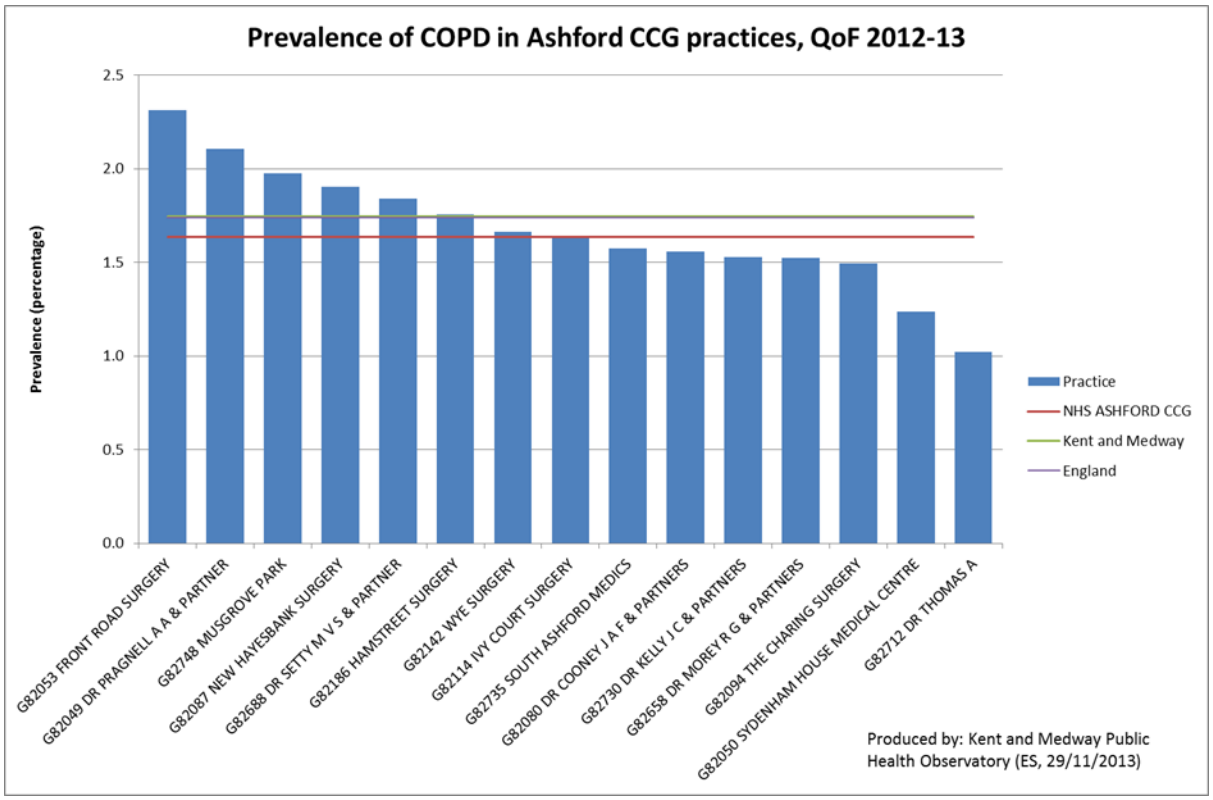


Figure 62: COPD prevalence by GP practice in Ashford compared to regional and national average

Emergency admissions for COPD were on average just over 1.5/1,000 registered patients Figure 63). Five practices had higher rates of emergency admissions: Hamstreet Surgery, South Ashford Medics, Willesborough Medical Centre, Charing Surgery and Sydenham House Medical Centre. This compares to a comparatively low prevalence of COPD in the registered population of Sydenham House Medical Centre (just over 1%).

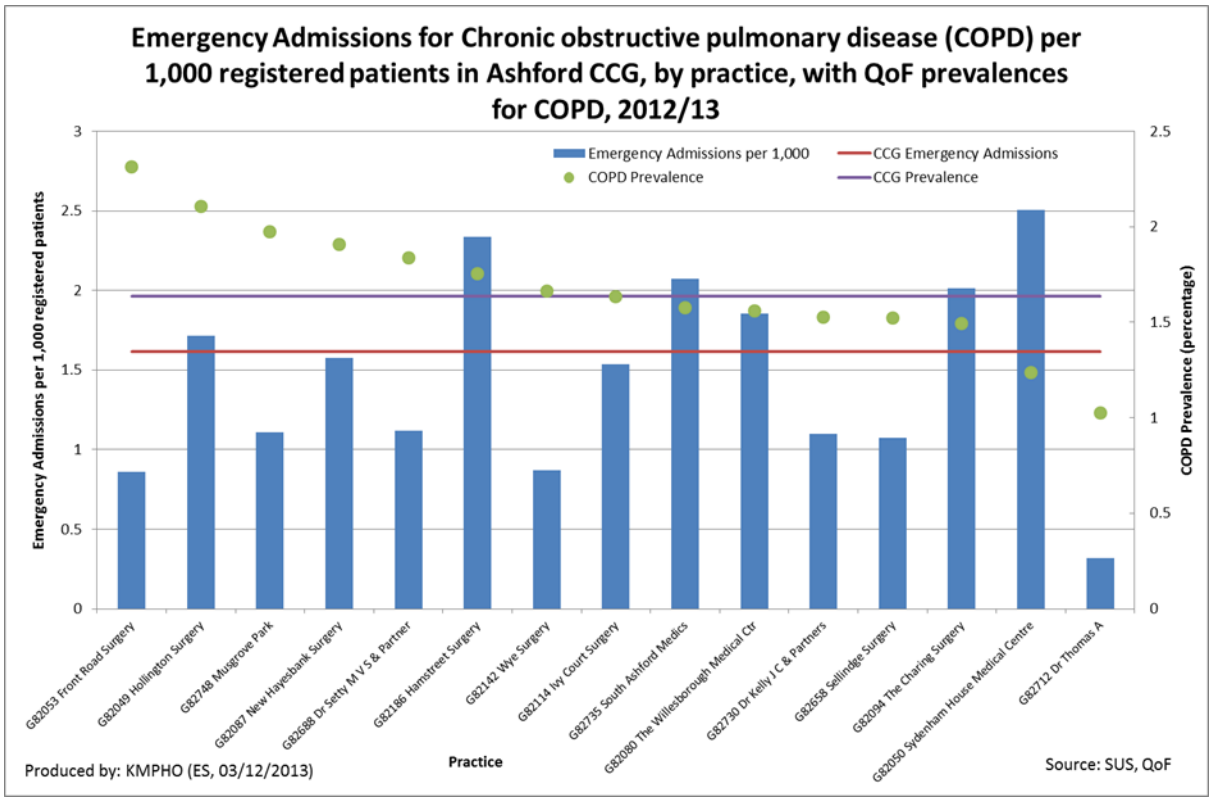


Figure 63: Emergency admissions for COPD by GP practice compared with COPD prevalence

8.6 MENTAL HEALTH

On average, just over 0.6% of GP registered people in Ashford are diagnosed with mental health problems. There is a lot of variation by GP practice (Figure 64). In patients registered with Practice Dr Pragnell & Partner, Musgrove Park Practice and New Hayesbank Surgery the prevalence is over 1%. In the practices Front Road Surgery and Dr Setty the prevalence is less than 0.4%.

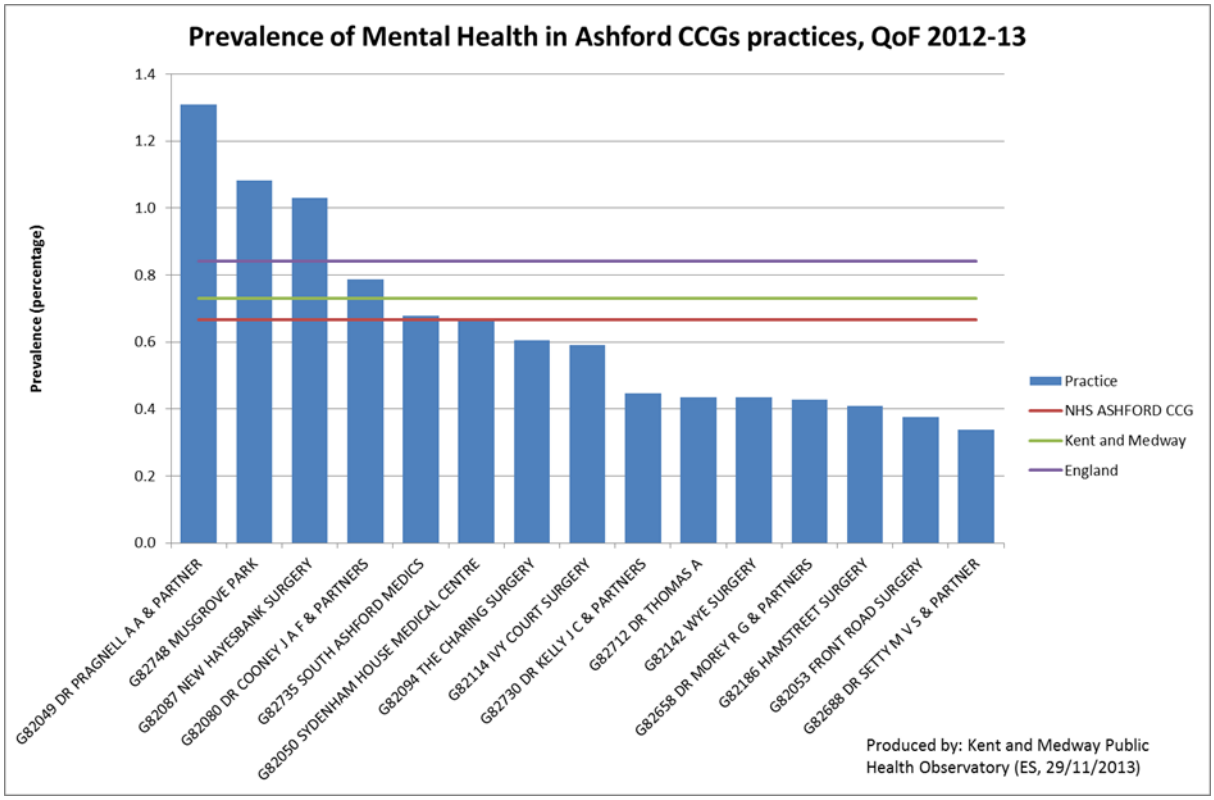


Figure 64: Prevalence of mental Health Problems by GP practice in Ashford compared to regional and national average

There is large variation in emergency admissions for mental health problems. The Ashford average lies around 1-1.5/1,000 registered patients. The highest admission rate has practice Dr Thomas with over 3/1,000 emergencies in 2012/13 whereby prevalence in the practice population is relatively low at around 1%.

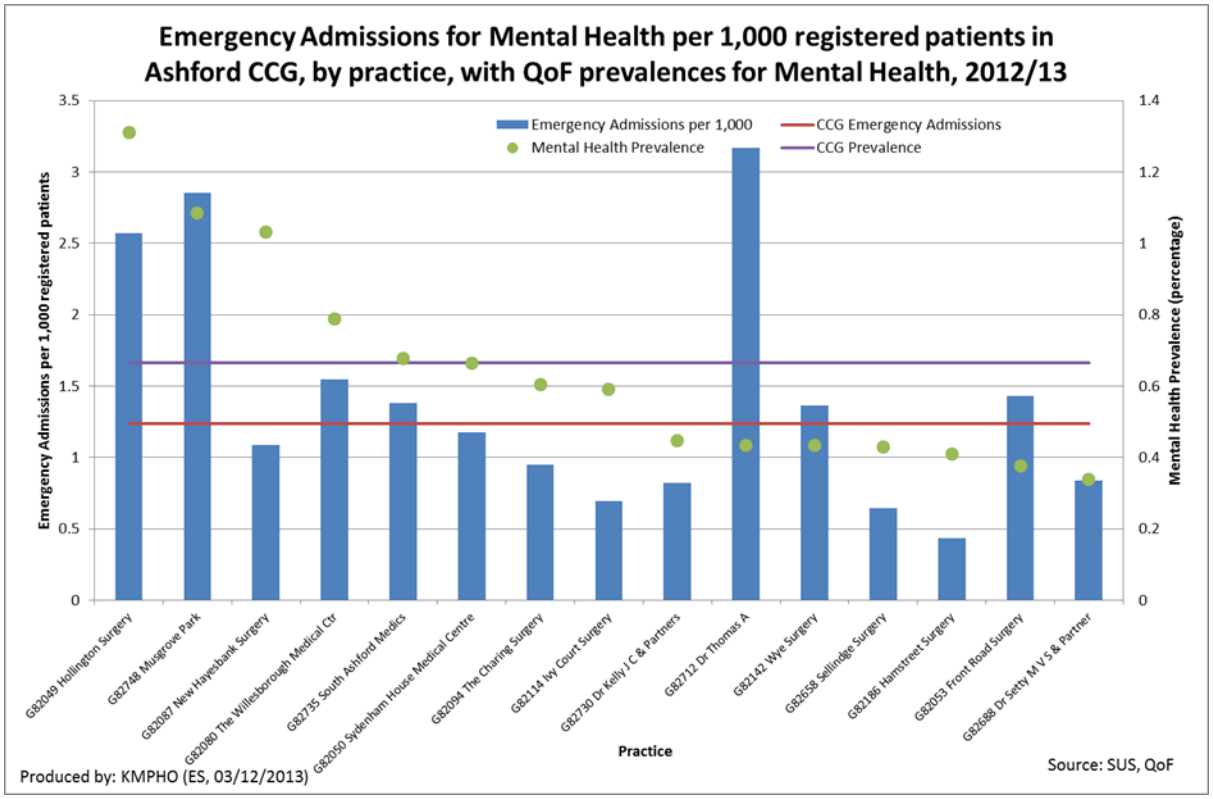


Figure 65: Emergency admissions for mental health problems by GP practice compared with prevalence of mental health problems

Public Health Interventions and Recommendations:

The prevalence of LTCs in Ashford is similar to rates in England. There is, however, some variation by GP practice. Whilst a low prevalence in the population is desirable, under diagnosis of LTCs is a concern. Practices should actively pursue case finding e.g. using the information gathered from health checks. It is expected that prevalence of LTCs will increase initially but this will enable to target prevention programmes to appropriate patient groups.

The National Service Framework (NSF) for Long Term Conditions was published in 2005[30]. It aims to improve health outcomes for people with LTCs and reduce emergency bed days and access to services. The focus is on neurological conditions but it encourages commissioners to use it for non-neurological LTCs as well as it can be applied to a range of conditions. The guidance outlines 11 quality requirements, some of which are:

- A person-centred service: people receive all information about their condition, make informed decisions and are supported in managing the condition themselves where appropriate.
- Early recognition, prompt diagnosis and treatment: prompt access to specialist expertise as close to home as possible.
- Providing equipment and accommodation: appropriate assistive equipment to support people to live independently.
- Providing personal care and support: health and social care services work together to provide care and support.
- Supporting family and carers: access to appropriate support and services that recognise their needs both in their role as carer and in their own right

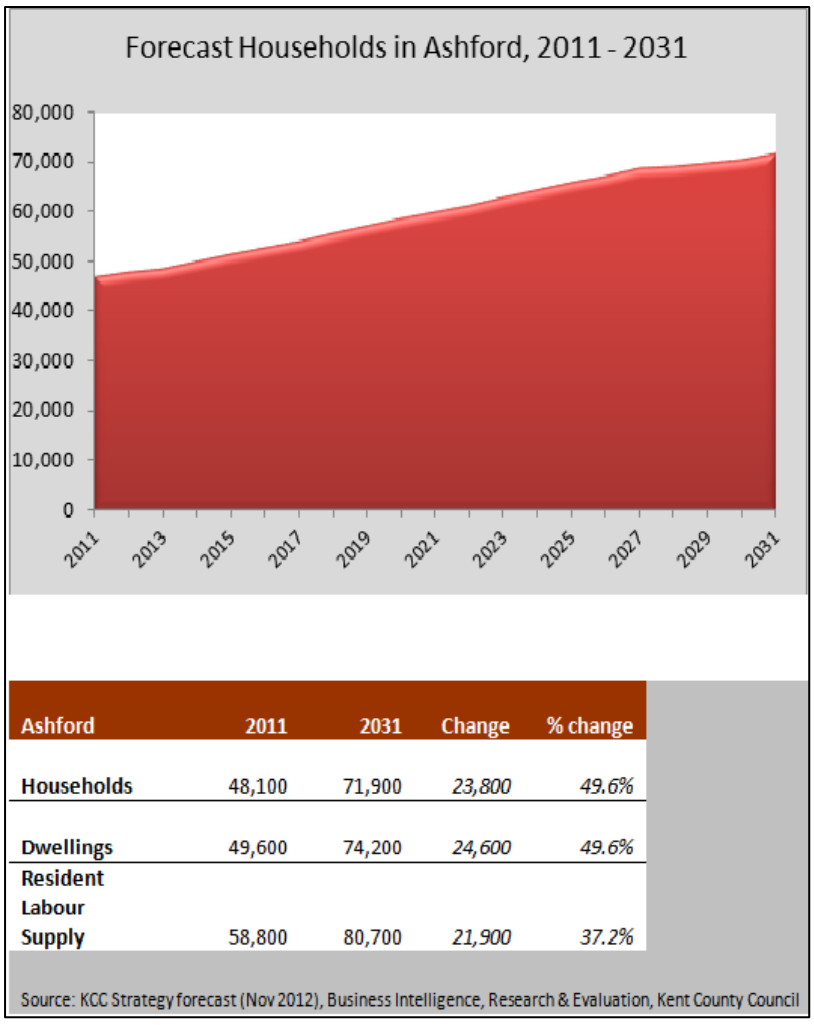
[30]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf

9 ASHFORD'S PLANS FOR EXPANSION

9.1 NEW DEVELOPMENTS

In 2003, the Labour government identified Ashford as a Growth Area in the government's Sustainable Communities Plan. "Following an assessment of social, economic and environmental factors it was concluded that Ashford town had the capacity to provide an additional 31,000 homes and 28,000 jobs over the period 2001 to 2031."[31]

The KCC Strategy Forecast team predicts that between 2011 and 2031, the number of dwellings will increase by 49.6% (Figure 66).



Ashford	2011	2031	Change	% change
Households	48,100	71,900	*23,800*	*49.6%*
Dwellings	49,600	74,200	*24,600*	*49.6%*
Resident Labour Supply	58,800	80,700	*21,900*	*37.2%*

Source: KCC Strategy forecast (Nov 2012), Business Intelligence, Research & Evaluation, Kent County Council

Figure 66: Estimated increase of dwellings in Ashford between 2011 and 2031

Plans have been published by Ashford Borough Council that, a) describe developments in Ashford town centre with a potential of 2,500 further homes, b) identify development sites within Ashford urban area aiming for 3,500 new homes and c) give details of urban extension areas: Chilmington Green and Cheeseman's Green with plans for about 10,000 new homes on these sites altogether[32].

[31] http://www.ashford.gov.uk/core-strategy-2008
[32] http://www.ashford.gov.uk/?page=local-plan-documents

9.2 IMPLICATIONS ON PUBLIC HEALTH

Rapid population growth has significant impacts on Public Health and whilst developments are at the planning stage, it is important to recognise "the critical link between our built environments and public health. How well we plan land use, amenities, transportation, economic development and natural resource protection will have dramatic effects on our communities far into the future".[33]

1. Primary care

    a. Access to General Practitioners
    Good access to primary care is important because it has positive effects on the health of individuals. Gravelle et al[34] looked at self-reported health in data obtained from the Health Survey for England. They found that an increase in GP supply increased the probability of reporting very good health significantly Access is firstly related to availability. GP provision can vary widely within the UK as the BBC reported a few years ago[35]. Adding new developments to a confined area in Ashford will need careful consideration to see if more GPs are needed. Oversubscribed practices will have a negative impact on access with fewer appointments available. Any new practice should be well connected to public transport systems.

    b. Prevention of diseases
    Primary care provision is crucial for disease prevention in the population. Newly built communities will need to be included in prevention programmes including screening, vaccination, health checks etc. Capacities need to be reviewed and additional measures may be needed to include 'hard to reach' population groups.

2. Encouraging physical activity

    a. Open spaces and recreation grounds
    Any new development should include open spaces and/or parks to give residents the opportunity to exercise (walking, jogging, etc.). Children can play in safe areas and explore the natural environment.
    Apart from physical health benefits, spending time outside in green spaces and connecting with other residents can reduce stress and have a positive impact on mental health.

    b. Street design
    Pedestrians and cyclists need to be safe; therefore roads should have secure pavements and dedicated cycle lanes. Traffic calming interventions are important and have been shown to reduce accidents, air pollution and traffic noise.[36]

[33] http://www.healthycommunitiesbydesign.org/
[34] Gravelle H, Morris S, Sutton M. Are family physicians good for you? Endogenous doctor supply and individual health. Health Serv Res 2008;43:1128–44
[35] http://news.bbc.co.uk/1/hi/health/4228745.stm
[36] http://www.its.leeds.ac.uk/projects/primavera/p_calming.html

c. Amenities
   Amenities that are within walking or cycling distance may avoid car journeys and further contribute to healthy activities. This should be taken account of at the development stage of new communities.

3. Promoting healthy eating

   a. Fresh produce
      Fruit and vegetable consumption is important and should be available locally and fresh. This may be in supermarkets, local farm shops or regular markets. Developers need to make sure that spaces needed for these sellers are accommodated in their plans.

   b. Community gardens
      Community gardens and farms bring lots of benefits to a community: They produce fresh food and encourage healthy diets. They also positively impact on community cohesion, physical activity, enable learning of new skills and improve mental health.[37]

Conclusion and Recommendations

Rapid growth of the population in Ashford invariably impacts on Public Health. This brings opportunities to positively influence the planning stage of new developments.

- There should be adequate GP provision to ensure good access to preventative health programmes.
- Physical activity should be encouraged and made easier by including open spaces and recreation grounds within the design of new estates. Street design should be safe for cyclists and pedestrians and amenities should be local to avoid car journeys.
- The promotion of healthy eating should be supported with opportunities to obtain healthy foods locally and, ideally, encourage own produce in gardens/community gardens.

Further benefits from these interventions would be expected, including an improvement in social cohesion, development of a community spirit and positive influences on people with mental health problems.

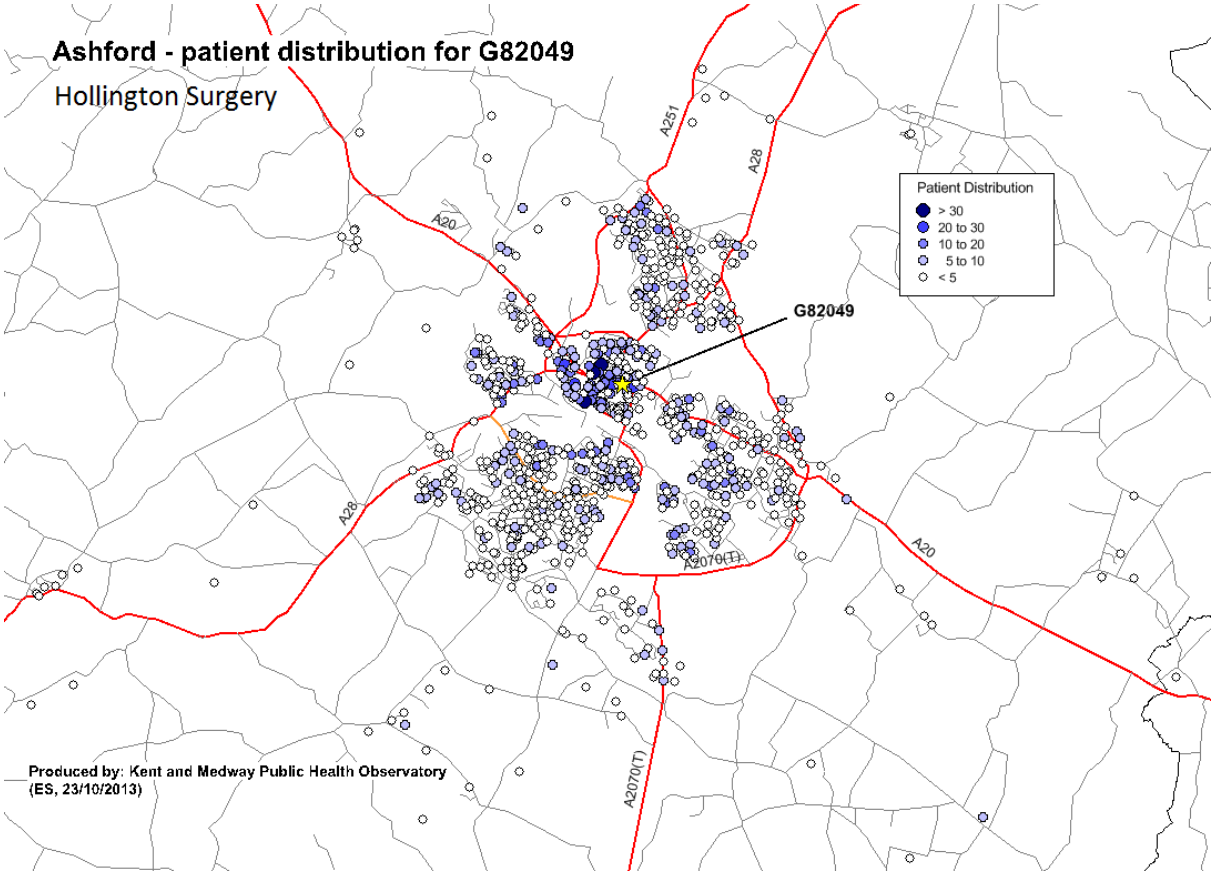
[37] http://www.farmgarden.org.uk/farms-gardens

Practice Level Information – Ashford CCG

Patient Distribution Maps and APHO Practice Profile

G82049 – Hollington Surgery

http://www.nepho.org.uk/gpp/index.php?CCG=09C&PracCode=G82049



G82050 – Sydenham House Medical Centre

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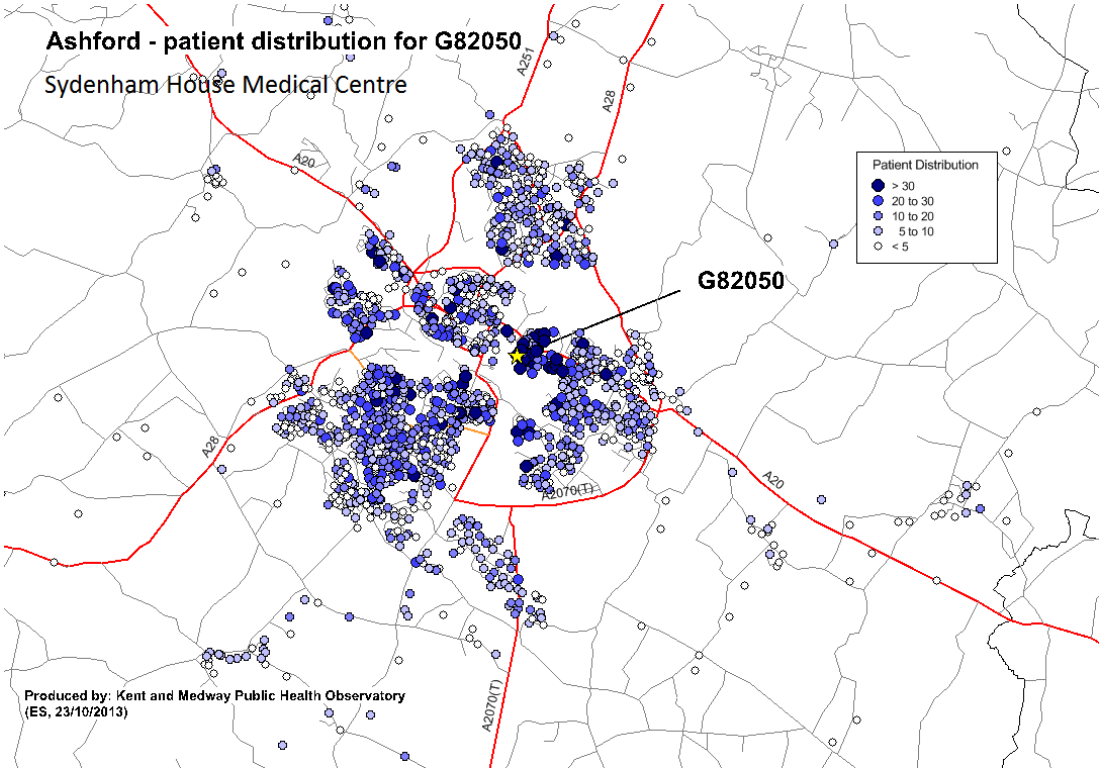

G82053 – Woodchurch Surgery

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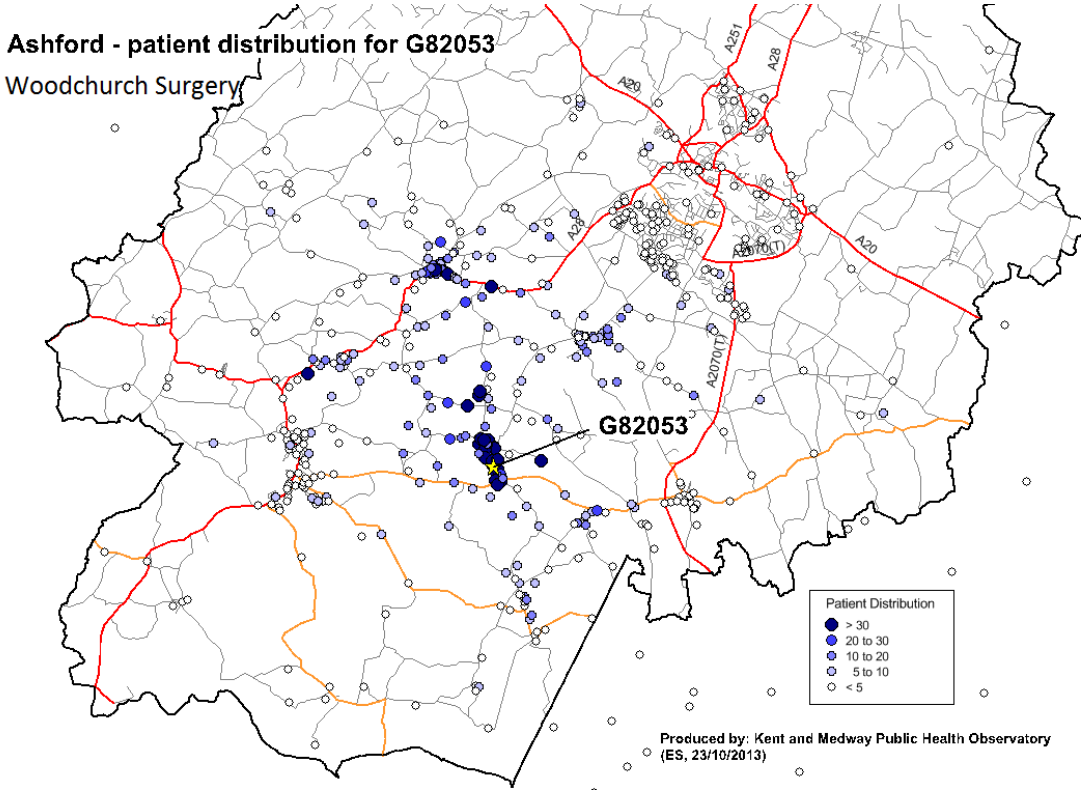

G82080 – Willesborough Health Centre

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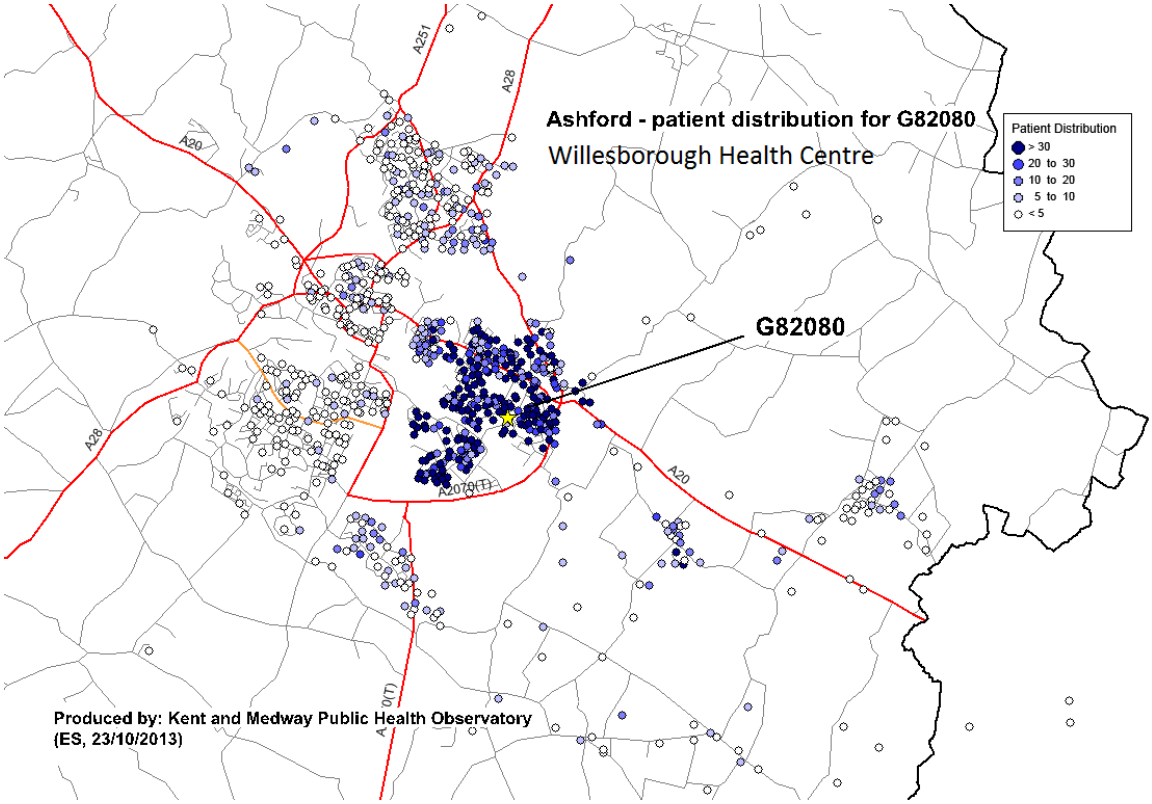

G82087 – New Hayesbank Surgery

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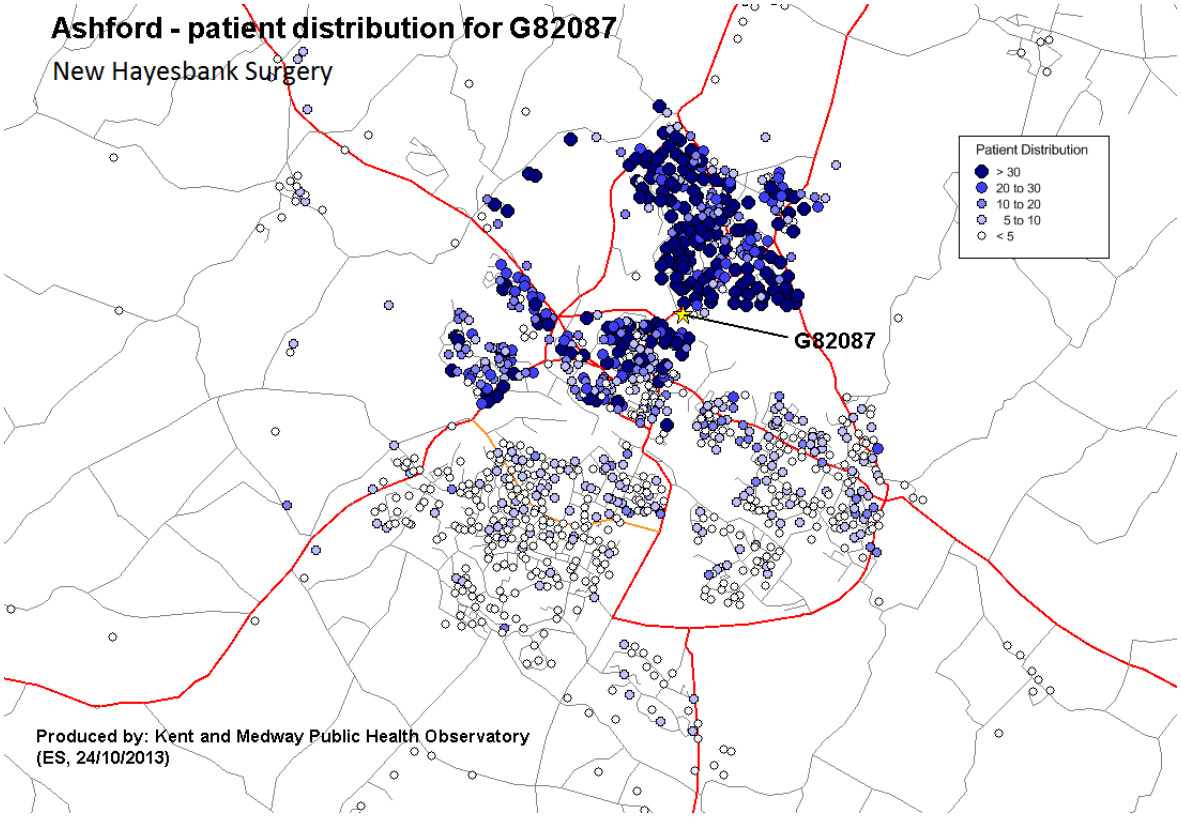

G82094 – Charing Medical Partnership

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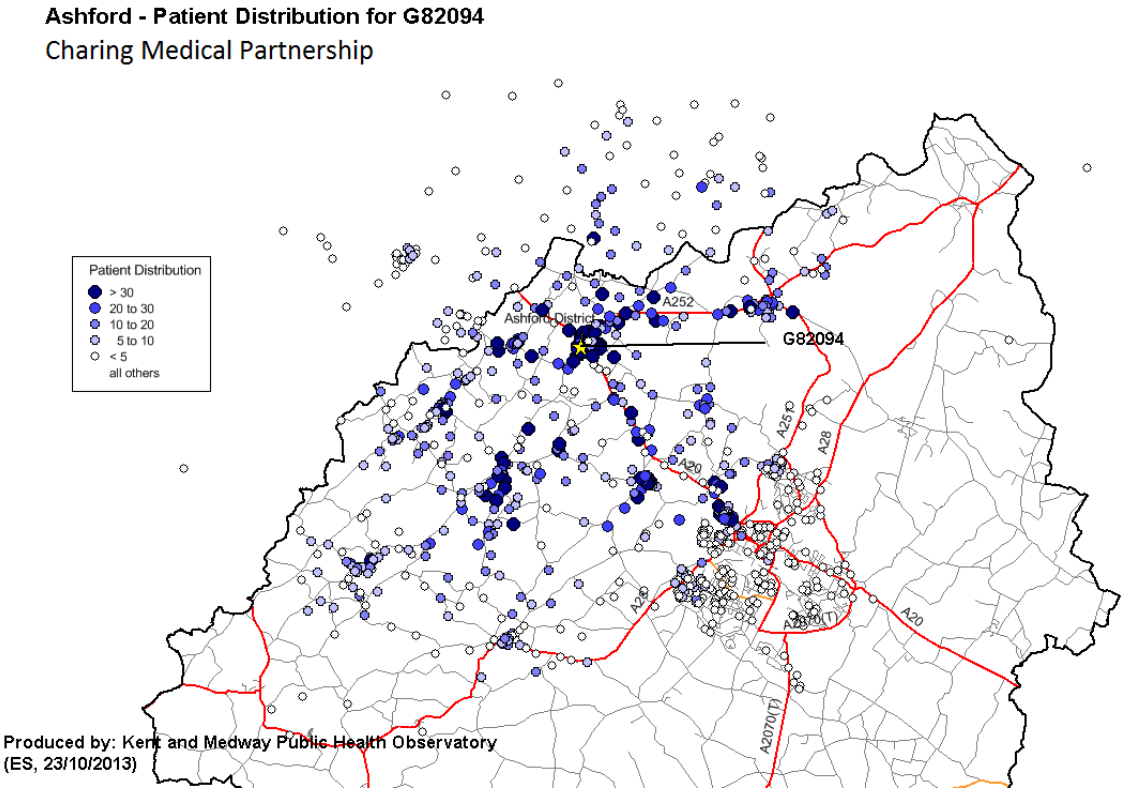

G82114 – Ivy Court Surgery

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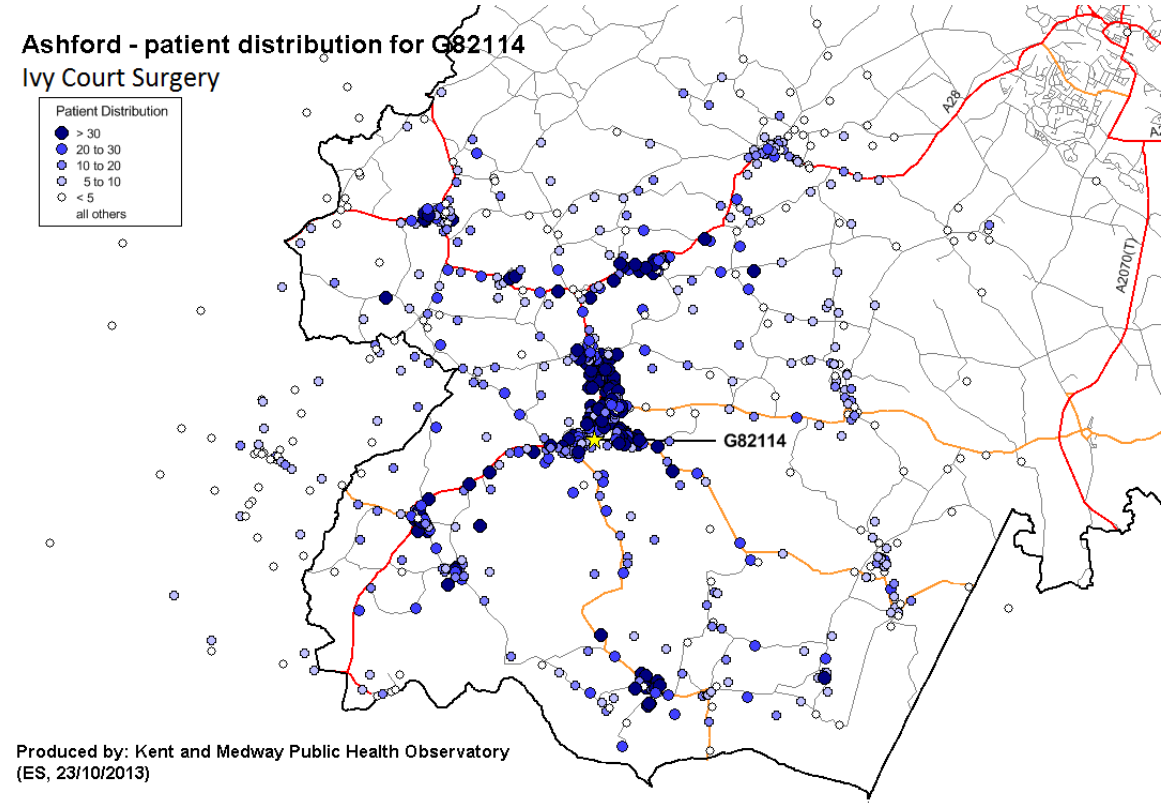

G82142 – Wye Surgery

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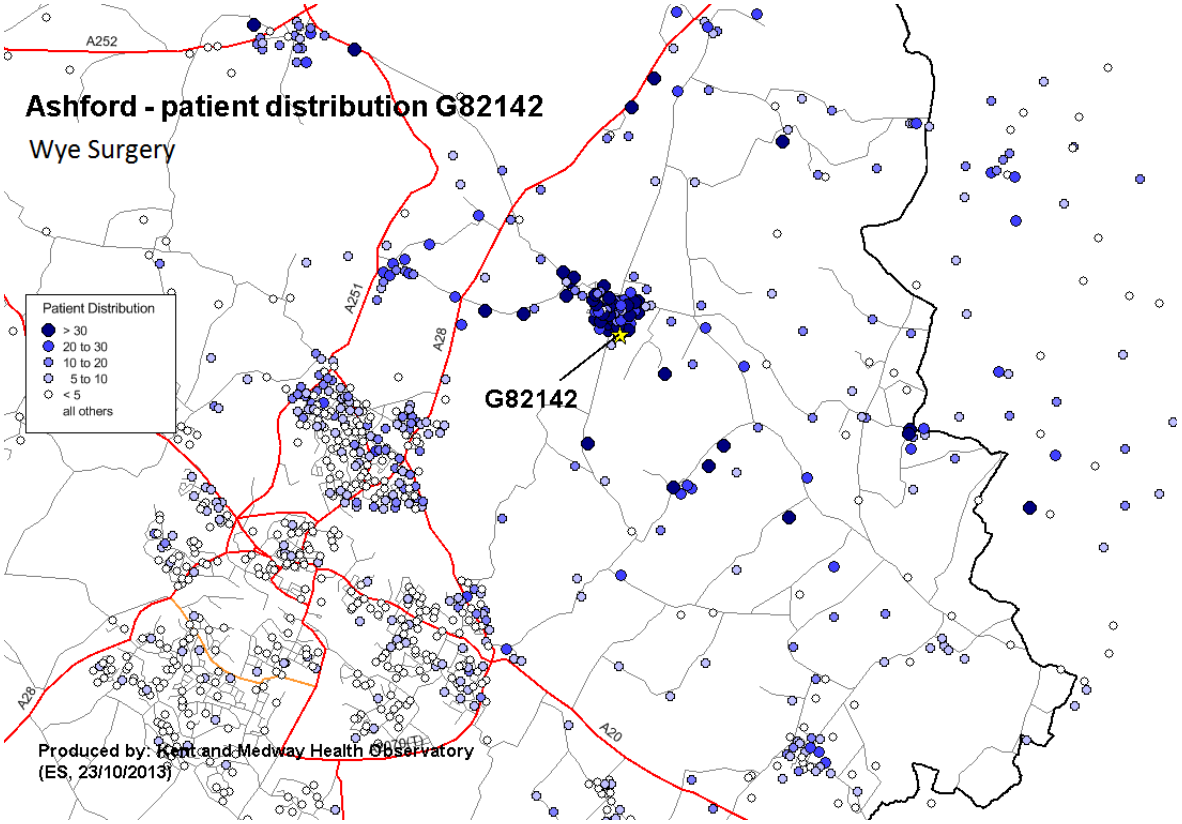

G82186 – Hamstreet Surgery

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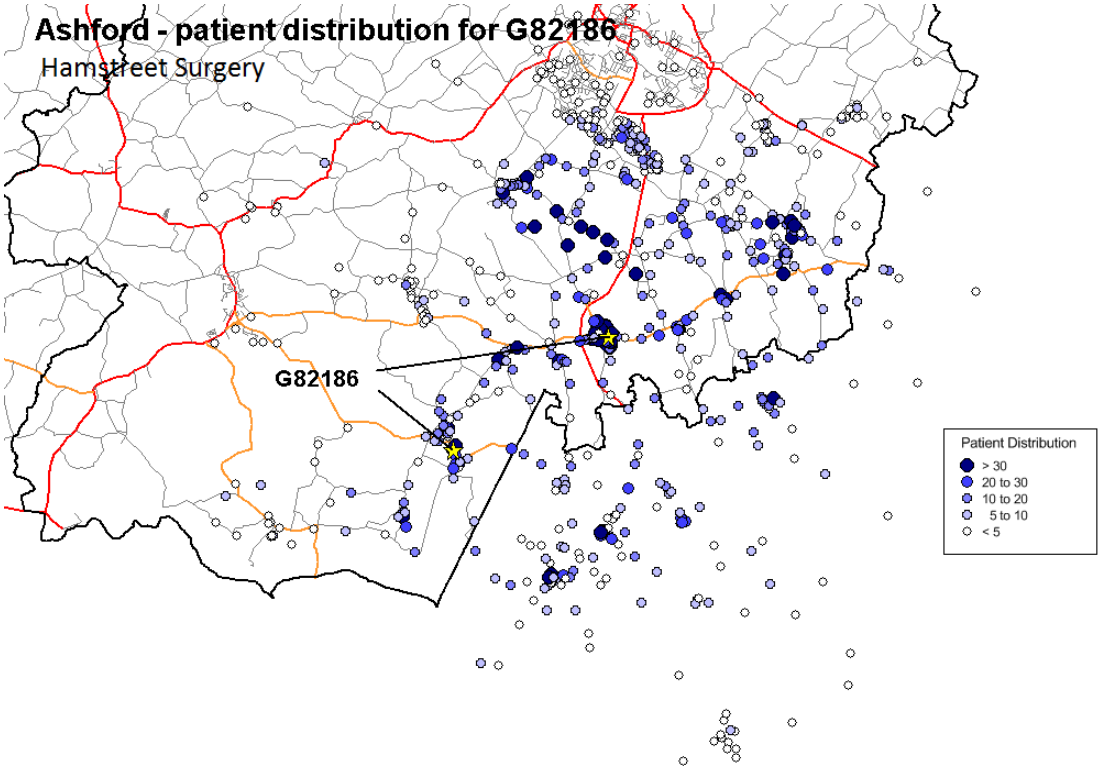

G82658 – Sellindge Surgery

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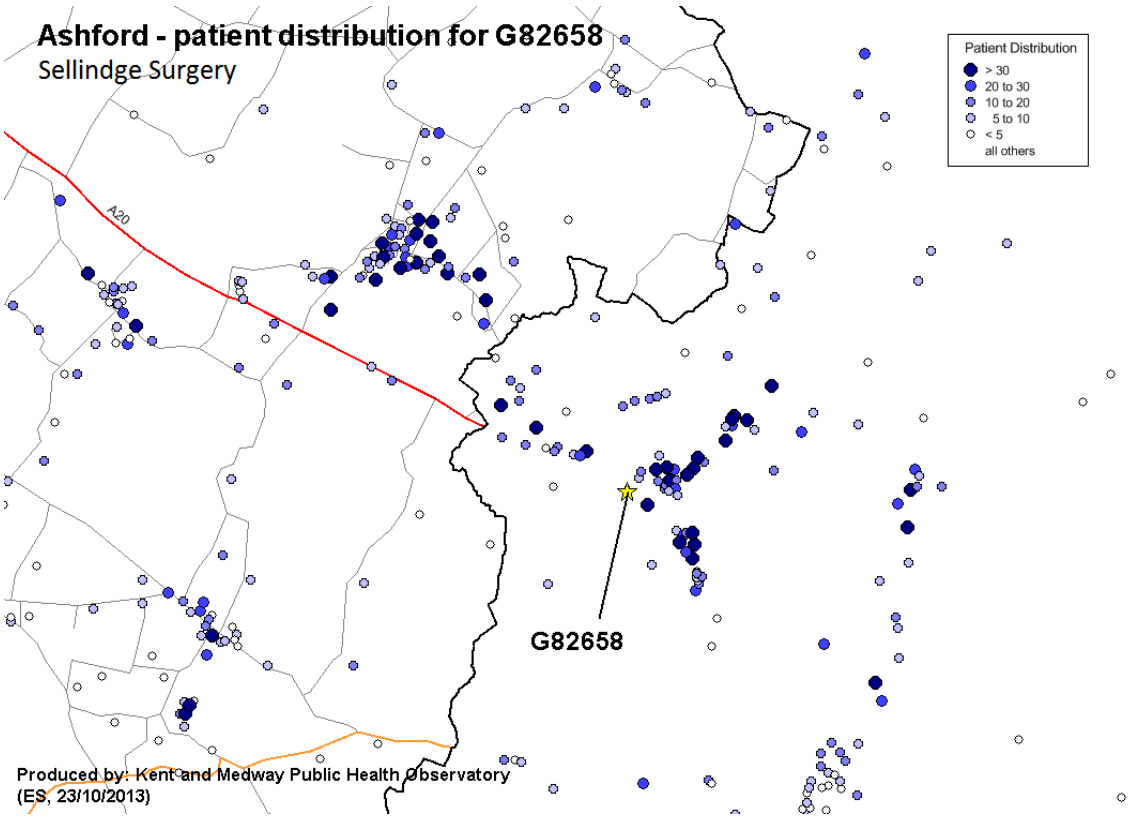

G82688 – Singleton Surgery

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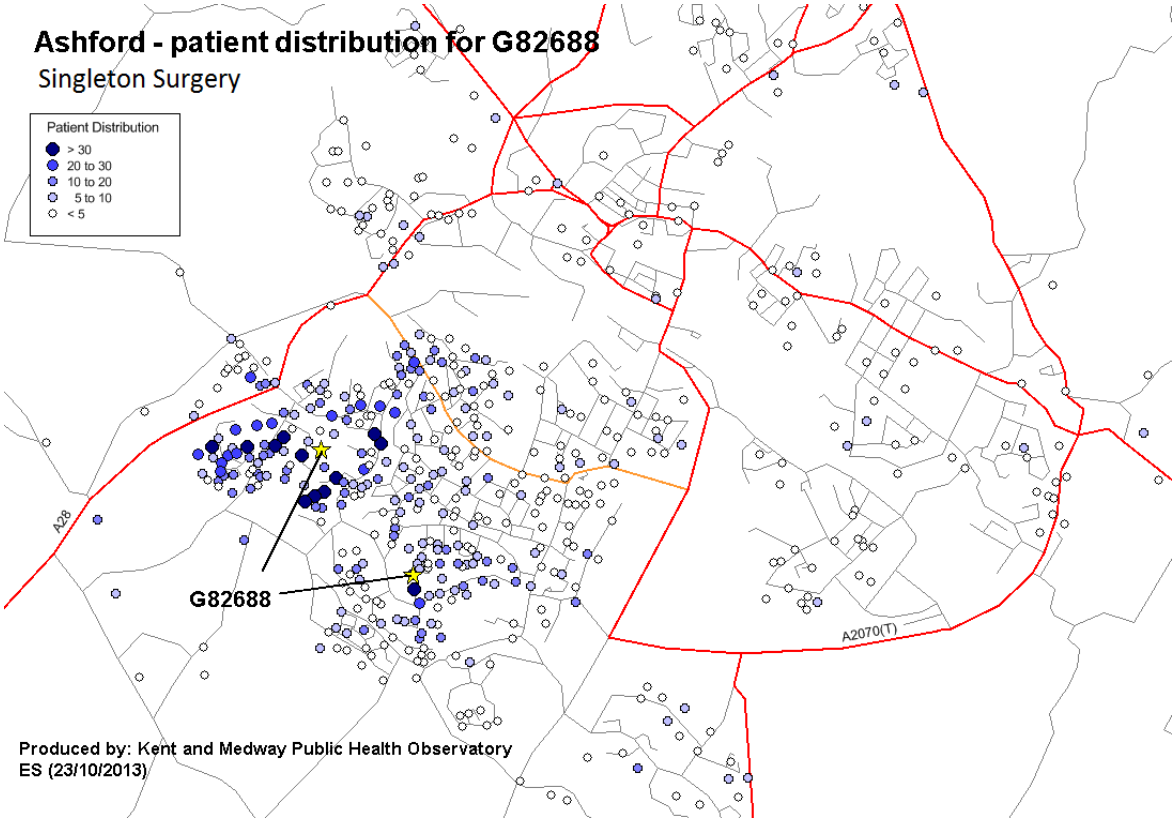

G82712 – Singleton Medical Centre

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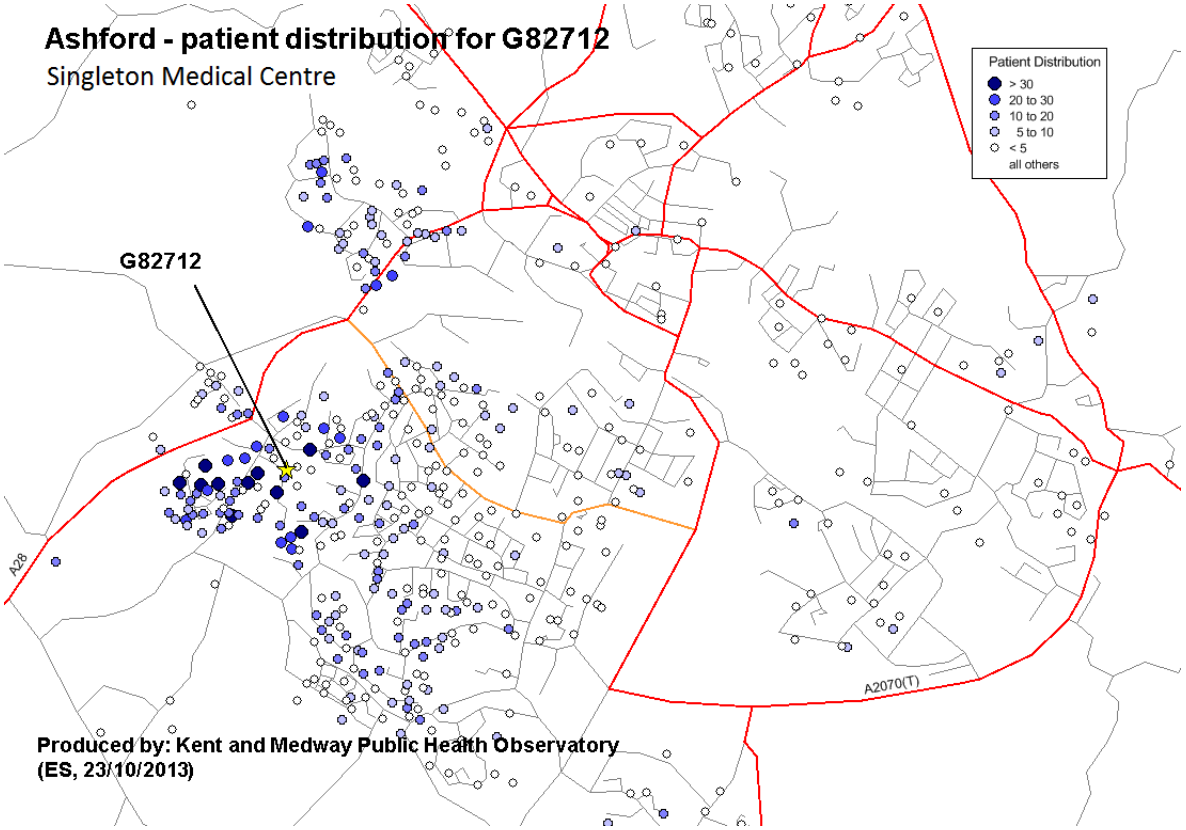

G82730 – Kingsnorth Medical Practice

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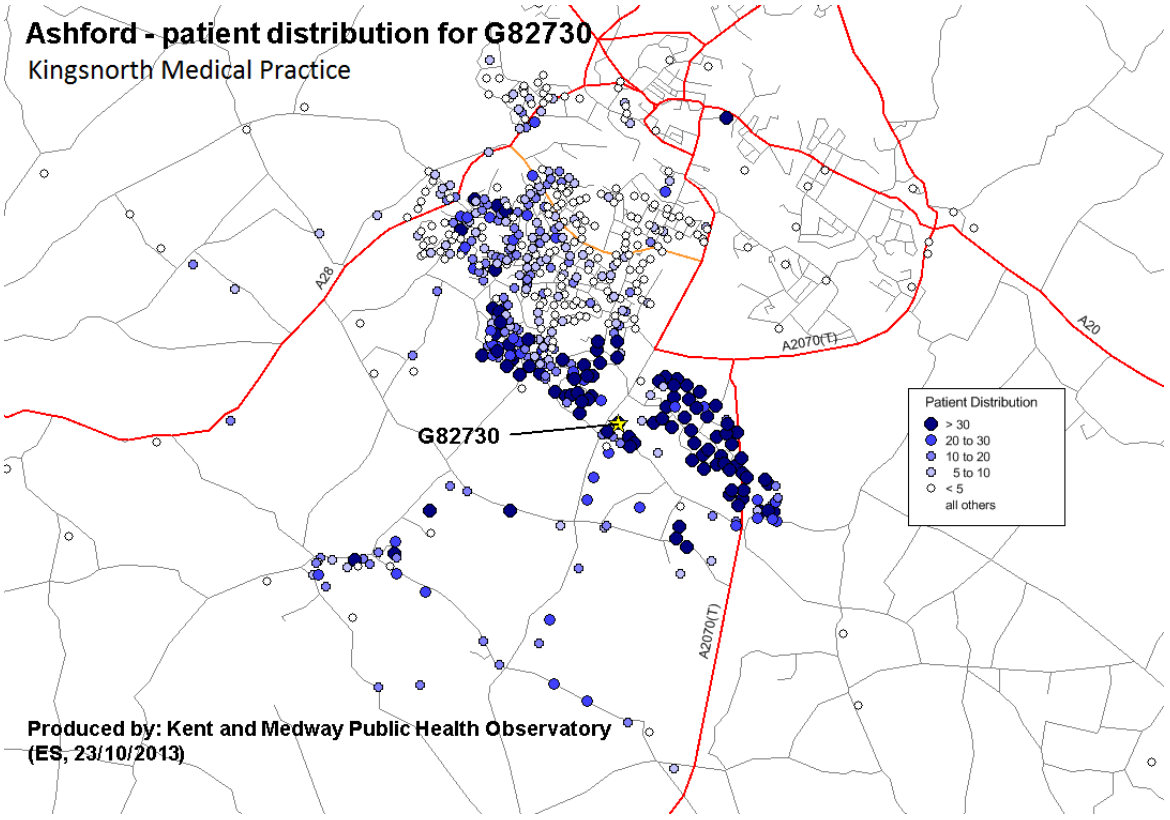

G82735 – St Stephens Health Centre

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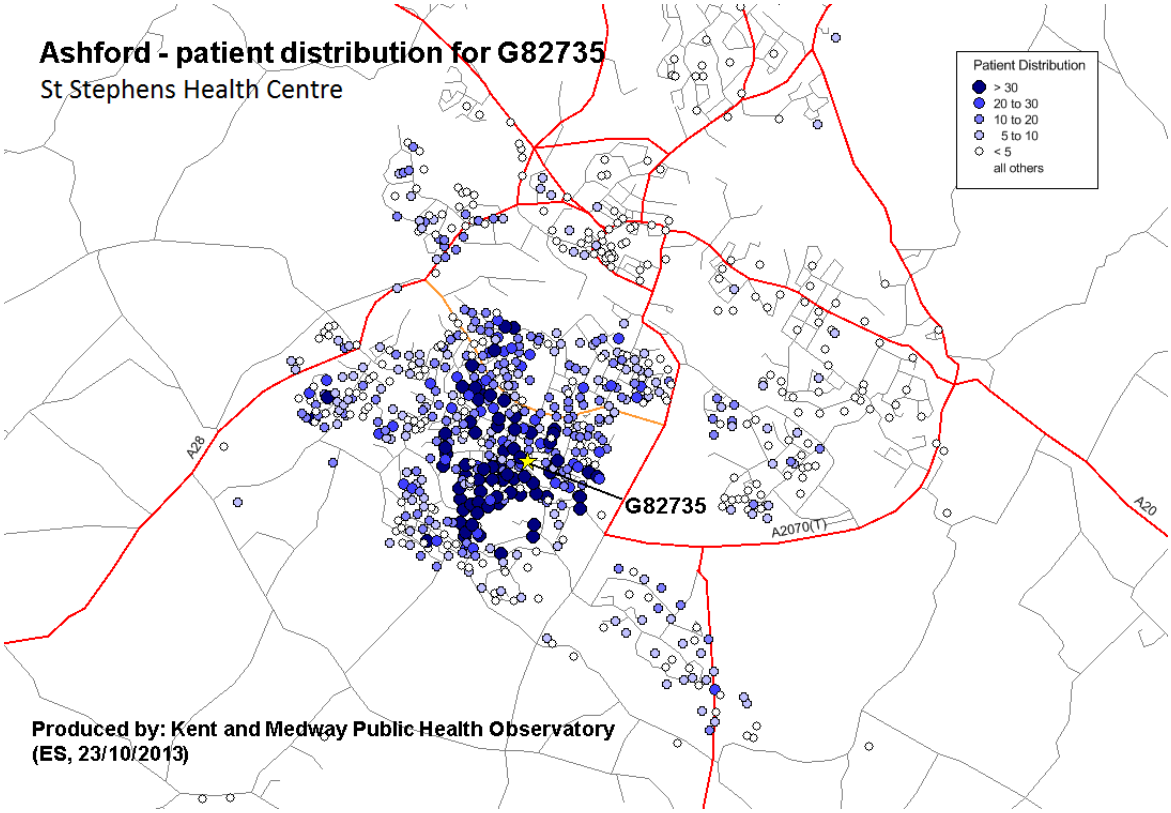

G82748 – Musgrove Park Medical Centre

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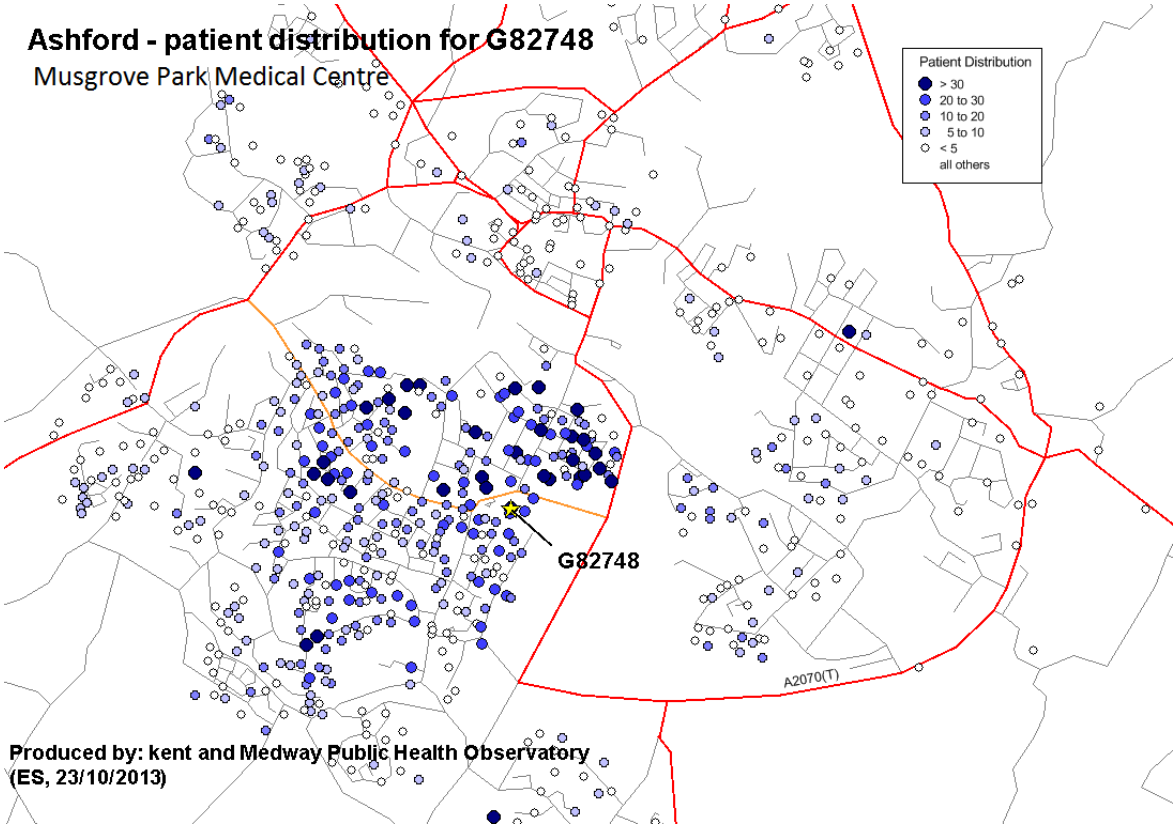
Ashford - patient distribution for G82748
Musgrove Park Medical Centre
Patient Distribution
> 30
20 to 30
10 to 20
5 to 10
< 5
all others
G82748
A2070(T)
Produced by: kent and Medway Public Health Observatory
(ES, 23/10/2013)