

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 October 2014 at 12.00 noon

Agenda

	Page Nos.
1. Welcome and Apologies	
2. Declarations of Interest:- To declare any interests which fall under the following categories, as explained on the attached document:	1
a) Disclosable Pecuniary Interests (DPI)	
b) Other Significant Interests (OSI)	
c) Voluntary Announcements of Other Interests	
<p>See Agenda Item 2 for further details – but please note this is an Ashford Borough Council document which members might nonetheless find helpful. It is understood that KCC will be issuing guidance to members on interests in the near future.</p>	
3. Notes of the Meeting of this Board held on the 23rd July 2014.	
<p>To be approved subject to Minute 1 ‘Declaration of Interest’ being amended to read “Martin Harvey made a ‘Voluntary Announcement’ as his wife had obtained a placement with Turning Point and that may well be ‘Turning Point, Ashford’ and the addition of the following words at the end of the sentence in Paragraph 4.3 “for both employer and employee”</p>	
4. CQC Report on the William Harvey Hospital & Action Plan (Simon Perks)	2-8
5. CCG Merger: Update (Navin Kumta/Neil Fisher)	9-25
6. CCG Strategic Commissioning Plan 2014-19 (Navin Kumta/Neil Fisher)	26-110
7. Focus on Healthy Weight:	
(a) Introduction – Simon Harris (ABC)	111- 127
(b) Presentations 1: Firefit – Rachel Spencer (KFRS)	128
(c) Presentations 2: Healthy Weight County Perspective – Val Miller (Public Health, KCC)	129- 136

	Page Nos.
(d) Presentations 3: Healthy Weight Ashford Perspective – Simon Harris (ABC)	137- 143
8. Lead Officer Group Quarterly Report – Christina Fuller	144- 147
9. Partner Updates	
(a) Clinical Commissioning Group – Neil Fisher	148- 149
(b) Kent County Council (Social Services) – Philip Segurola	150- 151
(c) Kent County Council (Public Health) – Faiza Khan	152-
(d) Ashford Borough Council – John Bunnett	155- 158
(e) Ashford Children’s Health & Wellbeing Board – Stephen Bell	159- 160
10. Forward Plan	
<u>January 2015</u> – Mental Health/Dementia Action Plan (CCG Lead) and Commissioning Plan Update (CCG)	
<u>April 2015</u> – Independent Living & Self Management for those with Long-term Conditions and Falls Prevention (KCC Lead) plus Commissioning Plan Update (CCG)	
<u>July 2015</u> – Sustainable Development for Health & Wellbeing (ABC)	
<u>October 2015</u> – Progress Report and Refreshment of AHWB Priorities (ALL)	
11. Next Meeting & Dates for 2015	
21 st January 2015	
22 nd April 2015	
22 nd July 2015	
21 st October 2015	
20 th January 2016	
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).	

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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 July 2014.

Present:

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

Faiza Khan – Public Health, KCC;
Caroline Harris – Health Watch Representative;
Martin Harvey – Patient Participation Representation, Lay Member CCG;
Tracy Dighton – Voluntary Sector Representative;
Mark Lemon – Policy and Strategic Relationships, KCC;
Stephen Bell – Local Children’s Trust;
Sue Luff – Ashford CCG;
Peter Marsh – Dementia Alliance;
Keeley Taylor – Dementia Carer;
Christina Fuller – Cultural Projects Manager, ABC;
Richard Robinson – Housing Improvement Manager, ABC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;
Belinda King – Management Assistant, ABC.

Also Present:

Councillors Chilton and Clokie.

Apologies:

Peter Oakford (KCC Member, Portfolio Holder for Childrens Services appointed as substitute for Jenny Whittle), Simon Perks, Paula Parker, Mairead MacNeil, Neil Fisher, John Bunnett, Sheila Davison.

1 Declaration of Interest

Martin Harvey made a “Voluntary Announcement” as his wife had obtained a placement on “Ashford Turning Point”.

2 Notes of the Meeting of the Board held on the 23rd April 2014

The Board agreed that the Minutes were a correct record.

3 Kent Health and Wellbeing Board Update

- 3.1 The covering report dealt with the 28th May meeting and therefore Mark Lemon gave an oral report on the 16th July meeting. He advised that issues covered were Dementia Care and Support in Kent, a presentation from Kent

Fire and Rescue Service who had expressed a wish to work with public services over a range of health and wellbeing topics such as the “Falls Agenda” and “Fire Fit” which focussed on fitness and exercise.

- 3.2 Navin Kumta also said that the Fire Service were happy to help in terms of being the public face of initiatives the Board wished to progress.
- 3.3 Mark Lemon suggested that in due course the Board may wish to consider asking for a presentation from the Kent Fire and Rescue Service.

The Board noted the report.

4 Kent Joint Health and Wellbeing Strategy

- 4.1 Included within the agenda papers was the above strategy which had been published by Kent County Council on behalf of the Kent Health and Wellbeing Board.
- 4.2 In response to a comment about whether the document should include more statistics, Mark Lemon explained that the information contained within the document had been drawn straight from the Joint Strategic Needs Assessment (JSNA) which had been previously presented to the Board and was available to view on the Kent and Medway Observatory website. The Chairman referred to Outcome 3 in terms of older people and disabled audits and enquired whether those audits had been undertaken. Mark Lemon said he was not aware of the current position but agreed to find out for the Chairman.
- 4.3 Martin Harvey referred to Outcome 4 regarding mental health and said the initiative to increase employment of people with mental illness should be subject to appropriate risk assessments being undertaken.
- 4.4 Mark Lemon advised that the Kent Health and Wellbeing Board had welcomed the strategy and that further work would be undertaken on it with a view to reporting back to the November meeting of the Kent Board. Martin Harvey commented that it would be appropriate to include actual targets within the performance measures stated and Mark Lemon confirmed that this work was ongoing and would be included. Christina Fuller hoped that the performance indicators within the document could be considered by the Lead Officer Group to ensure that the priority work Ashford was undertaking echoed the KCC strategy.
- 4.5 Mark Lemon advised that there would be no formal consultation period as the document had largely been a refresh of documents formerly presented to the various Boards. It would be placed on the website and it was expected that the document would be used as a consultation tool in its own right in terms of engaging local populations. It was important that the strategy was completed to inform commissioning decisions from September.

- 4.6 Navin Kumta hoped that the Ashford Health and Wellbeing Board would be able to consider the revised document at its October meeting prior to its consideration by the main Kent Board in November.
- 4.7 Tracy Dighton said that in terms of engagement with the voluntary sector and patients it was not clear how the document would help the Board to engage on current “hot issues” and commented that the Kent Board’s priorities might not tie up with the local Board’s priorities.
- 4.8 Navin Kumta replied and explained that it was for the local Board to consider how to approve schemes within its area and local variations could be included but there was a need to ensure that they did not contradict the aims of the wider over-arching Kent Strategy.
- 4.9 Mark Lemon commented that in Ashford certain circumstances may vary from other areas of the County and therefore it was important that the Board could react to “hot issues” by setting key local priorities. Both Stephen Bell and Caroline Harris said they had concerns that there would be no further consultation on the revised document. Stephen Bell also had concerns as the JSNA was based on historical data and therefore it was important to be aware of the current position.
- 4.10 Navin Kumta accepted that there was a need for a refresh document but explained that the JSNA was the starting block.
- 4.11 The Chairman said that in view of the comments made at the meeting he wondered whether there was a need for a root and branch review on how the Board and the various Partners were engaging the public and explaining the Board’s goals.

The Board noted the report subject to the comments made at the meeting and as included within the discussion outlined above.

5 Focus on Dementia – Introduction and Covering Report

- 5.1 The Chairman drew attention to the report which had been included within the agenda papers for the meeting. The Board considered the three following presentations prior to considering the recommendations.
- 5.2 a) **Dementia Alliance “Guess What? You Can Still Live Well with Dementia”**

Peter Marsh of the Dementia Alliance gave the above presentation. A copy of the slides used was available in the agenda papers for the meeting. He outlined the work of the Dementia Alliance and explained that on the 18th June 2014 there had been a community event which had been attended by 57 people.

Richard Robinson gave details of the work being undertaken on Farrow Court in Stanhope and he advised that the first phase of

accommodation was on target to be completed by March 2015 with the associated Day Centre following in April 2015. The design of the development had been dementia friendly with an aim to be able to help the broader community. He further explained that residents of Farrow Court were being trained to ensure that they were dementia friendly. Phase 2 would be completed at the end of 2016 when the final total of 104 new units of accommodation would be available.

In response to a question as to whether the themes of the Farrow Court development would be rolled out for schemes in other areas of the Borough and in villages such as Aldington, Richard Robinson explained that the development at Aldington was only a third of the size of the Farrow Court development but said that it was hoped that the principles adopted for the Farrow Court scheme would be rolled out for schemes in other villages.

The Board discussed whether there was a perceived attitude people adopted in terms of the diagnosis of dementia and a feeling that people were often reluctant to be assessed as they wished to avoid increasing stress if such a diagnosis was made. Navin Kumta said that from his personal experience more members of the public were coming forward for diagnosis but he was aware that those persons did not want to be seen as a burden. He believed that the stigma was no longer attached to the diagnosis of dementia but said that there was a challenge to ensure that healthcare providers had increased support networks available to allow people to still enjoy a long and healthy life.

b) Dementia Strategic Framework – An Ashford CCG Perspective

Sue Luff gave a presentation on the CCG perspective and a copy of the slides she used was included within the agenda papers for the meeting. As part of her presentation she explained that there was one Admiral Nurse devoted to Ashford who had needed administrative support to ensure that she could meet the needs required of her position. The development of community networks by the CCG was evolving and would involve work with existing village networks.

In response to a question as to how Ashford compared to other areas in terms of the provision of Admiral Nurses, Sue Luff explained that in terms of East Kent the figure was comparable but this was less than other areas of the country. It was for this reason that steps had been taken to bring the Admiral Nurse in with the rest of the support team.

c) Carers Support – Supporting Carers in Ashford, Shepway and Swale

Keeley Taylor gave a presentation, a copy of which had been included within the agenda papers and explained the role of Carers Support. She explained that the organisation supported those aged 16 and older and helped to support people who were supporting adults. She said carers could be wide ranging, for example a neighbour who undertook

shopping for another person but she said that it was estimated that in the region of 6,000 people every day took on a caring role. One of the issues of this was, however, that quite often the carer's own health deteriorated as they needed time to themselves. Carers Support offered help and a response within 48 hours and could offer respite care or telephone or face to face support. She then spoke in detail about two particular case studies and outlined the outcomes which were available to provide support.

In response to a question, she indicated that in the region of 11% of existing patients were indeed themselves carers and sometimes carers had dementia themselves. She further explained that currently there were 1,694 people identified with dementia in Ashford, Shepway and Swale but she estimated that this would rise to 8,000 in two years' time. In terms of help, she said that Carers Support often made recommendations that support be given via Crossroads, however, other options were available to offer patients choice.

Navin Kumta said that the emphasis of support was still based on assistance being given for people in their own home, however, he said it was important to ensure that the patient was safe. Keeley Taylor said she was confident that Carers Support could deal with the anticipated increase in the number of cases they were dealing with but she indicated that there was a need for appropriate support to be made available by the CCG to allow the service to continue.

d) General Discussion on Presentations and Recommendations

The Board considered that there was a gap in terms of a day centre provision to support and provide dementia care although there was a facility at West View, Tenterden. However, for a number of people within the Borough this was a difficult location for people to get to.

Richard Robinson said in terms of the work at Farrow Court he referred to earlier, discussions were being held with Age UK with a view to providing dementia support on Saturdays and Sundays. In terms of the recommendations, Navin Kumta suggested that the word "strategies" in Recommendation (c) be substituted with the word "activities".

Martin Harvey suggested that there was a need to consider involving the private sector and in particular employers in Ashford who may wish to buy into the aspirations of the provision of a new centre. He offered his direct assistance on this initiative based on his previous experience with a major charity. Richard Robinson agreed to feed back this offer to a future meeting which was looking into this issue.

In terms of the location of a centre, the Chairman suggested that Repton Park would be an ideal location where it was easily accessible from the town centre.

The Board recommended that:-

- (a) An action plan be received from the Ashford Dementia Action Alliance for subsequent consideration and adoption by the Board.**
- (b) Work continue towards the provision of additional affordable dementia care provision for the residents of Ashford with this becoming an Ashford HWB “must do” project.**
- (c) Endorse those activities that promote earlier diagnosis of people with dementia.**
- (d) Actively promote Carers’ Support Services alongside support for patients.**

6 Lead Officer Group Quarterly Report

6.1 The report provided an update of the work which had been progressing since the previous meeting held on the 23rd April 2014. The report also set out details of the following “must do” projects identified by Lead Officers given their need for a multi-agency approach:-

- Community Networks (Lead CCG)
- Farrow Court (Lead ABC)
- Rough Sleeping (Lead ABC)
- Dementia Friends/Day Care (Dementia Alliance)
- Healthy Weight – Obesity (Lead KCC)
- Infrastructure Planning (Lead ABC)

Christina Fuller explained the background to the “must do” projects outlined above and in reference to “the infrastructure planning group” she considered it was important that whilst this was not a task and finish project, the work by the group was important to feed in to the Local Plan.

The Board agreed the “must do” projects outlined within the report that support the AHWB priority areas and agreed that the LOG monitor progress and report quarterly to the Board.

7 Partner Updates

7.1 Included with the Agenda were A4 templates submitted by Partners. Comments made at the meeting in respect of the following individual updates as set out below:-

(a) Clinical Commissioning Group (CCG)

Navin Kumta explained that the vote as to whether the Ashford and Canterbury CCG’s should merge would be taken at a meeting to be held the following day. Following the result of the vote there would be a meeting of the Working Group to discuss how this could be communicated to the public and

other affected Partners. In terms of the constitutional aspects of the potential merger, Mark Lemon explained that the current Board was a Sub-Committee of the main Kent Health and Wellbeing Board and as it presently stood it would be expected that there be one local Board covering both areas. However, he said that at a recent Kent Health and Wellbeing Board it was considered that there was a need to be pragmatic over this particular issue and one Board for both areas may not be the outcome.

Martin Harvey said that in his view there was a need to protect the interests of the public.

(b) Kent County Council (Social Services)

No further comments.

(c) Kent County Council (Public Health)

Faiza Khan gave further details on work currently being undertaken by Kent Public Health. This included an alcohol strategy; tenders for sexual health services; suicide prevention and teenage pregnancies initiatives. She also commented there was an issue that once health visitors had received their training they were taking posts in London as a higher salary was available for those positions. In an attempt to remedy the situation, steps had been taken to ensure that if this happened the cost of training was now recovered from the health visitors. She said that other issues being worked on were a new model scheme for school health, breast feeding and there had been a response by the Kent County Council on the consultation on plain packaging for tobacco.

(d) Ashford Borough Council

Christina Fuller advised of an amendment to the statement produced by Ashford Borough Council and advised that the capital funding obtained from the Arts Council for the Jasmin Vardimon International Dance Academy was £150,000 and not the figure of £362,000 as set out in the report. The figure of £362,000 related to the total funding required for the Stage 2 aspect of the bid to the Arts Council.

(e) LCT/Children's Operational Group

Stephen Bell advised that the membership of the Children's Board had now been established and the new group would be meeting in September. There was a need to align the strategy of the Kent Children's Health Programme with those of the Ashford Health and Wellbeing Board.

The Chairman commented that he believed that the CXK premises within the former Magistrates' Court building had totally transformed and he had been very impressed on the internal layout of the facilities which he believed were good news for Ashford.

8 CCG Strategic Commissioning Plan 2014 - 2019

- 8.1 The presentation was included for information within the agenda papers. There was disappointment that Neil Fisher was unable to attend and present the strategy. Navin Kumta indicated that if any members of the Board had any further comments to make on the document they should be sent directly to Neil Fisher at the CCG. Martin Harvey said he understood that a user friendly version for the website was due to be produced by the 23rd July 2014 and he asked whether this had been done. Navin Kumta said he was not aware of the current situation. Mark Lemon advised that the Chairman of the Board would in due course be receiving a letter from Roger Gough asking the Board to ensure that their plans were tied in with those set out within the strategy.

9 Next Meeting

- 9.1 The Chairman advised that the main topic of the next meeting would be Healthy Weight. The next meeting would be held on 22nd October 2014.

(KRF/AEH)

MINS:Ashford Health & Wellbeing Board - 23.07.14

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East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Quality Report

William Harvey Hospital,
Kennington Road,
Willesborough,
Ashford TN24 0LZ
Tel: 01233 633331
Website: www.ekhuft.nhs.uk


Date of inspection visit: 5, 7, 19, 20 March 2014

Date of publication: 13 August 2014

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Inadequate 


Accident and emergency

Inadequate 

Medical care

Requires improvement 

Surgery

Inadequate 

Critical care

Good 


Maternity and family planning

Requires improvement 


Services for children and young people

Inadequate 

End of life care

Requires improvement 

Outpatients

Requires improvement 

Summary of findings

Letter from the Chief Inspector of Hospitals

William Harvey Hospital (WHH) is one of five hospitals that form the East Kent Hospitals University NHS Foundation Trust, which is one of the largest hospital trusts in England. The trust provides services to the whole of East Kent, which has a population of around 759,000 people.

William Harvey Hospital had approximately 476 inpatient beds. It provided accident and emergency (A&E) services, outpatient services and a range of other specialties. We spoke to more than 75 patients, 18 relatives, and 120 staff while visiting the wards and departments in the hospital. We also held a listening event on 5 March 2014 where we spoke with around 25 people who came to share their views on this and the other hospitals managed by the trust. We undertook unannounced visits to WHH on 19 and 20 March 2014 when we inspected A&E, ward areas and spoke with the estates department.

Before and during our inspection we heard from patients, relatives, senior managers, and other staff about some key issues that were having an impact on the service provided at this hospital.

An issue which dominated many discussions was the trust's recent proposal to centralise surgical services to this site. The staff we spoke with did not feel consulted in this decision and did not support the decision made by the Board on 14 February 2014. Clinical staff raised detailed concerns with the Care Quality Commission (CQC) and with executives within the trust.

This inspection was undertaken because the East Kent trust had been identified as potentially high risk by the CQC's intelligent monitoring system.

Overall this hospital was rated as good for caring, requires improvement for effective, inadequate for being responsive to patients' needs and being well led, and inadequate for safety. We therefore rated this hospital as inadequate overall.

Our key findings were as follows:

- We saw that staff in all areas of the hospital were caring and responsive to patients' needs.
- We found that there were not always enough appropriately skilled staff, which placed patients at risk of receiving inappropriate care.
- The records of patients' waiting times in A&E were not an accurate reflection of the time patients waited.
- The trust's major incident policy was up to date however staff referred to the out of date policy and there had been mock major incident practice event.
- Children's needs were not always being appropriately met at this hospital.
- Most patients on medical wards received care according to national guidelines.
- Clostridium difficile (C Diff) and Meticillin-resistant staphylococcus aureas (MRSA) for the trust were within expected statistical limits.
- Some equipment was not maintained in accordance with manufacturers' guidance and therefore may not be fit for use.
- There was not enough staff to provide a safe service to women during their pregnancy. The midwife to birth ratio was up to beyond 1:33. This was above the national recommended ratio of midwives to births of 1:28.
- Risk management and clinical governance relating to the care of children was not managed effectively. Areas identified as serious concerns had not been addressed for long periods.
- Some clinics were routinely overbooked because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times, although they were kept informed about the expected length of delay. Patients who required follow-up appointments often had these appointments cancelled, moved to a later date and often there was a significant delay in patients receiving a follow-up appointments.

We saw an area of good practice:

Summary of findings

- The critical care unit monitored its performance and data from Intensive Care National Audit and Research Centre (ICNARC) and showed that patient outcomes were good.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.
- Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.
- Ensure all staff are up to date with mandatory training.
- Protect patients by means of an effective system for the reporting of all incidents and never events of inappropriate or unsafe care, in line with current best practice and demonstrate learning from this.
- Ensure that paper and electronic policies, procedures and guidance referred to by staff in the care and treatment they provide to patients are up to date and reflect current best practice.
- Ensure that the assessment and monitoring of patients' treatment, needs, and observations are routinely documented to ensure they receive consistent and safe delivery of care and treatment.
- Ensure that the environment in which patients are cared for is well maintained and fit for purpose.
- Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are completed appropriately to reduce the risk to patients.
- Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply and that in-depth cleaning audits are undertaken in all areas.
- Implement regular emergency drills for staff.
- Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.
- Review the provision of end of life care to ensure a coordinated approach.

In addition the trust should:

- Ensure that patients are informed of the reasons why their appointments are cancelled.
- Ensure that letters to patients' GPs are provided within the timescales established by the trust.
- Aim to reduce the number of transfers between wards experienced by patients.
- Review discharge arrangements for patients to reduce the risk of re-admissions.
- Ensure that strategies are developed and implemented, and that staff are fully aware of them in relation to escalation, emergencies, and dealing with patient capacity issues.
- Ensure that patients' privacy and dignity is maintained at all times.
- Manage patient documentation better to minimise risk of breaches to patient confidentiality.
- Introduce a policy to make clear the timescales for changing bed curtains.
- Ensure handwash and hand gel dispensers are kept topped up, as we found some that were empty or half full.
- Review the layout of the A&E majors area to provide improved visibility of patients from the nurses' station.
- Promote the Friends and Family Test (FFT) around the hospital to improve participation.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Inadequate



Rating Why have we given this rating?

We found that there were not enough appropriately skilled staff in A&E, which placed patients at risk of receiving inappropriate care. Patients' privacy and dignity were compromised at times. For example, extra chairs and trolleys were used to meet demand but at times this resulted in conversations being overheard or care being delivered in inappropriate areas of the department. Children attending A&E did not always receive treatment from appropriately trained and experienced children's staff. We saw that staff were caring and responsive to patients' needs. Staff did not always maintain the documentation needed to show this was happening. We saw examples of good individual leadership in the department, but there was evidence that ongoing safety issues, for example the issue of insufficient substantive staffing had not been resolved by the senior management team.

Medical care

Requires improvement



Patients told us they felt well cared for, and that staff always respected their privacy and dignity. However, we saw that there were not always enough nurses to staff the increase number of beds that were made available in response to winter pressures. Patients told us there were not always enough nurses to care for them at night. We also noted that patients were unhappy about the length of time they had to wait for their medication before they could be discharged. Some patients told us they had been moved up to four times between wards, which could lead to inconsistent care and treatment. Most patients received care according to national guidelines. There was evidence of effective practice across the medical division at WHH but it was inconsistent and not fully embedded. Staff at all levels told us that they were well supported by their immediate line managers but were unclear about the wider vision and values of the hospital and the trust as a whole. Not all junior doctors felt supported by their consultants.

Surgery

Inadequate



We found significant staffing issues on some of the wards we inspected, including inappropriate staffing

Summary of findings

Critical care

Good



levels at night. Some wards were cluttered and cramped, resulting in a potential hazard for people whose mobility was unsteady following surgery. Some equipment was not maintained in accordance with manufacturers' guidance and therefore may not be fit for use.

The surgical risk register, which identified potential risks, was dated August 2013. When we reviewed this document we noted area that had not been updated since February 2013. We could not be assured that any potential current risks to the department had been identified and steps taken to mitigate the risk. Patients told us that they felt their care and treatment at the hospital was good, and they were generally happy with the standard of facilities.

The unit was visibly clean, and there were systems in place to manage infection control. Infection control rates reported to be zero by the trust in the last two years. Staff said they felt well supported by their colleagues and that there was good team working. There was a concern that a culture of bullying had not been addressed within the nursing staff. There was a high number of vacancies within the nursing staff although a recruitment programme was underway. Junior doctors felt the current rota was not sustainable in the longer term and a business case to increase the number of doctors on the rota had been approved but not yet implemented.

Maternity and family planning

Requires improvement



Mothers received care that was delivered with compassion, dignity and empathy. However, There was not enough staff to provide a safe service to women during their pregnancy. The midwife to birth ratio was up to beyond 1:33. This was above the national recommended ratio of midwives to births of 1:28.

There had been frequent closures of the midwife-led Singleton unit in recent months. This had reduced choice for women and meant that some women were transferred to other units for non-clinical reasons.

We found that leadership vacancies and interim arrangements had continued for significant periods. Clinical guidance and policies used by staff were out of date. Some essential equipment was in short supply.

Summary of findings

Services for children and young people

Inadequate



The children's ward, special care baby unit, and neonatal intensive care unit provided a safe and suitable environment in which to care for and treat children. Other areas in the hospital where children were seen and treated had not been risk assessed to make sure that it was a safe and suitable place to treat children.

There were suitable numbers of appropriately trained nursing staff and the skill mix reflected current guidelines in the wards. Parents told us they were happy with the care and support that was provided on these units. Children did not receive care from appropriately trained and skilled staff in other areas of the hospital. In the day surgery unit, the staff caring for children did not have any specialist training or experience. In A&E children were not always seen by a specialist children's nurse and there was no specialist input into the care and treatment for children.

Risk management and clinical governance relating to the care of children was not managed effectively. Areas identified as serious concerns had not been addressed for long periods.

There was no leadership strategy in place for children's services and no clear accountability. Leaders were unaware of significant issues threatening the delivery of safe and effective care.

End of life care

Requires improvement



The specialist palliative care (SPC) team provides specialist advice and guidance for individual patients and family members. The staff are experts in pain management and deliver a holistic approach including emotional, spiritual, and psychological care, as well as providing up-to-date advice on symptom control.

Since the removal of the Liverpool Care Pathway, we saw little evidence of strategic trust-wide leadership and support for end of life care. The provision of end of life care was disjointed across the wards and departments. Although individual staff were committed to delivering good care, the result was an ad-hoc reactive response to people who needed care at the end of their lives.

Outpatients

Requires improvement



All the patients we spoke with told us they felt they had been treated with dignity, and that they had found staff in the outpatients department polite and caring. We found that some clinics were very busy

Summary of findings

and that staff routinely overbooked patients for clinics because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times, although they were kept informed about the expected length of delay.

Patients who required follow-up appointments told us that they often had these appointments cancelled, moved to a later date and often there was a significant delay in patients receiving a follow-up appointments. Staff told us that when appointments needed to be cancelled, they generally cancelled follow-up appointments as this did not affect how the trust met the two and 18-week referral to appointment time targets. We found that staff were collecting data on waiting times and overbooked clinics, however despite this felt unable to make improvements.



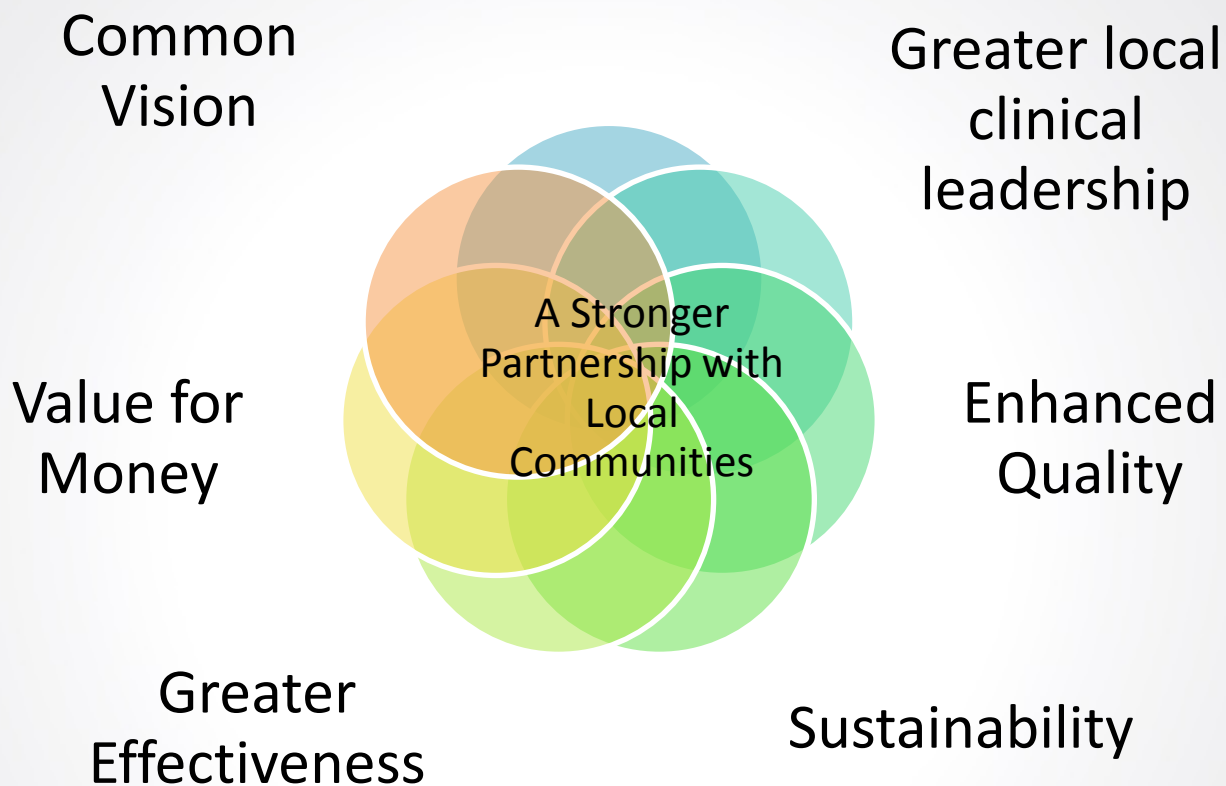
Preparing for the future

Building Clinical Commissioning
Supporting Local Populations
Delivering Better Care for Patients



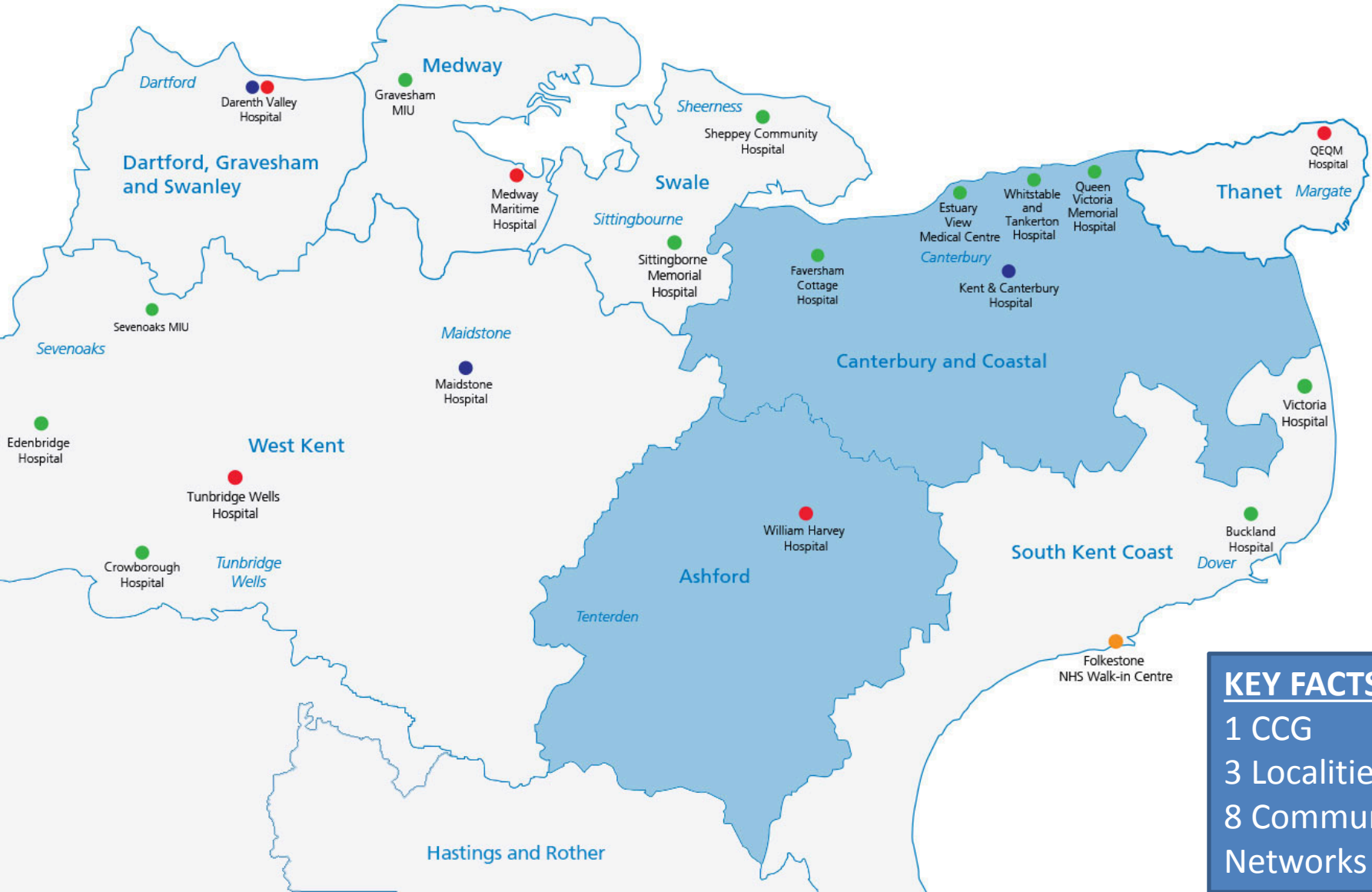


Why Merge





The CCGs



KEY FACTS
1 CCG
3 Localities
8 Community Networks



Our Local Population

Ashford CCG

- Expanding Population (Local Plans)
- Ageing Population (83.4)
- Large 40-69 Population
- Increasing numbers with LTC
- Increasing Prevalence of Dementia
- Main Cause of Death:
 - Circulatory Disease
 - Cancer
 - Respiratory
- Mental Health Prevalence

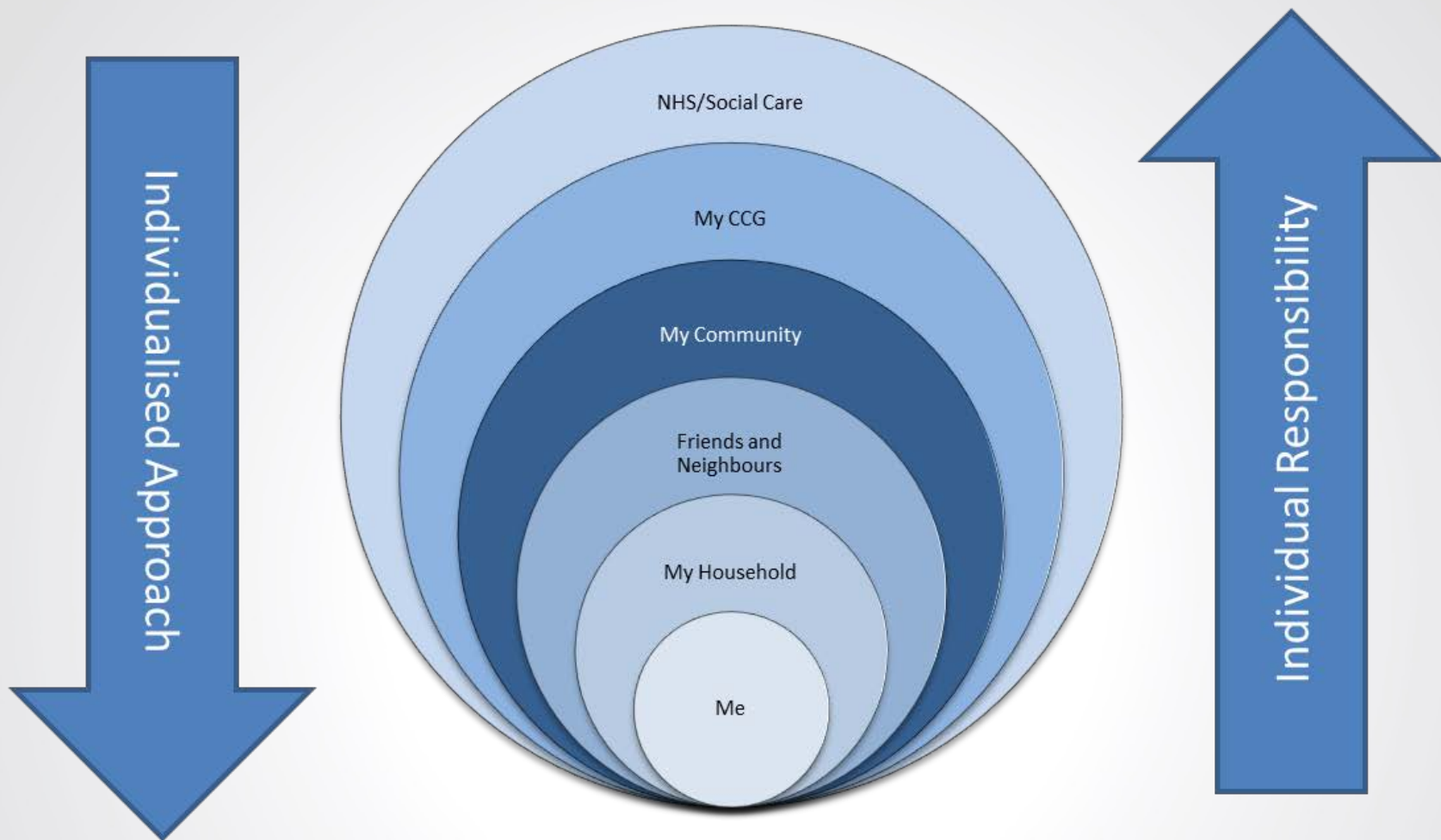
Canterbury & Coastal CCG

- Expanding Population (Local Plans)
- Ageing Population (81.2)
- Large 15-29 Population
- Increasing numbers with LTC
- Increasing Prevalence of Dementia
- Main Cause of Death:
 - Circulatory Disease
 - Cancer
 - Respiratory
- Self Harm





Joint Strategic Direction





A Natural Progression

Closely aligned organisations which already share an Operational Leadership Team and key members of staff

Much of our vision, values and planning is aligned and this would not necessarily be the case with other CCGs.

Need to invest additional resources in Locality Teams

We want to support the future direction of primary care

Capacity of Clinical Leadership remains a significant challenge





Our Common Vision

Primary Care

We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.

Community Networks

Primary and community care services working closer together, along with voluntary organisations and other independent sector organisations.

Mental Health

We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities

Urgent Care

We want care that crosses the boundaries between primary, community, hospital and social care.

Maternity and Young People

We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation

Planned Care

We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.





Key Successes

Achieved all finance targets in 2013/14

Quality Visit framework implemented

Independent safeguarding review

Placement review board

Integrated Urgent Care Centre

Care Homes Project

Integrated Health and Social Care Teams

Improved waiting times for counselling services (IAPT)

Primary Care Mental Health workers

Our role in the community





What we will do better...

Primary Care

- Co Commissioning

Urgent Care/Long Term Conditions

- DVT/Anti-Coagulation

Mental Health

- Parity of Esteem

Maternity, Children and Young People

- Early Pregnancy Unit redesign

Planned Care

- Orthopaedic redesign





Developing the Commissioning Capacity

Sustainable Clinical Leadership

Commissioning Capacity aligned to locality teams

Developing local clinical leadership

Develop Local Commissioning Academy, including GP Trainee Scheme

Realising the benefit of being an intelligent customer





Risks and Benefits of Merger

Current Risk

- Insufficient capacity for Clinical board members to focus on service development within localities
- Duplicated committees and discussions
- Duplication of efforts for both the CCGs and our partners
- Inequity of services and outcomes for patients across the two CCGs
- Fragmented community and acute services
- No Primary Care Strategy

Benefits

- Clinical board members focussing on services and development within localities
- Strengthening role of Committees through new governance arrangements
- Efficiency benefits within the CCG and with partners
- Improved quality of services for our patients through reducing inequity
- Development of Local Services for Patients (Community Networks)
- Co-produced Primary Care Strategy



Financial case for merging

Cash Saving Description	£'000
Clinical Input	121
Internal Audit	40
External Audit	50
External Commissioning Support	420
Total	631

Resource Saving Description	Whole Time Equivalent	£'000
Executive team	0.93	104
Commissioning team shared posts	0.66	43
Commissioning team CCG specific posts	0.26	11
Finance team	1.94	44
Health economy as a whole	0.54	29
Total	4.33	231





Impact of Merging

Risk

- Reduction in membership and public ownership
- Loss of local focus
- Diversion of management attention during implementation phase
- Reduced Organisational Effectiveness

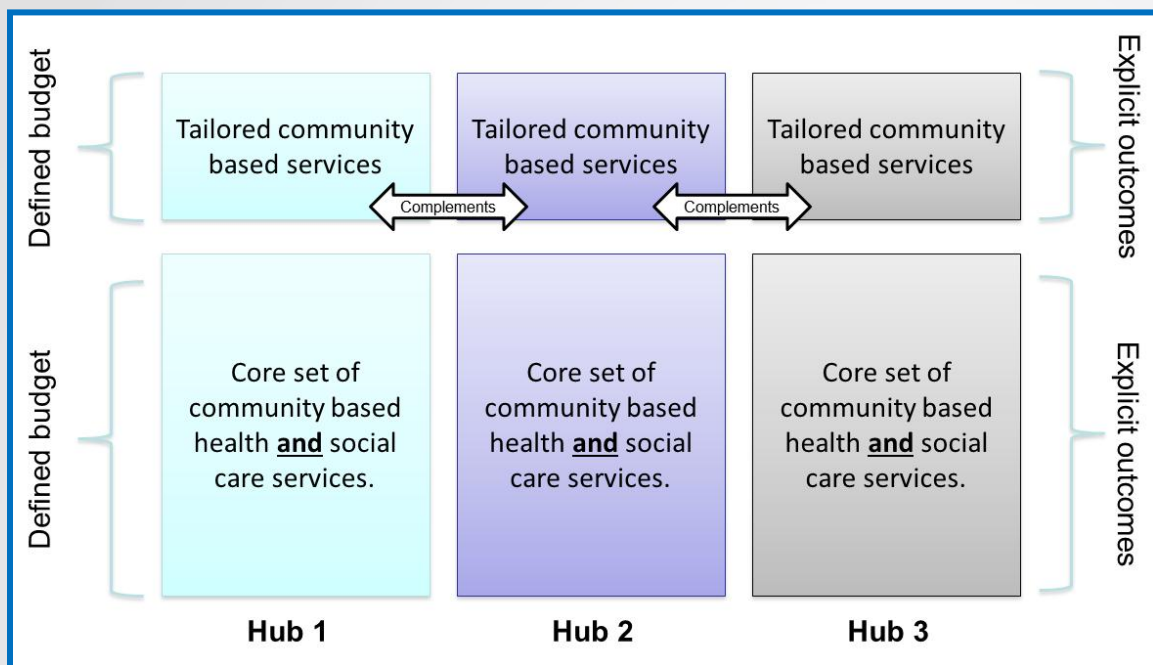
Mitigation

- Co-Design of Community Services
- CCG staff and reporting realigned to Localities
- Improved, efficient processes reducing duplication and creating capacity within existing resource
- Organisational Development Plan





Community Networks

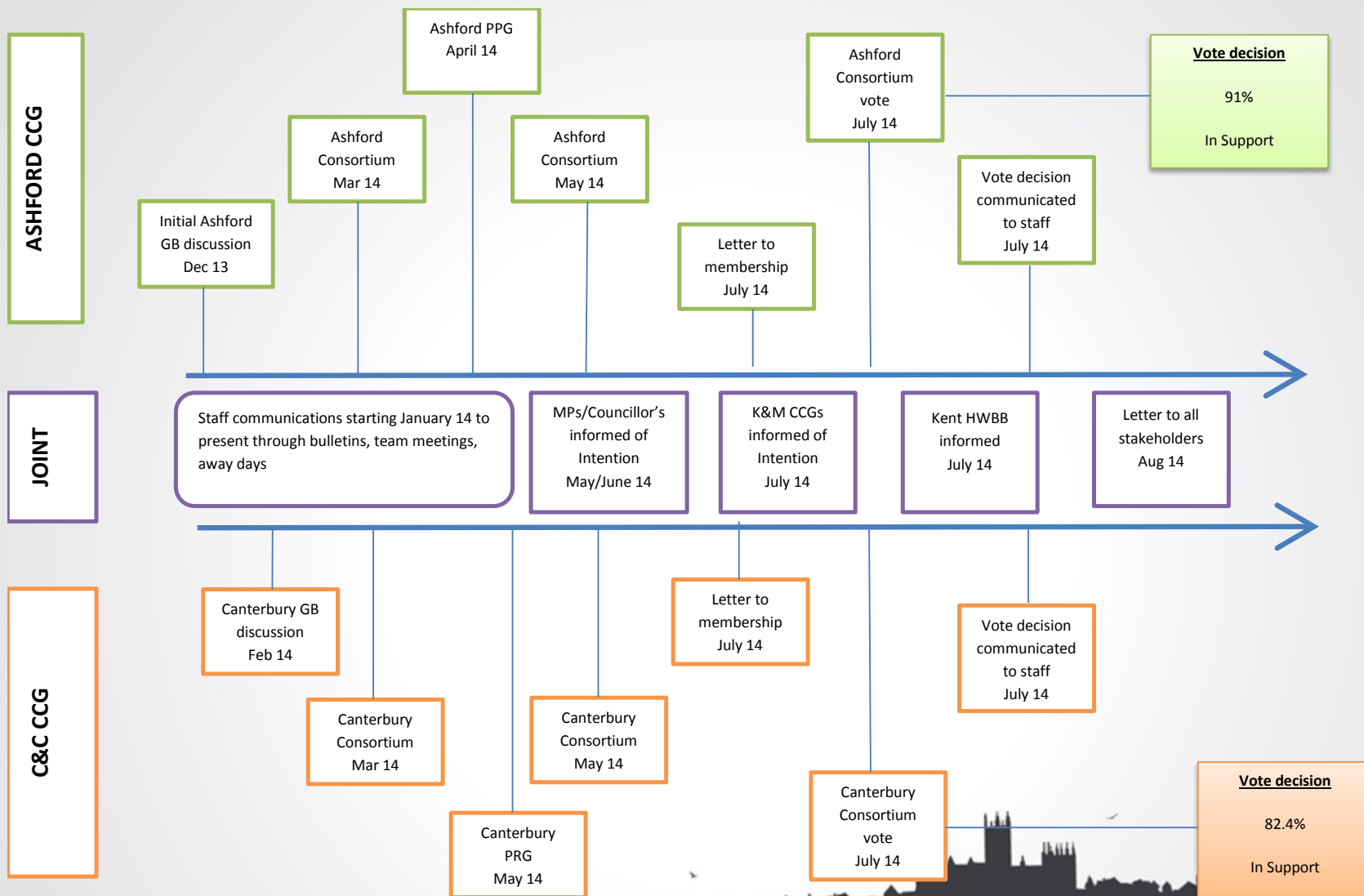


<p>Tailored community based services e.g. :</p>	<ul style="list-style-type: none"> Outpatients Specialist Diagnostics Addiction Services
<p>Core community based health and social care services e.g. :</p>	<ul style="list-style-type: none"> Assisted Living Befriending Care Homes Care Planning Carer Support Citizen's Advice Community Equipment Counselling Services Community Nursing Dementia Support End of Life Care General Practice Home Support Assessment Inpatient Beds (Step-Up and Step-Down) Meals-on-Wheels Minor Injuries Physiotherapy Pharmacy Respite Care Sexual Health



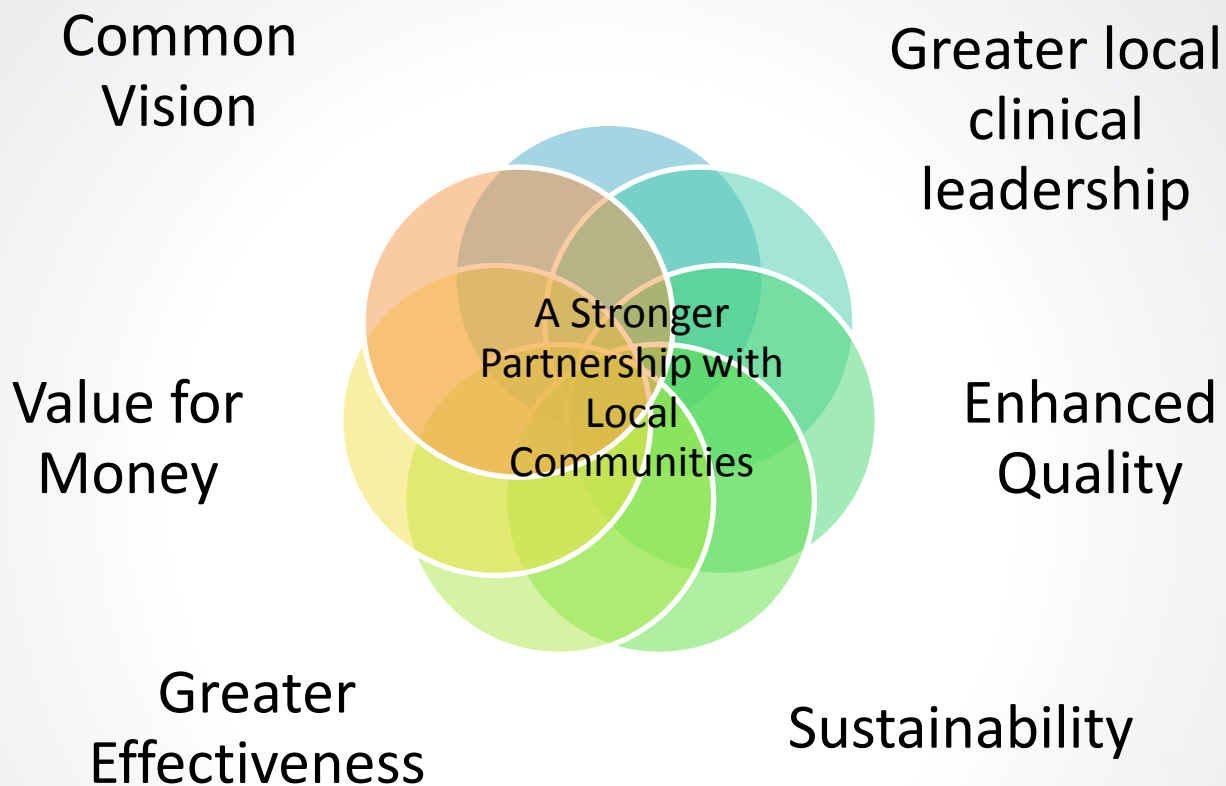


Partner Engagement





The Merged CCG will Deliver....





NHS

*Ashford, Canterbury and Coastal
Clinical Commissioning Group*

Thank You



Meeting:	Ashford Health and Wellbeing Board
Date of Meeting:	
Agenda item:	
Subject:	Strategic Commissioning Plan
Reporting Officer:	Neil Fisher, Head of Strategy and Planning

Action Required: This paper is for:

Approval	Decision	Discussion/ Assurance	X	Information
Paper (no more than 4 sides long):				
<p>The aim of our Commissioning Plan 2014-19, final version attached, is to explain how we will move from Joint Strategic Needs Assessment to delivering services that will drive improvements in health outcomes.</p> <p>The CCG was required to submit a final plan to NHS England on 20th June, therefore this paper represents an opportunity to assure the Health and Wellbeing Board that the CCG fulfilled our responsibilities in this regard.</p> <p>Before publication, significant public discussion has taken place which conforms with the CCG duty to ensure that individuals, to whom the services are being provided, are involved in the planning of services. Following final sign off, we have undertaken the following immediate steps:</p> <ul style="list-style-type: none"> • Press release for media • Publish on CCG Website • Update briefing for Health Overview and Scrutiny Committee, Kent Health and Wellbeing Board and Ashford Health and Wellbeing Board <p>Whilst this represents the final stage of the production on the initial five year plan, our efforts do not cease. We have now commenced refreshing the document to reflect the progress we have made to date, national policy changes which have come into force since April 2014 and recent announcements, such as Mental Health Access standards.</p> <p>In December, we anticipate that NHS England will publish the NHS Mandate and planning guidance for 2015/16 which will set out the expectations of what we will deliver in 2015-16 and contain indications of changes between now and 2020.</p> <p>Early indications include CCGs taking on a role in commissioning Primary care (GP) services and a focus on personal budgets for patients with long term needs. This is in addition to the Mental Health standards which we announced on 8th October.</p>				

Conflict of Interest? (if yes describe)	None					
Finance Assessment Completed?	Yes		No		N/A	X
Equality Impact Assessment Completed?	Yes		No		N/A	X
Strategic Objective link: Risk Register links (reference number)	If the Plan is not approved there significantly negative impact on the CCG's reputation and undermine the CCG's ability to meet NHS England's Quality Assurance process.					
The Health and Wellbeing Board are asked to: The Health and Wellbeing Board is being asked to note the current version of the SCP.						



Ashford Clinical Commissioning Group

Strategic Commissioning Plan

2014 - 2019





Strategic Commissioning Plan		Page
Introduction		4
Review of 2013/14		5
NHS Constitution Standards		10
Moving Forward: National Context		12
Our Local Population		14
Health and Wellbeing		18
Public and Patient Involvement		20
Our Strategic Priorities		27
The View Across East Kent		43
Key Enablers		51
The Financial Challenge		55
Improvement Measures		57
The Next Two Years		Page
Delivering The Plan		59
Organisational Development		60
Delivering Harm Free Care		62
Future Operating Model		66
The Financial Challenge		69
Strategic Objectives, Aims and Risks		72
Annex A: Plan on a Page		73
Annex B: Armed Forces		74
Annex C: Public Health		76
Annex D: Strategic Clinical Networks		78



NHS Ashford CCG covers the town of Ashford as well as surrounding rural areas.

The CCG is made up of the 15 general practices (doctors' surgeries) in the Ashford area. The day-to-day work is overseen by a governing body, which is responsible to the GP practices for commissioning the right healthcare services for people in Ashford and ensuring they provide high quality, value for money care.

There are 6 GPs on the governing body, a chief nurse, registered nurse, hospital doctor, three lay and independent members with particular expertise in audit, patient engagement and strategy and planning as well as senior CCG managers. The governing body is supported by a number of sub-committees and working groups, including an Audit Committee. The full list of governing body representatives, senior management profiles, members of the Audit Committee and a statement setting out governance arrangements for the CCG are detailed in annexe one and two of this report.

The CCG has an annual budget of £133 million to deliver healthcare services for the 122,000 people registered with a GP surgeries in the Ashford area. That equates to around £1,095 per person.

The vast majority of the CCG budget was spent on care provided in a hospital setting, other services such as specialised care, the healthy child programme and primary care (GPs, Pharmacy and Optometrists) are paid for by NHS England. Kent County Council commissions public health services, such as sexual health, stop smoking and healthy weight programmes.

Data Point	Data
Registered patient population:	122,000
Number of GP practices:	15
Neighbouring CCGs	4
Community Hospitals	0
Acute Hospital (within CCG boundaries)	1

Our priorities for 2013/14 were developed in consultation with local residents and informed by Kent County Council's Joint Strategic Needs Assessment (JSNA), the local health and wellbeing strategy and national policy.

Each priority was led by a GP Clinical Lead and supported by a team of commissioning staff. Patient and public views were incorporated in both the setting of these priorities and as the work programme emerged which ensured that a patient and clinical perspective was at the core of every discussion and decision.

In line with the Kent Health and Wellbeing strategy, we also aimed to ensure:

- Every child has the best start in life
- People take greater responsibility for their own health
- The quality of life for those with long-term conditions is improved with quality care and support
- Those with mental ill health are supported to live well
- People with dementia are assessed and treated earlier

Our work also dovetailed with the NHS outcomes framework, which included:

- 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

Our priorities for 2013/2014 were:

1. Maintain the health status of the population
2. Reduce health inequalities across wards
3. Maintain clinical effectiveness
4. Dementia



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.

There is one main provider for adult mental health services across Kent and Medway (Kent and Medway Social Care Partnership Trust - KMPT) and the provision for children and adolescent mental health services (CAMHS) is through Sussex Partnership Trust. More generally the Young Healthy Minds programme, run by Kent County Council puts in place services and resources to support children's emotional wellbeing.

Mental health disorders take many different forms and affect people in different ways. Schizophrenia, depression and personality disorders are all types of mental health problem. 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.

"Live it Well" is a partnership between social care mental health commissioning (KCC and Medway Council) and NHS commissioning. Live it Well will change the emphasis of mental health services, redirecting some of the resources, away from secondary, statutory services which have traditionally decided on the service with service users as passive recipients; and instead commissioning services that are closer to, and responsive to, the needs of service users and carers, for instance in primary care.

The CAMHS service is tiered to provide assessment and treatment for children, young people and their families up to the age of 18, who are presenting with signs and symptoms of severe, complex and enduring mental illness.

What have we achieved

This period we have hosted a community event at which we have asked our local population to help identify the service gaps as well as provide suggestions on possible solutions and the priority they should be delivered in. In response to this work we have undertaken the following:

- Implemented a mental health crisis hot line for GPs to enable them to better support patients in their own care setting; and
- Improved access to psychological therapies by increasing the number of providers which has driven down the average waiting time for assessment and treatment to two weeks

In addition we also initiated a review of the mental health urgent care pathway; the aim of this work is to reduce patients being admitted to hospital through access to timely appropriate support. We expect the review to be completed in the summer 2014.



Health Help Now

In December 2013 NHS Ashford CCG launched Health Help Now - an innovative new service to help people in the Ashford area.

The Health Help Now web app can be found online at www.healthhelpnow-nhs.net and is free to everyone who lives and works in the area.

It functions like a mobile phone app and helps people check their symptoms and find the best place for treatment – showing which services near them are open. It breaks down symptoms by age – baby, child, teenager, adult and older adult. This is to make it easier for people to find the right treatment for them.

The app has been developed with input from local GPs, hospital doctors, paramedics and other health professionals

Health inequalities are defined as the “differences in health status or in the distribution of health determinants between different population groups” Those differences are inequitable when they can be determined as being unfair or avoidable.

Social determinants of health are a collective set of conditions in which people are born, grow-up, live and work. The World Health Organisation notes that in turn these conditions are shaped by a powerful over riding set of forces: economics, social policies and politics.

Our influence on many of these factors is limited but we are able to ensure that any services we commission are offered and delivered equitably. One of the ways we have achieved this is by reviewing our existing services offered from primary care to ensure they are offered on an Ashford wide basis rather than individual practice based:

- Gynecological service – We implemented an additional consultant led community based clinic at Wye as our review found that community provision did not cover patients in that locality. This has reduced the need for patients to travel to hospital and has reduced the length of time patients wait for assessment.
- We have been involved in a national project run by KCC which supports “troubled families” to address health needs of their entire family. For the CCG this means targeting services and liaising with respective GPs on areas such as health assessments, childhood vaccinations and immunisation and access to appropriate psychology services if required).

The principle behind maintaining clinical effectiveness is to ensuring that all care given by the NHS is safe, evidence based, cost effective and delivers consistent high quality outcomes.

In our first full year we have attempted to review all the services commissioned by the CCG to ensure they meet and where possible exceed the above aspirations. On areas where we felt this was not the case we worked collaboratively with the providers to support them to achieve the high standard we and our population.

For example, Joint injections (non-back related) were provided by a number of providers each with slightly differing criteria for treatment and each using different approaches. This resulted in service inconsistencies across Ashford and increased hospital visits for patients. To combat this we agreed standard clinical criteria and standardised treatment procedures, in addition we implemented a primary care delivered service which reduced the need to attend hospital ensuring the appropriate treatment at point of assessment.

During this period we have implemented the NHS England Risk Stratification approach and tool. This is a decision-making approach used to identify those patients at risk of admission to hospital. The approach brings together teams from a variety of agencies, including health and social care, so that we can offer earlier intervention to help patients to improve the management of their condition.

Carpal Tunnel Syndrome

Carpal Tunnel Syndrome has a national prevalence in primary care, around 1.8% of population. It is caused by compression of the median nerve as it travels through the restricted space between the wrist bones.

There are a number of common treatments offered for Carpal Tunnel Syndrome. Night time wrist splinting keeps the wrist straight, and relieves symptoms for approximately 30% of patients. Previously splints were available for the patient to buy themselves or given as part of an outpatient attendance at hospital.

To avoid an unnecessary referral to hospital, we have now made it possible for GPs to give splints (provided by the CCG) to patients as a first line treatment. As this is a remedy for many people, hospital referrals have reduced and patients do not have to attend the hospital.



Community Geriatrician

In June 2013 we initiated our innovative geriatrician pilot project which offered support to care homes from a full-time consultant (known as a geriatrician) and a community matron working extended hours, who are the first point of contact for care homes when a resident's health deteriorates. They offered expert care to residents who became seriously unwell, without them needing to be taken to hospital.

The project, which is part of the Health Foundation's Safer Clinical Systems programme, was nationally recognised in September 2013 when it won a Health Service Journal (HSJ) Efficiency Award for community service redesign.

About 750,000 people in the UK have diagnosed dementia with approximately 689 of these people residing in the Ashford CCG area.

This number is expected to double over the next thirty years and this in turn will bring its own challenges to the way health services planned for. As a starting point we hosted a dementia event, which was attended by the general public, volunteers, care organisations and providers, to identify current service gaps as well as designing an action plan to address these.

The CCG is committed to improving the care and experience of people with dementia and their carers and the outputs from this work have been incorporated into our commissioning intentions for 2014/15 and our five year plan.

Starting with our GPs we have trialled a screening tool in three GP practices. The tool supports GPs to diagnose dementia. In addition KMPT have worked with GP practices to ensure their patient lists are complete for patients diagnosed with dementia, thus ensuring they receive the right support from appropriate services.

We recognise that carers of dementia sufferers are equally important and to support them in their role we have implemented a directory of services, accessed through their GP, which provides information on a wide range of services, including the voluntary sector services available to patients and their carers.

The CCG has joined KCC to implement the dementia friendly project, this project is attempting to ensure both local businesses and community groups have an improved understanding and awareness of dementia. Through increased awareness members of the public suffering with dementia will be supported to live independently and will not be subjected to stigma.



The NHS Constitution identifies a range of standards to which patients are entitled and which we are committed to deliver. We have set out our performance during 2013/14 against these standards below.

Referral To Treatment waiting times for non-urgent consultant-led treatment	Current Performance	Remedial Actions
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	91.70%	Achieving – No Additional Actions Required
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	98.00%	Achieving – No Additional Actions Required
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	94.30%	Achieving – No Additional Actions Required
Diagnostic test waiting times	Current Performance	Remedial Actions
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%	99.79%	Achieving – No Additional Actions Required
A&E waits	Current Performance	Remedial Actions
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%	94.77%	Underachieving – Investment through Winter Funding has brought recent improvement against this standard.
Cancer waits – 2 week wait	Current Performance	Remedial Actions
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%	95.59%	Achieving – No Additional Actions Required
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%	93.41%	Achieving – No Additional Actions Required

Cont...

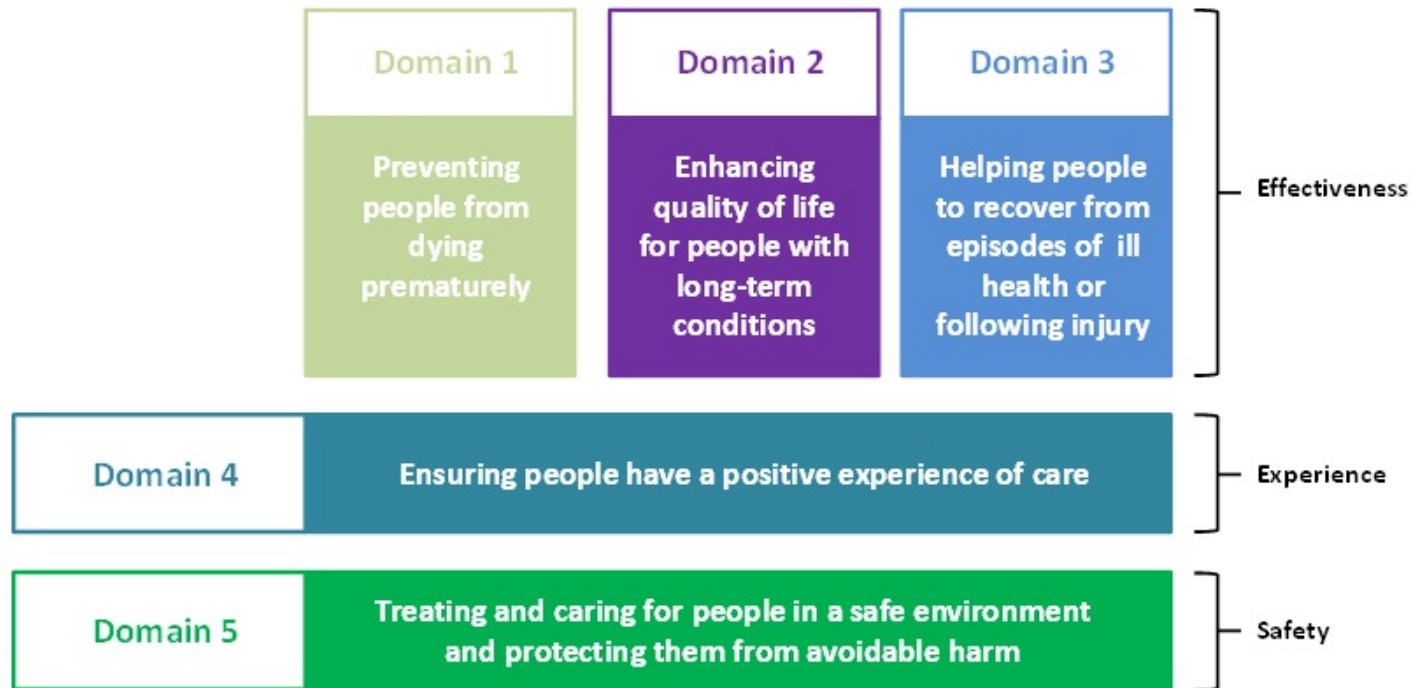


Cancer waits – 31 days	Current Performance	Remedial Actions
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%	98.79%	Achieving – No Additional Actions Required
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%	97.17%	Achieving – No Additional Actions Required
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%	100.00%	Achieving – No Additional Actions Required
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%	100.00%	Achieving – No Additional Actions Required
Cancer waits – 62 days	Current Performance	Remedial Actions
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%	87.96	Achieving – No Additional Actions Required
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%	100%	Achieving – No Additional Actions Required
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	66.70%	Underachieving – With the work already completed and further plans for improvement, March is predicted to be compliant against this target
Category A ambulance calls	Current Performance	Remedial Actions
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)	75.95%	Achieving – No Additional Actions Required
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%	96.95%	Achieving – No Additional Actions Required



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.

Much of the basis for the government’s mandate to NHS England is the NHS Outcomes Framework which describes five main categories of better outcomes demanded from local services. Our ambitions will always be focused on delivering the outcomes in these five domains:



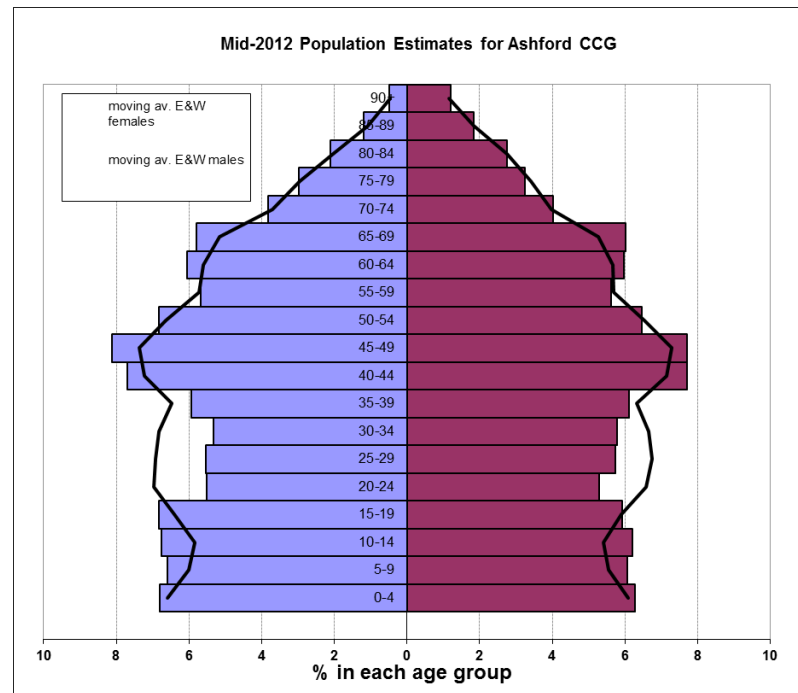
NHS England has translated these outcomes into specific measurable ambitions which against which we can track our progress. Here we explain how our plan meets the expectation of these ambitions

National Ambition	Our Vision
<p>Securing additional years of life for the people of England with treatable mental and physical health conditions.</p>	<p>We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities.</p>
<p>Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.</p>	<p>We will see practices working together in collaboration in support of Community Networks to offer wider variety of services, including social care and voluntary sector, with improved access for traditional GP services.</p>
<p>Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.</p>	<p>Through effective implementation of the Better Care Fund we will have primary and community care services working closer together, along with social care, voluntary organisations and other independent sector organisations.</p>
<p>Increasing the proportion of older people living independently at home following discharge from hospital.</p>	<p>To use the Better Care Fund as an opportunity to commission services together with other public sector partners. Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services as we develop our Community Networks.</p>
<p>Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.</p>	<p>We will work with providers to put mechanisms in place to systematically gather real-time patient and carer feedback including ensuring the Friends and Family Test is in place across all providers</p>
<p>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.</p>	<p>We will ensure that vertical and horizontal integration of all services, through community networks which include health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation</p>
<p>Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.</p>	<p>We will work with our providers and use the contractual levers available to ensure that patients are treated in a safe environment, with an emphasis on zero tolerance of avoidable harm and ensuring that nursing care is of the highest standard.</p>



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.

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.



The distribution of the Ashford CCG population means 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.



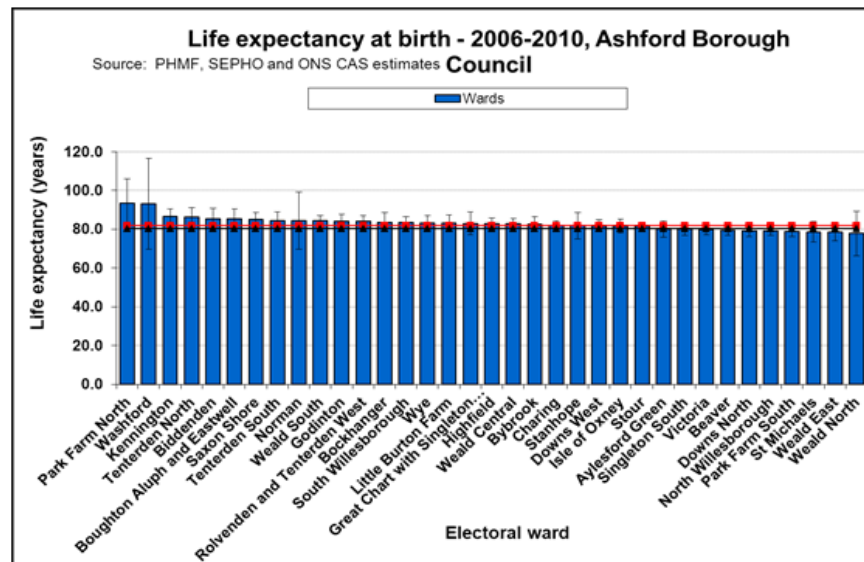
Life Expectancy	<p>The average life expectancy in Ashford is 83.4 years for females compared to males at 80.7</p> <p>The lowest life expectancy figures are in the wards of St Michaels and Weald East and Weald North, with the highest figures in Park Farm North and Washford. The difference in the number of years between the highest and lowest life expectancy at</p>
Cause of Death	<p>Circulatory Disease is now the main cause of death (34% of deaths), followed by Cancer (26%), and respiratory disease (15%).</p>
Lifestyles	<p>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.</p> <p>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</p>
Long-Term Conditions	<p>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</p>
Dementia	<p>Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65.</p>
Mental Health	<p>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 seen in Weald North.</p>



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

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



Cancer

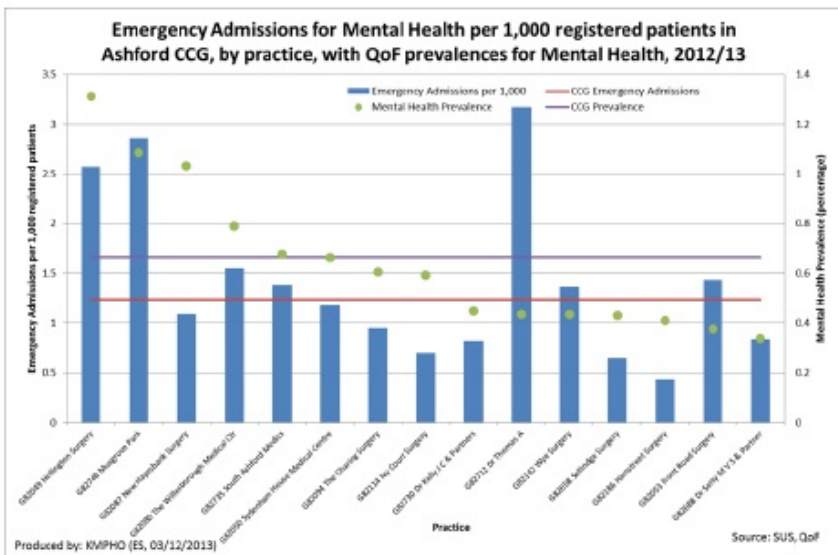
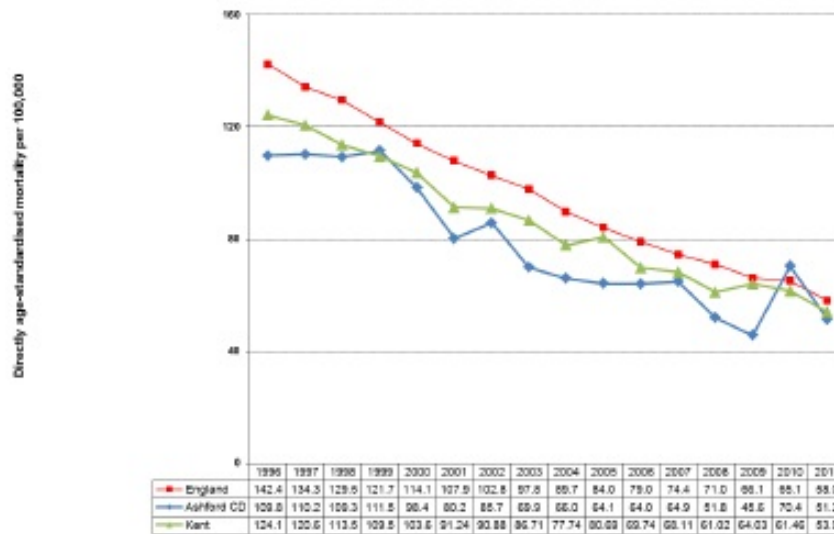
Mortality from cancer has decreased from 156/100,000 deaths in 1996 to 100/100,000 deaths in 2011. Again, a similar trend is observed for the whole of England.

Circulatory Disease

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.

Mortality from all circulatory disease aged under 75, both sexes

Source: NCHOD



Mental Health

There is large variation in emergency admissions for mental health problems. The Ashford average lies around 1-1.5/1,000 registered patients.

The Kent Health and Wellbeing Strategy informs the NHS 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 come five 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). 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.

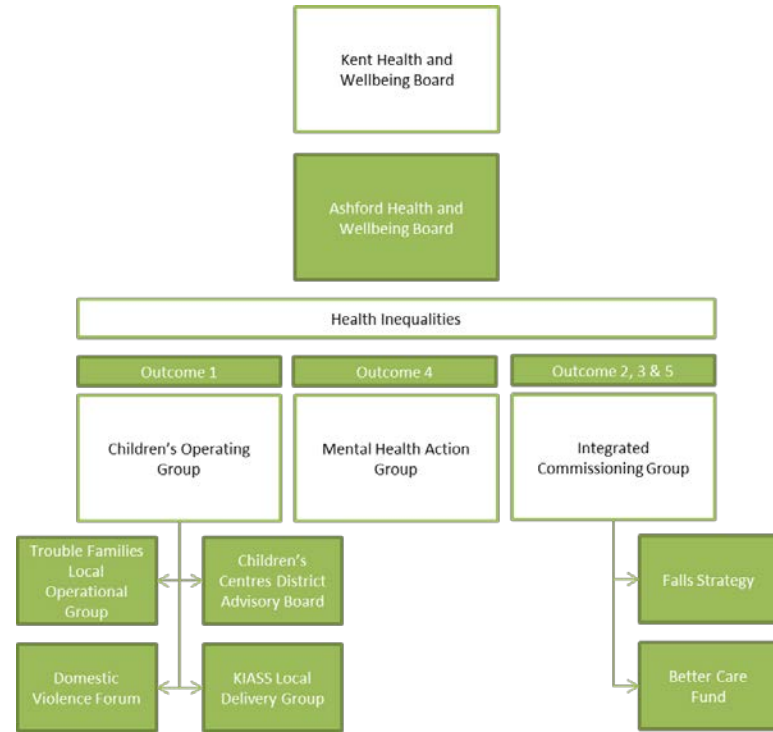


The Ashford Health and Wellbeing Board brings together the statutory and voluntary organisations which are involved locally in healthcare, social care and public health to champion the delivery of better, more efficient and integrated services in the area.

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.



Kent Integration Pioneers



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 .

In order to discharge its responsibilities, the board has identified three working groups to deliver against the domains of the Kent Health and Wellbeing Strategy





NHS Ashford CCG views engaging our patient and public as crucial to our role as commissioners of local health services. The experiences of patients and their families are extremely important to us because we know how their experiences are critical to both individual patients and their families and goes well beyond the health outcomes of care.

When we talk about making sure people have a good patient experience we mean doing more than just meeting their physical needs, we need to meet their emotional needs too by:

- Providing good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way
- Giving people information to make choices, to feel confident and to feel in control
- Talking to and listening to people as an equal; treating them with honesty, respect and dignity.

It is also important to involve people much more in their own healthcare and in shaping health services for the population as a whole. This is an on-going process, so we need continue to use opportunities that arise to get the views of our patients on our priorities and direction of travel. The population we serve – patients, carers, residents – should be free to hold us publicly to account directly or through elected representatives, Health Watch or overview and scrutiny committees



As the leaders of the local NHS, we want to build on and strengthen existing relationships, work with our patients and communities to inform decision making and planning and be an effective guardian and promoter of one of the country’s most cherished brands – the NHS – at a time when the media and public spotlight in NHS services is brighter than ever.

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

Means of Engaging Patients and Public	Detail
Stakeholder engagement events	We regularly hold partnership and stakeholder engagement events. These are usually well attended with representatives from organisations that reflect the needs of everyone in the community, thus ensuring quality and diversity is maintained.
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)	We aim to develop a Public Reference Group, with representatives from the PPGs as well as representatives from key voluntary 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 is an independent organisation set up to champion the views of patients and social care users across Kent. Their mission is to raise the public's voice to improve the quality of local health and social care services in Kent.
@AshfordHealth	Twitter account for Ashford CCG with latest news, tips and advice for Ashford’s local community



“The NHS was set up to provide high quality care for patients, free at the point of need. The NHS has stayed true to this aim and to do so in the future, we must embrace new ways of working. The NHS, like every other healthcare provider in the world, is facing these challenges. Too often, the answers are to reduce the offer to patients or charge for services. That is not the ethos of the NHS and I am clear that our future must be about changing, not charging. To do so we must make bold, clinically-led changes to how NHS services are delivered over the next couple of years.” – Sir David Nicholson, Chief Executive, NHS England 2013

In 2013, NHS England called on patients, the public and staff to join in a discussion about the future of the NHS, so would plan how best to deliver services, now and in the years ahead. This call to action set out the facts about future demands on NHS services, how the budget is currently spent and how services are delivered.

In line with our firm commitment to stakeholder engagement, we embarked on a process of engaging with practices, patients, carers, the public and other stakeholder groups in developing our commissioning priorities. These events focused on information giving, updating stakeholders on our role and activities, and information gathering, enabling us to interact with our ‘Patient and Public’ and ‘organisational’ stakeholder groups in a structured way to secure their input into this strategic commissioning plan.



“DOING NOTHING IS NOT AN OPTION – THE NHS CANNOT MEET FUTURE CHALLENGES WITHOUT CHANGE.”



Stakeholder Feedback	How are we addressing this?
<p>Need to ensure that adequate resources are available in primary care so that long term conditions are managed</p> <p>Better outcomes achieved through improved integrated community services rather than patients being admitted to hospital</p> <p>Multi-disciplinary teams (an overarching team) working from a 'local' practice to look at all of the patients health needs, as quite often there are several conditions which need addressing in a patient with LTCs</p>	<p>By putting General Practice at the centre of Community Network, we will invest in our practices to support them in becoming the gatekeepers of these community based services</p> <p>We have already implemented the Neighbourhood Care Teams, Along with General Practice are using this approach as the foundation on which our Community Networks will be based.</p>
<p>The group discussed patient data being available to all agencies involved in their care (with the patients consent) so the patients' medical history is readily accessible. A single database detailing all aspects of patients' needs</p> <p>A better triage system is required to ensure that when there are issues regarding social care rather than clinical care, an adequate response is given i.e. issues around food, hygiene etc.</p>	<p>One of the major issues faced in the development of Community Networks will be the independent IT systems.</p> <p>We are already working with a software manufacturer to develop a web-based tool which will pull information from a number of sources into a single database.</p> <p>As part of our Cluster Teams we have a local referral unit. These individuals act as a single point of contact for clinicians, patients and their carers. This allows for triage to take place ensuring that the right care is offered by the right person, first time and avoids duplication and multiple visits.</p>
<p>"Mental Health Centres" across the community, to allow outpatient appointments and face-to-face contact – include ability for partnership working within the centres.</p>	<p>We recognise that patients have a number of complex needs and that mental health and long term poor health are interlinked.</p>

Cont...



Stakeholder Feedback

How are we addressing this?

A public awareness campaign advising/educating patients regarding how they should be using emergency services and out of hours services.

We have a robust communication strategy highlighting the role of General Practice, Pharmacies, NHS111 and Minor Injury Services.

However, communication is clearly not enough and so we have also taken steps to ensure that patients with urgent needs are seen by their GP on the same day, regardless of appointment availability.

Additionally, we are integrating primary care (both in and out of hours) into our local Urgent Care Centres to ensure that patients receive the most appropriate level of care according to their clinical needs.

Patients should be managed/supported in the most appropriate setting for their individual case. Delivered as close to home as possible

Therefore, as we build on our Community Networks we will ensure that Mental Health services are front and centre of our approach. This will ensure that patients will be able to access services which support all of their needs and not just those associated with physical health.

In-reach services from Voluntary Sector to GP surgeries

We fully anticipate that the voluntary sector will have a crucial role as partners in the Community Networks.

We fully appreciate that the voluntary sector provides high quality services for a vast range of needs.

Many ailments do not require secondary care appointments and should be treated in primary care.

We are transforming the way in which patients access outpatient services.

For example, post-operative follow up could be carried out in primary care

First through the introduction of Advice and Guidance services for GP so that they can continue to manage patient need themselves, but also through the introduction of "One-Stop" Clinics and earlier discharge from outpatient with advice and support for GPs.



As part of gathering patient views, and in partnership with Canterbury and Coastal CCG, 153 people responded to our survey. They provided a variety of views but stated overall satisfaction with both the location and quality of community based services

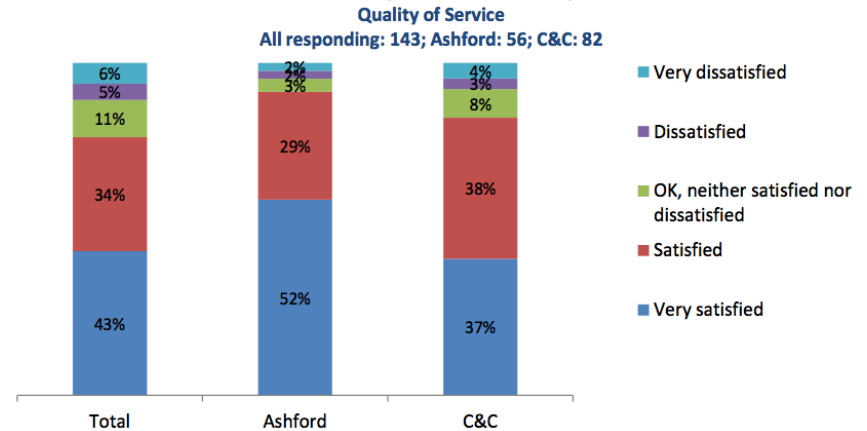
GP the key

- The most frequent point of contact for patients and carers.
- General good level of care.
- However issues in terms of time waiting for an appointment and telephone access.
- Time with the GP is too limited.

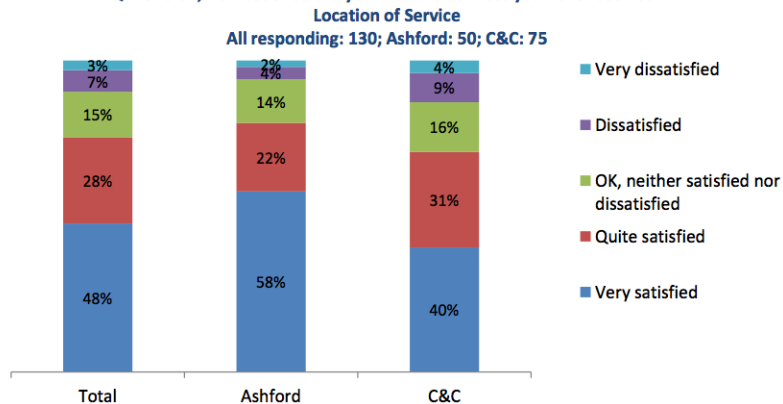
Location, Location, Location

- Generally positive
- However would like to see more services provided in a community setting
- More locally based day services for carers and patients

Q4: Overall, how satisfied are you with the services you have received?



Q4: Overall, how satisfied are you with the services you have received?



Care Planning

- Respondents not aware of care planning
- Low ratings for getting help at an early stage to avoid a crisis
- Not enough information about service availability
- Not enough information on choices regarding treatment and care

Communication

- Insufficient communication between healthcare professional and patients
- Communication between healthcare professionals not good enough and leading to delays in receiving appropriate treatment and care





The Friends & Family Test

Feedback on patient experience is sought from a number of sources including Health Watch, Patient Participation groups; patient reference groups, health networks, and the family and friends test. NHS Ashford CCG will monitor providers' compliance with the Friends and Family test by:

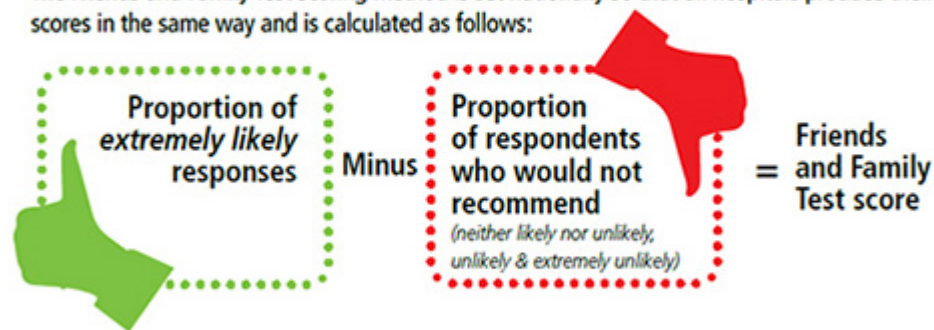
- Scrutiny of data produced for the monthly Quality Report – National CQUINS
- Support and advise providers on methods to increase response rates for the FFT.

We will continue to use real-time feedback from our patients and carers and build on this to assess the experience of people who receive care and treatment from a range of providers in a coordinated care package across health and social care.

How is the score calculated?

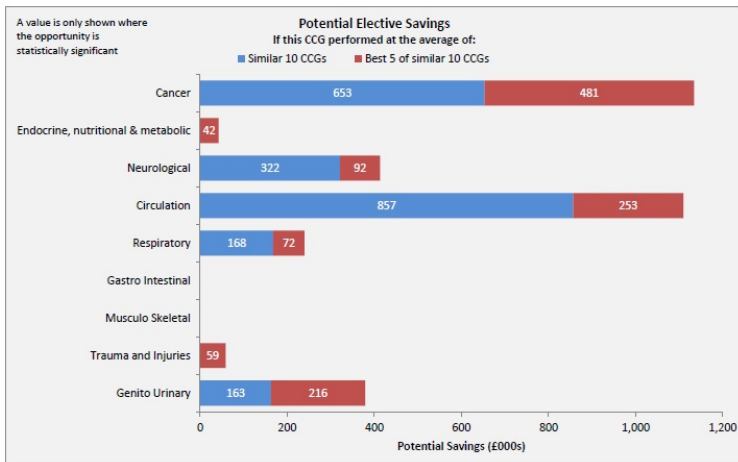


The Friends and Family Test scoring method is set nationally so that all hospitals produce their scores in the same way and is calculated as follows:



Likely and don't know answers are not included in the score. Scores can range from -100 to +100. Monthly results are now published on our wards, in A&E, and also on NHS Choices.



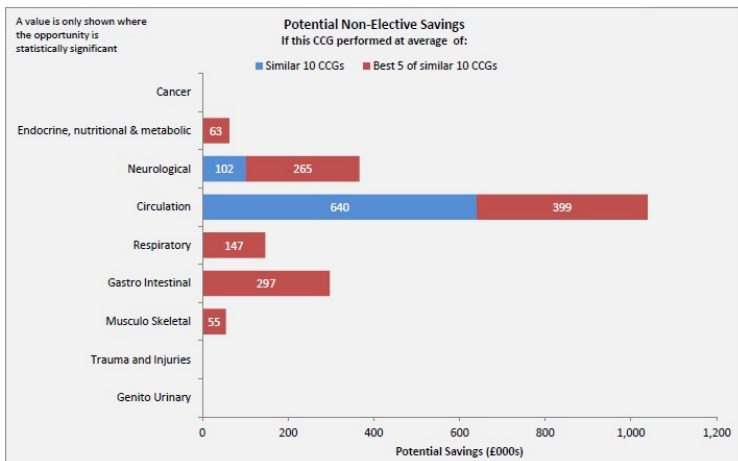


The CCG has identified a number of areas where there appears to be opportunities to increase value and improve outcomes. Some of these have been drawn from the Commissioning for Value packs that have been produced for each CCG by NHS England in association with Public Health England. The Commissioning for Value approach begins with a review of **indicative data** to highlight the top priorities (opportunities) for transformation and improvement.

These insights have been utilised to help inform and prioritise commissioning activities in the first phase of the strategic plan.

The data is drawn primarily from the 2011-12 financial year. Whilst some actions have been taken in the intervening period to address these areas, the CCG believes that a significant proportion of the financial opportunities remain in place.

The programme areas that appear to offer the greatest opportunity in terms of financial savings are: Cancer, Circulation problems (CVD) and Neurological System Problems.



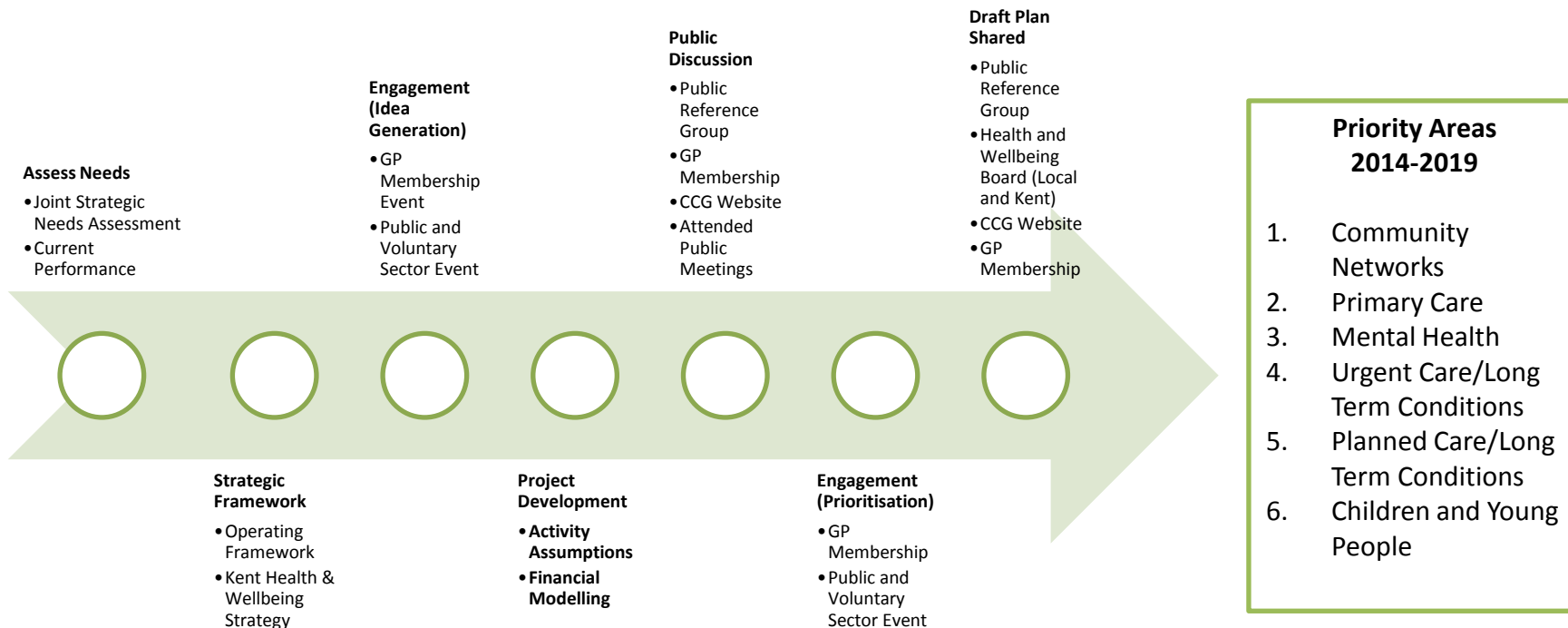
Having identified these opportunities, the next steps are to undertake a further detailed examination of the programmes/services and to secure cross organisational engagement of clinicians and managers to confirm the opportunity and to devise the measures to be taken.



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.

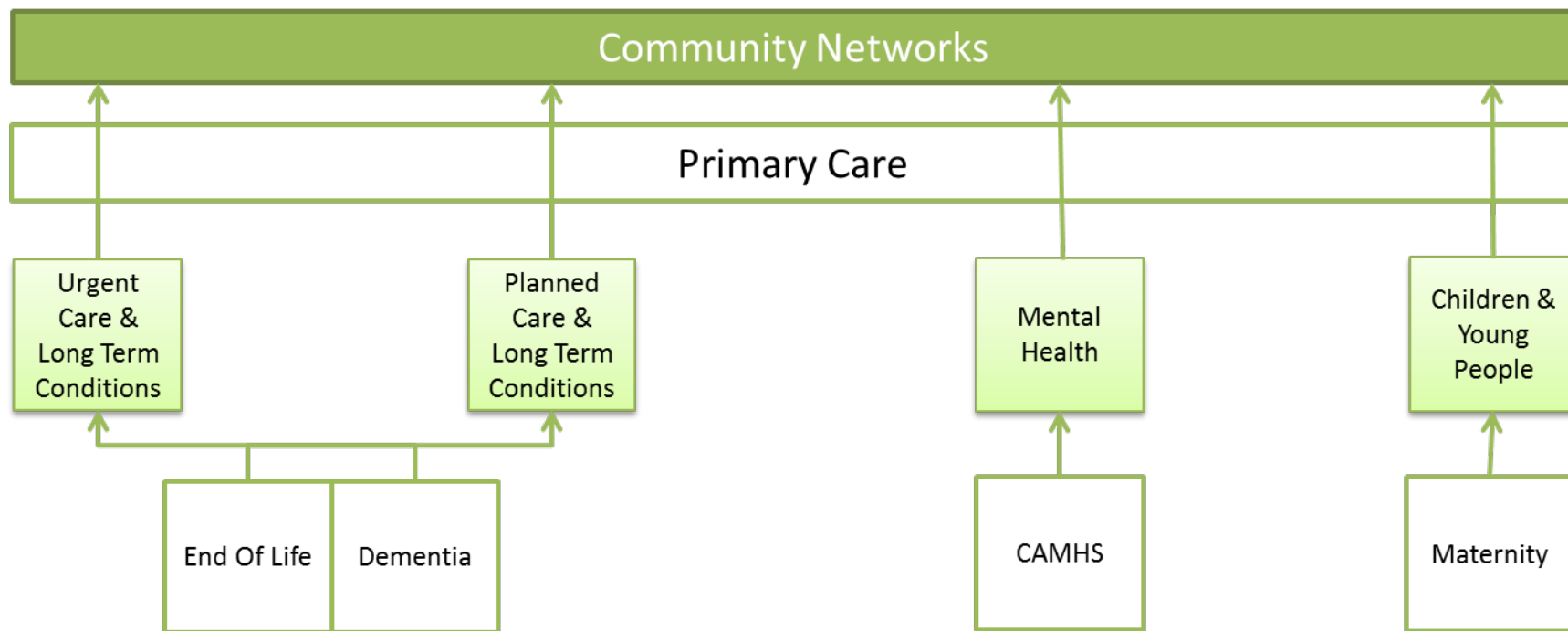
During the course of the year we have engaged our member practices, exploring local needs and inequalities (supported by Public Health). We have also engaged with the public we service, to shape our work plans and set local priorities the outputs of which are summarised in this document. We are also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



The fundamental, underlying, principle of our five year vision is that care will be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations within their local area –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals.

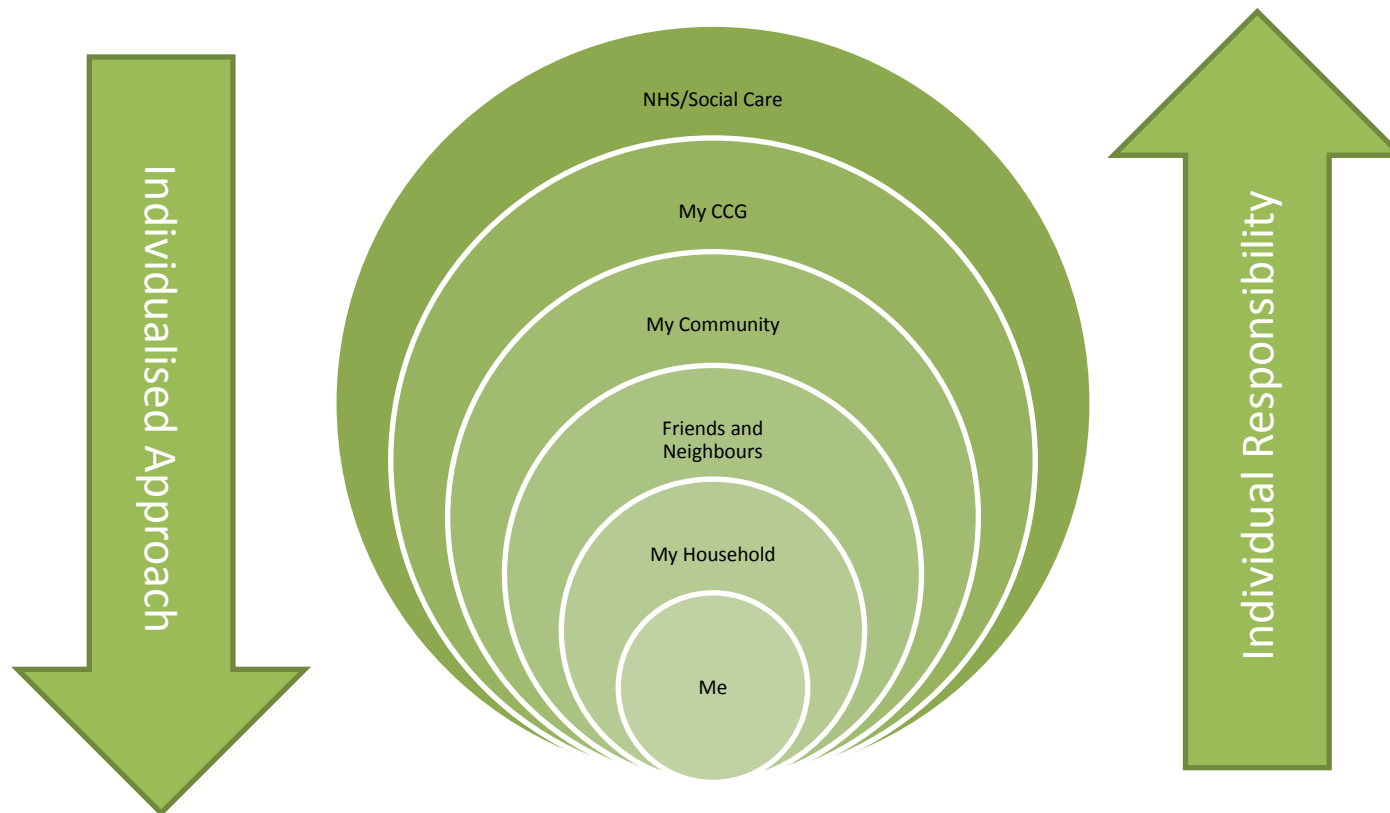
Our vision of community based networks will ensure the provision of healthcare services to enable patients, with a long term health issue or post an acute intervention, to live an independent life in the community or their homes. An essential element of this is closer integration of services provided out of hospital, available 24/7, and co-ordinated with specialist expertise in hospitals, among mental health providers and in related forms of care. Increasing attention needs to be given to care that is preventive and proactive with the aim of supporting people to remain independent for as long as possible and avoid the inappropriate use of hospitals and care homes.

In most cases, the community model would be led by GPs and would have freedom to deliver the outcomes required to meet the needs of their specific population. This would include the freedom to provide services directly or alternatively to arrange for them to be provided by others.



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 the local health economy and, by working with our members and partners, drive improvements in local services for patients.

Our patients and carers should be enabled to take ownership of their health and social care and with that accept responsibility for their health behaviour and use of health and social care services. They should expect a high quality, compassionate, safe and personal service based around their needs, present and future.



NHS Ashford CCG worked on our, vision and strategic priorities as we progressed through the authorisation process to become a statutory commissioning body and have continued to develop these further since April 2013.

The outcome is the result of consultation with our patients, members, partners and Governing Body. They are also aligned to and informed by both the Kent Health and Wellbeing Strategy and national strategic directions, as set out through “Everybody Counts”

Mission

"We strive to be ‘a healthcare partnership’ to be proud of and we are committed to improving the health and wellbeing of the population of Ashford."

Vision

"Improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs, social care and community services including the voluntary sector."

Listen: We will listen to patients, be responsive and ensure their thoughts and needs shape the CCG’s commissioning decisions.

We will strive to ensure all patients have the best possible experience of the NHS.

Be realistic about the challenge ahead: We know that with the increasing demands on services we need to deliver sustainable services that we can afford. We will be open and honest with all our patients and stakeholders and work closely with them to prioritise commissioning decisions.

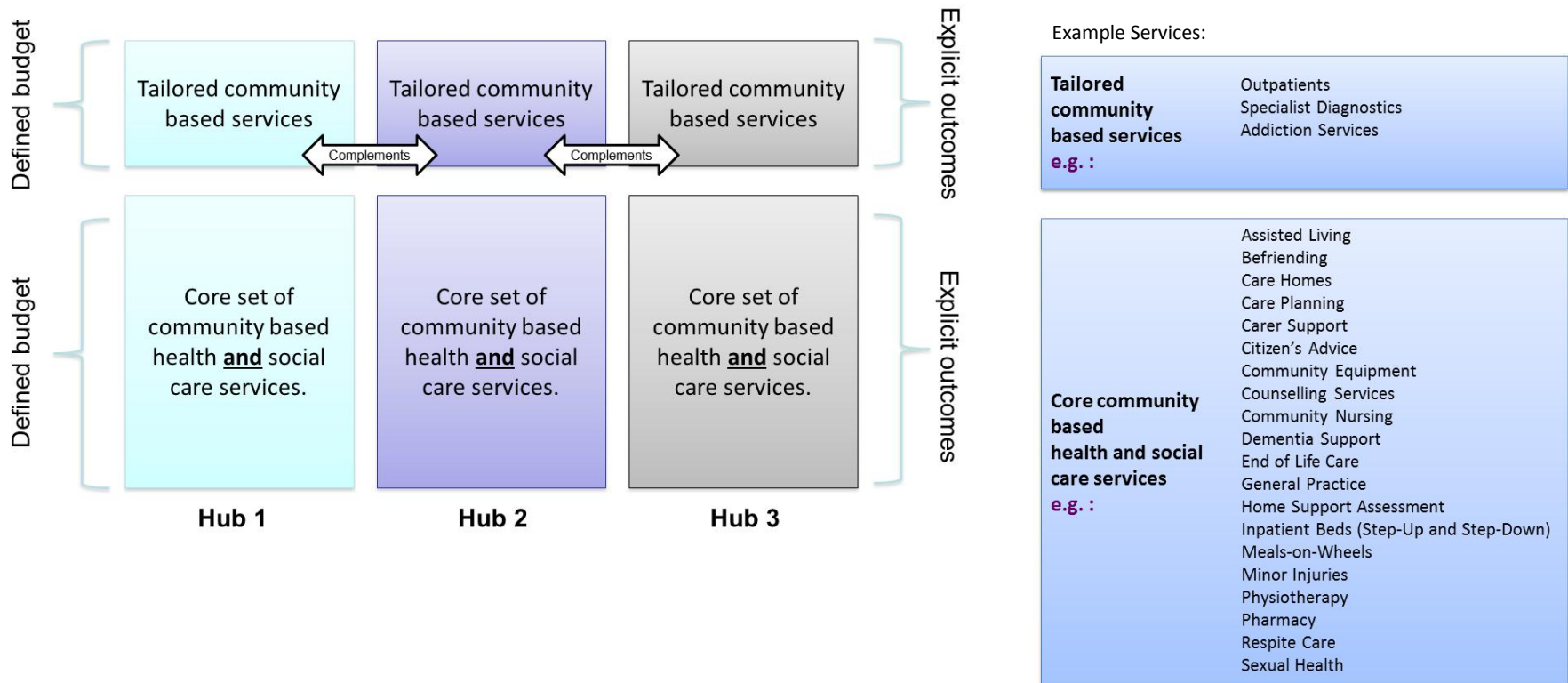
Collaborate: Best healthcare is delivered when working together – clinicians, patients, stakeholders and all sections of the community. We will work as one with our stakeholders within the area and partner with the other clinical commissioning groups in East Kent so that we become recognised as a confident organisation that listens, learns and delivers.

Be open to change: As the needs of patients change and new treatments develop we will strive to make sure we always commission high-quality and value-for-money services.



We want our patients to recognise that the local NHS is sited within their own community and not around specific estate or hospitals. We want these networks to offer the largest possible range of services meeting the largest possible range of needs and that most aspects of any patient journey, through the health and social care system, is local to them.

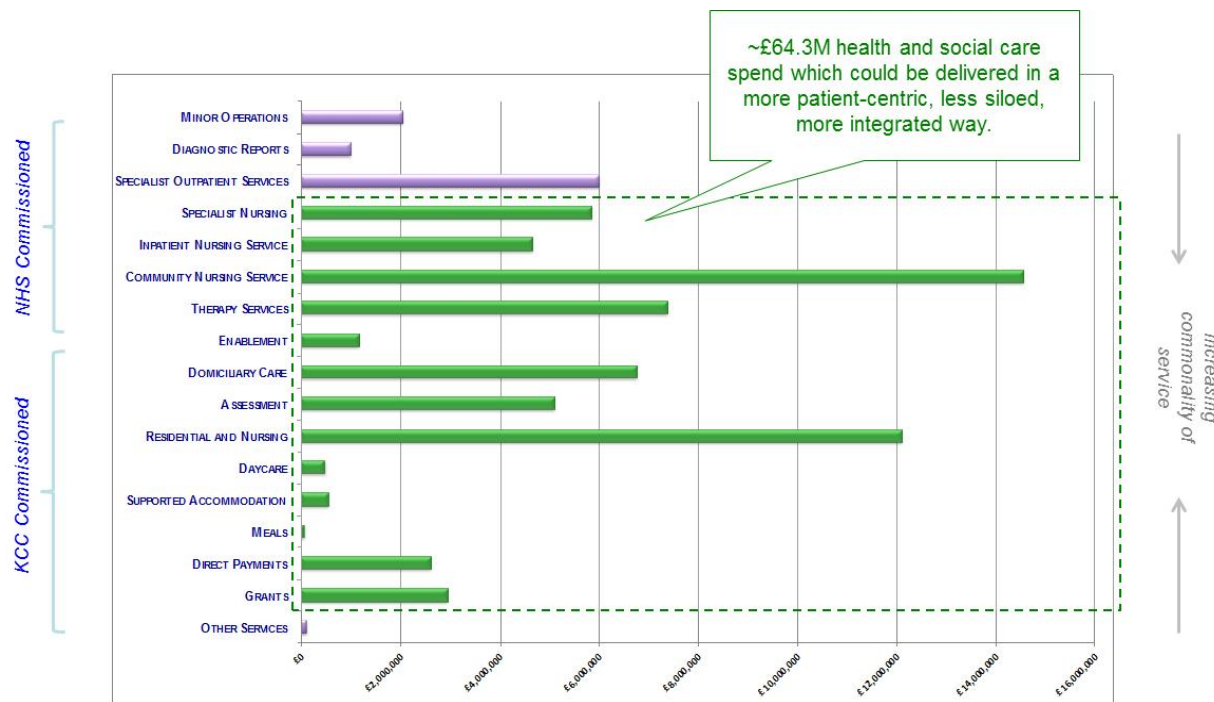
One of the attractions of this approach would be to liberate local communities enabling them to innovate in how care is delivered in order to meet local need allowing scope for different approaches to be developed in different areas. For the public and patients, community networks have the potential to offer accessible and responsive services that extend well beyond what is currently available in general practices. These services would have general practice at their core, with practices working hand-in-hand with a range of other services that people need to access from time to time. GPs would help people navigate through these services and would retain a key role in co-ordinating care in different settings.



The development of community networks will require some services to change to support the aims and vision we want to achieve, others will need stability.

All of our local partners will continue to experience considerable financial challenges and therefore our transformation programme is designed to generate significant efficiencies within the whole system of care to ensure that the health and care system remains sustainable and of high quality.

Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services as we spend the taxpayers' funding wisely. The schemes we have identified in our plan are about applying targeted investment to transform the system and improve outcomes for citizens and the entire care economy.



Example figures. These figures include both NHS Ashford CCG, NHS Canterbury and Coastal CCG as well as Kent County Council Adult Social Services

Building on a long history of joint commissioning of services, the Better Care Fund provides further opportunity to commission services together. Through the two approaches, set out below, we will deliver the transformation of health and social care – delivering the ‘right care, in the right place at the right time by the right person’ to the individual and their carers that need it.



Integrated Commissioning

We will design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services by apply a proactive, rather than a reactive, model that means the avoidance of hospital and care home admissions.

We will introduce community based co-design partnerships between local authority, social care, patients, carers, voluntary sector partners, healthcare providers and CCGs with strong links to innovation, evaluation and research networks.

These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.

We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense, achieving the shift from spend and activity in acute and residential care to community services

New procurement models will be in place, such as alliance, lead provider, key strategic partner and industry contracts, delivering outcome based commissioned services incentivising providers to work together.

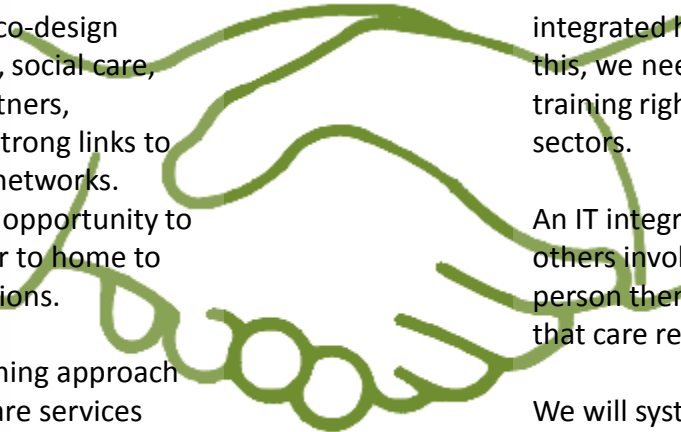
Integrated Provision

A model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community, primary & secondary care interfaces will become integrated.

We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors.

An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless.

We will systematise self care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.



By 2015

- Co-production of Community Networks will have commenced
- First Community Network established
- Cluster Teams established ensuring links with acute, mental health, end of life care, pharmacy, voluntary sector and other specialist input as appropriate. Teams working 7 days a week, in local communities.
- Reduced admissions to acute care, having worked in a planned and phased approach, working with the population identified by risk stratification.

By 2016:

- Two Community Networks established
- Patients will have access to a shared care plan so that they and their carers know about their care and local support, enabling them to live independent lives.
- Access services through a local referral unit with access to crisis teams and rapid response
- Patients with LTCs further down the risk pyramid are fully engaged in self care schemes and may also consider purchasing technology solutions for themselves

Within 5 years:

- All Community Networks fully established
- A fundamental change in how the health and social care system operates, but also in how practitioners operate within this and how workforce planning needs to accommodate integration.
- Reduced length of stay through integrated working in the A&E department to enable improved treatment for patients and support them to return home with effective health and social care support.
- Everyone coming through an MDT has an integrated anticipatory care plan – this plan not only identifies someone's needs should they go in to crisis but also supports self-care and contingency planning.
- Telemedicine and interactive technology used to reduce the need for patient to be in same physical space as carer or clinician before clinical care can take place.
- Through our digital engagement strategy, we will see a vast number of people in our communities benefiting from connected care using readily available technologies.



Our Vision:

We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.

General practice is widely recognised to be the foundation on which NHS care is based, Ashford is no different. General practice has a central role within our vision for the next five years, providing care alongside other NHS staff working in the community, voluntary sector organisations and colleagues in social care.

Whilst NHS England have responsibility for commissioning GP services through the national GMS and PMS contracts, general practice delivers significantly more services than ten years ago and this trend will continue with a proportion of this additional work transferred from traditional community or hospital bases. In order for this to be possible a number of changes in the way which general practice operates will need to occur.

This may require moving away from the current model of small, independently minded practices towards new forms of organisation that enable practices to work together and with other providers to put in place the networks of care that are required

Ultimately we anticipate that the outcome of this longer term approach will mean larger or federated practices offering more services, including Social Care, acting as the central hub for a wider variety of services and with improved access for traditional GP services.

By 2015:

- More patients will be managed in primary care with referrals only made when either access to more detailed diagnostics is needed or patients require specialist assessment.

By 2016:

- CCG commence Co-Commissioning of General Practice alongside NHS England
- Increased emphasis to be on General Practice seeing patients requiring home visits as early as possible in the day.
- Trial of roving GP scheme for home visits, reducing impact on individual GP practices.

Within Five Years:

- Individual practices, or groups of practices working together, delivering traditional GP services seven days per week



By 2015:

- Introduction of the Integrated Urgent Care Centres (IUCC) across each of our local acute hospital sites.
- Increase capacity in the Pulmonary Rehabilitation Service supporting patient self-management exercise groups

By 2016:

- New contract in place for GP “out of hours” services in April 2016 integrated with IUCC
- Falls pathway in place, linked to community networks, reducing the levels health and social care interventions required as a consequence of falls.
- Patients will have access to a shared care plan so that they and their carers know about their care and local support, enabling them to live independent lives.

Within Five Years:

- Community Networks providing high quality alternatives to urgent care services
- Reduction in emergency bed capacity and excessive periods of additional escalation beds.

Our Vision:

We want care that crosses the boundaries between primary, community, hospital and social care.

People using services and their 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. Furthermore, 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.

Traditional models of Urgent Care services have often been described as being highly fragmented and generate confusion among patients about how and when to access care.

The proposed model, working alongside the community networks, will bring services together to ensure that care will achieve a number of goals including a rapid multi-disciplinary assessment with 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 prevent a significant cohort of patients from having to attend hospital, improve recovery following an event and ensure that patients retain independence.



Our Vision:

We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.

Our approach to the management of patients with long term health and social needs also links with our vision for urgent care and our community based approach. The number of patients with long term needs is expected to rise due to an ageing population and certain lifestyle choices that people make.

We will continue our current approach of identifying patients requiring additional support through risk profiling. Risk stratification tools are utilised to support the identification of patients at risk and GPs are working locally with community nurses and members of the integrated health and social care teams (locally referred to as Neighbourhood Care Teams) to ensure Management Care Plans are developed to support and educate patients to manage their own conditions.

The expenditure on dementia care is expected to rise as the expected prevalence for dementia is estimated to be higher than the recorded prevalence. In response to the National Dementia Strategy in Kent, action plans have been put in place to deliver high quality services for people with dementia to ensure that 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.

In addition improved access to community support, including supported housing options and dementia friendly communities, will lead to patients being able to stay within their own communities for longer.

By 2015:

- Implementation of new outpatients model, following completion of 2013/14 public consultation .
- Increased rate of dementia diagnosis ensuring that patients and their families can access support at the appropriate time, improving their quality of life.

By 2016:

- Completed roll-out of “One-Stop Clinics” ensuring delivery of care in the right place, at the right time by the right clinicians
- Lead provider delivering evidence-based, outcome-based and innovative MSK Pathways
- Reduced fragmentation in cardiology pathways leading to improved health outcomes through earlier diagnosis and treatment of common cardiology and reducing the number of referrals and admissions.

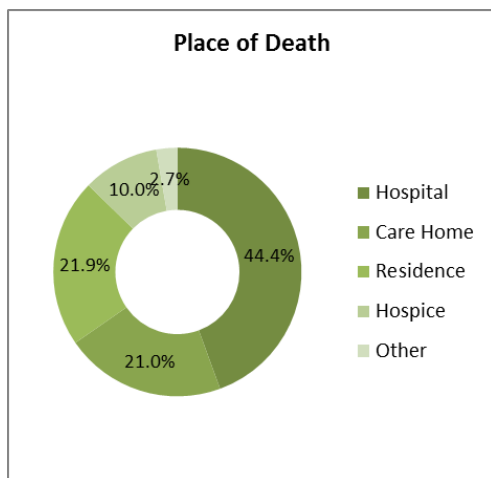
Within Five Years:

- Telemedicine and interactive technology used to reduce the need for patient to be in same physical space as carer or clinician before clinical care can take place.
- Improved overall patient experience of planned care services



Dying is an inevitable event. That said, the process of dying, a phase often referred to as "the end of life" can be puzzling and frightening to patients, their family and their carers. It can be hard to know what to expect, how to get help and to know that the help is right for you and your family. All care decisions must come from a shared partnership between the health and social care professional alongside the individual, family and carer. For those who do not have capacity for their choices, or may lose that capacity in the future it is important that the right choices are made as early as possible. Too often, the final stages of life are treated as an emergency as demonstrated by a National Audit Office report which highlighted that up to 40% of the people dying in hospital had no medical need which would benefit from further treatment.

Despite preferences that suggest otherwise, the acute hospital remains the most frequent place of death (44%) for the Ashford residents who die annually. This proportion has been steadily reducing but the disparity between preferences of place of death and the reality remains stark. Early identification of individual wishes is the most important factor in maximising the chance for patients and health professionals to plan adequately and ensure needs and preferences of individuals are met.



When diagnosed with a terminal illness, or entering the last stages of their life; patients, carers and their families will be offered the opportunity to discuss the type of care the individual would like to receive, and where they would like to be treated. Families will also be supported to have conversations regarding where they would like to die and what is important to them in the last days of their life such as discussions about pain relief, family issues, and spiritual guidance, for example.

Key outcomes:

- Reduction by 15% in the number of people at the end of their lives being inappropriately admitted as emergencies to hospital by April 2016;
- Reduction in the number of patients dying in hospital by 15% by April 2016;
- Increase by 15% in the number of patients dying in their normal place of residence by April 2016;
- Reduction by 15% in care home admissions for patients who are at the end of their life and who can be appropriately supported in their own home environment by April 2016



Improving the mental health and wellbeing of our population is a priority for the CCG. Parity of esteem is defined as 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.

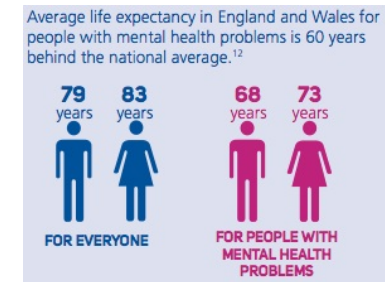
These deficiencies cannot be redressed solely - or even primarily - through greater investment, although it is crucial that mental health attracts greater priority in allocation decisions. Achieving parity between mental health and physical illness will require a fundamental change to the culture of healthcare, and in the way services are commissioned and provided.

The NHS needs to change fundamentally to meet the challenges of the future. Putting mental health on a par with physical health is an ambition that would transform the health service, enabling it to address the widespread prevalence of mental health disorders and the unacceptable inequalities experienced by those with mental illness.

50% of all people suffering with mental health issues experienced their first episode before the age of 14. By investing in early intervention and health promotion schemes for people with mental disorders the NHS can realise cost savings even in the short term.

“Crisis can happen at any time - two o'clock in the morning, Christmas Day - and people need help when it happens. I don't know what I would have done if crisis care hadn't been available to me when I needed it. You wouldn't say to somebody with a broken leg or a heart attack that they have to wait to see a doctor during office hours. It should be exactly the same with mental health.

We really need to close this gap and start seeing mental health as important, and in need of the same amount of care, thought and urgency, as physical health.”



By 2015:

- Integrated all-age pathway for ADHD, reducing need to transition across paediatric and adult services
- All age Eating Disorders improving 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

By 2016:

- Increased community based service provision with shared care between GPs and specialist services
- Everyone coming through an MDT has an integrated anticipatory care plan – this plan not only identifies someone's needs should they go in to crisis but also supports self-care and contingency planning.

Within Five Years:

- Improved collaborative commissioning arrangements, working with partners across health and social care which reduce health inequalities and achieve better outcomes for those with, and others working with, mental health and well-being services.
- Improved innovation in community based services that support individuals in managing their mental health problems without the need to be admitted to an inpatient bed

Our Vision:

We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities

As with the CCG's underlying principle, wherever possible, services will be community-based and close to where people live, to this end we are already trialling a scheme of delivering care alongside GP practices

Alongside the successful increase in recovery rates for patients through the talking therapy projects, we will improve recovery rates for those with mental illness referred to secondary care and we improve the management. We are determined to improve the experience of those with enduring mental illness whether it is schizophrenia, bipolar or borderline personality disorder or whatever.

We have already invested in increasing the number of inpatients beds locally and will now turn our attention ensuring that crisis teams are being effective to prevent admissions and that the quality of in patient care is optimised and that efforts are made to admit patients as locally as possible. Additionally we will ensure that patients requiring urgent support are offer the same four-hour guarantee as those seeking urgent care service for physical conditions.

We will identify mental health services where integration in the long term is most likely to deliver sustained clinical and financial value. We will enhance good mental health and wellbeing as part of the community networks in order to reduce the number of people who get common mental health problems, and lessen the stigma and discrimination associated with mental ill-health. We will ensure that prevention is targeted at those at higher risk but also that the right services are there when people need them.



Our Vision:

We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation

As our health profile demonstrates, NHS Ashford CCG will see significant growth in the child population during the next 7 years; however some of the largest increases will fall within the 0-4 age range, creating significant demands on paediatric services.

The current system within NHS Ashford CCG area is disjointed and parent carers have also stated that it is confusing and difficult to navigate. There are a range of access points within the health system for children, young people and their families including GP practice, minor injuries, A&E, Short Stay Paediatric Assessment Unit and out of hours, community children's nursing service, health visiting service and school nursing service.

Through our community networks, we will ensure the integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation. This approach is supported by national research and best practice in relation to developing a whole system approach to improving emergency and urgent care for children, young people and their families.

We will align our paediatric transformation programme, and whole system approach for urgent and emergency care for children and young people, with the wider transformation programmes outlined above to maximise impact and promote effective transition to adult services.

By 2015:

- Established improved access and support in place for mothers in early stages of their pregnancy .

By 2016:

- Increased rates of initiation and sustained breastfeeding
- We would also like to see targeted support on healthy eating in families leading to an increase in healthy weight levels.
- Ante natal and post natal maternity pathway improvements.

Within Five Years:

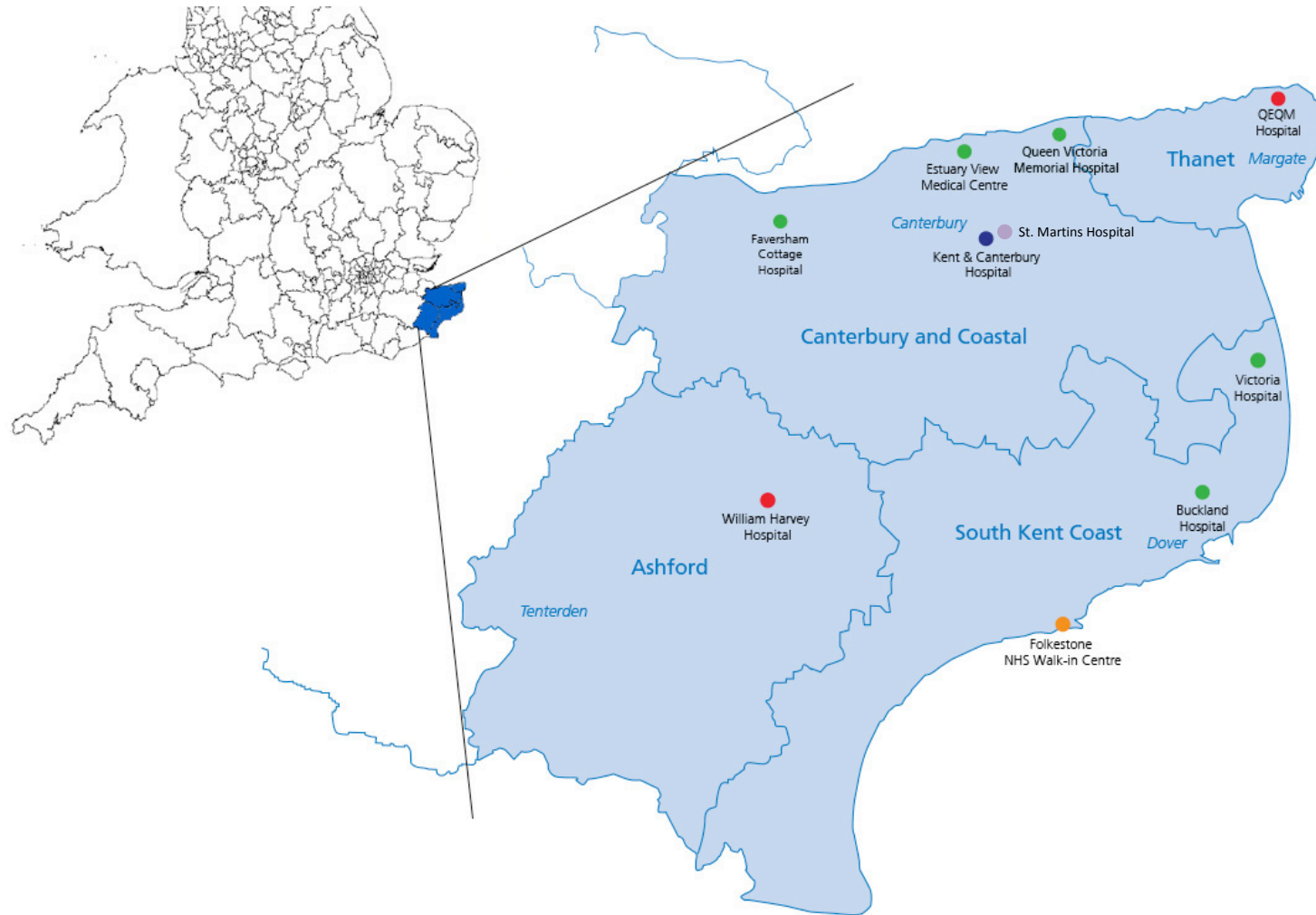
- Community Networks will ensure that children and young people with complex health needs are able to receive high quality, locally accessible community based support.
- All disabled children and young people, those with special educational needs are met through their individual Education, Health and Care Plan
- Parents and children are able to exercise greater choice and control through the use of a personal budget.
- Looked After Children receive high quality integrated care and are enabled to progress through the adoption system in a timely manner.

NHS Ashford CCG commissions services from a wide range of providers with provision well distributed across the patch. Quality and performance are good but not consistent across all providers. There is an increasingly diverse provider market but the local geography and poor transport links can limit the willingness and ability of people to travel to receive care.

NHS Domain	What services does this cover?	Who are our main providers?
Primary care	Predominantly traditional general practice services, however a number of GP practices offer a wide range of additional services including Minor Injuries, Ophthalmology, ENT, Cardiology and Minor Surgery	Our 15 GP Practices
Secondary Care (Acute)	Secondary (or 'acute') care is the healthcare that people receive in hospital. It may be unplanned emergency care or surgery, or planned specialist medical care or surgery	East Kent Hospitals University Foundation NHS Trust
Emergency Response	Ambulance trusts in England run the services that respond to emergency (999) calls for healthcare. These services are equipped to provide treatment at the scene of an accident. One ambulance service provider covers the whole of Kent, Sussex and Surrey.	South East Coast Ambulance NHS Trust
GP Out-of-Hours	Outside normal surgery hours patients may require a service normally offered by their GP, in this instance they are usually directed to an out-of-hours service. The out-of-hours period is from 6.30pm to 8.00am on weekdays and all day at weekends and on bank holidays.	IC24
NHS111	NHS 111 is available 24 hours a day, seven days a week. It can provide medical advice and details of the best local service that can provide care.	SECAMB in conjunction with Harmoni
Acute Mental Health Services	Unlike primary care services, which usually treat milder mental health problems, England's mental health trusts provide specialist care for people with more severe problems such as: severe and disabling anxiety, depression, obsessive compulsive disorder, schizophrenia, bipolar disorder, psychosis etc. Patients may also present a high risk to themselves, such as self harm or suicidal thoughts.	Kent and Medway NHS and Social Care Partnership Trust
CAMHS (Tier 1-3)	Tier 1: consists of non specialist services, for instance, common problems of childhood such as sleeping difficulties or feeding problems. Tier 2: consists of specialised support to other professionals around child development; assessment and treatment in problems in primary care, such as family work, bereavement, parenting groups etc. This also includes Substance Misuse & Counselling Services. Tier 3: consist of specialist multi disciplinary teams for more complex issues such as development problems, autism, hyperactivity, depression, early onset psychosis	Sussex Partnership Trust
Community healthcare	Wide-ranging NHS care for people, in their community, in a range of settings including people's own homes, nursing homes, health clinics, community hospitals. Services include, specialist diabetes services, cardia rehabilitation, continence support and advice, Epilepsy Specialist Nursing Team, Sexual Health (including contraception, GUM and young people's services) and educational nutrition and dietetics sessions.	Kent Community Healthcare NHS Trust
Specialist services	Specialist services such as transplantation, HIV and AIDS treatment, paediatric neuro- surgery and specialist cancer care. Tier 4 CAMHS consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated	Guys and St Thomas' NHS Foundation Trust Kings College Hospital NHS Foundation Trust South London and Maudsley NHS Trust (CAMHS Tier 4) Royal Marsden University College London
Hospice Care	Patients can access a range of individual or group activities which aim to support them in all areas of daily living from managing symptoms and planning for future needs, developing new skills and interests and meeting others. This offers patients and carers the information and support they need to continue leading an active and independent life in the community for as long as possible.	Pilgrims Hospices
Other services	This covers a wide range of services, such as; <ul style="list-style-type: none"> • Drug and alcohol services. • Hearing aid services. • Support for carers. • Support services for patients suffering from long term conditions. • Physiotherapy services. 	Predominantly smaller providers including the voluntary sector and General Practice



The four CCGs in East Kent serve a population of approximately 659,000, with a combined budget of £831m. Services are commissioned from a number of different sites, including 88 GP practices, the main sites though are detailed below:



On the basis of population growth and CCG allocated funding projections, the gap between available funds and expected health costs will be as follows

	2018/19 Gap (Budget Share)	2018/19 Gap (Demographic Forecast)
NHS Ashford CCG	£24 million	£27 million
NHS Canterbury & Costal CCG	£44 million	£49 million
NHS South Kent Coast CCG	£47 million	£52 million
NHS Thanet CCG	£35 million	£40 million
East Kent Total	£151 million	£168 million



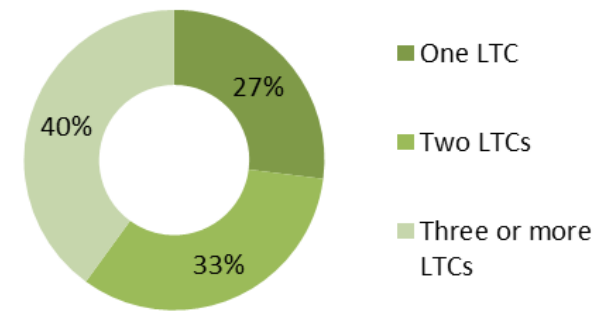
Evidence indicates that in cases where patients have more than one Long Term Condition (LTC) the associated cost of treating their conditions is compounded by their co-morbidities.

Evidence from the Department of Health estimates that the average health and social care cost per person per year increases with number of LTC:

- no LTCs, average health and social care cost per person per year approx. £1,000;
- one LTC, average health and social care cost per person per year approx. £3,000;
- two LTCs, average health and social care cost per person per year approx. £6,000; and
- three or more LTCs, average health and social care cost per person per year approx. £7,700.

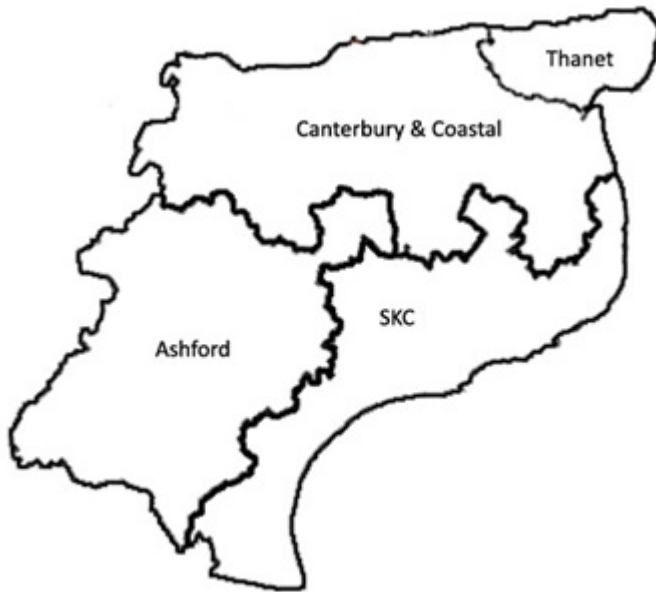
Furthermore, research outlines that 25% of over 60s have 2 or more LTCs. It is clearly important to consider the potential impact on cost of the health economy for the East Kent Planning Group of co-morbidities of LTCs.

Proportion of emergency admissions in East Kent where patients have at least one LTC



Demographics:

- Older patients tend to have longer spells and are readmitted more frequently after a first hospital spell
- Based on recent trends, the proportion of the population requiring mental health services will increase, especially for people over 65
- The number of people with Long Term Conditions will increase with population growth
- Ageing is a fundamental factor, as the prevalence of LTCs is up to 6 times higher in over 65s than in under 65s
- Patients with LTCs have been recently estimated to account for 70% of the total health and care spend in England



A key element to the development of more joined up patient care will be effective communication between clinicians in different areas of the health system. The local governance arrangements have allowed our strategy and plans to be shaped through continued membership engagement and support.

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.

- Clinical Forum – Enables clinical discussion to explore areas where the four CCGs can work together in the development of strategy.
- Federation Forum and Whole System Board – Provides strategic oversight of the collaborative work across East Kent.



Part of our five year ambition is to ensure that we have specific, appropriate contracts that allow us to act fast on behalf of the patient when services do not meet the standards which our population expects and demands. Although contract management may be seen as operational rather than strategic – the impact it has had on our strategic outcomes means that this is a key enabler for us in delivering the outcomes set out in this Plan. As we move towards new contract mechanisms, whether alliance, lead provider, or Special Purpose Vehicle, we have laid the foundations for both risk and benefit sharing with our main providers, through the following contractual developments:

East Kent Hospitals University NHS Foundation Trust

Local arrangements are being negotiated that will embed (and assure) delivery of acute elements of the CCG's QIPP programme as well as incentivising the provider to go further by sharing some of the benefits. This approach will also reduce some of the risks inherent in the acute contract that has been in operation throughout 2013/14. Further changes to the plan are expected once the approach is agreed.

Kent Community Health NHS Trust

East Kent CCGs are moving away from the traditional block agreement towards a re-allocation based upon usage of community services. Whilst not ready for cost-per-case procurement, the re-based block better reflects the reality of service provision. This creates a cost pressure of £2.4m in 2014/15 (subject to change), although the effect is mitigated if considered across both Canterbury and Ashford CCGs.

Kent and Medway Partnership NHS Trust

Work is on-going to derive PBR based costs and tariffs for mental health services in Kent. Although not ready for live implementation, CCGs may agree a movement towards a fairer usage base in 2014/15. Currently a cost pressure of £0.9m is assumed for this change, although it may be revised when contract negotiations are concluded.

The View Across East Kent: Future Model of Provision

Primary Care

Whilst the 4 CCGs in East Kent have slightly different models for future primary care and community service delivery (community hubs; proactive care & universal teams) they share many common characteristics and all have the patient and GP at the centre.

The CCGs believe the ability to commission high quality primary care is a fundamental building block which enables delivery of their plans. As a consequence, there is strong interest in co-commissioning of primary care which ranges from as desire to commission jointly to wishing to explore the possibility of delegated commissioning responsibility.

Specialist Centres

East Kent CCGs vision is to commission services for those people who need treatment at specialist centres with the right facilities and expertise in order to maximise chances of survival and a good recovery, as close as possible to where they live.

In order to achieve this, discussions will be progresses across a Kent & Medway wide planning footprint as engagement with NHS England including specialised commissioning and Strategic Clinical Networks (SCN).

This will involve a strategic review of services, such stroke and vascular care, where a K&M or wider approach would benefit.

Additionally, we are keen to establish the repatriation of services which now lend themselves to more local delivery

Acute Care

Compared against peer groups both locally and nationally, our main acute provider performs favourably against a number of key metrics connected to operational activity and clinical outcomes.

However, a number of challenges will emerge over the longer term, and it is within this context that our main provider, East Kent Hospitals NHS University Foundation Trust (EKHUFT) commenced the development of an outline 5-10 year strategy 'Looking to Our Future', identifying key levers, drivers and their interrelationships, with a set of strategic options that illustrate the potential impact of those options on activity and the financial position of the organisation.

With the implications of our five year strategy, outline in this plan, it is clear that activity levels across the acute sector will reduce and therefore this will have an impact on how services are configured across EKHUFT's estate. Some of the activity reductions may create capacity for EKHUFT to respond to the CCG desire to repatriate services from London centres.

Part of the rationalisation has already commenced with a public consultation on the transformation of outpatient services. However it is clear that further developments will follow, specifically with regards high risk general elective and emergency (abdominal) surgery and the development of Integrated Urgent Care Centres outlined elsewhere in this plan.

Community Services

Kent Community Health NHS Trust (KCHT) are transforming their services so that they meet the future health and financial challenges. This programme of work, known as “The Human Touch”, is will lead to an improvement of services in five major ways:

- Transforming models of care – to be more integrated and patient focused. Helping people to remain living at home at times of vulnerability, rather than see an unwanted, costly and unnecessary hospital admission.
- Transforming the times and places where care is provided – moving away from traditional health care settings to offer more services either within people’s own homes or close by in friendly, community venues, making good health part of everyday life.
- Transforming the workforce - developing generic roles across directorates and functions, for example combining elements of the health care assistant role and the health trainer role to support the long-term conditions pathway.
- Transforming clinical support systems – offering better access for patients and more efficient ways of working for through technology.
- Transforming partnerships – alongside the CCG community networks, integrating health and social care teams, developing innovative joint solutions to support wider health and social care system transformation.

Mental Health

Kent and Medway NHS and Social Care Partnership Trust has embarked upon the implementation of a significant transformation programme which will support the delivery of excellence in all that the Trust does. This includes:

- **Improved recovery** through the implementation of community wellbeing centres and primary mental health care workers delivered in partnership with community networks thereby delivering a more seamless pathway of care and a more holistic approach to recovery.
- **Clinical Strategy** which aims to provide excellent community services close to home reducing the number of people who need inpatient care.
- **Organisational Development Strategy** which aims to ensure that we are not only an employer of choice but that we support the continued growth and development of all of our workforce to ensure that they have the skills to deliver excellence in all that they do.
- **Service User and Carer Engagement Strategy** which aims to ensure that we have a comprehensive range of approaches to engaging with service users and carers
- **Estates Strategy** which aims to ensure that all of our facilities provide a high quality therapeutic environment for service users and carers.
- **Information Communications and Technology [ICT] Strategy** which aims to promote the delivery of services through mobile technology.



The CCG are keen to work in partnership with major providers to ensure that we can protect essential services for our local population. However, we expect to see a shift towards more integration between provider and an increase in health and social care community providers. Within that context we will develop a local market where there is only a plurality of providers where appropriate and where that doesn't undermine the underlying system vision of integrated services for our patients.

To facilitate a transformation in care, we will increase capacity in the community to manage a larger cohort of patients; embrace technology to support delivery of the urgent care strategy and enhance communication across Health and Social Care.

In any provider market we wish to develop an environment conducive to high quality training, for *all* providers, which ensures that our patients will receive the highest quality of care both clinically and non-clinically.

The CCG inherited many difficulties on being authorised regarding contracts and how contracts were managed together with a real difficulty in being able to set KPIs with our supporting services, as both organisations were only just starting. Many of these issues had an impact on the quality of services and outcomes for our patients – we have been able to address many of these during our first year.

Part of our five year ambition is to ensure that we have specific, appropriate contracts that allow us to act fast on behalf of the patient when services do not meet the standards which our population expects and demands. Although contract management may be seen as operational rather than strategic – the impact it has had on our strategic outcomes means that this is a key enabler for us in delivering the outcomes set out in this Plan.



A key area of patient concern and feedback related to our desire to integrate services and the consequent need for clinical information systems to talk to each other. Our patients were keen for us to identify a method which would ensure that whoever saw them had access to their relevant medical information, provided this was secure.

The MIG has been developed by providers of GP Systems and allows controlled real time access to some details in GP Record for other local providers;

1. **Summary** (including current problems, current medication, allergies, and recent tests)
2. **Problems view**
3. **Diagnosis view**
4. **Medication** (including current and past prescriptions, and issues)
5. **Risks and warnings**
6. **Procedures**
7. **Investigations**
8. **Examination** (blood pressure only)
9. **Events** (consisting of encounters, admissions and referrals)
10. **Patient demographics**

The MIG currently works with the GP systems currently in use across our GP practices and can work with the local GP Out-of-Hours service, our local hospitals and the “Share My Care” system.

Only clinicians with valid credentials from an organisation which has been given access, the GP practices, and with a valid reason to view a patient’s record will be able to access information. Even in this scenario, at the point of access patient consent will be required.

Patient Consent

The patient consent model is as follows:

- Access will only be available to clinicians from an organisation with access. They must have a Smartcard log-in. Log-ins will be audited by trusts under their existing policies.
- The clinician, with a **legitimate relationship** with the patient, and **while the patient is with them**, will ask explicit consent to view the detailed care record. Patients have the right to refuse and this will be recorded for future reference.
- In the event of an **emergency** or other instance where the patient is incapacitated and cannot give explicit consent, the clinician will be required to give a reason for viewing, and an alert will be triggered to the Caldicott Guardian.

The GP Clinical Leadership in Commissioning (CLIC) rotation is an innovative or integrative GP training post (ITP). ITPs 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.

Testimonials

"I feel that because of being placed in the Commissioning rotation, I was able to think more clearly about individual patient management beyond the consulting room and into the need for referral, prescriptions, costs of services, sick notes, social aspects, family dynamics, access to the services and needs assessments. I was able to put these together with the commissioning angle which I was exposed to sitting in some of the meetings at the CCG where pilots were being approved and the cost and implications of new services were being discussed."

"I plan to work as part of the CCG."

"I was able to realise that clinical assessment and management of patients forms only one point on a list of important skills that was expected and needed to face the challenges of current NHS."

"I feel that there is a strong case to argue that this should become a standard part of training as a formalised rotation across the country; as important as Paediatrics or Psychiatry rotations within General Practice. The future of General Practice lies in the hands of trainees who are not able to appreciate the importance of engagement in designing and implementing services for safe and effective NHS. They are likely to suffer from the tunnel vision of Clinical and Communication skill acumen alone as important skills a GP will need in the future, where clearly these form only part of the arsenal of skills required."



Creating Social Value means increasing the social, economic and environmental wellbeing of the people we serve.

We will develop a strategy which sets out our approach to implementing the Public Services (Social Value) Act 2012. It will detail the potential of the Act to support NHS Ashford CCG goals, the legislative and ethical imperatives to address social value and that a phased approach to implementation will be taken, which seeks to continuously improve effectiveness.

This strategy will define our first approach to embedding social value and is intended to guide and communicate our commitment to local NHS staff, patients and public, providers, partners and other stakeholders.

Social Value presents a useful framework for NHS Ashford CCG to achieve its goals and meet commitments as set out below...

Strategic and Corporate opportunities to...

- Reduce health inequalities
- Improve health outcomes
- Increase value from commissioning investment
- Use commissioning influence to improve health outcomes

Legislative and corporate requirements

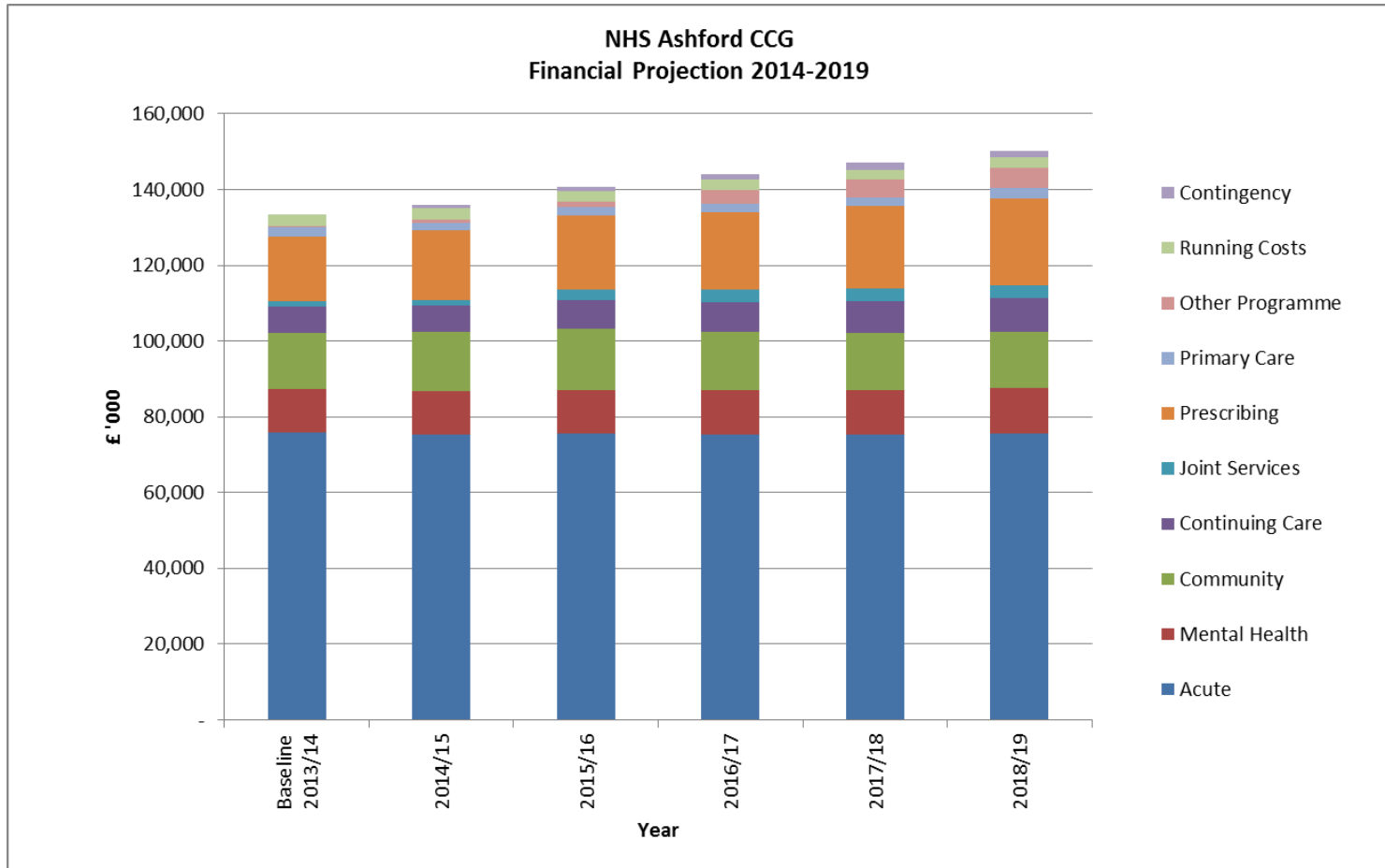
- Public services (social value) Act 2012
- Climate Change Act
- Civil Contingencies Act
- CCG Assurance re Capability and organisational health and Domain 4(e) Environmental & social sustainability
- NHS Sustainability Strategy Nationally

Social Value should...

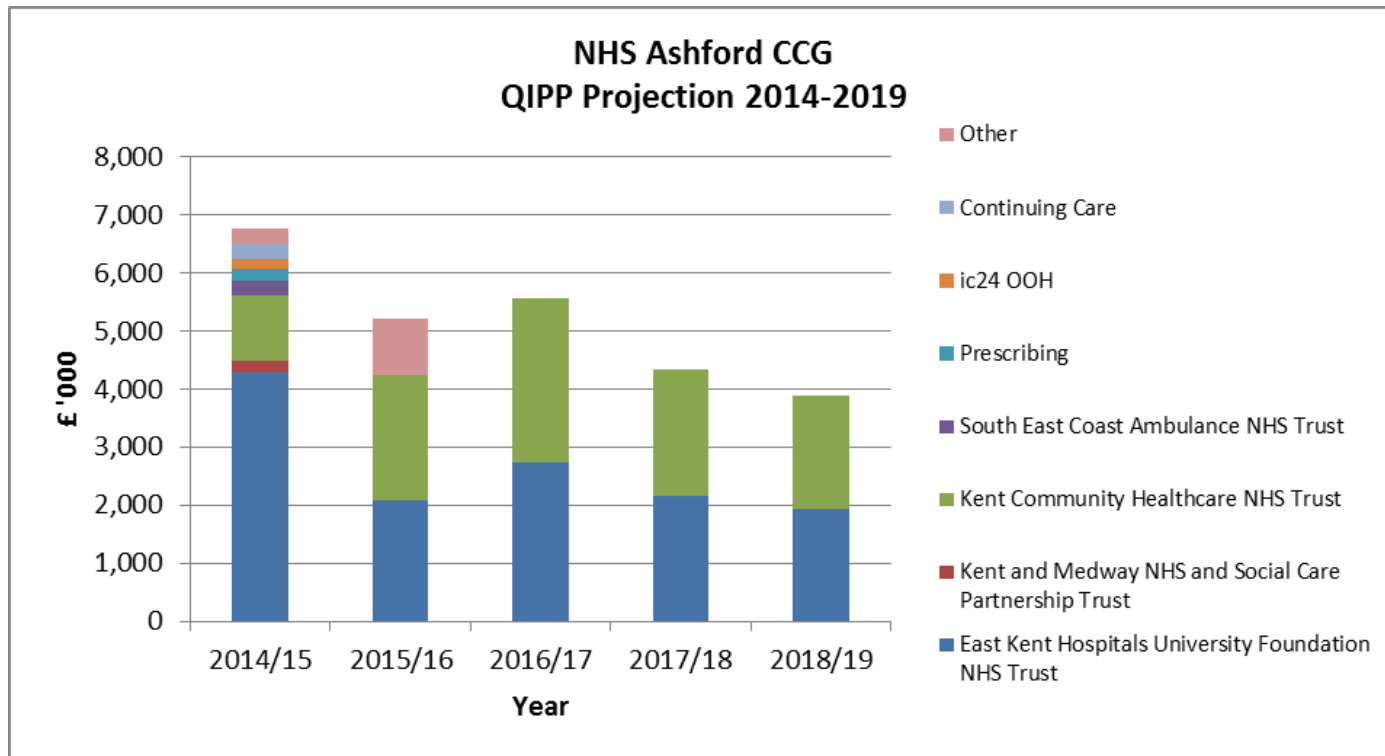
- Reflect and deliver CCG Vision, objectives and values and support improved health outcomes
- Influence local health economy, healthy population
- Provide leadership for a town wide approach



The CCG budget for 2014/15 is £133m and we are expecting growth on this budget to decline over the 5 year strategy period leading to a budget of £150m in 2018/19. 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 majority of the 2% strategic change funding to support this position.



These are efficiencies that are the direct responsibility of the CCG. NHS financial allocations are expected to rise by around 0-1% each year over the next five years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth would continue at around 6% a year because of the ageing population, new medical technologies and rising expectations. System wide QIPP programmes are the actions required to keep overall growth at an affordable 0-1% level rather than the historical 6%.



PERFORMANCE INDICATOR	Metric	Baseline	2018/19 Target
Securing additional years of life for the people of England with treatable mental and physical health conditions.	PYLL (Potential years lives lost) per 100,000	1507.9	1229.5
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 EQ5D tool in the GP Patient Survey).	75.20	76.0
Reducing emergency admissions	Total emergency admission for the any of the conditions considered avoidable per 100,000 population	1584.0	1540.8
Number of C.Diff Infections	Calculated annually based on previous year	TBC	24 (in 2014/15)
Increasing the number of people having a positive experience of hospital care.	The proportion of people reporting poor patient experience of inpatient care	139.9	137.8
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.	The proportion of people reporting poor experience of General Practice and Out-of-Hours Services	7.1	6.2
Dementia Diagnosis	% of people diagnosed as proportion of anticipated prevalence	40.1%	75.0%
Access to Psychological Therapies	Proportion of people having attended two treatment contacts and a moving towards recovery	TBC	55.0%



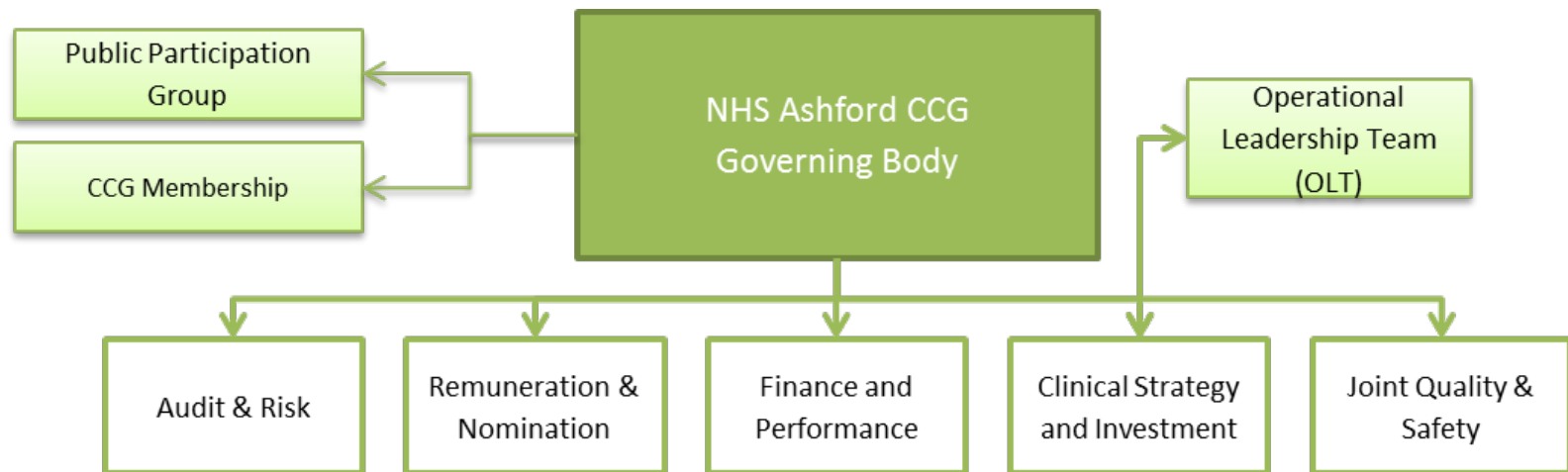
The Next Two Years

2014 – 2016

Operating Plan

To ensure that NHS Ashford CCG remains focused on delivery of its plans throughout 2014/19 and beyond we have implemented 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 and Investment committee meetings



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



The objective of organisation development is to improve the organisation's capacity to succeed in its goals. It seeks to facilitate improved interpersonal and group processes, more effective communication, enhanced ability to cope with organisational problems, more effective decision-making processes, more effective leadership style, improved skill in dealing with conflict, and higher levels of trust and cooperation among members of the organisation. An OD approach places strong emphasis on assessing issues and challenges using robust diagnostic techniques; not making assumptions or too-quick judgments on the solutions to problems.

Building a new vision with supporting strategy and policies

The CCG will build a clear and deliverable vision of how we will transform clinically services and ensure that our plans are strategically aligned with local health and social care commissioners to effect a whole system transformation.

Central to our vision is ensuring clinical leadership of service transformation and services are reformed and reorganised so that both community services and strengthened primary care, integrate with out-of-hospital services to meet patients needs.

We will ensure that our plans are strategically aligned with other health and social care partners and key stakeholders and partners are committed to delivering the our plans.

All of the above needs to be more than aspirations for the CCG and its Governing Body. We will put in place process to ensure the Governing Body's vision is owned by its membership and used to underpin and drive strategic change.

People and Behaviour

In the outline approach we have created Town Teams that will enable the local leadership of the commissioning and transformation of local services, as defined in the community . The new Town Teams operate a matrix model of working where accountability without control and influence without authority will become the normal way of working:

Each Town Team will be provided with the commissioning resources to scale up local services at pace within the overall strategic direction set by the CCG.

To support the devolution of resources and responsibility we will ensure that our systems are clear and credible and deliver improvement to quality and productivity. We will do this by having in place processes for tracking and monitoring outcome based commissioning.

Governance systems will be robust, clinically led and properly constituted. They will operate with complete transparency and accountability and be rigorous enough to withstand challenge. As a commissioning organisation we will remain accountable to our local community.



Ashford CCG and Canterbury and Coastal CCG are in their second year as stand alone commissioning organisations. Both organisations are able to demonstrate a track record of success but in their first year of operations did not deliver enough of what they planned to do. This was against a backcloth of an increasingly complex range of stakeholders who need to be engaged in the planning and delivering services.

Both CCGs recognise that they need to find better ways of working with Local Authority stakeholders and with communities, patients and their carers as co-producers and deliverers of care and that this will require a different kind of commissioning organisation that is more responsive and adaptable

The CCGs also recognise that 2014/15 and beyond brings even greater challenges for the CCGs as commissioners. Maintaining the status quo is therefore not an option and the longer organisational restructuring/change is delayed the more difficult it will become.

Merging with Canterbury and Coastal CCG

The membership of Ashford CCG and Canterbury and Coastal CCG are being consulted on a proposal to merge the two organisations. The membership understand the risks of merger through losing local focus and further distancing of local practices from a larger organisation but also understand the risks of not merging:

- The CCGs being limited in their ability to invest additional resources in Town Teams to support primary care in commissioning and provider effort
- Potential gaps appearing in clinical leadership roles that go unfilled
- Continued dilution of senior management team effort by having to operate two CCG
- Loss of focus through operating and delivering two separate commissioning teams
- Opportunities to manage financial risk reduced because of small size of existing CCGs
- The risk that if one CCG begins to fail, critical senior management time is diverted to fire fight thereby compromising the stability of the other

Stakeholder Survey

In March 2014 Unlocked Development surveyed stakeholders on their views on a merger of Ashford CCG and Canterbury and Coastal CCG. Stakeholders included CCG representatives, Local Authority Councillors, Local Authority Officers, Area Team, Local NHS Providers and Local LMC.

In summary the surveys key points are:

- Stakeholders expressed no opposition to the idea of merger and most could see no downside to the idea
- Nearly all recognised the need to achieve economies of scale in commissioning and contracting and recognises that a merged organisation will have more commissioning muscle and leverage with providers
- The need to ensure that effort and resources put into delivering the merger does not distract from delivering business as usual
- The importance that the merger is happening for the right reasons
- Appropriate Governance arrangements were seen to be critical

Overall responsibility for quality lies with the NHS Ashford CCG Governing Body, it is driven by the Chief Nurse and the CCG Quality Committee to ensuring that high quality safe care is at the forefront of the organisation.

NHS Ashford CCG aims to put the patient at the centre of all that we do and as such believe that quality underpins all that we strive to achieve.

The Chief Nurse provides assurance to the Governing Body at every meeting in relation to:

Patient Safety

Health Care Associated Infection (HCAI), safeguarding reviews and Domestic Abuse; safe workforce; serious incidents and never events, quality accounts, intelligence and risk, National Safety Thermometer

Clinical Effectiveness

NICE compliance, research and development, mortality data, medicines management, clinical pathway quality reviews, clinical audit, staff training and development

Patient Experience

Patient Experience (feedback), Commissioning for Quality and Innovation (CQUINS), CQC compliance, Safe Care and Compassion, Complaints

Our Aims

- All patients/users experience dignified and compassionate care.
- We listen to any concerns of the public, patients and carers and use their feedback to inform our decision making.
- To maintain and improve the safety and effectiveness of all commissioned services, and ensure that they meet the necessary standards of quality, and enhance the patient experience.
- To deliver on the national and local health outcomes priorities for 2014-19 and beyond.

Our Approach

- To use hard and soft intelligence to identify risks to patients and staff and understand at an early stage if there are any concerns in any service or provider organisation.
- To promote a culture of transparency,
- To develop a robust schedule of Quality visits to all providers
- To harness shared learning within the CCG for the benefit of all parties.
- To maintain and promote access to all, ensuring services help to reduce social inequalities and improve access for vulnerable or excluded groups.
- To ensure that the right quality governance mechanisms are in place to provide assurance



Our approach to quality has been informed by 3 key national quality reports following incidents at Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital.

Francis Report

NHS Ashford CCG will, through its governance and assurance process, secure an effective whole system response to the Francis enquiry reporting to the Governing Body on how it is responding to the five main principles of:

- Fundamental standards of care where non-compliance should not be tolerated
- Openness transparency and candour in every healthcare organisation
- Proper standards of nursing care ensuring that no one should provide hands on care that is not properly trained and registered.
- Strong patient-centred leadership where local leaders are held to account for failures.
- Accurate and useful information available to demonstrate compliance with fundamental standards.

The CCG will expect providers to:

- Develop and refresh action plans underpinned by the recommendations of Francis (2013). These will be presented at the Quality Meetings that are held with providers.
- Demonstrate that nursing, midwifery and care staffing are underpinned by the recommendations made by the National Quality Board: *How to ensure that the right people, with the right skills, are in the right place at the right time* (2013).

Berwick Report

Following the Francis Report, Don Berwick led a national advisory group around Patient Safety. The report details the specific changes required in the NHS as a result of the Francis and Keogh inquiries; Four guiding principles fall out of this report;

1. Place the quality and safety of patient care above all other aims for the NHS
2. Engage, empower, and hear patients and carers throughout the entire system, and at all time
3. Foster wholeheartedly the growth and development of all staff
4. Insist upon, and model in your own work, thorough transparency

NHS Ashford CCG will undertake to support the recommendations made by Berwick, (in summary):

- Placing the quality of patient care, especially patient safety above all aims.
- Fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.
- Embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

Winterbourne Report

The Winterbourne Report is a national response to Winterbourne View Hospital following the uncovering of years of physical and psychological abuse of patients with learning disabilities (LD) and challenging behaviour

- Highlighted the need to stop hospitals becoming homes for LD patients
- CCG responsible for jointly reviewing with local authority partners all patients in NHS funded in-patient LD facilities
- CCG responsible for finding supported community placements with appropriate personal care planning in place for these patients

NHS Ashford CCG is committed to implement the recommendations of Winterbourne View findings.

A Kent Winterbourne Working Group involving Kent County Council, Kent and Medway Partnership NHS Trust and Kent Community Health NHS Trust has been established to consider the current and future need and demand for specialist community and in-patient services for people with learning disability or autism.



Safeguarding

Maintaining a focus on safeguarding for the most vulnerable groups is a priority concern for NHS Ashford CCG and the organisation will work in partnership with all stakeholders to ensure statutory responsibilities are undertaken as effectively as possible. In particular:

- To host designated safeguarding leads for both adult and child within the CCG with direct access to the chief nurse to share and escalate concerns.
- Quality In Care homes project
- To host CAF (Common Assessment Framework) completed by health Services on behalf of vulnerable children and families.
- Learning disabled residents care and placements are reviewed in response to the Winterbourne View Findings.
- Chief Nurse ensures the CCG has a designated representative to the Safeguarding Adults Board and Health Safeguarding Group (a Sub group of Kent Safeguarding Children Board)
- Designated doctor for safeguarding children and a designated paediatrician for unexpected deaths in childhood provide CCG advice and support
- Assurance in place for providers meeting safeguarding child and adult training.

We will continue to work closely with our local authority partners to continually improve the safeguarding of children and vulnerable adults and to continue to be active members of the local safeguarding boards to maximise opportunities for greater coordination and integration of adult and children's safeguarding arrangements

Hospital Acquired Infections

We will continue to reduce the number of Health Care Associated Infections (HCAIs) through the implementation of local action plans and we remain committed to a zero tolerance approach. We will employ expert resource in this field to bridge the gap between primary and secondary care and ensure that learning can be embedded throughout the health and social care sector.

Management of Serious Incidents (SI) and Never Events

All Serious Incidents and never events are reviewed and discussed by the quality committee. The administration of these is supported by KMCS to allow Kent wide learning and early identification of any trends. The CN together with the Quality Lead monitor these alerts and ensures the providers act accordingly to review and understand the root causes of the SI and ensure that action plans are in place to minimise recurrence.

We will encourage a culture of transparency, openness and candour across the health system, to ensure that staff, patients and carers feel safe and secure when raising concerns and that we learn from patient safety incidents and 'never events' to prevent them from happening again.



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..

Freedom of Information (Fol)

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

From

“I do not know who is in charge of my care”

“It would be helpful if the different people involved in my care talked to each other and knew what the others were doing”

“I panic when I have a crisis, who should I contact? Will they know my wishes?”

“I feel that I need to depend on others for my care and cannot live my own life, independent.”

“When the consultant or nurse discharges me, I don’t know what happens next.”

Change Project

- **Integrated Urgent Care Service** – Multi-disciplinary service within hospital consisting of GP, Hospital Specialists, Mental Health and Health and Social Care Teams. Improving the co-ordination and flow of patients through the urgent care system, with 24/7 care co-ordination centre and enhanced ambulatory care services.
- **Cluster Teams** - Extend Cluster Team approach, offering extending hours
- **Enhanced Support to Care Homes** – An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes
- **Mental Health** – Primary Care MH Specialist pilot, Community link workers in primary care, Targeted community development work
- **Winterbourne** – Implementation of joint plan with KCC, discharge of patients currently within in-patient facilities to community placements with providers able to support people with complex needs
- **End of Life** – Improved co-ordination and timeliness of care, Palliative care education programme, Increased specialist bereavement counselling service, Procurement of system wide electronic palliative care system
- **Falls Pathway** – Implementation of falls pathway to include prevention, treatment and ongoing support

To

“I feel confident that I am in control of my own care, supported by my GP”

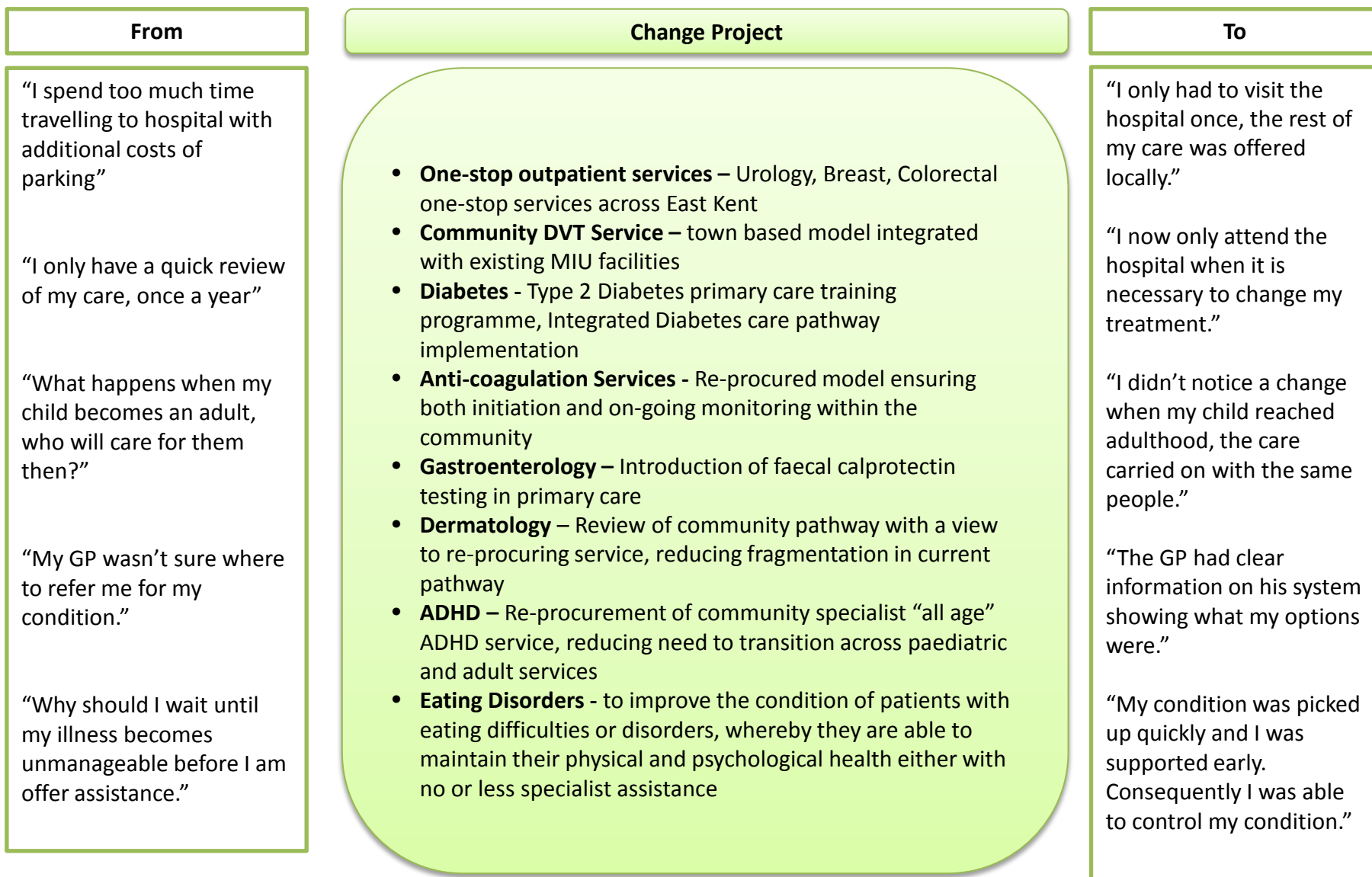
“Everyone seems to know what is happening with my care. Clearly they talk to each other.”

“I had the details of a single contact and everyone else could see my preferred treatment options electronically.”

“I am supported to live my life how I wish because I know that support is there when I need it.”

“Whenever I had to see someone new, there was a plan for my care and they could see my records”





From

“I needed help last night when my carer had to go into hospital. I cannot cope alone with my dementia.”

“When I had problems in my pregnancy, I had to go to A&E, this really wasn’t where I wanted to be.”

“All we needed to Mum to go home was the right equipment. This took days to arrive and so she was stuck in hospital”

“Why do I always have to go to hospitals for my eyes when there is an Optometrist down the road?”

Change Project

- **Dementia** – New out-of-hours service for older people with Mental Health problems and Dementia
- **Early Pregnancy** – Improve awareness of pathway and services to reduce the level of EPAU in A&E
- **Transformation of Acute Children’s Services** - New urgent and emergency care clinical network for children and young people, using assistive technology. Working with Public Health and the School Nursing Service to deliver key messages in schools.
- **Cardiology** - Reducing fragmentation in the patient pathway. To improve health outcomes through earlier diagnosis and treatment of common cardiology conditions offering better clinical effectiveness and increase quality of service
- **Community Loan Store** - Procure joint social and health care loan store service, implementing seven day working offering a faster, more responsive, service appropriate to patient need
- **Ophthalmology** – Review of hospital eye services with a view to re-procurement of specific pathways suitable for management in the community. Macular Oedema – A central acute site to deliver treatment and drug administration, with hub and spoke community model to provide monitoring

To

“When my carer was admitted, the NHS stepped in to make sure I had support.”

“I was able to access the Early Pregnancy Unit and had my scan took place straight away. ”

“The equipment turned up the next day and Mum was back home where she wanted to be.”

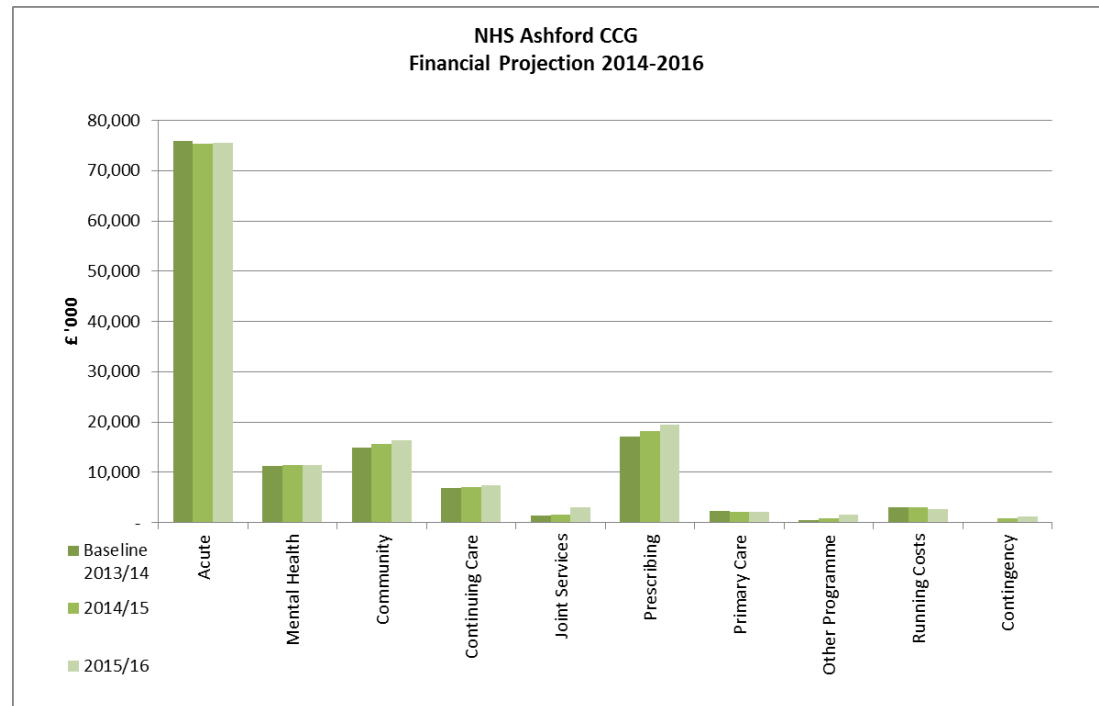
“I saw the consultant for my eye problem once and now I go to see my usual optometrist and that is so much more convenient.”



In 2014/15 and 2015 /16 the main challenge and risk concerns delivery of planned benefits from new quality, innovation, productivity and prevention (QIPP) schemes totalling £6.7m and £5.2m respectively and accounting for over 5% of the resource limit (after the full year effects of previous schemes are added). The key themes include integrating health and social care as well as providing an integrated urgent care service to navigate the health system for the benefit of patients, whilst avoiding unnecessary admissions. Several projects underpin these key strategic aims and the CCG is establishing a rigorous programme management process to ensure delivery.

Contingency

It is assumed that the contingency will be absorbed during the year to support the CCG's positions around its main contracts. Although potentially leaving little headroom for unexpected risks, this should be significantly mitigated by the nature of the agreement with EKHUFT currently being negotiated. The CCG also has to absorb a £0.9m contribution to the NHSE risk share pool in respect of legacy CHC provisions.



Better Care Fund:

The CCG is setting aside £2.5m in 2014/15 to enable key projects for the Better Care Fund. There is a close relationship with the QIPP programme and an emphasis upon initiatives to join up health and social care. In 2015/16 the CCG contribution increases to £8.9m plus an allocation of £3.7m. This significant re-direction of funds must be invested (together with other stakeholders) to deliver immediate financial benefits if the CCG is to continue to meet its target surplus requirement.



Central to our strategic vision is an ambition to ensure that all of our patients receive the highest quality care. The Commissioning for Quality and Innovation (CQUIN) payment framework ties part of a provider’s income to quality and innovation requirements. These requirements - known as CQUINs - cover a whole range of areas, including training to ensure that staff get the updates they need and Friends and Family results that look at patient experience and satisfaction.

In addition to the nationally defined incentives, during 2014-2016, we have decided to have four local measures, shared across both our community and acute providers. Our local quality incentives are designed to focus on specific local health needs, support the integration between providers and drive the system change we need to secure a health system which is fit for the future.

COPD	Over 75s (with Long Term Condition)	Diabetes	Heart Failure
2014/15	2014/15	2014/15	2014/15
Work collaboratively to analyse the current COPD pathway of care provided by the Community Trust and the Acute Hospital Trust to identify gaps and issues and agree a future integrated pathway and outcome measures.	In relation to Share my Care (SMC), working with all contributors to the pathway, agree standard documentation to upload to SMC and responsibilities within this process. Agree a standard set of information to be uploaded and maintained on SMC.	Working with acute colleagues to analyse current pathways, in comparison to the new pathway identified by the CCG’s. Identify areas which need change and undertake that change to deliver the new model within agreed contract.	Work collaboratively to analyse the current Heart Failure pathway of care provided by the Community Trust and the Acute Hospital Trust to identify gaps and issues and agree a future integrated pathway and outcome measures.
2015/16	2015/16	2015/16	2015/16
Work collaboratively to embed and measure performance of new integrated care pathway for COPD patients, with ultimate aims being to reduce non-elective admission/readmission by; <ul style="list-style-type: none"> • Delivering care close to home • Improving transfer of care • Improving self-management 	Embed and measure performance, with ultimate aims being to; <ul style="list-style-type: none"> • Develop a collaborative shared care plan approach • Improve transfer of care between providers • Improve the safety and quality of patient care 	Embed and measure performance, with ultimate aims being to reduce non-elective admission/readmission by; <ul style="list-style-type: none"> • Delivering care close to home • Improving transfer of care • Improving self-management 	Work collaboratively to embed and measure performance of new integrated care pathway for Heart Failure patients, with ultimate aims being to reduce non-elective admission/readmission by; <ul style="list-style-type: none"> • Delivering care close to home • Improving transfer of care • Improving self-management



PERFORMANCE INDICATOR	Metric	Baseline	2014/15 Target	2015/16 Target
Securing additional years of life for the people of England with treatable mental and physical health conditions.	PYLL (Potential years lives lost) per 100,000	1507.9	1447.6	1389.7
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 EQ5D tool in the GP Patient Survey).	75.20	75.4	75.5
Reducing emergency admissions	Total emergency admission for the any of the conditions considered avoidable per 100,000 population	1584.0	1575.3	1566.6
Number of C.Diff Infections	Calculated annually based on previous year	TBC	45	TBC
Increasing the number of people having a positive experience of hospital care.	The proportion of people reporting poor patient experience of inpatient care	139.9	139.5	139.1
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.	The proportion of people reporting poor experience of General Practice and Out-of-Hours Services	7.1	6.9	6.7
Dementia Diagnosis	% of people diagnosed as proportion of anticipated prevalence	40.1%	67.0%	75.0%
Access to Psychological Therapies	Proportion of people having attended two treatment contacts and a moving towards recovery	TBC	50.0%	55.0%



National Outcome Indicators			Local Priorities					
Seven Outcome Ambitions	Strategic Risks	Measures	Urgent Care	Planned Care	Mental Health	Community Network	Child Health and Maternity	Primary Care
1 Securing additional years of life for the people with treatable mental and physical health conditions	Failure to delivery key projects aimed at reducing health inequalities will result in the continued health gap between the poorest and the most affluent wards	PYLL (Potential years lives lost) per 100,000			✓	✓	✓	✓
2 Improving the health related quality of life of people with one or more long-term condition, including mental health conditions	Community and social settings may be unable to pick up increased demand as care moves away from acute settings.	Health related quality of life for people with long-term conditions (measured using EQSD tool in the GP Patient Survey).	✓	✓	✓	✓	✓	✓
3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Systems across services not integrated and therefore do not enable shared care plans between organisations to support integrated outcome measurement and monitoring.	Total emergency admission for the any of the conditions considered avoidable per 100,000 population	✓	✓	✓	✓	✓	✓
4 Increasing the proportion of older people living independently at home following discharge from hospital.	Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / home care activity by 2015/16, impacting the overall funding available to support care services and future schemes	No indicator available at CCG level.	✓	✓		✓		✓
5 Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Shifting resources to fund new schemes may destabilise current services and providers, particularly in the acute sector.	The proportion of people reporting poor patient experience of inpatient care	✓	✓	✓		✓	
6 Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community.	Patients and providers may not know how to access services within an integrated system to ensure services are used appropriately	The proportion of people reporting poor experience of General Practice and Out-of-Ours Services	✓	✓	✓	✓	✓	✓
7 Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	Shifting resources from acute services may lead to a reduction in the right people, with the right skills, being in the right place at the right time	Indicator in development	✓	✓			✓	
8 Ensuring a sustainable financial future and good governance	Non-delivery of the projects within this programme will have significant effect on the CCG's ability to meet its statutory obligations. The lack of detailed baseline data and the need to rely on current assumptions may mean that financial targets are unachievable.	Non qualified annual accounts	✓	✓	✓	✓	✓	✓
9 Achieve objectives through effective stakeholder engagement, public engagement and partnership working	The CCG may suffer reputational damage if we fail to deliver the outcomes detailed.	Recognised as the local leader of the NHS (Social Capital)	✓	✓	✓	✓	✓	✓



"Improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs, social care and community services including the voluntary sector."

- Securing additional years of life for the people with treatable mental and physical health conditions.
- Improving the health related quality of life of 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 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.
- Ensuring a sustainable financial future and good governance
- Effective stakeholder engagement, public engagement and partnership working.

Primary Care	We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.
Community Networks	Primary and community care services working closer together, along with voluntary organisations and other independent sector organisations.
Mental Health	We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities
Urgent Care	We want care that crosses the boundaries between primary, community, hospital and social care.
Maternity, Children and Young People	We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation
Planned Care	We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.

- Governance**
- Governing Body and supporting committee structure
 - Kent Health and Wellbeing Board
 - Canterbury and Coastal Health and Wellbeing Board with supporting sub-group structure
 - Whole Systems Delivery Board
 - Public Reference Group
 - Programme Boards for Urgent and Planned Care
 - Programme Management Office

- Success Criteria**
- Delivery of improvements against NHS Operating Framework Domains
 - Achievement of financial stability and balance
 - People are supported to live in their own homes or communities.
 - We will see less acute admissions and reduced length of stay.
 - Carers are 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

- High Level Risks**
- Ensuring that we have a workforce with skills to deliver integrated care.
 - Ability of providers to respond to competing priorities
 - Maintaining quality and safety during period of service transformation
 - Achievement of financial balance
 - Public support for change programme



Military personnel put themselves in harm's way in the service of their country. The health service's obligations to our armed forces were recently set out in the *2011 Armed Forces Covenant*, the key component being that our armed forces shouldn't face an disadvantage in accessing timely, comprehensive and effective healthcare and that they receive bespoke services for their particular needs or combat-related conditions including, for instance, specialist limb prostheses and rehabilitation. Whilst the majority of services for our military are commissioned by the Ministry of Defence, the CCG is responsible for commissioning services required by Armed Forces' families where registered with a local GP Practice, and services for veterans and reservists when not mobilised. Bespoke services for veterans, such as veterans' mental health services, are also commissioned by the CCG

Armed Forces Network

In line with the NHS Operating Framework, Regional Armed Forces Networks have been set up across the country. The South East Coast Armed Forces Network was launched in February 2011, and covers Kent, Surrey and Sussex. The stated aims of the South East Coast Armed Forces Network are:

- To provide regional NHS leadership, advocacy and points of liaison for military health and veterans issues.
- To work with regional military, social services and third sector organisations to ensure delivery of armed forces community programmes

Veterans/Ex-Services Personnel Rights

The term veteran is itself controversial, since such a large proportion of so-called veterans would not describe themselves as such. Younger members of this population would perceive the word veteran as applying to the World War Two veterans who are so visible at national veteran events. This cohort would be more likely to identify themselves as 'ex-military' or 'ex-service'.

A veteran is someone who has served in the armed forces for at least one day. There are around 9,000 veterans in the Ashford Area. All veterans are entitled to priority access to NHS hospital care for any condition as long as it's related to their service, regardless of whether or not they receive a war pension.



The CCG has an identified **Forces Champion** with the role of signposting and promoting services available to ex-military personnel.

Our vision is to obtain the best health benefit from the available resources by commissioning high quality, safe and effective care for Armed Forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

System Values

To achieve our vision we will:

- Work with Defence Medical Services to support them in their task of **promoting, protecting and restoring** the health of the Defence population in order to maximise fitness for role. We will achieve this by commissioning a comprehensive core service.
- Make evidence based decisions
- Listen to and learn from patient experiences
- Ensure that Armed Forces personnel are not disadvantaged in their access to healthcare be that offer, access or outcome
- Ensure that special consideration is given to those injured as a proper return for their sacrifice

System Objective One

Services for the armed forces are commissioned to achieve the best health outcomes, in line with the commitments of the Armed Forces Covenant

Delivering better care through the digital revolution

- increase use of E-referrals, including advice and guidance functionality, within DPHC
- increase the use of telemedicine as an alternative to face to face care where appropriate;
- increase access to national screening programmes
- link DMS systems to Child Health Information Systems

Overseen through following governance arrangements

- Area Team internal meetings
- Armed Forces Operational Group
- Joint Commissioning Group
- Armed Forces Oversight Group

System Objective Two

We work in partnership with the MoD to commissioning healthcare in line with the partnership agreement and in support of DMS's objective to promote, protect and restore the health of the Defence population in order to maximise fitness for role.

Co-ordinated access to musculoskeletal pathway

- Improved use of E-referrals and its functionality within DPHC for access to secondary / tertiary referral for MSK conditions
- re-design MSK pathways to make best use of recognised good practice in rehabilitation

Measurement

- Increased referrals made electronically
- Sustained RTT performance
- Co-produced workforce measures
- Access to screening programmes
- Number & % of agreed health plans
- Register of Armed forces champions
- Mental Health services directory

System Objective Three

We will work with the MoD and CCGs to improve the model of integrated care that service leavers with mental health or complex physical health needs receive

Improved access to mental health services

- Improve care co-ordination on service discharge
- Improve signposting to appropriate mental health services including crisis services
- Improve choice of recognised good practice services for mental health such as online counselling

Sustainability

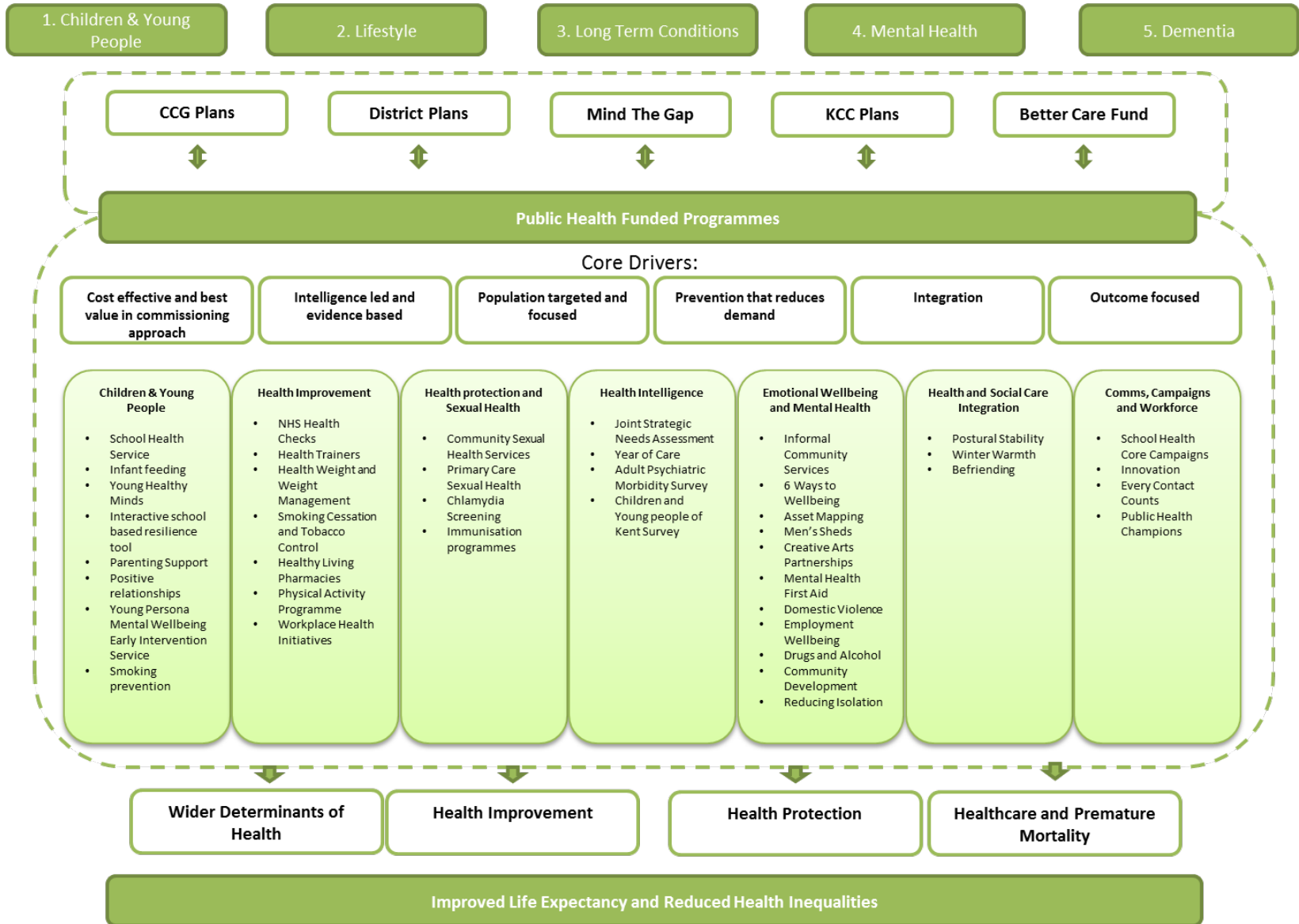
- We will consider sustainability and affordability in our approach to decision making.
- We will work with DMS to, where possible, standardise the approach to state funded items to help deliver affordability and sustainability.

System Objective Four

We will collaborate with CCGs and Health and Wellbeing Boards to develop and embed strong armed forces Networks to ensure that the armed forces community receives appropriate care regardless of commissioner

WIS leavers to have an agreed health plan

Work with the MoD to ensure that all WIS service leavers leave with a personal health plan; designed to empower patients to take more control of their long term health and direct them to the most appropriate professional under the primary care team to manage their routine needs.

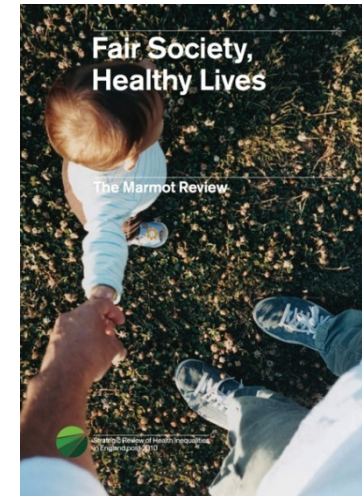


The Marmot Review, published in 2010, highlighted that people with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, 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.

Delivering the policy objectives set out in the Marmot Review requires action by central and local government, the NHS, the third and private sectors and community groups .

The Kent-wide health inequalities action plan (Mind the Gap, Building Bridges to Better Health for All) provides strategic direction and a shared commitment to reducing inequalities. The Action Plan is aligned to existing national programmes, Kent’s Joint Strategic Needs Assessment, Sir Michael Marmot’s objectives for reducing inequalities and the recent Public Health Outcomes Framework to ensure that priorities and commitment are owned and achievable.

The local level Health and Wellbeing Board, detailed elsewhere within this plan, provides opportunities for the CCG, Kent County Council and our District Councils to work collaboratively to reduce health inequalities across the CCG.



NHS England has set out its plan for a small number of national networks to improve health services for specific patient groups or conditions. Called strategic clinical networks, these organisations will build on the success of network activity in the NHS which, over the last 10 years, has led to significant improvements in the delivery of patient care.

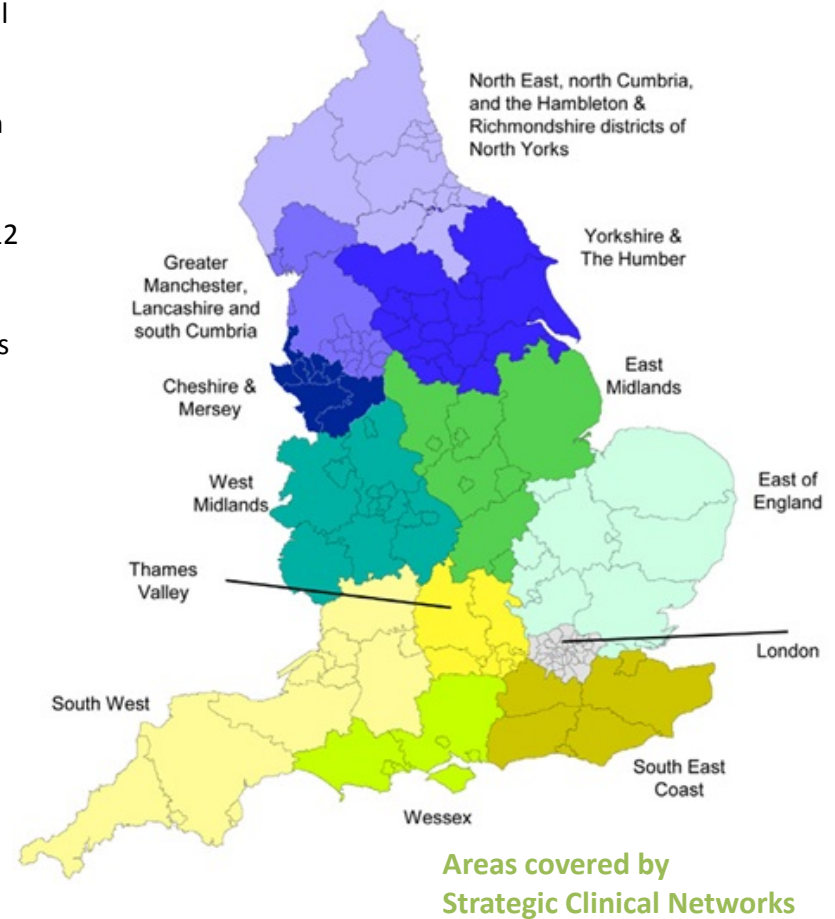
Strategic clinical networks, hosted and funded by the NHS England, will cover conditions or patient groups where improvements can be made through an integrated, whole system approach. These networks will help local commissioners of NHS care to reduce unwarranted variation in services and encourage innovation.

These networks will exist for up to five years and will be managed by 12 locally based support teams. These teams will build and oversee effective network arrangements for their area and help networks develop an annual programme of quality improvement in local services

The conditions or patient groups chosen for the first strategic clinical networks are:

- Cardiovascular Disease
- Cancer
- Maternity and Children's Services
- Mental health, dementia and neurological conditions

Combining the experience of clinicians, the input of patients and the organisational vision of NHS staff they have supported and improved the way we deliver care to patients in distinct areas, delivering true integration across primary, secondary and often tertiary care. For example, stroke networks have enabled transformation in the way services are delivered in many parts of the country leading to measurable improvements in both outcomes and experience for patients.



Strategic Clinical Network: Cancer

A network of patients, carers, the public, clinicians and commissioners who have come together to agree, refine and implement improved Cancer healthcare outcomes across Kent, Surrey and Sussex. Improved patient experience and safety underpin all our work programmes

Objective: The prevention of premature morbidity and mortality from cancer, matching the levels of the best in Europe (Outcome Domain 1)

Delivered through a programme of raising awareness and earlier diagnosis of cancer

- A review of referral rates, emergency presentation, stage of disease at diagnosis (May 2014)
- Review current uptake rates of direct access within primary care in order to identify areas for improvement (September 2014)
- Work with primary care colleagues to describe optimal clinical practice and systems with a case for change to ensure streamlined diagnostic/cancer pathways (2015)
- A targeted local education programme agreed for GPs (September 2015)

Overseen through the following governance arrangements

- Shared system leadership Oversight Group overseeing implementation of all SCN programmes
- Cancer programmes and improvement interventions overseen by Cancer Steering Group
- Project task and finish groups overseen by Clinical Advisory Groups, patient and public and commissioner forums

Objective: To improve survival and health outcomes for cancer patients related to cancer treatment (Outcome Domain 3)

Delivered through a programme that ensures patients are as fit as possible to undergo and recover from cancer treatment

- Developed treatment protocols for the physical optimisation of patients with cancer as they progress through treatment, e.g. chemotherapy, radiotherapy and surgery (September 2015)

Measured using the following success criteria

- Supports sustainable and affordable services
- Delivery of the outcomes framework
- Reduction in unwarranted variations of care quality, identified in 2013 baseline reviews

Objective: To increase patients' ability to self-manage their recovery (Outcome Domain 2)

Delivered through implementation of the "Recovery Package"

- Audit current practice of Holistic Needs Assessment and care planning, Treatment Summaries and cancer reviews, and patient education and support events (September 2014)
- Address variation in Holistic Needs Assessment and care planning (March 2015)
- Shared care Treatment Summaries agreed between primary and secondary care (March 2015)
- Framework for patient education and support events agreed (June 2015)
- Encourage adoption of EPaCCS across SEC and improvement of ACP (April 2015)

System values and principles

- We seek improvement through clinical leadership, strategic focus and large-scale change and transformation
- We will maximise value by seeking the best outcomes for every pound invested
- We put the public and clinical voice central to all we do
- We will align and collaborate with strategic partners such as AHSN and HEE
- We embrace innovation
- We will contribute towards delivering NHS England's commitment to 'parity of esteem'

The Cancer Awareness and Early Diagnosis dashboard produced by the Quality Observatory and South East Coast Cancer SCN brings together a number of measures on one page with the aim of providing an overall picture of performance by CCG.

Two week wait referrals

Ashford CCG has a higher rate of referrals than the national figure, which may be an indication of a higher percentage of over 65s in the locality than the England average

Emergency admissions with cancer per 100,000 population

Ashford CCG has a lower rate of emergency cancer admissions than the national average, despite the age profile .

Two week wait referrals with cancer: conversion rate

The conversion rate is the number of Two Week Wait referrals subsequently diagnosed with cancer. Ashford CCG's figure of 9% is one of the lowest in the Kent, Surrey and Sussex region where CCG rates range from 6% to 13%. This is also lower than the national average.

Screening uptake (breast, cervical, bowel)

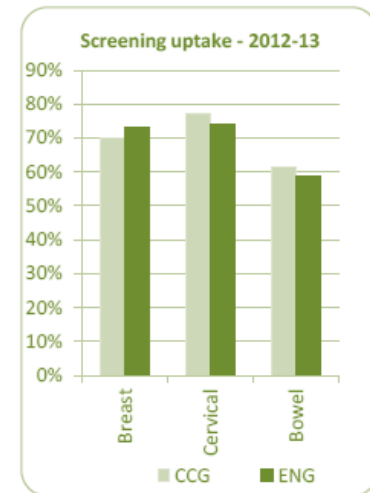
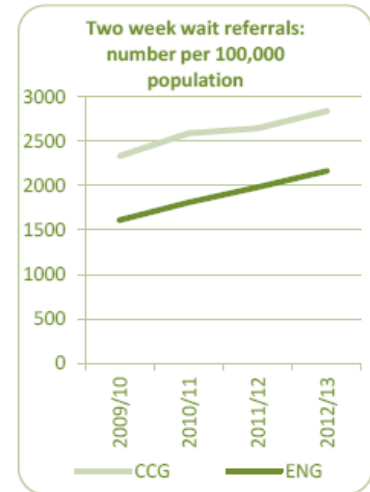
For breast screening, CCG uptake rates in Kent, Surrey and Sussex range from 49% to 77%. Ashford has an uptake rate of 70% so below the average for the region.

Uptake rates for cervical screening in the region range from 72% to 79%. The CCG has one of the higher rates with an uptake of 77%.

For bowel screening, regional uptake rates range from 56% to 66%. Ashford is towards the higher end of this range with a rate of 62%.

National Cancer Patient Experience Survey

Question1 asks how many times a patient saw their GP before being told they needed to go to hospital. 81% of patients from East Kent saw their GP once or twice, indicating relatively high levels of early diagnosis in the area.



Strategic Clinical Network: Cardiovascular

A network of patients, carers, the public, clinicians and commissioners who have come together to agree, refine and implement improved cardiovascular (cardiac, stroke, renal and diabetes) healthcare outcomes across Kent, Surrey and Sussex. Improved patient experience and safety underpin all our work programmes

Objective: The prevention of premature morbidity and mortality from cardiovascular disease (Outcome Domain 1)

Transformational programme that increases the earlier detection ability of Primary Care

Delivered through a programme of raising awareness and earlier diagnosis of cardiovascular disease

- SEC NHS Health Check Forum supported to increase offer and uptake rate of NHS Health Checks (2018)
- NICE anticoagulation guidelines agreed across SEC for Atrial Fibrillation (September 2014)
- Guidelines for clinicians for AF management (December 2014)
- Case for change model for identification, diagnosis and treatment of AF (December 2014)
- Guidance on Standards for Chronic Kidney Disease (CKD) identification and referral advice systems in primary care (2014-15)

Overseen through the following governance arrangements

- Shared system leadership Oversight Group overseeing implementation of all SCN programmes
- CVD programmes and improvement interventions overseen by SEC SCN CVD Steering Group
- Project task and finish groups overseen by multi-stakeholder Clinical Advisory Groups (cardiac, renal, stroke & diabetes) and commissioner forums

Objective: To improve the quality of life after illness from cardiovascular disease and optimising cardiovascular health (Outcome Domain 2)

Delivered through a programme on optimising care for those living with cardiovascular disease

- Case for change for best practice heart failure model (March 2015)
- Cases for change for diabetes integrated care models, foot care pathways and patient empowerment (2014-15)
- Encouragement of adoption and improvement of EPaCCS and Advanced Care Planning (ACP) in extending to other conditions (LTC and dementia) (April 2015)

Measured using the following success criteria

- Supports sustainable and affordable services
- Delivery of the outcomes framework
- Reduction in unwarranted variations of care delivery and quality, identified in 2013 baseline reviews

Objective: To reduce the variation in care for patients with cardiovascular disease (Outcome Domain 3)

Transformational programme that consolidates acute cardiovascular expertise in a reduced number of emergency care centres (Hub & Spoke)

Delivered through a programme on improving health outcomes through standardising acute models of cardiovascular care and reducing unwarranted variation

- SEC-wide agreed service specification for 6-month review for stroke survivors (Sept 2014)
- Baseline mapping of invasive cardiology services including heart attack pathways and sustainable cases for change developed (July 2014)
- Acute stroke pathway reviews across SEC and support for cases for change (April 2015)
- Cases for change for other acute cardiovascular services, e.g. complex cardiology and renal services (2014-16)
- Development of guidance on AKI care bundles for secondary care (April 2015)
- Best Practice framework for life after stroke (2014)
- Framework for provision of generic and integrated rehabilitation services and skills (2016)
- Consolidating acute cardiovascular expertise in a reduced number of emergency care centres (hub and spoke) (2018)

System values and principles

- We seek improvement through clinical leadership, strategic focus and large-scale change and transformation
- We will maximise value by seeking the best outcomes for every pound invested
- We put the public and clinical voice central to all we do
- We will align and collaborate with strategic partners such as AHSN and HEE
- We embrace innovation

Strategic Clinical Network: Maternity, Children and Young People

A network of patients, carers, the public, clinicians and commissioners who have come together to agree, refine and implement improved Maternity, Children & Young People (MCYP) healthcare outcomes across Kent, Surrey and Sussex. Improved patient experience and safety underpin all our work programmes

Objective: To reduce perinatal mortality and morbidity (Outcome Domain 1)

Delivered through a programme on reducing perinatal mortality and morbidity

- Agreed best practice pathway and associated case for change for pre-term birth (March 2015)
- Agreed model of care to support prevention of stillbirth (2015-16)

Overseen through the following governance arrangements

- Shared system leadership Oversight Group overseeing implementation of all SCN programmes
- MCYP programmes and improvement interventions overseen by SEC MCYP SCN Steering Group
- Project task and finish groups overseen by multi-stakeholder Clinical Advisory Groups (maternity, children and young people, transition) and commissioner forums

Objective: To reduce inappropriate paediatric attendances and admissions to secondary care (Outcome Domain 2)
Transformational programme that increases capability in community services

Delivered through a programme on moving the clinical care of children & young people from secondary to community and primary care settings (NHS at Home)

- Agreed Children's Community nursing service model and service specification (2015)
- Agreed models of care and smooth transition pathways from childhood to adult services for children and young people with diabetes, epilepsy and asthma (2015-16)
- Review of all transition areas which require specific focus, including end of life care services (September 2014)
- Encourage adoption of EPaCCS across children's end of life care services (April 2015)
- Production of slide set/report with a visual guide and narrative explaining who commissions what across the CCG, Direct, Specialised and Joint commissioning system for CYP services (2014)

Measured using the following success criteria

- Supports sustainable and affordable services
- Delivery of the outcomes framework
- Reduction in unwarranted variations of care delivery and quality, identified in 2013 baseline reviews

Objective: To promote high quality maternity care and experience

Delivered through a programme on high quality maternity care and experience

- Agreed maternity service standards across SEC (March 2014)
- Developed and agreed maternity key performance indicators (September 2014)
- Agreed maternity dashboard that supports both providers and commissioners (September 2014)

System values and principles

- We seek improvement through clinical leadership, strategic focus and large-scale change and transformation
- We will maximise value by seeking the best outcomes for every pound invested
- We put the public and clinical voice central to all we do
- We will align and collaborate with strategic partners such as AHSN and HEE
- We embrace innovation

Strategic Clinical Network: Mental Health, Dementia and Neurological Conditions

A network of patients, carers, the public, clinicians and commissioners who have come together to agree, refine and implement improved Mental Health, Dementia and Neurological Conditions (MHDN) healthcare outcomes across Kent, Surrey and Sussex.
Improved patient experience and safety underpin all our work programmes

Objective: Development of acute access to mental health and neurological specialist (Outcome Domain 1)

Delivered through rapid access to specialist care for people with mental health and neurological acute conditions

- Audit of psychiatric liaison and crisis intervention teams (July 2014)
- Baseline of emergency attendance in neurology (May 2014)
- Case for change for emergency crisis intervention in psychiatry (Sept 2014)
- Agreed emergency model of neurology acute assessment (March 2015)
- Case for change for the innovative 'networked' model of acute neurology assessment (September 2015)
- Agreed model of emergency mental health access (April 2016)
- Solution for Section 136 issues for children and young people (Sept 2014)

Overseen through the following governance arrangements

- Shared system leadership Oversight Group overseeing implementation of all SCN programmes
- MHDN programmes and improvement interventions overseen by MHDN Steering Group
- Project task and finish groups overseen by Clinical Advisory Groups, patient and public and commissioner forums

Objective: Development of clear pathways for those with long term neurological conditions – Parkinson's Disease, Multiple Sclerosis, Motor Neurone Disease and Epilepsy (Outcome Domain 2)

Delivered through development of clear and navigable pathways

- Baseline of current activity and spend on neurological LTCs (May 2014)
- Future LTC pathway described (October 2014)
- Mapping of neurology services (November 2014)
- Case for change for alignment of LTC pathways 'moving investment around' (June 2015)
- New pathways commissioned (December 2015)
- Improvement of ACP and extension of EPaCCS to include LTC care plans (April 2017)

Measured using the following success criteria

- Supports sustainable and affordable services
- Delivery of the outcomes framework
- Reduction in unwarranted variations of care delivery and quality, identified in 2013 baseline reviews

Objective: Timely diagnosis of dementia with immediate post-diagnosis support and long-term self-management (Outcome Domain 2)
Transformational programme that increases Primary Care capacity

Delivered through moving more dementia diagnostics into primary care and improving long-term care of dementia

- Describe primary care diagnostic model (May 2014)
- Develop a case for change for moving diagnostics (September 2014)
- Describe a model of post-diagnostic support (September 2014)
- Describe a networked 'admission avoidance' plan which can be used by commissioners (September 2016)
- Improvement of ACP and extension of EPaCCS to include dementia care plans (April 2017)

System values and principles

- We seek improvement through clinical leadership, strategic focus and large-scale change and transformation
- We will maximise value by seeking the best outcomes for every pound invested
- We put the public and clinical voice central to all we do
- We will align and collaborate with strategic partners such as AHSN and HEE
- We embrace innovation
- We will contribute towards delivering NHS England's commitment to 'parity of esteem'

Objective: Fully integrated model of care for children and young people accessing mental health service (Outcome Domain 3)
Transformational programme that achieves large-scale integration

Delivered through development of clear and navigable pathways

- Model of integrated system developed and published in line with NHS England guidance and priorities (March 2015)
- Case for change for acceptance by CCGs and HWBs (September 2015)
- New pathways commissioned (April 2016)



Introduction and Covering Report (Simon Harris Ashford Borough Council)

1. The priority theme for today's meeting is Healthy Weight (including obesity). Three presentations are being given. In order to help members to prepare for the meeting, a brief summary of each presentation is provided below along with specific recommendations for the Ashford Health and Wellbeing (AHWB).
2. The purpose of the presentations is to help the Ashford HWB identify progress and gaps in service provision and to question how the information provided can be used to influence future projects and inform commissioning decisions.
3. The Lead Officer Group along with the Ashford Health and Wellbeing Board highlighted "Healthy Weight (including obesity)" as a "must do" project with a strategic lead being provided by Kent County Council Public Health Team, working closely with Ashford Borough Council as the project coordinator.
4. Kent Fire and Rescue Service (KFRS) will be providing a presentation (including film footage) at the meeting. It should be noted that the Kent HWB on the 16 July recognised the valuable role that KFRS plays. While particular value was attributed to their work which is relevant to falls prevention and dementia this is another area in which joint work is enormously beneficial.
5. Members are asked, in advance of the meeting, to consider how the subject of obesity and healthy weight links to their sphere of influence, to ask what more they believe could or should be done and to think about how the Lead Officer Group might assist the Board in terms of this priority.

Kent Fire & Rescue Service Fire Fit Scheme (Rachael Spencer, Vulnerable Person Liaison Officer)

6. The presentation covers the "FireFit" initiative which focuses on improving inclusion, quality of life and a excellent engagement tool which can support multiple campaigns within KFRS and external partners.
7. An example of this work was previously carried out with the NHS Stop Smoking team who were able to highlight the advantages of a healthy lifestyle at a pop up event, whilst also promoting smoke free homes whilst conducting home safety visits.
8. KFRS would like to work closer with other partners in the borough of Ashford and would like to seek the support of the Health and Well Being Board in working towards achieving progress in a number of areas.

Kent County Council Public Health (Val Miller, Public Health Specialist)

9. The presentation reports on how KCC Public Health (KCCPH) is working towards creating a Healthy Weight Strategy. The timeline for the Kent Strategy will be available in draft form in early 2015 and will go back to the Kent Health and Wellbeing Board sometime after this.
10. KCCPH have recently carried out a countywide consultation on Healthy Weight which is currently being analysed and would be available in the early November. Stakeholder workshops will be arranged to shape the strategy and a model for a healthy weight service.

Ashford Borough Council (Simon Harris, Sports Projects Manager)

11. The results from three months of mapping and scoping current preventative schemes and local priorities and services required within the borough of Ashford are to be presented.
12. Appendix A provides further information. An example action plan covering the key themes which maybe incorporated within an Ashford plan is provided.

Healthy Weight Recommendations

The AHWB is asked to:

- a) Support the need for a localised action plan for subsequent consideration by the Board.
- b) Request an action plan that promotes healthy weight interventions be brought to a future meeting of the Board.
- c) Support the work of the KFRS as relevant to the Boards priorities as a “must do” project.

Appendix A

Brief: The Ashford Health and Wellbeing Board highlighted (in July 2014) that one of the priority projects is Healthy Weight including obesity. Table 1 below provides the action point from the Board.

Table 1

What we are focusing on for the next quarter <u>specific to the key projects</u>	<ul style="list-style-type: none">• Healthy weight – Preparation for the October Board meeting and the focus on obesity. This meeting needs to establish local priorities and service required. Need to establish whether focus is on adults or children. Scoping with key partners.
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Officers within Ashford Borough Council were tasked with scoping and identifying a project (s) on the subject and reporting to the board at the meeting in October 2014.

Background

We know that physical inactivity and eating poorly contribute to gaining weight leading to obesity. Both obesity and a lack of exercise is more prevalent in areas of relative lower incomes and certain people in the borough of Ashford are more at risk of obesity and the related conditions such as diabetes and heart disease.

A recent national study by the Chief Medical Officers (CMO) concluded that 77% did not recognise that they were overweight or obese.

Obesity is a complex problem for which there is no simple solution. It cannot be addressed through single interventions undertaken in isolation.

NICE recommendations on preventing obesity and helping people to manage their weight should be undertaken in parallel, wherever possible. They should also:

- be implemented as part of a broad approach, which involves a variety of organisations, community services and networks operating at a range of levels
- be implemented as part of integrated programmes that address the whole population, but also address local health inequalities, for example, within specific neighbourhoods
- be underpinned by a robust, community-wide approach that includes monitoring and evaluation
- comprise specific actions commissioned to meet local needs and priorities, for example to encourage healthy eating and physical activity and to develop community programmes to combat obesity.

The key stakeholders will include Kent County Council Public Health Team, the Ashford and Canterbury Clinical Commissioning Group (CCG) and Ashford Borough Council (ABC). Any partnership work should be encouraging outcomes on supporting healthy eating, physical activity and maintaining a healthy weight among the important lifestyle factors for primary prevention. This also reflects the Public Health Outcomes Framework 2013 – 2016 for England.

Rationale for decision

For many years the health of the local community particularly from deprived backgrounds has worsened and the health bodies have attempted to engage with these groups providing a range of projects which are normally short term and may not achieve the agreed outcomes. The “sticky plaster” analogy needs to be addressed and now is the opportunity with organisations such as Public Health and the CCG now established of pulling resources together to improve the healthy of the community.

Project Proposal

Following an in-depth scoping and consultation exercise the following recommendations should be discussed;

- 1) The Ashford Health and Wellbeing Board are asked to support a Healthy Weight Strategy for the borough to be written by April 2015.
- 2) This plan may include headline sections such as Maternity and Early Years, Maternity, Breast Feeding and Infant Nutrition , Early Years, Prevention in Schools, Treatment of children who are overweight (tier 2), Treatment of children who are obese (tier 3), Prevention of adults obesity (tier 1), Environment and Workplaces. Appendix 1 provides an example from Harrow on their Healthy Weight Strategy. It must also be noted that there is no targeted work on the subject of malnutrition and this could be developed in the planning.
- 3) The Action Plan would be produced with key stakeholders such as KCC, ABC and the CCG within a coordinated working group.
- 4) The Action Plan would support the KCC Public Health County plan but based on local need.
- 5) The Plan will include sections including Recommendations from the Needs Assessment, strategic actions, the Lead organisation, the Performance Measures, by when and any costs associated with the work.
- 6) The Terms of Reference would require sign off by the Health and Wellbeing Board.
- 7) The work from the action plan will support any commissioning decisions by the various bodies such as KCC Public Health and the CCG's.

Outcomes

The Action Plan will achieve the following high level outcomes:

- 1) To ensure we have a fully operational pathway to prevent, identify and treat excess weight in the borough of Ashford that complies with national guidance.
- 2) To ensure we do not have any further increase in the prevalence of excess weight for young children.
- 3) To ensure we at least maintain or better our relative position for the prevalence of excess weight in adults compared to the rest of Kent and England average.

Simon Harris Sept 2014

Appendix 1

4.2 Harrow Maternity and Early Years Obesity Pathway Strategic Action Plan

1.0 Maternity and Early Years (General)

Recommendations from Harrow Obesity Needs Assessment:

- Services cannot be prescribed and must be based around the needs of the identified group
- Local areas need to take every opportunity in commissioning and funding processes to embed healthy weight outcomes
- Opportunities need to make healthy weight everyone's business by making every contact count within the public sector and community services
 - A review should take place of the policies within stakeholder agencies to ensure they actively support healthier eating choices and do not promote an obesogenic environment

Strategic Actions for Pathway Group:	Lead	Performance measure	Date
1. Develop an obesity pathway for Maternity and Early Years	Public Health and Maternity	1. An operational pathway in line with national guidance	Dec 2014
2. Promotion and communication of the agreed obesity pathway to all stakeholders and promotion that obesity is 'everyone's responsibility'	Public Health	2. Engagement from stakeholders through the pathway group and implementation of Obesity Communications Plan	Sep 2014
3. Development of a central information point on obesity services and pathways for professionals	Public Health	3. An operational information point and number of hits on the webpage	Sep 2014
4. Development of self assessment tools for promotion in appropriate settings	Public Health	4. Operational self assessment tools in settings across Harrow and self referral to appropriate tier 2 services	Dec 2014
5. All stakeholders should agree a Harrow Obesity Charter for participating agencies and their approach to healthy eating which includes workplace catering	Public Health	5. Number of agencies signed up to the Obesity Charter (Target number tbc)	July 2014

2.0 Maternity

Recommendations from Harrow Obesity Needs Assessment:

To develop a maternity obesity pathway which includes;

- Clear brief advice guidelines for professionals in Harrow on healthy eating, nutrition and physical activity advice from preconception, during pregnancy to postnatal and early years (should include active travel and play)
- The antenatal and postnatal pathway to be led by maternity provider services and a pathway for new mothers to be led by public health
- Postnatal weight management services should include prevention of childhood obesity and be linked to the children's obesity pathway

Strategic Actions for Pathway Group:	Lead	Performance measure	Date
1. Develop an obesity pathway for Maternity (antenatal and postnatal) and 'New Mothers' (post 6 weeks)	Public Health and Maternity	1. An operational pathway in line with national guidance	Dec 2014
2. Devise a clear message regarding nutrition and physical activity which is consistent for obese and non obese women (and is culturally specific)	Public Health	2. Development and implementation of an Obesity Communications Plan	Sept 2014
3. Review appropriateness of weight management services available for antenatal and postnatal women (including education groups run by dietetics)	Dietetics	3. Coordination of a review of existing services to inform the new pathway development	Dec 2014
4. Development of a postnatal weight management programme, making use of existing adult physical activity services	Public Health	4. A specified and operational postnatal weight management pathway	Dec 2014

3.0 Breast Feeding and Infant Nutrition

Recommendations from Harrow Obesity Needs Assessment:

- All health professionals including early year's practitioners to be following Weaning Guidelines for Harrow when promoting good infant nutrition
- Protocols around data sharing should be in place to help assist in identifying mothers where there may be areas for additional support
- Breastfeeding peer support should be included as part of the pathway to tackle obesity
- Weaning workshops to be provided via health visitors and early years practitioners across the borough

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
<ol style="list-style-type: none"> 1. The breast feeding and infant nutrition pathway should aligned to the new Maternity (antenatal and postnatal) and 'New Mothers' (post 6 weeks) Obesity Pathway 2. Weaning guidance to be developed 3. Health professionals and early years professionals to receive standardised training to ensure quality of messages distributed around infant nutrition 	Public Health HV (Health Visitors) HV	<ol style="list-style-type: none"> 1. Clear guidance in the obesity pathway linking to the breast feeding and infant nutrition services. 2. The production and adoption of weaning guidance. 3. The development and attendance of training sessions (Target number tbc) 	Dec 2014 May 2014 Sep 2014

4.0 Early Years

Recommendations from Harrow Obesity Needs Assessment:

- Nurseries and all other childcare facilities in Harrow should be supported to minimise sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions
- All childcare facilities and nurseries should be supported to review their catering procurement to encourage healthy eating
- Children's Centres should engage with the Harrow's Healthy Children's Centre Programme where they can seek support and training regarding nutrition

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
1. Incorporate and promote local physical activity services in early years settings	Children's Centre	1. Refinements to the pathway to include development physical activity in early years setting and numbers of activities taking place 2. Number of active healthy eating champions and cooking classes (Target number tbc)	Dec 2014
2. Continuation of healthy eating work in children's centres	Public Health (PH)		

4.3 Harrow Children and Young People Obesity Pathway Strategic Action Plan

1.0 Prevention in Schools

Recommendations from Harrow Obesity Needs Assessment:

- Schools should provide regular opportunities for physical activity with the types of activity directed student choice (at break times, before, after school, in the curriculum)
- School policies should support children to maintain a healthy weight in line with national school food standards (as set out in the Education (Nutritional Standards and Requirements for School Food) (England) Regulations 2007)
- Schools should review their catering procurement to support healthier options in line with the school food plan
- More schools should engage with the TFL travel plan initiative and those already engaged should improve their accreditation
- More schools in Harrow should engage with Healthy Schools London and gain accreditation for Bronze, Silver and Gold
- A review should take place of the policies within stakeholder agencies to ensure they actively support healthier eating choices and do not promote an obesogenic environment

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
1. Encourage schools to access specialist support from Public Health and Harrow School Improvement Partnership (HSIP) particularly regarding the use of DfE School Sports funding	PH & HSIP	1. Number of schools signed up for specialist support such as the School Sports funding and TFL travel plan (Target number tbc)	Sept 2014
2. Create a network of partners for school health to guide any new developments, to include school governors	Public Health	2. Establishment of a school health network and engagement with key groups e.g. governors	April 2014
3. Commission specialist support to schools to implement the school food plan	Public Health	3. Procurement and delivery of the specialist support to school food plan	Sept 2014
4. Where possible, PH should influence the schools expansion programme	Public Health	4. Evidence of partnership working with schools expansion programme	July 2014

<p>Create a programme of support for Healthy Schools London</p> <p>All stakeholders should agree a Harrow Obesity Charter for participating agencies and their approach to healthy eating which includes workplace catering</p>	<p>Public Health</p> <p>Public Health</p>	<p>5. An established programme of support offered and number of schools accepted.</p> <p>6. Number of agencies signed up to the Obesity Charter (Target number tbc)</p>	<p>July 2014</p> <p>July 2014</p>
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2.0 Treatment of children who are overweight (tier 2)

Recommendations from Harrow Obesity Needs Assessment:

- Children who are measured and classified as overweight should be referred to a programme that addresses lifestyle within the family and social setting
- NCMP results should be routinely fed back to families and then follow up children who are above a healthy weight
- NCMP data by ward or NCMP data by school clusters should be used to inform commissioning of weight management services
- All treatment of overweight children should be multicomponent and include recommendations to be physically active and to reduce inactivity
- The target audience should be consulted and their needs and motivations determined
- Interventions should include measures to help develop a positive body image and build self-esteem

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
1. Review the NCMP pathway and consider re-commissioning an age specific weight management service (tier 2)	PH and SN*	1. Review of tier 2 completed and procurement of services where necessary	Dec 2014
2. Guidance to be produced for primary care regarding NCMP pathway, correspondence with parents should be adapted to reflect pathway changes	PH and SN	2. Development and circulation of guidance of the children and young people's obesity pathway to primary care	Dec 2014
3. Return of Investment analysis (ROI) of interventions	Public Health	3. Completion of a review of ROI of interventions and any appropriate recommendations that are agreed by the pathway groups included in the pathway	Dec 2014

*SN= School Nursing

3.0 Treatment of children who are obese (tier 3)

Recommendations from Harrow Obesity Needs Assessment:

- A care pathway for tier 3 services should be specified and agreed by all relevant stakeholders and should commence with the accurate assessment of children using the appropriate techniques and equipment
- Referral to an appropriate specialist should be considered for children who are overweight or obese and have significant comorbidity or complex needs (for example, learning or educational difficulties)
- Children who are measured and classified as obese should be referred to family based programmes, which are multi-component and include recommendations to be physically active and to reduce inactivity

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
1. Review gaps in tier 3 provision	Public Health and CCG	1. Review of tier 3 completed	Dec 2014
2. Establish a clear pathway with all commissioners	Public Health	2. 2. Specified pathway and procurement of tier 3 services	Dec 2014
3. Consider providing cognitive behavioural therapy or health coaching (poss. health trainers)	Public Health	3. Review of tier 3 completed	Dec 2014

4.4 Harrow Adults Obesity Pathway Strategic Action Plan

Prevention of adults obesity (Tier 1)

Recommendations from Harrow Obesity Needs Assessment:

- Staying active should be promoted across Harrow and with particular focus on those wards identified as having higher obesity and lower physical activity in the South and East, and should be using all professionals who work within the community; health, social services, housing, education and workplaces in these areas.
- Leisure services provision should include reviewing the barriers to using these services such as affordability, access, and their location and the transport within the borough.
- A review should take place of the policies within stakeholder agencies to ensure they actively support healthier eating choices and do not promote an obesogenic environment

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
1. A new Adult Obesity Pathway should be developed in Harrow which includes physical activity and brief advice for those with a BMI of over 25	Public Health	1.An operational pathway in line with national guidance	Dec 2014
2. A communications plan of the agreed Adult Obesity Pathway should be developed and include engagement of all stakeholders	Public Health	2.Development and implementation of communications plan	Dec 2014
3. A universal means of the promotion of physical activity should be introduced using available resources such as the Get Active London online resource	Library, Sport and Leisure	3.Number of searches for Harrow on the Get Active London website ((Target number tbc)	Sep 2014
4. Development of physical activity opportunities for specific and vulnerable adult groups such as people with disabilities and people with poor mental health and their carers	Public Health	4.Procurement and development of physical activity opportunities for vulnerable groups as part of the pathway	Dec 2014
5. All stakeholders should agree a Harrow Obesity Charter for participating agencies and their approach to healthy eating which includes workplace catering	Public Health	5.Number of agencies signed up to the Obesity Charter (Target number tbc)	Jul 2014

Environment

Recommendations from Harrow Obesity Needs Assessment:

- Cycle lanes, cycling and walking routes or clubs green spaces that help facilitate staying active should where appropriate be supported and promoted across the borough
- Planning, licensing or other regulations should assess their impact on people's health and should include the impact of concerns about safety and crime.
- Data on obesity should be shared with planning teams to contribute to an assessment of the health impacts

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
1. Ensure the obesity pathway groups have links to green grid planning and strategic planning decisions	Public Health	1. Attendance in the pathway group from Planning and completed examples of joint working in the pathway action plan	July 2014
2. Strategic links should be developed between the Obesity Pathway groups with the Harrow Council Active Travel programme which address the identified needs	Transport	2. Attendance in the pathway group from Transport and completed examples of joint working in the pathway action plan such as promotion of cycling	Aug 2014

Workplaces

Recommendations from Harrow Obesity Needs Assessment:

Workplaces should be supported to have the following:

- Healthy choices in workplace restaurants, hospitality, vending machines and shops for staff and clients, in line with existing Food Standards Agency guidance
- Active travel policies for staff and visitors
- Supportive physical environment (easily visible stairwells, showers and secure cycle parking)
- Recreational opportunities (out-of-hours active social activities, lunchtime walks and use of local leisure facilities)
 - Employers should be engaged and supported to have travel plans that facilitate active travel and include measures such as cycle facilities and travel expenses for active work journeys
 - Effective ways to monitor the number of high energy 'junk' type food outlets in Harrow should be developed through partnerships between schools, children centres, community centres, regulatory services, public health, planning and environmental health. Support should focus on promoting healthier options in premises.
- The community should have support to ensure they have easy access to affordable fresh produce

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
1. Further development of the Healthy Catering Commitment (HCC) in 2014-15 and effective use of existing partnerships with businesses within the council on travel planning and workplace health initiatives	Environmental Health	7. Number of new premises signed up to the HCC accreditation (Target number tbc)	July 2014
2. Development of a workplace health programme to engage with employers in Harrow and include smaller and medium sized businesses	Public	1. Development of workplace programme and number of employers signed up to self assessment and implementation of programme (Target number tbc)	May 2014

Treatment of Adults who are overweight (Tier 2)

- Recommendations from Harrow Obesity Needs Assessment:**
- All agencies in Harrow should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes only if they follow best practice (See NICE Guidance CG43).
 - All advice on weight management should include being physically active and the reduction of inactivity.
 - The requirements for referral to tier 2 services should be specified as part of the pathway and those people who are identified as overweight with a BMI of over 25 should be referred to behavioural support:
 - An appraisal of the efficacy and cost effectiveness of tier 2 weight management services should be completed to inform both the model and approach. The review should inform the commissioning process and be based on the desired outcomes and resources available.

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
<ol style="list-style-type: none"> 1. A review of tier 2 weight management interventions and consider recommissioning. 2. A review of the identification of overweight and obesity, and access to weight management services to inform improvements to accessibility 3. Review and improvements should continue to the Health Check pathway and use of the Healthwise weight management programme. 	Public Health	<ol style="list-style-type: none"> 1. Completed review of tier 2 and where appropriate procurement of tier 2 services 2. Completed review of identification as part of the pathway redesign 3. Number of overweight and obese people referred and taking up the Healthwise programme as part of the Health Check pathway (Target number tbc) 	Dec 2014

Treatment for adults who are obese (tier 3)

Recommendations from Harrow Obesity Needs Assessment:

1. Health professionals should be encouraged to assess the weight of patients who they suspect as being obese by measuring their BMI. Those patients with BMI of 30 and above should be referred to a multi-component intervention in Harrow that includes interventions to:
 - Increase physical activity
 - Improve eating behaviour
2. Drug treatments for obesity should only be considered after dietary, exercise and behavioural approaches have been started and evaluated.
3. A referral should be made to the appropriate surgical clinician for adults with obesity if all of the following criteria are fulfilled:
 - They have a BMI of 40 kg/m² or more, or between 35 kg/m² and 40 kg/m² and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight
 - All appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least 6 months if they have a BMI greater than 50 and for 12-24 months otherwise
 - The person has been receiving or will receive intensive management in a specialist obesity service
 - The person is generally fit for anaesthesia and surgery
 - The person commits to the need for long-term follow-up⁶².
4. All surgical interventions are followed up with multi component weight management including physical activity support

Strategic Actions for Pathway Group:	Lead	Performance Measure	Date
<ol style="list-style-type: none"> 1. Review gaps in tier 3 provision of multicomponent and multidisciplinary weight management support 2. Establish a clear pathway with all commissioners 3. Psychological input should be included into the tier 3 pathway 4. The pathway should include synergy with the eating disorder programme 	CCG	<ol style="list-style-type: none"> 1. Review completed of tier 3 and re modelling of provision 2. Agreed pathway and model for tier 3 3. Agreed pathway and model for tier 3 4. Agreed pathway and model for tier 3 	Dec 2014

Get fit with your fire and rescue service



Kent Fire & Rescue Service
FireFit scheme

“FireFit” is an initiative to raise the standards of health and fitness throughout KFRS (Kent Fire & Rescue Service) and communities in Kent & Medway.

Firefighters have to be fit to do their job. That makes them good role models for the benefits of healthy lifestyle. FireFit uses firefighters in the local community to promote healthy living through exercise. The programmes are developed with local partners to target local communities and those most likely to be at risk.

FireFit gives people the opportunity to test out the training equipment used by firefighters to keep them in shape, and also test their speed by getting involved in firefighter activities such as rolling out a fire hose and reeling them in. Also trying on breathing apparatus equipment which is used in firefighting and rescuing a casualty.

FireFit acts as an excellent engagement tool which can support multiple campaigns both internally within KFRS and externally with our partners. An example of this work previously carried with the NHS Stop smoking team we were able to highlight the advantages of a healthy lifestyle at a pop up event, whilst also promoting smoke free homes whilst conducting home safety visits.

Get Fit with your local Fire & Rescue Service!
Get Fit. Get FireFit.

Healthy Weight in Kent

Val Miller

Public Health Specialist

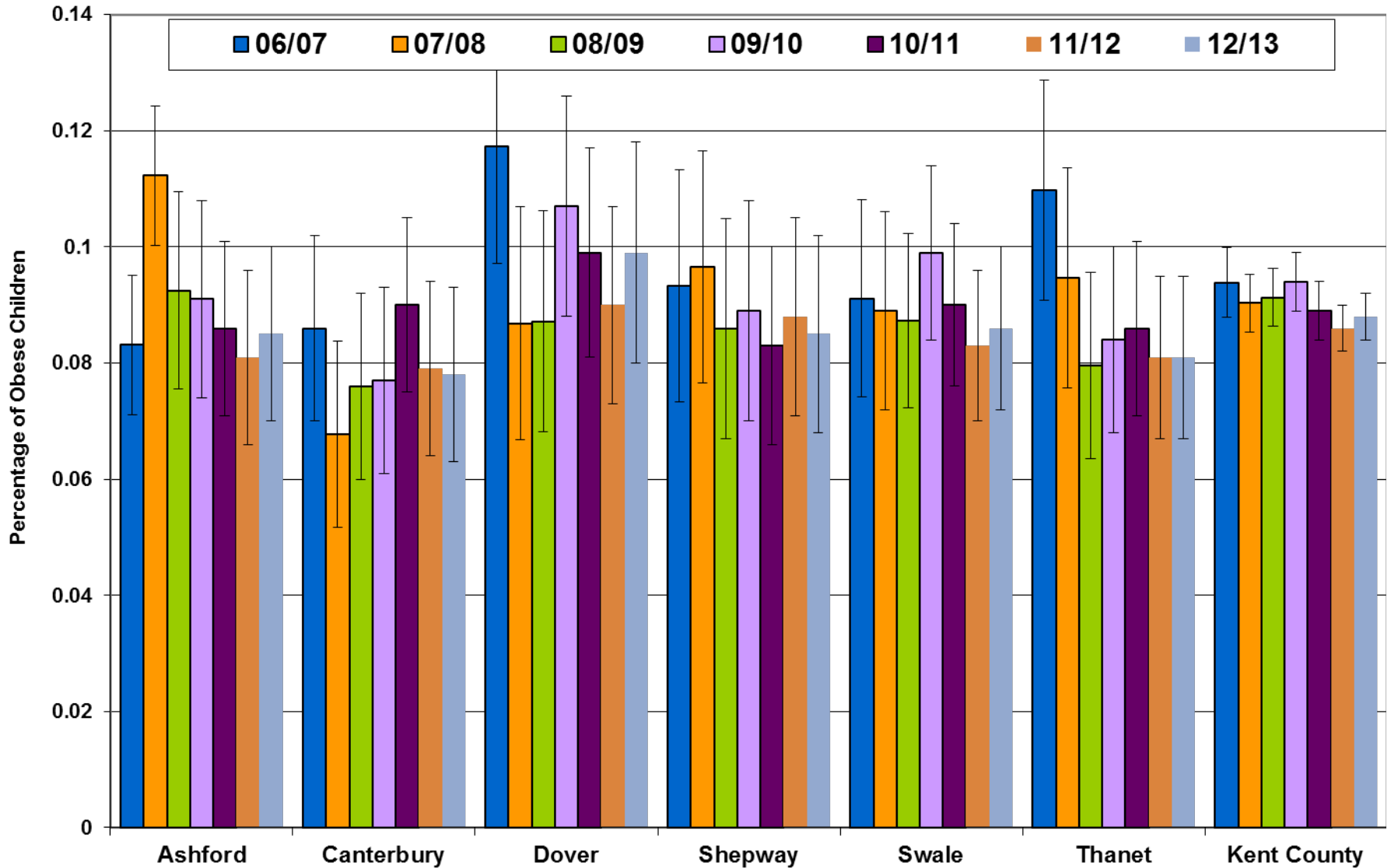
Excess weight in adults in Kent 2012

- The England rate for adults who have excess weight (overweight and obesity combined) is 63.8%. Kent is 64.6%, which is statistically similar to England. Within this there is some variation across the County. This translates into 771,476 people across Kent aged sixteen and above and the following numbers of individuals by District:

Ashford	64,275	Canterbury	69,009
Dartford	53,554	Dover	58,009
Gravesham	53,887	Maidstone	84,142
Sevenoaks	61,172	Shipway	59,146
Swale	75,761	Thanet	75,118
Tonbridge and Malling	63,203	Tunbridge Wells	54,696

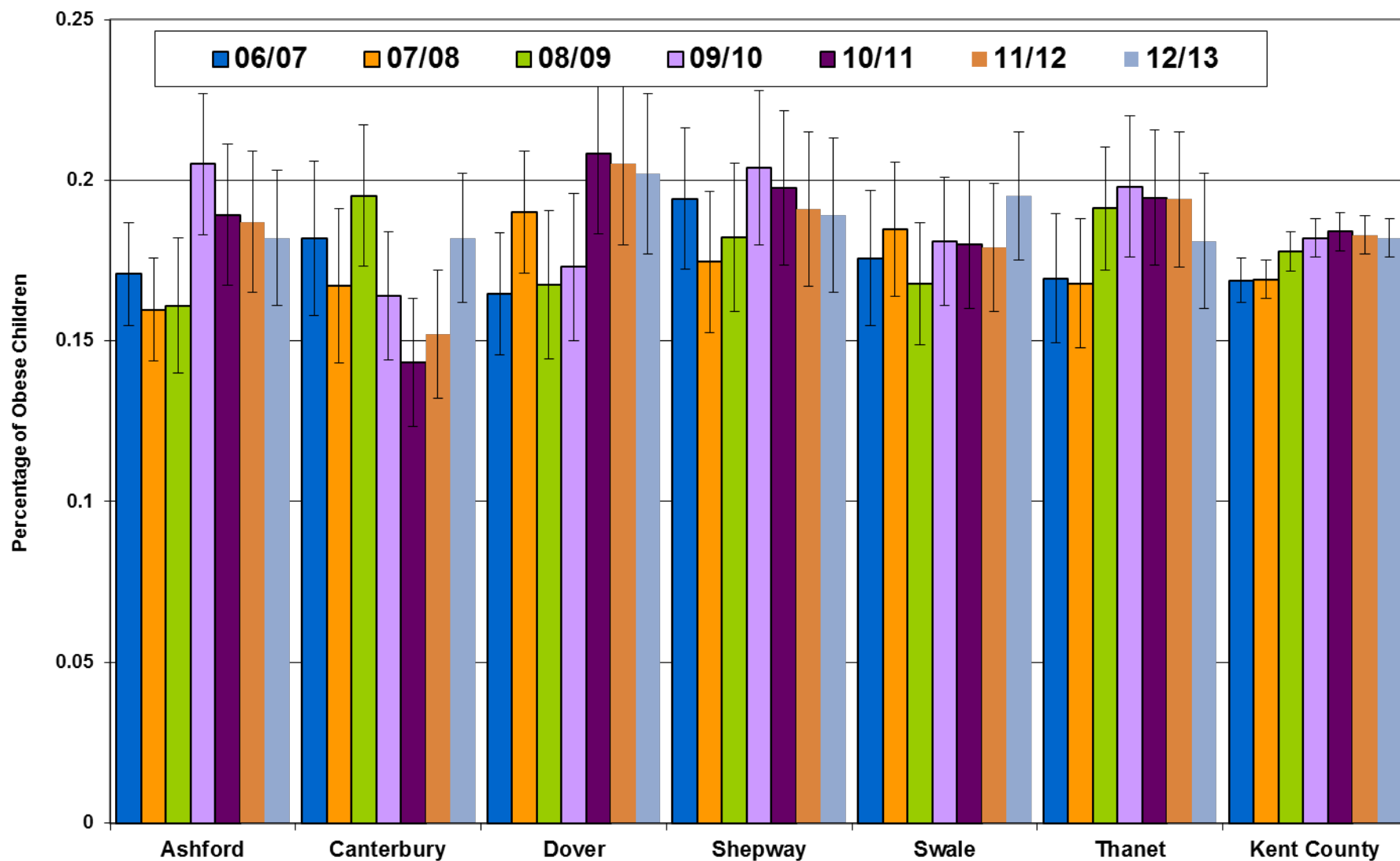
Percentage of Obese Children in Year R by LA in Kent - 06/07 to 12/13

Source: National Child Measure Programme



Percentage of Obese Children in Year 6 by LA in Kent - 06/07 to 12/13

Source: National Child Measure Programme



Commissioned services to increase the prevalence of healthy weight in Ashford

Kent County Council Public Health has

- Recently invested in Children's Centres infant feeding and healthy weight
- Commissioned from Kent Community Health Trust

Adult healthy weight Tiers 1&2

Exercise Referral Scheme

Health Walks

Fresh Start

Food Champions

Health Trainers

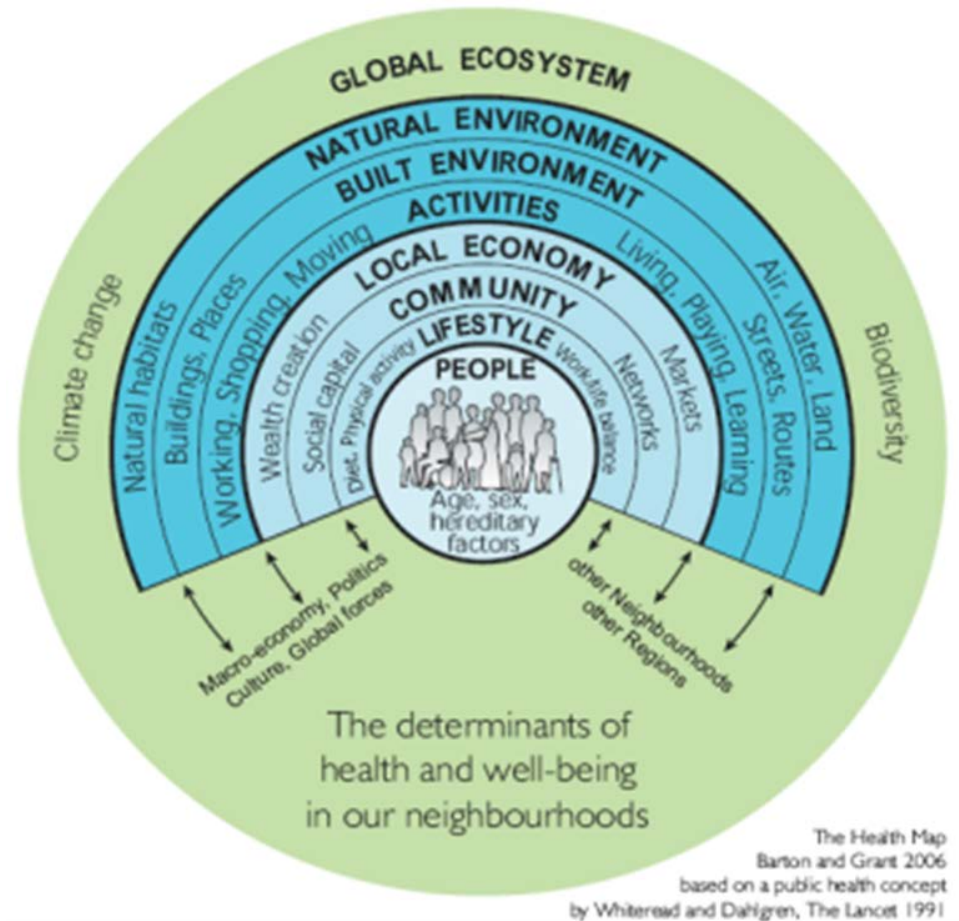
Family lifestyle clubs

National Child Measurement Programme

Healthy Schools Team

- Commissioned Tier 3 4healthyweight service for people with a high BMI who have not been able to lose weight on their own

But ..how to engage with the wider determinants of health?



Moving Forward

- Publication of Public consultation outcomes
 - Develop further needs assessment adults and children
 - Develop a Healthy Weight Strategy for adults and children in Kent
 - Develop a commissioning model for Kent
-

Working in Ashford

What opportunities are there for joint working to reduce the prevalence on unhealthy weight in children and adults?

Healthy Weight Presentation

By Simon Harris



ASHFORD
BOROUGH COUNCIL



Key Statistics

- 77% of people did not know they were overweight or obese **Source: CMO**
- 18.2% of year 6 children in Ashford were obese in 2014
Source: Public Health England
- 22.7% of adults in Ashford were obese in 2014
Source: PHE
- Stanhope is a hotspot area

Why are interventions not perceived as working/making a difference?

- Complex issues
- Results take years
- Organisations are not learning by mistakes
- Biggest concern =
- **Lack of COMMUNICATION between Stakeholders**

Concerns

- Professionals do not share information
- Referrals are inconsistent
- The community do not know about the 'offer'

Recommendations

- ‘Whole systems’ approach
- Develop a locally tailored plan

Outcomes

- Evidence based services
- Locally aligned with core pathways
- Build on what is already there
- The importance to facilitate and collaborate systematically

Questions

- Contact Details:
- Simon Harris
- Ashford Borough Council
- Tel: 01233 330232
- Email: simon.harris@ashford.gov.uk

Ashford Health & Wellbeing Board (AHWB)

AGENDA ITEM 8 – Lead Officer Group (LOG) Report (Christina Fuller, Chair)

Local Implementation of the Kent Joint Health and Wellbeing Strategy

1. The Kent Health and Wellbeing Board at its last meeting considered the final draft of the Joint Health and Wellbeing Strategy. One of the recommendations agreed was that the strategy should be used to engage with the public at a local level in order to stimulate discussion and understanding about the changes that will inevitably occur as integration gathers pace and services are moved out of hospitals and into the community. Local health and wellbeing boards were charged with ensuring that the strategy would be reflected in all public engagement activities planned by partner organisations and that *meaningful engagement on the issues involved was being undertaken*. If this is not the case then plans should be made to address any gaps. Local health and wellbeing board should report back to the November meeting of the Kent Board on this process.
2. A second recommendation agreed by the Kent Board requires the local Health and Wellbeing Boards to ensure local plans *demonstrate how the priorities, approaches and outcomes of the Strategy will be implemented at local levels* and report this assurance to the Kent Board in November 2014. Again, if any gaps are identified actions to remedy these deficiencies should be taken.
3. The LOG briefly discussed these requirements and agreed that a dedicated meeting is required to:
 - a) study Public Health's recently produced Assurance Framework that provides the direction of travel for Ashford against the indicators in the Joint Health and Wellbeing Strategy;
 - b) discuss what further action is required;
 - c) agree how best to capture local interpretation of the Kent priorities; and
 - d) identify gaps in engaging and communicating with local people.

The voluntary sector and Health Watch are key to such discussion and relevant Board members have been invited to attend this meeting.

4. All lead partners have been asked to collate relevant information in readiness. The meeting is scheduled for November just before the Kent Board, allowing Ashford's representative to report as requested. Feedback from the Kent Board will help the LOG report on gaps to the Ashford Health and Wellbeing Board at its meeting in January.

The AHWB is asked to:

- **Note the LOG's need to meet to respond to the Kent Health and Wellbeing Board's request to evidence local engagement and implementation of the Joint Health and Wellbeing Strategy;**

- Authorise the Ashford representative to report on outcomes at the Kent Health and Wellbeing Board meeting in November; and
- Agree for a report to come to the Board in January on the above.

‘Must do’ Project Progress

5. A progress template for each agreed ‘must do’ project has been created and the lead partners will be including key performance outputs and delivery risks. These will be provided at the January Board giving the LOG time to discuss project aims and joint targets. The following provides a brief summary of progress to date.

a) Community Networks (lead CCG)

Ashford has three community networks – Ashford South, Rural and Ashford North. Work is completed to set up the Rural Community Network and there have been several GP group meetings for Ashford South where the notion of a new health zone was discussed. Two conferences for residents and professionals on local health needs have taken place. Areas such as more mental health services, continuity of care, preventative working, family support and improved communications between agencies, and access to community services were highlighted.

b) Farrow Court (lead ABC)

Construction commenced September 2013 and Phase 1 completion (31 no. apartments) is on schedule to finish March 2015 with communal facilities coming on stream in May 2015. Service and funding arrangements with Age UK and KCC are ongoing.

c) Rough Sleeping (lead ABC)

Links with health and other relevant agencies to help rough sleepers or those in danger of becoming rough sleepers have taken place. The root causes of their homelessness and how a safe environment for assessment of their needs is still being explored. The project is being scoped further.

d) Dementia Day Care (Dementia Alliance)

The new Dementia Alliance has recently agreed 3 key areas of work in addition to looking at extending dementia day care. These include consulting local people living with dementia on what service they need, promoting the dementia helpline, and holding an awareness raising event. Further discussion on an additional dementia day centre is required but opportunities to undertake further dementia work at the new care scheme at The Warren will be pursued.

e) Obesity

The Board will be receiving a set of presentations on Healthy Weight to help identify gaps in service provision. A priority project may emerge.

d) Infrastructure Working Group

This working group is an excellent opportunity to consider the nature, scale and capacity of health service provision across the borough and how that may influence the decision-making process on which new sites should be brought forward under the Local Plan. Council planners have engaged with colleagues from KCC in looking at likely future pressures on their service-providing facilities and a forthcoming meeting will engage health service colleagues. As a starting point, a dialogue around the pressures arising from new housing growth will be useful so it can establish a basis for the consideration of where new development should be located.

The AHWB is asked to:

- **Note the progress of projects to date.**

Arrangements for dealing with requests for the Ashford Board to consider strategy, policy and issues of growing concern

6. A number of organisations, including partners, request that strategy documents are brought before the Ashford Health and Wellbeing Board (the Board). In order to ensure that such strategies are appropriately considered it is recommended that they are initially reviewed by the LOG and where necessary a presentation given at their monthly meetings (unless a Board meeting falls in that month). Such timing is unlikely to delay the presentation of any strategy to the Board.
7. The LOG undertakes to report to the Board the outcome of the review via the LOG quarterly report. This report will include any relevant recommendations and where appropriate the strategy document, policy or other similar document will be circulated to Board Members.
8. When necessary the LOG will recommend a full presentation to the full Board. This will, where possible, be tied into a meeting that is focusing on a theme of relevance to the strategy. Regular strategy documents e.g. the CCG commissioning plan will be programmed into the Board's forward plan. In the case of consultation documents the above will be influenced by any deadlines and where necessary the LOG will suggest alternative handling arrangements.
9. There is also request for discussion on issues of growing concern. The horizon scanning part of the partner update reports goes some way to flag such issues that Board members can then discuss. Updates are also thought valuable from the voluntary health sector and Health Watch and it is suggested to the Board that the representatives also, if needed, produce an update report for the Board's information.

The AHWB is asked to:

- **Approve the handling of requests for the Ashford Board to consider strategy, policy and other similar documents through the LOG where appropriate.**

- **Endorse the need for the voluntary sector rep and Health Watch to include a Partner Update if needed.**

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from(delete as applicable)	CCG
Quarter concerned (delete as applicable)	July to September 2014
What's going on in our world	<p>Joint public and stakeholder workshop held with KCC to discuss implementation of the community networks. Three top priorities identified, including Mental Health.</p> <p>Working with partners to develop Children's and Young People strategy</p> <p>Care Quality Commission Report into East Kent Hospitals University NHS Foundation Trust published.</p>
Success stories since last AHWB	<p>Continued development of integrated services to support 7 day working at practice within Tenterden</p> <p>Signed off of the Local Referral Unit business case which includes social services</p> <p>Winter Surge funding allocated</p>
What we are focusing on for the next quarter <u>specific to the key projects</u>	<p>Implementing community network over winter period to test model assumptions</p> <p>Implementing revised specification for Westview to support creating of capacity for GP beds and non-weight bearing patients</p> <p>Developing local stakeholder groups</p>
Anything else relevant to AHWB priorities NOT mentioned above	NHS England published " Achieving Better Access to Mental Health Services by 2020" setting out waiting times standards for mental health services
Strategic challenges & risks including horizon scanning?	Ensuring that implementation of community networks is balanced with current demands of capacity
Any thing else the Board needs to know	
Signed & dated	Neil Fisher, Head of Strategy and Planning 10 October 2014

AHWB key projects are:

Community Network

Project Lead: Clinical Commissioning Group (Sue Luff)

Project Coordinator: Peter Marsh, KCC, Dementia Officer (Email: peter.marsh@kent.gov.uk)

Dementia Day Care

Project Lead: Clinical Commissioning Group (Sue Luff)

Project Coordinator: Peter Marsh, KCC Dementia Officer (Email: peter.marsh@kent.gov.uk)

Healthy Weight (specific project TBC)

Project Lead: KCC, Public Health (TBC)

Project Coordinator: Simon Harris, Ashford Borough Council, Sports Projects Manager & Active Ashford Coordinator, Cultural Projects (Email: simon.harris@ashford.gov.uk)

Farrow Court

Project Lead: Ashford Borough Council (Tracey Kerly)

Project Coordinator: Richard Robinson, Ashford Borough Council, Housing Improvement Manager, Housing Improvement (Email: Richard.robinson@ashford.gov.uk)

Rough Sleeping

Project Lead: Ashford Borough Council (Housing, Tracey Kerly)

Project Coordinator: Sharon William, Ashford Borough Council, Housing Operations Manager, Housing Options (Email: sharon.williamson@ashford.gov.uk)

AHWB priorities are:

Independent living & self management for those with long-term conditions

Dementia

Homelessness

Obesity

Falls prevention

Sustainable development for health & wellbeing

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from	KCC (Social Services)
Quarter concerned	July to September 2014
What's going on in our world	<ul style="list-style-type: none"> • Continuing with KCC Transformation • Home Care tender –now mobilised • Community Equipment tender- work ongoing • Developing Core Offer for Mental Health Services in the community • Falls workshop 24/06/14, excellent attendance, Task and finish group started 12/09/14 • Mobilising Integrated Discharge teams with CCG, EKHUFT, and KCHT in WHH • Malnutrition task force conference 01/10/14. Action plan to be developed to support older people at risk of Malnutrition
Success stories since last AHWB	<ul style="list-style-type: none"> • Chamberlain Manor extra care- Under construction. Landlord Housing 21, 67 units of rented and shared ownership • Young persons supported housing- The Limes – planning permission granted March 2014 for high support scheme, landlord Golding Homes, support provider to be tendered for
What we are focusing on for the next quarter <u>specific to the key projects</u>	<ul style="list-style-type: none"> • Working with CCG to develop Community Networks • Our Place (Wye and Hixhill, supporting a community to be self-sufficient) • Mobilisation of Home care providers • Working with Westview Integrated care centre to understand their nutritional policy • Farrow court- Sheltered scheme undergoing remodelling to extra care, will provide 84 older persons fats, 12 LD and 8 recuperative care • Charing- Feasibility underway for extra care scheme and bungalows as part of larger residential development
Anything else relevant to AHWB priorities NOT mentioned above	KCC Transformation programme, increased access to teletechnology and enablement services. Work ongoing with Dementia Friendly communities. Dementia Web and Carers short breaks service commissioned supporting people in crisis. KCC Older People and Physical disability teams have been restructured across Kent

Strategic challenges & risks including horizon scanning?	No
Any thing else the Board needs to know	No
Signed & dated	Paula Parker 06/10/14

AHWB key projects are:

- **Community Network**
Project Lead: Clinical Commissioning Group (Sue Luff)
Project Coordinator: Peter Marsh, KCC, Dementia Officer (Email: peter.marsh@kent.gov.uk)
- **Dementia Day Care**
Project Lead: Clinical Commissioning Group (Sue Luff)
Project Coordinator: Peter Marsh, KCC Dementia Officer (Email: peter.marsh@kent.gov.uk)
- **Healthy Weight (specific project TBC)**
Project Lead: KCC, Public Health (TBC)
Project Coordinator: Simon Harris, Ashford Borough Council, Sports Projects Manager & Active Ashford Coordinator, Cultural Projects (Email: simon.harris@ashford.gov.uk)
- **Farrow Court**
Project Lead: Ashford Borough Council (Tracey Kerly)
Project Coordinator: Richard Robinson, Ashford Borough Council, Housing Improvement Manager, Housing Improvement (Email: Richard.robinson@ashford.gov.uk)
- **Rough Sleeping**
Project Lead: Ashford Borough Council (Housing, Tracey Kerly)
Project Coordinator: Sharon William, Ashford Borough Council, Housing Operations Manager, Housing Options (Email: sharon.williamson@ashford.gov.uk)

AHWB priorities are:

- Independent living & self-management for those with long-term conditions
- Dementia
- Homelessness
- Obesity
- Falls prevention
- Sustainable development for health & wellbeing

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from(delete as applicable)	Public Health
Quarter concerned (delete as applicable)	July to September 2014
What's going on in our world	<p>Breastfeeding services The tender award for the Kent Infant Feeding Service has been made to PS Breastfeeding. Further communication will be announced shortly. Mobilization is under way and the official commencement date is 1 October 2014.</p> <p>Healthy Weight Consultation on healthy weight services has closed – this focused on Kent residents and the type of interventions / services they would like to see. We are due to report on this in November. Further consultation will be needed with other stakeholders and partners before the future model of service provision is agreed.</p>
Success stories since last AHWB	<p>Smoke Free Parks and play spaces Kent Public Health and Ashford Borough Council are working together to pilot an initiative to keep children's plays areas Smoke Free in Ashford. This will form part of Ashford's litter campaign.</p>
What we are focusing on for the next quarter <u>specific to the key projects</u>	<p>Falls County wide contracts will be tendered for future postural stability classes in community settings commencing at the end of this year. In the meantime, Voluntary Action Maidstone (Brighter Futures) delivers some short-term 12 week courses in East Kent (including Ashford and Tenterden). Contact VAM for more info.</p> <p>Healthy Weight Obesity / Healthy Weight – Public Health is committed to being a lead partner in the work AHWB agrees in relation to this key project. The Public Health team have begun work on producing a county strategy on healthy weight which will support the implementation of local activity.</p>
Anything else relevant to AHWB priorities NOT mentioned above	<p>Healthy Living Pharmacies The Healthy Living Pharmacy programme has been launched and a total of 149 pharmacies in Kent are signed up to take part. 12 of the 20 (60%) pharmacies in Ashford have expressed an interest in the accreditation. The pharmacies will be contacted by the training provider in the next few weeks to arrange attendance at the free Health Champion</p>

	<p>(Understanding Health Improvement) training which forms part of the eligibility criteria. Further details will be published shortly on the Kent Local Pharmacy Committee website.</p> <p>Tobacco Control New Tobacco Control initiatives are being considered to include harm reduction programmes and to incorporate the findings of the recent stop smoking service review. The detail and recommendation of the Rapid Review of Quit Smoking Services is currently being finalised and will inform future strategy and commissioning approach for stop smoking programmes. CCGs and Acute Health services will be included in the development of a future approach. Babyclear stop smoking programme for pregnant women is continuing to be delivered by Health Visitors.</p>
Strategic challenges & risks including horizon scanning?	<p>Priorities for Ashford identified in the district Health Profiles are being considered at the Ashford Lead Officer Group. In the 2014 Health Profile performance data set, Ashford performs significantly worse than the England average on three indicators (Statutory Homelessness, Smoking Status at time of Delivery and Breastfeeding initiation). This shows an improvement from 2013 where five indicators performed significantly worse. This included GCSEs achieved and Obese Adults which are now not significantly different from the England average. Consideration needs to be given to the continued commitment and strategic approach to addressing priorities to ensure that resources are effectively targeted but also that priorities are not abandoned once short term improvements have been identified. Activities that support the indicators should be effective in the long term and sustainable.</p>
Any thing else the Board needs to know	
Signed & dated	2 ND October 2014

AHWB key projects are:

- **Community Network**
Project Lead: Clinical Commissioning Group (Sue Luff)
Project Coordinator: Peter Marsh, KCC, Dementia Officer (Email: peter.marsh@kent.gov.uk)
- **Dementia Day Care**
Project Lead: Clinical Commissioning Group (Sue Luff)
Project Coordinator: Peter Marsh, KCC Dementia Officer (Email: peter.marsh@kent.gov.uk)
- **Healthy Weight (specific project TBC)**

Project Lead: KCC, Public Health (TBC)

Project Coordinator: Simon Harris, Ashford Borough Council, Sports Projects Manager & Active Ashford Coordinator, Cultural Projects (Email: simon.harris@ashford.gov.uk)

- **Farrow Court**

Project Lead: Ashford Borough Council (Tracey Kerly)

Project Coordinator: Richard Robinson, Ashford Borough Council, Housing Improvement Manager, Housing Improvement (Email: Richard.robinson@ashford.gov.uk)

- **Rough Sleeping**

Project Lead: Ashford Borough Council (Housing, Tracey Kerly)

Project Coordinator: Sharon William, Ashford Borough Council, Housing Operations Manager, Housing Options (Email: sharon.williamson@ashford.gov.uk)

AHWB priorities are:

- Independent living & self management for those with long-term conditions
- Dementia
- Homelessness
- Obesity
- Falls prevention
- Sustainable development for health & wellbeing

Ashford Health & Wellbeing Board (AHWB) - Ashford Borough Council Partner Quarterly Update

Update from	Ashford Borough Council
Quarter concerned	July to September 2014
What's going on in our world	<p>Strategic projects</p> <ul style="list-style-type: none"> • Junction10a again progressing with submission by the Highway Authority through the Development Consent Order process in Autumn 2015, aiming to complete the scheme by Spring 2018. • Jasmin Vardimon International Dance Academy – Funding now in place for initial stage of the project. Council leading the business case and project viability assessment. • Elwick Place plans progressing to mixed retail, leisure, office and residential (estimated 600 jobs). Proposals being developed for hotel, cinema, additional car parking and 153 dwelling. • Designer Outlet Expansion (phased extension to double floor space. Public exhibition of plans and extensive publicity. Pre-application consultation underway. • Ashford College (£25m campus for 1,000 students) progressing with revised design produced by Hadlow College. Phase 1 construction by end 2016. • International Station spurs (finding signalling solutions to enable future interoperability for all international service providers. Key to retaining Eurostar and other services in Ashford. Programme management and governance group established. • Chilmington Green (development based on Garden City principles (1000 jobs and 5,750 houses) planning application scheduled for consideration 15th October. • Commercial Quarter (55,000 sq m commercial office floor space plus 150 homes). Agent appointed & architects working on design and layout. • Public realm works on the Commercial Quarter (between Dover Place and Station) have been granted planning permission. • International model railway museum. Visit from Roger Daltrey to discuss proposal to locate the museum on the former Klondyke Works site in Ashford. • Ashford has been named as the best business location in Kent following market research undertaken by FACTS International commissioned by Kent Online. • Eurostar is to launch a new direct service to the south of France (Paris, Marseille and Lille).
Success stories since last AHWB	<ul style="list-style-type: none"> • Self Harm Project – aimed at improving mental wellbeing for young people. Key elements were a training programme for front line professionals and curriculum sessions and activities at HOUSE. Training completed other

	<p>elements of programme ongoing until end November. Anticipate securing CCG extension funding.</p> <ul style="list-style-type: none"> • Dementia Kent Action Alliance – Ashford BC signed up. Training sessions in July & August with more planned. About 200 staff have undertaken dementia friends training. ABC hosted first meeting of Ashford Dementia Action Alliance with 3 projects identified to take forward: Insight gathering into what people living with dementia actually want in terms of services and support: promotion of the Kent dementia helpline and a dementia awareness raising event. • Homelessness – New process developed as a direct recommendation from the ‘Think Housing First Action Plan’ linking those in temporary accommodation to GPs. • Mind the Gap – Graduate EHO continuing to documenting Council inequality work. Update provided to September LOG. Agreed to concentrate on strategies and programmes being pursued by partners as viewed against know deprived areas. This will form the overall action plan and help identify any gaps in service provision or where focus needs to be shifted. Also to use the Health and Social Care maps as evidence base. • Affordable Homes Programme 2015-18 - Successful bid of £2.12m made for 106 properties. • Social Housing - Council given permission by the Department for Communities and Local Government to borrow £1.4 million to build new social housing in Charing. • Domestic Abuse – Additional funding of £150 committed over three years. Will enable Ashford to have a full time IDVA and One Stop Shop/Freedom Coordinator. • Christchurch House – Official opening has taken place. The Council purchased the former commercial property earlier this year and has turned it into short-stay accommodation and support for people who find themselves homeless. • Chamberlain Manor – topping out ceremony took place in August on this 67 apartment scheme near the Drovers roundabout in Ashford. When complete in March 2015 it will offer a mix of one and two bed accommodation, half for shared ownership and half for affordable rent • Little Hill Extra Care Scheme – this Council site was gifted to KCC in June this year as part of the Excellent Homes for All PFI project. When complete in April 2016 it will offer 41 extra care apartments at affordable rents.
<p>What we are focusing on for the next quarter <u>specific to the key projects</u></p>	<ul style="list-style-type: none"> • Dementia - Detailed discussions continue with ABC, Social Services and Age UK about the arrangements for making the Day Centre at the new Farrow Court facility a centre of excellence. The discussions include aiming to deliver services seven days a week with a specific focus on dementia clients at weekends.

	<ul style="list-style-type: none"> • Healthy weight – Focus of October Board meeting. Actions as a consequence of the Boards discussions. • Farrow Court – building work continues on site with dwellings in phase 1 due for completion in March 2015 and communal facilities in April/ May 2015. Once phase 1 is complete phases 2 and 3 will commence in May/June 2015 with anticipated completion of these in late 2016. • Homelessness - Ashford Homelessness Strategy Review and Refresh Stakeholder Event being held 17th November 9.30am to 1.00pm, Civic Centre, Tannery Lane, Ashford. Partners invited to attend. • Community network (Stanhope) – Project brief agreed and initial meeting between ABC & CCG. Working group established, project aims clarified and next steps agreed. • Infrastructure health projects - Desire to better integrate health within Borough growth agenda and coordinate capital s106 funding. Need to develop closer links with the NHS England Area Team. Meeting between ABC, CCG, KCC, NHS England, NHS Property Services scheduled for 16th October to address key developments.
Anything else relevant to AHWB priorities NOT mentioned above	<p>Council is continuing to participate in work with the Integrated Commissioning Group around falls prevention and surge resilience as we approach the winter months.</p> <p>Meeting between Leader and Health & Wellbeing Portfolio Holder with CCG to address merger proposals and also CQC report regarding hospital trust.</p> <p>Council officer participation in the Community Networks workshops and Health Watch Kent – who are we? Workshop.</p>
Strategic challenges & risks including horizon scanning?	Responding to issues raised by future population and housing growth in the Borough, including engagement with the council on the emerging Local Plan to 2030.
Any thing else the Board needs to know	
Signed & dated	Sheila Davison – 07 October 2014

<p>AHWB key projects are:</p> <ul style="list-style-type: none"> • Community Network Project Lead: Clinical Commissioning Group (Sue Luff) Project Coordinator: Peter Marsh, KCC, Dementia Officer (Email: peter.marsh@kent.gov.uk) • Dementia Day Care Project Lead: Clinical Commissioning Group (Sue Luff) Project Coordinator: Peter Marsh, KCC Dementia Officer (Email: peter.marsh@kent.gov.uk) • Healthy Weight (specific project TBC) Project Lead: KCC, Public Health (TBC) Project Coordinator: Simon Harris, Ashford Borough Council, Sports Projects Manager & Active Ashford Coordinator, Cultural Projects (Email: simon.harris@ashford.gov.uk)
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Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from(delete as applicable)	Ashford Children's Health & Wellbeing Board
Quarter concerned (delete as applicable)	July to September 2014
What's going on in our world	<p>The CHWB board are creating a matrix of priorities from across all agencies and aligning these to the county and district health and wellbeing boards priorities additionally linking to the public health priorities and new emerging processes namely the Kent family support framework (KFSF)</p> <p>The ACHWBB have requested to be an early adopter of any training on this new assessment approach to ensure that no children or young people are lost between the transfer from CAF to the new system</p>
Success stories since last AHWB	Securing of resource from ABC of £50K over the next three years to support domestic violence support services
What we are focusing on for the next quarter <u>specific to the key projects</u>	<p>The key issues the board will be focused on over the next quarter are</p> <ul style="list-style-type: none">• Transfer to the KFSF for CAF and ensuring this is shared across all agencies and that pathways to services are clearly understood as are thresholds• Young people's mental health and accessing early help• Children's centre reform and access to services• Childhood obesity 0-4 priority
Anything else relevant to AHWB priorities NOT mentioned above	None to report although the ACHWBB meeting on the 15 th October may inform this item which will be updated verbally at the next meeting.
Strategic challenges & risks including horizon scanning?	The change to the CAF system and poor communication of change by KCC
Any thing else the Board needs to know	None
Signed & dated	Stephen Bell 10/10/14

AHWB key projects are:

- **Community Network**
Project Lead: Clinical Commissioning Group (Sue Luff)
Project Coordinator: Peter Marsh, KCC, Dementia Officer (Email: peter.marsh@kent.gov.uk)
- **Dementia Day Care**
Project Lead: Clinical Commissioning Group (Sue Luff)
Project Coordinator: Peter Marsh, KCC Dementia Officer (Email: peter.marsh@kent.gov.uk)
- **Healthy Weight (specific project TBC)**
Project Lead: KCC, Public Health (TBC)
Project Coordinator: Simon Harris, Ashford Borough Council, Sports Projects Manager & Active Ashford Coordinator, Cultural Projects (Email: simon.harris@ashford.gov.uk)
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