Ashford Health and Wellbeing Board

ASHFORD
BOROUGH COUNCIL

Notice of a meeting, to be held in the Council Chamber, Civic Centre, Tannery Lane, Ashford, Kent TN23 1PL on Wednesday, the 22nd April 2015 at 09.30 am

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The Members of this Board are:-

Cllr Michael Claughton – Deputy Leader Ashford Borough Council, Portfolio Holder Community & Wellbeing (Chairman)

Dr. Navin Kumta – Clinical Lead and Chair Ashford Clinical Commissioning Group (Vice-Chairman)

Cllr Peter Oakford – Cabinet Member for Specialist Children's Services, Kent County Council

Simon Perks – Accountable Officer at NHS Ashford and NHS Canterbury and Coastal Clinical Commissioning Groups

Bill Millar – Chief Operating Officer, NHS Ashford Clinical Commissioning Group

Neil Fisher – Head of Strategy and Planning (Ashford and Canterbury), Clinical Commissioning Group

Paula Parker – Commissioning Manager – Community Support, lead for urgent and intermediate care, Kent County Council

Faiza Khan – Public Health Specialist, Kent County Council

Mark Lemon – Policy Advisor, Kent County Council

Caroline Harris – HealthWatch representative

Tracy Dighton – Voluntary Sector representative

Martin Harvey – Patient & Public Engagement (PPE) Ashford Clinical Commissioning Group

Stephen Bell – Chair of Local Children's Trust

Philip Segurola – Acting Director of Specialist Children's Services, Kent County Council

John Bunnett – Chief Executive, Ashford Borough Council

Sheila Davison – Health, Parking and Community Safety Manager, Ashford Borough Council

Christina Fuller – Cultural Projects Manager, Ashford Borough Council.

Agenda

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10. Forward Plan

July 2015 – Sustainable Development for Health & Wellbeing (ABC)

October 2015 – Progress Report and Refreshment of AHWB Priorities (ALL)
January 2016 – Mental Health Update

11. Next Meeting – 22nd July 2015 – to include election of Chairman

Other dates:
21st October 2015
20th 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).

KRF/VS
13th April 2015

Queries concerning this agenda? Please contact Keith Fearon:
Telephone: 01233 330564 Email: keith.fearon@ashford.gov.uk
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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

(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 **21st January 2015.**

Present:

Navin Kumta – Vice-Chairman in the Chair - Clinical Lead, Ashford CCG;

Tracy Kerly – Head of Communities and Housing, ABC;
Deborah Smith – Public Health, KCC;
Sheila Davison – Head of Health, Parking & Community Safety, ABC;
Neil Fisher – Head of Strategy and Planning, CCG;
Caroline Harris – HealthWatch Representative;
Martin Harvey – Patient Participation Representative (Lay Member for the CCG);
Tracy Dighton – Voluntary Sector Representative;
Amanda Godley – Ashford MHAG Co-Chair and SpeakUpCIC, Project Co-ordinator;
Mark Lemon – Policy and Strategic Relationships, KCC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;
Belinda King – Management Assistant, ABC;
Renu Sherchan – Environmental Health, ABC.

Also Present:

Councillor Britcher.

Apologies:

Cllr. Michael Claughton – Chairman – Cabinet Member, ABC;
Peter Oakford – Cabinet Member, KCC;
Philip Segurola – Social Services Lead, KCC;
Faiza Khan – Public Health, KCC;
Simon Perks – Accountable Officer, CCG;
John Bunnett – Chief Executive - ABC;
Christina Fuller – Cultural Projects Manager, ABC.

1 Declarations of Interest

Tracy Dighton made a Voluntary Announcement as she was employed by two 'not for profit' organisations, namely Ashford Counselling Service and SpeakUpCIC. She was also a Trustee for Case Kent.

Amanda Godley made a Voluntary Announcement as Co-Chair of Ashford MHAG and a SpeakUpCIC Project Co-ordinator.

2 Notes of the Meeting of the Board held on the 22nd October 2014

The Board agreed that the Notes were a correct record.

3 CCG Merger: Update

3.1 Navin Kumta advised that the merger was no longer taking place and this was despite successful presentations being made to a Panel in Tonbridge and discussions with patients and HealthWatch. The Panel saw no reason not to proceed with the merger however a letter had been received from NHS England stating that they believed that small CCG's offered better traction for achieving plans. Navin Kumta said that despite this the two CCG's were still looking at working closely together in order to reduce the risk which created the need to look into merger discussions in the first place.

The Board noted the update.

4 Focus on Mental Health – Mental Health Needs and Service Performance in Ashford

4.1 Circulated separately from the agenda was a copy of the PowerPoint presentation produced by Neil Fisher of the Clinical Commissioning Group. Neil Fisher gave the presentation, and set out below under the specific headings, answered questions raised by members of the Board. In introducing the presentation Neil Fisher explained that people with mental health problems died on average 20 years earlier than people with no mental health problems, with the principle cause of death being cardiovascular illness. He explained that his presentation included only specific information as it related to Ashford's profile, but he advised that the full 120 page document was available for viewing on the Public Health website.

Proportion of CCG Budget Spent on Mental Health Services

4.2 Tracy Dighton advised that she understood that the CCG spent in the region of 8.7% on mental health services, whereas the national average figure was 13%. Neil Fisher acknowledged that the need was greater than the current spend and that nationally it was recognised that mental health services were under-funded. Tracy Dighton further commented that studies showed that investment in mental health services helped to reduce and achieve savings in other areas of health provision. Sheila Davison referred to the data regarding emergency admissions for self-harm over 100,000 population that whilst not indicating a particular issue within Ashford it had been a subject of concern over the past year. Neil Fisher said that whilst the figure for Ashford on this particular issue was lower than the rest of England, there was a need to ensure that help was available, as principally if problems could be identified at an earlier stage it would address issues for later in that person's life. Sheila Davison said that she thought it was useful to map the trends of these indicators for the future and be aware of feedback from those working with young people.

4.3 In terms of the percentage of the population of Ashford with mental health diagnosis, Neil Fisher said this was slightly lower than the national picture. Furthermore nearly 90% of patients had a comprehensive care plan which he believed was a very good figure. In terms of the percentage of the patients

admitted as an in-patient Neil Fisher explained that the figures for Ashford were significantly lower in proportion than the rest of England and commented that the reasons for this could be because high standard community based services had reduced the need for admission. He acknowledged that some would comment that it was because Ashford did not have any mental health in-patient beds. On balance he considered that there was an element of both points in the shown figures.

4.4 Tracy Dighton said that she understood that 25 patients from the county occupied beds out of the area. Neil Fisher said that for the last two quarters in terms of Ashford's residents there had been no admittances outside of the Ashford area. He said they were predominantly to the north of Kent where the nearest hospital provision could be outside of the county.

4.5 With reference to the slides on patients on Care Programme Approach in settled accommodation, and patients on Care Programme Approach in employment, Neil Fisher considered that the figures reflected very well on the position as it related to Ashford. However the figures on patients on Care Planning were relatively poor.

4.6 Neil Fisher also explained that in terms of peer group comparators, the Ashford CCG was compared with ten others from around the country by NHS Right Care, and they looked at the pathways of care and what those pathways of care were looking to achieve.

Dementia Diagnosis

4.7 Neil Fisher explained that the overall target was 67.5% by the end of March 2015. However the CCG figures were in the region of 50%. The CCG were in regular contact with their General Practitioners about this and stressing that although there was limited treatment available for patients with dementia, there were social care provisions which would provide help. He believed that the work being undertaken would see an improvement in the overall figures by the end of March.

Strategic Aims – Focus for 15/16

4.8 Tracy Dighton asked whether care planning was reducing. Neil Fisher commented that NHS Right Care had said that Ashford could do better and that patients should all have a care plan upon discharge from hospital and for long-term conditions.

Mental Health Priorities

4.9 In terms of waiting times for people entering a course of treatment in Adult IAPT Services, Neil Fisher explained that at the present time there were no targets for children or young people but he believed that over time a target would probably be set.

General Questions arising from the Presentation

4.10 Mark Lemon commented that Government targets appeared to be skewed to acute treatment time. Neil Fisher said he agreed with the comment and new targets were being introduced on a regular basis and this was leading to changes in the system to enable those targets to be met.

4.11 Tracy Dighton asked what qualitative feedback the CCG received in terms of mental health service users. In terms of issues which affected Ashford, Neil Fisher stated that communication was sometimes raised as an issue by patients with service providers not always being unaware what services were available. He also said that he believed the correlation between health and social care was weak but believed that the community networks were improving this situation and that this Board was helping to improve the links between health and social care and other areas where there was an overlap between services. Although he accepted that concern had been expressed about the availability of beds in the area, he did not think that evidence supported this perception.

4.12 Caroline Harris said that HealthWatch was undertaking work with mental health providers which could be fed back to the Mental Health Groups. Neil Fisher also explained that he understood the Care Quality Commission was looking at the performance of the mental health service providers. Tracy Dighton suggested that the Chief Executive of Kent and Medway Partnership Trust be invited to a future meeting.

4.13 Amanda Godley had concerns over appropriate training for GP's in terms of mental health services. Neil Fisher explained that GP's had eight formal training sessions per year, one of which would have been on mental health. Additionally GP's could pick up on this area on a personal basis. The CCG was trying to emphasise what services existed to provide support for patients with mental health issues.

4.14 Tracy Dighton commented that the Voluntary Sector had no direct funding which could lead to some organisations ceasing to exist. She asked whether there would be a fund available to support such groups in the future. Navin Kumta explained that in his capacity as Chairman of the CCG that they were attempting to shift spend in the secondary sector to increase funding for the community networks. He explained that funding was stretched due to problems of demand at Accident and Emergency and said that if persons sought help from other available resources such as GP's or walk-in centres, then this would allow funds to be freed up to support funding for other sectors. Neil Fisher explained that Canterbury CCG had allocated £20,000 to help in terms of grants to the Voluntary Organisations and he commented that it would be helpful if this issue was vocalised within the community and in particular that expenditure on Accident and Emergency resulted in there being less funds available to spend on other health services. Navin Kumta suggested that the Better Care Fund could be another avenue to be explored in terms of support. Mark Lemon believed that the Board's discussion on this particular issue would be helpful. Neil Fisher agreed to give a similar

presentation for the voluntary sector to address the issues raised including Better Care Fund.

4.15 In conclusion Navin Kumta thanked Neil Fisher for the presentation which all had found very useful and said that he believed that Mental Health should be covered by future Lead Officer Group reports in order to keep the Board updated about developments. Mental health would also be subject to further consideration at subsequent meetings held in January of the Board. He said he would support the invitation of mental health providers to attend that meeting. These recommendations were supported by the Board.

5 Lead Officer Group (LOG) Quarterly Report

5.1 The report provided an update of the work which had been progressing since the previous meeting held on the 22nd October 2014 and set out a series of recommendations for consideration by the Board.

5.2 Sheila Davision referred to the draft Local Performance Progress Plan which had been circulated separately from the main Agenda. KCC Public Health had been leading on gathering the information for the Plan and work was still in progress.

5.3 In terms of individual projects Sheila Davison referred to the initiative on rough sleeping and advised that Ashford Borough Council had identified a budget of £20,000 towards the cost of a scheme in conjunction with Porchlight. The need for additional funding was highlighted.

5.4 With reference to the Infrastructure Working Group, Neil Fisher said that in relation to Ivy Court, Tenterden he had attended a meeting that week and said that there was a need for options to be developed as it was apparent that there was a need to make available more health provision from those premises. He had met with NHS England and Property Services to take this forward with a view to a further meeting being held on the 5th February 2015.

5.5 The report advised that the Kent Board had adopted the Kent Alcohol Strategy 2014-16 and that the LOG would consider this in February to assess whether there was a need for additional priority action for Ashford. Neil Fisher explained that brewers themselves had a legal obligation in terms of drink awareness but this also related to wider areas such as the availability of alcohol and the operation of pubs and clubs. Sheila Davison said she believed that there were two aspects to this issue. Firstly the health and wellbeing issue and secondly community safety. She explained that at the present time the Kent Alcohol Strategy was not a priority of the Ashford Health and Wellbeing Board but felt that in due course this would need to be considered. She said that the issue was a priority under the Community Safety Agenda falling within substance misuse.

5.6 For future reports Navin Kumta asked that the names of the officers on the LOG be included within the report.

The Board agreed that:

(i) the emerging draft Local Performance Progress Plan (LPPP) (circulated separately from the Agenda) be used as a robust framework to identify and evidence the local response to the Joint Kent Health and Wellbeing Board.

(ii) information be inputted to the LPPP and work on presenting ideas for joint promotion be considered by the Board in April together with the Chairman's formal report.

(iii) it be noted that Ashford Borough Council had identified a budget of £20,000 towards the cost of a Rough Sleeping initiative from April 2015 and partners be invited to consider any financial support they can provide to meet the shortfall of £14,155.

(iv) the Project Updates and that further work on project outcomes be required to collorate with the Kent Joint Health and Wellbeing Strategy, be noted.

(v) the Lead Officer Group to consider the request for funding to support the Rough Sleeping Project as referred to in Recommendation (iii) above.

(vi) the Kent Board's adoption of the Kent Alcohol Strategy and work required to identify priority local delivery be noted.

(vii) the progress for developing the new Homelessness Strategy be noted and consideration be given to the potential and the need for closer joint working in the future to address areas of common concern.

6 Partner Updates

6.1 Included with the Agenda were A4 templates submitted by Partners

(a) **Clinical Commissioning Group (CCG)**

Noted.

(b) **Kent County Council (Social Services)**

Noted.

(c) **Kent County Council (Public Health)**

Deborah Smith referred to recent data which showed an increase in smoking prevalence in Ashford. The Board was supportive of the need to consider this particular issue further.

(d) **Ashford Borough Council**

Tracey Kerly advised that a bid had been made to DWP for funding from the Flexible Support Fund to help those with mental health problems. Furthermore the new Welfare HUB was now available to provide assistance.

(e) **Ashford Children's Health & Wellbeing Board**

Noted.

(f) **Case Kent/Voluntary Sector Representative**

Tracy Dighton drew attention to the difficulties encountered by small voluntary groups in accessing funding via the Kent Business Portal due to the complex nature of the process.

Deborah Smith explained that a new commissioning system would be introduced which although it required certain steps to be followed, it was a lot simpler than the current system. She agreed to ask a colleague to send details of this system to Tracy Dighton and also said that she saw no reason why an officer who handled those grants could not attend a network meeting with the Voluntary Sector to explain how the process worked.

(g) **HealthWatch Kent**

Caroline Harris explained that HealthWatch had carried out a review of visits to the William Harvey A&E and Outpatients and would review them again in the Spring. Navin Kumta considered that the HealthWatch perspective should be reflected within the Action Plan.

Tracey Dighton explained that she had suggested that the Voluntary Sector be invited to give a presentation at a future LOG meeting with a view to them becoming more involved in the process.

7 Forward Plan

7.1 The Board noted the Forward Plan for subsequent meetings of the Board.

8 Next Meeting and Dates for 2015

8.1 Keith Fearon advised that the next meeting on the 22nd April 2015 would provisionally be held at Chamberlain Manor, Drovers Roundabout, Ashford subject to the satisfactory completion of the development. He indicated that he would let Members of the Board know in due course when the position was cleared.

(KRF/VS)

Ashford Health & Wellbeing Board, Chairman's Report April 2015

Overview of opportunities and activity during the past year

The Board brings together elected members, local commissioning leads from Public Health, NHS, CCG's, social care and the voluntary sector to work together and support one another to improve the health and wellbeing of the local population and reduce health inequalities. The Board provides a forum for challenge, discussion and the involvement of local people.

By working collaboratively the Board and recently established Lead Officer Group have broadened appreciation of each other's agenda which has made for a clearer understanding and better incorporation of the work and views of other stakeholders such as Healthwatch & Patient Participation.

It has been important to focus on the local impact of key commissioning plans for primary care, led by the CCG, and adult social care. We have also provided a platform to engage over the development our housing strategies and public health commissioning. In addition, with the introduction of priority themes, we have shared, discussed and agreed direction on key areas including housing and homelessness, healthy weight, dementia, mental health services and independent living are service areas that we consider of prime importance at local level.

With regards to best practice for local delivery the Integrated Commissioning Group (recently renamed the Joint Commissioning Delivery Group) has concentrated on how health can best support adult social care, whilst the newly formed local Children's Health and Wellbeing Committee is focusing on children and young people's mental health services. The Infrastructure Health Group is adding the health and social care dimension to the development of the Local Plan. They are all playing an important role in reshaping services and planning the future health infrastructure.

The Board has followed the progress of a number of priority projects to help demonstrate how the many different strategies and commissioning plans are influencing change and work on the ground. Clearly, the Community Networks are significant local change management vehicles, the impact of which will be seen over time. Smaller neighbourhood projects such as the The South Ashford Hub has involved considerable cooperation between Board members, securing funding bids from Public Health and Ashford Supporting Families.

Partners have also supported each other on several others projects including smoking initiatives, development of Ivy Court, Rough Sleepers initiative and support for the Dementia Care Programme. The Day Centre at the new Farrow Court is planned as a facility of excellence.

The Board's aims and aspirations are now clear and should be pursued in order to ensure success. There is no doubt however that the process has created a

considerable amount of work where the overall administration of the Board meetings is concerned.

The upcoming year

I leave the chair after two years. It is a well organised forum where working relationships are forming strong and desirable outcomes for the benefit of local residents. If this is to continue the Board needs strong attendance with an emphasis on better engagement and more effective communication with its community. It also needs greater clarity as to the role of the local health and wellbeing boards and the relationship with its Kent Board which I have recently discussed with the chairman.

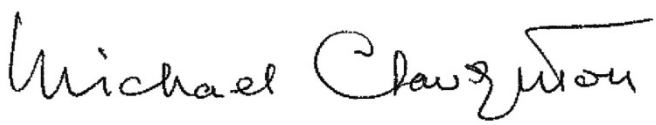
The work by the Local Officer Group on producing a Local Performance Plan should be acknowledged and a review of Ashford's Health Profile will once again help set the agenda for the Board's key local priorities over the summer. This is an opportunity to recognise and support education, job creation, community development, environmental protection & sports, leisure & culture provision ie those elements that have the greatest and most sustainable influence on health & wellbeing. We would all agree the funding mechanisms and commissioning is still very much directed towards health and social service provision so it will be important to look at further integration.

Going forward we will need to understand and react to new announcements about health and social care. The views of local policy shapers, professional groups and the public will be crucial. We know that the NHS will be under increasing financial strain, despite plans for additional funding and pressures on GPs and adult social care will be even greater.

I would recommend a workshop takes place to enable Board members to reflect again on this complex and changing environment and agree the fundamental aims of the Board and help ensure commitment for joining up locally.

I conclude by asking all involved to ensure that as much effort and energy as possible is put into making this local Board work as well as it possibly can for the residents of Ashford. I recognise that health and wellbeing is probably one of the most challenging agendas and it is only by working together that we can and will continue to make progress and build on the positive start we have made.

I should personally like to thank all Board members for their help and support.



Cllr Mike Claughton

Portfolio Holder for Health and Communities

Focus on Independent Living & Self Management

Introduction and Covering Report (Paula Parker – KCC, Social Services)

1. The priority theme for today's meeting is independent living & self management for those with long-term conditions. Two presentations are being given. In order to help Board members to prepare for the meeting, a brief summary of each presentation is provided below along with specific recommendations for the Ashford Health & Wellbeing (HWB).

2. The purpose of the presentations is to update the Ashford HWB on new projects relevant to this priority theme and provide an opportunity to give feedback and identify how support can be provided by partners. The presentations will also enable Board members to think about possible gaps in service provision relevant to the theme and to question how the information provided can be used to influence future projects and inform commissioning decisions.

3. Both presentations will endeavour to show integrated commissioning opportunities. The purpose of both in Ashford is to co-develop with local partners new and innovative services that aim to reduce the risk of and prevent vulnerable older people being admitted to hospital. These services will focus on maximising the independence and self-reliance of older people using a range of approaches including promoting self-management, peer support, building and maintaining social networks and practical support alongside existing health and social care interventions. The partners will plan for success in designing, building and operating a robust care management and delivery model that brings together all the support provided by different agencies, including the voluntary sector, into a single coherent care programme that contributes to a financially sustainable health and social care system.

4. Board members are asked, in advance of the meeting, to consider where there might be opportunities to support the projects as they go forward.

5. This is also an opportunity to advise the Board of a bid for funding that is being made by the Borough Council towards the redevelopment of their sheltered scheme at Tenterden, Danemore. In summary the old scheme of 33 units and four adjacent bungalows will be demolished to make way for 43 new flats and six chalet bungalows. PRP architects are designing the scheme (they also designed Farrow Court) so it will meet the Housing our Ageing Population: Panel for Innovation (HAPPI) standards and be dementia friendly. KCC are supportive of the proposal as it meets the strategic priorities of the Accommodation Strategy. There are also opportunities for joint working with health and social care to reduce pressures on hospital and CCG services through the provision of an extra care scheme in Tenterden and linking to services provided at Ivy Court and Westview. The scheme clearly links to the priority themes of the Ashford HWB.

6. Finally an update is provided on the Falls Strategy as Appendix A to this report.

Presentation 1

Building Community Capacity (Emma Hanson, Head of Strategic commissioning Community Support - KCC)

7. This presentation covers the Community Capacity Building Programme which will explore and better understand the role that community support plays in preventing or delaying the need for statutory services. This will support KCC to develop a commissioning approach for building community capacity including a core offer or menu of services to support wellbeing, social inclusion and independence across the county. The core offer will consist of a range of services developed through co-production principles and built on an understanding of what people need to remain active, well and connected to their communities. All services will be designed to support self-management, enabling people to find their own care and support solutions and prevent or delay the need for statutory assessment and services. For those who do require statutory services, the core offer will offer cost effective alternatives to traditional social care provision, providing increased choice and control.

8. As part of this presentation Emma will tell the HWB about KCCs work with the community of Wye. This is a project about testing new models of care and support that are more community focussed and accountable, through working with local residents to co-design alternative models or care and support.

Presentation 2

Age UK Integrated Care Programme (Diane Aslett, Development Officer, Age UKs in Kent Consortium)

9. This presentation reports on an Age UK pilot that brings together voluntary organisations and health and social care services to provide an innovative combination of medial and non-medial support for older people living with multiple long term conditions.

10. The primary aims of the programme being jointly developed by the partners are:

    - Improving the physical health, mental health and social care outcomes and experiences of older people.
    - Increasing the independence of older people with high level of health and social care needs.
    - Reducing avoidable emergency admissions to acute care among older people.
    - Reducing the dependency of older people upon social care services including delaying the use of high intensity social care (residential and domiciliary care).
    - Ensuring more appropriate use of statutory services for older people with different kinds of need (allocative efficient use of resources).

- Supporting financial sustainability across the health and social care economy.

Independent Living & Self Management Recommendations

The AHWB is asked to:

a) **Note the detailed briefings on the projects.**

b) **To consider how the projects can be supported by stakeholders and commissioners especially through the life of the projects.**

c) **Agree that updates and outcomes will be brought to future meetings.**

d) **To endorse the redevelopment of the sheltered scheme at Danemore, Tenterden and agree that updates will be brought to future meeting.**

Appendix A

Falls Strategy Update

Pathway Review

1. A scoping exercise was undertaken and completed in early June 2014, this focused predominantly on the health pathways. On the 24th June Ashford and Canterbury CCGs held a joint falls workshop with KCC. The workshop was well attended by over 42 interested stakeholders including South East Coast Ambulance Service (SECamb), Age UK, Kent and Medway NHS and Social Care Partnership Trust (KMPT), East Kent Hospitals University Foundation Trust (EKHUFT), GPs, Kent Community Health Trust (KCHT) and Care Home representatives (Care Homes Nursing and Residential).

2. Both the re-active pathway, ascertaining what happens when someone has had a fall and the pro-active pathway, considering what opportunities there are to prevent people from falling, were reviewed and discussed at the event. The outputs from the workshop have been used to inform next steps.

3. A task and finish group was established to pull together all of these activities and outcomes, meetings are held on a monthly basis with two meetings having taken place to date. There is representation on the group from SECAmb, EKHUFT, KCHT, KCC (including Public Health), Integrated Care 24 (IC24), Kent Fire and Rescue Service (KFRS), Local Authority and Voluntary Sector representation.

4. A high level re-active pathway has been developed illustrating the interdependencies between each of the core services, work is underway to draft the detail that sits behind each of the core services including role, remit, inclusion and exclusion criteria. As part of this consideration is being made to the development of joint clinics between Community Geriatricians (EKHUFT) and Integrated Care Teams (KCHT) to reduce duplication and improve communication.

5. The Local Referral Unit (LRU) has been proposed as the central point of contact for all Ashford and Canterbury falls referrals. A top level analysis of falls related activity at EKHUFT has been undertaken to highlight key themes. The 65+ age cohort was looked at in further detail due to the fact that this age group accounted for 72.4% of the overall falls activity (5802 out of 8014).

6. The task and finish group will continue to meet monthly over the next six months to support the move to an integrated service.

Contact: Paula Parker
Commissioning Manager
Kent County Council
email: paula.parker@kent.gov.uk

Community Capacity Building

Please note this is an abridged version of Internal KCC document for sharing with stakeholders

Date: 6 March 2014

Programme Lead: Emma Hanson, Head of Strategic Commissioning Community Support

Senior Responsible Owner: Mark Lobban, Director of Strategic Commissioning

1 BACKGROUND

In May 2012 Kent County Council set a Blueprint for the Transformation of Adult Social Care, in doing so we established the key foundations for transformation;

- A determined focus on prevention and targeted intervention, ensure that services respond rapidly and are more effective.
- To encourage and empower individuals to do more for themselves and ensure greater support is available to carers
- And importantly to this programme brief that we would develop a new deal with both voluntary and independent providers; one that is based upon trust and incentivisation

This is a transformation programme that will deliver savings, not a savings programme that will deliver transformation

Through transformation our goal is straight forward:

That people are at the heart of all adult social care activities, receiving integrated services that are easy to access, of good quality and that maximise their ability to live independently and safely in their community.

This Programme Brief was developed for the Adult Social Care Transformation Board to gain agreement to a new approach to commissioning community based services being planned by Strategic Commissioning Community Support Unit. The objective of the programme is to build community capacity in order to support the transformation of adult social care.

2 PURPOSE OF DOCUMENT

Through the Community Capacity Building Programme we will explore and better understand the role that community support plays in preventing or delaying the need for statutory services. This will lead us to develop a commissioning approach for building community capacity including a core offer or menu of services to support wellbeing, social inclusion and independence across the county.

Our core offer will consist of a range of services developed through co-production principles and built on an understanding of what people need to remain active, well and connected to their communities. All services will be designed to support self-management, enabling people to find their own care and support solutions and prevent or delay the need for statutory assessment and services. For those who do require statutory services, the core offer will offer cost effective alternatives to traditional social care provision, providing increased choice and control.

The current arrangements are based on how services have developed locally without a considered and planned strategic direction. Developing a core offer will mean that there is no postcode lottery about what type of support is available in the community. New services will be designed to maximise inclusion in the wider community, prevent social isolation, promote access to mainstream activities and support people to make informed choices about care early enough to support and maximise independence.

A precedent for this approach has been established, as a core offer for Carers Assessment and Support is already in place. Developing and commissioning the carers core offer involved ending a history of grant funding, 37 grants with 13 organisations including MIND, MENCAP and Age UK/Concern. An outcome based service specification was developed and contracts awarded to 4 providers who meet regularly with commissioners to ensure the contract is fully mobilised. This approach has rationalised the market, reducing the resources needed to monitor services and has established a culture of performance management. In addition, this contract was jointly commissioned with all Kent CCGs via a section 265 agreement underpinning an integrated commissioning approach which directly benefits recipients of the service.

Community based core offers could/should include services such as:

- Information, advice and guidance (including benefit maximisation)
- Social inclusion opportunities- connecting people with their communities
- Employment support
- Befriending
- Caring for Carers
- Advocacy
- Co-production and Engagement Forums
- Tele-technology

Key principles:

- Easily accessible – no wrong door
- Tailored to individuals needs
- Generic services where possible – specialised **only** where proven essential
- Proactive and designed to support self-management
- Jointly commissioned wherever possible

To ensure that:

- People are able to make informed choices about when, how and where to get their support.
- People using services have as much choice and control as possible when building their support package.
- People are able to access services at the right time and place

This programme brief will need to be shared and discussed with all Kent's Clinical Commissioning Groups (CCGs). Kent's Integration Pioneer Programme contains work streams of Self Care and Personalisation which will be directly impacted by this programme; we believe this is a key area for joint commissioning considerations with both CCGs and Public Health. We will use Integrated Commissioning Groups as a means of sharing and gaining 'buy in' to the programme ensuring more effective use of resource and better demand management. For Mental Health the service improvement groups and performance oversight groups with the CCG's will be central to decisions going forward.

This is a programme to ensure the right community based services and support are available across Kent to promote independence and wellbeing, delaying or preventing the need for statutory services. Most of these services are currently provided by the voluntary sector and predominantly through grant funding so inevitably the programme will involve moving a range of services from grants into longer term contracts, requiring a transformation in the way we work with, and fund the voluntary sector.

3 OUTLINE VISION STATEMENT

In repeated consultations with people who use our services and those who choose not to, we been told that ……. ***people want a life not a service.*** However, our current case management model has developed over years to be primarily about supporting people to access care package services. This programme of community capacity development is central and crucial to transformation in two key ways:

- By providing a range of community based services that support independence and wellbeing, diverting people away from formal social care systems (cost avoidance)
- By providing a range of quality, value for money services that provide an alternative to, or supplement traditional care packages (cost savings)

The commissioning of these services supports both the Pathway and Optimisation work streams of transformation by ensuring that individuals who are supported through enablement are supported post enablement to maintain their levels of independence and that the right services are in place to support people in their communities, preventing the need to provide 'dollops of care'.

The programme will move adult social care from a position of inequitable service provision through annually awarded grants to a consistent core offer of services that support independence and wellbeing on longer term funding arrangements, with the majority of support secured via competitive contracts, which can be effectively performance managed.

The programme will seek to assess and understand the impact of investment in community capacity and be able to demonstrate return on investment in two ways:

1. As direct substitute for other forms of support, (cost savings) e.g. enablement or home care, and,
2. In preventing or delaying the need for on-going support (cost avoidance)

Evidence demonstrating the return on investment for preventative or voluntary sector services is minimal, although the evidence that does exist suggests that services delivered by voluntary sector organisations can result in care packages being reduced and positive outcomes. Given the work undertaken by Newton Europe to understand the true cost of care provision within KCC, cost savings will be measurable as services are commissioned with performance monitoring systems in place and regular monitoring. However, cost avoidance is harder to demonstrate and work will need to be undertaken with providers to ensure that performance measures allow for the collection of information that will capture this.

It will be essential to work with optimisation and care pathways work streams to ensure that gaps in service provision are identified, that commissioned services complement and enhance existing services on an individual's pathway through social care and that processes are in place to promote referrals to these services as with any other commissioned service.

The programme will determine the work of the community support unit within strategic commissioning over the next 1- 3 years and will shape the service provision for future generations of vulnerable adults.

Due to the current nature of grant funding, this programme will, by default re-shape Adult Social Care's relationship with the voluntary sector market and consideration must be given to the management of that process.

This programme will support the transformation of adult social care by aligning with on-going work programmes within Community Support, such as Home Care and Accommodation Strategies. It will look at ways to breakdown silos between differing types of provision and support the move towards prime integration partners and local networks of supply.

Core offers will be built upon the needs and requirements of the people of Kent. Central to this programme's development will be the engagement of people who use our services, their families and carers but also members of the general public who do not use services.

This programme cannot be developed or delivered in isolation and wherever possible we will look to jointly commission with public health and Kent's CCGs. Joint/Integrated Commissioning opportunities will be fully explored as the programme develops; including opportunities for KCC to lead commissioning in this area through either section 75 or 256 agreements.

4 OUTLINE DESCRIPTION OF THE BENEFITS

We face some fundamental choices to ensure that we have a sustainable model of social care fit for the future and are able to continue to meet the needs of the most vulnerable in our communities. A different approach is needed if we are to succeed in a context of increasing demand, rising public expectations and less funding. This means adopting an asset based approach which empowers individuals, families/carers and communities to meet their own needs outside of a social care model of support.

Newton Europe our efficiency partner completed a mini diagnostic assessment focused on current provision with the voluntary sector. The diagnostic showed that there was scope for greater use of the voluntary sector as our care pathways are redesigned to direct people to find different solutions in the community. However, the current proposal is to reconfigure services within existing budgets. Monitoring of services will give clear indication of the levels of demand and we will work with providers to understand the impact on their capacity. By understanding the return on investment this approach produces it will be possible to make recommendations regarding future levels of investment or disinvestment in these types of services.

This programme offers a unique opportunity to understand and design methods to evidence impact of investment and explore means of understanding and assessing the wider social return on investment (SROI).

The core offer will enable us to deliver this new model with the following benefits:

- Effective demand management through increase promotion of independence
- Standardised access to community based services for vulnerable people across Kent
- It will enable us to reinvigorate our approach to personalisation and Think Local, Act Personal (TLAP) initiative ***'Making it real'***.
- People accessing services at the right time and in the right place
- Increase the take up of direct payments -a more ***attractive and realistic*** prospect for a wide range of people.
- Review and reduce some service provision, reducing duplication and inefficiencies and commission cost effective services that are fit for purpose.
- Supporting new relationships/federations and consortiums within voluntary sector to create fewer points of management for the local authority

Required Outcomes:

- Reduction in the numbers of people entering care system including the secondary mental health care system
- Reduced residential care admissions
- Reduce average stay in care homes
- Reduction in domiciliary care hours
- Reduced hospitals admissions

- Number of visits to GP (reduction in frequent visits)
- Range of quality of life indicators – including reduced loneliness/isolation, increased confidence and ability to cope

Issues for consideration - dis benefits

- Some voluntary sector organisations may be unsustainable without LA funding
- Changes to voluntary sector can be extremely sensitive and attract press interest
- This programme will require Member agreement to proceed and Members will need regular and substantial briefings as the programme develops

4. Resources

The programme will be funded via decommissioning historic grants and moving to outcome focussed contracts. We aim to fund the programme within the current envelope but will also be looking to secure through robust business plans joint investment with public health and CCGs.

Timeframes are projected and are subject to variation based on approach, governance and capacity issues. If the programme is accepted a detailed project plan will be developed outlining commissioning options and timescales once the core offer for older people, physical disability and dementia services has been identified.

Core offer is being considered for all client groups. However, prioritisation is recommendation for the following:

- Mental Health services core offer. Mental Health grants are already aligned into a core offer with performance measures and therefore are well placed to move to a contracted core offer.

- Older People's core offer. Greatest demand for services is within this client group. Ensuring that older people have access to community services is essential to the success of Transformation programme. We need to ensure we have capacity in local communities to support people coming out through enablement, or who are self-funders or those vulnerable people on the cusp but not quite ready for formal social care.

Services for older people will need to include the needs of older people with dementia, sensory issues and / or with learning disabilities in service specifications and providers will need to demonstrate they can meet these needs.

Consideration will also be given to whether support is commissioned on client group basis or whether there are some services, for example, advocacy which could be commissioned as a generic service across all client groups.

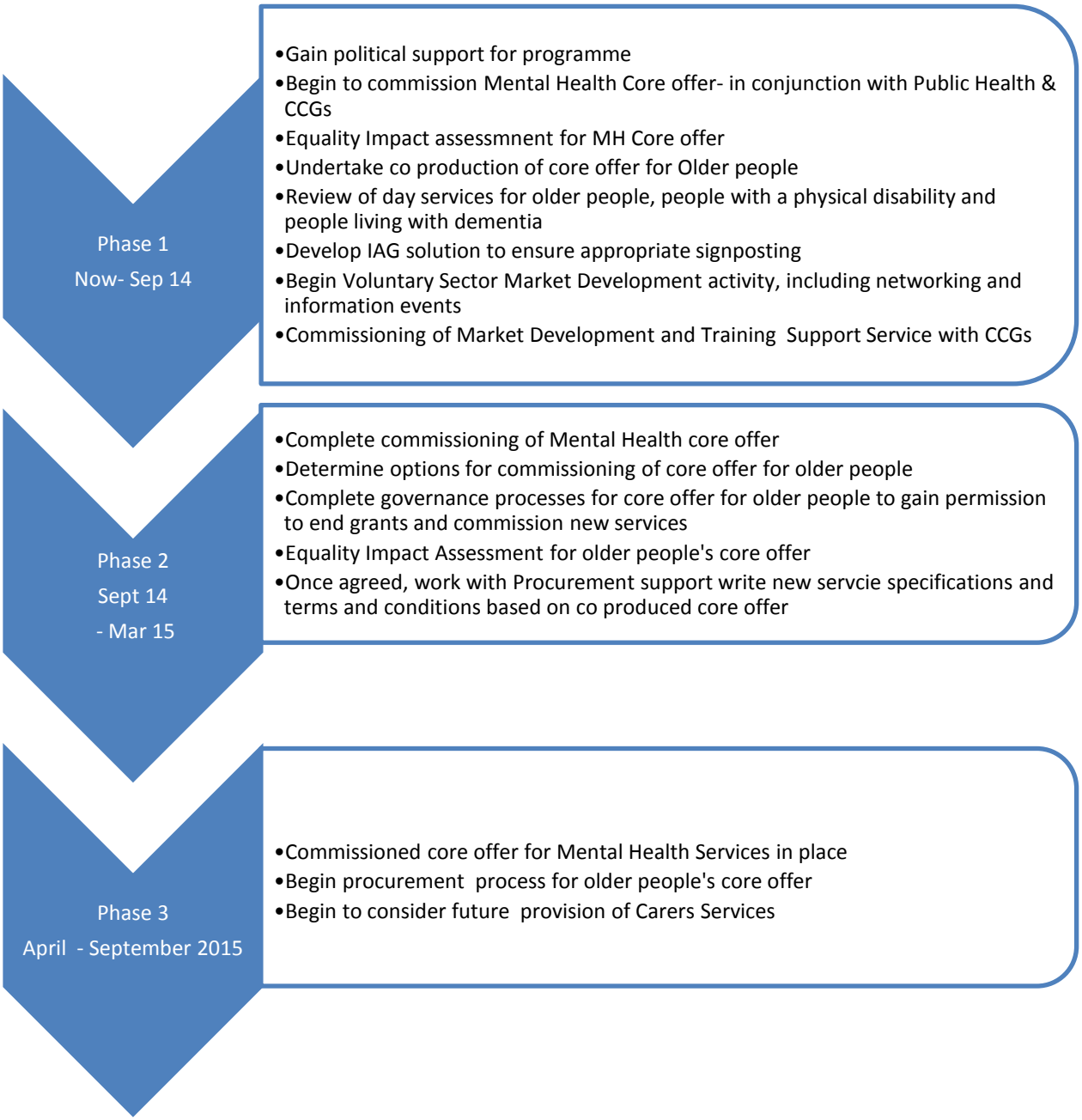
These considerations will be explored through the co-design of services and a range of options presented to Transformation Board as the programme is implemented.

Governance of the programme will be through a Programme Board. This board will link to the Integration Pioneer work streams of self-care and personalisation and report directly to Transformation Board.

It is proposed that Emma Hanson, Head of Service for Strategic Commissioning for Community Support will chair the board. Other members of the board will include representatives from:

- Older People / Physical Disability (Assistant Director(s))
- Learning Disability / Mental Health (Assistant Director(s))
- Strategic Commissioning
- Public Health
- CCG Representatives
- Other operational colleagues as required
- Category Manager Procurement
- Policy
- Performance
- Key partners / providers from the sector

A stakeholder co-production panel will be established to ensure real people's voices are key in influencing future service redesign.


Phase 1
Now- Sep 14
•Gain political support for programme
•Begin to commission Mental Health Core offer- in conjunction with Public Health & CCGs
•Equality Impact assessmnent for MH Core offer
•Undertake co production of core offer for Older people
•Review of day services for older people, people with a physical disability and people living with dementia
•Develop IAG solution to ensure appropriate signposting
•Begin Voluntary Sector Market Development activity, including networking and information events
•Commissioning of Market Development and Training Support Service with CCGs
Phase 2
Sept 14
- Mar 15
•Complete commissioning of Mental Health core offer
•Determine options for commissioning of core offer for older people
•Complete governance processes for core offer for older people to gain permission to end grants and commission new services
•Equality Impact Assessment for older people's core offer
•Once agreed, work with Procurement support write new servcie specifications and terms and conditions based on co produced core offer
Phase 3
April - September 2015
•Commissioned core offer for Mental Health Services in place
•Begin procurement process for older people's core offer
•Begin to consider future provision of Carers Services

AGE UK Integrated Care Programme

March 2015

Briefing for Ashford Health and Wellbeing Board

Age UK is implementing a national Integrated Care Programme across England. It brings together voluntary organisations and health and care services in local areas to provide an innovative combination of medical and non-medical support for older people who are living with multiple long term conditions, at risk of recurring hospital admissions. Through the programme Age UK staff and volunteers become members of primary care led multi-disciplinary teams, providing care in the local community.

The first pilot site was established in Cornwall in 2012 and there are three other pilot sites in development elsewhere in England.

The pilots are seeing good results in terms of acute hospital admission avoidance and patient outcomes/satisfaction. In the first year with a cohort of 100 patients, using the Edinburgh and Warwick mental well-being scale, a 23% average improvement was observed amongst older people in the cohort and there were 30% fewer non-elective hospital admissions.

Early financial calculations showed the potential to save up to £4 for every pound spent for the local health and care system. This relies on re-shaping acute trust services to realise cashable savings. This ratio creates a surplus that is a sufficiently powerful incentive to engage all the key stakeholders in the local health economy to work together. Projections suggest that, over a period of one year, with a £500 service investment for each older person, £2000 could be saved to help meet incremental demand, support re-configuration and provide net savings to invest in prevention.

The initiative is receiving considerable national attention. It won the HSJ Long Term Conditions Management award. Simon Stevens and Norman Lamb have endorsed the approach and are encouraging other areas to adopt it. The Nuffield Trust is supporting the programme with an evaluation.

Age UK has been seeking a further pilot area and has indicated that Kent would be a strong contender. An invitation to bid to become the next pilot was published at the end of October 2014. Ashford and Canterbury applied to become a pilot site.

Age UK in Kent operates a consortia arrangement and the local braches/consortia expressed an interest in applying for the pilot. KCC, KCHFT, Ashford and Canterbury CCG and EKHUFT all agreed to work with Age UK to assess the potential to become the next pilot site for the national project.

A initial meeting of interested parties in Kent was held on 10 October, hosted by the national and local Age UK offices. All interested parties were represented.

Subsequent meeting have happened since where confirmation has been given by all parties to proceed.

2. Background

2.1 Aim of the Age UK Integrated Care Programme

The purpose of the Age UK Integrated Care programme is to co-develop with local partners new and innovative services that aim to reduce the risk of and prevent vulnerable older people being admitted to hospital. These services will focus on maximising the independence and self-reliance of older people using a range of approaches including promoting self-management, peer support, building and maintaining social networks and practical support alongside existing health and social care interventions.

2.2 Objectives

The primary objectives of the programme are:

- Improving the physical health, mental health and social care outcomes and experiences of older people.
- Increasing the independence of older people with high level of health and social care needs.
- Reducing avoidable emergency admissions to acute care among older people.
- Reducing the dependency of older people upon social care services including delaying the use of high intensity social care (residential and domiciliary care).
- Ensuring more appropriate use of statutory services for older people with different kinds of need (allocative efficient use of resources).
- Supporting financial sustainability in the local health and social care economy.

In achieving these aims the partners will monitor and respond to the health and social care outcomes and experiences of carers of people on the programme and seek to increase participants' uptake of wider community services and support

2.3 The key features

- **Partnership**

The Age UK approach is based on strong local health and social care partnerships. Commissioners, local Age UKs, NHS and other providers come together to co-design the service based on a model of integrated care that targets a specific cohort of older people. Risk sharing protocols (resources, finances, commitments etc.) are developed between the organisations as well as measures to monitor and review

achievements. Importantly the strength of this partnership enables all organisations to work towards the same set of outcomes, first and foremost improving the quality of life for the individual concerned.

- **Risk stratification**

The pilot uses risk stratification to identify those older people most likely to be admitted to hospital and to focus resources most appropriately. Evidence from

- **The guided conversation**

Using a 'guided conversation' an Age UK Personal Independence Co-ordinator works with and alongside the older person. They draw out the goals that the older person identifies as most important for them.

- **Signposting**

A key feature is supporting people through the effective signposting and care co-ordination to increase independence and reverse the cycle of dependency. The pilot connects the services that already exist locally through other public and private providers and charities so the services 'wrap around' the older person; e.g. benefits advice, social activities and home help, as part of their support plan.

- **Self-care and independence**

While each older person on the pathway is matched with a volunteer to support them to achieve their goals, all the older people are encouraged to take the lead in managing their own care and wellbeing. An intensive support service is provided to the older person for three months, with the aim of them having achieved their goals and a greater sense of control, confidence and independence by the end of this period. After this, the older person may still be supported as they are also always able to make contact again through their practice or Age UK Co-ordinator if they wish.

- **Integrated working**

Integrated working is co-ordinated and supported through a shared care plan, developed with the older person and reviewed regularly by a multi-disciplinary team based within a primary care setting. There are also clear safeguarding and escalation protocols in place to ensure that if and when medical attention is required, this is delivered effectively and in a timely way. This promotes independence from primary and community health services, as well as preventing avoidable hospital admissions.

- **Systems benefits**

The programme aims to achieve the following system wide benefits:

- Efficiencies and cashable savings in the local health and social care economy

- Aligned incentives and rigorous performance management systems
- High quality patient tracking and data collection systems
- New models of integrated health and social care that harness social capital

2.4 Timeframe

The programme runs for between one year and nine months and two years. Funding is attached, details to be confirmed.

2.5 Appendices

See Appendix 1 for the co- design principles and Appendix 2 for the main phases, activities and roles.

3. Assessment

It is proposed that the pilot initially focus on east Kent (Ashford and Canterbury Coastal) for the following reasons:

- The east Kent Age UK branches are the most interested
- There is a previous Age UK project in Canterbury that will give a good foundation
- The neighbourhood teams and MDT working is well established in the Ashford and Canterbury area
- Health and social care co-ordinators are established in the eastern localities
- There is a good strategic fit with the Ashford and Canterbury Coastal integrated community networks development
- The health trainer model operates effectively in the eastern localities.
- Rural Ashford has set up a virtual ward which would work well with this model.

4. Recommendation

Ashford Health and Wellbeing board to note details in briefing. Ashford Health and Wellbeing board to ask for updates and outcomes to be returned to the board at a future date

Project Group

Nichola Gardner, Strategy and Transformation Director KCHFT

Paula Parker, Commissioning Manager, Strategic Commissioning KCC

Diane Aslett, Development Officer, Age UKs in Kent Consortium

Sue Luff, Head of Service, NHS Ashford and Canterbury & Coastal CCGs

Loraine Goodsill, Transformation Programme Director, NHS Ashford and Canterbury & Coastal CCGs

Rachel Jones, EKHUFT

Appendix 1

The Co-design Principles

Build on existing services

- Build on existing initiatives in Kent, and collectively commit to add value to what is already happening

Use best practice

- Combine proven international best-practice and local best-practice in the service model of care integration

Identify an appropriate patient cohort

- predictive risk stratification to identify patients (500) who would most benefit from the programme, alongside case management and other relevant criteria agreed by the partners
- Develop additional approaches for identifying social care service users who would most benefit from the programme.

Focus on improvement opportunities related to patient conditions and co-morbidities

- Actively consider those morbidities/conditions where evidence from international best-practice demonstrates improvements in care and reductions in avoidable emergency admissions can be made, alongside other local data specific to the morbidities most relevant to Kent

Build multi-disciplinary working including the third sector

- Multi-disciplinary teams of GP and community health providers that include dedicated voluntary sector key workers and volunteers with tailored case management to achieve the key patient and system outcomes.

Support health and wellbeing approaches

- Prevention and wellbeing services provided to people that include self-management support, guided conversation and motivational support through volunteers, coordination of clinical and non-clinical interventions, evidence based and clinically endorsed care pathways

Develop Workforce

- Draw on learning to shape future workforce requirements, including that of volunteers
- Identify values and principles that support the delivery of personalised care
- Co-design and develop an operational climate that enables the multi-disciplinary teams to identify and overcome operational barriers

Demonstrate clear benefits

- Demonstrate how benefits will be realised in the programme. This will include better quality of life for older people, improved service provision, managing clinical risk and identifying efficiencies and cashable savings in both health and social care

Develop sustainable financial and contracting models

- The pilot will explore innovative funding mechanisms; for example, we are modelling a new approach to evidencing cashable savings in order potentially to secure a Social Impact Bond. To support this Age UK are working with partners to adopt different contractual mechanisms that can align incentives and drive change such as Alliance Contracting.

Use effective performance management systems

- Include the development of performance management tools and processes required to track progress
- Measure and track all of the key outcomes throughout the programme

Incorporate appropriate evaluation

- Use both internal formative evaluation processes linked directly to performance management, and external summative evaluation through involvement with the Nuffield Trust evaluation of the wider integrated care programme
- Develop and co-design within each work stream ‘real time evaluation’ and continuous service improvement throughout the programme

Develop wider learning

- Develop the programme on the basis of a ‘shadow’ gain-share and risk-share model across all of the partners to inform understanding and learning about the potential for creating an integrated care alliance contract between the partners
- Contribute learning from the programme to inform the development of the wider national Age UK integrated care programme

Development of tools

- The partnership agrees that all partners have ‘joint ownership of tools developed to support the programme

Appendix 2 Programme Phases and Roles

The pilot involves with following phases and main activities and roles:

Phase	Co-diagnosis 3 months	Co-design 6 months	Build and delivery One year
Tasks	Shared analysis of the challenge and the opportunities Understanding the 'fit' of the programme with existing initiatives. Joint assessment of readiness for change Identify the patient cohort (500-1000)	Create Partnership Agreement. Undertake detailed work streams covering: • Governance and stakeholder engagement • Patient cohort and financial model • Care pathways and clinical governance • Workforce development • Patient and system-wide performance management, patient tracking and evaluation	Recruiting staff and volunteers Development of multi-disciplinary teams in participating GP practices 'Guided conversations' with patients as they join the programme Performance management of the programme Real-time evaluation to inform service and system improvement
Roles	Age UK conversations with local partners, analyse documents and policies etc. CCG undertakes initial data analysis of patient cohort. Meeting of key partners to assess potential for the programme	Local statutory staff and local AUK staff undertake workstream tasks within existing resources e.g. data analysis, agreeing care pathways Age UK national support for tasks through specialist advisers e.g. alliance contracting, financial modelling,	Amendments to existing statutory service practice to meet requirements of care pathways and system changes Service delivered by local MDTs and volunteers and support from wider 3rd sector

End.

Delivering Differently in Neighbourhoods

Kent County Council in partnership with the communities of Wye and Newington

Project Rationale: The biggest demand pressure facing local government is from Adult Social Care because of ageing populations, increased longevity and rising expectations combined with the required dramatic budget reductions. Transformational change is urgently needed to secure a sustainable model of social care which will continue to meet the needs of the most vulnerable people in our communities. Our project is about how we support individuals', carers' and communities' resilience - supporting people to support themselves and others.

Project Description: In essence our project is about testing out new models of care and support that are more community focussed and accountable, through working with local residents to co-design alternative models of care and support**.**

It is becoming increasingly apparent that traditional models of public service delivery cannot solve our most complex social problems. In recent years policymakers and politicians have taken a growing interest in' bottom up' ways of working that give citizens and communities more control.

Traditional models of time and task social care find recruitment and retention of staff increasingly difficult, businesses are finding it difficult to drive enough profit out of care to succeed and therefore cuts that are made impact on the quality of the service delivered.

The Coalition government's Mutuals Programme, run by the Cabinet Office has recognised the value of employee ownership in creating greater freedom and innovation of staff and the added social value via reinvesting profits back into the local community and services.

Social Care Co-operatives: Are not-for-profit businesses owned and run by and for their members (customers, employees and residents). As a minimum our intention is that co-operatives deliver social care in the home e.g. tasks of daily living and personal care. However our aspirations are broader: we will also explore whether the co-operatives can undertake assessment and signposting activity and indeed do preventative work e.g. befriending/preventing loneliness, facilitating attendance at community activities, providing information and advice.

Our aim is to work with a range of community stakeholders using co-production techniques to explore and understand what people need to remain active, well and connected to their communities:

- To support self-management, enabling people to find their own care and support solutions and prevent or delay the need for statutory assessment and services.

- To explore viable alternatives to traditional social care provision which are more locally accountable to the communities that they service, providing increased choice and control.

Kent County Council will work with two communities in contrasting neighbourhoods, testing out whether this is a financially viable vision that achieves better outcomes for individuals and communities and the impact on internal processes and systems, to determine whether there is a case to roll this approach out across Kent.

The two neighbourhoods are:

- Wye and Hinxhill, a largely ***'affluent and rural***' parish near to Ashford
- Newington, a ***'deprived and urban'*** ward in Ramsgate, Thanet

In Wye and Hinxhill KCC has been championing and supporting the development of the DCLG Locality Programme "Our Place" which is in essence is about community budgets.

KCC has been working closely with the parish council and local advocates and already considerable needs analysis and asset mapping has been undertaken.

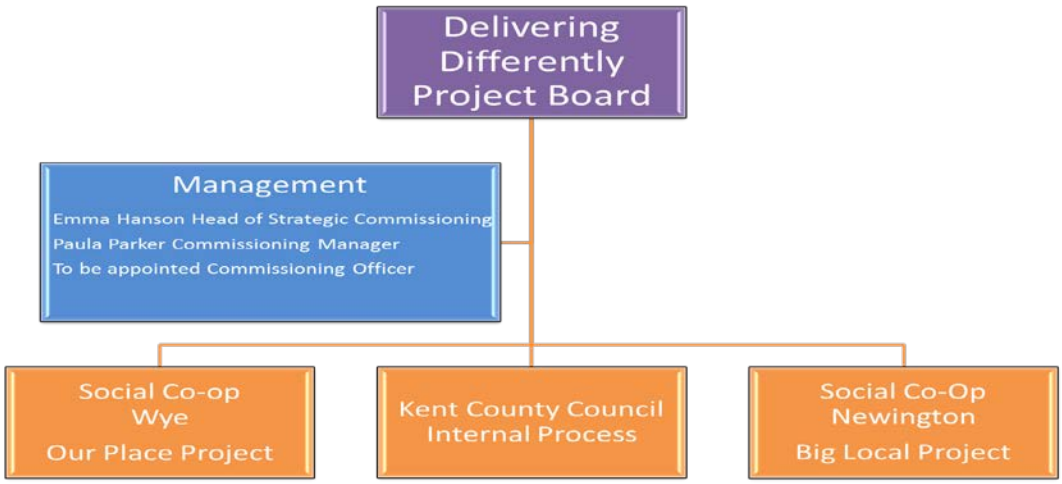
We anticipate being able to create a social care co-operative quickly in Wye because of the significant foundation established from Our Place and because we are already well engaged with the community who are already thinking along these lines.

Newington, an urban ward in Ramsgate, was given money in December 2012 under Big Local. They have an active residents' committee to oversee the funding which, amongst many other things, is doing some innovative work around skills and independence training for people with learning disabilities. This neighbourhood is very different from Wye, but again the residents are already organised and we anticipate that we can move quickly. Newington is also an area with considerable needs in relation to families under pressure, and we recognise that this model has wider application than adult social care.

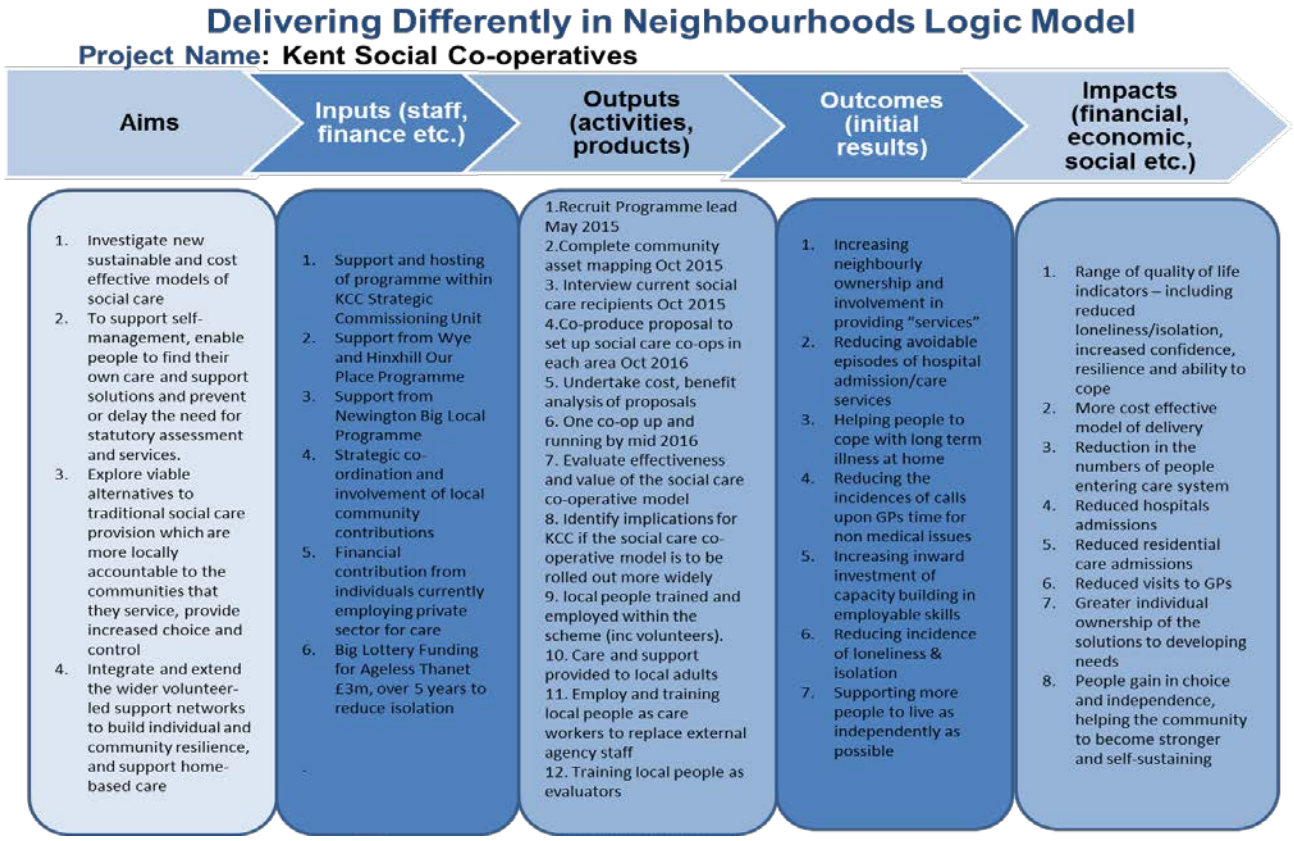
By contrasting these two areas with one where there is not yet a well-defined residents' committee or group, we will learn what the challenges are in co-designing and establishing a social care co-operative in an area that has not had additional funding for a neighbourhood project. This will be important for assessing the costs of roll out more widely.

Project Governance

Our project has three main workstreams: two community-based projects where Wye and Newington will establish what is required locally to establish a social co-op and one KCC workstream to investigate what business processes and policies need to alter to facilitate local social co-operatives.



Project Logic Model



Project Outline and Key Deliverables

- Establish project management & governance
- Map local assets and resources
- Establish/research numbers of people currently in receipt of care support – privately funded and/ or via KCC/NHS
- Programme of "conversations" with current users of services to ascertain how well current support meets need and what is missing
- Understand issues relating to "switching" to social co-op new provider – how choice sits with a co-op model, implications for current providers
- Establish critical mass - would the co-op be just Wye/Newington or need to cover further afield, other communities, villages & parishes
- Research and establish local interest in being a worker in the co-op, terms and conditions rates of pay role and duties
- Explore connection with both communities – economies perhaps on joint arrangements for training, finance and organisational
- Engagement programme from local people - stakeholders especially people in receive of care and their and families
- Undertake cost benefit analysis of social co-op model
- Explore social return on investment and payment by results/outcomes
- Explore funding & investment opportunities
- Develop business case for roll out to other communities

Wye Community

The overall aims and objectives of the Our Place:Wye strategy are to nurture a more inclusive, integrated community, which is more resilient and responsive to individual needs, age and social profile, and stimulates a healthy, caring and sustainable community in Wye and the surrounding areas.

We anticipate that to achieve this we will need to plan and deliver a programme consisting of up to nine projects, comprising three priority projects, four or five 'stepping stone' projects, and an over-arching independent monitoring and review project. These will all be undertaken over a three-year timeframe, delivering value as they go along.

The principles behind The World Health Organisation [WHO] model for Age Friendly communities will also be embedded into our specific project for Intergenerational Learning. The principles will be carried forward into other project areas, so that over the life span of the overall programme, we will be demonstrating a commitment to having our community recognised as one of the first villages in the UK to receive WHO accreditation, which is seen as a planned programme outcome and one of our key performance indicators.

The overall Our Place: Wye operational plan seeks to deliver 8 projects over a five year period.

Project 1: Establishing the community connector service:
Project 2: Developing the social enterprise and new cooperative ways of working:
Project 3: Establishing the community café/food hub:
Project 4: Establishing a community information and technology hub:
Project 5: Extending the community information network:
Project 6: Extending the range of care services in the community:
Project 7: Creating the Intergenerational Activity in the community:
Project 8: Measuring Outcomes through independent Assessment

Project 2: Developing the social enterprise and new cooperative ways of working is closely aligned to the Delivering Differently in Neighbourhoods project, because it aims to establish a multi-stakeholder Social Co-operative way of working, which is responsive at a human scale to serve an ageing population, who are known and understood as individuals, with person-centred care. In essence, the scope and objectives of Project 2 are:

- Creating a new age-friendly enterprise for the community to improve health and well being;
- Clarifying what services will be included in the new ways of working;
- Gaining commitment and funding from stakeholder partners on redirecting commissioning of services more locally.

Through several of these projects we intend to develop a series of new service delivery models that are economically efficient, and replicable; we want this to integrate with and extend, the wider volunteer led support networks already in place to build individual and community resilience, and to support more home-based care.

Timetable:

- March-June 2015 to evaluate the options for a new enterprise, and to consider establishing the new organisational structure and legal format.
- Autumn 2015 – Developing the new commissioning arrangements for agreement with stakeholders.
- Mid 2016 – March 2017: Planning the transition to new arrangements

Process of setting up the co-operative structure in Wye

The Parish Council remains the accountable body for Our Place: Wye until April 2015 when our new governance body – the Programme Management Group – will be created to oversee the development and implementation of the Programme.

Emma Laycock, the Co-operative Advice Manager at Co-operatives UK, has advised us to engage either one of the Co-operative Development Bodies: - Principle Six or Mutual Advantage to advise on the appropriate business case. We are breaking new ground in Kent as most social co-operatives are worker-owned, so we will draw on the experience of co-

operative development experts. Emma Laycock will also help us with the **governance arrangements** and Co-Ops UK will produce an **Options Paper** to highlight appropriate legal forms and models and assist with the **registration.** Emma indicated that the entire process could be completed within three months approximately and for around £2,000. We have the funds for this in the current budget.

Newington Community

Newington is a Big Local community. Big Local is an exciting opportunity for residents in 150 areas around England to use at least £1m each to make a massive and lasting positive difference to their communities. Big Local brings together all the local talent, ambitions, skills and energy from individuals, groups and organisations who want to make their area an even better place to live. Big Local is funded by the Big Lottery Fund and managed by Local Trust. Nationally they work with a range of partners to deliver Big Local, building on the skills and experiences of others to provide expert advice and support for residents.

The Big Local programme aims to achieve the following outcomes:

- Communities will be better able to identify local needs and take action in response to them
- People will have increased skills and confidence so that they can continue to identify and respond to local needs in the future
- The community will make a difference to the needs it prioritises
- People will feel that their area is a better place to live

Two years of community engagement, (Newington was announced as a Big Local area Dec, 2012) led to the creation of a resident led partnership (residents must always form at least 51%) that seeks to engage with stakeholders, including local authorities in order to make Newington an even better place to live. Local Trust endorsed Newington's community led plan for the first two years of the programme – setting out priorities and aspirations, in autumn 2014 – including the pursuit of locally connected models of care and support. The Newington plan states:

> **….. one persistent problem in Newington is that services are often 'parachuted' in from outside. Agencies and staff are not known to local residents, and as a result take-up can be very poor; we rarely see the creation of paid roles for local people.**

The social co-operative will build on work in Newington to date and the projects planned for the coming year. For example, Newington has access to the 'Star People' programme run by UnLtd, (alongside Big Local): The Foundation of Social Entrepreneurs – which encourages

people in Big Local areas to think co-operatively. Although the 'Try it', 'Do it', 'Build it' approach was initially designed for individual social entrepreneurs; we believe it could be adapted to a whole community.

Newington is also a 'Connecting Communities', (C2) area, (pre-dating Big Local): a cost-effective way of working with communities to empower both local residents and frontline service personnel to improve health, well-being and local conditions in disadvantaged areas. Newington residents have been working with Hazel Stuteley OBE on C2. Hazel Led the reversal of a deeply stigmatized 'sink' estate in the 90's which became a national 'flagship' for health improvement and community renewal (Beacon Project, Falmouth 1995-1999). Hazel is Fellow of the Centre for Welfare Reform.

West Kent Housing recently won the contract to build a new 40 bed extra care sheltered scheme in the heart of Newington. We envisage developing new and exciting outreach and in reach models of care and support; making shared facilities, including a restaurant and gym available for the wider community.

The Newington Project will have strong intergenerational element to align with our aim of revolutionising delivery of social care in the long term. With this in mind we will seek to engage young people through the Marlowe Academy – a secondary school that sits at the heart of the community and whose Sponsor/Chair of Board of Trustees is Sir Roger De Haan CBE. Sir Roger is supporting major initiatives to improve access to education at primary and secondary levels and received a knighthood for services to Education and to Charities in Kent and overseas in the New Year Honours 2014. It is hoped that we can build on this spirit by supporting young people to develop skills that can be reflected in a social care co-op model for the community; changing perceptions of care as a career path.

Kent Rural Community Council

Action with Communities in Rural Kent is the delivery partner in the county for 'Village SOS': a new initiative from the Big Lottery Fund to launch a rural revival and inspire people to start community businesses that will breathe new life into their areas and create jobs. The programme offers tools, support and expert guidance to help communities take a step towards starting their own businesses and guide them through the journey from their initial idea to transforming the area. We believe working with Rural Kent on Village SOS between the two neighbourhoods could fit well with the creation of the social care co-op.

Co-Designing New Models of Care

One clear feature of an age-friendly society would be the consistent involvement of older people in the governance and co-production of services, initiatives and activities, and our approach to 'Care and Support' has this at its centre. Creating the social co-operative will be an essential infrastructure step towards this, but overtime, we want to go further than just arranging a new way to manage what exists today.

We think that there are three elements to the issues of "care and support" that will need enhancement to achieve greater levels of sustainability and closer integration with community/village life:

- Improving the quality of the arrangements whereby people enter into contracts with private/third sector to provide non- personal care for family members, provision of meals, cleaning, shopping etc
- The support for family carers
- Developing design and implementation options for new services for joint Community-led, publicly funded care, currently managed through KCC and the NHS.

Burstow's Report – Commissioning on Home Care

If homecare is not yet in crisis, it soon will be. That was the stark message delivered by former care minister Paul Burstow's commission on homecare. Key recommendations from the Key to Care report include a living wage for all care workers, along with clear training and career pathways for care workers in both health and social care.

We believe that this project will inform and enable new and locally accountable models of delivery which will support KCC in achieving the key outcomes of the Burstow's Report. Local people working to provide care in their communities will reduce travel time, the roles developed will be far broader than just time and task home care with workers in the co-op working to ensure peoples wellbeing and independence is maximised. The model will be locally accountable for delivery of outcomes and high quality dignified care.

Internal processes and policies with Kent County Council

The KCC internal workstream will scope out what processes and policies need to alter to support development and delivery of local social co-op including:

- Referral Systems
- Assessment of Need
- Eligibility and allocation of resources
- Case Responsibility
- Safe Guarding / mental capacity and consent
- Impact on charging policy and Care Act Care Cap Calculations
- Social return on investment and payment for results / outcomes
- Developing mechanisms to fund social co-op for delivery of care and support

    - Provider Managed Services
    - Community Brokerage
- Information Governance Issues and data sharing protocols

Cost Benefit Analysis

We must understand if our vision for a social co-op is financially viable, delivers better outcomes for individuals at educed costs and what changes would be needed to KCC's internal processes and systems.

Mapping of adult social care current spend in the two communities shows;

- Wye and Hinxhill with 2282 residents of which 35% are over 65 and 54 people are aged 90 or over there are 28 people who receive an ongoing support package. The total annualised average spend is over £358,000 - in addition to this will be many people who fund their own care.

- Newington with 5210 residents of which 14.5% are aged over 65 and 20 people aged 90 or over. There are 51 people receiving an ongoing support package. The total annualised average spend is over £168,000 - with less people funding their own care.

In both communities care and support is currently provided via a range of different contracted and grant funded providers. The residents in receipt of support have a range of needs. Most are older people but some are people with physical, sensory and learning difficulties and people with mental health needs. We believe that it will be possible to provide the more tailored support that people want, more cheaply through the co-operative model, but …… **The most important benefit must be reduced health and social care costs, because if this model does not significantly reduce costs then it will not be possible to roll it out.** The evaluation must therefore provide robust evidence of cost reduction and increased efficiency.

Identification of other stakeholders and partners

Although this project has begun being adult social care sponsored and focused through the life of the project we will be identifying opportunities to work with other stakeholders and commissioners including:

- Public Health
- Clinical Commissioning Groups
- Children's Commissioning
- Thanet District Council (Newington)
- Ashford Borough Council (Wye)

Project Sponsors/Partners

Carl Adams Newington Community
carl.adams@ruralkent.org.uk
Mobile: 07771 932 605

Emma Hanson Kent County Council
emma.hanson@kent.gov.uk
Mobile: 07595088589

Peter Begley Wye Community
peter.begley@initiativesincare.co.uk
Mobile: 07972216419

Planning for tomorrow, delivering today

Operating Plan 2015/16 summary

This summary plan gives an overview of our work programme for 2015/6. Our operational plan is intended to make sure that what we set out to do is realistic and achievable, given the resources we have.

The plan sets out how we will focus on delivering a number of foundation projects for mental health, long-term conditions, urgent care, and planned care aligned to Health and Well Being Board priorities. It also sets out how we will work with our providers to meet NHS Constitution standards and what we will do to deliver harm free, high quality care in a financially sustainable way.

Key to the delivery of our plans will be Commissioning for Value, a collaboration between NHS Right Care, NHS England and Public Health England. This will enable us identify real opportunities to improve outcomes and increase value for local populations. It will also help us to prioritise areas for change, better utilise resources and make improvements in healthcare quality, outcomes and efficiency.

Aligning local plans to Health and Well Being Board priorities and national outcomes

		National Outcome Indicators			Health and Wellbing Strategy Outcomes	Local Priorities				
		Seven Outcome Ambitions	Strategic Risks	Measures		Community Network	Commissioning for Value	Parity of Esteem	Urgent Care	Primary Care
Effectiveness	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 EQ5D 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.	✔	✔	✔	✔	✔	✔
Experience	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	✔	✔	✔	✔	✔	✔
Safety	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	✔	✔	✔	✔	✔	✔
Accountability	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	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)		✔	✔	✔	✔	✔

Commissioning priorities for the year ahead

The priorities set out in our 2014/19 Strategic Commissioning Plan 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.

2014/15

Our commissioning projects were designed to put the foundations in place, allowing for stabilisation during 2015/16 and significant transformational change during 2016/17, supporting people to look after themselves within their local community.

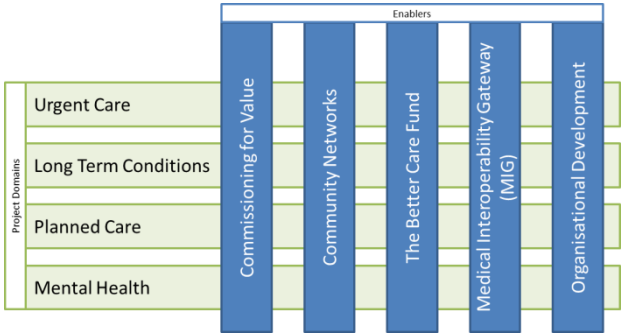
To this end a number of projects have been delivered during the first year of our plan. Examples of these are:

- ***Long Term Conditions***
  - Community Networks have been set up
  - Increased our dementia diagnosis rates
  - Our care homes projects have led to a reduction in urgent care attendances and admissions
- ***Mental Health***
  - Primary Care base mental health workers are now in place
  - Significant progress in increasing recovery rates with our IAPT services whilst also reducing waiting times.
- ***Urgent Care***
  - New integrated discharge teams
  - Reduced delays in having care packages in place for timely discharge following inpatient care
  - Local Referral Unit ensures that patients are offered support within their own homes
  - Trialled weekend opening for general practices

2015/16

The CCGs have recognised that in previous years we have attempted to effect change across too many fronts and have subsequently not have sufficient capacity to deliver the goals we have set ourselves.

Commissioning for Value is a collaboration between NHS Right Care, NHS England and Public Health England. The programme is about identifying priority programmes which offer the best opportunities to improve healthcare for our populations – improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system. As a consequence of this approach, we are able to focus the work of its limited commissioners on areas that will generate best outcome clinically and financially.



Commissioning for Quality and safety

Patients and the quality and safety of care they receive continues to be the focus of all that we do. By ensuring that quality improvement is integral to our future strategy as well as the CCGs vital assurance role, we are able to commission clinical services which provide high quality care, the best outcomes for patients and a positive patient experience.

Commissioning projects 2015/16

	Anticpated Outcome	Constitutional Standard	M	J	J	A	S	O	N	D	J	F	M	2016-17
Urgent Care														
– Integrated Urgent Care Centre	Reduction in A&E Attendances	A&E												
– Seven Day Primary Care	Reduction in A&E Attendances	5YFV												
– Minor Injuries Units	Reduction in A&E Attendances	A&E												
– Care Homes Support	Reduction in Non-Elective Admissions	Better Care Fund												
– Paramedic Practitioner	Reduction in Non-Elective Admissions	A&E												
– NHS 111 Procurement														
Planned Care														
– Orthopaedics Triage Service	Reduction in referrals and procedures	RTT												
– Rheumatology	Reduction in referrals	RTT												
– Personal Decision Aids	Reduction in referrals and procedures	RTT												
– Dermatology	Reduction in referrals	RTT												
– Wet Age-Related Macular Degeneration	Reduced cost of treatment													
– Falls Prevention and Treatment		Better Care Fund												
– Community Loan Store	Earlier discharge from inpatient episode													
– Community DVT Service														
– Anti-Coagulation Service														
– Breast Cancer														
Mental Health														
– Care Programme Approach	Reduce admissions, increased employment	NHS Right Care												
– IAPT Procurement		NHS Right Care												
Long Term Conditions														
– Cardiology	Earlier identification, Reduced non-elective admissions	NHS Right Care												
– Chronic Kidney Disease	Earlier identification, Reduced non-elective admissions	NHS Right Care												
– Diabetes	Community based care													
– End of Life Care	Community based care													
– Neurology		NHS Right Care												
– Stroke		NHS Right Care												
– Dementia	Earlier diagnosis	5YFV												
– Age UK														
– Reducing Community Nursing Demand	Increase capacity													
Child Health and Maternity														
– Children's Strategy														

Health Reform Group - New Cases

Health Reform Group - Post Implementation Review

Review of 2014/15: NHS Constitution Standards

Referral To Treatment waiting times for non-urgent consultant-led treatment	Target	2014/15	Commentary
Admitted patients to start treatment within a maximum of 18 weeks from referral	90.00%	Underachieving	EKHUFT has failed to achieve the national referral to treatment standard this year. A recovery plan was agreed with the Trust, including action by the east Kent CCGs to reduce referral rates in T&O, to achieve compliance by April 2015. This plan failed due to the following factors: Lack of uptake in the independant secto; staff sickness; increasing numbers of cancer referrals, and consultant compliance to pathways ie spinal. A revised plan returning the trust to RTT complaince by October 2015 has been received by CCGs and the activity that undpins it is included in 2015/16 activity plans and contractual values. The CCGs support this more realistic (given the scale of the backlog and previous deleivery performance) trajectory. We will, however, be seeking further assurance on the 12 assumptions that support the delievery of EKHUFT's plan, many of which relate to acute sector capacity.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95.00%	Achieving	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92.00%	Achieving	

Diagnostic test waiting times	Target	2014/15	Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99.00%	Achieving	Recruitment to key posts have meant that this standard underachieved in Q1,2 & 3 through a robust action plan and recruitment campaign performance improved in December 2014 and remains compliant.

A&E waits	Target	2014/15	Commentary
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95.00%	Underachieving	While A&E attendance levels have remained broadly flat waiting time performance steadily worsened during 2014/15 with the EKHUFT failing the standard, despite an investment of £8m in east kent with the majoriy of this resource deployed to the acute trust. A system wide improvement plan was agreed in January 2015 and at the same time the CCGs in east Kent revised and strenghtened governance and performance management arrangements. Plans have been monitored weekly against agreed recovery trajectory with bi weekly senior operational leadership review. Due to ongoing failure of this standard CCGs issued EKHUFT with a contract query notice in March 2015. A new 'Emergency Access Recovery Plan' has been submitted to the CCGs by EKHUFT. EKHUFT have invited Emergency Care Intensive Support Team into Trust on 13-15 May to underatake a full diagnostic of both the flow of patients through A&E and a review of all patients with a LOS greater than 7 days. CCGs will continue to work with the Trust and health economy partners on a sustainable plan to achieve this standard by the end of Quarter 2 2015 - this will include individual provider plans which will underpin the system wide improvement plan. Compliance of this standard by October 2015 is contingent on the findings of the ECIST report.

Cancer waits – 2 week wait	Target	2014/15	Commentary
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93.00%	Achieving	Achievement of cancer targets has been variable throughout 2014/15, with the majority of challenges arising in 2 week waits for first appointment, and 31 day wait for subsequent surgery. The overall target of 62 days from referral to first treatment was challenging throughout the year, but has shown improvement and recovered performance to standard through the production of a trust wide action plan which led to a revised referral form for GPs to follow for 2 week breast cancer patients and trust wide changes to diagnostic support and workforce. EKHUFT has made significant improvements to booking procedure allowing the service to recover its position in part although GP refferals remain high along delays on complex pathways, taking longer to diagnosis primary cancer and therefore initiate treatment. The standard is now being monitored through a senior cancer group to ensure these standards are met through the robust monitoring of a revised cancer plan.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93.00%	Underachieving	

Review of 2014/15: NHS Constitution Standards

Category A ambulance calls	Target	2014/15	Commentary
Category A calls resulting in an emergency response arriving within 8 minutes	75.00%	Achieving	Achievement of the national targets for ambulance response times has been variable throughout the year. Recruitment of additional paramedics has been initiated in 2014/15, with plan s in 2015/16 to train additional paramedic practitioners. Development of an improved integrated local first responders team is planned for 2015/16.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95.00%	Achieving	

Mental Health	Target	2014/15	Commentary
Dementia - % diagnosis rate	66.70%	Underachieving	The CCG aims to improve the identification and care for patients with Dementia from 62.2% as at February 2015 to 66.7% by the first quarter of 2015/16. Throughout 2014/15 actions have been taken to increase the number of patients identified as having dementia in all GP practices, including data cleansing and programmes of training and support for practices to sign post and support patients following diagnosis and additional GP support to enable the identification of dementia patients.The reported position for the end of Feb 15 was 62.2% of patients identified in C&C and 49.91% for Ashford. Practice engagement remains the challenge in Ashford with plans to achieve this standard by Q2 2015/16 with C&C expected to meet the standard by Q1 of 2015/16. CCG clinical chairs will continue to work with practices to ensure all of the necessary support is in place to enable compliance.
Inpatient Follow-up - within 7 days after discharge from in-patient care	95.00%	Achieving	Exception reports for non-compliance are reviewed through contract meetings.
IAPT - access proportion	15.00%	Achieving	The CCG continues to exceed the target rate for access to psychological therapies. Targets for recovery rates are met for 2014/15.
IAPT - Recovery Rate	50.00%	Achieving	
IAPT - Treatment within 6wks of referral	75.00%	N/A	New target for 2015/16
IAPT - Treatment within 18wks of referral	95.00%	N/A	New target for 2015/16
Psychosis - Treatment within 2wks	50.00%	N/A	New target for 2015/16

Delivering harm free, high quality care in a financially sustainable way

The CCGs received a reduced allocation from the autumn statement, 1.4%, with growth per capita below 1% and some of the lowest in the country. In 2015/16 the main challenge and risk concerns delivery of planned benefits from Quality, Innovation, Productivity and Prevention (QIPP) schemes to fund the pressures above the funding growth.

NHS Ashford CCG

The plan balances in year, maintaining the 2014/15 surplus. However, it does not return the CCG to a 1% surplus within 15/16. A recovery plan has been submitted to NHS England in line with planning guidance. The plan details the actions being taken to address the longer term financial position of the CCG utilising the NHS Right Care approach to deliver value in commissioning.

NHS Canterbury and Coastal CCG

The plan delivers a 1% surplus, but assumes return of surplus from 2014/15 to fund some non recurrent investments in Mental Health, Community Networks (MCP development) and the NHS Right Care program.

Activity

The contract with the main acute providers are being planned at the previous years contract out turn levels with the exception of areas where additional activity is needed to achieve constitutional targets. The CCGs have implemented referral management services and non elective changes that will maintain the activity at these levels. Further QIPP/Commissioning for Value savings are required to reduce the contracts below 14/15 out turn to fund pressures in CHC, prescribing and national initiatives such as parity of esteem. The main activity reductions are within urgent care, with an expected reduction of between 2-3 admissions per site per day.

QIPP/Commissioning for Value

Through revision of the planning and contract discussions with providers the QIPP target has been reduced to 2% for Canterbury and 3.1% for Ashford. The main schemes are :

- Continuation, and expansion to other specialities, of the orthopaedic triage and management process
- Reduction in HCD expenditure through use of best practice and potential drug alternative s such as bio similar products
- Roll out of the successful winter schemes and implementation of IUCC to reduce unscheduled care admissions
- Review of community nursing staff provision and OOH services
- Securing better value in CHC placements through market and process management
- Review of products supplied to care homes
- Continued implementation of the NHS Right Care programme

Quality and Safety Plans 2015/2016

The Quality and Safety team covering NHS Ashford CCG and NHS Canterbury and Coastal CCG will continue to develop a quality approach that is influenced by three national reports, The Winterbourne report, The Berwick report and the Francis report. The CCGs five year plan outlines this approach in further detail.

The CCG will continue to work with commissioned providers to gain assurance in relation to the quality and safety of services and outcomes. This is to be strengthened in 2015/2016 via improved schedule four quality metrics focussing on year on year improvement.

The CCG will act as the link across providers to drive service improvement, patient safety and patient experience. Collaborative local CQUINs are being put into place for 2015/2016 across both the acute and community providers to ensure that whole system pathways in relation to heart failure, diabetes, COPD and the frail elderly are developed and implemented. These are central to our strategic approach to deliver quality related improvement at a reduced spend.

The CCG is committed to ensuring safe clinical services and will be working with commissioned providers and the local health and social care economy to ensure that the actions required by the Care Act 2015 are fully embedded within our own and commissioned organisations. This focus also includes the actions relating to the national PREVENT agenda.

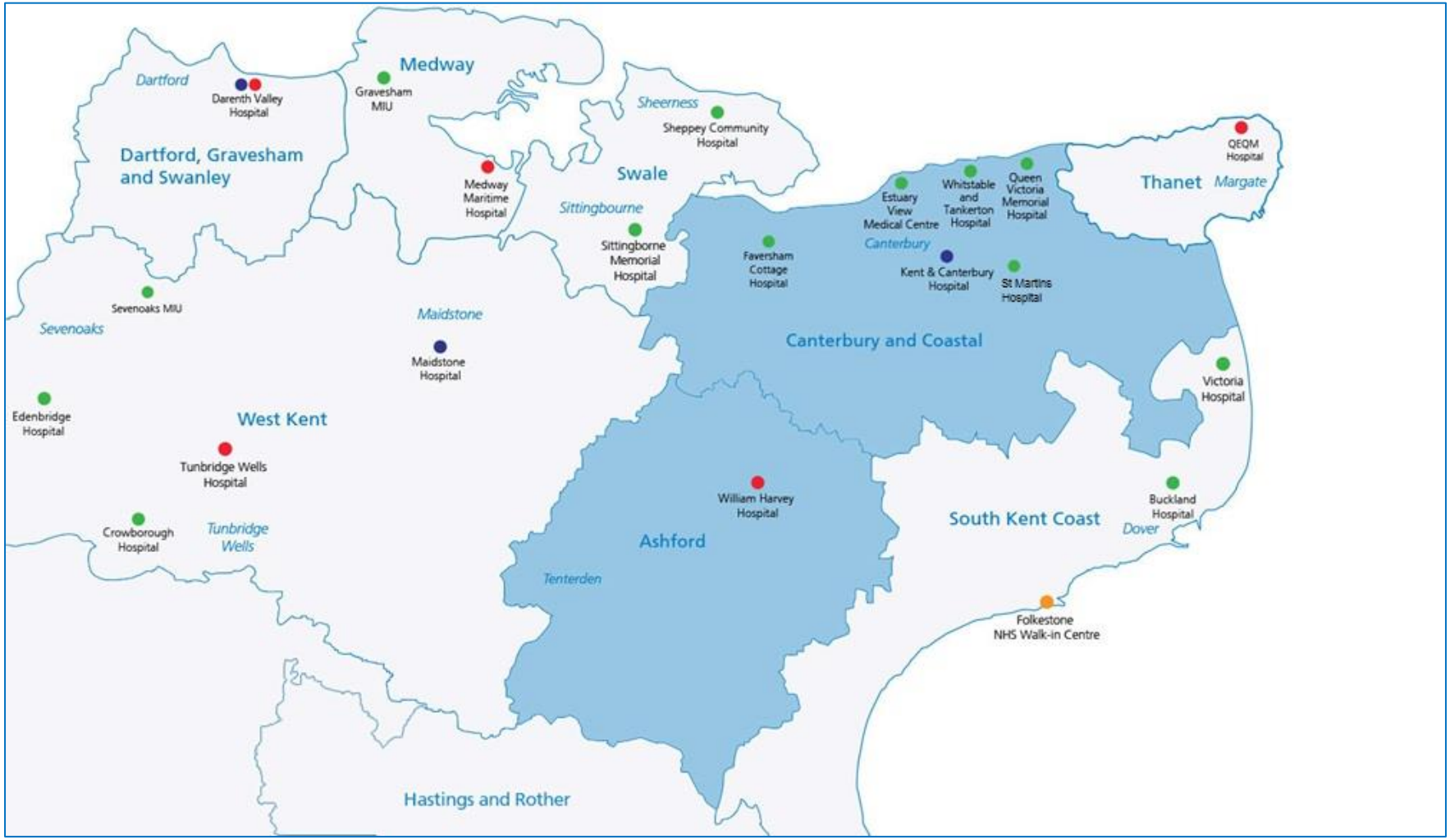
The CCG plans for 2015/2016 include further improvements in the reduction of healthcare associated infections as well as maintaining the zero case MRSA achievement made in 2014/2015.

The CCG plan to continue to work with care homes within the locality in order to improve the quality of care provided. This work supports the longer commissioning strategy within the CCG five year plan.

Planning for Tomorrow, Delivering Today

Strategic Commissioning Plan 2014 - 2019

Contents


Dartford
Darenth Valley Hospital
Dartford, Gravesham and Swanley
Medway
Gravesham MIU
Medway Maritime Hospital
Sheerness
Sheppey Community Hospital
Swale
Sittingbourne
Sittingborne Memorial Hospital
Sevenoaks MIU
Sevenoaks
Maidstone
Maidstone Hospital
Edenbridge Hospital
West Kent
Tunbridge Wells Hospital
Crowborough Hospital
Tunbridge Wells
Faversham Cottage Hospital
Canterbury
Estuary View Medical Centre
Whitstable and Tankerton Hospital
Queen Victoria Memorial Hospital
Kent & Canterbury Hospital
St Martins Hospital
Canterbury and Coastal
QEQM Hospital
Thanet
Margate
Victoria Hospital
William Harvey Hospital
Ashford
Tenterden
South Kent Coast
Buckland Hospital
Dover
Folkestone NHS Walk-in Centre
Hastings and Rother

Introduction

In our five year Strategic Commissioning Plan, both NHS Ashford CCG and NHS Canterbury CCG stated an intention to merge into a single CCG. Whilst this will not now proceed, and CCGs retain their individuality in statutory responsibilities, our planning assumptions continue to reflect the fact that both our patient demographics and needs are very similar.

This plan gives an overview of our work programme for 2015/6. Our operational plan is intended to make sure that what we set out to do is realistic and achievable, given the resources we have. The plan sets out how we will focus on delivering a number of foundation projects for mental health, long-term conditions, urgent care, and planned care aligned to Health and Well Being Board priorities. It also sets out how we will work with our providers to meet NHS Constitution standards and what we will do to deliver harm free, high quality care in a financially sustainable way.

Key to the delivery of our plans will be Commissioning for Value, a collaboration between NHS Right Care, NHS England and Public Health England. This will enable us identify real opportunities to improve outcomes and increase value for local populations. It will also help us to prioritise areas for change, better utilise resources and make improvements in healthcare quality, outcomes and efficiency.

NHS Ashford CCG covers the town of Ashford as well as surrounding rural areas, including Tenterden, Wye and Charing.

The CCG is made up of the 15 general practices (doctors' surgeries) in the Ashford area. The CCG is co-terminus with Ashford Borough Council.

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.

NHS Ashford CCG	Data
Registered patient population:	122,000
Number of GP practices:	15

NHS Canterbury and Coastal CCG covers the City of Canterbury, the towns of Faversham, Whitstable, Herne Bay, Sandwich & Ash as well as surrounding rural areas.

There are 21 practices in Canterbury and Coastal, 15 of which are located in Canterbury City Council area. Three practices are located in within Swale Borough Council area and the other three practices are located in the Dover District Council area. There is also a branch practice located in Chilham which is in the Ashford Borough Council area.

The CCG has an annual budget of £239 million to deliver healthcare services for the 211,651 people registered with a GP surgeries in the Canterbury and Coastal area. That equates to around £1,130 per person.

NHS Canterbury and Coastal CCG	Data
Registered patient population:	211,651
Number of GP practices:	21

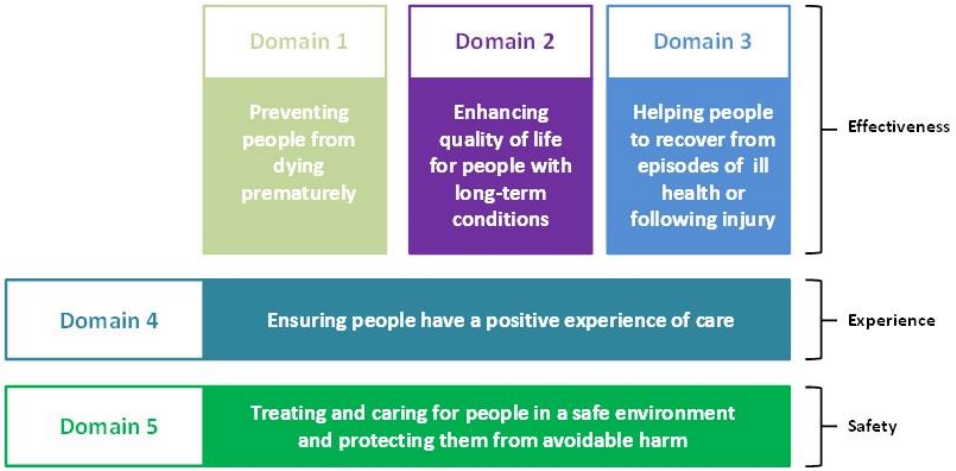
Moving Forward: The National Context

Our vision and goals within our plan have not been developed in isolation and reflect the broader strategic context in which we operate as statutory bodies. 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 domains.

"Five Year Forward View" identifies that, in order to meet patients' needs and expectations, we need to develop a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction that the NHS should taking:

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

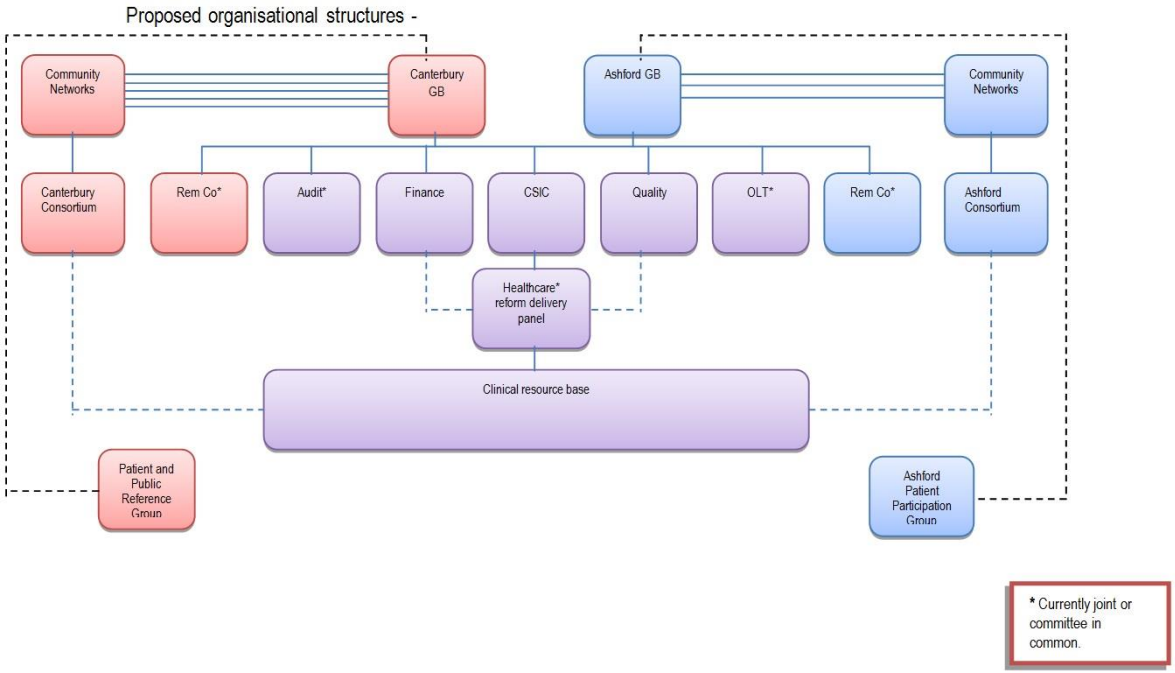
For both NHS Ashford and NHS Canterbury & Coastal CCGs this approach is supported through our Community Networks programme which will offer accessible and responsive services that extend well beyond what is currently available in general practices.



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

Both CCGs work closely with all Kent and Medway CCGs to ensure alignment of plans and agree how any variances or misalignments are resolved. There is a significant amount of work being undertaken with our main providers (EKHUFT, KCHT, KMPT) as well as social care to achieve alignment of plans and clinical strategies to deliver new models of integrated care. Key examples include the development of the MCP model at Estuary View which is a national vanguard site, the learning from which will be rolled out to other areas wherever practicable.

Our GP members meet every other months throughout the year and are actively engaged in developing the CCG Plan. The Governing Body regularly reviews the delivery of the CCG Plan, hearing from the Lay Member about public and patient engagement, considers the performance of its key providers, and reviews the financial position of the CCG. The Clinical Strategy and Investment Committee clinical leadership for the delivery of the CCG Plan and clinically based strategic direction and oversight.



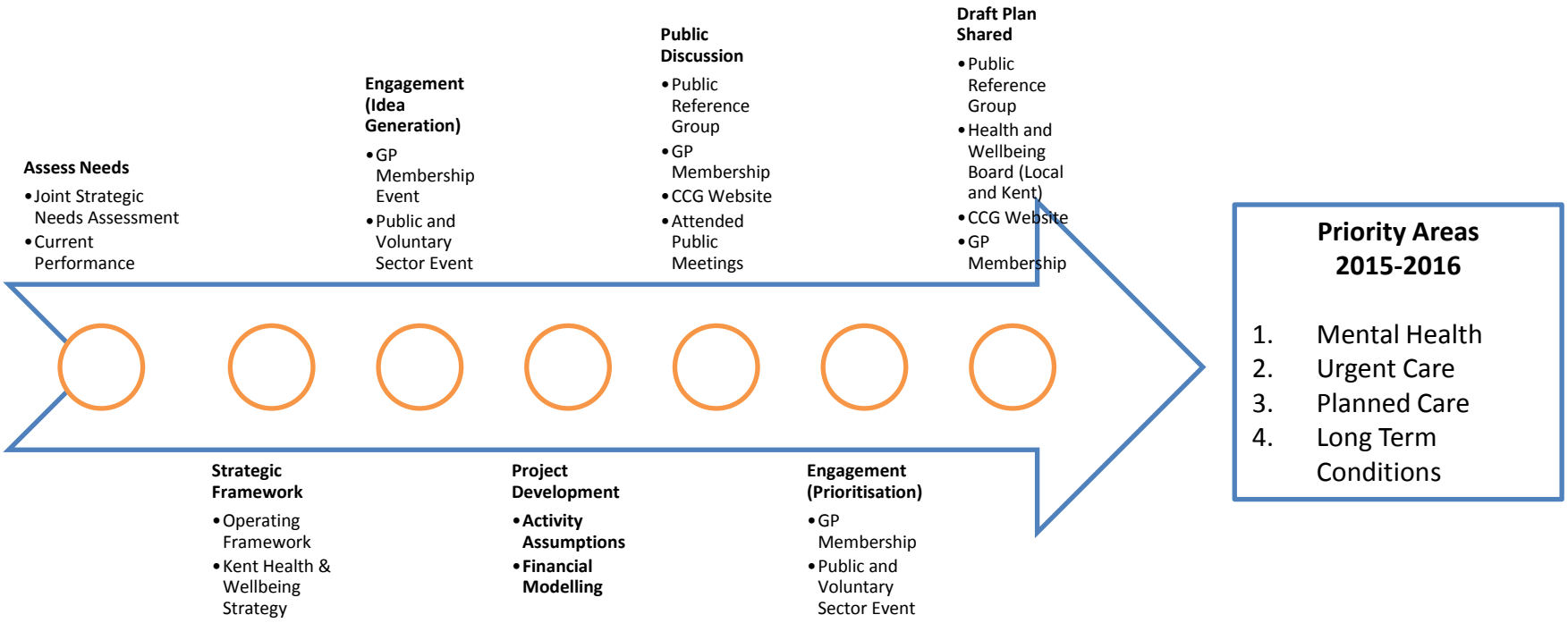
Monitoring the performance of the providers is a key responsibility of the Governing Body. A detailed review of quality and performance takes place at the Quality and Safety Committee whilst the Audit and Risk Committee has responsibility for audit and for providing assurance to the Governing Body that the systems and processes which the CCG has in place are working well. The CCG cannot deliver its ambitions on its own. We work in partnership, particularly with our District Councils and all members of our local and county Health and Wellbeing Boards.

We are currently reviewing the governance arrangement for those areas of federated commissioning across east Kent, developing risk and assurance platform to incorporate performance and strategic risks across providers and commissioners

This Strategic Commissioning Plan and the component projects, which we set out last year, were the product of our ambition to continually improve the quality and patient experience of local health care services. They built on our experience and robust information and analysis and developed in partnership with key partners including Social Care, local Government, our patients, carers and Public Health colleagues.

During the course of the Plan's development we engaged our member practices, exploring local needs and inequalities (supported by Public Health). We 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.

Another key element in the Plan's development were Health and Wellbeing Boards who both contributed to and 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.



Strategic Objectives, Aims and Risks

		National Outcome Indicators			Health and Wellbing Strategy Outcomes	Local Priorities				
		Seven Outcome Ambitions	Strategic Risks	Measures		Community Network	Commissioning for Value	Parity of Esteem	Urgent Care	Primary Care
Effectiveness	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 EQ5D 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.	✔	✔	✔	✔	✔	✔
Experience	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	✔	✔	✔	✔	✔	✔
Safety	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	✔	✔	✔	✔	✔	✔
Accountability	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	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)		✔	✔	✔	✔	✔

Overall responsibility for quality lies with the CCG Governing Bodies, 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.

Our Governing Bodies aim 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

Both CCGs will, through our 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

Both CCGs 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

Both CCGs 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 the CCGs and we will continue 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

Care Quality Commission

Across east Kent we pride ourselves on commissioning and providing excellent care for our patients. When we fail to live up to our own high standards, we look to rectify the position. During 2014-15, local providers have been assessed by the CQC and as a consequence have introduced actions plans to address shortfalls in performance.

East Kent Hospitals

The action plan resulting from the inspection is focussed on recruitment and retention of clinical staff, ensuring policies are up-to-date and communicated widely with staff, that the environment and equipment used for treatment is maintained to a high standard, waiting times for treatment are reduced and that reporting structures for incidents and risks are refined.

Kent Community Health

The action plan resulting from the inspection is focussed on end of life care, children's services, recruitment and staff retention, care planning and that the environment and equipment used for treatment is maintained to a high standard.

We continue to monitor progress against both of these action pans.

Management of Serious Incidents (SI) and Never Events

All Serious Incidents and never events are reviewed and discussed by the quality committee.

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.

Healthcare Associated 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.

The First Year

2014-2015: Progress to Date

The priorities set out in our 2014/19 Strategic Commissioning Plan 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.

2014/15

Our commissioning projects were designed to put the foundations in place, allowing for stabilisation during 2015/16 and significant transformational change during 2016/17, supporting people to look after themselves within their local community.

To this end a number of projects have been delivered during the first year of our plan. Examples of these are:

- ***Long Term Conditions***
  - Community Networks have been set up
  - Increased our dementia diagnosis rates
  - Our care homes projects have led to a reduction in urgent care attendances and admissions

- ***Mental Health***
  - Primary Care base mental health workers are now in place
  - Significant progress in increasing recovery rates with our IAPT services whilst also reducing waiting times.

- ***Urgent Care***
  - New integrated discharge teams
  - Reduced delays in having care packages in place for timely discharge following inpatient care
  - Local Referral Unit ensures that patients are offered support within their own homes
  - Trialled weekend opening for general practices

Review of 2014/15: NHS Constitution Standards

Referral To Treatment waiting times for non-urgent consultant-led treatment	Target	2014/15	Commentary
Admitted patients to start treatment within a maximum of 18 weeks from referral	90.00%	Underachieving	EKHUFT has failed to achieve the national referral to treatment standard this year. A recovery plan was agreed with the Trust, including action by the east Kent CCGs to reduce referral rates in T&O, to achieve compliance by April 2015. This plan failed due to the following factors: Lack of uptake in the independant secto; staff sickness; increasing numbers of cancer referrals, and consultant compliance to pathways ie spinal. A revised plan returning the trust to RTT complaince by October 2015 has been received by CCGs and the activity that undpins it is included in 2015/16 activity plans and contractual values. The CCGs support this more realistic (given the scale of the backlog and previous deleivery performance) trajectory. We will, however, be seeking further assurance on the 12 assumptions that support the delievery of EKHUFT's plan, many of which relate to acute sector capacity.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95.00%	Achieving	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92.00%	Achieving	

Diagnostic test waiting times	Target	2014/15	Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99.00%	Achieving	Recruitment to key posts have meant that this standard underachieved in Q1,2 & 3 through a robust action plan and recruitment campaign performance improved in December 2014 and remains compliant.

A&E waits	Target	2014/15	Commentary
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95.00%	Underachieving	While A&E attendance levels have remained broadly flat waiting time performance steadily worsened during 2014/15 with the EKHUFT failing the standard, despite an investment of £8m in east kent with the majoriy of this resource deployed to the acute trust. A system wide improvement plan was agreed in January 2015 and at the same time the CCGs in east Kent revised and strenghtened governance and performance management arrangements. Plans have been monitored weekly against agreed recovery trajectory with bi weekly senior operational leadership review. Due to ongoing failure of this standard CCGs issued EKHUFT with a contract query notice in March 2015. A new 'Emergency Access Recovery Plan' has been submitted to the CCGs by EKHUFT. EKHUFT have invited Emergency Care Intensive Support Team into Trust on 13-15 May to underatake a full diagnostic of both the flow of patients through A&E and a review of all patients with a LOS greater than 7 days. CCGs will continue to work with the Trust and health economy partners on a sustainable plan to achieve this standard by the end of Quarter 2 2015 - this will include individual provider plans which will underpin the system wide improvement plan. Compliance of this standard by October 2015 is contingent on the findings of the ECIST report.

Cancer waits – 2 week wait	Target	2014/15	Commentary
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93.00%	Achieving	Achievement of cancer targets has been variable throughout 2014/15, with the majority of challenges arising in 2 week waits for first appointment, and 31 day wait for subsequent surgery. The overall target of 62 days from referral to first treatment was challenging throughout the year, but has shown improvement and recovered performance to standard through the production of a trust wide action plan which led to a revised referral form for GPs to follow for 2 week breast cancer patients and trust wide changes to diagnostic support and workforce. EKHUFT has made significant improvements to booking procedure allowing the service to recover its position in part although GP refferals remain high along delays on complex pathways, taking longer to diagnosis primary cancer and therefore initiate treatment. The standard is now being monitored through a senior cancer group to ensure these standards are met through the robust monitoring of a revised cancer plan.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93.00%	Underachieving	

Category A ambulance calls	Target	2014/15	Commentary
Category A calls resulting in an emergency response arriving within 8 minutes	75.00%	Achieving	Achievement of the national targets for ambulance response times has been variable throughout the year. Recruitment of additional paramedics has been initiated in 2014/15, with plan s in 2015/16 to train additional paramedic practitioners. Development of an improved integrated local first responders team is planned for 2015/16.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95.00%	Achieving	

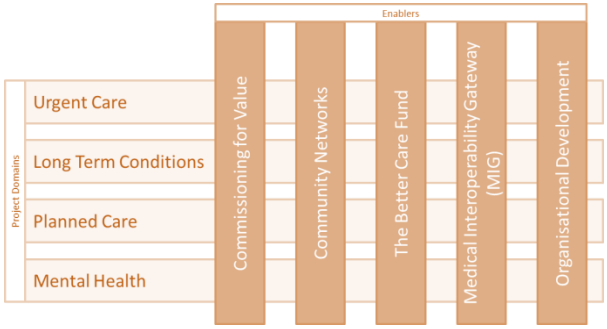
Mental Health	Target	2014/15	Commentary
Dementia - % diagnosis rate	66.70%	Underachieving	The CCG aims to improve the identification and care for patients with Dementia from 62.2% as at February 2015 to 66.7% by the first quarter of 2015/16. Throughout 2014/15 actions have been taken to increase the number of patients identified as having dementia in all GP practices, including data cleansing and programmes of training and support for practices to sign post and support patients following diagnosis and additional GP support to enable the identification of dementia patients.The reported position for the end of Feb 15 was 62.2% of patients identified in C&C and 49.91% for Ashford. Practice engagement remains the challenge in Ashford with plans to achieve this standard by Q2 2015/16 with C&C expected to meet the standard by Q1 of 2015/16. CCG clinical chairs will continue to work with practices to ensure all of the necessary support is in place to enable compliance.
Inpatient Follow-up - within 7 days after discharge from in-patient care	95.00%	Achieving	Exception reports for non-compliance are reviewed through contract meetings.
IAPT - access proportion	15.00%	Achieving	The CCG continues to exceed the target rate for access to psychological therapies. Targets for recovery rates are met for 2014/15.
IAPT - Recovery Rate	50.00%	Achieving	
IAPT - Treatment within 6wks of referral	75.00%	N/A	New target for 2015/16
IAPT - Treatment within 18wks of referral	95.00%	N/A	New target for 2015/16
Psychosis - Treatment within 2wks	50.00%	N/A	New target for 2015/16

The Second Year…

2015 – 2016: Operating Plan

The CCGs have recognised that in previous years we have attempted to effect change across too many fronts and have subsequently not have sufficient capacity to deliver the goals we have set ourselves.

Commissioning for Value is a collaboration between NHS Right Care, NHS England and Public Health England. The programme is about identifying priority programmes which offer the best opportunities to improve healthcare for our populations – improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system. As a consequence of this approach, we are able to focus the work of its limited commissioners on areas that will generate best outcome clinically and financially.



Commissioning for Quality and safety

Patients and the quality and safety of care they receive continues to be the focus of all that we do. By ensuring that quality improvement is integral to our future strategy as well as the CCGs vital assurance role, we are able to commission clinical services which provide high quality care, the best outcomes for patients and a positive patient experience.

Contracting

The CCG will work to further integrate Health and Social Care services through delivery of the Better Care Fund (BCF). This programme will be the vehicle by which the local system, through early identification of deterioration, will achieve reductions in A&E attendance and subsequent admission and premature admissions to long term care.

The CCG will negotiate a 2015/16 contract with East Kent Hospitals University Foundation Trust (EKHUFT) that provides financial security to both the Trust and the CCG, by limiting the reliance upon activity counting and unit prices. This will reduce bureaucracy and allow focus on improving patient services and delivering value for money.

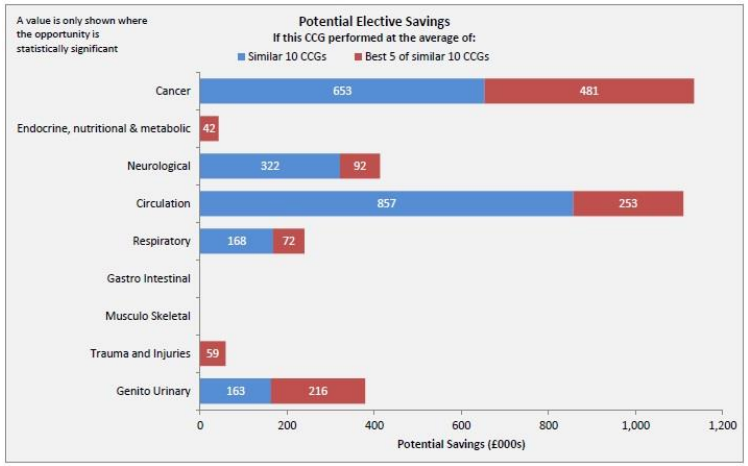
The CCG will ensure that parity of esteem for mental health patients is captured within all contracts for 2015/16.

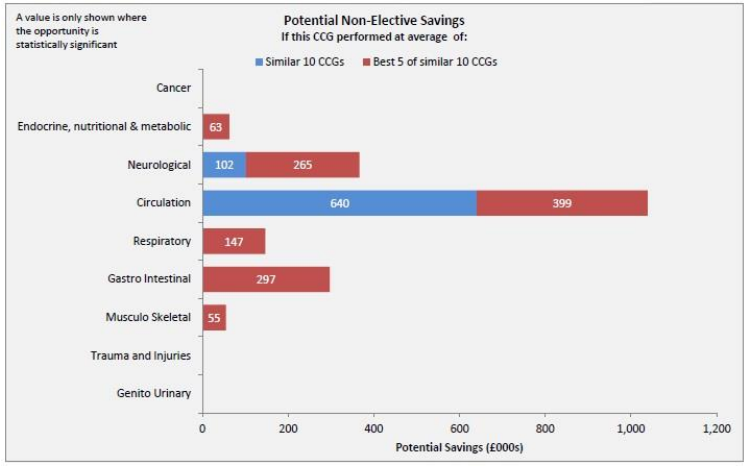
The CCG will continue to develop the Local Health Economy (LHE) Workforce, including a Health and Social Care Apprenticeship Programme, to ensure 'right care' by the 'right person' at the 'right time', to provide clinical leadership and support recruitment and retention. All with the intention of supporting delivery of our transformative plans for new models of care.

The CCG will develop system integration via the Medical Interoperability Gateway (M.I.G) where access to the patient GP record (with patient consent) will be visible across multiple providers to avoid duplication and improving care for patients by enabling them to tell 'us once'.

CQUINs will be targeted towards incentivising a continued focus on patients aged over 75, to compliment the named GP policy incentivised as part of change to GP contracts from April 2015. CQUINs of all major providers will be tailored towards adding capacity and capability to our, already successful, neighbourhood teams which currently bring together GPs, Social Services and Community Services to deliver improved outcomes for all residents.

Enabler: Commissioning For Value





The CCGs have 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.

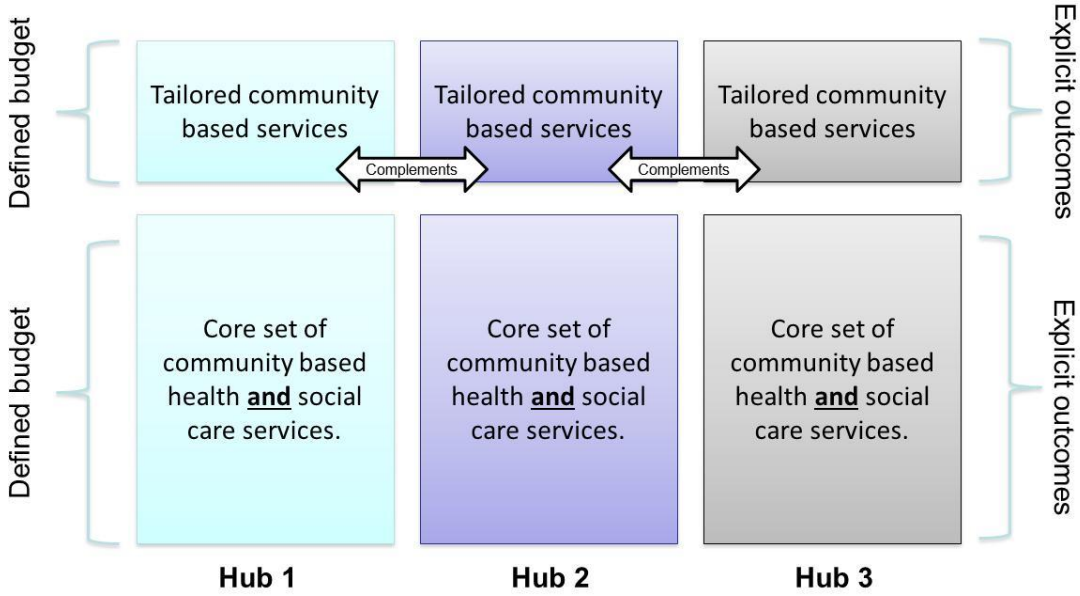
The programme areas that appear to offer the greatest opportunity in terms of financial savings are: Cancer, Circulation problems (CVD) and Neurological System Problems.

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.

Enabler: Community Networks

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.



Example Services:

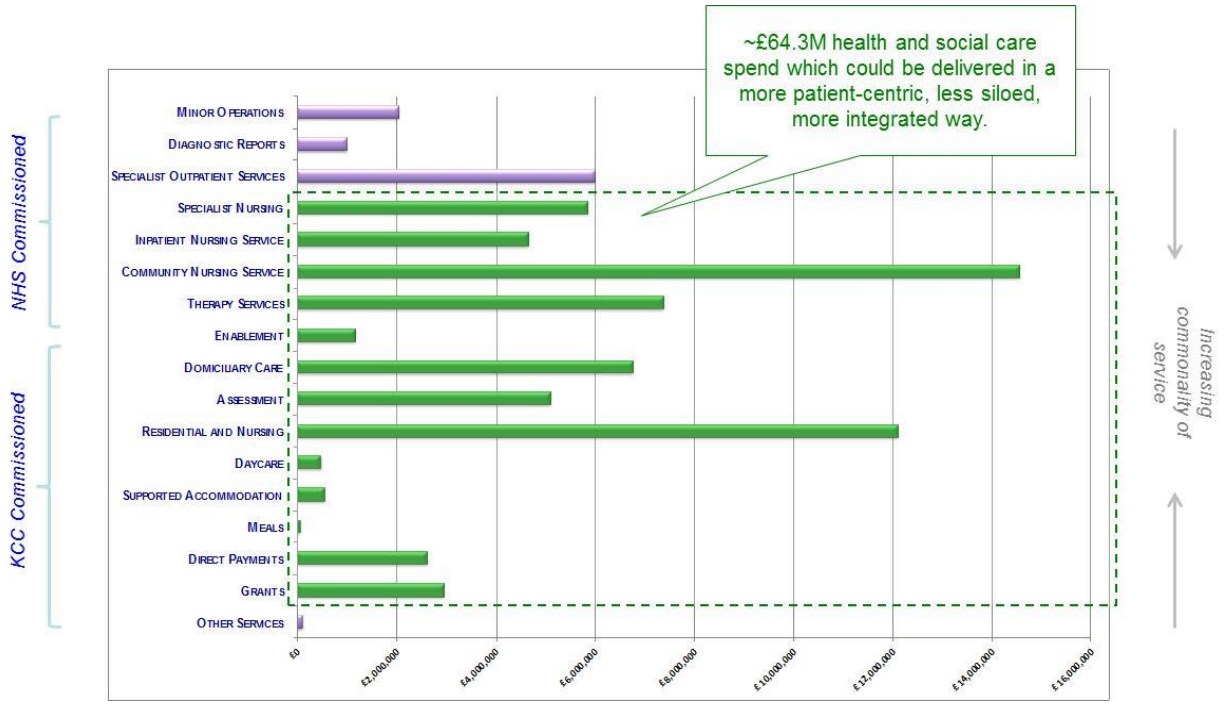
Tailored community based services e.g. :	Outpatients Specialist Diagnostics Addiction Services
Core community based health and social care services e.g. :	Assisted Living Befriending Care Homes Care Planning Carer Support Citizen's Advice Community Equipment Counselling Services Community Nursing Dementia 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

Enabler: The Better Care Fund

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.

Enabler: Medical Interoperability Gateway (MIG)

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.

Enabler: Organisational Development

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 we planned to do. The CCGs also recognise that 2015/16 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.

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

The CCG have recruited support to deliver a detailed year long OD programme, commencing with diagnostic workshops for staff, Governing Body and clinical leads in March and April, resulting in four key work streams that will focus on:

- leadership and people development
- vision, values, behaviour and culture
- communication, staff & clinical engagement
- recruitment, retention, performance & reward

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 memberships vision is owned by the Governing Body and used to underpin and drive strategic change.

People and Behaviour

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

Each Community Network 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.

Programme: Urgent Care

From	To
"My problem isn't an emergency but I do need care urgently, where do I go?"	"It doesn't matter who I contact when I need care urgently, everyone seems to know what is happening with my care."
"Why can't I see my GP at the weekend?"	"It's such a relief knowing I can see my GP any day during the week"
"A&E is always so busy"	"They came into my home and treated me there, I didn't need to go to hospital like I thought"
"I didn't really want to go into hospital, but here I am."	"We have care plans for all our residents, so we know exactly what to do when one is ill"
"Whenever one of our residents is ill we need to call am ambulance because we don't know who else to contact"	"I just called NHS111 and they made sure I was seen by the right person."
"Calling NHS111 or the evening doctor is a waste of time"	

Integrated Urgent Care Centre
The IUCC is an initiative which will bring together providers across health and social care settings under one management structure. The team will be responsible for working both within the Acute aspects of Hospitals (A&E, Clinical Decision Unit and Surgical Assessment Unit) and also the speciality inpatient wards, covering a 7 day per week service provision

Seven Day Primary Care
Doctors will treat patients at their surgeries seven days a week under fresh plans to help improve access for patients with long term conditions and to improve access for all patients. It means ill patients can receive GP services on Saturday and Sunday instead of using the out-of-hours doctor.
cover.

Minor Injury Units
Increase capacity and coverage of our MIU to reduce need for patients to attend A&E

Paramedic Practitioner
Paramedics who can give people emergency care at home, giving advice to colleagues and taking referrals to visit patients who have called 999 but don't necessarily need to go into hospital. They can also refer on to other health professionals for follow-up treatment

Care Homes Support
This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions.

NHS 111/Out of Hours GP Service
Overarching objectives of future modelling include greater responsiveness of services, reduced duplication and greater integration. It is proposed that by re-configuring existing services, the health economy will improve health outcomes for patients, increase the number of out of hours treatments undertaken in a patient's home or place of residence, reduce the need for acute admission to Hospital and length of stay in Hospital and the overall experience for patients.

Programme: Long Term Conditions

From

"I spend too much time travelling to hospital with additional costs of parking just for a quick review of my care"

"I don't want to die in hospital, I'd rather be at home"

"Why should I wait until my illness becomes unmanageable before I am offer assistance."

"Mum just isn't herself these days, she forgets things and we just don't know where to turn to."

Cardiology
Undertake GP refresher on identification of cardiac diseases. Improved care planning supported by the Heart Failure Nursing Team and increase and appropriate usage of the GPwSI Service, including advice and guidance. Review procedure criteria for undertaking angioplasty

Chronic Kidney Disease
Improving detection in primary care through use of IT monitoring to identify changes in eGFR, creatinine and prescriptions to avoid admission, Improved outpatient discharge criteria, reducing the number of follow-up appointments and audit urgent admissions to understand the reason for attendance and/or admission

Diabetes
Type 2 Diabetes primary care training programme, Integrated Diabetes care pathway implementation

End of Life Care
Ensure more formal and named professional co-ordination between the main end of life providers (District Nurses, Pilgrims Hospice, EKHUFT and the ambulance service) to deliver a 15% reduction in both admission to hospitals and/or care home admissions for patients who are at the end of their life.

Neurology
Develop and enhance pathways of care with particular attention on reducing admissions for epilepsy, levels of prescribing and improving outcomes

Stroke
Enhance/redesign/manage prevention and primary care system to optimise detection and care planning

Dementia
To sustain diagnosis rates, increasing where practical, ensuring that at least 67.5% of patients in our anticipated prevalence has a diagnosis and to further develop, with our partners in Kent County Council and district councils, dementia friendly services

Age UK
Age UK's Integrated Care Programme operates across England. Through the programme Age UK staff and volunteers become members of primary care led multi-disciplinary teams, providing care in the local community.

Community Nursing
We intend to review all patients and set clear criteria for what constitutes "housebound", allowing patients to be discharged from the care our the nursing teams thus freeing up capacity for patients at greater need

To

"I only had to visit the hospital once, the rest of my care was offered locally."

"We were able to care for Mum at home until she died."

"My condition was picked up quickly and I was supported early. Consequently I was able to control my condition."

"Since Mum was diagnosed with dementia, we have received support from social services and Age UK"

Programme: Mental Health/Planned Care

From

"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."

"I just don't know whether the operation is right for me"

"Dad keeps falling over and we are spending most of our time up the hospital"

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

Psychosis
The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs

Improving Access to Psychological Treatment
We are currently going through the procurement of improved IAPT services, ensure that we are able to meet the new Mental Health waiting times standards.

Orthopaedic Triage Service
Reduce primary care Orthopaedic referrals to through GP-triage and compliance with existing agreed clinical pathways

Personal Decision Aids
Personal Decision Aids (PDA) are designed to help people make decisions about difficult healthcare choices. Each PDA contains good quality information about all the options and the health problem, and questions to help patients make informed decisions about their treatment which focusses on their individual lifestyle and health needs

Dermatology
Review of community pathway with a view to re-procuring service, reducing fragmentation in current pathway

Wet Age-Related Macular Degeneration
Procurement of community based service to improve access for patients at reduced cost to the NHS

Falls Prevention and Treatment
Address the historically fragmented way health and social care services work together, starting from when an ambulance is called out to elderly faller, all the way to a person being assessed and referred for community based exercise programmes to prevent falls.

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

Community DVT Service
Implement town based model integrated with existing MIU or Primary Care facilities

Anti-Coagulation
Re-procured model ensuring both initiation and on-going monitoring within the community

To

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

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

"I was able to look at all my options and chose the one which best suited me.

"They gave Dad some exercises. He seems so much steadier on his feet these days."

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

The Financial Challenge

The CCGs received a reduced allocation from the autumn statement, 1.4%, with growth per capita below 1% and some of the lowest in the country. In 2015/16 the main challenge and risk concerns delivery of planned benefits from Quality, Innovation, Productivity and Prevention (QIPP) schemes to fund the pressures above the funding growth.

NHS Ashford CCG

The plan balances in year, maintaining the 2014/15 surplus. However, it does not return the CCG to a 1% surplus within 15/16. A recovery plan has been submitted to NHS England in line with planning guidance. The plan details the actions being taken to address the longer term financial position of the CCG utilising the NHS Right Care approach to deliver value in commissioning.

NHS Canterbury and Coastal CCG

The plan delivers a 1% surplus, but assumes return of surplus from 2014/15 to fund some non recurrent investments in Mental Health, Community Networks (MCP development) and the NHS Right Care program.

Activity

The contract with the main acute providers are being planned at the previous years contract out turn levels with the exception of areas where additional activity is needed to achieve constitutional targets. The CCGs have implemented referral management services and non elective changes that will maintain the activity at these levels. Further QIPP/Commissioning for Value savings are required to reduce the contracts below 14/15 out turn to fund pressures in CHC, prescribing and national initiatives such as parity of esteem. The main activity reductions are within urgent care, with an expected reduction of between 2-3 admissions per site per day.

There is a there is tension with the Better Care Fund (BCF) in this area where CCG schemes outside of those in the BCF are required to balance the plan rather than fund the pay for performance element of the BCF. Clear monitoring and delivery reporting is required to demonstrate the causality of activity reductions and the individual schemes. The BCF is being finalised with KCC and whilst the level of integration could be greater, KCC are integral partners in the community networks and the governance structures within the section 75 have been operating for the last year.

Parity of Esteem

The KMPT contract is being increased through further investment in additional bed capacity and the rebasing of the contract from fair shares. In addition the joint management of CHC patients is expected to increase the contract whilst generating overall savings to the health economy.

QIPP/Commissioning for Value

Through revision of the planning and contract discussions with providers the QIPP target has been reduced to 2% for Canterbury and 3.1% for Ashford. The main schemes are :

- Continuation, and expansion to other specialities, of the orthopaedic triage and management process
- Reduction in HCD expenditure through use of best practice and potential drug alternative s such as bio similar products
- Roll out of the successful winter schemes and implementation of IUCC to reduce unscheduled care admissions
- Review of community nursing staff provision and OOH services
- Securing better value in CHC placements through market and process management
- Review of products supplied to care homes
- Continued implementation of the NHS Right Care programme

The approach to CCG QIPP in 2015/16 is an extension to the approach in 14/15, with most savings being identified jointly, jointly managed and delivered with all parties sharing the cost savings. There are other saving plans there are a higher risk on as we look to pull non elective activity from East Kent Hospitals University NHS Foundation Trust and will require them to close beds to make cost savings. The risk is the contracts work on cost, and in the example of shutting beds, as the trust currently operate at c.95-98% occupancy there is a quality and safety requirement to reduce this before savings can be released.

Schemes within the EKHUFT contract

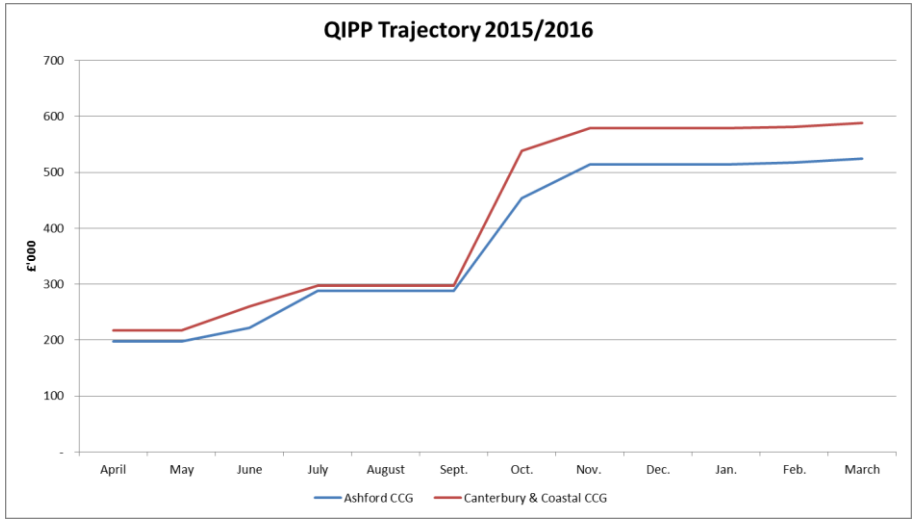
We will continue and expand the referral management approaches in the CCG, the first 3 months of which have shown 35-45% reduction in orthopaedic referrals. We are looking to expand the models to include other pressured services including Dermatology, ENT and General Surgery.

The main area of focus in reducing our usage of high cost drugs are specifically related to our Wet AMD project and the implementation of the "Southampton Model" for rheumatology which together could save in the region of £6m for a full year.

Despite poor A&E achievement, locally the growth in A&E attendances and subsequent admissions was relatively low, 3% or so in Ashford and Canterbury. The CCG is looking to continue our investment in Integrated Urgent care centre, LRU and integrated discharge team to reduce. The savings included in QIPP equate to 2 or 3 admissions per site per day, which has been achieved during the early implementation phase funded through winter resilience.

With partners, we will set up joint funded assessment service for patients fit for discharge that otherwise would be DTOCs or admitted to care homes. This model will discharge to the appropriate setting and thus save the whole health and social care economy.

NHS Right Care – the CCGs have a number of pathway reviews in place under the remit of right care, CKD alone could save £1.6m between the CCGs. These will take longer to implement but work has started on these with the second session in April.



Schemes within Mental Health

The CCG's in east Kent are discussing with KMPT the potential to better manage patients placed outside of the provider due to capacity constraints and inefficiencies and the management of CHC patients in a better, more planned way. Should the Trust withdraw from this plan the CCG will revise the process for approval of CHC placements, increasing the clinical challenge to the panel and ensuring the rules and processes are rigidly applied.

Schemes within Prescribing

Both CCGs have agreed a 2 year incentive scheme based on the Isle of Wight model that delivered a significant reduction on prescription costs. The risk is the CCGs are currently the two of the most efficient prescribers in Kent, but the final astro-PU value in the IoW is lower than both CCGs current performance.

Schemes within Funded Nursing Care

Ashford CCG has proportionately the highest FNC usage in east Kent, and there are a number of areas where we are picking up costs for other CCG's and Governmental bodies including KCC. The CCG is reviewing these and the planned savings are the target set on early understanding / benchmarking where available.

Commissioning for Quality and Innovation (CQUIN)

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, we have decided to have seven local measures; four shared across both our community and acute providers and to further support our strategic ambition to close the gap between mental and physical health, we have devised 3 local quality incentives with our main mental health provider.

National CQUIN

Acute Kidney Injury	Sepsis	Dementia and Delirium
2015/16	2015/16	2015/16
To improve the follow up and recovery for individuals who have sustained AKI, reducing the risks of readmission, re-establishing medication for other long term conditions and improving follow up of episodes of AKI which is associated with increased cardiovascular risk in the long term.	Providers are expected to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock.	To support the identification of patients with dementia and delirium, alone and in combination alongside other medical conditions. It aims to prompt appropriate referral, follow up, and effective communication between providers and general practice, through the introduction of a care plan on discharge; after the patient is discharged from hospital or community services following an episode of emergency unplanned care.

Mental Health CQUIN

Transition from adolescent to Adult Mental Health care	Dementia	Crisis Plans
2015/16	2015/16	2015/16
Full implementation of safe effective transition pathway for adolescence from CAMHS to adult mental health services	Full implementation of ratified multi-agency integrated pathway for patients with Dementia	Full implementation of agreed % crisis plans across key acute cluster pathways. Reduced crisis episodes and unplanned admissions

Acute and Community CQUIN

COPD	Over 75s (with Long Term Condition)	Diabetes	Heart Failure
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; • Delivering care close to home • Improving transfer of care • Improving self-management	Embed and measure performance, with ultimate aims being to; • 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; • 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; • Delivering care close to home • Improving transfer of care • Improving self-management

Commissioning Projects 2015-16

	Anticpated Outcome	Standard	A	M	J	J	A	S	O	N	D	J	F	M	2016-17
Urgent Care															
– Integrated Urgent Care Centre	Reduction in A&E Attendances	A&E Constitution													
– Seven Day Primary Care	Reduction in A&E Attendances	Five Year Forward View													
– Minor Injuries Units	Reduction in A&E Attendances	A&E Constitution													
– Care Homes Support	Reduction in Non-Elective Admissions	Better Care Fund													
– Paramedic Practitioner	Reduction in Non-Elective Admissions	A&E Constitution													
– NHS 111 Procurement	Reduction in A&E Attendances	A&E Constitution													
Planned Care															
– Orthopaedics Triage Service	Reduction in referrals and procedures	RTT Constitution													
– Rheumatology	Reduction in referrals	RTT Constitution													
– Personal Decision Aids	Reduction in referrals and procedures	RTT Constitution													
– Dermatology	Reduction in referrals	RTT Constitution													
– Wet Age-Related Macular Degeneration	Reduced cost of treatment	RTT Constitution													
– Falls Prevention and Treatment	Reduction in Non-Elective Admissions	Better Care Fund													
– Community Loan Store	Earlier discharge from inpatient episode	A&E Constitution													
– Community DVT Service	Reduction in referrals	RTT Constitution													
– Anti-Coagulation Service	Reduction in referrals	RTT Constitution													
– Breast Cancer	Reduction in referrals	Cancer Constitution													
Mental Health															
– Care Programme Approach	Reduce admissions, increased employment	NHS Right Care													
– IAPT Procurement	Improved choice, access and recovery	Mental Health Constitution													
Long Term Conditions															
– Cardiology	Earlier identification, Reduced non-elective admissions	NHS Right Care													
– Chronic Kidney Disease	Earlier identification, Reduced non-elective admissions	NHS Right Care													
– Diabetes	Community based care	RTT Constitution													
– End of Life Care	Community based care	A&E Constitution													
– Neurology		NHS Right Care													
– Stroke		NHS Right Care													
– Dementia	Earlier diagnosis	Five Year Forward View													
– Age UK	Reduction in referrals	A&E Constitution													
– Reducing Community Nursing Demand	Increase capacity	A&E Constitution													
Child Health and Maternity															
– Children's Strategy															

Health Reform Group - New Cases

Health Reform Group - Post Implementation Review

By: Deborah Smith Public Health Specialist, KCC

To: Ashford Health and Wellbeing Board

Date: 30th March 2015

Subject: ASHFORD Local Performance Plan

Classification:

Purpose and summary of report

The Ashford Local Performance Plan is a live document illustrating the range of activities and programmes delivered in the Ashford Clinical Commissioning Group area, organized under the Kent Health and Wellbeing Strategy outcomes:

1. Every child has the best start in life
2. Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.
3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
4. People with mental health issues are supported to 'live well'
5. People with dementia are assess and treated earlier and are supported to live well.

The Plan was originally drafted in November 2014 to provide Ashford's response to the Kent Health and Wellbeing Board's request for local contributions to the delivery of the Kent Health and Wellbeing strategy. Since then, this plan has further consolidated the partnership activities undertaken in Ashford that supports this agenda. The list of programmes and activities is not exhaustive and some of those identified will be unique to Ashford while others will be delivered locally in Ashford as part of Kent wide strategies. It is recommended that the activities within this Plan should be reviewed and updated by Ashford Lead Officers Group to identify challenges and good practice and include new initiatives where appropriate, in order to inform the Ashford Health and Wellbeing Board of changes and progress.

Progress against the Health and Wellbeing Board outcomes are measured through national indicator sets (the majority of which are Public Health Outcome Framework indicators) and the Ashford Local Performance Plan highlights local Kent and Ashford performance values where available. The activities and programmes articulated in the Plan will contribute towards the indicator, but it should be acknowledged that there are a number of broader initiatives and determining factors that will also influence performance pertaining to the targets and indicators and it is not possible to include all of these.

Ashford Health and Wellbeing Board may wish to identify and monitor a number of key activities in the plan on a regular basis. Closer and more detailed inspection on a few

activities rather than all, may ensure that monitoring and overview is more manageable.

The local smoking prevalence trends have been updated more recently and early indications show that this may be a priority for Ashford. Smoking will therefore be considered in the priority setting agenda at the Ashford Health and Wellbeing Board next July 2015. Further information is provided in the LOG update report.

Recommendations

The Ashford Health and Wellbeing Board is asked to:

1. Note the contents of the Ashford Local Performance Plan
2. Agree that the Ashford Lead Officers Group raise any specific concerns and/or good practice that arise from the plan to the Ashford Health and Wellbeing Board.
3. Agree to identify a number of key priority activities and to receive regular updates and reports on the progress of these activities.
4. Endorse the plan as an information resource to update the Kent Health and Wellbeing on Ashford's local achievements in relation to the Kent Health and Wellbeing Strategy priorities and outcomes.

Contact details

Report Authors:
Deborah Smith, Public Health Specialist
Deborah.Smith@kent.gov.uk Tel: 03000 416696

Faiza Khan, Public Health Consultant
Faiza.Khan@kent.gov.uk

Ashford Local Performance Plan

Introduction

The Ashford Local Performance Plan is designed to provide a local response to the Kent Health and Wellbeing strategy, providing examples of partnership programmes that are being delivered within the Ashford Clinical Commissioning Group area. Some of the activities are unique to Ashford, others may be part of Kent strategic programmes delivered at a local level. All activities are organized within the agreed four priorities and five outcomes and the Kent Health and Wellbeing strategy.

The list of activities are not exhaustive and will be revised on a regular basis by the Local Officers Group (LOG) that serves the Ashford Health and Wellbeing Board. The Plan will be a 'live' document so that updates can be made to refresh the content and ensure that the document can continue to serve as an information tool to capture key initiatives being delivered against shared priorities and outcomes.

Performance values against national and local targets have been included to illustrate local performance where possible. It should be noted that the activities **contribute** to outcome targets but are not the sole contributor. There may be a range of additional programmes, policies and wider determining factors that may influence performance which is not possible to articulate in this plan. The LOG will review the performance and targets within the Plan on quarterly basis and report particular concerns and achievements to the Ashford Health and Wellbeing Board.

Ashford Local Performance Plan

The Kent Health and Wellbeing Strategy sets out 4 priorities. Each priority has 5 outcome areas.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average
Priority 2 – Tackle health inequalities
Priority 3 – Tackle the gaps in service provision
Priority 4 – Transform services to improve outcomes, patient experience, and value for money

Outcome 1-Every child has the best start in life
Outcome 2-Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
Outcome 3-The quality of life for people with long term conditions is enhanced and they have access to good quality care & support
Outcome 4-People with mental health issues are supported to 'live well'
Outcome 5-People with dementia are assessed and treated earlier, and are supported to live well

This action plan is to be read in conjunction with the Local HWBB Performance Report.

Outcome 1	**Every child has the best start in life**		**Targets and Indicators**	**Comments**
1.1	A reduction in the number of pregnant women who smoke at time of delivery	Baby Clear programme is being delivered in acute trusts by midwives. There has been commitment from the CCG to get the midwifery services on board with the initiative This will also be part of the Health Visitor role Baby Be Smoke free. A programme for teenage pregnant mums being piloted in Kent.	**National Target**: 11% by 2015 **Latest Kent Value**: 13.1% (Local figures) **Time Period**: 2013/14	

		Smoke free policy covering hospital grounds Work with Children Centres on the ' Smoke free home' agenda (PH) Smoke free parks and family spaces	**Source**: HSCIC Control Action Plan **Lead**: Public Health	
1.2	An increase in breastfeeding Initiation rates	Best Beginning programme in birthing centres and acute trusts From October 1st 2014 PS Breast feeding will be delivering the countywide contract for Infant Feeding Services to work with hospitals, community health services and children centres to increase initiation and continuance. Breastfeeding friendly public venues/booths Also included as part of HV role. **Sure Start** Breastfeeding Peer Supporters available for mums	**National Target**: 73.90% **Latest Kent Value**: 72.10% **Time period**: 2012/13 **Source**: PHOF national average 12/13 **Lead**: CCGs	
1.3	An increase in breastfeeding continuance 6-8 weeks	From October 1st 2014, PS Breast feeding will be delivering the countywide contract for Infant Feeding Services to work with hospitals, community health services and children centres to increase initiation and continuance. Also to focus on improving the quality of data recording and reporting of breastfeeding.	**National Target**: 47.20% **Latest Kent Value**: 40.80% **Time Period**: 2012/13 **Source**: PHOF national average	

			12/13 **Lead**: Public Health	
1.4	A reduction in conception rates for young women aged under 18 years old (rate per 1,000)	Kent Teenage Pregnancy Strategy developed. Would require strong Leadership provided by the local HWBB CCG level H&W action plans with SMART targets Integrated performance framework for the strategy at CCG and district level Decrease in pregnancies between 15-18 and steady numbers falling in older groups. ASHFORD- Sexual health education/ Regular screening for STDs (indirectly helps in informing the teenage about the pregnancy).	**National Target**: 25.9 **Latest Kent Value**: 25.9 **Time Period**: 2012 **Source**: PHOF Kent level 2012/13 **Lead**: Public Health	
1.5	An improvement in MMR vaccination uptake two doses (5 years old)	Improving call and recall in GP practices Timely reporting of data Accurate information to parents to help them make an informed decision	**National Target**: 95% **Latest Kent Value**: 92.2% **Time Period**: 2012/13 **Source**: Public Health **Lead**: NHS England (Supported by PHE)	
1.6	An increase in	The 'Born to move' initiative is a Health Visitor led project to	**National Target:**	

	school readiness: all children achieving a good level of development at the end of reception as a percentage of all eligible children	raise awareness of the importance of human interaction between parent /carer and infant or child to enable optimal development, physically & emotionally. Health improvements are addressing inequalities from the start through a universal multi-agency project: 'Making everywhere as good as the best'. Make sure the whole team understand biological, social and psychological aspects of child health....up to date with neuroscience, with skills to promote positive parenting' *Transforming Community Services: Ambition, Action, Achievement' - Department of Health: 2011* 'Move from valuing what we measure to measuring what we value' to demonstrate improved outcomes. The project supports the five key stages in public health: starting well; developing well; living well; working well; ageing well. Long term outcomes of the project are:- • Increased vocabulary at 5 years predicts future success at GCSE and beyond, so improving educational attainment and communication skills. • Children develop positive attitudes towards physical activity – reducing childhood obesity levels. Avon longitudinal study identifies 8 risk factors in first year to target help where it is needed most. • Increased parent and carer participation and awareness of their vital role in helping children to achieve improved self-esteem, ability for social interaction and	51.7% **Latest Kent value:** Still awaiting for value **Source**: PHOF national average 12/13 **Lead**: To be determined	

		development of problem solving skills. In addition to this there is also a Health Visitor/School Nurses collaborative called 'Clean and Dry, and 'Ready for School' to improve school readiness.		
1.7	A reduction in the proportion of 4-5 year olds with excess weight	KCC responsible for commissioning the Mandatory programme weight and measurement programme for Yr R and Yr 6 (National Child Measurement Programme), this programme provided by KCHT School Nursing Team. KCHT Healthy Schools Team support local schools, healthy weight is a key element of this provision. Provision of programmes for children and families also provided by KCHT Health Improvement Team. Sports Partnership team at KCC provide many resources for schools to increase physical activity. Public Health working with Children Centres to increase the amount of activates offered and engaged with which promote healthy lifestyle KCC's walking bus scheme to be promoted in schools Public Health Team are leading on developing a County strategy on Healthy Weight. Public consultation on healthy weight – findings due in November 2014. **Healthy weight programme**- focused based on early years development	**National Target**: <21.7% **Latest Kent value**: 21.7% **Time Period**: 2012/13 **Source**: Public Health **Lead**: Public Health	
1.8	A reduction in the proportion of 10-11	Mandatory programme to weight and measure Yr R and Yr 6 (National Child Measurement Programme), KCC commissions	**National Target**: <32.7%	

	year olds with excess weight	KCHT School Nursing Team to do this. KCHT Healthy Schools Team support local schools, healthy weight is a key element of this provision. Provision of programmes for children and families also provided by KCHT Health Improvement Team. Sports Partnership team at KCC provide many resources for schools to increase physical activity. Public Health Team are leading on developing a County strategy on Healthy Weight. Public consultation on healthy weight – findings due in November 2014 **Active Green Travel project**- encourages primary school children to use an active travel method estimated 120,000 journeys saved already. Schools selected on the basis of obesity data. **Ashford's collaboration with PHE to produce local strategy on Healthy Weight**	**Latest Kent Value**: 32.7% **Time Period**: 2012/13 **Source**: Public Health **Lead**: Public Health	
1.9	An increase in the proportion of SEN assessments within 26 weeks	KCC has published a Strategy to improve the outcomes for Kent's children and young people with SEN and those who are disabled (SEND and create at least 275 additional places for pupils with autism (ASD) or behavioural, emotional and social needs (BESN), increasing the number of Kent special school places and establishing new specialist resourced provision (SRP) within our schools, alongside investment in the skills of school staff creating capacity across all schools. The benefits will include greater choice for parents and a reduction in the number of children placed outside the maintained sector in county. We have steadily increased the number of	**National Target**: 90% **Latest Kent Value**: 94.5% **Time Period**: March 2014 **Source**: Cabinet Report	

		assessments completed within 26 weeks, however the Children & Families Act, from September 2014, will require assessments to be completed within 20 weeks and we are introducing new systems to be compliant with the statutory changes. • Undertake a process analysis for the new assessment process and implement steps to deliver a 20 week completion timescale • Ensure all professionals engaged in the integrated assessments in each district are aware of revised timescales • Complete a review of paper based processes within the assessment procedures and identify areas where paperless working can minimise timescales and reduce administration in assessments • Evaluate the impact of the pilot for Local decision making for assessments, ensure it is encouraging school to school support and the delivery of Core Standards • Identify and test systems for robust monitoring and timely access to High Needs Funding (HNF) as an alternative to assessment. • Analyse trends in assessments requests and compare with HNF requests	**Lead**: KCC	
1.10	A reduction in the number of Kent children with SEN placed in independent or out of county schools	• Implement a 3-year plan to increase specialist resourced provision (SRP) in mainstream • Develop Service Level Agreements for SRPs • Liaise with NHS therapy commissioners and NHS providers to ensure relevant services are in place in new mainstream provision	**National Target**: No target stated **Latest Kent Value**: 583 **Time Period**: March 2014	

		• Ensure that SEN commissioning plans are included in the school capital programme • Implement the outcome from a review of Special school designations • Extend core standards to special schools • Review PEO impact and direct expertise to Kent schools and annual reviews • Introduce a Dynamic Procurement System (DPS) for out county placements • Develop robust systems for College placements and high needs funding • Ensure new commissioning arrangements for Warm Stone PRU are operating effectively	**Lead**: KCC	
1.11	A reduction in CAMHS average waiting times for routine assessment from referral	The commissioners of CAMHS services (CCG) are working with Sussex Partnership to reconfigure services and drive up performance. This includes retention and deployment of staff. Performance is closely monitored by CCG ensuring all partners are aware of their responsibility for children's emotional wellbeing. A cross Kent Children and Young Persons Emotional Wellbeing strategy is being developed.	**National Target**: 6 weeks **Latest Kent value:** Still awaiting for value **Source**: KMCS **Lead**: CCGs	
1.12	A reduction in the number waiting for a	The commissioners of CAMHS services (CCG) are working with Sussex Partnership to reconfigure services and drive up	**National Target**: 10 weeks	

	routine treatment CAMHS	performance. This includes retention and deployment of staff. Performance is closely monitored by CCG ensuring all partners are aware of their responsibility for childrens emotional wellbeing. A cross Kent Children and Young Persons Emotional Wellbeing strategy is being developed. **Focus on Looked After Children**, children receiving Free School meals and Children with Special Educational Needs. **Sharing Practices between agencies**	**Latest Kent Value**: (565) **Time period**: (April 2014) **Source**: KMCS **Lead**: CCGs	
1.13	An appropriate CAMHS caseload, for patients open at any point during the month	The commissioners of CAMHS services (CCG) are working with Sussex Partnership to reconfigure services and drive up performance. This includes retention and deployment of staff. Performance is closely monitored by CCG ensuring all partners are aware of their responsibility for children and emotional wellbeing. A cross Kent Children and Young Persons Emotional Wellbeing strategy is being developed.	**National Target**: 8408 (Kent & Medway) **Latest Kent Value**: 8523 **Time period**: April 2014 **Source**: Business Continuity Capacity Plan **Lead**: CCGs	
1.14	A reduction in unplanned hospitalisation for asthma (primary diagnosis) people	Through the 'Transformation Programme for Children and Young People' the rate of admission for asthma in < 19yr olds will be reduced. **Smoke free parks and family spaces**- Targeted campaign to	**National Target**: No target stated **Latest Kent Value**: 14.6	

	aged under 19 years old (rate per 100,000)	reduce children's exposure to second hand smoke '**The Truth About TB'** – Housing services to take part in public health publicity campaigns on recognising the signs of tuberculosis to encourage earlier diagnosis and treatment	**Time period**: 2013/14 **Lead**: NHS England (supported by CCG)	
1.15	A reduction in unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 100,000)	Through the 'Transformation Programme for Children and Young People' the rate of admission for diabetes in <19yr olds will be reduced.	**National Target**: No target stated **Latest Kent Value**: 7.3 **Time period**: 2013/14 **Lead**: NHS England (supported by CCG)	
1.16	A reduction in unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 100,000)	Through the 'Transformation Programme for Children and Young People' the rate of admission for epilepsy in <19yr olds will be reduced.	**National Target**: No target stated **Latest Kent Value**: 8.8 **Time period**: 2013/14 **Lead**: NHS England (supported by CCG)	
Outcome	**Effective prevention of ill health by people taking greater responsibility for their**		**Targets and Indicators**	**Comments**

2	**health and wellbeing**			
2.1	An increase in Life Expectancy at Birth	Breast feeding 6-8 weeks health check Immunisation Antenatal screening programme Public Health programmes to reduce smoking in pregnancy Post natal support to mother Increase the number of healthy births to families Sustain the drive to reduce teenage pregnancy.	None stated as of yet. **Source**: PHOF Kent Level **Lead**: Public Health	
2.2	An increase in Healthy Life Expectancy	Public Health are leading on programmes to encourage as many primary aged school children in the borough, as possible, to use active travel to school. The project is running with some current target schools. It needs additional funding to be expanded into target areas of the borough. Due to the age of the children they are accompanied on the walk / cycle / scoot to school by parents or extended family members, increasing exercise by household, on a wholesale basis. **Smoke free Play Spaces Pilot** **Smoke free homes project-** Introducing no smoking clauses in tenancy agreements	None stated as of yet. **Source**: PHOF Kent Level **Lead**: Public Health	
2.3	A reduction in the	Public Health are looking to develop a project to help support	None stated as of yet.	

	Slope Index for Health Inequalities	young people at risk of self-harm. The project will aim to link in closely with local schools, GPs and other relevant agencies (including in relation CAMHS and Young Healthy Minds). It is likely that the project will focus on supporting individual young people on a one-to-one basis. There may also be scope to work therapeutically with small groups of young people where this issue has been identified. **Mind the Gap**- Identifying strategies and programmes being pursed by partners as viewed against known areas of deprivation. Focus on Areas of deprivation that is decided through number of determinants. Action plan to reduce the inequalities within the borough and collectively improving the Ashford average against Kent and England's average.	**Source**: PHOF Kent Level **Lead**: Public Health	
2.4	A reduction in the proportion of adults with excess weight	Fresh Start is delivered by the local pharmacy advisor and involves a weekly appointment to discuss a personal weight loss plan. The programme includes advice and support on healthy eating, recipes and meal ideas and beating the cravings. In addition KCC PH team also commission the Health Trainer programme which offers free, confidential one-to-one support, to help patients make positive lifestyle changes. The programme is active in the most deprived areas of Kent to reduce health inequalities. Up to six free sessions are offered to support, encouragement and practical assistance in local venues. Health Trainers work with individuals to establish what changes the person wishes to make, to develop a personalised behaviour change plan and to provide support and encouragement to enable them to achieve their goals. Issues that can be helped you with include: - accessing local	**National Target**: <64.6% **Latest Kent Value**: 64.6% **Time period**: 2012 **Source**: PHOF Kent Level 2012 **Lead**: Public Health	

		services - physical activity - healthy eating - healthy weight - stopping smoking - alcohol/drugs concerns - reducing stress - sexual health concerns Public Health Team are leading on developing a County strategy on Healthy Weight. Public consultation on healthy weight services – findings due in November 2014		
2.5	An increase in the number of people quitting smoking via smoking cessation services	This is an important measure to support the 4 week quit indicator, but there are additional measures that we should include to reduce the take up of smoking under a preventative approach and harm reduction initiatives. Eg: • Promote smoke-free acute and mental health hospitals (PH48)) • Support Smoke-free legislation (through standardised packaging of tobacco products and smoke free work vehicles etc.) • Support smokers to cut down to quit where they are not yet ready to quit abruptly (PH45) • Support educational approaches to reducing the risk of young people taking up smoking (through schools, youth settings etc) **(note: national target to reduce smoking prevalence of 15yr olds to 12% by 2015)** There are also other potential indicators for smoking cessation services to record quit smoking rates at 12 weeks and for quits to be CO verified (rather than self reported). Another emerging issue is to support people with learning disabilities and mental health issues to quit smoking or reduce their levels of smoking. Explicitly targeting take up of stop smoking services and	**National Target**: 9249 or 52% quit rate **National Smoking Prevalence:** 18.4% **Latest Kent value:** Smoking Prevalence: 19% **Ashford Local value:** Smoking Prevalence 21.1% **Source**: Public Health **Lead**: Public Health	

		reducing smoking prevalence from routine and manual workers and areas of deprivation .		
2.6	An increase in the proportion of people receiving NHS Health Checks of the target number to be invited	Increase outreach opportunities for those not accessing checks at GP practice. Increase awareness about the NHS Health Check across Kent through targeted marketing. **Linking homeless households to GPs-** Referrals from Housing options officers to a range of services that would potentially increase number of homeless households accessing primary health care services.	**National Target**: 50% **Latest Kent value:** Still awaiting for value **Source**: Public Health **Lead**: Public Health	
2.7	A reduction in alcohol related admissions to hospital	Will be addressed via the Kent Alcohol strategy 2014-16. Each HWB area is requested to develop a local alcohol action plan to implement the Kent Alcohol Strategy 2014-16. **Safety in Action:** workshops for year 6 children covering range of safety issues including drug awareness and accident prevention	No target stated. **Lead**: Public Health	
2.8	(Breast Cancer Screening) An increase in the proportion of eligible women screened adequately within the previous years on 31st March	The breast screening units send out regular reports to GP practices regarding screening uptake during the practice's screening round in order to make practices aware of who is attending or not, and to encourage informed choice and uptake. We are currently starting a piece of what to understand how practices use that information and identify how best to use it going forward.	No target stated. **Lead**: NHS England	
2.9	(Cervical Cancer Screening) An increase in the proportion of eligible	The breast screening units will start to send the Screening and Immunisation Team uptake data on each round so that in advance vans going to particular areas (especially those with low uptake historically), we can support and encourage	No target stated. **Lead**: NHS England	

	women screened adequately within the previous 3 years on 31st March	practices to make use of promotional material to reach their eligible population.		
2.10	A reduction in the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000)	PH strategy to prevent young p from taking up smoking and also to increase the number of smokers quitting. Targeting areas of deprivation and routine and manual workers, people with mental health and learning disabilities. There are also specific indicators on mortality due to lung cancer which could be included (PHOF 51). Also could include PHOF 29: smoking related deaths (all ages) and COPD prevalence	No target stated. **Latest Kent value**: 285.2 **Time Period**: 2010-12 **Lead**: Public Health	
2.11	A reduction in the under-75 mortality rate from cancer (rate per 100,000)	Ashford, Canterbury and Coastal, South Kent Coast and Thanet Clinical Commissioning Groups and East Kent Hospitals University NHS Foundation Trust have developed a Cancer Recovery Plan to improve cancer care and reduce under 75 mortality from cancer.	No target stated. **Latest Kent Value**: 138 **Time Period**: 2010-12 **Lead**: Public Health	
2.12	A reduction in the under-75 mortality rate from respiratory disease (rate per 100,000)	**CCG**	No target stated **Lead:** Public Health	
Outcome 3	The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.		**Targets and Indicators**	**Comments**

3.1	An increase in clients with community based services who receive a personal budget and/or direct budget	Under the Care Act there will be an increase in the number of carers who can access a direct payment that they can use to support them in their caring role. An increase in the number of people who have taken up a direct payment for homecare services	**National Target**: To be determined. **Latest Kent Value**: 67% **Time Period**: Feb 2014 **Lead**: Social Care	
3.2	An increase in the number of people using telecare and telehealth technology	Kent wide Telehealth service is being discussed as part of the work of the Kent Integrated Pioneer programme, through the Integrated Teletechnology Steering Group under Anne Tidmarsh, which has put forward an options paper for CCGs and other Pioneer partners to consider. This paper considers the integration of Telecare and Telehealth services and the broadening of the range of Technology Enabled Care Services (TECS) solutions available to fit in with individual's health and social care needs, and as part of promoting self-management and patient activation.	**National Target**: To be determined **Latest Kent value**: 2,992 **Time Period**: Feb 2014 **Lead**: Social Care	
3.3	An increase in the proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after	**Community Geriatrician** In June 2013 the innovative geriatrician pilot project offered support to care homes from a full-time consultant 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	**National Target**: To be determined **Latest Kent value**: 84% **Time Period**: March 2014	

	discharge from hospital in reablement/ rehabilitation services	Service Journal (HSJ) Efficiency Award for community service redesign 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.	**Lead**: Social Care	
3.4	A reduction in admissions to permanent residential care for older people	Carer assessment and support services and short breaks for carers in place to help prevent carers breakdown which is one of the main reasons people go into residential care. Community equipment service being retendered to provide effective support to keep people in their own home Mental health services are being re-commissioned in partnership with public health to create a core offer of services to help people remain connected to their local communities. Community capacity building being explored in Wye to understand how communities can support themselves. This is through the delivering Communities Differently- a project we have been grant funded to progress	To be determined **Lead**: Social Care	
3.5	An increase in the percentage of adults with a learning disability who are	KCC has recently completed a pilot for people with a learning disability in order to ensure that they are able to live in their own homes for longer and also to ensure that they can become more independent. The final report is encouraging about the	To be determined **Lead**: Social Care	

	known to the council, who are recorded as living in their own home or with their family (Persons/Male/Female)	potential for the use of telecare for people with a learning disability and an implementation plan is being developed to ensure that the recommendations are acted on. The Pathways to Independence Project looks at enabling people with a learning disability to achieve increasing independence in their daily lives from creating confidence to enable people to travel independently to take part in voluntary work. This enablement projects aims to boost independence with the impact of enabling people with a learning disability to engage with their community and to stay at home for longer. Case studies can be found on KNeT on: http://knet/ourcouncil/Pages/SC-pathways-to-independence-case-studies.aspx.		
3.6	An increase in the percentage of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support. (Persons/Male/Female)	% of people in settled accommodation (NI149) which KMPT have to report on as part of their dashboard the target.	To be determined **Lead**: Social Care	
3.7	A reduction in the gap in the employment rate between those with a learning disability	The Pathways to Independence address this issue. In addition to this there is a lot of work that goes on through the Kent Learning Disability Partnership about employment. Through the 'What I Do Group', the Learning Disability Partnership has engaged with Kent Supported Employment who regularly	To be determined **Lead**: Social Care	

	and the overall employment rate	attend meetings and provide information and advice to people with learning disabilities. The Department of Work and Pensions has a member of staff who attends meetings of the Partnership Board. The What I Do Group has created a training DVD for Job Centre Plus staff which trains the staff in how to meet the needs of people with learning disabilities through longer appointments, having meetings in meeting rooms, being ready to help people with learning disabilities use the computers etc.		
3.8	An increase in the early diagnosis of diabetes.	Integrated diabetes care pathway is currently being developed across East Kent CCGs which focuses on early diagnosis as part of better care for diabetic patients.	To be determined **Lead**: To be determined.	
3.9	A reduction in the number of hip fractures for people aged 65 and over (rate per 100,000).	Ashford and Canterbury CCG are working collaboratively in addressing falls amongst older adults aged 65 and over. Based on the Falls Framework which was agreed by the Kent Health and Wellbeing Board, a task and finish group has been set up as a cross organisational group to develop an effective pro-active and re-active falls pathway across the localities of Ashford and Canterbury and Coastal. The group's aim is to implement recommendations in line with the Better Care Fund, development of the Community Networks and the Integrated Urgent Care Centre (IUCC) and the Over 75 CQUIN, over 2014/15: The outcomes expected to be achieved is to reduce the rates of injury as a result of a fall in the over 65's by: i) Early identification of those likely to have a fall (e.g. medication reviews, housing issues)	**National Target**: No target stated **Latest Kent Value**: 544 **Time period**: 2012/13 **Lead**: Public Health	

		ii) Engaging with the community postural stability classes for continued care through therapeutic exercise classes to help reduce the likelihood of another fall. **Sheltered scheme managers** given specific health related target for 2014 to promote events in scheme with health theme e.g. exercise, healthy eating, falls prevention work		
Outcome 4	**People with mental ill health issues are supported to 'live well'**		**Targets and Indicators**	**Comments**
4.1	An increased crisis response of A&E liaison within 2 hours – urgent	<u>CCG future operating model:</u> **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.	**National Target**: 95% **Latest Kent Value**: 73.5% **Time Period**: Q3 2013/14 **Source**: KMCS **Lead**: CCGs	
4.2	An increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours	<u>CCG future operating model:</u> **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.	**National Target**: 100% **Latest Kent Value**: 100% **Time Period**:	

			Q3 2013/14 **Source**: KMCS **Lead**: CCGs	
4.3	An increase in access to IAPT services	CCGs are responsible for commissioning IAPT services and will be able to report on progress against national targets. HWBB partners can assist by letting the public and clients know that the services can be accessed directly or via their GP. For further information on how to access IAPT NHS funded talking therapies in primary care go to www.liveitwell.org.uk. KCC Public Health is promoting well-being in the general population through a mental wellbeing investment programme. This is themed around the ways to well-being and includes a wide range of interventions to help people well and increased access to IAPT services.)	To be determined **Lead**: CCGs	
4.4	An increase in the number of adults receiving treatment for alcohol misuse	Promoting well-being in the general population (eg IAPTS & Six ways to well-being) Will be addressed via the Kent Alcohol strategy 2014-16. National measures: Kent sits in top quarter for achieving successful / completed treatment outcomes for alcohol treatment.	To be determined **Lead**: KDAAT/ Public Health	
4.5	An increase in the number of adults receiving treatment for drug misuse	Will be addressed via the Target schedule (contract) based on successful completions	To be determined **Lead**: KDAAT/ Public Health	
4.6	A reduction in the	Nationally, this can't be measured and community data capture	No target	

	number of people entering prison with substance dependence issues who are previously not known to community treatment	system is not aligned. New national measures have just been announced. Local work is progressing to implement this new measure via a system to track referrals from community treatment to prisons and vice versa. **Community Safety Partnership Projects** around substance misuse e.g. community engagement day in Victoria Park. Partnership working arrangements to encourage and enable the sharing of appropriate and relevant information that meets legislative requirements.	**Lead**: KDAAT/ Public Health	
4.7	An increase in the successful completion and non-representation of opiate drug users leaving community substance misuse treatment	The system was recently revised to a Recovery Treatment focus system which is very successful. National measures: Kent sits in top quarter for achieving successful / completed treatment outcomes for drug treatment. A working group is being established to address low service uptake for this cohort and alternative models are being scoped for those with addiction to prescription only medications and OTC.	To be determined **Lead**: KDAAT/ Public Health	
4.8	An increased employment rate among people with mental illness/those in contact with secondary mental health services	This is a key target in the 'Live it Well Mental Health 'strategy for Kent. KCC and CCG are going out to consultation to decipher whether the strategy is fit for purpose and meets all priorities. **Self-Harm Project-** improving mental wellbeing for young in Ashford. Training programme for 20+ front line professionals and curriculum sessions and activities at HOUSE.	**National Target**: 10% (PCA) **Latest Kent value**: 7.4% **Time period**: 2012/13 **Source**: Needs confirmation from	

			KCC **Lead**: CCGs	
4.9	A reduction in the number of suicides (rate per 100,000)	Public Health are working with KMPT to reduce the risk of suicide in high risk groups by putting measures in place to support middle aged and older men Promoting wellbeing in the general population (eg IAPTS & Six ways to well-being) Reducing the availability and lethality of suicide methods (eg Working with Network Rail re safety measures on the railway) Improving the reporting of suicide in the media Monitoring suicide statistics regularly **Sk8side Saturday night opening at HOUSE** educational and diversionary activities to support young people in improving and managing mental wellbeing	To be determined **Latest Kent value**: 7.36 **Time Period**: 2010/12 **Lead**: Public Health	
4.10	An increase in the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey	There are the commissioned services, dementia cafés, peer support and day care run by either Age UK, EKIDS and Alzheimer's society depending on location. With regards Dementia Friendly Community projects. In Ashford following the Community event the CCG task and finish group transformed into an action Alliance this is very well supported and similarly to Faversham is carrying out insight gathering, promoting the dementia help line and providing	No target **Lead**: Social Care	

		content for the dementia friendly website, 220 council staff have attended dementia friends information sessions as have a number of the housing mangers and in one case the residents of an extra care housing unit. The Alliance has identified three objectives for their first quarter of promoting the dementia help line, insight gathering and providing content for the dementia friendly website In Ashford Age UK are moving from their present site into Farrow Court. This will allow Age UK to expand their services, in a building designed to be dementia friendly. Age UK do provide a pop in service (Joe Fagg) in St John's Lane in Ashford which can provide support and advice on services and other information. Age UK can be contacted on 01233 620635. **Provision of land and extra care scheme** in St.Michael's and extra care scheme progressing at the Warren. **Dementia Kent Action Alliance-** ABC signed up. About 200 staff have undertaken dementia friends training. ABC hosted first meeting of Ashford Dementia Action Alliance. Key projects identified.		
4.11	An increase in the percentage of adult carers who have as much social contact at they would like according to the	The Alzheimer's Society runs a dementia café at the Conningbrook Hotel in Ashford. This is aimed at people with dementia and their carers and is also a source of information and support. The café takes place every third Tuesday of the month and more details can be obtained by contacting 08450 405 919. Although this is not a day service, it is an opportunity	No target **Lead**: Social Care	

	Personal Social Services Carers survey	to meet and talk to other people in similar situations. Crossroads Care also provides a short break service which provides planned respite for the carers of people with dementia. The service is delivered in people's own homes and the carers are all trained to manage people with dementia		
4.12	An increase in the percentage of respondents who, according to the survey, are satisfied with their life, who are not feeling anxious, and who feel their life is worthwhile.	Please note 4.10	No target (4 measures) **Lead**: Social care	
Outcome 5	**People with dementia are assessed and treated earlier and are supported to live well.**		**Targets and Indicators**	**Comments**
5.1	An increase in the reported number of patients with Dementia on GP registers as a percentage of estimated prevalence	This is a national priority and the CCGs have a target to meet of 67% diagnosis rate (against expected prevalence) by March 2015. The CCG is developing actions to achieve this.	To be determined **Latest Kent Value**: 43.40% **Time Period**: 2012/13 **Lead**: CCGs	
5.2	A reduction in the rate of admissions to hospital for patients older than	This isn't a specific target, but we do now have a dashboard which monitors admissions. Better communication with CMHTOP- in GPs	To be determined **Latest Kent Value**: 24.8	

	64 years old with a secondary diagnosis of dementia, rate per 1000	**Good Neighbourhood scheme-** anticipatory care plans	**Time Period**: 2012/13 **Lead**: CCGs	
5.3	A reduction in the rate of admissions to hospital for patients older than 74 years old with a secondary diagnosis of dementia, rate per 1000	As above.	To be determined **Latest Kent Value**: 49.6 **Time Period**: 2012/13 **Lead**: CCGs	
5.4	A reduction in the total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000	As above.	To be determined **Latest Kent Value**: 229.3 **Time Period**: 2012/13 **Lead**: CCGs	
5.5	A reduction in the total bed-days in hospital per population for patients older than 64 years old with a	As above.	To be determined **Latest Kent value**: 458.7 **Time Period**:	

	secondary diagnosis of dementia, rate per 1000		2012/13 **Lead**: CCGs	
5.6	An increase in the proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who a. have been identified as potentially having dementia b. who have been identified as potentially having dementia, who are appropriately assessed c. who have been identified as potentially having dementia, who are appropriately assessed, referred on to specialist services in	This is the national CQUIN which acute trusts have to achieve. EKHUFT are on track with this. **Dementia friendly Ashford**- Dementia friendly communities Programmes	To be determined. **Lead**: CCGs	

	England (by trust)			
5.7	A reduction in the proportion of people waiting to access Memory Services - waiting time to assessment with MAS.	Don't think we are going to reduce the number of people waiting for assessment anytime soon as referrals have continued to increase over the last two or three years. KMPT have a KPI to achieve of ensuring that 95% of people who are referred to MAS have their first assessment within 28 days. The last data we have (for July) for Canterbury shows 73% achievement. **Support for self-management** – risk profiling, single point of access, shared decision making process with patients.	**Target**: 90% within 4 weeks **Latest Kent value:** Still awaiting for value **Source**: KMCS **Lead**: CCGs	
5.8	An increase in the proportion of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	This is part of the dementia QOF. Therefore if the diagnosis rates and therefore QOF registers increase, so should the number of people being reviewed.	To be determined **Lead**: CCGs & KCC	
5.9	A reduction in care home placements	This is one of the CCG aims, although I'm not sure there is a specific target. This is being supported by the geriatrician project. Increase the availability and choice of accommodation for vulnerable people- **Delivering further 39 new build dwellings** – will ensure some are tailored around families with complex needs i.e. adapted properties.	To be determined **Lead**: CCGs & KCC	

Ashford Health & Wellbeing Board (AHWB)

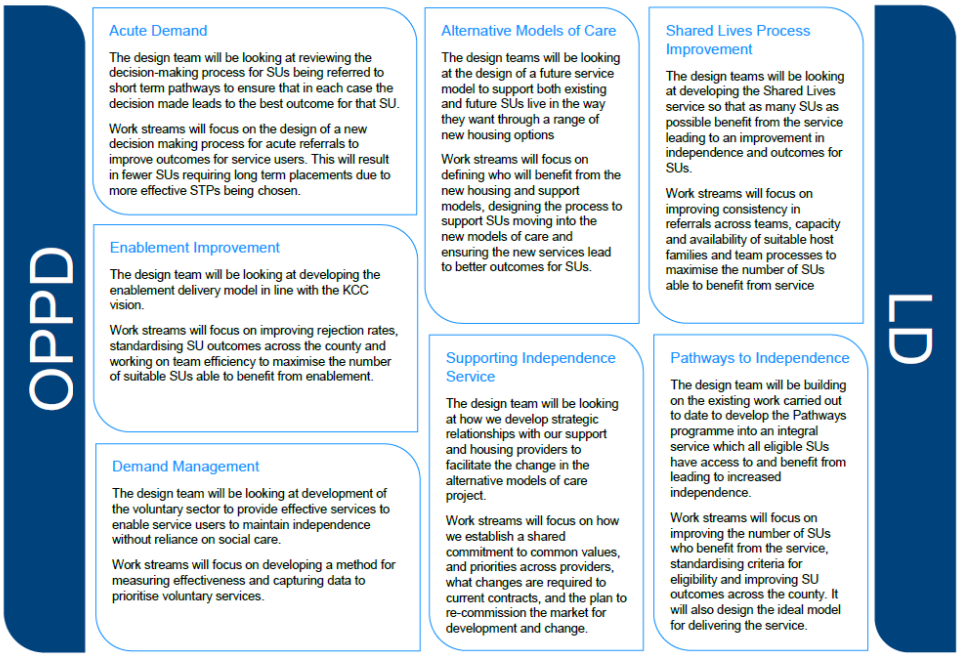
Partner Quarterly Update for the Clinical Commissioning Group – Quarter 4: January to March 2015

What's going on in our world	Local Referral Unit now operational giving alternative pathways to A&E attendances and admissions 7 Day working in Ashford Rural Network has continued to offer in excess of 200 additional appointments per month as alternative to A&E attendances. During winter months we have also offered similar service across Ashford town as part of national approach to reducing winter pressures of hospital A&E depts. Currently awaiting outcome of PM Challenge Fund bid for extended 7 day working Refresh of Annual Operating Plan for 2015-16 being written.
Success stories since last AHWB	Achieving IAPT national recovery rate Winter surge funding has reduced attendances and admissions through A&E Increased care plans, through IT system, available to all health providers Dementia diagnosis rate increased to over 50% but currently behind planned trajectory Whilst underachieving against national target for A&E waiting times, remained the only health economy in Kent to achieve zero-breach of 12-hour target
What we are focusing on for the next quarter <u>specific to the key projects</u>	Continued development of community network over winter period to test model assumptions Implementing revised specification for Westview to support creating of capacity for GP beds and non-weight bearing patients
Anything else relevant to AHWB priorities NOT mentioned above	
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	

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Kent County Council Social Services – Quarter 4: January to March 2015

<table>
<tr><td>What's going on in our world</td><td>KCC Transformation projects phase 2 are underway
For Adults and people with Learning Disability
 

KCC are working with WYE on 'Our Place Project'
Community equipment tender ongoing
Advocacy tender ongoing
Out for tender on current meals contract
Working with CCG and District council on local accommodation projects
Care Act training for all staff
</td></tr>
<tr><td>Success stories since last AHWB</td><td>Winter surge funding has reduced attendances and admissions through A&E

Integrated discharge team in hospitals

Care navigators funded as part of integrated discharge teams

Support at Home Service set up to support people at risk of a hospital admission and support people who need low level support in the community on discharge set up for Ashford though KCC and Age UK

Successfully bidded to become a pilot site for Age UK 'integrated care pilot' joint partners with CCG, KCHFT, EKHUFT and Age UK, to start in Rural Ashford.</td></tr>
<tr><td>What we are focusing on for the next quarter <u>specific to the key projects</u></td><td>Continued development of community network over winter period to test model assumptions

Working with CCG on implementing revised specification for Westview to support creating of capacity for GP beds and non-weight bearing patients

Developing integrated care pilot in Rural Ashford</td></tr>
</table>

	Working with WYE on developing 'Our Place' project Scoping and developing 'Community Agent' in Wye Developing winter and escalation plans
Anything else relevant to AHWB priorities NOT mentioned above	Integrated Commissioning group has changed its name to 'Joint Commissioning Delivery group' Chaired by Lorraine Goodsell, Transformation Programme Director NHS Ashford and Canterbury & Coastal CCGs Remit is Community Networks and BCF projects.
Strategic challenges & risks including horizon scanning?	Ensuring that implementation of community networks is balanced with current demands of capacity Ensuring transformation projects are on target
Any thing else the Board needs to know	
Signed & dated	Paula Parker 25/03/15

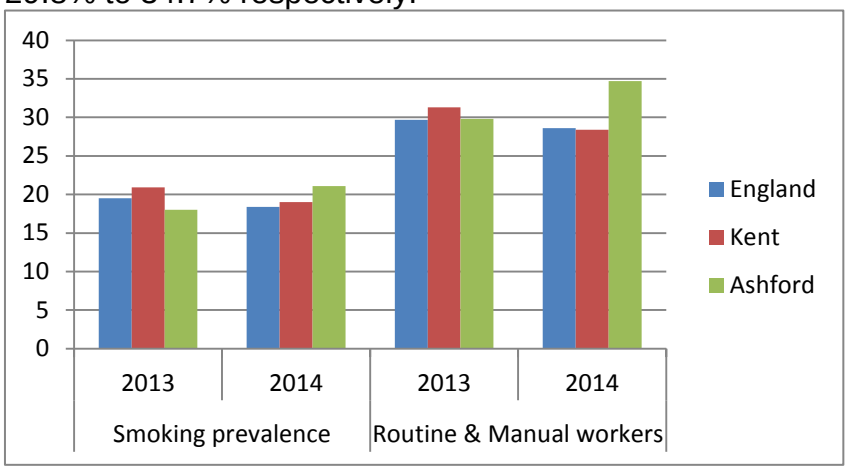
Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the KCC Public Health –

Quarter 4: January to March 2015

What's going on in our world	Smoke Free Parks and play spaces – Kent Public Health and Ashford Borough Council are working together to pilot an initiative to keep children's play areas Smoke Free in Ashford. Smoke free play areas will be self-enforcing and focus groups to date, have demonstrated considerable support for this initiative. Ashford's play parks will be equipped with additional trail games to promote physical activity and mental wellbeing and will require accompanying adults to ensure children are not exposed to second hand smoke. The first launch event will be at Kilndown Court park in Stanhope on the 14th April. Alcohol Strategy – Ashford will prepare an Alcohol Action plan from the Kent Alcohol Strategy which will be delivered, with partners, through the Community Safety Partnership strategy (Substance Misuse group). The draft action plan will be shared with the Ashford Health and Wellbeing Board for agreement prior to implementation. Tobacco Control – On the 9th March, Kent County Council signed the Local Authority Declaration on Tobacco Control. The Declaration pledges the council's commitment to reduce smoking prevalence and health inequalities through the effective implementation of policies, plans and partnership support. District Councils, CCGs and the Acute Trusts are also encouraged to sign their respective district council declarations and NHS statement of support. CAMHS – The Kent Children and Adolescent Mental Health Service Needs Assessment has been drafted and is currently out to professional consultation before being available for public consultation. The Needs Assessment provides prevalence data and needs analysis at CCG level, which can assist Ashford identify local needs against resources. Breastfeeding - Kent County Council has produced a new website to promote breastfeeding peer support and encourage more women to breastfeed. Click this link to access the site: http://www.kent.gov.uk/social-care-and-health/health/breastfeeding
Success stories since last AHWB	Health Profiles for Ashford The local Area Health Profiles for 2014 were published last August and show local performance compared against the

	national average on a range of health improvement indicators. A separate paper has been prepared for Ashford LOG detailing performance in Ashford from 2013 to 2014. In summary, Ashford has improved from performing worse than the national average to around the national average for **GCSE achieved (5A*-C inc. English and Maths)** and for numbers of **obese adults**. There have also been significant improvements in the number **of alcohol specific hospital stays for under 18s** improved from being in line with the national average in 2013 to performing higher than national average in 2014. In 2014, Ashford is performing above the England average for: **Deprivation** **Children in Poverty (under 16s)** **Violent crime** **Long term unemployment** **Smoking related deaths** **Alcohol specific Hospital stays for under 18s** **Hospital stays for self harm** **Hospital stays for alcohol related harm** **Drug misuse** **Acute sexually transmitted infections** **Life Expectancy at birth (Male and Female)** **Under 75 mortality rate: cancer** And worse than the England average for: **Smoking status at time of delivery** **Breastfeeding initiation** **Statutory Homelessness** Smoking Prevalence and Smoking Prevalence among routine and manual workers Can also be added to these priorities as more recent data has indicated a sharp increase performance worse than the national and Kent average. Further detail on trends and performance are illustrated in the accompanying paper on Ashford Health Profiles.
What we are focusing on for the next quarter <u>specific to the key projects</u>	Men's Sheds – Groundwork South will be liaising with Community Development workers in Ashford to develop Men's sheds in the locality. The sheds can be themed against a range of wellbeing topics and activities, with potential to link in to Community networks, wellbeing, dementia and obesity support groups.
Anything else relevant to AHWB priorities NOT mentioned above	Tobacco Control – Recent Public Health England Local Tobacco Profile data has identified Ashford's smoking prevalence increase from 18% to 21.1% between 2013 and 2014. Routine and

	Manual worker smoking prevalence has also increased from 29.8% to 34.7% respectively.  *Source: Local Tobacco Control Profiles* Ashford and Thanet are the only districts in Kent that have seen an increase in both of these indicators within this period. Ashford is higher than the Kent and national average for these indicators. Although consideration needs to be given to the accuracy of estimates calculated at a local level, this is still a particular concern considering the health conditions associated with smoking and the economic impact it has for individuals and for services. A separate paper on this has been provided to the Ashford LOG for discussion.
Strategic challenges & risks including horizon scanning?	Smoking rates - Increased smoking rates may be a concern for Ashford if the trend continues to increase, bucking the national and Kent trend for smoking.
Any thing else the Board needs to know	
Signed & dated	Deborah A. Smith 18th March 2015

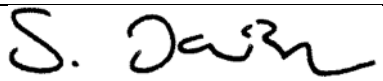
Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Ashford Borough Council – Quarter 4: January to March 2015

What's going on in our world	• **Proposed acquisition of Ashford town centre retail facility** – recommendation being made to April Council meeting. Will be subject to detailed due diligence and final negotiation of contracts. Acquisition linked to longer term town centre development plans. • **M20 Junction10a** –consultation to take place summer 2015. Email updates for the scheme via www.highways.gov.uk/roads/road-projects/m20-junction-10a/ • **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. Planning application expected in next few months. • **Designer Outlet Expansion** (phased extension to double floor space). Planning application submitted. The application proposes demolishing part of the existing Designer Outlet Centre and building an extension comprising retail shops and restaurants, as well as a re-configured car park, public realm improvements, landscape and highway works and other associated enhancements. • **Ashford College** (£20m campus for 1,000 students) Hadlow Group's bid to the SE LEP successful securing over £8 million with a £5 million grant from the Skills Funding Agency also secured. Phase 1 construction due for completion early September 2017 £2 million loan from the Council to kick-start the development. • **International Station spurs** (finding signalling solutions to enable future interoperability for all international service providers). Key to retaining Eurostar and other services in Ashford. News received that there will be £2m invested into signalling at Ashford International Station as part of the Growth Deal announced early February by the Government. • **Chilmington Green** (development based on Garden City principles (1000 jobs and 5,750 houses) resolution to grant planning permission given. Ongoing s106 discussions. • **Commercial Quarter (**55,000 sq m commercial office floor space plus 150 homes). Agent appointed & architects working on design and layout. • **Public realm works** Works to create a new public realm around International House begin in March and will continue until August. The council is working in partnership with the Homes and Communities Agency (HCA) and design practice, BDP, to enhance the environment and physical appearance around International House and Dover Place. The new public realm, funded by £1.3m from HCA, will create an attractive first impression of the town for visitors arriving at the international station. • **TENT1 –** (additional 249 homes in Tenterden). Delays over section 106

	discussions by final decision imminent. • **Conningbrook Lakes Country Park** has moved a step closer following the signing of agreements between the Brett Group and the Council. Land now effectively handed over to the council to begin preliminary works. Aim to open the park to the public and water sports clubs summer 2015. • **Repton Park Community Centre.** Planning application submission anticipated in early summer 2015. New project commissioned to support the enhancement of the design of the building, bring forward options for a name for the centre and signage, working alongside well renowned artists. Also use this project as a platform to inform the community development programme which clearly captures the communities aspirations and ambitions. • **Housing Services new e-newsletter** – New monthly e-newsletter called "Tell Us". Opportunity to communicate with ABC tenants and gauge feedback electronically. • **Support to rural business funding** – Ashford's rural businesses soon to have access to millions of pounds of funding, supporting job creation and growth in the rural economy. Achieved as a result of successfully lobbying to access the new LEADER programme, which is financed by the EU and DEFRA, offering rural development grants to projects that create jobs and grow the rural economy. Further details of the LEADER programme can be found at https://www.gov.uk/rural-development-programme-for-england-leader-funding.
Success stories since last AHWB	• **Self Harm Project** - Project review pointed to a new approach to any further work, focusing on one to one work with young people referred to the programme through partners. Further funding secured from the CCG for an extension to the project. Sk8side to be commissioned to deliver this work. • **Dementia** – planning officers have developed a design brief of good practice for dementia friendly design and are promoting with developers of older persons accommodation. Six Housing & Community staff are trained as dementia champions and are running a programme of dementia friends training from ABC sheltered schemes for residents and the wider community. Council is actively involved with the Ashford Dementia Action Alliance, provides a meeting room and contributing to planning activities for dementia awareness week. Area manager for sheltered schemes attended conception meeting for Tenterden Dementia Friendly Community initiative and is working with the group to progress this project. Kent Dementia Helpline has been promoted via Ashford Voice and Housing News, latter also featured reading well on prescription project from the libraries service. New council website promoting it work on dementia including our Dementia Friends work and the Farrow Court scheme. Information at http://www.ashford.gov.uk/dementia-friends. • **Domestic Abuse** – Community Safety Partnership top up funding to support crèche and after school facilities at the Ashford Refuge. • **Little Hill Extra Care Scheme –** this Council site was gifted to KCC in June last 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. This Project will also deliver 12 units of move-on (short-term)

	accommodation at St. Stephens Walk in Ashford to help people acquire the skills to live independently. The scheme will be operational in September 2015. • **National Acclaim for Ashford's Innovative Housing** - 'Elphicke-House' report, compiled by Ms Natalie Elphicke (a foremost housing finance expert) and Mr Keith House (a board member of the Homes and Communities Agency), recognises that many more local authorities should follow Ashford's lead and offer proactive support to provide quality new homes while helping to build strong and sustainable communities. The review praises the way this council has taken advantage of opportunities such as HRA self-financing, and acted entrepreneurially through our property company and 'ABC Lettings' to discharge our statutory duties and offer other services in innovative ways. Link to report: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398829/150126_LA_Housing_Review_Report_FINAL.pdf • **New Build Affordable Homes** - Programme agreed to deliver the fifth phase of the programme which was the provision of 106 units of which 50 units were proposed for the redevelopment of an existing sheltered housing scheme at Danemore in Tenterden. Access the full programme at http://www.ashford.gov.uk/developments-coming-soon • **Spearpoint sports facilities**. Sports Council funding secured and approval given to replace the Spearpoint pavilion with a new community building. • Singleton Village Hall. Extension under construction. • **'Smoke Free' Play Spaces** – Pilot project to encourage an emotional response from local residents, discouraging them from smoking in public places and around children. Secured £15k from Kent Public Health and circa £4k from other sources including Moat Housing. Three key elements: entrance signage to play areas asking adults to not smoke, suite of pavement games which add play value to our play spaces but also promote key 'stop smoking' messages and community days & school sessions delivered by Sure Start and other key health partners to promote the campaign. To operate in six play spaces i.e. Stour Centre, Moat play spaces (X3) in Stanhope, Bulleid Place, Newtown Green, with further ones delivered subject to budget Installation starts April 2015.
What we are focusing on for the next quarter specific to the key projects	• **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. • **Healthy weight** – Focus of October Board meeting. The Board agreed with the proposal of an action plan being written. A task and finish group will be meeting in the New Year. Local projects are under review and a new emphasis on this work and a potential new project being supported with additional links to the Stanhope Hub project. • **Farrow Court** – building work continues on site with 33 dwellings in phase 1 due for completion by early June 2015 including communal. Once phase 1 is complete phases 2 and 3 will commence with anticipated completion of these in late 2016.

	• **Homelessness** – Progressing the Rough Sleeper project. Porchlight have appointed a project worker to take forward the Rough Sleeper Project. Short term funding stream identified but not sustainable in the longer term. Will require joint commissioning and further discussions due in April/May 2015 towards achieving this. • **Community Health Zone, (Stanhope & South Ashford)** – Project brief defined and key local partners engaged in project development. Discussions with KCC Public Health, Ashford BC, Ashford Supporting Families and CCG re funding. Funding secured for a pilot period of an initial six months. This pilot period includes the need for a project coordinator. Start date of project will be when coordinator in post, which will be advertised shortly. • **Local Plan (and Community Infrastructure Levy)** - in the process of preparing it and are looking to get to a final draft version by the end of the year. Reminder to Board members of the need for involvement and dialogue in order to embed an integrated approach to promoting public health and wellbeing through planning. A useful guide on this subject is proided at: http://www.lgiu.org.uk/briefing/planning-health-and-wellbeing-new-lgiu-essential-guide/
Anything else relevant to AHWB priorities NOT mentioned above	• **Walk to School Project** - Need to identify funding to continue supporting the 'Walk to School' project. At present ABC is struggling to find resources to expand to additional schools.
Strategic challenges & risks including horizon scanning?	Elections (national and local). Outcomes are not possible to predict with so many parties, marginal results & possible government options being touted. ABC policy team geared to provide highlights of boards issues and more detailed analysis of specific issues.
Any thing else the Board needs to know	
Signed & dated	 Sheila Davison – 8 April 2015

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Ashford Children and Young Person's Health & Wellbeing Committee – Quarter 4: January to March 2015

What's going on in our world	Priorities **Mental Health – including emotional health** • Changes from CAF to Early Help – identified need for an on-going training programme to be rolled out to all staff & Head teachers. A sub-committee to design programme. • Key – understanding thresholds. Conversations are happening between committee and relevant partners. **Play/ Early Start** • Due to lack of CC's in rural areas there is a need for mobile play to be readily available. An application to be made for 'Themed Grant' for play activities. • There is a concern around lack of engagement from the GRT community in rural Ashford. • Need to improve access to materials. Play leaflets to be resurrected and updated. • Training to ensure that pre-school workforce are aware of what 'play' is. • Upskilling parents –more provision to active learning. **Healthy Living – Obesity & Smoking** • Obesity – looking at cause and response by age group • Smoking – as above. Focusing on prevention; reduction and cessation. • A significant piece of work to reduce number of year R and year 6 who are overweight is happening in Stanhope – use template to extend this across the area. **NEET's** • Statutory duty sits with KCC. They have identified priorities for Ashford as - Those below L2 at KS4 - Special school leavers - Home educated - CIC - Young people wishing to work in Construction - In addition to the above, the committee have also identified pre-further education careers guidance. - Representation from KCC will be attending the next committee meeting to present on the above and discuss how the committee can support.

Success stories since last AHWB	• CC's are working with rural school to organise an event for GRT community and arranging for visits to sites for face to face discussions to establish need and look at taking services out to the communities. • Police have reported a 75% reduction in ASB, mainly by YP in the Ashford district.
What we are focusing on for the next quarter <u>specific to the key projects</u>	The key issues the board will be focused on over the next quarter are • Collecting relevant data and establishing what is already being provided in the district. • Engagement with schools for - Whole school approaches to healthy weight/active lifestyles - Training – changes from CAF to Early Years/importance of 'play' - School readiness - Support to prevent NEET's
Anything else relevant to AHWB priorities NOT mentioned above	Need to recruit secondary head teacher representative to committee – lead on NEET's. Next meeting to be held on Thursday 23rd April.
Strategic challenges & risks including horizon scanning?	• Lack of funding • Reaching/engaging key families • Adult mental health/CAMHS thresholds go up
Any thing else the Board needs to know	Nothing to report

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from(delete as applicable)	Case Kent/ Voluntary Sector representative
Quarter concerned (delete as applicable)	January to March 2015
What's going on in our world	Many voluntary and community sector organisations involved in health and welfare have received rollover funding for next year from KCC. There are concerns about a lack of clarity about what funding will be available and the future format of commissioned services and grants from KCC and the CCGs. Rollover funding makes it hard for charities to do their business planning and much effort is therefore focused on keeping services going or planning for reducing services and redundancies.
Success stories since last AHWB	There are over 350 voluntary and community organisations in Ashford so here are a couple of examples as a flavour of what's happening in the sector overall. **Charing Gardening Club** was awarded £9k by Awards for All for a therapeutic gardening project for patients of Charing Surgery. Among the aims of the project is to provide local vulnerable a chance to meet people and socialise and as a means of promoting exercise and well-being. Three voluntary organisations who work with disabled people had to leave International House when it closed recently. CASE Kent, the voluntary and community sector infrastructure body which covers Ashford provided a workshop, funded by Ashford Borough Council, to help the groups find new premises, potential partners for collaborative work and to work on their financial sustainability. Unfortunately, one of these organisations, Voice 4 Kent will be closing due to their having no further funding. The other two organsations, ASD Ashford & Centre for Independent Living held a successful launch in January at their new office at the Old Mobility Shop in County Square Shopping Centre.
What we are focusing on for the next quarter <u>specific to the key projects</u>	CASE Kent has secured Lottery funding to produce a 'State of the Sector' report on the Voluntary Sector. This will look at how 'cost-effective' the sector is, funding issues for the sector, sustainability and engagement with statutory bodies (including health and local CCGs). They have appointed a consultant, Barbara Beaton of Sandpiper Business Support, to help them produce the report. Work on this report will begin in late April.

Anything else relevant to AHWB priorities NOT mentioned above	CASE Kent put in a bid to run some Dementia Awareness Road shows in Ashford. This bid was based on a successful project ran by CASE Kent as part of a previous health promotion project in 2009-2010. The bid was unsuccessful as it was pointed out that The Alzheimer's Society have a Dementia Awareness 'bus' travelling to local Tesco's across the country but the CASE Kent model intended to Dementia-specific services out to local village halls/health centres so it is still a project worth consideration as it has the potential to reach a lot of people at a relatively low-cost.
Strategic challenges & risks including horizon scanning?	A lack of proportionality in grants and contracting arrangements with small and medium not-for-profits creates a risk that the smaller organisations will not be able to gain funding and will not be able to deliver the same impact as at present. Some risk closure as alternative sources of funding are increasingly difficult to obtain. Within 1 -2 years the impact of the loss of the volunteering time currently provided will be felt. Some organisations do not need funding from the statutory sector but benefit from support and infrastructure advice. The trustees of CASE Kent, have issued notice that lack of funds means they need to consider future options for the organisation, including closure. This would have a strong negative impact on smaller not for profits that rely on their help.
Anything else the Board needs to know	Greater communication and engagement with the sector is needed as many smaller organisations have found it difficult to keep up with the changes in the statutory sector and to predict the future direction. We would like to invite CCG and KCC representatives to our next Ashford VCS Network Meeting. We are prepared to set a date according to their availability in late April/May.
Signed & dated	Tracy Dighton, Michael James. 24th March 2015.

AHWB key projects are:

- **Community Network**
  Project Lead: Clinical Commissioning Group (Neil Fisher)
  Project Coordinator: Sue Luff, Head of Commissioning Delivery (Email: s.luff@nhs.net)

- **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 Localised Action Plan**
  Project Lead: KCC, Public Health
  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 for the Healthwatch – Quarter 4: January to March 2015

What's going on in our world	**Healthwatch Kent – Ashford focus** ➢ Monthly meetings with Monitor regarding the EKHUFT CQC Action Plan and the dedicated team of volunteers is still on going and proceeding well. ➢ Recently published positive reports following Enter & View visits to William Harvey A&E (plus other EKUHFT sites). Return visits planned for late Spring ➢ Working with KMPT on the action plan regarding Mental Health Carers and Beds ➢ Published our report about the support received from GPs by mental health patients. Copies of this report have been sent to every GP surgery
Success stories since last AHWB	**Healthwatch Kent – Ashford focus** ➢ Presented to the Ashford Chronic Pain Group explaining about Healthwatch Kent ➢ Presented to Ashford CCG Practice Managers requesting that information be made available in all reception areas, this will be followed up ➢ Presented to the Kent Seniors Forum ➢ Attended the Public Open meeting with Sussex Partnership Foundation Trust at County Hall ➢ Met with Simon Stevens, NHS England to discuss upcoming priorities ➢ Latest Healthwatch Kent public meeting held on the Isle of Sheppey ➢ Just completed 3 public events to talk about improvements to stroke services. Events were in West Kent but will feed into the Kent wide stroke review
What we are focusing on for the next quarter specific to the key projects	**Healthwatch Kent – Ashford focus** ➢ Continue to work with the CCG in attending the Community Network meetings ➢ Continue to look at ways that patient / public awareness can be built up involving Healthwatch Kent ➢ Mental health & CAMHS ➢ Complaints processes for health and social care ➢ Dementia services ➢ Care Plans ➢ Visiting GP surgeries in Ashford to raise the profile of Healthwatch Kent ➢ Improving public consultations – launching the Healthwatch Kent Best Practice Guide to Consultations ➢ Planning for the Healthwatch Kent Red Bus which will travel across Kent in June gathering experiences from

	patients about services. More info to follow
Anything else relevant to AHWB priorities NOT mentioned above.	**Healthwatch Kent – Ashford focus** • We are going to be working to support EKUHFT on the development of their 5 year strategy. More info and how to get involved to follow • We will be involved with the Kent wide review of stroke and vascular services • Continuing to recruit and train new Healthwatch volunteers • Publishing our Strategic Priorities for 2015/16
Strategic challenges & risks including horizon scanning?	**Healthwatch Kent – Ashford focus**
Any thing else the Board needs to know	**Healthwatch Kent – Ashford focus**
Signed & dated	