Ashford Health and Wellbeing Board

Notice of a meeting, to be held in Committee Room 2 (Bad Münstereifel Room), Civic Centre, Tannery Lane, Ashford, Kent TN23 1PL on Wednesday, the 20th January 2016 at 09.30 am

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The Members of this Board are:-

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

Faiza Khan – Public Health Specialist, Kent County Council (Vice Chairman)

Cllr Brad Bradford – Lead Member for Highways, Wellbeing and Safety, Ashford Borough Council

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

Mark Lemon – Policy Advisor, Kent County Council

TBA - HealthWatch representative

Michael James – Voluntary Sector representative

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

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

Helen Anderson – Ashford Local Children's partnership Group

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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12. Forward Plan

March 2016 Mental Health Strategy, Wellbeing Café, Mental Health Trust and MIND – Lisa Barclay

CCG Commissioning Plan – Neil Fisher
Agreeing Priorities – Faiza Khan

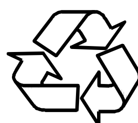
13. Dates of Future Meetings

23rd March 2016
20th July 2016
19th October 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/AEH
11th January 2016

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



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

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

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

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

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

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

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

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

Advice to Members on Declarations of Interest:

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

(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 **19th October 2015.**

Present:

Simon Perks – Accountable Officer, CCG (in the Chair);

Councillor Brad Bradford, Lead Member – Highways, Wellbeing and Safety, ABC

Tracey Kerly, Head of Communities and Housing, ABC;
Mark Lemon – Policy and Strategic Partnerships, KCC;
Caroline Harris – HealthWatch representative;
Tracey Dighton – Voluntary Sector Representative;
Richard Robinson – Housing Improvement Manager, ABC;
Christina Fuller – Cultural Projects Manager, ABC;
Lisa Barclay – Head of Programme Delivery, Ashford CCG;
Michelle Byrne – Funding and Partnerships Officer, ABC;
Chris Bown – Interim Chief Executive, East Kent Hospitals University NHS Foundation Trust;
Charlie Fox – Chief Officer, Red Zebra Community Solutions;
Michael James – Red Zebra Community Solutions;
Lorraine Williamson – Services Director, Crossroads Care;
Helen Mattock – Manager, Caring Altogether on Romney Marsh (CARM);
Sue Sawyer – Manager, Ashford Volunteer Centre;
Belinda King – Management Assistant, Environmental Health, ABC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;

Apologies:

Peter Oakford - KCC Cabinet Member, Specialist Children's Services;
Jenny Whittle - KCC Member; Philip Segurola - KCC Social Services; Paula Parker – KCC Social Services; Faiza Khan - KCC Public Health; Sheila Davison – Head of Health, Parking & Community Safety, ABC; Dr Navin Kumta - Clinical Lead and Chair Ashford Clinical Commissioning Group; Neil Fisher - Head of Strategy and Planning, CCG; Martin Harvey – Patient Participation Representative (Lay Member for the CCG)

1. Declarations of Interest

Tracey Dighton said that she wished to add to her Declarations of Interests made previously, the fact that she was a Trustee of Case Kent and Red Zebra Community Solutions.

2. Notes of the Meeting of the Board held on the 22nd July 2015

The Board agreed that the notes were a correct record.

3. East Kent Hospitals University NHS Foundation Trust

3.1 Chris Bown, Interim Chief Executive of East Kent Hospitals University NHS Foundation Trust, attended the meeting and updated the Board on the following three issues:-

(a) Quality Care Commission Review
(b) Financial Situation
(c) Future Strategy

(a) Quality Care Commission Review

3.2 Chris Bown gave the background to the present position and advised that in March 2014 the Quality Care Commission had inspected the East Kent Hospitals and arising from that inspection the Trust had been placed in Special Measures. He described the principle issues of concern highlighted by the report and advised that since his appointment in April 2015 the Board had been refreshed and an Action Plan had been developed to tackle the issues raised arising from the inspection. In July of this year 50 inspectors had visited the three sites of the East Kent Hospitals and a report on the outcome of that visit was expected by the end of October or early November. Mr Bown said that he did not expect the report to contain any surprises as the Trust was aware of those areas which still required improvement, for example the performance of Accident and Emergency at the William Harvey Hospital. He believed that there were a range of areas which had seen significant improvements and from his discussions with staff there was a feeling that things were changing for the better. Despite this he considered there was still a long way to go. A Quality Summit would also be organised with a view to producing a revised and refreshed Action Plan.

3.3 In response to a comment that there did not appear to be enough communication with the public on issues at the right time, Chris Bown said that all staff were sent in advance any statements which were due to be made to the media and that good news articles were circulated on a daily basis but they were rarely published in the media. He said that staff had all been working incredibly hard and they were often disappointed if negative media coverage was given to issues being tackled by the Trust. The Trust was strengthening its communications capacity recognising the challenges ahead.

(b) Financial Situation

3.4 Chris Bown explained that across the whole country the NHS was currently looking at a deficit of £2b and the East Kent Hospitals Trust had a current projection of a £37m deficit from its overall budget of in the region of £540m if it was able to deliver £16m of savings. The programme to deal with this financial situation would take three years to turn around. He gave details of the substantial investment in staff which had recently been taken in terms of the recruitment of nurses from the UK and various countries in Europe and he also explained the difficulty of the fact that across the three Trusts there were currently ten Accident and Emergency Consultant vacancies. Where there were gaps in staffing, agency staff and locums were used but the cost of this provision was high. For example he explained that East Kent was currently

spending more on locum doctors than on nurses. Keeping all three acute hospitals staffed to a safe level was proving difficult and the Trust was required to pay premium rates. Of the current deficit of £37m that figure reflected the fact that the Trusts had to deliver £16m worth of savings in the current year and over the next three years a total of approximately £90m savings were needed. Appropriate Quality Impact Assessments were needed for all cost improvement plans but he emphasised that if the quality of care could be improved this would lead to a reduction in cost e.g. patients not staying in acute hospital beds longer than they needed to.

3.5 Simon Perks explained that across East Kent a Strategy Board had been established to collectively drive the changes outlined by Chris Bown. He said in particular Ashford CCG was challenged because it was required to break even on its budget. He believed that the overall issue of how health care was provided needed to be re-considered.

3.6 In response to a question, Chris Bown explained that the shortage of medical staff was an issue common to the whole country and was a big issue for the NHS. Locally in Kent it was difficult to maintain acute rotas for the three hospital sites and to ensure that those services were safe for the public.

(c) Strategic Future Strategy

3.7 Chris Bown said that in the short term workforce supply would not change and he believed there was a need to configure services very differently to ensure that they were always safe and effective. He said that technology and how services were provided would undoubtedly have a major contribution to this aim. However, it was important to be mindful of the needs of the elderly in terms of the application of new models of care both in the community and in hospital. He referred to the view of many clinicians that if a new hospital was built this would allow all emergency services to be located in one location covering East Kent. However this would cost in the region of between £600m-£700m and was therefore not affordable. Therefore clinicians were looking at the various options to provide safe, effective and affordable services in the future and this was likely to be subject to a public consultation exercise in Spring 2016. Work was being undertaken with HealthWatch prior to formal consultation with the public. A new Head of Communications had been appointed by the CCG's to head up the process but he emphasised that there had been no decisions made at the present time.

3.8 In response to a question as to whether the £90m of savings was achievable, Chris Bown considered that some elements of this were down to the Trust, but other elements were not and whether this figure could be achieved would not be known until all the options had been presented and considered. Once options had been developed Chris Bown explained that they would be brought before the various Health and Wellbeing Boards for consideration. Simon Perks commented that the overall resolution to the issue was not solely for the Trust as the issue of healthcare needed to be examined and more care provided in the community and thereby reduce the need for patients to spend time in hospital.

3.9 In terms of the steps the Trust was taking to improve the financial situation Chris Bown explained that already within the Action Plan there was an aim to improve productivity and he emphasised that the number one priority of the Trust was to ensure that it did not run out of cash in 2015/16. The Trust would be selling assets and the capital programme had been reduced.

3.10 Simon Perks referred to the upcoming comprehensive spending review and commented on how that might further affect the funding for the CCG's.

3.11 Tracey Dighton commented that there may be a point reached where consideration would need to be given to agreeing increased waiting times for certain types of care. Simon Perks commented that it was possible to consider the different levels of treatment throughout the country by consulting the document entitled "Atlas of Variation".

3.12 In conclusion Chris Bown reiterated that it was hoped to consult with the public in Spring 2016 following the examination of the various options presented by clinicians.

3.13 The Chairman thanked Chris Bown for attending the meeting.

4. The Voluntary Community and Social Enterprise Sector (VCSE) in Ashford

4.1 Included with the Agenda Papers was an introduction and covering report which set out details of the presentations the Board would receive and included recommendations for consideration. The presentations had subsequently been published with the Agenda for the meeting and were available on the Council's website. https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=1907

(a) The State of the Sector

4.2 Charlie Fox, Chief Officer, Red Zebra Community Solutions gave a presentation. The presentation provided an overview of the VCSE Sector and explained how Red Zebra Community Solutions played a vital role in facilitating increased effectiveness of front line VCSEs and improving their resilience. Charlie Fox summarised the areas the further three presentations would cover and drew attention to the recommendations set out at the end of the covering report.

(b) How the Voluntary Sector Can Support People's Health and Wellbeing

4.3 Helen Mattock, Manager of Caring Altogether on Romney Marsh gave a presentation. Helen Mattock explained that CARM's key services included befriending, and enabling and reminiscence, which worked to improve the lives of their beneficiaries and demonstrated how such organisations could support the statutory sector in early intervention. The main focus of their services was for older people and the organisation currently had 120 volunteers and 8 part-time staff.

Liz Thorne who was the Chief Executive of the Tenterden and District Day Centre explained that she had worked with CARM on a number of issues and she believed that the work helped reduce the feeling of isolation for elderly people. She also emphasised that as a Sector voluntary organisations had changed and were more business-like and worked in partnership with each other.

(c) Community Care Navigator and Trusted Assessor

4.4 Sue Sawyer, Manager of the Ashford Volunteer Centre gave a presentation. The presentation covered how the Care Navigator Service operated at the William Harvey Hospital and helped patients to get the right help to meet their needs. During the presentation Sue Sawyer provided details of a case study which enabled a lady, following input of a Care Navigator, to have an operation and a short stay in hospital.

4.5 In response to a question, Sue Sawyer advised that KCC funded the Community Care Navigators whereas the CCG supported those Care Navigators who operated at the William Harvey Hospital.

(d) Social Return on Investment and Carer's Breaks

4.6 Lorraine Williams, Services Director of Crossroads Care gave a presentation. This drew attention to the needs of carers which were addressed in Ashford by Crossroads Care. This ensured that carers remained able to care for their loved ones and prevented them from having to access health services or falling into a cycle of poor mental health. She explained that within Kent there was in the region of 151,000 carers which saved the county a significant amount in potential costs if the care was provided by a statutory provider.

4.7 In response to a question Lorraine Williams explained that services were provided free of charge as carers were often not in a financial position to be able to pay for services or give up their employment. She also expressed concern that a letter had been received from the Kent County Council asking that they review their costs and had been given only two weeks to respond.

(e) Discussion and Questions

4.8 Mark Lemon explained that in terms of the issue of value versus cost it was difficult to persuade the Treasury in Whitehall in terms of making such investments as they did not appear to be interested in issues associated with prevention. He believed that the Sector did add value to the overall provision of health care and he explained that a recent Kent Board Meeting had discussed the relationship with the Voluntary Sector and a desire that local Boards developed effective relationships with those groups. Central to this was also the issue of how a local Board could demonstrate that it has an effective relationship with the Sector and he suggested that this issue should perhaps be considered by the Lead Officer Group (LOG).

4.9 Tracey Dighton believed that the Voluntary Sector should be treated as equal partners with the statutory providers but at the present time she considered this desire was far from being achieved. Simon Perks considered that there

was a need to understand collectively what would be lost if the various aspects of work undertaken by the Voluntary Sector were lost.

4.10 In conclusion Simon Perks suggested that in terms of the recommendations set out within the covering report, these should be considered by the Lead Officer Group including the role of the Local Board on this issue and to consider what mechanisms could be put in place to assess whether the relationship between the Board and the Voluntary Sector was robust.

The Board recommended that the recommendations set out within the covering report be referred to the Lead Officer Group for consideration and the outcome of those discussions be brought back to a future meeting of the Board.

5. Lead Officer Group (LOG) Report

5.1 The report provided an update of the work which had been progressing since the previous meeting in July 2015. Caroline Harris explained that the following key areas had been examined:-

- Obesity
- Smoking
- Road Safety
- Avoidable Admissions to Hospital
- Homelessness
- Workforce Pressures
- Domestic Abuse
- Mental Health
- A&E Pressures

5.2 The report explained that the LOG had considered each of the above areas and suggested that the HWB draw its priorities from that list. The LOG would continue its work with a view to recommending to the Board at its January meeting what should be considered as its key priorities for 2016. Caroline Harris then referred to two requests for HW Board membership and gave reasons why the LOG considered that the Board should decline the requests.

5.3 Mark Lemon also referred to eleven recommendations which were made by the Kent Health & Wellbeing Board for the Local Board which were considered important in developing a work programme.

5.4 Christina Fuller expressed concern that this was a significant amount of work for the LOG to undertake given its other work and Simon Perks suggested that an ad hoc meeting involving the Chairman and others be arranged to take forward this particular issue.

Recommended:

That (i) the current applications to join the Board be not supported for the reasons set out within the report.

(ii) the Local Children's Partnership Groups be included on the January 2016 Agenda to enable fuller discussion to take place and detailed reporting arrangements to be agreed.

(iii) the Chairman be consulted on how to take forward the recommendations of the Kent Board Meeting held on the 10th September 2015.

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)

Noted.

(d) Ashford Borough Council

Tracey Kerly confirmed that the Full Council at its meeting on the 15th October had supported the Cabinet's recommendation in terms of the Syrian Refugee Resettlement Programme. Under the programme up to 50 refugees would be taken per year over a 5 year period. Christina Fuller explained that in terms of the new Local Plan the decision on this was now likely to be taken in April 2016 and work would need to be channelled via the Lead Officer Group.

(e) Voluntary Sector Representative

Noted.

(f) HealthWatch Kent

Caroline Harris explained that there would be an integrated Health and Social Care Seminar to be held on 1st November 2015 at Singleton Village Hall. She explained that she would forward details of the event to the Borough Council for circulation to Health and Wellbeing Board Partners.

7. Update on the Kent Health & Wellbeing Board – 16th September 2015 and Kent Health & Wellbeing Strategy

7.1 The report included within the Agenda Papers included information on the Kent Joint Strategic Needs Assessment Workshop held on the 22nd June

2015 and the Kent Health & Wellbeing Board Meeting on the 16th September 2015. The report also covered the Local Health & Wellbeing Boards and their relationship with the Kent Health & Wellbeing Board and the Kent Health & Wellbeing Board Strategic Relationship with the Voluntary and Community Sector. Mark Lemon explained that further information on these issues could be obtained by following the website link included within the covering report.

The Board noted the report.

8. Forward Plan

8.1 Lisa Barclay agreed to check the position in terms of the Mental Health & East Kent Health Strategy and whether it would be in a position to be considered by the Board at its January 2016 meeting. Simon Perks also advised that he hoped that the Board would be able to consider the Health Strategy at its January meeting.

9. Date of the Next Meeting and Dates for 2016

9.1 The next meeting would be held on the 20th January 2016.

9.2 The following dates were also agreed for subsequent meetings:-

20th April 2016
20th July 2016
19th October 2016
17th January 2017

(KRF/VS)
MINS: Ashford Health & Wellbeing Board - 19.10.15

Ashford Health and Wellbeing Board Priorities

1. Purpose of the paper

The purpose of the paper is to generate discussion to identify priorities for the Ashford Health and Wellbeing Board that will lead to health improvement and reduce health inequalities in the coming years.

2. Introduction

The drivers for change leading to the development of the priorities and an action plan for Ashford Health & Wellbeing Board are as following:

- Kent Health and Wellbeing Strategy
- NHS Five Year Forward View
- Public Health Outcomes Framework
- Right Care
- Demographics
- Health inequalities

2.1. Kent Health and Wellbeing Strategy

The five year vision for Kent County Council outlined in the Health and Wellbeing Strategy highlights five strategic outcomes:

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

2.2. The five Year Forward View

The Five Year Forward View states that the The NHS has dramatically improved over the past fifteen years. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. There are particular challenges in areas such as mental health, cancer and support for frail older patients. Any actions require new partnerships with local communities, local authorities and employers. The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.

2.3. Public Health Outcomes Framework

The Public Health Outcomes Framework Healthy lives, healthy people: Improving outcomes and supporting transparency sets out a vision for public health, desired

outcomes and the indicators that will help in understanding how well public health is being improved and protected.

2.4. NHS Right Care

The primary objective for Right Care is to maximise value that the patient derives from their own care and treatment and the value the whole population derives from the investment in their healthcare.

2.5. Demographics

The population of elderly people in Ashford between 2016 to 2037 is going to gradually increase in numbers over the next two .This will require innovative service planning for the future in order to cope with the needs and demands of the older population.

2.6. Health inequalities

The health of the population of Kent has improved progressively over the years but the health gap between men and women has stayed the same. Less affluent people are much worst effected by ill health as compared to people who are affluent.

3. Discussion

Using the drivers for change outlined above the Health and Wellbeing Board can identify priorities to develop a vision. The vision for Ashford should be centred around "A Healthier Ashford'' so that everyone in Ashford is born as healthy as possible, and lives a full, healthy, and happy life. That Ashford compares well with England and South East region and health inequalities across Ashford are reduced. To deliver the vision the Health and Wellbeing Board can consider adopting a life course approach:

- Starting Well
- Living Well
- Ageing Well

Dr Faiza Khan
Consultant in Public Health
Kent County Council
8th Jan 2016

Ashford Health and Wellbeing Board Priorities for Discussion

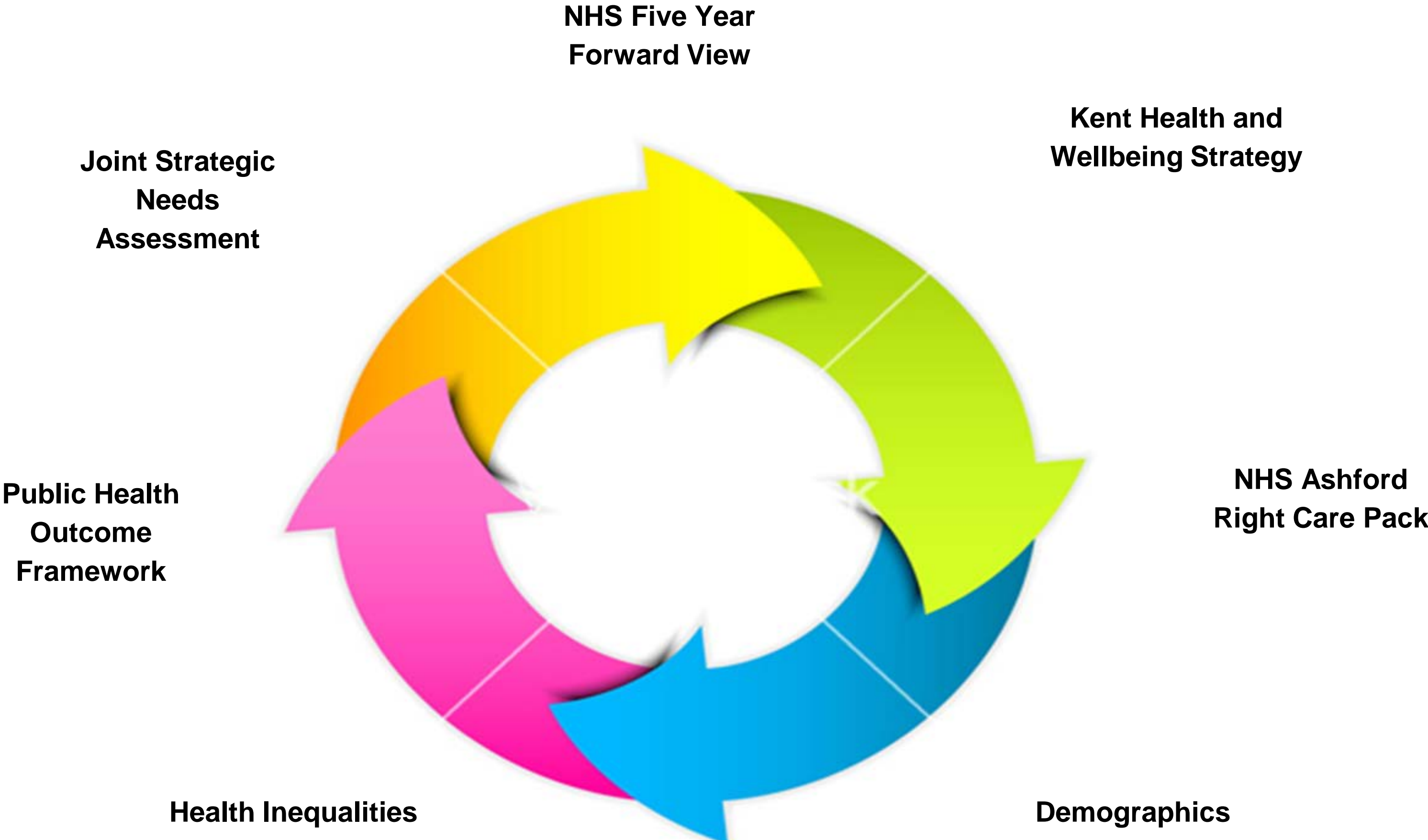
Dr Faiza Khan

Consultant in Public Health

January 2016

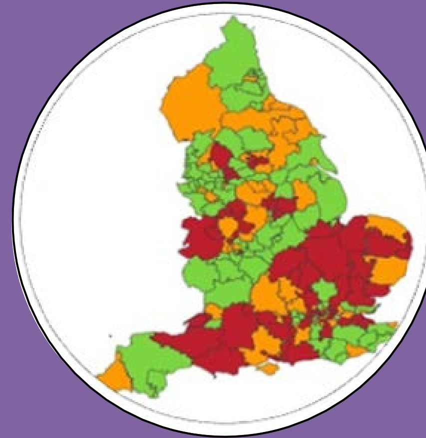
Kent County Council
kent.gov.uk

Drivers for Change



Flu vaccination /pregnant women
Smoking at time of delivery
Breastfeeding
Childhood obesity
alcohol
Dementia
Health checks
CHD
Emergency admissions for 75+
Unplanned hospital admissions
Spend on vision, neurology, infectious diseases, skin, poisoning and endocrine adverse effects

Cancer
Stroke
Mental Health
Integration
Prevention
Reduce inequalities



CVD
Smoking
NHS Health Check
Homelessness
Violent crime
COPD
Chlamydia
Killed or seriously injured in RTA

Every child has the best start in life
People taking greater responsibility for their health and wellbeing
Long term conditions
Mental Health
Dementia

Reduce gaps in service, reduce inequalities and improve outcomes for patients

Resources used for identification of priorities

1. **Health and Wellbeing Strategy-Kent County Council**
2. **Public Health Outcomes Framework-Public Health England**
3. **Joint Strategic Needs Assessment-CCG, KCC, Voluntary Sector**
4. **NHS Ashford Right Care Pack-NHS England**

Kent County Council kent.gov.uk

Kent
Joint Health and
Wellbeing
Strategy
Outcomes for Kent
2014 – 2017

Joint Health and Wellbeing Strategy

4 Priorities

Tackle Key Health Issues where Kent is **performing worse** than the England average

Tackle health **inequalities**

Tackle the **gaps** in service provision

Transform services to **improve outcomes**, patient experience, and value for money

5 Outcomes

Every child has the **best start** in life

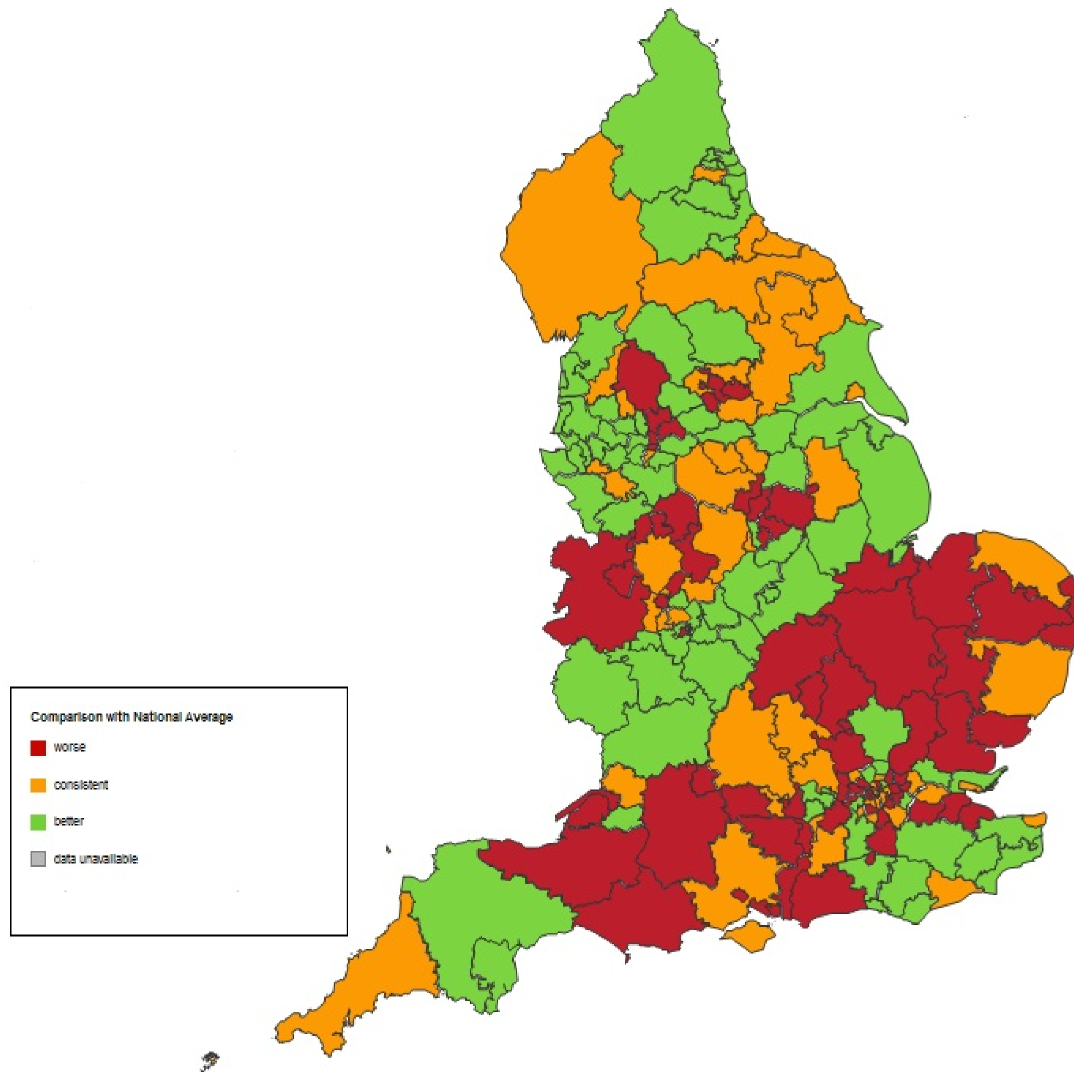
Effective **prevention** of ill health by people taking greater responsibility for their health and wellbeing

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

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

People with **dementia** are assessed and treated earlier, and are supported to live well

Public Health Outcomes Framework



1.Wider Determinants of Health

- Rate of people reported killed or seriously injured on the roads , all ages, per 100,000 resident population. Ashford 50 per 100,000

2. Health Profile

- Homelessness acceptance per 1000 households. Ashford 3.3 per 1000 households

- Crude rate of violence against the person, offences per 1000 population. Ashford 13.2 per 1000
- **3. Health Protection**
  Rate of Chlamydia detection per 100,000 young people aged 15-24 yrs. Ashford rate 1,368 per 100,000

- Late diagnosis of HIV-Ash 50%

4. CVD profiles

Cardio Vascular Disease: Hypertensive patients who were given lifestyle advice in the last 12 months. Ashford 68.3%

Smoking: Smoking status recorded in the last 24 months for people aged 15yrs+. Ashford performance at 84.4%

Smoking: Smokers aged 15+ with a record of an offer of support and treatment in the last 24 months. Ashford performance 80.8%

NHS Health Check: Cumulative percentage of eligible population aged 40-74 offered an NHS Health check who received an NHS health check. Ashford Performance 34.7%

5. Lung health profile

COPD patients with MRC dyspnoea score >=3 w oxygen saturation value (last 12 months) Ashford 88.7%

6. Health Improvement

- Breastfeeding initiation: percentage of mothers who breastfeed in the first forty eight hours of delivery. Ashford 71.3%
- Obesity: Percentage of adults classified as obese or overweight. Ashford 67.5%
- Smoking: Prevalence of smoking amongst people aged 18+. Ashford 26.4%
- Smoking: Prevalence of smoking amongst people aged 18+ from the routine and manual groups. Ashford 42.1%

KENT PUBLIC HEALTH OBSERVATORY

Joint Strategic Needs Assessment

Kent County Council
kent.gov.uk

1. Cancer

Most cancers in Ashford are being diagnosed at a late stage of disease and majority are presenting as emergency admissions as compared to England average

2. Stroke

Ashford CCG has a high prevalence of stroke and transient ischaemic attack and atrial fibrillation .

3. Mental Health

rate of people living with any neurotic disorder in Ashford, (124.1 per 1000 people) may be lower than the Kent and Medway district average. The projected increase in common mental disorders by 2020 in Ashford is actually the highest amongst all the Kent CCGs. The overall increase from 2013 to 2020 of common mental disorders amongst 18-64 year olds is projected to be 9.87%. This means addressing mental health need within the Ashford CCG community must be a priority.

4. Prevention

- Prevention to be included in all pathway work; both primary and secondary.
- Everybody's business thus Making Every Contact Count (MECC) a priority for all Commissioners

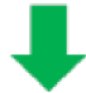
5. Integration

Integration between NHS, Adult Social Care and Public Health to prevent ill health and lifestyle diseases, and tackling their determinants

Reducing the gap in health life expectancy

6. Inequalities

Gap between most deprived and least deprived increasing

 Gap between most deprived and least deprived falling

Gap between most deprived and least deprived unchanged

	Cancer		Circulatory disease		Respiratory disease		All other diseases		All causes	
CCG	75+	All ages	75+	All ages	75+	All ages	75+	All ages	75+	All ages
Ashford	↑	↑	↑	↑	↑	↑	↑	↑	↑	↓
C4	↑	↑	↓	↑	↑	↑	↑	↑	↑	↑
DGS	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
SKC	↑	↓	↓	↓	↑	↓	↑	↑	↑	↑
Swale	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
Thanet	↔	↔	↑	↑	↔	↓	↓	↓	↑	↑
West Kent	↔	↑	↔	↑	↓	↑	↑	↑	↑	↑
Kent	↑	↑	↔	↑	↑	↑	↑	↑	↑	↑

Public Health England

RightCare

NHS England

Commissioning for Value: Integrated care pathways

NHS Canterbury and Coastal CCG

February 2015

NHS England Publications Gateway ref: 03066

1.Maternity and Early Years Pathway

- Flu vaccination for pregnant women
- Smoking at time of delivery
- Breastfeeding initiation (within 48hrs)
- Breastfeeding at 6-8 weeks
- % of children 4-5 who are overweight or obese

2. Inpatient spend for those aged 75yrs +

- Spend on vision, neurology, infectious diseases, skin, poisoning and endocrine adverse effects
- Unplanned hospital admissions for chronic ambulatory care sensitive conditions.

3. Substance Misuse and Mental Health Pathways

- % of alcohol users treated who did not re-present within 6 months

4. Dementia

- Dementia diagnosis rate
- % of dementia patients who had a face to face review
- Rate of emergency admissions aged 65+ with dementia
- % of emergency admissions with dementia who stay 1 night or less

5. Long Term Conditions

- Reported to estimated prevalence of CHD
- Employment rate difference between those with LTC and all of those of working age
- Rate of emergency admissions aged 75+ with a stay in hospital of less than 24 hours
- Unplanned hospitalization of chronic ambulatory care sensitive conditions
- % of people aged 16+ classified as inactive
- % of people aged 40-74 receiving a health check

Proposal for Taking the Priorities forward

Children's Operational Group	Ashford CCG	Integrated Commissioning Group	Ashford District Council	Community Safety Partnership
Breastfeeding	Flu vaccination for pregnant women	Dementia	Homelessness	alcohol
Childhood obesity	Smoking at time of delivery	Integration	Obesity	Violent crime
Chlamydia	Health checks	Reducing inequalities	Smoking	Killed or seriously injured in RTA
	LTC			
	Emergency admissions for 75+			
	Smoking			
	Mental Health			
	Breastfeeding initiation			

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East Kent Strategy Board

Update for Ashford Health and Wellbeing Board

1. Introduction

The East Kent Strategy Board has been established by local health and care commissioners to spearhead a new drive to determine how best to provide health and care services to the population of east Kent. As one of the Accountable Officers for the four clinical commissioning groups covering east Kent and the Clinical Chair for the East Kent Strategy Board, this update outlines the latest developments regarding the future of local health and care services.

Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services. The Board will oversee a work programme and advise local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

This update aims to provide some context about the ambitions and work of the Board, and the subsequent programme of activity that it will oversee. We don't yet have answers to all the questions, but will keep you regularly involved and updated as we progress with our work.

2. Why do we need to make changes?

While staff and organisations work hard to provide local people with the best care, the quality and range of services which patients currently receive vary significantly according to the area of the county where they live. There are variations in the quality of some services, in health outcomes, in access to services and in key aspects of diagnosis and treatment. For example, some areas record much lower numbers of patients with long-term health conditions, such as heart disease or diabetes, than national trends suggest: indicating that people's illnesses may not have been diagnosed. For those who have a diagnosis, the quality of care doesn't always meet national quality standards. These variations are unacceptable and we believe that everyone in east Kent deserves to receive the very best care, wherever they live.

The NHS is under increasing strain and must look at ways to transform the way care is delivered if we are to give the best care within available funding and resources. The reasons for this are plain: the NHS is operating with an unprecedented – and changing - demand for services, with fewer available specialists, in an acutely challenging financial environment.

We have an ageing population with high levels of multiple long term conditions needing complex care and treatment from different organisations. This can be difficult for patients and their families and carers to navigate. It is time that care became more personalised, coordinated and community based.

In addition, we are seeing a rise in long-term health problems such as diabetes as a result of lifestyle choices. It takes time, effort and new approaches to keep people with these conditions well and out of hospital.

We in east Kent are not alone in needing to change. At a national level, the *NHS Five Year Forward View* (published in October 2014) made a compelling case for the need to transform if the NHS is to meet the needs of the population. This includes new ways of working and providing more services out of hospitals and in our local communities.

3. New approaches to delivering care are already underway

The East Kent Strategy Board recognises that some of this work has already begun. For example:

- Hubs in Folkestone and Dover provide GP appointments 8am-8pm seven days a week, thanks to funding from the Prime Minister's GP Access Fund. Patients are referred by their practice or NHS 111.

- Primary care mental health specialists in a number of GP practices across east Kent support people who are acutely mentally unwell so they are less likely to need care from secondary mental health services (provided by Kent and Medway NHS and Social Care Partnership Trust).

- A new 'multi-speciality community provider' model is being tested in the Canterbury, Faversham and Whitstable areas, with £1.6million from the NHS England Transformation Fund. It plans extended practice opening hours, paramedic practitioners who will visit housebound patients, an integrated nursing service involving both community and practice nurses and an increase in the number of outpatient services provided through specialist GPs.

- In addition, East Kent Hospitals University NHS Foundation Trust is developing a new clinical strategy, working closely with Healthwatch and clinicians to shape services to meet the needs of patients and talking directly to patients and the public about their views and experiences.

But we now need to make sure that these new approaches are joined up, coherent and working to support each other, as part of an overall strategy for delivering care in the future for the people of east Kent.

4. Where will the Board focus its work?

It is clear that we need to tackle service pressures at the same time as developing a future model of care for the people of east Kent that meets changing needs. We need to develop a model of care that works in a joined up way across primary, community, mental health and acute services, and with social care partners.

The Board is committed to developing and delivering a comprehensive and cohesive transformation programme that improves health and wellbeing, delivers high quality and safe care both in and out of hospital settings and puts the services that so many people value on the path to a bright and sustainable future. The Board will oversee a programme of design work over the coming months that will set out proposals for a new pattern of services across east Kent. The work will be clinically led, working closely with staff, patients, carers and the local community to co-design solutions to meet the challenges we face.

The Board has not yet considered or tested any options for change and no decisions about how services might be organised in the future have been made. Any decision-making on the future pattern of services remains with the commissioning bodies (the four clinical commissioning groups, NHS England and Kent County Council) who have the statutory responsibility to take decisions about what health and care services should be provided for their local populations.

Transforming services around the interests of patients is at the heart of our ambition and we are committed to engaging with and consulting all those who provide, deliver – and most importantly of all – use health and care services.

Simon Perks
Accountable Officer, NHS Ashford CCG, NHS Canterbury and Coastal CCG

The East Kent Strategy Board member organisations include:

NHS South Kent Coast CCG; NHS Canterbury and Coastal CCG; NHS Ashford CCG; NHS Thanet CCG; East Kent Hospitals University NHS Foundation Trust; Kent Community Health NHS Foundation Trust; Kent & Medway NHS and Social Care Partnership Trust; South East Coast Ambulance NHS Foundation Trust; and Kent County Council.

Agenda Item No:	6
Report To:	**Ashford Health & Wellbeing Board**
Date:	20th January 2016
Report Title:	**Kent Health and Wellbeing Board and Local Health and Wellbeing Board Relationships and Future Options, report to the Kent Health and Wellbeing Board on 16th September 2015:** **Implications for the Ashford Health and Wellbeing Board**
Report Author:	Mark Lemon
Organisation:	Kent County Council

Summary:	A report considering the relationship between the Kent Health and Wellbeing Board and those established at a CCG level was presented to the Kent Board on the 15th September 2015. The implications of this report for the Ashford Health and Wellbeing Board are explored below.

Recommendations:	**The Ashford Health & Wellbeing Board be asked to:-** discuss to what extent it wishes to take the development opportunity provided to consider how it wishes to move forward.

Policy Overview:	Revised arrangements concerning the relationship between the Kent Health and Wellbeing Board and its sub-committees (local health and wellbeing boards).
Risk Assessment	No
Equalities Impact Assessment	No
Background Papers:	Kent Health and Wellbeing Board and Local Health and Wellbeing Board Relationships and Future Options, report to the Kent Health and Wellbeing Board on 16th September 2015. https://democracy.kent.gov.uk/documents/g5835/Public%20reports%20pack%2016th-Sep-2015%2018.30%20Health%20and%20Wellbeing%20Board.pdf?T=10 or Appendix 1
Contacts:	Email: Mark.lemon@kent.gov.uk Tel: 03000 416387

Agenda Item No.6

Report Title: **Kent Health and Wellbeing Board and Local Health and Wellbeing Board Relationships and Future Options, report to the Kent Health and Wellbeing Board on 16th September 2015:**

Implications for the Ashford Health and Wellbeing Board

Purpose of the Report

1. To appraise the Ashford Health and Wellbeing Board of the implications of the report agreed at the Kent Health and Wellbeing Board proposing changes to the relationship between the Kent Board and its local sub-committees.

2. To discuss the opportunity to access developmental support for the Ashford Board provided by the LGA (Local Government Association).

Background

3. A report considering the relationship between the Kent Health and Wellbeing Board and those established at a CCG (Clinical Commissioning Group) level was presented to the Kent Board on the 15th September 2015. This report was based on a number of discussions with relevant members of the Kent and local boards and outlined the issues that were of concern to those members along with a suite of 17 recommendations that applied to both the Kent Board and its local subcommittees.

4. These recommendations provide a framework for clarifying the relationship between the Kent Board and its subcommittees and make more explicit the mutual expectations that the boards can legitimately expect of each other. The report also creates an opportunity for local boards to reflect upon their role and purpose, including the ambitions and aspirations they hold, and consider whether they are constituted in the best way to achieve these. These considerations can include the local board membership and the subgroups and working groups the boards relate to in order to ensure their business is conducted effectively. A linked report concerning the Kent Board's relationship with the community and voluntary sectors also contained implications for local boards. This included a particular reference to local boards needing to assure themselves that the relationships they have established with the community and voluntary sectors were effective to deliver the business of the boards.

5. The report can be found at: https://democracy.kent.gov.uk/documents/g5835/Public%20reports%20pack%2016th-Sep-2015%2018.30%20Health%20and%20Wellbeing%20Board.pdf?T=10 or Appendix 1

6. The Recommendations and their implications

The specific recommendations of the report and the implications for the Ashford Board are as follows:

6.1 Kent Health and Wellbeing Board

6.1.1 The Kent Health and Wellbeing Board will produce an outline work programme for the start of each year to enable local boards to plan their activity accordingly.

The workplan for the year 2016-17 will be considered at the January meeting of the Kent Board.

6.1.2 The Kent Board will clarify the means by which local issues can be escalated to the Kent Board.

The role and function of the Kent Health and Wellbeing Board agenda setting meeting will be considered at the meeting of the 2nd February.

6.1.3 The Kent Health and Wellbeing Board will ensure that relevant issues are referred to local boards with clear expectations regarding further action at a local level.

6.1.4 The Kent Board will provide policy support to the local boards to assist in the development of relevant substructures and work programmes.

Local Boards should consider how they wish to make use of this offer.

6.1.5 Opportunities for development work for both chairs of the boards, and individual boards themselves, will be investigated and made available to local board members.

The LGA offer of support for the development of local boards is available and being accessed by a number of the boards. This is also an opportunity for boards to reflect on their role and purpose as well as their ambitions and aspirations.

6.1.6 The Kent Board will provide data and information through its sub-group the Multi-Agency Data and Information Group.

The MADIG group is considering how this is best implemented.

6.2 Relationship between the Kent Board and local boards

6.2.1 The LHWB chairs will meet with the chair of the Kent Board every six months. This meeting will include consideration of the workplan of the Kent Board, and its relationship to the work plans of local Boards.

The most recent meeting of local board chairs was held on 18th November and others are now scheduled.

6.2.2 Each LHWB will send a representative to every Kent HWB, to update the Kent board on their activities locally, and to take any relevant information from the

Kent board back. This representative will also be responsible for liaising with the Kent Board concerning issues and matters that would benefit from consideration at the Kent Board.

Up until now the mechanisms for representing local boards at the Kent Board have been unclear, based on common membership of boards. Some members of the Kent Board may be “representing” a number of different interests, e.g. the CCG, the local board, the individual district council or “district councils” as a group. This recommendation simply requires one of the members of the local board that attends the Kent Board to have a specific responsibility to speak for and represent the local board as such (rather than their own organisation) where appropriate, and to be the conduit for information and other discussion between the two boards. They should also be involved in the Kent Board agenda setting process.

6.2.3 Proceedings of the Kent Board to be a standing item on all local board meeting agendas with particular reference to issues referred from the Kent Board for local consideration and action.

Local boards should ensure that they receive proper feedback form the Kent Board from their designated member (as above). This should be an item on every local board meeting agenda.

6.2.4 All agenda items that come to the Kent Board will be considered as to how local boards could and should be involved in their future progression. All local boards will provide an annual report to the Kent Board regarding how they have been progressing with the five outcomes of the Kent Joint Health and Wellbeing Strategy, and their engagement with the commissioning plans of their constituent organisations. The report will also describe how issues referred from the Kent Board have been considered and how local implementation of any necessary activity has been supported.

Local boards will now need to provide an annual report to the Kent Board (which will be reflected in the Kent Board’s workplan) to assure the Kent Board that the relevant issues have been properly considered as above.

6.3 Board business

6.3.1 All local boards will develop a work programme for the coming year. This work programme will relate to:

- the five outcomes of the Kent Joint Health and Wellbeing Strategy
- the health and wellbeing priorities of the area as identified by the Kent Public Health department
- the health inequalities within the area and between the area and others in Kent
- engagement with the development of commissioning plans of the organisations represented on the board.

This recommendation reflects, at a local level, the requirement that the Kent Board will produce a workplan.

6.3.2 Engagement with the commissioning plans of partner organisations should focus on opportunities to promote integration, especially between health and social care services. Whether the plans offer the best possible approaches to local issues should also be considered.

Local Boards should consider whether the structures they have in place enable them to discharge this responsibility adequately.

6.4 Structure and Governance of local boards

6.4.1 All LHWBs should have an agreed Terms of Reference by March 2016. Proposals for Terms of Reference, to be drafted following discussion at meeting of Chairs of Boards, to be brought to the Kent Health and Wellbeing Board at its meeting in January 2016.

The Ashford Board already has an agreed Terms of Reference. Whether these remain fit for the future intentions of the board may be an area the board wishes to consider if it reviews its role and purpose.

6.4.2 Local boards to review their membership, substructures and associated working groups to ensure they are fit for purpose. Substructures should provide capacity to deliver the activity required to implement the work of the board to deliver the five outcomes of the Joint Health and Wellbeing Strategy and allow proper oversight of commissioning plans. The substructure may include the local Children's Operational Group(s) and Integrated Commissioning Groups. The responsibilities of groups in a Board's substructure for reporting to the Board on specific outcomes from the H&WB Strategy should be clearly defined.

Local Boards will need to consider these issues to assure themselves they have the relevant structures in place with clear expectations of how they will operate.

6.4.3 Relationships between the local boards and other meetings of commissioners and providers should be clarified.

Local Boards will need to consider these issues to assure themselves they have the relevant structures in place with clear expectations of how they will operate.

6.5 Wider relationships

6.5.1 The substructure adopted by the local boards must also ensure that the appropriate relationships with service providers within the area are properly represented.

6.5.2 Appropriate relationships with representatives of other important sectors and organisations should also be reflected in the membership of the board or within its substructures. These should include the Voluntary and Community Sector and could include other local stakeholders such as Parish Councils.

Local Boards will need to consider these issues to assure themselves they have the relevant structures in place with clear expectations of how they will operate.

Other Options Considered

7. No other options are currently available.

Consultation

8. Discussions were held with stakeholders as advised above.

Implications Assessment

9. See body of report.

Handling

10. No specific issues as information is already in public domain.

Conclusion

11. Board development

11.1 The overall approach from the Kent Board remains an enabling one, the purpose of the report considered at the September meeting being to clarify expectations rather than impose a more restrictive structure on local boards. It is therefore possible to consider these recommendations as a checklist for Boards to “tick off” and satisfy themselves that they are operating adequately in their current form or with minor adjustments.

11.2 However, there have been many changes affecting health and social care since the inception of the local health and wellbeing boards, and if anything the pace of change will increase in the coming months and years. Now is a good time for boards to reflect and review their purpose and aspiration and consider how they go about their business in order to achieve these. The offer of development support from the LGA is an opportunity to refocus the Ashford Board. In particular the Board may wish to explore how it can respond to the new developments that are already emerging in the area.

11.3 The NHS England Five Year Forward View demands that new models of care are developed that will properly integrate health and social care, mental and physical health, and primary and acute care. These new models of care need to be informed by the needs and wishes of the local population of Ashford and should not be adopted by default. To do this Ashford needs a voice in the discussions around the strategy for East Kent, the future shape of the East Kent Hospitals University Foundation Trust, and how the Multispecialty Community Providers that arise through the federation of local GPs will evolve. The Ashford Health and Wellbeing Board needs to position itself in the best place to influence developments rather than be on the receiving end of them and to do this it needs to discuss what leadership role it wishes to take and how this can be achieved. The issue of how far the Ashford Board wishes to develop as a commissioning body that takes responsibility for the pooled finances and risks of the currently separate organisations will need to be resolved.

11.4 Recommendations are given on the summary page.

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From: Roger Gough – Cabinet Member for Education and Health Reform

To: **Kent Health and Wellbeing Board**

Subject: **Kent Health and Wellbeing Board and Local Health and Wellbeing Board Relationships and Future Options**

Summary:

This report provides a brief overview of the piece of work being undertaken to review the relationship between the Kent Health and Wellbeing Board (KHWB) and Local Health and Wellbeing Boards (LHWBs). This report outlines the current relationships between the boards and provides details gleaned from an audit carried out to determine how the KHWB and the LHWBs are functioning and working locally and together.

In addition, this report describes the insight gathering, which has been undertaken with key stakeholders, and the key themes, issues and ideas which have emerged from this process. This insight gathering and audit material has helped to provide some context which has shaped the future options and recommendations for the Kent Health and Wellbeing Board and the Local Health and Wellbeing Boards.

Recommendation – for the Kent Health and Wellbeing Board to discuss the recommendations outlined in section 7 of this report.

1. Background

1.1 The Kent Health and Wellbeing Board was established following the enactment of the Health and Social Care Act 2012. From 1 April 2013 it became a committee of Kent County Council, prior to April 2013 the Health and Wellbeing Board operated in shadow form.

1.2 Bringing together County and District Councillors, senior officers from KCC, the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from Kent Healthwatch, the intention was to provide an effective body where commissioners, patient representatives and elected officials could have a collective overview of the health system in Kent, align areas of work, and share commissioning plans and good practice.

2. Local Context

2.1 Given the scale and geography of Kent, it was agreed that a series of sub-committees known as Local Health and Wellbeing Boards should be created. It was intended that the local Boards would lead and advise on the development of integrated commissioning strategies and plans at the local CCG level. This would ensure that there was a local focus on health and wellbeing, including a clear interest and emphasis on prevention, and enabling effective local engagement and monitoring of local outcomes.

2.2 It is recognised that the LHWBs have delivered good work at a local level. However, it has been identified that since their introduction, they have struggled to achieve clarity on the scope, purpose and direction of the local boards. In addition there is a lack of a clear mechanism for communication between the local boards and the Kent Board. LHWB priorities may differ in line with local needs and demands, but the membership, size of the Board, and level of engagement with member organisations can also differ. This has consequently led to a variety of ways of operating at the local level. Whilst this is inevitable, and to a certain extent desirable, it can create difficulties in terms of monitoring progress and empowering the Local Boards to deliver key outcomes.

3. Scope of the work

3.1 In response to the issues highlighted above, and the LHWBs' request for a stronger sense of purpose, it was decided that work was required to look in detail at how the KHWB and the LHWBs are currently operating, and how an audit and insight gathering process can be used to support and develop future recommendations for the boards. The Audit captures the current priorities and actions of both the Kent board and the LHWBs, and the mechanisms for sharing information between the boards. The audit has helped define current roles and responsibilities, aiming to provide clarity and consistency in the future. This process has identified gaps within the relationships between the boards. The Audit provides some key context for current issues and therefore provides a basis for future options and possible changes to ways of working and relationships, described within the future options section of this report.

3.2 The second phase of the project concerned engagement with key partners and stakeholders. It was important to identify these key stakeholders and partners and arrange individual and group meetings with a wide variety of people to obtain a clear understanding of where the current issues lie, as well as identify how we can ensure that the LHWBs feel empowered to deliver their responsibilities with greater clarity and purpose, whilst the Kent Board focusses on strategic issues.

3.3 The conversations with stakeholders and partners have provided key themes and information which has helped to identify gaps in the ways that the LHWB and the Kent Board are working, and identify possible options for future relationships. This has informed proposals as to how the boards should operate in the future to ensure stronger and more sustainable relationships.

4. Audit

4.1 Audit Process

4.1.1 The audit process was designed to establish the current relationships and ways of working of both the LHWBS and the Kent HWB. This process has also helped to identify how these two tiers of boards are working together, and how effective this relationship is.

4.1.2 The audit process has mostly been carried out through desk top research which has involved looking at the LHWB and the Kent HWB published data and information online. Assessing the content of the minutes has also helped to identify a lot of key information concerning the quality of the discussion and actions taken forward from each meeting.

4.1.3 The attendance and the membership of the boards has also provided some key context around the roles and responsibilities of those on the board, and helped to shape some ideas around the capabilities and willingness of these members. Whilst looking at this in detail it was also important to assess the frequency of the meetings, and whether there is a consistent and regular approach for the boards across Kent.

4.1.4 A key part of the process of understanding the current ways of working and relationships between the Kent HWB and the LHWBs is by looking into the Boards' Terms of Reference and Work Plans, if they should have them. Again, this has aided in determining any variation between the boards, as well as between what the Terms of Reference and Work Plans suggest should be done, and what is actually achieved.

4.1.5 A further piece of work has been undertaken to add to the audit which highlights the LHWB priorities (as reflected in the CCG and others' plans), the specific agenda items discussed at the LHWB meetings, and the health priorities in each local area. This information helps to map the boards' position in relation to the issues that have been identified locally.

4.2 Audit Outcomes and Emerging Themes

4.2.1 The Kent HWB is a statutory body; therefore the minutes and agendas are published online. The LHWBs publish information, minutes, agendas and attendance details on their local authority websites. From studying this information, however, there seem to be discrepancies concerning the quality and quantity of the information provided. In some cases, information was not provided at all and the frequency in which boards meet is also unclear.

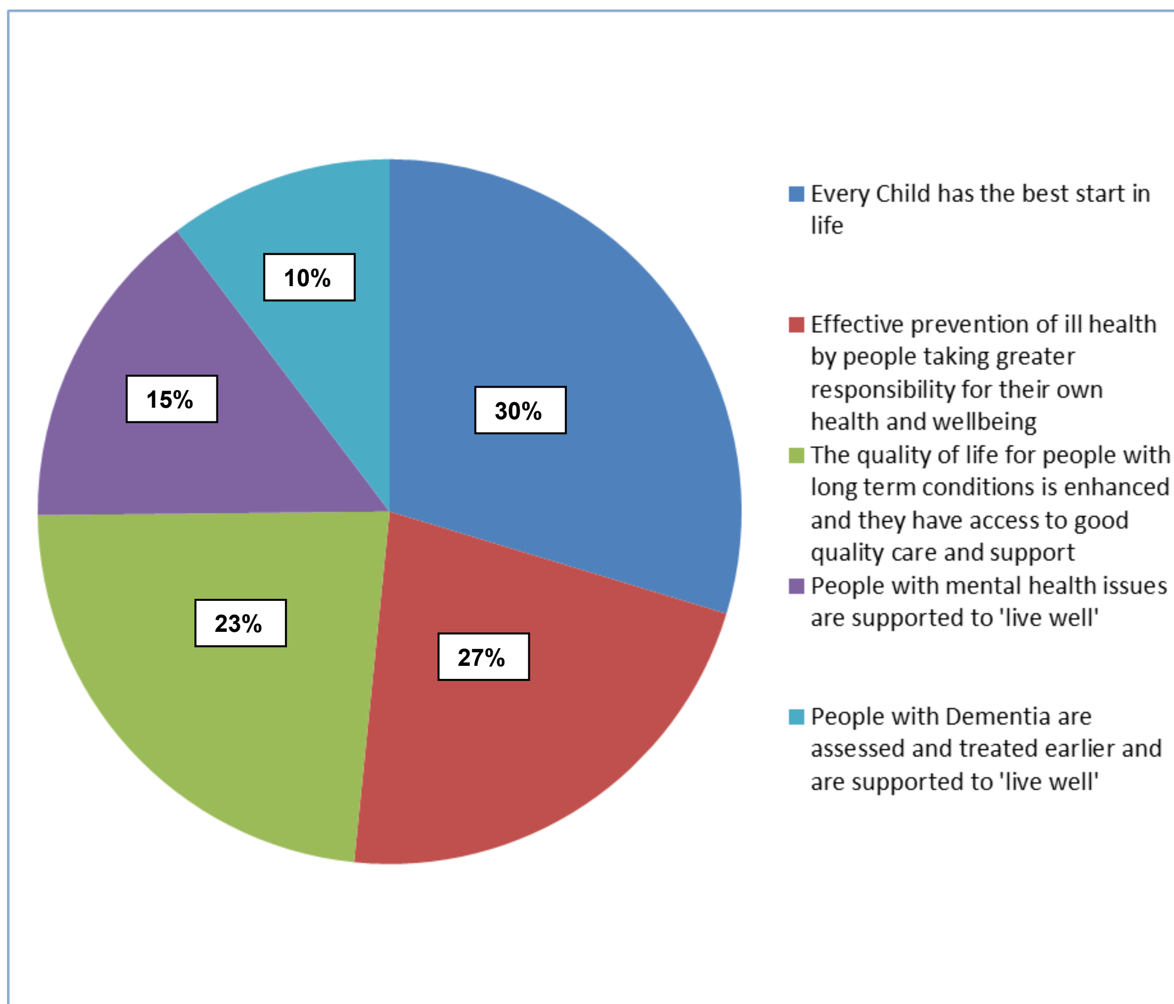
4.2.2 It has been recognised that there are several differences between the seven boards in the ways in which the meetings are scheduled and consequently run. Some of the LHWBs meet regularly and fairly frequently, every two or three months, others appear to meet less frequently with irregular timing between meetings. Similarly, the attendance differs significantly across the boards where some have frequently high levels of attendance, with many of the same members attending each time; however, some of the LHWBs have more inconsistent attendance. It is also important to note that some of

those who attend on a regular basis are official members; however, some LHWBs have frequent attendance from unofficial members, or representatives. In some cases there is reliance on a smaller 'core' group of attendees. This raises questions around membership, sustainability and succession planning.

4.2.3 A key part of the audit process was to assess the level and quality of work currently being undertaken by the LHWBs. It was recognised that within this scope, it would be important to understand not only the Local Priorities but the content of the LHWB meetings plus the quality of these conversations and the actions taken forward. As part of this process, the health and wellbeing priorities have been identified for each local area. This helps to inform the accountability and functions of each of the boards. Whilst this information usually relates specifically to public health priorities it raises wider questions about how the local boards are focusing on local priorities, how these are identified by the board and subsequently how they influence the agenda setting.

4.2.4 From this part of the audit it is clear that the specific health issues and priorities within a local area have been discussed in some detail within the LHWB meetings. In some cases there is a clear link between the priority and agenda items of the LHWBs, but in other cases there seems to be no obvious link. Due to the lack of publicly available LHWB work plans, it is difficult to identify whether the boards are addressing the priorities by design, or whether they are identified locally in a different way, such as being discussed at sub groups. It could for example be the case that other sub groups are taking forward local priorities and that the LHWB is providing a platform to discuss these issues through update reports from these group as opposed to specific agenda items.

4.2.5 The chart below represents the Kent Health and Wellbeing Strategy Outcomes, and the percentage of time the LHWBs spend on activities relating to these outcomes. Broadly speaking this shows that LHWBs are maintaining a focus on the five outcomes of the Joint Health and Wellbeing Strategy. Concerns that, for example, children's issues may not receive sufficient attention because agendas may concentrate on those regarding adults would appear to be unfounded. However, the chart does not give any indication as to whether discussion of issues on the agenda has led to concrete action or improved outcomes.



4.2.6 There is a wider issue about transparency which should be considered, given that the LHWB's are public facing and information about their work should be more readily available. However, there also needs to be a much closer connection and communication stream between the LHWB and the Kent Board and an agreement about the work plan and focus of the local boards. In this sense the issue around transparency links with the role of the Kent HWB and its role as a co-ordinating and to some degree 'tasking' group for the local boards. It has been suggested that the Kent Board needs to be operating at a higher strategic level and consequently feeding information and direction down to the Local Boards. From this, the LHWBs should have the knowledge, capacity and capability to deliver outcomes locally and consequently feed this information back up to the Kent Board. In this way the Local Boards will be more accountable and empowered to improve the health and wellbeing within their geographical areas.

5. Insight Gathering

5.1 Insight Gathering Process

5.1.1 Ensuring partner and stakeholder engagement was a vital process within this piece of work. It was identified that it would be important to have some attributable and informal conversations with relevant colleagues and partners to determine their views. It also provided the opportunity for issues to be raised.

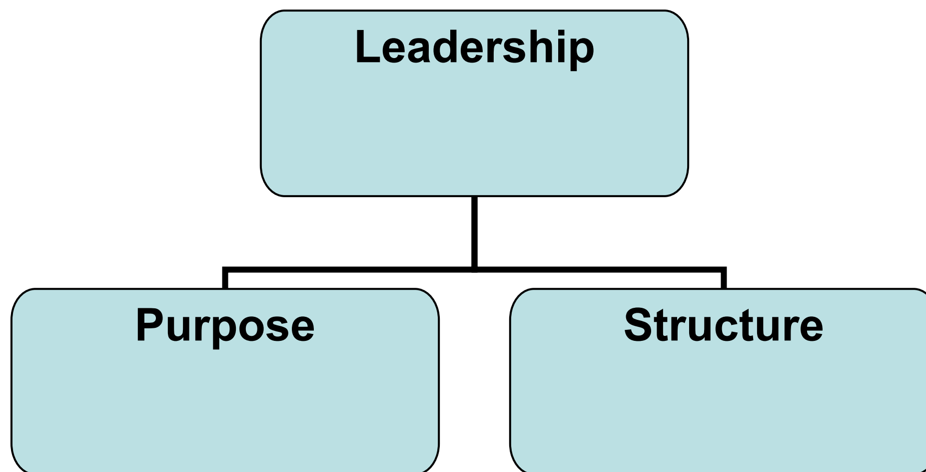
5.1.2 A number of key individual stakeholders and groups of people were identified as part of this engagement process. These included the following:

- A group meeting for the Chairs of all 7 LHWBs in July.
- Individual meetings with the Chairs of the LHWB
- Group or individual meetings with key KCC Members such as Graham Gibbens, Peter Oakford, Chris Smith, and Geoff Lymer
- Some KCC Corporate directors and Heads of Commissioning
- We also met with key external Partners such as Steve Inett (Healthwatch) and Dr Robert Stewart. (Chair of Pioneer Steering Group and Director of Clinical Design)
- The Kent Leaders (through attendance at their meeting on the 21st July).
- The Joint Kent Chiefs (through attendance at their meeting of March 12th)

6. Key Themes derived from Insight Gathering

6.1 The LHWBs have carried out good work to deliver outcomes locally but there are several issues which have been identified through conversations with partners and stakeholders, as areas for improvement.

6.2 Many of these key issues were identified in a number of different ways, and are common across different organisations represented on the boards. These common themes were raised by LHWB chairs, partners, senior officers and Members. Indeed there were common themes identified from across both the audit and the insight gathering. The key issues concern communication and relationships between the boards, accountability and purpose, engagement and representation, confidence and competence and the role of the Kent HWB. They can be grouped under three key headings; Leadership, Purpose and Structure.



Where there is a lack of leadership, the purpose and structure of the Local Boards is likely to be unclear. All three are required to ensure a fully functioning and effective working model.

6.2 Leadership

6.2.1 Feedback identified that there are issues around whether the members of the LHWBs have the perceived confidence or the skills to make a difference locally. One of the issues highlighted was that the boards are not statutory and therefore membership is voluntary and that this meant some partners were not willing to engage or share information freely. It was felt that members needed to be empowered to deliver outcomes.

6.2.2 Some stated that that there needs to be stronger communication streams coming from the Kent board to ensure that the Local Boards understand the high level priorities and strategies and feel as though they have the power to make a difference. It was felt that the Kent Health and Wellbeing Board needed to have a greater focus on the overarching strategic plan and priorities and consequently feed these messages down to the local boards. It was also felt to be important to recognise that the communication streams need to be improved from the LHWBs back to the Kent Board, and that they could provide a platform for Kent Board to understand what is being delivered locally, which would give the local boards greater confidence that the work they were undertaking was contributing to the Kent priorities and that it was having an impact.

6.2.3 Another common area of concern was that there is no agreed work plan between the Kent Health and Wellbeing Board and the LHWBs, and a lack of clarity around the ways in which the boards could be communicating to each other. It is this lack of clarity that has caused some members of the LHWBs to feel as though they are not empowered to deliver outcomes and make a difference. It is felt that the Kent Board should be working hard to be a strategic body which filters relevant information down.

6.2.4 In summary it was felt that the Kent Board needed to provide stronger leadership and direction based on the priorities set out through key documents such as the Joint Health and Wellbeing Strategic and JSNA and relating this to the work of the local boards more effectively. It was often

expressed that the Kent Board focused too much on the detail and rather should be setting the strategic direction whilst empowering the local boards to deliver the outcomes that are collectively agreed.

6.2.5 Whilst it is important to note that it was felt that the Kent HWB should be the leader for the Local Boards and be empowering the boards to be achieving outcomes locally, local partners must accept this role and invest responsibility and accountability in their representatives on the LHWBs. Without support from partner organisations, the LHWBs cannot function simply on the clear direction of the Kent HWB.

6.3 Purpose

6.3.1 Many stated that the Kent Board needed to start focussing more on policy as the county wide statutory board. However, there is some confusion over the role of the LHWB to support these responsibilities with the activities that they carry out locally and whether the LHWBs are acting as a statutory sub structure of the Kent Health and Wellbeing Board.

6.3.2 A key issue raised was that of accountability and whether the LHWB's were an important or indeed the right vehicle for taking forward specific areas of work. Due to the lack of clarity around the purpose of the boards, some organisations and members did not appear to be bought into the LHWB as a vehicle for tackling priorities and this was felt to be a particular issue for social care. In fact some commented that members of the LHWBs could sometimes focus too much on operational and local issues rather than considering the wider priorities.

6.3.3 This was felt to emphasise that the local boards are more of a collection of partners than an entity in their own right with partners not devolving accountability to the LHWBs as a vehicle to deliver their activities. The effectiveness of boards to make decisions and to hold their constituent members to account can therefore be compromised.

6.3.4 There is no standardised terms of reference represented across each of the LHWBs. This adds to the difficulty in understanding the representation of the members on the boards, as well as the roles and responsibility to the boards, and in sharing information with partners and to their own organisations. Some local boards have adopted terms of reference especially where there is a degree of co-terminosity between CCGs and district councils. Where boards straddle more than one district boundary issues of comparative influence in any decision making process has been difficult to resolve. The status of district authority officers has also proved problematic including whether they can be bound by the KCC code of conduct which would require them to declare any interests they may have that are relevant to the meeting.

6.3.5 Some district councils also find themselves having to attend multiple boards where their district straddles two CCG areas.

6.3.6 Whilst the good work being done locally by the boards was highlighted, the lack of clarity of purpose can mean some partners do not see the board as an effective vehicle for delivering their priorities. The purpose of the boards needs to be revisited and clarified in order to empower members. This is very much linked to the discussion around leadership and direction from the Kent Board.

6.4 Structure

6.4.1 Many respondents expressed confusion around representation on the LHWBs and the capacity in which people attended. From local government there is representation from both officers and Members. A number of members will fulfil more than one role. For example a local authority member of the local board could be chairing the board, representing their own district at a local board whilst also attending the Kent Board as a representative of their own authority, district councils more generally and their own health and wellbeing board. Who speaks for whom and when is not always clear. There is no mechanism to determine who should represent local boards at the Kent Board and vice versa.

6.4.2 There has also been a question raised around the roles of VCS on the local Boards. Some boards have VCS representatives but this is not consistent and there remains a question over the capacity in which they attend; is this as a provider or as a champion of the sector and if so what are the mechanisms for filtering information back in to the local VCS? An additional report has been provided on this issue setting out the opportunities for a future relationship between the VCS and the Kent HWB and local boards and should be read in conjunction with this report.

6.4.3 There is also an issue around how the Kent Board engages with partner organisations who are not board members. It has been established that providers should not be board members; however, an effective communication stream was felt to be vital to ensure that the provider relationship with the local board is constructive and effective. Some areas have established, or are proposing, arrangements where commissioners and providers meet collectively at a health economy level outside the local board structure. The relationships between these groups and the local boards are unclear apart from sharing membership of a number of people.

6.4.4 There are inconsistencies around how the LHWBs work with their sub committees. It has been recognised that some of the sub groups to the boards have been set up directly through the LHWB, for example the Mental Health Task Group in Canterbury. However some of these groups existed prior to the LHWBs being introduced. This has, in some cases, caused difficulty in developing a clear link between the sub groups, and a lack of a clear communication stream throughout.

6.4.5 Some LHWBs utilise their Integrated Commissioning Groups to a greater extent than others. Similarly Children's Operational Groups that exist in most areas are still exploring their relationships with local boards. (Also known as

Local Children's Partnership Groups these are intended to give consistency to partnership working to drive improvements in specific outcomes related to children and young people). It has also been recognised that some of the LHWBs may have effective relationships with some but not all of their sub groups. For example Ashford has a Lead Officer Group which acts as a steering group for officer prior to putting issues to the board, and also a Health Infrastructure Working Group. Ashford LHWB works well with these sub committees but less effectively with others, where communication streams and links are less clear.

6.4.6 Different boards are developing different substructures in order to address local priorities. Other differences exist in the existence of groups that may supplement the work of the boards such as Integrated Commissioning Groups. It is clear that there is no common work plan or strategy for the LHWBs and how they should be utilising their sub committees to improve the health and wellbeing within their geographical areas. There is a lack of clarity around the purpose of these sub committees and how the LHWBs could, or should, be relating to them.

7. Recommendations

7.1 Kent Health and Wellbeing Board

7.1.1 The Kent Health and Wellbeing Board will produce an outline work programme for the start of each year to enable local boards to plan their activity accordingly.

7.1.2 The Kent Board will clarify the means by which local issues can be escalated to the Kent Board.

7.1.3 The Kent Health and Wellbeing Board will ensure that relevant issues are referred to local boards with clear expectations regarding further action at a local level.

7.1.4 The Kent Board will provide policy support to the local boards to assist in the development of relevant substructures and work programmes.

7.1.5 Opportunities for development work for both chairs of the boards, and individual boards themselves, will be investigated and made available to local board members.

7.1.6 The Kent Board will provide data and information through its sub-group the Multi-Agency Data and Information Group.

7.2 Relationship between the Kent Board and local boards

7.2.1 The LHWB chairs will meet with the chair of the Kent Board every six months. This meeting will include consideration of the workplan of the Kent Board, and its relationship to the work plans of local Boards.

7.2.2 Each LHWB will send a representative to every Kent HWB, to update the Kent board on their activities locally, and to take any relevant information from the Kent board back. This representative will also be responsible for liaising with the Kent Board concerning issues and matters that would benefit from consideration at the Kent Board.

7.2.3 Proceedings of the Kent Board to be a standing item on all local board meeting agendas with particular reference to issues referred from the Kent Board for local consideration and action.

7.2.4 All agenda items that come to the Kent Board will be considered as to how local boards could and should be involved in their future progression. All local boards will provide an annual report to the Kent Board regarding how they have been progressing with the five outcomes of the Kent Joint Health and Wellbeing Strategy, and their engagement with the commissioning plans of their constituent organisations. The report will also describe how issues referred from the Kent Board have been considered and how local implementation of any necessary activity has been supported.

7.3 Board business

7.3.1 All local boards will develop a work programme for the coming year. This work programme will relate to:

- the five outcomes of the Kent Joint Health and Wellbeing Strategy
- the health and wellbeing priorities of the area as identified by the Kent Public Health department
- the health inequalities within the area and between the area and others in Kent
- Engagement with the development of commissioning plans of the organisations represented on the board.

7.3.2 Engagement with the commissioning plans of partner organisations should focus on opportunities to promote integration, especially between health and social care services. Whether the plans offer the best possible approaches to local issues should also be considered.

7.4 Structure and Governance of local boards

7.4.1 All LHWBs should have an agreed Terms of Reference by March 2016. Proposals for Terms of Reference, to be drafted following discussion at meeting of Chairs of Boards, to be brought to the Kent Health and Wellbeing Board at its meeting in January 2016.

7.4.2 Local boards to review their membership, substructures and associated working groups to ensure they are fit for purpose. Substructures should provide capacity to deliver the activity required to implement the work of the

board to deliver the five outcomes of the Joint Health and Wellbeing Strategy and allow proper oversight of commissioning plans. The substructure may include the local Children's Operational Group(s) and Integrated Commissioning Groups. The responsibilities of groups in a Board's substructure for reporting to the Board on specific outcomes from the H&WB Strategy should be clearly defined.

7.4.3 Relationships between the local boards and other meetings of commissioners and providers should be clarified.

7.5 Wider relationships

7.5.1 The substructure adopted by the local boards must also ensure that the appropriate relationships with service providers within the area are properly represented.

7.5.2 Appropriate relationships with representatives of other important sectors and organisations should also be reflected in the membership of the board or within its substructures. These should include the Voluntary and Community Sector and could include other local stakeholders such as Parish Councils.

8. Background Documents

Appendix 1 Kent Health and Wellbeing Board Organisational Structure

9. Contact details

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Kent HWB

Members

Roger Gough (Chairman), Dr Fiona Armstrong, Dr Bob Bowes (Vice-Chairman), Ian Ayres, Cllr Andrew Bowles, Hazel Carpenter, Paul Carter (KCC Leader), Andrew Scott-Clark, Dr Darren Cocker, Ms Patricia Davies, Graham Gibbens, Felicity Cox, Steve Inett, Andrew Ireland, Dr Mark Jones, Dr Elizabeth Lunt, Dr Navin Kumta, Dr Tony Martin, Peter Oakford, Simon Perks, Dr Robert Stewart, Cllr Paul Watkins, Cllr Lynne Weatherly

Ashford CCG HWB

Members

- Cllr Michael Claughton
- Dr Navin Kumta
- Cllr Peter Oakford
- Simon Perks
- Bill Millar
- Neil Fisher
- Paula Parker
- Faiza Khan
- Mark Lemon
- Caroline Harris
- Tracy Dighton
- Martin Harvey
- Stephen Bell
- Philip Segurola
- John Bunnett
- Sheila Davison
- Christina Fuller

Canterbury and Coastal CCG HWB

Members

- Eileen Shrubsole
- Debbie Smith
- Jayne Faulkner
- Faiza Khan
- Dr Mark Jones (Chairman)
- Sue Chandler
- Velia Coffey
- Amber Christou
- Michelle Farrow
- Neil Fisher
- Graham Gibbens
- John Gilbey
- Joe Howes
- Steve Inett
- Mark Lemon
- Paula Parker
- Simon Perks
- Cllr Ken Pugh
- Jonathan Sexton
- Sari Sirkia-Weaver
- Anne Tidmarsh
- Paul Watkins
- Alison Hargreaves (Secretary)
- Christopher Ives

Dartford, Gravesham and Swanley CCG HWB

Members

- Councillor Mrs Ann D Allen MBE
- Lesley Bowles
- John Britt
- Andrew Scott - Clark
- Andrew Scott- Clark
- Councillor Jane Cribbon
- Councillor Roger Gough
- Catherine Handley
- Dr Elizabeth Lunt
- Melanie Norris
- Councillor Tony Searles
- Debbie Stock
- Ann Tidmarsh

South Kent Coast CCG HWB

Members

- Councillor Paul Watkins (Chairman)
- Dr Joe Chaudhuri (Vice-Chairman)
- Theresa Oliver
- Karen Benbow
- Councillor Sue Chandler
- Councillor Patrick [Pat] Heath
- Jennifer Hollingsbee
- Mark Lobban
- Geoff Lymer
- Michael Lyons
- Ms Jessica Mookherjee
- Jan Perfect
- Mr Steve Inett

Swale CCG HWB

Members

Thanet CCG HWB

Members

- Colin Thompson
- Dr Tony Martin
- Councillor Mrs Iris Johnston (Vice-Chairman)
- Hazel Carpenter
- Dominic Carter
- Esme Chilton
- Councillor Graham Gibbens
- Councillor Elizabeth Green
- Madeline Homer
- Mark Lobban

West Kent CCG HWB

Members

- Gail Arnold
- Julie Beilby
- William Benson
- Councillor Mrs Annabelle Blackmore
- Dr Bob Bowes (Chairman)
- Lesley Bowles
- Alison Broom
- Cllr Alison Cook
- County Councillor Roger Gough
- Jane Heeley
- Fran Holgate
- Dr Caroline Jessel
- Dr Tony Jones
- James Lampert
- Mark Lemon
- Jonathan MacDonald
- Reg Middleton
- Cllr Mark Rhodes
- Dr Sanjay Singh
- Penny Southern
- Malti Varshney
- Cllr Lynne Weatherly

Sub Groups

Ashford CCG HWB

- Children's Health and Wellbeing Sub Committee
- Lead officer group
- Health Infrastructure Working Group

Canterbury and Coastal CCG HWB

- Children's Operational Group
- Mental Health Action Group
- Joint Commissioning Delivery Group
- Alcohol strategy group and safeguarding group
- Children's Centres District Advisory Board
- KIASS Local Delivery Group
- Troubled Families Local Operational Group

Dartford, Gravesham and Swanley CCG HWB

- Children's Operational Group
- Health Inequality groups
- Mental Health group

South Kent Coast CCG HWB

- Integrated Commissioning Group
- Children's Strategic and Operational group
- Healthier South Kent Coast Group

Swale CCG HWB

- Health improvement partnership
- Swale/DGS Integrated Operational Commissioning Group
- Children's Operational Group

Thanet CCG HWB

- Children's Sub Committee

West Kent CCG HWB

- Task and finish group on long term conditions
- Childhood obesity task and finish group
- Tobacco control and smoking cessation working group
- Children's Operational Group

Ashford Health & Well Being Board 20th January 2016

Voluntary Sector Next Steps

This paper has been compiled following discussion at the Lead Officer's Group meeting on 17/11/15 in response to the Voluntary Sector presentations to the board on 19th October.

The presentations featured Ashford Voluntary Community & Social Enterprise organisations providing services that prevent or delay escalation to more costly health and care interventions and can:

- Improve wellbeing
- Reduce unnecessary health appointments
- Reduce reliance on medication

Following these presentations the following recommendations were made to the board:

- Explore ways to engage meaningfully, with the VCSE as an equal partner and to develop joint initiatives to leverage in additional, external funding not accessible to the statutory sector
- Recognise the social and economic value of community based services that address social isolation, improve independence and reduce costs to statutory services
- Create an a 'resilience' funding to support smaller organisations
- Change how VCSEs are funded; longer term funding that enables organisations to make strategic decisions and to respond to statutory sector objectives
- Develop a social prescribing scheme for Ashford
- Work with the VCSE to better understand economic savings to the system

The purpose of this paper is to focus on three areas where resources might be concentrated so some these recommendations can be met.

1. Social Prescribing

Red Zebra have obtained funding through The RAISE CHALLENGE FUND "to partner with local GPs to design and develop a new social prescribing model offering a holistic approach to health and wellbeing. By coordinating local support services, community groups and healthcare professionals this innovative pilot aims to trial a more coordinated approach to healthcare that could be used elsewhere across the UK."   This pilot is launched in January 2016 and Red Zebra is in consultation with South Coast Kent CCG with regards to piloting a scheme in one of the districts they cover. There is a potential for a Ashford pilot scheme facilitated by Red Zebra and it is suggested this possibility be discussed by Ashford Health & Well Being board.

2. Funding/Grants

Rolling Funding

This could be aimed at organisations providing services where there is an overlap with Board priority areas. Rolling Funding to cover a three-year period would allow organisations to plan ahead strategically and concentrate on service delivery.

Small Grants

Hastings and Rother CCG have a small grants fund of £225k which provides resilience funding for small Voluntary organisations that provide very localised services. This is administered in the form of small grants by the local Infrastructure organisation who provide support with applications and who ensure funding is for projects which reflect priority areas. This model could be managed in Ashford by Red Zebra to enable small organisations to provide health-related services.

3. Ashford Community Forums

Red Zebra could provide support to the Four Community Forums in Ashford to help them develop and more cohesive strategy with regards to feeding into the Health and Well Being Board agenda. This could involve a series of structured workshops, facilitated discussion around priority-setting, focus groups.

Tracy Dighton & Michael James - January 2016

To:	**Ashford Health and Wellbeing Board**
From:	**Faiza Khan, Consultant in Public Health**
	Karen Sharp, Head of Commissioning Public health
Date:	**20th January 2016**
Subject:	**Public Health Programmes**

Summary

This paper gives an update on the transformation programme for Public Health commissioned services. Over the last few months a series of stakeholder and public consultation events have taken place, alongside a review of national developments, and a review of the performance of current services. This paper outlines some of the work to date, key findings and the recommended changes.

The Board are asked to:

1. Note and comment on the work.
2. Note the recommendations for future delivery.
3. Identify colleagues to be involved in the upcoming procurement processes.

1. Introduction

1.1. This paper gives an update of the work since then to review services commissioned from the Public Health grant. The services in scope for the review were services for children, including the Health Visiting service, School Public Health (school nursing) service and also the core public health programmes for adults, including healthy weight, health trainers and smoking cessation services.

2. Stakeholder engagement

2.1. During September and October the Public Health team engaged with a range of stakeholders to gather their input into the process. A number of themes come out of this stakeholder engagement. These include a much more effective approach to communication about health across the population, and also a much greater focus on tackling health inequalities. It was consistently clear that better use of data, intelligence and customer insight can be used to effectively message with a range of different communities and can also be used far more effectively to proactively target communities with the highest health inequalities.

3. Locally Flexible Services

3.1. The current approach to the commissioning of services has been based on a one size fits all model across Kent. Future procurement will include local

representation to ensure a model which can vary according to local priorities and reflect local need. Local representatives are welcomed to be involved in developing this model.

4. Children and Young People

4.1. Services in scope of the review included Health Visiting, the Family Nurse Partnership (FNP), the School Public Health Service (also known as the School nursing service) and the Young People's Substance Misuse Service.

4.2. A public consultation took place on Public Health services for children and young people aged 0 – 19 closed on December 15th and received a good level of response. The favoured delivery model from the consultation is for services to be focused more clearly across age groupings for 0 - 4, 5 – 11 and 12-19. The response suggests a clear preference for a model which has a much greater focus on addressing children's needs aligned to their age and developmental needs. There will be a series of meetings during January to follow this model up with key stakeholders.

4.3. Several focus groups were delivered throughout Kent with participants who are currently involved with, or who have had recent involvement with the Health Visiting service. The initial report identifies that whilst there is a largely positive experience of the service, there is a lack of a clear and consistent understanding of the priorities of the Health Visiting service and the breadth of the service offer. This consultation echoed the review of the School Public Health service which identified some positive experience of the service, but also particularly from professionals a lack of visibility of the service clarify on what the service should offer, the priorities for the service, and eligibility for the service. It also echoed consultation with the Kent Youth County Council on public health services for children and young people in which a majority of young people highlighted that the school nursing offer of service in secondary schools should be much more visible to students and should focus on managing emotional health and wellbeing as well as physical health needs. This supports the public consultation for a more focused approach on the specific challenges adolescents face.

4.4. Market engagement events have been held as part of the consultation. This brought a good number of local and national providers together and the event enabled service providers to feedback their views. Key considerations raised included making sure that in any model transition arrangements were clear and that there should be a fairer distribution of total resources across the age range. The feedback also clearly suggested that the skills to deliver drug and alcohol treatment interventions are significantly different to universal work with all families and that whilst these services should be clearly aligned in key pathways of care, an organisation skilled and experienced in substance misuse should with be procured, to deliver this aspect of the pathway.

4.5. In addition, a workforce modelling tool has been commissioned with the current providers of Health Visiting and School Nursing to assess the service's current capacity to deliver all aspects of the service. This with the needs

assessment for Ashford will ensure that the capacity of service that we commission is much more closely aligned with population size and community need.

4.6. Discussions are also underway with NHS England to explore the opportunities to align commissioning of their contracted services for school aged immunisations and the Child Health Information System. NHS England has confirmed that they would like to align their procurement process with KCC through the joint development of specifications and a joint evaluation process.

4.7. Both Ashford and the Kent Health and Wellbeing Board have identified tackling obesity as key priority and activity to address this is being embedded in future model development. Kent's Emotional Health and Wellbeing Strategy identified the need for a stronger approach in universal services on mental health for children and young people to meet need before issues escalate. The new service models will prioritise these issues contribute to this universal offer, ensuring that support is available at the earliest opportunity.

5. Adult health improvement

5.1. Public Consultation

5.1.1. During November and December a proposed model to integrate core public health services such as smoking and healthy weight, was tested with the public through a consultation process and a series of focus groups. To ensure that a comprehensive picture was developed there were three elements to the consultation.

5.2. Online/Paper consultation

5.2.1. This involved a consultation document which was promoted for an online response, as well as paper copies which were distributed to GPs surgeries, Libraries among other community venues. This allowed us to engage with the wider public, explaining the proposed model, the options we have considered and to get opinions of how the service should be shaped.

5.2.2. The key findings were that the proposed model was generally well received. Three quarters (75%) of respondents agreed with the proposed model, and only 9% disagreed. Just over half (54%) of respondents felt that they should be allocated based on need, with the remaining respondents stating that they should be open to everyone (19%), 'by referral only' (18%) and 'other' (9%)

5.3. Focus Groups

5.3.1. The second element of the insight work, consisted of focus groups that were run to investigate further into people's attitudes to services, why they would or wouldn't access them, and testing our assumptions about the services and the proposed model. There were twelve focus groups that reflected different demographics.

5.3.2. The 12 workshops showed that Participants considered health to be about both their physical and mental health, they recognised the wider determinants of poor health and that people are acutely aware that health inequalities exist. There was huge support for an integrated model dealing with a range of health issues. However participants also recognised the limits to what services can and should do given that adults are in control of whether they engage in unhealthy behaviours. This suggests that the message about self-motivation as being key to success must be consistently conveyed.

5.4. **Behavioural Insights**

5.4.1. A behavioural insight study has also been undertaken, which focused on developing our understanding of why those people with the unhealthiest lifestyles are least likely to engage with our services. The report showed that people with no qualifications were more than five times as likely as those with higher education to engage in all four poor behaviours.

5.4.2. The Behavioural Architects were appointed to carry out a piece of in depth research, working with twelve people over a course of two weeks, understanding their daily choices, and the influences on their behaviour. The key findings from the work which supported the integrated model included

- Identity is strongly tied to local friends and family and the area around where people live
- Consistent habit loops for all four behaviours enables them to be used interchangeably
- Unhealthy habits reinforce one another through ‘negative snowballing’ clearly indicates that an integrated model would be more likely to support this group of people to make a sustained change.
- Unhealthy behaviours are incredibly accessible and offer a way to exert choice and control
- Unhealthy behaviours are often default coping strategies for dealing with more acute challenges

5.4.3. Each of these studies will enable us to create an informed service that has the person at the heart , whilst enabling us to develop campaigns that will help to motivate people to change their lifestyles, and then to engage with our services if they need support to make a change.

6. Market Engagement

6.1. A series of market engagement events have been conducted which indicated a strong willingness by many providers to engage in the transformation work. The exercise involved representatives from more than 80 service provider organisations from the public, private and community and voluntary sector. Feedback included a strong appetite to engage in the programme and suggestions that go beyond traditional ‘service-based’ approaches e.g. using behavioural science, technology and marketing approaches to generate motivation.

7. Next Steps

7.1. The key issues identified through service, stakeholder, public and market engagement will feed into the development of service specifications and our commissioning approach for Public Health services, with the procurement plan to be finalised during February 2016.

8. Timeline

8.1. The work to transform public health services has been divided into three phases and is on track for delivery. To deliver within this timescale any new procurement process will need to begin in March to deliver the new model to start by October 2016.

9. Conclusion

9.1. Development of a new approach is needed to meet the challenges faced in public health, the changing needs of the population and the financial envelope of the public health grant.

9.2. The stakeholder engagement phase of the project clearly supported the direction of travel.

10. Recommendations

10.1. The Board are asked to:

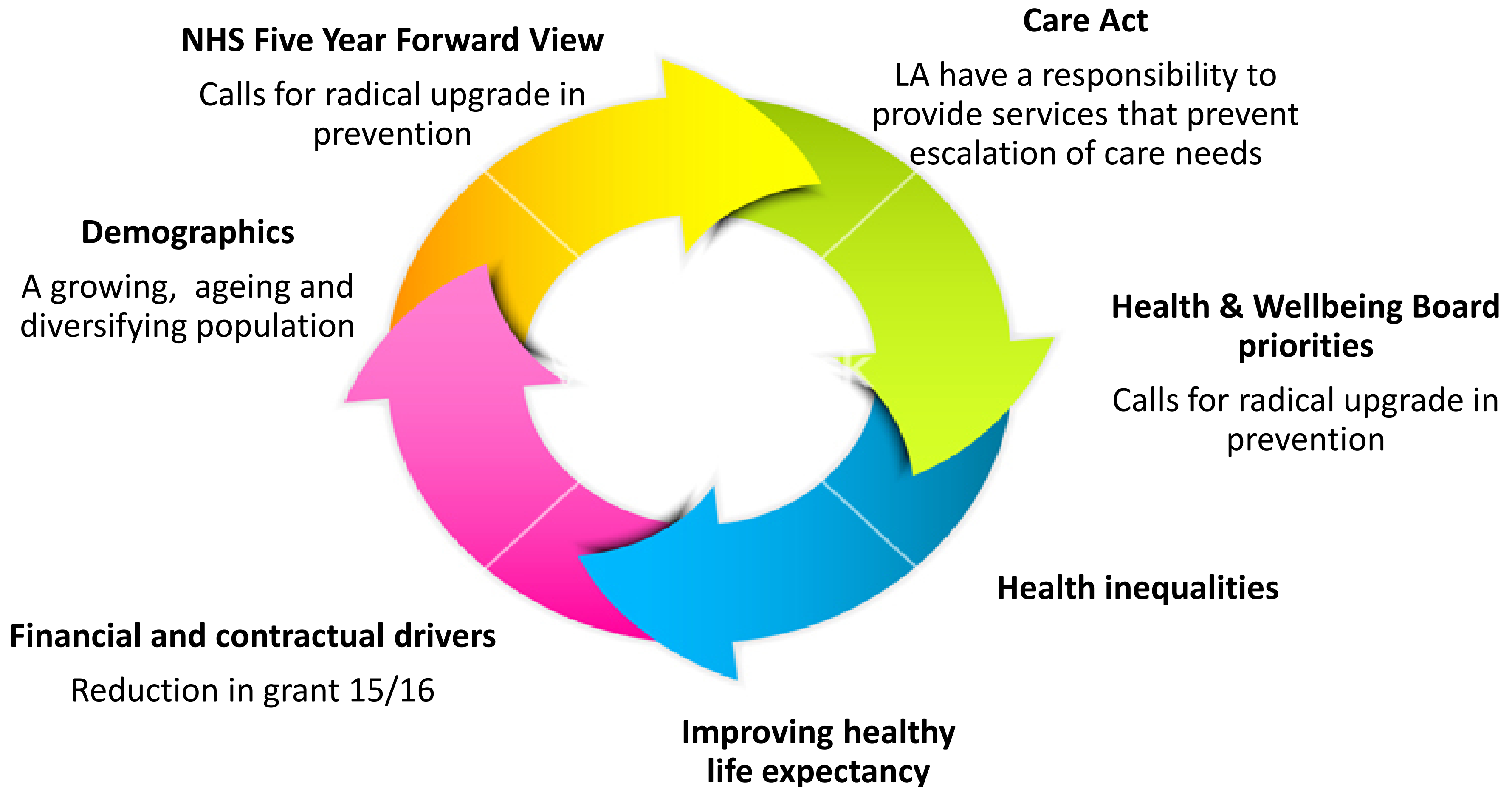
- Note and comment on the work.
- Note the recommendations for future delivery.
- Identify colleagues to be involved in the upcoming procurement processes.

Public Health Improvement Commissioning Strategy

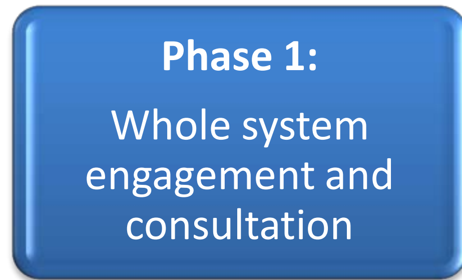
Ashford Health & Wellbeing Board 20th January 2016

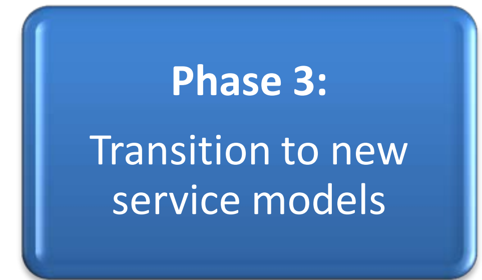
Kent County Council
kent.gov.uk

PH Transformation Programme - Drivers for Change



Timeline





March – September 2015:

- Member briefings and Cabinet Committee
- Stakeholder consultation
- Outcomes agreed
- Analysis and Review
- Health and well being boards consultation
- Market engagement
- Contract management

October 2015 –April 16

- New models of provision and specifications developed
- Public Consultation
- Key decisions taken
- Resourcing agreed
- Invitations to tender issued
- Procurement processes run
- KCC Making Every Contact Count

April 2016 onwards:

- Transition to new service models
- Staff reconfiguration
- Change management and communication

Kent County Council
kent.gov.uk

Public Health Transformation - Our Key Questions

- Are our services fit for purpose?
- Do we invest our grant in the right way?
- What is mandated and what is discretionary?
- How many people and do the right people benefit from our services?
- How do our services perform?
- How do our contractual arrangements limit what we can do?
- Are we planning for the future?

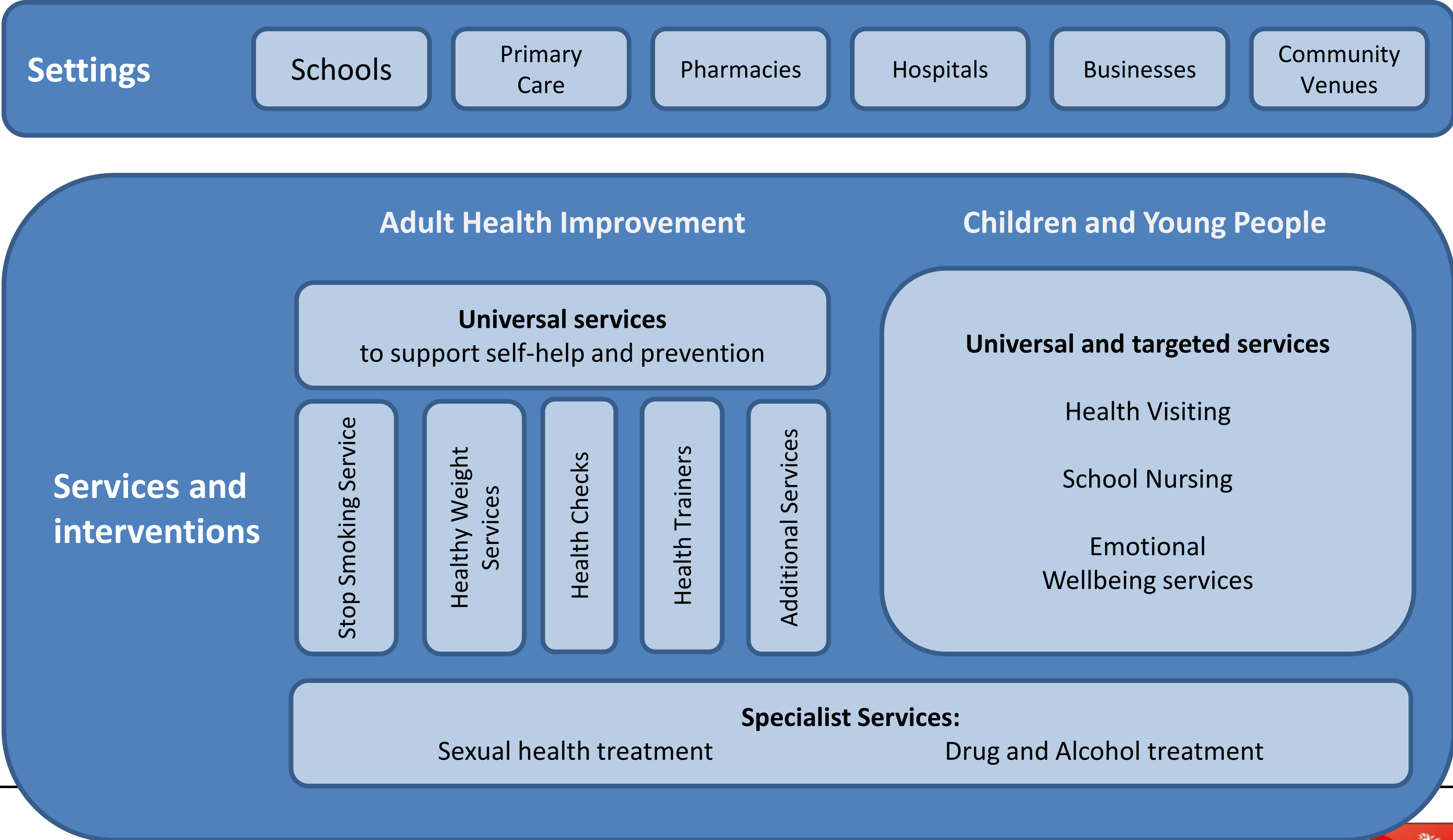
Review

- Reviewed:
  - Outcomes
  - Spend
  - Performance of services
  - Health profiles across Kent
  - National developments and Key research
  - The Market
  - Wider system priorities
  - Customer insight

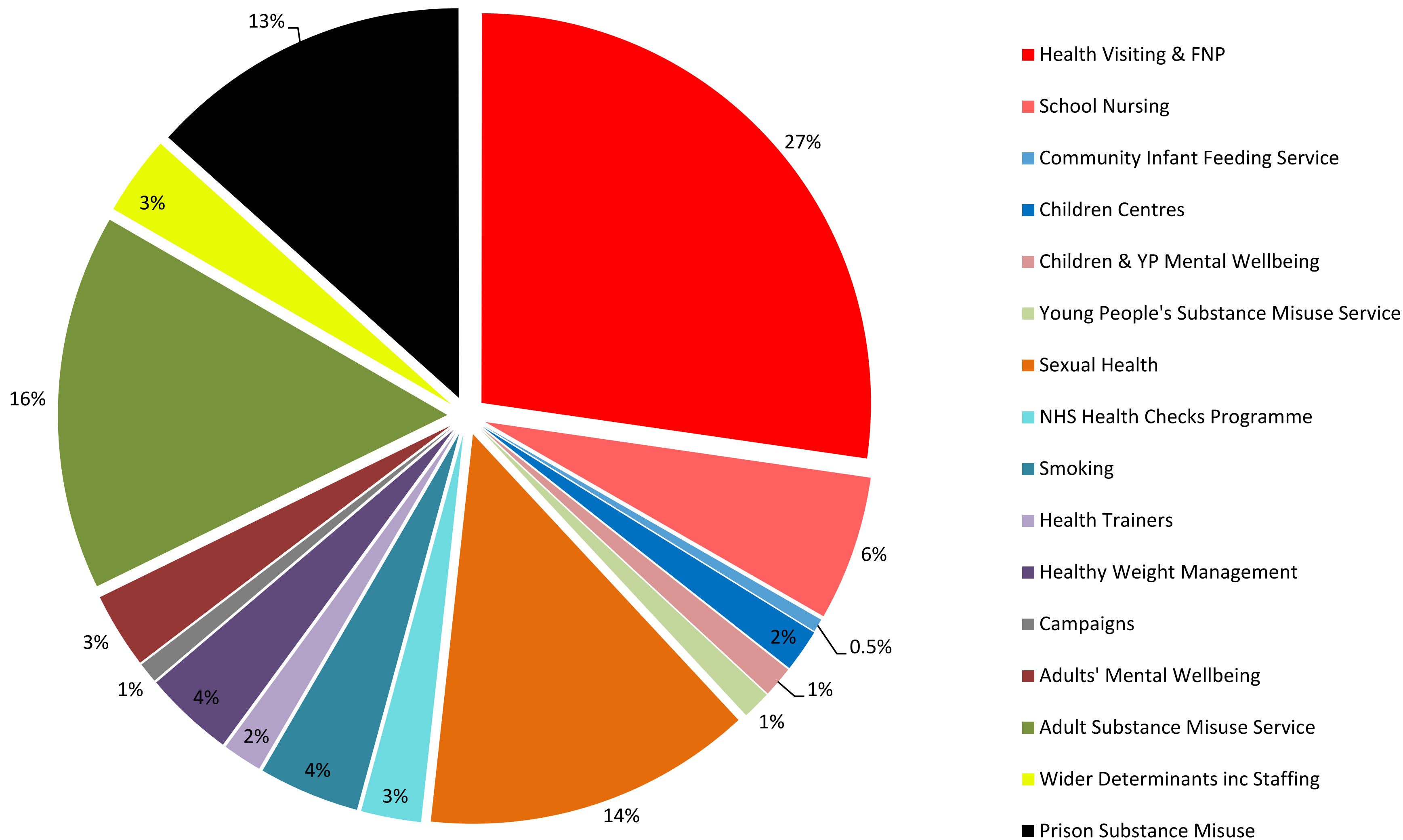
Key Outcomes

	Starting Well	Living Well	Ageing Well
Smoking	• Reduce smoking prevalence in general • Reduce in target populations		
Healthy Eating, Physical Activity & Obesity	• Reduce levels of excess weight • Increase levels of physical activity • Increase levels of breastfeeding • Reduce levels of tooth decay in children (5 year olds)		
Alcohol & Substance Misuse	• Reduce alcohol-specific admissions to hospital • Increase successful completions for drug and alcohol misusers		
Wellbeing (including Mental Health and Social Isolation)	• Improve wellbeing of population • Reduce self harm and suicide rates • Reduce social isolation • People >65 with mental ill health are supported to live well		
Sexual Health & Communicable Disease	• Maintain access to specialist sexual health services • Reduce rates of sexually transmitted infections • Reduce levels of teenage pregnancy • Reduce excess <75 mortality rates		

Current Model



Ashford Public Health Spend Breakdown 15/16 - based on NHS England Formula



Starting Well – Ashford

	Agreed Outcomes	Current Health Performance *Source: PHOF unless stated*	PH Activity
Smoking	Reduce smoking prevalence at age 15	Smoking prevalence at age 15 (2009-12) – *regular smokers only*: Ashford: 9.1%	Stop Smoking Service Tobacco control programmes
	Reduce smoking prevalence at time of delivery	Smoking prevalence at time of delivery (Q2 14/15) Ashford CCG: 10.1%	
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight in children	% children classified as overweight or obese (2013/14) 4-5 yr olds (YR): 22% 10-11 yr olds (Y6): 35%	Early Help Workforce funding Ready Steady Go Change4Life
	Increase levels of breastfeeding	% all mothers who breastfeed their baby in first 48hrs after delivery (breastfeeding initiation) (2013/14): Kent: 71.3%	Community Infant Feeding Service
	Increase physical activity in young people	*No data available*	Sky Ride
	Reduce levels of tooth decay	% children with one or more decayed, missing or filled teeth (aged 5 years) (2012): Kent 19.8%	Dental Health Programmes
Alcohol & Substance Misuse	Reduce under 18 hospital admissions due to alcohol	Alcohol specific admission rate per 10,000 population aged <25 (2011/12 to 2013/14) – Source: SUS, ONS Ashford: 7.0	Young People's Substance Misuse Service
	Reduce levels of drug taking and use of legal highs	Drug specific hospital admissions: rate per 10,000 population aged <25 (2011/12 to 2013/14) – Source: SUS, ONS Ashford: 6.6	
Wellbeing	Increasing emotional resilience in families and young people	Admissions for mental health, rate per 1,000 population, ages 0-17 (2011/12 to 2013/14) – Source: SUS, ONS Ashford: 1.1	Domestic Abuse Projects Mental Health First Aid Youth Mental Health Matters Helpline Positive Relationships Social Integration Activities Project Young Healthy Minds
	Ensure levels of social and emotional development	School readiness: % children achieving a good level of development at end of reception year (2013/14) Kent: 68.5%	
	Reducing levels of self-harm and suicide rates	Deliberate self harm admission rate per 10,000 population aged 0-17 (2011/12 - 2013/14) – Source: SUS, ONS Ashford: 10.4	
Sexual Health, Communicable Disease	Reduce rates of Chlamydia	chlamydia positivity screening rate/ 100,000 15-24yrs (Q2 14/15) Ashford: 934	Condom Programme Integrated Sexual Health Service National Chlamydia Screening Programme Pharmacy Sexual Health Programme
	Reduce rates of STIs	all new STI diagnoses (exc. Chlamydia <25 yrs) 15-64 yrs/100,000 (2013) Ashford: 578	
	Reduce levels of teenage pregnancy	<18 conception rate /1,000 (2013) Ashford: 23.5	
All Priorities	As above	As above	Children Centres Health Visiting & FNP School Nursing

Living Well – Ashford

	Agreed Outcomes	Current Health Performance *Source: PHOF unless stated*	PH Activity
Smoking	Reduce smoking prevalence in general population	Smoking prevalence in general population 18+ (2013) Ashford: 21.1%	Smoking Cessation Service Tobacco Control
	Reduce smoking prevalence in routine and manual workers	Smoking prevalence in routine and manual workers (2013) Ashford: 34.7%	
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight	% excess weight in adults (2012) Ashford: 67.4%	Ready Steady Go Change 4 Life Fresh Start Tier 3 Weight Management
	Increase levels of physical activity	% physically inactive adults (2013) Ashford: 24.2%	Health Walks Exercise Referral Scheme
Alcohol & Substance Misuse	Reduction in number of people drinking at problem levels	Alcohol specific admission rate /10,000 population aged 25 - 64 (2011/12 - 2013/14) – Source: SUS, ONS Ashford: 37.0	Adult Substance Misuse Service
	Reduction in hospital admissions due to alcohol	Drug specific hospital admissions, rate per 10,000 population aged 25+ (2011/12 to 2013/14) – Source: SUS, ONS Ashford: 8.2	
	Reduction in drug misuse		
Wellbeing	Improve wellbeing of population	Mental Health Contact rate per 1,000 people, aged 25-64 (2014) – Source: KMPT, ONS Ashford: 35.3	Domestic Abuse Projects Kent Sheds Mental Health Community Services Mental Health First Aid Mental Health Matters Helpline Mental Wellbeing Programmes Primary Care Link Workers
	Reduction in suicide rates	age-standardised mortality rate from suicide and injury of undetermined intent/100,000 population (2011-13) Ashford: 7.6	
	Reduction in domestic abuse	rate of domestic abuse incidents (recorded by the Police) /1,000 (2013/14) Kent: 18.1	
Sexual Health, Communicable Disease	Increase early diagnosis of HIV	Late diagnosis of HIV % newly diagnosed with a CD4 count less than 350 cells per mm^2 (2011-2013) Ashford: 42.9	Integrated Sexual Health Service Pharmacy Sexual Health Programme Psychosexual Counselling
	Reduce rates of STIs	all new STI diagnoses (exc. Chlamydia <25 yrs) 15-64 yrs /100,000 (2013) Ashford: 578	
	Reduce excess under 75 mortality rates	Mortality rate from diseases considered preventable (persons) /100,000 (2011-2013) Ashford: 147.8	NHS Health Checks Programme
All Priorities	As above	As above	Children's Centres Health Trainers Healthy Living Pharmacies Learning Disability Health Improvement Programme NHS Health Checks Programme

Ageing Well – Ashford

	Agreed Outcomes	Current Health Performance *Source: PHOF unless stated*	PH Activity
Smoking	Reduce smoking prevalence	Smoking prevalence in general population 18+ (2013) Ashford: 21.1%	Smoking Cessation Service Tobacco Control
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight	% excess weight in adults (2012) Ashford: 67.4%	Fresh Start Tier 3 Weight Management Health Walks Exercise Referral Scheme
Alcohol & Substance Misuse	Reduction in number of people drinking at problem levels Reduction in hospital admissions due to alcohol	Alcohol specific admission rate /10,000 population aged 65+ (2011/12 - 2013/14) - Source: SUS, ONS Ashford: 21.3	Adult Substance Misuse Service
Wellbeing (inc Mental Health & Social Isolation)	Improve wellbeing	Mental Health Contact rate per 1,000 people, aged 65+ (2014) – Source: KMPT, ONS Ashford: 34.8	Kent Sheds Mental Health Community Services Mental Health First Aid Mental Health Matters Helpline Mental Wellbeing Programmes Primary Care Link Workers
	Reduce social isolation	% adult social care users who have as much social contact as they would like (2013/14) Kent: 45.8%	
	People with mental ill health are supported to live well	Mental Health Contact rate per 1,000 people, aged 65+ (2014) – Source: KMPT, ONS Ashford: 34.8	
Sexual Health	Reduce rates of STIs	*No data available for 65+*	Integrated Sexual Health Service
All Priorities	As all above	As all above	Health Trainers Healthy Living Pharmacies Learning Disability Health Improvement Programme NHS Health Checks Programme

Market Engagement and research 1

- Much research points to understanding issues with clustering of unhealthy behaviours (King's Fund analysis)
- Providers keen to explore new opportunities and diversify their service offer to engage with us
- Many providers are doing a great deal of thinking about their strategies - some are re-focusing their service offer to respond to the potential market for health improvement
- Organisations included integrated health improvement hub models that have recently been established e.g. Live Well Dorset, Live Well Suffolk.
- Some providers expressed concern about the idea of creating an integrating health improvement model. Eg dilution of specialist expertise, risk of restricting the market

Market Engagement

- Suggestions for commissioning programmes that go beyond traditional 'service-based' approaches e.g. using behavioural science and marketing to generate motivation for healthier lifestyles .
- A number of different providers suggested commissioning a generic 'behaviour change service'
- Providers wish to understand more about how VCS can come together in partnerships to bid
- Pharmacies are keen to engage in health improvement agenda offer a wider range of public health services
- Few suggestions for reductions in spend; most suggestions on principles of 'invest to save over the long-term'

Key themes

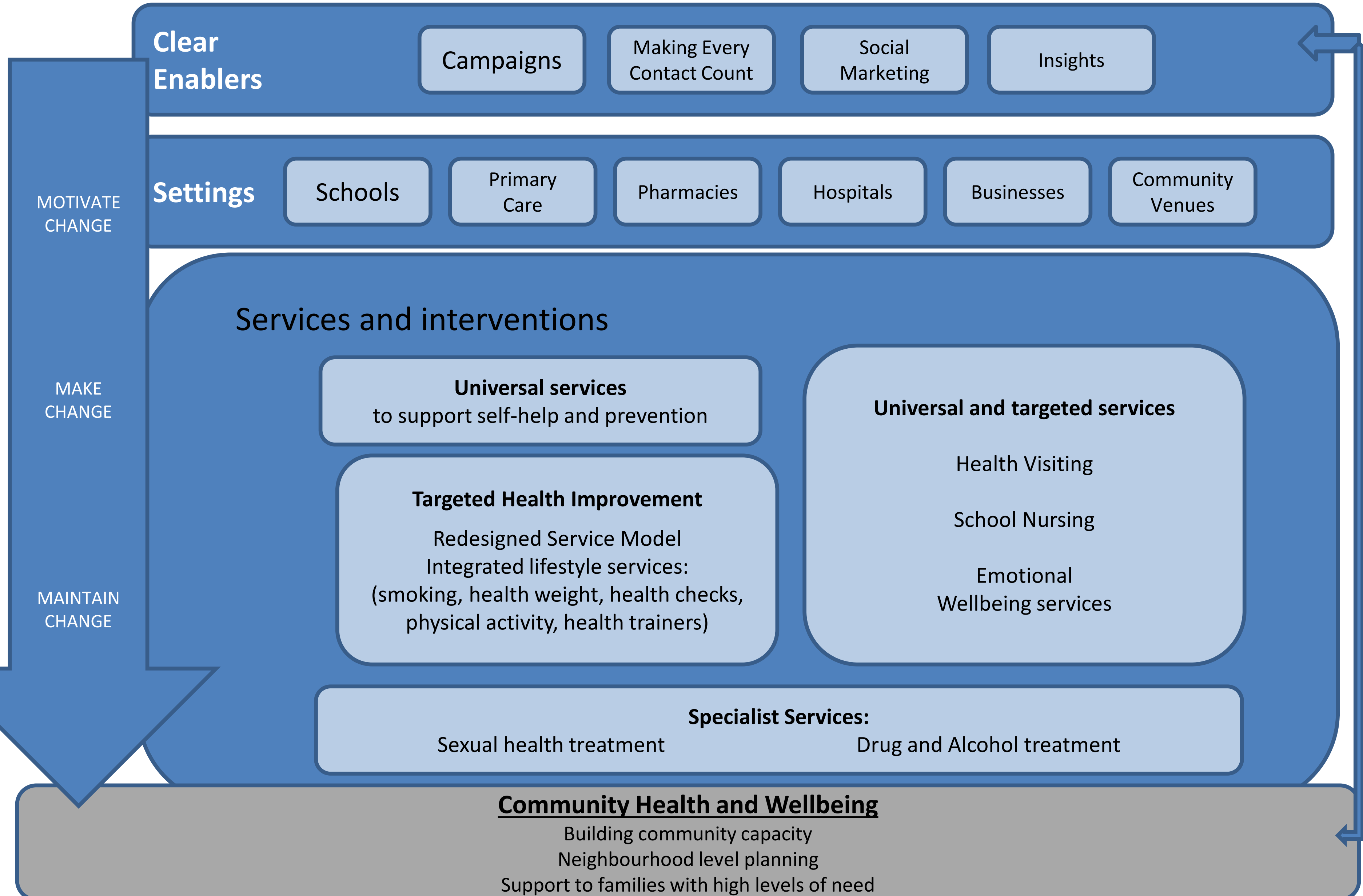
- Health Promotion across the population
  - Co-ordination with partners
  - Enhancing the approach to motivation
- Focus on health inequalities
- Locally flexible services (co-design)
- Integration of adult health improvement services
- Children and young people's services
  - Better visibility and Shared records
  - Better and further integration of services
- Embedding a the focus on emotional health and wellbeing

The 9 High Impact Areas

- The Best Start in Life
- Healthy Schools and Pupils
- Helping People find and stay in work
- Active and Safe Travel
- Warmer and Safer homes
- Access to Green and Open spaces
- Strong communities, Wellbeing and Resilience
- Public protection and regulatory services
- Health and Spatial services

Improving the Public's health – The 9 High Impact areas The Kings Fund 2013

Adult and Children Health Improvement Model



Local Public Health Model

Local priorities to inform approach, with mental and emotional wellbeing underpinning everything we do

Whole Population Health Promotion

Campaigns and communications
Making Every Contact Count
Community Champions
Websites and social marketing
Partner Communications

Universal Access Services

Health Visiting
School Nursing
Health Checks
Healthy Living Centres
Healthy Living Pharmacies
Universal Health Improvement Services

Targeted Health Improvement Services

Integrated Adult Health Improvement Service
Motivational approaches

Specialist Services

Alcohol, drugs & Sexual health

Motivate Change
Make Change
Maintain Change

Integrated community approaches

Community Health and Wellbeing

Building community capacity and improving access to community resource

Next Steps

- Stakeholder engagement continues
- New models of provision developed
- Public Consultation
- Further customer insight work
- Resourcing agreed
- Models and specifications finalised
- Procurement processes as appropriate

By: Barbara Cooper, Corporate Director, Growth Environment and Transport, KCC
Katie Stewart, Director Environment Planning and Enforcement, KCC

To: Health and Wellbeing Board

Date: 18 November 2015

Subject: Growth and Infrastructure Framework

Classification: Unrestricted

Summary:
This report provides an overview of the recently launched Kent and Medway Growth and Infrastructure Framework, and the associated action plan. It also seeks the Board's input to the development of the GIF, with a view to strengthening particularly the health and social care infrastructure evidence base and using it to help shape health infrastructure provision to support housing growth.

Recommendations:
The Board is recommended to:

a) note the contents and conclusions of the first GIF and its associated action plan;
b) agree to help shape the future of the GIF by contributing robust and timely data and analysis to the next refresh; and
c) agree to use the GIF to help shape discussions about the future shape of health and social care service delivery

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1. Background

1.1. Board members will be aware of increasing pressure on local authorities across the UK in delivering housing and economic growth. Within Kent and Medway alone, approximately 160,000 new houses are planned to 2031. In order to deliver such housing numbers, it is vital that the right infrastructure is in place to support that growth – infrastructure including not just roads and rail, but public services required to serve these new communities including education, leisure facilities, and critically health and care services.

1.2. The Kent and Medway **Growth and Infrastructure Framework (GIF)** has been developed to provide a clear picture of housing and economic growth to 2031

and the infrastructure needed to support this growth. It was finalised following its consideration by County Council in July and Kent Leaders in September. The full GIF can be accessed via the following weblink: www.kent.gov.uk/gif.

1.3. At a time when the Government has prioritised the delivery of housing and economic growth more generally, it is an absolutely critical time for Kent to use the GIF to not only promote Kent and Medway's infrastructure priorities, but also shape a more sustainable approach to funding infrastructure in the long term.

1.4. To this end, the final version of the GIF includes a **10-point action plan**, which taken together will ensure that the GIF becomes a framework and platform for creating a more sustainable and effective approach to planning, investing and delivering infrastructure to support growth. Please see Appendix for a summary of these actions.

2. The GIF on health and social care

2.1. As part of the infrastructure to support growth in Kent and Medway, the GIF provides evidence on the provision of healthcare and social care capacity across the area – both current provision and provision that would be required to support the planned housing growth to 2031.

Healthcare provision

2.2. It should be noted that there were challenges in gathering robust data on health infrastructure provision for this first version of the GIF – a challenge which it is hoped can be overcome in working more closely with partners in the sector. The data for existing provision was taken from NHS Choices data, whilst the future requirements and associated costs were derived from modelling that applies population growth to existing provision.

2.3. Specifically, the GIF provides the following data:

Current provision	Required provision to 2031
• Current primary healthcare, including: ○ Number of GPs ○ Patient list size ○ Patients per GP ○ Population per dentist ○ Population per pharmacy ○ Population per optician	• Primary healthcare required to support population growth to 2031

• Current provision of hospital capacity, including:
  ○ Existing acute NHS hospitals
  ○ Existing community hospitals
	• Additional beds required to support population growth – including both hospital beds and mental health beds

2.4. The GIF is based on the existing healthcare model using population growth forecasts to establish level of demand for healthcare services. For acute hospital and mental health beds needed, the current UK bed to person ratios (i.e. steady state) was used and has been applied according to the forecast population growth.

2.5. Future requirements and associated costs and funding assumptions for primary, acute and mental healthcare have been based on benchmark modelling and have not yet, due to time constraints been validated or agreed by the NHS. In most cases of development, after developer contributions have been taken into account, the outstanding costs to deliver necessary infrastructure are usually met by the NHS. However, given the known funding deficit across public sector organisations including the NHS, it is expected that the NHS may no longer be able to meet the full cost of this funding requirement in future. As such, in the GIF, the proportion of the gap after developer contributions that is funded by the NHS has been reduced down from 100% to 75% in order to give a best estimate of future funding requirements.

Social care provision

2.6. The GIF maps current social care provision across Kent, including provision for people with learning disabilities; people with mental health needs; older people; and people with physical disabilities. The following capacity issues are identified:

Client group needs	Capacity issues in:
Learning disabilities	Ashford Dartford Dover Sevenoaks Tonbridge and Malling Tunbridge Wells
Mental health	Dartford Dover Tonbridge and Malling
Older people	Dartford Swale

	Thanet
Physical disabilities	Dartford Dover Gravesham Maidstone Swale Thanet Tonbridge and Malling Tunbridge Wells

2.7. Costs and future provision requirements are estimated on the basis of the Social Care Accommodation Strategy which sets out the forecast change in demand for the full range of care clients. This analysis has highlighted the need for considerable investment in older persons nursing and extra care accommodation and also supported accommodation for clients with learning disabilities.

2.8. Given the limitations on the data used for the GIF, there is a clear need to refine the picture of health and care infrastructure to meet future growth in the next and future iterations of the GIF. Nonetheless, whilst the findings of the GIF should be read with caution, they **highlight a critical challenge in funding health and social care provision to meet future demand**. In particular, the GIF has highlighted challenges in such provision in growth areas where there viability is more marginal.

3. Developing the health infrastructure of the future for Kent and Medway

3.1. In order to refine our understanding of this challenge and provide as robust an evidence base as possible from which to potentially attract funding and/or explore new delivery models, it is critical that the GIF is shaped by partners, including those around the Health and Wellbeing Board. There is also a clear opportunity to shape this part of the GIF with local Health and Wellbeing Boards moving forward.

3.2. From this work to refine the evidence base, the GIF could give the HWB a platform from which to **identify priorities for healthcare infrastructure for the future**. In doing so, the HWB is potentially a key partner in the GIF action plan, particularly around raising the profile of the need for better alignment of funding for healthcare infrastructure with growth.

3.3. Similarly, local partners will **be using the GIF to engage with London on more proactive management of the impact of London's growth** on Kent

and Medway. This will form part of a strategic conversation across the Southeast to ensure that where this growth impacts outside of London, the right infrastructure is delivered to support that growth. To broker this engagement, KCC will work through the Southeast Strategic Leaders (SESL) network, as well as Southeast authority officer networks (including a planning policy officers and directors groups).

3.4. Further, and perhaps more importantly, the GIF is intended to give partners a tool with which **to test the impact of new delivery models.** Within the current GIF, the option of an integrated health and social care model, similar to the Estuary View Medical Centre in Whitstable, is applied to the whole of Kent and Medway. The cost is estimated to be c. £500m, but the impact of revenue savings as a result of more efficient delivery may be deemed to outweigh this initial capital cost in the medium to long term. Further work on exploring the cost of such a model and the potential savings in revenue terms could be undertaken using the GIF as a framework.

3.5. Finally, KCC will use the GIF to enable a more **proactive approach to attracting investment** – not only from Government but from potential private sector sources as well. Work will be scoped to explore the potential of institutional investment, as well as to proactively prepare for future rounds of Local Growth Funding and/or other Government funding.

4. Recommendation

4.1. The Board is recommended to:

a) note the contents and conclusions of the first GIF and its associated action plan;
b) agree to help shape the future of the GIF by contributing robust and timely data and analysis to the next refresh;
c) agree to use the GIF to help shape discussions about the future shape of health service delivery

Report author/Relevant Director:

	Katie Stewart
	Director, Environment, Planning and Enforcement
Directorate	Growth, Economy and Transport
Tel:	03000 418827
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APPENDIX: GIF Action Plan

Action 1: Innovation in financing
Discussions with Government on the shortfall in capital funding growth and work collaboratively to find 'new innovative ways' of closing the funding gap (e.g. Tax Increment Funding (TI F), Institutional Investment, better application of CIL etc).

Action 2: A single Infrastructure Delivery Plan for Kent
Explore the feasibility of producing a single Infrastructure Delivery Plan for Kent and Medway reflecting the robust partnership working with the district authorities and Medway.

Action 3: A stronger relationship with London and the Southeast
Engage with South East Strategic Leaders and the County Councils in the South East on strategic issues and priorities, in particular transport, including linkages to London and radial routes to better connect the wider South East.

Action 4: Reform of CIL and developer contributions
Engage Government, using existing networks such as the County Councils Network where appropriate, to explore means of refining the current CIL and developer contribution mechanisms to better take account of varying viability in different areas of the country, to maximise the potential of CIL .

Action 5: The potential for private sector investment
Open discussions with the private sector including the development, pension and insurance sectors, and other investment sectors to explore the feasibility of establishing an 'Institutional Investment' pot for infrastructure and other mechanisms that may help fund infrastructure.

Action 6: A stronger relationship with the utilities
We will collaborate with the utilities sector to seek improved medium to long term planning aligned to the County's growth plans. A key role for the public sector will be to hold utilities companies to account to make the necessary capital investment. Through establishing County Council scrutiny arrangements for utility provision (which have the opportunity to feed into OFWAT, OFGEN, etc) matching utility companies' capital investment plans to the growth plan.

Action 7: Maximise the public estate
We will use the One Public Estate pilot commencing across Kent to seek to ensure we are maximising opportunities to lever in investment opportunities to fund and support growth.

Action 8: Ensuring the GIF is a "go-to" reference for infrastructure priorities

The GIF will be regularly refreshed to reflect the ongoing development of the Kent and Medway Local Plans and to enable refinement of many of the areas of evidence within the framework including costs and future funding assumptions.

Action 9: An integrated approach to planning and delivering growth
Monitor annually on a district-by-district basis:

- Progress of Local Plans;
- Delivery of housing and employment space;
- Receipts from developer contributions and CIL;
- Public and private sector investment in the county, including into the health and social care sectors and;
- Utility company capital investment.

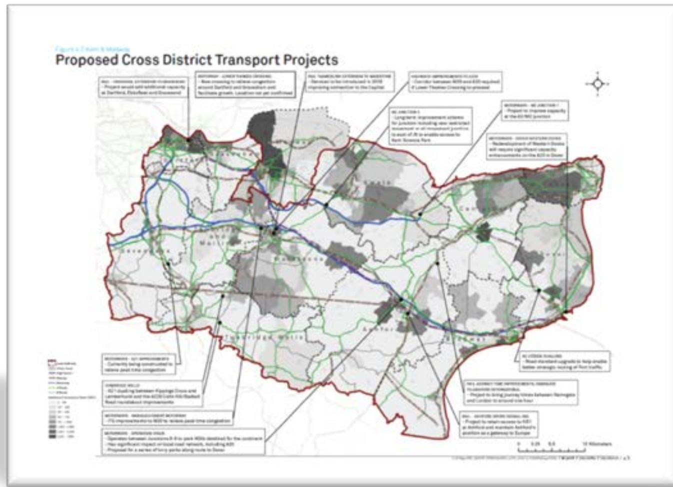
Action 10: A robust design agenda for Kent and Medway
Consider how we can build on and refine current activity in the county aimed at ensuring high quality design, including working with Kent Planning Officers' Group and Design South East and updating the Kent Design Guide where required.

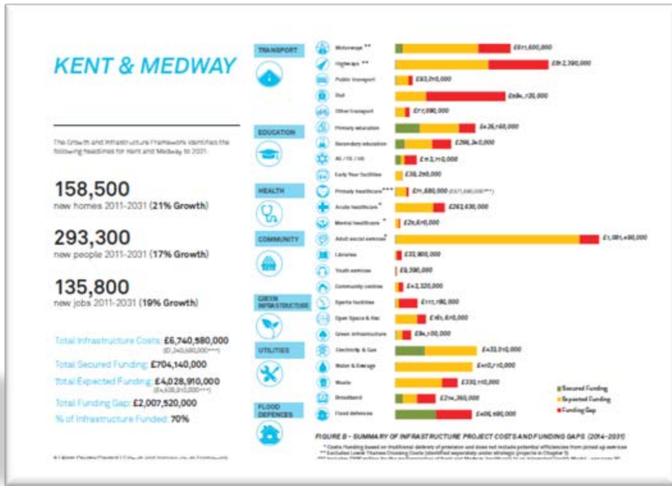
Kent and Medway Growth & Infrastructure Framework

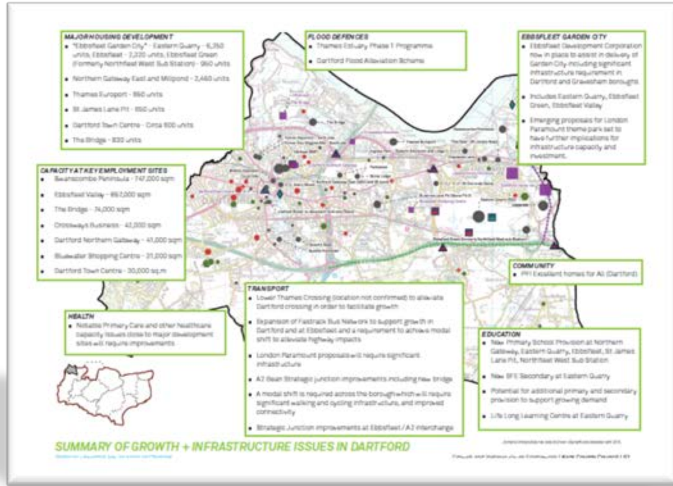
Stephanie Holt
Environment, Planning and Enforcement Division

Kent County Council
kent.gov.uk

What is the
Growth & Infrastructure Framework?







Kent County Council
kent.gov.uk

The purpose of the framework

To provide countywide picture of:

1. Growth to 2031 based on:

    - LPA planned growth
    - Demographic factors
    - Economic factors

2. Infrastructure needed to facilitate that growth

3. Infrastructure funding gap for Kent and Medway

The benefits of the framework

1. Evidence and support for Local Plans as they are developed
2. Opportunity to co-ordinate planning of new delivery models e.g. health, utilities etc
3. Single, strategic voice for Kent and Medway
4. Evidenced conversation with Government on funding and delivery barriers
5. Evidenced conversation with London on how it will meet its housing need

Kent & Medway – Growth to 2031

The Growth and Infrastructure Framework identifies the following headlines for Kent and Medway to 2031

158,500
new homes 2011-2031 (**21% Growth**)

293,300
new people 2011-2031 (**17% Growth**)

135,800
new jobs 2011-2031 (**19% Growth**)

Housing Growth

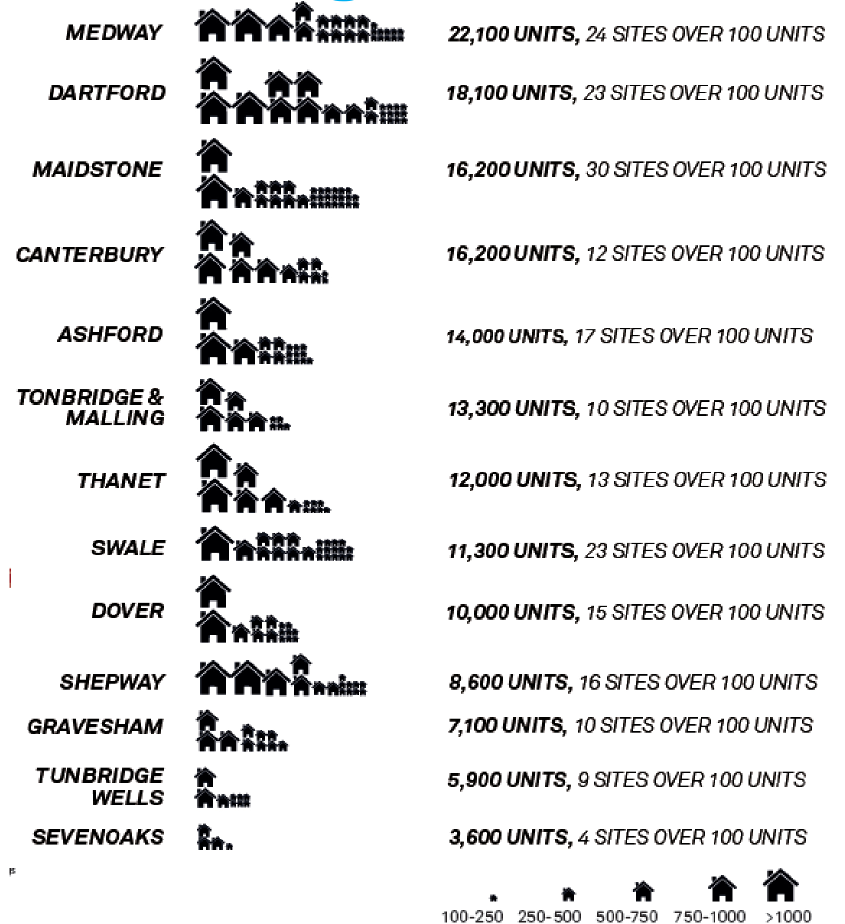
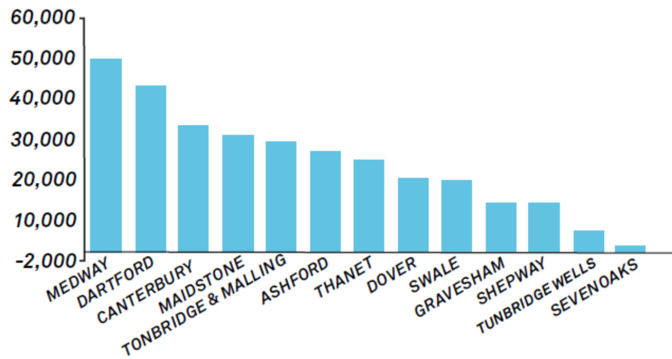


FIGURE 3.14 - NUMBER OF HOUSING SCHEMES (100+ UNITS) FORECAST FOR EACH LOCAL AUTHORITY

Population Growth

The population growth varies significantly within Kent & Medway, with the greatest increases in Medway, Dartford, Canterbury & Maidstone



Economic Growth

Kent & Medway – Infrastructure requirement

Statutory Local Government Infrastructure, Public Sector Partnership Infrastructure & Private Sector Infrastructure are necessary pre-requisites to support the scale of growth.

The cost of growth

Total for Kent and Medway	Total Amount	Amount per Annum
Infrastructure Cost from 2014 to 2031	£6.74 billion	£397 million
Secured Funding *	£0.70 billion	£42 million
Expected Funding**	£4.03 billion	£237 million
Funding Gap	**£2.01 billion**	**£118 million**

** Funding that is in the bank or committed via formal agreement   ** Funding that is anticipated to come in via government, developer contributions or private sector.*

The GIF makes abundantly clear that the current mechanisms for delivering growth do not provide the infrastructure needed for that development.

The agenda for infrastructure

Getting the evidence base right

– Explore the potential for a single Infrastructure Delivery Plan for Kent and Medway.

Influencing and attracting new investment

– Health and social care considered on two basis; continuing the existing model of provision, and a modern fit-for-purpose 21st century model

– Explore the potential for private sector investment in infrastructure

– Use the GIF to promote a more robust approach to quality design

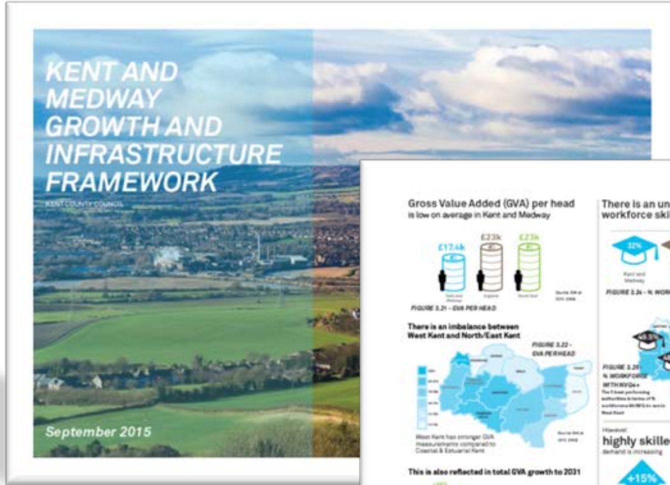
Working more effectively across boundaries to maximise infrastructure investment

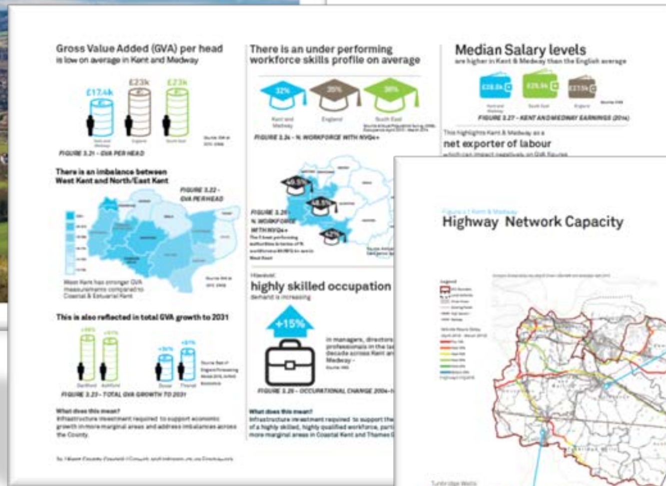
– Work with Government to explore innovation in funding of infrastructure including potential reform of CIL

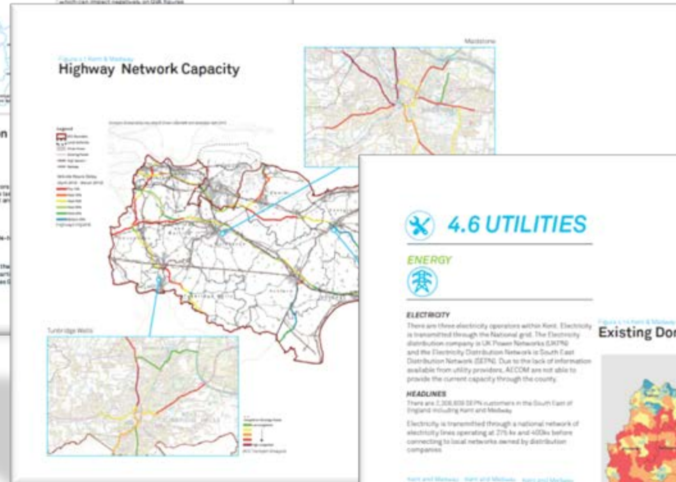
– Maximise the public estate to further support growth through Kent's One Public Estate pilot.

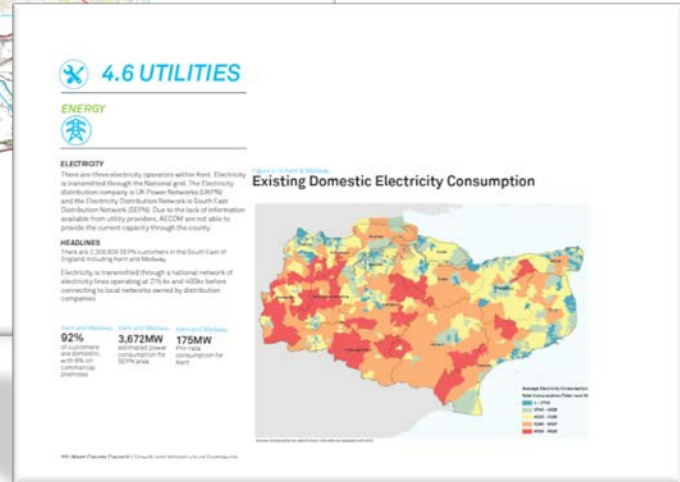
– Develop a stronger relationship with London and the South East

Further development of GIF









www.kent.gov.uk/GIF

GIF@kent.gov.uk

Infrastructure Needs and Requirements;
Chapter 4.3 – Health
Chapter 4.4 – Community

Area Breakdowns;
Chapter 5.1 - Ashford

Kent County Council
kent.gov.uk

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Clinical Commissioning Group – Quarter 3: October to December 2015

What's going on in our world	• New national guidance for planning – "Delivering the Forward View" – published in December 2015 • Action Plans in place to address underperformance against national constitution measures • Community Networks meeting continue
Success stories since last AHWB	• MSK Triage: Ashford – 31% reduction in the financial year to date in primary care referrals compared to same period last year generating **notional** savings of £758k-£1.008m depending on assumptions made • IAPT Re-Procurement • Re-design of Back Pain Pathway • Establishment of Age UK Living Well Programme • Establishment of Ashford Mental Health and Wellbeing Café • Implementation of online GP Referral Support Tool • Dementia diagnosis rate now over 61%, our highest rate, and continues to improve
What we are focusing on for the next quarter <u>specific to the key projects</u>	• Development of MCP model for Ashford locality, along similar line to national vanguard sites. • Development of Annual Operating Plan • Development of Sustainability and Transformation Plan, in line with national directive
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 • Designing and implementing new models of care as part of NHS Five Year Forward View • Delivering Sustainability and Transformation Plan by Summer 2016
Any thing else the Board needs to know	
Signed & dated	Neil Fisher – January 2016

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for KCC Social Services – Quarter 3: October to December 2015

What's going on in our world	• Following a competitive tendering exercise, KCC in partnership with the seven Kent NHS Clinical Commissioning Groups (CCGs), have appointed Nottingham Rehab Limited (trading as NRS Healthcare) to deliver a countywide Integrated Community Equipment Service. • We have also appointed Invicta Telecare Limited (trading as Centra Pulse and Connect) to deliver a countywide Digital Care and Telecare service. • The two new services will started on 30 November 2015 and both contracts will be for a period of five years, with the option to extend for a further two years. • Implementing developing the whole Systems work Discharge to Assess model • The Delivering Differently in Neighbourhood project in Wye continuing. • The Age UK integrated care pilot is live in Q3 2015 and a project officer has now been appointed to support this work.
Success stories since last AHWB	• Advocacy contract let
What we are focusing on for the next quarter <u>specific to the key projects</u>	• Working with Supported Living and Housing providers to strategically plan the delivery of KCC's My Life, My Home initiative over the next 2 to 3 years. KCC data predicts a growth in Supported Living across the Ashford & Shepway locality of around 40% over current levels by 2020. • Independent Advocacy tender of statutory and non-statutory services • Care homes contract • Building Community Capacity
Anything else relevant to AHWB priorities NOT mentioned above	KCC Transformation programme continues
Strategic challenges & risks including horizon scanning?	Potential impact of the National Minimum Wage / Living Wage,

Any thing else the Board needs to know	No
Signed & dated	Paula Parker - 08/01/16

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Ashford Borough Council – Quarter 3: October to December 2015

What's going on in our world	• **Chief Executive** – John Bunnett has resigned and will be leaving us mid February. More information at http://www.ashford.gov.uk/search/text-content/ashford-is-much-richer-for-his-service-13th-nov-1222
	• **New corporate plan approved** - Four priority areas:
	  o Enterprising Ashford - Economic investment and growth
	  o Living Ashford - Quality housing and homes for all
	  o Active & Creative Ashford - Healthy choices through physical, cultural and leisure engagement
	  o Attractive Ashford - Countryside & townscape, heritage & conservation
	Further details at: http://www.ashford.gov.uk/news/ashford-for-aspiration-action-and-achievement-council-sets-out-five-year-plan-14th-oct-1195/
	• **The dark sky's the limit** - ambitious and creative plans for a unique International Dark Sky Designation have taken a step forward following endorsement by the Council in December.
	• **Park Mall** – New traders moving into Council owned Park Mall. Also very healthy statistics about town centre footfall.
	• **M20 Junction10a** – Traffic modelling completed. Consultation is due to commence on 14th January 2016 for 9 weeks. The formal Development Consent Order application is likely to be submitted in June 2016, with a start on site in late 2017, with about an 18 months construction period.
	• **Elwick Place** - planning permission has been granted for the first phase, including the cinema, hotel and restaurants.
	• **Public realm works around International House** - now complete.
	• **Designer Outlet Expansion** (phased extension to double floor space). Planning application has now been approved i.e. as of 23 Sept 2015.
	• **Ashford College** (£16m campus for 1,000 students) Demolition of old buildings on site underway. Campus will be completed in early 2017 and open from September that year.
	• **International Station spurs** (finding signalling solutions to enable future interoperability for all international service providers). European Commission has agreed to contribute half of the required funding for an essential update of signalling equipment at Ashford International Station. The remainder of the funding will be covered by the South East Local Enterprise Partnership. This investment will ensure that Ashford remains an international destination, maintaining direct rail access to continental Europe.
	• **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). Council working with local developers Quinn Estates Ltd and George Wilson Holdings Ltd on the site earmarked for the first new office building in the Ashford Commercial Quarter. Together they will help bring forward the exciting plans to redevelop the area into a dynamic new main business hub in the town.
	• **TENT1 –** (additional 249 homes in Tenterden). Planning permission has now been issued and development is expected to start on site in 2016.
	• **Conningbrook Lakes Country Park** – it is open. Over time the park will offer a range of leisure and water based activities while also providing a gateway for

	walkers and cyclists to explore the Stour Valley. • **Repton Park Community Centre** - Planning application submitted October 2015 Planning Committee likely in February 2016. Name decided by community competition as Repton Connect. • **Local Plan** – A new Local Plan is currently being prepared which will look ahead to 2030. It is expected that formal public consultation on a draft Plan will take place next April. • **Syrian Vulnerable Persons Re-location Scheme** – The first three families arrived in the borough in December. Homes were identified for these families in Newtown, Charing and Tenterden. Extensive liaison has taken place with KCC and the CCG and the Police and an intensive programme of support is in place. • **Council Housing** – As a consequence of Government proposals to reduce national cost of Housing Benefit, rents are to be reduced by 1% each year for the next 4 years. This results in a loss of £10 million over this period. A cost recovery programme has been agreed by the Council. This includes the East Stour Sheltered Scheme rebuild being postponed and other options explored, maintenance programme savings and salary savings associated with some compulsory redundancies (linked to the maintenance programme). The programme includes steps to increase alternative Council housing related income schemes. More information available from Bob Smart (Housing Resource Manager). • **MIPIM** – Council returned to MIPIM (the UK's largest exhibition and conference for property professionals) to promote Ashford. Further details at http://www.ashford.gov.uk/news/ashford-makes-triumphant-return-to-mipim-uk-19th-oct-1198/. • **Victoria Park** – Key partners from a variety of professional backgrounds met recently with a creative consultant to discuss a proposed Community Engagement Plan for Victoria Park. This is in preparation for a planned Heritage Lottery Fund bid application for the fountain and surrounding piazza area of the park.
Success stories since last AHWB	• **Self Harm Project** - AKA 'About You'. Progress is being made in terms of partnership working with the CCG via Community Networks, some work still to do with Ashford schools. • **Dementia** – Supported the Kent Dementia Action Alliance Dementia Friendly Exhibition and Awards. Information on Farrow Court made available. • **Domestic Abuse** – One Stop Shop 5th Birthday event 6th November. Domestic Abuse Forum just achieved charitable status. • **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 summer 2016 it will offer 41 extra care apartments at affordable rents in Tenterden. • **St. Stephens Walk** - The Excellent Homes for All PFI 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 became operational in December 2015. • **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 although the 1% rent cut planned each year for 2016-20 will impact this programme. A bid for funding for the Danemore scheme has been made through the Care and Support Specialised Housing Fund (CaSSH) phase 2. Outcome will be known hopefully early in 2016.

	• **Poppy Fields, Charing** – All 21 families should be moved into their new affordable properties by early 2016 • **Chamberlain Manor extra care scheme (Housing and Care 21) -** opened officially on 17th July. 67 units for rent and shared ownership and communal facilities. All rented apartments are allocated. Approximately half of the shared ownership apartments are now reserved. Hairdressing salon (part of the facilities to benefit the wider community as well) is let. • **Spearpoint sports facilities**. Sports Council funding secured and approval given to replace the Spearpoint pavilion with a new community building. Construction to start in 2016. • **Spearpoint Trim Trail** – Now open with ten pieces of equipment for teens and adults over a 1000-metre trail, the trail will be a great addition to the recreational facilities at Spearpoint. • **'Smoke Free' Play Spaces** – Pilot project to encourage an emotional response from local residents, discouraging them from smoking in public places and around children. All phase 1 sites complete apart from Bulleid Place which will follow as part of the refurb. Evaluation report complete and signed off by Public Health. Initial interest by Tonbridge and Malling and Maidstone BC to roll out the scheme. Tenterden Council considering introducing on the Recreation Group play space with a letter to Parish Councils to be sent out shortly. A successful project. • **MIND café** – Now open 6 - 9.45pm every Friday and Saturday night at HOUSE. • **Kingsnorth Multi Use Games Area** – Now open. The new MUGA will allow the community to play a variety of sports and is open during the evenings, weekends and school holidays, whilst local children and students from the nearby school can use the space as a play area during the day.
What we are focusing on for the next quarter <u>specific to the key projects</u>	• **Dementia -** Day Centre at the new Farrow Court facility is now operational. • **Healthy Weight** - the group are currently populating the Healthy Weight Action Plan which should be signed off early in the New Year' (many of the actions are already underway). 'The Aspirational Health Zone' project is currently in a 'mapping and asset registering stage' and should be in a position to begin delivering from March 2016 onwards. • **Farrow Court** – Phase 1 of the scheme is now complete with all current residents having moved into their new accommodation and a formal opening event for phase one took place in December. • **Rough Sleepers Project**, Porchlight commissioned, joint working started and a multi agency working group has been set up, involving all relevant agencies, including churches and the street pastors. A Rough Sleeper Estimate was publicised widely and was undertaken on 19th November and revealed a total of 5 known rough sleepers within the Borough on that night. Porchlight are working closely with us to target those individuals to offer advice and support to obtain a home. The Severe Weather Emergency Placements (SWEP) Protocol will be in force over the winter period and will be coordinated by Housing Options and Porchlight. This provides that when the temperature dips below freezing on consecutive nights arrangements will be made to place any known rough sleeper where possible until the temperature rises above freezing again. • **Homelessness Strategy** – Being reviewed. Following Cabinet approval on 8th October the draft strategy will be out for public consultation on the Council's consultation Portal. Please ensure that you take the time to feed into the strategy. If information required contact sharon.williams@ashford.gov.uk. This strategy will identify actions to prevent and reduce homelessness working closely with partners.

Anything else relevant to AHWB priorities NOT mentioned above	• **District Deal** - The Leaders of Ashford Borough Council and Kent County Council met this week to formally sign a document which sets out how the two councils will work more closely together on a number of specific projects. See http://www.ashford.gov.uk/news/councils-join-forces-to-improve-delivery-9th-dec-1246/ • **Domestic Abuse** – The bid made by ABC Housing that aimed to provide accommodation to local residents needing to flee their property for a short time due to domestic abuse was unsuccessful. Feedback requested.
Strategic challenges & risks including horizon scanning?	
Any thing else the Board needs to know	• **"Know Your Score"** - helped promote the Kent alcohol brief advice (IBA) online self-assessment tool, "Know Your Score". This is a web-based version of the alcohol IBA scratch card and supports the Kent Alcohol Strategy. Promoted during Alcohol Awareness Week (16 to 22 Nov).
Signed & dated	Sheila Davison – January 2016

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Voluntary Sector – Quarter 3: October to December

What's going on in our world	In October Voluntary Organisations in receipt of KCC grants were given two weeks to reapply for their 2016-17 Grant. The deadline was extended but it is widely felt this is the last year that Grants will be available and that from 2017 KCC will put services out to tender.
Success stories since last AHWB	Ashford Counselling Service won a Big Lottery Reaching Communities Grant of £144k to deliver a year project focussing on Post Natal Depression – this will incorporate one to one counselling with mothers and group work involving fathers and children.
What we are focusing on for the next quarter specific to the key projects	Tracy Dighton has a new job and has stood down from the board so Red Zebra has started looking for a new Voluntary Representative to sit on the Board.
Anything else relevant to AHWB priorities NOT mentioned above	
Strategic challenges & risks including horizon scanning?	It is generally felt that 2016-17 will see further cuts in funding really take effect and this is likely to jeopardise the future of many Voluntary and Community Organisations.
Anything else the Board needs to know	
Signed & dated	Michael James 5th January 2015

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for Ashford Local Children's Partnership Group– Quarter 3: October to December 2015

What's going on in our world	Local Children's Partnership Board has been set up whereby Helen Anderson was elected as Chair and a corporate agreement made by the initial members of this group to share the tasks according to best fit and availability, working as a team. Two meetings have taken place one of the 16th of October and another on the 8th of December 2015. The first meeting on the 16th of October 2015 was scene setting and identifying key partners and involved defining the current local priorities for a multi-agency group for Ashford in relation to CYP (where is needed a combined effort rather than single agency work). The second meeting on the 8th of December was attended by Thom Wilson, KCC Head of Strategic Commissioning, who set the scene for the further development of LCPGs as well as talking through the development of the CYPP. Attached is the Improving outcomes through LCPGs presentation and Blueprint which was presented at the LCPG meeting. I attended the County chairs meeting on the 17th December 2015 where the strategic thinking and actions required for LCPGs were shared. Centrally they are looking at the best way to work to 4 broad outcomes across all the LCPGs with a local flavour being incorporated based on data and local intelligence.
Success stories since last AHWB	Enthusiastic partner engagement and collaboration at LCPG and priorities being developed with some quick wins achieved through training related to the first target being offered as a multi-agency opportunity. Effective linkage in place and developing with other strategic groups (Community Safety Partnership, AHWB, 0-25 Health & Well-being Board, Local Inclusion Forum Executive etc.)
What we are focusing on for the next quarter specific to the key projects	• Hard to reach families including Gypsy Travellers, young carers, CINs • Emotional health and well being
Anything else relevant to AHWB priorities NOT mentioned above	Safeguarding – Prevent, child sexual exploitation, gangs, substance misuse, homophobia, racism and educating parents

	Ability to react to emerging trends / local groups Families we are concerned about not engaging in services Other priorities to be agreed within the broad headings: Breast feeding, healthy weight for children, oral health and smoking in pregnancy.
Strategic challenges & risks including horizon scanning?	One data set for Ashford is required (this is being supplied for all LCPGs in early 2016) Ensuring continued active commitment from key partners to achieve shared outcomes Best use of funding and resources, the ability to bid effectively and use new services/opportunities. Being prepared for funding challenges and local developments (e.g. population increase, welfare reforms etc.)
Any thing else the Board needs to know	On the 27th of January there is Outcomes Based Accountability training for 3 LCPG There is a county CYP plan being developed Linkage with the county HWB by having two chairs from the LCPG attend each 0 – 25 HWB County meeting The next Board meeting will be 9th February 2016. During this meeting dates for the year will be set at this time bearing in mind the need to link with Ashford HWB dates.
Signed & dated	Helen Anderson 08.01.2015