Ashford Health and Wellbeing Board

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

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

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

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

3. Notes of the Meeting of this Board held on the 20th January 2016 — 2-9

4. Ashford Health and Wellbeing Board Priorities (Faiza Khan) — 10-21

5. Mental Health – Covering Paper and Presentations (Lisa Barclay)(to follow)

(a) Mental Health Strategy – Verbal Update (Louise Piper- East Kent Mental Health Commissioning Team)
(b) Wellbeing Café – (Julie Blackmore, MIND)
(c) Other Local Voluntary Sector Projects – Verbal Update (Lisa Barclay)

6. CCG Operational Plan 2016/17 (Neil Fisher) — 22-54

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9. Kent Health & Wellbeing Board Meetings held 27th January and 16th March 2016 – Navin Kumta – verbal update (links: https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6179) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6180)

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11. Forward Plan

<u>July 2016</u>

- The Syrian Project – Sharon Williams
- Community Networks – Presentation from each Network
- East Kent Hospitals University NHS Foundation Trust – Meet the new Chief Executive
- Smoking

12. Dates of Future Meetings

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

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

KRF/AEH
14th March 2016

Queries concerning this agenda? Please contact Keith Fearon:
Telephone: 01233 330564 Email: keith.fearon@ashford.gov.uk
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Declarations of Interest (see also "Advice to Members" below)

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

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

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

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

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

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

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

Advice to Members on Declarations of Interest:

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

(b) The Kent Code of Conduct was adopted by the Full Council on 19 July 2012, with revisions adopted on 17.10.13, and a copy can be found in the Constitution at http://www.ashford.gov.uk/part-5---codes-and-protocols

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

Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the
20th January 2016.

Present:

Dr. Navin Kumta – Clinical Lead and Chair, Ashford CCG, (Chairman);
Faiza Khan – Public Health Specialist, KCC (Vice-Chairman);

Councillor Brad Bradford, Lead Member – Highways, Wellbeing and Safety, ABC
Councillor Geoff Lymer, Deputy Cabinet Member for Adult Social Care and Public Health, KCC
Mark Lemon – Policy Advisor, KCC;
Theresa Oliver – HealthWatch
Michael James – Red Zebra Community Solutions;
Martin Harvey - Patient Participation Representative (Lay Member for the CCG);
Sheila Davison – Head of Health, Parking & Community Safety, ABC;
Lisa Barclay – Head of Programme Delivery, Ashford CCG;
Charlie Fox – Chief Officer, Red Zebra Community Solutions;
Stephanie Holt – Head of Countryside, Leisure & Sport, KCC
Belinda King – Management Assistant, Health, Parking & Community Safety, ABC;
Danny Sheppard – Senior Member Services and Scrutiny Support Officer, ABC;

Apologies:

Peter Oakford - KCC Cabinet Member - Specialist Children's Services, Philip Segurola - KCC Social Services, Simon Perks - CCG, Neil Fisher – CCG, Helen Anderson – Ashford Local Children's Partnership Group, Tracey Kerly – ABC, Debbie Smith – KCC Public Health.

1. Notes of the Meeting of the Board held on the 19th October 2015

The Board agreed that the notes were a correct record.

2. Ashford Health & Wellbeing Board Priorities

2.1 Faiza Khan– Public Health Specialist, KCC, gave a presentation in order to facilitate a discussion on the priorities that the Ashford Health & Wellbeing Board might like to consider. These would be with the particular aims of reducing gaps in service, reducing health inequalities and improving outcomes for patients in the Ashford Borough in the coming years, all under the banner of 'A Healthier Ashford'. The presentation outlined the drivers for change leading to the development of the priorities and an action plan for this Board and detailed some of the particular issues that Ashford already faced and how they compared to other areas in the region and nationally.

2.2 Faiza Khan asked what the Board would like to see next in terms of data. The Board considered it would be useful to bring a specific paper to the next meeting to drill down in to some of the causes for the particular problem areas

highlighted for Ashford, and whether there was anything the Board could do about them when agreeing its priorities. The projected increase in mental health disorders was flagged as a particular issue. It was reiterated that whilst the issues were health related, many of the causes may be outside of the control of healthcare such as employment, population growth etc.

2.3 The Board then discussed health inequalities and examined a slide which gave an overview of what was happening in Ashford and other Kent Districts. The slide showed the gap between the most deprived and least deprived in Ashford in both the 75+ and 'all ages' categories was increasing in terms of cancer, circulatory diseases, respiratory diseases and all other diseases. There was one anomaly in the 'all causes – all ages' category where the gap was decreasing. The Board considered that the overall statistics were incredibly depressing bearing in mind all of the work that had gone in to addressing health inequalities over the years and asked if Faiza Khan could do some more analysis of the data to see what other areas which were performing slightly better, such as South Kent Coast and Thanet, were doing differently. A Member also asked if the cancer statistics could be broken down in to male/female. This would all be with a view to reporting back to the Board to see if there was anything it could be doing to affect the situation.

2.4 In terms of taking the priorities forward, it was agreed that the previously mentioned follow up report would come back to the next Board Meeting. Reducing inequalities was a cross cutting issue for the Board to consider and the table contained at page 30 of the Agenda papers could act as a good 'starter for 10' in terms of which organisations would be responsible for which areas within that. It was agreed that the issue of 'alcohol' should be re-labelled as 'substance abuse' and the issue of 'obesity' was not really one that ABC could take a lead on – this would be more for KCC Public Health. The Chairman said it would be useful to send this table to the next meeting of the Lead Officer Group (LOG) to determine how much work was already been undertaken by each organisation in these areas, and to come back to this Board with a maximum of five overarching priority areas to move forward on whilst also attaching some timescales. Early suggestions for priority areas included obesity, mental health, dementia and early diagnosis and prevention.

2.5 There was a wider discussion on the topic of obesity and it was considered that this would be an issue of education. There was perhaps a need to work more with schools to promote the benefits of healthy eating, proper cooking and exercise. It had to be targeted at school children, perhaps even at Primary level, as it was often too late to re-educate parents. It was considered that this should be one of the priority areas and be fed to the Children's Board.

3. East Kent Strategy Board

3.1 The Chairman introduced the report which had been submitted by Simon Perks explaining that the East Kent Strategy Board had 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. The update provided some context about the ambitions and work of the Board and the programme of activity it would oversee. These changes were

necessary in the context of increased demand for services in an increasing challenging financial environment and there would be a need to develop new approaches and models for delivering care going forward. The work of the Board was supported by each of the four East Kent Clinical Commissioning Groups.

3.2 In response to a question about the timeframe for starting to look at and test options, the Chairman advised that there was a huge communication workstream to work through but they were aiming for late Summer/Autumn 2016.

4. Kent Board Relationship with Local Boards and Future Options

4.1 Mark Lemon – Policy Advisor, KCC introduced the report which had been submitted to the Kent Health & Wellbeing Board in September 2015 and had contained 17 specific recommendations for discussion, all around reviewing the relationship between the Kent Health & Wellbeing Board and the Local Boards. The work as described in the report had been undertaken in order to clarify the expectations the Kent Board had of the Local Boards, communications between the Boards and how business was transacted.

4.2 Mark Lemon said that it was clear that there was a lack of clarity on the purpose of the Local Boards and how they linked to the Kent Board. The list of recommendations had sought to provide some clarity and he drew attention to two specific recommendations; firstly suggesting an outline work programme for the Kent Board for the start of each year to enable Local Boards to plan their activity accordingly; and secondly for each Local Board to send a representative to every Kent Board meeting, to update on their activities locally, and to take back any relevant information from the Kent Board. This representative would also be responsible for liaising with the Kent Board concerning issues and matters that would benefit from consideration at the Kent Board. He also advised that there had been an offer from the Local Government Association (LGA) to run some development sessions with Local Boards to help reflect on what they did, look at their aspirations and help analyse what they needed to have in place to deliver those. He asked the Board if that was something they wanted to take up.

4.3 The Board said it would certainly be interested in engaging with the LGA and developing the question ‘what are we here for?’ The Chairman said that the Board’s meetings had covered some good ground, but there were certainly wider questions about what impact the Board was having and whether their time was currently being spent wisely. This was a time of rapid and necessary change in the health service and it would be important to position the Board correctly to assist in that and to be a truly commissioning organisation in the future. It was noted that a formal terms of reference for the Ashford Local Board was yet to be agreed and that doing this would probably be necessary as part of any work with the LGA. It was agreed to take discussions on the LGA development work forward to February’s Lead Officer Group (LOG) meeting.

4.4 The Board agreed that Navin Kumta as Chairman would act as the Ashford Board's representative on the Kent Board.

Resolved:

That (i) the Board accept the LGA offer to undertake some development sessions and further discussions take place at the Lead Officer Group in February.

(ii) Navin Kumta act as the Ashford Board's representative on the Kent Health & Wellbeing Board.

5. Voluntary Sector Next Steps

5.1 Michael James - Red Zebra Community Solutions, tabled a slightly amended version of the report that was included within the Agenda papers. He advised that the report had come as an update from discussions at the last Board meeting on 19th October 2015 on the Voluntary Sector. The report focussed on three areas where resources might be concentrated to help support general health and wellbeing.

5.2 Charlie Fox, Chief Officer, Red Zebra Community Solutions, discussed social prescribing and advised that this could be an area which could be developed in Ashford. Red Zebra was currently working with the Multi-speciality Community Provider (MCP) GP group based at Whitstable Medical Practice to co-design and implement a social prescribing service. The service aimed to improve access by local people to the full range of services offered by the voluntary and community service in order to support them with improving their health and wellbeing. There was potential for an Ashford pilot scheme facilitated by Red Zebra and it was agreed to pursue this through the three Ashford Community Networks. Red Zebra had also suggested they could provide support to the three Ashford Networks (North, South and Rural) in helping them develop a more cohesive strategy with regard to feeding into the Health & Wellbeing Board agenda generally. This could involve a series of structured workshops, facilitated discussion around priority setting and focus groups.

Action: Lisa Barclay to add Michael James to the invitation list for the three Ashford Community Networks.

5.3 With regard to funding and grants Michael James advised that rolling funding could be aimed at organisations providing services where there was an overlap with Board priority areas. If rolling funding could cover a three year period this would allow organisations to plan ahead strategically and concentrate on service delivery. A small grants model could be managed in Ashford by Red Zebra to enable small organisations to provide health-related services. This would not just be about keeping the Voluntary and Community Sector going, but about delivering specific targets and outcomes as set by the Board. Areas already mentioned at this meeting such as mental health, healthy eating etc. could all be prioritised.

6. Public Health Programmes

6.1 The paper gave an update on the transformation programme for Public Health commissioned services. A series of stakeholder and public consultation events had taken place, alongside a review of national developments and a review of the performance of current services and the paper outlined some of the work to date, key findings and recommended changes.

6.2 The Board agreed that Faiza Khan and Sheila Davison would work together to identify colleagues to be involved in the upcoming procurement processes. A representative from HealthWatch was suggested as one possibility.

Resolved:

That (i) the work be noted.

(ii) the recommendations for future delivery be noted.

(iii) Faiza Khan and Sheila Davison work together to identify colleagues to be involved in the upcoming procurement processes.

7. Kent Health & Wellbeing Board Meeting – 18th November 2015

7.1 The Chairman advised that the meeting had covered a lot of ground and most of the areas had already been covered by this Board. One of the main areas of focus had been the Growth and Infrastructure Framework which would be covered by Stephanie Holt in the next Agenda item.

7.2 Mark Lemon mentioned Local Digital Road Maps and asked whether there was any role for the Local Boards to sign them off. The Chairman said this was his understanding and this would form part of the Local Board's agendas.

8. Growth and Infrastructure Framework

8.1 Stephanie Holt – Head of Countryside, Leisure & Sport, KCC, introduced the paper and gave a presentation which provided an overview of the recently launched Kent and Medway Growth and Infrastructure Framework (GIF), and the associated action plan. She advised that the GIF had been developed to provide a clear picture of housing and economic growth to 2031, the infrastructure needed to support that growth and the infrastructure funding gap for Kent and Medway. One of its key elements was the evidence base on the provision of healthcare and social care capacity across the area, both at the current time and that which would be required to support the planned housing growth to 2031. The GIF would help shape discussions about the future shape of health and social care service delivery. The initial GIF had been well received by National Government but it had been necessary to produce it quite quickly and there was now a need to further analyse the local data that had been produced, some of which was already out of date, and

discuss priorities with local partners such as this Board. The document remained live and Officers were working towards a complete refresh using updated data by January 2017. She concluded by saying that the following issues needed further consideration: -

- What other data sources would be useful in terms of pulling together the chapters on health, community/social care and Ashford itself?
- Who else should they be linking with to develop the GIF?
- What outcomes would the Board like to see that would be useful for everyone involved?

8.2 Mark Lemon said it was also important to understand what the GIF was showing in terms of the infrastructure funding gap and what that was likely to do to health inequalities. Stephanie Holt said that an action plan would need to be developed across each area to deal with this as there was obviously only so much funding to go around.

8.3 In response to a question about the definition of funding Stephanie Holt advised that 'expected funding' was where there had been a commitment to funding whereas 'secure funding' was that which had already been received.

8.4 In terms of other groups that KCC should be linking with in order to develop the GIF the following were suggested: - the Clinical Commissioning Group Strategy Board; Ashford Borough Council's Strategic Planners; NHS England; the local Health Infrastructure Groups; local Police, local Fire and local Community Safety Units. The Chairman also agreed to send the Ashford Health Estates Paper through to Stephanie Holt.

8.5 Martin Harvey said that the potential funding gap in terms of Adult Social Care was alarming and although this may be adjusted by the Autumn Budget Statement, it was still an area to be cognisant of.

Resolved:

That (i) the contents and conclusions of the first GIF and its associated action plan be noted.

(ii) the Board agree to help shape the future of the GIF, along with the Health Infrastructure Group, by assisting in the contribution of robust and timely data and analysis to the next refresh.

(iii) the GIF be used to help shape discussions about the future shape of health and social care service delivery.

9. Partner Updates

9.1 Included with the Agenda were A4 templates submitted by Partners:-

(a) Clinical Commissioning Group (CCG)

Lisa Barclay asked for feedback on the CCG's Sustainability and Transformation Plan which had been sent around and could be sent

again on request. This would be an agenda item for the next Board meeting in March.

Martin Harvey drew attention to the forthcoming Patient and Public Engagement (PPE) Strategic Engagement Day on Wednesday 30th March at the Singleton Environment Centre. All were welcome.

(b) Kent County Council (Social Services)

A question was raised regarding the focus on the Care homes contract and whether this was a review of the specification. It was agreed to seek clarification from Paula Parker.

(c) Kent County Council (Public Health)

No update.

(d) Ashford Borough Council

Sheila Davison advised that John Bunnett would be leaving his post in February and Tracey Kerly would be taking over as Interim Chief Executive of Ashford Borough Council and would continue to attend meetings of this Board. The Board noted its best wishes for the future to John.

The Syrian Vulnerable Persons Re-location Scheme was underway and the first three families had arrived in the Borough in December. Homes had been identified and extensive liaison had taken place with KCC, the CCG and the Police. An intensive programme of support was in place. Officers had indicated that the early signs were positive and the families had settled well. The Board agreed that it would be useful to get an update on the scheme at their July 2016 meeting.

Councillor Bradford advised that Farrow Court was now formally open and phase 1 of the scheme was complete with all current residents having moved in to their new accommodation. He said that he had been amazed by the facilities there and the whole project was a credit to Ashford and the Council. It was suggested that a future Ashford Health & Wellbeing Board meeting could be held there.

(e) Voluntary Sector Representative

Update noted.

Michael James advised that they were looking to appoint a permanent successor to Tracey Dighton as Voluntary Sector Representative on the Board and that would be in place for the next meeting in March.

(f) HealthWatch Kent

No update.

(g) Ashford Local Children's Partnership Group

Update noted

10. Forward Plan

10.1 The Chairman advised that the focus of the next meeting in March would be mental health. It would also include an update on the CCG's Sustainability and Transformation Plan from Neil Fisher, a follow up report on priority setting from Faiza Khan and any update on the LGA development work.

10.2 As previously mentioned the July meeting would receive an update from Ashford Borough Council on the Syrian Vulnerable Persons Re-location Scheme.

11. Dates of Future Meetings

11.1 The next meeting would be held on the 23rd March 2016.

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

20th July 2016
19th October 2016

(DS)
MINS: AHWBB Minutes 20-01-16

Ashford Health and Wellbeing Board Priorities

1. BACKGROUND

A list of indicators was presented to the Ashford Health and Wellbeing Board (AHWB) meeting on 20th January against which Ashford was performing significantly worse or worse as compared to the comparator CCGs, South East region, and England. Following this meeting these indicators were discussed at the Lead Officer Group where the following two priorities were agreed to be put forward for approval by the Board.

- Smoking
- Obesity (Adults and Children)

The three main principles underpinning these priorities will be:

- Reduction in health inequalities
- Early diagnosis
- Early help and co-design.

Mental health is now the commonest single cause of disability adjusted life years lost in the Western world ,23% compared to 16% each for cardiovascular disease and cancer. It affects 18% of working age adults at any one point in time and over a third of adults during the course of a year. Mental health is responsible for more sickness absence than any other illness. Mental health problems represent the largest single cost to the NHS (11% of current spending). Most mental, emotional or psychological problems, which fall short of diagnosable mental illness, together account for more disability than all physical health problems put together. In addition mental illness is an important cause of social inequality, violence and unemployment as well as a consequence. Amongst the main causes of death for people with a mental health condition are cardiovascular disease, cancer and pulmonary disease. Those affected by these conditions die 20 years earlier than a person with no mental illness on average.

A review of the mental health data for Ashford has shown that it is not significantly different to its comparator areas therefore mental health doesn't merit becoming a priority. Work is being done in the mental health subgroup of the LCPG Local Childrens Partnership Group and in the CCG which will address this area of need.

2. PRIORITY 1: SMOKING

2.1 Reasons for selecting smoking as a priority

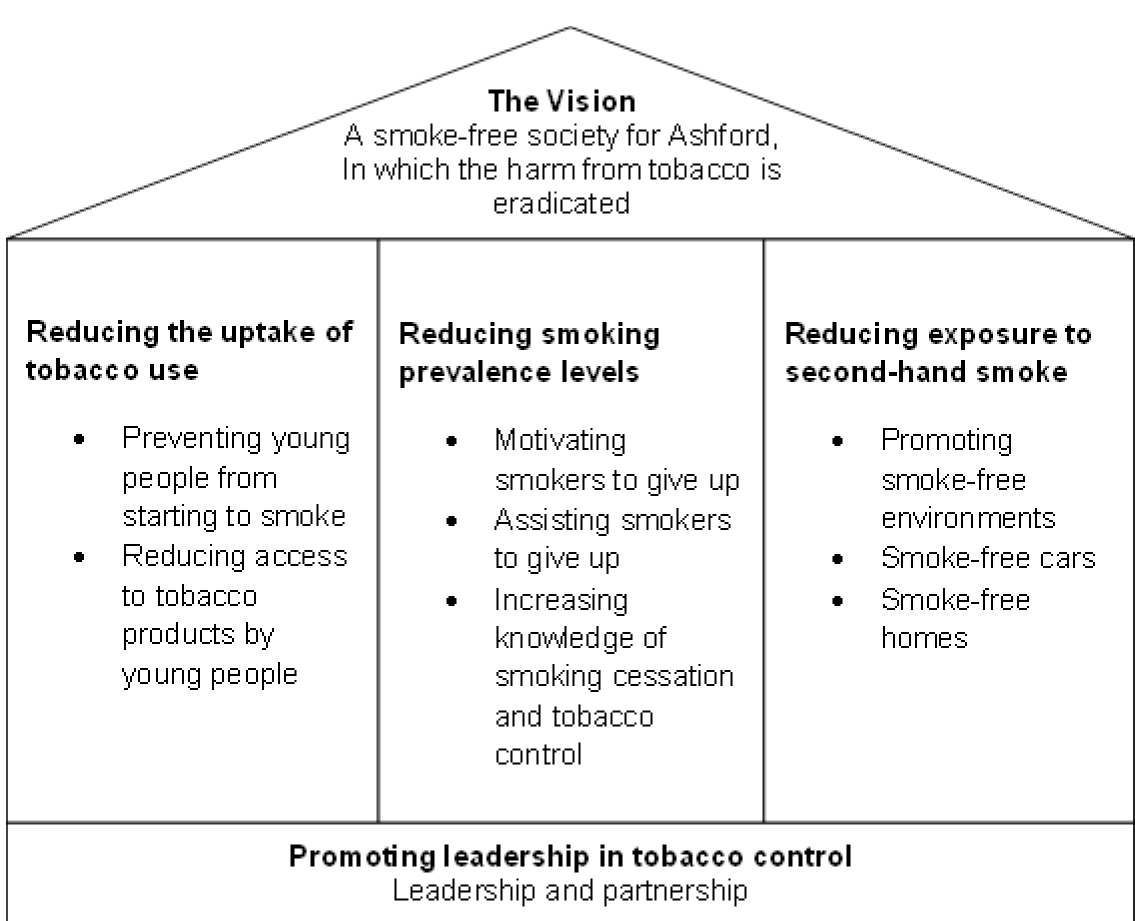
Smoking is still the leading cause of preventable death and disease in the UK, responsible for more deaths than obesity, alcohol, drugs and HIV combined (ASH 2013). About half of long term smokers will die prematurely losing, on average, about 10 years of life. In Ashford, there were 480 estimated deaths attributable to smoking per 100,000 population aged 35+ between 2011 and 2013 (Tobacco Control Profiles 2014).

In 2014 smoking prevalence reduced to 19% in Kent in line with, but slightly above, the national rate of 18.4%. The smoking prevalence in Ashford amongst persons aged 18 years and over is 26.4% and amongst the routine and manual workers it is 42.1%. Prevalence of smoking among persons aged 18 years and over who have never smoked is 38.9%. All of these indicators are significantly worse when compared to the South East Region and England. Smoking in Kent costs the local economy 391.4 m per year equating to £ 1,736 per smoker. Appendix 1.

2.2 Targets for next three years

The proposed target for smoking is a reduction of 2% in the next three years for prevalence of smoking amongst 18 years and over, routine and manual workers and an increase of 2% in the proportion of adults who have never smoked.

2.3 To achieve these targets the action plan for Ashford can be based on four strategic action areas:



Promoting Leadership in Tobacco Control

Leadership is necessary at all levels to drive forward change and reduce smoking prevalence levels. Reducing smoking prevalence rates requires a co-ordinated multi-agency, multi-sector partnership approach with clear outcomes to which members of the Ashford Health and Wellbeing Board are held accountable. Responsibility for tobacco control needs to be joined up and cross-boundary.

Reducing the uptake of smoking

- Preventing young people from starting to smoke
- Reducing access to tobacco products by young people

Reducing smoking prevalence levels

- Motivating smokers to give up
- Assisting smokers to give up using nicotine replacement therapy including E-cigarettes
- Target priority groups
- Enhance the role of primary and community care
- Smoking cessation in secondary care
- Workplace initiatives
- Increasing knowledge of smoking cessation and tobacco control through campaigns

Reducing exposure to second-hand smoke

- Promoting smoke-free environments
- Smoke-free cars
- Smoke-free homes

3. PRIORITY 2: OBESITY

Obesity is a significant problem in today's society and is predicted to worsen if nothing is done. It is linked to a range of health problems which both reduce individuals' life expectancy and quality of life. The Foresight report identified that the number of people that are obese in the UK had more than doubled in 25 years. The report predicted that by 2050, 60% of men, 50% of women and 25% of children in the UK could be obese, causing Britain to be a mainly obese society with factors such as income, gender and ethnicity increasing the impact of obesity in certain population groups. Britain is now the most obese nation in Europe. The majority of the adult population and 30% of children are either overweight or obese. The huge and rapid increase in the numbers of children and adults who are classified as obese has led to the use of the term "obesity epidemic" which has resulted in national policies, strategies and directives to address obesity that require the input of a wide range of agencies working with their communities.

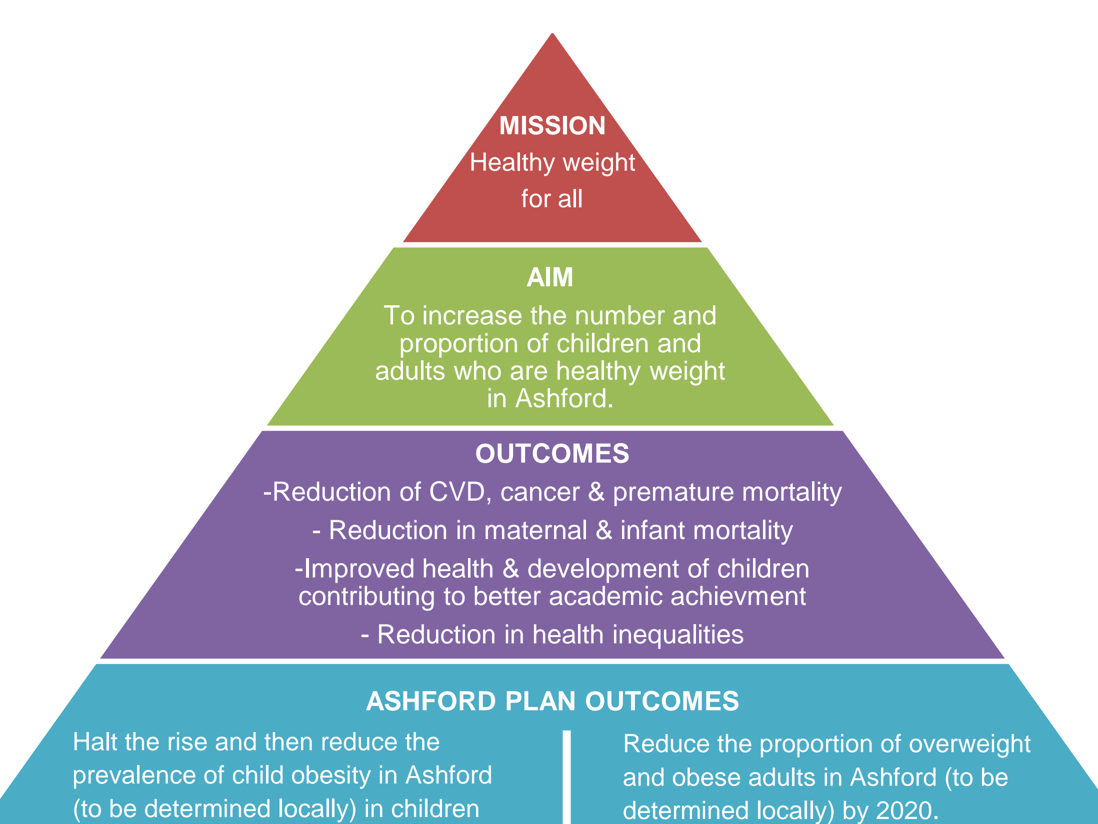
It is well documented that people who are overweight and obese increase the risk of a range of diseases that can have a significant health impact on individuals. Obesity is associated with type 2 diabetes and hypertension - which are major risk factors for cardiovascular disease and cardiovascular related mortality. Obesity has also been associated with cancer, disability and reduced quality of life, and can lead to premature death. Most importantly, there appears to be a link between obesity and level of deprivation.

The prevalence of adult obesity in Ashford is 67.5% as compared to 63.4% for the South East region and 64.6% for England. Rates are highest in Beaver, Stanhope, Norman and Aylesford Green wards. Appendix 2.

3.1 Targets for obesity

The national recommendation is that all areas should show a down ward trend in the prevalence of obesity and it will be reasonable for Ashford to also to aim for this.

3.2 Ashford Mission for obesity



3.3 Role of different organisations in taking forward the obesity action plan (NICE guidance)

Local Authorities	providing facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways) considering in particular people who require tailored information and support, especially inactive, vulnerable groups.
Early years	Nurseries and other childcare facilities should minimise sedentary

settings	activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions implement Department for Education and Skills, Food Standards Agency and Caroline Walker Trust guidance on food procurement and healthy catering.
Schools	Head teachers and chairs of governors, in collaboration with parents and pupils, should assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools.
Workplaces	Workplaces should provide opportunities for staff to eat a healthy diet and be physically active, through active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with existing Food Standards Agency guidance working practices and policies, such as active travel policies for staff and visitors a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking recreational opportunities, such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities.
Self-help, commercial and community settings	Primary care organisations and local authorities should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes only if they follow best practice
Health Visitors	Health professionals should discuss weight, diet and activity with people at times when weight gain is more likely, such as during and after pregnancy, the menopause and while stopping smoking.

Dr Faiza Khan
Consultant in Public Health
Kent County Council, March 2016

Appendix 1, Tobacco statistics for Ashford

Definition	Period	Count	Ashford	South East Region	England	South East Worst	South East Best
Smoking prevalence amongst persons aged 18 years and over	2014	-	26.4%	16.1 %	18.0%	29.8%	6.1%
Prevalence of smoking amongst persons aged 18 years and over in the routine and manual group	2014	-	42.1%	26.4 %	28.0%	45.3%	6.2%
Estimated deaths attributable to smoking per 100,000 population aged 35+	2011-2013	480	241.8	245.6	279.7	458.5	163.5
Directly standardised rates of smoking attributable admissions in people aged 35 +	2014/15	846	1211	1301	1671	2835	812
Index of multiple deprivation score (IMD 2010)	2010	-	15.3	-	21.7	4.5	43.4
Prevalence of smoking among persons aged 18 years and over	2014	-	26.45%	16.6 %	18.0%	29.8%	6.1%
Prevalence of smoking among persons aged 18 years and over- ex-smokers	2014	-	34.7%	36.8 %	33.9%	53.5%	14.4%
Prevalence of smoking among persons aged 18 years and over- never smoked	2014	-	38.9%	46.6 %	48.1%	32.2%	68.3%
Prevalence of smoking among persons aged 18 years and over-	2014	-	20.6%	34.9 %	30.8%	69.8%	11.6%

ex-smokers in routine and manual occupations							
Prevalence of smoking among persons aged 18 years and over in routine and manual occupations – never smoked	2014	-	37.4%	38.7 %	41.2%	13.5%	68.3%
Smoking prevalence in adults- current smokers (QOF)	2014/ 2015	18,338	18.6%	-	18.6%	27.2%	11.7%
Smoking prevalence modelled estimates – regular smokers aged 11-15 years	2009-12	201	3.3%	-	3.1%	4.8%	1.1%
Smoking prevalence modelled estimated- occasional smokers aged 11-15 years	2009-12	103	1.7%	-	1.4%	2.1%	0.5%
Smoking prevalence modelled estimates- regular smokers aged 15 years	2009-12	123	9.1%	-	8.7%	13.0%	3.2%
Smoking prevalence modelled estimates- occasional smokers aged 15 years	2009-12	62	4.6%	-	3.9%	5.5%	1.4%
Smoking prevalence modelled estimates- regular smokers aged 16-17 years	2009-12	466	15.4%	-	14.7%	21.2%	5.7%
Smoking prevalence	2009-12	204	6.8%	-	5.8%	8.1%	2.2%

modelled estimates- occasional smokers aged 16-17							
Estimated deaths attributable to smoking per 100,00 population, aged 35+	2011-13	480	241.8	245.6	279.7	458.5	163.5
Age-standardised rate of mortality from lung cancer per 100,000 population	2012-14	179	52.4	49.8	59.5	107.7	29.8
Age-standardised rate of mortality from chronic obstructive pulmonary disease per 100,000 population	2012-14	148	43.5	44.6	51.7	103.6	23.5
Smoking attributable deaths from heart disease	2012-14	51	24.6	24.2	29.7	58.1	16.1
Smoking attributable deaths from stroke	2012-14	-	-	7.7	9.3	-	-
Premature live births (gestational age less than 37 weeks) and still births per 1,000 live births and stillbirths	2010-12	-	-	-	-	-	-
Directly standardised rate of Smoking Attributable Admissions in people aged 35 and over	2014/15	846	1,211	1,301	1,671	2,835	812
Cost per capita of smoking attributable hospital admissions	2011/12	2,393, 198	35.0	33.2	38.0	59.3	23.0
Age-standardised registration rate for lung cancer per	2010-12	214	67.0	67.0	76.0	146.8	40.1

100,000 population							
Age-standardised rate for oral cancer registrations per 100,000 populations	2010-12	31	9.4	9.4	13.2	21.6	6.4
Fatalities from accidental fires ignited by smoking materials and cigarette lighters	2013/14	-	-	-	72	-	-
Accidental fires ignited by smoking related materials	2013/14	-	-	-	3,300	-	-

Appendix 2, Obesity statistics for Ashford

Definition	Period	Count	Ashford	South East Region	England	South East Worst	South East Best
% of adults classified as overweight and obese	2012-14	-	67.5%	63.4%	64.6%	74.8%	46.0%
% children aged 4-5 classified as overweight or obese	2014-15	334	23.6%	20.3%	21.9%	30.7%	14.9%
% children aged 10-11 classified as overweight or obese	2014-15	447	34.0%	30.1%	33.2%	43.2%	21.1%

Appendix 3, List of indicators for which Ashford is significantly worse as compared to South East region and England.

Definition	**Ashford Value**
Rate of people reported killed or seriously injured on the roads , all ages, per 100,000 resident population.	50 per 100,000
Homelessness acceptance per 1000 households.	3.3 per 1000 households
Crude rate of violence against the person, offences per 1000 population.	13.2 per 1000
Rate of Chlamydia detection per 100,000 young people aged 15-24 yrs.	rate 1,368 per 100,000
Late diagnosis of HIV	50%
Cardio Vascular Disease: Hypertensive patients who were given lifestyle advice in the last 12 months.	68.3%
Smoking: Smokers aged 15+ with a record of an offer of support and treatment in the last 24 months.	80.8%
NHS Health Check: Cumulative percentage of eligible population aged 40-74 offered an NHS Health check who received an NHS health check.	34.7%
COPD patients with MRC dyspnoea score >=3 w oxygen saturation value (last 12 months)	88.7%
Breastfeeding initiation: percentage of mothers who breastfeed in the first forty eight hours of delivery.	71.3%
Obesity: Percentage of adults classified as obese or overweight.	67.5%
Smoking: Prevalence of smoking amongst people aged 18+.	26.4%
Smoking: Prevalence of smoking amongst people aged 18+ from the routine and manual groups.	42.1%
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	
Ashford CCG has a high prevalence of stroke and transient ischaemic attack and atrial fibrillation .	
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.	124.1 per 1000
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	
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	
Spend on vision, neurology, infectious diseases, skin, poisoning and endocrine adverse effects	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions	
% of alcohol users treated who did not re-present within 6 months	
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	
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	

East Kent Mental Health Commissioning Team

Five Year Mental Health Strategy for East Kent

Ashford Clinical Commissioning Group

Canterbury and Coastal Clinical Commissioning Group

South Kent Coast Clinical Commissioning Group

Thanet Clinical Commissioning Group

East Kent Mental Health Commissioning Team

The East Kent Mental Health Commissioning Team is based in South Kent Coast CCG office but covers all of east Kent and has been established to:

- Provide leadership and delivery of the East Kent CCG wide mental health strategy
- Provide leadership for East Kent CCG on Kent wide service developments
- Support development of local CCG Mental Health strategies

Aims to work closely with

- CCG Mental Health Leads in East Kent
- GPs
- Mental health commissioners in the rest of Kent
- Kent County Council Social Care
- Public Health
- Kent Police
- NHS England
- District Councils
- Third sector providers

Mental Health Facts

- Between 8 and 12 per cent of the adult population experience depression in any one year
- Among people under 65 nearly half of all illness is mental illness
- Mental illness is far easier to treat before it becomes entrenched. Yet only a quarter of all those with a mental illness such as depression are receiving any treatment
- Poor physical health and poor mental health often go hand in hand

Mental Health Facts Continued:

The adult population of east Kent is 642,000 and at any one time;

- 92,946 (14 %) will have a common mental health problem such as anxiety and depression
- 34,632 (5%) will have longer term and more complex mental health problems
- 45,454 (7%) will have mental health problems associated with their physical health needs
- This equates to 26% of the east Kent population being affected by mental health problem at any one time

Figures from the Kent Public Health Observatory Joint Strategic Needs Assessment 2014

Canterbury and Coastal
Clinical Commissioning Group

South Kent Coast
Clinical Commissioning Group

Thanet Clinical Commissioning Group

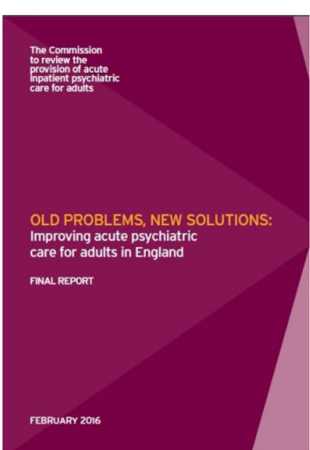
Five Year Mental Health Strategy

- Sets out the four east Kent Clinical Commissioning Groups (CCG's) priorities for improving the Mental Health outcomes for the adult population of east Kent in the next five years
- Informed by;

  'Five Year Forward View for Mental Health' by the Mental Health Taskforce & 'Old Problems, New Solutions' by the Royal College of Psychiatrists

  both published in February 2016

THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH



NHS
Ashford Clinical Commissioning Group

Canterbury and Coastal Clinical Commissioning Group

NHS
South Kent Coast Clinical Commissioning Group

Thanet Clinical Commissioning Group

What We Are Trying To Achieve:

1. Early intervention and prevention
2. 24/7 access to good mental health services including mental health liaison services in acute hospitals
3. An integrated approach to mental and physical health
4. The promotion of good mental health and preventing poor mental health at key moments in someone's life

Ashford Clinical Commissioning Group

Canterbury and Coastal
Clinical Commissioning Group

South Kent Coast
Clinical Commissioning Group

Thanet Clinical Commissioning Group

Priority Areas for Change 1

- Community Services:
  - Community Mental Health Teams: Review and redesign
  - Early Intervention services: Delivering on access and treatment targets and developing all age plan
  - Rehabilitation Services: Review services ensuring best use
  - Increase mental health provision in primary care
  - Better coordinated working in relation to co-morbid mental health and drug / alcohol issues
  - Increase in IAPT (NHS Talking Therapy) access and recovery rates

Priority Areas for Change 2

- Acute and Crisis Care:
  - Reduce numbers of adults who are admitted to ‘out of area’ beds
  - Reduce Delayed Transfers of Care
  - Review and redesign Psychiatric Intensive Care beds
  - Service review of Crisis Home Resolution Teams
  - Reduce section 136’s by Police by working with the Crisis Concordat
  - Review and redesign liaison psychiatry in acute hospitals to provide 24 / 7 access to urgent care

Priority Areas for Change 3

- Specialist Services:
  - Perinatal mental health services: Develop strategy for implementation in east Kent
  - Personality Disorders: Improved provision of care and outcomes
  - Eating Disorders: Implement Kent wide strategy in east Kent
  - Review other Specialist services: includes Neuro-psychology, Neuro-psychiatry and Chronic Fatigue

Priority Areas for Change 4

- Placements for Specialist Treatment
  - Review placements and monitoring arrangements of out of area beds
  - Review appropriateness of placements
  - Repatriation of people as soon as possible
- User and Carer Engagement
  - Communication Engagement and Co production Strategy implemented to ensure meaningful inclusion with those who are affected by services in our decision making

Priority Areas for Change 5

- Physical Health and Mental Health
  - Reduction of health inequalities for people with mental health issues with physical health checks
  - Delivery of integrated physical and mental health for people with long term mental health issues and the mental health needs of people with long term physical health issues
- Transition
  - Working closely with East Kent Childrens and Young Persons Service to implement the Kent transformation plan and to develop a 0 – 25 age pathway
- Integration
  - Work with public health, social care, district councils, Kent County Council and other agencies to ensure integrated approach to health and mental health

Priority Areas for Change 6

- Personalisation and Choice
  - Development of agenda across primary and secondary care
- Parity of Esteem
  - To ensure mental health is treated with equal priority to physical health across the whole east Kent health economy
- Best Practice
  - Review ability to deliver full range of NICE evidence based best practice interventions includes;
    - outcomes based approach
    - BAME communities
    - anti stigma

Ashford Clinical Commissioning Group

Canterbury and Coastal
Clinical Commissioning Group

South Kent Coast
Clinical Commissioning Group

Thanet Clinical Commissioning Group

Next Step

- We are running an online survey from 1 April to 31 May 2016 to find out:
  - priorities for Mental Health in east Kent
  - views on the future mental health services
  - asking you to be involved in the coproduction our work in the future

If you want the survey emailed out to you or require a paper copy email: ekmentalhealth.commissioning@nhs.net

Ashford Clinical Commissioning Group

Canterbury and Coastal Clinical Commissioning Group

South Kent Coast Clinical Commissioning Group

Thanet Clinical Commissioning Group

Thank you

any questions?

ekmentalhealth.commissioning@nhs.net

Ashford Clinical Commissioning Group

Canterbury and Coastal Clinical Commissioning Group

South Kent Coast Clinical Commissioning Group

Thanet Clinical Commissioning Group

Ashford Wellbeing Café

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Purpose of this Report

This report has been maintained to chart performance of the service and to provide evidence for further funding and provision.

Background

We ran a successful pilot scheme in Swale from December 2014 through August 2015 which indicated clearly that a need was being addressed. Ashford's Care Commissioning Group approached MMK Mind to pilot the Wellbeing Café service locally and the following gives a picture of how this is developing thus far:

Attendance at the Wellbeing Café

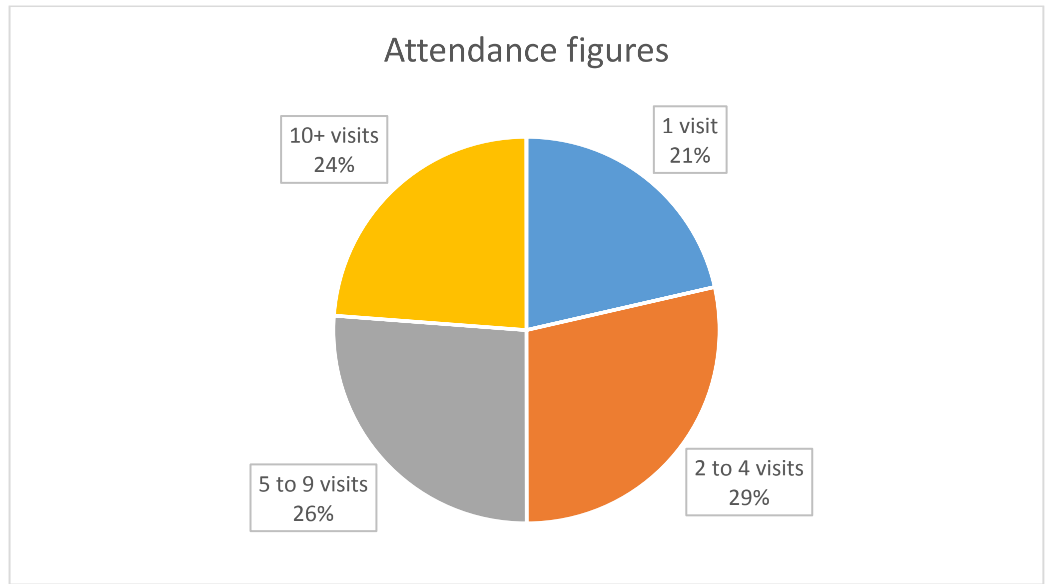
We have supported 42 individuals so far – most attend regularly and we average 4 new service users per week.

These have attended a total of 270 times between them

None have ceased use of the Wellbeing Café altogether

79% have used the Wellbeing Café on multiple occasions

24% have used the Wellbeing Café more than 10 times



Risk Assessment

This was carried out initially and is reviewed on a continuous basis by a qualified risk assessor, please refer to Appendix 1 for details.

Equality Impact Assessment

We have conducted a thorough survey to ensure we are reaching a demographic commiserate with the local populous and to more deeply understand our service user's backgrounds and needs. Please refer to Appendix 2 for details.

Other Options Considered

The choice of venue was made following consideration of the Gateway in the High Street which was dismissed as it would be difficult to implement safeguarding outside of its usual opening times.

After initial discussion with service users Mindful colouring books have come through as the preferred activity although many new suggestions have come through the more recent survey results below which we would like to consider.

Hot food was offered as an option at the outset but lighter snacks were favoured and again the survey suggests that satisfaction with this choice has continued.

Friday and Saturday evenings were chosen as there is evidence this is a large portion of the time that people are most at risk and feel the greatest isolation and only two days were funded initially. Sunday is also a distressing part of the week for individuals who are experiencing difficulty with their mental health and are likely to be isolated. We would like to extend the service through the entirety of the weekend should funding allow, particularly as 100% of surveyed users have asked for Sunday provision.

Consultation

Our acting CEO and manager attended The Patient Representation Group and Ashford MHAG to discuss options such as hours of operation and location with mental health service users and carried out a survey with service users via Ashford specific social media.

More detailed survey was carried out around towards the end of the initial pilot provision. It is note-worthy that our service was evaluated as 100% better than others in the area and that it is felt that there is little else to access, particularly with the imminent closure of the Live it Well Centre.

Results from the last consultation survey carried out with service users at the Wellbeing Café:

100% of service users would like the Wellbeing Café to become permanent

100% of service users would like Sunday delivery, 45% on weekdays, and 36% on weeknights

100% report staff to be polite and helpful, 50% go so far as to say they are amazing

100% report that the facilities are clean and tidy

100% report that refreshments are suitable although a few have stated it would be good to see items to suit particular dietary needs such as diabetes and gluten intolerance

50% feel the location is easy to access, 50% feel it could be better located.

91% have had no issues with staff

In comparison to other mental health support service users have stated the following about our Wellbeing café:

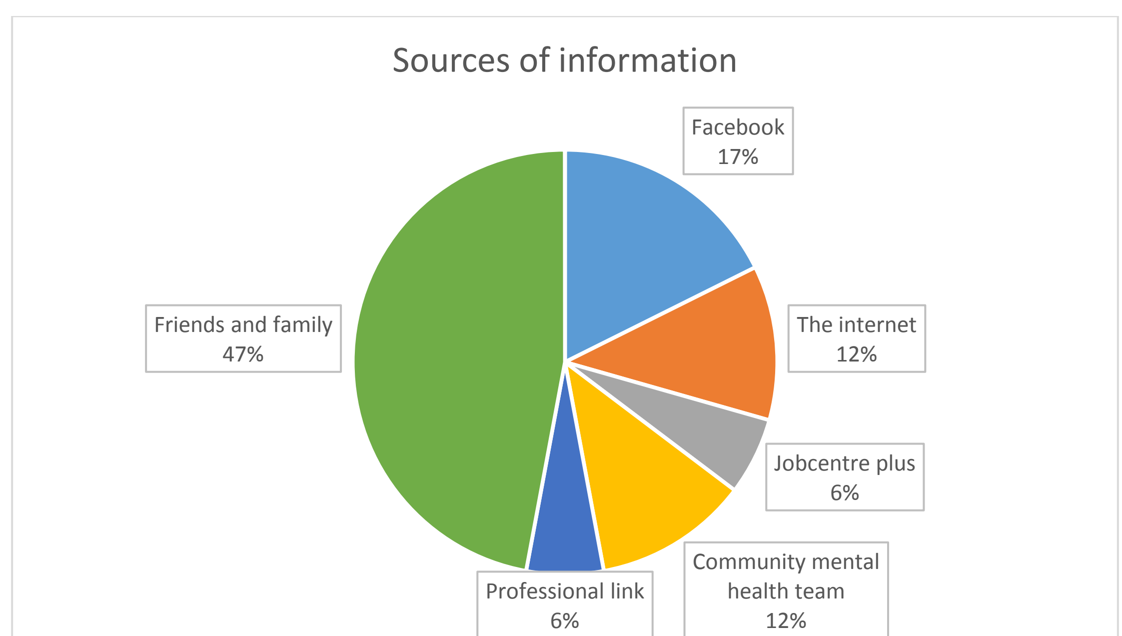
- The crisis team is unhelpful
- Our service works well alongside the main services
- We are more engaged and caring
- 100% better than similar services previously attended

Some reasons given for accessing our service are:

- There is nothing else in Ashford, certainly not evenings and free of charge
- We deliver a good level of mental health support
- The only other option is the crisis team and they are not the best service
- Looking towards the future and recovery
- Advice and socialisation
- Signposting
- Supporting others and receiving support for own issues
- Would otherwise return to being a recluse
- To avoid isolation
- To avoid feeling down and perhaps being in crisis

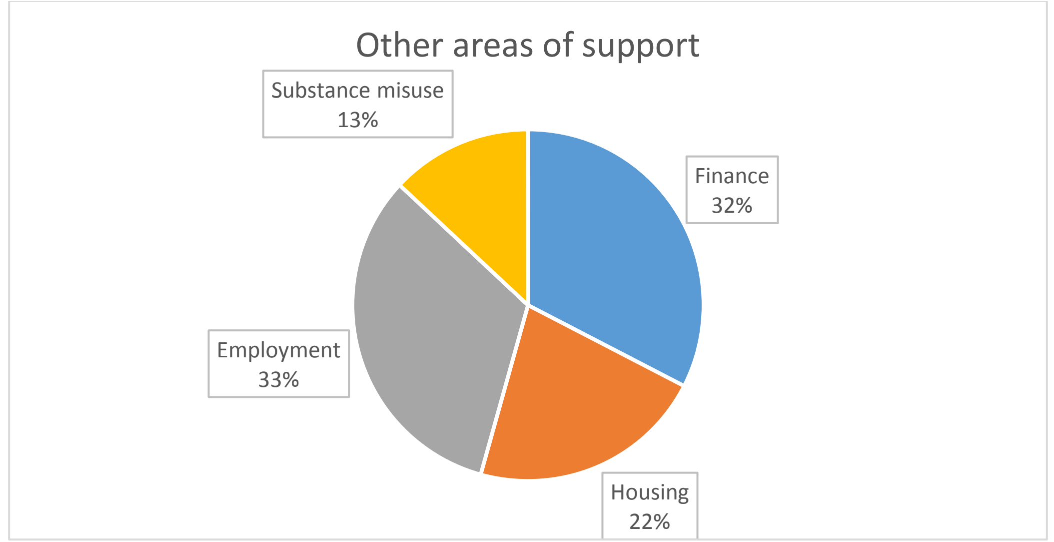
Some suggestions to improve the service are:

- Higher numbers of participants
- More advertising budget and local services being more on-board with spreading the word
- More central location or at least further community policing as there is an issue with loitering youths in the area and smoking just in front of the premise. A few feel it is poorly lit and a little spooky in the area and would prefer to be in the town centre.
- Further staff training including conflict resolution for the odd times these occur.
- Service users have reported the following sources from which they heard of the service:



The service is spreading well through word of mouth indicating that clients feel it would benefit others.

39% of service users have identified other areas that they would like support in



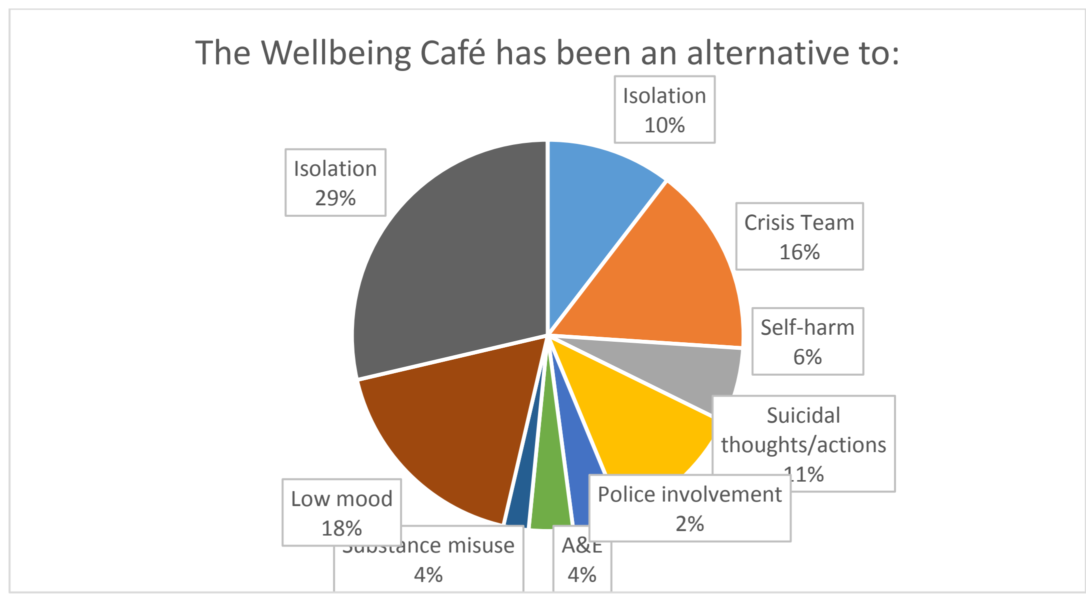
Implications Assessment

Reported impact on Services and those dealing with difficulty in regard to their mental health in the local community

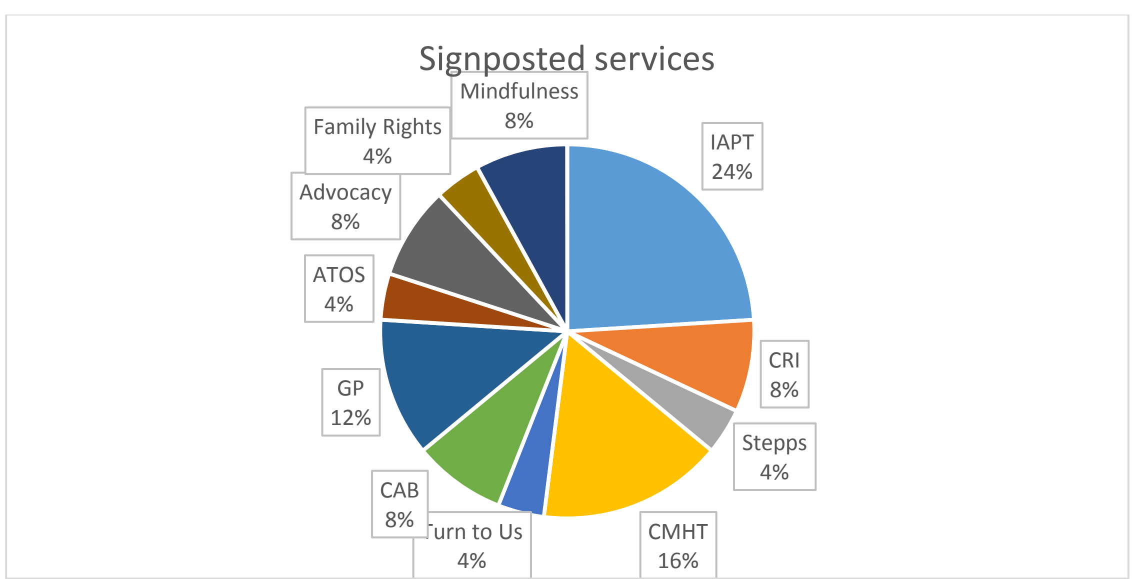
33% of the attendances have been identified as preventing A&E visits, possible hospital admissions, police involvement, or use of the crisis team.

11% of attendances have reported that suicidal thoughts and possible attempts have been averted.

Isolation has been reduced significantly by use of the Wellbeing Café



73% of service users have been signposted to other services



Conclusion

To date the pilot service has seen significant growth in numbers with up to 36 of a current total of 42 individuals over a single weekend. The security that a four year contract would give service users would be significantly salubrious, particularly in light of the imminent closure of the Live it Well Centre. This would also continue to have an exponential knock-on effect of alleviating pressure upon the front line services such as the Crisis Team, A&E, and the Police.

Contacts

Julie Blackmore – Acting CEO julieblackmore@mmkmind.org.uk
James Walker – Operations Manager jameswalker@mmkmind.org.uk
01622 692383

Appendix 1

Risk Assessment – Well-being cafes

Hazard	Who is Affected	What is in place	Risk Level	Additional work required	Responsibility
Slips, Trips and Falls	All staff and service users	• Pulse and well-being cafes have own risk assessments in place	LOW	None	
Fire	All staff and service users	• Pulse and well-being cafes have own risk assessments in place	LOW	None	
Lone Working	Staff working alone	• Lone working policy • No staff will be at café alone • Emergency contact number • Book in and out system	LOW	Ensure minimum two people in café at all times Staff given support number to contact in emergency and notify or arrival and leaving session locations	PO

Hazard	Who is Affected	What is in place	Risk Level	Additional work required	Responsibility
Confidentiality	Service User's details disclosed to other parties	• Private room available • Confidentiality policy • Data protection in place	LOW	Ensure private room available if requested	PO
Service User harm	Service User leaves sessions and harms themselves or someone else	• Project brief followed • CRISIS team contacted if considered high risk • Follow up actions taken by support team • Training provision	LOW / MED	Staff provided clear guidelines on dealing with vulnerable people. Mental health awareness training provided to all staff	PO
Abuse	Staff abused or assaulted	• Lone working policy in place • Never single person on site • Emergency contact number • CRISIS team contact	LOW / MED		PO

<table>
<tr><th>Hazard</th><th>Who is Affected</th><th>What is in place</th><th>Risk Level</th><th>Additional work required</th><th>Responsibility</th></tr>
<tr><td>Safeguarding</td><td>Working with vulnerable people</td><td>• DBS Checks for staff
• Safeguarding training
• Safeguarding Policy</td><td>LOW</td><td>Sessional staff are vetted and approved to have all necessary documentation and completed training.</td><td></td></tr>
<tr><td>Venue</td><td>Venue is inappropriate for use</td><td>• Venue Assessed</td><td>LOW / MED</td><td>Venue have been visited by project management and deemed appropriate.</td><td>PO</td></tr>
<tr><td colspan="2">Date Reviewed</td><td>Signature</td><td colspan="2">Name</td><td>Next Review</td></tr>
<tr><td colspan="2">September 2015</td><td></td><td colspan="2"></td><td>April 2016</td></tr>
</table>

Appendix 2

About our service users at the Wellbeing Café

Gender

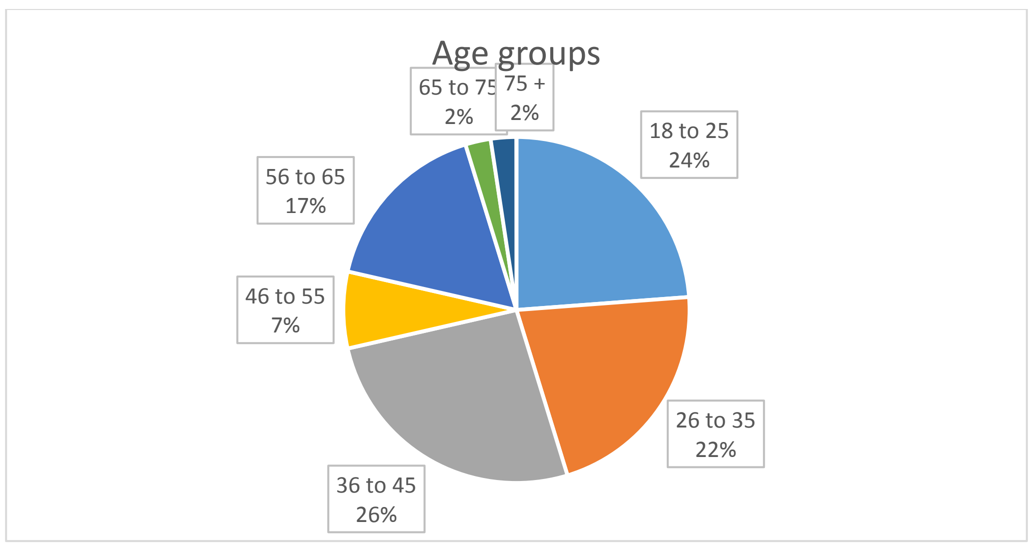
39% are male, 61% are female

Ethnic background

Of those reported 94% are white British and 6% Asian/Asian British – Ashford's population is just under 90% white British

Age

Service users are quite evenly distributed across age groups up to pensionable age.



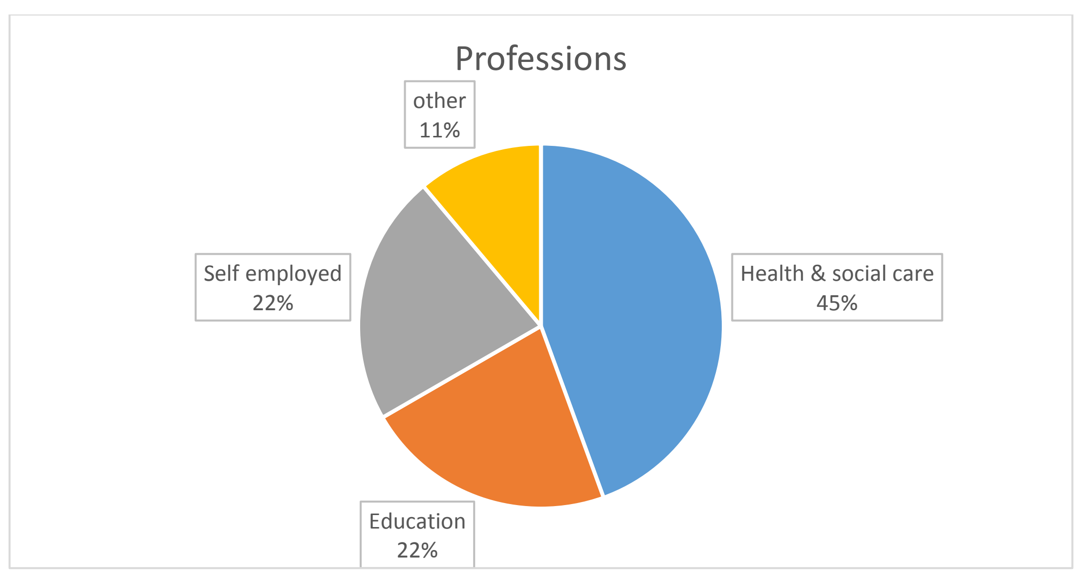
Carers

43% of service users are carers for others

Employment

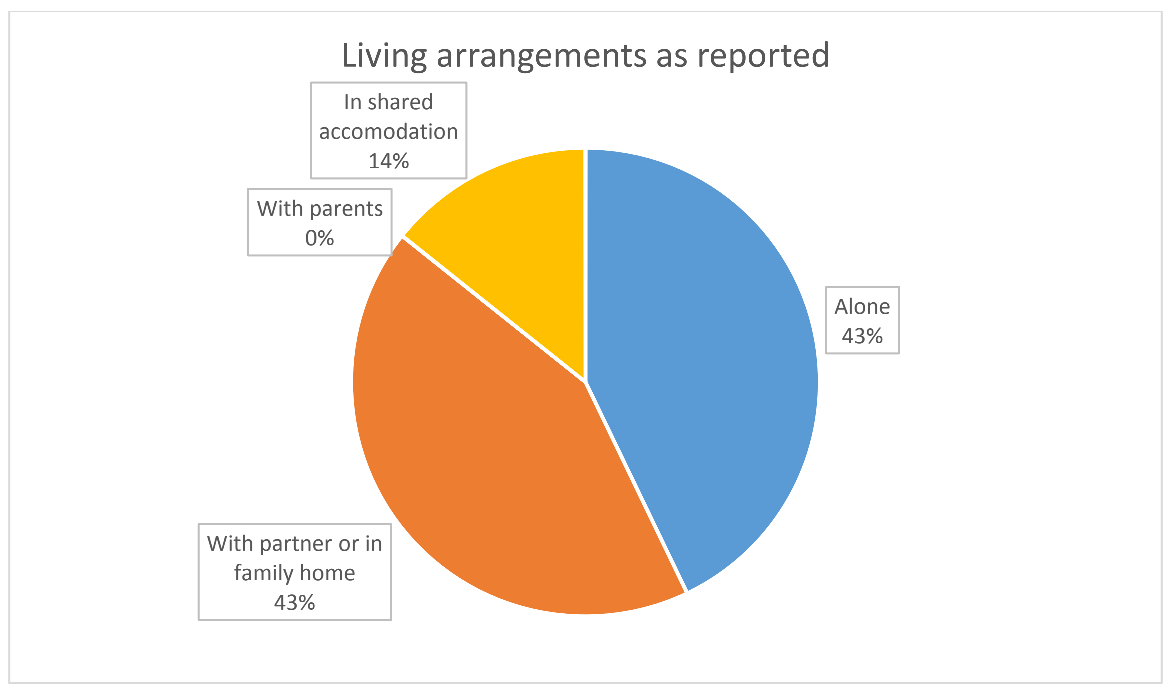
48% are unemployed or voluntary workers, 4% are retired, 9% have not stated

39% are employed with a concentration in health, care, and support work



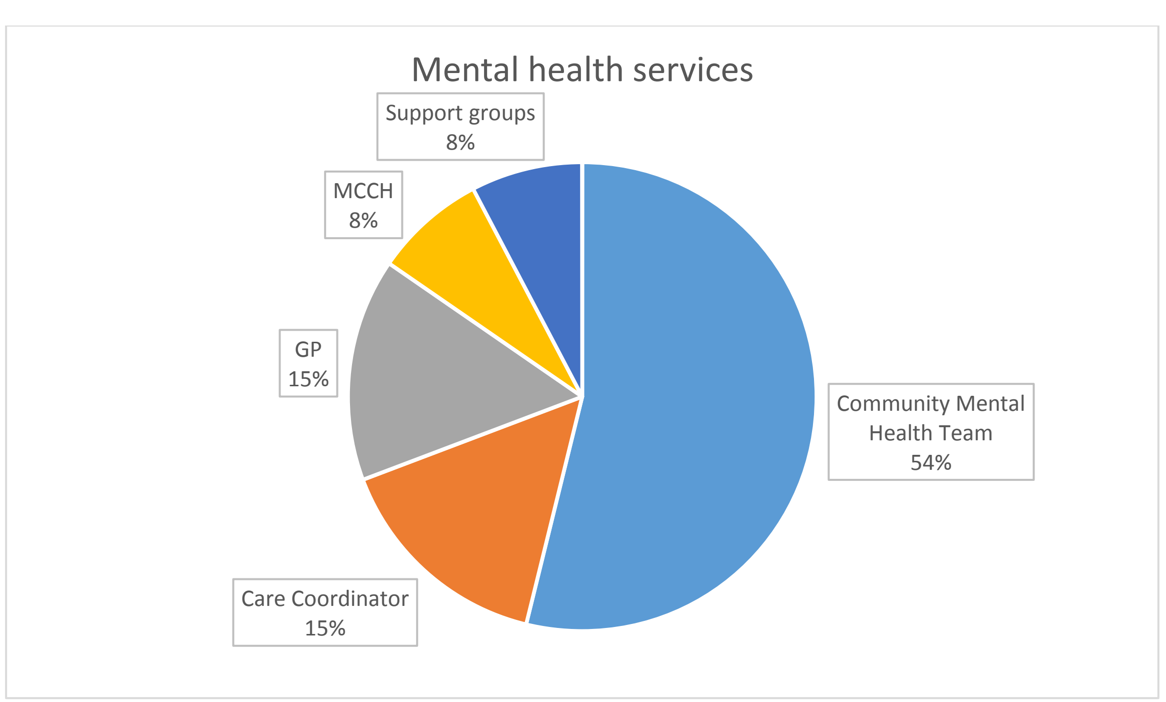
Accommodation

96% are in independent accommodation, 4% in supported living schemes

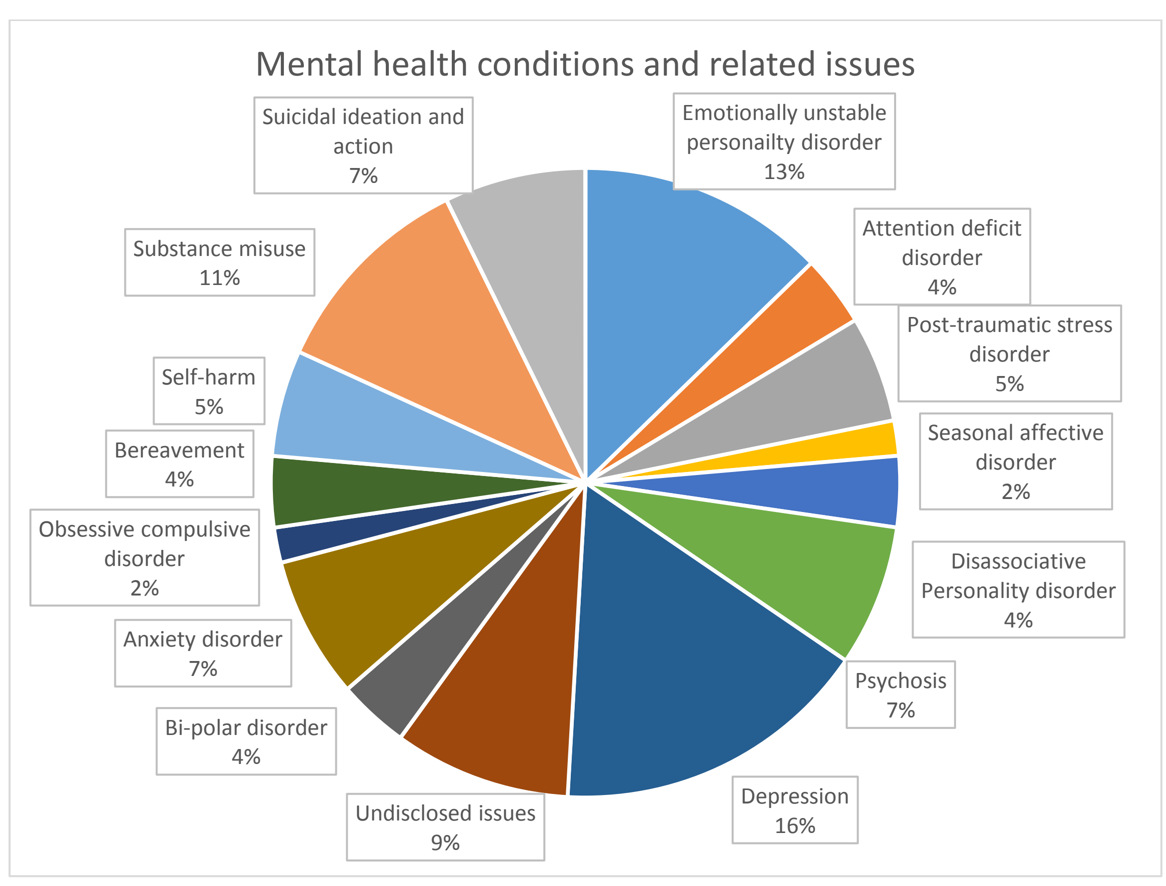


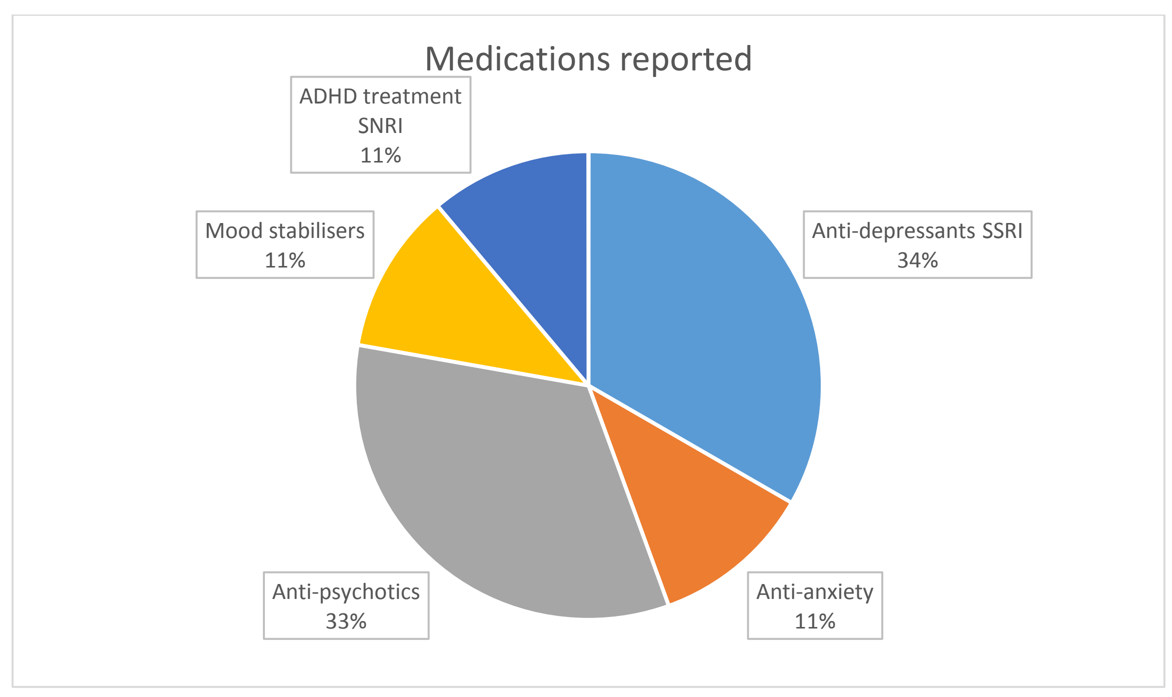
Other mental health services accessed as reported

57% of service users at the Wellbeing Café report using other mental health services.


Mental health services
Support groups 8%
MCCH 8%
GP 15%
Care Coordinator 15%
Community Mental Health Team 54%

Identified mental health and related issues as reported





Ashford Wellbeing Café

Date

Wellbeing worker

Service User

DOB

Address

Telephone and email

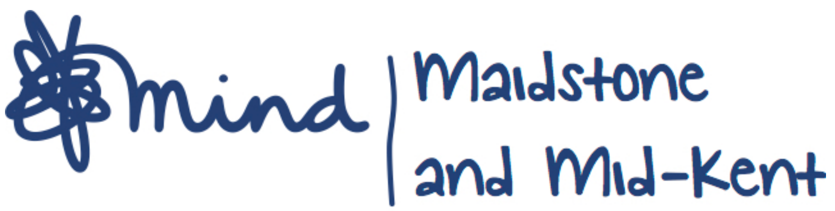
What wellbeing issue did you attend the café for

What would you have done without the cafe

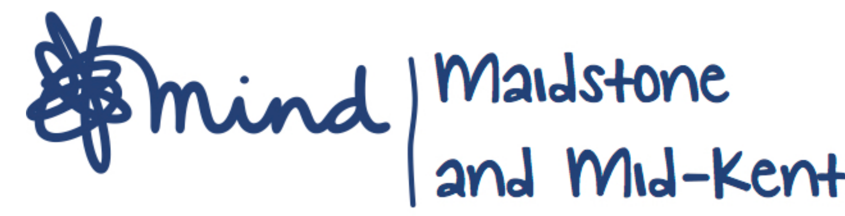
Are you known to the local Community Mental Health Team	YES / NO
Have you ever contacted the Crisis Team	YES / NO
Have you ever attended a local hospital about your mental health	YES / NO
By attending the café have you used these services less	YES / NO
Do you take prescribed medication for you mental health / wellbeing	YES / NO
Have you medication levels reduced since using the café	YES / NO
Has information from the café allowed you to access additional services	YES / NO
Do you feel you are better able to cope since accessing the café	YES / NO
Do you feel that your mental health and wellbeing are improved	YES / NO
Is “House” a good venue for the café	YES / NO
Would you attend the café it moved to a different location	YES / NO

Notes

Further actions required



Ashford wellbeing Café



The purpose of the cafe is to provide out of hours support to people experiencing mental health problems which do not require hospital admission and can be supported by mental health support workers and volunteers.

Attendance at the Ashford Wellbeing Café

We have supported 42 individuals so far – most attend regularly and we average 4 new service users per week.

These have attended a total of 270 times between them

None have ceased use of the Wellbeing Café altogether

79% have used the Wellbeing Café on multiple occasions

24% have used the Wellbeing Café more than 10 times

- **Implications Assessment**
- Reported impact on Services and those dealing with difficulty in regard to their mental health in the local community
- **33% of the attendances have been identified as preventing A&E visits, possible hospital admissions, police involvement, or use of the crisis team.**
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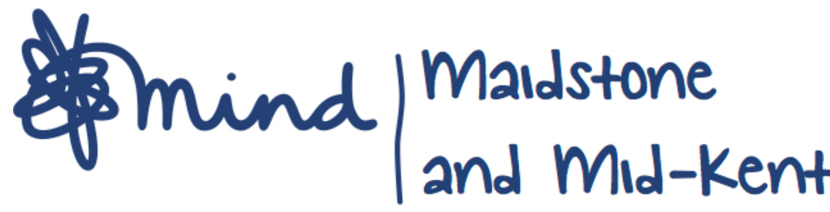
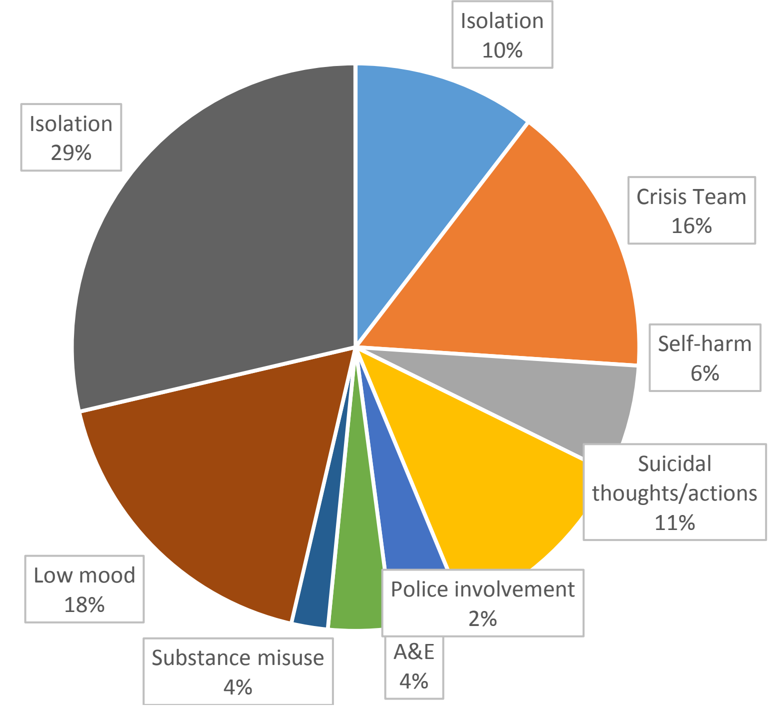
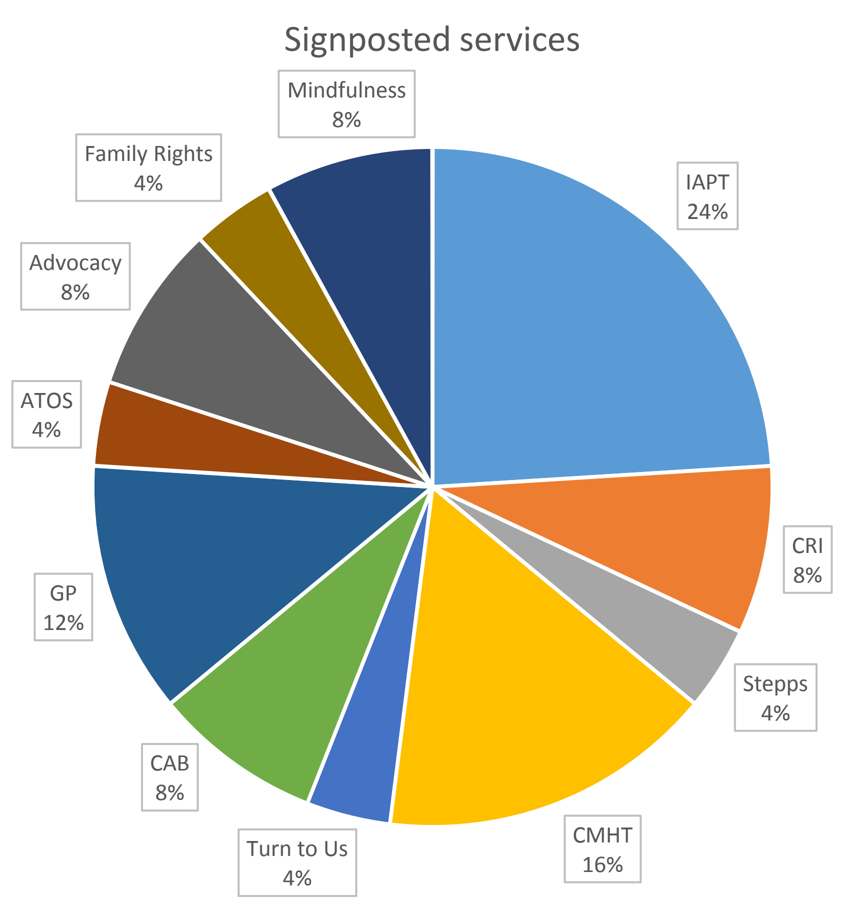
- Isolation has been reduced significantly by use of the Wellbeing Café

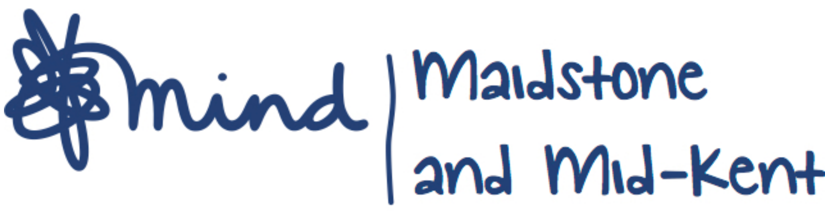


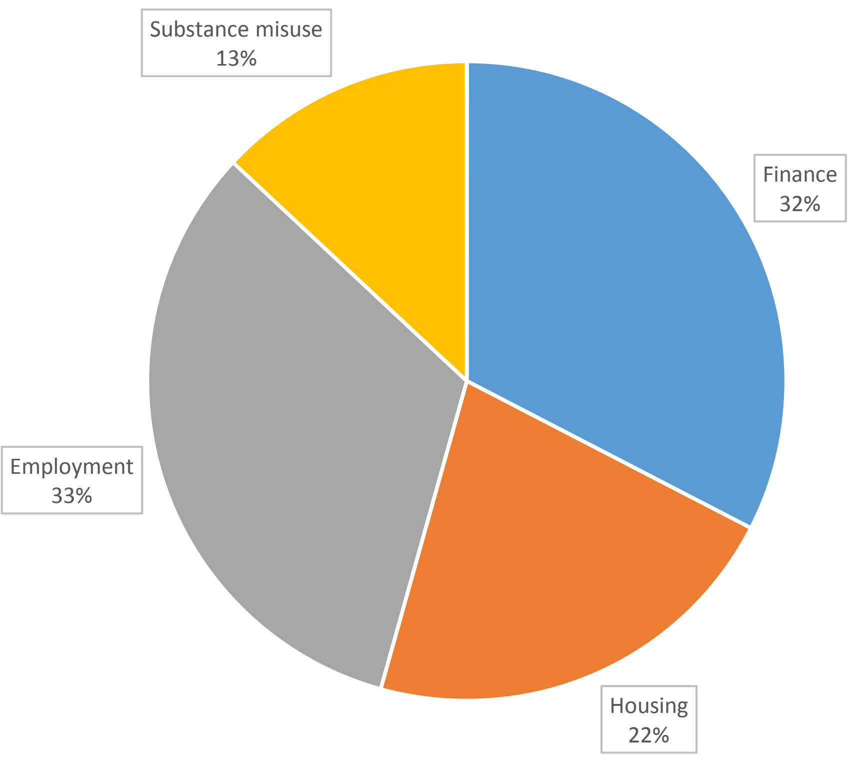


Getting the message across we need your help.

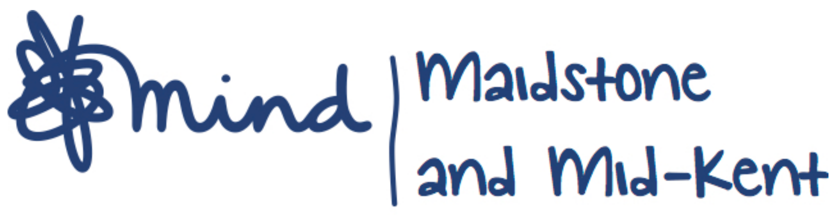


73% of our service users have been signposted to other services





39% of service users have identified other areas that they would like support in.



Conclusion

To date the pilot service has seen significant growth in numbers with up to 36 of a current total of 42 individuals over a single weekend. The security that a four year contract would give service users would be significantly salubrious, particularly in light of the imminent closure of the Live it Well Centre. This would also continue to have an exponential knock-on effect of alleviating pressure upon the front line services such as the Crisis Team, A&E, and the Police.

Agenda Item No:	6
Report To:	**Ashford Health & Wellbeing Board**
Date:	
Report Title:	CCG Annual Operating Plan
Report Author:	Neil Fisher, Head of Strategy and Planning
Organisation:	NHS Ashford CCG

Summary:	At this point annually, the CCG is asked to produce an Annual Operating Plan (AOP) detailing out commissioning intentions for the forthcoming financial year. This document is a work in progress, with the final submission to NHS England due on 4th April 2016. The current draft still requires amendment in line with some of the feedback received from NHS England – most notably relating to the CCG actions to address constitutional standards. Additionally, Better Care Fund guidance was published on 22nd February and has not therefore been taken into account in developing this version of the Plan.

Recommendations:	**The Ashford Health & Wellbeing Board be asked to:-** Formally support current draft and offer direction for updated versions. The final AOP will be shared across our membership, community networks and public meetings and shared with the membership of the HWBB.

Background Papers:	
Contacts:	Neil Fisher neil.fisher@nhs.net

Annual Operating Plan 2016/17

NHS Ashford Clinical Commissioning Group
NHS Canterbury & Coastal Clinical Commissioning Group

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Version 1.5

Context

Political, Economic and Service Pressures

As we enter the third year of CCGs, the NHS faces a number of local and national challenges. Each of these has an impact on how we will commission services, for the residents of both Ashford and Canterbury areas, in the coming years.

- **East Kent Hospitals NHS University Foundation Trust has recently been re-visited by the Care Quality Commission (CQC) and. Whilst the position has improved since the initial visit, their report continues to raise a number of concerns about the quality of local services.**

- **Workforce continues to be a challenge for all NHS organisations across the country, both in terms of increasing demand by also in the reduced numbers of doctors and nurses being trained. Additionally, sub-specialisation puts additional pressure on the training of the consultants of the future.**

- **NHS Constitutional targets, relating to waiting times for surgery, A&E and cancer, continue to drive much of how we commission services, increasing demands offer additional pressure on our ability to achieve these standards.**

- **The 2020 Financial Challenge for the NHS to save £30bn is also felt locally, leading to continuous budget restraints and greater focus on ensuring that we commission the best outcomes but a lower overall cost to the NHS budgets.**

- **The facilities from which local services are delivered are a mix of both old and new. Additionally they are based on historical patterns of need and no longer meet the demands of a modern national health service. We continue to work within these constraints, however this is not sustainable in the longer term.**

- **The expectations of our patients continues to rise. From waiting times, to the localisation of services and the difficulty in access for those patients reliant on public transport. From a greater focus on services in the community, to reduction in the need to travel further afield for specialist services. Each of these, and other expectations, of our local population also drive much of how we commission services.**

All of this leads to an unsustainable pattern of services and service provision. As such across east Kent we are currently working on a five-year Sustainability and Transformation Plan which will show our population how your local NHS intends to address each of these concerns. This document represents the first year of that plan and is based on the foundation we have laid in the first two years of our existence.

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Context

NHS Ashford CCG Health Profile

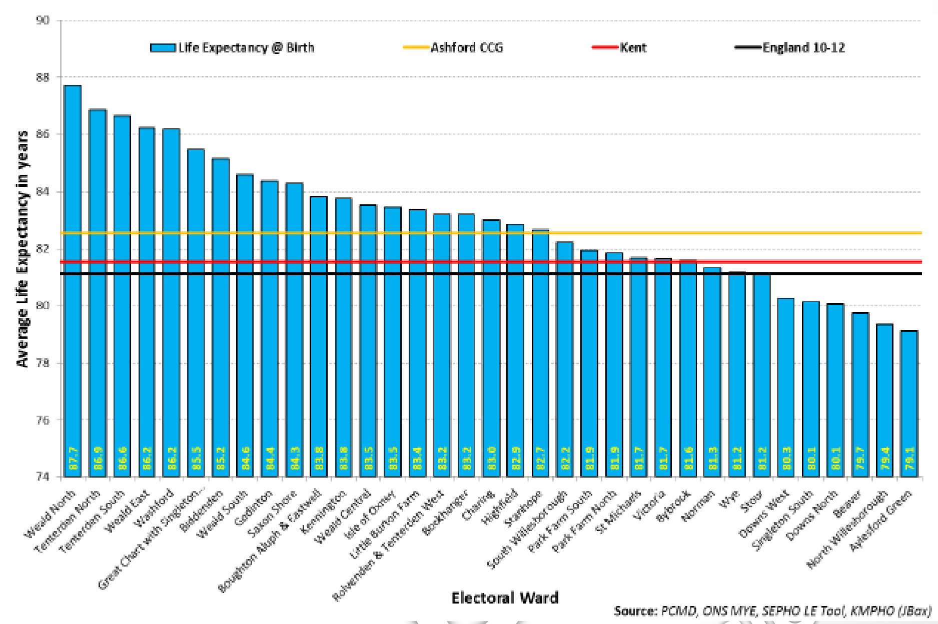
The registered population for NHS Ashford CCG was 126,400 as of 31/12/2014 Overall Ashford broadly presents a similar proportional representation for each age band compared to Kent, however there are a few slight differences between the two with Ashford presenting a higher proportion of 0-14 and 40-49 year old females and 5-19 and 40-54 year old males. Whereas in both genders there is a slightly smaller representation of 20-24s, 55-64s and those aged 70+. The predicted trends for males aged 65+ and 85+ are what you'd expect as they're showing a gradual increase in numbers over the next 24 years which will require innovative service planning for the future in order to cope with the needs and demands of the older population.

The Ashford CCG area has a life expectancy of 82.5 years making it the highest of all the Kent CCGS and significantly higher than the Kent & England averages. The highest life expectancy from birth is in Weald North ward at 87.7 years, there are 25 wards in Ashford CCG with a significantly higher life expectancy compared to Kent and 6 wards are significantly worse than the England average. The ward with the lowest life expectancy is Aylesford Green at 79.1 years; 2.4 years lower than the Kent average.

As the CCG Outcomes Tool, shown on the following page, demonstrates the CCG has made progress against a number of indicators, although needs to reflect on the deterioration against others. In many cases, the CCG compares favourably against the England average, even in those where our performance has not improved.

Significantly, "the years of life lost" indicator has deteriorated for both females and males. We are also pleased to note the significant improvement in access to psychological therapies, which is a reflection of our investment in Mental Health services.

The main concern in these indicators relate to cancer outcomes, this is reflected in the prioritisation we have given to two cancer projects in this years plan.



What have we achieved to date?

NHS Outcomes Tool Highlights – NHS Ashford CCG

Indicator Name	Value	Spine chart (min)	Spine chart (max)
1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare - Female (2014)	1,726	1055	3204
1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare - Male (2014)	1,787	1325	3902
1.2 Under 75 mortality rates from cardiovascular disease (2014)	57.2	35.7	127.2
1.17 Record of stage of cancer at diagnosis (2013)	49.1	38.9	86
1.18 Percentage of cancers detected at stage 1 and 2 (2013)	29.3	21.3	60.6
1.22 Hip fracture: incidence (Jul 2014 - Jun 2015)	524	55	584
2.1 Health-related quality of life for people with long-term conditions (2014/15)	0.77	0.63	0.81
2.2 Proportion of people who are feeling supported to manage their condition (2014/15)	67.2	50.6	75.3
2.10 Access to psychological therapies services by people from Black and Minority Ethnic (BME) groups (2014/15)	847	242	2882
2.11a Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable recovery following completion of treatment (2014/15)	51.0	17.6	64.6
2.11b Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable improvement following completion of treatment (2014/15)	68.9	24.8	76.8
3.1 Emergency admissions for acute conditions that should not usually require hospital admission (Jul 2014 - Jun 2015)	1,251	252	2368
3.2 Emergency readmissions within 30 days of discharge from hospital (2011/12)	12.1	8.9	14.5
3.6 People who have had an acute stroke who receive thrombolysis (2014/15)	20.30	0.8	27.4
3.7 People with stroke who are discharged from hospital with a joint health and social care plan (2014/15)	94.1	1.3	100
3.8 People who have a follow-up assessment between 4 and 8 months after initial admission for stroke (2014/15)	18.90	0	89.6
4.1 Patient experience of GP out-of-hours services (2014/15)	65.2	49	85.3
5.3 Incidence of Healthcare Associated Infection (HCAI) – Methicillin-resistant Staphylococcus aureus (MRSA) (Apr 2013 - Sep 2015)	2.35	0	9.98
5.4 Incidence of Healthcare Associated Infection (HCAI) – C. difficile (Apr 2013 - Sep 2015)	55.6	24	133

In worst quartile In IQ range In best quartile Sig change Non-sig change No change
England Mean Cluster mean

NHS Ashford Clinical Commissioning Group

NHS Canterbury & Coastal Clinical Commissioning Group

Context

NHS Canterbury and Coastal CCG Health Profile

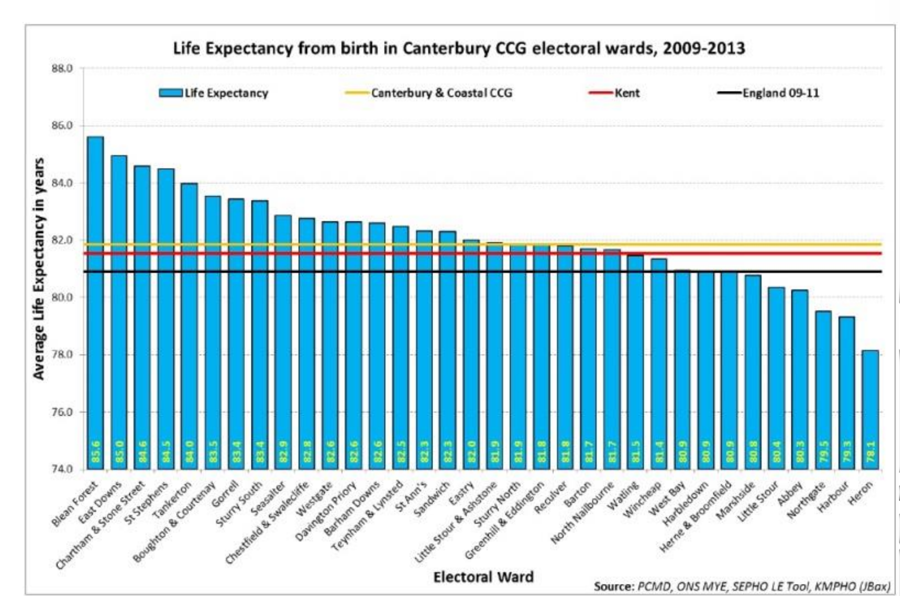
The registered population for Canterbury & Coastal CCG at 31/12/2014 was 215,285 with significant transient student population leading to a much larger percentage of 15-24 year olds compared to the England average. The predicted trends for population aged 65+ and 85+ are showing a gradual increase in numbers over the next 24 years and approximately one quarter of the Canterbury & Coastal CCG population will be aged over 65 by 2037. This will require innovative service planning for the future in order to cope with the needs and demands of the ageing population. We estimate that, based on the current district council local plans there would be an increased population of 33,540 people by 2031.

The Canterbury & Coastal CCG area has a life expectancy of 81.9 years making it higher than the Kent & England averages. The highest life expectancy from birth is in Blean Forest ward at 85.6 years, there are 23 wards in Canterbury & Coastal CCG with a significantly higher life expectancy compared to Kent and 6 wards are significantly worse than the England average.

As the CCG Outcomes Tool, shown on the following page, demonstrates the CCG has made progress against a number of indicators, although needs to reflect on the deterioration against others. In many cases, the CCG compares favourably against the England average, even in those where our performance has not improved.

Significantly, "the years of life lost" indicator for males has improved, whilst there is a deterioration for females. We are also pleased to note the significant improvement in access to psychological therapies, which is a reflection of our investment in Mental Health services.

The main concern in these indicators relate to cancer outcomes, this is reflected in the prioritisation we have given to two cancer projects in this years plan.



Draft Version

What have we achieved to date?

NHS Outcomes Tool Highlights – NHS Canterbury and Coastal CCG

Indicator Name	Value		Spine chart	
1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare - Female (2014)	1,841		1055	3204
1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare - Male (2014)	2,068		1325	3902
1.2 Under 75 mortality rates from cardiovascular disease (2014)	52.5		35.7	127.2
1.17 Record of stage of cancer at diagnosis (2013)	45.3		38.9	86
1.18 Percentage of cancers detected at stage 1 and 2 (2013)	30.1		21.3	60.6
1.22 Hip fracture: incidence (Jul 2014 - Jun 2015)	461		55	584
2.1 Health-related quality of life for people with long-term conditions (2014/15)	0.78		0.63	0.81
2.2 Proportion of people who are feeling supported to manage their condition (2014/15)	73.4		50.6	75.3
2.10 Access to psychological therapies services by people from Black and Minority Ethnic (BME) groups (2014/15)	1,283		242	2882
2.11a Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable recovery following completion of treatment (2014/15)	42.8		17.6	64.6
2.11b Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable improvement following completion of treatment (2014/15)	64.4		24.8	76.8
3.1 Emergency admissions for acute conditions that should not usually require hospital admission (Jul 2014 - Jun 2015)	1,340		252	2368
3.2 Emergency readmissions within 30 days of discharge from hospital (2011/12)	13.4		8.9	14.5
3.6 People who have had an acute stroke who receive thrombolysis (2014/15)	15.20		0.8	27.4
3.7 People with stroke who are discharged from hospital with a joint health and social care plan (2014/15)	81.6		1.3	100
3.8 People who have a follow-up assessment between 4 and 8 months after initial admission for stroke (2014/15)	17.50		0	89.6
4.1 Patient experience of GP out-of-hours services (2014/15)	72.0		49	85.3
5.3 Incidence of Healthcare Associated Infection (HCAI) – Methicillin-resistant Staphylococcus aureus (MRSA) (Apr 2013 - Sep 2015)	3.22		0	9.98

In worst quartile · In IQ range · In best quartile · Sig change · Non-sig change · No change
England Mean · Cluster mean

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The National 'Must Dos'

Whilst developing our local Annual Operating Plan, we are required by NHS England to ensure that we plan to meet priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation. Included in this are the following objectives:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.
2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.
4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.
6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

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Sustainability and Transformation

What will your NHS look like in 2020?

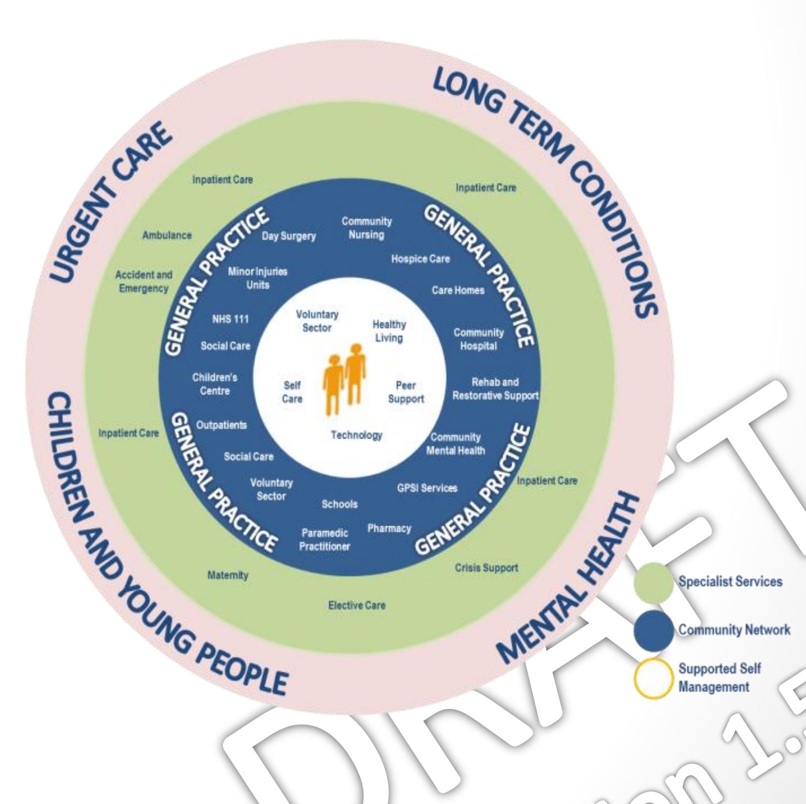
In October 2014, NHS England published "Five Year Forward View" (5YFV), which set out their vision for services over the coming five years. This document identifies that, in order to meet patients' needs and expectations, we need to dissolve traditional boundaries. Long term conditions are now the central focus of the NHS commissioners; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care.

As a result there is now quite wide consensus on the direction which the NHS needs to take. Increasingly we need to manage systems – networks of care – not just organisations. We need to ensure that we have comprehensive, integrated local care and health services which are;

- tailored to communities
- provided through Multispecialty Community Providers (MCP)
- supported by a chain of high quality, smaller, acute hospitals with access to safer specialist service

Both NHS Ashford CCG and Canterbury and Coastal CCG are in a good position to deliver against these expectations. Our initial five year strategic vision, which was published in 2014, clearly set out our intention to transform our services towards a more community centric approach through our Community Networks approach.

Additionally, we are fortunate to have a national exemplar model – Encompass – which is currently being delivered across the Whitstable, Canterbury and Faversham areas and is designed to test out these new models of care.



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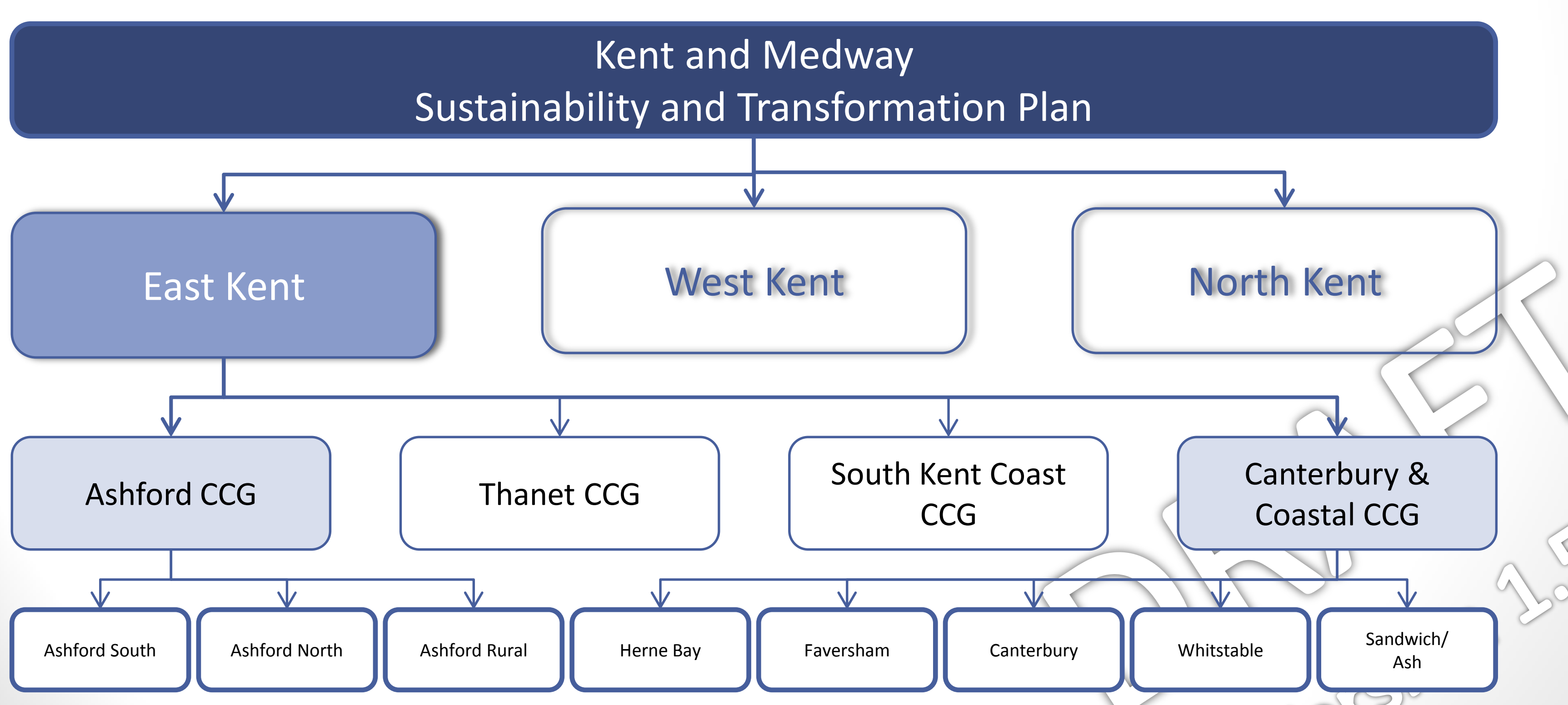
What will your NHS look like in 2020?
Sustainability and Transformation Plan (STP)

Some of the services commissioned by the CCG, particularly those around urgent and emergency care such as trauma, stroke and vascular are commissioned countywide. As a consequence of this there will be a single STP, with a Kent and Medway Board providing assurance on the plan to NHS England. As part of the STP, in order to reflect the differing needs across the county, there will also be sections of the plan covering each of the three health economies, north, west and east.

We will also retain the Community Networks approach designed to liberate local communities, enabling them to innovate in how care is delivered in order to meet local need allowing scope for different approaches to be developed in different areas. For the public and patients, community networks have the potential to offer accessible and responsive services that extend well beyond what is currently available in general practices. These services would have general practice at their core, with practices working hand-in-hand with a range of other services that people need to access from time to time



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What will your NHS look like in 2020?

Achieving Sustainability Across East Kent

Neither Ashford CCG nor Canterbury CCG operates completely in isolation but is part of a wider health and social care community. As such, when it comes to planning for the future needs of our patients and the wider community, we work closely with our partners from across East Kent.

With all organisations involved in the planning, provision and delivery of health and care services in this area, we have recently established the East Kent Strategy Board to spearhead a new drive to determine how best to provide health and care services to the population of east Kent in the future. Membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services and 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 is clinically led, working closely with staff, patients, carers and the local community to co-design solutions to meet the challenges we face.

How will we get there?
An East Kent Strategy and Roadmap

In order to achieve the level of sustainability our services require in order to meet the future need of our patients, there are clear steps which any transformational change will need to undertake. The Kings Fund give a sense of the direction which we will need to be taking:

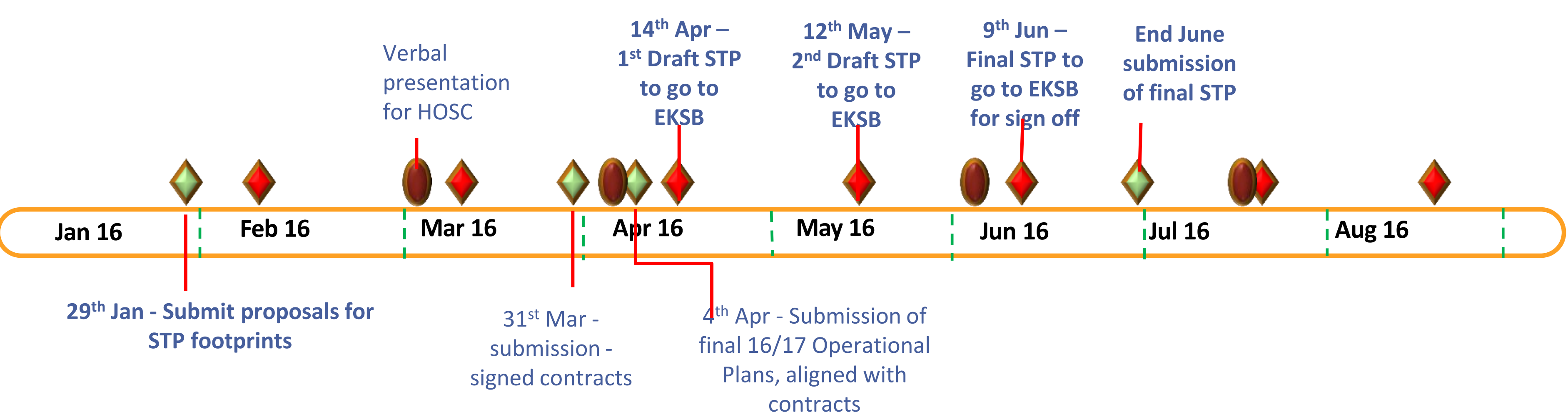
- Simplify services and remove unnecessary complexity.
- Wrap multidisciplinary teams around groups of practices, including mental health, social care, specialist nursing and community resources.
- Use these services to build multidisciplinary care teams for patients with complex needs.
- Support these teams with new models of specialist input.
- Develop teams and services to provide support to patients as an alternative to admission or hospital stay.
- Build the information infrastructure, workforce, and ways of working and commissioning that are required to support this.
- Reach out into the wider community to improve prevention, provide support for isolated people, and create healthy communities

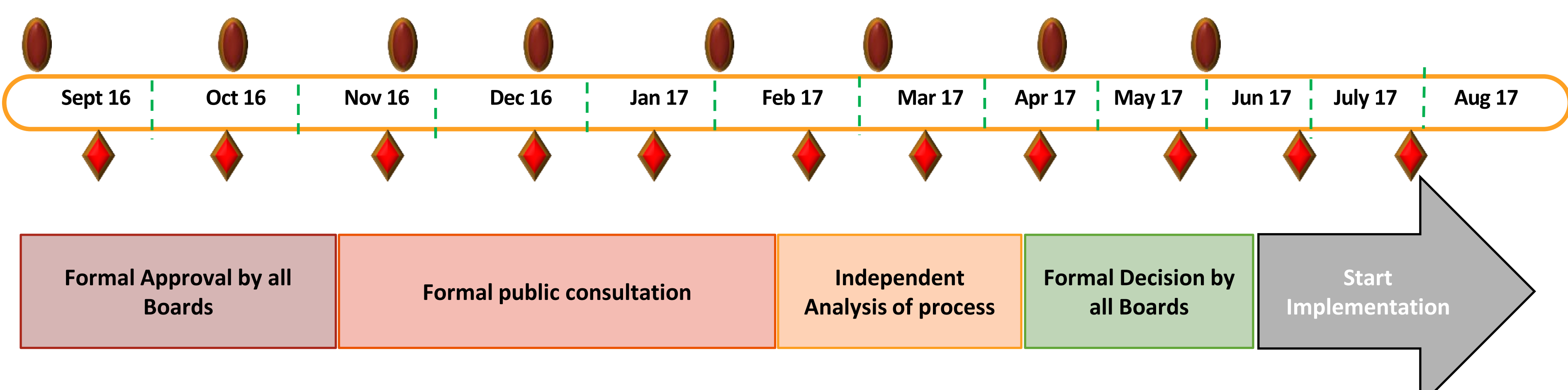
Whilst the East Kent Strategy Board has not yet considered or tested any options for change, and no decisions about how services might be organised in the future have been made, the Five Year Forward View sets out a clear direction of travel for the NHS as a whole. Currently, based on our previous five year strategic plan, the roadmap for change would run as follows:

In Place	2016/17	2017/18	2018/19	2019/20
• **Community Networks** • **Canterbury, Whitstable and Faversham MCP (Encompass)** - *Commenced*	• **East Kent Clinical Strategy** - *Development* • **Encompass** - *Phase 2* • **Ashford Integrated Care** - *Phase 1* • **Herne Bay Integrated Care** - *Phase 1*	• **East Kent Clinical Strategy** - *Phase 1* • **Encompass** - *Phase 3* • **Ashford Integrated Care** - *Phase 2* • **Herne Bay Integrated Care** - *Phase 2*	• **East Kent Clinical Strategy** - *Phase 2* • **Encompass** - *Phase 4* • **Ashford Integrated Care** - *Phase 3* • **Herne Bay Integrated Care** - *Phase 3*	• Smaller, safer, more specialist secondary care services • Secondary care (physical and mental health) support to primary care out of hospital • Out of hospital provision through Multispecialty Community Providers (MCP) • Access conducive to decrease health inequalities

East Kent Strategy Programme Timeline

KEY
East Kent Strategy Board Meeting
HOSC meeting





New Models of Care

NHS Vanguard - Encompass

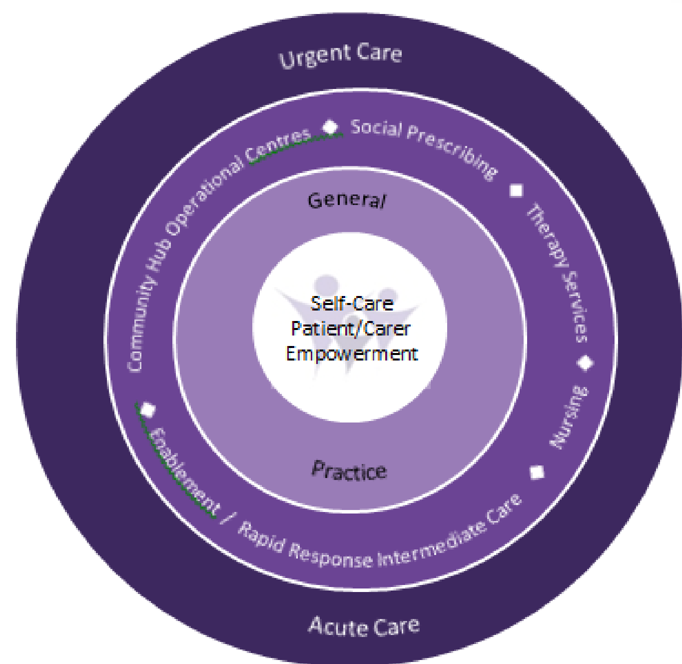
Encompass – previously known as the Whitstable, Faversham and Canterbury Community NHS Vanguard - seeks to deliver an integrated health and social care model of care through the transformation of local services to deliver proactive care and support focused on promoting health and wellness, rather than care and support that is solely reactive to ill health.

The MCP integrated model of care will deliver holistic health and social care services through **Community Hub Operating Centres (CHOCs)** located in Whitstable, Canterbury, Faversham and Sandwich. Each CHOC will support clusters of GP practices. Although there will be room for local variation in each CHOC, to enable services to be tailored to meet specific population needs. We are working to confirm the CHOC sites, with a view to collocating them with existing community health facilities. For example, the Whitstable CHOC is likely to operate from Estuary View Medical Centre, which already houses a range of outpatient and diagnostic services and an MIU. Sites for the other CHOCs are being finalised.

Each hub will incorporate:

- General Practice
- Integrated nursing and social care (including domiciliary care)
- Functional therapy services
- Access to voluntary and community service via social prescribing
- Health promotion and prevention services
- Integrated mental health services

Schematic of the Model of Care



Enablers for effective service integration

- IT Integration
- Patient Engagement
- Patient Empowerment / Self Care
- Transport to facilitate people being supported in the community setting

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New Models of Care

Fast Follower – Ashford Community Providers

We also have the development in Ashford as a 'fast follower' with clinical lead from Ashford Clinical Providers (ACP) now a member of Vanguard (E**n**compass) MCP Steering Group.

Ashford Clinical Providers recognise that commissioning needs robust locality wide cost effective alternatives to allow shift from hospital to community built on the strengths of local Primary care. Shared early outcomes from key Vanguard projects have enabled ACP to refresh their plans and adopt a similar integrated hub model approach across three localities based on the following geography:

- Ashford South
- Ashford North
- Ashford Rural

Achievements To Date

ACP already have a track record of delivering changes to local services. In 2015, with help from additional funding from the CCG, ACP trialed weekend opening of GP services in both North and South Hubs, to complement the existing service in the Rural Hub.

In 2015, ACP started delivering an Orthopaedic referral triage pilot which has successfully redirected 33% of patients to community GPSi (Limb) and ESP (spinal) services. The service has provided savings for the local health economy, streamlined patient care closer to home, decreased pressure on local secondary care outpatient services AND built capacity in the existing Community MSK provider service which has lower tariffs.

Long Term Plans

In the longer term, ACP are aiming for more timely access to health and social care needs through service redesign including:

- Weekend/evening GP access in all 3 Ashford Hubs.
- IT integration (EMIS Web with MIG)
- Ever expanding GPSi and consultant delivered local patient triage, assessment and treatment services
- In partnership with the CCG further develop the rural hub model of weekend working
- Integration of the Community Teams into primary care with the help of the CCG
- Relocation of care/community teams (mental health, health visitor, midwife, social worker, district and community nurses etc).
- Acute care collaboration between ACP and EKHUFT.

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New Models of Care

Herne Bay Integrated Care Centre (ICC)

The vision for the Herne Bay Integrated Care Centre is to commission "A resource for the community where primary and community care will work together to relieve pressure on the local health economy by providing a wide range of services closer to patient's homes", with the intention to base the centre at the Queen Victoria Memorial Hospital (QVMH)

The ICC will act as a hub where patients will be able to access a range of urgent and outreach services including access to diagnostics. This will include minor injury and illness, urology, DVT, wound and day case clinics. The service will be delivered in accordance with the 'Priority Three'. The service will be nurse led with GP oversight provided by all four local practices with support from the Community Network to ensure maximum interface between primary and community care.

Current services of this nature are not located locally to the population of Herne Bay, requiring travel to Canterbury, Margate or Whitstable with limited public transport options. Care will be overseen by local GPs to ensure the patients are known and to identify where core primary care services need strengthening to reduce the burden on other services. The ICC will provide advice including self-care and social care which can be wrapped around the patients' needs, will help to reduce the impact of any potential downgrading or changes to acute services and will assist in ensuring the viability and suitability of the community hospital in the context of a growing population need in the locality.

The ICC will be the first step towards the delivery of patient-centric, integrated health and social care services across Herne Bay driven by primary care and supported by the Community Network.

Phase 1

- Nurse/paramedic practitioner led ICC (including minor injuries) supported by GP surgeries
- Linked IT between the centre and the practices
- Nurse led urology clinic for planned and urgent care
- Utilising existing (albeit limited) x-ray facilities

Phase 2

- Day case procedures T&O hand and wrist
- Extended hours GP clinic
- DVT clinic
- Improved diagnostic services – co-located x-ray, ultrasound and MRI facility
- Improved mental health care planning
- Appropriate diversions for ambulance services to reduce pressure on urgent and emergency facilities
- Integrated working with existing wound care clinic, community nursing team and voluntary services

Phase 3

- Develop urgent appointment facilities for existing ophthalmology and ENT services
- Ambulatory care unit
- Focused service to assist care for young families in non-clinical settings
- Host specialist primary care based MDT clinics for the locality in areas of significant spend i.e. respiratory and diabetes

Better Care Fund

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

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

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

Building on a long history of joint commissioning of services, the Better Care Fund provides further opportunity to commission services together. We will use this integrated commissioning approach to buy integrated health and social care services where this makes sense, achieving the shift from spend and activity in acute and residential care to community services

INSERT OUTCOMES AN PLANS FOR 2016

General Practice
Sustainability and Quality

General practice has a central role within our vision for the next five years, providing care alongside other NHS staff working in the community, voluntary sector organisations and colleagues in social care. General practice delivers significantly more services than ten years ago and this trend will continue with a proportion of this additional work transferred from traditional community or hospital bases. General practice and wider primary care services in England have a number of internationally recognised strengths:

- Registered lists are a key tool in the coordination and continuity of care; the vast majority of the population is registered with a general practice in the UK
- There is a strong generalist tradition in the NHS; general practice is well placed to utilise its knowledge of patients and their families in a local community gained from repeated consultations over time to holistically improve physical, emotional and social wellbeing
- General practice, plays a central role in the management of people with chronic disease and identifies those at risk of worsening chronic ill health
- General practice displays a highly systematic use of information technology to support the management of long term conditions, track changes in health status and support population health interventions such as screening and immunisation
- There are numerous examples of innovation in general practice leading to improvements in quality of care and wider service transformation

If we stand still on the improvement ladder, we will fail to progress and meet the evolving needs and expectations of our population. For this reason, improving the quality of primary care services for the our diverse population is a priority for the CCG serving this population, working in partnership with and in collaboration with patients, our GP membership, local authorities (LAs), and other key stakeholders.

In order for this is be possible a number of changes in the way which general practice operates will need to occur. This may require moving away from the current model of small, independently minded practices towards new forms of organisation that enable practices to work together and with other providers to put in place the networks of care that are required

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General Practice
Strategy Group

Strategic Objective
Aim to balance the benefit of small and local organisations with the scale and capacity to improve quality and deliver a wider range of services

The Primary Care Strategy Group was created to oversee the development and implementation of a strategy for primary care within NHS Ashford and NHS Canterbury and Coastal CCGs that reflects the needs of the local population and which will meet the objectives within the CCGs Strategic Commissioning Plans and to inform CCG approach to co-commissioning in line with "Five Year Forward View"

Additionally the group was tasked with:

- Leading the development, implementation and monitoring of a new model for primary care in NHS Ashford and NHS Canterbury and Coastal CCGs, working collaboratively with other agencies
- Advising on workforce plans that support the achievement of the primary care strategy and aim to maximise the recruitment and retention of professionals and support staff;
- The group comprised
  - 1 representative from each of the 8 community networks
  - CCG Chairs
  - CCG Chief Operating Officer
  - CCG Head of Strategy and Planning
  - CCG Primary Care Workforce Tutor
  - Kent LMC representative
  - NHS England (Kent and Medway Area Team) representative

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General Practice

Our Ambitions

Following discussion with the GP membership of the CCG, the Primary Care Strategy Group have identified eight ambitions which they believe with improve local services for our patients, specifically these are;

Ambition 1 – Patient Access.

Every patient will have access to a core offer of high quality primary care which is continuously improving and delivering excellent health outcomes.

Ambition 2 – Patient Participation.

We will have effective engagement with our patients, and their carers, to ensure that our services and information meet their needs and lifestyles.

Ambition 3 – Workforce.

We will have an attractive training environment which develops our doctors, nurses and allied staff to be the best healthcare workforce.

Ambition 4 – Premises.

The premises used to deliver services will be fit for purpose meeting the current, and future, needs of our growing population

Ambition 5 – Quality and Outcomes.

Every patient will have access to a core offer of high quality primary care which is continuously improving and delivering excellent health outcomes.

Ambition 6 – Integration.

Patient care by removing boundaries between primary, community, hospital and social care.

Ambition 7 – Technology.

We will use technology to deliver the highest quality care in the most appropriate manner.

Ambition 8 – Payment and Investment.

We will ensure that there is a payment and incentive system to support improved outcomes, ensure value for money and reflect the workload.

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Achieving Constitution Standards
Urgent Care Standards

Performance against this target continues to be poor despite repeated attempts by the commissioning team to drive improvement have proved ineffective. A number of interlinked programmes have been introduced in order to help reduce pressure on our Accident and Emergency Departments, and further steps are being introduced to further improve services.

In Hospital

- New site management arrangements on all 3 main hospital sites
- Health and Social care partners agreeing support arrangements with ECIS
- Complete demand and capacity work to further understand bottlenecks and their impact across the system
- A&E Performance meetings organised in addition to regular contractual meetings.
- New induction programme for new nursing staff in A&E.
- Analyse capacity and demand patterns & roster staff at peak demand
- Increase medical staffing over evenings and weekends in line with high levels of breaches at these times.

Out of Hospital

- Ivy Court Medical Practice (Ashford Rural) operating 7 day a week Primary Care
- "Encompass" implemented 7 day working
- Reviewed structure of Integrated Discharge Team and assign new KPIs (5 discharges per site per day)
- Implemented Discharge To assess pathways across all acute sites
- Introduction of new CQUIN to encourage ambulances to access LRU to avoid conveyances to Hospital
- Introduction of Paramedic Practitioner services to reduce Ambulance conveyances to Hospital in Whitstable (Seen 5% reduction in managed conveyance rate)
- Implemented real time escalation, imbedding best practice into front line response & tracking actions in real time

Historically, across the NHS, the winter period brings additional pressure on the urgent care system. In order to plan for this, the health economy as a whole (including main health providers plus KCC Social Care) developed the Winter Escalation Plan. During the course of the 2015/16 winter, a number of risks have been identified including an increased number of delayed discharges and ambulance handover, impact of Operation Stack and adverse weather (specifically flooding), increased length of stay and a higher acuity of certain cohorts of patients.

To address this, a number of steps have been taking and mitigating actions put in place. This includes a focused system response to reduce the number of medically fit patients in acute hospitals, improved flexibility in existing community and social care bed capacity, further reductions in Ambulance patient conveyances through expansion of paramedic practitioner pilot, increased provision of support to elderly in homes, improved response and capacity for mental health services (specifically Liaison Psychiatry) and the realisation of the full potential of the Discharge to Assess pilots to improve patient flow.

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Achieving Constitution Standards

Referral to Treatment (RTT) Standards

To Be Completed

Achieving Constitution Standards

Cancer Standards

To Be Completed

Achieving Constitution Standards
Mental Health Standards

To Be Completed

Transforming Care

People with Learning Disabilities

As part of both CCG's response to Transforming Care, the local in-patient assessment and treatment unit for people with learning disability (The Birling Centre) was decommissioned in 2014, closing 10 in-patient beds which served Kent and Medway health economy. The budget for the Birling Centre was fully reinvested in enhanced community learning disability (LD) services. The enhanced team now allows for more preventative interventions to be planned and delivered. Work is ongoing to embed the new care pathway and new ways of working in the community which will be supported through Integrated LD Commissioning arrangements between the CCG and KCC from April 2016. The CCG has also entered into formal joint commissioning with KCC for children and young people in the 0-25 age group.

The care pathway for people with LD now includes a new Complex Care Response pathway that sets out how community practitioners from our 3 statutory sector providers; KMPT, KCC and KCHFT, come together to work intensively with an individual whose community support arrangements are at risk of breaking down and who is at risk of being admitted to hospital as a result. The aim of the Complex Care Response part of the LD care pathway is to reduce the numbers of people with LD or ASC being admitted to in-patient services. Since these new elements of LD services have been commissioned in January 2015, the CCG has not been required to admit any adults with LD to specialist in-patient units such as the former Birling Centre.

Through the integrated commissioning arrangements, we work in partnership with the other CCGs in Kent and KCC, forming a Kent Transforming Care Partnership. Together with our partners we submitted the first draft of our Transforming Care Plan on 8th February. Our plans have identified some gaps in our provision which we plan to address. These include:

- the provision of safe accommodation in the community as an additional measure to prevent inappropriate hospital admission. This will provide an additional resource to the enhanced community teams working with people at risk of admission.
- forensic outreach services. We are working with NHS England Specialised Commissioning Team on the development of a forensic outreach service which would enable people who may present a risk to themselves or the community to be safely discharged and also work with people who may be at risk of offending to prevent admission.

We are also applying to the national £30 million fund to help develop further the support for people with Autism who may challenge and / or have additional mental health problems through implementation of our new neurodevelopmental delay pathway.
Our plan estimates that we will need access to 48 beds across Kent to meet the needs of people with LD / Autism who present challenges or who may have additional mental health problems. With the measures above and the continued work to discharge people we will be on track with our partners to reduce our reliance on specialist in-patient beds.

The CCG continues to work in collaboration with commissioning and provider partners, including Specialised Commissioning, to ensure that we have an appropriate range of community services and accommodation for people with LD or ASC.

Local procedures are in place to ensure that national Care and Treatment Review Policy and Guidance is implemented for every patient who is referred for in-patient treatment. We are currently reviewing Tier 4 CAMHS admission procedures to ensure that CTRs are extended to this cohort during the early part of 2016/17.

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Transforming Care
Children, Young People and Maternity

To Be Completed

Quality Strategy
Improvements in Quality

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

Both CCGs aim to put the patient at the centre of all that we do and as such believe that quality underpins all that we strive to achieve.

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

Patient Safety

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

Clinical Effectiveness

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

Patient Experience

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

Provider Specific – East Kent Hospitals NHS Foundation Trust

The CQC inspection report highlighted quality issues throughout the Trust. Governance, leadership, culture and strategy are all themes that affect patient safety and the quality of care. Recovery Action Plans are in place for A&E, Cancer and RTT and work is being undertaken to ensure these raise the quality of patient care and safety as well as improving performance. Further high level action plans are in place across the trust for areas including End of Life care, outpatients, diagnostics and safeguarding.

Maternity services will be evaluated following the national review and redesigned to deliver safe and effective care, reducing maternal and neonatal morbidity and mortality.

Provider Specific – Kent Community Health NHS Foundation Trust

Service redesign is moving at pace to provide integrated teams - patient experience and quality of care will be embedded in these new pathways

Services are being reviewed during contract negotiations with workforce and productivity being closely monitored to ensure safe care is delivered

Patients safety incident reporting will continue to be monitored; Priority needs to be given to develop skilled clinical leadership to deliver focused care based on improving patients health outcomes

Provider Specific – Kent and Medway Partnership Trust

Monitor CQC action plan and identify where mitigation needs to be taken to reduce avoidable deaths and patient harm

Support provider to develop robust serious Incident process including reporting, investigating and learning from serious incidents.

Quality Strategy
Delivering Harm Free Care

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

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

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

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

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

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

The Financial Challenge

Achieving Financial Balance

The CCG's have received their predicted growth in allocations for the next five years. Population growth and an ageing population in NHS Ashford and NHS Canterbury CCG are expected to put considerable pressure on the finance resource.

Clinical Leadership of Financial Planning

The Both CCG's have implemented the Commissioning for Value (Right Care) process for decision making and performance management. In addition the CCGs have escalated to oversight of projects and delivery with executive steering oversight, lead by AO on a two weekly basis. Both CCG's to date are delivering over 80% of the QIPP / CfV savings plans, however as the plan for Ashford is proportionately greater than Canterbury, almost twice, this non delivery in Ashford is a significant issue that the CCG is addressing through strengthening controls, driving delayed programmes and ensuring that all funds due to the CCG are recovered.

NHS Ashford CCG

The plan is to deliver a 1% surplus in 2016/17 and thereafter. The challenge will be greater in 2016/17 with the current forecast for 2015/16 predicted to be break even, therefore having no prior year surplus to invest to support the position. The plan is also to increase the contingency from 0.5% to 1.5% to cover risks of overspending in programme budgets. These planning assumptions and the provider pressures in the system for 2016/17 and thereafter will mean that delivery of transformational change programmes becomes a priority for the CCG.

NHS Canterbury CCG

The plan is to deliver a 1% surplus in 2016/17 and thereafter. NHS Canterbury CCG will have the benefit of the prior year surplus to support the position. The plan is also to increase contingency from 0.5% to 1.5% contingency to cover risks of overspending in programme budgets. These planning assumptions and the provider pressures in the system for 2016/17 and thereafter will mean that delivery of transformational change programmes becomes a priority for the CCG.

QIPP

The scale of the QIPP to be delivered is significant. Transformational schemes that commenced in 2015/16 will be extended and reinforced in 2016/17 such as Orthopaedics and those that have been planned over the last financial year are planned to be phased in over 2016/17.

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2016/17 Commissioning Intentions

Commissioning for Value

Our priorities for 2016/17 come from a number of different approaches. They are drawn from our original five year plan, pressures identified through ongoing performance managements and through a newer approach known as "Commissioning for Value".

We took this approach following a review and reflection upon previous annual plans, from this we identified that we attempted too much change and only fully achieved about 1/3 of our intended priorities. We therefore needed to focus our efforts on areas that would generate best outcome clinically and financially and to streamline our approach to commissioning by reducing the number of priorities and revamping our internal monitoring regime.

In November 2014 we therefore engaged the national led for NHS Right Care, Professor Matthew Cripps, and by end of January 2015 we had;

- Reviewed the data using various sources, Pathways on a Page, Atlas of Variation etc., to identify key opportunities for improvement
- Held a workshop, lead by clinicians, to formulate our local decision tree which would give us a consistent approach to prioritising projects
- Undertook a series of engagement approaches through presentations and discussions with staff, Governing Bodies, Membership and key providers who endorsed the approach
- Held a joint CCG "clinician to clinician event", involving both GPs and Consultants to launch optimal pathway design based on key priorities identified through the process
- Completely redesigned our business and governance processes, including the creation of the "Health Reform Delivery Panel" chaired by Dr Navin Kumta, creating a single filter for decision making and allowing for a single route for ***all*** proposed projects to be considered
- Changed culture to one of evidence based decision making, using evidence from national and internationally recognised sources – such as Cochrane – to assess the efficacy of proposed models of care
- Produced a revised set of templates for commissioners and partners to compile Initial Viability Assessments, Outline Business Cases and Post-Implementation Reviews to bring to the panel

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2016/17 Commissioning Intentions

Elective Care

Project	Summary	Estimated Savings
Musculoskeletal (MSK) Triage	To triage all GP referrals for musculoskeletal (MSK) conditions to Trauma and Orthopaedics (T&O) at EKHUFT. This will be provided by Ashford Provider Group utilising GPs with expertise in MSK in Ashford, and by identified Community Network-based providers in Canterbury; and will complement the use of Referral and Treatment Criteria (RaTC) within the Demand Management.	£ 3,880,000
Musculoskeletal (MSK) – Spinal Injections	To introduce a new clinical pathway for patients with chronic back pain to ensure they are managed in a supportive way using techniques for managing pain on a day to day basis. This will maximise care in primary and community care through implementation of specialised therapy and counselling support thereby reducing referrals to secondary care. Patients currently on the T&O waiting list for spinal pain injections will be reviewed to see if according to the new pathway they could now be treated in primary and community care.	£ 800,000
Further Musculoskeletal (MSK) Pathway Development	The focus for 2016/17 will be: · Finish implementing the Back Pain Pathway (Spinal Injections – see above) · Fully implement MSK triage (See above) · Addressing variation in referrals for direct access MRI · Working with clinical and management teams in EKHUFT to develop service development options, in addition to addressing referral variation, for addressing the variation in surgical intervention rates, readmission rates and complications for Hip replacements (including revisions), knee replacements (including revisions) and arthroscopies. · This development will be phased over the course of the year. The first 6 months will focus on projects already underway and new projects will be developed to begin to take effect in the second half of the year	£ -
Wet Age-Related Macular Degeneration	Procurement of a new community service for patients suffering with eye conditions which fall into the category of Macular oedema and specifically Wet Age-related Macular Degeneration. The current pathway is provided solely in acute services but there is potential to repatriate patients back to primary/community care for much of the pathway especially once diagnosis has been established. At the same time this will give a financial benefit and ease capacity issues in acute services to offset the increasing demand for new drugs and new treatments being recommended by NICE	£ 200,000
Ophthalmology Triage	Northgate Medical Practice has provided an ophthalmology service for many years lead by Dr Andy Charley since the retirement of Dr Simon Ellis in March 2013. The service currently accepts all internal non urgent practice referrals from clinicians working within NMP and direct Optometric referrals from community Optometrists via GOS18's, treating those which can be within the teams competence and referring those on that need to be.	£ -
Dermatology Advice and Guidance	To pilot an integrated intermediate tele-dermatology triage service for dermatology referrals, excluding Cancer 2 week wait (2ww) referrals. To ensure that patients are assessed quickly and have access to the correct treatment based within a community setting, thereby ensuring that secondary care has the capacity to manage cases requiring surgery or specialist intervention as a result of reduced referrals. A community service model will be embedded across Ashford and Canterbury CCGs to ensure that all providers are delivering one-stop pathways	£ 1,262,481

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2016/17 Commissioning Intentions

Urgent Care and Long Term Conditions

Project	Summary	Estimated Savings
Discharge to Assess	○ **Pathway 1** - discharge home with 'wrap around' community teams to provide assessment to specify on-going care needs over a 72hr period. The focus on home first and reduce the number of patients that are transferred to Health & Social Care Village (H&SCV) beds for rehabilitation. ○ **Pathway 2** – discharge to assess where home is not an option, to bed-based facilities (community Hospitals / KCC step down beds) for ongoing assessment and rehabilitation for a period of 2- 6 weeks. Patients who require 24hr nursing care, daily medical review and rehabilitation to support discharge home, within 21 days of admission. ○ **Pathway 3** – Discharge to assess to nursing home for patients who require assessment of their long term care needs outside an acute hospital environment, providing a period of assessment during which an appropriate placement can be sourced. Assessment and placement are completed within 6 weeks by dedicated CHC nurses and social worker.	£ 2,000,000
Over 75s Admissions	To support the reduction in urgent care admissions for patients over 75 through the implementation of a number of different schemes: • Unplanned Admissions DES • End of Life • Care Homes • Frailty CQUIN • Community Geriatrician Project • Practice-based over 75s Scheme • Integrated Care Team Review	£ -
Age UK Living Well Programme	This is a national project which looks at reducing reliance upon health and social care through promotion of wellbeing. The project looks at taking cohort of patients in Ashford Rural, Faversham and Herne Bay over 65 years, with 2 or more long term conditions, who have had 1 unplanned hospital admission in the last 12 months and a high likelihood of another; and providing a period of intensive support to them through Living Well Coordinators to help them achieve identified health and wellbeing goals.	£ 920,380
Canterbury Transitional Beds	Six-month pilot starting in February 2016 for 3 additional transitional beds to prevent hospital admissions for patients requiring short-term support within the Canterbury community whilst remaining under the care of their registered GP. The pilot will focus on two conditions: Urinary tract infection, and lobar pneumonia. Three beds will be purchased to give capacity for 59 patients, based on an average length of stay of 7 days and 75% occupancy rates	£ 182,516
Anticoagulation Services	NHS England has confirmed they will be decommissioning the pharmacy-delivered anticoagulation monitoring services from March 2016. This provides the CCG with an opportunity to review anti-coagulation services provided by primary care in parallel, with a view for all provision to sit under one service specification underpinned by robust contractual arrangements that are managed by the CCG. Current contracting arrangements focus on activity rather than patient outcomes. This will be addressed in the service review. The review will be undertaken in two phases: **Phase one:** procure monitoring services only - excludes initiation of anti-coagulation treatment. **Phase two:** Review and procurement of initiation of anti-coagulation treatment. This will include a Post Implementation Review (PIR) of the Ashford initiation service. The draft business case is proposing a single service where, as a minimum, all providers • offer the entire service in accordance with the service specification • are able to offer home visits as a compulsory element against the criteria defined in the service specification, rather than optional as current • will monitor the patients according to the service specification • can see patients from all practices • will be expected to use INR Star • will be expected to prescribe warfarin or acencoumarol • conduct training in accordance with the service specification	£ -

Contracted Activity 2016/17

NHS Canterbury and Coastal CCG

Activity Line	15/16 Forecast Outturn	16/17 Plan	Growth Assumption
Total Referrals (GP and Other)	75663	75849	0.2%
Consultant led Total 1st Outpatient attendances	63706	62989	-1.1%
Consultant led Follow up outpatient attendances	119532	119109	-0.4%
Total Elective admissions (spells)	30270	30342	0.2%
Total Non-elective admissions (spells)	25628	25655	0.1%
Total A&E attendances	57447	57424	0.0%
Total Endoscopy tests	5643	5744	1.8%
Total Diagnostic tests (excluding Endoscopy)	74838	76099	1.7%
Total Cancer 2WW referrals	9689	9574	-1.2%
Total Cancer 62 day waits	622	624	0.3%

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Agenda Item No: 7

Report To: **Ashford Health & Wellbeing Board**

Date:
23 March 2016

Report Title:
East Kent Strategy Update

Report Author:
Simon Perks

Organisation:
Ashford CCG

Report:

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. 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 obesity, diabetes and heart disease. It takes time, effort and new approaches to support people to make healthy choices and 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.

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.

Recommendations:	**The Ashford Health & Wellbeing Board be asked to:-** Note the content of the report

Policy Overview: N/A

Financial Implications:

Risk Assessment	~~YES~~/NO (delete as appropriate, if yes provide necessary information)
Equalities Impact Assessment	~~YES~~/NO (delete as appropriate, if yes provide necessary information)
Other Material Implications:	
Background Papers:	
Contacts:	Email: simon.perks@nhs.net Tel: 03000 424045

Agenda Item No. 7

Report Title: East Kent Strategy Update

Purpose of the Report

1. For information

2.

Background

3.

4.

Report Specific Section Headings

5.

6.

Risk Assessment

7. N/A

Equality Impact Assessment

8. N/A

Other Options Considered

9. N/A

Consultation

10. N/A

Implications Assessment

11. N/A

Handling

12. N/A

Conclusion

13.

Contacts: Email: Simon.perks@nhs.net
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Ashford Borough Council:

- Local Plan to 2030
- Infrastructure Delivery Plan
- Community Infrastructure Levy

March 2016

Local Plan

- Sets out a planning policy framework for the Borough up to 2030
- Establishes housing and job targets
- Allocates new development sites in sustainable locations
- Working assumption:
  – SHMA suggests a ‘target' of around 14,680 net new dwellings from 2011-30 (773 pa),
  – Existing commitments equal to about 11,000 dwellings,
  – New allocations for about 3500 – 4000 dwellings to meet this ‘target’
- Most in and around Ashford – most sustainable location and can utilise existing infrastructure

Infrastructure Delivery Plan

- Key supporting document to the Local Plan 2030 and the Reg 123 list
- What infrastructure is needed?, when?, what is the cost?, how will it be funded?, how critical is it?
- What model of provision is wanted from providers and how can the Local Plan assist?
- Extensions to existing services / understanding their stresses / need for new provision / what are the land-take needs / what is the role of developer funding

Community Infrastructure Levy

- A planning charge to help deliver infrastructure to support development
- How much CIL are we actually likely to receive?
- Different rates for different value areas, no ability to use CIL to claw-back money spent
- Role of CIL versus S106 (major allocations versus strategic delivery of infrastructure)
- CIL is examined in public

The challenge…………

- What is the best chance of delivering the needed services in a very difficult financial climate……….
- What role does the Local Plan, IDP, CIL have?
- What role do providers have?

- **Provision needs to be justified and evidenced……..**

Timescales

- Draft Local Plan, IDP and CIL to be published at the end of **May 2016**
- Min. 8 weeks of formal public consultation
- Public examination – late 2016/early 2017
- Adoption – Summer 2017

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for Ashford Clinical Commissioning Group – Quarter 4: January to March 2016

What's going on in our world	• Annual Operating Plan nears completion • Contractual discussions with all main providers underway • Action Plans in place to address underperformance against national constitution measures • Community Networks meeting continue • Development of MCP model for Ashford locality, along similar line to national vanguard sites.
Success stories since last AHWB	• 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 62%, our highest rate, and continues to improve
What we are focusing on for the next quarter specific to the key projects	• Continued development of MCP model for Ashford locality, along similar line to national vanguard sites. • 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 March 2016

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for KCC Social Services – Quarter 4: January to March 2016

What's going on in our world	The Growth, Environment and Transport change portfolio oversee's transformation and major programme activity. This includes: **Strategic programmes and projects to deliver the core business of the directorate.** These specific programmes and projects are likely to be technical and detailed in nature, or transform the day-to-day delivery of specific services, such as our LED street light programme, our new Waste Strategy and our Customer Service. . **Transformation programmes and projects include:** • Kent Scientific Services • Libraries, Registrations and Archives (LRA) • Transport service review • Kent Country Parks • Trading Standards and Community Safety • Highways Transportation and Waste service redesign • Libraries, Registration and Archives redesign
Success stories since last AHWB	**LD integration – collaborative working** The first meeting of the new Integrated Commissioning Board for learning disability (LD) met in February, which brought together key people representing KCC, including Public Health and the seven Kent Clinical Commissioning Groups (CCGs). The purpose of the board is: "To deliver collaborative working between the partners to the S75 Agreement for integrated commissioning, for learning disability across Kent, in order to deliver the agreed outcomes of the annual joint commissioning plan for learning disability and the Transforming Care Programme." From April, there will be a single commissioning team for learning disability, managed by KCC, who will work on our behalf and the seven Kent CCGs
What we are focusing on for the next quarter specific to the key projects	**Community Mental Health and Wellbeing Service** KCC along with the seven CCGs, have consulted widely with a range of stakeholders, including people living with mental health issues to co-produce a new Community Mental Health and Wellbeing Service. This new service will go live in April and replaces a range of historic grant funded services - providing person centred support that champions mental wellbeing within communities, builds resilience and supports people to stay well or recover from mental health problems.
Anything else relevant to AHWB priorities NOT	

mentioned above	
Strategic challenges & risks including horizon scanning?	As above
Signed & dated	Paula Parker 14/03/16

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for KCC Public Health – Quarter 4: January to March 2016

What's going on in our world	Stop Smoking Campaign – Developments for a newly commissioned Kent-wide campaign to help raise the profile of stop smoking services and to develop new ways that can help people quit (such as quit packs and e-cigarette support). Ashford District has seen the sharpest increase in smoking prevalence in Kent in the last year so campaign resources will be targeted in the Ashford district as well as other areas of high prevalence. Smoking in Pregnancy – Kent Public Health and East Kent Hospitals University Foundation Trust are co-appointing a midwife with a specialism of reducing smoking in pregnancy. The post will be appointed in April and will support and train midwives to implement the babyClear programme and network with other relevant health professionals to tackle smoking in pregnancy prevalence in the East Kent Hospitals Trust.
Success stories since last AHWB	
What we are focusing on for the next quarter specific to the key projects	- Integrated commissioning model for Health Improvement services across Kent - Suicide prevention campaign - District Alcohol Action Plan - Reducing Smoking Prevalence - Local Obesity Strategy
Anything else relevant to AHWB priorities NOT mentioned above	
Strategic challenges & risks including horizon scanning?	Public Health anticipate further cost savings to be made in 2016.
Any thing else the Board needs to know	
Signed & dated	14/03/16

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Ashford Borough Council – Quarter 4: January to March 2016

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<tr><td>What's going on in our world</td><td>

Park Mall – The work to revitalise Park Mall has been welcomed by Damian Green MP, who in February visited the ever-improving shopping centre that was bought by Ashford Borough Council in 2015.
M20 Junction10a –Consultation has just closed. 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.
Victoria Way - Leading property regeneration company U+I is developing plans to bring forward more than 800 homes and new amenities across two sites in Ashford with a total value of £180 million. Both sites are in close proximity to the station. The proposed schemes for both sites, designed by local architect, Guy Holloway, will help to create over 200 jobs for the local area and build a new community on Victoria Way, which is already benefiting from £25m of public realm investments and improved highway infrastructure.
Repton Connect (the new Community Centre) – Planning permission approved in February 2016. Progressing with the tender process starting at the end of March with completion in 2017 being planned.
Spearpoint Pavillion - The old Spearpoint Pavilion building has now been demolished and site preparation is underway. The new building should be ready by mid-September.
Population growth - The Guardian contained an article on population growth which featured Ashford and how we are coping with more residents moving to the borough. Full article at: http://www.theguardian.com/world/2016/feb/09/is-britain-full-home-truths-about-population-panic.
Victoria Park –Key partners 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.
Council Tax – ABC's element of council tax is the lowest in Kent (and one of the lowest precepts in the country). Ashford given special dispensation by government in acknowledgement that that it is one of "the most economical authorities" to raise its element of council tax by up to £5 a year for the forthcoming financial year, without triggering a referendum. Members did not however increase to the full extent.
Create festival – To be on a Saturday for the first time in its 21-year history, this year on Saturday 23rd July. An opportunity for HWB partners to promote services especially to young people.
Ashford Voice – See February edition via http://www.ashford.gov.uk/news/februarys-issue-of-ashford-voice-is-out-now-18th-feb-1295/. Note HWB members can use our monthly 'e-zine' for their own news.
Local Government Boundary Commission – Ashford Electoral Review 2016/17 - The LGBC are about to commence an electoral review in Ashford Borough.
Royal Military Canal Cycle Path Project – This week it has been confirmed that £70,000 has been awarded by the Marsh Million Economic Project Scheme (EPS) to progress the planning application for the Royal Military Canal cycle path project between Aldergate Bridge in West Hythe and Appledore Bridge.

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Success stories since last AHWB	• **'Housing Business Ready'** – Council is the first in the south east to be declared 'Housing Business Ready'. Being Housing Business Ready recognises the way in which we not only cover our statutory responsibilities as an authority to affordable housing provision but how we use assets and other resources to go beyond minimum requirements, how we work with our private sector partners, and how in doing so we provide inspirational local leadership.
What we are focusing on for the next quarter <u>specific to the key projects</u>	• **Healthy Weight** – On-going work on how best to target those groups most in need. • **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 shortly.
Anything else relevant to AHWB priorities NOT mentioned above	• **'Smoke Free' Play Spaces** – Pilot project to encourage an emotional response from local residents, discouraging them from smoking in public places and around children. We are currently replacing signs where sadly they have been vandalised and, if funding permits, extending to other play spaces across the urban area. This work will be complete by the end of March. Canterbury Council have picked up the Smoke Free play spaces baton. They have been promoting the scheme on Radio Kent and Ashford has been mentioned positively on several occasions. • **Ashford Dementia Action Alliance** – For Dementia awareness week, the Ashford Dementia Action Alliance, , is planning a dementia friendly afternoon tea party running from the Joe Fagg pop in centre and neighbouring Baptist Church on Sunday 15th May. They are also hoping to have some school involvement as well. If any HWB members have access to any funds to help support refreshment and entertainment costs it would be much appreciated. Contact Liz Taylor (Chair of the DAA) for more information.
Strategic challenges & risks including horizon scanning?	
Any thing else the Board needs to know	• **Council's front of house** – Return to the Civic Centre late March as we withdraw from Ashford Gateway Plus.
Signed & dated	Sheila Davison – March 2016

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for Healthwatch Kent – Quarter 4: January to March 2016

What's going on in our world	• CAMHS project in progress So far over 200 people have given their feedback via an online survey, they have also identified some issues around autism and other areas of concern. Sussex Partnership Trust are also delivering packs to patients and families in Tunbridge Wells and Swale. • Mental health out of County bed project - desktop research and statutory context is well underway. A sample of Trusts have been contacted and asked a set of questions, the responses will be evaluated in a couple of weeks. A really moving and challenging case study has been provided by the police and meetings have been organised with user and carers groups. • Steve Inett has started attending the monthly monitoring of the KMPT improvement plan following the CQC visit. This seems to be on target. • We are meeting with KMPT soon to discuss how we might look at community services. • Ashford is Public Voice focus for March. We are contacting people from seldom heard groups such as LBGT & Russian speakers to gather their experiences of health and social care services.
Success stories since last AHWB	• Contacted every PPG in Kent Over 90 replies to survey to find out good practise and which ones may need some support • Completed review of EKHUFT hospitals following CQC inspection end of 2014. A&E at QEQM and William Harvey hospitals and outpatients at RVH, BHD, and K&C Hospital Reports will be available by end of April. • Published Best Practise Consultation guidelines and working with organisations.
What we are focusing on for the next quarter specific to the key projects	• Carers -Impact of the Care Act • Care at Home • Physical Disability Forum runs for a year from January 2016
Anything else relevant to AHWB priorities NOT mentioned above	
Strategic challenges & risks including horizon scanning?	
Any thing else the Board needs to know	
Signed & dated	Theresa Oliver - 11/03/16

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for Ashford Local Children's Partnership Group– Quarter 4: January to March 2016

What's going on in our world	Local Children's Partnership Group meeting met on the 9th of February 2016, to date this was the 3rd meeting. Andy Jones from KCC Commissioning attended to discuss how Ashford would work to achieve and invite the LCPG to comment on the indicators proposed for the Children and Young Peoples Plan.
Success stories since last AHWB	Bids have been made for Grant funding (£48,000 for one year) for voluntary sector organisations to deliver against 4 priorities • 0-25 year olds make safe and positive decisions • 0-25 year olds have good physical, mental and emotional health • 0-25 year olds grow up in safe families + communities • 0-25 year olds learn + have opportunities to achieve throughout their lives The outcome of these bids will be communicated later this month and we will ensure that these new services link in effectively with services already working within Ashford.
What we are focusing on for the next quarter specific to the key projects	Using the resources locally from the Grant funding for VSO and ensuring this links with other work that is being undertaken by services within Ashford.
Anything else relevant to AHWB priorities NOT mentioned above	The schools in Ashford held a district inclusion conference during February where all schools were represented and the strategic direction was determined. A report can be made available to members who would be interested.
Strategic challenges & risks including horizon scanning?	Reduction in budgets next year is likely so coordination of resources and possible opportunities to bid for other sources of funding will be vital. This will require the cooperation and transparent conversations about what is available to happen. NEETs (Not in Education, Employment or Training) still continue to be a high priority for all partners and a reduction will only be achieved if every agency takes on responsibility for this work.
Any thing else the Board needs to know	There is a new District Partnership Manager (DPM) for Ashford and the work related to embedding the Trouble Families programme and local priorities will now be easier to drive forwards.
Signed & dated	Helen Anderson 10.03.16