AGENDA

WEST KENT CCG HEALTH AND WELLBEING BOARD MEETING

Date: Tuesday 18 October 2016
Time: 4.00 pm
Venue: Tunbridge Wells Borough Council

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1.	**Welcome and Introductions**	
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3.	**Matters Arising**	
4.	**Assurance Framework** - Assuring Outcomes for West Kent	
5.	**Commissioning Children's Services - Outline Proposals & Prospects**	
6.	**Update: Implementing the Health and Wellbeing Board Annual Report Recommendations** - Progress: Officer Development Event 16 August 2016 - Relationships with Local Children's Partnership Groups - Board Development Event 17 January 2017	7 - 8
7.	**Delivering the Five Year Forward View** - Kent & Medway Plan - NHS West Kent Clinical Commissioning Group Primary Care - Strategy	9 - 16

Continued Over/:

Issued on 10 October 2016

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact Yvonne Wilson** on 01732 375251.

8. **Kent Health and Wellbeing Board**

- Feedback
- Issues to be addressed by the West Kent Health and Wellbeing Board

9. **National Childhood Obesity Strategy** 17 - 19

- Update on Tackling Obesity Conference

10. **Any Other Business - Future Agenda Items**

Update: Health Inequalities Action Plans
Commissioning Children's Services

11. **Date of Next Meeting**

20 December 2016, Tonbridge & Malling Borough Council

12. **West Kent Health & Wellbeing Board Meetings 2016 - 2017:**

- 21 February 2017 - Maidstone Borough Council
- 18 April 2017 – Sevenoaks District Council

Quorum 7: To be made up of at least one representative from each of the main partners (Kent County Council, District/Borough Councils and West Kent CCG)

WEST KENT CCG HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON TUESDAY 5 JULY 2016

Present: **Councillor Bowes (Chairman), and Councillors Bowes, Gough, Jones, Lemon and Weatherly, Heather Brightwell, Hayley Brooks, CLIC Trainee, Karen Hardy, Matt Roberts, Thom Wilson, Yvonne Wilson.**

1. WELCOME AND INTRODUCTIONS, APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting.

Apologies had been received from the following Board members:

Gail Arnold	Chief Operating Officer, NHS West Kent CCG
Julie Beilby	Chief Executive, Tonbridge & Malling Borough Council
Cllr Annabelle Blackmore	Maidstone Borough Council
Lesley Bowles	Chief Officer for Housing, Health, Communities and Business, Sevenoaks District Council – Substitute, Hayley Brooks
Alison Broom	Chief Executive Maidstone Borough Council – Substitute, Matt Roberts
Reg Middleton	Finance Director, NHS WK CCG
Dr Andrew Roxburgh	GP representative NHS WK CCG
Dr Sanjay Singh	GP representative, NHS WK CCG
Penny Southern	Director of Disabled Children, Adults, Learning Disability & Mental Health, KCC
Malti Varshney	KCC Public Health/CCG Aligned PH Consultant

2. DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS

There were none.

3. MINUTES OF THE PREVIOUS MEETING 19 APRIL 2016

The minutes of the previous meeting were agreed.

4. MATTERS ARISING

The Chair, Bob Bowes invited specific feedback on the following Action Points from previous meeting:

7/16: Welfare Reforms and Housing Planning Bill (2015 – 2016): Impact on Health
Hayley Brooks reported that initial discussions were yet to be held on the feasibility of setting up a Task & Finish Group. The HWB Partnerships Officer reported on a number of developments since the previous meeting which addressed recommendations of the last meeting including housing and homelessness workshop facilitated by Maidstone Borough Council involving participants from NHS WK CCG; Maidstone & Tunbridge Wells NHS Trust

representation; national and local community voluntary sector; service users; Public Health; faith organisations; KCC and WK HWB.

Cross-borough Housing Strategy development event held (TMBC, SDC and TWBC) which included reflection on economic and health impacts and offered an opportunity to share the outcome of the recent Board deliberations and feed into the strategy development.

Liaison and engagement commenced with local Citizen's Advice Bureaux about the contribution they make, establishing links also with the Self-Care, Self-Management Task & Finish Group work.

Meeting held between NHS WK CCG and Sevenoaks District Council officers to explore joint work supporting work to address Delayed Transfers of Care.

CCG has accepted representation on cross-Kent Board developing protocols for Disabled Facilities Grant.

8/16: Growth & Infrastructure Framework (GIF)
Hayley Brooks reported that Chris Metherill, KCC had duly made contact with borough/district councils as recommended following the last Board Meeting.

5. ELECTION OF WK HWB CHAIR AND VICE CHAIR

Dr Bob Bowes was re-elected as Chair of the WK HWB. Cllr Roger Gough was re-elected as Vice Chair of the WK HWB.

6. KENT HEALTH AND WELLBEING BOARD - FEEDBACK

Cllr Roger Gough highlighted the following key issues from the Kent HWB meeting:

- Discussion on Delivering the Five Year Forward View had been the main agenda item focussing on issues which were at that time a reflection of progress made. Cllr Gough explained that the work had moved on from articulating a 'vision' to developing a 'plan'.

- Workforce Task & Finish Group co-chaired by Hazel Carpenter and Philippa Spicer presented its final report to the Board setting out issues and steps to tackle these. The Kent HWB agreed that this Action Board would serve under the governance of the Delivering the Five Year Forward View Group.

- The Board considered Kent's Better Care Fund (BCF) for 2017-18 which reflected little change from the previous year. The Kent HWB noted that there would be new arrangements for the BCF from 2018 – 2019 with a significant increase in monies from the period 2019 – 20 as part of the programme drive health and social care integration.

- A major review of Obesity work led by local HWBs was conducted and highlighted positive work across Kent. Cllr Gough noted that work on Delivering the Five Year Forward View had begun to recommend a strong focus on prevention, including tackling obesity and highlighting a need to promote increased levels of physical activity.

- Elements of the Joint Strategic Needs Assessment were reviewed.

7. UPDATE: DELIVERING THE FIVE YEAR FORWARD VIEW

Mark Lemon outlined the KCC position as set out in the attached paper as at 19 May 2016. Mr Lemon explained that the Steering Group was meeting regularly and a series of drafts reflecting on progress had been produced.

Cllr Gough reported the following additional information to Board members:

- System Leaders' workshop was held on 21 June 2016 (Bob Bowes and Cllr Roger Gough were in attendance)
- Draft Plan had been submitted to the NHS Executive on 30 June 2016 (this was the 5th version of the Plan)
- Kent & Medway System leaders (including Cllr Gough), were due to meet the NHS Chief Executive on 25 July 2016. The 'centre' had posed a number of key questions for the System Leaders, including how sustainability in the acute sector would be addressed; what investment would look like and how hospital rationalisation will be managed
- Emerging information suggests that the Plans submitted would be graded into three categories, those that adequately set out the plans for the designated footprint area; plans which demonstrated that the work being developed by the System Leaders was broadly on track and the final group where more work was required to construct a credible plan. Early indications suggested that 'support/assistance' may be given to footprint areas falling within this last category
- Localities would be given the period over the summer to do further work on Plans in time for re-submission in September 2016
- The current Plan version contained a coherent and cogent section on prevention
- Emerging Governance arrangements would need to involve 8 CCGs, 23 Providers and Commissioners and a total of 43 'relationships' in the system, a measure of the complexities across the Kent and Medway 'footprint'.

Bob Bowes reported on the "CCG position" and explained that there was now a new way of looking at issues, and no longer an approach which represented a 'CCG view'. Important areas for consideration included prevention; focus for investment; addressing population growth; ways of managing the clustering of populations around GP Federations; the clustering of services in community settings and staffing/skill-mix. A Kent Commissioning Forum and CCG representative body was being established as a Clinical Reference Group in the Delivering the Five Year Forward View governance structures.

8. TASK & FINISH GROUP REPORTS

Self-Care, Self- Management

Tony Jones reported that the group had now held a first meeting with participants drawn from a range of agencies and also including service user representatives. The following was agreed at the first meeting:

- Terms of Reference
- Chair and Vice – Chair arrangements

- Core principles/values and ways of working
- Priorities for action and lead officers

Governance

The HWB Partnerships Officer reported that the Group had not yet completed the task set by the HWB in response to the Kent HWB report on relationships, functioning and leadership, though all the issues highlighted by the Kent HWB had been reviewed in the drafting of the Annual Report before the WK HWB.

WK HWB Annual Report

Bob Bowes introduced the report and acknowledged that it offered the Board important opportunities to:

- place a sharper focus on the work it had carried out
- assess achievements
- refresh its 'direction of travel' within the context of the emerging new agenda
- consider the experience of the Task & Finish Groups
- evaluate the extent to which the HWB had been able to influence/drive forward the integration agenda
- review whether the HWB had influenced strategic commissioning

Bob Bowes invited Cllr Gough's comments as the Chair of the parent Committee to this Board. Cllr Gough expressed the view that the local HWBs were asked to conduct two differing types of business, within an environment in Kent, very different to many other places. Cllr Gough acknowledged the presence of social care at Board meetings had been patchy; discussions around commissioning and the drive towards integration had been limited. However, the role of the district/borough councils was central to the HWB making progress towards a prevention focus and the need for effective relationships between the CCG and councils at a local level was paramount in addressing inequalities and wider determinants. This aspect of the local HWBs work was felt to be what required strengthening as alluded to in the report.

Cllr Gough outlined his position in relation to implementing the Five Year Forward View developed, which was that as new models of care developed including stronger association between commissioners and providers, the rationale for and nature of HWBs as initially established must necessarily change.

Bob Bowes reported that as chair, he felt there needed to be a stronger focus on looking at how to make the HWB more effective by focusing on the population outcomes; how to ensure populations are better served in relation to addressing wider determinants as a result of improved strategic and operational efforts between the CCGs, councils and others.

Cllr Weatherly felt that the HWB had worked very hard, but had not achieved much that affected residents in obvious ways. Pat Graham commented that there was a need to identify common concerns and to understand the needs of different agencies.

The HWB Partnerships Officer drew members' attention to the recommendations set out within the boxes in the Annual Report and emphasised the importance of the Board being able to measure its success, track the work carried out and identified as important and link this to improved outcomes .

It was resolved:

The Chair and HWB Partnerships Officer to meet and review the recommendations and proposed work plan in detail and bring key issues back to an all Board member facilitated away-day' event on 16 September for agreement on the way forward. *ACTION: BB/YW*

To consider ways of strengthening CCG engagement with local councils:

- Discuss with CCG lead officers what potential opportunities exist to progress CCG business priorities by working more collaboratively with district and borough councils
- Invite district and borough council officers to participate in the CCG 'Town Hall' where the whole CCG staff come together to consider organisation-wide development. *ACTION: BB/YW/HB/JH/MR/MV*

That the Board give consideration to identifying a limited number of strategic priorities to which it can apply a stronger focus with the intention of making a measurable difference. *ACTION: WK HWB Event 16 September 2016*

9. LOCAL CHILDREN'S PARTNERSHIP GROUPS INCLUDING CHILDREN & YOUNG PEOPLE'S PLAN: PROGRESS AND PROSPECTS - PRESENTATION ATTACHED

Thom Wilson, Head of Strategic Commissioning, Children's Social Care, Health & Wellbeing at KCC delivered a presentation to the Board based on the slide pack distributed in advance. Mr Wilson explained that the Section 10 of the Children's Act xxxx set out a requirement that agencies collaborate and that each area must maintain a partnership body to undertake strategic and operational planning around the needs of children and young people. In addition, Ofsted required each area to produce a strategy for children and young people.

KCC has developed a 'blueprint', setting out arrangements across the county area that also enables a district focus. Mr Wilson reported that the Children and Young People Plan is being finalised against which 17 indicators of the health and wellbeing of local children and young people have been identified. Each Local Children's Partnership Groups has a strong focus on tracking and measuring indicators of success supported by training in Outcome Based Accountability (OBA) the methodology for delivering interventions capable of addressing the factors at the root cause of the chosen concern/problem/issue. Mr Wilson explained that a performance Dashboard is being compiled using public health and other data which will assist each of the LCPGs and the parent body, the 0-25 Health and Wellbeing Board to assess progress against the Plan ambitions. Mr Wilson described the programme for rolling out training for OBA for commissioning officers and LCPG members. Mr Wilson also explained that it may be possible to offer training on OBA to partners so that there is a shared understanding about the process and meaning behind the OBA methodology.

The Chairs of the West Kent LCPGs had been invited to attend the HWB, Heather Brightwell, the independent chair of the Sevenoaks LCPG was in attendance and shared her reflections on the challenges facing partnership groups to provide a real focus on making a difference and in making sure that identifying real outcomes for local communities, especially those most in need was at the heart of the partnership's work.

Bob Bowes commended the efforts to boost the effectiveness of the Local Children's Partnership Groups and reminded members that careful though needed to be given to making sure the efforts of the LCPG were acknowledged and supported by the HWB which also has a duty to carefully consider how to establish strategic links with these and other strategic partnerships. It was agreed that this issue should also feed into the work to strengthen the HWB's effectiveness. *ACTION: BB/YW/MV/HWB members*.

10. WK HWB REPRESENTATION ON NHS WEST KENT CLINICAL COMMISSIONING & GROUP PRIMARY CARE COMMISSIONING COMMITTEE (ORAL UPDATE)

Cllr Pat Bosley had volunteered to represent the interests of the WK HWB on this newly established Committee. Bob Bowes reported that the first meeting was being held this evening 5 July.

11. ANY OTHER BUSINESS - FUTURE AGENDA ITEMS

None.

12. DATE OF NEXT MEETING

Tuesday 18 October 2016, 4.00pm – 6.00pm, Tunbridge Wells Borough Council

AGENDA ITEM 6

To: **West Kent Health and Wellbeing Board**

From: **Yvonne Wilson, Health and Wellbeing Partnerships Officer**

Date: **18 October 2016**

Subject: **Update on Implementing the Health and Wellbeing Board Annual Report Recommendations**

1. Introduction

This report provides the Board with a brief update on progress in delivering on the ambitions outlined in the Board's Annual Report. Following on the July Board meeting a number of steps were taken to deliver on the following decisions agreed by the Board:

- Carry out a review of the recommendations and proposed work plan in detail and bring key issues back to an all Board member facilitated away-day' event on 16 September and agree the way forward. *ACTION: BB/YW*

- To consider ways of strengthening CCG engagement with local councils (Discuss with CCG lead officers what potential opportunities exist to progress CCG business priorities by working more collaboratively with district and borough councils)

- Invite district and borough council officers to participate in the CCG 'Town Hall' where the whole CCG staff come together to consider organisation-wide development.

- Careful thought needed to be given to making sure the efforts of the Local Children's Partnership Groups (LCPGs) were acknowledged and supported by the HWB which also has a duty to carefully consider how to establish strategic links with these and other strategic partnerships. It was agreed that this issue should feed into the work to strengthen the HWB's effectiveness.

2 Implementation

2.1 <u>Preparing for the Future: Officer Development Event 16 August 2016</u>

2.1.1 A half – day workshop was held involving the WK HWB Chair, Public Health Consultant and sixteen senior officers from across health and local council sectors. The workshop included a series of presentations in which officers outlined:

- Policy Landscape: National Drivers
- NHS (including new primary care strategy)
- Local Authority

- District Authority
- Public Health Assessment – View across West Kent
- Strategic priorities: delivery of the STP

2.1.2 Round table discussions identified a number of important areas/issues:

- Barriers to effective Partnerships/Shared Ownership
- Shared Leadership/Ownership Challenges
- How the Barriers might be overcome

Emerging ideas, topics and issues to be fed into a future Board Development Event.

2.1.3 Chair and NHS West Kent CCG Accountable Officer arranging visits with each of the four District/Borough Council Chief Executives.

2.2 Relationships with Local Children's Partnership Groups

2.2.1 Chair held a series of one-to one meetings with 3 out of four Local Children's Partnership Group Chairs and a further round-table discussion with all the chairs took place – though only two LCPG Chairs attended due to unplanned urgent commitments.

2.2.2 Discussions focussed on understanding developments within the specific LCPG and work underway to focus delivery on local priorities and outcomes. LCPG chairs discussed ways for the HWB to assist their work and ambitions and vice versa. Agreement reached on the value of open dialogue with HWB Chair and commitment to further reflect on the role that the HWB has on influencing changes/developments in services via the commissioning route.

2.3 Board Development Event

2.3.1 Whole Board development event scheduled for 17 January 2017 with an opportunity for focused work on many of the issues highlighted at the Officer's Development event in August 2016.

3. Recommendation

3.1 That the Board discuss and note the developments outlined in the report and seek further timely updates on relevant issues at future Board meetings.

NHS
West Kent
Clinical Commissioning Group

A Vision for a Vibrant and Sustainable Future For Out of Hospital Services in West Kent 2016 - 2021

1

Foreword

- *I decided to become a GP in 1984. The idea of practising holistic medicine in the community with a stable team of fellow professionals has always appealed to me. Having been at my practice for nearly thirty years, I recognise my patients in the street and remember their very personal stories. I have seen their children born and been able to help as they get older. It has been a privilege to share these journeys with my patients, even right up to the end of their lives.*
- *But during this time the star of general practice and primary & community care has fallen. Investment in "out of hospital" services and personnel has fallen back compared to "in hospital" services. So we now see some practices being unable to meet their costs and fewer junior doctors wanting to become GPs. There's also been a fourfold increase in demand over my working life. It's not just about the numbers of patients; the population's needs are more complex. All this forces a real crisis on General Practice.*
- *Yet, the increase in people with multiple long term conditions, frailty and complex social, emotional, medical and psychological problems can only be addressed by harnessing the holistic skills unique to General Practitioners*
- *To meet these challenges, Primary Care has to change. It has to become more capable but also more capacious. GPs need to work more closely with other professionals, leading multidisciplinary teams, managing patients who are more unwell and fostering joined up care..*
- *I am absolutely convinced that strong and effective General Practice is essential to serve the majority of health needs in West Kent. To play their role in this, GPs will need to work in new ways within bigger teams. This strategy explains how commissioners will make this happen*

Dr Bob Bowes, Chair of NHS West Kent Clinical Commissioning Group

Vision for New Primary Care

- Clinicians are working in practices they are proud of, delivering care to patients in a wider truly integrated team.
- Networks of practices are working together in **Multisystem Community Providers**; integrated with care teams from community, secondary care, social care and the voluntary sector.
- New structures and workforce models are in place to allow clinicians to spend more time with their patients, with greater continuity of care and higher quality care for their patients.
- The system allows easy access to the right clinician at the right time, whilst patients with complex needs are managed proactively in the community by a wider multidisciplinary team headed up by their GP and appropriate specialist.
- Everything is underpinned by a shared clinical record.
- The West Kent population benefits from strong primary care provision across Primary Care Strategy for West Kent 2016-2020

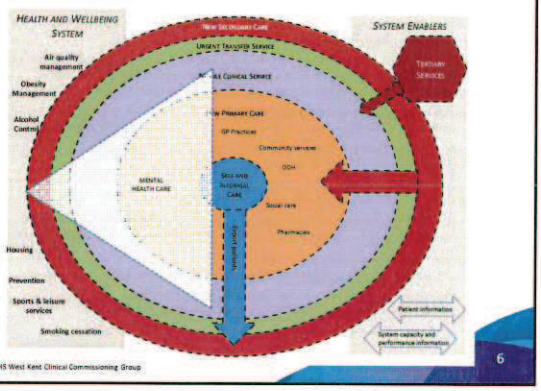
Purpose of the Strategy

- This strategy aims to improve the health, well-being and independence of people living in the West Kent through delivering a step-change in more accessible, sustainable and higher quality out-of-hospital care.
- The outcome will be a range of services from primary, community, children & families and mental health care working in a way which wraps around the patient with the support of social care to ensure that patients stay healthier, independent and at home for longer.
- There will be local solutions in place for better use of resources, allowing more patients to be treated in the most appropriate manner, a better work / life balance for those working in primary and community care and sustainable out of hospital provision.
- The strategy has both to strengthen General Practice and develop New Primary Care.

Mapping the Future

- Mapping the Future (MTF) is a programme of work in West Kent that aims to describe what the health and care system needs and what a modernised health and care service for the 480,000 people who live in West Kent will look like.
- The programme produced an initial future picture of the modern, efficient health and care services that need to be provided in order to meet the changing needs of people in West Kent over the next 5 years. This programme is delivering the NHS Call to Action within West Kent.
- Mapping the Future sets out a whole system approach for West Kent where all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and well-being problems, where people are encouraged and supported to take greater responsibility for their health and healthy choices (the Blueprint).
- Identified the essential role of New Primary Care which is defined as integrated, highly productive and holistic health and social care services delivered close to or in peoples homes. Also foresaw a greater emphasis on prevention and self care. It is a model for more capable out of hospital services to reduce the reliance on the secondary sector
- New Primary Care is an expansion of the capacity and capability of out of hospital care and can only take place on a platform of strong General Practice
- Mapping the Future matches the Five Year Forward View and the Forward view for General Practice. This blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer

Mapping the Future



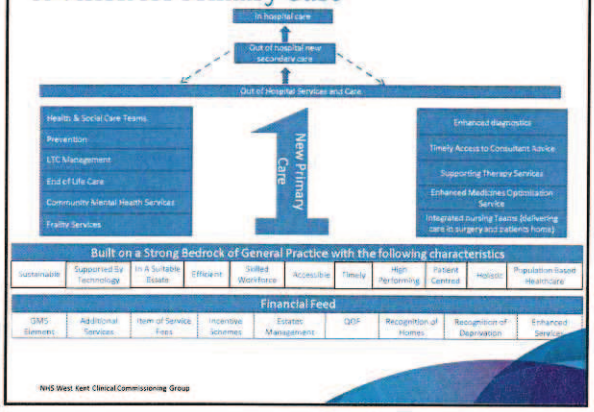
Five Year Forward View

- The *5 Year Forward View* sets out a vision of transformation in health services with emerging 4 key models of care delivery - Primary & Acute Systems (PACS) & Multi-speciality Community Providers (MCPs) models, Integrated Urgent Care Systems & Care Home Commissioning.
- MTF was revisited in light of the Five Year Forward View and the clinical direction agreed that the design of transformed health and care service in West Kent are likely take the form of:
  - **New Primary Care** under a MCP model to deliver 'Out of Hospital' Preventative, Proactive and Planned care services
  - **Integrated Urgent care services** to cover both in and Out of Hospital urgent care services led by Secondary care.
  - **New Secondary Care** to deliver specialist services that need a hospital infrastructure or are better placed in the hospital on specialist expertise, quality or economic basis.

GP Forward View Commitments

- Investment – to accelerate funding for primary care
- Workforce – to expand GP and wider primary care staffing
- Workload – reduce practice burdens and release time
- Practice Infrastructure – develop primary care estate and invest in technology
- Care Redesign – a major programme of improvement support for practices

A Vision for Primary Care



Built on a Strong Bedrock of General Practice

- We aspire to General Practice
  - which is sustainable,
  - in suitable estate,
  - is efficient,
  - has all suitable IT support,
  - has a skilled workforce,
  - is accessible and timely,
  - is high quality and good value for money (including reducing bureaucracy),
  - is holistic and helps to address inequalities
- We will help this by CCG programmes to:
  - help manage demand,
  - strengthen the workforce,
  - develop IT in General Practice
- We will provide disproportionate investment to those practices that face particular problems of demand.
- We will support the development of GP estate.
- We will reduce the complexity of reporting required from Out of Hospital Services

Current Primary Care

- Primary care is defined as the first contact of a patient with a healthcare provider, usually a GP, dentist, pharmacist or optician, in a given episode of illness; it is people's entry point for the prevention and treatment of illness.
- Although people often use 'Primary Care' to mean General Practice, the sector includes a rich diversity of professionals ranging from GPs, Nurse Practitioners, Nurses, Opticians and Pharmacists through to allied health professionals and social care workers.
- Advances in technology and changing demographics mean that, with the right premises and the correct skill mix, a wider range of services can be delivered in a primary care setting.
- Primary Care also has a key role to play in improving health outcomes and reducing health inequalities, promoting healthier lifestyles and prevention
- Primary care services are effective gatekeepers for secondary care and thus ensure that the populations needs are met with high quality and value for money.
- Primary care works closely with Community care, Social care and Mental Health Providers yet the commissioning and provision of these services are not integrated or strategically aligned
- Scale and impact of primary care in the UK
  - GPs and nurses in general practice see over 800,000 people a day;
  - dentists and dental teams see around 250,000 people per day;
  - opticians provide around 12 million NHS sight tests each year; and
  - an estimated 1.2 million people visit a community pharmacy every day.

Challenges in Delivering Core GMS

Challenges in Delivering Core GMS 2

- Present contracts are either activity based or block contracts, depending on the particular sector of the NHS. The former reflects activity in price, not cost and can also lead to activity driving budgetary demand.
- Block contracts run the risk of under performing, with consequent unmet need. In both cases, lack of clarity in specifying both outcomes and the population to be served can lead to under or over performance
- In addition, the multiplicity of commissioners means that there is duplication and omission in assessing need, designing and specifying pathways and delivering outcomes.
- In order to address these weaknesses, place based commissioning offers the opportunity to assess the needs of the whole population, design and agree strategy that meets those needs and then utilise the totality of resources available to commissioners.
- Contracts must therefore specify in detail the outcomes required for the population and increasingly require providers to work together across different sectors to deliver services together.
- Providers will be required to deliver the same services for the same contract and not allowed to apply their own exception criteria.
- Performance will be managed across all contracts. Budgets will be merged across existing commissioning boundaries.

West Kent Primary Care Services: the Case for Change

Strengths

- High calibre, committed workforce
- High quality General Practice compared to national picture
- Good if informal relationships between practices

Weaknesses

- Primary care services are not integrated and therefore a)do not provide a seamless experience for patients and b) could be more productive
- Variable quality across all sectors of primary care
- Demands on health services are increasing but no new primary care investment has been made available
- The primary care estate is variable, lacks flexibility and is not being fully utilised
- The GP workforce is overloaded
- No local system leadership of out of hospital care

West Kent Primary Care Services: the Case for Change

Opportunities

- West Kent CCG operating plan: to develop new primary care and enhance prevention, improve timely diagnostics and health improvement with local authorities
- People are living longer and our opportunities to lead fulfilling lives into old age have grown.
- Improvements in medical and information technology allow better care closer to home
- Potential for enhanced capability and capacity of New Primary care to help the population to live longer and lead fulfilling lives into old age have grown
- Good training arrangements in place
- More interventions are possible in a primary care setting due to Medical and IT advances
- Co-commissioning of GP services

Threats

- Care is fragmented, of varying quality, lacks capacity and has been underinvested. It has not realised its productive potential
- The current model is not flexible enough to adapt services for the most vulnerable in our community
- The demographics of the population are changing. Society is ageing, with an increasing number of people living with long-term conditions and frailty
- Lifestyles have changed and continue to change, affecting our healthcare needs and expectations.
- Traditional GP opening hours may not suit some people while some are less willing to wait for appointments
- Large list sizes in some area making it difficult for GP to deliver anything other than core services

Benefits of Strengthening General Practice

Building teams of community and complex care nurses round clusters of practices who serve populations (of 30-80k, depending on geography) will

- enhance access to diagnostics and specialist nurses and advice from Consultants
- help "make every contact count" and empower patients to take responsibility for their own health
- enhance mental health provision outside hospital
- prevent ill health
- support vulnerable families
- deliver better care for patients with long term conditions, those who are frail or near the end of life, those with dementia, those at higher risk of hospital admission and those with mental illnesses
- Maintain the crucial role of the GP as the senior diagnostician in primary care

Benefits of Federated Working

- General practice teams of the future will be working with groups of other practices and providers as federated or networked organisations. Such organisations permit smaller teams and practices to retain their identity (through the association of locality, personal care, accessibility and familiarity) but **combine 'back-office' functions, share organisational learning** and **co-develop clinical services.**
- **Federated or networked practices** are therefore **well positioned to act as the provider arm** of local communities **and** can work together **to provide extended services** (such as those currently defined as 'enhanced services'), as well as **providing community nursing** services and **GPs with extended clinical roles**.
- Within federations, patients are more than likely to be able to self-refer, if they wish (or be cross referred within the federation), for **physiotherapy, talking therapies** and other services provided in **community-based clinics.** Patients who require routine care will be more than likely to receive this from a **range of community-based providers** working as a **team – including primary care nurses, healthcare assistants, pharmacists, physiotherapists, mental health workers and GPs.**
- Practices within federations will offer more community services to the population registered within their respective practices – for example, **dietetic services, podiatry,** and outreach services dependent on GP skills (e.g. **minor surgery** and **complex contraceptive services**).
- Some practices will form large federations, incorporating hospital, third-sector, private and community providers.
- The GP of the future is likely to be contracted using a number of arrangements, including, but not exclusively, as a salaried practitioner (either as part of a larger provider organisation, a federation, foundation or equivalent trust, or an employee of a third-sector and/or private company organisation) and/or as a self-employed practitioner.
- Federated organisations will be better able to **coordinate out-of-hours care** and ensure the provision of personalised care for those patients who particularly require continuity with their treating team, both in and out of hours. They will also be better placed to monitor, understand and **manage inappropriate variability** in clinical performance, through **joint learning approaches, audit, peer review and other quality-improvement mechanisms**.

Integrated Working – an MCP Model

- Our new primary care model is based on 'hub and cluster' model, but working with the other local care providers to fully align and further develop to full 'Multi-specialty Community Provider' (MCP) status.

- Getting serious about prevention, empowering patients and engaging communities, smarter use of technology and efficiency and more money
- Empowering patients to take responsibility for their own health

Why an MCP over a PACs Model?

- The CCG will set out a commissioning & financial framework for NPC in West Kent with a view to commencing implementation in 2017
- In west Kent we have a good primary care infrastructure with reasonably good performing practices
- We are not able to implement a MCP model for every practice, so we will be seeking to cluster practices together and we envisage that the two emerging federations will evolve to become part of our MCP model
- The CCG wish to work proactively to nurture and evolve our current federations into potent MCPs over a 2-year period
- From 2016/17 onwards, the CCG will be seeking to reconfigure provider contracts aligning the delivery teams of KCHFT and KMPT around the two West Kent GP federations and for provider leadership to be integrated with Federation leadership
- If West Kent Federations and their provider partners are not in a position by 2017 to play a strong part in the new delivery model then a PACS model with the local acute trusts taking the lead may be the only viable choice for NPC. This would go against the wishes of the CCG membership and significantly reduce the value of the contribution to the local health economy made by General Practices having Independent Contractor status

New Model of Primary Care

- The 'hub and cluster' model proposed was developed by considering three key issues:
  - **Individual General Practices** - how can practices retain some autonomy, independence, flexibility and continuity within a new model?
  - **General Practice at scale** - how can practices work SMART together, have a 'collective voice' in the system, share the workload and achieve economies of scale to achieve sustainability?
  - **Multi-speciality Community Provider** - how can general practice work with health and care partners to extend primary care services and extend primary care hours in an integrated patient-centred way, through access to multidisciplinary and specialist advice and support?

Why this model of delivery?

- Achieves Integrated delivery
- Ensuring a critical mass of patients to sustain desired range and levels of service
- Ability to deliver required patient and service outcomes
- Clinical interdependencies
- National thinking and experience of Vanguards
- Value for money from delivering primary care at scale
- Ability to recruit and retain a sustainable workforce

Emerging Primary Care Hub & Cluster Model

The Five Year Forward View sets out a clear policy direction for General Practice to evolve into Multispecialty Community Providers (MCPs). We are underway to design a new MCPs hub and cluster model for primary care in West Kent, which will allow primary care to work at a larger scale reducing the need to go to hospital but ensuring personalised care for patients is maintained.

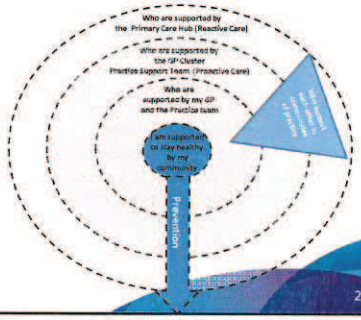
The aim is to establish a new model of care in which clinicians and other care professionals want to work, and that local people want to use - a model that results in better local care.

The hub and cluster model will have the patient at its centre with a named GP and the practice based support team providing in hours GP services for the patient.

The registered list, based in General Practice, will remain the foundation of NHS care.

The Primary Care Cluster will see GP Practices coming together to deliver services as provider networks.

The centralised Primary Care Hubs will provide extended access to patient services, with all elements of the model working together to provide wrap around out of hospital care for the patient.



Primary Care Hub & Cluster Model Outcomes

- Serve a population of patients (to be determined) in a building fit for purpose
- Deliver extended opening to cover 7 day access and additional services (including diagnostics, imaging and CT).
- Create synergy between services by bringing them together e.g. health & social services and voluntary services & public health.
- It will involve the transfer of community services and some existing secondary care services' on a non PBR basis.
- Use a centralised call centre (with ability to offer prescribing out of hours)
- Offer step up and step down beds
- Offer a range of health promotion and prevention services, helping patients to live independently for as long as they wish to
- Offer inpatient and outpatient therapy and ' day case' services.
- Integrate district nurses, health care assistants, therapists, mental health services, social workers, health and social care coordinators palliative care nurses and health visitors, and offer new, innovative ways of providing care
- Use the single integrated patient care record/Care Plan Management on GPIT systems
- Use a principal clinical system that meets the GPSoC standards that will support on line booking for patients, on line access for patients to their records, the ability to receive electronic messages from other care providers (including discharge letters and notifications, transfer of care messages, test results and the ability to generate electronic referral messages)
- Maximise use of other technologies e.g. telemedicine and consider virtual delivery options
- Provide access to common space and facilities e.g. additional rooms/training facilities/medical school/CEPN

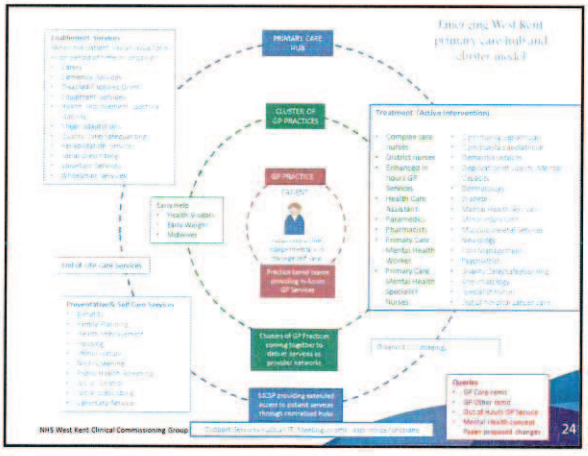
- Encourage general practices to work together to cover a population of patients (to be determined)
- Have teams of staff employed by the hub or its agent "wrapped around" a group of practices serving a minimum number of patients (to be determined)
- Have some roles working within the hub and constituent practices serving a minimum of number of patients (to be determined) e.g. complex care nurses and some other health professionals, dieticians, pharmacists, therapists and midwives

- Use existing practice teams
- Evolve to cover populations of at least 8000 patients (to meet the NHS England threshold for investment)

- A reduction in outpatients
- An increase in complex cases
- A growth in repatriation from tertiary sector

The Cluster Team

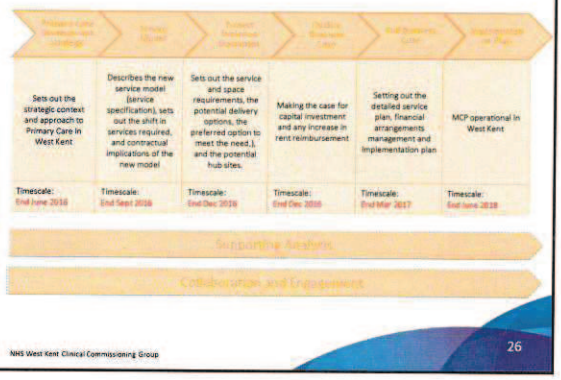
- The Cluster Team **pools the knowledge and care resources** of primary care, community and mental health services, social care, pharmacists and voluntary, community and social enterprise sector partners, to manage the population health of their community.
- They will operate in a single team under the leadership of our local GP's. A team may operate at the level of a large practice, a group of smaller practices, or at a whole locality level. The locality should determine which arrangement works best for them and delivers the greatest improvements.
- Each team will use their combined knowledge and the information about those in their population at greatest risk.
- Informatics tools are available to support this and the aim is to identify the **5% of the population at greatest risk of a health crisis.**
- The Cluster Team will work with each of these people to co-design a **care and support plan** that meets their needs and goals.
- The team will work together to support the delivery of these plans.
- The Cluster Team pools the care resources of primary care, community and mental health services, social care, pharmacists and the voluntary, community and social enterprise sector, to manage the population health of their community
- The Cluster Team will operate in a single team under the leadership of local GP's.
- As a team they will provide enhanced & integrated preventive & proactive care for vulnerable groups of patients - Mental health, End of life, Frail Elderly & LTCs.



The Cluster Team Around The Patient

- Out of hospital care is currently provided in silos with patients often having to attend multiple locations on different occasions to receive their treatment.
- Interagency transaction costs cause delays, expense and poor patient service. Present IT arrangements add to transaction costs.
- We aspire to a create a **network of teams** around the patient (which will serve populations from 30 - 80,000 people depending on geography) whose members manage their patients using all the skills of their colleagues to safely share clinical risk, allow patients to be looked after in their own homes and deliver high quality care. This will require the use of an **shared care record for each team.**
- Since GP systems have records for the entire population served, these will form the basis of this IT. Wherever possible, reporting should be at the level of individual practitioners
- **Team development to enhance working relationships** will be a fundamental part of the new primary care model. The microsystem approach delivers some but not all of this need.
- We need **premises** that will allow these teams to deliver the services described; this might involve a team being housed in a local hub
- Teams will be able to access expertise from secondary care when required, without necessarily having to admit the patient to a hospital bed or to transfer responsibility to secondary care.
- Teams will include GPs, community nurses, specialist nurses, social workers, community mental health workers,
- Pharmacists, therapists and other Allied Health Professionals (AHPs). Almost without exception, there are shortages of each of these professions. Therefore there is a considerable challenge to **recruit and retain this workforce**; the CCG is working to address this.

Developing the Model of NPC



Supporting Strategies & Interdependencies

- Kent & Medway Sustainability & Transformation Plan
- West Kent CCG Operating Plan 2016/17
- West Kent Estates Framework
- West Kent Digital Roadmap
- Quality Improvement Strategy (in production)
- Urgent Care Strategy
- Transforming Outpatients Strategy
- Self Care Strategy
- End of Life Care Strategy
- Dementia Strategy

Emerging CCG Work Programmes

Strengthened General Practice	Developing New Primary Care
Manage demand for general practice services	Mental health provision outside hospital
GP Estate Strategy	Building teams of community and complex care nurses round clusters of practices who serve populations of 30-80k
Disproportionate investment in those practices that face particular problems of demand due to deprivation or high numbers of care home patients	Enhance access to diagnostics
Reduce the complexity of reporting required from General Practice	Specialist Nurses
Develop IT in General Practice	Make every contact count
	Out of hospital bed capacity/Care homes
	Advice from consultants
Strengthen the workforce; recruitment, training and retention	
Working with partner agencies, such as KCC for social care and voluntary sector to create integrated services	

Afterword

- *The NHS is facing some of the greatest challenges in a generation. The population is ageing, more people have long-term conditions, and resources are not keeping pace with demand. Morale amongst frontline clinical staff is an issue and this is leading to problems with recruitment and retention in many areas.*
- *In the face of rising demand and finite budgets, the model of general practice must change if the challenges of preventing ill health, easier access to healthcare and the rising demand of complex technological healthcare are to be met. The Primary Care Strategy tells the 'story' of general practice in West Kent, looks at the challenges ahead and provides a vision for the future. It recognises that the status quo is probably no longer an option.*
- *The strategy discusses initiatives designed to improve provision in a number of key areas and has been designed under the overarching principle of delivering safe and effective health services which patients value and trust. New models of primary care delivery are beginning to emerge across the country and West Kent aspires to be a leader in the delivery of these innovative new models, accepting that there may be slightly different approaches and speed of change in the four localities within West Kent.*
- *Our vision is one where all clinicians will be working in practices that they are proud of, delivering care to patients in wider truly integrated teams.*

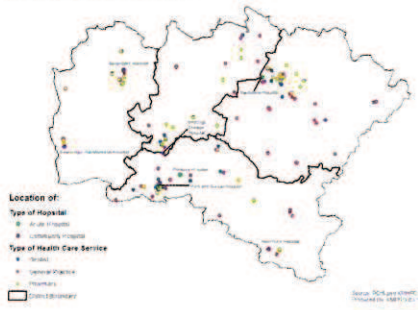
Alistair Smith, Lay Chair of Primary Care Co-commissioning Committee

NHS West Kent Clinical Commissioning Group

Appendix Setting the Scene for Primary Care in West Kent

Primary Care Services in West Kent

West Kent CCG primary health care services



The latest information suggests there will be an approximate 20,704 new dwellings built in NHS West Kent CCG (2006-2031).

An Overview of Primary Care in West Kent

- The number of people registered with a GP in the West Kent area was **476,577 patients**, as at 30 September 2015.
- There are **61** general practices located in the NHS West Kent CCG area.
- Operating out of 81 separate premises including branch surgeries
- Across the NHS West Kent CCG area there are **305** individual GPs registered to practice however, a number work on a part –time basis and therefore this equates to **245.2** full time equivalent GPs working in the NHS West Kent CCG area.
- The practice list sizes range from the largest with **19,832** patients and 8.24 FTE GPs to the smallest **1983** patients and 1.67 FTE GPs.
- However those Practices with the 6 largest lists are currently looking after a combined total of **100,000** patients.
- The individual list sizes for GPs range from **2843** to **9831** patients in the West Kent area.
- There are 68 dental practices, 66 community pharmacists and 50 optometrists premises in West Kent

Setting the Scene

NHS West Kent Clinical Commissioning Group (CCG) is made up of the 61 general practices (doctors' surgeries) in the West Kent area and the majority of patients registered with West Kent practices live in the districts of Maidstone, Sevenoaks, Tonbridge & Malling (T&M), and Tunbridge Wells. The exception being Swanley (Sevenoaks district area) whose residents are predominantly registered with practices in the Dartford Gravesham and Swanley CCG area.

The day-to-day work is overseen by a governing body, which is responsible to the GP practices for commissioning the right healthcare services for people in West Kent and ensuring they provide high quality, value for money care.

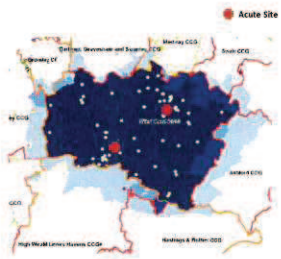
The Governing Body membership comprises 12 GP locality representatives, plus an independent nurse member, an independent secondary care doctor member, a lay member for audit and governance, a lay member for patient and public involvement and the lay chair of the CCG's Primary Care Commissioning Committee as well as the Accountable Officer, the Chief Finance Officer and a Consultant in Public Health. The Governing Body is supported by a number of sub-committees and working groups, including an Audit Committee.

The CCG has an annual budget of £609.8 million to deliver healthcare services for the 480,000 people registered with a GP surgery in the West Kent and those unregistered but resident in West Kent. That equates to around £1,270 per person. The vast majority of the CCG budget was spent on care provided in a hospital setting, other services such as specialised care, the healthy child programme and small elements of primary care (Pharmacy and Optometrists) are paid for by NHS England. Kent County Council commissions public health services, such as sexual health, stop smoking and healthy weight programmes.

Approximate catchment areas of Clinical Commissioning Groups in Kent & Medway

Registered Patient Population	480,000
Number of GP practices:	61
Neighbouring CCGs	9 8 within the south east region 5 within Kent and Medway 1 within London region
Community Hospitals	4
Acute Hospital (within CCG boundaries)	1 hospital across 2 sites (Maidstone and Tunbridge Wells)

Who We Are



- 480, 000 patients
- 61 practices
- 250+ GPs
- 1 Mental Health site with community facilities
- 2 Acute Hospitals
- 4 Community Hospitals
- 9 Neighbouring CCGs

Our Local Population

Population Demographics

- The age profile of the West Kent CCG population is broadly similar to that of Kent; however, it has slightly lower proportions of people aged 16 and 20, and marginally higher proportions of people aged between 40 and 54 years.
- Population demographics will change significantly over the next 5-20 years, with an increasing ageing population, but also in diversity, particularly in town centre areas. Implications for health, social care and education:
  1. Over the next five years it is estimated that the 85 aged population will increase by 22.4% (2,848 individuals)
  2. Over the next twenty years, there will be a population increase of 19%. The largest increase is expected in the over 65 age band, an increase of 59.4%
  3. Nearly 5% of West Kent CCG population is from non-white background.
- Between mid-2012 and mid-2013, despite some outward migration there was a net increase in migration into West Kent of approximately 10,000 people, of which almost one third was classified as international migration. The majority of this migration appears to be within Maidstone, and the population are most commonly aged between 25 and 49, although there are also a high number of the under 15 population. This potentially indicates that a large proportion of migration will consist of families, however, there could be a possibility of unaccompanied young people.

Deprivation and wider determinants

- Each district within West Kent has areas with poor health outcomes that are also the areas with high deprivation, poor levels of educational attainment, high in fuel poverty, poor air quality and high crime rates. This provides challenges as well as the opportunities for partner organisations to develop collaborative commissioning plans to address wider determinants that affect health outcomes.
- Nationally funded programmes are often available through districts to address the wider determinants, such as Warm Homes for energy efficiency or Troubled Families programme for families with multiple problems. These programmes, if used effectively can reduce [illegible] financial and human terms.

Children and Young People

- Childhood indicators such as infant mortality and low birth weight babies are similar to the Kent average, although there is variation between wards. Breastfeeding at six weeks is higher and smoking in pregnancy is lower than the Kent average. Six wards are among the highest two quintiles of teenage conceptions in Kent: Parkwood, Shepway, Snodland East, East Malling, Sherwood and Trench. Of these six, Parkwood is in the highest quintile.
- More children are placed in KCC (Kent County Council) Foster care in West Kent than the Kent average.
- Sevenoaks has the highest number of children from Irish Traveller and Gypsy Roma communities in Kent, also found to be high in Maidstone.
- The gap in school achievement between those entitled and not entitled to universal free school meals is greater in West Kent than the Kent average, with those in poorer households achieving less in the education arena.

Older people

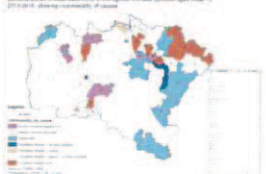
- The highest rate of domiciliary care for people aged over 65 is currently Snodland East and Judd wards (51.3 and 32.4 respectively per 1,000 population). With an expected increase above the Kent average of people over age 85 in Maidstone and Tonbridge and Malling, this picture could change, but will certainly place higher demand on services for both health and social care. In addition there are several wards in West Kent with people over 60 living in deprived households, known to be higher users of services.

West Kent Health Profile Highlights 1

Generally West Kent enjoys good health in comparison to neighbouring geographical areas, but there are still inequalities between areas.

Health Indicators

- Although people in West Kent generally live longer than the rest of Kent, there are still inequalities, in which those in more deprived areas can experience death up to 13.1 years less life than those in more affluent areas.
- Data within this document highlights that within the areas of high deprivation, poor levels of education, high crime rates particularly against the person, housing conditions, homeless people and poorer health outcomes can be found. For example Maidstone has the second highest rates of homeless people in Kent, almost four times the number of people in 2008, usually found within the town centre.



Life Expectancy

- In West Kent life expectancy is higher than for the Kent average (82.7 and 81.7 years respectively). Over the last five years whilst the life expectancy has increased across the whole CCG area, it has increased marginally faster in the most deprived quintile compared to least deprived quintile but there is still a gap of 13.1 years, between the poorest and most affluent areas within the CCG.

Trends in Mortality

- Life expectancy has increased at the average rate of 0.26 years over each two year time period, with marginal increase in the most deprived quintile.
- Mortality rates for under 75 cancer, circulatory and liver disease have decreased, although there has been an increase in under 75 respiratory mortality. The age standardised mortality rate from under 75 liver disease has increased by 1.17 deaths per 100,000 population between 2011-13 and 2012-14.
- Over the most recent recorded ten year period, the average ratio of excess winter deaths in West Kent has remained similar to the Kent ratio (17.4% and 17.5% respectively). This said the West Kent ratio was high in the first five year period, followed by a decrease in the second five year period. Fuel poverty is highest in Tunbridge Wells and Maidstone.

West Kent Health Profile Highlights 2

Diabetes

- Recorded prevalence of diabetes in West Kent CCG is lower than the Kent average, but varies between practices. Recorded diabetes has been increased at a similar rate to the Kent average, and is estimated to continue to do so. There is a moderate association between recorded diabetes and obesity. Additional risks of complications among people with diabetes are higher in West Kent CCG than England and Wales, in particular Heart Failure, Stroke, major and minor amputations and Renal replacement therapy.

Asthma

- Prevalence of asthma in West Kent CCG is similar to Kent (5.6% and 5.5%) but there is variation between practices (ranging between 3.6% to 8.4%). There is no strong correlation between prevalence of asthma and hospital admissions.

COPD

- The prevalence of COPD is below the Kent average (1.49% and 1.8% respectively). Modelling estimates large numbers of undiagnosed cases.

Coronary Heart Disease

- Prevalence of CHD is lower than Kent and Medway and England, again modelling estimates that prevalence is significantly higher, as with hypertension, with an estimated 6,300 undiagnosed patients.

Cancer

- West Kent CCG has a slightly higher recorded cancer prevalence (2.3%) then both Kent and Medway (2.2%) and England (2.1%). Recorded cancer prevalence ranges from 0.8% to 3.9%. Mortality rates are highest in lung cancer for men, and for women rates are highest for lung and breast cancer.
- 54% of lung cancer admissions are emergencies, whilst only 25% are diagnosed at an early stage.
- An estimated 12,788 people in West Kent are living with and beyond cancer up to twenty years after diagnosis.

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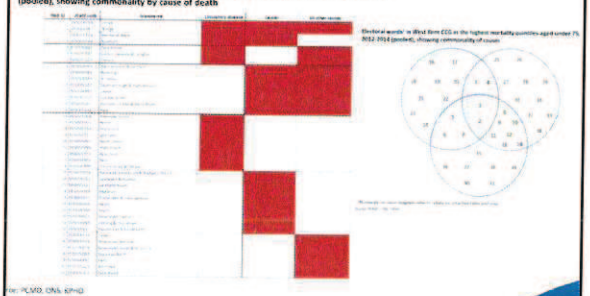
Mortality Rates by Ward

Electoral wards in West Kent CCG in the highest mortality quintile, aged under 75, 2012-2014 (pooled), showing commonality by cause of death



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West Kent Health Profile Highlights 3

Mental Health

- Prevalence is similar to Kent and Medway, and lower than national. Hospital admission rates vary and a number are higher than the West Kent CCG and there is a mild association between prevalence and admissions
- Bridge and Shepway South have the highest contact rates for those aged between 15 and 64 with a mental health condition, although contact rates vary across West Kent CCG from 34.8% to 41.0%
- Emergency admissions for mental illness vary between practices (51.0 to 296.4 per 100,000 population)
- Prevalence of depression is lower in West Kent CCG than in Kent and Medway and England, but there is a variance of 2% to 12.1% between practices
- Suicide rates are similar to Kent, although female are slightly higher. Male rates increase with each age band and peak at 50 to 59, rates then reduce until aged 80 and over. Females remain relatively low and are highest at age 80 and over.

Learning Disability

- Prevalence of patients with learning disabilities is lower in West Kent CCG than in Kent and Medway, and contact rates are highest in Lenham, Park, Bridge and Hildenborough. The overall West Kent CCG contact rate (those in contact with services) for those with mental health learning disabilities is lower than Kent. Detailed analysis also suggests low uptake of annual health checks in some areas.

Dementia

- Dementia prevalence in West Kent CCG is similar to Kent and Medway and England at 0.6%. Referrals into memory assessment clinics continue to increase by approximately 405 per year and emergency admissions with dementia codes as primary or secondary diagnosis have increased by 106.6 per 100,000 population.

Falls

- Hospital admissions due to falls rose steadily until 2011/12 and fell in 2012/13. A small increase occurred in 2013/14 and trend analysis estimates the increase to continue.

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West Kent Lifestyle Factors Affecting Health

Alcohol

- Eleven MSOAs* (have an estimated binge drinking prevalence of above 18.9%, all of which are within Maidstone and Tunbridge Wells wards
- The highest numbers of licenced premises in West Kent are restaurants and cafes, most densely found in town centres. Although pictorially there appears to be higher admissions for obesity or alcohol related conditions from these areas, this is more likely to be due to deprivation as analysis shows no correlation

Obesity & Diet

- An estimated 28% of adults are classified as obese within six MSOAs in West Kent: Snodland East and West; Sherwood; Shepway North and South; Parkwood
- Obesity in reception aged children has reduced from 9.4% to 8.2% and has plateaued. Conversely, at year 6 obesity levels have increased from 16.3% to 18.5% between 2013 and 2014. This equates to prevalence of 30% obesity or overweight at year 6. There are variations in prevalence between wards
- Only 15% of residents from eleven MSOAs in West Kent are estimated to consume the recommend five portions of fruit and vegetables a day

Smoking

- Prevalence of smoking is relatively low in West Kent, but seven wards (six of which are in Maidstone) have a prevalence of over 30%

Air Quality

- Maidstone has measured some of the highest NO_2 concentrations in Kent, particularly around the route from town centre towards Tovil. The crossroads on Tonbridge Road at Wateringbury also has consistently high recorded levels of NO^2

Sexual Health – Contraception, etc

- The uptake of young people's preventative sexual health services is highest in Maidstone
- Abortion rates in West Kent are similar to Kent, but the number of repeat abortions is increasing and is higher than the England average in all CCGs in Kent
- The administration of long acting reversible contraception (LARC) by GP is higher in West Kent than the England average
- Genitourinary Medicine (GUM) clinic attendances are highest in Maidstone, but this is possibly due to the provision of more specialist services at this site. Tonbridge and Malling has the highest number of new appointments. Sevenoaks has the highest number of patients attending out of area services, often in London clinics
- The burden of new Sexually Transmitted Infections (STIs) is increasing in most districts within West Kent, with the exception of Tonbridge and Malling, which was highest in West Kent in 2013 and dropped significantly in 2014
- STIs are highest in those aged 25 and under, but this is expected due to proactive Chlamydia screening
- Maidstone has a higher Chlamydia positivity rate than Kent, although all other West Kent districts were lower
- Gonorrhoea has increased by 2.51% in West Kent, also Genital Herpes 3.56 cases per 100,000 population
- Diagnosed HIV prevalence is lower than Kent in all West Kent districts, but late diagnosis has increased in West Kent between 2009 and 2013

Super Output Areas (SOAs) are a geography for the collection and publication of small area statistics. They are used in the Neighbourhood Statistics site and across National Statistics. There are [illegible] layers of SOA, Lower Layer Super Output Area (LSOA) and Middle Layer Super Output Area (MSOA). The SOA layers form a hierarchy based on aggregations of Output Areas (OAs). The MSOA has a minimum population of 5,000 people and 2000 households and a mean population 7,200 and is built from Lower Layer SOAs. MSOA also fit within local authority districts so are also built from [illegible] within a local authority area.

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AGENDA ITEM 9

To: **West Kent Health and Wellbeing Board**

From: **Jane Heeley, Chief Environmental Health Officer, TMBC and Healthy Weight Lead WKHWB**

Lynne Weatherly, Health Portfolio, Tunbridge Wells and Member Lead for Healthy Weight, WKHWB

Date: **18th October 2016**

Subject: **National Tacking Obesity Conference and Healthy Weight Update**

1. Introduction

This report provides feedback from the National Tackling Obesity Conference on 22nd September 2016, attended by Councillor Lynne Weatherly and Jane Heeley, and considers how the learning from this event might be used to further update our Obesity and Overweight Action Plan to positive effect.

2. Key points from the National Tackling Obesity Conference

2.1 The conference was reminded of the scale of this serious health epidemic:

- one in three children in Year Six are overweight or obese;
- seven out of ten men and six out of ten women are overweight or obese;
- in the last ten years obesity prevalence has increased from 15% to 25%;
- socio-economics are a significant contributor to this.

The conference programme focussed on national guidance and monitoring, through contributions from the authors of the Childhood Obesity Action Plan and NICE, as well as highlighting a number of interventions that have achieved some strong outcomes.

2.2 The presentation from the NICE representative reviewed the main themes that have been identified in the NICE Obesity Pathway and perhaps not surprisingly several of these are themes have been recognised by the Board and its members in developing the Healthy Weight Action Plan; for example the need for practitioner training, evaluation of commissioned activity, identifying barriers for change and addressing those during interventions and additionally the need to take a long term strategic approach both nationally and locally to reducing prevalence. Locally Boroughs and Districts are working with KCC, recognising that local environment is important to enabling and sustaining change, recognising that healthy behaviours need to become part of everyday life and interventions need to be tailored to the needs of the individual.

2.3 It was interesting to note that the NICE evaluation on cost effectiveness showed that moderate cost interventions (£10 to £100 per head) were deemed to be cost effective if they generated a weight reduction of just one kilogram, if that was maintained for life. Low cost interventions (£10 or less per head) were cost effective if a weight loss of less than one kilogram was achieved, even in the short term. Exercise referral schemes had been shown not to be cost effective if the individual was inactive or sedentary, but otherwise healthy.

2.4 Understandably there was much debate round the effectiveness of professionals from across the health sector to talk to patients or clients about overweight and obesity. Different schools of thought emerged from both presenters and the audience. There is clearly a mixed situation in practice, with some professionals readily taking the opportunity to engage on these matters with patients and but also the acknowledgement that many do find these conversations difficult and would benefit from training in having those difficult conversations sensitively and effectively.

2.5 A number of high profile case studies/interventions were discussed in detail, including:

- The Deal for Health and Wellness – Wigan's approach to Weight Management – www.wigan.gov.uk ;
- Brighton – Sugar Smart City – www.brighton-hove.gov.uk ;
- HENRY – Health, Exercise and Nutrition for the Really Young – www.henry.org and
- UK Active Kids – physical activity programmes www.ukactive.com

More details of all these initiatives are available through the website links, however, there is not one thing that they had in common apart from huge enthusiasm and passion for their project. In part Wigan's success could be attributed to the pooled budgets across the Council and CCG, this has greatly facilitated integrated working and been able to resource 8,500 places per annum on their Lose Weight, Feel Fabulous weight management programme. To date participants have numbered 23,000and shed 20,000 pounds between them.

2.6 One of the principle sessions outlined the content of the national strategy for Childhood Obesity – A Plan for Action, which was published in August. It includes the following key actions that are intended to reduce childhood obesity:

- Introducing a soft drinks levy – for both producers and importers;
- Taking out 20% of sugar in products – particularly food consumed by children, e.g. breakfast cereals, yogurts etc. This will be a voluntary scheme for now;
- Making healthy options available in public sector buildings – hospitals, council offices and leisure centres;
- Provide support with the cost of healthy food for low income families – continue with the Healthy Start Scheme
- Clearer food labelling
- Children – 1 hour of physical activity
- Healthy rating scheme – administered by Ofsted, including healthier school food

- Enabling health professionals to support families – MECC

Full detail of the document can be found at:
https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action

The content of the Plan was certainly not welcomed by all, with some strong expressions that the Strategy had not gone far enough in controlling the food manufacturing sector and advertising of unhealthy products.

That said, there are a number of areas for the Task and Finish group to consider, which are outlined in the following paragraph, along with more general learning points from the conference, and with the Board's agreement will be incorporated into our Action Plan and presented at a subsequent meeting.

3. Actions for this Board to consider

- Identify the range of interventions that should be monitored and review the cost effectiveness of these and their outcomes over time, including outcomes from Tier 2 and 3;
- Address the provision of healthy food offers in public sector buildings;
- Continue developing the MECC strategy and progress training at scale and pace, consider whether alternative training is available to deal specifically with conversations about weight;
- Ensure we know where we need to best target our resources to motivate change and identify the local resources and assets to do this;
- Consider how we can get local communities engaged with this agenda through our wider services;
- Review what we are doing around early intervention and develop plans around this;
- Explore what technology is available to support individuals' on this pathway; and
- Ensure that Board members maximise opportunities for engagement with the Kent Change 4 Life campaign.

4. Recommendations

Through this report the Task and Finish Group would like to recommend to the Board that we review how these actions can be incorporated into our existing Action Plan and present to the next meeting of the Board the relevant changes, with suggestions on how they will be implemented.

Jane Heeley
and
Lynne Weatherly