Public Document Pack

SWALE HEALTH AND WELLBEING BOARD MEETING

Date: Wednesday, 17 September 2014
Time: 9.30 am
Venue: Committee Room - Swale House

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Swale Health and Wellbeing Board

Public Meeting

Wednesday 17 September 2014, 9.30am – 11.30am

Committee Room, Swale House, East Street, Sittingbourne, ME10 3HT

AGENDA

Item	Time	Item	Lead
1	9.30	Introductions and apologies for absence	Chair
2	9.35	Minutes of last meeting*	Chair
3	9.40	Medway Foundation Trust Review	Dr Phil Barnes and Shena Winning, MFT
4	10.05	Alcohol Strategy for Kent 2014-2016*	Linda Smith, KCC Public Health
5	10.30	Local Plan and Integrated Delivery Plan	Gill Harris, SBC
6	10.45	Dementia Action Alliance	Tracey Schneider, KCC
7	11.00	Better Care Fund	Tristan Godfrey, KCC
8	11.05	Kent Health and Wellbeing Board: https://democracy.kent.gov.uk/ieListDocuments.aspx?MId=5468&x=1&	ALL
9	11.15	Forward Plan*	ALL
10	11.20	Partners Update/AOB*	ALL
		Dates of future meetings: 19 November 2014 28 January 2015 18 March 2015 20 May 2015 15 July 2015 16 September 2015 18 November 2015	

* Papers attached

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DRAFT MINUTES

Health and Wellbeing Board – Third Formal Meeting

Meeting held on Wednesday 16 July 2014 at 09:30am

Committee Room, Swale House, East Street, Sittingbourne, ME10 3HT

Present:	**Cllr Andrew Bowles (AB), *Leader, SBC (Chair)*** **Cllr Ken Pugh (KP), *Cabinet Member for Health, SBC*** **Amber Christou (AC), *Head of Housing, SBC*** **Patricia Davies (PD), *Accountable Officer, Swale CCG*** **Debbie Stock (DS), *Chief Operating Officer, Swale CCG*** **Dr Fiona Armstrong (FA), *Chair Swale CCG*** **Cllr Geoff Lymer (GL), *Vice-chair Adult Social Care and Health Cabinet Committee, KCC*** **Tristan Godfrey (TG), *Policy Manager, KCC*** **Terry Hall (TH), *Public Health, KCC*** **Bill Ronan (BR), *Community Engagement Manager, KCC*** **Sarah Williams (SW), *Assistant Director, Swale CVS*** **Steve Furber (SF), *Vice-Chair, Swale Mental Health Action Group*** **Lyn Gallimore (LG), *Kent Healthwatch*** **Jo Purvis (JP), *Health Partnerships Officer, SBC*** **Lesley Clay (LC), *Partnerships Manager, Joint Policy and Planning Board*** **Sarah Williamson (SWi), *Project Worker, Joint Policy and Planning Board***
Apologies:	**Cllr Chris Smith, *Chair Adult Social Care & Health Cabinet Committee, KCC*** **Dr Faiza Khan, *Public Health Consultant, KCC*** **Abdool Kara, *Chief Executive, SBC*** **Paula Parker, *Commissioning Manager, KCC*** **Alan Heyes, *Mental Health Matters*** **Penny Southern, *Director Learning Disability and Mental Health, KCC*** **Mark Lemon, *Strategic Business Advisor, KCC*** **Simon Perks, *Accountable Officer, Canterbury and Coastal CCG***

NO	ITEM	ACTION
1.	**Introductions**	
1.1	AB welcomed attendees to the meeting.	
1.2	All attendees introduced themselves and apologies were noted.	
2.	**Minutes from Last Meeting**	
2.1	The minutes from the previous meeting were approved.	
2.2	Outstanding actions were: § p.3, 4.2 – meeting between SBC, Swale CCG and KCC to be arranged re local priorities § p.3, 4.2 – KS to confirm that local PH data will be available by end July. JP to chase.	**JP/DS/FK** **JP**

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3.	Think Housing First	
3.1	LC and SWi gave an overview of Think Housing First, the Housing Health Inequalities Plan for Kent. The key points were: § The Joint Policy and Planning Board (JPPB) is a strategic group, bringing housing and health together across Kent. membership includes all 12 Local Authorities, KCC Social Care, Kent Public Health, Kent Probation and the Prison Service § Think Housing First is a strategic health inequalities plan with two purposes: 1) to show how housing can reduce health inequalities and 2) to demonstrate to other agencies what housing does. § The importance of this work has been recognised by the Smith Institute: http://www.smith-institute.org.uk/file/Housing%20associations%20and%20the%20NHS.pdf § There are lots of private sector housing impacts on health. Organisations such as Staying Put, Swale's Home Improvement Agency, can undertake work in people's homes that can save the health service money in the long-run, i.e. around falls prevention § Housing is an important part of any partnership alongside health and social care and the Care Act 2014 states that housing is a health-related service § Progress has already been made, including LAs agreeing to signpost households placed in temporary accommodation to GP services; working with KFRS to identify households where there is a risk of fire from smoking to develop targeted campaigns and health and safety checks; and promoting healthy eating courses through the Kent Tenant Engagement Group § Currently exploring the pathway for rough sleepers with TB, including length of time they spend in hospital unnecessarily § Health promotion work can be carried out through Kent HomeChoice, the system used by Kent residents to bid for social homes, which receives around 5,000 visits per day § JPPB are also developing a housing and health calculator to show how improving health conditions can reduce costs to health	
3.2	Points made in the discussion included: § Wholehearted support for this agenda and bringing housing and health closer together. The links between housing and health were clearly recognised at the LGA Conference. § GPs can currently write prescriptions for exercise but is there a case for them writing prescriptions for housing interventions? In Leicester this is already happening. JP to find out more. http://www.telegraph.co.uk/earth/energy/10842297/GPs-to-prescribe-a-boiler-to-patients-living-in-cold-homes.html § Need to establish a baseline, so we can show how we've made a difference. This will be done through Think Housing First monitoring arrangements, which will set a baseline in year one. Staying Put's contract with Swale CCG also has targets which are monitored monthly. § SBC Housing Services will be piloting how to better identify people	**JP**

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	with mental health issues and get them referred to appropriate services, particularly those who need intervention before they go into crisis. Need to ensure links with psychological therapy services. § LC will be attending all local HWBs to highlight Think Housing First and the links between housing and health inequalities. Happy to return and feedback at the November HWB.	**LC/JP**
4.	**Physical Inactivity Programme**	
4.1	AF gave a presentation on Kent Public Health's Physical Inactivity Programme. The key points were: § Reducing physical inactivity is not just about weight loss. There is a proven link with all cause mortality. § Highest risk people are those who do no/less than 30 mins exercise per week. § Active People Survey mapped out areas where there is a prevalence for people doing less than 30 mins exercise per week. Sheerness is one of these areas. § Main reasons given were: injury/disability; lack of time; lack of money; not seen as important/necessary. § Kent Public Health are looking to set up a support programme to help people access appropriate activities and provide motivation to encourage them to partake in exercise. § Developing an assessment tool to identify what sections of the population they need to target. Will screen GP patients lists for those at high risk of conditions which suggest they may be physically inactive i.e. diabetes, hypertension. Will then screen down further to those who really need intervention and will potentially cost health more in the future. § The assessment tool will establish what type of support they need – brief intervention, 12 months support or recommendations for more activity. § Public Health are working with Kent HomeChoice to see how the assessment process can be built into the housing register application process § Have a provisional budget, but still needs to be agreed by KCC	
4.2	Key points raised in the discussion were: § Keen to embed this into Swale CCG communications with GPs; FA happy to arrange workshops/presentations to GPs § GP time is limited but practice nurses have more time, do health checks and have more dialogue with patients § Need to consider how this links into IPCTs § Need to consider barriers to activity within the built environment. Are working with Kent Highways and other partners around travel to work. § Physical activity can also have great impacts on mental health, need to think how we link this into the mental health pilot work.	**FA/AF** **AC**
5.	**Mental Health POC Review**	
5.1	KP spoke about the Member review of mental health provision, undertaken by SBC's Policy Overview Committee and circulated their recommendations. The key points were: § SBC are not a provider to mental health services but will work with partners to influence. Strong links have already been made with the CCGs and local partnerships, including SBC attending the Swale CCG	

	mental health commissioning groups to oversee MH contracts. § Right that mental health is include across all the HWB sub-groups and that we have a metal health representative at the main HWB. § Young people's mental health will be picked up by the Children's Operational Group sub-group. Head start services to build young people's emotional resilience are being piloted in Canterbury. § The recommendation around a crisis house for those living hospital without somewhere to live has been discussed with KCC, who have shown interest in the idea. Awaiting more details around potential costings and will discuss further with KCC and report back to the HWB. § KP suggested that Kent Police attend a future HWB to talk about what they are doing around the mental health concordat and the street triage service.	**JP/AH** **JP**
6.	**Better Care Fund**	
6.1	TG updated the Board on the Kent submission: § The Government are introducing a pay for performance element related to a reduction in emergency admissions; they are recommending a local target of 3.5%. Concerns were raised about having a Kent target as there are different levels of admissions across the different hospitals within the Kent economy.	
6.2	DS updated the Board on the Swale CCG approach to the BCF: § Swale CCG are taking a programme management approach –Alison Davies is the programme manger working across Swale CCG, DGS, CCG and KCC Social Care § Focussing on the Integrated Primary Care Teams and the Integrated Discharge Teams and putting additional dementia nurses into the community teams. AD can provide an update at a future meeting if required.	**JP/AD**
7.	**Kent Health and Wellbeing Board**	
7.1	§ Concerns were raised around the late paper tabled on integrated intelligence. Swale CCG had not been consulted on this. § Agreement to the principle of integration but concerns about how it is being done. There was a feeling that this was being rushed through. § Cllr Joe Howes attending the Kent HWB as a District representative as AB and KP unable to attend. JP to brief on Swale HWB's position before the meeting. § PD to raise concerns directly with Roger Gough as Chair of the Kent HWB.	**JP** **PD**
8.	**Partners Update**	
8.1	<u>Swale CCG</u> § Dr Phil Barnes is now Acting Chief Executive of Medway Foundation Trust (MFT), following Nigel Beverley's departure. § MFT have not made progress since their last CQC inspection and will remain in special measures § Swale CCG commission services from MFT, but have limited leverage and are not responsible for their regulation	
8.2	<u>Swale CVS</u>	

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	§ Currently delivering arts intervention across Swale § Working with the Healthy Living Centre on the 6 Ways to Wellbeing	
8.3	Kent Healthwatch § Undertaking work into CAMHS; deep dive into mental health services and impact of the move of mental health in-patient provision from Medway on patients and families.	
8.4	KCC § Developing an integrated care pathway for alcohol in Swale. Planned stakeholder event for 29th September. All to hold in diary. Invites will be sent by Public Health.	**ALL**
8.5	Mental Health Matters § Also looking at impact of travel to Dartford for acute services on patients and families § Welcome the Live it Well hub that Swale CCG are looking to develop within the Sheerness Gateway	
9.	**Future Meetings**	
9.1	JP advised that meeting dates for 2015 need to be set. All agreed to continue with bi-monthly meetings based on the Kent Health and Wellbeing Board timetable. JP to arrange.	**JP**

Next meeting date: **Wednesday 17 September 2014***

Time: **9.30am – 11.30am**

Location: **Committee Room , Swale Borough Council**

***This meeting will be in public**

Future Meetings Dates (all 9.30 – 11.30 at Swale House):

19 November 2014

28 January 2015

18 March 2015

20 May 2015

15 July 2015

16 September 2015

18 November 2015

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By:	Linda Smith Public Health Specialist, KCC Jess Mookerjee, Public Health Consultant, KCC
To:	Swale Health and Wellbeing Board
Date:	17 September 2014
Subject:	Alcohol Strategy for Kent 2014-2016
Classification:	Unrestricted

Summary

Although the majority of people drink alcohol responsibly, there are still a proportion of people for whom alcohol misuse is a problem. Liver disease is on the increase and alcohol misuse can also lead to violence and family disruption. In Kent it is estimated that alcohol harm accounts for approximately £108m of Health commissioning resource each year.[1]

The National Alcohol Strategy makes key recommendations on enforcement and disorder that are echoed in the Kent Strategy. The Kent Strategy for 2014-16 goes further by pledging action to improve the current prevention and treatment arrangements in Kent.

Currently there is evidence that not enough people are being referred for Alcohol Treatment and that too few people are aware of the harm that alcohol misuse is causing them. There are also a number of vulnerable groups, whose needs must be addressed.

This Alcohol Strategy has six pledges for action to reduce alcohol-related harm and seven evidence-based steps that we will take to reduce harm from alcohol consumption. Each local Health and wellbeing Board is asked to consider developing local action plans for implementation of the Kent strategy.

Recommendations

The Swale Health and Wellbeing Board is asked to:

1. note this report and consider key actions from the strategy to be taken
2. develop a Local Alcohol Action Plan to implement the Kent Alcohol Strategy
3. consider creating a multi-partner Task and Finish Group to address the six pledge areas of the Kent Alcohol Strategy

[1] Data Extracted from NHIS Alcohol Impact Model

1. Purpose

1.1 To inform the Swale Health and Wellbeing Board about the Kent Alcohol Strategy 2014-2016 that was approved by Kent Adult Social Care and Health Cabinet Committee earlier this year. [Appendix 1]

2. Background

2.1 Although the majority of people in Swale and the UK consume alcohol responsibly, excessive consumption of alcohol is a growing problem in Kent and across the country and contributes to health issues such as liver disease and obesity. Alcohol also contributes to crime and disorder, is linked to domestic violence, mental distress and family disruption.

2.2 Liver disease is almost wholly attributed to alcohol misuse and is the fifth largest cause of death in England. Liver disease is the only chronic condition that is increasing rapidly in the UK, with a five-fold increase in the development of cirrhosis in 35-55 year olds over the last 10 years. The average age of death from liver disease is 59 years, compared to 82-84 years for heart and lung disease or stroke.

3. Local Needs

Local Authority (LA) and Clinical Commissioning Group (CCG) level information on a number of indicators is available through Local Alcohol Profile (LAPE). Some key points from LAPE (2013) are:

a) Both male and female alcohol specific admissions have decreased from 2006-2008 trends

b) Predicted trends are for admissions to increase

c) Emergency admissions <18 years is declining. Only one indicator: males by Local Authority shows an slight increase (not by CCG area)

d) Liver disease emergency admissions, top three LA wards: West Downs, Sheerness, East, Kemsley (all ages, 2009-20014)

e) Alcohol specific emergency admissions, top three LA wards: Sheerness East, Leysdown & Warden, Sheerness West (all ages, 2009-20014)

f) Liver disease mortality, top three LA wards: Leysdown & Warden, Sheerness East, Abbey (all ages, 2009-20014)

g) 11 indicators are better than the South East average

Further information relating to alcohol profiles is available both at ward and CCG level (please see appendix 2 for an example selection).

4. Kent Alcohol Strategy 2014-2016

The National Alcohol Strategy focuses on the importance of preventing and reducing the impact of alcohol on crime and disorder across the UK.

The New Kent Alcohol Strategy builds on the previous Alcohol Strategy for Kent 2010-2013.

4.1 The Key aims of the Alcohol Strategy for Kent 2014-2016 are to:

a) Reduce alcohol-related specific deaths
b) Continue to reduce alcohol-related disorder and violence year on year
c) Raise awareness of alcohol-related harm in the population
d) Increase pro-active identification and brief advice at primary care
e) Increase numbers referred into treatment providers as appropriate

4.2 The new strategy will strengthen many of the positive actions of the 2010-13 strategy: namely in the area of trading standards and local alcohol partnerships. The Kent Community Action Partnerships (KCAP) were identified nationally as best practice and showed how local action between police, trading standards, industry and the community could have good results in tackling under-age sales, town centre disruption and irresponsible licence holding. The new 2014-16 strategy will expand on this by enabling more KCAP sites across Kent.

4.3 The 2014-16 Kent Alcohol Strategy goes further than the previous strategy in a number of areas, notably the health prevention and treatment pathways. Currently there is capacity in the existing Alcohol Treatment Services which is not being utilised fully.

The development of an Integrated Care Pathway for alcohol and the introduction of a Locally Enhanced Service for Primary Care and pharmacy will help to provide the preventative element and increase earlier access to specialist treatment services.

4.4 A section has been developed for each key area (pledge element) which explores current action, the planned activity for the future and how we will know it has been successful (Table 1).

Table 1

Alcohol Strategy Pledge area	**Priority Actions to Address**
Prevention and Identification	Identification and Brief Advice (IBA) in Primary Care and pharmacies, Training, Social Marketing and targeted promotion. The development of an integrated care pathway for alcohol, increasing access/earlier access into specialist treatment provider services. Proactive case-finding for IBA screening in Primary Care especially those with mental health conditions and vulnerable populations

Treatment	Improve liaison at A&E, Pro-active care into and away from hospital, Creating a liaison team and after-care packages, better signposting. Better joint working and pathways into primary care.
Enforcement and responsibility	Tackling night-time economy, reduction of violence, use of crime & community partnerships, spot checks on traders, working with industry.
Local Action	Continue good practice using KCAP model and expand into areas where there is no KCAP. Improve data and needs assessment. Widen the partnerships. Support local schemes like street pastors and Alcohol Zones.
Vulnerable groups and inequalities	Prioritise dual diagnosis by improving the links between mental health workers and substance misuse treatment providers, domestic violence awareness campaigns and working with perpetrators. Work with the military covenant groups to increase awareness in ex-military/ veteran population.
Children and Young People	Continue with RisKit, lead a Kent-wide campaign, co-ordinate hidden harm strategy linked to KIASS, systematic screening in A&E.

4.5 The development of the Alcohol Strategy for Kent 2014-16 commenced in 2013, and took account of good practice being developed, and therefore many of the actions identified within the strategy are already underway.

- An improved 'in reach' system from the community treatment provider into the A&E in Maidstone and Tunbridge Wells Hospitals and the Queen Mother Queen Elizabeth in Margate.
- Agreement has been reached with many Kent Clinical Commissioning Groups (CCGs) to provide improved access to 'Identification & Brief Advice', where GPs are incentivised to pro-actively screen patients for alcohol misuse and then provide advice and/ or referral to treatment providers.
- Pharmacies will also be incentivised to pro-actively screen patients for alcohol misuse and then provide advice and/ or referral to treatment providers.

5 Implementation

5.1 A strategy implementation group will monitor progress on Kent Alcohol Strategy. This group will meet on a quarterly basis to monitor progress and will review the strategy on an annual basis. The implementation group will include a range of partners.

5.2 Each Health and Wellbeing Board should consider developing a detailed local action plan with a timeline and agreed responsibilities to ensure that actions developed will be focussed on achieving the outcomes within the Kent strategy.

5.3 Each locality will be provided with the widest range of alcohol profiles at Ward and CCG level as available. This will enable each area to target areas for action and provide information to monitor progress against aims and inform commissioning intentions.

6. Conclusion

Whilst much progress has been made in some areas, notably the reduction of admissions in those under 18 years, there is much work to be done to address the actual and predicted trend in hospital admissions across all ages.

By using the clear action 'road-map' of the Kent Alcohol Strategy 'Six Pledges' and 'Seven High Impact steps' and building upon the work to date and willingness to tackle alcohol related harm in our communities, it is anticipated that Kent will make good progress against the aims of the Kent Alcohol Strategy provided that:

- The importance of addressing and implementing the Kent Alcohol Strategy should be (and be seen to be) of high priority amongst organisations
- There should be a willingness to extend data capture and share data
- There should be support for workforce training
- Organisations should work together to avoid duplication and work flexibly to facilitate an integrated and comprehensive approach to tackling alcohol harm in Kent

7 Recommendations:

Members of the Swale Health and Wellbeing Board are asked to:

1. note this report and consider key actions from the strategy to be taken
2. develop a Local Alcohol Action Plan to implement the Kent Alcohol Strategy
3. consider creating a multi-partner Task and Finish Group to address the six pledge areas of the Kent Alcohol Strategy

8. Background Documents

Appendix 1 Kent Alcohol Strategy
Appendix 2 Local alcohol data profiles

9. Contact details

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  Jessica.Mookherjee@kent.gov.uk

Appendix 1 Kent Alcohol Strategy 2014-2016

Kent Alcohol Strategy 2014_16.pdf

Appendix 2 Local alcohol data profiles

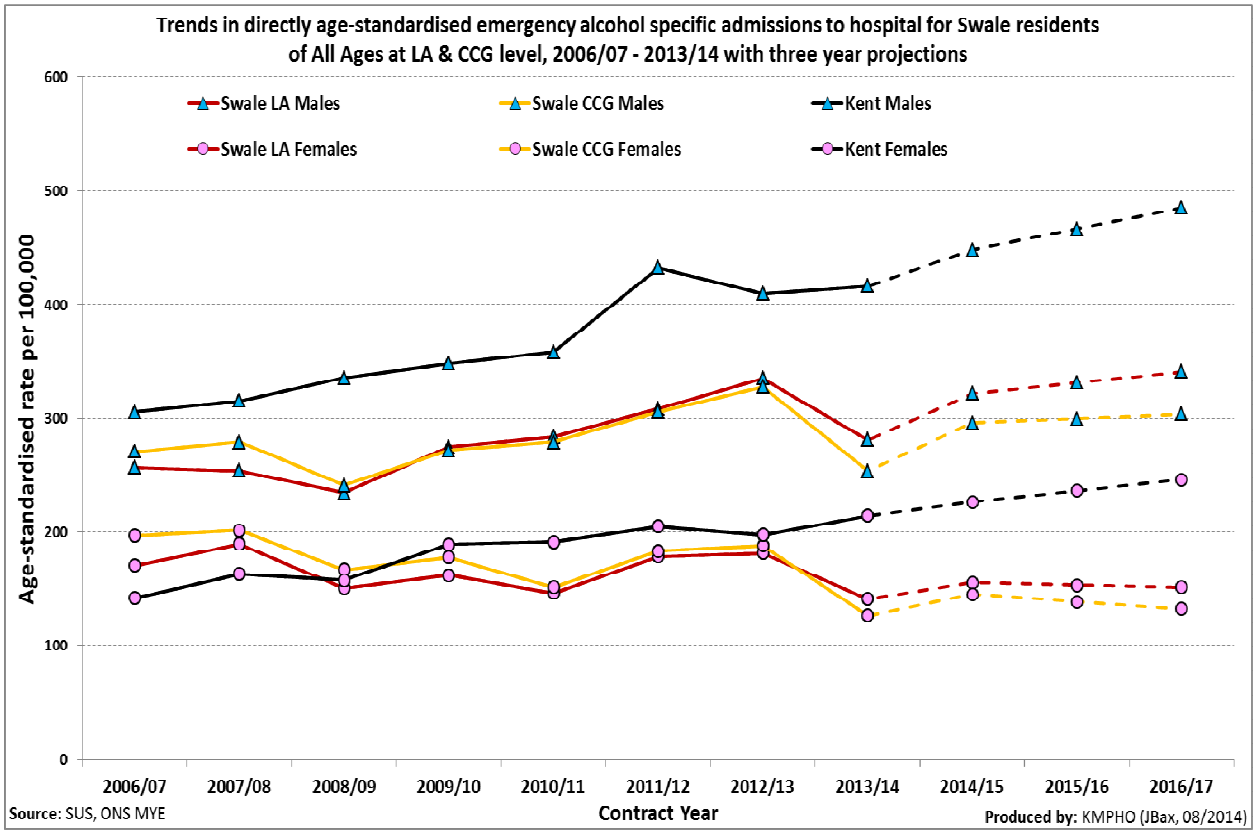
Table 1 Summary of LAPE profile Indicators, 2013 (Source: NWPHO, KMPHO)

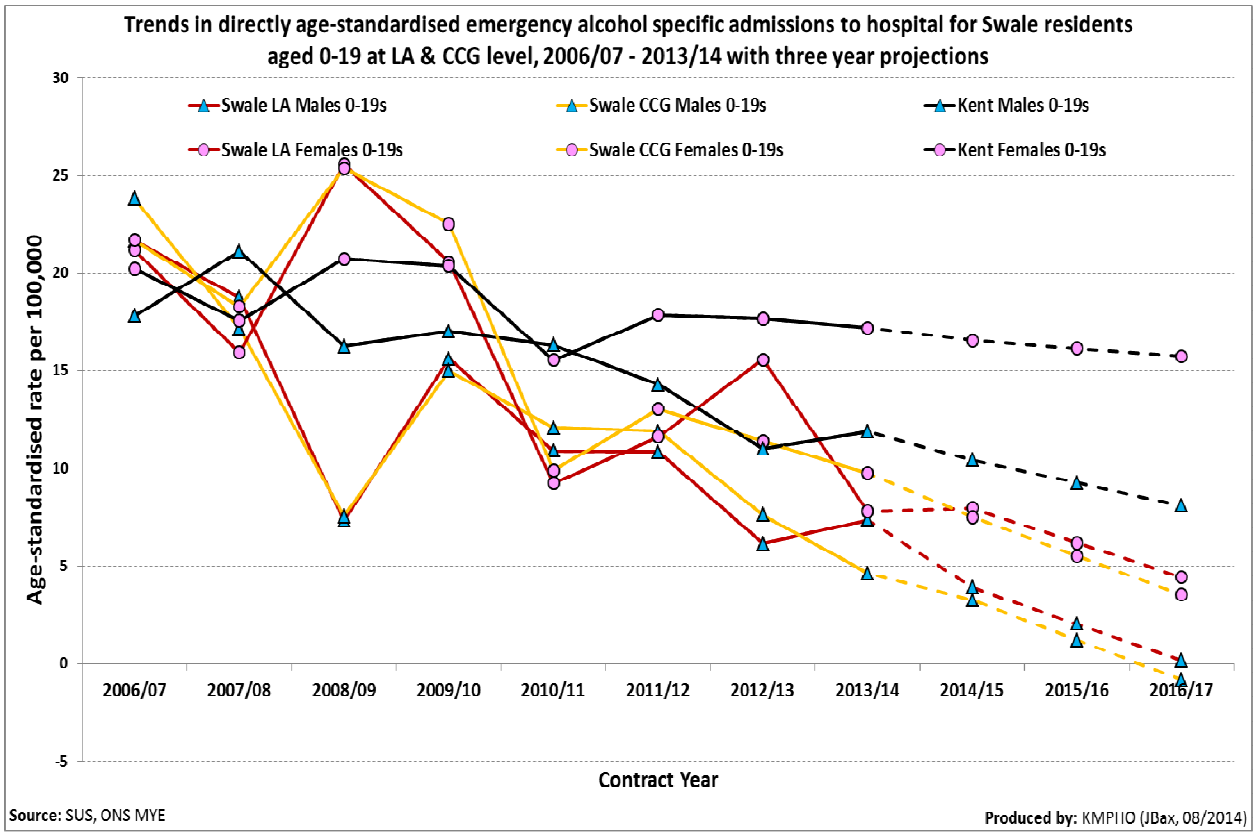
	Indicators	Swale	South East region
Mortality	Months of life lost - males	10.32	9.89
	Months of life lost - females	5.58	4.72
	Alcohol-specific mortality - males	10.40	11.78
	Alcohol-specific mortality - females	5.57	5.35
	Mortality from chronic liver disease - males	13.10	12.94
	Mortality from chronic liver disease - females	8.09	6.92
	Alcohol-related mortality - males	70.16	58.49
	Alcohol-related mortality - females	30.52	25.95
Admissions	Alcohol-specific hospital admission - under 18s	24.68	37.30
	Alcohol-specific hospital admission - males	301.51	375.53
	Alcohol-specific hospital admission - females	166.44	188.37
	Alcohol-related hospital admission (Broad) - males	1509.85	1409.59
	Alcohol-related hospital admission (Broad) - females	746.81	705.48
	Alcohol-related hospital admission (Narrow) - males	517.19	495.95
	Alcohol-related hospital admission (Narrow) - females	262.43	267.25
	Admission episodes for alcohol-related conditions (Broad)	1713.29	1615.65
	Admission episodes for alcohol-related conditions (Narrow)	501.91	513.12
Crime	Alcohol-related recorded crimes	5.65	4.90
	Alcohol-related violent crimes	4.14	3.60
	Alcohol-related sexual offences	0.11	0.11
Other	Abstainers synthetic estimate	14.32	14.73
	Lower Risk drinking (% of drinkers only) synthetic estimate	73.70	72.71
	Increasing Risk drinking (% of drinkers only) synthetic estimate	19.66	20.54
	Higher Risk drinking (% of drinkers only) synthetic estimate	6.63	6.75
	Binge drinking (synthetic estimate)	16.50	18.10
	Employees in bars - % of all employees	1.53	1.59

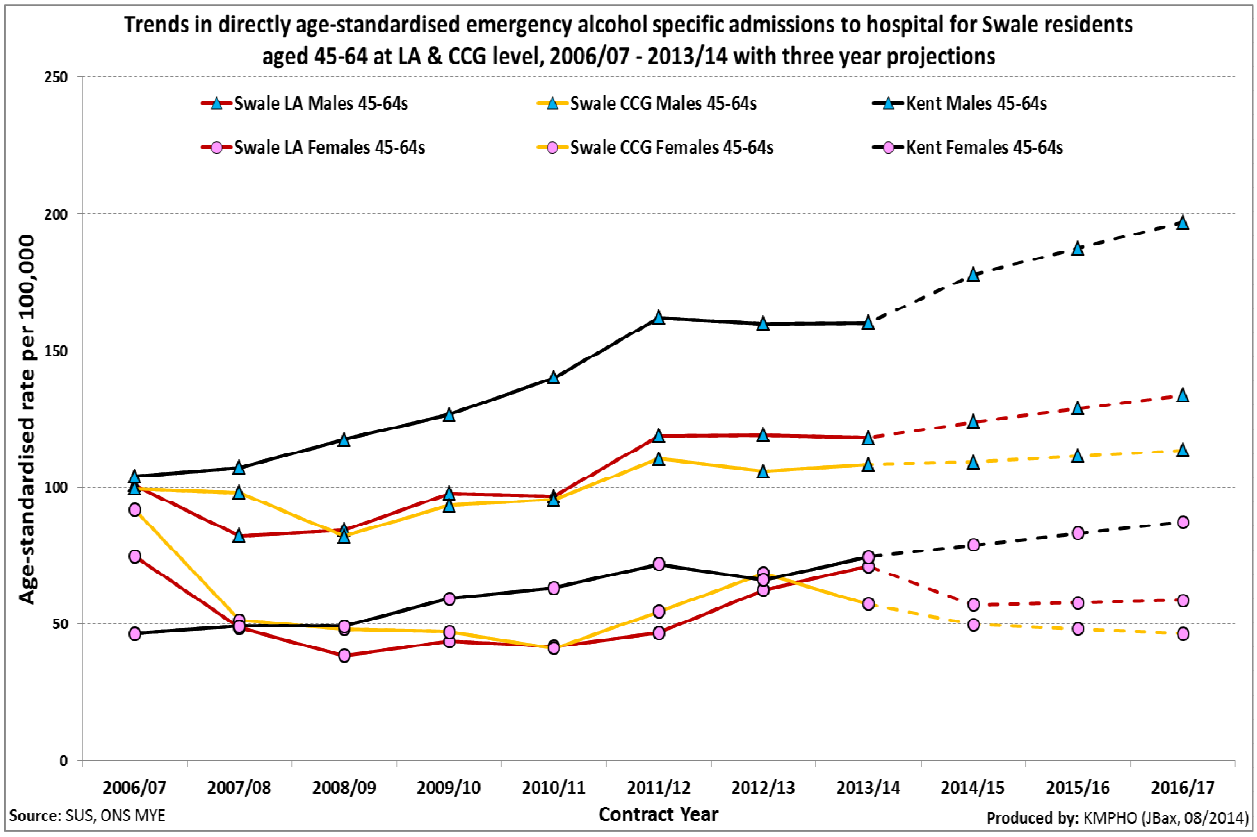
	Best locally
	Better performance than regional average
	Worse performance than regional average
	Worst locally

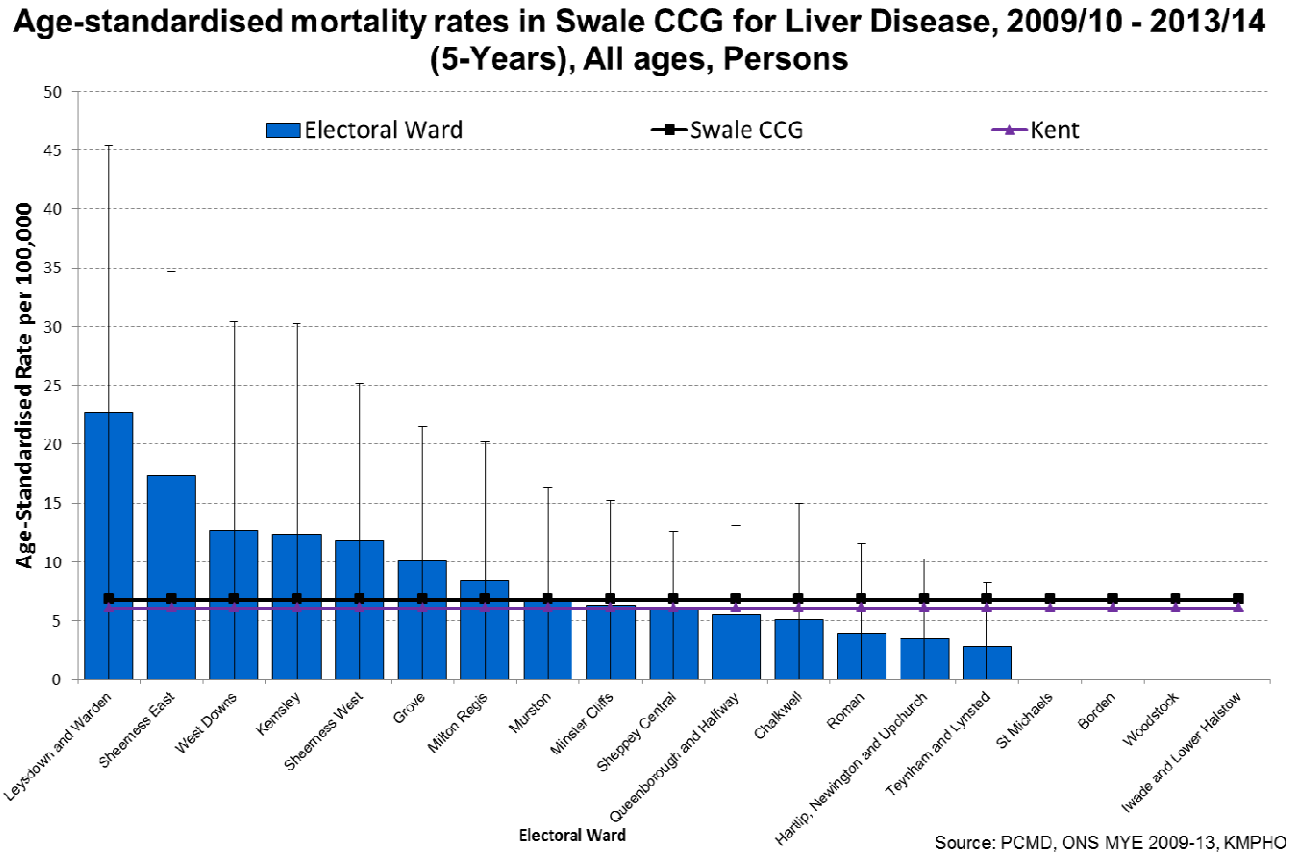
Tables 2 LAPE locality profile with definitions

(278903957) SwaleLAPEProfile201

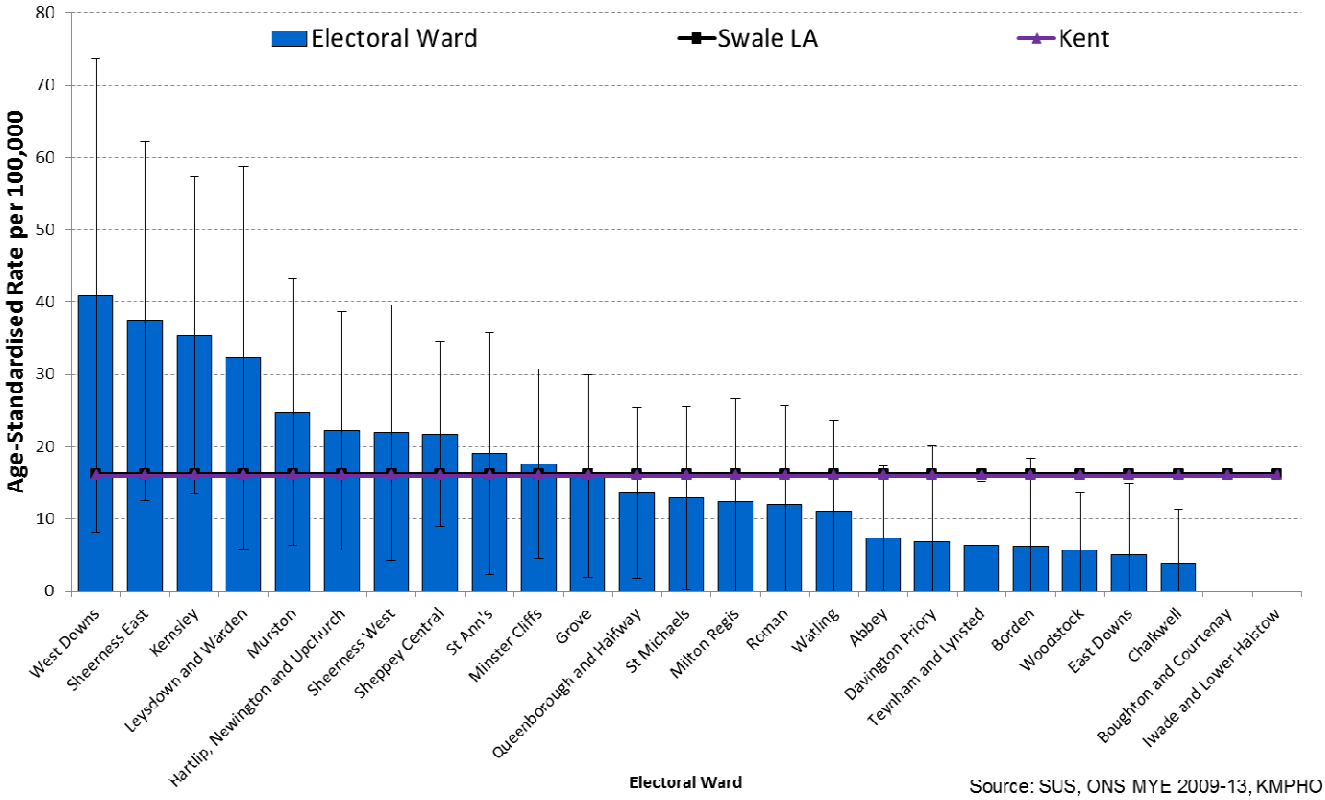

Trends in directly age-standardised emergency alcohol specific admissions to hospital for Swale residents of All Ages at LA & CCG level, 2006/07 - 2013/14 with three year projections
Swale LA Males
Swale CCG Males
Kent Males
Swale LA Females
Swale CCG Females
Kent Females
Age-standardised rate per 100,000
600
500
400
300
200
100
0
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Contract Year
Source: SUS, ONS MYE
Produced by: KMPHO (JBax, 08/2014)


Trends in directly age-standardised emergency alcohol specific admissions to hospital for Swale residents aged 0-19 at LA & CCG level, 2006/07 - 2013/14 with three year projections
Swale LA Males 0-19s
Swale CCG Males 0-19s
Kent Males 0-19s
Swale LA Females 0-19s
Swale CCG Females 0-19s
Kent Females 0-19s
Age-standardised rate per 100,000
30
25
20
15
10
5
0
-5
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Contract Year
Source: SUS, ONS MYE
Produced by: KMPHO (JBax, 08/2014)


Trends in directly age-standardised emergency alcohol specific admissions to hospital for Swale residents aged 45-64 at LA & CCG level, 2006/07 - 2013/14 with three year projections
Swale LA Males 45-64s
Swale CCG Males 45-64s
Kent Males 45-64s
Swale LA Females 45-64s
Swale CCG Females 45-64s
Kent Females 45-64s
Age-standardised rate per 100,000
250
200
150
100
50
0
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Contract Year
Source: SUS, ONS MYE
Produced by: KMPHO (JBax, 08/2014)

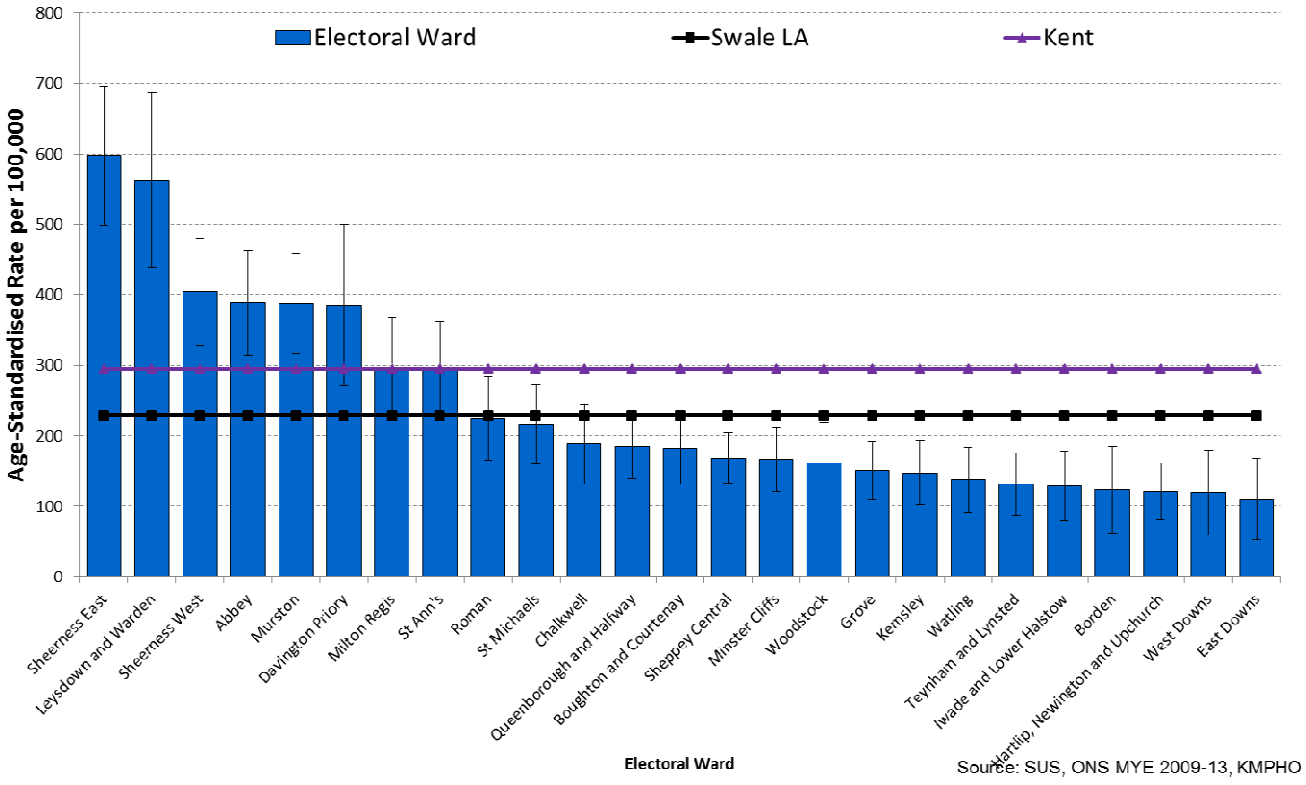

Age-standardised mortality rates in Swale CCG for Liver Disease, 2009/10 - 2013/14 (5-Years), All ages, Persons
Electoral Ward
Swale CCG
Kent
Age-Standardised Rate per 100,000
50
45
40
35
30
25
20
15
10
5
0
Leysdown and Warden
Sheerness East
West Downs
Kemsley
Sheerness West
Grove
Milton Regis
Murston
Minster Cliffs
Sheppey Central
Queenborough and Halfway
Chalkwell
Roman
Hartlip, Newington and Upchurch
Teynham and Lynsted
St Michaels
Borden
Woodstock
Iwade and Lower Halstow
Electoral Ward
Source: PCMD, ONS MYE 2009-13, KMPHO

Age-standardised emergency admission rates in Swale LA for Liver Disease (Primary Diagnosis= K70), 2009/10 - 2013/14 (5-Years), All ages, Persons



Source: SUS, ONS MYE 2009-13, KMPHO

Age-standardised emergency admission rates in Swale LA for Alcohol-specific conditions, 2009/10 - 2013/14 (5-Years), All ages, Persons



Source: SUS, ONS MYE 2009-13, KMPHO

Health and Wellbeing Board – Forward Plan

To schedule:		
Item	**Lead**	**Approx Discussion Date**
0-5 Public Health Children's Commissioning	Kent Public Health	Jan/March
Integrated PCTs and Integrated DTs	Swale CCG	Jan/March

Standing Items	Lead
Swale CCG Update	Patricia Davies/Debbie Stock, Swale CCG
Kent Public Health Update	Terry Hall, Kent Public Health
Better Care Fund	Tristan Godfrey, KCC
Kent Health and Wellbeing Board Papers	All

Sub-group updates	Lead	Discussion Date
Integrated Commissioning Group	Paula Parker, KCC	November 2014
Health Improvement Partnership	TBC	January 2015
Children's Operation Group	TBC	March 2015
Integrated Commissioning Group	TBC	May 2015
Health Improvement Partnership	TBC	July 2015
Children's Operation Group	TBC	September 2015

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Date	Items	Lead Officer/Organisation	Paper Required?	Apologies
17th Sept 2014	Dementia Action Alliance	Tracey Schneider, KCC	No	Paula Parker Debbie Stock Bill Ronan
	Swale Alcohol Pathway	Linda Smith, Public Health	Yes	
	Local Plan and Integrated Delivery Plan	Gill Harris, SBC	No	

Health and Wellbeing Board – Forward Plan

Date	Items	Lead Officer/Organisation	Paper Required?	Apologies
	Medway Foundation Trust Review Update	MFT	No	
	KMPT MH Quality Review	Swale CCG/KMPT	No	
19th Nov 2014	Integrated Commissioning Group Update	Paula Parker, KCC	Yes	Alan Heyes
	Think Housing First Update	Lesley Clay, JPPB	Yes	
	Health and Wellbeing Board Prioritisation	SBC/Kent Public Health/Swale CCG	Yes	
28th January 2015	Mental Health Concordat and Street Triage	Kent Police	No	
	KCC Accommodation Strategy	KCC	Yes	
	Mental Health Crisis House	MHM/KCC/SBC	Yes	

Health and Wellbeing Board – Forward Plan

Date	Items	Lead Officer/Organisation	Paper Required?	Apologies
18th March 2015				
20th May 2015				
15th July 2015				

Health and Wellbeing Board – Forward Plan

Date	Items	Lead Officer/Organisation	Paper Required?	Apologies
16th Sept 2015				
18th Nov 2015				

Health and Wellbeing Board – Forward Plan

Date	Items	Lead Officer/Organisation	Paper Required?	Apologies

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To:	Swale Health and Wellbeing Board
By:	Debbie Smith, Public Health Specialist
Date:	17th September 2014
Subject:	Healthy Living Pharmacy Programme (HLP)

Summary

The HLP is a voluntary national programme aimed at improving the quality of pharmacy services for health improvement. Kent was one of the National early adopters and has the highest concentration of HLP in UK. In Kent it has been adapted to ensure a consistent 'quality platform' across pharmacies, which will form the basis to expand the types of services which may be commissioned in the future. It will also increase and improve the access of the public to Health and Wellbeing services across Kent.

A Kent bespoke e-learning platform has been developed to support pharmacies and will also be available to dentist and opticians in the Autumn 2014. This is particularly important as it offers a tool to train large provider workforces to provide identification and brief advice for lifestyle interventions on the industrial scale required.

Following three launch events in Kent in June 2014, 149 of the 278 pharmacies in Kent are in the process of being registered to the programme. 16 pharmacies registering are from the Swale CCG area. Health Champion training is being offered to two members of staff at each pharmacy to help meet the Healthy Living Pharmacy criteria.

1. Introduction

1.1. The purpose of this paper is to report the status of the HLP programme in Swale.

Background

1.2. The national HLP programme was started in 2011. Kent participated in the national pathfinder work and saw 47 pharmacies participate. Two of these were from the Swale CCG area (Delmergate and Paydens in Sheerness). Evaluation has shown the results are cost-effective and have high levels of public approval.

1.3. The Kent programme was revised in early 2014 with new eligibility and supporting mechanisms and currently has 149 pharmacies registering to the programme.

1.4. A technology grant has been secured to fund a novel and bespoke to Kent, e-learning programme to support pharmacies achieve the development aims of the programme. It will also be made available to opticians and dental services. This e-learning course will also incorporate learning for brief interventions for alcohol and smoking amongst others.

2. Service model aims

- To recognise the significant role pharmacies have in the community and encourage proactive pharmacy leadership and multi-disciplinary working
- To deliver consistent and high quality health and wellbeing services linked to outcomes
- To reduce health inequalities
- To provide proactive health advice and interventions – 'make every contact count'
- To create healthy living 'hubs' and engage with the local community
- To meet commissioners' needs

3. Swale

There are 23 pharmacies located in the Swale CCG area. 16 of these have registered to become Healthy Living Pharmacies. Swale CCG area has the highest percentage of pharmacies registering (70%) and represent 6% of all Kent pharmacies.

Swale Pharmacies registering for Healthy Living Pharmacy		
1.	Asda	Sittingbourne
2.	Boots	Sheerness
3.	Delmergate	Sheerness
4.	Halfway	Sheerness
5.	Iwade	Sittingbourne
6.	Kamsons	Sittingbourne
7.	Kemsley	Sittingbourne
8.	Lloyds	23 London Road, Sittingbourne
9.	Memorial Hospital	Sittingbourne
10.	Minster	Sheppey
11..	Paydens	Sheerness
12.	Sheppey Hospital	Sheppey
13.	Superdrug	Sittingbourne
14.	Tesco	Sheerness
15.	Co-op	Queensborough
16.	Co-op	Sittingbourne

Swale Pharmacies not yet registering for Healthy Living Pharmacy		
17.	Austinoma	Sittingbourne
18.	Boots	Faversham
19.	Boots	Sittingbourne
20.	H2H	Sittingbourne
21.	Lloyds	80 High Street, Sittingbourne
22.	Mistrys	Sheerness
23.	Superdrug	Sheerness

4. Financial Implications

4.1. Kent Local Pharmaceutical Committee (LPC) are funding the pharmacist e-training (leadership element) and will also provide training for the wider workforces of pharmacy, optometrists and dentistry staff to undertake identification and brief advice for alcohol and smoking amongst others.

4.2. Kent Public Health are funding two 'champions' places per pharmacy in the Autumn 2014. All pharmacies registering for HLP will be offered two free places for counter staff.

4.3. Funding has been secured via the technology bid to hold two further event launches across Kent in October and November 2014 (dates and venues to be confirmed).

5. Conclusion

5.1. The HLP is a well-recognised, successful national programme which continues to evolve. The work being done in Kent has a high profile nationally being so comprehensive and integrated into existing and proposed commissioned services.

5.2. The Kent HLP has the potential to substantially increase the capacity and access to Health and Wellbeing services, not only in pharmacies but has the potential to include dentistry and optical outlets also.

5.3. By facilitating a robust 'quality platform', we also may increase our capacity to have 'treatment' services in such outlets in addition to the planned lifestyle interventions.

6. Background documents

Appendix 1 Kent Healthy Living Pharmacy prospectus

HLP Kent prospectus 2014.docx

For Further information please contact:

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NHS Swale CCG

Integrated Performance Report

Month 2 2014/15 (July 2014)

Table of Contents

A) Introduction

This report details the key messages regarding NHS Swale CCG's achievement against the NHS Constitution, Outcomes Framework and delivery of QIPP plans. In addition it provides a summary of contract performance at Medway NHS Trust.

Information within this report covers the financial year 2014/15.

Key points of note are detailed in the Executive Summary. Actions and next steps to mitigate any performance concerns are detailed in the relevant section of the report.

B) Executive Summary

NHS Outcomes Framework

- The CCG is reporting improvements in performance or sustained levels of performance across the range of outcomes with the exception of:
  - Patient experience of GP out of hours services
  - Incidence of Healthcare associated infection - MRSA

NHS Constitution

- For the latest reporting month, May 2014, the CCG has achieved all, but five national targets; Category A Red 1 and 2 8 minute response times, A&E four hour waits, 31 day subsequent treatment (surgery) and 62 day to first treatment GP urgent cancer referral waits.
- For quarter one 2014/15, cumulative, the CCG is meeting all its national standards, except for A&E four hour waits (where two months of data exist).
- For the latest reporting month, May 2014, the CCG has met all, but three national supporting measures; 52 week waits, mixed sex accommodation and Ambulance Handovers.
- For quarter one 2014/15, cumulative, the CCG has met all, but two national supporting measures; 52 week waits and mixed sex accommodation.

Quality Premium

- The CCG is estimating its achievement against the Quality Premium payment to be 46.8%. This is unchanged from the previous month's report.

Provider Performance – Medway NHS Foundation Trust

- There are concerns around the sustainability of referral to treatment standards in a number of specialties, including Orthopaedics. Four hour A&E waits continues to remain below standard.

C) CCG Assurance Framework

BALANCED SCORECARD

The CCG Assurance Framework Balanced Scorecard (Q3) is presented below:

Domain 1	Are local people getting good quality care?	AMBER-GREEN
Domain 2	Are patients rights under the NHS Constitution being promoted?	AMBER-RED
Domain 3	Are health outcomes improving for local people?	AMBER-GREEN
Domain 4	Are CCGs delivering services within their financial plans?	AMBER-GREEN
Domain 5	Are conditions of CCG authorisation being addressed and removed (where relevant)?	NO RAG

Performance for Domain 2 relates to the non-compliance against the A&E 4 hour target and mixed sex accommodation. Further detail in relation to A&E performance and mixed sex accommodation can be found in Section “F” of this report.

Performance for Domain 3 has deteriorated due to the case reported for incidence of healthcare associated infection (HCAI); further information can be found in the Quality & Safety report.

D) NHS Outcomes Framework

SCORECARD:

Target met | within 5% of target | >5% away from target

	NHS Outcome Framework Domain and Indicator - 2013/14 (DGS)	Period	National Average	Current Data	Previous Data	Direction
1- Preventing people from dying prematurely						
1a	Potential Years of life Lost (PYLL) from causes considered amendable to healthcare (rate per 100,000 population)	2012	2060.8	1728.3	2073.9	↑
1.1	Under 75 mortality from cardiovascular disease	2012	65.5	71.9	71.8	→
1.2	Under 75 mortality from respiratory disease	2012	27.4	22.9	26.3	↑
1.3	Emergency admissions from alcohol related liver disease	Oct 12 - Sept 13	24.7	37.7	36.6	→
1.4	Under 75 mortality from cancer	2012	123.3	118.3	132.9	↑
2 - Enhancing quality of life for people with long-term conditions						
2a	Health related quality of life for people with long term conditions	Jul 12-Mar 13	74%	72%	71%	→
2d	Proportion of people feeling supported to manage their condition - PROXY MEASURE	Mar-Sep 13	64.0	62.1	63.8	→
2.3i	Unplanned hospitalisation from chronic ambulatory care sensitive conditions (adult rate per 100,000 population)	Oct 12 - Sept 13	788	783.5	773.1	→
2.3ii	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Oct 12 - Sept 13	311	319.5	312.1	→
3 - Helping people to recover from episodes of ill health or following injury						
3a	Emergency admissions for acute conditions that should not usually require hospital admission	Oct 12 - Sept 13	1186.5	1175.1	1178.7	→
3b	Emergency readmission within 30 days of discharge from hospital	2011/12	11.80%	11.1%	12.30%	↑
3.1i	PROMs for elective procedures - hip replacement	2011/12	0.41	0.44	0.37	↑
3.1ii	PROMs for elective procedures - knee replacement	2011/12	0.29	0.28	0.29	→
3.1iii	PROMs for elective procedures - groin hernia	2011/12	0.08	0.14		
3.2	Emergency admissions for children with lower respiratory tract infections (LRT)	Oct 12 - Sept 13	385.3	377.4	367.7	→
4 - Ensuring that people have a positive experience of care						
4aii	Patient experience of GP out of hours services - PROXY MEASURE	Mar-Sep 13	67.5%	57%	65.5%	↓
5 - Treating and caring for people in a safe environment and protecting them from avoidable harm						
5.2i	Incidence of health care associated infection: MRSA (rate per 100,000 population) - PROXY MEASURE	04/13 - 12/13	1.8	1.9	0	↓
5.2ii	Incidence of health care associated infection: Cdifficile (rate per 100,000 population) - PROXY MEASURE	04/13 - 12/13	27.9	24.3	28	↑

Please note that the NHS Outcomes reported have been updated in some incidences with proxy measures in order to have a more timely position with which to assess CCG achievement. In these cases the data used may not match exactly to the national measurement methodology, but gives a good indication of trend.

Proxy reporting for the suite of emergency admission outcomes is being developed by the CCG/KMCS and will be ready for the next report.

Based on the proxy measures and the outcomes based upon timely nationally published data the CCG is reporting improvements in performance or sustained levels of performance across the range of outcomes with the exception of:

- Patient experience of GP out of hours services
- Incidence of Healthcare associated infection - MRSA

Actions:

- The outcomes will continue to be monitored and more timely proxy measures identified to improve reporting.
- Patient engagement forums through the process of re-commissioning of Out of Hours services will identify why patient experience has reduced and highlight possible mitigation.

E) NHS Constitution

SCORECARD: MAY 2014/15

Indicators	Level	Target	Period	Monthly Performance	Q1 - YTD
Referral to treatment - admitted patients within 18 weeks	Swale CCG	90%	May-14	91.60%	90.88%
Referral to treatment - non-admitted patients within 18 weeks	Swale CCG	95%	May-14	97.15%	97.31%
Referral to treatment - incomplete pathways less than 18 weeks	Swale CCG	92%	May-14	94.95%	94.67%
Diagnostic waiting times - six week breaches	Swale CCG	99%	May-14	99.81%	99.63%
Emergency access - A&E 4 hour waits	MFT	95%	May-14	84.38%	88.91%
Cancer - two week wait from urgent referral	Swale CCG	93%	Apr-14	95.53%	95.53%
Cancer - two week wait for breast symptom referral	Swale CCG	93%	Apr-14	93.10%	93.10%
Cancer - 31 day diagnosis to treatment	Swale CCG	96%	Apr-14	100.00%	100.00%
Cancer - 31 day subsequent treatment (Surgery)	Swale CCG	94%	Apr-14	90.00%	90.00%
Cancer - 31 day subsequent treatment (Anti-cancer drug regime)	Swale CCG	98%	Apr-14	100.00%	100.00%
Cancer - 31 day subsequent treatment (Radiotherapy)	Swale CCG	94%	Apr-14	100.00%	100.00%
Cancer - 62 day urgent referral to first treatment	Swale CCG	85%	Apr-14	81.82%	81.82%
Cancer - 62 day screening referral to first treatment	Swale CCG	90%	Apr-14	100.00%	100.00%
Cancer - 62 day consultant upgrade referral to first treatment	Swale CCG	n/a	Apr-14	100.0%	100.00%
Ambulance response - category A all calls in 8 minutes (Red 1)	SECAMB	75%	May-14	73.01%	75.60%
Ambulance response - category A all calls in 8 minutes (Red 2)	SECAMB	75%	May-14	73.82%	76.30%
Ambulance response - category A all calls in 19 minutes	SECAMB	95%	May-14	96.81%	95.70%
Supporting Indicators	**Level**	**Target**	**Period**	**Performance**	**Q1-YTD**
Mixed sex accommodation breaches	Swale CCG	0	May-14	8	8
Operation cancelled on or after day of admission	Swale CCG	0		Quarterly Reporting	
Operation cancelled 2nd time	Swale CCG	0		Quarterly Reporting	
Care Programme Approach 7-day follow up	KMPT	95%		Quarterly Reporting	
Zero tolerance to over 52 week waiters	Swale CCG	0	May-14	4	6
Emergency access - A&E 12 hour waits from decision to admit	MFT	0			0
Ambulance Handover Compliance*	SECAMB	100%	Apr-14	80.20%	80.2%

SUMMARY:

For the latest reporting month, May 2014, the CCG has breached five national standards, and two supporting measures. The failing national standards are SECAMB Category A Red 1 and Red 2 8 minute response times, A&E four hour waits, 31 day subsequent treatment (surgery) and 62 day to first treatment GP urgent cancer referral waits.

The supporting measure failures are for 52 week waiters, mixed sex accommodation and Ambulance Handovers, although it should be noted that the latter does not form part of the CCG Assurance Framework delivery dashboard and assurance conversations with the Area Team / NHS England.

The CCG Assurance process continues to be run on a quarterly basis, and for the cumulative position for Quarter one of 2014/15, where at least two months of data exists, the CCG is meeting all its national standards, except for A&E four hour waits, and failing two of the supporting measures: 52 week waits and mixed sex accommodation.

A&E FOUR HOUR WAITS:

For the latest reporting month, May 2014, Medway Foundation NHS Trust (MFT) failed the 95% standard achieving 84.38%. From latest SITREPs performance for the week ending 6th July, achievement is at 89.27%, which is an improvement as the average for the past four weeks has only been at 84.61%.

Whilst Swale, from unvalidated data, appears not to have seen a greater level of admissions as a result of pressures in A&E, the Trust as a whole is seeing an increase, after a drop I the levels of admissions of 9.2% in 2013/14. During 2013/14 the average admissions per day from A&E was 29, this has increased in the year to date to 37 admissions via A&E. The growth can be seen back to January and Swale with the lead commissioner, NHS Medway, are working with the Trust to understand this growth, including a direct link to the winter ward.

The pressure in the system, caused by a high level of agency staffing, lack of middle grade doctors and use of locums, and the general operational issues through the Trust, will all potentially reduce the threshold for admission.

In recent months there has been an evidenced increase in the numbers of patients attending from their GP and will be part of an audit at the end of July.

Ambulance conveyances appear to have been sustained at their high levels of 2013/14, with an average of 90 ambulances a day, but at the same time SECAMB to MedOCC pathway utilisation has increased which suggests an overall growth in demand.

Actions:

- An audit of A&E attendances with a particular focus on how patients are presenting, looking at pathway utilisation, GP referrals, and alternative pathways.
- Close monitoring of admissions as the Medway IDT expands, having more of a front end presence. What is the impact of working more closely with clinicians to avoid admissions.

AMBULANCE CATEGORY A RED 1 AND 2, 8 MINUTE / CATEGORY A 19 MINUTE RESPONSE TIMES:

As reported last month, concerns regarding SECAMB's ability to maintain performance in its three national standard KPIs has proved correct and all three failed in May 2014. It should be noted that cumulative quarterly performance is still within the national target, but combined with the failure of this target during 2013/14 there is on-going concern that actions are not in place to mitigate the under-performance within the 2014/15 contract, recognising that it is yet to be signed.

Action: As part of the contract it is expected that SECAMB will produce an improvement plan for Red1 and 2 targets. In the meantime the CCG is able to apply financial penalties for non-achievement of these targets.

52 WEEK WAITS:

In May 2014, the CCG reported nine 52 week waiters, 8 at Kings College Hospital and 1 at UCLH. The CCG awaits a report via KMCS for the UCLH breach. The King's breaches remain in the specialties of General Surgery, Gastroenterology and Neurosurgery and the reasons for the breaches have been outlined in previous months' reports. Kings have given assurances that no patient harms have occurred as a direct result of the long waits and the Quality team are reviewing whether the statement provided gives the CCG assurance on patient harms. In addition the CCG continues to liaise with Kings regarding the status of its patients and the achievement of the recovery plan as outlined in last month's report.

It should be noted that Kings have applied for additional monies via the recent national process for RTT additional activity plans. Most of the activity relates to specialist services and so the impact on the CCG's contract is minimal.

Actions:

- CCG to review the Kings statement on patient harms and if required go back to the Trust to seek further assurance.
- CCG to continue to liaise with Kings regarding the achievement of the recovery trajectory and position statement on Swale long waiting patients.

ADMITTED REFERRAL TO TREATMENT TIME STANDARD:

Last month it was reported that Swale had failed the RTT admitted target, however revised national figures now report achievement of the standard at 90.07%. Despite this there are obviously still issues at certain providers as reported last month that still require investigation.

Whilst the CCG still awaits information regarding Plastic Surgery at Queen Victoria Foundation Trust, it should be noted that the national directive for additional RTT activity and funding has resulted in Swale CCG receiving additional funding of £329k, of which £229k is allocated to Medway Foundation Trust. This should help to alleviate the issues within Orthopaedics in particular where the Trust plans to utilise weekend working and Independent Sector providers to extend capacity in July and August in order to reduce their backlog of over 16 week waiters.

CANCER WAITS:

Whilst the CCG has breached two cancer waiting times standards it should be noted that due to the very small number of patients concerned only a combined total of three breaches has caused the failure in these standards. As such the CCG will continue to monitor these standards, but have not allocated specific actions for rectification prior to evidence of a continued underlying trend.

F) Quality Premium

Against the pre-qualifying criteria and Quality Premium national and local measures the CCG is estimated to achieve 46.8% of the available payment. This represents no movement from the position detailed in last month's report.

The tables have been updated to include delivery information against the CCG's three local priorities which were submitted to the Area Team as evidence of its achievement. Previous information was based upon the CCG's self-certification submission for quarter 4 which indicated that all local priorities had been achieved.

The Area Team will now make an assessment as to whether the information supplied by the CCG is sufficient as evidence.

The Quality Premium is intended to reward CCGs for improvements to the quality of the services that they commission and for associated improvements in health outcomes.

The Quality Premium will be paid to CCGs in 2014/15, based on the quality of health services in 2013/14. This will be based upon four national measures and three local priorities.

In addition there are two pre-qualifying criterion:

- A CCG manages within its total resource envelope for 2013/14, and does not exceed the agreed level of surplus drawdown.

- The total payment for a CCG (based on the seven national/local measures) will be reduced if its Providers do not meet the NHS Constitution rights and pledges for patients in relation to four key areas. Each failure will result in a 25% reduction to the available Quality Premium payment.

Please note NHS England reserves the right not to make any Quality Premium payment in the case of serious quality failures i.e. if the Care Quality Commission judge a provider, from whom the CCG commissions services, is in serious breach of its registration requirement.

QUALITY PREMIUM MEASURES:

Indicator	Target	Value Towards Quality Premium	Period	Performance	Predicted Quality Premium Achievement
National Measures					
Potential Years of Life Lost from cause considered amenable to Healthcare; adults, children and young people	3% reduction 2014 cf. 2013	12.50%	2012 cf. 2011	-16.7%	12.5%
Avoidable Emergency Admissions Composite Measure	Reduction or 0% change 2013/14 cf. 2012/13	25%	Oct-12 to Sep-13	All four measures are maintinaing previous levels of performance	0.00%
ends and Family Test	Improvement in average FFT Score for Inpatients and A&E - Q1 2014/15 cf. Q1 2013/14	12.50%	Q4 v Q1 2013/14	Q4 - 21.3%	12.50%
Incidence of MRSA and Cdiff	No cases of MRSA and Cdiff is below threshold	12.50%	Apr-Mar 2013/14	MRSA Cases - 2 Cdiif Cases 26 cf. 30 Target	0%
Local Priority Measures					
Percentage of people on the hypertension disease register who have a face to face cardiovascular risk assessment (QOF Indicator PP1)*	50%	12.50%	Apr-Mar 2013/14	60.20%	12.50%
No. of people identified through risk stratiifcation as at highest risk of hospital admission who have an anticipatory care plan produced by a multi-disciplinary team*	300	12.50%	Apr-Mar 2013/14	366	12.50%
Patients included on an End of Life Register as a proportion of predicatable deaths*	25% / 199 People	12.50%	Apr-Mar 2013/14	35% / 282 patients	12.50%
				Predicted Quality Premium Achievement	**62.5%**

* Local priorities have been assessed as achieving within the 2013/14 Quarter 4 CCG Self-Certification. Data providing evidence of that achievement will need to be agreed with the Area Team prior to the end of September 2014.

PRE-QUALIFYING CRITERIA:

Indicator	Target	Period	Level	Performance	Impact on Level of Quality Premium Available
Patients on Incomplete Non-emergency pathways Waiting Less than 18 Weeks	<92%	Apr-Mar 13/14	CCG	94.4%	25%
Patients should be admitted, transferred or discharged, within 4 hours of their arrival at an A&E department	>95%	Apr- Mar 13/14	MFT	88.8%	0%
Maximum 62 day wait from urgent GP referral to first definitive treatment for cancer	>85%	Apr-Mar 13/14	CCG	90.1%	25%
Cat A Red 1 Ambulance calls resulting in an emergency response arriving within 8 Minutes	>75%	Apr- Mar 13/14	SECAMB	76.8%	25%
				Total	**75%**

G) Provider Performance – Medway NHS Foundation Trust

NHS CONSTITUTION:

Indicators	Level	Target	Period	Monthly Performance	Q1 - YTD
Referral to treatment - admitted patients within 18 weeks	MFT	90%	May-14	91.24%	91.24%
Referral to treatment - non-admitted patients within 18 weeks	MFT	95%	May-14	97.75%	97.75%
Referral to treatment - incomplete pathways less than 18 weeks	MFT	92%	May-14	96.42%	96.42%
Diagnostic waiting times - six week breaches	MFT	99%	May-14	99.83%	99.83%
Emergency access - A&E 4 hour waits	MFT	95%	May-14	84.38%	88.91%
Cancer - two week wait from urgent referral	MFT	93%	Apr-14	93.03%	93.03%
Cancer - two week wait for breast symptom referral	MFT	93%	Apr-14	94.12%	94.12%
Cancer - 31 day diagnosis to treatment	MFT	96%	Apr-14	96.70%	96.70%
Cancer - 31 day subsequent treatment (Surgery)	MFT	94%	Apr-14	95.00%	95.00%
Cancer - 31 day subsequent treatment (Anti-cancer drug regime	MFT	98%	Apr-14	100.00%	100.00%
Cancer - 31 day subsequent treatment (Radiotherapy)	MFT	94%	Apr-14		
Cancer - 62 day urgent referral to first treatment	MFT	85%	Apr-14	92.63%	92.63%
Cancer - 62 day screening referral to first treatment	MFT	90%	Apr-14	100.00%	100.00%
Cancer - 62 day consultant upgrade referral to first treatment	MFT		Apr-14	100.00%	100.00%
Supporting Indicators	**Level**	**Target**	**Period**	**Performance**	**Q1-YTD**
Mixed sex accommodation breaches	MFT	0	May-14	29	29
Operation cancelled on or after day of admission	MFT	0		Reported Quarterly	
Operation cancelled 2nd time	MFT	0		Reported Quarterly	
Zero tolerance to over 52 week waiters	MFT	0	May-14	0	0
Emergency access - A&E 12 hour waits from decision to admit	MFT	100%		0	0

The Trust has reported breaches in two targets; A&E four hour waits and mixed sex accommodation. All other targets have been achieved for the months of April/May 2014/15.

Actions and mitigations are included within the CCG NHS Constitution section of this report and the Quality Report.

Contract Performance:

Please note that SUS data is not yet available to the CCG for 2014/15. As such information within this section has been drawn from both real time data and the Trust's performance report. Therefore it is an indication of CCG performance and can only be used to highlight key trends.

Non-admitted and Admitted Electives:

From real time data, comparing April to June 2014 to the same period in the previous year, outpatient activity is showing a growth rate of -0.2%, daycases 11.0% and inpatients -0.4%.

Whilst this may convert to favourable contract financial performance, the CCG will need to understand the impact on waiting lists and also Referral to Treatment Times (RTT) and backlogs, given the issues of capacity and RTT performance highlighted within the NHS Constitution section of this report.

Actions:

- When SUS data is available IPM to review the contract performance in admitted and non-admitted electives and triangulate this with referrals, waiting lists and RTT performance.

Unscheduled Care:

From real time data, comparing April to June 2014 to the same period in the previous year, total unscheduled care discharges are showing a growth of -3.5%. This is mirrored in both long and short stays, with long stay, over one day length of stays down by -3.6% whilst short stays are down -3.3%.

Accident and Emergency attendances have grown by 5.0%, or 175 attendances year on year. The volume of discharges are down by 64 which would suggest that activity arriving into the Emergency Department is not of a higher acuity.

Actions:

- The A&E audit at the end of July will review how patients are presenting to the Emergency Department to help to understand the growth in A&E attendances.

H) Programme Management

QIPP Update

At the time of writing this report SUS data was not available to allow the monitoring of the delivery of the QIPP schemes in 2014/15. As such this section of the report focuses on providing an update on the programme areas in terms of their implementation, highlighting on an exception basis any risks to delivery at this stage.

Urgent Care

There are a total of eight schemes of which 5 have a financial QIPP allocated to them, totalling £744k of savings. Of these schemes seven are rated as on plan and only one is flagged as amber.

a. JAS01 Support to Nursing and Residential Homes (Amber): Whilst implementation of this project is rated as green with the care home facilitator in post, on-going Information Governance issues cause the project to be amber overall. This prevents the production of the care homes dashboard which would be used to monitor the overall impact of the project. In the interim a manual report form the care home facilitator will be used to assist in financial modelling of the delivery of the project. The scheme has £125k of savings identified.

Actions:

- Liaise with IPM to evaluate the options available to identify care home patients.

Planned Care

There are a total of seven schemes of which have a financial QIPP allocated to them, totalling £566k of savings. Of these schemes one is rated Red, and six are Amber.

a. Polysomnography (Amber): Rated amber due to the late commencement of the service in early August rather than as planned in June. The delay has been caused by the refurbishment of rooms to allow study to commence.
b. Direct Access Pathology Pricing (Red): There was an expectation in planning that the block contract for Medway Foundation Trust pathology could be reduced by £150k. Whilst the contract is not yet signed this is not going to be implemented and so will not realise any savings in 2014/15.

c. Ophthalmology – Repeat pressures scheme and PEARS (Amber): rated amber due to the delay in the primary eye assessment and referral scheme. Whilst six optometrists in Swale have been trained and assessed the outcome of that is awaited.
   Action: The PEARS service in Medway has been notified to treat Swale patients to ensure that the expected level of reduction in outpatient appointments to Maidstone and Tunbridge Wells NHS Trust is achieved while we await the commencement of the Swale service.
d. Ear Microsuction Service (Amber): A General Practitioner has been identified as an interested party in offering this service. However the lead commissioner is struggling to get engagement from Medway Foundation Trust given the current organisational difficulties the Trust is experiencing.
e. Outpatient Improvement Programme (Amber): This compromises of two schemes, the first to achieve a reduction to the block in outpatients (£180k saving) within the Medway Foundation Trust contract, and the second to set follow-up outpatient rates in the contract (£198k saving). Again, whilst the contract is not signed the 2014/15 contract is based on outpatients being charged on a cost per case basis. However the combined scheme remains amber rated as the move to cost per case would be offset by the contractual follow-up rates and so the net position will not be known until the contract is agreed and monthly monitoring commences.
f. Anticoagulation Service (Amber): This is an AQP procurement planned to increase the provision within community and primary care with an associated reduction in the Medway Foundation Trust block, to deliver a zero net impact. Community contracts have now been issued and the Boots pharmacy service commencement is imminent. However the latter has been delayed due to the lack of access to pathology results.

MENTAL HEALTH

There are a total of nine schemes of which have a financial QIPP allocated to them, totalling £80k of savings, however that is net of £388k in investments. Of these schemes and three are rated Amber and the rest are on plan.

a. ADHD All Age Pathway (Amber): This is a two year project with scoping occurring in 2014/15 and potential procurement in 2015/16. The scheme has been delayed, but the CCG has been notified that a project manager has been identified and will commence the start-up of the project on 7th July. There are no identified QIPP savings in 2014/15.
b. Review Substance Misuse Service (Amber): Whilst there are no savings identified in the Mental Health programme there will be associated savings identified within the Prescribing QIPP schemes. The service has been in place for nine months, however the level of referrals is not yet at planned levels in order to reduce prescribing savings.

Actions:

- A revised pathway is currently being completed by the provider to simplify the referral process in case this is causing a blockage.
- The CCG and provider (Turning Point) to meet with all participating practices to advice of revised pathway.

c. Urgent Care Pathway Review (Amber): A local CQUIN has been developed, based on a North-East England model, regarding reconfiguration of the crisis team and their urgent response. The purpose being to reduce A&E attendances at Medway Foundation Trust, reduce ambulance conveyances, reduce Mental Health inpatient admissions, improve patient care, response times and access to service by GP and patient. This scheme is rated amber as the local CQUIN has not been agreed related to system redesign.