SOUTH KENT COAST HEALTH AND WELLBEING BOARD

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8 April 2013

Dear Councillor

I am now able to enclose, for consideration at the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** on Tuesday 9 April 2013 at 3.30 pm, the following reports that were unavailable when the agenda was printed.

5 **TERMS OF REFERENCE** (Pages 2 - 7)

To receive an update from Caroline Davis, Business Strategy Advisor, Kent County Council (report attached).

7 **JOINT INTEGRATED COMMISSIONING STRATEGY AND PLAN** (Pages 8 - 9)

To receive an update from Mark Lobban, Director of Strategic Commissioning, Kent County Council (report attached).

8 **INTERMEDIATE CARE SERVICES PROJECT UPDATE** (Pages 10 - 17)

To receive an update from Joanne Empson, Commissioning Manager, Kent County Council and Karen Benbow, Chief Operating Officer, NHS South Kent Coast CCG (report attached).

10 **HEALTH AND WELLBEING BOARD SPONSORED PROJECTS UPDATE** (Pages 18 - 19)

To receive an update from Jess Mookherjee, Assistant Director of Public Health at NHS Kent and Medway (report attached).

Yours sincerely

Chief Executive

South Kent Coast CCG Health and Wellbeing Board

Draft Governance Arrangements

The Kent Health and Wellbeing Board (HWB) leads and advises on work to improve the health and wellbeing of the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to:

- secure better health and wellbeing outcomes in Kent
- reduce health inequalities and
- ensure better quality of care for all patients and care users.

The HWB has a primary responsibility to make sure that health care services paid for by public monies are provided in a cost-effective manner. It is supported in this work by a series of sub committees referred to as CCG level Health and Wellbeing Boards.

Role of the CCG level Health and Wellbeing Board

The CCG level Health and Wellbeing Board (HWB) will lead and advise on the development of CCG level Integrated Commissioning Strategy and Plan; ensure effective local engagement and monitor local outcomes. It will focus on improving the health and wellbeing of the people living in their CCG area through joined up commissioning across the NHS, social care, district councils, public health and other services (that the HWB agrees are directly related to health and wellbeing,) in order to secure better health and wellbeing outcomes in their area and better quality of care for all patients and care users.

Terms of Reference:

The CCG level HWB will:

1. Be appointed and act as a sub committee of the Kent Health and Wellbeing Board (a committee of Kent County Council).

2. Develop and deliver a CCG level Integrated Commissioning Strategy and Plan, based on the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and partners Commissioning Plans. This will be signed off by the Kent Health and Wellbeing Board.

3. Consider the totality of the resources in the CCG area for health and wellbeing and consider how and where investment in health improvement and prevention services could (overall) improve the health and wellbeing of local residents.

4. Works with existing partnership arrangements, e.g. children's commissioning, safeguarding and community safety, to ensure that the most appropriate mechanism is used to deliver service improvement in health, care and health inequalities.

5. Endorse and secure joint arrangements where agreed and appropriate; including the use of pooled budgets for joint commissioning (s75), the development of appropriate partnership agreements for service integration, and the associated financial protocols and monitoring arrangements, making full use of the powers identified in all relevant NHS and local government legislation.

6. Undertake monitoring of local outcomes.

7. Ensure effective local engagement on health and care issues, using existing engagement mechanisms where necessary and linking in to any county level engagement work where established.

8. Responsible for developing a local Communication and Engagement Strategy to ensure clear lines of communication/consultation with residents, County Council, Neighbourhood Forums and Patient/Public Networks.

9. Provide advice (as and when requested) to the Kent Health and Wellbeing Board on local service reconfigurations that may be subject to referral to the Kent County Council Health Overview and Scrutiny Committee or the Secretary of State on resolution by KCC HOSC.

10. Be the focal point for joint working in the CCG area to ensure facilities and accessibility, in order to enhance service integration.

11. Report to the Kent Health and Wellbeing Board on an annual basis on its activity and progress against the milestones set out in the Integrated Commissioning Strategy and any established work plan.

12. Responsible for overseeing local project resource to facilitate local pathway redesign, as appropriate

13. Provide recommendations how and where investment, resources and improvements can be made within the Shepway and Dover Districts.

14. Identify how to make the best use of the flexibilities at the Board's disposal, such as devolved/pooled budgets.

Membership:

The Chairman will be elected by the CCG level HWB.

DDC:	Cllr Paul Watkins, Leader
DDC:	Cllr Pat Heath, Portfolio Holder for Health, Well-Being and Public Protection
SDC:	Cllr Pamela Carr, (insert title)
SDC:	Cllr Michael Lyons, (insert title)
SKC CCG:	Karen Benbow, Chief Operating Officer
SKC CCG:	Dr Joe Chaudhuri (insert title)
KCC:	Cllr Roger Gough (insert title) – to be advised
KCC:	Mark Lobban, Director of Strategic Commissioning Families and Social Care
Public Health:	Jess Mookherjee, Consultant in Public Health
Case Kent:	Jan Perfect (insert title)
Health Watch:	To be advised
Local Children's Board Trust:	To be advised

The administering Local Authority is Dover District Council.

Procedure Rules

1. **Conduct.** Members of the HWB are expected to subscribe to and comply with the Kent County Council Code of Conduct. Non-elected representatives on the HWB (e.g. GPs and officers) will be co-opted members and, as such, covered by the Kent Code of Conduct for Members for any business they conduct as a member of the HWB.

2. **Declaration of Disclosable Pecuniary Interests.** Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the HWB and any sub committee of it. A register of disclosable pecuniary interests is held by the Clerk to the HWB, but HWB members do not have to leave the meeting once a disclosable pecuniary interest is declared.

3. **Frequency of Meetings**. The HWB meets at least quarterly. The date, time and venue of meetings is fixed in advance by the HWB in order to coincide with the key decision-points and the Forthcoming Decision List.

4. **Meeting Administration.**
   - HWB meetings are advertised and held in public and administered by the nominated District/Borough/City Council.
   - The HWB may consider matters submitted to it by local partners.
   - The administering Council gives at least five clear working days' notice in writing to each member of every ordinary meeting of the HWB, to include any agenda of the business to be transacted at the meeting.
   - Papers for each HWB meeting are sent out at least five clear working days in advance.
   - Late papers may be sent out or tabled only in exceptional circumstances.
   - The HWB holds meetings in private session when deemed appropriate in view of the nature of business to be discussed.
   - The HWB meetings will be web cast where the facilities are in place
   - The Chairman's decision on all procedural matters is final.

5. **Meeting Administration of Sub Committees**. HWB sub-committees are administered by a principal local authority, in the case of the Clinical Commissioning Group level HWBs, by a District Council in that area. They will be subject to the provisions stated in these Procedure Rules.

6. **Special Meetings.** The Chairman may convene special meetings of the HWB at short notice to consider matters of urgency. The notice convening such meetings shall state the particular business to be transacted and no other business will be transacted at such meeting.

   The Chairman is required to convene a special meeting of the HWB if they are in receipt of a written requisition to do so signed by no less than three members of the HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within five clear working days of the Chairman's receipt of the requisition.

7. **Minutes.** Minutes of all of HWB meetings are prepared recording:

   - the names of all members present at a meeting and of those in attendance
   - apologies
   - details of all proceedings, decisions and resolutions of the meeting

   Minutes are printed and circulated to each member before the next meeting of the HWB, when they are submitted for approval by the HWB and are signed by the Chairman.

8. **Agenda.** The agenda for each meeting normally includes:

   - Minutes of the previous meeting for approval and signing
   - Reports seeking a decision from the HWB
   - Any item which a member of the HWB wishes included on the agenda, provided it is relevant to the terms of reference of the HWB and notice has been give to the Clerk at least nine working days before the meeting.

   The Chairman may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. He must state these reasons at the meeting and the Clerk shall record them in the minutes.

9. **Chairman and Vice Chairman's Term of Office.** The Chairman and Vice Chairman's term of office terminates on 1 April each year, when they are either reappointed or replaced by another member, according to the decision of the HWB, at the first meeting of the HWB succeeding that date.

10. **Absence of Members and of the Chairman.** If a member is unable to attend a meeting, then they may provide an appropriate alternate member to attend in their place, subject to them being of sufficient seniority to agree and discharge decisions of the Board within and for their own organisation. The Clerk of the meeting should be notified of any absence and/or substitution at least five working days prior to the meeting. The Chairman presides at HWB meetings if they are present. In their absence the Vice-Chairman presides. If both are absent, the HWB appoints from amongst its members an Acting Chairman for the meeting in question.

11. **Voting.** The HWB operates on a consensus basis. Where consensus cannot be achieved the subject (or meeting) is adjourned and the matter is reconsidered at a later time. If, at that point, a consensus still cannot be reached, the matter is put to a vote. The HWB decides all such matters by a simple majority of the members present. In the case of an equality of votes, the Chairman shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chairman. For clarity, each Clinical Commissioning Group has one vote, irrespective of whether both the Clinical Lead and Accountable Officer for that Clinical Commissioning Group attend the HWB.

12. **Quorum.** A third of members form a quorum for HWB meetings. No business requiring a decision shall be transacted at any meeting of the HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman either suspends business until a quorum is re-established or declares the meeting at an end.

13. **Adjournments.** By the decision of the Chairman, or by the decision of a majority of those members present, meetings of the HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the HWB decides.

14. **Order at Meetings.** At all meetings of the HWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. They decide all questions of order that may arise.

15. **Suspension/disqualification of Members.** At the discretion of the Chairman, any body with a representative on the HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive meetings without good reason or without the prior consent of the Chairman, or if they breach the Kent Code of Conduct for Members.

Local Health and Wellbeing Board Highlight Report:	**Period (Qtr):** 2012/13 Quarter 4

South Kent Coast Integrated Commissioning Group Update

This report provides an update to the South Kent Coast Health and Wellbeing Board on the Integrated Commissioning Group's planning work thus far. This report provides an overview of the work undertaken and the short, medium and longer term priorities proposed.

The Integrated Commissioning Group includes members from the two DCs, SKC CCG and KCC. The group has met a number of times over the same period the shadow SKC HWBB has been meeting, a couple of membership changes have occurred in this time but this has not affected meeting frequency/occurrences.

As well as completing planning documentation, work is also now underway across the partnership to jointly complete the SKC intermediate care needs assessment, a recognised and key priority for this local area. The project group, which has already been established is aiming to complete project objectives by June 2013 and a highlight report has been circulated to the HWBB for information at Agenda item 8.

Report author: Jo Empson, Commissioning Manager, KCC

MONTHLY/QUARTERLY R/A/G STATUS 2013

Q4 Jan – Mar '13	Q1 Apr – June '13	Q2 July – Sept '13	Q3 Oct – Dec '13
Green			

Agenda Item No 7

Key Milestones:	Achievements / actions completed (From inception to March 2013)
▪ Integrated Commissioning Group set up; ▪ Lead the development of an Integrated Commissioning Toolkit to support development of commissioning strategies and plans (one of the key responsibilities of the CCG level HWBBs); ▪ Manage the Understand Phase; consider where joint efforts offer the highest levels of added value ▪ Manage the Prioritisation Phase and confirm priorities ▪ Manage the Outcomes Phase – ensuring resources are pitched at highest shared priorities, timescales are agreed and outcomes achieved	▪ Integrated Commissioning Group set up and getting to know each other, permanent members confirmed and contributing regularly; ▪ Development of an Integrated Commissioning Toolkit has supported consistency of commissioning strategies/plans countywide; ▪ Managed Understand Phase - sharing of partners priorities and plans, growing understanding of high level finance information and areas where joint working will create added value; ▪ Developed SKC Commissioning Strategy, key themes and sub themes – Prevention and Self Care, Short term care and support (goal orientated), long term care and support and End of Life Care ▪ Developed SKC area documentation to 'stock take' areas of work ▪ Recommend that Intermediate Care, Falls, Teletechnology and Healthy Living should be the highest priorities for integrated commissioning group work – plan currently being re-focused to highlight these immediate priorities ▪ Intermediate Care Project Group initiated
New risks: ▪ Lack of accurate and comparable data is likely to be challenging for partners to draw down and interrogate to appropriate levels for the plan - different outputs required from existing systems ▪ Lack of accurate and comparable data needed to complete the intermediate care needs assessment and other outputs may not be delivered according to plan within the short timescales identified, which may delay work on Intermediate Care priorities and thereby other priorities on the plan. ▪ Competing priorities within each organisation **New issues:** ▪ N/A	**Key Actions for next period (April to June):** ▪ Finalise Integrated Commissioning Plan, ensuring all agree on short, medium and longer term priorities; ▪ Agree plans and workstreams for the Falls, Teletechnology and Healthy Living priorities; ▪ Intermediate Care Project to be supported to decision making phases including the following: o Needs assessment completed – early May; o Future vision for model of care developed based on needs assessment – mid May; o Engagement plan developed and inputs to strategy and model of care sought – mid May; o Engagement with all partners regarding model of care – mid May; o Project group develops commissioning options – end May; o Financial impact of options developed – early June; o Reports submitted through CCG Clinical Cabinets/Partner governance for consideration and decision – mid June; o Report to HWBB outlining project outputs

Local Health and Wellbeing Board Highlight Report:	**Period (Qtr):** 2012/13 Quarter 4

South Kent Coast Intermediate Care Review Project

This report provides an update to the South Kent Coast Health and Wellbeing Board on the Intermediate Care Review Project. This report provides an overview of the project objectives and current status, the key milestones and project risks and issues.

A small 'Task and Finish' project group has been established to deliver the project outputs. The project group includes members from the CCG, KCC, KCHT, EKHUFT as well as patient and voluntary sector representatives. The project group had an initial meeting at the end of March 2013 to approve the project plan and agree the project approach.

Work is now underway across multiple partners to jointly complete the SKC intermediate care needs assessment. The project group are signed up to completing all project objectives by June 2013.

Integrated Commissioning Plan Theme: Short term care and support.

Aims/Objectives: Review of intermediate care focusing on achieving the right model of care for SKC residents. The project objectives are:

(a) An agreed a definition of intermediate care – to achieve a common understanding of intermediate care to steer the project and to support the development and delivery of the future model of care;
(b) Robust needs assessment of intermediate care – to show current provision and service efficiencies, current need and impact on services and future population and service needs;
(c) Commissioning options – informed by needs assessment outcomes to achieve the future vision for intermediate care. These options will include short and medium term options.
(d) Outline business case (if required) – for future model of care.

Report author: Zoe Mirza, Head of Integrated Commissioning South Kent Coast Clinical Commissioning Group.

For further details of project please see appendix.

MONTHLY/QUARTERLY R/A/G STATUS 2013			
Q4 Jan – Mar '13	**Q1 Apr – June '13**	**Q2 July – Sept '13**	**Q3 Oct – Dec '13**
Green			

Key Project Milestones:

- Project initiation – February to March;
- Agree intermediate care definition – March;
- Complete needs assessment - March to May;
- Confirm commissioning options for future model of care – May to June

Achievements / actions completed (February to March)

- Integrated Commissioning Group approval of project objectives and methodology on 26 February;
- Project team membership established to include representatives from all key partners as well as patient and voluntary sector representatives by 11 March;
- 'Task and Finish' Project Group established and held first meeting on 25 March and agreed the following:
  (a) Defined project scope;
  (b) A definition of intermediate care;
  (c) Information requirements for needs assessment;
  (d) Commitment between partners to deliver the project according to plan.

New risks:

- Project outputs not delivered according to plan within short timescales identified – the project group have signed up to deliver the objectives but recognise the challenge of completing all outputs by June;
- Lack of accurate and comparable data needed to complete the needs assessment – project group have agreed data requirements against a clear definition and will use the same timeframe of measurement where possible and have agreed specific deadlines for providing the data.

New issues:

- Inaccurate understanding of aims of project by external agencies – project group recognise the need to ensure the use of consistent messages when communicating the purpose and scope of project.

Key Actions for next period (April to June):

- Partners to provide data to inform needs assessment by 15 April;
- CCG to undertake initial analysis of needs assessment data 20 April;
- Project group to review initial analysis of the first stage of the needs assessment and finalise outstanding information requirements on 23 April;
- Engagement with virtual patient participation group supporting the project to seek views – early May;
- Needs assessment completed – early May;
- Project group develops future vision for model of care based on needs assessment – mid May;
- Further engagement with virtual patient participation group to seek input into the model of care development – mid May;
- Engagement with CCG members on model of care – mid May;
- Project group develops commissioning options – end May;
- Financial impact of options developed – early June;

	▪ Report to CCG Clinical Cabinet for consideration and decision – mid June; ▪ Report to HWBB outlining project outputs.

APPENDIX
Project Brief: South Kent Coast Intermediate Care Review

Project Aim:
This South Kent Coast (SKC) Health and Wealth Being Board (HWBB) sponsored project is an opportunity for multiple partners to work together on assessing the future needs of intermediate care services in the Dover, Deal and Shepway areas to inform the commissioning of an intermediate care model of care which is both innovative and effective at delivering care closer to or within patients own homes whilst responding to changes in the local population needs.

Description:
A detailed assessment will be undertaken of the needs for intermediate care services in SKC to assess whether the current model of care, including the number of and access to intermediate care beds and other community options is appropriate for future local needs.

A small 'Task and Finish' group will be established to ensure engagement with key stakeholders and ownership across partners.

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Task and Finish Project Group:
Zoe Mirza –Head of Integrated Commissioning, NHS SKC CCG (Project Lead);
Dr Joe Chaudhuri – GP and LTC Clinical Lead, NHS SKC CCG (Project Clinical Lead);
Paula Parker – Commissioning Manager Lead for Urgent and Intermediate Care, KCC;
Jo Empson – Commissioning Manager Lead for Reablement and Homecare, KCC;
Janice Duff – Head of Service Dover and Thanet, KCC;
Debbie Pyart - Senior Operations Manager UCLTC, East Kent Hospital University Trust
Karen Jefferies – Community Services Director South Kent Coast and Thanet, Kent Community Health Trust;
Nicola Osbourne – Head of Intermediate Care Service, Kent Community Health Trust;
Debbie Barry – Chief Officer Deal Age Concern and Chair DASP (Voluntary Sector representative);
Tricia Cole – CEO Carers Support (Voluntary Sector representative);
Sue Chitty – Chair of Patient Participation Group Shepway (Patient representative)

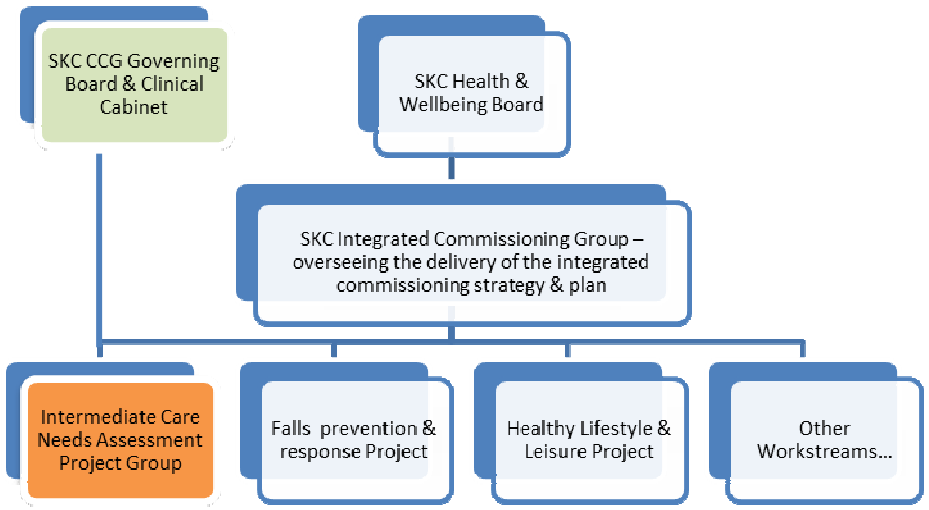
Additional Project Support:
Alison Scantlebury – Kent and Medway Commissioning Support Unit - information support;
Deborah Bateson/Peter Hodgson – CCG Finance Support;
Jessica Mookherjee – Public Health Support

A small virtual group of service users has been identified to support the project and will be communicated with by the project lead and the project's patient representative.

Each representative must be able to provide data and information from their organisation to support the needs assessment completion and contribute towards the development of the future options for an innovative intermediate care model of care.

Project Governance:
This project is one of several that reports to the Integrated Commissioning Group which is a sub-committee of the SKC HWBB.

This project reports to the SKC CCG Governing Board (through the Clinical Cabinet) as well as the appropriate governance routes within KCC.



Scope:

(i) South Kent Coast geography and residents – outputs split by Dover, Deal and Shepway localities;

(ii) All current Intermediate Care Service functions (aligned to agreed definition). To include:

- Unplanned carers respite;
- Kent Enablement at Home (KEAH) – care workers in patient's own home;
- Domiciliary Care – in patient's own home;
- Short term residential beds – social care enablement and or/ ICT therapies;
- Broadmeadow Care Home – integrated care beds;
- Deal Community Hospital Intermediate Care Beds – should accept both 'step-up' and 'step-down' intermediate care patients;
- Dover /Deal/Shepway Community based Intermediate care teams

Project Outcomes:

(i) Agreed Definition - a common understanding of intermediate care to steer the project and to support the development and delivery of the future model of care;

(ii) Needs Assessment - a robust analysis of data to show current provision and service efficiencies, current need and impact on services and future needs of intermediate care;

(iii) Commissioning options - informed by needs assessment to achieve the future vision for intermediate care. These options will include flexible short and medium term options;

(iv) Outline business case (if required) - for future model of care.

The outputs of the project will be reported to the SKC HWBB and the SKC CCG Clinical Cabinet.

Project Information Requirements:

The needs assessment information requirements will be mapped against an agreed definition. And will be analysed to show current service efficiencies

INFORMATION	SPLIT BY	DATA SOURCE	PROVIDED BY
Current capacity (by location/service)	Number of patients that can be seen by service / number of beds	Carers Support KCC KCHT	Tricia Cole Jo Empson / Paula Parker Karen Jefferies
Actual demand (by location/service)	Total no's of admissions / placements; Source of referrals; Patients not accepted with reasons; Waiting Lists and waiting times; Occupancy rates / empty bed days; Average length of stay; DTOCs / reasons; Discharge destinations; Patient health outcomes Re-admisison rates		
Patient Flows	Mapped to show where patients are currently receiving IC; Reasons if provided outside of SKC	As above – above data will inform mapping	N/A
Population Needs (to show impact on service and future need)	Current population rates – mapped against age and medical condition of patients receiving IC; Projected population growth (next 5-10years) – mapped against increase in elderly population, and increase in long term condition prevalence	Public Health risk stratified analysis	Jess Mookherjee Other public health specialists

Additional data will be requested from the acute trust.

Measurement timescales agreed by Project Group – April 2011 to March 2012.

Key Milestones :

(a) 26 Feb – Draft Project Brief to be developed further by Integrated Commissioning Group;
(b) 11 March – Project Group members to be finalised and informed of Project Brief;
(c) 25 March – Project Group meets to sign off Project Brief and agree intermediate care definition and information requirements of needs assessment;
(d) 9 April – Project update to SKC HWBB;
(e) 10 April – Project update to SKC Clinical Cabinet;
(f) April to May - Commissioner to undertake wider engagement with SKC CCG members through locality meetings;
(g) 15 April– Project Group makes available information to complete needs assessment and meet to assess the outputs;
(h) April – Project Group jointly reviews information analysis and options for future vision;
(i) Early May – undertake discussion with patient participation group;
(j) Early May – Commissioner develops, with input from project group, recommendations and develops options for future vision;
(k) May – further engagement with SKC CCG members to share project outputs;
(l) End May – Project Outputs Final Report signed off by Project Group;
(m) June (exact dates TBC) – Report to the SKC CCG appropriate committee and SKC HWBB.

Risks:

(a) Lack of engagement with stakeholders – keep project group small with minimal meetings yet drive project forward with regular communication as project progresses. Undertake engagement with service users via the project patient representative and the project's virtual patient participation group.
(b) Lack of accurate and comparable data – agree with project member's data requirements with a clear definition for each set of data and use the same timeframe for measurement where possible and agree deadlines for providing data.
(c) Unable to deliver project within timeframes – review and agree milestones with project group and report any issues within the CCG in advance if project moves off track and highlighting the reasons.

Report to the South Kent Coast Health and Wellbeing Board 9th April 2013

Draft Proposal and Outline for a localised Health and Wellbeing Strategy - Update

Recommendation:
The SKC HWBB agree the Working Group and Strategy outline (as detailed below).

Summary:
At the SKC HWBB on Tuesday 5th February 2013 it the development of the above strategy was noted. The Strategy is being progressed by what is proposed to be the Wellbeing/Healthier Group. It is proposed this group consists of a suggested minimum:

DDC – Michelle Farrow/Caroline Hargreaves
SDC – Rob Jackson
Public Health – Jess Mookherjee/Ivan Rudd
CCG – Dr Sarah Montgomery
CCG – Karen Benbow – to be advised
Parent Governor rep(s) – to be advised
Voluntary and Community Sector rep – to be advised

Rather than have a number of separate documents (localised JHWBs/Health Inequalities Action Plan/Child Poverty Action Plan), it is proposed the Strategy (to be fully consulted on, once signed off by the SKC HWBB) will consist of:

Purpose of the document:
1. To represent the full well being strategy for SKC HWBB incorporating all of the workstreams of the Board
2. Health Inequalities is threaded thought the strategy as it is an integral function of the well being strategy
3. The strands of the Inequalities Actions have been represented also as a separate chapter for clarity.

Chapter 1: Integrated Commissioning Strategy:
With focus on (if agreed at the meeting on 9th April 2013) Falls and Housing Environment, Intermediate Care and Re-ablement, Lifestyle and leisure

Chapter 2: Health and Wellbeing Improvements:
With focus on mental health, social and physical regeneration, reducing health inequalities and poverty mitigation, and finding the 'missing people'.
Antidotes to our big challenges: connected communities, social connectedness, volunteering, self-efficacy, asset building (people and places).

Chapter 3: Children and Young People:
With focus on Teenage pregnancy, smoking in pregnancy, childhood obesity and linking to the Troubled Families agenda.

Chapter 4: Summary of Health Inequalities.
Public Health information will be a thread throughout Chapters 1-3.

Throughout the strategy will be shared performance outcomes, linked through to the JSNA and Kent wide HWBS, plus the CCG Annual Operating Plan and local authority corporate objectives. Data will be referred to in relevant documents so this Strategy can be kept as short and simple as possible.

Running through the Strategy will the aims of:
- Equality and Equity of access
- Working to scale and dealing with the 'whole' population
- 'Going the extra mile', with the right service, in the right place, at the right time and 'everybody doing their job'

The group is working to the shared values of:

- sharing data and information
- sharing expertise
- Working in partnership to enhance outcomes

Timeline:
To be agreed