

Thanet Clinical Commissioning Group
Governing Body
Governing Body - Part 1 (Public)
08 December 2015 - 13:30
Council Chamber, Thanet District Council, Margate, CT9 1XZ

AGENDA

1	Opening Business <i>Owner: Chair</i>	13.30
1.01	Apologies, Declarations of Interest, Quoracy <i>Owner: Chair</i>	13.30
1.02	Questions from the Public <i>Owner: Chair</i>	13.32
1.03	Minutes of meeting held on 14 July 2015 and Matters arising <i>Owner: Chair</i>	13.37
	1.3a Draft Minutes Thanet CCG GB held 14 July 2015	6
	1.3b Matters Arising from the Thanet Board Meeting	11
1.04	Joint Report from Clinical Chair and Accountable Officer <i>Owner: Clinical Chair and Accountable Officer</i>	13.40
2	Public and Patient Engagement (PPE) <i>Owner: Lay Member, Public & Patient Engagement</i>	13.50
2.01	Public and Patient Engagement Update <i>Owner: Lay Member, Public & Patient Engagement</i>	13.50
	2.1a Cover sheet Public and Engagement Update	12
	2.1b Communications and Engagement Report Dec 2015	14

3	Strategy & Planning: 2016-17 <i>Owner: Chair</i>	14:00
3.01	Report from Clinical Leadership Team: Key Issues <i>Owner: Committee Chair</i>	14.00
3.02	Development of Thanet Plan <i>Owner: Chief Operating Officer</i>	14.10
	3.2 Development of Thanet Plan 16-17	26
3.03	Presentation for Development of Health and Wellbeing Board <i>Owner: Chief Operating Officer</i>	14.20
3.04	East Kent Strategy Update <i>Owner: Accountable Officer</i>	14.30
4	In-year review of Quality, Finance and Performance <i>Owner: Committee Chair</i>	14.35
4.01	Report from the Quality and Operational Leadership Team <i>Owner: Committee Chair</i>	14:35
4.02	Chief Nurse Report including Safeguarding Annual Report <i>Owner: Chief Nursing Officer</i>	14.45
	4.2a CNO Report Front Sheet - December 2015	36
	4.2b Chief Nursing Officer Report - Dec 2015	37
	4.2.2a Front sheet for Safeguarding Annual report	42
	4.2.2b Safeguarding Children Annual Report	43
4.03	Integrated Quality and Performance Report: summary only <i>Owner: Chief Operating Officer</i>	14.55
	4.3a Cover sheet IQPR Report for Governing Body	70
	4.3b IQPR Summary November 2015	72
4.04	Financial Report <i>Owner: Chief Finance Officer</i>	15.05
	4.4a Thanet CCG Finance Report cover sheet	87
	4.4b Draft Thanet CCG Finance Report Month 7 1516	88

4.05	Update on procurements - ICES <i>Owner: Chief Operating Officer</i>	15.15
	4.5.1 Update on ICES procurement	106
4.05	Update on procurements - IAPT <i>Owner: Chief Operating Officer</i>	15.17
	4.5.2 Cover sheet report IAPT update Dec 15	108
5	Governance, Assurance and Compliance <i>Owner: Chair</i>	15.20
5.01	Report from Chair of Governance and Risk Committee <i>Owner: Chair of Governance and Risk Committee</i>	15.20
5.02	Review of Committee terms of reference <i>Owner: Company Secretary</i>	15.30
	5.2.1a cover for review of terms of reference	110
	5.2.1b Governance and Risk TOR	111
5.02	Serious Incidents Review Group <i>Owner: Company Secretary</i>	15:32
	5.2.2a Front sheet for SI Paper	116
	5.2.2b Serious Incidents group	118
5.03	Information Governance Update <i>Owner: Company Secretary</i>	15.35
	5.3a Cover Sheet Information Governance Toolkit	129
	5.3b IGT V13 Change Release Note_V1_Final_May15	131
5.04	Approval of risk management policy <i>Owner: Company Secretary</i>	15:40
	5.4a Cover paper for Risk Mgt Policy	139
	5.4b Risk Management Policy Statement for thanet	140
6	For information only <i>Owner: Chair</i>	15.45
6.01	Thanet Health and Wellbeing Board <i>Owner: Chair</i>	15.45
	6.1.1 minutes 19.11.15 THWBB	147

6.01	Kent Health and Wellbeing Board <i>Owner: Chair</i>	15.47
	6.1.2 Kent Health and Wellbeing Board Minutes 16.9	150
7	Questions and Answers <i>Owner: Chair</i>	15.50
7.01	Questions and Answers <i>Owner: Chair</i>	15.50
8	Date of Next Formal Meeting - 8 March 2016 <i>Owner: Chair</i>	

Attendees

Index

1.3a Draft Minutes Thanet CCG GB held 14 July 2015.docx.....	6
1.3b Matters Arising from the Thanet Board Meeting Part 1 he.....	11
2.1a Cover sheet Public and Engagement Update.docx.....	12
2.1b Communications and Engagement Report Dec 2015 final.doc.....	14
3.2 Development of Thanet Plan 16-17.pdf.....	26
4.2a CNO Report Front Sheet - December 2015.docx.....	36
4.2b Chief Nursing Officer Report - Dec 2015.docx.....	37
4.2.2a Front sheet for Safeguarding Annual report Governing	42
4.2.2b Safeguarding Children Annual Report.pdf.....	43
4.3a Cover sheet IQPR Report for Governing Body.docx.....	70
4.3b IQPR Summary November 2015.pdf.....	72
4.4a Thanet CCG Finance Report cover sheet.docx.....	87
4.4b Draft Thanet CCG Finance Report Month 7 1516.docx.....	88
4.5.1 Update on ICES procurement.docx.....	106
4.5.2 Cover sheet reportIAPT update Dec 15.docx.....	108
5.2.1a cover for review of terms of reference.docx.....	110
5.2.1b Governance and Risk TOR.docx.....	111
5.2.2a Front sheet for SI Paper.docx.....	116
5.2.2b Serious Incidents group.docx.....	118
5.3a Cover Sheet Information Governance Toolkit.docx.....	129
5.3b IGT V13 Change Release Note_V1_Final_May15.pdf.....	131
5.4a Cover paper for Risk Mgt Policy.docx.....	139
5.4b Risk Management Policy Statement for thanet.docx.....	140
6.1.1 minutes 19.11.15 THWBB.pdf.....	147
6.1.2 Kent Health and Wellbeing Board Minutes 16.9.15.doc.....	150

Thanet Clinical Commissioning Group

Minutes of the Thanet Clinical Commissioning Group Governing Body Meeting (Part 1) held on Tuesday 14 July 2015 Council Chamber, Thanet District Council, Cecil Street, Margate, CT9 1XZ

Members Present:

Dr Tony Martin (Chair)	GP Clinical Chair
Dr Adem Akyol	GP Clinical Lead
Jonathan Bates	Chief Finance Officer
Hazel Carpenter	Accountable Officer
Clive Hart	Lay Member, PPE
Dr Mark Elliott	GP Clinical Lead
Dr John Neden	GP Clinical Lead
David Lewis	Lay Member, Governance

In Attendance:

Colin Thompson	Public Health consultant
Sue Martin	Company Secretary (minutes)
Maria Reynolds	Head of Quality, Thanet CCG
Kallie Heyburn	Head of Strategic Commissioning, Thanet CCG
Adrian Halse	Senior Business Analyst, Thanet CCG

Minute No.	Agenda Item
GB/15/07/167	<p>Apologies, Declarations of Interest, Quoracy and Announcements</p> <p>The Chairman welcomed everyone to the meeting of the Governing Body.</p> <p>Apologies were received from Prof. Devaka Fernando, Secondary Care Doctor; Sharon Gardner-Blatch, Chief Nursing Officer; Dr Tariq Rahman, GP Elected Member; and Ailsa Ogilvie, Chief Operating Officer.</p> <p>There were no additional declarations of interest.</p> <p>The meeting was confirmed as quorate.</p>
GB/15/07/168	<p>Questions from the Public</p> <p>No questions had been received. The Chair invited questions at the end of the meeting.</p>
GB/15/07/169	<p>Minutes of the meeting held on 10 March 2015 and Matters Arising</p> <p>The minutes were agreed as an accurate record of that meeting. IT WAS RESOLVED THAT the minutes be APPROVED by The Governing Body. Matters arising were closed.</p>
GB/15/07/170	<p>Joint Report from the Clinical Chair and Accountable Officer (Verbal Update)</p> <p>The Accountable Officer reported that, following media interest in plans for Accident and Emergency at EKHUFT, the 4 Clinical Chairs had issued a public letter assuring the public that</p>

Thanet Clinical Commissioning Group

	<p>any service changes would be consulted on. She and the Clinical Chair were working with other CCGs and with EKHUFT to agree the shape of services for Thanet.</p> <p>The Clinical Chairs and Accountable Officers from the East Kent CCGs and Chief Executive and Medical Director from EKHUFT had met with the MPs from East Kent to discuss the case for change at EKHUFT.</p> <p>CQC was re-inspecting EKHUFT this week.</p> <p>The Clinical Chair said that Dr Braga had decided he was unable to take his position as a member of the Governing Body because of time commitments. He and the AO were visiting practices to discuss the feasibility of working together and of setting total budgets for a local area. The governance at East Kent had been reviewed.</p> <p>The 111/Out of Hours procurement was being put on hold following a directive from NHSE.</p>
GB/15/07/171	<p>Patient and Public Engagement Update</p> <p>Clive Hart presented his update. He expressed his thanks to colleagues who had helped him during the first months of his role. A number of consultations were in hand. The most controversial issue had been dealt with through the CCG Chairs' Open Letter. He had met with the voluntary sector, the first of a number of meetings.</p> <p>The Governing Body welcomed the dementia programme and hoped that it could be kept going.</p> <p>The Governing Body NOTED the update on Patient and Public Engagement</p>
GB/15/07/172	<p>Update on Thanet Plan</p> <p>Kallie Heyburn updated the Governing Body on the reprioritisation of the Thanet Plan. The dashboard which had been discussed at the Quality and Operational Leadership Team meeting was presented for Governing Body approval. Jonathan Bates welcomed the dashboard, although there were still a number of gaps in it. It would enable the Governing Body to be clear about where the CCG was having success in delivering its priorities and where more work needed to be done.</p> <p>The Governing Body AGREED to</p> <ul style="list-style-type: none"> • RATIFY the title of Programme Dashboard • AGREE that the Dashboard should take into account changes recommended by Quality and Operational Leadership Team • AGREED that performance should be reported by exception with accompanying narrative to include mitigating actions
GB/15/07/173	<p>Health and Wellbeing Board (HWBB) Development</p> <p>Hazel Carpenter spoke to the report, which set out the discussions which had been held at the HWBB about the integration of health and social care in relation to commissioning. By September, it was hoped to have "open finances" to show where the costs really are. JB said that he had discussed the importance of transparent reporting with KCC so that people could</p>

Thanet Clinical Commissioning Group

	<p>understand the finances around the services which the HWBB would oversee, at Kent level and locally. DL said that it was important that the local HWBB was supported and was successful because it could be a powerful voice for Thanet.</p> <p>Clive Hart reported that the voluntary sector had asked whether it could be included in the local HWBB. HC said that locally they were not included at the moment. She was aware that discussions were being held nationally about the role of the voluntary sector on the HWBB. Nonetheless, the HWBB included commissioners of services, not providers; they would be involved in the Integrated Care Organisation.</p> <p>The Governing Body APPROVED the direction of travel agreed by Thanet Health and Wellbeing Board.</p>
GB/15/07/174	<p>Chief Nurse Report</p> <p>Maria Reynolds spoke to the CNO's report, drawing the Governing Body's attention to the areas in the report where the CCG had limited assurance about the quality of services provided by a number of providers.</p> <p>The Governing Body NOTED the CNO's report.</p>
GB/15/07/175	<p>Health Care Acquired Infection Annual Report</p> <p>Maria Reynolds introduced the report, publication of which was a statutory responsibility of the CCG. It showed that the CCG had not breached its trajectory for C Difficile and in fact there had been a 40% reduction in cases reported. A key issue for the future was the administration of antibiotics, especially for complex patients, where primary care needed to prescribe for longer periods. This would be addressed through the action plan.</p> <p>The Governing Body APPROVED the HCAI Annual Report for publication</p>
GB/15/07/176	<p>Integrated Quality and Performance Report</p> <p>Adrian Halse spoke to the report. HC said that Monitor, the TDA and NHSE had written to the CCG and to EKHUFT about the failure to meet the 62 day cancer target, requiring an improvement plan by the end of August.</p> <p>Tony Martin commented on the number of reds in the report, including dementia for which there was no information at the moment. Other breaches were for cancer, Referral to Treatment, and Accident and Emergency. These were significant lapses which would be addressed with EKHUFT at the Performance meeting.</p> <p>The Governing Body NOTED the Integrated Quality and Performance Report.</p>
GB/15/07/177	<p>Finance Plan 2015/16</p> <p>Jonathan Bates introduced the budget for 2015/16 which had been updated since its presentation to the Governing Body in March 2015, following the completion of negotiations with the providers on their contracts.</p>

Thanet Clinical Commissioning Group

	<p>He reported that at the moment the CCG was staying within its budget but there were significant challenges in relation to prescribing and CHC costs. The CCG had fallen behind on its savings programme and it would be challenging to make the necessary savings without damaging patient care. The Governing Body discussed how to exert pressure on practices to control their prescribing costs. TM reported that it was disappointing that the Government would not support some of the schemes for changing to cheaper drugs eg for ophthalmology.</p> <p>The Governing Body APPROVED the updated revenue budget for 2015-16.</p>
GB/15/07/178	<p>Risk Register</p> <p>Sue Martin presented the risk register. She said that the register would be updated to reflect the reprioritisation of objectives. HC confirmed that the risk register included the risks which were most significant to her as AO.</p> <p>The Governing Body REVIEWED the risk register, particularly the most serious risks to the CCG</p>
GB/15/07/179	<p>Assurance Framework</p> <p>Sue Martin introduced the updates to the Assurance Framework, whose purpose was to give the Governing Body assurance that the Governing Body was delivering its key strategic objectives. The Governing Body agreed that it was important that the Assurance Framework was integrated into its business.</p> <p>The Governing Body NOTED the Assurance Framework</p>
GB/15/07/180	<p>Changes to the NHSE Assurance Framework for CCGs in 2015/16</p> <p>The Governing Body NOTED the changes to the NHSE's CCG Assurance Framework and that the Governance and Risk Committee would continue to review the response from the Area Team to assurance meetings</p>
GB/15/07/181	<p>Report from the Chair of Governance and Risk Committee</p> <p>David Lewis introduced his report. He reported that the internal and external auditors had commented favourably on the preparation of accounts and on the CCG's financial control in challenging times.</p> <p>The Governing Body NOTED the report from the Chair of the Governance and Risk Committee.</p>
GB/15/07/182	<p>Report from the Chair of the Remuneration Committee</p> <p>David Lewis spoke to his report.</p> <p>The Governing Body NOTED the report from the Chair of the Remuneration Committee.</p>
GB/15/07/183	<p>Questions and Answers</p> <p>There were no questions from the public.</p>

DRAFT

Matters Arising from the Thanet Governing Body Meeting - Part 1 – 14 July 2015

Minute No.	Action	By When	Member Responsibility	Status
GB/15/03/161	Financial Plan 2015-16 Development of a Financial Recovery Plan which QOLT can monitor	QOLT meeting in April	Jonathan Bates	Completed

Thanet Clinical Commissioning Group

Report to:	Thanet CCG Governing body	Agenda item:	2
Date of Meeting:	8 December 2015		
Title of Report:	Public and Patient Engagement update		
Author:	Emma Burns, Principal Associate – Media and Communications		
Board Sponsor:	Clive Hart, Lay Member, Public and Patient Engagement		
Status:	Information		
Appendices			

1.	Strategic Objectives Link
<i>[Highlight which strategic object(s) this recommendation aims to support – removes those not relevant]</i>	
1.1.	Patients receive high quality equitable and accessible GP services;
1.2.	Patients receive high quality integrated out of hospital care covering physical and mental health;
1.3.	Patients receive timely, clinically appropriate and high quality care in hospital;
1.4.	Patients receive high quality mental health and wellbeing care in the most appropriate setting;
1.5.	To ensure high quality children's services
1.6.	To contribute with partners to reduce health inequalities in Thanet

2.	Purpose of Paper
This report highlights progress since the last governing body meeting in public and highlights key engagement that has taken place with our communities, stakeholders and the voluntary and community sectors.	

3.	Introduction/Background
NHS Thanet CCG recognises that listening to and acting on what matters to local people is key to the delivery of our commissioning intentions and plans.	
Engaging and communicating with patients and local people to jointly design and commission services will make them a more active and powerful resource. It will also help us to gain a much better return on the money we invest in local services.	

4.	Recommendation
The Governing Body is asked to note this report.	

Author: Emma Burns, Principal Associate, SE CSU	Version:1
Sponsor: Clive Hart, Lay Member, PPE	Date:8 December 2015
Agenda no: 2.1	Page 1 of 2

Thanet Clinical Commissioning Group

5.	Summary of Issues
As 2. above.	

6.	Risks
Not applicable	

7.	Appendices
Not applicable	

Author: Emma Burns, Principal Associate, SE CSU	Version:1
Sponsor: Clive Hart, Lay Member, PPE	Date:8 December 2015
Agenda no: 2.1	Page 2 of 2

Communications and engagement progress report November 2015

Introduction

NHS Thanet Clinical Commissioning Group recognises that listening to and acting on what matters to local people is key to the delivery of our commissioning intentions and plans.

Engaging and communicating with patients and local people to jointly design and commission services will make them a more active and powerful resource. It will also help us to gain a much better return on the money we invest in local services.

A summary of recent activity is included below.

1.0 Patient and stakeholder engagement

- 1.1 Since the last Governing Body meeting in public, Lay Member Clive Hart has met his fellow Lay Members for Patient and Public Engagement (PPE) from the other clinical commissioning groups in Kent and Medway and is pleased to report that all appear to be working to a similar brief / system / process.

He was also delighted to hear strong support for greater patient and public engagement from Tim Kelsey, Professor Paul Corrigan and Sir Bruce Keogh at national level, during a recent NHS England PPE Summit in London.

Locally, Clive continued to meet Thanet GP surgeries' respective patient participation groups (PPGs). Further to earlier reported meetings with East Cliff PPG, Westgate PPG and St Peter's PPG, he has now met with Bethesda PPG, Minster PPG, Birchington PPG, Northdown PPG and Mocketts Wood PPG and he continues to be impressed by Thanet patient volunteers' passion and commitment.

Clive is progressing arrangements to meet with the remaining PPGs across Thanet and has also promoted local PPGs through the Thanet press and social media.

Clive recently invited the chairs of all Thanet's PPGs to a 'brainstorming session', looking for even better ways to work together in the future. Subsequently, a meeting has been scheduled for January to establish a regular reference group for the CCG to hear patients' views Thanet-wide. These meetings will also provide networking opportunities for the PPGs and thereby help to promote best practice.

He attended a further Westgate PPG meeting which was open to the public. It proved to be very popular and Clive was very pleased to witness a clear desire by local residents for preventative solutions to their healthcare needs.

Indeed, self-care has been a prominent theme since our last Governing Body meeting in public. Clive supported the CCG discussions with social care and the voluntary sector at East Cliff surgery and, more recently, a workshop at Trinity Resource Centre.

He also supported our partners Healthwatch Kent with their local engagement event at Christchurch Campus in Broadstairs.

Clive attended the event held at Turner Contemporary on behalf of the CCG and NHS England to discuss stroke and vascular services. He is pleased to report he was later informed the Thanet event was one of the best attended in Kent. The NHS was looking for local people to share their experiences of and views on how to improve local stroke care, particularly in the vital first 72 hours after first symptoms are experienced and Thanet residents offered some very strong views.

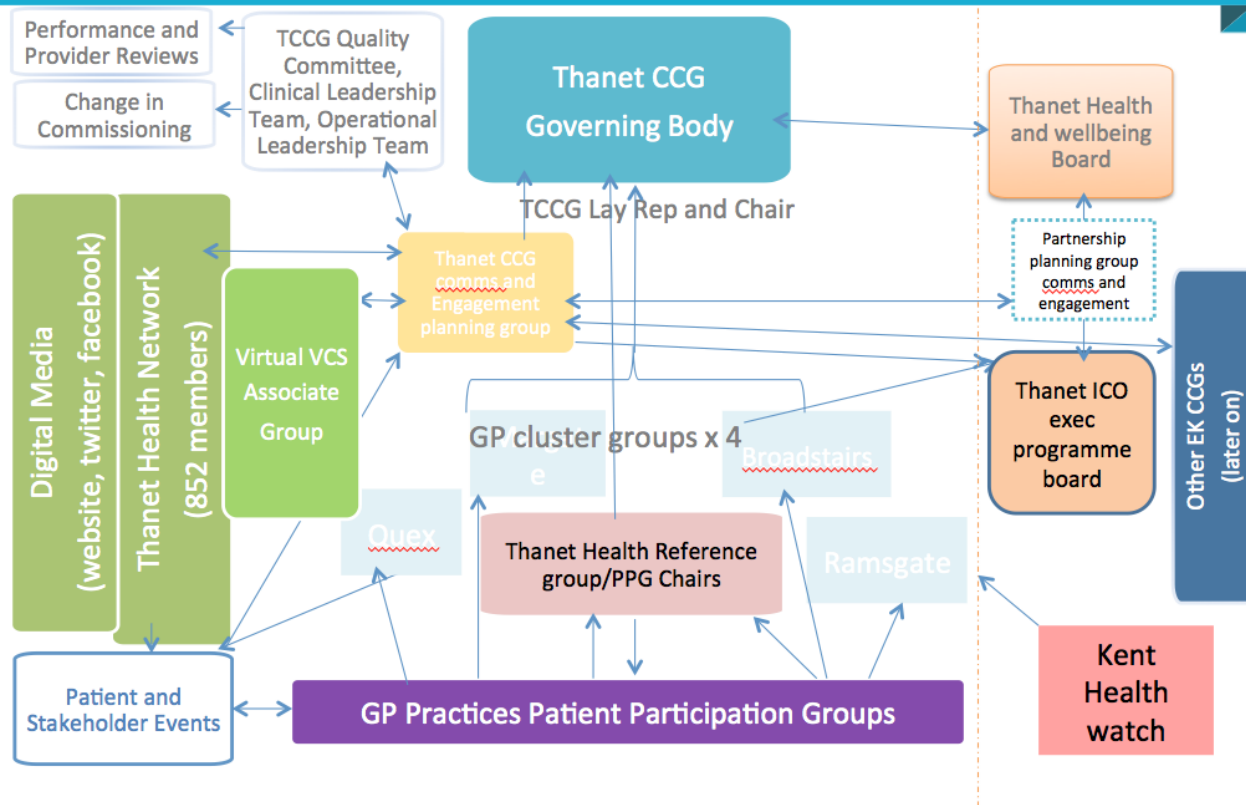
Back in the summer, Clive chaired a very positive meeting with members of the third sector to discuss better two-way working relationships between the CCG and community/voluntary sector.

He attended the Thanet Community Support Partnership (TCSP) along with Thanet third sector groups and now regularly attends Thanet Adult Strategic Partnership.

Improving working relations with patients' groups and the third sector is, and will continue to be, a clear priority for Clive and the CCG.

Below is a chart mapping the network of relationships that make up our patient and stakeholder involvement. Its complexity is an indication of how rich and wide-ranging our engagement is. It supports our commitment to listening to and acting on what local people tell us about what matters to them.

Thanet CCG Patient and Stakeholder Involvement



1.2 Integrated Care Organisation

The integration of health and social care has been acknowledged as the way forward, as the means of delivering better care and improving quality and outcomes for citizens, as well as efficiencies across the system. NHS Thanet CCG has formally agreed a compact which captures each organisation's commitment to partnership working to deliver improved integrated health and social care for the populations they serve.

By working in partnership we can achieve much more than working apart and therefore in Thanet we have established a multi organisational partnership approach to developing and delivering a new model of health and social care provision.

Organisations signed up are: Thanet Clinical Commissioning Group, East Kent Hospitals University NHS Foundation Trust, Kent Community Health NHS Foundation Trust, Kent County Council, Thanet District Council, Healthwatch Kent, South East Coast Ambulance Service NHS Foundation Trust, Kent Local Medical Committee, the University of Kent, Integrated Care 24, Invicta Health, Avondale care and KIAC.

Five outcome areas for delivery have been agreed:

1. People take greater responsibility for their own health

2. People stay well in their own homes (wherever that home may be)

Developing services to support the people of Thanet in the community and provide people with an integrated point of contact which, for most people, will be general practice.

3. People receive timely and appropriate high quality care

Concentrating hospital-based care on the provision of specialist, complex care and support and advice to primary care; ensuring timely access to urgent and acute specialist care.

4. People receive safe care and have a positive experience of care

Patient safety and experience is at the centre of everything we do; improving outcomes for the people of Thanet.

5. There is better use of the Thanet pound

Collectively, we can demonstrate value for money and delivery of cost-effective services. Through integration, we can reduce duplication and agree collaborative spend priorities in order to improve outcomes for the people of Thanet.

The GP practices are now working in four clusters covering Quex, Margate, Ramsgate and Broadstairs. They will be working with partner organisations to discuss how they can collectively work closer together to improve care, particularly community nursing. They are also exploring the potential for extending GP car so that it is available 8am to 8pm.

1.3 Self-care partnership working

Following the successful workshop with partners in September, the CCG has shared self-care marketing materials with practices, and provided links to resources via the CCG membership team. The CSU engagement and communication team supported the successful Big Thanet Health check, and made contacts with various voluntary and community sector organisations to continue raising the profile of the support that's on offer to people locally to help them stay well.

The British Heart Foundation has been particularly generous in providing free information on various cardiovascular problems and how to prevent them or seek support to manage symptoms.

During self-care week (November 16 to 22), Thanet District Council ran events with students at Hartsdown Academy to promote sports activities and provide them with self-care information – including how to cope with stress, and advice on healthy life styles.

And Social Enterprise Kent sent out a daily e-mailshot focusing on self-care and support for the main long-term medical conditions with two simple helpline numbers. They also worked with Age UK Thanet, Citizen's Advice Bureau and the job centre to promote health and self-care at various locations with advisors and stalls offering information and support. And helped support the work of the CCG with Thanet Senior Citizens Forum and other community networks to spread the word.

1.4 Personal Health Budgets

Self-care and personal health budgets were the topic of conversation with 40 Thanet residents on 19 November at Trinity Community Centre.

First, people discussed self-care and staying healthy, their reasons for accessing health services, and how they choose which professional/service they see.

Then the discussion moved to how the CCG and our partners could do more to support people to self-care. This will inform our next steps on increasing support to people to self-care and manage their health and mental wellbeing.

At the CCG, we are just starting to consider how personal budgets might be offered to patients and carers in Thanet from April 2016, so the group discussed developing an approach to support people effectively and having a phased approach which targets those who most need help in Thanet.

The meeting also looked at which conditions should be a priority to receive support, what support people would need to make the scheme work well for them, and the type of criteria which might be needed to make it work effectively.

Evaluation sheets show those present were enthusiastic about the opportunity to discuss this important topic, and wanted additional sessions to help work through the criteria. They valued the time taken to explain things, felt listened to, and found the group work was an excellent way of working through the subjects, although noise levels sometimes made hearing difficult and people had concerns over not knowing enough at the moment.

We will be feeding back to those who attended the workshop and taking this work forward over the next few months.

1.5 Re-procurement of integrated out-of-hours services – east Kent area

Over the last year, patients' views and experience have informed a service specification for integrating NHS111 and urgent out-of-hours medical care. We are planning further engagement with patients about our plans which include using paramedics to support the out-of-hours home visiting service from 2016.

After a pause pending further guidance from NHS England, the procurement re-started in November. Patients continue to be part of the procurement dialogue and there is a commitment from all four CCGs involved to create a Patients' Charter in the new year, working with patients and the public to set out their expectations for urgent care services. This will inform and influence the delivery of various services which offer patients help when they urgently need it.

1.6 Kent and Medway stroke services review

We are part of a Kent and Medway wide review of stroke services, which is looking at the care that people receive immediately after having a stroke (the hyper-acute / acute phase). The aim of the review is to deliver clinically sustainable, high quality, hyper-acute / acute stroke services for the next ten to fifteen years, that are accessible to Kent and Medway residents 24 hours a day, seven days a week.

All the clinical commissioning groups in Kent and Medway are part of this review. In October, we and the other CCGs ran a survey for anyone who had experience of local stroke services. In total, 285 people completed it. The full report will be available soon but, in summary, people said that:

The most important things when a stroke or TIA **first happens** are:

- Fast ambulance response
- Getting quick diagnosis and treatment

The most important things relating to the **hospital stay** are:

- Specialist care
- Being treated with respect and dignity

The most important things relating to the **staff** are:

- That staff knew my case, treatment and care plan
- That staff treated me as a person not just a patient

The things of most importance **after discharge** are:

- Physical rehabilitation information and exercises
- Follow up visits from nurses to check on progress

During September and October, 11 focus groups were organised in Kent and Medway by the Stroke Association or independent stroke groups to enable the NHS to listen to the experiences and hear the views of 172 people affected by stroke, their families and volunteers. The review also received views from East Sussex and Bromley.

Full reports will be available soon but, in summary, people in Kent and Medway said:

The most important things when a stroke or TIA **first happens** are:

- Fast ambulance response
- Quick diagnosis and treatment
- Getting swift access to specialist support is of equal importance with being admitted to a specialist unit.

The most important things relating to the **hospital stay** are:

- Being treated with dignity and respect
- Specialist care
- Clear information and support to understand my treatment

The most important things relating to the **staff** are:

- That staff treated me as a person not just a patient
- That staff knew my case, treatment and care plan.
- That staff respond as quickly during the night as during the day.

We are also working with voluntary and community organisations that support people from black and minority ethnic communities, and others whose specific needs will be considered within the overall plan, to ensure their views are heard.

In November and December, the review is holding three “deliberative events” with panels of the public, stroke survivors and carers, and community representatives, including voluntary organisations. They will review the case for change, possible options for the future, and the criteria that should be used in taking decisions on options. The panels have been carefully recruited to ensure they have a representative mix of people from different communities and locations.

The stroke review is overseen by a Stroke Review Programme Board, which has representatives from all the eight clinical commissioning groups in Kent and Medway, the South East Cardiovascular Network, public health, communications and engagement, a stroke survivor, the Stroke Association and Healthwatch Kent.

The Review Programme Board is supported by a Clinical Reference Group (CRG) which is represented at the RPB through its Chair, Dr David Hargroves, lead stroke consultant at East Kent Hospitals University NHS Foundation Trust, in his role as South East Clinical Network stroke lead.

Consultants from the four main hospital trusts in Kent and Medway are on the CRG, along with specialist nurses and senior managers. The ambulance trust is also represented. The role of the CRG is to provide clinical guidance and assurance to the review process.

Recommendations about changes to stroke services will be put forward by the Stroke Review Programme Board to clinical commissioning group Governing Bodies, which will take the final decisions.

The Health Overview and Scrutiny Committee for Kent and Health and Adult Social Care Overview and Scrutiny Committee for Medway have agreed to form a joint committee to review the plans and process used by the stroke review. It is expected to meet for the first time in January.

1.7 Integrated community equipment service

We have worked closely with Kent County Council and the other clinical commissioning groups in Kent on the procurement of a new integrated community equipment service. It will provide health and social care equipment to people of all ages who have been professionally assessed as needing equipment to help them live independently at home.

We are the lead commissioner for the NHS. Contracts for the community equipment service were awarded in September 2015. The new service includes the loan of equipment such as hospital beds, pressure care equipment, walking frames and other daily living equipment to help older and disabled people to live independently in their own homes. It also includes Telehealth services in Kent. Acute and community staff will be able to order a broad range of community equipment to support patients and carers. The new service also offers patients the convenience of having all their equipment delivered at one time, and extended hours for deliveries which they can arrange at a time to suit them.

We have been working with the new provider, NRS Healthcare; the former lead provider for equipment, Kent Community Health NHS Foundation Trust; with staff who order equipment in hospitals, the community, social care and hospices; and

with Kent County Council to ensure people have the information they need for a smooth transition.

The new service started on 30 November 2015.

1.8 Wheelchair services

A Kent and Medway wide review of wheelchair services is looking at existing experience of services as well as gathering feedback on potential changes, ahead of re-procurement of the service in 2017. A survey has been conducted with people who use wheelchair services and their carers to ask about their experience of and views on the service they have received. A total of 129 responses were received and feedback highlights the following themes:

The majority were generally positive about the wheelchair service overall citing repairs, efficient service, quick assessments and good customer care

A third of respondents experienced a delay of more than two months for assessment (32 per cent). Over half indicate 'no delay' for service on a wheelchair (54 per cent). Three-fifths of those experiencing a delay were not aware of the reason for it (61 per cent)

"Need more wheelchair assessors."

The majority of respondents support the orders being prioritised by date and postural/pressure care needs (68 per cent) although a third do not (32 per cent)

"...there need to be guidelines on how long non priority patients should wait."

The majority of respondents support the possibility of stopping self-referrals for those already with wheelchairs (64 per cent) although more than a third do not (37 per cent). (Numbers were rounded).

"Need to implement a three strike rule. If patients do not turn up three times, they cannot self-refer again."

The feedback will be taken into account as we consider recommendations for the service in the future. Further engagement is planned as the service is developed.

1.9 Patient Transport Service

We are very grateful to patients who have helped us, working with the other clinical commissioning groups across Kent and Medway, to evaluate tenders for the Kent and Medway patient transport service. Patients helped both to shape the specification, and particularly the Patients' Charter setting out what people expect from the service, and to evaluate bids.

We expect to announce the outcome of the procurement in December 2015. The current contract expires at the end of June 2016 and will be replaced by three separate contracts covering respectively: renal patients, Darent Valley Hospital patients, and the general Kent and Medway Patient Transport service.

2.0 Spreading the word through the media and other communications

2.1 Thanet's main media outlets are the Isle of Thanet Gazette and the KM Group Thanet Extra. The CCG's media profile in these publications is positive, and media coverage is supportive of the CCG's work.

Over the past two months, news releases have covered many topics, including the east Kent careers fair and encouraging the use of pharmacies for minor illnesses.

The CCG also worked closely with KCHFT for the 'Big Thanet Health Check' when more than 200 health checks and health MOTs were carried out at 'pop-up' clinics in the community during the first week of November.

Teams from KCHFT set up a temporary health clinic in ASDA in Broadstairs, where Dr Tony Martin was interviewed by ITV Meridian television, advising Thanet people about the importance of self-care.

A precis of the NHS Thanet CCG annual report has been produced, for CCG members and local people, highlighting the CCG's core strategy and finances. This will be available in print and digital form.

Most recent press releases:

- Engaging Thanet's public (covering a patient engagement event in Margate).
- Antibiotics won't help but simple steps can beat the bug
- Listening to stroke survivors
- Use your pharmacist for minor illnesses.

2.2 Urgent care communications

The CCG has a national requirement to produce an operational resilience and capacity plan. This is to help manage seasonal pressures. As part of the plan for 2015/16, the CCG has developed a communications plan to support key messaging around use of A&E. We will work closely with providers of NHS services and Kent County Council communications on delivery of the plan, and are seeking innovative ways to engage with other organisations in Thanet to spread the word.

A key part of this for us is **Health Help Now**, the mobile optimised website and app for Kent and Medway.

- As of 22 November, the Health Help Now web app had been used 88,431 times by people using 65,689 devices (such as smartphones, tablets or computers). Users stay on for two and a half minutes on average. Thirty nine per cent of users are aged 18 to 34, 23 per cent are 35 to 44, 17 per cent 45 to 54, 11 per cent 55 to 64, and 10 per cent 65 plus. Two-thirds of usage is by women.
- The downloadable app, which launched on 9 December 2014, had been used 9,364 times and downloaded 5,906 times. People typically stay on for just over three minutes and look at eight screens.

In the build-up to winter and the festive break, we will work with the media and partner organisations to get out clear messages encouraging people to use Health Help Now and avoid the QEQM A&E unless it is an emergency.

The CCG always sends out such releases during peak holiday times (such as Christmas) and bank holidays.

2.3 Dementia awareness

NHS Thanet CCG is continuing its work with other CCGs in Kent – and Kent County Council and Kent and Medway NHS and Social Care Partnership Trust (KMPT) – to raise awareness of dementia and increase early diagnosis.

The dementia diagnosis rate in Thanet for October is 57.3 per cent, up from 48.27 per cent in March 2015. The diagnosis rate is lower than other parts of Kent.

The next stage of the publicity campaign will be to focus on the four main benefits of diagnosis:

- Early planning and assistance
- Checking concerns
- Treatment
- Health management.

The campaign, starting in December, will comprise press releases, social media and the use of visual images to complement the main message.

2.4 Medicines waste

Poster and stickers have now been produced for the CCG and are being distributed. The main message is 'only order what you need' to discourage excess ordering with repeat prescriptions.

Part of this phase of the campaign includes an emphasis on getting the message across in the local press, with emphasis on:

- In east Kent approximately £3 million is wasted on medicines which aren't used. This could fund ...
- Once a patient picks medicine up from the pharmacist, that medicine cannot be reissued to another patient.
- Research has shown that some people continue to cash in prescriptions for medicines they don't need or want to take, sometimes stockpiling medicines.
- We want to encourage patients to talk about their medication, ask questions and let their doctor, pharmacist or nurse know if they are not taking medication.
- Key message – 'only order what you need'.

2.5 Patient newsletter

The four-page patient newsletter will be distributed at Christmas/New Year time and will feature at least one patient case study.

The newsletter will also feature an article from the Lay Member for Patient and Public Engagement, Clive Hart and a public health message on mental health.

2.6 Digital and social media

The CCG continues to use new technologies to better engage and communicate with patients and stakeholders.

The CCG's Twitter account @NHSThanetHealth now has 2,130 followers, and the quality and quantity of tweets has increased. This has generated more 'likes' and re-tweets. There has also been a greater use of more pictures linked to tweets, generating more interest.

Recent tweets include:

Birchington Medical Centre supports @ThanetHealth at King Ethelbert School Skillsfest. Inspiring Thanet's youth! <http://ow.ly/i/eCvp4>

What is #self-care? #Thanet people get together to discuss how we can help the #NHS by helping ourselves. <http://ow.ly/i/eAmlc>

Excellent turnout for @ThanetHealth #NHS patient engagement meeting in Trinity Resource Centre, #Margate. <http://ow.ly/i/eAlg9>

Want to know why we're reviewing #stroke services in #Kent & #Medway? Read the case for #change: <http://ow.ly/UL8nm> #yourNHS

Take Care and Self Care this Winter. NHS Thanet CCG is proud to support #Selfcareweek 2015

Thank you. The @NHSKentCHFT team have been really busy! Very well done to all 'Working Towards a Healthier #Thanet'

3.0 Public affairs and stakeholder management

3.1 Health overview and scrutiny

We regularly update KCC's Health Overview and Scrutiny Committee (HOSC) on progress. The HOSC oversees the planning, provision and operation of health services under Section 244 of the National Health Service Act 2006 and amendments contained in the Health and Social Care Act 2012.

At its meeting on 9 October, we briefed HOSC on the East Kent Strategy Board so that members are aware of the context for many of the changes that need to take place. The

committee was also updated on progress with our integrated care organisation (ICO) and the emotional wellbeing strategy for children, young people and adolescents.

East Kent Hospitals University NHS Foundation Trust (EKHUFT) briefed the committee on its clinical strategy, finances and chemotherapy service.

KCC presented an update on the transformation of public health services and NHS England an update on specialist vascular services.

3.2 Stakeholder briefings

There have been no requests for MP briefings since the last meeting.

Thanet CCG: Planning 2016/17

Early national messages: Operational plans

2016/17 -

1 year detailed operational plan. As a minimum, plans must demonstrate 'on aggregate' that the system:

- Is commissioning sufficient activity to ensure performance against operational standards
- Expects to achieve overall financial balance so that contracts can be negotiated and signed
- Is starting to deliver on the £22bn challenge

Early national messages: Strategic Plans

Five year plan (to 2020):

- Each health care system to produce a Sustainability and Transformation Plan (STP)
- Ownership and buy-in of the whole local health economy should reflect a joint vision for the area
- The collaborative process of agreeing the STP is at least as important as the final product

Early guidance for the Sustainability and Transformation Plan

The Plan should have the following key elements:

- A summary of progress against the existing Strategic Plan
- A brief, focused narrative, describing the desired state for the health and care system in 2020/21
- **Application of Faster Safer Better; Right Care; Atlas of Variation principles and tools**
- Details of priorities for improving quality and outcomes
- Proposed changes to specific services, including the adoption of new models of care
- Details of how the transformed system will secure sustainable health and care services
- Implications for individual organisations, including finance, activity and workforce
- Details of the agreed systems and processes to ensure that the plan will be delivered

What does the evidence tell us?	What plans do we have which align to the evidence?	Comments
<u>Atlas of Variation (outlier areas):</u>		
Cancer (diagnostics/late diagnosis/ mortality rates)	Cancer strategy	
Flu immunisation rates for COPD patients and pregnant women very low	No CCG plan	
CHD reporting lower than expected prevalence	No CCG plan	
AF – patients not identified and in receipt of anti-coagulation prior to suffering a stroke	No CCG plan	
Patients registered with a GP with severe mental illness (high numbers)	MH crisis teams and psychiatric liaison	High priority
Ratio of reported to expected prevalence of dementia very low	Increase dementia diagnosis rates	Mandated
DEXA scan – low numbers	No CCG plan	
Bone sparing agent – identification of patients who have already experienced a fall could benefit from intervention to prevent further fracture(s)	No CCG plan	
Reported health gains from primary hip replacement very low	No CCG plan	
People aged over 75 admitted with a length of stay less than 24 hours	Integrated Health and Social Care Teams, Discharge to Assess, Frailty Pathway, Integrated Primary Care at the front door of A&E, Enhanced support to care homes	Links to ICO
3.2 Development of Thanet Plan		Page 5 of 10

What does the evidence tell us?	What plans do we have which align to the evidence?	Comments
<u>Commissioning for Value (outlier areas):</u>		
Public Health – smoking at time of delivery/ breastfeeding/obesity in 4-5 y/o	No CCG plan	
Inpatient spend for under 5 – MSK, cancer, neurological, gastro, poison, circulation	No CCG plan	
Dementia diagnosis	Increase dementia diagnosis rates	Mandated
Reporting vs expected prevalence of CHD	No CCG plan	
Low numbers of care plans for people with LTCs	No CCG plan	Links to self-care
% of emergency admissions with dementia who stay one night or less	Increased support to people with dementia	Mandated
High spend on complex patients with circulation problems	No CCG plan	
Complex patients – high o/p attendances (circulation/orthopaedics)	MSK service redesign (integrated provision). No plan for circulation	
People aged over 75 admitted with a length of stay less than 24 hours – highest	Integrated Health and Social Care Teams, Discharge to Assess, Frailty Pathway, Integrated Primary Care at the front door of A&E, Enhanced support to care homes	Links to ICO
3.2 Development of Thanet Plan		Page 6 of 10

What can others deliver? Draft for discussion

Outlier areas Atlas of Variation	Delivery areas:			
	Public Health	Primary Care	CCG	Provider
Cancer (diagnostics/late diagnosis/ mortality rates)	X	X	X	
Flu immunisation rates for COPD patients and pregnant women very low		X		
CHD reporting lower than expected prevalence		X		
AF – patients not identified and in receipt of anti-coagulation prior to suffering a stroke		X		
Patients registered with a GP with severe mental illness (high numbers)			X	
Ratio of reported to expected prevalence of dementia very low		X		
DEXA scan – low numbers		X	X	
Bone sparing agent – identification of patients who have already experienced a fall could benefit from intervention to prevent further fracture(s)				X
Reported health gains from primary hip replacement very low				X
People aged over 75 admitted with a length of stay less than 24 hours			X	

What can others deliver? Draft for discussion

Outlier areas: Commissioning for Value	Delivery areas:			
	Public Health	Primary Care	CCG	Provider
Public Health – smoking at time of delivery/breastfeeding/obesity in 4-5 y/o	X			
Inpatient spend for under 5 – MSK, cancer, neurological, gastro, poison, circulation			X	
Dementia diagnosis		X		
Reporting vs expected prevalence of CHD		X		
Low numbers of care plans for people with LTCs		X	X	
% of emergency admissions with dementia who stay one night or less			X	
High spend on complex patients with circulation problems			X	
Complex patients – high o/p attendances (circulation/orthopaedics)		X	X	X
People aged over 75 admitted with a length of stay less than 24 hours (highest)			X	

Considerations:

- A number of 'must do's' (Diabetes, CAMHS, LAC, disabled children, EOL & procurements)
- Cancer strategy agreed with plan in development
- Need to establish closer working with PH
- Mental Health & Dementia a strong theme
- Gaps where variation has been identified (AF, CHD, CVD)
- Paediatric project focuses on A&E attendances rather than admissions
- Ability to deliver with existing resources

Questions for discussion:

- Does the Governing Body feel assured that the plans going in to next year are sufficiently evidence based?
- How does the Governing Body propose that the gaps are managed and are we assured that we are focusing on the right areas?
- Are the plans for Mental Health next year sufficiently robust to assure NHSE that we are prioritising MH services?

Thanet Clinical Commissioning Group

Report to:	Thanet CCG Governing Body	Agenda item:	4.2.1
Date of Meeting:	8 December 2015		
Title of Report:	Chief Nursing Officer Report		
Is this report for internal distribution only?	No		
Author:	Sharon Gardner-Blatch, Chief Nursing and Quality SKC and Thanet CCGs		
Board Sponsor:	Sharon Gardner-Blatch, Chief Nursing and Quality SKC and Thanet CCGs		
Status:	Discussion of progress with key quality concerns across commissioned providers and confirmation that the Governing Body is assured by management response.		
Appendices	NA		

1. Purpose of Paper

This paper provides the Governing Body with an assurance report across the Chief of Nursing and Quality executive portfolio relating to key statutory duties of the CCG Quality of commissioned services, Safeguarding, Placements, Infection Control and Winterbourne View.

2. Introduction/Background

The issues in this report have all been presented at the Quality and Operational Leadership Team Committee for scrutiny and to seek assurance on behalf of the Governing Body that appropriate actions were underway to address any quality of commissioned service issues and assurances were gained that CCG requirements were being met.

3. Recommendation

The Governing Body is requested to review and discuss the report, identifying any concerns or gaps in assurance and to direct further action as appropriate.

4. Summary of Issues

Quality of Commissioned services.

CCG requirements; Safeguarding, Winterbourne, Infection Prevention and Control, and Individual Placements.

1.0 Introduction

This paper provides an assurance report to the Governing Body across the Chief of Nursing and Quality's portfolio. It informs the Governing Body about the current levels of assurance on the quality of services provided by the NHS Trusts commissioned by Thanet CCG and the decisions reached by the Quality, Operational and Leadership Team Committee (QOLT) following its scrutiny of the latest quality and safeguarding information and action the CCG is taking to drive up quality of its commissioned services.

It further reports on the CCG's delivery, as a statutory NHS organisation, of its safeguarding duties, health funded placements and infection control duties.

2.0 Commissioned Providers – Quality of Services

The CCG meets with its commissioned NHS providers at least monthly in joint Quality and Performance contractual meetings to review quality of services information for assurance, actions planned and progressed since the last meeting and to agree further improvements where necessary. Additionally quality visits are undertaken to commissioned providers.

2.1 East Kent Hospitals United Foundation Trust (EKHUFT)

The CQC undertook an announced inspection on the 13th to 17th July followed by an unannounced inspection on the 29th July. The 2014 CQC inspection judged the Trust as 'inadequate' overall. The 2015 inspection report has rated the Trust as 'requires improvement'. It should be noted, that in both inspections the Trust was rated as 'Good' in relation to caring for patients. There was variation in overall judgement of services by site; WHH, QEQM and KCH were 'requires improvement' with Buckland hospital and Royal Victoria Hospital rated as good. The quality team will receive the CQC Action plan and will ensure that there are no gaps between existing action plan and revised action plan.

Significant progress has been made over the last six months following the appointment of new executive team members, in particular in terms of staff and stakeholder engagement. CQC will reinspect key aspects of care within the next six months to make a further determination on this.

The CCG has discussed the specific areas of concern raised in the QEQM report and is conducting site visits to gain additional assurances that action is taken.

2.1.1 A/E service provision

The Quality team has conducted a 'deep dive' into AE services at the QEQM site as the service is failing to see and treat / discharge at least 95% of patients within 4 hours. Given the CQC and Emergency Care Intensive Support Team (ECIST) have already reviewed AE services from a regulatory and operational focus the CCG deep dive sought to identify any gaps and seek assurance.

The report has identified governance, induction, training, and safeguarding is as areas where additional assurance is required by the CCGs. The Trust is working with the CCGs to provide the additional assurances with these being reported to the CCG QOLT Committee.

A Deep dive exercise is underway focusing on the WHH AE department following concerns about delays in treatment and early recognition and management of deteriorating patients. South Kent Coast CCG, with Ashford CCG and Canterbury and Coastal CCG are conducting the review which, once complete, will be reported to the QOLT committee.

2.1.2 Maternity

The Trust has provided a maternity dashboard to the CCG. The CCG have requested site specific information to provide assurance regarding the quality of maternity services. This will now be presented regularly to the contract meetings. The Maternity Clinical Network dashboard pilot has now concluded and is being rolled out to all providers and the CCG will have access once implemented by the Trust. Maternity services were reported as inadequate within the CQC report given the lack of progress. The quality team continues to support the Trust with the actions that have been put into place to address some of the significant cultural and workforce issues identified which are impacting on the care that women are experiencing.

The CCGs with NHSE and the Trust have commissioned a Royal College review which is underway to support the service to make further improvements.

2.1.3 Delivering Same Sex Accommodation (DSSA)

Breaches continue to occur within the Trust Clinical Decision Units (CDU) predominantly at the WHH site. Tracking, monitoring and reporting continues in accordance with the agreed process and policy.

The Trust is reporting all breaches according to the National guidance. Justifiable breaches are reported to commissioners. The CCG continue to monitor the situation and will be reviewing the Trust action plan for bathroom breaches.

This was discussed at the contract meeting in November and will continue to be a focus of the CQC action plan.

2.1.4 Healthcare Associated Infections (HCAI)

The Post Infection Review (PIR) for an MRSA bloodstream infection identified lapses with the , Trust's has not been followed the MRSA screening policy consistently. This is now being addressed and the CCG are monitoring this through the HCAI Panel.

The numbers of serious incidents the Trust has open are reducing. There remain a small number of open cases that are breaching the time frame for investigation. There is focused work internally, led by the Director of Nursing for EKHUFT aimed at strengthening divisional SI processes and reducing the numbers of open investigations further.

The Trust has reported a Never Event, a serious incident that should never happen as national guidance has been issued to prevent harm taking place and the Trust has declared compliance with the best practice. The incident, relating to a naso-gastric feeding tube, is currently under investigation. The CCG taking steps, in partnership with Ashford CCG, Canterbury and Coastal CCG, SKC CCG and NHS England to gain assurance that current practice meets national guidance and any learning from this incident is embedded in practice.

2.2.4 Looked After Children (LAC)

The Trust is not meeting their statutory target of assessing 85% of children within 28 days of becoming 'looked after'. The CCGs have issued a Contract Performance Notice with the initial meeting being held on 6th November. A remedial action plan is being developed and will be monitored to closure through the contract meetings.

3. Kent Community Health NHS Trust

3.3.1 Infection Prevention Control Training

The Trust has achieved 95% for training. There are differences between services and this continues to be monitored through the contract meeting.

3.3.2 Workforce

A recent quality visit to the Long Term Conditions team noted that the trust was not using a caseload tool to assess the long term conditions existing caseload. The Trust have responded to the CCGs concerns and are in the process of implementing a caseload tool. This will ensure that patients are being managed and visited as identified by highest clinical need.

3.3.3 LAC

The Trust is not completing health histories for care leavers. This is a statutory requirement. The Trust has agreed to start health histories when children become looked after as part of their standard service

Kent and Medway Partnership Trust (KMPT)

4.4.1 CQC Report

The KMPT CQC inspection was undertaken in March 2015; report was published in July 2015. The CQC rated the Trust overall as “requires improvement.”

The Trusts action plan identifies the 27 Must Do Actions and the 4 Should Do Actions.

The plan is divided into 3 parts internal actions, capital requirement actions and system wide actions. The Quality team will monitor the internal actions through the contract meetings, local operational meetings and quality meetings

4.4.2 Serious Incidents (SIs)

The Chief of Nursing and Quality and the Head of Quality have met with the Medical Director for KMPT to discuss the continued concerns around SI investigations. As part of agreeing a way forward the NHS England South (South East) SI lead has agreed to work with the Trust and CCGs to facilitate improvements and optimize learning for patients.

5.1 CCG Safeguarding Arrangements

The Designated Nurses are reviewing the CCG’s compliance with our safeguarding duties as an NHS organisation. The CCG recognizes its strategic role in safeguarding as a partner organisation and is looking to embed safeguarding throughout its day to day functions.

The CCG policies for Safeguarding Children and Adults are being revised and will be presented to the Governing Body at its meeting in January 2016 following QOLT review.

The Child Safeguarding Annual Report is presented to this Governing Body meeting and sets out progress and further actions over 2015/16

5.2 Unaccompanied Asylum seeking Children (UASC)

There continue to be large numbers of UASC in the county who have the status of ‘looked after children’ on arrival and require statutory health assessments.

Services for primary care, vaccination programmes, dentistry and ophthalmology are being developed in conjunction with NHS England.

The health assessments are being progressed and the CCG has had a good response to a national advert for community pediatricians to address the surge in numbers. The CCG has progressed arrangements with a London CCG to ensure that children who have been placed in London Boroughs by Kent can receive their initial health assessment.

The CCG is progressing increased Designated Doctor for LAC capacity to develop and ensure robust systems are in place to meet the continued increased demand for LAC services.

The Governing body needs to be aware of potential risks associated with UASC; not all health assessments will be completed within the statutory timescales and the CQC has been informed of this. There is a 3 month follow up requirement to the initial health assessment which will place a further demand on capacity; there will be a financial impact from the increase in numbers of UASC.

6.0 Winterbourne

The CCG continues to deliver relocation for people who have been identified as being inappropriately placed in line with the timescales required nationally

7.0 Placements

7.1 Integrated Placements

The CCG scrutinises the operational management of all current placements and referrals management in its Quality Committee bi- monthly. The CCG has improved assurance about the operational process which supports it to deliver its statutory duties.

The CCG is aware the CQC have a number of concerns in care homes within the CCG geography and works closely with the social services, CQC and Health watch to identify and minimise any impacts on patients. Some of the local nursing home beds are for CCG commissioned patients. Where this occurs the Placements Team undertake additional quality assurance monitoring and action.

The CCG is working with the Commissioning Support Unit to review their financial forecasting model as it does not have robust assurance that this is supporting the CCG to identify emerging risk.

8.0 Healthcare Associated Infections (HCAI) in primary care

The CCG has breached its C difficile reduction trajectory. The CCG is working with the acute and community providers to understand the increase of cases. The CCG and EKHUFT have jointly undertaken a deep dive of Quarter 1 data. The main themes identified were lack of adherence to antibiotic formulary, delay in testing for c diff and lack of adherence to Infection Prevention and Control (IPC) policies in both primary and secondary care.

Thanet CCG IPC specialist is working with the Trust to ensure that actions are embedded and that testing is undertaken in appropriately whilst Thanet residents are in patients. The Medicines Management lead is working with the Antibiotic Stewardship Group

Conclusion

The CCG continues to commission services from providers who have a number of challenges. The Quality Team working with our GP clinical leads analyses intelligence to identify early warnings and mitigate any developing or actual patient safety or quality risks.

Report to:	Thanet Governing Body	Agenda item:	4.2.2a
Date of Meeting:	8 December 15		
Title of Report:	Safeguarding Children Annual Report 2014/15		
Author:	Sheridan Morrison, Designated Nurse for Safeguarding Children.		
Board Sponsor:	Sharon Gardner-Blatch, Chief Nurse, Thanet CCG		
Status:	For Approval		

1.	Purpose of the Paper
The Paper includes progress towards priorities during the year 2014/15 and an outline of how the CCG is meeting statutory responsibilities for Safeguarding Children.	

2	Introduction
The report has been presented at the Quality and Operational Leadership Team Committee for scrutiny and to seek assurance on behalf of the Governing Body that CCG requirements for Safeguarding children were being met.	

3.	Recommendations
The Governing Body is requested to accept the report and note the contents.	

4.	Summary of issues
<p>Thanet CCG has a statutory responsibility to ensure that there are safe systems in place to safeguard children at risk of abuse and neglect. The CCG is required to provide assurance to Kent Safeguarding Children Board and NHS England as to how the CCG are meeting statutory responsibilities for Safeguarding Children.</p> <p>Evidence was submitted to NHS England and the Kent Safeguarding Children Board in early 2015 and was able to demonstrate compliance in the majority of areas and partial compliance in remaining areas. Any gaps have been identified and included in Safeguarding Children work plan for 2015/16 which is monitored through the Quality and Operational Leadership Team Meeting. Gaps in Provider assurance are also monitored through the relevant Performance and Quality meetings.</p>	

Safeguarding Children Annual Report

Thanet Clinical Commissioning Group

October 2015

By Sheridan Morrison - Designated Nurse for Safeguarding Children

Contents	Page
1. Introduction	4
2. Local Context	4
3. Governance and Accountability Arrangements	8
4. National Legislation and Guidance	9
5. Summary of Progress and Achievements 2014/15	10
6. Kent Safeguarding Children Board	12
7. Changes to the CAF Process/ Early Help	14
8. Central Referral Unit	14
9. The Child Death Review Service	15
10. Serious Case Reviews and Case Reviews	15
11. Child Sexual Exploitation (CSE)	16
12. Female Genital Mutilation (FGM)	18
13. Domestic Abuse	18
14. Sexual Assault and Referral Centre (SARC)	19
15. Inspections of Safeguarding and Looked After Children	19
16. Thanet CCG Safeguarding Assurance	20
17. Supporting Safeguarding Standards in Primary Care	21
18. Thanet CCG Key Provider Summary 2014/15	22
19. Conclusions	25
20. Priorities for 2015/16	26
21. Links and References	27

Executive Summary

The purpose of this Annual Report for Safeguarding children is to provide assurance to the Governing Body on how Thanet Clinical Commissioning Group (CCG) is fulfilling its statutory duties in relation to safeguarding children.

The CCG has in place governance and accountability arrangements including regular reporting via the Quality and Operational Leadership Team Meeting and there is direct access by the Designated Professionals to the Chief Officer. The CCG submitted evidence and assurance returns to NHS England to demonstrate compliance with statutory functions. In addition, the Section 11 Audit was returned to Kent Safeguarding Children Board which demonstrated compliance in the majority of areas. Areas for development are covered in the report and are included in the Safeguarding Work plan for 2015/16.

Thanet has high levels of deprivation and issues which impact on the welfare of children which provides challenges for all organisations working with children and families and strong multi-agency partnerships are vital. The CCG makes a significant contribution to the work of the Local Safeguarding Children Board and is represented through the Chief Nurse and Designated Nurses. In particular there is positive work on Child Sexual Exploitation and this work is being further developed in light of the “Lakeland” Operation locally.

Safeguarding Assurance processes are in place with providers and the CCG has partial assurance related to provider safeguarding through KSCB and CCG processes for 2014/15 based on the evidence available. This is being further developed in 2015/16. This has been a year of transition from a hosted model but Designated Nurses are now employed directly and based within the CCGs. This will enable safeguarding processes to be strengthened further and more robust assurance processes put in place.

There have been a number of national developments including the updated Working Together to Safeguard Children 2015 and an updated Accountability Framework from NHS England. Relevant policies will be updated to reflect these.

Safeguarding is everyone's responsibility and it is essential that all CCG staff are aware of their responsibilities for safeguarding children. The role of the CCG also includes ensuring that providers from which they commission health services are effectively discharging their statutory responsibilities and the Designated Nurses and the Governing body in particular have a key role.

1. Introduction

- 1.1 This report provides Thanet Clinical Commissioning Group (CCG) Governing Body with an overview of safeguarding across health services during 2014 -2015. The purpose is to assure the Governing Body that the CCG is fulfilling its statutory duties in relation to Safeguarding Children across the health services it commissions. The report covers the period from 1st April 2014 until 31st March 2015.
- 1.2 CCGs are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children at risk of abuse or neglect. This includes specific responsibilities for Looked After Children (LAC) and for supporting the Child Death Overview process. Local authorities have the same responsibilities in relation to the public health services they commission.
- 1.3 In April 2014, a hosted model for safeguarding children, as well as the LAC statutory functions was in place and the eight CCGs in Kent and Medway shared a joint team of designated nurses hosted by Medway CCG. A Safeguarding Partnership Board was in place to monitor safeguarding arrangements across Kent & Medway CCGs. The Safeguarding Partnership Board undertook a review of working arrangements and with agreement from the Governing Body made the decision to disaggregate the hosted team. From 1st January 2015, designated professionals for safeguarding children have been directly employed by their respective CCGs and report to the Chief Nurse within each CCG. A shared resource for LAC and Child Death across the CCGs is hosted within Swale CCG.
- 1.4 Thanet and South Kent Coast share the Designated Nurse for Safeguarding Children and there is 1 WTE working across the two CCGs. The previous Designated Nurse for Safeguarding Children left in March 2015 and the new Designated Nurse was appointed in May 2015. The report was written by the new Designated Nurse for Safeguarding Children with input and support from the other Designated Professionals in Kent who were part of the hosted model during the time period the report covers.

2. Local Context

- 2.1 NHS Thanet CCG sits within the area covered by Thanet District Council and is part of Kent County Council. The area includes Margate, Ramsgate, Broadstairs, Westgate, Birchington, Thanet villages and rural areas.
- 2.2 Thanet Clinical Commissioning Group (Thanet CCG) covers patients from 21 practices with a registered practice population of approximately 140,000 of which there are around 8360 children aged 0-4. Central Harbour, Eastcliff, Dane Valley and Cliftonville West have the highest number of children aged 0 to 4 and the wards with the fewest are Birchington North, Kingsgate and Bradstowe. (Early Years Profile 2015). A significant number of these children live in circumstances where they are at risk of suffering harm from abuse and neglect.
- 2.3 The Health and Social Care Act 2012 places a statutory duty on health services to reduce inequalities in health. Demonstrating this intention is also a requirement of CCGs for the purposes of authorisation by NHS England. In the Index of Multiple Deprivation (2015), Thanet is the 35th most deprived District in England and Wales out of 326 in total. These statistics are made up of indices including income, crime, housing and health. The area has become significantly more deprived since the 2010 statistics and this is only part of the picture as Thanet is diverse and also has areas which are in the least deprived in the IMD which masks the high levels of deprivation in some areas when looking at District Level.
- 2.4 Margate Central and Cliftonville West Wards are among the most deprived in the country and have become even more deprived in the 2015 statistics. For example one of the Lower Super Output areas in Cliftonville West is now the 4th most deprived in the whole country, the second most deprived in the South East and the most deprived in Kent. Other areas in Thanet which have high levels of deprivation are Eastcliffe and Central Harbour in Ramsgate and Dane Valley in Margate.
- 2.5 Margate Central and Cliftonville West have particular challenges for agencies. There are high numbers of multiple occupancy housing, substandard housing and has a high turnover of residents. There are also issues with vulnerable people placed from other local authorities and a Margate Taskforce is in place to provide a multi-agency response

to the issues. Some of the issues in Thanet which impact on children are highlighted below.

2.6 Under 18 conceptions - Thanet has the highest teenage conception rate across Kent.

In 2012, the rates for conceptions for girls aged 15-17 was 36.1, compared with the Kent rate of 25.9. In Thanet, Teenage conceptions are highest in Cliftonville West and Margate Central wards. While for some young people, having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is difficult and many pregnancies are unplanned. Teenage pregnancy often results in poor outcomes e.g. Babies born to teenage mothers have a 60% higher infant mortality rate and a 63% increased risk of being born into poverty compared to babies born to older mothers. (JSNA 2011/14/15).

Key risk factors for teenage pregnancy are:

- being a looked after child
- some minority groups
- being a child of a teenage parent
- living in a deprived area

2.7 Unemployment and Low Income - There are vast differences in the unemployment rate across Thanet. In Cliftonville West, it is 19.7% and the lowest is Kingsgate with a rate of 1.5%. The average for the district is just under 6%. There is a clear link between childhood accidents and poverty. Children of parents who have never worked or who are long term unemployed are 13 times more likely to die from unintentional injury and 37 times more likely to die as a result of exposure to smoke, fire and flames than children of parents in higher managerial and professional occupations. (Better Safe than sorry report – Audit Commission 2007). The high levels of deprivation in Thanet and in particular the very high deprivation in Margate Central and Cliftonville West mean that children are at higher risk of accidental and non-accidental injury.

2.8 Kent Vulnerable Children Data (As of 31st March 2015 - Data taken from KSCB Annual Report 2014/15)

Category	Number
Children subject to a Child Protection Plan	1240
Children in Need	1129
Children open to Early Help and Preventative Services	5380
Children in Care	1502

Children in Care placed in Kent by other Local Authorities	1303
Children in Care who are placed out of Kent (Not including Unaccompanied Asylum Seeking Children)	148
Unaccompanied Asylum Seeking Children (UASC)	368

2.9 Children in Care - Thanet has the highest number of children in care placements in Kent at 306. This is much higher than the other districts with the next highest being Swale with 187 children. There is a well -established link between deprivation and children coming into care such as unemployment, low income, inadequate accommodation and lone parent status. The majority of children who remain in care are there because they have suffered abuse or neglect. Past experiences, poor start in life, care processes, placement moves and many transitions mean that these children are often at risk of having inequitable access to health services, both universal and specialist. In addition, Kent has a high number of Unaccompanied Asylum Seeking Children and this figure has increased significantly in 2015.

2.10 Domestic Abuse - During 2013/14 there were 25,365 domestic abuse incidents Reported to Kent Police. This is an increase of 8.4% from 2012/13. The DV rate per 1000 population in Thanet has increased from 19 per 1000 in 2009/10 to 23 per 1000 in 2013/14. This compares with the Kent and Medway rate which increased from 13 per 1000 to 15 per 1000 during the same period. This is likely to be a significant underestimate as it is known that many victims of domestic abuse are abused many times before they seek help and many do not report. MARACs (Multi-agency Risk Assessment Conferences) are designed for victims and families assessed at high risk of significant harm or murder. In MARAC meetings, agencies share information and agree to an action plan to support victims. During 2013/14, 1862 high risk cases were referred to MARAC, with 2394 children living in those high risk households. This is an increase of 32% on the previous year. 230 (12%) of MARACs were from Thanet.

2.11 Risk of Child Sexual Exploitation - Any child or young person may be at risk of sexual exploitation, regardless of their family background or other circumstances. This includes boys and young men as well as girls and young women. However, some groups are particularly vulnerable. These include children and young people who have a history of running away or of going missing from home, those with special needs, those in and leaving residential and foster care, migrant children, unaccompanied

asylum seeking children, children who have disengaged from education, children who are abusing drugs and alcohol, and those involved in gangs. Many of these groups are issues in Thanet therefore all agencies need to consider CSE. There is not any reliable data on CSE but a new multi-agency team is being set up which will look at addressing the issue. (See section 11.)

2.12 Overall, it can be seen that Thanet has a range of significant issues which contribute to the vulnerability of children. Three of these factors (Domestic abuse, Mental health and Domestic abuse) are a feature in a significant number of Serious Case Reviews nationally and are known as the “ Toxic Trio “.

3. Governance and Accountability Arrangements

3.1 In March 2013, the NHS Commissioning Board (now known as NHS England) published the “Accountability and Assurance Framework: Safeguarding Vulnerable People in the Reformed NHS”, which set out the safeguarding accountabilities of CCGs and include:

- Plans to train staff in recognising and reporting safeguarding issues;
- A clear line of accountability for safeguarding properly reflected in the CCG governance arrangements;
- Appropriate arrangements to co-operate with local authorities in the operation of Local Safeguarding Children Boards (LSCBs).
- Securing the expertise of a designated doctor and nurse for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood;

The Framework has been updated by NHS England in 2015 and this will be reviewed by the Designated Nurses to ensure that the CCG is compliant.

3.2 Safeguarding accountability sits within the portfolio of the Chief Nurse, who provides strategic direction on safeguarding, including Looked after Children, and has direct or delegated representation on the local Safeguarding Children’s Board.

3.3 Governance is achieved for Thanet CCG via the Quality and Operational Leadership Meeting which is established in accordance with Thanet Clinical Commissioning Group’s Constitution, Standing Orders and Scheme of Delegation.

3.4 Clinical Commissioning Groups need to secure the expertise of a designated doctor and nurse for safeguarding children to provide strategic and clinical leadership and advice, not only for themselves but also for the local authority. The role of these designated professionals is to assist the CCGs in fulfilling their responsibilities as commissioners of services to safeguard children. Thanet CCG has a Designated Nurse for Safeguarding children which is shared with South Kent CCG. There is a Designated Doctor and this is being reviewed in 2015/16.

3.5 Looked After Children and Child Death functions are achieved through the hosted model and are employed by Swale CCG.

3.6 All CCG staff are expected to undertake safeguarding children training appropriate to their role and this is being reviewed in 2015/16 and in addition to e-learning, face to face sessions are being provided to the CCG. In addition, training is planned to the governing body to ensure that they are aware of their responsibilities in relation to safeguarding.

4. National legislation and Guidance

- The Children Act 1989
- Children Act 2004
- Working Together to Safeguard Children 2015
- Children and Families Act 2014
- Health and Social Care Act 2012
- Safeguarding Children and Young People: roles and competencies for health care staff: Intercollegiate Document 2014

4.1 Roles and Competencies of healthcare staff in safeguarding children

All staff that come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection. They must also clearly understand their responsibilities, and should be supported by their employing organisation to fulfil their duties. Chief Executive officers and independent contractors, such as GPs, in particular have a responsibility to ensure that all staff across the organisation have the knowledge and skills to be able to meet this requirement. This

responsibility also applies to staff working primarily with adults who have dependent children that may be at risk because of their parent/carer's health or behaviour.

To fulfil these responsibilities, it is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing. The latest version of intercollegiate document jointly published by the Royal Colleges and professional bodies was updated in April 2014 to emphasize the crucial role of the Executive Team and Board members, whilst also taking into account the structural changes which have occurred across the NHS.

5. Summary of Progress and Key Achievements in Safeguarding Children 2014/15

5.1 The NHS Kent and Medway Annual Safeguarding Report 2013/14 set out priorities for the year and the Designated Professionals as part of the hosted model worked on these. Below is a summary of how those priorities have been implemented:

1. Ensure achievement against actions required from NHS England following their assurance process

Completed - *Action plans submitted and assurance given to NHSE*

2. Implement Service Level Agreements, Job Plans and JDs for all designated doctors across Kent and Medway, securing this statutory provision

In progress – *to be completed during 2015/16*

3. Area Teams (NHSE) are responsible for recruitment to Named GP, to ensure collaborative working

In progress – *NHS England are planning to set up an SLA to discharge this responsibility via the CCGs.*

4. Review policies, strategies and guidance in line with recent key national documents, national and legislation

In Progress - *Updated Safeguarding Policy to reflect updated national guidance will be completed by December 2015*

5. Transfer the Child Death Function into a CCG

Complete - *hosted by Swale CCG.*

6. Deliver training for CCG employed staff and Governing Bodies

In progress – All CCG staff undertake safeguarding children training via e-learning. It was identified as part of the assurance to NHSE that face to face sessions should be provided to CCG staff and the governing body. These will be completed during 2015/16

7. Consolidate Designated Nurse's alignment to CCGs and chief nurses

Complete - As part of disaggregation of hosted team and Designated Nurses being employed directly by CCGs.

8. Build on work already completed to develop robust arrangements and relationships

Ongoing – A memorandum of understanding is in place with the Designated Nurses who meet monthly. Chief Nurses also meet regularly.

9. Attendance and influence at KSCB sub-groups

Ongoing – full attendance at all KSCB sub-groups is achieved by all CCGs being represented as outlined in the safeguarding MOU.

10. Implement Safeguarding Work plans for all CCGs 14/15

Complete – The safeguarding children work plan for Thanet CCG has been developed and is monitored through the Quality and Operational Leadership meeting.

11. Continue to develop robust arrangements and relationships with provider organisations including standardisation of data collation and safeguarding representation at local operational meetings

In progress – safeguarding metrics have been agreed and are incorporated into all provider contracts. This will be further developed during 2015/16.

5.2 Key Achievements in 2014/15

- The Designated Nurse role has been strengthened within the CCG and attends key meetings. The Designated Nurse for Safeguarding Children post was successfully recruited and the new post holder started on the 18th May 2015.
- Development of robust networks and relationships with designated nurse across CCG to ensure robust arrangements and application of thresholds to protect children. Collaboration achieved through a Memorandum of Understanding (MOU).
- Successful multiagency working to protect and safeguard children and young people particularly with Operation Lakeland.
- There was a scoping exercise across provider health organisations to review their preparedness to recognise sexual exploitation.
- Provision of advice and support to GP staff and other primary care professionals.
- KSCB Section 11 assessment of CCGs completed and submitted
- Safeguarding input at key CCG meetings and KSCB Board and Subgroups.

6. Kent Safeguarding Children Board

6.1 Local Safeguarding Children Boards (LSCBs) were established in law by the Children Act 2004 and have two main responsibilities:

- To co-ordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in their local community.
- To ensure the effectiveness of what is done by each such person or body for those purposes.

6.2 CCGs have a statutory duty to be members of the LSCB working in partnership with local authorities to fulfil their safeguarding responsibilities. These statutory duties fall under Section 11 of the Children Act 2004 and apply to a range of organisations as well as the health economy. Section 11 places a duty on key persons and bodies to make arrangements to ensure that they have regard to the need to safeguard and promote the welfare of children when undertaking their roles.

6.3 LSCBs have a responsibility to assess whether their local partners are fulfilling their statutory obligations under section 11. Kent Safeguarding Children's Board do this every 2 years via a multi-agency audit. All health organisations in Kent including providers and CCGs have been required to submit an s.11 self-assessment with final submissions to KSCB in March 2015. The Designated Professionals review the S 11 returns submitted by providers and work with the KSCB to follow up any gaps.

6.4 Kent Safeguarding Children Board is made up of senior representatives from all main agencies and organisations. CCGs are represented by one Chief Nurse from the Kent CCGs who represents the interests of all CCGs.

6.5 The KSCB has sub-groups which are formed to tackle the various area of concern to the KSCB on a more targeted and thematic basis. Health providers across Kent are members of all sub-groups and the designated nurses for safeguarding children are active members who give the strategic health expertise and oversight of the whole health economy.

These include:

- Policy and Procedures Sub-group
- CSE and Trafficking Sub-group
- Case Review Sub-group
- Learning & Development Sub-group
- Child Death Overview Panels (CDOP)
- Quality & Effectiveness Sub-group
- Health Safeguarding Group
- Health Reference Group

6.6 KSCB develops an annual report and Business Plan which sets out what it intends to achieve and how its success will be measured. www.kscb.org.uk. KSCB set five strategic priorities for 2014/15 which should be familiar to the CCG GB and should be reflected in any commissioning decisions they make:

- **Priority 1 - *Co-ordinate, monitor and challenge the effectiveness of local arrangements of the quality and appropriateness of early help and preventative services***
- **Priority 2 - *Ensuring multi-agency and joined up working which protects and supports children with specific vulnerabilities, including the provision of timely and appropriate services***
 - This will include focus on the following groups of vulnerable young people:
 - Missing young people
 - CSE young people
 - Those being trafficked
 - Those affected by gangs
 - Those affected by 'on line' safety and those at risk of on line threats
- **Priority 3 - *Develop a family focused approach in relation to substance misuse, mental health problems and domestic abuse***
- **Priority 4 - *Provide evidence assurance to the KSCB through robust monitoring, scrutiny and challenge, that multi-agency safeguarding practices are improving and there is ongoing learning and development for staff***

7. Changes to the Common Assessment Framework (CAF) process and Early Help

Following the review of the Common Assessment Framework (CAF) process, the Early Help and Preventative Services (EH&PS) was piloted from 1st September 2014 using a phased approach. The assessment process replaced the CAF whose name was changed to the Kent Family Support Framework. The KFSF provides a streamlined process which includes:

- Early Help advice and support from an Early Help co-ordinating team.
- Request for access to EH&PS support from Kent Integrated Family Support Service (KIFSS) and Kent Integrated Adolescent Support Service (KIASS) by completing and uploading a notification form.
- A simplified triage process for all notifications to ensure effective decision making and allocation to access appropriate advice and support including Early Help and Troubled Families commissioned services.
- A closer working relationship with social care to ensure more effective step up and step down processes.
- The use of revised assessment, plan and review tools to ensure high quality interventions are made to achieve better outcomes for the child and family.
- An identified key worker to be a single point of contact for families and schools.
- More details of the pilot including a KFSF flowchart diagram are available on the following webpages (www.kelsi.org.uk/earlyhelp)

8. Central Referral Unit (CRU)

A Central Referral Unit (CRU), which is a multi-agency hub that evaluates and assesses Safeguarding for both children and adult concerns, bringing together the information held within the multi-agency environment, evaluating the level of risk and planning the necessary action through strategy discussions. The CRU is made up of staff from different agencies including Police, Social Services, Health and Probation. There isn't currently performance data available on this service but this is being taken forward in 2015/16 and will be reported on in the next annual report.

9. The Child Death Review Service – Kent

9.1 The Child Death Review Service works in partnership with Kent's Health Economy to ensure that the statutory requirements of Regulation 6 of the *Local Safeguarding Children Board Regulations*, 2006, made under section 14(2) of the Children Act 2004, are met. The statutory guidance in Chapter 5 Working Together to Safeguard Children 2013 states that every child's death occurring within the boundary of Kent Safeguarding Children Board (KSCB) and/or any death of a child normally resident within the boundaries are reported to KSCB within 1 working day of the child's death.

During 2014/15, there were 78 child deaths in total within Kent. Of these, 70 cases were children within the KCHT/KSCB boundaries and 8 were out of area cases. A total of 36 cases were unexpected with the remaining being classified as expected or expected/explained cases, i.e. neonatal. The largest group of child deaths was in the neonatal category (27 cases). Thanet had 7 cases in 2014/15. (See Child Death Review Service Annual Report 2014/15 for further information).

10. Serious Case Reviews (SCR) and Case Reviews

10.1 KSCB has a Case Review Sub Group which is responsible for reviewing cases where a child has died or has been seriously harmed in circumstances where abuse or neglect is known or suspected, and for co-ordinating and disseminating learning from these. The groups provide advice to the Independent Chair on whether the criteria for conducting a Serious Case Review (SCR) has been met and will support the Chair in establishing the initial scope for any SCR that is commissioned. The purpose of SCRs is to learn lessons and make improvements to services but also to consolidate good practice. They are carried out under the auspices of the LSCB who should oversee the implementation of action plans.

10.2 Two SCRs were commissioned by KSCB during 2014/15 and will be completed during 2015/16. In addition, seven formal Management Reviews have been completed.

Key topics from Kent Case Reviews 2014/15

- Sexual Abuse (including awareness and understanding of the Sexual Abuse Medical Pathway, Agencies responses and awareness that children cannot make “ lifestyle choices” that result in sexual activity with older men)

- Record Keeping
- Child Protection Conferences/Review Conferences (including staff who attend understanding their role, submitting reports if unable to attend)
- Strategy discussions (Requirement for appropriate professionals to attend, especially health if sexual abuse is suspected and appropriate challenge if professionals not present)
- Self-Harm (including the need for early responses to self-harm)
- Voice of the Child
- Supervision
- Toxic Trio (Working with adults who have Domestic Abuse/Substance Misuse/Mental health issues, full consideration must be given to the impact on the children/young people in the family)
- Working with Families (Including working with hostile and resistant families, escalating when ongoing concerns remain, respectful uncertainty)

11. Child Sexual Exploitation (CSE)

11.1 In recent years the issue of CSE has gone from being largely hidden and rarely acknowledged to the subject of significant media and political attention and concern. CSE is a safeguarding issue and there is a strong need to improve health professionals' understanding of child sexual exploitation, in order to protect victims and support them to recover well. Additionally there is a need to improve the evidence base in order to improve the overall response from health. Sexually exploited children may suffer from a range of significant health vulnerabilities, including physical injury from violence, sexual health problems, pregnancy, terminations, drug and alcohol misuse, depression, low self-esteem, self-neglect, self-harm and attempted suicide.

11.2 CSE can only be tackled through collaboration between senior managers and safeguarding professionals to provide direction through the Joint Health and Wellbeing Strategy, the Local Safeguarding Children's Board and partnership working. Health professionals should be proactively contributing at every stage of the commissioning cycle and delivery of services along the care pathway for children who are sexually exploited. Children who are victims of CSE should have easy access to health services not just for sexual health, but also for their physical and mental health, reflecting the broad range of health problems they may have.

- 11.3 At a national level, the government produced its strategy “Tackling Sexual Exploitation” (March 15). It responds to the numerous reports and subsequent enquiry in sexual exploitation by the Office of Children’s Commissioner and should be read in conjunction with “Information Sharing Letter”
- 11.4 CSE protocols for Kent and Medway are in place and the strategy and protocols are being reviewed in 2015. Kent and Medway multi agency partners are in the process of developing a Multiagency Sexual Exploitation team (MASE) which will co-ordinate soft intelligence, data and safeguarding responses to victims of CSE. The first scoping meeting will be in June 2015. In addition, the Designated Nurse is part of the KSCB CSE and trafficking sub-group.
- 11.5 A CSE action plan has been devised by Kent and Medway LSCBs and all multi-agency providers will provide assurance and organisational action plans where gaps are identified. A scoping exercise was undertaken by the Designated Professional with providers in 2014. This will be reviewed further in 2015/16.
- 11.6 Ofsted undertook a thematic inspection of practice in protecting children and young people in relation to issues of child sexual exploitation (CSE) across eight local authorities of which Kent was one. The aim of the inspection was develop their understanding of the factors which facilitate or hinder good quality practice and effective protection of children and young people relating to issues of child sexual exploitation. The inspection was completed in October 14 via a programme of small group meeting interviews with key individuals, and tracking of a selected number of cases.
- 11.7 In 2013, Police and partner agencies became increasingly concerned about the risk of Child Sexual Exploitation, particularly related to ethnic and minority communities. In October 2013, a dedicated team was set up to address these issues and was named “ Operation Lakeland”. This was a large scale police operation including a high number of potential perpetrators and the investigation initially looked at around 100 potential victims of CSE which were reviewed and risk assessed. These included a number of victims from Eastern European communities. As a result of this operation, KSCB has commissioned a Case Review to look at 3 representative victims of CSE and identify learning for the agencies involved. The Case Review is currently in progress and will be reported on during 2015/16.

12. Female Genital Mutilation (FGM)

12.1 HM Government has issued multi-agency practice guidelines regarding FGM and the Department of Health has issued guidance for GPs on recording FGM. Mandatory mandatory reporting will be required by all professionals in 2015.

12.2 All provider organisations have been asked to review their FGM procedures and identify any gaps and this will be reviewed during 2015/16. FGM is now to be included in any training delivered to staff. The Designated nurses will seek assurance from all those providers that they have processes in place to do this.

13. Domestic abuse

13.1 Domestic abuse is defined as: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

13.2 The NICE guidance (February 2014) "Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively" makes a number of recommendations, including developing an integrated commissioning strategy through local strategic partnerships and commissioning integrated care pathways - Domestic Violence and Abuse Service and Swale Action to End Domestic Abuse. The Kent and Medway Domestic Abuse Strategy Group, a multi-agency group, is responsible for setting the strategy, and is accountable to the Community Safety Partnerships. The Domestic Abuse Strategy (2013 – 2016) and Delivery Plan is available on the Kent and Medway Domestic Abuse website www.domesticabuseservices.org.uk

13.3 Domestic Homicide Review (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. Revised guidance has been issued, applicable from August 2013. A DHR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect perpetrated by:

- (a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or
- (b) a member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death. An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

A number of DHRs have been undertaken in Kent and lessons disseminated.

14. Sexual Assault and Sexual Assault Referral Centres (SARC)

14.1 On 1st April 2013, NHS England became responsible for commissioning health services for people who experience sexual assault or rape. This includes responsibility for overseeing the commissioning of services from sexual assault referral centres (SARCs). NHS England is committed to ensuring that all victims can access safe, confidential and high quality support, health care and forensic examinations from a local SARC.

14.2 NHS England's Kent and Medway Area Team and the Police Crime Commissioner's Office have been working in partnership with Kent Police and other partner organisations to establish a new sexual assault referral centre (SARC) for Kent and Medway and to improve the services that are available to support victims of sexual assault.

15 Inspection of Safeguarding and Looked after Children

15.1 In April 2014 the CQC undertook a Review of Health Services for Children Looked After and Safeguarding in North and West Kent as part of the Children Looked After and Safeguarding Inspection Framework. The purpose of the CQC review was to evaluate the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements for health for all children in the area. The specific focus of the review was on the experiences of looked after children and children and their families who receive safeguarding services. While the report focused on the West Kent area, the hosted model was in place at the time and lessons have been shared at the Health Reference Group Meeting and learning disseminated.

15.2 From 2015, there will be joint safeguarding inspections and an updated inspection framework. Pilots and consultations have been happening and the outcome will be updated in 2015.

16 Thanet CCG Safeguarding Assurance

16.1 Following disaggregation of the hosted safeguarding team, the designated nurse became a member of the Quality and Safety Team. This has allowed closer relationships in quality, safety and safeguarding assurance. Soft intelligence, data collection and scrutiny are shared within the team and have added to a collective picture of assurance and risk assessment. These processes will be further developed in 2015/16 with the development of a commissioning toolkit which includes Safeguarding to ensure that safeguarding is considered at all parts of the commissioning cycle.

16.2 The effectiveness of the safeguarding is assured and regulated by a number of mechanisms. These include:

- Provider internal assurance processes and Board accountability
- The Local Safeguarding Children Board S 11
- External regulation and inspection - CQC and Monitor
- Locally developed peer review and assurance processes
- Effective commissioning, procurement and contract monitoring.

16.3 The Section 11 return was submitted in 2015 and was compliant in the majority of areas and partially compliant in a few areas. These areas include updating and reviewing policies and procedures for safeguarding to reflect national guidance including an allegations policy and ensuring the training needs analysis is updated. In addition, there is a requirement for Senior Managers to promote a culture of listening to and engaging in dialogue with children when developing services and this was assessed as partially met. The safeguarding policy was due for review in June 2015 but due to the changes in Designated Nurses and transition and updated national guidance it was agreed to extend this policy to December 2015 and this is being updated. An allegations policy is also being developed.

16.4 All provider services, now including every General Practice, are required to comply with the Care Quality Commission Essential Standards for Quality and Safety which include safeguarding standards (Standard 7).

16.5 NHS Thanet CCG manages each provider organisation via formal contract meetings.

In addition, the Designated Nurses attend Provider Quality and Performance Meetings where relevant to raise safeguarding issues and meet with Safeguarding leads to seek further assurance.

17. Supporting Safeguarding Standards in Primary Care

17.1 Although not directly responsible for commissioning primary care services during 2014/15, CCGs have a duty to support improvements in the quality of primary medical care. The Designated Nurses have supported this through providing relevant information through the GP Bulletins e.g. local and national guidance and information.

17.2 The General Medical Council (GMC) has provided guidance to all GPs outlining GP's individual responsibilities in achieving and maintaining their professional competencies. As independent GP contract holders, monitoring of compliance with these professional standards is a function of NHS England through the GP revalidation process.

17.3 In meeting requirements of registration with the CQC, a number of Thanet GP Practices have already been subject to inspections. Following these visits reports are made publicly available and allow the public to see if GP practices and other primary medical services are meeting the essential standards. The Designated Nurses will work with NHSE, the CCG Membership Development team and GP Safeguarding leads to review any themes from inspections.

17.4 There is not currently a Named GP in place in East Kent. This is being progressed by NHSE and CCGs in 2015/16.

18. Thanet CCG Key Providers Summary 2014/15

Kent Community Health Foundation Trust (KCHFT)

- Kent Community Health NHS Trust (KCHT) was formed on 1 April 2011 from the merger of Eastern and Coastal Kent Community Services NHS Trust and West Kent Community Health. KCHT is one of the largest NHS community health providers in England and became a Foundation Trust on the 1st March 2015.
- The Executive Lead with the responsibility for safeguarding in Kent Community Health Foundation Trust is the Director of Nursing and Quality, who is also a standing member of the Kent Safeguarding Children Board. KCHFT actively participates at the Kent Safeguarding Children Board sub-groups.
- KCHFT provides the health support at the Central Referral Unit (CRU) for the Kent Health economy to improve information sharing and decision making in relation to preventive and reactive safeguarding work to protect children, young people and adults at risk. Safeguarding assurance within KCHT is provided by the Head of Safeguarding and the team, which includes named doctors and nurses.
- There is a KCHFT safeguarding committee and a Designated Nurse for Safeguarding Children attends this on behalf of all Designated Nurses in Kent.
- KCHFT has submitted their s.11 self-assessment as requested by KSCB. They have self-assessed that they are compliant in all areas.

East Kent Hospitals NHS Foundation Trust (EKHUFT)

- EKHUFT has an executive Lead for Safeguarding is in place with a Named Nurse and Safeguarding Advisors.
- EKHUFT is represented both Kent Safeguarding Boards and subgroups.
- A Safeguarding Committee was reported to be in place during 2014/15 but this is now on hold and being re-launched.
- EKHUFT was subject to a CQC Inspection in 2014 and was found inadequate in some areas including effectiveness of children and young people's services and overall in A and E. Key issues were the lack of appropriately trained children's staff which the CQC considered could affect the treatment and care delivered to children attending A&E. It was highlighted that staff were not always able to access the mandatory and specialist training they needed to deliver safe, effective care. The inspection also found that best practice guidelines or national standards were not always followed and information related to the safe care of children was out of date.

The report did identify overall that staff knew what action to take about safeguarding vulnerable people and children from abuse and 95% of staff had received this training. EKHUFT has an A and E recovery plan in place and this is being monitored by the CCG along with the lead CCG.

- EKHUFT has arrangements in place to safeguard children and has completed a Section 11 return to KSCB in 2015 and have assessed themselves as being compliant all areas.

Kent & Medway NHS and Social Care Partnership Trust (KMPT)

- The trust provides adult mental health services and is commissioned by the CCGs across Kent. This includes an early intervention in psychosis service for people aged 14-35 years old, and MIMHS, a mother and infant mental health service.
- The named nurses for safeguarding children are active in Kent and Medway in ensuring that practitioners recognise the 'Think Family' agenda and have developed a checklist for practitioners to use with adult clients to ensure that children are considered in all assessments and consultations.
- The Executive Lead for Safeguarding is the Director of Nursing and Governance who sits on the Trust board. There is a Head of Safeguarding who is also the Prevent Lead with 1 WTE Named Nurse for East Kent.
- KMPT plays a full role within the Safeguarding Boards and subgroups and the Executive Lead for Safeguarding holds a seat on the Safeguarding Board and the Head of Safeguarding Deputises when required.
- KMPT has submitted their s.11 self-assessment as requested by KSCB. They have self-assessed that they are compliant in all areas except "The need to update the Safeguarding Children Policy in line with the Intercollegiate document, change of named doctor role and 'Working Together to Safeguard Children 2013'" – which has been allocated to the named nurse for completion.

Sussex Partnership Foundation Trust (SPFT)

- The Trust provides Tier 2-3 services (targeted and specialist support) which are commissioned by the CCGs, with West Kent CCG being co-ordinating commissioner.
- The Executive Lead for Safeguarding is the Executive Director of Nursing and Quality and there is a Full time Named Nurse for Kent and Medway.

- The Thanet CCG Designated nurses for Safeguarding work with their CCG colleagues, through the safeguarding network arrangement, to gain assurance around safeguarding activity. All Designated nurses meet with the SPFT named nurse for safeguarding from time to time throughout the year.
- SPFT have submitted their s.11 self-assessment as requested by KSCB. They have self-assessed that they are compliant in all areas.

South East Coast Ambulance Service (SECamb)/111

- NHS Swale CCG leads the contract for service provision by South East Coast Ambulance Service. The NHS 111 service for Kent is provided from two call centres, one in Ashford and one in Dorking. The 111 service in Dorking is provided by Care UK and the contract is managed by SECamb.
- A safeguarding quality review has been undertaken on behalf of NHS Swale CCG by the designated nurses for safeguarding Adults and Children on the 111 service.
- Time was spent in visiting both 111 sites and with meeting key individuals at 111 and SECamb. The organisations' commitment to safeguarding was evident throughout the process and where issues were identified; there was an acknowledgement that further work was needed. The Designated nurses for Safeguarding were assured that SECamb and 111 have satisfactory arrangements in place to meet statutory and national requirements for safeguarding, with the proviso that additional work is required in a number of areas. It is expected that progress will be reported back as part of the three times a year reporting at the Clinical Quality Review Group (CQRG) meetings and at meetings with the Designated nurses for Safeguarding.
- SECamb have submitted their s.11 self-assessment as requested by KSCB. They have self-assessed that that they are not compliant in five areas. The outstanding areas which require additional work include the following:
 - A specific SECamb safeguarding strategy to support the organisational strategy is planned for Q1 2015.
 - Overarching policy and procedures to manage allegations against staff are in development which will be completed by May 2015
 - Specific reference within safeguarding procedures to safeguarding supervision of safeguarding lead and team is required.

There are a number of other smaller providers and a full review will be undertaken in 2015/16.

Summary of Safeguarding Assurance in relation to Providers

Safeguarding metrics for children and adults have been agreed and inserted into the 2015/2016 contracts. This includes compliance with Safeguarding training. Designated Professionals work with the Head of Quality and the Quality team to review provider performance by attending Provider Quality Meetings and raising issues related to gaps in Safeguarding assurance. In addition, further assurance is received through meetings with Providers and attending Safeguarding Assurance Committees where these are in place.

There have also been a number of updates in National Guidance and from NHS England. Designated Professionals are now embedded within the CCG and a full review of all providers safeguarding assurance evidence will take place in 2015/16 to identify any gaps in safeguarding assurance and these will be fed in to the CCG Quality and Performance reports and shared through Designated Professional Networks and KSCB where relevant.

19. Conclusions

Thanet has significant issues including very high levels of deprivation particularly in Margate Central and Cliftonville West but also in other parts of the District. There are also a range of issues including higher rates of Domestic Abuse, Teenage pregnancy and looked after children which have an impact on safeguarding children. A high profile operation “Lakeland” has highlighted issues relating to Child Sexual Exploitation and there is increasing evidence highlighted by the Margate Taskforce of potential wider exploitation of children including gangs and Missing Children. It is clear that these are issues that cannot be tackled in isolation and agencies must work together around the needs of the child and share information effectively. Strong Multi-agency working and building on existing relationships and good practice in particular through Kent Safeguarding Children Board is key to success.

Designated Professionals have a key role to play in providing leadership including working with providers and supporting Safeguarding Leads to raise standards. In particular all health providers need to ensure that front line staff are able to respond effectively to safeguard children and understand their role. The volume of change including new legislation and guidance is a challenge and it is essential that all staff receive the training they need but also that the training is effective and up to date and takes in to account lessons from Serious Case Reviews nationally and locally.

Thanet CCG has made significant progress around safeguarding children and was able to demonstrate through the NHS England Assurance process and the KSCB Section 11 audit how they are meeting statutory requirements. Policies and procedures need to be updated in 2015 to reflect recent guidance and legislation and disseminated to all staff. In addition, there is further work to be done by the CCG in ensuring that the voice of the child and safeguarding is considered through all parts of the commissioning cycle. We also need to seek assurance from our providers as to how they ensure the child's voice is heard when delivering services.

National serious case reviews consistently highlight multi-agency working and it is also known that times of re-organisation can present additional challenges and potential risks. While Designated Professionals have a key leadership role to play in safeguarding, it is essential that all staff within organisations at all levels and in particular Governing Body members understand their responsibilities to safeguard children.

20. Safeguarding Priorities - 2015/16

- Review policies, strategies and guidance in line with recent key national documents, national and local SCR/DHR/Case Reviews.
- Build on work already completed to develop robust arrangements and relationships with providers and partner agencies.
- Implement and monitor Service Level Agreements, Job Plans and JDs for all designated doctors across Kent and Medway, securing this statutory provision.
- Assist in the recruitment to the named GP within East Kent CCGs and develop measures to ensure collaborative working.
- Continued attendance and influence at KSCB sub-groups.
- To work with Designated Professionals, CCG colleagues and SECSU to develop standardised assurance and data collation in relation to Safeguarding.
- To ensure that national developments / lessons learnt from SCRs are disseminated to local health providers and Primary Care colleagues.
- Develop a Quality and Safeguarding Commissioning Toolkit
- Seek further assurance on how providers are addressing CSE and contribute to the CSE work through KSCB
- Work with the Margate Taskforce and other agencies to address the challenges in Thanet.

- Work with the Designated Nurse for Looked After Children to ensure that the needs of Children in Care are addressed.
- Seek assurance on how providers are implementing FGM legislation
- Deliver face to face training to CCG staff and Governing body members to supplement e-learning and ensure everyone is aware of their role in safeguarding children

References and Links

<http://www.kpho.org.uk/joint-strategic-needs-assessment/jsna-children/jsna-teenage-pregnancy>

http://www.kpho.org.uk/__data/assets/pdf_file/0019/44074/Domestic-Abuse-JSNA-Chapter-FINAL.pdf

http://www.kpho.org.uk/__data/assets/pdf_file/0005/46589/Children-in-Care-JSNA-2015.pdf

http://www.kpho.org.uk/__data/assets/pdf_file/0017/43109/Thanet-Early-years-profile.pdf

http://www.kscb.org.uk/__data/assets/pdf_file/0015/48021/KSCB-Annual-Report-2014-15-FINAL.pdf

<http://www.kscb.org.uk/about-kscb/the-board-and-its-groups/child-death-overview-panel>

http://dea.ioe.ac.uk/6412/7/Bettersafethansorry_Redacted.pdf

Thanet Clinical Commissioning Group

Report to:	Governing Body	Agenda item:	4.3
Date of Meeting:	Tuesday 8 December 2015		
Title of Report:	Integrated Quality and Performance Report Summary		
Is this report for internal distribution only?	Yes		
Author:	Tamsin Flint, Quality Intelligence Lead; Emily Fagg, BI Information Analyst; Adrian Halse, Senior Business Analyst; Maria Reynolds, Head of Quality		
Board Sponsor:	Ailsa Ogilvie, Chief Operating Officer, Sharon Gardner-Blatch Chief Nursing Officer		
Status:	For information and decision		
Appendices	Appendix 1: Quality and performance escalation processes		

1. Purpose of Paper

The Integrated Performance and Quality Report was provided to the Quality and Operational Leadership Team on the 24 November 2015. This report has been summarised here for the Governing Body. It provides the CCG dashboard and each of the provider dashboards from the IQPR.

The paper is provided to Governing Body to highlight key quality and performance issues and provide assurance that these are being considered and tackled by the CCG in partnership with GPs and local providers.

2. Introduction/Background

This is a standing item.

3. Recommendation

The Governing Body is asked to note the report.

4. Summary of Issues

Where the data drives performance or quality concerns a commentary is provided, summarising the concerns and action being taken.

Author: Tamsin Flint, Quality Intelligence Lead; Emily Fagg, BI Information Analyst; Adrian Halse, Senior Business Analyst; Maria Reynolds, Head of Quality
Agenda no:4.3

Version:1
Date: 25/11/15

Page 1 of 2

5.	Risks
Whilst the report contains performance and quality information which may relate to risks faced by the CCG, the noting of the report does not present any risks.	

6.	Appendices

PLEASE CONTINUE WITH YOUR REPORT ON THIS PAGE, IF NECESSARY

Author: Tamsin Flint, Quality Intelligence Lead; Emily Fagg, BI Information Analyst; Adrian Halse, Senior Business Analyst; Maria Reynolds, Head of Quality	Version:1 Date: 25/11/15
Agenda no:4.3	Page 2 of 2

Integrated Performance and Quality Report Summary

November 2015

THANET CCG: Headline indicators

Outcome 1 - Preventing People from Dying Prematurely

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Cancer (All providers, Thanet CCG)						
H	2 week wait (%)	Sep	A G A A A G	93.0%	95.0%	92.0%
H	2 week wait breast symptomatic (%)	Sep	G R R R R R	93.0%	85.7%	85.1%
H	31 day diagnosis to treatment (%)	Sep	R R A A R R	96.0%	88.0%	91.0%
H	31 day subsequent surgery (%)	Sep	G R G R R R	94.0%	83.3%	88.6%
H	31 day subsequent drug treatment (%)	Sep	G G G G G G	98.0%	100.0%	100.0%
H	31 day subsequent radiotherapy (%)	Sep	G G G G G G	94.0%	100.0%	98.4%
H	62 day referral to first treatment (%)	Sep	R R R R R R	85.0%	77.8%	72.4%
H	62 day screening referral to first treatment (%)	Sep	G G G R	90%		83%
H	62 day consultant upgrade (%)	Sep		100.0%		90.0%
Diagnostics (All providers, Thanet CCG)						
U	Diagnostic waiting times under 6 weeks (%)	Aug	G G G G G G	99%	99.9%	99.9%
U	Diagnostic activity	Aug			5,340	26,639
Cancelled operations (EKHUFT, All CCGs)						
N	No. of elective ops cancelled: non-clinical reason	Q2			112	206
N	No. not treated w/in 28 day of cancellation	Q2			0	2
Mortality Indicators (Thanet CCG)						
H	SHMI	2013/14	Annual indicator		3,917	N/A
H	HSMR	2013/14	Annual indicator		78	N/A
H	Under 75 mortality from liver disease	2014/15	Annual indicator		20	N/A
H	Emergency admission from alcohol related liver disease	2014/15	Annual indicator		19	N/A
H	Under 75 mortality from cancer	2014/15	Annual indicator		144	N/A
H	Under 75 mortality from respiratory disease	2014/15	Annual indicator		34	N/A
H	Under 75 mortality from cardiovascular disease	2014/15	Annual indicator		74	N/A
H	Potential years of life lost from causes amenable to health	2014/15	Annual indicator		2,175	N/A

Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Treating People out of Hospital (Thanet CCG KCHFT)						
	Community Hospital step-up					Data currently unavailable
P	Admissions avoided (LTC,ICT)	Aug			116	772
	Re-admission following discharge					Data currently unavailable
	Delayed Transfer of Care					Data currently unavailable
Patient Reported Outcomes (Thanet CCG)						
	Increased health gain - Hip replacement	2013/14	Annual indicator		0.40	N/A
	Increased health gain - Knee replacement	2013/14	Annual indicator		0.33	N/A
	Increased health gain - Groin hernia	2013/14	Annual indicator		0.02	N/A
	Emerg. admis. children lower Respiratory Tract Infections	2014/15	Annual indicator		579.1	N/A
	Emerg. Admis. acute conds that shouldn't require hospital	2014/15	Annual indicator		1,462.1	N/A
H	Health-related quality of life - LTC	2014/15	Annual indicator		0.70	N/A
H	Health-related quality of life - Carers	2014/15	Annual indicator		0.77	N/A
H	People feeling supported to manage their condition	2014/15	Annual indicator		58.8	N/A
H	Unplanned admission <19 asthma, diabetes & epilepsy	2014/15	Annual indicator		434.8	N/A
H	Unplanned admission ambulatory care adult	2014/15	Annual indicator		761.7	N/A
Mental Health LTD (Thanet CCG)						
H	IAPT Recovery rate	Jul	G G A R G	50.0%	53.8%	-11.9%
H	IAPT Access (%)	Jul	G G G G G	1.3%	2.3%	7.7%
H	IAPT Entered Treatment w/in 6 Weeks	Jul	R R R R A	75%	73%	67%
H	IAPT Entered Treatment w/in 18 Weeks	Jul	G G G G G	95%	98%	99%
H	IAPT Finished Course who Entered Treatment w/in 6 Weeks	Jul	R R R R R	75%	62%	
H	IAPT Finished Course who Entered Treatment w/in 18 Weeks	Jul	G G G G G	95%	100%	
Q	Dementia diagnosis rate (%)	Jun	R R R R	60.6	51.7	51.7

Outcome 3 - Helping People to Recover from Episodes of Ill Health, or Following Injury

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Referral to Treatment (All providers, Thanet CCG)						
U	Admitted in 18 wks (%)	Sep	R R R R R R	90%	78%	78%
U	Non admitted in 18 wks (%)	Sep	G A A A A A	95%	93%	94%
U	Incomplete under 18wks (%)	Sep	R A R A A A	92%	90%	88%
U	52+ week waiters	Sep	R R R G G R	0	2	8
U	Audiology assessment in 18 weeks (%)	Sep	G G G G G G	99%	100%	100%
A&E						
	A&E activity (CCG)	Oct			4,111	29,281
P	A&E seen within 4 hrs (EKHUFT Trust Level)	Sep	R R R R R R	95%	87%	88%
	A&E Admissions (CCG)	Oct			963	5,941
Ambulance Waiting Times (SECAMB, Thanet CCG)						
P	% Red 1 <8 min (Thanet CCG)	Oct	G R G G G G	75.0%	85.5%	81.9%
P	% Red 2 <8 min (Thanet CCG)	Oct	G G G G G G	75.0%	85.0%	83.2%
P	% Category A19 <19 min (Thanet CCG)	Oct	G G G G G G	95.0%	99.5%	97.8%
Stroke (EKHUFT Level ALL CCGs)						
P	Met on arrival in the ED by member of stroke thrombosis team	Jul	R R R R	92.0%	55.4%	60.8%
P	24/7 access to CT Scan w/in 1Hr (QEQM)	Jul		TBC	62.5%	63.6%
P	Direct admission to a stroke unit w/in 4 Hrs (QEQM)	Jul	G R R A	75.0%	72.0%	66.1%
P	Brain Imaging w/in 12Hrs of ad to A&E	Jul	G G G G G	90.0%	100.0%	99.1%
P	Patient Spending 90% of Their Time on Stroke Unit	Jul	A R G G G	90.0%	95.0%	90.2%
P	Stroke patients seen by a consultant	Jul	R R A A A	90.0%	86.4%	84.0%
P	stroke specialist within 24 hours of Swallow screen within 4 hours of admission into the stroke unit	Jul	A R A A A	95.0%	92.1%	91.0%
P	High risk patients seen within TIA fast track clinic within 24 hours of referral	Jul	R A R G	93.0%	100.0%	82.4%
Mental Health Care Planning Approach (KMPT, Thanet CCG)						
P	Proportion of adult services on CPA (%)	May	G G G G		95.9	97.2

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS DH = Dept of Health U = Unify

Outcome 3 (continued) - Helping People to Recover from Episodes of Ill Health, or Following Injury

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
General and Acute Activity (All providers, Thanet CCG)						
DH	Total G&A Elective Spells	Aug	R G G A A G	1,731	1,680	8,607
	Non-elective spells (G&A)	Aug	R G G G G G	1,293	1,281	6,546
	All First Outpatient Attendances (G&A)	Aug	R R G R A G	2,689	2,333	14,263
	GP Referrals for a First Outpatient Appointment (G&A)	Sep	G G R R R A	2,503	2,605	15,799
All Specialties Activity (All providers, Thanet CCG)						
	Total all specialties elective spells	Aug	R A G A A G	1,839	1,797	9,243
	Non-Elective Spells (All Specialties)	Aug	R G A A A R	1,467	1,541	7,758
	All First Outpatient Attendances (All Specialties)	Aug	R R G R R G	3,041	2,903	17,877
Medicines Management (All practices, Thanet CCG)						
	% Cephalosporins or Quinolones	Aug	G G G G G G	10.0%	6.4%	6.8%
	% of Cephalosporins, Quinolones or Co-Amoxiclavs	Aug	G G G G G G	11.6%	9.6%	10.0%
	Antibiotics by STAR PU	Aug	A A A A A A	1.17	1.19	1.19
	Ibuprofen and Naproxen as % NSAIDs	Aug	G G G G G G	65.0%	68.6%	68.5%

Summary

Performance Issues

Cancer: A CPN has been issued to EKHUFT and remedial action is now being monitored across by CCGs across East Kent. Thanet CCG is looking to understand local drivers around high levels of patient cancellation of 2 week wait appointments, and late diagnoses.

RTT: Verified October has confirmed that the CCG is compliant with the incomplete standard. The focus is now on ensuring that this is sustainable. Primary care referrals continue to be higher than planned and present a risk to long term sustainability against this indicator. Practice visits are being undertaken to support outlier practices, and alternative pathways are being considered.

Dementia Diagnosis Rates: Within Thanet the growth in the rate of diagnoses has plateaued. The target will not be hit in March 2016 unless new action is taken. QOLT have requested that clinical leadership and staff resource allocation are considered at CLT.

Outcome 4 - Ensuring that People Have a Positive Experience of Care

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Friends and Family Test: Patients (EKHUFT, KCHFT, KMPT, SECAMB all CCGs)						
N	A&E: % would recommend	Sep	R R R R R R	88	81	81
	Inpatients: % Would recommend	Sep	A A A A A A	96	94	94
	Outpatients: % Would recommend	Sep	A A A A A A	92	91	90
	Maternity: % Would recommend	Sep	A G G R A G	96	96	95
	Mental Health: Would recommend %	Sep	R R R R G G	87	88	83
N	Community: Would recommend %	Aug	G G G G G G	95	97	97
	Ambulance: Would recommend %	Aug	G G G G G G	94	96	98
Friends and Family Test: Staff (EKHUFT, KCHFT, KMPT, SECAMB all CCGs)						
N	Staff: Would recommend work %	Q1 15	A A	63	56	56
	Staff: Would recommend care %	Q1 15	A A	79	78	78
Mixed Sex Accommodation (Thanet CCG)						
N	Mixed Sex Accommodation Breaches	Sep	R G R R G R	0	1	14

IAPT 6 week standard: Nationally reported performance differs from local data and is being investigated with the providers.

A&E: Performance is still poor, but EKHUFT are making progress in delivering their recovery plan. A new system wide ECIP plan is now being developed which will focus on improving specific measures which contribute to the 4hr wait performance. This will enable more effective measurement of progress and help provide focus to improvement efforts.

Stroke: It is likely that low performance figures reflect data collection issues rather than poor performance. These are new metrics for the Trust to measure, but EKHUFT have been tasked to ensure data collection in this area improves. Aside from this, there is a shortage of SALT therapists in the Trust, and an issue with general medicine patients being placed in stroke units. An update from the Trust is expected next month, and a regular stroke standards meeting is now in place.

Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Health Care Associated Infections (HCAI) (Thanet)						
PH	MRSA Bactermaemia	Sep	G G G R R G	0	0	2
	C-Diff	Sep	G R R G G G	4	2	22
	MSSA	Sep			5	22
	E-Coli	Sep			10	63
Quality of Care						
C	Care Quality Commission				See provider pages	
Preventing avoidable harm						
N	VTE Risk Assessments (EKHUFT)	Q1 15	G G A A A G	95	96	95
N	Safety Thermometer: Harm Free Care (EKHUFT, KCHFT, KMPT)	Sep	A A A A A A	95	93	94
Incident Reporting						
N	Serious Incidents Reported (TCCG)	Sep			2	23

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS DH = Dept of Health U = Unify

SERIOUS INCIDENTS: THANET CCG SEPTEMBER 2015

Breakdown of Serious Incidents for Thanet CCG patients logged in September 2015

CCG	STEIS Ref	Date Logged	Time to report	Incident Date	Date incident identified	Provider	Site of Incident	Clinical Area	Category	Never Event	Due Date
Thanet	2015/29438	9-Sep-15	12	19-Aug-15	24-Aug-15	KMPT	Public Place	Psychiatry	Unexpected / potentially avoidable death	No	2-Dec-15
Thanet	2015/30092	16-Sep-15	14	27-Aug-15	27-Aug-15	KMPT	136 Suite, Canterbury	Psychiatry	Actual / alleged abuse	No	9-Dec-15

DATA SOURCE: STEIS & CCG

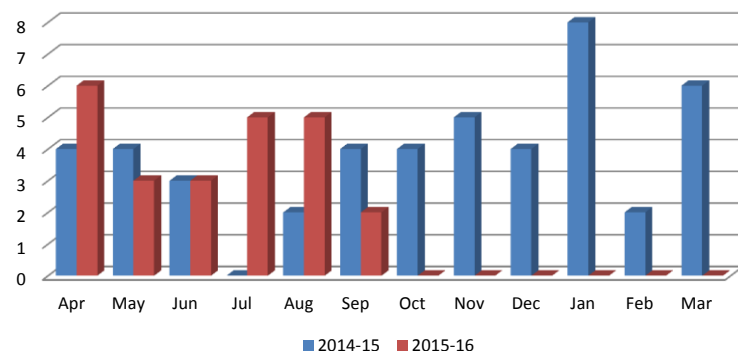
SI Reporting Breach Rate by Provider: September 2015

Provider	SI's reported in July	SI's reported within 2 days	Breach rate
KMPT	2	0	100%
Total	2	0	100%

On-Going SI's by Provider: Investigation Completion Breach Rate

Provider	Total number of ongoing SI's	SI's with provider awaiting completion of investigation	SI's with CCG awaiting closure	SI's back with provider awaiting further information	SI's met deadline	Total SI's breaching deadline	Breach rate
EKHUFT	20	13	2	5	10	10	50%
KCHFT	8	2	6	0	7	1	13%
KMPT	25	10	12	1	18	7	28%
Pilgrims	1	0	1	0	1	0	0%
IC24	1	0	1	0	1	0	0%
NSL	1	1	0	0	0	1	100%
Total	56	26	22	6	37	19	34%

Thanet CCG: Number of Serious Incidents Reported by Month Year on Year



EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST (EKHUFT): Headline indicators

Outcome 1 - Preventing People from Dying Prematurely

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Cancer (EKHUFT, Thanet CCG)						
H	2 week wait (%)	Sep	A G A A A G	93.0%	95.5%	92.0%
H	2 week wait breast symptomatic (%)	Sep	G R R R R R	93.0%	85.7%	85.1%
H	31 day diagnosis to treatment (%)	Sep	R A A A R A	96.0%	91.3%	90.9%
H	31 day subsequent surgery (%)	Sep	G R G R R R	94.0%	66.7%	82.8%
H	31 day subsequent drug treatment (%)	Sep	G G G G G G	98.0%	100.0%	100.0%
H	31 day subsequent radiotherapy (%)	Sep	G	94.0%		100.0%
H	62 day referral to first treatment (%)	Sep	R R R R R A	85.0%	82.4%	73.6%
H	62 day screening referral to first treatment (%)	Sep	G G R	90.0%		83.3%
H	62 day consultant upgrade (%)	Sep		100.0%		85.7%
Diagnostics (EKHUFT, Thanet CCG)						
U	Diagnostic waiting times under 6 weeks (%)	Aug	G G G G G G	99%	100.0%	99.9%
Cancelled Operations (EKHUFT, all CCGs)						
N	No. of elective ops cancelled: non-clinical reason	Q2			112	206
N	No. not treated w/in 28 day of cancellation	Q2			0	2

Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Treating people out of hospital (EKHUFT, All CCGs)						
P	Readmission 7 Days (%)	Aug	R R R R R R	2.00%	3.96%	4.06%
P	Readmission 30 Days (%)	Aug	G A A A G A	8.32%	8.68%	8.30%
P	Delayed Transfers of Care (average)	Sep			32.0	36.5
Dementia (National CQUIN)						
P	Cases identified (%) (EKHUFT)	Jun	G G G G G G	90.0	99.3	99.0
P	Cases with diagnostic assessment (%) (EKHUFT)	Jun	G G G G G G	90.0	90.7	91.3

Outcome 3 - Helping People to Recover from Episodes of Ill Health, or Following Injury

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Referral to Treatment (EKHUFT, Thanet CCG)						
U	Admitted (%)	Sep	R R R R R R	90.0%	77.5%	76.8%
U	Non admitted (%)	Sep	G A A A A A	95.0%	92.1%	93.2%
U	Incomplete (%)	Sep	R R R R A A	92.0%	90.1%	87.5%
U	52+ weeks	Sep	R R R G G R	0	2	8
Audiology (EKHUFT, Thanet CCG)						
K	Assessment in 18 weeks (%)	Sep	G G G G G G	99%	100%	100%
A&E/IP						
K	A&E Activity (CCG)	Oct			4,090	29,118
K	A&E seen within 4 hrs (EKHUFT Trust Level)	Sep	R R R R R R	95%	87%	88%
K	A&E Admissions [CCG]	Oct			963	5,941
Stroke (Trust Level unless Otherwise Indicated)						
	Met on arrival in the ED by member of stroke thrombosis team	Jul	R R R R	92.0%	55.4%	60.8%
	24/7 access to CT Scan w/in 1Hr (QEQM)	Jul		TBC	62.5%	63.6%
	Direct admission to a stroke unit w/in 4 Hrs (QEQM)	Jul	G R R A	75.0%	72.0%	66.1%
	Brain Imaging w/in 12Hrs of ad to A&E	Jul	G G G G G	90.0%	100.0%	99.1%
	Patient Spending 90% of Their Time on Stroke Unit	Jul	A R G G	90.0%	95.0%	90.2%
	Stroke patients seen by a consultant stroke specialist within 24 hours of admission	Jul	R R A A	90.0%	86.4%	84.0%
	Swallow screen within 4 hours of admission into the stroke unit	Jul	A R A A	95.0%	92.1%	91.0%
	High risk patients seen within TIA fast track clinic within 24 hours of referral	Jul	R A R G	93.0%	100.0%	82.4%

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS U = Unify

Outcome 4 - Ensuring that People Have a Positive Experience of Care

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Friends and Family Test: Patients						
N	A&E: % would recommend	Sep	R R R R R R	88	81	81
N	Inpatients: % Would recommend	Sep	A A A A A A	96	94	94
N	Outpatients: % Would recommend	Sep	A A A A A A	92	91	90
N	Maternity: % Would recommend	Sep	A G G R A G	96	96	95
Friends and family Test: Staff						
N	% Would recommend Work	Q1 15	R R	63	52	52
N	% Would recommend care	Q1 15	R A	79	76	76
Friends and family Test Score (national CQUIN)						
P	Increase Response A&E %	Sep	G G G G G G	21	25	27
P	Increase Response Inpatient %	Sep	G G G R G G	33	34	36
P	Increase Response outpatients %	Sep	R A G G R A	15	14	15
P	Increase Response Maternity %	Sep	G G G G G R	21	49	
P	Reduce Neg Res A&E %	Sep		11	11	
P	Reduce Neg Res Inpatients %	Sep		2	3	
P	Reduce Neg Res outpatients %	Sep		4	4	
N	Reduce Neg res rate maternity %	Sep		1	1	
Adult Inpatient Experience						
P	Overall Adult Inpatient Experience Responses %	Sep	G G G G G G	80	89	89
Complaints/Compliments						
P	Compliments	Sep		2678	15735	
P	Formal Complaints	Sep		89	491	
P	Informal Concerns	Sep		95	534	
P	PALS Contacts	Sep		188	1424	
P	Compliance against first response met (%)	Sep	G G G G G G	85	97	94
P	Referred to PHSO	Sep		7	19	
P	Cases Open with PHSO	Sep		23	23	
Mixed Sex Accommodation (MSA)						
N	MSA Breaches	Sep	R R R R R R	0	26	250
PLACE Scores						
N	Cleanliness	Q1 15	A	98	94	
N	Food	Q1 15	R	88	83	
N	Privacy, Dignity and Wellbeing	Q1 15	R	86	77	
N	Condition, Appearance & Maintenance	Q1 15	A	90	90	
N	Dementia	Q1 15	A	75	72	

Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Care Quality Commission						
C	Safe	Aug-14				Inadequate
C	Effective	Aug-14				Requires Improvement
C	Caring	Aug-14				Good
C	Responsive to People's Needs	Aug-14				Requires Improvement
C	Well-Led	Aug-14				Inadequate
Health Care Associated Infections (HCAI)						
P	MRSA Bacteraemia	Sep	G G G R R G	0	0	5
P	C-Diff	Sep	G G G G G G	45	4	16
P	MSSA (post 48 hours)	Sep			1	10
P	E-Coli (post 48 hours)	Sep			4	27
P	HCAI Training %	Sep	A A A A G G	85	86	84
Venus Thromboembolism (VTE)						
N	VTE Risk Assessments	Q1 15	G G A A A G	95	96	95
S	New VTE (%)	Sep			2	23
Safety Thermometer (National CQUIN)						
S	Harm Free Care %	Sep	A G G A A G	93	94	93
S	No. of New Pressure Ulcers	Sep			5	27
S	No. of Falls with Harm	Sep			5	34
Incident Reporting						
P	Serious Incidents (EKHUFT)	Sep			2	35
P	Serious Incidents (Thanet CCG)	Sep			0	0
P	Never Events (EKHUFT)	Sep	G G R R G R	0	1	5
P	Never Events (Thanet CCG)	Sep	G G G G G G	0	0	0
Central Alerts System (CAS)						
CAS	Compliance with deadlines	Aug	R R G R G G	100	100	88
Workforce						
P	% hours filled planned v actual	Aug			94	95
P	Sickness absence %	Jul	G	3.50	3.47	
P	Appraisal rate %	Aug	R	90	76	
P	Turnover rate %	Aug	R	8	12	
P	Stat/mand training avg %	Aug	R	85	80	
P	Agency usage %	Aug			8.2	8.8

Queen Elizabeth the Queen Mother Hospital (QEQM only data)

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Outcome 4 - Ensuring that People Have a Positive Experience of Care						
Friends and Family Test: Patients QEQM						
N	A&E: % would recommend	Sep	G G G G G G	57	80	79
N	Inpatients: % Would recommend	Sep	G G G G G G	74	95	94
P	Increase Response A&E %	Sep	G G G G G G	21	26	26
P	Increase Response Inpatient %	Sep	G G G R G R	33	30	34
P	Reduce Neg Res A&E %	Sep	G G G G G G	16	13	13
P	Reduce Neg Res Inpatients %	Sep	R R R R R R	1	2	3
Complaints/Compliments QEQM						
P	Compliments	Sep			1283	
P	Formal Complaints	Sep			30	
P	Informal Concerns	Sep			33	
P	PALS Contacts	Sep			51	
Mixed Sex Accommodation (MSA) QEQM						
P	Number of episodes of occurrences	Sep			1	29
P	Hours of Occurrences	Sep			15	330
P	No. of patients affected	Sep			5	104
PLACE Scores QEQM						
N	Cleanliness	Q1 15	A	98	96	
N	Food	Q1 15	R	88	84	
N	Privacy, Dignity and Wellbeing	Q1 15	A	86	85	
N	Condition, Appearance & Maintenance	Q1 15	G	90	92	
N	Dementia	Q1 15	R	75	71	
Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm						
Care Quality Commission QEQM						
C	Safe	Aug-14				Requires Improvement
C	Effective	Aug-14				Requires Improvement
C	Caring	Aug-14				Good
C	Responsive to People's Needs	Aug-14				Requires Improvement
C	Well-Led	Aug-14				Inadequate
Incident Reporting QEQM						
P	Serious Incidents	Sep			0	0
Workforce QEQM						
P	% hours filled planned v actual	Sep	A A R R R R	100	94	94

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS

KENT COMMUNITY HEALTH NHS FOUNDATION TRUST (KCHFT): Headline Indicators

Level	INDICATOR	Latest Period	6 Month Trend	Plan	Actual	YTD
Outcome 1 - Preventing People from Dying Prematurely						
P	Heart Failure	Mar	G G	90	93	
P	COPD	Mar	G G	90	94	
P	Response to stop smoking referrals within 2 working days (CQUIN) (%)	Mar	G G	90	91	
Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions						
C	Admissions Avoided (LTC)	Aug		71	300	
C	SECAMB Admissions Avoided (LTC)	Aug		0	3	
C	SECAMB Conveyances Avoided (LTC)	Aug		1	10	
C	Activity (LTC : Cardiac)	Aug	R G R R G R	132	115	666
C	Activity (LTC : Respiratory)	Aug	R R R R R R	125	51	376
Outcome 3 - Helping People to Recover from Episodes of Ill Health, or Following Injury						
C	Admissions Avoided (ICT)	Aug		45	472	
P	Activity (ITAC : SLT)	Aug	A A G G G G	122	131	1,072
P	Activity (ITAC : Physio)	Aug	R R R R R G	138	152	909
Outcome 4 - Ensuring that People Have a Positive Experience of Care						
P	Complaints	Aug		38	80	
P	Patient Experience %	Aug		90	97	
N	FFT Patients: Would Recommend %	Aug	G G G G G G	95	97	97
N	FFT Staff: Would Recommend Work %	Q1 15	G G	63	70	70
N	FFT Staff: Would Recommend Care %	Q1 15	G G	79	86	86
N	Cleanliness	Q1 15	G 0	97.6	97.4	
N	Food	Q1 15	A 0	88.5	90.7	
N	Privacy, Dignity and Wellbeing	Q1 15	G 0	86.0	81.6	
N	Condition, Appearance & Maintenance	Q1 15	A 0	90.1	88.9	
N	Dementia	Q1 15	R 0	74.5	57.8	
P	MSA Breaches	Sep	G G G G G G	0	0	0
Outcome 5 - Ensuring that People Have a Positive Experience of Care						
P	Care Quality Commission: Safe	Sep 14	Good			
P	Care Quality Commission: Effective	Sep 14	Requires Improvement			
P	Care Quality Commission: Caring	Sep 14	Good			
P	Care Quality Commission: Responsive	Sep 14	Good			
P	Care Quality Commission: Well-Led	Sep 14	Good			
P	Serious Incidents Reported	Sep		1.0	15.0	
P	Compliance with Deadlines (%)	Sep	G G G G G G	100.0	100.0	0.0%
C	Harm Free Care (LTC)	Aug		99.4%	99.2%	
C	Harm Free Care (ITC)	Aug		100.0%	98.4%	

Commentary:

This is a new style report for KCHFT which aims to give a much more complete picture of performance across the Trust. A key concern is the lack of targets/plans for some KPIs which makes it difficult to monitor by exception. This will be raised with the Trust. It is hoped that this report will facilitate more effective challenge of the Trust at Performance and Quality meetings.

The Trust continue to report significant underperformance for activity. An issues report is included in the following pages.

Serious Incidents: In July there were 16 Serious Incidents reported by the Trust, one of which was attributable to Thanet CCG. There have been a total of 13 Serious Incidents reported YTD.

	Latest Period	LONG TERM CONDITIONS (LTC)				INTERMEDIATE CARE TEAM (ICT)				PODIATRY				MUSCULOSKELETAL PHYSIOTHERAPY				CHRONIC PAIN SERVICE				ORTHOPAEDICS				LYMPHOEDEMA					
		CCG				CCG				EAST KENT				EAST KENT				KENT				KENT				KENT					
		6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD		
Outcome 3 - Helping People to Recover from Episodes of Ill Health, or Following Injury																															
Activity	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	9,301	2,652	17,002	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	5,897	4,283	12,526	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	1,230	921	5,067	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	55	316	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	199	207	1,363	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	259	211	1,128	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	266	335	1,624	
Referrals	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	523	2,275		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	187	1,467		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	37	158	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	124	636		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	271	1,309		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	7	41							
Waiting Times (% Seen within 18 Weeks)	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	100.0%	100.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	95.0%	84.9%	94.3%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	95.0%	100.0%	100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	95.0%	99.5%	99.6%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	95.0%	99.5%	99.9%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>					
Outcome 4 - Ensuring that People Have a Positive Experience of Care																															
Complaints	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	2	8		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	2	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0			
Patient Experience (%)	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	90.0%	97.4%	95.8%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	90.0%	98.2%	98.8%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	94.0%	94.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0.0%	100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	90.0%	98.0%	98.5%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	90.0%	98.5%	98.2%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>			0.0%		
Friends and Family Test Score	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	95.0%	100.0%	100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	95.0%		98.3%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		66.7%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	100.0%		100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>			100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>			100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>			0.0%		
Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm																															
Serious Incidents	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	1		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0			
Patient Incidents	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	2	22		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	4	15		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	5	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	0		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	4		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0	8		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>			0		
Mandatory Training (All)	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	14.7%	14.7%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	13.1%	13.1%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0.0%	0.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	15.7%	15.7%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	7.1%	7.1%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	-0.6%	-0.6%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	14.2%	14.2%			
Infection Prevention & Control Training	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	84.4%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	84.4%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	97.3%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	94.5%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	95.1%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	100.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>					
Safeguarding Children Training	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	77.9%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	75.3%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	91.9%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	94.5%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	92.7%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	97.1%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>					
Safeguarding Adults Training	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	84.4%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	76.5%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	86.7%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	84.9%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	95.6%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	85.0%	100.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>					
Appraisals	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		95.2%	95.2%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		94.4%	94.4%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		100.0%	100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		100.0%	100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		100.0%	100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		100.0%	100.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>					
Long Term Sickness	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	4.5%	6.8%	4.6%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	4.5%	2.1%	2.2%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0.0%	0.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0.0%	0.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0.0%	0.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0.0%	0.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	3.1%	0.0%	1.7%		
Short Term Sickness	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	1.3%	2.4%	2.6%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	1.3%	1.1%	2.6%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0.0%	21.1%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	1.0%	1.9%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	0.2%	1.3%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	1.0%	0.5%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	1.3%	7.4%	3.7%		
Turnover	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		20.0%	20.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		14.1%	14.1%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>		0.0%	0.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	16.1%	16.1%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	27.0%	27.0%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	17.4%	17.4%		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>					
Vacancy Rate	Aug	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	5.0%	14.7%	14.7%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	5.0%	13.1%	13.1%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	5.0%	0.0%	0.0%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	15.7%	15.7%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	5.0%	7.1%	7.1%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	5.0%	-0.6%	-0.6%	<div><div></div><div></div><div></div><div></div><div></div><div></div></div>	5.0%	14.2%	14.2%		

KENT COMMUNITY HEALTH NHS FOUNDATION TRUST (KCHFT)

		CONTINENCE				EPILEPSY				DIABETES				LOAN EQUIPMENT				WHEELCHAIR SERVICE				DIETETICS AND NUTRITION				CARDIAC REHABILITATION						
		KENT				KENT				KENT				KENT				KENT				KENT				KENT						
		Latest Period	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD		
Outcome 1 Preventing People from Dying Prematurely																																
Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions																																
Outcome 3 - Helping People to Recover from Episodes of Ill Health, or Following Injury																																
Activity	Aug	<div><div>RRRRRR</div><div></div></div>	236	147	803	<div><div>AGGG</div><div></div></div>	29	20	184	<div><div>GGGGAG</div><div></div></div>	161	185	894	<div><div>GGGRR</div><div></div></div>	1,071	1,011	5,561					<div><div>GRRRR</div><div></div></div>	639	422	2,410	<div><div>GRRRR</div><div></div></div>	493	386	2,164			
Referrals	Aug	<div><div></div><div></div></div>		53	425			7	19			51	315	<div><div></div><div></div></div>					<div><div></div><div></div></div>	41	266			0			19	155				
Waiting Times (% Seen within 18 Weeks)	Aug	<div><div></div><div></div></div>																			95.0%	97.4%	99.4%									
Outcome 4 - Ensuring that People Have a Positive Experience of Care																																
Complaints	Aug	<div><div></div><div></div></div>		0	0				0	0			0	0						0	0			0	1			0	0			
Patient Experience (%)	Aug	<div><div>GGGGGG</div><div></div></div>	90.0%	98.2%	98.1%			90.0%	88.0%	88.0%	<div><div>GGGGGG</div><div></div></div>	90.0%	96.1%	93.8%			0.0%	0.0%			100.0%		<div><div>GGRRGG</div><div></div></div>	90.0%	98.4%	98.5%	<div><div>GGGGGG</div><div></div></div>	90.0%	100.0%	99.2%		
Friends and Family Test Score	Aug	<div><div></div><div></div></div>			95.6%					100.0%			100.0%			0.0%					100.0%			100.0%			100.0%	100.0%				
Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm																																
Serious Incidents	Aug	<div><div></div><div></div></div>		0	0					0	0			0	0					0	0			0	0			0	0			
Patient Incidents	Aug	<div><div></div><div></div></div>		0	0					0	0			0	0					0	0			0	3			1	2			
Mandatory Training (All)	Aug	<div><div></div><div></div></div>	15.3%	15.3%				-16.8%	-16.8%			0.0%	0.0%			9.7%	9.7%			14.1%	14.1%			7.3%	7.3%			-3.3%	-3.3%			
Infection Prevention & Control Training	Aug	<div><div>GGGGGG</div><div></div></div>	85.0%	94.4%						<div><div>GGGGGG</div><div></div></div>	85.0%	96.0%			<div><div>GGGGGG</div><div></div></div>	85.0%	98.1%			<div><div>GGGGGG</div><div></div></div>	85.0%	100.0%			<div><div>RGAGAG</div><div></div></div>	85.0%	95.1%			<div><div>GGGGGG</div><div></div></div>	85.0%	95.1%
Safeguarding Children Training	Aug	<div><div>GGGGGG</div><div></div></div>	85.0%	100.0%						<div><div>RRRRRR</div><div></div></div>	85.0%	76.0%			<div><div>RRRRRR</div><div></div></div>	85.0%	76.5%			<div><div>GGGGGG</div><div></div></div>	85.0%	97.1%			<div><div>RGAGAG</div><div></div></div>	85.0%	92.7%			<div><div>AGAGGG</div><div></div></div>	85.0%	92.7%
Safeguarding Adults Training	Aug	<div><div>GGGGGG</div><div></div></div>	85.0%	94.4%						<div><div>RRRRRR</div><div></div></div>	85.0%	79.3%			<div><div>RRRRRR</div><div></div></div>	85.0%	N/A			<div><div>GGGGGG</div><div></div></div>	85.0%	100.0%			<div><div>RGAGAG</div><div></div></div>	85.0%	95.6%			<div><div>RGGGGG</div><div></div></div>	85.0%	95.6%
Appraisals	Aug	<div><div></div><div></div></div>	93.8%	93.8%				100.0%	100.0%			100.0%	100.0%			58.1%	58.1%			100.0%	100.0%			96.3%	96.3%			100.0%	100.0%			
Long Term Sickness	Aug	<div><div></div><div></div></div>	0.0%	1.9%				0.0%	0.0%			0.0%	0.0%			3.3%	1.4%			3.3%	1.2%			4.2%	0.8%			0.0%	1.8%			
Short Term Sickness	Aug	<div><div></div><div></div></div>	1.7%	1.7%				0.0%	3.4%			1.3%	1.2%			1.4%	1.5%			1.2%	1.1%			0.4%	1.3%			4.9%	2.0%			
Turnover	Aug	<div><div></div><div></div></div>	28.3%	28.3%				0.0%	0.0%			2.2%	2.2%			23.1%	23.1%			28.9%	28.9%			13.9%	13.9%			9.6%	9.6%			
Vacancy Rate	Aug	<div><div>GGARR</div><div></div></div>	5.0%	15.3%	15.3%	<div><div>GGGGGG</div><div></div></div>	5.0%	-16.8%	-16.8%	<div><div>RNRGGG</div><div></div></div>	5.0%	0.0%	0.0%			5.0%	9.7%	9.7%	<div><div>RRRRRR</div><div></div></div>	5%	14.1%	14.1%	<div><div>GGGRR</div><div></div></div>	5.0%	7.3%	7.3%	<div><div>RGGGGG</div><div></div></div>	5.0%	-3.3%	-3.3%		

		PULMONARY REHABILITATION				LEARNING DISABILITIES				CHILDRENS COMMUNITY NURSING				ADULT SPEECH & LANGUAGE THERAPY				UNIVERSAL SPEECH & LANGUAGE THERAPY				ITAC (Activity relates to OT)							
		KENT				KENT				KENT				KENT				KENT				KENT							
		6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD	6 Month Trend	Plan	Actual	YTD
Outcome 1 Preventing People from Dying Prematurely																													
Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions																													
Outcome 3 - Helping People to Recover from Episodes of Ill Health, or Following Injury																													
Activity	Aug	<div><div>RRRRRR</div><div></div></div>	281	43	561	<div><div>GAGGG</div><div></div></div>	322	294	1,811	<div><div>GGGGG</div><div></div></div>	257	486	3,075	<div><div>RRRRR</div><div></div></div>	172	138	809	<div><div>GAGGG</div><div></div></div>	380	246	2,866	<div><div>GGGGG</div><div></div></div>	154	188	1,683				
Referrals	Aug	<div><div></div><div></div></div>		19	122	<div><div></div><div></div></div>				<div><div></div><div></div></div>				<div><div></div><div></div></div>		44	188	<div><div></div><div></div></div>				<div><div></div><div></div></div>							
Waiting Times (% Seen within 18 Weeks)	Aug	<div><div></div><div></div></div>				<div><div></div><div></div></div>				<div><div></div><div></div></div>				<div><div></div><div></div></div>	95.0%	99.0%	99.2%	<div><div>AAARRR</div><div></div></div>	95.0%	93.8%	89.7%	<div><div>GGGGG</div><div></div></div>	95.0%	100.0%	100.0%				
Outcome 4 - Ensuring that People Have a Positive Experience of Care																													
Complaints	Aug	<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	1		<div><div></div><div></div></div>	0	0					
Patient Experience (%)	Aug	<div><div>AGGRRR</div><div></div></div>	90.0%	0.0%	99.3%	<div><div></div><div></div></div>		0.0%		<div><div>GGGGGG</div><div></div></div>	90.0%	98.6%	97.7%	<div><div>GGGGGG</div><div></div></div>	90.0%	96.3%	99.1%	<div><div>GGGGGG</div><div></div></div>	90.0%	100.0%	98.4%	<div><div>GGGRRG</div><div></div></div>	90.0%	97.6%	96.7%				
Friends and Family Test Score	Aug	<div><div></div><div></div></div>	0.0%	100.0%		<div><div></div><div></div></div>		0.0%		<div><div></div><div></div></div>			100.0%	<div><div></div><div></div></div>			100.0%	<div><div></div><div></div></div>		83.3%		<div><div></div><div></div></div>			97.0%				
Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm																													
Serious Incidents	Aug	<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0					
Patient Incidents	Aug	<div><div></div><div></div></div>	1	1		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	0		<div><div></div><div></div></div>	0	1		<div><div></div><div></div></div>	0	0					
Mandatory Training (All)	Aug	<div><div></div><div></div></div>	10.6%	10.6%		<div><div></div><div></div></div>	11.4%	11.4%		<div><div></div><div></div></div>	16.4%	16.4%		<div><div></div><div></div></div>	5.2%	5.2%		<div><div></div><div></div></div>	11.6%	11.6%		<div><div></div><div></div></div>	11.3%	11.3%					
Infection Prevention & Control Training	Aug	<div><div>GGGGG</div><div></div></div>	85.0%	100.0%		<div><div>GGGGG</div><div></div></div>	85.0%	90.5%		<div><div>GGGGG</div><div></div></div>	85.0%	96.7%		<div><div>GGGGG</div><div></div></div>	85.0%	96.7%		<div><div>GGGGG</div><div></div></div>	85.0%	98.9%		<div><div>GGGGG</div><div></div></div>	85.0%	96.3%					
Safeguarding Children Training	Aug	<div><div>RAAAG</div><div></div></div>	85.0%	88.2%		<div><div>GGGGG</div><div></div></div>	85.0%	96.6%		<div><div>GGGGG</div><div></div></div>	85.0%	100.0%		<div><div>GGGGG</div><div></div></div>	85.0%	100.0%		<div><div>GGGGG</div><div></div></div>	85.0%	100.0%		<div><div>GGGGG</div><div></div></div>	85.0%	94.5%					
Safeguarding Adults Training	Aug	<div><div>RRGGG</div><div></div></div>	85.0%	92.3%		<div><div>RRAAA</div><div></div></div>	85.0%	83.1%		<div><div>RRGGG</div><div></div></div>	85.0%	93.8%		<div><div>RRGGG</div><div></div></div>	85.0%	93.8%		<div><div>GGGGG</div><div></div></div>	85.0%	96.0%		<div><div>GGGGG</div><div></div></div>	85.0%	90.1%					
Appraisals	Aug	<div><div></div><div></div></div>	89.4%	100.0%		<div><div></div><div></div></div>	89.4%	89.4%		<div><div></div><div></div></div>	90.9%	90.9%		<div><div></div><div></div></div>	96.2%	96.2%		<div><div></div><div></div></div>	100.0%	100.0%		<div><div></div><div></div></div>	94.6%	94.6%					
Long Term Sickness	Aug	<div><div></div><div></div></div>	0.0%	0.0%		<div><div></div><div></div></div>	3.1%	1.1%		<div><div></div><div></div></div>	1.0%	1.4%		<div><div></div><div></div></div>	0.0%	0.5%		<div><div></div><div></div></div>	1.3%	1.0%		<div><div></div><div></div></div>	2.6%	0.8%					
Short Term Sickness	Aug	<div><div></div><div></div></div>	2.1%	1.0%		<div><div></div><div></div></div>	1.1%	1.6%		<div><div></div><div></div></div>	1.3%	1.7%		<div><div></div><div></div></div>	2.1%	1.5%		<div><div></div><div></div></div>	1.3%	1.2%		<div><div></div><div></div></div>	1.0%	1.3%					
Turnover	Aug	<div><div></div><div></div></div>	11.8%	11.8%		<div><div></div><div></div></div>	16.2%	16.2%		<div><div></div><div></div></div>	19.1%	19.1%		<div><div></div><div></div></div>	16.7%	16.7%		<div><div></div><div></div></div>	18.3%	18.3%		<div><div></div><div></div></div>	19.0%	19.0%					
Vacancy Rate	Aug	<div><div>GAAARR</div><div></div></div>	5.0%	10.6%	10.6%	<div><div>GGGAAR</div><div></div></div>	5.0%	11.4%	11.4%	<div><div>RRRRRR</div><div></div></div>	5.0%	16.4%	16.4%	<div><div>RRRRR</div><div></div></div>	5.0%	5.2%	5.2%	<div><div>RRRRRR</div><div></div></div>	5.0%	11.6%	11.6%	<div><div>RRRRRR</div><div></div></div>	5.0%	11.3%	11.3%				

KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST (KMPT): Headline indicators

Outcome 1 - Preventing People from Dying Prematurely							Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions							Outcome 3 - Helping People to Recover from Episodes of Ill Health, or Following Injury							
Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	
Mortality (KMPT, Thanet CCG)							Treating people out of hospital (KMPT, Thanet CCG)							Activity (KMPT, Thanet CCG)							
P	7 day follow-up after discharge (on CPA) (%)	Sep	G G G G G G	95.0	100.0	97.1	P	Emergency readmission w/in 28 days (%)	Sep	R R R R R R	5.0	5.6	8.1	P	IP Admissions	Sep			20	133	
P	7 day follow-up after discharge (All) (%)	Mar	G G G G G G	95.0	100.0	94.8	P	Delayed transfers of care (%)	Sep	R R R R R R	7.5	22.5	13.1	P	IP Discharges	Sep			26	128	
P	Number of Suicides (suspected) while in KMPT Care	Sep			3.0	17.0	P	Crisis resolution home treatment team gatekeeping (%)	Jun	G G G		100.0	100.0	P	EIS cases	Sep			6	27	
P	Number of patient safety incident related deaths reported to NPSA	Sep			1.0	18.0	Care programme approach (CPA)							P	CMHT referrals (inc. OP)	Sep			137	1095	
Improving physical health (KMPT, Thanet CCG)							P	People on CPA in accomodation (%)	Sep	G G G G G G	75.0	84.9	85.3	P	CMHT Referrals not accepted	Sep			2	22	
P	Physical health checks in-patients (%)	Sep	R R R R R R	95.0	87.2	87.1	P	People on CPA in employment (%)	Sep	R R R R R R	13.0	8.6	7.3	P	CMHT caseload	Sep			1253	14202	
P	Physical health checks community (%)	Q2 15	R R	80.0	36.0	36.0								Waiting times (KMPT, Thanet CCG)							
														P	4 Week wait for assessment (%)	Sep	R G G G G G	85.0	99.2	89.2	
														P	18 Week wait for treatment (%)	Sep	A G G G G G	95.0	99.0	99.1	
														Quality of Care (KMPT, Thanet CCG)							
														P	Proportion of patients in eligible clusters on CPA (%)	Jan		R R R	90.0	27.8	27.8
														P	CPA 12 month review (%)	Sep	G A G G G G	95.0	95.0	96.0	

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS

Outcome 4 - Ensuring that People Have a Positive Experience of Care

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Friends and Family Test						
N	FFT Staff: Would Recommend Work (%)	Q1 15	G	55	55	55
N	FFT Staff: Would Recommend Care (%)	Q1 15	R	70	63	63
N	FFT Patients: Would Recommend %	Sep	R R R R G G	87	88	83
Complaints/Compliments						
P	Compliments	Aug		36	144	
P	Total complaints (incl. MP enquiries)	Aug		37	192	
Mixed Sex Accommodations (MSA)						
N	MSA Breaches	Sep	G G G G G G	0	0	0
P	Wrong Gender Bathroom Incidents	Sep	G G G G G G	0	0	0
Nutritional Assessments						
P	% Nutritional Assessment received	Sep	R R R R R R	95	80	72
Care Planning & Co-ordination						
P	% of service users in PbR clusters 4, 8 & 10 who have designated care co-ordinator (%)	Q1 15		75	75	
P	% of service users in PbR clusters 4, 8 & 10 receiving a comprehensive assessment (%)	Q1 15	R	78	77	
P	% of service users using a Recovery Star (%)	Q1 15		7	8	
Restraint & Seclusion						
P	No. of Inpatients experiencing 1 or more incidents of control & restraining	Q2 15		287		
P	Inpatients experiencing 1 or more incidents of seclusion (%)	Q2 15		50		
PLACE Scores						
N	Cleanliness (%)	Q1 15	G	98	99	
N	Food (%)	Q1 15	G	88	90	
N	Privacy, Dignity and Wellbeing (%)	Q1 15	G	86	91	
N	Condition, Appearance & Maintenance (%)	Q1 15	G	90	94	
N	Dementia (%)	Q1 15	G	75	90	

Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Care Quality Commission						
C	Safe	Jul-15				Requires Improvement
C	Effective	Jul-15				Requires Improvement
C	Caring	Jul-15				Good
C	Responsive	Jul-15				Requires Improvement
C	Well-Led	Jul-15				Requires Improvement
Health Care Associated Infections (HCAI)						
P	MRSA Bacteraemia	Sep	G G G G G G	0	0	0
P	C-Diff	Sep	G G G G G R	0	1	1
P	Hand Hygiene Training	Sep	G G G G G G	85	91	91
Safety Thermometer: National CQUIN						
S	Harm Free Care	Sep	G G G G G G	95	97	98
S	Number of New VTE	Sep			4	7
S	Number of New Pressure Ulcers	Sep			1	2
S	Number of Falls with Harm	Sep			3	16
Incident Reporting						
p	Serious Incidents (KMPT)	Sep			28	116
p	Serious Incidents (Thanet CCG)	Sep			2	7
P	Never Events (KMPT)	Sep	G G G G G G	0	0	0
P	Never Events (Thanet CCG)	Sep	G G G G G G	0	0	0
Central Alerts System (CAS)						
CAS	Compliance with Deadlines %	Sep	R G R R G R	100	60	75
Safeguarding						
P	Level 1 - Children Training	Sep	G G G G G G	85	99	99
P	Level 2 - Adults Training	Sep	G G G G G G	85	91	92
Workforce						
P	Vacancy Rate %	Jun	R	15	18	16
P	Sickness Absence %	Jun	R	3.9	4.2	4.7
P	Staff Turnover %	Jun	G	14.0	10.9	5.7

Summary

Performance Issues:

Delayed Transfers of Care continue to be an issue for the Trust. Latest information indicates that Thanet DTOCs relate to older adults and the Trust has raised concerns about available accommodation, the Continuing Care Panel and the Section 117 process.

Waiting time performance within 4 weeks has improved but is still poor against the 18 weeks standard (and is significantly worse than other East Kent CCGs). The Trust has action plans in place to support improvement and has highlighted high caseloads as a particular problem.

The Trust has acknowledged that Thanet CCG is lagging behind the others in terms of the % clustered. The Trust has improved internal processes, supervision and training to provide a better focus on this target.

Quality Issues:

KMPT continue to actively recruit to all vacant posts.

Managers have systems in place to monitor both caseload and staff levels and will escalate any issue on a weekly basis. A Scrutiny Group has been introduced which reviews every vacancy within the Trust to ensure that resources are being used appropriately and that the right skills mix is maintained.

New controls and monitoring for temporary staffing has been introduced which has resulted in a reduction in agency costs.

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST (SECAMB): Headline indicators

Outcome 1 - Preventing People from Dying Prematurely

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
P	Cardiac Arrest: Return of spontaneous circulation (ROSC) (%)	May	G G G G G	27.4	48.1	55.6
P	Cardiac Arrest: patients discharged from hospital alive (%)	May	G R R R R	26	10.5	13.6
P	Stroke: arriving at a hyperacute stroke unit within 60 minutes (%)	May	G G G G G	57.6	63.9	64
P	STEMI: angioplasty within 150 minutes	May	G G G G G	87.7	89.3	90.3

Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Handover (SECAMB, Thanet CCG)						
P	QEQM Recorded patient H/O %	Oct			76.1%	
P	WHH Recorded patient H/O %	Oct			84.2%	
P	KCH Recorded patient H/O %	Oct			77.9%	

Outcome 3 - Helping People to Recover from Episodes of Ill Health, or Following Injury

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Activity						
P	Hear & Treat (Thanet CCG)	Oct	A G G G G	254	272	1,983
P	See & Treat (Thanet CCG)	Oct	G G G G A	821	858	5,946
P	See & Convey - HCP (Thanet CCG)	Oct	G G A G R A	222	232	1,400
P	See & Convey - 999 (Thanet CCG)	Oct	G G G A G	1,229	1,094	7,944
P	Total Activity (Thanet CCG)	Oct	G G A R G	2,526	2,456	17,273
P	% Non-Conveyance (Thanet CCG)	Oct			46.0%	45.9%
Waiting Times						
P	% Red 1 <8 min (Thanet CCG)	Oct	G R G G G	75%	86%	82%
P	% Red 2 <8 min (Thanet CCG)	Oct	G G G G G	75%	85%	83%
P	% Category A19 <19 min (Thanet CCG)	Oct	G G G G G	95%	100%	98%
111 Service KPIs (Trust level)						
P	Calls within 60 seconds (%)	Aug	A G A A A R	95	89	93
P	% of answered calls triaged	Aug	G G G G G	60	87	87
P	% of patients advised to attend A&E	Aug	R R R R R	5	6.9	6.9

Outcome 4 - Ensuring that People Have a Positive Experience of Care

Source	Indicator	Latest period	6 month trend			Plan	Actual	YTD			
Friends and Family Test											
N	Staff: Would Recommend Work %	Q1 15		R		R	62	50	50		
N	Staff: Would Recommend Care %	Q1 15		G		G	77	83	83		
N	Patients: Would recommend %	Sep		G	G	G	G	G	94	100	98
Complaints/Compliments											
P	Compliments	Jun						237	602		
P	Formal Complaints	Jun						23	48		
P	Informal Complaints	Jun						59	97		
P	111 Service Formal Complaints (Kent)	Jul						3	39		

Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Care Quality Commission						
C	Safe	Oct-14			Met Standard	
C	Effective	Oct-14			Met Standard	
C	Caring	Oct-14			Met Standard	
C	Responsive	Oct-14			Met Standard	
C	Well-Led	Oct-14			Met Standard	
Infection Prevention and Control (IPC)						
P	IPC Training	Jul	R R R	95.0	54.5	54.5
Incident Reporting						
P	SECAMB No. of Serious Incidents reported	Sep			2	17
P	111 No. of Serious Incidents reported	Sep			0	2
P	Serious Incidents (Thanet CCG 999/111)	Sep			0	0
Central Alerts System (CAS)						
C	Compliance with Deadlines %	Aug	G G R G G	100	100	93
Safeguarding						
P	Safeguarding Training	Aug	R R R R	95	62	
Workforce						
P	SECAMB Sickness Absence Rate %	Aug	G G G A G	4.5	5.6	4.8
P	SECAMB Vacancy Rate %	Aug			15.7	15.0
P	SECAMB Turnover Rate %	Aug			13.4	12.9
P	SECAMB Appraisal Rate %	Aug			49.4	31.8

Summary

Quality Issues:

The Trust is currently undertaking a review of its cardiac arrest strategy to clearly define its intentions and improvement methodologies.

Although at the beginning of the year the trust had shown some improvement in survival to discharge, unfortunately this has not been sustained, with the trust currently ranked 9th nationally compared with 5th in March 2015.

The trusts Quality Improvement Group launched a stroke awareness campaign which focused on the stroke care bundle throughout March 2015 and it is anticipated performance will continue to increase.

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS

Sussex Partnership Foundation Trust (SPFT): Headline indicators

Outcome 1 - Preventing People from Dying Prematurely

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
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Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
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Outcome 4 - Ensuring that People Have a Positive Experience of Care

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
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Friends and Family Test: Patients

N	Patients: Would recommend %	Sep	A G G R R A	87	86	84
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Friends and Family Test: Staff

N	Staff: % Would recommend Work	Q1 15	R G	62	64	64
N	Staff: % Would Recommend Care	Q1 15	R A	77	74	74

Complaints/Compliments

P	Complaints	Sep		5	39	
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PLACE Scores

N	Cleanliness %	Q1 15	G	98	98	
N	Food (%)	Q1 15	G	88	91	
N	Privacy, Dignity and Wellbeing (%)	Q1 15	G	86	88	
N	Condition, Appearance & Maintenance (%)	Q1 15	G	90	91	
N	Dementia (%)	Q1 15	G	75	82	

Outcome 3 - Helping People to Recover from Episodes of Ill Health, or

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
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Activity

P	Total number on all caseloads (at end of month)	Sep			1,157	6,983
P	Total number of external referrals received	Sep			88	583

Waiting times

P	Assessment waiting list	Sep			91	663
P	Treatment waiting list	Sep			30	277
P	<6 weeks wait for assessment (%)	Sep			35%	56%
P	<10 weeks wait for treatment (%)	Sep			83%	73%
P	Out of Hours emergency referrals < 24 hr (%)	Sep	G G G G	100%	100%	100%

Signposted to other services

P	% inappropriate (based on external referrals) (%)	Sep			39%	16%
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Outcome 5 - Treating and Caring for People in a Safe Environment:

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
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Care Quality Commission

C	Safe	Jan-15			Requires Improvement	
C	Effective	Jan-15			Requires Improvement	
C	Caring	Jan-15			Outstanding	
C	Responsive	Jan-15			Requires Improvement	
C	Well-Led	Jan-15			Good	

Incident Reporting

P	Number of Serious Incidents Reported (SPFT)	Sep			3	11
P	Number of Serious Incidents Reported (Thanet CCG)	Jun			0	0

Central Alerts System (CAS)

C	Compliance with Deadlines (%)	Sep	R G G G G G	100	100	98
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Summary

Performance Issues:

SPFT have recently undergone a change to their systems, and whilst data provision has recommenced, we are still lacking July data for some measures.

Therefore year to date figures are subject to change.

Guidance in the latest SPFT data for September also suggests an additional data quality issue. This involves the under reporting of electronic contacts.

NSL: Headline Indicators

Outcome 1 - Ensuring that People Have a Positive Experience of Care

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD

Outcome 2 - Enhancing Quality of Life for People with Long Term Conditions

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
P	Patients arrive prior to appointment	Aug	R R R R R R	98%	77%	75%
P	Return journey collected within 60 mins	Aug	R R R R R G	95%	95%	87%
P	Discharges/xfers booked on the day collected 2 hrs	Aug	R R R R R R	98%	80%	82%
P	Journeys aborted by provider	Aug	R R R R R R	0%	3%	3%
P	Journeys up to 10 mins no more than 90 mins in vehicle	Aug	G G G G G G	95%	100%	100%
P	Journeys 11-35 mls no more than 90 mins in vehicle	Aug	G G G G G G	80%	98%	98%
P	Journeys 36-50 mls no more than 150 mins in vehicle	Aug	G G G G G G	95%	99%	99%
P	Travel in single occupancy	Aug	G G G G G G	100%	100%	100%

Outcome 3 - Helping People to Recover from Episodes of Ill Health or Following Injury

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
P	Core service activity (Thanet CCG)	Aug			1,554	8,044
P	OOH activity (Thanet CCG)	Aug			4	14
P	Unplanned activity (Thanet CCG)	Aug			363	1,833
P	Bariatric (Thanet CCG)	Aug	R R	40	58	399
P	HDU (Thanet CCG)	Aug	G G	5	1	3
P	1 person crew (Thanet CCG)	Aug	G G	421	384	1,976
P	2 person crew (Thanet CCG)	Aug	R R	250	343	1,893
P	Stretcher (Thanet CCG)	Aug	G R	105	159	665
P	Walker (Thanet CCG)	Aug	G G	755	581	3,124
P	Wheelchair (Thanet CCG)	Aug	G G	541	395	1,831

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC)

PH = Public Health England K = KMCS

Outcome 4 - Ensuring that People Have a Positive Experience of Care

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Friends and Family Test: Patients						
P	Patients: Would recommend %	Jul	G G G G G G	90.0	95	97
P	% of FFT responses	Jul			3	3
Complaints/Compliments						
P	No. of Compliments	Jul			0	8
P	No. of Complaints	Jul			16	71
P	No. of concerns	Jul			7	13

Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Care Quality Commission						
C	Safe	Jul-14			Met Standard	
C	Effective	Jul-14			Not Met Standard	
C	Caring	Jul-14			Not Met Standard	
C	Responsive	Jul-14			Met Standard	
C	Well-Led	Jul-14			Met Standard	
Incident Reporting						
P	Total Incidents Reported	May			26	52
P	Serious Incidents (NSL)	Jun			0	0
Safeguarding						
P	Staff DBS Checks	Mar	<div><div>G</div><div>G</div><div>A</div><div>G</div><div>G</div><div>G</div></div>	100	100	
P	Safeguarding Alerts Reported by NSL	Jul			7	11
Workforce						
P	% Staff Absence	Jul			6	
P	% of workforce NSL Demential Friends	Jul			53	

Summary

Quality Issues:

The Care Quality Commission (CQC) originally inspected NSL in November 2013. NSL failed to meet standards in relation to staffing and providing care, treatment and support that meets people's needs. NSL were re-inspected in March 2014 and it was found that whilst improvements had been made NSL was still not meeting the required standards. NHS West Kent is the lead commissioner for this contract and is working with NSL to seek assurance of improvement. the CQC are taking action against this provider.

Key areas of concern regarding performance and quality of care provided by NSL include:
Safeguarding
Infection Prevention and Control
Serious Incident Management and Reporting
DNA CPR Policy

A PTS Reprocurement Project Board has been established to revise the service specification. The current contract expires in July 2016.

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC)

PH = Public Health England K = KMCS

PILGRIMS HOSPICE: Headline Indicators

ASHFORD							CANTERBURY							THANET							TOTAL PILGRIMS HOSPICE									
Outcome 4 - Ensuring that People Have a Positive Experience of Care							Outcome 4 - Ensuring that People Have a Positive Experience of Care							Outcome 4 - Ensuring that People Have a Positive Experience of Care							Outcome 4 - Ensuring that People Have a Positive Experience of Care									
Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD			
Complaints							Complaints							Complaints							Response Times									
P	Total complaints	Sep	G R R G R R G	0	0	4	P	Total complaints	Sep	R G G R R R R	0	1	7	P	Total complaints	Sep	G R R R R G	0	0	8	P	Hospice at home response (<4hr)	Sep	A R A A R R	100	74	89			
Response Times							Response Times							Response Times																
P	Referral to 1st assessment time (days)	Sep	R G G R R R R	7	7	8	P	Referral to 1st assessment time (days)	Sep	G G G G G G G	7	4	5	P	Referral to 1st assessment time (days)	Sep	G G G G G G G	7	6	5										
PLACE Scores							PLACE Scores							PLACE Scores																
P	Cleanliness	Q1 15		G	98	99	P	Cleanliness	Q1 15		G	98	98	P	Cleanliness	Q1 15		G	98	99										
P	Food	Q1 15		G	88	96	P	Food	Q1 15		G	88	95	P	Food	Q1 15		G	88	96										
P	Privacy, dignity & wellbeing	Q1 15		G	86	100	P	Privacy, dignity & wellbeing	Q1 15		G	86	89	P	Privacy, dignity & wellbeing	Q1 15		G	86	94										
P	Condition, appearance & maintenance	Q1 15		G	90	99	P	Condition, appearance & maintenance	Q1 15		G	90	96	P	Condition, appearance & maintenance	Q1 15		G	90	96										
Bed Occupancy							Bed Occupancy							Bed Occupancy																
P	% Bed Occupancy PHA	Sep	G G G G G G G	75	100	92	P	% Bed Occupancy PHC	Sep	G G G G G G G	75	78	87	P	% Bed Occupancy PHT	Sep	G G R G R G G	75	90	78										
Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm							Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm							Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm							Outcome 5 - Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm									
Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD	Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD			
Care Quality Commission							Care Quality Commission							Care Quality Commission							Workforce									
C	Safe				Good		C	Safe				Good		C	Safe				Met Standard		P	Vacancy Rates %	Sep		3.4	8.4				
C	Effective				Good		C	Effective				Good		C	Effective				Met Standard		P	Sickness Rates %	Sep		3.2	2.3				
C	Caring				Outstanding		C	Caring				Good		C	Caring				Met Standard		P	Turnover Rates %	Sep		3.8	1.3				
C	Responsive to people's needs				Outstanding		C	Responsive to people's needs				Good		C	Responsive to people's needs				Met Standard		P	Appraisal and PDP Rates %	Sep	R R R R R R R	85	49	57.5			
C	Well-Led				Good		C	Well-Led				Good		C	Well-Led				Met Standard		P	Induction Rates %	Q2 15	R R R R R R R	100	89				
Health Care Associated Infections (HCAI)							Health Care Associated Infections (HCAI)							Health Care Associated Infections (HCAI)							Training									
P	C. diff	Jun		G G G	0	0	0	P	C. diff	Jun		G G G	0	0	0	P	C. diff	Jun		G G G	0	0	0	P	Infection control training %	Q2 15	R R R R R R R	100	79	
P	MRSA Bacteraemia	Sep		G G G G G G G	0	0	0	P	MRSA Bacteraemia	Jun		G G G	0	0	0	P	MRSA Bacteraemia	Sep		G G G G G G G	0	0	0	P	Hand Hygiene training %	Q2 15	R R R R R R R	95	79	
P	Hand hygiene audits	Sep		A G G G G G G	95	100	99	P	Hand hygiene audits	Sep		G G G G G G G	95	100	99	P	Hand hygiene audits %	Sep		G G G G G G G	95	100	100	P	Safeguarding Children Training %	Q2 15	G G G G G G G	85	82	
Pressure Ulcers and Falls							Pressure Ulcers and Falls							Pressure Ulcers and Falls																
P	Hospice acquired Pressure Ulcers	Sep		R R R R	0	1	11	P	Hospice acquired Pressure Ulcers	Sep		R R R R	0	1	14	P	Hospice acquired Pressure Ulcers	Sep		R R R R	0	4	18	P	Safeguarding Adult Training %	Q2 15	R R R R R R R	85	69	
P	Inherited Pressure Ulcers	Sep		R R R R	0	1	20	P	Inherited Pressure Ulcers	Sep		R R R R R R R	0	5	33	P	Inherited Pressure Ulcers	Sep		R R R R	0	7	60	P	MCA Awareness training %	Q2 15	R R R R R R R	100	70	
P	Number of Falls	Sep		R R R R R R R	0	3	16	P	Number of Falls	Sep		R R R R R R R	0	1	21	P	Number of Falls	Sep		R R R R R R R	0	3	20	P	MCA Level 2 and DOLS training %	Q2 15	R R R R R R R	100	40	
Incident Reporting							Incident Reporting							Incident Reporting																
P	Number of incidents	Sep		R R R R R R R	0	6	33	P	Number of incidents	Sep		R R R R R R R	0	6	27	P	Number of incidents	Sep		R R R R R R R	0	13	40							
P	Serious Incidents	Sep		G G G G G G G	0	0	1	P	Serious Incidents	Sep		G G G G G G G	0	0	0	P	Serious Incidents	Sep		G G G R G G G	0	0	1							
Safeguarding							Safeguarding							Safeguarding																
P	Adult Protection orders initiated	Sep		G G G G G G G	0	0	0	P	Adult Protection orders initiated	Sep		G R G G G R G	0	0	2	P	Adult Protection orders initiated	Sep		G G G G G G G	0	0	0							
DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS U = Unity																														
Summary: Data: Partial assurance around data provided by Pilgrims Hospice. They are currently improving their data capture and monitoring systems with the expectation that the Q3 data dashboard will be fully validated. Pressure Ulcers: Pilgrims Hospice are currently doing a lot of validation work to review inherited/acquired pressure ulcers, with the new Tissue Viability Lead nurse reviewing care plans and educating staff about correct grading and reporting onto STEIS. Pilgrims are to start a piece of work with Hospice UK on Standards for Prevention of Pressure Ulcers in Hospices. Falls: Pilgrims have appointed a 'Lead in Falls' who is rolling out and monitoring fall assessments. Every patient coming into Pilgrims will have a falls assessment. Hospice at home response times: The decline in response times is due to the resource being abused. Pilgrims are to review the process to ensure Hospice at Home is appropriately set up.																														

Summary:
Data: Partial assurance around data provided by Pilgrims Hospice. They are currently improving their data capture and monitoring systems with the expectation that the Q3 data dashboard will be fully validated.
Pressure Ulcers: Pilgrims Hospice are currently doing a lot of validation work to review inherited/acquired pressure ulcers, with the new Tissue Viability Lead nurse reviewing care plans and educating staff about correct grading and reporting onto STEIS. Pilgrims are to start a piece of work with Hospice UK on Standards for Prevention of Pressure Ulcers in Hospices.
Falls: Pilgrims have appointed a 'Lead in Falls' who is rolling out and monitoring fall assessments. Every patient coming into Pilgrims will have a falls assessment.
Hospice at home response times: The decline in response times is due to the resource being abused. Pilgrims are to review the process to ensure Hospice at Home is appropriately set up.

Spencer: Headline Indicators

Outcome 1: Preventing People from Dying Prematurely

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
P	Expected deaths	Q2 15			1	1
P	Peri-operative mortality	Q2 15			0	0

Outcome 2: Enhancing Quality of Life for People with Long Term Conditions

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
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Outcome 3: Helping People to Recover from Episodes of Ill Health, or Following Injury

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
P	No. of Unplanned Transfers	Q2 15			0	2
P	No. of Unplanned Re-admissions	Q2 15			2	2
P	No. of Unplanned Return to Theatre	Q2 15			2	3
P	Theatre list delays/overruns	Q2 15			3	9
P	Theatre Cancellations/Postponements	Q2 15			14	26

Outcome 4: Ensuring that People Have a Positive Experience of Care

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Friends and Family Test: Patients						
N	FF respondents who would recommend Inpatient care (%)	Sep	G G G A G G	96	100	98
N	FFT: response rate %	Sep			31	42
Complaints/Compliments						
P	Complaints (East Kent)	Q2 15			6	16
PLACE Scores						
N	Cleanliness	Q1 15	G	98	100	
N	Food	Q1 15	G	88	100	
N	Privacy, Dignity and Wellbeing	Q1 15	G	86	97	
N	Condition, Appearance & Maintenance	Q1 15	G	90	100	

Outcome 5: Treating and Caring for People in a Safe Environment: Protecting Them from Avoidable Harm

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
Care Quality Commission						
	Safe	Feb-15			Good	
	Effective	Feb-15			NA	
	Caring	Feb-15			Good	
	Responsive	Feb-15			Good	
	Well-Led	Feb-15			Good	
Health Care Associated Infections (HCAI)						
P	MRSA Bacteraemia	Q2 15			0	0
P	C-Diff	Q2 15			0	0
P	Handwashing training % completed	Q2 15			100	100
Safety Thermometer						
P	Harm Free Care Pressure Sores (%)	Q2 15	G	G	95	100.0
P	Harm Free Care VTE (%)	Q2 15	G	G	95	100.0
P	Harm Free Care Urinary Infection (%)	Q2 15	G	G	95	100.0
P	Harm Free Care Falls (%)	Q2 15	G	G	95	99.6
Incident Reporting						
P	Clinical Incidents	Q2 15			4	9
P	Serious Incidents	Q2 15			0	1

Summary

Source	Indicator	Latest period	6 month trend	Plan	Actual	YTD
CQC Report Headlines						
Spencer Private Hospital (Margate) was rated good in all five domains in both its inpatient and outpatient services. Key findings of the CQC report include:						
<ul style="list-style-type: none"> There is a number of robust processes in place which include: appointing medical staff to the service under practicing privileges arrangements, Clinical Governance and Complaint management Serious incidents are monitored and reported and lessons were learnt. Patient satisfaction levels are high. MRSA and C. Difficile is monitored with no hospital-acquired cases reported in the last 12 months There were systems for the effective management of staff. The area where the provider needs to take action is around reviewing the arrangements for the storage of all medicines and ensure they are stored securely and at the recommended temperatures to maintain their efficacy. 						

DATA SOURCE KEY: C = Care Quality Commission P = Provider N = NHS England S = Safety Thermometer H = Health and Social Care Information Centre (HSCIC) PH = Public Health England K = KMCS

Thanet Clinical Commissioning Group

Report to:	Thanet CCG Governing Body	Agenda item:	4
Date of Meeting:	8 December 2015		
Title of Report:	Finance Report		
Is this report for internal distribution only?	Yes		
Author:	Jonathan Bates, Chief Finance Officer, South Kent Coast and Thanet CCGs		
Board Sponsor:	Jonathan Bates, Chief Finance Officer, South Kent Coast and Thanet CCGs		
Status:	For information		
Appendices	2		

1. Strategic Objectives Link

To ensure that we can afford to deliver excellent clinical care and achieve statutory financial targets

2. Introduction/Background

Thanet CCG Month 7 Report.

3. Recommendation

To note the financial challenges that the CCG faces in the current year.

4. Summary of Issues

Month 7 management accounts show the CCG faces financial risk in some areas.

5. Risks

The CCG must meet statutory financial duties in 2015/16.

6. Appendices

Appendix 1: Thanet CCG Board Report

Appendix 2: Extracts from Month 5 South East CSU Report

Thanet CCG
Finance Report to 31st October 2015 (month 7)

1. Introduction

- 1.1 Month 7 position shows year to date expenditure of £119.08m. This is £912,000 over plan before contingency.
- 1.2 The table below shows the main variance's to budget: (+ve overspend, -ve underspend)

	£000
EKHUFT	196
Kent Community HFT	226
Prescribing	117
Planned Care	260
Other Acute Contracts	277
CHC Placements	385
Mental Health out of area beds	777
Underspending area's	-1326
Total	912

- 1.3 In addition to the adverse variances shown above the CCG has substantial risks associated with Placements sending and Out of Area Mental Health beds. Current forecasts show substantial adverse variances. The Finance Department is preparing plans to mitigate these costs. However the risk is substantial and will lead to failure to achieve financial targets unless mitigated.
- 1.4 The latest information available shows the CCG continues to miss its action plan target for both EKHUFT and KCHFT; this has been reflected in the month 7 position. The reasons for this are detailed on Page 2 and 3. More detailed information is shown in the CSU extract section of this report, see Appendix 2.
- 1.5 Month 5 PPA information for prescribing shows a decrease in the full year forecast of £118,349 against the increase of £368,000 at month 4. This will still result in a net overspend against budget for Thanet CCG.
- 1.6 The planned care over performance relates to AQP contract activity.
- 1.7 Based on current CHC placements forecasts received the CCG will have a £550,000 overspend for 2015/16. The CSU Team continues to review forecasting and reporting

Thanet Clinical Commissioning Group

techniques. Bills for 2013/14 have now all been received and this has led to a cost pressure which has been added to forecasts prepared by the CSU.

1.8 Month 5 information received from the CSU is showing an overspend for both Guy's and St Thomas' and University College London. The full year forecast overspend for 2015/16 is £583,000 over plan. This is due to higher activity than plan in elective care and high critical care spend.

1.9 Month 6 detailed spending report is set out in Appendix 1

2. Risk Areas

The 4 largest financial risk areas for the CCG are,

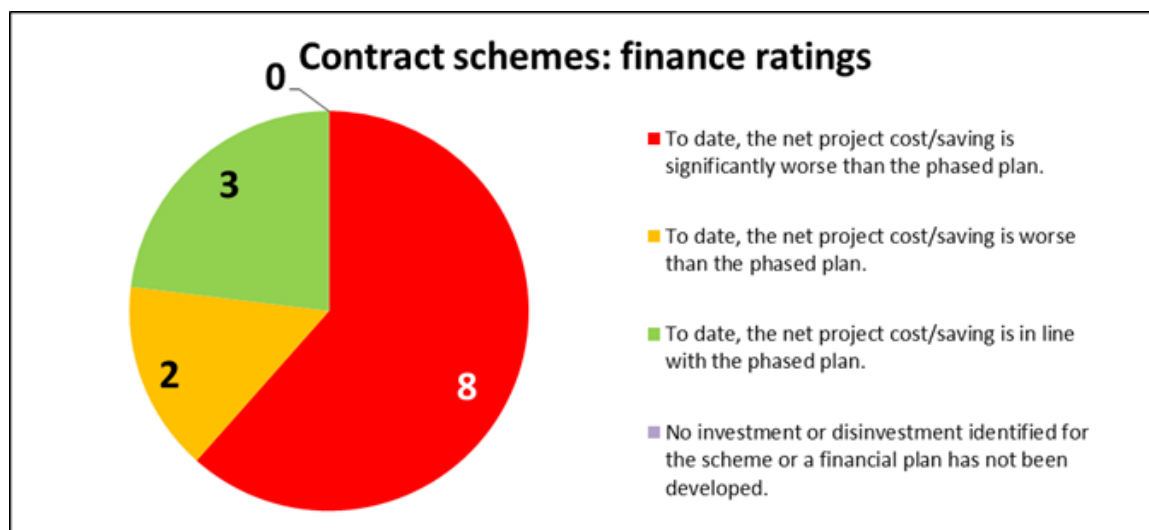
- i. Contract Action Plans (including referral management for T&O and the other "Trigger Specialities")
- ii. Mental Health Out of Area Beds
- iii. Placements
- iv. Prescribing

2.1 EKHUFT AND KCHFT

Each of these contracts has an action plan attached to it. The full impact to the CCG of current, very slow, implementation will be £468,000 for EKHUFT and £403,000 for KCHFT.

The chart below shows a summary of the Finance ratings for the 2015/16 Schemes.

Further details can be found in the CCG's Programme Dash Board.



Thanet Clinical Commissioning Group

While we have a capped contract with EKHUFT a number of areas are still on a cost per case basis. Activity in these areas must be in line with plan. If they go above plan the CCG will have the following risks:

Risk of additional payment – This risk is increasing as activity is rising.

Achievement of Savings – This risk is high based on the information below and needs immediate action.

Memorandum of Understanding Trigger Specialties

	Referrals	Attendances	Admissions
Orthopaedics			
Dermatology			
Ophthalmology			
DVT			
Accident and Emergency			

The current areas of risk in the trigger specialties outlined in the MoU are:

- Orthopaedic admissions are below plan year to date but forecast to increase over plan by year-end, raising the continued risk of financial penalties to CCGs as long as primary care referrals are also over plan across the whole of East Kent.

Action Required

- *A schedule of savings areas has been prepared to be discussed with EKHUFT in order to quantify possible savings made.*
- *However in some areas further work is required in order for savings to be achieved. The top six outlying practices have been identified. Visits are being arranged to discuss their current position and to identify if support is required.*

2.2 KMPT OUT OF AREA BEDS

Based on information received and discussions the current forecast for KMPT out of area beds for the CCG is £1.8m against a budget of £0.5m. Action is required to bring costs under control.

Action Required

An action plan has been implemented by CCGs as follows:

Thanet Clinical Commissioning Group

- *The CCG has implemented telephone calls with KMPT twice a week to monitor the bed situation. This has resulted in a significant drop in out of area beds across East Kent CCG's. At the beginning of October there were 21 patients in out of area beds, there are at present 2.*
- *However Thanet CCG continues to be the highest user of KMPT beds within East Kent. This needs to be monitored closely.*
- *These telephone calls will continue at present to ensure that any problems or blockages are resolved and also to continue to monitor bed use.*

2.3 PLACEMENTS

Placements are a high risk area to the CCG. Forecasts continue to be produced by the Placements Team that are considerably higher than plan. In addition bills for 2014/15 have now all been received and this has led to a cost pressure which has been shown in the accounts.

Actions Required

- *The Chief Nurse and the Finance Team are working with the CSU Placements Team to ensure the activity plan that has been implemented continues to remain on plan.*
- *Review of forecasts is taking place by the Finance Team to ensure that all individuals on forecasts are reflected accurately.*

2.4 Prescribing

Month 5 data continues to show a forecast overspend for the current year. There is also current uncertainty regarding the amount of reimbursement that the CCG will receive for Public Health for spend of prescribing.

Actions Required

- *Additional staff are now in post and are being deployed robustly to manage prescribing levels in practices.*
- *Action plans are being reviewed to identify any further savings that can be implemented.*
- *Resolution of Public Health reimbursement issues is now a priority to be achieved as soon as possible.*

CCG Savings and risk avoidance plan

Thanet Clinical Commissioning Group

Below is the CCG savings plan, this will need to be delivered in order to obtain financial balance. This has been reviewed and updates made following meetings with the Commissioning Team.

THANET CCG								
Savings and Risk Avoidance Action Plan - 2015/16								
No.	Area	Overall Responsibility	RAG	Main Action	Immediate Action Required	Savings	Risk Adjustment	
1	KMPT Out of Area Beds	Jonathan Bates/Andy Oldfield/Emma Emery		Work to reduce use of out of area beds and bring spend back in line with plan	Daily telephone calls and weekly meetings	750,000	80%	600,000
2	KMPT underperformance	Jonathan Bates/Andy Oldfield/Emma Emery		Negotiate closing position with Trust with regards to underperformance against activity	Negotiate year end agreement	300,000	20%	60,000
3	Placements	Sharon Gardner-Blach/finance Team		Ensure robust forecasting and action planning to bring spend back to an appropriate level	Review forecasts received on monthly basis ensuring queries are addressed in a timely manner	500,000	40%	200,000
4	KCHFT Safe Operating Procedures	Ailsa Ogilvie/Fay Hames		To look at Safe Operating Procedures in line with the Trust's modelling	Review Progress made to date	175,000	80%	140,000
5	KCHFT MOU Agreement	Ailsa Ogilvie/Commissioning Team		Work to ensure that items identified in the MOU are prioritised and actioned	Review Progress made to date, follow-up outstanding issues	577,000	60%	346,200
6	KCHFT LIS scheme	Quality and Finance		Ensure that information is reviewed to clarify achievement	Review evidence and raise questions	172,979	40%	69,192
7	CQUIN Payments	COO/CFO		Robustly manage the plans to ensure only appropriate payments are made	Work with Quality Team to ensure robust reviews are ongoing	2,623,074	5%	131,154
8	Over 75 payments	COO/CFO		Review evidence against plans, as well as outcomes, before payment is agreed	Review evidence and raise challenges	700,000	10%	70,000
9	Ogden Wing and Westbrook House	Ailsa Ogilvie/Commissioning Team/Finance		Unpick finance information to ensure value for money and service is in line with what has been commissioned	Joint work with KCC to unpick financial information	100,000	80%	80,000
10	Prescribing	Head of Medicines Management		Additional resource within the Medicines Management Team to support Practices	deploy robustly to manage prescribing levels in practices	500,000	50%	250,000
11	East Kent Hospitals MOU	AO/CFO		Work to ensure that items identified in the MOU are prioritised and actioned	Gather evidence to present to Trust	150,000	75%	112,500
12	East Kent Hospitals underperformance	AO/CFO		Negotiate closing position with Trust with regards to underperformance against activity	Gather evidence to present to Trust	600,000	50%	300,000
13	ADHD Prescribing	CSU/Finance		Review current contract and data provided to ensure charges are in line with agreements	Meet with provider to review arrangements	200,000	40%	80,000
14	Guy's and St Thomas	CSU/Finance		Review contract and activity to ensure that equipment / work undertaken is NOT charged to the CCG and is classed as specialist commissioning which is charged to NHS England	CSU to review activity data	150,000	50%	75,000
15	Planned Care	Ailsa Ogilvie/Commissioning Team/Finance		Review activity for community contracts making sure that referral and treatment criteria is followed	Ensure Identified services are followed up	170,000	50%	85,000
16	Quality Premium	Ailsa Ogilvie/Commissioning Team/Finance		Quality Premium template to be submitted timely	Template to be submitted timely	50,000	100%	50,000
17	LES - Tissue viability	Ailsa Ogilvie/Commissioning Team/Finance		Review service	Review claims received	5,000	20%	1,000
18	Salary sacrifice - lease cars	Ailsa Ogilvie/Finance		Discuss implementation as £500 saving per car	Discuss with exec	1,500	75%	1,125
18	Prop co - review of vacant properties	Finance		Review vacant properties in line with procurement process	Review	5,000	30%	1,500
						7,729,553	2,652,670	

3. East Kent Hospitals

Point of Delivery	NHS Thanet CCG - Month 5 YTD							
	2014-15 ACTUAL Activity	2015-16 ACTUAL Activity	Variance Activity	Var %	2014-15 ACTUAL £ (000)	2015-16 ACTUAL £ (000)	Variance £ (000)	Var %
Non-Admitted								
New Outpatients	16,640	18,902	2,262	13.6%	£2,510	£2,727	217	8.7%
Follow-up Outpatients	32,495	39,492	6,997	21.5%	£2,724	£3,084	360	13.2%
Outpatient Procedures (first)	2,044	1,923	-121	-5.9%	£404	£307	-97	-24.1%
Outpatient Procedures (follow up)	4,386	4,273	-113	-2.6%	£733	£618	-115	-15.7%
Ward Attenders	867	909	42	4.8%	£146	£138	-8	-5.5%
Pre-Operative Assessment	3,237	3,081	-156	-4.8%	£244	£243	-0	-0.2%
Outpatient Radiology	0	0	0	0.0%	£656	£657	0	0.0%
Regular Attenders	816	932	116	14.2%	£358	£381	23	6.4%
Non-Admitted Total	60,485	69,512	9,027	14.9%	£7,776	£8,155	379	4.9%
Admitted PbR Spells								
Daycase	7,541	7,701	160	2.1%	£5,150	£4,708	-442	-8.6%
Short Stay Elective	1,068	0	-1,068	-100.0%	£1,729	£0	-1,729	-100.0%
Elective Long Stay	628	1,770	1,142	181.8%	£2,616	£4,849	2,233	85.3%
Elective Excess Bed Days	456	336	-120	-26.3%	£105	£77	-28	-27.0%
Admitted PbR Spells Total	9,237	9,471	234	2.5%	£9,600	£9,633	34	0.3%
PbR Unscheduled Care								
Non-elective Short Stay Emergency	3,635	3,073	-562	-15.5%	£2,815	£2,504	-311	-11.1%
Unscheduled Care Assessment	932	776	-156	-16.7%	£389	£316	-73	-18.7%
Non-elective Long Stay Emergency	3,033	3,707	674	22.2%	£8,470	£9,165	695	8.2%
Non Elective Non Emergency	824	875	51	6.2%	£1,421	£1,603	182	12.8%
Non-elective Emergency Excess Bed Days	3,015	2,753	-262	-8.7%	£697	£585	-112	-16.1%
Non-elective Non-emergency Excess Bed Days	22	58	36	163.6%	£8	£20	13	163.5%
PbR Unscheduled Care Total	8,424	8,431	7	0.1%	£13,799	£14,193	394	2.9%
A&E Attendances								
A&E Attendances	26,538	25,754	-784	-3.0%	£2,793	£3,011	218	7.8%
PbR AE Total	26,538	25,754	-784	-3.0%	£2,793	£3,011	218	7.8%
Other Cost-per-Case Areas and AQP								
Cost-per-Case Areas and AQP	480,638	495,658	15,020	3.1%	£6,250	£5,844	-406	-6.5%
Total Other Cost-per-Case Areas and AQP	480,638	495,658	15,020	3.1%	£6,250	£5,844	-406	-6.5%

The table above shows a comparison for EKHUFT activity and finance for 2014/15 and 2015/16.

The high level of referrals is leading to substantial adverse variances for new and follow-up outpatients.

In 2015/16 there is an agreement with EKHUFT that the CCG would align non-elective paediatric admissions, meaning it no longer falls under short stay non-elective admissions and all paediatric non-elective admissions regardless of length of stay are now classified as long stay.

Thanet Clinical Commissioning Group

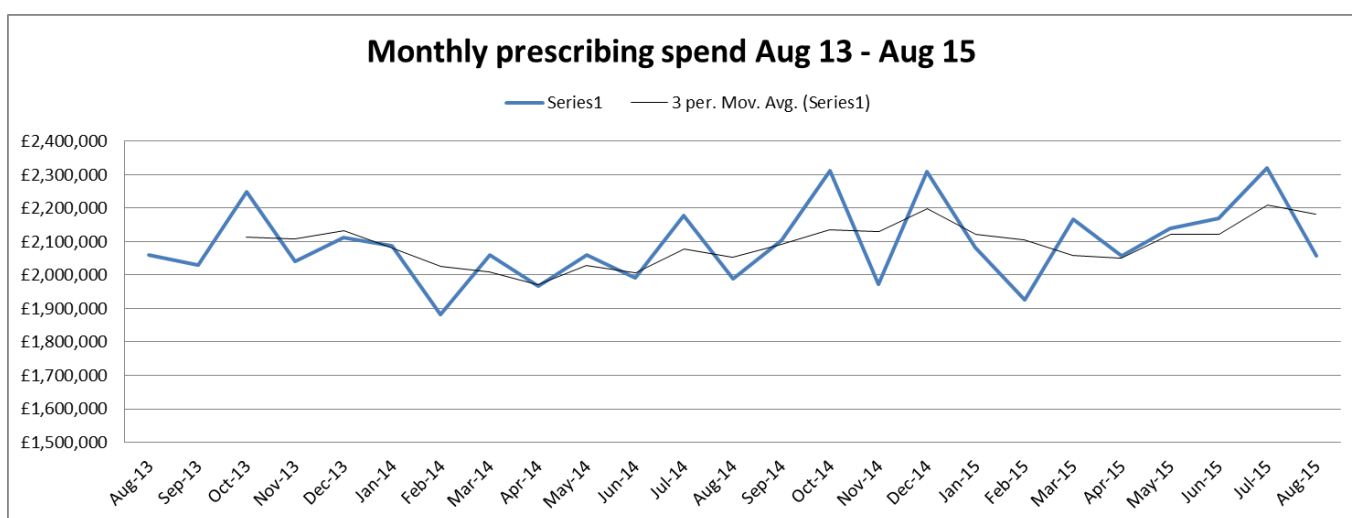
Short and long stay elective admissions are combined in 2015/16, but were differentiated in 2014/15.

4. Prescribing

4.1 The most up to date available data is August 2015. The trend chart is shown below.

4.2 August spend is 3% above 2014/15 spend and 1% above average August spend for all years.

4.3 Information below shows actual and predicted spend by practice and locality. Highlighted values represent overspends.



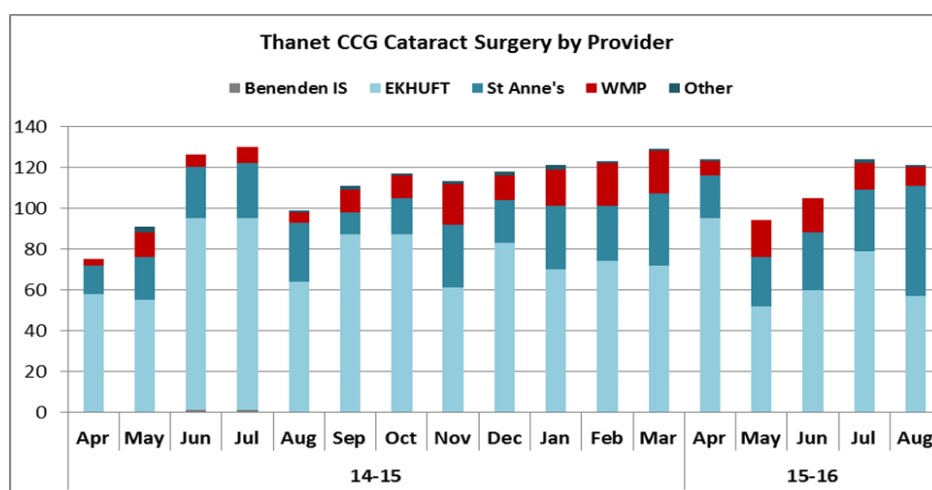
August 2015 YTD		YTD Spend			Annual Forecast Outturn (FOT)		
Practice	G Code	Actual	Expected	YTD Overspend	FOT	Budget	FOT Overspend
Birchington Medical Centre	G82666	£880,465	£691,104	£189,362	£2,122,626	£1,666,113	£456,514
Minster Surgery	G82107	£577,249	£544,510	£32,739	£1,391,631	£1,312,704	£78,927
Garlinge Surgery	G82810	£244,669	£255,293	£-10,624	£589,848	£615,460	£-25,612
Westgate Surgery	G82079	£715,466	£745,245	£-29,779	£1,704,438	£1,796,637	£-92,200
Total QUEX Locality		£2,417,849	£2,236,151	£181,698	£5,808,544	£5,390,914	£417,630
Summerhill Surgery	G82046	£552,056	£448,917	£103,139	£1,330,898	£1,082,250	£248,648
Newington Road Surgery	G82150	£616,184	£518,655	£97,530	£1,485,498	£1,250,373	£235,125
The Grange Practice	G82020	£890,417	£828,546	£61,871	£2,146,618	£1,997,459	£149,158
East Cliff Medical Practice	G82126	£974,165	£1,045,258	£-71,093	£2,337,303	£2,519,909	£-182,606
Wickham Surgery	G82812	£107,042	£127,837	£-20,796	£258,056	£308,190	£-50,134
Dashwood Medical Centre	G82064	£460,229	£555,890	£-95,661	£1,109,520	£1,340,140	£-230,620
Total Ramsgate Locality		£3,600,094	£3,525,104	£74,990	£8,667,893	£8,498,322	£169,571
Mocketts Wood Surgery	G82650	£615,103	£512,528	£102,575	£1,482,890	£1,235,602	£247,288
St Peter's Surgery	G82219	£282,961	£296,039	£-13,078	£682,162	£713,691	£-31,529
The Albion Road Surgery	G82796	£384,988	£494,077	£-109,089	£928,130	£1,191,122	£-262,992
Osborne Road Surgery	G82210	£106,636	£140,617	£-33,981	£257,078	£339,000	£-81,922
Total Broadstairs Locality		£1,389,688	£1,443,261	£-53,573	£3,350,261	£3,479,415	£-129,154
Northdown Surgery	G82066	£795,101	£720,604	£74,498	£1,916,831	£1,737,231	£179,600
Bethesda Medical Centre	G82105	£1,157,659	£1,119,191	£38,468	£2,790,885	£2,698,147	£92,738
The Limes Medical Centre	G82052	£741,625	£724,734	£16,891	£1,787,909	£1,747,188	£40,721
Union Row Surgery	G82649	£189,929	£230,805	£-40,876	£457,881	£556,424	£-98,543
Cecil Square Surgery	G82769	£89,668	£136,744	£-47,075	£216,172	£329,662	£-113,489
Total Margate Locality		£2,973,982	£2,932,077	£41,906	£7,169,678	£7,068,652	£101,026

4. Community Contracts

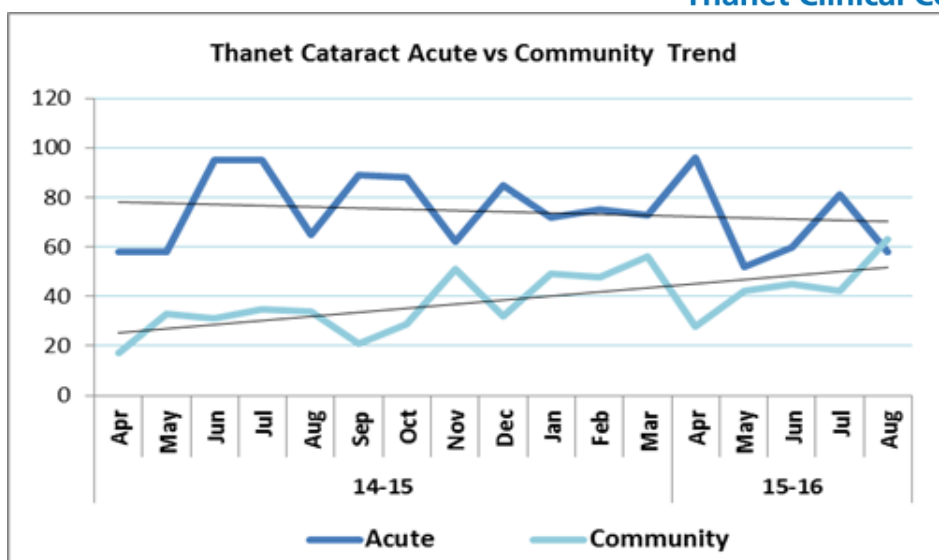
A number of Thanet AQP and small Community contracts are showing an overspend in month 7. These are Cataracts, Physiotherapy and Ultrasound.

Below is further information relating to Cataracts, this was prepared by the CSU following queries as to why community provider spend was increasing.

Community Cataract Analysis: An in-depth review of cataract surgery across all providers has been carried out to examine the activity spread across both acute and community providers. Total activity remains relatively stable however there is a trend of activity moving out of the EKHUFT and increasing at community providers. The nature of the EKHUFT block contract means this movement in activity to cost per case providers raises a financial risk to the CCG.



Thanet Clinical Commissioning Group



5. Running Cost Allowance

Corporate budgets are currently showing spend to plan. However there is a risk of overspend due to the current staff structure and the CSU contract taking up a very large proportion of the allocation.

6. Allocations

6.1 Details of allocations are shown in the table below

Source	Allocation	£'000
NHS England - Central	Programme Baseline allocation	195,718
NHS England - Central	Running costs	3,058
NHS England - Central	Better Care Fund	2,631
NHS England - Central	2014-15 recurrent transfers post allocation setting	789
NHS England - Central	CAMHS Eating Disorder Service funding	86
NHS England - Central	Ophthalmology Enhanced Service	4
NHS England - Central	Tier 3 Neurology Commissioning Responsibility Transfer -	25
	Total Recurrent Allocation	202,311
NHS England - Central	Brought Forward surplus/(deficit)	2,652
NHS England - Central	ETO/DTR Funding	665
NHS England - Central	GP IT	367
NHS England - Central	Waiting list validation & improving operational processes	4
NHS England - Central	Liaison Psychiatry - Mental Health	35
	Total Non-Recurrent Allocation	3,723
	Total Allocation at Month 7	206,034

7. Public Sector Payments Policy

BETTER PAYMENT PRACTICE CODE	
Organisation	10E
Current reporting month	Month 7
Non NHS	
Cumulative Performance by Value	£'000s
Value of Non-NHS Bills paid within target (30 days)	23,720
Value of Non-NHS Bills paid	24,174
% of all Bills paid in target (by value)	98.1%
Cumulative Performance by Volume	
Volume of Non-NHS Bills paid within target (30 days)	4,268
Volume of Non-NHS Bills paid	4,421
% of all Bills paid in target (by volume)	96.5%
NHS	
Cumulative Performance by Value	£'000s
Value of NHS Bills paid within target (30 days)	80,900
Value of NHS Bills paid	81,046
% of all Bills paid in target (by value)	99.8%
Cumulative Performance by Volume	
Volume of NHS Bills paid within target (30 days)	1,221
Volume of NHS Bills paid	1,244
% of all Bills paid in target (by volume)	98.2%

7.1 The 95% target has been exceeded in all areas.

8 Cash

	Apr £ m	May £ m	Jun £ m	Jul £ m	Aug £ m	Sep £ m	Oct £ m
Opening	0.07	0.7	2.7	2.2	2.6	3.2	3.2
Drawdown	15.2	15.5	15.2	14.6	14.0	14.6	14.1
Receipts	0.7	0.6	0.6	1.0	0.6	0.6	0.6
Payments	-15.3	-14.2	-16.3	-15.2	-14.0	-15.2	-16.5
Month End Cash							
Balance	0.72	2.68	2.22	2.65	3.24	3.22	1.47

8.1 The CCG's cash position is currently being managed to target. Drawdown in month 7 was £14.1m and payments were £16.5M. The cash balance at the end of the month stood at £1.47m.

9 Statement of Financial Position

Thanet Clinical Commissioning Group

	Apr-15 £'000s	May-15 £'000s	Jun-15 £'000s	Jul-15 £'000s	Aug-15 £'000s	Sep-15 £'000s	Oct-15 £'000s
Non Current Assets:							
Plant, property, equipments	14	14	13	13	13	12	12
Total non current assets	14	14	13	13	13	12	12
Current Assets:							
Trade and other receivables	(624)	150	205	950	810	1,315	2,887
Cash and cash equivalents	719	2,680	2,224	2,648	3,239	3,223	1,469
Total current assets	95	2,829	2,429	3,598	4,049	4,538	4,356
Total Assets	109	2,844	2,442	3,611	4,061	4,550	4,368
Current liabilities:							
Trade and other payables	13,481	14,254	15,495	14,803	16,143	16,647	17,258
Accrued Liabilities	0	78	196	141	0	0	0
	13,481	14,332	15,691	14,944	16,143	16,647	17,258
Total Assets less Current Liabilities	(13,372)	(11,488)	(13,249)	(11,332)	(12,082)	(12,097)	(12,890)
Financed by Taxpayers' Equity	(13,372)	(11,488)	(13,249)	(11,332)	(12,082)	(12,097)	(12,890)

10 Recommendations

The Governing Body is asked to note the contents of this report

Jonathan Bates
Chief Finance Officer
November 2015

Appendix 1

Thanet CCG Board Report M7 2015/16

	14/15 Full Year Spend £'000s	Annual Budget £'000s	Month Budget £'000s	Month Actual £'000s	Month Variance £'000s	Year-to-date Budget £'000s	Year-to-date Actual £'000s	Year-to-date Variance £'000s
Acute								
Local Acute Contracts	87,859	87,060	7,255	7,269	(14)	50,785	51,004	(219)
Other Acute Contracts	3,904	3,944	329	379	(50)	2,301	2,538	(238)
High Cost Drugs	1,724	2,227	186	184	2	1,299	1,280	19
Ambulance Services	6,630	6,574	548	548	(0)	3,835	3,808	27
Independent Sector	4,350	4,379	365	479	(114)	2,555	2,814	(260)
Urgent Care	1,595	1,788	149	170	(21)	1,043	1,013	30
Non-contract	2,424	2,360	197	155	41	1,377	1,035	342
Acute Total	108,487	108,333	9,028	9,185	(157)	63,194	63,492	(298)
Community								
KCHT Contract	18,186	17,158	1,430	1,457	(27)	10,009	10,235	(226)
Other Community	4,161	8,256	688	569	119	4,816	4,253	563
Community Total	22,348	25,415	2,118	2,026	92	14,825	14,489	337
Continuing Health Care								
Continuing Health Care	11,045	11,545	962	988	(26)	6,734	7,127	(392)
Continuing Health Care Retrospective	284	744	-	-	-	744	744	-
Continuing Health Care Reserves	-	-	-	-	-	-	-	-
Continuing Health Care Total	11,329	12,289	962	988	(26)	7,478	7,871	(392)
Mental Health								
KMPT Contract	13,604	13,267	1,106	1,106	(0)	7,739	7,740	(1)
Other Mental Health	4,211	4,788	429	578	(149)	2,793	3,505	(713)
Other Mental Health Reserves	-	-	-	-	-	-	-	-
Children Mental Health	1,749	1,870	156	158	(3)	1,091	1,099	(8)
Dementia	170	170	14	(83)	97	99	31	68
Mental Health Total	19,734	20,095	1,705	1,759	(55)	11,722	12,376	(653)
Primary Care								
Out Of Hours	1,208	1,262	105	106	(1)	736	742	(6)
Local Enhanced Service	1,785	1,924	160	147	13	1,122	1,015	108
Prescribing	25,354	26,440	2,169	2,115	54	15,246	15,362	(117)
Oxygen	276	279	23	24	(1)	161	141	21
GP IT	359	367	31	31	(0)	214	214	0
Primary Care Total	28,982	30,271	2,489	2,424	65	17,480	17,474	5
Other								
Patient Transport	1,079	1,088	91	98	(7)	634	630	4
Children's Commissioning	640	830	69	111	(42)	484	398	86
Children's Commissioning Reserves	-	-	-	-	-	-	-	-
Prop Co Recharge	499	987	82	82	-	576	576	-
Other Total	2,217	2,904	242	291	(49)	1,694	1,604	90
Corporate								
Corporate	3,524	3,058	246	246	0	1,775	1,775	0
Corporate Total	3,524	3,058	246	246	0	1,775	1,775	0
QIF QIPP		-	-	-	-	-	-	-
Reserves								
Contingency	-	1,028	85	-	85	600	-	600
General Reserve Programme	-	536	45	-	45	313	-	313
2.5% Top Slice	-	-	-	-	-	-	-	-
Reserves Total	-	1,564	130	-	130	912	-	912
TOTAL EXPENDITURE	196,621	203,929	16,919	16,918	0	119,081	119,081	0
Resource Limit	-	(206,034)	(17,094)	(17,094)	-	(120,309)	(120,309)	-
TOTAL RESOURCE	-	(206,034)	(17,094)	(17,094)	-	(120,309)	(120,309)	-
SURPLUS / (DEFICIT)	2,652	2,105	175	176	(0)	1,228	1,228	(0)

Appendix 2

Extracts from Month 5 South East CSU Report

Summary

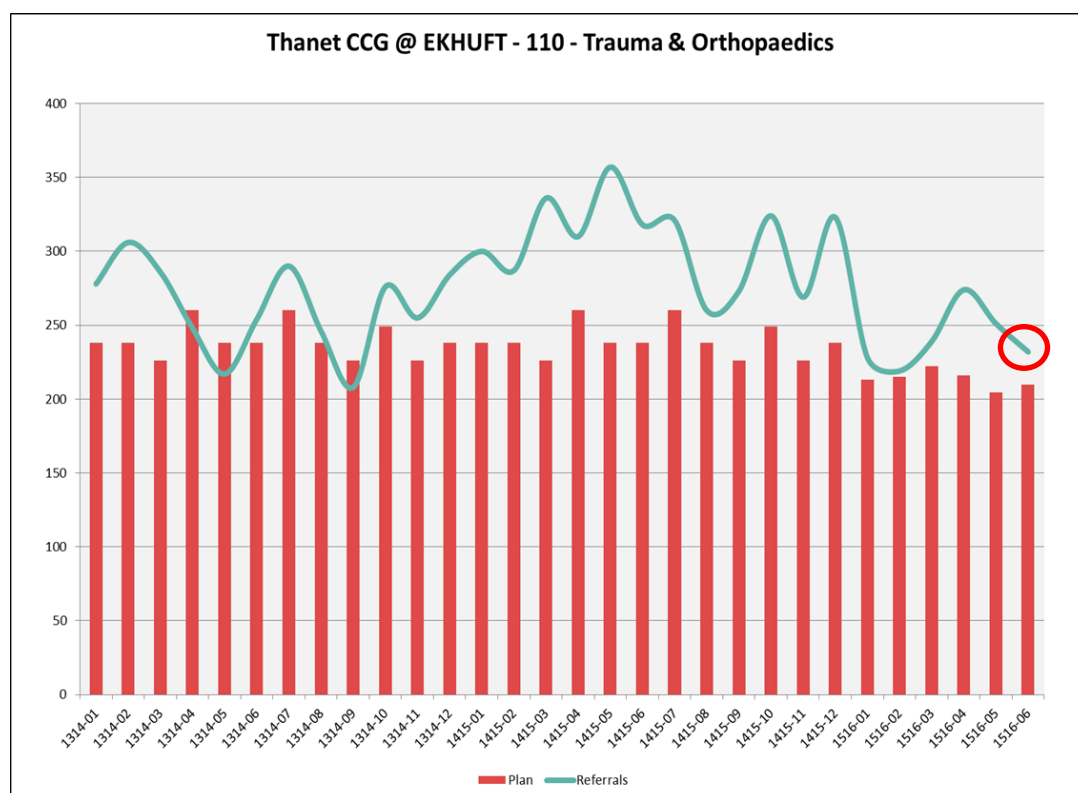
Referrals, including T&O, are substantially higher than plan.

A&E activity is close to plan level.

Trauma & Orthopaedics

Orthopaedic – Referrals

At month six there is waiting list growth comprising largely of those patients waiting between 4-9 weeks for an appointment. This is primarily due to the reduction in activity during August and does not appear to be due to GP referrals. Low August outturn is a common occurrence as leave is often taken during this particular summer period. As such activity is expected to increase though September, as was also seen last year.



	Actual	Plan	Variance	% Variance
Current Month	232	210	22	10.71%
Year to Date	1443	1280	163	12.78%

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The table below shows those practices with the greatest referral rates per 10,000 population to the orthopaedic services at EKHUFT.

Referral rates detailed in red at month six highlight those practices experiencing an increase in referrals to the Trust since the previous month. As anticipated most practices have seen an increase in September following the usual August lull as clinicians and patients often use this period to take leave.

Despite being one of the practices submitting the least number of orthopaedic referrals to EKHUFT each month, Union Row Surgery has one of the highest referral rates per 10,000 population in comparison to its peer practices.

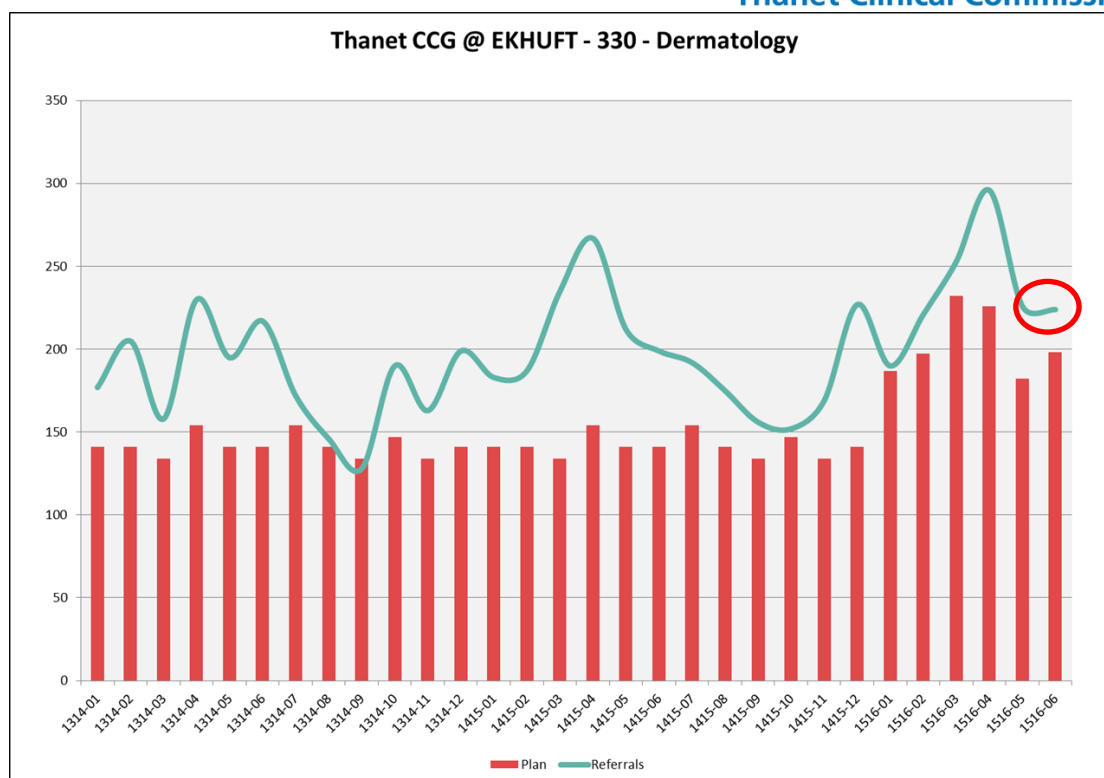
110 - Orthopaedics		Actual Referrals					
Practice Name	Referrals per 10,000 (weighted)	M1	M2	M3	M4	M5	M6
G82649 - Union Row Surgery	37	19	18	19	16	13	16
G82650 - Mocketts Wood Surgery	33	43	54	57	58	48	53
G82107 - Minster Surgery	31	49	32	36	37	45	51
G82796 - Albion Road Surgery, The	30	24	20	21	19	15	22
G82020 - Grange Practice, The	24	58	51	64	73	72	69
G82046 - Summerhill Surgery	24	30	40	26	31	29	31
G82066 - Northdown Surgery	21	49	53	48	63	48	42
G82064 - Dashwood House	15	24	44	46	43	22	35
G82812 - Wickham Surgery	15	5	7	11	7	9	11
G82150 - Newington Road Surgery	15	29	30	33	37	27	35
G82105 - Bethesda Medical Centre	14	63	65	74	66	62	48
G82210 - Osborne Road Surgery	14	5	6	10	5	11	6
G82126 - East Cliff Medical Practice	13	53	54	62	81	42	55
G82219 - St Peter'S Surgery	13	14	15	19	32	20	23
G82052 - Limes, The	12	38	47	57	62	46	47
G82079 - Westgate Surgery	11	38	28	45	42	37	32
G82810 - Garlinge Surgery	10	15	17	16	11	16	19
G82666 - Birchington Medical Centre	6	35	42	51	40	46	37
G82769 - Cecil Square Surgery	4	7	5	8	6	4	5

Dermatology

Dermatology – Referrals

Primary care referrals into EKHUFT's dermatology service reached their peak in month four which saw 296 patients referred in to the Trust. Levels have since reduced by approximately thirty patients per month, but in totality still remain at levels greater than plan as has been seen consistently to date throughout 2015/16.

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	Actual	Plan	Variance	% Variance
Current Month	224	198	26	13.01%
Year to Date	1410	1223	187	15.30%

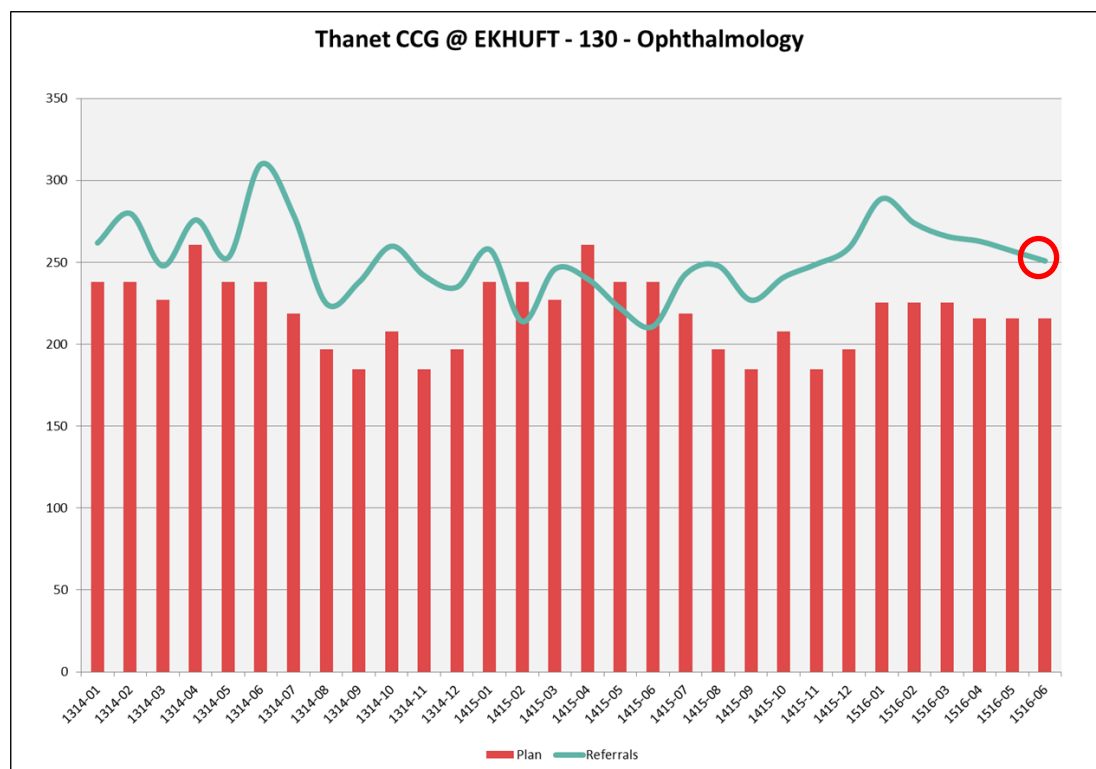
The practices leading the high pressure demand on the service are Mocketts Wood Surgery and Albion Road Surgery, with rates of all Thanet practices shown in the following table:

330 - Dermatology		Actual Referrals					
Practice Name	Referrals per 10,000	M1	M2	M3	M4	M5	M6
G82650 - Mocketts Wood Surgery	35	23	28	26	15	27	24
G82796 - Albion Road Surgery, The	25	5	9	2	9	6	7
G82666 - Birchington Medical Centre	24	26	33	34	43	32	24
G82810 - Garlinge Surgery	24	10	5	10	5	9	5
G82812 - Wickham Surgery	20	3	2	3	0	5	5
G82126 - East Cliff Medical Practice	19	33	25	24	33	33	31
G82649 - Union Row Surgery	17	10	5	4	10	6	3
G82079 - Westgate Surgery	16	15	29	22	32	18	20
G82066 - Northdown Surgery	15	16	16	35	21	13	15
G82210 - Osborne Road Surgery	14	4	3	4	8	3	5
G82105 - Bethesda Medical Centre	13	24	20	23	31	18	24
G82064 - Dashwood House	13	13	14	23	28	13	22
G82107 - Minster Surgery	12	6	19	12	20	13	8
G82020 - Grange Practice, The	12	13	15	26	30	12	23
G82046 - Summerhill Surgery	11	9	10	15	16	12	18
G82219 - St Peter'S Surgery	11	6	7	6	11	12	2
G82052 - Limes, The	10	13	15	15	20	21	14
G82150 - Newington Road Surgery	10	9	13	15	13	16	12
G82769 - Cecil Square Surgery	0	0	0	0	5	1	1

Ophthalmology

Ophthalmology – Referrals

Whilst ophthalmology referrals have seen a gradual reduction through 2015/16, total levels still remain significantly greater than plan.



	Actual	Plan	Variance	% Variance
Current Month	251	216	35	16.28%
Year to Date	1600	1324	276	20.86%

The table below details GP practices within Thanet CCG and their level of referrals into EKHUFT's ophthalmology service. The Albion Road Surgery is a distinct outlier in terms of ophthalmology referrals per 10,000 population at almost double the rate of any other Thanet practice.

Thanet Clinical Commissioning Group

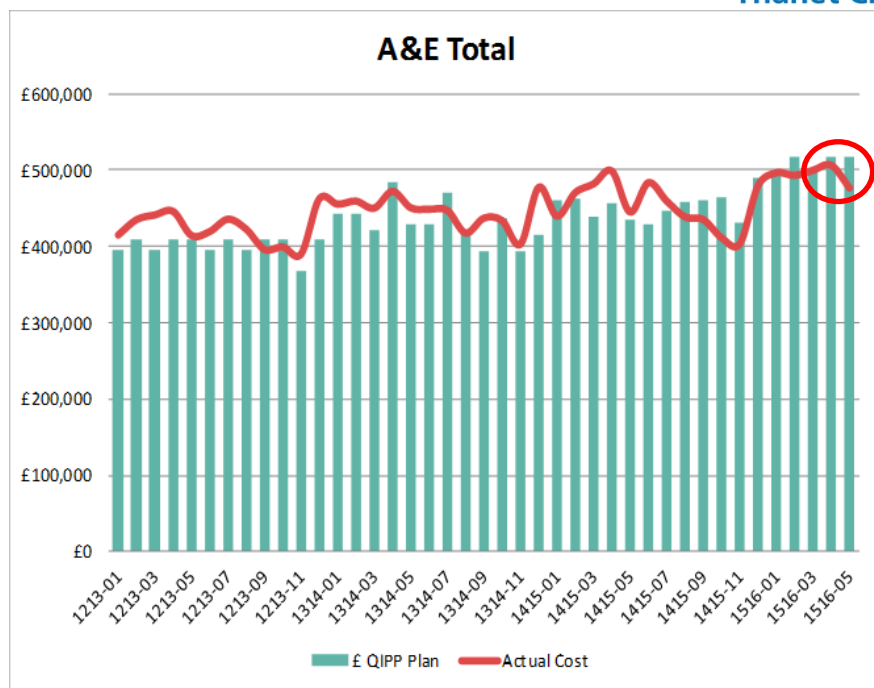
130 - Ophthalmology		Actual Referrals					
Practice Name	Referrals per 10,000	M1	M2	M3	M4	M5	M6
G82796 - Albion Road Surgery, The	61	19	15	21	15	11	9
G82219 - St Peter'S Surgery	33	19	23	15	10	15	17
G82650 - Mocketts Wood Surgery	29	27	36	27	24	20	22
G82649 - Union Row Surgery	23	12	5	3	14	4	17
G82066 - Northdown Surgery	22	45	26	40	31	28	27
G82666 - Birchington Medical Centre	22	43	33	46	41	34	33
G82046 - Summerhill Surgery	21	25	17	21	23	23	15
G82079 - Westgate Surgery	20	27	32	37	40	30	25
G82020 - Grange Practice, The	20	34	54	47	36	37	43
G82810 - Garlinge Surgery	19	13	9	17	16	15	17
G82064 - Dashwood House	18	25	13	27	28	21	17
G82107 - Minster Surgery	18	26	18	27	30	25	39
G82105 - Bethesda Medical Centre	18	52	53	35	47	40	38
G82126 - East Cliff Medical Practice	17	52	40	56	46	48	42
G82812 - Wickham Surgery	15	3	10	3	5	4	3
G82150 - Newington Road Surgery	15	25	21	26	21	17	15
G82769 - Cecil Square Surgery	13	3	1	0	2	2	3
G82052 - Limes, The	12	32	34	31	24	35	29
G82210 - Osborne Road Surgery	9	6	4	5	9	3	3

Accident & Emergency

Attendances to accident and emergency by Thanet CCG patients have fallen below contractual planned levels, broadly in line with the trends seen in recent months to date. The practices with the greatest number of attendances to the A&E department at EKHUFT are as listed in the table below.

GP Practice	Month 5 - August	
	Attendances	Finance
The Bethesda Medical Centre	500	£60,307
The Limes Medical Centre	374	£43,345
Northdown Surgery	349	£42,899
East Cliff Practice	327	£39,797
The Grange Medical Practice	303	£36,302

The year-end forecast is anticipating Thanet CCG to under-perform against their annual plan by £-92k. Year to date performance is detailed in the following chart.



Thanet Clinical Commissioning Group

Report to:	Governing Body	Agenda item:	4.5.1
Date of meeting:	8 th December 2015		
Title of Report:	Integrated Community Equipment Services		
Status:	Note		
Board Sponsor:	Sue Martin, Company Secretary		
Author:	Sue Martin, Company Secretary		
Appendices:	None		

1	Purpose
1.1	To inform GB members that the contract for delivery of Integrated Community Equipment Services (ICES) has been awarded to Nottingham Rehabilitation Services Limited.
2	Background
2.1	Having an effective community equipment provision will be key to each CCG's strategy of providing more care in the community and closer to home. Although not a huge budget, an effective service can make a critical difference to people's ability to stay in their home.
2.2	Kent County Council and the 7 Kent CCGs agreed to procure jointly the provision of community equipment, building on the current arrangements for jointly procuring certain equipment. The specification covers all community equipment which may be needed for social care and health purposes. There is a health budget, a social care budget and a joint health and social care budget.
2.3	KCC and the CCGs redesigned the specification for the service. The contractor will be required to source appropriate equipment, supply and install it, maintain it, collect it at the end of its use and recycle it wherever possible.

Author: Sue Martin	Version: 1
Sponsor: Sue Martin	Date: 1 December 2015
Agenda no: 4.5.1	Page 1 of 2

3	Summary
3.1	The Quality and Operational Leadership Team gave in principle approval to the Accountable Officer to sign the contract with NRS on the CCG's behalf. The contract has now been finalised and signed and the name of the successful contractor is in the public domain.
3.2	The new contractor, NRS, took over responsibility for delivery of the contract from 1 st December. Communications to stakeholders and the public have been developed to ensure that people are clear about how the new arrangements will operate.
3.3	The total health budget for the community equipment store for adults and children, based on last year's activity, is in the order of £7m, £1.5m of which is for the integrated community equipment service. These costs will be spread across all 7 CCGs based on their usage.
4	Recommendations
4.1	The Governing Body is asked to note that the Integrated Community Equipment Services contract has been awarded to Nottingham Rehabilitation Services Limited.

Author: Sue Martin	Version: 1
Sponsor: Sue Martin	Date: 1 December 2015
Agenda no: 4.5.1	Page 2 of 2

Thanet Clinical Commissioning Group

Report to:	Thanet CCG Governing body	Agenda item:	4.5
Date of Meeting:	8 th December 2015		
Title of Report:	Update on Procurement for IAPT		
Is this report for internal distribution only?	Yes		
Author:	Linda Caldwell		
Board Sponsor:	Andy Walton/Jihad Milasi		
Status:	Note		
Appendices	None		

1. Purpose of Paper

The purpose of the paper is to provide the Governing Body with an update on the re-procurement of IAPT services.

2. Introduction/Background

As agreed at CLT in April 2015 the current IAPT contracts were extended until the end of December 2015 to enable a re-procurement process to be undertaken. That process has now been completed and the providers of the new contract have been notified and the new contracts will commence on 1 January 2016.

There will be four IAPT providers per CCG. For Thanet CCG the three existing providers, Dover Counselling Centre, ThinkAction (formally KCA) and Insight, have been awarded contracts. The fourth provider is University Medical Centre, which has previously only had a contract in Canterbury, but will be working closely with Dover Counselling Centre to deliver a service in Thanet.

The process included:

- A market engagement event.
- Evaluation of provider bids.
- Presentation from providers.

A range of individuals were involved in the evaluation process, including

- GPs.
- Quality leads.
- HR.
- Commissioning leads.
- Service users.

Thanet Clinical Commissioning Group

The service specification has been revised to ensure there are a range of therapies available and that the service can be accessed in a variety of ways, including face to face and via telephone and will be provided in a range of venues, which could include the patient's own home if this is more appropriate for the patient. The age at which people can access the service has also been lowered to 17.

The payment structure has been reviewed and simplified and a number of financial penalties will be introduced, particularly in relation to access targets which are those areas where the CCG will be scrutinised by NHSE.

Other areas which will be subject to financial penalties include:

- Incomplete treatments.
- Recovery rates.
- Split between step 2 and step 3 (east Kent is currently an outlier).

Meetings have been held with all the providers to discuss mobilisation plans to ensure services can be delivered in a seamless manner when the new contract commences.

3. Recommendation

The Governing Body is asked to note the outcome of the IAPT procurement.

4. Summary of Issues

IAPT contracts were extended until the end of December 2015 to enable a re-procurement process to be undertaken. That process has now been completed and the providers of the new contract have been notified and the new contracts will commence on 1 January 2016.

Four IAPT providers have been awarded the contract for Thanet CCG

- Dover Counselling Centre,
- ThinkAction (formally KCA)
- Insight
- University Medical Centre

5. Risks

There is a risk that the move to the new contract could impact on the provider's ability to deliver the constitutional targets. However, as Thanet will retain all three of its existing providers, the risk should be minimal.

Report to:	Thanet Governing Body	Agenda item:	5.2.1a
Date of Meeting:	8 December 2015		
Title of Report:	Review of Committee Terms of Reference		
Author:	Sue Martin		
Board Sponsor:	Sue Martin, Company Secretary		
Status:	Approval		
Appendices	Appendix 1: Revised terms of reference for Governance and Risk Committee		

1.	Purpose of the Paper
To ask the Governing Body to approve the Terms of Reference for the Governance and Risk Committee.	

2	Discussion
<p>The Constitution requires that the terms of reference of each Committee are reviewed and approved annually. The terms of reference of Governance and Risk Committee has been reviewed by the Committee and are now put forward to the Governing Body for approval. No significant changes to the terms of reference are being requested.</p> <p>For the Remuneration Committee, the reference to meeting jointly with Thanet has been removed.</p> <p>The Remuneration Committee, Clinical Leadership Team and the Quality and Operational Leadership Team will be asked to review their terms of reference by the end of the financial year.</p>	
3.	Recommendations
<p>The Governing Body is asked to</p> <ul style="list-style-type: none"> • Approve the revised terms of reference for the Governance and Risk Committee • Note that Remuneration Committee, Clinical Leadership Team and the Quality and Operational Leadership Team will be asked to review their terms of reference by the end of the financial year. 	

Author: Sue Martin, Company Secretary	Version:1
Sponsor: Sue Martin	Date:8 December 2015
Agenda no: 5.2.1a	Page 1 of 1

GOVERNANCE AND RISK COMMITTEE

NHS Thanet Commissioning Group

Terms of Reference

Constitution

The Clinical Commissioning Group's (CCG) Governing Body (~~"the Group"~~) hereby resolves to establish a committee of the Governing Body known as the Governance and Risk Committee. The Committee is established in accordance with Thanet Clinical Commissioning Group's Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the group and shall have effect as if incorporated into the CCG's constitution. The Committee is a non-executive committee of the Governing Body and has no executive powers other than those specifically delegated in these Terms of Reference.

Purpose

The purpose of the Governance and Risk Committee is to assist Thanet CCG to deliver its responsibilities for the conduct of public business, and for the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Governing body that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards;
- Public money is safeguarded and properly accounted for;
- Financial Statements are prepared in a timely fashion, and give a true and fair view of the financial position of Thanet CCG for the period in question;
- Affairs are managed to secure economic, efficient and effective use of resources;
- Reasonable steps are taken to prevent and detect fraud and other irregularities.

Responsibilities

The responsibilities of the Committee can be categorised as follows:

Governance, Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's Group's activities (clinical and non-clinical) including partnerships that support the achievement of the CCG's Groups objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit statement~~–~~, external audit opinion or other appropriate independent assurances, prior to endorsement by the CCGGroup;
- the structures, assurance processes and responsibilities for identifying and managing key risks facing the CCGGroup, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; and

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, Counter Fraud and Security Management Service and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from senior employees and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Governing Body. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework;
- considering the major findings of internal audit work (and the Executive senior team's response) and ensuring co-ordination between the internal and External Auditors to optimise audit resources;
- Facilitating/ensuring access to all information required to undertake effective audit, including from third party providers (such as commissioning support and lead / specialist commissioners);
- Supporting implementation of recommendations arising from the findings of audit reviews.
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the Group; and
- an annual review of the effectiveness of internal audit.

External audit

The Committee shall review the work and findings of the External Auditors and consider the implications and the senior team's responses to their work. This will be achieved by:

- consideration of the performance of the External Auditors, as far as the rules governing the appointment permit;
- discussion and agreement with the External Auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy;

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- discussion with the External Auditors of their local evaluation of audit risks and assessment of the CCGGroup and associated impact on the audit fee;
- review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCGGroup and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;
- overseeing the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, making a recommendation to the Governing Body with respect to the appointment of the auditor;
- developing and implementing a policy on the engagement of the external auditor to supply non-audit services; and
- considering the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal.

Financial reporting

The Committee shall monitor the integrity of the financial statements of the CCGroup and any formal announcements relating to the CCGroup's financial performance.

The Committee shall ensure that the systems for financial reporting to the CCGGroup, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCGGroup.

The Committee shall review the Annual Report and financial statements before submission to the Governing Body and the CCGGroup, focusing particularly on:

- the wording in the governance statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies, practices and estimate techniques;
- major judgemental areas; and significant adjustments resulting from the audit;
- unadjusted mis-statements in the financial statements;
- significant judgements in preparing of the financial statements;
- significant adjustments resulting from the audit;
- Letter of representation; and
- qualitative aspects of financial reporting.

Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the CCGGroup and consider the implications to the governance of the organisation.

These will include but not be limited to:

Thanet Clinical Commissioning Group

- any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority); and
- professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies),

In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Governance and Risk Committee's own scope of work.

Counter fraud

- 7.10—The Committee shall satisfy itself that the CCGGroup has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

Management

- 7.11 The Committee shall request and review reports and positive assurances from members of the Governing Body and senior employees on the overall arrangements for governance, risk management and internal control.
- 7.12 The Committee may also request specific reports from individual functions within the CCGGroup as they may be appropriate to the overall arrangements.

Authority

The Committee is authorised by the CCG Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any CCG Committee or employee and all employees are directed to cooperate with any request made by the Committee.

The Committee is authorised by the CCG Governing Body to obtain external legal or other independent professional advice and to secure the attendance of advisers with relevant experience and expertise it is considers this necessary.

Membership

The membership of the Committee will be:

- Independent Lay Member on the Governing Body, with a lead role in overseeing key elements of governance, who will chair the Committee.
- Independent Lay Member of the Governing Body, with a lead role in overseeing patient and public engagement, who will be deputy chair of the committee
- Independent Secondary Care Doctor
- Up to two-co-opted independent members
- Independent Lay Member of the Governing Body of South Kent Coast CCG, with a lead role in overseeing key elements of governance

Thanet Clinical Commissioning Group

Quorum

A quorum shall be two (2) members, one of whom must be the chair or deputy chair of the Committee,).

Attendance

The Chief Financial Officer, Chief Nursing Officer, ~~CCG Company Secretary, Head of CCG Governance~~, the Head of Internal Audit, the Counter Fraud Specialist and representatives from External Audit shall normally attend meetings.

~~The Committee will meet privately. At least once a year the Group should meet privately~~ with the External and Internal Auditors without any managers present before each Committee meeting.

The ~~Accountable Officer and~~ Chief Operating Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Chief Operating Officer.

The Accountable Officer should be invited to attend and discuss at least annually with the Governance and Risk Committee when the Committee is considering recommending the Annual Governance Statement.

The Clinical Chair should be invited to attend and discuss at least annually with the Governance and Risk Committee when the Committee is considering the Annual Members' Report.

Reporting arrangements

The minutes of the Governance and Risk Committee shall be formally recorded and submitted to the CCG Governing Body. The Governance Lay member or Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or require executive action.

The Group will report to the CCG Governing Body annually on its work in support of the Governance Statement, specially commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the CCG and the integration of governance arrangements.

Administration

The ~~Company Secretary Head of CCG Governance~~, or nominated representative, shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairperson and committee members.

Frequency of meetings

Meetings shall be held at least four times per year, with additional meetings where necessary. The External Auditor shall be afforded the opportunity at least once per year to meet with the Committee without ~~members of the Governing Body~~ CCG officers present.

The Committee members shall be afforded the opportunity to meet at least once per year with no others present.

Review

These Terms of Reference will be reviewed on an annual basis or sooner if required with recommendations made to the CCG Governing Body for approval.

Thanet Clinical Commissioning Group

Report to:	Governing Body	Agenda item:	5.2.2a
Date of Meeting:	8 th December 2015		
Title of Report:	Serious Incident Review Group		
Is this report for internal distribution only?	No		
Author:	Maria Reynolds, Head of Quality, Tamsin Flint QI Lead and Tim Smith SI and Quality Officer		
Board Sponsor:	Sharon Gardner Blatch		
Status:	Decision		
Appendices	Appendix 1. SIRG Terms of reference. Appendix 2. Quality Assurance Checklist for Serious Incidents. Appendix 3 SIRG flowchart		

1. Purpose of Paper

Proposal to implement Serious Incident Review Group to support the Quality Committee in the review and closure of Serious Incidents

2. Introduction/Background

The role of the CCG as a commissioner is to gain assurance that incidents within our commissioned providers are properly investigated, that action is taken to improve clinical quality and that lessons are learnt to minimise the risk of similar incidents occurring in the future. The RCA should be robust and presented in a timely manner; it should be evaluated to gain assurance that learning and action plans will help to prevent recurrence.

The CCG must be able to demonstrate a clear and effective procedure for managing SI's in order to support quality assurance and the timely closure of investigations. NHS England's revised Serious Incident Framework in 2015

3. Recommendation

For the committee to agree to the implementation of a Serious Incident Review Group (SIRG).

4. Summary of Issues

To ensure that the CCGs have robust systems and processes in place to confirm assurance of the proportionate and robust scrutiny of Serious Incidents.

Implementation of a multi -disciplinary SIRG to support the CCG's closure process for SI's.

To assist the CCGs to deliver the statutory responsibilities for care quality, including the domains of safety, effectiveness and patient experience.

5.	Risks
A delay in the closure of Thanet Sis and subsequently a delay in actions and learning being embedded within provider organisations.	

6.	Appendices
Appendix 1. SIRG Terms of reference. Appendix 2. Quality Assurance Checklist for Serious Incidents. Appendix 3 SIRG flowchart	

PLEASE CONTINUE WITH YOUR REPORT ON THIS PAGE, IF NECESSARY

Author: Maria Reynolds, Head of Quality Thanet CCG	Date 8 th December 2015
Agenda no: 5.5.2a	Page 2 of 2

Serious Incident Review Group

Introduction

This paper sets out a proposal to review the current process for closing Serious Incidents (Sis) within Thanet CCG.

NHS England defines a Serious Incident as the following:

“Events in health care where the potential for learning is so great or the consequences to patients, families and carers, staff or organisation are so significant that they warrant using additional resources to mount a comprehensive response. Serious Incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisations ability to deliver ongoing healthcare.”

NHS England revised the Serious Incident (SI) Framework in March 2015. The purpose was to ensure the framework continues to be fit for purpose and supports the need to take a whole-system approach to quality improvement. The key simplifications implemented to support this approach were the following;

- Removal of the grading system.
- Introduction of the single 60 day timescale for all investigation reports to be completed.

The framework also endorses the application of the recognised system-based method for conducting investigations, commonly known as Root Cause Analysis (RCA). This is a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying cause(s) and environmental context in which the incident happened. It identifies how RCA utilises understanding of Human Factors and the Systems Approach to clarify the Root Cause(s) of the incident. This in turn enables actions to be targeted to reduce the risk: the probability of a similar incident occurring again in similar circumstances.

This framework provides guidance to ensure the CCG continues to promote and build on the fundamental purpose of patient safety investigation, which is to learn from incidents rather than apportion blame.

Purpose

The role of the CCG as a commissioner is to gain assurance that incidents within our commissioned providers are properly investigated, that action is taken to improve clinical quality and that lessons are learnt to minimise the risk of similar incidents occurring in the future. The RCA should be robust and presented in a timely manner; it should be evaluated to gain assurance that learning and action plans will help to prevent recurrence.

The CCG must be able to demonstrate a clear and effective procedure for managing SI's in order to support quality assurance and the timely closure of investigations.

The revised SI Framework is an opportunity for Thanet CCG to review its current process for reviewing and closing Serious Incidents and to consider the following, does the current process provide;

- The opportunity to scrutinise the investigations submitted for closure?
- Assurance that the current process for managing actions is robust.
- Support Thanet CCG's Quality Assurance Framework to drive up quality within providers?

Proposal

This paper sets out a proposal for an alternative process to support the Quality and Operational Leadership Team Committee (QOLT) to close Serious Incidents. This proposal does not intend to remove the accountability related to the closure of Serious Incidents from QOLT but to support, inform and direct the committee. The proposal is to implement a Serious Incident review group (SIRG). The SIRG would meet monthly prior to the Quality Committee to review all completed investigations and RCA's submitted to the CCG for closure. This group which will be multi-disciplinary to ensure robust scrutiny of Serious Incidents. The NHS E quality assurance checklist standard quality assurance checklist will be the tool used to assess whether the RCA meets the criteria and confirm that it provides adequate assurance in order to put forward to the Quality Committee to consider closure.

Membership

The suggested membership of this group is as follows;

- Clinical Lead (chair)
- Head of Quality
- SI and Quality Officer
- Designated Safeguarding Lead/ Children/ adults
- Lay member

Based on the review by the SIRG, one of the following decisions will be presented at the Quality Committee:

- The investigation and action plan are sufficient, the CCG can be assured that the risk of future incident has been eliminated or sufficiently mitigated against and therefore recommend the incident for closure.

- The investigation and action plan are insufficient and further information is required for the CCG to be assured that all contributory care/service delivery problems have been identified and/or appropriate actions are taking place to prevent recurrence and therefore recommend the incident not for closure.
- All completed SI investigations and RCA's will continue to be submitted to the QOLT along with the SI sub-group's recommendation.
- The QOLT will then review and decide whether the SI can be closed. If further information is required before agreeing closure, then concise feedback will be provided for the quality team to follow up with the provider.

Next steps

- QOLT to feedback/decide on principle of having a SI sub-group
- QOLT to feedback on SI sub-group Terms of Reference

SERIOUS INCIDENT REVIEW GROUP

Terms of Reference

Appendix 1

Introduction

- 1.1. The Serious Incident Review Group (SIRG) is established in accordance with the Terms of Reference of the NHS Thanet Clinical Commissioning Groups (CCG) Quality and Operational Leadership Committee (QOLT).
- 1.2. The Group is authorised by the Governing Body, via the QOLT, to act within these terms of reference. All members and employees of the CCGs are directed to co-operate with any request made by the group.
- 1.3. Nothing in these Terms of Reference delegates, or purports to delegate, the exercise of the statutory functions of the CCGs to the group. The role of the group is to assist and advise the QOLT.

2. Purpose

- 2.1. To support the QOLT in their decision making by presenting a summary of the recommendations and comments of the members of the SIRG in a SMART way
- 2.2. To ensure that the CCGs have robust systems and processes in place to confirm assurance of the proportionate and robust scrutiny of Serious Incidents. The aim of which is to minimise the risk of recurrence of a similar incident and to assist the CCGs to deliver the statutory responsibilities for care quality, including the domains of safety, effectiveness and patient experience.
- 2.3. The SIRG facilitates the review of Serious Incidents within 20 working days of receipt of a request for closure in accordance with the Serious Incident Framework (NHSE 2015).

3. Membership

- 3.1. The Group shall be appointed with agreement by the CCGs and may include individuals who are not on the Governing Body.
- 3.2. The Group will be chaired by the Head of Quality or Clinical Lead.

3.3. The membership of the group shall consist of:

- Head of Quality
- Clinical Lead
- Designated Safeguarding Lead for Adults
- Designated Safeguarding Lead for Children
- Lay member
- Serious Incident and Quality Officer

By invitation:

- Representative from commissioning as appropriate i.e. Mental Health, Children's.
- Infection Prevention Control Specialist Nurse

4. Administration

4.1. Recommendations to the Quality Committee and feedback to providers will be recorded by the Serious Incident and Quality Officer or other member of the Quality team.

5. Quorum

5.1. In order for the group to be quorate there should be representation from at least three members to include:

- Clinical Lead
- Head of Quality /Nurse
- Designated Safeguarding Lead

6. Frequency of meetings

6.1. Meetings shall be held monthly at least 10 working days prior to the CCGs Quality Committee(s) to allow for the necessary documents to be prepared and available for circulation with the agenda prior to the Quality Committee.

7. Remit and responsibilities of the Group.

The Group will:

- 7.1. Receive, review and scrutinise the investigation reports (and supporting evidence) into Serious Incidents occurring in commissioned services in accordance with the NHSE Serious Incident Framework (2015).
- 7.2. Review incidents against the Quality Assurance checklist (Appendix 1) prior to the SIRC and receive a verbal précis, in an SBAR format, delivered by the CCG Serious Incident Quality Officer, summarising the incident, investigation and actions planned/completed.

- **Situation:** brief description of the incident and outcome.
- **Background:** relevant patient history and context.
- **Assessment:** Investigation findings – main factors contributing to the outcome and any incidental learning identified which did not contribute to the outcome.
- **Recommendations:** explanation of actions completed / planned to mitigate recurrence.

7.3. Discuss, seeking further clarification from providers as appropriate, and agree a summary of the groups review utilising the Quality Assurance checklist to provide a rationale in relation recommendations as follows:

- Closure recommended: full assurance of a robust investigation, action plan and quality improvement
- Closure recommendation pending: full assurance not available at the SIRG meeting but can be submitted by the provider within 5 working days to enable a closure recommendation to be submitted to the Quality Committee. If the further assurance is not forthcoming within the 5 days then Closure not recommended would be applied. This mechanism aims to support providers to facilitate improved timeframes for the closure of Serious Incidents.
- Closure not recommended: incomplete or absence of assurance of a robust investigation, action plan and quality improvement.

7.4. Formally submit recommendations to the Quality Committee as follows:

- Closure recommended: fully assured of a robust investigation and action plan. Quality improvement evidenced by compliance with the Serious Incident Quality Assurance Checklist. The Quality Committee will receive the investigation report, action plan, supporting evidence and summary of SIRG review within the Committee papers. To further clarify the rationale for the closure recommendation, a verbal précis of the incident, investigation, actions and SIRG rationale for the closure recommendations will be delivered to the committee in an SBAR format.
- Closure not recommended: incomplete or absence of assurance of a robust investigation and action plan. Quality improvement not (fully) evidenced due to absence of or incomplete compliance with the Serious Incident Quality Assurance Checklist. The committee will receive the summary of the SIRG review within the Committee papers.

8. Notice of meetings

- 8.1. Meetings of the Group, other than those regularly scheduled as above, shall be summoned by the Chair.
- 8.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed and supporting papers, shall be forwarded to the members of the Group no later than five working days before the date of the meeting.

9. Conduct of the Group

- 9.1. The terms of reference of the Group shall be reviewed by the Quality Committee(s) at least annually.

Appendix 2

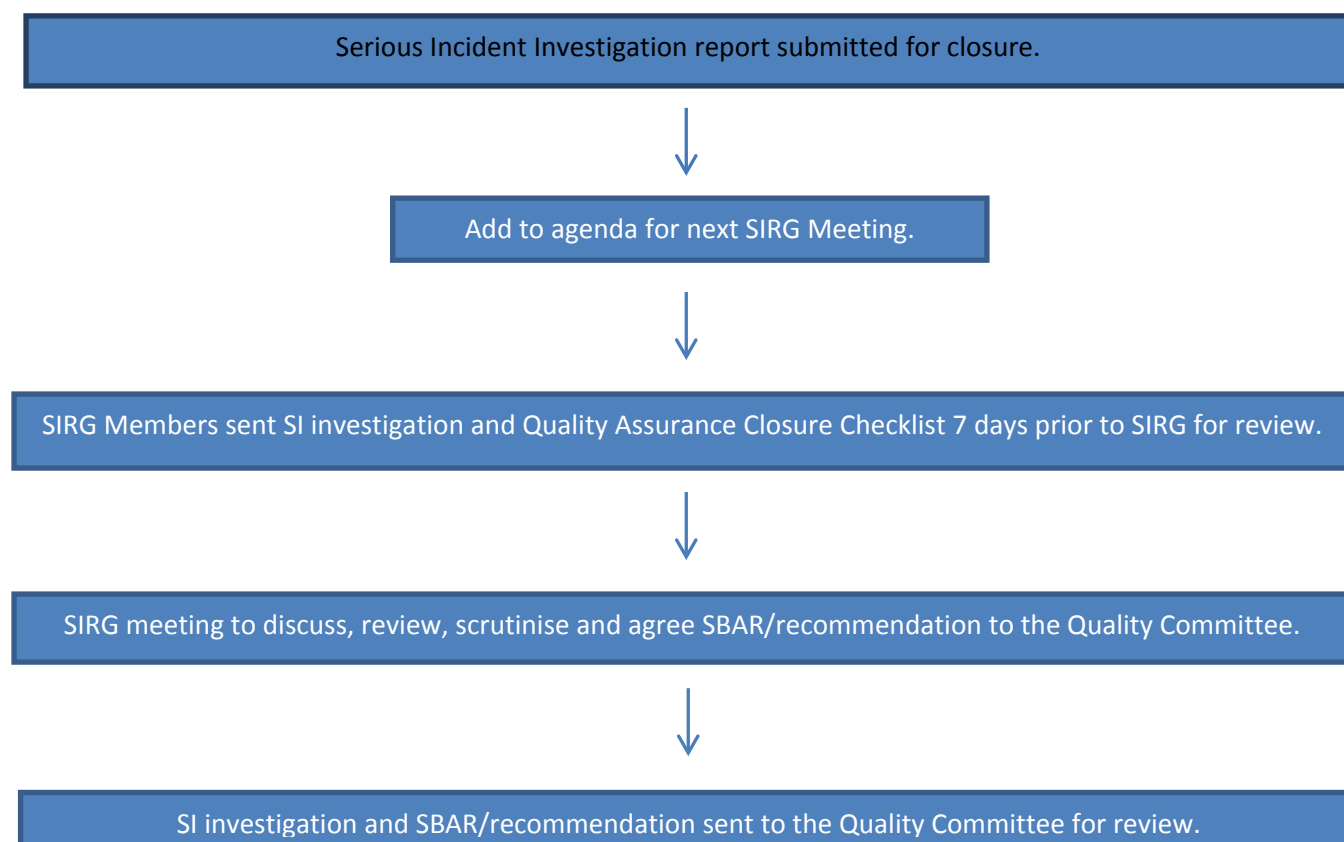
Quality assurance (closure) checklist

Provider:		STEIS No	
CCG:			
Documents reviewed:		Date:	
Phase of investigation	Element	Assured?	If no, was there a robust rationale and that prevents this affecting the quality of the investigation?
For Quality Team Only			
Set up/ preparation	Is the Lead Investigator appropriately trained?	Yes/no	
	Was there a pre-incident risk assessment?	Yes/no	
	Did the core investigation team consist of more than one person?	Yes/no	
	Were national, standard NHS investigation guidance and process used?	Yes/no	
For all SIRG Members			
Gathering and mapping	Was the appropriate evidence used (where it was available) i.e. patients notes/records, written account?	Yes/no	
	Were interviews conducted?	Yes/no	
	Is there evidence that those with an interest were involved (making use of briefings, de-briefings, draft reports etc.)?	Yes/no	
	Is there evidence that those affected (including patients/staff/ victims/ perpetrators and their families) were involved and supported appropriately?	Yes/no	
	Is a timeline of events produced?	Yes/no	

	Are good practice guidance and protocols referenced to determine what should have happened?	Yes/no				
	Are care and service delivery problems identified? (This includes what happened that shouldn't have, and what didn't happen that should have. There should be a mix of care (human error) and service (organisational) delivery problems)	Yes/no				
	Is it clear that the individuals have not been unfairly blamed? (Disciplinary action is only appropriate for acts of wilful harm or wilful neglect)	Yes/no				
Analysing information	Is there evidence that the contributory factors for each problem have been explored?	Yes/no				
	Is there evidence that the most fundamental issues or root causes have been considered?	Yes/no				
Generating solutions	<p>Have strong (effective) and targeted recommendations and solutions (targeted towards root causes) been developed?</p> <p>Are actions assigned appropriately?</p> <p>Are the appropriate members i.e. those with budgetary responsibility involved in action plan development?</p> <p>Has an options appraisal been undertaken before final recommendation made?</p>	Yes/no				
Throughout	Is there evidence that those affected have been appropriately involved and supported?	Yes/no				
Next steps	Is there a clear plan to support implementation of change and improvement and method for monitoring?	Yes/no				
Overall assessment and feedback						
SIRG / Quality review findings	Closure Recommended		Recommendation Pending		Closure not recommended	
Reviewer			Date			

Quality Committee decision	Closure agreed Closure not agreed <i>(delete as applicable)</i>	Date	
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Flowchart



Thanet Clinical Commissioning Group

Report to:	Governing Body	Agenda item:	5.3a
Date of meeting:	8 th December 2015		
Title of Report:	Information Governance Toolkit Update		
Status:	Note		
Board Sponsor:	Sue Martin, Company Secretary		
Author:	Sue Martin, Company Secretary		
Appendices:	Change notice		

1	Purpose
1.1	To inform GB members of the additional requirements which the CCG must meet this year in order to achieve Level 2 compliance with the Information Governance (IG) Toolkit.
2	Background
2.1	Achieving at least Level 2 compliance with the IG toolkit annually is a requirement for the CCG, on which we have to report in our Annual Governance Statement and on which the CCG is audited.
2.2	There are some new requirements which we need to draw to the GB's attention.
3	Summary
3.1	Responsibility for Information Governance sits with the Governing Body. Reports on progress to achieving compliance are made to the Governance and Risk Committee.
3.2	Version 13 of the IG Toolkit was published in May 2015, setting out some new requirements (attached). These include: <ul style="list-style-type: none"> To strengthen the leadership around Information Governance in accordance with the requirements of Caldicott 2, ensuring that the Caldicott Guardian is appropriately trained to meet the organisation's assessed IG needs

Author: Sue Martin Company Secretary	Version:1
Sponsor: Sue Martin	Date:8 December 2015
Agenda no: 5.3a	Page 1 of 2

- Changes to the requirements for IG training, including awareness of guidance around treating confidentiality with respect and duty to share information for care purposes
- Staff access to confidential personal information must be monitored and audited.
- Inclusion of information governance responsibilities in the NHS Standard Contract

3.3 The CCG will be doing its own submission to the IG toolkit, rather than via the CSU. All IG policies will need to be reviewed to ensure they meet the CCG's current needs. The internal auditors will be undertaking a review of the CCG's preparedness for submission and identifying areas for improvement.

3.4 The Caldicott Guardian will continue to be Dr Tony Martin. The Senior Information Risk Owner is Jonathan Bates and the Company Secretary is responsible for completing the Toolkit requirements.

4 Recommendations

4.1 The Governing Body is asked to note:

- the new requirements of the Toolkit;
- the CCG's plans to achieve Level 2 compliance; and
- the responsibilities of senior staff for achieving compliance.

Information Governance Toolkit

Version 13

Change Release Note

Issued 29th May 2015

By External Information Governance Delivery Team

Contents

1	Overview of Changes	3
1.1	Summary of Changes to Functionality for IGT V13 Release	3
1.2	Summary of Changes to Requirements for IGT V13 Release.....	4
2	Change Control Notice	5
3	Summary of IGT V13 Requirement Sets.....	6
4	Publication of IG Toolkit Assessment Deadlines	7
5	Implementation Guidance	8
5.1	IG Toolkit User Guides	8
5.2	Requirement Guidance	8
5.3	Helpdesk	8

1 Overview of Changes

This release note covers changes from version 12 to 13 of the Information Governance Toolkit.

1.1 Summary of Changes to Functionality for IGT V13 Release

New 'Auto closure' functionality for incidents recorded on the IG Toolkit Incident Reporting Tool and not closed within the advised timeframe specified within the HSCIC ['Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation'](#) Guidance. An overview of how this works below:-

- If your organisation has reported or recorded any incidents (of any level of severity) via the IG Toolkit and has not closed or updated the incident within 80 days (from the date the incident was entered on the tool) the system will send relevant contacts an email notifying that the incident(s) will be automatically closed in 10 days' time.
- This gives the contacts time to update or close the incident or, if no action is taken, the system will automatically close the incident.
- When incidents are automatically closed another notification email is sent to inform contacts of the closure(s).
- The auto closed incident report may be re-opened if necessary or updated before the date indicated for closure within the notification email. This will maintain the incident record as 'open' and still under investigation.
- There are also options for Organisations to Close the incident themselves before the indicated closure date, withdraw or mark the incident as duplicate if this is appropriate.
- An audit trail of the warning notification email and confirmation that incidents have been auto closed can be found at the bottom of the incident details page under 'Auto closure notification email details' section.
- See the relevant [News](#) item or see the [Incident Reporting Tool User Guide](#) for further detail, available from the Help page of the website.
- Consideration should also be given to the quality, accuracy and appropriateness of level 2 closed incident reports and the HSCIC commitment to publication of information as specified within the IG Toolkit Incident Reporting Publication Statement found on the IG Toolkit ['Publication'](#) page.

1.2 Summary of Changes to Requirements for IGT V13 Release

1. Various essential updates made to the content where needed, such as removal of outdated references to deprecated standards, guidance, knowledge base, publications etc. and in response to issues raised by IGT users.
2. The [Area Team/Region/Hosted Body](#) view has been archived by the request of NHS England as Area Teams no longer complete individual IG Toolkit assessments, they are included as part of the NHS England IG Toolkit assessment.
3. Further and more significant changes made in line with the Government response to the Caldicott 2 report and changes in the NHS England contract. Requirement attainment level criteria and evidence are aligned with the changes to the requirement statements listed below:

Requirement 201 and CSU 201

New changes to Requirement Statement:

The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner.

Requirement 202 and CCG 232

New changes to Requirement Statement:

Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected.

Requirement 203

New changes to Requirement Statement:

Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use.

Requirement 206, CSU 206 and CCG 235

New changes to Requirement Statement:

Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request.

Further details on changes featuring in v.13 are noted within the Change Control Notice document referenced below.

2 Change Control Notice

Further detail of the version 12 to 13 changes can be found in the ['IGT Version 12 to 13 Change Control Notice \(CCN\)'](#) document under columns labelled 'Guidance changes' and 'Knowledgebase Changes'.



IGT V12 to V13
CCN-Final_Publish_Ma

3 Summary of IGT V13 Requirement Sets

The table below summarises the number of requirements in each organisation view. Detail within the 'IGT V12 to 13 Change Control Notice' document also maps which requirements are relevant to which organisation types. See the Organisation Types guidance for further detail on the definition of the types available on the Help page - [Organisation Types](#)

No. of Requirements	Acute Trust	Ambulance Trust	Any Qualified Provider: Clinical Services	Any Qualified Provider: Non-Clinical Services	Commercial Third Party	Commissioning Support Unit	Community Health Providers	Clinical Commissioning Groups	Community Pharmacy / Dispensing Appliance	Dental Practice	Eye Care Service	Area Teams /Regions/Hosted Bodies	Data Service for Commissioners
Version 12	45	35	34	19	17	41	39	28	16	16	16	36	36
Version 13	45	35	34	19	17	41	39	28	16	16	16	Archived	36
Abbreviation used on supporting spreadsheet	ACUTE	AMT	AQP: CLIN	AQP: NONCLIN	CTP	CSU	CHP	CCG	DAC	DEN	EYECARE	AT/R/HB	DSC
No. of Requirements	Mental Health Trust	NHS Business Partner	NHS Business Services Authority	Prison Health	Secondary Use Organisation	Voluntary Sector Organisations	Health and Social Care Information Centre	NHS England	Public Health England	Local Authority			
Version 12	45	29	34	18	30	19	36	36	41	28			
Version 13	45	29	34	18	30	19	36	36	41	28			
Abbreviation used on supporting spreadsheet	MHT	NHSBP	NHSBSA	PH	SUO	VOLUNTARY	HSCIC	NHSE	PHE	L.A.			

4 Publication of IG Toolkit Assessment Deadlines

The deadlines for IG Toolkit publication remain unchanged:

- **ALL** NHS organisations (including Foundation Trusts, CCGs, CSUs, general practices, dental practices, NHS eyecare services and community pharmacies/DACs), and the National Bodies listed below must publish their version 13 IG Toolkit assessment by **31 March 2016**.
- All other organisation types should publish no later than 31 March 2016 or by the date their annual review is due if the assessment is in support of an NHS Standard Contract /Agreement or section 251 application renewal.

Certain healthcare Commissioners and Providers are additionally subject to 3-stage reporting, as displayed below. This includes the following organisation views on IG Toolkit V13:

- Acute Trust
- Ambulance Trust
- Mental Health Trust
- Commissioning Support Unit
- Community Health Provider
- NHS England
- Public Health England
- Health and Social Care Information Centre

Baseline	31 st July 2015
Performance Update	31 st October 2015
Final	31 st March 2016

5 Implementation Guidance

5.1 IG Toolkit User Guides

The link below allows new users to access a number of supporting guidance documents which can be found on the Help page at <https://www.igt.hscic.gov.uk/help.aspx>. These include how to complete the online IG Toolkit assessment, how to produce an improvement plan, how to register, how to contact the helpdesk for advice etc.

When logged into the Toolkit the 'Resources' menu provides downloadable versions of the requirements which can be printed out or exported into a spreadsheet format to assist local implementation and planning. A knowledge base directory and glossary is also available from this area and may be helpful when producing evidence to support IG compliance.

5.2 Requirement Guidance

Each requirement contains a general guidance section and attainment level criteria, both of which are useful for understanding and clarifying what the organisation should have in place, how to comply or approach conformance with standards and considerations for local implementation. <https://www.igt.hscic.gov.uk/requirementsorganisation.aspx>

5.3 Helpdesk

A Helpdesk Service is available to users requiring additional assistance after referring to the guidance already made available. The Helpdesk can advise on administrative, technical, functional issues and with interpretation of guidance. The Helpdesk can be contacted via: <https://www.igt.hscic.gov.uk/ContactUs.aspx>

Thanet Clinical Commissioning Group

Report to:	Governing Body	Agenda item:	5.4a
Date of Meeting:	8 th December 2015		
Title of Report:	Revised Risk Management Policy		
Author:	Sue Martin		
Sponsor:	Sue Martin, Company Secretary		
Status:	Approval		
Appendices	Draft Risk Management Policy and Guidance for staff		

1.	Purpose of Paper
1.1	To seek the Governing Body's approval to the revised Risk Management Policy. It has been reviewed by the Governance and Risk Committee.

2.	Introduction
2.1	The Integrated Risk Management Framework is overdue for review (May 2014).
2.2	The attached draft has been radically shortened (from 34 pages to 5 pages) and therefore, while the approach to managing risk has not changed, the Governing Body's approval of the revised policy is requested.

3.	Discussion
3.1	The previous version of the Integrated Risk Management Framework was adopted from the PCT. It was extremely comprehensive. However, few staff or clinical leads have read the Policy and still express confusion about how to complete the risk register.
3.2	The revised draft policy has therefore been deliberately shortened and written in an accessible format which (hopefully) staff can easily read and understand. The Governance and Risk Committee welcomed the shorter policy and made some suggestions for improvement, which have been included.

4	Recommendations
4.1	The Governing Body is asked to approve the revised Risk Management Policy and Guidance.



Thanet Clinical Commissioning Group

MANAGING RISK: POLCY AND GUIDANCE FOR STAFF

Version	3.0
Ratified by:	Governing Body
Date ratified	December 2015
Next review date	December 2018
Name of Author	Sue Martin, Company Secretary
Contact for Queries	Michelle Harris, Risk and Assurance Manager

Risk Management Policy Statement

Introduction

1. Thanet CCG recognises that managing risks to its business is critical to being a well-governed and effective organisation. All activity carries some element of risk. However, the CCG is interested in identifying and managing those risks which might prevent the CCG from achieving its objectives.

What do we mean by “risk”?

2. There are a number of definitions of risk, including hazards. In this policy, we define “risk” as the effect of some uncertainty on our objectives; for example, the possibility of an event happening which may have an adverse impact on an outcome we want to see. (The Health and Safety Policy and procedure for reporting incidents deal with managing hazards in the workplace.)

What is our “risk appetite”?

3. The Governing Body is responsible for deciding when it is prepared to accept a level of risk to achieve its objectives. There will be circumstances where the Governing Body will not be willing to accept any risk; for example, if it relates to patient safety or to complying with the law. However, there will be occasions when the Governing Body thinks that a level of risk is tolerable to achieve an outcome; for example, the Governing Body may be willing to tolerate a certain level of financial risk in order to achieve a reward. Risks must always be carefully managed.

How does the risk register link to the Assurance Framework?

4. The Assurance Framework is primarily a tool for the Governing Body so that it can tell whether it is on track to deliver its key strategic objectives. The Assurance Framework includes those projects which are “mission critical” to the CCG. It will include reference to some key risks related to each strategic objective but it is a “high level” document which allows the Governing Body to have an overview of what is happening.

Who is responsible for identifying and managing risk?

5. Everyone in the CCG has some responsibility for identifying and managing risks to the CCG’s business. The overall responsibility, however, sits with the Governing Body.

Governing Body	Assures itself that risks to the CCG have been properly identified and are being managed effectively through reports it receives particularly from the Governance and Assurance Committee; sets the risk appetite for the CCG
Quality and Operational Leadership Team	Scrutinises the risk register in depth to ensure that operational, financial and quality risks are being properly managed
Governance and Risk Committee	Ensures that the arrangements in place to

	manage risk are effective and working properly and reports to the Governing Body
Accountable Officer	Has overall accountability for the management of risks
Chief Operating Officer	Oversees the management of operational risks on a day to day basis, ensuring that proper controls are in place and reported on
Chief Finance Officer	Oversees the management of financial risks to the CCG on a day to day basis, ensuring that proper controls are in place and reported on
Chief Nursing Officer	Oversees the management of quality and safeguarding risks, including those of the CCG's providers, ensuring that proper controls are in place and reported on
Company Secretary	Oversees the management of business risks, ensuring that proper controls are in place and are reported on. Takes responsibility for the overall management of the risk register, reporting to the Governing Body and its Committees; updates policies relating to management of risk to ensure they are legally compliant and up to date; and provides advice on the risk management process
Risk and Assurance Manager	Supports the Company Secretary with the maintenance of the risk register, takes day to day responsibility for updating the risk register, in discussion with colleagues, and provides advice on the risk management process.
Clinical Leads and Managers	Identifies and manages key risks to the achievement of the CCG's objectives in their area of expertise
All CCG staff and agency staff	Identifies and reporting risks to their manager, taking action to protect themselves from exposure to risk in the workplace

Reporting risks

6. Red/high risks are reported to the Governing Body quarterly with a report from the Governance and Risk Committee on their conclusions about how assured they are that risks are being managed properly.

7. The Governance and Risk Committee will receive a report on high risks at least four out of its five meetings.
8. Quality and Performance Committee will receive a quarterly report on risks, including new red risks added to the register, those risks which are overdue, risks which have been downgraded, and risks which are recommended for closure.

Reviewing this policy

9. The policy will be kept under review by the Company Secretary to ensure that any legal updates are incorporated. The formal review of the policy will be undertaken each three years. The Governance and Risk Committee will be asked to approve revisions to the policy for recommendation to the Governing Body.

September 2015

Risk management procedures: some guidance for CCG staff

The risk register

The risk register is a log which provides an audit trail of actions to manage risks. It includes:

- a description of the risk,
- an assessment of the inherent impact and likelihood (if no action were taken),
- current mitigation,
- further actions which are planned to reduce the risk,
- the target impact and likelihood (where we feel comfortable with the level of risk),
- progress since the last update was done and
- clinical and officer owner of the risk

There is a page in the risk register for each “directorate” of the CCG eg commissioning, finance, quality corporate governance. There is also an overarching corporate risk register, which includes the highest risks. These are the ones reported to the Governing Body.

Identifying a risk

There are a number of questions which you can ask which will help you identify a risk:

- What do you want to achieve? What will stop it being achieved?
- How likely is this to happen?
- What would be the impact if it did? Eg what would it cost in terms of time, money and performance?
- What is the source of the risk? Is it something over which the CCG has total control, some or no control?
- What can be done to reduce/control the risk?

These questions will help you identify some of the content for the risk register.

Describing a risk

Risks can be described using the following formula:

“There is a risk that (cause)....., leading to (consequence)....., resulting in (impact description).....”

It is important to ask the “so what?” question. Why does this matter to the CCG? This will help you be focused in describing the risk and the actions you need to take.

Rating the risk

To score the risk, you need to establish the likelihood of the risk occurring and the impact if it did. You should use a scale of 1 to 5 for each (1 being lowest level and 5 being very likely and very high impact). These scores are then multiplied together to give a risk score.

- Thinking about impact

The impact of an event could range from negligible – hardly any impact at all, therefore a 1 – to minor (2), moderate impact (3), major impact (4) or even catastrophic (5).

- Thinking about likelihood

Even if an event might have a very serious or even catastrophic impact if it were to occur, it could be that it is extremely unlikely to happen. In this case you would rate the likelihood as low (1 or 2). If it is possible, rate it 3; if it is likely 4; if it is almost certain to happen, then you would want to rate it as 5.

The following is a guide for scoring impact and likelihood; but this is not an exact science. You need to use your judgement in coming to an assessment. Remember, you are the expert in your area so you are best placed to say what the impact of a risk may be and how likely it is to occur.

Impact v Likelihood

	Likelihood				
Impact score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 insignificant	1	2	3	4	5

Managing risks

You should identify the actions which the CCG needs to take to reduce the risk. It should be clear who is responsible for the action and when the action should be completed by. When all these actions are completed, you will need to say what an acceptable level of risk is ie what will the impact and likelihood be now that you have taken all these actions?

This will give you a target risk rating and a target date by which you expect the actions to have been completed and the reduction in risk to be in place.

Each month, you will be asked to update the risk register, reporting progress and assessing whether the risk has reduced.

The risk can only be closed when you have reached your target risk rating or if the risk has become obsolete.

Updating risks

It is good practice to discuss risks with your colleagues eg at a team meeting. They can help you define the risk clearly by challenging your statements about likelihood and impact, commenting on whether you have stated the risk clearly enough, and whether the actions you are proposing are adequate.

The Risk and Assurance Manager will meet with staff groups to update the risk register.

Closing a risk

To close a risk, you should inform the Quality and Operational Leadership Team of the reason for closure. They will agree or not. They may ask you to revisit the risk and assess whether the risk has really reduced to the level suggested.

All risks are kept on our system to ensure that we have an audit trail.

THANET HEALTH AND WELLBEING BOARD

**Minutes of the meeting held on 19 November 2015 at 10.00 am in the Council Chamber,
Council Offices, Cecil Street, Margate, Kent.**

Present: Dr Tony Martin (Chairman); Councillor L Fairbrass (Thanet District Council), Councillor Gibbens (Kent County Council), Madeline Homer (Thanet District Council), Colin Thompson (Kent County Council), Clive Hart (Thanet Clinical Commissioning Group) and Councillor Wells (Thanet District Council)

1. APOLOGIES FOR ABSENCE

Apologies were received from Hazel Carpenter, Esme Chilton and Mark Lobban.

2. DECLARATION OF INTERESTS

There were no declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 17 September 2015 were agreed.

4. THANET CANCER STRATEGY

Colin Thompson, Consultant in Public Health, KCC presented the item noting that Thanet was statistically worse than the England average for a number of cancer indicators. These indicators included; incidence and mortality in under 75's, prevalence, percentage of urgent GP referrals with cancer, stage at diagnosis and one year survival rate. Mr Thompson also noted that survival rates were generally much lower in more deprived areas of the district.

In response to comments and questions it was noted that:

- The Thanet Cancer Strategy 2015-2020 had been drafted as a first step in addressing these challenges.
- There was a need to encourage uptake of screening to improve early diagnosis, particularly in more deprived areas of the district.
- There would be a meeting towards the end on November to discuss delivery of the action plan.
- The Thanet Health Inequalities Group would report back to the Board in four to six months to advise how the more deprived areas of the district were being targeted.

5. OBESITY - FOLLOWING A COUNTYWIDE HEALTH NEEDS ASSESSMENT

Colin Thompson, Consultant in Public Health, KCC presented the item noting that it has been agreed at a recent Kent Health and Wellbeing Board meeting, to review local action plans to tackle obesity. Mr Thompson recommended to members that a Thanet Obesity Action Plan be drafted and tabled at the next Thanet Board meeting.

In response to comments and questions it was noted that:

- This was a good opportunity to develop an effective strategy/action plan.

- There was a Thanet wide need for a sustained public health campaign to educate people.
- Thanet could be a pilot for the national campaign to make physical health and social education (PHSE) statutory in schools.
- The Local Children's Partnership Board for Thanet, and KCC's education lead officer for the Thanet area could be key in delivering change in Thanet's primary schools.
- Mr Thompson would arrange an initial meeting with Peter Oakford (KCC Cabinet Member for Specialist Children's Services), the KCC education lead for Thanet, Tony Martin, and a representative from TDC, to look at an example of a school in Scotland that had demonstrated health and educational benefits from the introduction of regular physical exercise in school. Any suggestions arising from this meeting would be tabled at the next meeting of the Thanet Local Partnership Group for Children.
- The Thanet Health Inequalities Group would look at how obesity could be tackled across all age groups.

6. LEADING INTEGRATED COMMISSIONING - UPDATE

Ailsa Ogilvie, Chief Operating Officer, Thanet CCG, presented the update and introduced the terms of reference for each of the sub-groups.

In response to questions and comments it was noted that:

- The terms of reference were a good starting point and may develop once the subgroups meet. Any significant changes would be brought back to the Board for agreement.
- It was agreed that the integrated commissioning group is established to offer commissioning support to the Board during the transition. It will be a staff group representing senior commissioning staff from partner organisations.
- It was agreed that the integrated commissioning group would collate and issue the Board with regular updates on the work of the subgroups unless particular representation from a sub-group was required.

Sue Martin, Head of Governance, Thanet CCG presented an initial governance roadmap which sought the views of the Board.

In response to comments and questions it was noted that:

- Sue Martin would like to be put in contact with the relevant governance officers from each organisation to allow her to continue governance mapping. She would report her progress to the Board.
- The Board agreed to accept the LGA's offer to assist in the development of the Board. However this assistance should keep within the existing time table for development.
- The LGA had offered assistance to all Kent Boards, and it was thought that Swale and Canterbury had also expressed an interest in the LGA's offer.

7. BETTER CARE FUND UPDATE

Ailsa Ogilvie, Chief Operating Officer, Thanet CCG introduced the item, and Members noted the report.

8. ANY OTHER BUSINESS

Colin Thompson advised that the consultation documents for Transformation Health Improvement, referred to at the last Board meeting by Karen Sharp, were now available and a copy would be circulated to members.

Colin Thompson clarified that the agreement of the Kent Health and Wellbeing Board for 'Local Boards' to seek assurance from the local system resilience groups regarding winter preparedness plans, referred to East Kent Boards not the Thanet Health and Wellbeing Board.

Tony Martin advised that members should look at the County Growth and Infrastructure Framework as it had received a number of questions at the Kent Health and Wellbeing Board meeting.

Tony Martin added that he would circulate a document called 'Placed Based Systems of Care' for information as it had particular relevance to unified budgets.

Meeting concluded: 11.10 am

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 16 September 2015.

PRESENT: Mr R W Gough (Chairman), Mr P B Carter, CBE, Mr A Scott-Clark, Ms P Davies, Mr G K Gibbens, Mr S Inett, Mr A Ireland, Dr N Kumta, Dr E Lunt, Dr T Martin, Mr P J Oakford, Dr S Phillips, Dr M Philpott, Cllr K Pugh, Dr R Stewart and Mrs D Tomalin

IN ATTENDANCE: Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

163. Chairman's Welcome

(Item 1)

- (1) The Chairman welcomed Dr Sarah Phillips who is acting as clinical chair for Canterbury and Coastal CCG while Dr Mark Jones is on a sabbatical.
- (2) Mr Gough reminded the Board that a workshop to discuss the development of the JSNA would be held on 22 September and urged members to attend or to encourage others from their organisations to attend.
- (3) Mr Gough said that a consultation on closer working between the emergency services was taking place until 23 October. He said the consultation raised a number of interesting questions including the relationship between fire and rescue services and police and crime commissioners and a possible requirement to actively consider collaboration and integration. In addition parts of the consultation referred to the ambulance service. He said the County Council would respond to the consultation and that further information could be provided outside the meeting for those interested in examining and perhaps responding to the consultation.

164. Apologies and Substitutes

(Item 2)

- (1) Apologies for absence were received from Dr Armstrong, Mr Ayres, Dr Bowes, Mrs Carpenter, Ms Cox, Mr Perks and Cllr Weatherly.
- (2) Dr Philpott and Mrs Tomalin attended as substitutes for Dr Armstrong and Ms Cox respectively.

165. Declarations of Interest by Members in Items on the Agenda for this Meeting

(Item 3)

There were no declarations of interest.

166. Minutes of the Meeting held on 15 July 2015

(Item 4)

Resolved that the minutes of the meeting held on 15 July 2015 are correctly recorded and that they be signed by the Chairman.

167. Healthwatch Kent - Strategic Priorities 2015 and Annual Report for 2014/15

(Item 5)

- (1) Steve Inett (Chief Executive Officer- Healthwatch) introduced the report which summarised Healthwatch Kent's priorities for 2015 and included Healthwatch Kent's annual report which summarised its activities for 2014/15.
- (2) In response to questions, he said dental services were the third most frequently raised issue by members of the public; and that Healthwatch could play a role in communicating with the public about managing long term conditions, minimising waste and managing expectations about services and resources.
- (3) Resolved that the reports be noted.

168. JSNA Recommendations Report

(Item 6)

- (1) Mr Gibbens (Cabinet Member for Adult Social Care and Public Health) introduced the report and said the intention was to highlight key priorities in a way that would influence commissioning plans for next year. Dr Faiza Khan (Consultant in Public Health) gave a short presentation which is available online as an appendix to these minutes.
- (2) During discussion it was confirmed that: not all priorities had been highlighted in the presentation; the preventative agenda included addressing a range of activities including lifestyle issues such as smoking and obesity which had a significant impact on long term conditions and health inequalities; and local priorities were likely to vary across Kent. It was also stated that the NHS – Five Year Forward View and NHS England's priorities included similar priorities and that it would be useful to further develop the conversation about these issues at the JSNA event on 22 September 2015.
- (3) Resolved that:
 - (a) The report be noted;
 - (b) Local health and wellbeing boards be asked to develop their priorities based on the discussion of the board.

169. NHS England South (South East): Preparations for winter 2015/16

(Item 7)

- (1) Mrs Tomalin introduced the report which described the actions being taken by the health service to prepare for winter. She explained the structure for winter

planning activities and the toolkit being used by the Systems Resilience Groups to provide assurance on preparations for winter.

- (2) During discussion, questions were raised about the possibility of an exceptionally cold winter, the inclusion of the fire and ambulance service in planning for winter, the efficacy of the flu vaccine and the capacity of an already stretched system to respond to any abnormal increase in demand for services.
- (3) Comments were also made about: the need to raise public awareness of the challenges being faced by service providers; demographic changes such as the increased numbers of very elderly and very sick people; and the impact the increased need for double handed care packages had on the domiciliary care sector which had not fully recovered from last winter.
- (4) Resolved that:
 - (a) The report be noted;
 - (b) The pressures on the system continue to be monitored to identify reasons for any surge in demand;
 - (c) A further report containing an analysis of the situation and the impact of planned work programmes be considered by the HWB in January 2016.

170. Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years)- (CAMHS)
(Item 8)

- (1) Dave Holman (Head of Mental Health Programme) and Karen Sharp (Head of Public Health Commissioning) introduced the report which provided an update on the development of the Emotional Wellbeing and Mental Health Service for Children, Young People and Young Adults in Kent.
- (2) Mr Holman said the process of improvement started following concerns about CAMHS raised by the Health Overview and Scrutiny Committee in January 2014 and significant work had been undertaken to transform children's emotional wellbeing services in Kent including the development of an Emotional Wellbeing Strategy and a multi-agency delivery plan. He also said that performance in relation to assessment and treatment targets had improved following a surge in demand over the summer.
- (3) Mrs Sharp said the feedback from the consultation had influenced the design of the new model which included a whole-school approach to improving the emotional resilience of children and young people, a single point of access for specialist support and increased partnership working between health services and the local authority to facilitate a whole system approach.
- (4) Mrs Sharp said specifications were being finalised and had been developed following extensive consultation with a range of partners. She also said a joint programme board would be established to oversee the procurement of a contract for early help intervention by Kent County Council and a contract for additional and specialist help by the NHS.

- (5) In response to questions, it was acknowledged that the transition from children's to adults' services had not always been smooth and that efforts were being made to define requirements as part of the tender specification. It was anticipated that two years after the implementation of the new contracts fewer people would experience a crisis before getting support, waiting lists would be shorter and it would be easier to access help.
- (6) Resolved that:
 - (a) The contents of the report be noted;
 - (b) Progress would be reviewed by the Children's Health and Wellbeing board and at future meetings of the Health and Wellbeing Board.

171. Kent Health and Wellbeing Board and Local Health and Wellbeing Boards Relationships and Future Options
(Item 9)

(Joanna Fathers (Kent Graduate Programme) and Mark Lemon (Strategic Relationship Adviser were in attendance to present the report)

- (1) The Chairman introduced the report which provided an overview of the review of the relationship between the Kent Health and Wellbeing Board and the local health and wellbeing boards. He made particular reference to the wide ranging consultation with partners and the issues that had arisen including a need for clarity in relation to the roles of the Kent HWB and local health and wellbeing boards particularly in relation to taking forward specific areas of work, the development of a Kent workplan and its relationships to the work plans of local boards.
- (2) Joanna Fathers thanked all those who had contributed to the insight gathering which had shaped the proposals in the report.
- (3) During discussion, the need for a more systematic approach to planning agendas for the Kent Health and Wellbeing Board meetings and greater clarity about local health and wellbeing boards' role in reviewing services was acknowledged. It was suggested that as far as practicable, meetings of the chairmen of the local and Kent health and wellbeing boards should take place before or after other scheduled meetings.
- (4) Resolved that:
 - (a) An outline work programme for the Health and Wellbeing Board be produced for the start of each year to enable local boards to plan their activity accordingly;
 - (b) The means by which local issues can be escalated to the Kent Board be clarified;
 - (c) Relevant issues be referred by the Health and Wellbeing Board to local boards with clear expectations regarding further action at a local level;

- (d) Policy support be provided by the Health and Wellbeing Board to the local boards to assist in the development of relevant substructures and work programmes;
- (e) Opportunities for development work for both chairs of the boards, and individual boards themselves, be investigated and made available to local board members;
- (f) Data and information be provided by the Health and Wellbeing Board through its sub-group, the Multi-Agency Data and Information Group;
- (g) The chairmen of local health and wellbeing boards meet with the chairman of the Kent Board every six months. This meeting to include consideration of the workplan of the Kent Board, and its relationship to the work plans of local Boards;
- (h) Each LHWB sends a representative to every Kent HWB, to update the Kent board on their activities locally, and to take any relevant information from the Kent board back. This representative would also be responsible for liaising with the Kent Board concerning issues and matters that would benefit from consideration at the Kent Board;
- (i) Proceedings of the Kent Board to be a standing item on all local board meeting agendas with particular reference to issues referred from the Kent Board for local consideration and action;
- (j) All agenda items that came to the Kent Board would be considered as to how local boards could and should be involved in their future progression;
- (k) All local boards provide an annual report to the Kent Board regarding how they have been progressing with the five outcomes of the Kent Joint Health and Wellbeing Strategy, and their engagement with the commissioning plans of their constituent organisations. The report would also describe how issues referred from the Kent Board had been considered and how local implementation of any necessary activity had been supported;
- (l) All local boards develop a work programme for the coming year that relates to:
 - the five outcomes of the Kent Joint Health and Wellbeing Strategy
 - the health and wellbeing priorities of the area as identified by the Kent Public Health department
 - the health inequalities within the area and between the area and others in Kent
 - Engagement with the development of commissioning plans of the organisations represented on the board.

- (m) Engagement with the commissioning plans of partner organisations should focus on opportunities to promote integration, especially between health and social care services. Whether the plans offer the best possible approaches to local issues should also be considered.
- (n) All local health and wellbeing boards to have agreed terms of reference by March 2016. Proposals for terms of reference, be drafted following discussion at a meeting of chairmen of boards, and be brought to the Kent Health and Wellbeing Board at its meeting in January 2016;
- (o) Local boards review their membership, substructures and associated working groups to ensure they are fit for purpose. Substructures should provide capacity to deliver the activity required to implement the work of the board to deliver the five outcomes of the Joint Health and Wellbeing Strategy and allow proper oversight of commissioning plans. The substructure may include the local Children's Operational Group(s) and Integrated Commissioning Groups. The responsibilities of groups in a local board's substructure for reporting to the board on specific outcomes from the Health and Wellbeing Strategy should be clearly defined;
- (p) Relationships between the local boards and other meetings of commissioners and providers be clarified;
- (q) The substructure adopted by the local boards must ensure that the appropriate relationships with service providers within the area are properly represented.
- (r) Appropriate relationships with representatives of other important sectors and organisations to be reflected in the membership of the board or within its substructures. These should include the voluntary and community sector and could include other local stakeholders such as parish councils.
- (s) The Chairman be authorised to follow up issues of concern raised by some stakeholders outside the Board meeting.

172. Developing the relationship between Kent's Health and Wellbeing Board and the voluntary sector
(Item 10)

(Lydia Jackson (Policy and Relationships Adviser- VCS and Mark Lemon (Strategic Relationships Adviser) were in attendance to present the report)

- (1) The Chairman introduced the report which sought to address issues relating to the relationship between the Health and Wellbeing Board and the community and voluntary sector and the relationship between local health and wellbeing boards and the sector.
- (2) The important role of the community and voluntary sector was acknowledged as was the involvement of representatives from the sector in the development

of the Better Care Fund submission and their attendance at the JSNA event on the 22 September and at other events.

(3) Resolved that:

(a) The report be noted;

(b) A group, comprising Patricia Davies, Steve Inett, a representative from Public Health and others, be established to progress thinking on the relationship of the VCS with Kent Health and Wellbeing Board and with local health and wellbeing boards and to report to a future meeting of the Health and Wellbeing Board.

173. Health and Social Care Integration

(Item 11)

(1) Dr Stewart introduced the report which gave an update on health and social care integration including recent development and plans up to 2016.

(2) He then introduced a report providing an update on progress made with the Kent Health and Social Care Integration Test Bed Site submission and seeking approval to progress to the next stage in the application to become a test bed site for innovation in the integration of health and social care.

(3) Dr Stewart gave a brief outline of the submission, the challenges to be addressed through a Kent Test Bed Site, the types of innovation being sought, the requirements required for future collaboration and the funding available for those selected to be test bed sites

(4) Resolved that:

(a) The proposed next steps in taking forward health and social care integration be endorsed;

(b) Progress made on the Kent Health and Social Care Integration Test Bed site be noted;

(c) Progression to the next stage of the application to become a Test Bed Site for innovation in integrated health and social care be approved

174. Minutes of local health and wellbeing boards

(Item 12)

Resolved that the meetings of local health and wellbeing boards be noted as follows:

Ashford - 22 July

Canterbury and Coastal - 9 July

Dartford, Gravesham and Swanley – 19 August

Swale 20 May and 15 July

Thanet – 11 June

West Kent - 21 July

175. Dates of meetings for 2016-2017
(Item 13)

Resolved that meetings of the Health and Wellbeing Board for 2016/17 be noted as follows:

27 January 2016, 16 March 2016, 25 May 2016, 20 July 2016, 21 September 2016, 23 November 2016, 25 January 2017 and 22 March 2017

Date of Next Meeting - 18 November 2015
(Item 14)