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SOUTH KENT COAST HEALTH AND WELLBEING BOARD

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14 October 2013

Dear Member of the Health and Wellbeing Board

NOTICE IS HEREBY GIVEN THAT a meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** will be held in the Council Chamber at these Offices on Tuesday 22 October 2013 at 3.30 pm.

Members of the public who require further information are asked to contact Rebecca Brough on (01304) 872304 or by e-mail at rebecca.brough@dover.gov.uk.

Yours sincerely

Chief Executive

South Kent Coast Health and Wellbeing Board Membership:

Councillor P A Watkins (Chairman)	Dover District Council
Ms K Benbow	South Kent Coast Clinical Commissioning Group
Dr J Chaudhuri	South Kent Coast Clinical Commissioning Group
Councillor P G Heath	Dover District Council
Councillor J Hollingsbee	Shepway District Council
Mr R Kendall	Healthwatch
Mr M Lobban	Kent County Council
Councillor G Lymer	Kent County Council
Councillor M Lyons	Shepway District Council
Ms J Mookherjee	Public Health Representative
Ms J Perfect	Community and Voluntary Sector Representative
Mrs S S Chandler	Children's Trust Representative

AGENDA

1 **APOLOGIES**

To receive any apologies for absence.

2 **APPOINTMENT OF SUBSTITUTE MEMBERS**

To note appointments of Substitute Members.

3 **DECLARATIONS OF INTEREST**

To receive any declarations of interest from Members.

4 **MINUTES** (Pages 4 - 7)

To confirm the attached Minutes of the meeting of the Board held on 3 September 2013.

5 **MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD**

Any member of the Health and Wellbeing Board may request that an item be included on the agenda subject to it being relevant to the Terms of Reference of the Board and notice being provided to Democratic Services at Dover District Council (democraticservices@dover.gov.uk) at least 9 working days prior to the meeting.

There had been no items received within the required notice period.

6 **APPOINTMENT OF A VICE-CHAIRMAN**

To appoint a Vice-Chairman of the South Kent Coast Health and Wellbeing Board for the remainder of the municipal year 2013-14.

7 **CCG ANNUAL OPERATING PLAN**

To receive a presentation from Karen Benbow, Chief Operating Officer, South Kent Coast Clinical Commissioning Group.

8 **INTEGRATED TRANSFORMATION FUND** (Pages 8 - 15)

To consider the report of the Head of Leadership Support (Dover District Council).

9 **KCC FAMILIES AND SOCIAL CARE - ACCOMMODATION STRATEGY** (Pages 16 - 18)

To consider the attached report of Mark Lobban, Director of Strategic Commissioning (Kent County Council).

10 **SOUTH KENT COAST CCG HEALTH INEQUALITIES STRATEGY (REPORT) AND UPDATED PHE HEALTH PROFILES FOR DOVER AND SHEPWAY 2013** (Pages 19 - 29)

To consider the report of Jess Mookherjee, KCC Assistant Director, Consultant in Public Health.

11 **INTEGRATED COMMISSIONING GROUP**

To receive an update from the Head of Leadership Support (Dover District Council).

12 **URGENT BUSINESS ITEMS**

To consider any other items deemed by the Chairman to be urgent in accordance with the Local Government Act 1972 and the Terms of Reference. In such special cases the Chairman will state the reason for urgency and these will be recorded in the Minutes.

Access to Meetings and Information

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- Agenda papers are published five clear working days before the meeting. Alternatively, a limited supply of agendas will be available at the meeting, free of charge, and all agendas, reports and minutes can be viewed and downloaded from our website www.dover.gov.uk. Minutes are normally published within five working days of each meeting. All agenda papers and minutes are available for public inspection for a period of six years from the date of the meeting. Basic translations of specific reports and the Minutes are available on request in 12 different languages.

- If you require any further information about the contents of this agenda or your right to gain access to information held by the Council please contact Rebecca Brough, Team Leader - Democratic Support, telephone: (01304) 872304 or email: rebecca.brough@dover.gov.uk for details.

Large print copies of this agenda can be supplied on request.

Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 3 September 2013 at 3.30 pm.

Present:

Chairman: Dr J Chaudhuri

Board: Ms K Benbow
Councillor P M Beresford (In place of Councillor P A Watkins)
Mrs S S Chandler
Councillor P G Heath
Councillor J Hollingsbee
Mr M Lobban
Councillor G Lymer
Councillor M Lyons
Ms J Mookherjee
Ms J Perfect

Also Present: Ms Z Mirza (Head of Integrated Commissioning, South Kent Coast Clinical Commissioning Group)

Officers: Head of Communication and Engagement
Head of Leadership Support
Head of Strategic Housing
Leadership Support Officer
Team Leader Democratic Support

16 ELECTION OF A CHAIRMAN

It was proposed by Councillor S S Chandler and duly seconded

RESOLVED: That Dr J Chaudhuri be elected Chairman for the duration of the meeting.

17 APOLOGIES

An apology for absence was received from Councillor P A Watkins (Dover District Council).

18 APPOINTMENT OF SUBSTITUTE MEMBERS

In accordance with the Terms of Reference, Councillor P M Beresford had been appointed as substitute for Councillor P A Watkins (both Dover District Council).

19 DECLARATIONS OF INTEREST

There were no declarations of interest from members of the Board.

20 MINUTES

It was agreed that the Minutes of the Board meeting held on 18 June 2013 be approved as a correct record and signed by the Chairman.

21 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no matters raised by members of the Board within the notice period.

(a) Intermediate Care Project - Final Output and Recommendations

Ms Z Mirza (Head of Integrated Commissioning, South Kent Coast Clinical Commissioning Group) presented the report on the Intermediate Care Project to the Board. The project had been undertaken jointly by the South Kent Coast Clinical Commissioning Group (CCG), Kent County Council (KCC), Dover District Council (DDC) and Shepway District Council (SKC) with the objective of achieving the right model of care for CCG area residents.

The objective of the project was to get the patient back to their previous level of functionality and, where appropriate, to be cared for in their own home.

The project had demonstrated differences in the current situation between the two districts, with Shepway having a provision of intermediate care 'step-up / 'step-down' beds that was lacking in Dover. In the Dover District this function was being fulfilled by Deal Hospital and was delaying the return of patients to their homes.

The provision of these intermediate care beds was important as part of hospital admission avoidance as was the installation of home adaptations in enabling people to return home. As part of this there was a requirement for assertive case management to ensure that patients received the appropriate services (such as physio) at the right time to aid their return to previous levels of functionality.

If both of these were correctly used then it would free nursing beds for their proper purposes.

It was emphasised that the project was dependent upon all stakeholders engaging and planning strategically with short and long term measures. An example of this was the required time to under the necessary commissioning processes, such as the provision of extra care housing and increased investment in disabled adaptations which required a significant lead time to deliver. It required a short term alternative option while it was being delivered.

The Board discussed the role that the Buckland Hospital site might have in respect of the intermediate care project and was advised that the CCG was in discussions with East Kent Hospitals over potential uses for land at the site. However, it was confirmed that East Kent Hospitals were not putting any beds in the new Buckland Hospital.

The issue of care for dementia patients was highlighted and the shortage of extra care sheltered housing provision for them.

The Board was advised that the CCG Cabinet had approved the report.

RESOLVED: (a) That the Intermediate Care Project – Final Output and Recommendations be agreed.

(b) That the Board receive an update in six months time on the project.

(b) Falls Response Service

Ms J Empson presented the report on the Falls Response Service.

The Board was informed that the service promoted a multi-agency, multi-disciplinary approach and through integrated early intervention could make significant steps towards restoring independence.

Nationally, the NHS Federation had proposed that a falls prevention strategy could reduce the number of falls by 30%. It suggested that aligned budgets from health and social care organisations could result in efficiencies as where one organisation prevented a fall this created savings for others.

The Board discussed the role of district council housing in falls prevention and in particular the benefit of small adaptations could bring. Councillor S S Chandler advised that Dover District Council had created a new fund to help deliver small adaptations more effectively.

RESOLVED: That the briefing be received and noted.

22 FLEXING DOMICILLARY CARE

Ms J Empson advised the Board that the one year Flexing Domiciliary Care project had been launched in Dover and Thanet on 1 August 2013.

The aim of the project was through integrated service delivery to avoid unnecessary hospital admissions, avoid admission into long term care services and reduce delayed discharges. A key part of delivering this was to give service providers to ability to make more decisions to provide the right intervention at the right time. To participate in the project, the service provider needed to be either contracted, hold the relevant 'Approved Provider Status' and/or be delivering domiciliary care services in the two local authority areas and sign-up to the contract terms and conditions.

In response to concerns raised by Councillor S S Chandler that this kind of care was historically difficult to access in rural areas, the Board was advised that an analysis of location could be provided.

RESOLVED: That the Board receive an update in six months on the progress of the project.

23 PUBLIC HEALTH UPDATE

Ms J Mookherjee advised the Board that the uncommitted element of the public health budget would be identified by the end of September 2013. It could then be allocated to new projects.

(a) Addressing Health Inequalities in Kent

The report identified geographical areas where resources could be targeted at reducing health inequalities. This was particularly important in areas of deprivation as the data showed a significant link between poverty and early mortality.

The Board was advised that in tackling health inequality issues in the longer term there needed to be cultural changes achieved that would deliver improvements in 20 – 30 years' time. In tackling these issues it was vital to use the right medium to reach the desired target audience and build on existing strengths and successes. While overall public health was improving nationally there was a smaller proportion of the population for whom health inequalities were growing.

RESOLVED: That an update be provided to the next meeting on health inequalities for the South Kent Coast Health and Wellbeing Board area.

24 DEMENTIA FRIENDLY COMMUNITIES

The Leadership Support and Health and Wellbeing Manager provided an update on the Dementia Friendly Communities project. The Board was informed that Eastry had volunteered for the project and was being assessed. The first meeting would be held on 9 October 2013 at Eastry Village Hall.

RESOLVED: That the update be noted.

25 URGENT BUSINESS ITEMS

None.

26 CHILDREN'S SERVICES ARRANGEMENTS

The Leadership Support and Health and Wellbeing Manager provided an update on proposals for Children's Services Arrangements. It was proposed that while the new Children's Operational Groups (COG) would be based on CCG areas, its representatives on the CCG level Health and Wellbeing Boards would be based on district areas.

In the Dover district it was hoped to focus on the link with the troubled families work and that it would be project based (such as food and health).

RESOLVED: That the report be received and noted.

The meeting ended at 5.24 pm.

From: Roger Gough, Cabinet Member for Education and Health Reform

Mark Lemon Strategic Business Advisor

To: Kent Health and Wellbeing Board

Subject: The Integration Transformation Fund

Classification: Unrestricted

Summary:

The £3.8bn Integration Transformation Fund (ITF) announced by the Government dramatically accelerates the timescale for achieving the integration of health and social care services. Government expectations are that a fully integrated system should be in place by 2018 based on actions identified to start in 2014-15 and begin significant delivery in 2015-16. The funding consists of a number of existing components as well as new allocations from CCG budgets.

Plans to spend the funding must be agreed by Health and Wellbeing Boards who must assume responsibility for monitoring the achievement of the targets required, agree contingency plans for re-allocating funding if targets are missed, and be satisfied that providers, especially acute hospital trusts, have been effectively engaged in the planning process.

Recommendations:

The Health and Wellbeing Board is asked to:

(i) Acknowledge the timescales involved for the preparations of the Kent plan for the Integration Transformation Fund

(ii) Agree to establish the necessary processes and mechanisms to construct the plan and deliver the required activity across Kent.

1. Introduction

The Integration Transformation Fund was announced in the Comprehensive Spending Review It follows the NHS “Call to action” that identified a £30bn shortfall in NHS funding in 2020 unless action to manage demand is taken. This has also spawned the integrated care “Pioneer Programme”.

The funding is described as “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”

Funding will be awarded to local plans, based on a Health and Wellbeing Board footprint and with Boards as the leaders for implementation. Health and Wellbeing Boards will need to agree plans to spend the money to deliver agreed outcomes.

Plans will also need to take account of the implications for the acute sector of service transformation and set out arrangements for the redeployment of funding within the system if outcomes are not reached.

There will need to be some oversight and ministerial sign off of plans but it is intended that this be “light touch”.

The funding is a pooled budget, not a transfer, and local authorities and the NHS are equal partners. It is not necessarily confined to social care and other LA functions may be relevant. It is expected that the funding will be allocated under s256 arrangements.

A great deal of effort is already being devoted to furthering integration across Kent and there is a sound basis to build upon. The Integration Transformation Fund seriously increases the pace and the scale at which these developments need to deliver. The government expects “that each area moves to a wholly integrated approach to health and care by 2018” (Refreshing the Mandate to NHS England: 2014 – 2015 Consultation)

2. ITF Funding components

Half the ITF funding will come from existing commitments:

- £1.9bn of existing funding continued from 14/15 – this is money already allocated across the NHS and social care to support integration and including:

- £300m of CCG re-ablement funding

- £130m of CCG carers' break funding

- £900m existing transfer from health to social care plus £200m for the joint fund

- c. £350m in capital grants from government departments including £220m of Disabled Facilities Grant

Whilst it is not expected that these components will be diverted into funding other services the implication is that the plan associated with spending the ITF must show how each of these elements will contribute to the overall aim of achieving integrated services by 2018.

There is an additional element of £1.9bn from NHS allocations which includes funding to cover demographic pressures in adult social care and some costs associated with the Care Bill.

Of this £1bn has been designated as "at risk money". This will be paid dependent upon performance with particular reference to taking pressure off the acute sector and improving patient experience. If not paid, the funding will revert to the general NHS budget. The "at risk" funding will be split over the 15/16 financial year:

£0.5bn at start of 15/16 dependent upon performance in 14/15

£0.5bn at end of 15/16 dependent upon performance in 15/16

This £1.9bn contribution from core CCG budgets equates to £10m from an "average" CCG.

3. Conditions of the full ITF

The ITF will be a pooled budget that can be deployed locally on social care and health, subject to the following national conditions which will need to be demonstrated in the plans:

- joint agreement between local authorities and the NHS through the Health and Wellbeing Board.
- protection for social care services (not spending)
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health)
- ensure a joint approach to assessments and care planning
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached
- agreement on the consequential impact of changes in the acute sector.

4. Timetable

Money is for 1 year with no guarantee of repeat funding. There will be a general election and a further Comprehensive Spending Review in 2015. Funding is to establish practice that can be incorporated into allocation of base budgets in following years.

Further guidance and support will be issued in the Autumn to enable consideration within CCG commissioning plans for 14/15 with more events and engagement planned over the Autumn

However guidance states: “we think it is essential that CCGs and local authorities build momentum in 2014/15 using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and 2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter”.

5. Key Messages

- This will only work if services are redesigned to move activity from the acute sector to the community and primary care.

- Successful implementation of plans may lead to significant hospital reconfiguration. Potential impact on providers (acute trusts) needs to be part of the planning process. Changes to service that are not properly planned could potentially destabilise providers. This led to emphasis being placed on involvement of providers with an urgent need to revisit how they engage with the commissioners and the Health and Wellbeing Board.

- This is urgent – get on with it. There are early wins to be had regarding winter pressures and in any event Boards need to start building momentum towards 14/15.

6. Outcome measures

Measures to determine progress and success have not yet been established. The general view is that any outcome measures should be taken from existing outcome frameworks and should not generate extra data collection for new indicators.

Some new measures may be necessary to demonstrate how issues such as better data sharing based on use of the NHS number have progressed

7. Timetable and Alignment with Local Government and NHS Planning Process

Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows
- The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:
- August to October: Initial local planning discussions and further work nationally to define conditions etc
- November/December NHS Planning Framework issued
- December to January: Completion of Plans
- March: Plans assured

8. National next steps

NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

9. Other Issues

Analysis from Greater Manchester highlighted the scale of the issue. Their advice is that partners should agree how much money needs to move

across sectors in the system. Their calculation was that Greater Manchester needed to transfer £250m worth of activity from acute to community and primary care which translated into a potential 25% of hospital activity. There was concern whether existing systems such as HR and finance can cope with the required shift of resources and personnel around the system at this scale. Greater Manchester's experience also demonstrated the need for robust financial modelling and the need to "develop investable propositions".

10. Kent Workforce

Locally some discussions have already been held about how workforce planning needs to respond to the challenge posed by the integration agenda, including representatives from social care and KCHT. These discussions have led to the following summary for the Board:

The health and social care economy is reliant on the right staff and multi-professional teams being available at the right time, in the right place to deliver the right care and service. As we face the challenge of ensuring our services are sustainable for the future, meeting the need for improving outcomes and experience of patients whilst making best use of the public pound, a key factor in delivery will be workforce availability. This workforce stretches from carers through volunteers and on to registered health and social care professionals. How will HWBB commissioning partners be assured that the necessary workforce, with the right skills and competencies for future models of health and social care is being developed?

Health Education England (HEE) is the national NHS and social care body responsible for the education and development of the health workforce. The local presence of HEE is HE Kent Surrey Sussex who have a local partnership arrangements in Kent and Medway. The HEE work with their local membership of health providers and education institutes to ensure there are comprehensive workforce strategies and plans in place so that resources are appropriately focused. In order for providers to have detailed and deliverable workforce plans they need to have a clear strategic steer as to the future services to be commissioned. There is clearly a potential role for the HWBB partners to clearly describe the strategy for service change and development into the future in a way that enables HEKSS to respond.

The pioneer bid for integration provides an ideal and clear opportunity to test the new governance, roles and responsibilities with a focus on delivery. The HWBB should consider how it adequately describes the future service strategy in a way that the Local Partnership group, chaired by Marion Dinwoodie can consider how they provide assurance to the HWBB that plans are in place to implement the necessary changes in workforce that this may require. It is recommended that the Local partnership Board be asked to set out how local partners will develop the workforce to meet the requirements of the bid.

11. Issues for the Kent Health and Well Being Board

The Integration Transformation Fund raises a number of issues for the Health and Wellbeing Boards across Kent apart from the pace and scale of the changes required. The level of involvement in the planning process, oversight of effectiveness and responsibility to redeploy resources if plans are unsuccessful brings the Kent Board closer to being a joint-commissioning body and the group that manages risk within the wider system. The need to engage the acute trusts and others emphasises the importance of ongoing discussions about how to involve providers with the business of the Board.

In delivering the requirements of the Integration Transformation Fund it will be important that we bring all relevant resources to bear and there are a number of existing initiatives that can be deployed:

The Pioneer programme derived from the current bid could provide a focus for delivery of the plan

The local Health and Wellbeing Boards with their associated Integrated Commissioning Groups will be an essential element in developing plans.

12. Conclusions

The Board may wish to consider other ways the planning and delivery of the Integration Transformation Fund may be supported in Kent. In particular the Board will need to be assured that it can address the following questions.

What processes and mechanisms do we need to establish to deliver the ITF in Kent ?

Does the Pioneer Programme provide the vehicle for delivery ?

What will be the involvement and responsibility of local Health and Wellbeing Boards ?

How will providers, especially the hospital trusts, be engaged ?

Are local support systems including those for finance and Human Resources robust enough to deal with the scale of change within the system ?

How will the pooled funding be managed ?

Who will write the plan?

Recommendations:

The Health and Wellbeing Board is asked to:

(i) Acknowledge the timescales involved for the preparations of the Kent plan for the Integration Transformation Fund

(ii) Agree to establish the necessary processes and mechanisms to construct the plan and deliver the required activity across Kent.

13. Contact details

Report Author

Mark Lemon, Strategic Business Advisor, email: Mark.Lemon@kent.gov.uk

Subject:	**KCC FAMILIES AND SOCIAL CARE – ACCOMMODATION STRATEGY**
Meeting and Date:	**South Kent Coast Health and Wellbeing Board – 22 October 2013**
Report of:	**Mark Lobban – Director, Strategic Commissioning – KCC FSC**
Classification:	**Unrestricted**
Purpose of the report:	To provide an overview of the Accommodation Strategy being developed by KCC FSC and to outline the phases in its delivery
Recommendation:	To note the report

1. Summary

This report has been produced to provide South Kent Coast Health and Wellbeing Board an overview of the Accommodation Strategy being developed by KCC Families and Social Care and to outline the phases, stakeholders and timescales in its development and delivery.

2. Introduction and Background

2.1 KCC has a statutory duty to support people eligible for adult social care. An Accommodation Strategy is being developed to demonstrate the need for controlling FSC spend in a growing care market and to shape services that promote independence with better outcomes for those who use them. For many years, the care market has grown without any strategic direction or proper needs analysis for the types of services required. Historically, there has been greater care home provision in East Kent than there has been in West which has been identified as having cheaper, more suitable land and properties in comparison to West Kent. As a result, case managers have had to display different behaviours depending on the provision and have had to find alternative services for people eligible for FSC support. A whole system review is required to provide strategic direction to the market for all adult client groups; older people, learning disability, physical disability and people with mental health needs.

2.2 National research shows efficiencies can be made by developing services that are a genuine alternative to residential care and provide better outcomes for people. For some time, the strategic direction of the Council has been to develop extra care housing for older people and supported accommodation for people with learning disabilities or mental health needs. Access to capital monies to develop services is no longer available from KCC and opportunities for bidding for capital funding is reducing. However, there is still an active market with one or two care home applications being received every couple of weeks in the County.

2.3 There is clearly enough available resource and there is a need to redirect developers into looking at alternative housing provision that meets the need of those eligible for care services. There are economies of scale and KCC has been successful in delivering these services with its partners.

2.4 Kent County Council does not have a statutory duty for housing; this is the responsibility of the district or borough council. Therefore, this piece of work is being undertaken jointly with KCC's local authority partners with support from the Kent Housing Group. KCC has a long standing relationship with its housing partners with successful project delivery for the PFI extra care schemes, the NHS campus re-provision, Horizons redesign of mental health in-patient provision and other supported housing schemes. The Heads of Housing are fully engaged with the Strategy along with other key officers within the District Councils. A programme of visiting CCG colleagues is being planned to gain support and engagement going forward; particularly with the impact of community hospital provision and intermediate care.

3. Process for delivery

3.1 Continuing to fund accommodation based services with out strategic direction is not an option. KCC undertook stakeholder engagement in 2012/13 with local authority housing colleagues and the care home sector and has a fully represented Steering Group in place to take this piece of work forward. The Steering Group includes Health, housing and social care operational colleagues, Supporting People (who are also undertaking their needs analysis) and the private sector.

3.2 The needs analysis will be complete by the end of November 2013 along with the Strategy document and the mapping exercise. Once this is complete, a review will take place to prioritise and sequence 'candidate project' areas which will be identified as natural communities and clusters of services (or not). This means that when the candidate projects are identified, all stakeholders will be invited to review the areas and develop and undertake options appraisals. This will take into account the supply and demand, the impact of other local services (for instance community hospitals, enablement services etc) and local knowledge to start to shape service delivery in that particular area.

4. Timeline

July 2013 – November 2013	• Needs analysis • Stakeholder engagement • Regular Steering Group meetings • Map supply of provision • Publish document
November 2013 – January 2014	• Review findings • Identify candidate project areas and prioritise • Confirm any procurement activity to move projects forward • Map stakeholders for second phase projects
February 2014 – ongoing	• Publish candidate project areas and priority • Invite stakeholders to review workshops • Develop options • Confirm vision for the area • Engage in discussions with providers to move services into that vision • Make it happen

5. Recommendation

South Kent Coast Health and Wellbeing Board are asked to note the contents of this report

Report Author: Christy Holden – Head of Strategic Commissioning – Accommodation Solutions – KCC

Relevant Director: Mark Lobban – Director of Strategic Commissioning - KCC

Executive Summary

Coastal Poverty Leads to Health Inequalities

The population served by SKC CCG has the third lowest life expectancy at birth of all the CCGs in Kent, and considerable variations still exist between different localities. Reducing avoidable and unfair variations in health outcomes requires a commitment to justice, efficiency and good clinical care, values that have been central to the NHS since its inception.

In South Coast Kent CCG, 42% of the member practices are located in areas of significant rural and urban deprivation, which gives their doctors and nurses a real opportunity to make a difference to the lives of those people most at risk of premature death.

At present, most years of life are being lost prematurely to coronary heart disease (especially in men), respiratory disease, cancer and liver disease. Dementia is beginning to emerge as an increasingly common cause of death, especially in women. The first four are all conditions that can usually be treated or managed effectively, provided they are identified early and patients are empowered and enabled to act on the health information they are given. Dementia care requires intervention and support from both health and social care practitioners working closely together.

An Ethical and Equitable Organisation

The principle of Equity recognises that services need to be delivered proportionately, because some individuals will require more help and support than others in order to raise their chances of achieving similar health outcomes. It is a core theme to this strategy. SKC CCG has expressed its commitment to reducing health inequalities by making this one of its top ten priorities. It is determined to ensure that reducing health inequalities is part of its mainstream business of commissioning and quality improvement.

Clinicians have an important part to play in delivering equitable, high quality services, but they cannot reduce health inequalities by working alone. The strategy seeks to clarify where responsibility for different interventions lies, and to hold the CCG, its member practices and partners in Social Care and Local Government to account in delivering the action plan.

Local Clinical Leadership

This strategy recognises that the CCG will not achieve its aims by working in isolation. Health and Wellbeing Boards offer a new opportunity to make best use of the resources and skills of each of the member agencies. As part of the Health and Wellbeing Board at county level, SKC CCG will use its leadership role in commissioning to reduce dementia-related deaths and morbidity, and to improve socioeconomic determinants of health such as employment, housing, education, access to healthy food and an environment conducive to exercise.

As part of the local Health and Wellbeing Board it will share responsibility for services and policies that support local priorities, and have access to networks and voluntary organisations that can encourage better take up of primary health care services by those who are often hard to reach.

The CCG will support its member practices in providing excellent clinical care to all of their patients, following the principle of equity in identifying and treating the most vulnerable and difficult to engage patients, with an emphasis on evidence based practice and personalised care plans. It will also encourage GPs to recognise the powerful influence they can have on local and national policy makers by using their detailed knowledge of the realities of their patients' lives to advocate for change in factors that have an impact on health and wellbeing.

The Action Plan has the following components:

1. **Improving Equity in Access and Treatment**: through delivery of services in a proportionate way that permits outcomes to be the same, regardless of gender, ethnicity, age, vulnerability and deprivation, and using equity audits to inform commissioning.

2. **Doing the Job Properly**: ensuring that all member practices, and each organisation with which the CCG works in partnership, understand where their own responsibility lies in contributing to the reduction in health inequalities, and are held to account for delivering it

2. **Being Leaders**: recognising and using the influence of the CCG and its member practices to influence and shape policies and practices that have an impact on health and wellbeing, and to be advocates for our patients

4. **Making Every Contact Count**: ensuring that services are welcoming and sufficiently flexible in their working practices to respond to the needs of patients with complex needs, and enabling patients to act on the information they are given to improve their own health and wellbeing

5. **Going the Extra Mile**: supporting practices and services to work harder and go further for their own most deprived and vulnerable patients and in their care provision for other groups with complex needs including offenders, troubled families, looked after children and adults, and children with learning disabilities

From these components, **five key actions follow**:

1. The CCG will commission at least two Equity Audits each year. These audits will cover the whole pathway of care and will commence with services for conditions that evidence suggests are patchy, and which contribute most to premature mortality in the CCG area: eg Chronic Obstructive Pulmonary Disease (COPD), from smoking cessation and early identification in primary care to End of Life care. The results of the Equity Audits will be used to inform commissioning and provide the basis of a Health Inequalities position statement to be published in its annual report. Clinical Cabinet will receive biennial presentations on successful initiatives to reduce health inequalities by other commissioning organisations so that innovation may be informed by evidence.

2. CCG clinicians will lead the focus on health inequalities amongst their member practices by visiting their peers in order to discuss and listen to their experiences of providing equitable services, and to learn from the successes and difficulties they encounter

3. The CCG will celebrate and reward good practice amongst primary care teams in providing high quality, equitable care by introducing an annual award scheme

4. Protected Learning Time sessions will include training on health inequalities; covering evidence about inequity, what works, and practical steps that health care professionals can take to help patients change their lifestyle.

5. Through the partnerships with Health and Wellbeing Boards, the CCG will be pro-active in its approach to leading system change to support integration of services where this will lead to improvements in equitable care for vulnerable groups.

Dr Sarah Montgomery: GP Clinical Lead for Health Inequalities
Jess Mookherjee: Consultant in Public Health Kent

Public Health England

Dover

Health Profile 2013

This profile gives a picture of health in this area. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit the Health Profiles website for:

- Profiles of all local authorities in England
- Interactive maps – see how health varies between areas
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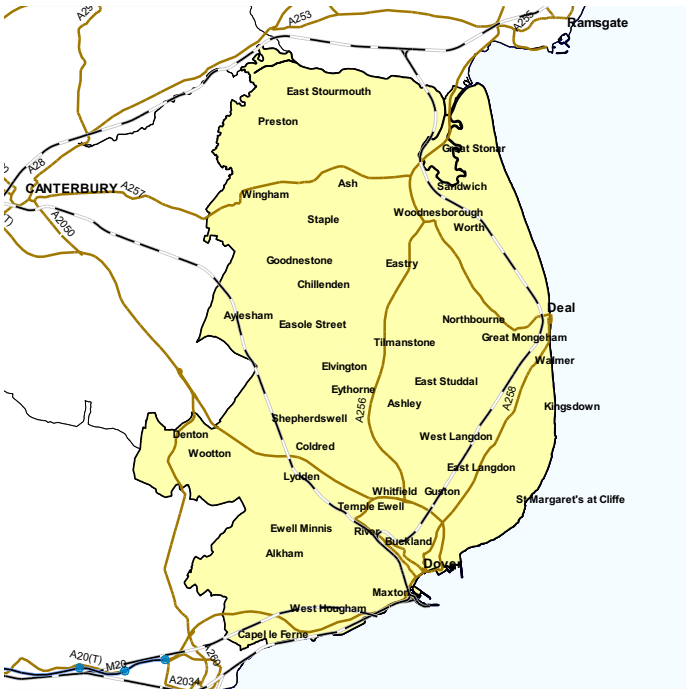
Health Profiles are produced by Public Health England.

www.healthprofiles.info



Population 112,000

Mid-2011 population estimate

Source: Office for National Statistics

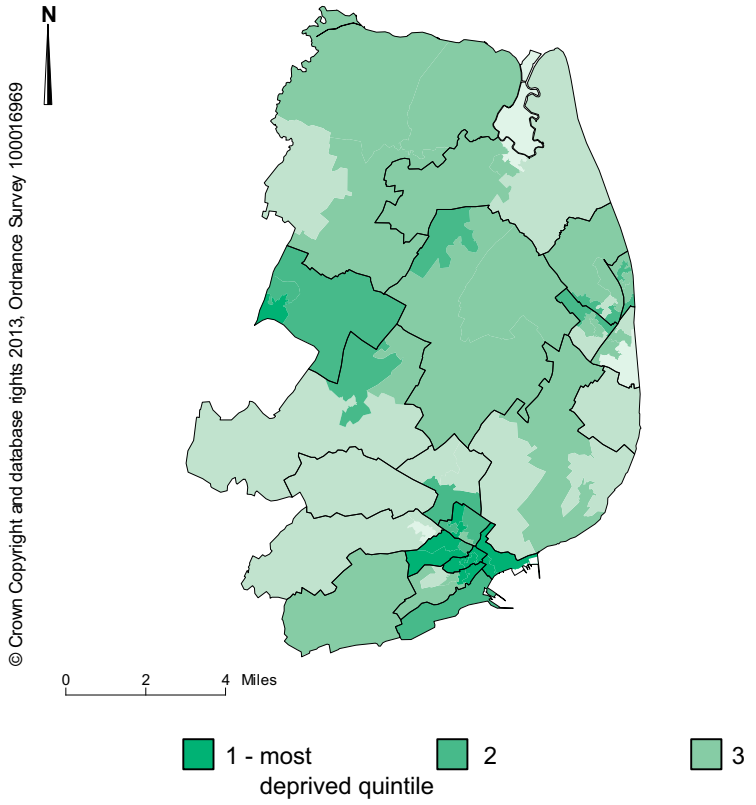
Published on 24th September 2013

Dover at a glance

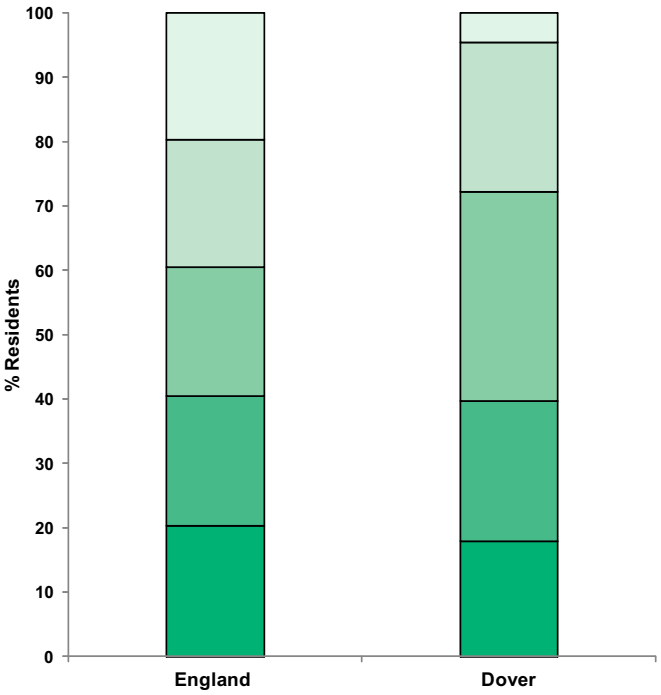
- The health of people in Dover is varied compared with the England average. Deprivation is lower than average, however about 4,100 children live in poverty. Life expectancy for both men and women is similar to the England average.
- Life expectancy is 7.5 years lower for men in the most deprived areas of Dover than in the least deprived areas.
- Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are similar to the England average.
- In Year 6, 20.5% of children are classified as obese. Levels of breast feeding and smoking in pregnancy are worse than the England average.
- Estimated levels of adult smoking and obesity are worse than the England average. The rate of smoking related deaths is worse than the England average. Rates of sexually transmitted infections, road injuries and deaths and hospital stays for alcohol related harm are better than the England average. The rates of statutory homelessness, violent crime, long term unemployment and drug misuse are better than average.
- Priorities in Dover include smoking in pregnancy, breast feeding and male life expectancy. For more information see www.southkentcoastccg.nhs.uk/ or www.kmpho.nhs.uk

Deprivation: **a national view**

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

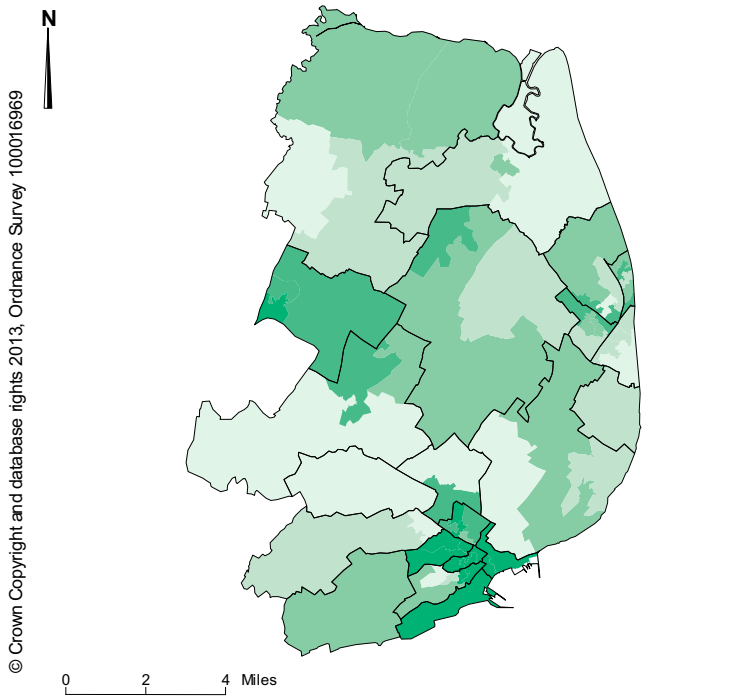


This chart shows the percentage of the population in England and this area who live in each of these quintiles.



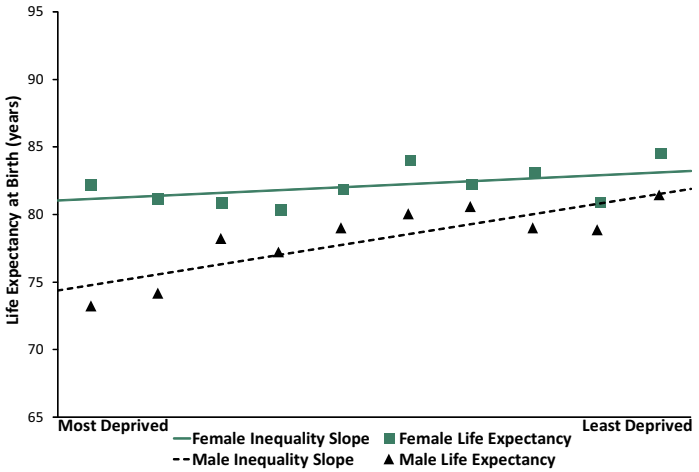
Health inequalities: **a local view**

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Legend as above

The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 7.5 years for males and 2.2 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.



Health inequalities: **changes over time**

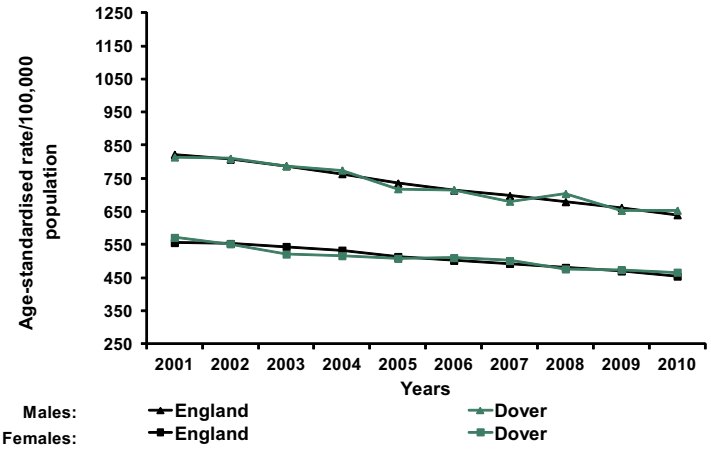
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

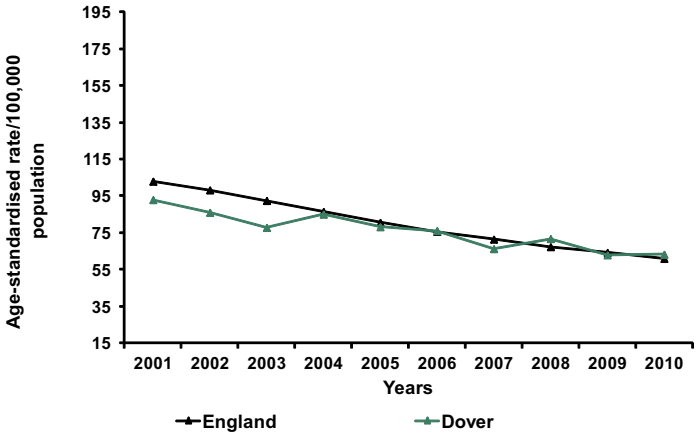
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

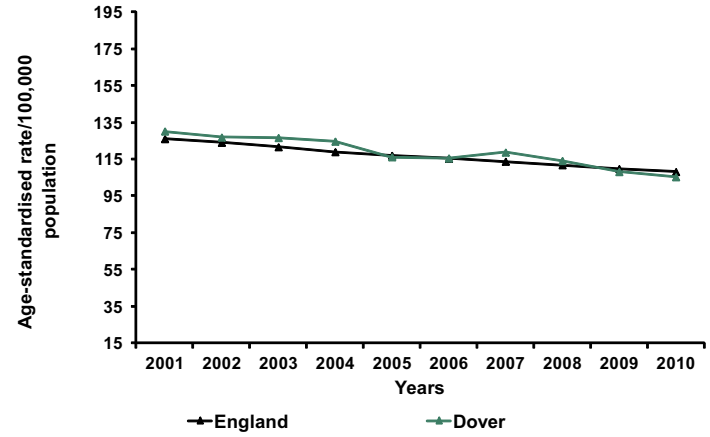
Trend 1:
All age, all cause mortality



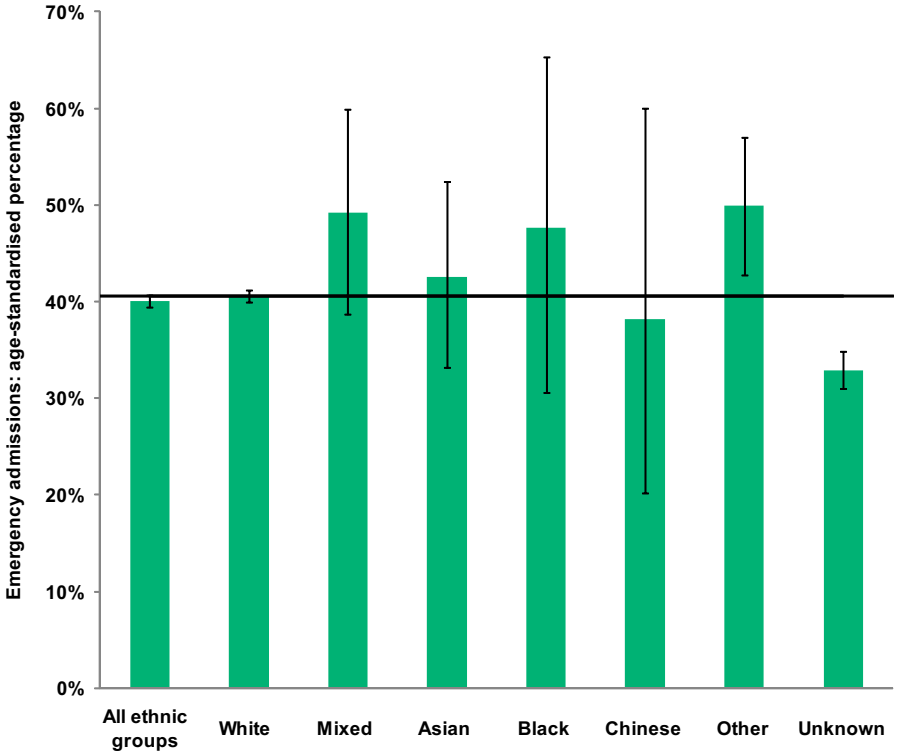
Trend 2:
Early death rates from heart disease and stroke



Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**



This chart shows the percentage of hospital admissions in 2011/12 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Dover

England average (all ethnic groups)

95% confidence intervals

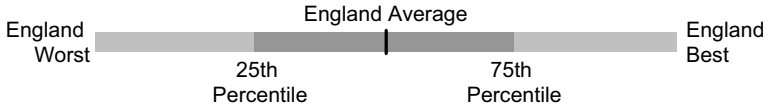
Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

11060	10137	44	45	13	7	96	718	**Local number of emergency admissions**
40.0%	40.6%	49.2%	42.5%	47.7%	38.1%	49.9%	32.9%	**Local value**
40.6%	41.1%	40.0%	45.3%	44.4%	38.0%	46.4%	30.1%	**England value**

Health summary for Dover

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	20075	18.0	20.3	83.7		0.0
	2 Proportion of children in poverty	4105	21.2	21.1	45.9		6.2
	3 Statutory homelessness	65	1.4	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	784	56.6	59.0	31.9		81.0
	5 Violent crime	1355	12.7	13.6	32.7		4.2
	6 Long term unemployment	530	7.7	9.5	31.3		1.2
Children's and young people's health	7 Smoking in pregnancy ‡	211	18.2	13.3	30.0		2.9
	8 Starting breast feeding ‡	834	71.7	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	199	20.5	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	13	58.0	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	82	38.4	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	27.4	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	22.7	22.3	25.1		15.7
	14 Healthy eating adults	n/a	26.0	28.7	19.3		47.8
	15 Physically active adults	n/a	56.2	56.0	43.8		68.5
	16 Obese adults ‡	n/a	26.8	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	18	15.4	14.5	28.8		3.2
	18 Hospital stays for self-harm	216	215.1	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	2466	1741	1895	3276		910
	20 Drug misuse	379	5.4	8.6	26.3		0.8
	21 People diagnosed with diabetes	5603	6.3	5.8	8.4		3.4
	22 New cases of tuberculosis	7	6.5	15.4	137.0		0.0
	23 Acute sexually transmitted infections	346	310	804	3210		162
	24 Hip fracture in 65s and over	148	488	457	621		327
Life expectancy and causes of death	25 Excess winter deaths ‡	66	17.5	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	78.5	78.9	73.8		83.0
	27 Life expectancy – female	n/a	82.5	82.9	79.3		86.4
	28 Infant deaths	7	5.8	4.3	8.0		1.1
	29 Smoking related deaths	241	233	201	356		122
	30 Early deaths: heart disease and stroke	92	63.2	60.9	113.3		29.2
	31 Early deaths: cancer	147	105.3	108.1	153.2		77.7
	32 Road injuries and deaths	37	33.3	41.9	125.1		13.1

‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2010 3 Crude rate per 1,000 households, 2011/12 4 % at Key Stage 4, 2011/12 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2011/12 6 Crude rate per 1,000 population aged16-64, 2012 7 % mothers smoking in pregnancy where status is known, 2011/12 8 % mothers initiating breast feeding where status is known, 2011/12 9 % school children in Year 6 (age 10-11), 2011/12 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2009-2011 12 % adults aged 18 and over, 2011/12 13 % aged 16+ in the resident population, 2008-2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % adults achieving at least 150 mins physical activity per week, 2012 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2008-2010 18 Directly age sex standardised rate per 100,000 population, 2011/12 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 21 % people on GP registers with a recorded diagnosis of diabetes 2011/12 22 Crude rate per 100,000 population, 2009-2011 23 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2011/12 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.08-31.07.11 26 At birth, 2009-2011 27 At birth, 2009-2011 28 Rate per 1,000 live births, 2009-2011 29 Directly age standardised rate per 100,000 population aged 35 and over, 2009-2011 30 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 31 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 32 Rate per 100,000 population, 2009-2011

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

Public Health England

Shepway

Health Profile 2013

This profile gives a picture of health in this area. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

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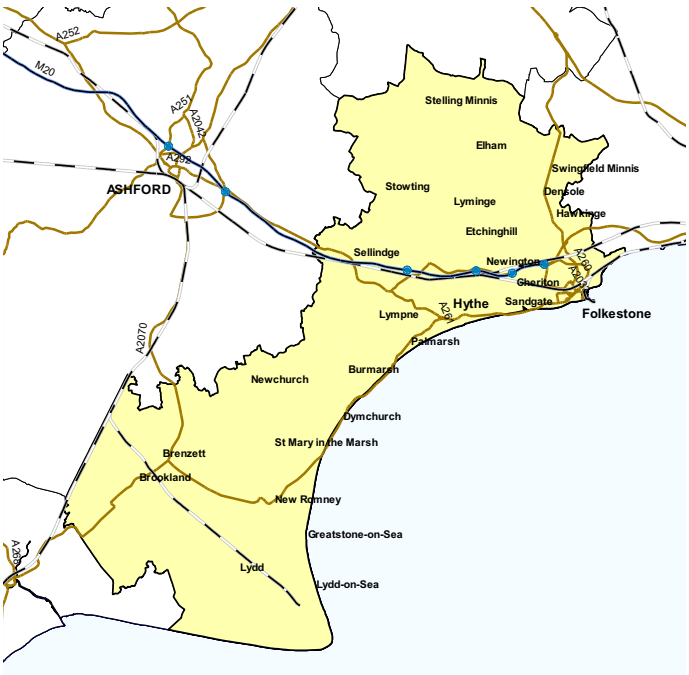


Population 108,000

Mid-2011 population estimate

Source: Office for National Statistics

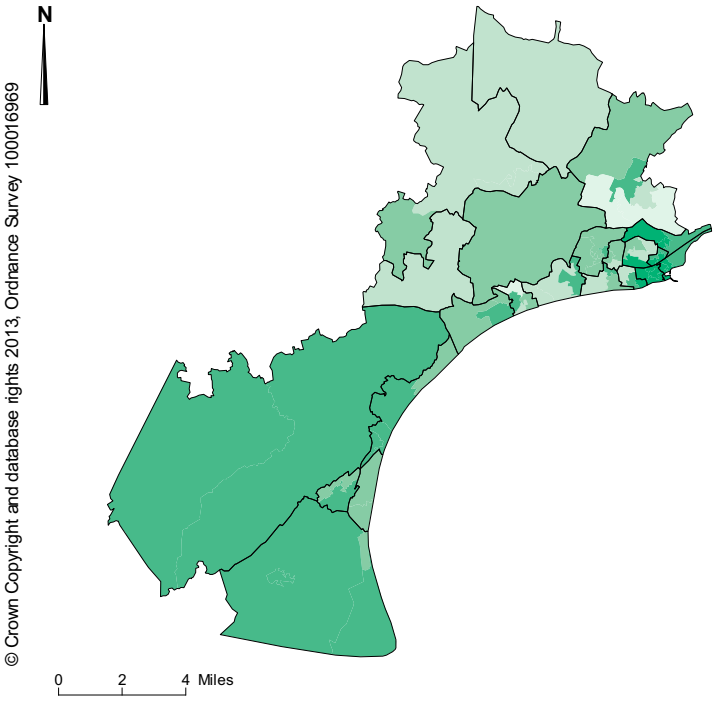
Published on 24th September 2013

Shepway at a glance

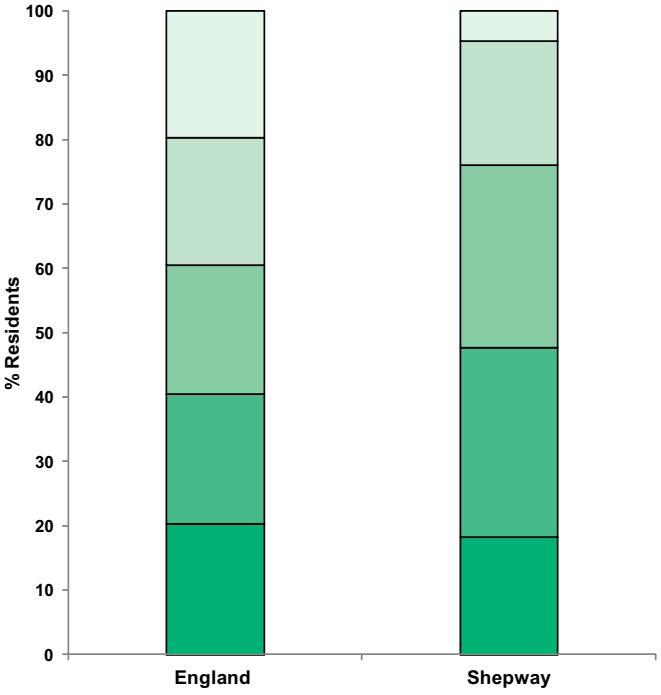
- The health of people in Shepway is varied compared with the England average. Deprivation is lower than average, however about 4,200 children live in poverty. Life expectancy for women is higher than the England average.
- Life expectancy is 9.4 years lower for men and 6.9 years lower for women in the most deprived areas of Shepway than in the least deprived areas.
- Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have also fallen.
- In Year 6, 19.1% of children are classified as obese. Levels of teenage pregnancy, breast feeding and smoking in pregnancy are worse than the England average.
- The estimated level of adult physical activity is worse than the England average. Rates of sexually transmitted infections, road injuries and deaths and hospital stays for alcohol related harm are better than the England average. The rates of long term unemployment and hospital stays for self-harm are worse than average. The rates of statutory homelessness and drug misuse are better than average.
- Priorities in Shepway include physically active children and adults, smoking in pregnancy and teenage pregnancy. For more information see www.southkentcoastccg.nhs.uk/ or www.kmpho.nhs.uk

Deprivation: **a national view**

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.



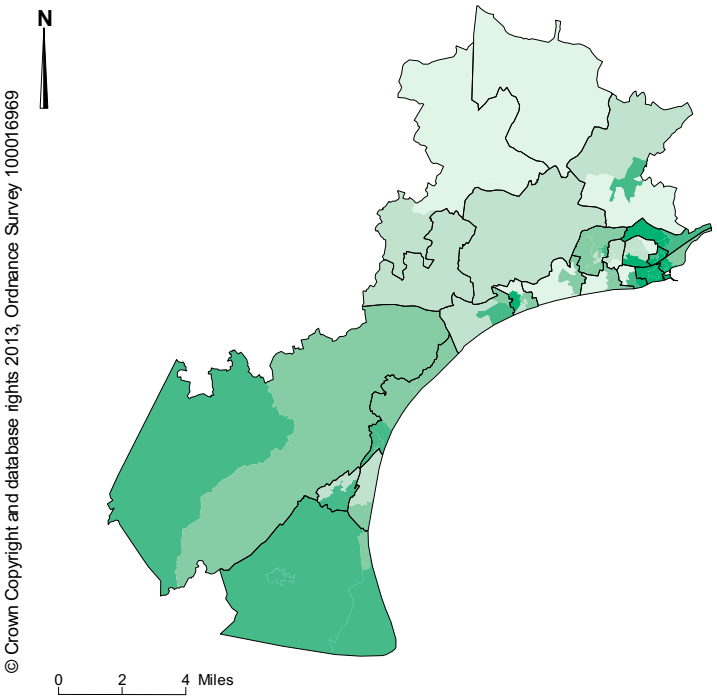
This chart shows the percentage of the population in England and this area who live in each of these quintiles.



1 - most deprived quintile | 2 | 3 | 4 | 5 - least deprived quintile

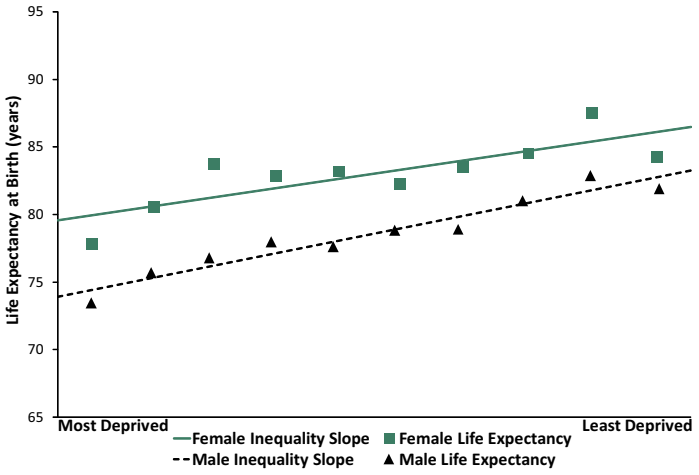
Health inequalities: **a local view**

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Legend as above

The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 9.4 years for males and 6.9 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.



Health inequalities: **changes over time**

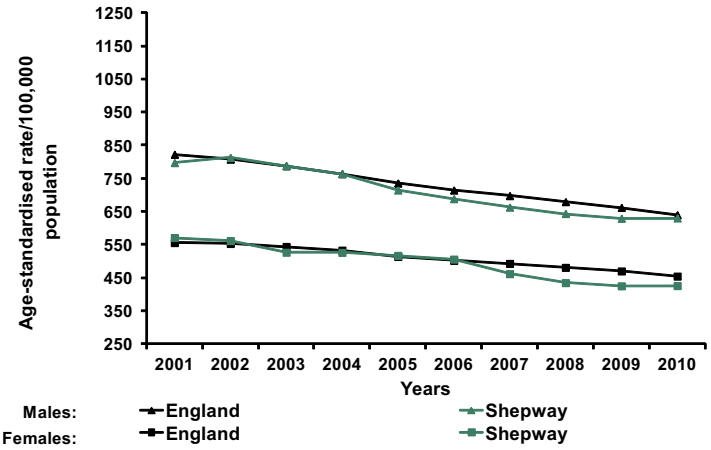
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

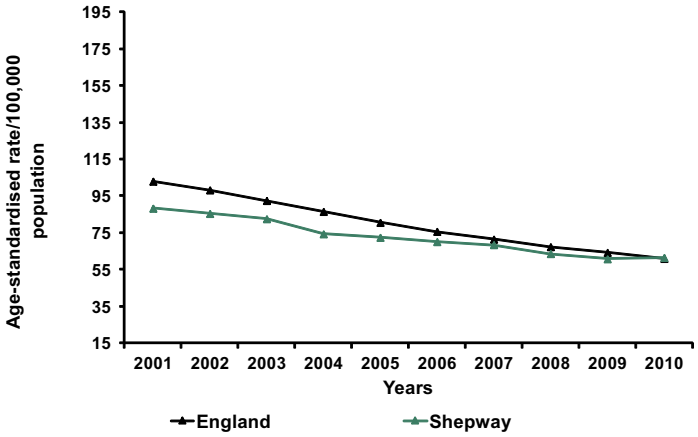
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

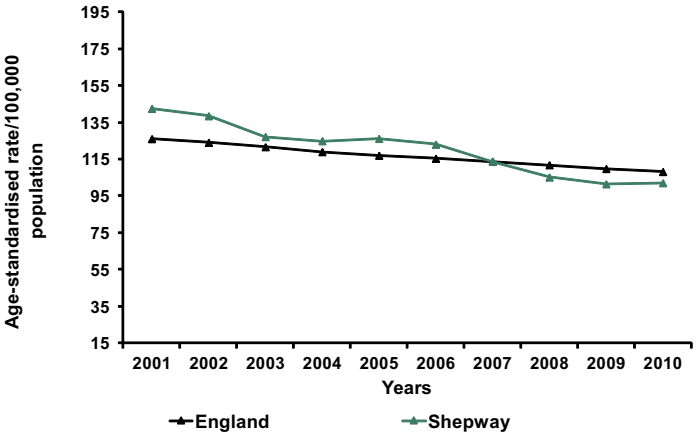
Trend 1:
All age, all cause mortality



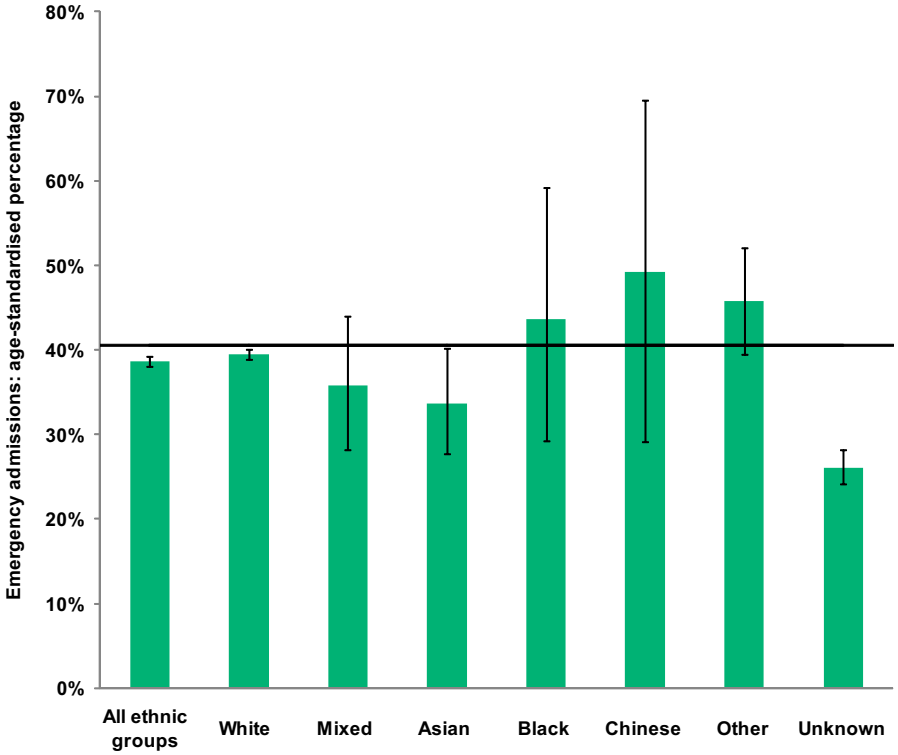
Trend 2:
Early death rates from heart disease and stroke



Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**



This chart shows the percentage of hospital admissions in 2011/12 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Shepway

England average (all ethnic groups)

95% confidence intervals

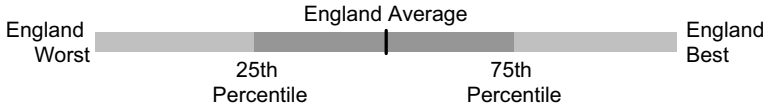
Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

11000	10272	51	74	16	9	411	467	**Local number of emergency admissions**
38.6%	39.5%	35.7%	33.7%	43.7%	49.2%	45.8%	26.1%	**Local value**
40.6%	41.1%	40.0%	45.3%	44.4%	38.0%	46.4%	30.1%	**England value**

Health summary for Shepway

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	19798	18.3	20.3	83.7		0.0
	2	Proportion of children in poverty	4225	22.2	21.1	45.9		6.2
	3	Statutory homelessness	55	1.3	2.3	9.7		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	640	60.3	59.0	31.9		81.0
	5	Violent crime	1326	13.1	13.6	32.7		4.2
	6	Long term unemployment	716	10.8	9.5	31.3		1.2
Children's and young people's health	7	Smoking in pregnancy ‡	213	18.2	13.3	30.0		2.9
	8	Starting breast feeding ‡	844	71.7	74.8	41.8		96.0
	9	Obese Children (Year 6) ‡	197	19.1	19.2	28.5		10.3
	10	Alcohol-specific hospital stays (under 18)	13	63.0	61.8	154.9		12.5
	11	Teenage pregnancy (under 18) ‡	78	39.2	34.0	58.5		11.7
Adults' health and lifestyle	12	Adults smoking	n/a	20.9	20.0	29.4		8.2
	13	Increasing and higher risk drinking	n/a	22.1	22.3	25.1		15.7
	14	Healthy eating adults	n/a	26.6	28.7	19.3		47.8
	15	Physically active adults	n/a	48.7	56.0	43.8		68.5
	16	Obese adults ‡	n/a	25.9	24.2	30.7		13.9
Disease and poor health	17	Incidence of malignant melanoma	15	13.4	14.5	28.8		3.2
	18	Hospital stays for self-harm	233	240.4	207.9	542.4		51.2
	19	Hospital stays for alcohol related harm ‡	2421	1747	1895	3276		910
	20	Drug misuse	437	6.5	8.6	26.3		0.8
	21	People diagnosed with diabetes	6005	6.5	5.8	8.4		3.4
	22	New cases of tuberculosis	10	10.2	15.4	137.0		0.0
	23	Acute sexually transmitted infections	686	634	804	3210		162
	24	Hip fracture in 65s and over	159	476	457	621		327
Life expectancy and causes of death	25	Excess winter deaths ‡	86	25.1	19.1	35.3		-0.4
	26	Life expectancy – male	n/a	79.3	78.9	73.8		83.0
	27	Life expectancy – female	n/a	83.7	82.9	79.3		86.4
	28	Infant deaths	3	2.5	4.3	8.0		1.1
	29	Smoking related deaths	223	218	201	356		122
	30	Early deaths: heart disease and stroke	86	61.5	60.9	113.3		29.2
	31	Early deaths: cancer	141	102.1	108.1	153.2		77.7
	32	Road injuries and deaths	33	31.2	41.9	125.1		13.1

‡ For comparison with PHOF Indicators, please go to the following link: **www.healthprofiles.info/PHOF**

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2010 3 Crude rate per 1,000 households, 2011/12 4 % at Key Stage 4, 2011/12 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2011/12 6 Crude rate per 1,000 population aged16-64, 2012 7 % mothers smoking in pregnancy where status is known, 2011/12 8 % mothers initiating breast feeding where status is known, 2011/12 9 % school children in Year 6 (age 10-11), 2011/12 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2009-2011 12 % adults aged 18 and over, 2011/12 13 % aged 16+ in the resident population, 2008-2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % adults achieving at least 150 mins physical activity per week, 2012 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2008-2010 18 Directly age sex standardised rate per 100,000 population, 2011/12 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 21 % people on GP registers with a recorded diagnosis of diabetes 2011/12 22 Crude rate per 100,000 population, 2009-2011 23 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2011/12 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.08-31.07.11 26 At birth, 2009-2011 27 At birth, 2009-2011 28 Rate per 1,000 live births, 2009-2011 29 Directly age standardised rate per 100,000 population aged 35 and over, 2009-2011 30 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 31 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 32 Rate per 100,000 population, 2009-2011

More information is available at **www.healthprofiles.info** Please send any enquiries to **healthprofiles@phe.gov.uk**