KENT COUNTY COUNCIL

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, 25 May 2016.

PRESENT: Mr R W Gough (Chairman), Mr I Ayres, Dr B Bowes (Vice-Chairman), Dr M Cantor (Substitute for Dr F Armstrong), Ms H Carpenter, Mr P B Carter, CBE, Ms F Cox, Mr G K Gibbens, Mr S Inett, Mr A Ireland, Dr N Kumta, Dr E Lunt, Mr G Lymer (Substitute for Mr P J Oakford), Dr T Martin, Mr S Perks, Dr S Phillips, Mr A Scott-Clark, Dr R Stewart, Cllr P Watkins and Cllr L Weatherly

ALSO PRESENT: Mr G Douglas and Mr M Ridgwell

IN ATTENDANCE: Mr T Godfrey (Policy and Relationships Adviser (Health)), Mr M Sage (Finance Manager (Frontline Services)), Mrs A Tidmarsh (Director, Older People and Physical Disability) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

212. Chairman's Welcome

(Item 1)

(1) The Chairman thanked Members for their support for letter that he and Mr Gibbens had sent to ministers and others in relation to pharmacies.

(2) He also welcomed Dr Phillips to the Board.

213. Apologies and Substitutes

(Item 2)

(1) Apologies for absence were received from Dr Armstrong, Dr Chaudhuri, Ms Davies, Mr Oakford and Cllr Pugh.

(2) Dr Cantor and Mr Lymer attended as substitutes for Dr Armstrong and Mr Oakford respectively.

214. Declarations of Interest by Members in items on the agenda for this meeting

(Item 3)

There were no declarations of interest.

215. Minutes of the Meeting held on 16 March 2016

(Item 4)

Resolved that the minutes of the meeting held on 16 March 2016 are correctly recorded and that they be signed by the Chairman.

216. Draft Sustainability and Transformation Plans - Presentation
(Item 5)

(1) The Chairman welcomed Glenn Douglas (Maidstone and Tunbridge Wells NHS Trust) and Michael Ridgwell (NHS England – Kent and Medway) who gave a presentation on Delivering the Five Year Forward View. A copy of the presentation is available on line as an appendix to these minutes.

(2) It was confirmed that the 1% of budget that CCGs were required to keep as a surplus was not available for their use and was often used to support providers' deficits.

(3) In response to questions, Mr Douglas said there were variations in the development of plans across Strategic and Transformation Plan (STP) areas but there was an expectation that by the end of June all plans would be sufficiently developed to enable them to be assessed. The development of the STP in Kent and Medway was not significantly behind the development of plans elsewhere and a meeting with NHS England would take place in July to agree an implementation plan. The plans were currently in a draft stage.

(4) Mr Douglas said the STP would set out the vision for health and social care provision, options for delivery and a plan for delivering the vision. He also said the direction of travel set out in the STPs submitted by the end of June would be an important, but not the only, factor in the determination of the financial allocation over the next five years.

(5) Mr Douglas also said: it was important to develop a system-wide understanding of the implications of commissioning intentions; the East Kent Strategy Board had begun to do this in East Kent and a similar exercise was required for West Kent.

(6) Mr Ridgwell said that the STP was a five-year strategy that would lead to plans with clear targets and milestones.

(7) The emphasis in the STP on preventing people being admitted to hospital was welcomed and the need to move away from relying on small scale public health services (relating to smoking cessation, health weight and alcohol use) to deliver large scale impacts was recognised.

(8) Comments were also made about the importance of challenging assumptions and understanding individual organisations' objectives as well as identifying 3-5 key actions to deliver sustainable health and social care services across Kent.

(9) The desirability of replicating the Vanguard model elsewhere in Kent was acknowledged as was the role of the Kent Integration Pioneer.

(10) The Integration Pioneer had been renamed the Kent and Medway Integration Pioneers and as well as being a working group of both the Kent and Medway HWBs it was suggested that it could become a working group of the Kent and Medway five- year forward view group. In addition, the Design and Learning Centre for Clinical and Social Innovation had been launched to make out of

hospital care safer with an initial focus on developing a prototype of an Integrated Community Healthcare Centre which, if rolled out across Kent, could radically reduce the need for acute care beds and ensure a shift of investment from the acute sector to the community as well as attracting innovation funding.

(11) Resolved that the presentation be noted.

217. The Kent Better Care Fund
(Item 6)

(1) Anne Tidmarsh (Director Older People and Physically Disabled) and Mark Sage (Finance Manager) introduced the report which set out the Better Care Fund (KBCF) Plan for 2016-17, the approval process and the development of the S75 Agreement as well as the final outturn position of the KBCF for 2015/16.

(2) Mr Sage said: the 2016-17 plan built on previous plans for establishing an integrated system and supported the implementation of the STPs; funding for the KBCF had increased to £105m for 2016/17 from £101m in 2015/16; the Social Care Capital Grant had ceased and the funding for the Disabled Facilities Grant had increased from £7.2m to £13.1m. Mr Sage also said that a Deed of Variation was being drafted to cover the continuation of the joint commissioning arrangements and drew particular attention to the KBCF outturn for 2015/16 set out in paragraph 5 of the report.

(3) In response to questions, it was confirmed that the Disabled Facilities Grant was now allocated to district and borough councils and was not a direct replacement for the Social Care Capital Grant.

(4) Attention was also drawn to the work planned for 2016/17 to assess and design a further phase of adult social care transformation and it was confirmed that this would be presented to the HWB in due course.

(5) Resolved that:

(a) The Kent BCF plan submitted to NHS England be endorsed;

(b) The work undertaken as part of the assurance process be noted;

(c) The progress towards the S75 Agreement 2016/17 be noted.

218. Workforce Task and Finish Group - Final Report and Recommendations
(Item 7)

(1) Tristan Godfrey (Policy and Relationships Adviser) introduced the report which summarised the findings of the task and finish group including the five priority areas that had been identified, an indicative action plan, and proposals to consolidate and operationalise the work.

(2) Mr Godfrey outlined the background to the establishment of the task and finish group and said that the recommendations of the group were intended to be supportive of the STP implementation.

(3) Mrs Tidmarsh said that, although the Task and Finish Group had completed its work, the work should continue in the form of a working group of the Integration Pioneer Steering Group that would align with the Workforce Action Board to identify best practice in health and social care and support the STP.

(4) During the discussion it was suggested that: the health of the workforce providing health and social care be included in the work of the Workforce Action Board to ensure staff modelled good lifestyle behaviours; assumptions should be tested in one or two community hubs and used to inform planning for wider implementation; some issues would need to be escalated nationally; there would be a need to assess which aspects of health and care work could be safely transferred to other staff and involve the voluntary sector and others in the delivery of care.

(5) Resolved that:

(a) It be agreed that the Workforce Task and Finish Group had completed its work but that the work should continue in the form of a working group of the Integrated Pioneer Steering Group and be aligned with the Workforce Action Board to meet the needs of the STP;

(b) The priority work areas for the group be those identified by the Task and Finish Group. That is
- existing and emerging gaps
- new models of care
- productivity
- recruitment and retention
- cross-cutting – “the Brand of Kent”

(c) The principle that the developing action plan recognises the importance of the activities at both the local and county-wide level be supported.

219. Addressing Obesity: Progress Report from Local Health and Wellbeing Boards
(Item 8)

(1) Andrew Scott-Clark introduced the report which provided information about the progress of local health and wellbeing boards in addressing obesity as requested by the Kent Health and Wellbeing Board at its meeting in November 2015. He said a national childhood obesity strategy was scheduled for publication during the summer, a county-wide obesity strategy was being developed and suggested that both strategies be considered by the Board in due course.

(2) Comments were made about: the difficulties in tackling obesity given the extensive advertising of foods containing fat, sugar and salt; the potential need for legislation similar to that used to reduce the number of smokers; and the need to measure the outcome of any interventions to reduce obesity.

(3) Resolved that:

(a) Obesity continues to be a priority for the local HWBBs across Kent;

(b) Tackling obesity be integral to the prevention strategy of the sustainability and transformation plan;

(c) A county-wide partnership healthy weight group be set up with representation from the local healthy weight groups/HWBB;

(d) The group be responsible for monitoring the progress of the local action plans and sharing learning.

220. Abridged Kent Joint Strategic Needs Assessment (JSNA) Overview Report 2016
(Item 9)

(1) Mr Scott-Clark introduced the report which included an abridged version of the refreshed Kent Joint Strategic Needs Assessment (JSNA) Overview Report 2016. He said that the report focussed attention on the key locality and Kent wide priorities that had emerged during the refresh.

(2) He drew particular attention to the eight priorities set out in paragraph 1.4 of the report.

(3) Comments were made about the differences in life expectancy across the county and the potential need for different levels of funding to close the gap as well as the need for consistent interventions at scale. It was also suggested that at the next review of commissioning plans the Board considered the extent to which they take the JSNA into account.

(4) In response to a question, Mr Scott-Clark said that although dementia was not specifically mentioned in the abridged JSNA report, it was a clear priority and outcome in the Health and Wellbeing Strategy and would be reviewed in detail by the HWB in November 2016.

(5) Resolved that the key strategic findings of the refreshed JSNA Overview Report 2016 and the priorities be endorsed.

221. Forward work programme of the Board
(Item 10)

Resolved that the Forward Work Programme be approved subject to the inclusion of the HealthWatch Annual Report on the agenda for the Health and Wellbeing Board meeting on 21 September 2016.

222. Minutes of the 0-25 Health and Wellbeing Board
(Item 11)

Resolved that the minutes of the meetings of the 0-25 Health and Wellbeing Board held on 12 January and 26 March be noted.

223. Minutes of the Local Health and Wellbeing Boards
(Item 12)

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

Ashford – 23 March 2016
Canterbury and Coastal – 9 March 2016
Dartford, Gravesham and Swanley – 6 April 2016
South Kent Coast – 26 January 2016
Swale – 27 January 2016
Thanet – 24 March 2016
West Kent – 19 April 2016

224. Date of Next Meeting - 20 July 2016
(Item 13)

(a) **FIELD**
(b) **FIELD_TITLE**

Delivering the Five Year Forward View

- National planning context
- Funding
- The challenge (population demographics including inequalities, quality, performance, finance)
- Governance
- Complexity of Kent and Medway
- Our four main focus areas
- Next steps

National planning context

The national planning guidance, Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 (NHS England, December 2015), outlined the requirement for local health and social care systems to develop:

- a five-year Sustainability and Transformation Plan (STP), place-based and outlining how the Five Year Forward View (FYFV) will be delivered; and
- a one-year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP (to form year-one of the five-year STP).

What we need to cover

The planning guidance indicates that the three interdependent and essential tasks that need to be progressed through the STP are to:

- improved health and wellbeing;
- transformed quality of care delivery; and
- sustainable finances.

…but also establish more robust system leadership.

The 10 big questions we need to answer

How are you going to prevent ill health and moderate demand for healthcare?

How are you engaging patients, communities and NHS staff?

How will you support, invest in and improve general practice?

How will you implement new care models that address local challenges?

How will you achieve and maintain performance against core standards?

How will you achieve our 2020 ambitions on key clinical priorities?

How will you improve quality and safety?

How will you deploy technology to accelerate change?

How will you develop the workforce you need to deliver?

How will you achieve and maintain financial balance?

Funding

- Place-based funding allocations for the period 2016/17 to 2020/21 were published by NHS England in January, comprising CCG allocations, primary care medical allocations and specialised services allocations.
- Separate additional funding has been identified and initially held at a national level for the sustainability and transformation fund, and other elements of transformation such as primary care.
- Kent and Medway 2016/17 STP place-based allocation is £2,897m in 2016/17.
- Allocation rises to £3,287m in 2020/21, without sustainability and transformation funds.
- Allocation rises by £122m to £3,409m in 2020/21 with indicative sustainability and transformation funds.
- Allocations for 2020/21 are indicative, not firm, and the additional funding will actually be distributed based on progress and the strength of STPs or using other targeted approaches.

The challenge

- We are facing a demographic and demand time bomb, with growth in the over 65s population four times that of under 65s. This means by 2020 the over 65s will make up nearly 20% of our total population.
- Significant housing development (e.g. Thames Gateway and Ashford).
- Within Kent and Medway we continue to have unacceptable levels of health inequalities and deprivation for an affluent part of the South East. In one of the most deprived areas of the county, Thanet, a woman who lives in the best ward for life expectancy can expect to live 21.88 years longer than a woman who live in the worst ward for life expectancy.
- We are struggling to recruit to key health and social care roles (for example, 10% of nursing posts are vacant).
- Modelling indicates we need to radically re-shape the health economy to provide far more out of hospital services and preventative support.
- Financially we are no longer managing within the available resources, with a deficit of circa £106m deficit in 2015/16, which rises significantly over the next five years unless we change the way we deliver care.

Our population

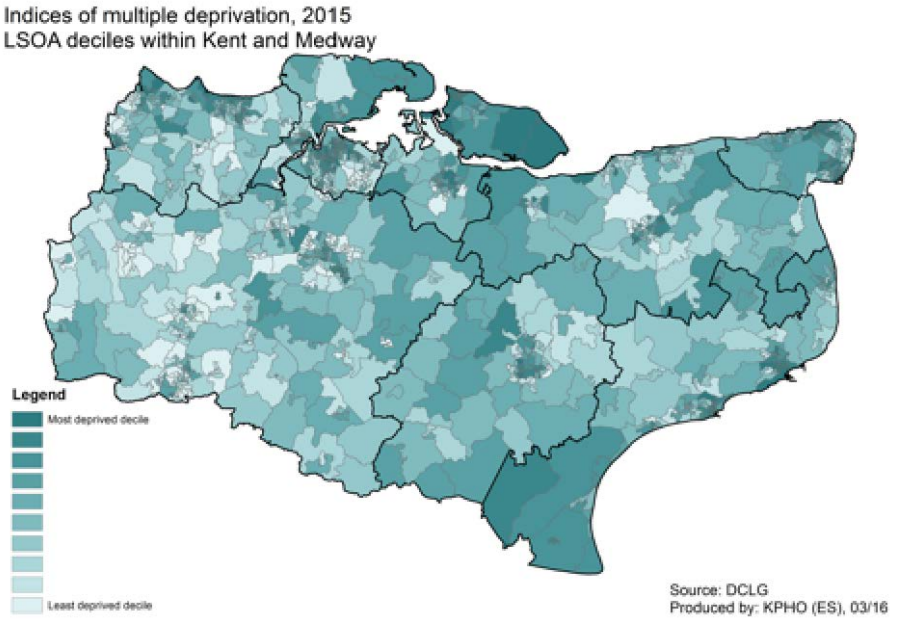
In 2011 the base population for Kent and Medway was calculated as 1,731,400. By 2031 this is projected to increase to 2,024,700, an increase of 293,300 that is equivalent to a 17% rise (circa 42,000 for Medway and 251,000 for Kent). In particular, the percentage of old people, who are living longer with multiple co-morbidities, is changing and by 2021 it is projected there will be a:

25.5% increase in number aged 65 years +

34.1 % increase in the number aged 85 years +

It is important to understand population changes at a local level as the above figures mask significant local variation.

The projected 17% increase in the local population also includes population increases as a result of a planned 158,500 additional dwellings that are expected between 2011 and 2031. These developments will have a skewed impact on different areas. There are significant developments planned in Dartford, Ebbsfleet and Ashford. There are also significant housing developments in Bexley, South-East London, which are not factored into the housing numbers referenced above but whose residents would look to Darent Valley Hospital as their local acute provider.



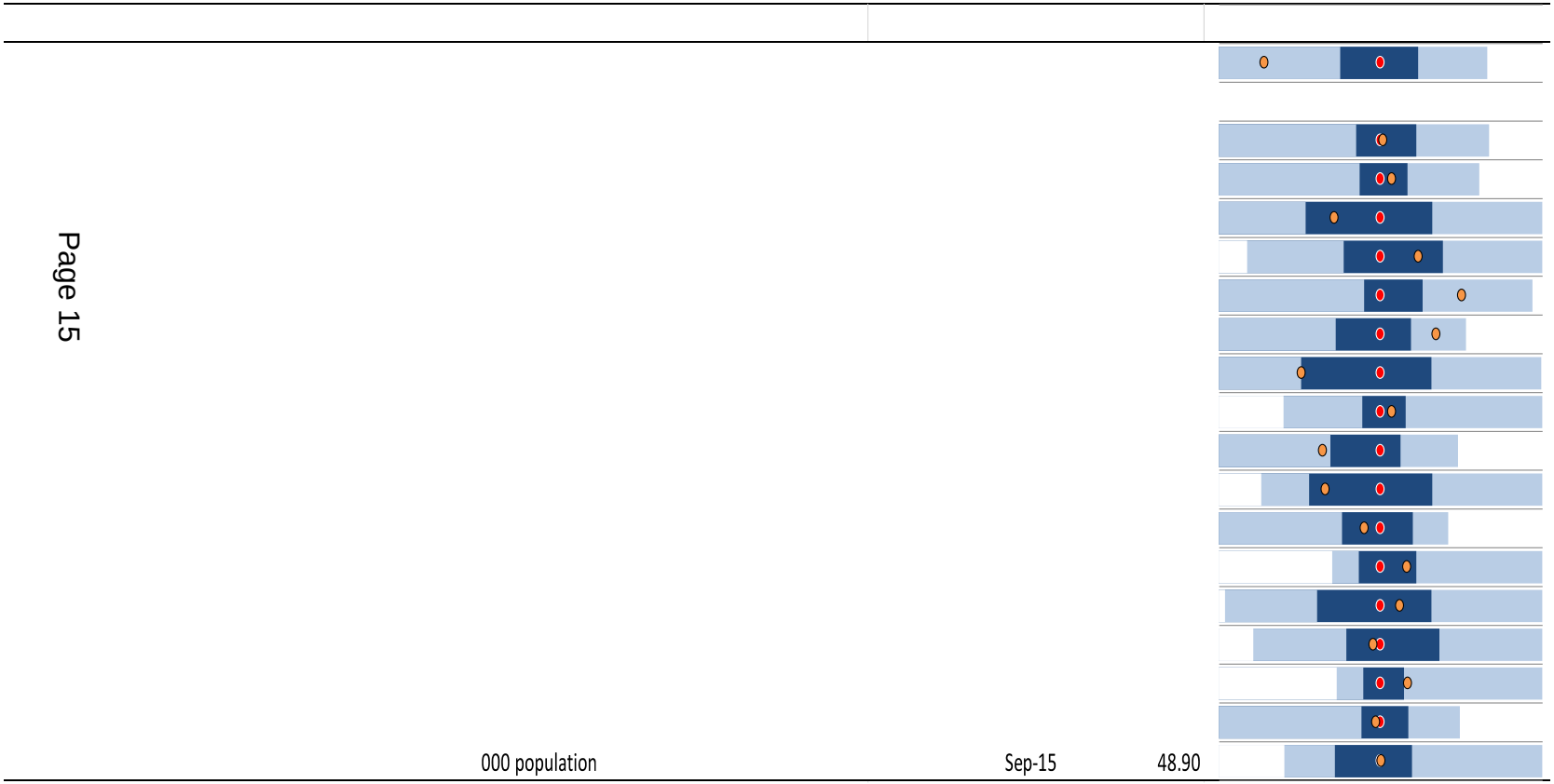
Financial position (NHS organisations)

	Quarter 3 financial forecast for 2016/17	
Organisation	Forecast financial outturn position for 31/03/16 (£/m)	%
Maidstone and Tunbridge Wells NHS Trust	-23.5	-5.9%
Medway NHS Foundation Trust	-58.1	-23.2%
Dartford and Gravesham NHS Trust	-7.9	-3.5%
East Kent University Hospitals Foundation NHS Trust	-33.9	-6.4%
Kent Community Health NHS Foundation Trust	3.5	1.5%
Kent and Medway NHS and Social Care Partnership Trust	-4.3	-2.3%
South East Coast Ambulance Foundation NHS Trust (across Kent, Surrey and Sussex)	0	0
Trust total	**-124.1**	**-6.8%**
Swale CCG	1.4	1.0%
Medway CCG	3.6	1%
Darford, Gravesham and Swanley CCG	0	0
West Kent CCG	5.6	1.0
Ashford CCG	0	0
Canterbury and Coastal CCG	2.7	1%
South Kent Coast CCG	2.8	1%
Thanet CCG	2.1	1%
CCG Total	**18.2**	**0.8%**
Net System Total:	**-105.9**	

Performance against targets

KEY - STP Range

The spine chart shows the relative performance of the STP – towards the right of the scale indicates “better” performance (which may relate to a lower or higher indicator value depending on the indicator in hand) and towards the left of the scale indicates “worse” performance. Percentiles are based on national data.



Population Characteristics

	Period	England	Kent and Medway STP	Ashford	Canterbury And Coastal	Dartford, Gravesham And Swanley	Medway	South Kent Coast	Swale	Thanet	West Kent
Obesity: QOF prevalence (16+)	2014/15	9.0	9.4	9.3	7.8	9.3	12.0	10.9	11.3	9.3	7.6
Percentage of physically inactive adults	2014	27.7	28.3	29.1	30.6	27.0	29.6	27.4	32.4	34.5	25.7
Estimated smoking prevalence (QOF)	2014/15	18.4	18.9	18.2	17.4	18.2	20.5	21.4	22.5	23.5	16.0
Smoking cessation support and treatment offered	2014/15	94.1	93.8	92.3	93.3	94.0	95.7	94.8	95.2	92.8	92.2
Alcohol-specific hospital admission	2013/14	374		212	327	261	243	290	196	412	271
Hypertension: QOF prevalence (all ages)	2014/15	13.8	14.5	14.3	14.0	14.5	14.1	16.3	14.9	16.2	13.6
Depression: QOF prevalence (18+)	2014/15	7.3	7.5	8.6	7.6	5.6	8.3	7.5	7.8	9.0	7.0
Learning disability: QOF prevalence	2014/15	0.4	0.4	0.4	0.4	0.3	0.4	0.7	0.4	0.6	0.3
Premature mortality from coronary heart disease	2014	40.0		33.3	28.5	34.7	53.3	31.2	52.9	54.1	27.0
Premature mortality from stroke	2014	13.5		6.4	12.8	20.7	18.5	14.2	9.2	8.9	12.2
Premature mortality from respiratory disease	2013	28.1		26.5	26.9	23.7	35.4	33.6	40.2	25.4	24.2

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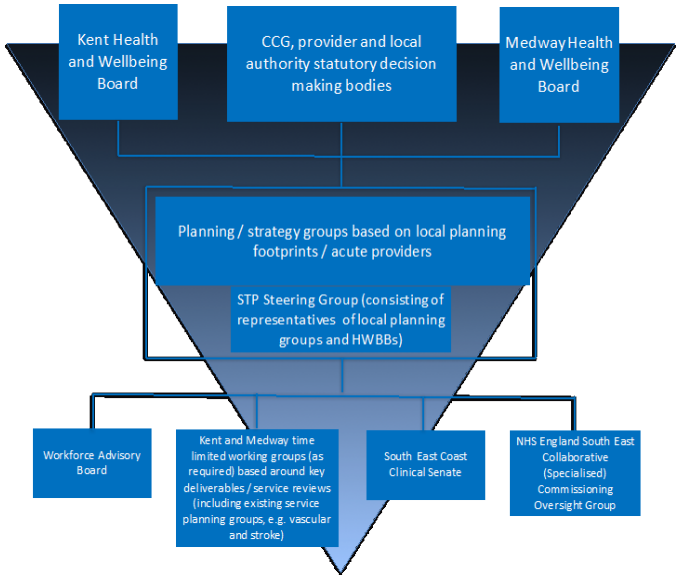
Outcome of CQC inspections (SECamb are not shown as inspected under the old system and now being re-inspected; Medway Community Healthcare have their services inspected individually)

	DGT	EKUHFT	KCHFT	KMPT	MFT	MTW
	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement
Safe						
Effective						
Caring						
Responsive						
Well-led						

	Good
	Requires improvement
	Inadequate

Governance

- Have been on a “journey” with organisations and worked at reaching a consensus around the approach and now good buy-in from constituent organisations
- Whilst still a focus on local planning a strong recognition of the K&M footprint, supported by a commitment to work together
- STP Steering Group formed and meeting (draws representation from local planning arrangements, HWBBs and upper tier local authorities – through this all statutory bodies have a seat at the table)



- Work streams initiated and / or existing working groups given new direction
- However, governance will need to be revisited and will need to evolve
- A proposed structure for the submission has been prepared and currently under review to ensure ownership (content being added)

Complexity of Kent and Medway

Like many areas Kent and Medway is complex. Working to a single STP footprint doesn't negate the need to work at different levels.

Eight CCGs working on the development of integrated primary, community and social care focused around four planning footprints

East Kent Strategy Board

A21 / A229 Corridor *

Kent and Medway

* Includes part of East Sussex that is outside the STP area and the Dartford and Gravesham NHS Trust vanguard with Guy's and St Thomas' NHS Foundation Trust

Our four main focus areas

1. Self-care and prevention (public health departments have developed the Kent and Medway plan) with identified health and finance benefits
2. Strengthened primary care and integrated out of hospital care (including mental health and social care)
3. Acute hospital strategy (including mental health):
   i. East Kent Strategy Board
   ii. A21 / A229
   iii. Pan Kent and Medway services (e.g. hyper acute stroke and vascular surgery)
4. Cost reduction measures (including “Carter” efficiencies)

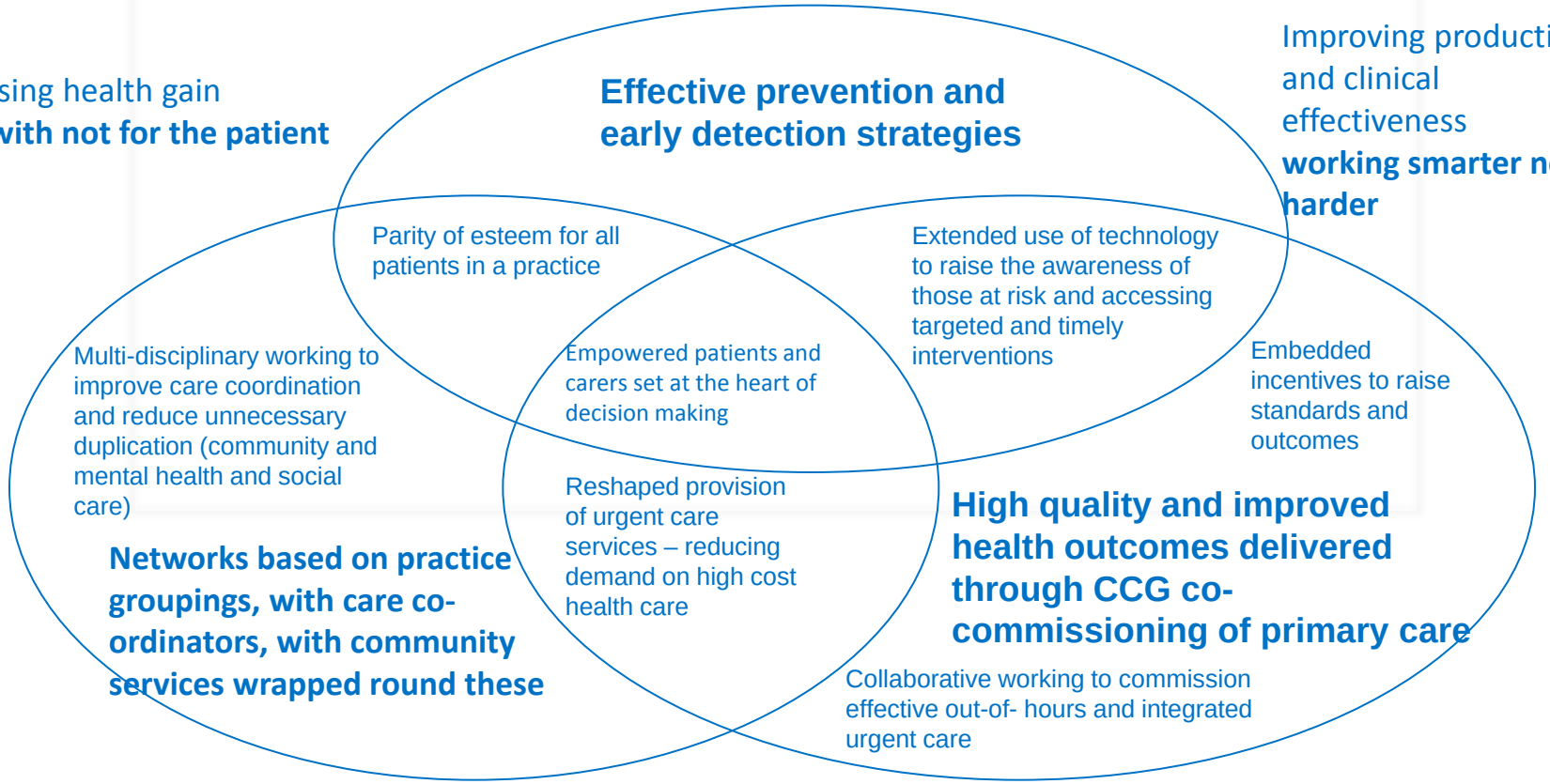
Self-care and prevention

- **Reducing the gap in health and wellbeing outcomes - working across the entire health and care system:** evidence suggests that poorer health behaviours and related outcomes, such as obesity prevalence, smoking prevalence, and higher premature mortality rates correlate strongly with deprived areas.
- **Making Every Contact Count:** use the millions of day to day interactions that organisations and individuals have with people to support them in making positive changes to their physical and mental health and wellbeing.
- **Primary prevention through lifestyle services,** focusing on:
  - **Improving mental health and wellbeing**, addressing:
    - *post-natal depression (PND)*
    - *depression in older people*
    - *conduct disorder mental health (prolonged anti-social behaviour)*
  - **Increasing smoking cessation**
  - **Increasing physical activity**
  - **Addressing overweight and obesity**
  - **Tackling alcohol misuse**

Primary care and integrated out of hospital care (networks of care focused on populations of 30,000 to 60,000 based on GP lists)

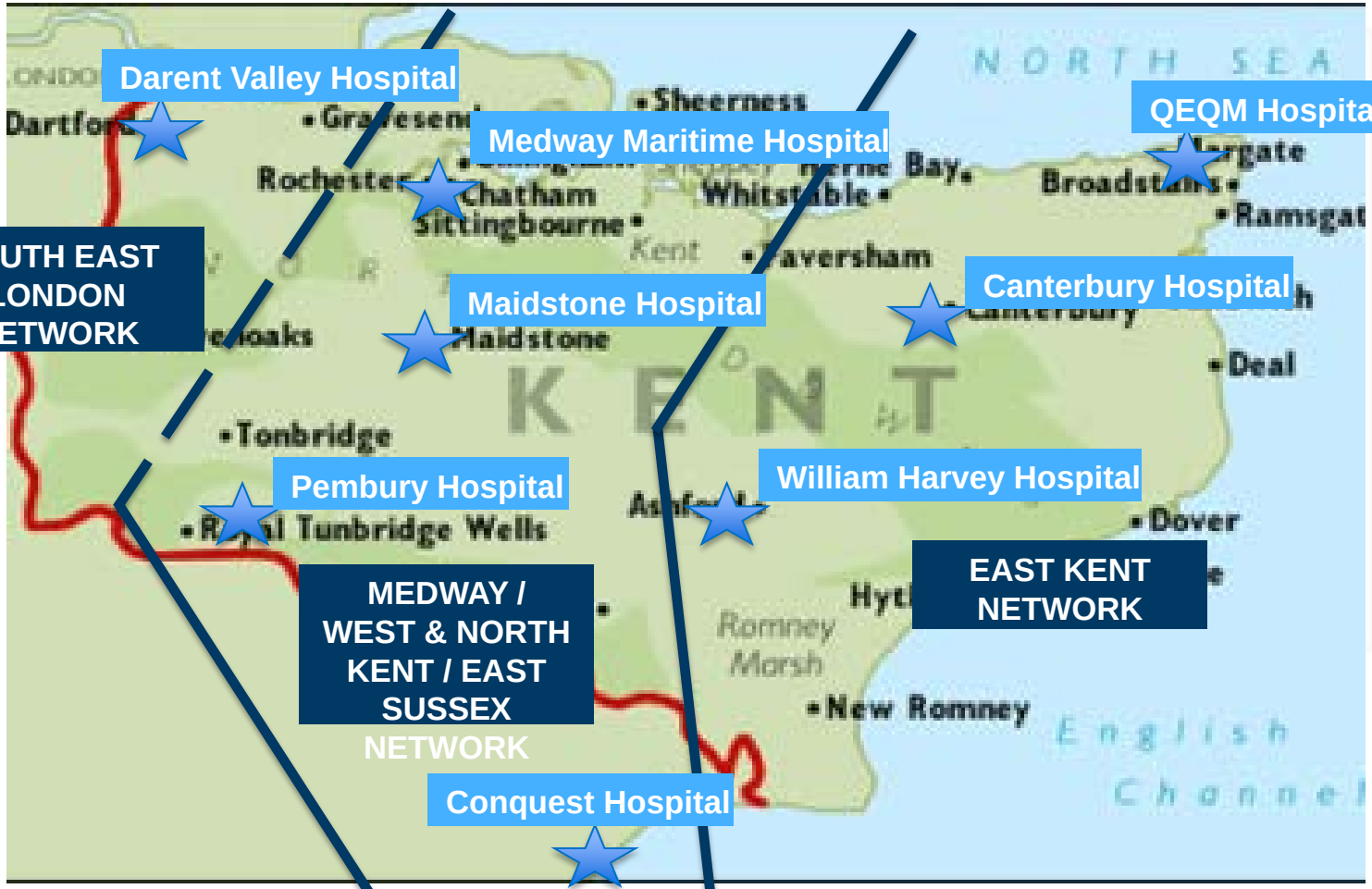
- Delivering the general practice Five Year Forward View
- A focus on multi-disciplinary team working, with shared decision making with the patient, focused around the patient's own health goals
- Risk stratification linked to detailed care planning and coordination of the highest risk patients (care coordination)
- Colocation of services, with telemedicine, and immediate access to an extended range of diagnostic services
- On site medicines management support and integration of pharmacist support into primary care and self-care pathways
- Effective triage and streaming, with rapid access for those who are most ill
- Patient held records that are interoperable between primary / community and secondary care
- Multi-disciplinary training
- Joint evaluation of quality outcomes for quality improvement
- Shared clinical protocols with secondary care
- A focus on well-being and prevention

From reactive to proactive



Care networks securing sustainability and resilience
focusing on people not conditions

Acute Strategy – emerging relationships



= Current major acute hospital site

Mental Health

Promoting wellbeing and reducing poor mental health:

- Use of Open Dialogue – systemic family intervention psychologically based
- Use of community assets to strengthen response – building communities and social networks and social prescribing
- Taking a preventative strategy where every contact counts
- Building on existing suicide prevention work

Integrated Physical and Mental Health Services:

- Biannual MHH/PH health checks for those with SMI and adherence checks
- Training on stigma for physical health teams
- Management of LTCs on an integrated manner – use of MCP
- Adoption of peer support model of recovery college in physical health

Improve crisis response:

- Integrated single point of access
- Implementation of an alternative place of safety
- Implementation of a Mental Health Decision Unit
- Development of liaison to include medically unexplained symptoms
- Crisis - use of virtual beds

Enabling strategies

- **Digital:**
  - To support direct care, including prevention and self-care
  - To support the sharing of patient information (including more electronic information in hospitals)
  - To support us to develop a better understanding of how the system is operating and the demands being placed upon it (informatics)
- **Workforce:** In terms of workforce there are two challenges:
  - Recruiting and retaining the required staff (
  - Initiatives to address the challenge that the number of posts that local organisations are seeking to fill is greater than the number of people within the employment market)
  - Transforming the roles of our staff to deliver new care models.
- **Estates: optimise utilisation**
- **Leadership:** develop shared system leadership

Cost Reduction

- Activity growth moderated by circa 1% on a sustainable basis
- Provider efficiency of at least 2% on a sustainable basis (Including Lord Carter efficiencies):
  - Pharmacy initiatives
  - Procurement efficiencies
  - Pathology
  - Electronic staff rostering, sickness and absence rates
  - Estate utilisation (clinical vs non-clinical)
  - Back office (administration) efficiencies
- Through expansion of best practice and ending “inexplicable” variation

Next steps

- Modelling to better understand financial and capacity gap
- Work-up four focus areas
- 30th June checkpoint submission (stocktake of work in progress)
- July review meeting with NHS England and NHS Improvement
- Further work over the summer

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