AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 20th July, 2016, at 6.30 pm Ask for: **Ann Hunter**

Darent Room, Sessions House, County Hall, Maidstone Telephone **03000 416287**

Refreshments will be available 15 minutes before the start of the meeting

Membership

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

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1 Chairman's Welcome

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes

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

To receive any declarations of Interest by Members in items on the agenda for the meeting

4 Minutes of the Meeting held on 25 May 2016 (Pages 5 - 10)

To receive and agree the minutes of the last meeting

5 Kent Environment Strategy (Pages 11 - 16)

To receive a report on the Kent Environment Strategy, links with the Health and Wellbeing Strategy and the work of Clinical Commissioning Groups.

6 Kent and Medway Crisis Care Concordat - Annual Report (Pages 17 - 36

To note progress and support planned work across agencies

7 Review of Outcome 2 - Prevention of Ill-health (Pages 37 - 46)

To receive an overview on Outcome 2 of the Kent Health and Wellbeing Strategy and plans for the future Kent Mind the Gap Action Plan aimed at reducing health inequalities.

8 Kent Health and Wellbeing Board Work Programme (Pages 47 - 50)

To agree a Forward Work Programme

9 Minutes of the Local Health and Wellbeing Boards (Pages 51 - 70)

To note the minutes of local health and wellbeing boards as follows:

Canterbury and Coastal – 10 May 2016
Dartford, Gravesham and Swanley – 6 April 2016
South Kent Coast – 17 May 2016
Thanet – 26 May 2016

10 Date of Next Meeting - 21 September 2016

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(03000) 416647

Tuesday, 12 July 2016

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**

From: Carolyn McKenzie Kent County Council

To: Kent Health and Well Being Board – 20 July 2016

Subject: Health and the Kent Environment Strategy

Summary: The *Kent Environment Strategy: A strategy for environment, health and economy* was adopted by Kent Leaders in November 2015, and Kent County Council in January 2016. Following this, a draft implementation plan is being developed focusing on those actions that are best delivered in partnership, giving the greatest outcome.

The purpose of this report is twofold: to highlight the links between the Kent Environment Strategy, the Health and Wellbeing Strategy and the work of Clinical Commissioning Groups, particularly associated risks and opportunities and to identify areas of activity where working together could lead to shared positive benefits and outcomes.

1. Introduction

1.1 The Kent Environment Strategy: A strategy for environment, health and economy (KES) was agreed by Kent Leaders in November 2015 and adopted by Kent County Council in January 2016. The strategy is currently being taken through borough and district authority decision processes. A draft implementation plan is being developed to deliver the strategic priorities identified. Activities within the plan will be outcome focused with a number of partners taking ownership of individual actions.

1.2 As a result of the development of the sustainability chapter of the JSNA, a significant change in the revised Strategy is the strengthened links between health and environment. There are a number of health risks related to environmental factors for example poor air quality, but also opportunities to deliver positive health benefits, particularly in relation to the natural and historic environment.

1.3 This report seeks to match the priorities of the KES against the Health and Well Being Strategy and the Public Health Outcomes Framework, identifying joint priorities for action,, where resources could be maximised and additional benefits achieved.

2. Health and Environment – Joint and Shared Priorities

2.1 Domains One and Two of the Public Health Framework and Outcome Two of the Kent Health and Wellbeing Strategy make the strongest links between health and the environment.

2.2 The areas where environmental factors have the most significant impact on health outcomes and indicators, both positive and negative, which could be tackled through joint commissioning are highlighted below.

- Utilisation of open space and the natural and historic environment to tackle health issues such as obesity, isolation and mental health

- Support for Active Travel initiatives which will have a positive impact on air quality, as well as obesity, mental health

- Initiatives to improve the warmth of the homes of those residents with pre-existing health conditions to reduce excess winter deaths and support independent living

- Identification and mitigation of the health risks of climate change and severe weather events on the health of Kent residents

2.3 There is now considerable research documenting these links and the mutual benefits that can be achieved through health and environment professionals co-commissioning outcomes. For example, supporting conservation volunteering can tackle obesity, social isolation and mental health issues and more directly the Kent Warm Homes and Winter Warmth project targets excess winter deaths as well as carbon reduction through installing heating systems in homes of those with pre-existing health conditions.

2.4 Appendix 1 maps the links between the Public Health Indicators and the KES Priorities and highlights some existing initiatives that are already delivering positive benefits. However, activity to date has not been consistent across Kent and much more could be achieved through the implementation of the KES.

3. Conclusions

3.1 There are strong links between health and the environment, both risks and also opportunities. Many positive benefits and outcomes could be achieved by those in the health and environment sectors co-developing and co-commissioning environment and health initiatives.

3.2 As part of the development and delivery of the KES, it is recommended that the Kent Health and Wellbeing Board agree a number of priority areas as outlined in section two of this report where health and environment professionals should be encouraged and supported by the HWBB to work together and jointly commission mutually beneficial outcomes.

9. Recommendations

The Health and Wellbeing Board is asked to:

1. Discuss the areas of synergy between the public health outcomes, the Kent Health and Wellbeing Strategy and the Kent Environment Strategy and agree the priority areas for action as highlighted in section two that will be supported and by the HWBB

2. Identify key personnel to work with the KES team to take these initiatives forward

3. Identify areas where more support is needed by health partners from the KES team

10. Background Documents – Kent Environment Strategy

http://www.kent.gov.uk/environmentstrategy

11. Contact details

Carolyn McKenzie Kent County Council
07740 185287 carolyn.mckenzie@kent.gov.uk

Appendix 1: Health and Environment Synergies		
Public Health Outcome	**Kent Environment Strategy Priority**	**Existing/potential initiatives**
Natural Environment – Access to/use of Green Spaces 1.16 Utilisation of outdoor space for exercise/health reasons 1.18 Social Isolation	1.1 Strengthen our understanding of the health, social and economic value of our natural and historical assets. 7.1 Improved access for all	Volunteering – Country Parks and Countryside Management Partnerships Green Gyms Forest Schools Explore Kent - promoting access to the countryside
Air Quality 3.01 Fraction of mortality attributable to particulate air pollution (England 5.3, South East 5.2, Kent 5.4)	1.5 Build our understanding of local air and noise pollution and associated health outcomes to determine targeted actions 7.2 Support residents, businesses and communities in being well connected to services, with sustainable and active travel options	Low Emissions Strategy (Development) Active Travel Strategy JAMBUSTERS - Support take up of Active Travel options – schools travel planning to reduce car use and support active travel
Fuel Poverty 1.17 Fuel Poverty Excess Winter Deaths	6.2 Improve the resource efficiency of our homes, reducing costs, tackling fuel poverty and improving health outcomes	Kent Warm Homes – www.kent.gov.uk/warmhomes and Winter Warmth Kent Fuel Poverty Action Plan
Severe Weather/climate change 3.07 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	1.2 Continue to assess the economic, health and social impacts of climate change on our businesses, services and residents and take action where appropriate.	Joint Strategic Needs Assessment Review, to incorporate new risks identified by the Committee on Climate Change Risk Assessment (12 July 06) Public Health Champions Training

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NHS
West Kent
Clinical Commissioning Group

Kent and Medway Mental Health Crisis Care Concordat

Kent Health and Wellbeing Board

20th July 2016

Patient focused, providing quality, improving outcomes

Summary
The paper provides an update on the commitments made in the Mental Health Crisis Care Concordat (MHCCC) across Kent and Medway. It provides an overview of the work that has both been completed and that is ongoing as part of the action plan.

A multi-agency framework is delivering Kent and Medway MHCCC plans through a partnership approach. This area of work is being addressed by use of existing and planned commissioning intentions and service delivery arrangements and through new partnership arrangements within Crisis Concordat focus working groups.

Recommendation

Members of the Board are asked to note progress and support planned work across agencies

1. Budget and Policy Framework

1.1. The Joint Health and Wellbeing Strategy for Kent set five strategic outcomes. Outcome 4 is that people with mental health issues are supported to 'live well'.

1.2. The NHS Forward View and local NHS CCG 2/5 year plans set a key strategic outcome to meet the national objective of improving parity of esteem and reducing inequalities for people with mental health problems

1.3. There is no additional or dedicated Mental Health Crisis Care Concordat budget identified in the national Crisis Care Concordat. Implementation of its commitments, the cost of governance arrangements and operational changes are matters for partnership agencies and are expected to be made through existing resources, or in future commissioning decisions.

2. Background:

2.1. The Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis, was published by Department of Health on 18th February 2014 and signed by 22 National Organisations, including NHS England, the Association of Chief Police Officers, the Local Government Association, Public Health England, the Care Quality Commission, the Royal College of General Practitioners, Mind, the Association of Directors of Children's Services (ADCS), and Adult Social Services (ADASS) and the Royal College of Psychiatrists.

2.2. The National Concordat Signatories made a commitment "to work together, and with local organisations, to prevent crisis happening whenever possible through prevention and early intervention. We will make sure we meet the

needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery".

2.3. The Concordat also provides important guidance based on service user experience about what is needed as urgent help.
It sets out the case for change, the core principles and four domains around which outcomes should be designed and measured:

- Access to support before Crisis Point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well/preventing future crisis

2.4 The signatories of the Concordat expect local partnerships between the NHS, Local Authorities and the Criminal Justice System to work to embed the Concordat principals into service planning, commissioning and service delivery.

2.5 The Mandate from the government to NHS England for 2014-15 established specific objectives including that "Every community to have plans to ensure no one in Crisis will be turned away, based on the principles set out in this Concordat".

2.6 The National Concordat recognised that real change can only be delivered locally and expects every locality across England to work together through local partnerships to adopt and implement its principals. This should be evidenced by/or the publication of a local Mental Health Crisis Care Concordat setting out the commitment of local agencies for:

- The development of a shared action plan to enable delivery;
- A commitment to reduce the use of police stations as places of safety;
- Evidence of sound local governance arrangements.

2.7 This expectation was reiterated in a joint letter to the Chairs of Health and Wellbeing Boards on 27th August 2014 from the Minister of State for Care and Support and the minister of State for Policing and Criminal Justice (see Background Papers).

2.8 This was further reiterated in the Queens Speech and the plans for the implementation of the Police and Criminal Justice Bill which will take forward the policing powers elements of the review of the use of sections 135 and 136 of the Mental Health Act 1983, including:

- prohibiting the use of police cells as places of safety for those under 18 years of age and further reducing their use in the case of adults
- reducing the current 72 hour maximum period of detention
- extending the power to detain under section 136 to any place other than a private residence

3. Governance and Process

3.1 Prior to the publication of the National Concordat, a Kent and Medway Policing and Mental Health Partnership Board were already in place with representation from NHS, the Local Authorities and the Police. This group was set up to address concerns over the lack of Mental Health Act S136 place of safety for children and young people in the county. This group provided the basis for the formal Kent and Medway Concordat Steering Group.

3.2 The group is Co-Chaired by Dave Holman, Head of Mental Health and Children's Commissioning, West Kent CCG & Rachel Ireland, Chief Superintendent, Head of Strategic Partnership Command, Kent Police

3.3 Membership of the Kent & Medway Concordat Steering Group includes:

- Kent and Medway Clinical Commissioning Groups (with West Kent CCG as the lead CCG)
- South East Coast Ambulance Service (SECAmb)
- Kent & Medway NHS and Social Care Partnership Trust (KMPT)
- Kent Police
- Sussex Partnership NHS Foundation Trust;
- Medway Council
- Kent County Council
- South East Commissioning Support Unit
- South London and Maudsley NHS Foundation Trust
- Medway NHS Foundation Trust
- West Kent Mind
- Samaritans
- Healthwatch
- The Magistrates Association.

3.4 Kent and Medway MHCCC declaration and initial action plan was first published in December 2014 in line with national guidance. The action plan is updated at after each MHCCC meeting.

3.5 The Steering Group developed a Multi-agency Action plan to enable the Concordat's core principles and outcomes to be delivered locally (see background papers). The plan is organised to address the four domains set out at 2.3. The Action Plan was last updated in May 2016.

3.6 There are three focused Task and Finish groups which can show tangible outcomes to achieve the core principles of the Concordat, ensuring the group's limited resources are better utilised. The current Task and Finish groups focus on:

a) Section 136 reductions in line with mandate from central government and as locally this is an urgent area to resolve.
b) The crisis prevention agenda and on supporting people following a mental health crisis (including Mental Health Triage Service, Acute Liaison Services and Crisis Café)
c) Single Point of Access development to provide a 24/7 access to a multi-disciplinary mental health team

3.7 Key performance indicators have been developed to measure the progress of delivery for each task and finish group.

3.8 Local governance for the local Mental Health Crisis Care Concordat is in place, the Concordat report directly to the Kent & Medway Health and Wellbeing Boards on an annual basis to monitor progress and for each board to provide the strategic partnership framework, which is crucial for this service area

3.9 A robust system of resolution exists to collate and analyse serious incidents at operational level between Kent Police and KMPT and incidents not deemed to meet the criteria of the Serious/Adverse Incident process are investigated locally by a network of Single Points of Contact, which has been agreed across different agencies so lessons can be learnt and applied to avoid and prevent future serious incidents. Serious Incidents are reported on through the MHCCC.

3.10 Over the last 12 months there have been 36 reported serious incidents, of which, zero incidents remain outstanding

4. Progress to date

4.1 Overall good progress continues to be made by the Kent & Medway Concordat Steering Group. The multi-agency action plan demonstrates the complexity of work that is required to ensure there is urgent and emergency access to crisis care for a person experiencing a mental health crisis; locally the response needs to be proportionate, focused upon the person's needs and co-ordinated across partner agencies.

4.2 A range of Kent and Medway CCGs' commissioning plans and intentions 2016/17 have been developed in line with Concordat requirements and good practice. The focus is on developing services to support patients in crisis and preventing attendance at Accident & Emergency and avoiding acute psychiatric admission. These include the developments of 24/7 acute Liaison Psychiatry, 111 service improvements , Street Triage initiative ,Crisis cafes and a focus on supporting Frequent attenders within the acute environment with holistic packages of support.

4.3 Reduction of Section 136:

4.3.1 The main aim of the crisis prevention agenda is to reduce the need for section 136 admissions and to provide alternative intervention services for people in crisis. (see 4.4– 4.6)

4.3.2 Kent and Medway have limited access to hospital based places of safety for both adults and children. There is currently one S136 Place of Safety for children and young people operational in the county, which is situated in Dartford. However it is recognised that there needs to be an increase in capacity, due to the fact that the suite in Dartford has two beds, and if a child is placed there, the other bed becomes unavailable. Currently negotiations are taking place between CCGs and KMPT to provide additional capacity in Canterbury and Maidstone to alleviate the risk to children and young people.

4.3.3 Arrangements to enhance smooth transition pathways across children and adult agencies are embedded in contracts for 2016/17. This includes operational co location between children and adult crisis services on a 24/7 basis.

4.3.4 Despite commissioning intentions to support people in crisis, such as street triage, which aims to help reduce the number of S136's, numbers have not significantly reduced and the trend to date indicates that S136's are increasing, this is due to a number of factors:-

- Limitations of the street triage service which only runs 3 nights a week
- Lack of alternative places of safety, such as the Sanctuary model in Manchester. This will be even more significant from April 2017 when new legislation comes into effect removing the use of police cells as a place of safety in all but violent patients that can't be managed in a health based place of safety
- Lack of crisis support such as crisis cafes

- Population of Kent, which has the 3rd highest prevalence of S136 nationally

4.3.5 Canterbury Christchurch University have been commissioned to undertake research to look at the demographics and contributing factors for why Kent has such a high rate of S136 nationally.

4.3.6 In the twelve month period from May 2015 to April 2016, 1018 section 136 assessments were undertaken for people presenting to the police from across Kent and Medway, (862 for Kent & 156 for Medway) of these 8% (79) resulted in an admission under section compared to 21% in 2014/15. 122 (12%) resulted in an informal admission and 817 (80%) were not admitted. The table below provides a monthly breakdown and summary of the outcome of these presentations.

	2015-05	2015-06	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	Grand Total
Admitted Informal	3	6	4	3	12	6	16	6	5	6	8	4	79
Admitted Sectioned	5	8	15	6	11	9	7	20	11	7	11	12	122
Not Admitted	64	73	69	71	61	56	70	79	68	71	68	67	817
Grand Total	**72**	**87**	**88**	**80**	**84**	**71**	**93**	**105**	**84**	**84**	**87**	**83**	**1018**

4.3.7 Work with partner organisations continues through the Crisis Concordat Steering group which has a great emphasis on reducing S136. The Policing and Crime Bill, currently before Parliament, seeks to make a number of amendments to the use of section 136. For example, it will seek to define what is meant by “exceptional circumstances”, it will remove police custody as a place of safety for people aged 17 and younger, and it will reduce the amount of time a person can be detained under section 136. These, and other proposals contained within the Bill will likely have the effect of further reducing the use of police custody for these detentions.

Crisis Prevention Agenda

4.4 Mental Health Triage Service (MHTS):

4.4.1 MHTS is when mental health professionals (usually mental health nurses) provide on-the-spot advice to Police Officers who are dealing with people with possible mental health problems. This advice can include a clinical opinion on the person’s condition, or appropriate information sharing about a person’s health history.

4.4.2 The aim is, where appropriate, to help police officers make appropriate decisions, based on a clear understanding of the background to these

situations. This should lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of section 136.

4.4.3 All CCGs across Kent and Medway have been working closely with KMPT in the development of a new service model for MHTS. The new service will examine not only diversion at the point of contact but identifying that contact much earlier and in a more timely way so we actually avoid the person reaching crisis point in the first place. This should then support the primary issue to reduce the use of Section 136 admissions.

4.4.4 The current MHTS operates Thursday to Saturday between 18.00 and 02.00 hours and is a pan-county service based out of the Kent Police force control room. The service includes an experienced mental health worker providing a telephone response within the control room and a mental health triage nurse response for assessment at the scene as required. The aim is to provide a swift and effective resolution to a mental health crisis and a reduction in the use of S136 MHA.

4.4.5 Plans to operate a similar service in partnership with South East Coast NHS Ambulance Foundation Trust [SECAmb] were delayed but have just been agreed. Following successful recruitment we aim to provide a mental health worker within their Emergency Operations Centre and a mental health triage nurse will provide assessment at the scene as required. Similar to the Police Street Triage Service the aim is to provide an effective resolution to a mental health crisis in the absence of a physical health concern and so avoid conveyance to A&E

4.4.6 The plan is for a daytime street triage service (0800 to 1800 hours, 7 days a week) to operate out of the police custodies across Kent and Medway through an enhancement of the current Criminal Justice Liaison and Diversion Service (CJLDS). This service responds to Police and SECAmb and was trialled out of Northfleet custody with plans to extend to other custody suites. Plans are still being finalised with NHSE, who fund the CJLDS, and the CCGs.

4.4.7 Below is a table demonstrating the number of referrals and Section 136 avoidances.

Street Triage referrals (night service)	Dec-15 (service commenced 12 Dec-15)	Jan-16	Feb-16	Mar – 16	Apr-16
Total Referrals	27	48	56	61	40

Total S136 Avoided	7	4	19	12	13

There is committed investment from each CCG to support the continuation of the service following the completion of a 6 month pilot in June 2016

4.5 Acute Liaison Psychiatry

4.5.1 People with mental health problems attending or admitted to an acute hospital environment should receive the same priority as those with physical health problems. In October 2014, NHS England and the DoH published *Improving Access to mental health services by 2020*; this document set out a first set of mental health access and waiting time standards for introduction in 2015/16. These commitments were reaffirmed in the NHS mandate and in the NHS Forward View.

4.5.2 Access to embedded liaison psychiatry with advice from a consultant specialising in mental health problems in hospitals needs to be available 24 hours in order to provide an urgent and proactive response.
All CCGs are working towards delivering a 24/7 service; currently Medway CCG are the only ones who have this.

4.5.3 In West Kent Adult Acute Liaison will be operating an 08.00-20.00hr service seven days a week on two sites and Children and Young Peoples will be running a service from 14.00-22.00hr seven days a week on two sites

4.5.4 In North Kent Acute Liaison services is currently operating between 09.00hrs and midnight seven days a week on one site and Children and Young Peoples service are present from 14.00 – 22.00hrs.

4.5.5 In East Kent Adult Acute Liaison services is currently operating between 8 – 8 seven days per week

4.6 Crisis Café (Wellbeing Café)

4.6.1 Crisis cafés are intended to offer additional support for people with mental health problems outside of normal office hours. Providing a safe place for people to go and receive support when in crisis without having to access mainstream mental health services. The scheme can be delivered through the voluntary sector.

4.6.2 It is evident that other crisis cafes in Kent (Sheppey, Thanet) and elsewhere (Aldershot) are beginning to demonstrate with additional community based

help, crises can be avoided and the impact on other services can be reduced and people with mental health problems show increased mental wellbeing, self-management and reduced isolation.

4.6.3 North Kent CCG opened a pilot wellbeing café in Swale for 6 months, but unfortunately further funding was not available to continue this.

4.6.4 East Kent CCG currently has a wellbeing café in Ashford and short term funding has been secured to continue until September 2016 following the end of the pilot scheme.

4.6.5 West Kent CCG will be running a pilot service from July 2016 – January 2017 Two Crisis cafés will be opened in Tonbridge and Maidstone, these will be run by West Kent Mind & Maidstone Mind. This service will be evaluated and a decision made whether to extend this depending on its impact in reducing demand for out of hours emergency services and how this is able to support the needs of those experiencing mental health crises.

4.4 Improved information sharing arrangements

4.4.1 It was a key priority last year to improve arrangements between partner agencies where there are specific causes for concern about particular individuals, including persons who may frequently present to local services in a crisis. This included the development of the following services:

4.4.2 Single Point of Access (SPoA):
Kent and Medway Partnership Trust (KMPT) have developed a single point of access to a multi-disciplinary mental health team. The SPoA is a referrals management function. The team is staffed by both clinically trained and support staff which was launched in April 2016. The service is available 24hrs, seven days a week, including bank holidays. Patients with an urgent or emergency referral can access services across Kent and Medway.

4.4.3 Early evaluation of SPoA has identified efficiencies through improved utilisation of resources, which better meet the needs of our patients. Staff have more time to provide treatment and meaningful contacts with their caseload of clients.

4.4.4 Service users who have used the Single Point of Access have been monitored and, from a report generated on 13 May, the following responses were recorded:

- 82% of those surveyed thought their call was answered promptly
- 88% said that staff members introduced themselves and explained the process they would be taken through
- 82% said they were kept informed about 'what will happen next'
- 82% of those surveyed said they were treated with dignity and respect by staff members at all times
- 82% said that they felt their views about the help they required were listened too.

4.4.5 This telephone number has been shared with the Police and local GPs. This service is also linked to Mental Health Matters Helpline and NHS 111 provision.

4.5 Development of a Health Service Directory.

4.5.1 This has been developed for emergency 111 services, so that callers can be signposted to appropriate services. It is a live directory which is updated regularly and contains all services that people can self-refer to.

4.6 Service User Engagement

4.6.1 The Concordat Steering Group have accessed various patient and Carer platforms including the Mental Health Action Groups established across Kent & Medway as a means to consult and engage with service user/patient groups and to highlight the commitments made in the local Concordat and improve information sharing.

4.6.2 There are several other standing groups across Kent and Medway that have within their Terms of Reference outcomes that contribute to achieving the principles of the local MHCCC. Strong links are being forged with each of these groups in order to achieve and ensure delivery of the MHCCC principles.

4.6.3 These groups include:

- The Kent & Medway Suicide Prevention Strategic Steering Group
- Kent Drug and Alcohol Action Team (DAAT) Board
- Kent Safeguarding Children's Board
- Kent and Medway CQUIN Working Group on Safe and Effective Transitions of
- Adolescents from Children and Young People Mental Health Services to Adult Mental Health Service
- Kent and Medway Adults Safeguarding Board
- Community Safety Partnership
- Kent and Medway Domestic Abuse Strategy Group

4.7 Approved Mental Health Practitioner Service (AMHP)

4.7.1 The AMHP service is a key part of the Mental Health Concordat and expects to measure itself against the national framework for the concordat in terms of its ability to respond to s136 and to referrals where a person requires an urgent Mental Health Act assessment.

4.7.2 The Kent AMHP Service has been in operation for almost two years. Medway have a dedicated daytime service but KCC deliver the AMHP Service on behalf of Medway during out of hours. This is between 5pm until 9am Mon - Friday and all hours Weekends and Bank Holidays.

4.7.3 Since the service began the demand for referrals has continued to rise across each CCG area. The dedicated AMHP workforce has increased and the Service now has a substantive Service Manager. There are other infrastructure developments planned as more is learned about how the service needs to operate from a perspective of governance, statutory compliance, performance and CQC regulations.

4.7.4 This year succession planning yielded 17 applicants for interview to train as AMHPs. This potential year on year growth will support the mixed role AMHP having to spend less time on statutory work and to focus on CMHT Service delivery

4.7.5 Work has been undertaken with Mental Health Matters Helpline to develop a new service to support people who are assessed under section 136 but not detained under the Mental Health Act. Mental Health Matters will provide telephone follow up for 4 days in order to support that individual. This new service commenced on the 24th May 2016. Referrals to this new service is made via the AMHP service

4.7.6 The s136 demand and subsequent discharge following assessment remains a strong indicator that the Mental Health Act is used as a primary consideration for the Police. This level of referrals and the attached timescales places significant pressure on the AMHP Service and can detract from other pressing Community referrals that do not carry a statutory timeframe. There is evidence of a lack of understanding around the process and systems as the Police will escalate if a s136 cannot be responded to promptly. This is not a satisfactory situation, and whilst relationships in the main are positive with the Police, a continued lack of understanding persists with no shift in practice.

4.7.7 Increasingly, the AMHP service follows up and assesses patients detained to private hospitals outside of Kent and Medway. This means sending AMHPs out of County or asking AMHPs services in the North of England to do

assessments on its behalf which entails paying them for their services. This continues to be a problem with detained patients going out of area. There are less reciprocal arrangements between Local Authorities (even with charging being available) across the Country as nationally there is a shortage of AMHPs. This results in the AMHP workforce becoming depleted and is not good use of time.

4.7.8 Outside of the Crisis Pathway, Kent AMHP Service has to ensure that it delivers Kent County Council & Medway Council Statutory Responsibilities for the displacement and appointment of Nearest Relatives, Guardianship Orders and review of Community Treatment Orders under the Mental Health Act.

4.7.9 The Kent AMHP Service has now set up an Off Shoot Nearest Relative process, which involves: regular meetings, a central data base, improved intelligence around displacements and appointments and all in all a robust system with strong governance, quality assurance and statutory compliance. There are plans to create a role specific to Nearest Relative as this is an area of unprecedented growth as the transient nature of family systems and relationships becomes more complex. An essential element of this role is the upholding of rights and safeguarding individuals.

4.7.10 Guardianship is maintained within the Local Authority and through the partnership this is well monitored and supported.

4.7.11 A Community Treatment Order (CTO) working group is currently being re-established and further this work forms part of a KMPT Task and Finish group which is reviewing the management of high risk cases in the Community. This will focus on all those with a statutory framework around their care, including; CTO, S37, S37/41, s41, absolute discharge for Ministry of Justice and Guardianship.

4.7.12 S136 statistics are reported upon within KMPT and these can be sourced upon request. As mentioned the pressure of s136 is a continued concern, and especially so as a significant percentage of referrals are of people subject to alcohol or substance abuse and therefore not fit to be interviewed.

4.7.13 Kent & Medway AMHP Service is delivered as part of the section 75 agreement between Kent County Council and Kent and Medway NHS & Social Care Partnership Trust. The Kent AMHP Service remains delegated to KMPT. It is a developing Service and is delivered in close partnership with the KCC Local Authority.

- Community Mental Health and Wellbeing service

4.7.14 Kent County Council has undertaken a procurement process to deliver a Community Mental Health and Wellbeing service in conjunction with the CCG This service will provide prevention, early intervention and recovery services for mental health. This service will help prevent entry into formal social care and health systems, reduce suicide and prevent negative health outcomes associated with poor mental health

4.7.15 The vision for the new service is to keep people well and provide a holistic offer of support for individuals living with mental health and wellbeing needs in Kent and to deliver support in line with national and local guidance and protocols**.** Everyone who experiences mental health needs has the right to individually tailored one-to-one support to engage in mainstream social leisure, educational, and cultural activities, in ordinary settings, alongside other members of the community who do not use services. The new approach will put a greater focus on outcomes and engage people in innovative ways**.**

4.8 The new Community Mental Health and Wellbeing Service went live on the 1st April 2016 and the contract term is for 5 years with an option to extend for a further 2 years.

4.9 KCC have awarded contracts to two Strategic Partners who will work with a range of providers across Kent & Medway. The Strategic Partner is responsible for selecting delivery partners who can demonstrate that they are able to meet the outcomes people want. The network will change and adapt to meet people needs and aspirations over the life of the contract.

4.10 The new Strategic Partners in Kent are:

Porchlight, covering: Dartford, Gravesham, Swanley CCG
Swale CCG
South Kent Coast CCG
Thanet CCG

Shaw Trust, covering: West Kent CCG
Ashford CCG
Canterbury Coastal CCG

4.11 Both Strategic Partners will work with a wide range of providers offering choice and individually tailored services. Both already deliver mental health services in Kent and bring a wealth of expertise that they will share with smaller organisations. The new service will have a common identity “Live Well Kent” and will include a number of existing grant funded organisations and new organisations specialising in arts, culture, employment, volunteering, exercise and sports, as well as linking with counselling and other social care

and healthcare services.

4.12 Kent County Council is responsible for performance managing the new contract and will be working in partnership with both Strategic Partners to ensure the contract requirements are met.

The core of the new service is the promotion of mental health and wellbeing. The key outcomes below ensure that people:

- are connected to their communities and feel less lonely and isolated
- have more choice and control and feel empowered
- have access to a wide range of opportunities to support their personal recovery which include life-long learning, employment and volunteering, social and leisure and healthy living support
- are appropriately supported to manage their recovery

4.13 The service is open access, where people can refer for an assessment and will be offered a range of services matched to their needs. There will be a number of ways people can access the new service. This includes a Freephone telephone number, walking into a community building, via telephone, or online. The service will have a target to respond to new enquiries within 2 working days to ensure people with mental health needs can be supported quickly.

4.14 There is a need to re-shape these services to meet increasing demand, re-balance investment across Kent and ensure compliance with the Care Act. The new service was implemented in April 2016 and this ended current grant funded services with the voluntary sector and move to an integrated new Community Mental Health and Wellbeing Service. The approach will use investment in a more effective way to ensure Parity of Esteem for people experiencing mental health problems.
The approach offers a unique opportunity to commission joined up services across social care, public health and CCG's, reducing duplication and ensuring best value across the whole spectrum of wellbeing. KCC are leading this piece of work but working collaboratively with CCG's

- Kent Police

4.15 A key issue remains for Kent police in that there is often no alternative but detention under Sec 136 of the Mental Health Act. Work has commenced with partners to look at an alternative place of safety model similar to the charitable sectors 'Sanctuary' model that operates in Manchester. A key time goal for this will be April 2017 when new legislation comes into effect removing the

use of police cells as a place of safety in all but violent patients that can't be managed in a health based place of safety. In the 15/16 financial year police cells were used 68 times and in the vast majority of cases their use was down to capacity issues with KMPT rather than violent patients.

4.16 Kent Police have developed a model that sees wellbeing workers from the mental health charity Mind working in the police control room taking calls from members of the public negating the need for a police response or accessing services of KMPT. This project is a national first and is in the process of being replicated nationally.

4.17 Improved training and learning on mental health crisis

4.17.1 This was identified last year as a key priority due to the high volume of suicides in Kent in 2014/15 (120). This issue highlighted the need for prevention and the need for suicide prevention training to be offered to other professional groups and to wider voluntary sector. Since the 2015-2020 Multi-agency Suicide Prevention Strategy was adopted last year a number of actions have been taken forward.

4.17.2 A major suicide prevention social marketing campaign called Release the Pressure has been developed and delivered mainly across Kent, although some informal marketing was carried out in Medway . The campaign consisted of radio and internet advertising, as well as posters in service station toilets, pubs and on buses which all encouraged men who are feeling under pressure to call a 24 7 helpline. As well as the paid-for advertising, the campaign received significant media attention across TV, radio and newspapers. Early results suggest that the number of calls to the helpline have increased by 20% which will hopefully mean less individuals experiencing a mental health crisis

4.17.3 KMPT have almost finalised their internal suicide prevention strategy which includes reference to the single point of contact and a new risk assessment framework

4.17.4 Suicide Prevention Training has been given to GPs and Primary Care Staff as part of a recent 'Protected Learning Time' session

4.17.5 Kent Police continue to provide a comprehensive police training package using the training DVD developed in 2014, which is now used nationally, as part of the police annual safety training.

4.17.6 Crisis and mental health awareness training continues to be delivered to local agencies through mental health First Aid Training.

5.0 **Key Priorities & Next steps for 2016/17**

5.1 Reducing the number of Sect 136 placements under the MH Act through a number of jointly agreed partnership initiatives providing officers with alternative options for someone presenting in crisis remains a key priority for the MHCCC for 2016/17 and the continued development of alternative places of safety as part of the crisis pathway is key in supporting this. The s136 working group has developed a local multi-agency improvement plan to address the specific key issues identified below:

- Reduction in S136 and increased % conversion rates of those admitted
- Improved access to places of safety across the county.
- Improved access to place of safety for children and young people
- Reduction in duration of lengthy S136 detention, focusing on the common causes i.e. AMHP availability / S12 availability / intoxication / access to a bed for admission and access to an interpreter
- Development of alternative place of safety (through a non NHS provider). KMPT and Kent Police have completed a Joint Strategic Threat and Risk Assessment for the Provision of Mental Health Support, which has made recommendations against the service provision gaps, these recommendations form a part of the action plan.
- Further development of the Mental Health Triage Service
- Avoidance of custody as a place of safety except in cases of extreme violence
- Continued education and training of police officers in recognising mental health issues. From April 2015 up until Mar 2016, 212 new police recruits received training along with 32 custody sergeants

Wider work plans, listed below, will continue to support the local action plan.

5.2 The MHCCC have developed a working group to look into alternative places of safety, focusing on successful models like The Sanctuary in Manchester, to help support people through a crisis and reduce the need for S136. The working group will feedback through the MHCCC and propose alternative solutions that may be considered in Kent & Medway.

5.3 Improved working with substance misuse services will be developed and will focus on reducing numbers of people detained due to intoxication. New models are being developed across the country to address this issue and the MHCCC will research these emerging models i.e. The Safe Haven project in

Manchester, and feedback through the MHCCC and propose alternative solutions that may be considered in Kent & Medway.

5.4 Improved working with British Transport Police (BTP) will continue as many detentions under S136 across Kent and Medway are through them and numbers are well above average when compared to national BTP data

6. Financial implications

6.1 There are no identified financial implications for the Kent & Medway Health and Wellbeing Board arising from this report. Implementation of the Concordat commitments, the cost of governance arrangements and operational changes are matters for partnership agencies and are expected to be made through existing resources and future commissioning intention. Through the 2016/17 NHS planning framework CCG's have committed finances incorporating the Parity of Esteem agenda, this includes crisis care commissioning plans.

7. Legal implications

7.1 The Health and Wellbeing Board has a statutory obligation under section 195 Health and Social Care Act 2012 to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in Kent & Medway. Supporting the development of the Kent & Medway Mental Health Crisis Care Concordat is therefore within the remit of the Health and Wellbeing Board.

8. Recommendations

8.1 The Health and Wellbeing Board is asked to support the work of Kent & Medway Mental Health Crisis Care Concordat

8.2 The Health and Wellbeing board is asked to agree to the governance framework of the concordat group to report annually progress to both the Kent and Medway Health and Wellbeing Boards.

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Background papers

DOH February 2014
https://www.gov.uk/government/publications/mental-health-crisis-care-agreement

Care Quality Commission October 2014
http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014

Policing and Crime Bill 2015-17 to 2016-17
https://www.gov.uk/government/collections/policing-and-crime-bill

Multi-agency ActionPlan

http://www.crisiscareconcordat.org.uk/areas/kent/

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From Graham Gibbens, Cabinet Member for Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

Date: 20th July 2016

Subject: Progress on Outcome Two of the Kent Joint Health and Wellbeing Strategy
Progress and future plans to reduce health inequalities in Kent.

Summary:
This report provides an overview on Outcome 2 of the Kent Health and Wellbeing Strategy and sets on the analysis, and plans for the future Kent Mind the Gap Action Plan aimed at reducing health inequalities.

Generally, the indicators relating to Outcome 2 are positive with and retain a green or amber status. There are a range of factors that have contributed to the improvements that include an increase in the prescribing of anti-hypertensive medication. There is still scope to improve. For example, there is a need to increase the proportion of people receiving a NHS Health Check of the eligible population.

Health needs in Kent are disproportionately greater in the most deprived populations. Closing the 'health gap' will require a faster improvement in health in these areas. Thus we will need to take a much greater place based systematic approach where we better engage these communities at a local level, make local plans (based on natural local communities) which aim to improve place based health through population, service and community based approaches

Recommendation:
The Kent Health and Wellbeing Board is asked to comment on progress made on key indicators reflecting progress in Outcome Two of the Kent Joint Health and Wellbeing Board Strategy and to support greater local Clinical Commissioning Group oversight for the NHS Health Check programme, particularly in encouraging practices where there is no engagement in delivery of the programme.

The Kent Health and Wellbeing Board is asked to CONSIDER, COMMENT and AGREE the following:

- The renewed approach to reducing health inequalities in Kent
- That Local Health and Wellbeing Boards take a place based approach and for local plans to encompass population, service and community development based approaches.
- That regular reporting of progress is shared with the Kent Health and Wellbeing Board
- That Kent Health and Wellbeing Board takes an overview on county wide progress

1.1 The Kent Health and Wellbeing Strategy sets out a vision "to improve health outcomes, deliver better coordinated quality care, improve the public's experience of integrated health and social care services, and ensure that the individual is involved and at the heart of everything we do".

1.2 The strategy identifies five outcomes

1.2.1 Every child has the best start in life
1.2.2 Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
1.2.3 The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
1.2.4 People with mental ill health issues are supported to live well
1.2.5 People with dementia are assessed and treated earlier

1.3 This paper updates progress made around outcome 2, and additionally reviews progress made in reducing health inequalities in the Kent population.

2. Performance in comparison to the Target/England average

2.1 Table 1 shows a range of indicators from national dataset to measure progress related to outcome 2. Generally, the results are positive with the majority of indicators being green (Target has been achieved or exceeded, or is better when compared to National).

2.2 There has been improved direction of travel in:

- Increases in life expectancy
- Increasing male healthy life expectancy
- Reducing the slope index for health inequalities for females
- Increasing the proportion of people quitting having set a quit date with smoking cessation services
- Reduced alcohol related admissions to hospital
- Reducing the rates of deaths attributable to smoking persons aged 35+,
- Reducing the under-75 mortality rate from cancer considered preventable
- Reducing the under-75 mortality rate from respiratory disease considered preventable and
- Reducing the under-75 mortality rate from cardiovascular disease considered preventable.

2.3 There has been a decline in the direction of travel for the following indicators:

- Increasing healthy life expectancy for females, (in effect healthy life expectancy has declined in females)
- Reducing the slope index for health inequalities for males (in effect the health inequality gap for males has become marginally worse)
- Increasing the proportion of people receiving a NHS Health Check of the eligible population and

- increasing the proportion of eligible women screened adequately in the breast cancer screening programme (in effect the proportion has got marginally worse)

All indicators with a decline in the direction of travel are above the target with the exception of increasing the proportion of people receiving a NHS Health Check of the eligible population.

2.4. Kent County Council took on the commissioning responsibility for the NHS Health Check programme from April 2013. Since this time, over 115,000 checks have been delivered, whilst over 280,000 of the eligible Kent population have been invited to have an NHS Health Check. Performance on overall uptake of checks as a proportion of invites issued has remained constant over the past two years at 42%. The decline in the actual number of checks completed is therefore likely to be the result of fewer invites needing to be issued in 2016/17 and the increasing capacity constraints in primary care. Public Health continues to work with Kent Community Healthcare Foundation Trust (KCHFT) in order to improve uptake. CCG support for encouraging further local uptake rates is sought.

2.5 The latest available data for the Stop Smoking Service shows that the service exceeded the 'quit-rate' target of 52% with a rate of 55%. For 2015/16, there were 6,236 Kent residents that set a quit date with 3,417 successfully quitting smoking via the service. Of the 3,417 residents who were successful in stopping smoking, 947 were from routine and manual occupations, 308 had never worked or had been unemployed for more than one year and 199 were home carers (unpaid).

2.6 Mortality rates are decreasing across all groups. This is a significant success for our population across all groups in society. A wide range of factors will have influenced the reduction in mortality rates, not least better disease detection and better treatments.

2.7 There is no change in the direction of travel in the proportion of adults with excess weight, but this was due to no previous status being reported in the Public Health Outcomes Framework for this indicator. It is based on a synthetic estimate measured via the Active People Survey between 2012 and 2014. The reported estimate for Kent is not significantly different from that for England.

Table 1: Range of indicators relating to outcome 2 of Kent Health and Wellbeing Strategy

Indicator Description	Target	Previous status 2011-2013	Recent status 2012-2014	DoT	Recent time period
2.1 Increasing life expectancy at birth (PHOF):					
Male (years)	79.5 (national)	79.9 (g)	80.1 (g)	⇧	2012-14
Female (years)	83.2	83.6 (g)	83.6 (g)	⇔	2012-14

Indicator Description	Target	Previous status 2011-2013	Recent status 2012-2014	DoT	Recent time period
	(national)				
2.2 Increasing healthy life expectancy (PHOF):					
Male (years)	63.4 (national)	62.8 (a)	63.7 (a)	⇧	2012-14
Female (years)	64.0 (national)	66.4 (g)	65.0 (a)	⇩	2012-14
2.3 Reducing the slope index for health inequalities (PHOF):					
Male (years)	9.1 (national)	7.1	7.4	⇩	2012-14
Female (years)	6.2 (national)	5.1	4.4	⇧	2012-14
2.4 Reducing the proportion of adults with excess weight (PHOF)	64.6% (national)	-	65.1% (a)	-	2012-14
2.5 Increasing the proportion of people quitting having set a quit date with smoking cessation services (Public Health)	52%	54% (g)	55% (g)	⇧	2015/16
2.6 Increasing the proportion of people receiving a NHS Health Check of the eligible population (Public Health)	50% full year	51% (g)	43% (a)	⇩	2015/16
2.7 Reducing alcohol related admissions to hospital (per 100,000. PHOF)	645 (national)	565 (g)	551 (g)	⇧	2013/14
2.8 Increasing the proportion of eligible women screened adequately in the breast cancer screening programme (PHOF)	75.4% (national)	77.6% (g)	77.0% (g)	⇩	2015
2.9 Increasing the proportion of eligible women screened adequately in the cervical cancer screening programme (PHOF)	73.5% (national)	77.1% (g)	77.1% (g)	⇔	2015
2.10 Reducing the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000. Estimated. Local Tobacco Control Profiles)	274.8 (national)	272.6 (g)	266.7 (g)	⇧	2012-14
2.11 Reducing the under-75 mortality rate from cancer considered preventable (rate per 100,000. PHOF)	83.0 (national)	79.3 (g)	78.4 (g)	⇧	2012-14
2.12 Reducing the under-75 mortality rate from respiratory disease considered preventable (rate per 100,000. PHOF)	17.8 (national)	16.7 (a)	16.5 (a)	⇧	2012-14
2.13 Reducing the under-75 mortality rate from cardiovascular disease considered preventable (rate per 100,000. PHOF)	49.2 (national)	49.3 (a)	46.0 (g)	⇧	2012-14

Key to KPI Ratings used

GREEN	Target has been achieved or exceeded, or in comparison to National
AMBER	Performance was at an acceptable level within the target or in comparison to National
RED	Performance is below an acceptable level, or in comparison to National
⇧	Performance has improved relative to the previous period

⇩	Performance has worsened relative to the previous period
⇔	Performance has remained the same relative to the previous period

3. Health Inequalities

Introduction

3.1 Health Inequalities are differences in health outcomes between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off, experiencing poorer health and shorter lives.

3.2 This section of the report provides an update on the public health analysis carried out following publication of the new national Index of Multiple Deprivation (2015) and sets out a proposed action plan.

4 Findings

4.1 Whilst mortality rates in Kent have been falling over the last decade for all populations in Kent, the gap in all age, all-cause mortality rates between the most and least deprived communities has remained constant. This gap is also consistent nationally where the Office of National Statistics recently reported a persistent fixed gap in life expectancy across England as a whole.

4.2 Our findings show that the most deprived populations have disproportionately worse life expectancy and the highest premature mortality rates signalling that if we are to begin to narrow the health inequalities gap, we need to understand exactly where and who these populations are.

4.3 Analysis of the causes of premature deaths in the most deprived population's show cancers, cardiovascular, respiratory and gastro-intestinal diseases account for the majority of the cause.

4.4 The populations that show the highest rates of all age, all-cause mortality and premature mortality are identified by segmenting Kent's population based on Lower Layer Super Outputs Areas (LSOAs). LSOAs are typically a population of about 1,500 people, and no smaller than 1000 people. LSOAs allow the reporting of small area statistics. Kent is made up of 880 LSOAs and thus the bottom decile is made up of 88 LSOAs

The geographical spreads of these 88 LSOAs is as follows:

Ashford District:	4
Canterbury District	7
Dartford District	4
Dover District	11
Gravesham District	7
Maidstone District	5
Sevenoaks District	2

Shepway District	8
Swale District	16
Thanet District	24

4.5 Further analysis of the 88 LSOAs and applying a segmentation tool known as MOSAIC shows that these populations have very different social characteristics and thus demonstrates that there will need to be multiple and differing approaches to improving life expectancy and reducing premature mortality.

4.6 However, a number of common themes are also evident in the analysis as follows:

- *Young people*: In general, the most deprived areas in Kent feature a high proportion of young adults. This is significant, as evidence shows that early choices and behaviours have lasting effects on life chances, and the health impacts of deprivation accumulate in individuals throughout their lives.

- *Children*: There should be a focus on child health and education, to provide opportunities to these children to break the cycle of deprivation. Even by the age of 3, there is a marked inequality gradient in childhood development which will impact on outcomes throughout life.

- *Education/Employment/Housing:* The big challenges in many of these communities are not health problems, but rather socioeconomic problems: education, employment, and housing. Any long term strategy to address health inequalities must address these issues. Housing in particular is a defining issue for some local areas.

- *Churn:* A number of areas are subject to high levels of 'transiency' i.e. people moving in and out of the area (churn). What this suggests is that efforts to tackle deprivation should not focus solely on individuals or households because those who do graduate through such programmes are likely to move away from the area, and be replaced by other young, struggling, individuals. Rather, there should be concurrent efforts to regenerate local communities themselves as physical, social and cultural spaces. This area-based approach will have an enduring impact on the health and wellbeing of local populations, however transiently they may live there.

4.7 Analysis of other social indicators such as school readiness, GCSE attainment, crime rates, over crowded accommodation and living environment shows exactly the same pattern of inequality, in fact some of the gradients are not linear, but rather curved which shows a disproportionate effect in the most deprived deciles. For example alcohol related premature mortality is six times higher in the most deprived decile than it is in the most affluent decile.

5 Actions Required

5.1 Reducing health inequalities requires a much more systematic, place based and disproportionate approach with a focus on those LSOAs identified above, as reducing health inequalities will require the health of these local populations to improve faster than the rest of the population.

5.2 It will also require a range of interventions and programmes that aim to deliver improved outcomes in the short, medium and long term. For example improving detection and optimising treatment for disease, particularly those diseases associated with premature mortality will provide short term (0-5year) outcomes, whereas lifestyle interventions such as stop smoking have medium term (0-10year) outcomes and modifying social determinants of health may well have longer term (0-15year) outcomes.

5.3 Plans also require buy in and action across a wide range of local stakeholders and can be split into three approaches as follows:

- Population approaches which describes the action by policy makers in addressing the wider determinants of health through, for example policy, legislation and regulation and local strategies of “Health in all Policies”.

- Service approaches which describes action by service providers relating to health for example general practice, acute services.

- Community development approaches which describes actions by community groups and local community leaders to build resilience and improve community wellbeing.

5.4 Traditional methods for community development have tended to focus upon prescribing top down solutions to the needs and deficiencies of deprived areas, with poor buy in and engagement of local communities. We are advocating for an asset based community development approach. This approach recognises the inherent assets, skills and capabilities of residents, citizen associations and local institutions and builds upon these in a co-productive way that creates sustainable long term change.

5.5 Community development can be carried out systematically in the deprived areas we have identified in this report. A methodology for systematically engaging communities is found in Chris Bentley’s Ten Point Plan of ‘System and Scale into Community Empowerment’.

- *Prioritisation of areas* : This has already been done by focussing on the most deprived decile LSOAs in Kent

- *Defining communities*: The next step is to define how communities define themselves, geographically and in a sociocultural sense

- *Asset mapping*: We then need to produce a stocktake of the positive resources in place in each community

- *Behaviour of partners*: A multi-agency response requires coordination, such as agreed common ways of working and the sharing of intelligence.

- *Community profiles*: Local profiles involve collating the top-down analysis already conducted with bottom-up views from the ground to construct a recognisable story of place and culture.

- *Community Based Research (CBR):* Local residents can be trained to be involved in assessing needs, barriers and aspirations, and exploring ideas for action. This develops skills, and raises self-esteem, in residents who can go on to become community champions.

- *Neighbourhood Action Plans (NAPS):* Plans for action should be community owned, but could also form the building blocks on which to base local Health and Wellbeing Strategies.

- *Outreach models*: Community empowerment should allow locals to have a say in how and where they receive services from a range of statutory sector and community venues.

- *Community Links Strategy:* There need to be ongoing mechanisms to involve all sections of the community in what services are provided and how they are provided. Solutions should not involve rigid structures, but mechanisms for on-going structured gathering and collation of local intelligence of community infrastructures.

- *Transfer of Service Ownership:* Change will be more sustainable if we transfer power and resources to genuinely empower communities to take more control of things that affect them e.g. through social enterprise.

5.6 Thus, a local three pronged approach which identifies the:

- NHS response
- The partnership response
- The community transformation response

6 Local Implementation

6.1 Public Health is currently working with local partners in each district to understand and map the natural communities which encompass the LSOAs outlined previously.

6.2 Concurrently PH are also mapping local community assets and positive local resources, as we recognise that there are currently other local initiatives happening, particularly community transformation initiatives such as “Big Local”, Housing Association initiatives, Community Safety initiatives, or indeed big infrastructure projects such as Ebbsfleet Garden city where the planning footprint includes existing populations in the populations of concern. We must work in a coordinated way and build upon what already exists, rather than “reinventing” local initiatives that are seen to compete or create confusion.

6.3 Our collective aim is to develop a number of local plans (based on natural local communities) which aim to improve place based health through population, service and community based approaches

6.3 As this is primarily about health inequalities and a place based approach, the over sight of local plans should be managed through local Health and Wellbeing Boards and Local children’s partnership groups.

6.4 Oversight at a Kent Strategic level will be managed at the Kent Health and Wellbeing board; as reducing health inequalities remains a priority of the Kent Joint Health and Wellbeing Strategy.

6.5 Local plans will be reported to local Health and Wellbeing Boards and to the Kent Health and Wellbeing Board in the New Year.

Recommendation:
The Kent Health and Wellbeing Board is asked to comment on progress made on key indicators reflecting progress in Outcome Two of the Kent Joint Health and Wellbeing Board Strategy and support greater local Clinical Commissioning Group support for the NHS Health Check programme, particularly in practices where there is no engagement with the service.

The Kent Health and Wellbeing Board is asked to **CONSIDER, COMMENT** and **ENDORSE** the following:

- The renewed approach to reducing health inequalities in Kent
- Agree that Local Health and Wellbeing Boards take a place based approach and for local plans to encompass population, service and community development based approaches.
- That regular reporting of progress is shared with the Kent Health and Wellbeing Board
- That Kent Health and Wellbeing Board takes an overview on county wide progress

Kent Public Health Annual Report 2015
http://www.kpho.org.uk/__data/assets/pdf_file/0005/57407/Final-Public-Health-Annual-Report-2015.pdf

10 Contact details

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

To: Health and Wellbeing Board, 20 July 2017

Subject: **Kent Health and Wellbeing Board Work Programme**

Classification: Unrestricted

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1. Introduction

(a) Following the Board's agreement in September 2015 that a Forward Work Programme should be developed and shared with local Boards, a draft was presented to the Board on 27 January 2016. The approach set out at this time was approved by the Board.

(b) The draft Forward Work Programme has been amended and updated. This is attached. The Forward Work Programme will remain a live document and is a standing item on the Agenda.

2. Recommendation

Members of the Kent Health and Wellbeing Board are asked to agree the attached Forward Work Programme.

Background Documents

None.

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WORK PROGRAMME –2016/17
Health and Wellbeing Board

Agenda Section	Items
21 September 2016	
Area 1 - Assuring Outcomes for Kent	• Review of outcome 3- Quality of Life for people with long term conditions • Relationship between the Kent Board and Local Boards Update
Area 2 - Core Documents	
Area 3 Promotion of Integration	• The Kent Board and Voluntary Sector Update
Area 4 Notifications	• One Public Estate/Local Estates Strategies Update
Area 5 Reports to the Board	• KSCB Annual report • HWB Annual Report • HealthWatch Kent Annual Report • HWB Work Programme • Local board minutes • Minutes of the 0-25 Health and Wellbeing Board
23 November 2016	
Area 1 - Assuring Outcomes for Kent	• Review of Outcome 5 - Dementia
Area 2 - Core Documents	• JHWS Development Process
Area 3 Promotion of Integration	• Sustainability and Transformation Plans Update
Area 4 Notifications	
Area 5 Reports to the Board	• Update on the Joint Health and Social Care Self-Assessment Framework • HWB Work Programme • Local board minutes • Minutes of the 0-25 Health and Wellbeing Board
25 January 2017	
Area 1 - Assuring Outcomes for Kent	• Review of Outcome 1 – Every Child has the Best Start in Life
Area 2 - Core Documents	•
Area 3 Promotion of Integration	• Better Care Fund Plans for 2017/18
Area 4 Notifications	•
Area 5 Reports to the Board	• Progress report on the Kent Emotional Health and Wellbeing Strategy for Children, Young People and Young Adults (CAMHS) • HWB Work Programme • Local board minutes • Minutes of the 0-25 Health and Wellbeing Board
22 March 2017	

Updated 03 06 16

Area 1 - Assuring Outcomes for Kent	
Area 2 - Core Documents	•
Area 3 Promotion of Integration	• **Review of Commissioning Plans**
Area 4 Notifications	•
Area 5 Reports to the Board	• **HWB Work Programme** • **Local board minutes** **Minutes of the 0-25 Health and Wellbeing Board**
Other items not allocated to a particular meeting	
	HWB Strategy Refresh

CANTERBURY CITY COUNCIL

CANTERBURY AND COASTAL HEALTH AND WELLBEING BOARD

Minutes of a meeting held on Tuesday, 10th May, 2016 at 6.00 pm in the Canteen, Council Offices

Present: Dr Sarah Phillips (Chairman)

Wendy Jeffreys
Simon Perks
Neil Fisher
Velia Coffey
Councillor S Chandler
Mark Lemon
Sari Sirkia-Weaver
Ellie Williams

1 **APOLOGIES FOR ABSENCE**

Samantha Bennett, Cllr Ken Pugh, Cllr Andrew Bowles, Mark Kilbey, Paula Parker, Amber Cristou, Graham Gibbens, Steve Inett, Cllr Joe Howes, Jonathan Sexton, Lorraine Goodsell.

2 **MINUTES OF THE LAST MEETING, ACTIONS AND MATTERS ARISING**

The minutes were approved as an accurate record.

3 **KENT CHILDREN AND YOUNG PEOPLE'S PLAN - SARI SIRKIA-WEAVER/WENDY JEFFREYS**

Sari Sirkia-Weaver advised that Kent County Council (KCC) has consulted the 12 Local Childrens' Partnership Groups (LCPG) across the county as well as the 0-25 County Board.

The following was noted:

- All have been asked to contribute their priorities and it was noted that some are the same as the Canterbury priorities however some are different and Canterbury will still be working to their area specific priorities.
- New data is being received from KCC and this has contributed to these indicators to create the dashboards.
- Many of these indicators have also been identified by the Kent Board. Eg alcohol, obesity, self harm and therefore these align with Kent's strategies.

The Canterbury dashboard was presented and some of the challenges were highlighted:,

- Early help notification is of concern.
- The statistics for early help notification and children on a child protection plan are both of concern. It was reported that Canterbury social services should have 27 social workers but only have 16 at present and there has been a request to reconfigure the service to address the severe under resource. Also Canterbury and Thanet have a higher numbers of looked after children than other districts and this could also contribute to these higher figures. It

Action: Sari Sirkia-Weaver to further analyse data for looked after children to establish whether the data is accurate and whether there is more that can be done to better provide for them.

Action: Mark Lemon to invite Thom Wilson, Head of Strategic Commissioning, Children's, Social Care, Health & Wellbeing at Kent County Council to the next meeting.

- Breastfeeding data may not accurate and the reasons for this was discussed. It was noted that this is a priority for South Kent Coast and the contract for health visiting this has been moved to the local authority from NHS England. Work is being done through children's centres.
  Action: Neil Fisher and Wendy Jeffreys to further investigate the accuracy of the breastfeeding data.

- Canterbury has a young person not in education, employment or training (NEET) reduction strategy and those leading attend the LCPG.
- It would be useful to know the source of the data so that there is better understanding of what has been measured and how.
  Action: Cllr Sue Chandler and Sari Sirkia-Weaver to raise this at the Chairs meeting.

It was reported that KCC LCPG grants have been awarded. A meeting has been arranged with all those awarded grants to make sure there is no overlap in the work being done to maximise the benefits of the money.

It was agreed that Swale and Dover representatives should highlight issues of common interest rather than sending minutes of the meetings.

It was reported that Dover is to pilot a scheme in one of their wards to help combat child obesity. The first stakeholder meeting is in May 2016. Sari Sirkia-Weaver will be attending this meeting so that learning can be cross cutting. It was noted that in some schools especially secondary level, pupils may live in different district to the school.

Action: Outcomes of the Dover child obesity pilot stakeholder meeting to be reported at the Health and Wellbeing Board meeting in July 2016.

4 **PRIMARY CARE CO-COMMISSIONING - JONATHAN SEXTON**

Simon Perks presented the paper in the absence of Jonathan Sexton. The following was highlighted:

- Primary care commissioning is now handled locally by the Clinical Commissioning Group (CCG) and the report sets out the responsibilities of the Group. Canterbury and Coastal is one of 6 CCGs exploring what the new GP contract may look like.
- NHS England requires that members of the local Health and Wellbeing Board (HWB) sit on the Commissioning Committee and as the HWB covers a number of local authority areas choosing the representatives may be complex.
- The Committee will be responsible for the core contract for primary care such as premises, QOFF, mergers etc.
- Contracts will still be held by NHS England.
- Resources for primary care have reduced significantly therefore services need to be stabilised before the future can be developed.

- Strong relationships with local authority planning teams is important so that can forward planning for increasing populations can be achieved and understanding where s106 funding may be available.

Two nominations are needed from the HWB and it was agreed that these should be elected members and with a KCC link as well as a local link. A query was raised as to whether these should be representatives from the local HWB or the Kent HWB?

Action: Canterbury and Coastal Health and Wellbeing Board to write to Roger Gough to ask to delegate this responsibility to the local HWB.

5 **LGA DEVELOPMENT DAY FEEDBACK**

Those who had attended the Development Day on 27 April gave feedback and the following was discussed/noted:

- Good discussion was held and the role of HWB explained.
- The Board needs a clearer remit to try and achieve more.
- Narrow down the number of priorities to 2 or 3 only.
- Priorities should be chosen to include all the stakeholders on the Board where collaboration can produce greater results.
- Should be a place for information to be collated and shared.
- Promotion of the HWB its importance and profile should be improved
- Other ways of achieving work rather than having meetings should be explored.
- There should be a greater link between community networks and HWBs.
- What support can the Board give to Vanguard?

6 **2016/17 PLANNING ROUND UPDATE - NEIL FISHER**

Neil Fisher presented the final version of the annual plan and reported that it had been sent to NHS England in April and changes made in response to their feedback.

Contracts have been awarded Out of Hours provider and 111 services and this is attracting trade press, especially the 111 contract which is now provided locally.

The Clinical Strategy Committee has agreed the Herne Bay integrated service which will now be considered by the Kent HWB for sign off.

A query was raised as to whether any information should be communicated more widely on this topic

Action: Neil Fisher to produce a summary document which could be circulated to Councillors and more widely eg community networks to show what the changes will mean to local people.

Action: It was agreed that a report on progress towards meeting the constitutional standards would be brought to the next meeting.

It was reported that the Herne Bay integrated service will have to go through procurement procedures due to the size of the contract. This has caused some tension but it was noted that the skilled workforce ie GPs is key in providing this service.

7 **EAST KENT HEALTH AND SOCIAL CARE STRATEGY BOARD UPDATE - SIMON PERKS**

The report was noted. There were no questions raised by the Board in relation to this report.

8 **MENTAL HEALTH ACTION GROUP REPORT - NEIL FISHER**

The report was noted. There were no questions raised by the Board in relation to this report.

9 **ANY OTHER BUSINESS**

Sari Sirkia-Weaver reported that 2 family support contracts will be awarded in Kent to support troubled families. It was noted that family support is currently provided by 7 organisations and TUPE will apply when this is reduced to 2 contracts which will make the process complicated.

A NEETS contract will be awarded in Kent and this has challenging targets to reduce the number of NEETS.

10 **DATE OF NEXT MEETING**

6 July 2016, 18.00 at the Guildhall, Canterbury.

DARTFORD BOROUGH COUNCIL

DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

MINUTES of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on Wednesday 8 June 2016.

PRESENT: Councillor Roger Gough (Chairman)
Councillor Mrs Ann D Allen MBE
Councillor Tony Searles

Sheri Green
Stuart Collins
Melanie Norris
Cecilia Yardley

ALSO PRESENT Haley Brooks, Tristan Godfey, Val Miller, and Dr Su Xavier

83. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor David Turner, Lesley Bowles, Graham Harris, Sarah Kilkie, and Andrew Scott – Clarke.

84. DECLARATIONS OF INTEREST

There were no declarations of Interest made by Members.

85. MINUTES

The minutes of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on 6 April 2016 were confirmed as a correct record.

86. KENT COUNTY COUNCIL HEALTH AND WELLBEING BOARD: MEETING HELD ON 25 MAY 2016

The Chairman reviewed the meeting of the Kent Health and Wellbeing board held on 25 May 2016 and reported on the following matters which could impact on our Board area.

- Draft Kent sustainability Plan
- Kent Better Care Fund
- Workforce Task and finish Group
- Addressing Obesity: Progress Report from Local Health and Wellbeing Groups
- The Abridged Kent Joint Strategic Needs Assessment (JSNA) Overview Report

87. URGENT ITEMS

The Chairman reported that there were no urgent items for the Board to consider.

88. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS.

The Board received a report on work issues which were outstanding from previous meetings and noted that the issue of grant funding for sports clubs had been added to the work plan.

89. POSSIBLE MERGER WITH SWALE HWB

It was reported that tentative enquiries had been received from the Swale Health and Wellbeing Board regarding a possible merger between the two areas.

It was noted that the Swale Board was experiencing some difficulties, both cultural and organisational, which was affecting its ability to function efficiently and that a merger with our Board was perceived as a possible remedy for the problems being experienced.

The Board discussed the matter and while being sympathetic towards the needs of Swale, expressed the following concerns regarding any merger.

- A loss of focus that might be experienced by our Board should another group join
- The lack of knowledge of Swale and its problems which may erode the working relationships that had been built during the operation of our Board
- The administrative and management difficulties that such a merger would generate
- The expansion of work load which would inevitably occur.

Accordingly it was agreed that it would not be in the best interest of this Board to merge with the Swale HWB and thus that the Swale board should be advised accordingly.

90. LOCAL CHILDREN'S PARTNERSHIP GROUPS

The Board received a presentation and report from Stuart Collins which explained the recently introduced Kent Children and Young People's Plan, and set a panel of key indicators against which each of the Board's three areas performed.

Mr Collins then presented individual data, in a “Performance Dashboard” basis which allowed comparison between areas against the indicators identified in the plan using the whole county levels as a benchmark figure.

He also added some data relating to missing children which had not been available when the report was produced.

Mr Collins explained that information relating to Swanley was contained within the individual data sheet for Sevenoaks but assured the Board that this would be rectified in the next report he made to the Board.

In general Mr Collins believed that the three Board areas were performing reasonably, and certainly better than some areas of Kent, and he highlighted some disparities across the Board areas and sought to explain them.

The Chairman thanked Mr Collins for his report and asked that the Board noted its content.

91. UPDATE ON THE IMPLICATIONS OF NEW DEVELOPMENTS FOR THE HEALTH SECTOR AND THE NEW SHAPE OF SERVICE PROVISION.

The Board received a presentation from Dr Xavier which considered the factors which were expected to impact upon the provision of Health Care across the Board area:

- An increasing level of demand for primary care from local residents
- Rising projected levels of population growth in the Board area;
- The speed of population growth and the projected age structure of the growth;
- The location of growth and the format that new developments were to take; and,
- Possible responses to growth

Dr Xavier reported that a steering group headed by the CCG was currently reviewing health care provision and structure, both current and projected; including GP numbers in the future, and had identified significant issues with maintaining the current provision model.

She stressed that based on the clinical model development work with Member GPs, it was believed that there would be a need for an additional three or four strategically placed integrated health and social care hubs to cater for future need, and presented a model of the provision which it was projected would need to be available.

Dr Xavier further informed the Board that the steering group was to meet in the near future and would be setting a firm way forward which would be reported to the Board in due course.

The Chairman thanked Dr Xavier for her presentation, asked the Board to note the information, and looked forward to receiving further updates on the matter in due course.

92. UPDATE ON LGA WORKSHOP

In the absence of Sarah Kilkie, who was leading on this matter, Melanie Norris reported that two dates had been identified as being suitable for the workshop, (the 25th and 31st of August) which was to be held at Gravesham Civic Centre.

Having considered the availability of Members it was agreed that the workshop be held on 25 August 2016 commencing at 9.00pm at Gravesham Civic Centre, Windmill Street, Gravesend, DA12 1AU.

93. MEETING SCHEDULE FOR 2016 / 2017 AND AVAILABILITY FOR A MEETING IN AUGUST

The Board received a report which detailed the programme of meetings and venues for the forthcoming Municipal Year, and which sought guidance on whether a meeting in August 2016 should be held and on what date.

It was noted that Members had already committed themselves to the LGA workshop in the morning of the 25th of August, and that it would be sensible to continue as a group later that day.

It was therefore agreed that the August meeting of the Board be held on 25 August, at Gravesham Civic Centre commencing at 1.30pm.

94. INFORMATION EXCHANGE

Mr Collins informed the Board that in addition to his existing post he had been appointed as Head of the Youth Offending Service.

95. BOARD WORK PROGRAMME

The Board received and noted the current schedule of work programmed to be considered at its meetings in the current year together with a list of items yet to be programmed.

It was noted that the agenda for the August meeting seemed very heavy and the Chairman undertook to review the number of items which were to be considered once it became clear exactly what was to be presented.

Additionally it was noted that there seemed to be a severe reduction in the service being offered by the DAAT team, possibly due to budget reductions, and it was agreed that a report on this should be presented to the Board as soon as possible.

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Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 17 May 2016 at 3.00 pm.

Present:

Chairman: Dr J Chaudhuri

Board: Councillor P M Beresford
Ms K Benbow
Councillor S S Chandler
Councillor J Hollingsbee
Councillor M Lyons
Councillor G Lymer
Ms J Mookherjee

Also Present: Mr M Lemon (Kent County Council)
Ms S Martin (South Kent Coast Clinical Commissioning Group)

Officers: Head of Leadership Support
Team Leader – Democratic Support

1 ELECTION OF A CHAIRMAN

The Team Leader – Democratic Support called for nominations for a Chairman for the ensuing municipal year 2016/17.

It was moved by Councillor J Hollingsbee, duly seconded and in the absence of any other nominations it was

RESOLVED: That Councillor P A Watkins be elected as Chairman of the South Kent Coast Health and Wellbeing Board for the ensuing municipal year 2016/17.

2 APPOINTMENT OF A VICE-CHAIRMAN

The Team Leader – Democratic Support called for nominations for a Vice-Chairman for the ensuing municipal year 2016/17.

It was moved by Councillor M Lyons, duly seconded and in the absence of any other nominations it was

RESOLVED: That Dr J Chaudhuri be elected as Chairman of the South Kent Coast Health and Wellbeing Board for the ensuing municipal year 2016/17.

(In the absence of the Chairman, the Vice-Chairman took the Chair for the remainder of the meeting.)

3 APOLOGIES

Apologies for absence were received from Ms J Duff (Kent County Council), Ms C Fox (Red Zebra), Mr S Inett (Healthwatch Kent), Mr M Lobban (Kent County Council) and Councillor P A Watkins (Dover District Council).

4 APPOINTMENT OF SUBSTITUTE MEMBERS

In accordance with the agreed Terms of Reference, it was noted that Ms J Duff had been appointed as substitute for Mr M Lobban.

5 DECLARATIONS OF INTEREST

There were no declarations of interest made by members of the Board.

6 MINUTES

It was agreed that the Minutes of the Board meeting held on 26 January 2016 be approved as a correct record and signed by the Chairman.

7 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

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

8 SOUTH KENT COAST HEALTH AND WELLBEING BOARD DEVELOPMENT DAY UPDATE

The Board received an update from M Farrow, (Head of Leadership Support, Dover District Council) on the outcomes of the recent development day concerning proposals for the future of the Health and Wellbeing Board as a commissioning body.

Members were advised that the development day identified issues of accountability, governance and the financial implications for partner organisations that needed further clarification. A report would be submitted to a future meeting of the Board on these matters and the best way to deliver integrated commissioning.

The consensus of opinion amongst those present at the development day was supportive of principle of integrated commissioning subject to clarification over the issues identified.

It was agreed that the current Health and Wellbeing Board arrangements should continue until the new arrangements had been agreed and that the target for the commencement of the new arrangements was in 2017.

RESOLVED: That the update be noted and the current South Kent Coast Health and Wellbeing Board arrangements be continued with until the new arrangements for a commissioning board were agreed.

9 LOCAL CHILDREN'S PARTNERSHIP GROUP UPDATE

Councillor S S Chandler (Dover District Council) and Councillor J Hollingsbee (Shepway District Council) provided an update to the Board on the Local Children's Partnership Group.

The Board was advised that the South Kent Coast Local Children's Partnership Group was the only one in Kent not based on district boundaries as it covered the areas of both Dover District Council and Shepway District Council.

The Group was focused on delivering measurable improvements in the priority outcomes set out in the Children and Young People's Plan (CYPP) as followed:

- Grow up in safe families and communities
- Have good physical, mental and emotional health
- Learn and have opportunities to achieve throughout their lives
- Make safe and positive decisions

It was noted that the second priority outcome (good physical and mental health) was of particular relevance to the activities of the Board.

For the Shepway District Council area, the following five priorities aligned to the CYPP outcomes had been identified:

- To reduce obesity in 0-25
- To improve dental health in under 5's
- To increase breast-feeding rates
- To improve perinatal mental health
- To reduce the rates of smoking in pregnancy

For the Dover District Council area there were concerns over the level of hospital admissions for self-harm which were the worst in Kent, although this needed further study to confirm if this was an on-going trend.

The remit of the Group included:

- To support the development and delivery of the Kent Wide Children and Young
- People's Plan and establish local outcomes and indicators
- Drive local activity focused on meeting the local outcomes and indicators
- Use local data and intelligence to support the SKC HWBB and the County-wide 0-25 Children's HWBB
- Provide a vehicle for identifying and addressing local needs and gaps in service provision
- Establish sub-groups where appropriate for task and finish projects to support the outcomes
- Facilitate and pool resources to meet the needs of local children and families

The Group had established a number of sub-groups:

- Service and Contract Review: Acute and Community Services Commissioners
- looking at co-dependencies and where services were best placed and what was already being commissioned.
- Children and Young People's Integration with Primary Care
- Early Years Task and Finish Group
- Town and Pier Healthy Weight Sub-Group

The Group had also awarded a number of grants for projects in Dover and Shepway.

There would be 6 meetings per year of the Group and the 'dashboard' of data would be updated in advance of each meeting, although it was noted that some data would only be updated quarterly,

The importance of measuring outcomes was discussed and the award of grants to projects dealing with children and young people's mental health was welcomed.

RESOLVED: That the report be noted.

10 DRAFT KENT HEALTHY WEIGHT STRATEGY

The Draft Kent Healthy Weight Strategy was presented by Ms J Mookherjee (Consultant in Public Health, Kent County Council).

The Board was advised that it was a 3 year strategy and that the draft action plan had been developed in conjunction with the South Kent Coast Clinical Commissioning Group, Dover and Shepway District Councils and Kent Public Health and it reflected existing and planned actions.

The cost of obesity to the South Kent Coast area was £13.4 million per year and the strategy hoped to raise awareness of being overweight as a medical issue that needed to be addressed through a multi-agency whole system strategy.

The four themes of the strategy were:

- Environmental and Social
- Children (which linked to the Children and Young People's Plan)
- Increasing the skills of the workforces to be able to have conversations about weight
- Interventions

The Board discussed the importance of promoting a consistent message to the public in respect of healthy eating and the need to engage with children and young people to foster healthy behaviour at a young age. It was recognised people could be aware that they were overweight but be unsure of how to tackle the problem.

RESOLVED: That the Draft Kent Healthy Weight Strategy be noted.

11 DRAFT SOUTH KENT COAST CLINICAL COMMISSIONING GROUP ANNUAL REPORT AND ACCOUNTS 2015-16

The Board received a presentation from Ms S Martin (South Kent Coast Clinical Commissioning Group) on the Draft Annual Report and Accounts 2015/16 for the South Kent Coast Clinical Commissioning Group.

Members congratulated Ms Martin on the Annual Report and Accounts for being a relatively easy to read despite the complexity of the subject matter and it was noted that a more concise version would be produced for the public.

RESOLVED: That the Annual Report and Accounts 2015/16 be noted.

12 SOUTH KENT COAST CLINICAL COMMISSIONING GROUP OPERATING PLAN 2016-17

Ms K Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group) presented the CCG Operating Plan 2016-17 to the Board.

The Board was advised that the key objectives for 2016-17 were:

- To develop a high quality Sustainability and Transformation Plan (STP) with partner organisations within the Kent and Medway STP footprint;
- To continue to maintain financial balance, including planned contributions to efficiency savings;
- To continue to implement plans to address the sustainability and quality of general practice;
- To recover and maintain the access standards for A&E and ambulance pathways;
- To recover and maintain the NHS Constitution standards for referral to treatment;
- To recover the NHS Constitution 62-day cancer waiting standard, maintain all other cancer waiting standards, and improve upon the 2015/16 position;
- To achieve and maintain the two new mental health access standards;
- To continue to deliver actions set out in local plans to transform care for people with learning disabilities; and
- To continue to implement plans to improve the quality and safety of services for patients.

The Board was advised that the CCG was working with East Kent Hospitals University NHS Foundation Trust in respect of A&E targets.

In respect of General Practice, a number of practices were struggling to recruit new staff in keeping with the national situation. Members of the Board requested an update for a future meeting, noting that activity was taking place at a Kent Health and Wellbeing Board level on this matter.

The Board was advised that Dr Jonathan Bryant had recently been appointed as the CCG's new Clinical Chair.

RESOLVED: (a) That the South Kent Coast Clinical Commissioning Group Operating Plan 2016-17 be noted.

(b) That an update be provided to a future meeting of the Board in respect of the situation in respect of recruiting staff for General Practice.

13 URGENT BUSINESS ITEMS

There were no items of urgent business items.

The meeting ended at 4.47 pm.

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 26 May 2016 at 10.00 am in the Pugin & Rossetti Rooms, First Floor, Council Offices, Cecil Street, Margate.

Present: Dr Tony Martin (Chairman); Councillor L Fairbrass (Thanet District Council), Councillor Gibbens (Kent County Council), Clive Hart (Thanet Clinical Commissioning Group), Madeline Homer (Thanet District Council), Mark Lobban (Kent County Council) and Linda Smith (Kent County Council)

1. APPOINTMENT OF CHAIRMAN AND VICE CHAIRMAN FOR 2016/17

Councillor Gibbens proposed, Councillor Fairbrass seconded and the Board agreed that Dr Martin be appointed as Chairman of the Thanet Health and Wellbeing Board for the ensuing year.

Dr Martin proposed, Mr Hart seconded and the Board agreed that Councillor Fairbrass be appointed Vice-Chairman of the Thanet Health and Wellbeing Board for the ensuing year.

2. APOLOGIES FOR ABSENCE

Apologies were received from the following Board members:

Hazel Carpenter
Colin Thompson, for whom Linda Smith was present.
Sharon McLaughlin
Councillor Wells

3. DECLARATION OF INTEREST

There were no declarations of interest made at the meeting.

4. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 24 March 2016 were agreed as a correct record.

5. GROWTH AND INFRASTRUCTURE FRAMEWORK

Stephanie Holt, Head of Countryside, Leisure and Sport Group, KCC presented the item, during which it was noted that:

- The Kent and Medway Growth and Infrastructure Framework (GIF) was developed to provide an understanding of the infrastructure required to support housing and economic growth up to 2031.
- It was recognised that there were gaps in the data used to create the GIF, and that accuracy was important as it would impact on local government funding. Errors could lead to funding gaps. It was intended that the GIF be updated by January 2017.
- Work would take place with district councils to agree infrastructure priorities.
- Public Health England developed a tool called SHAPE (a Strategic Health Asset Planning and Evaluation application) which KCC used to develop housing strategy. Data from SHAPE could be used to feed in to the GIF.

- Some key contacts to assist in the development of the GIF were:
    - Sue Martin – Head of Governance, South Kent Coast CCG and Thanet CCG
    - Colin Thompson – KCC – Consultant in Public Health
    - Alan Fitzgerald – KCC SHAPE lead.

6. THANET CCG ANNUAL REPORT

Sue Martin, Head of Governance, South Kent Coast CCG and Thanet CCG presented the item during which it was noted that:

- The auditors had given an unqualified opinion for the CCG accounts and also for value for money.
- Thanet CCG had achieved financial balance.
- Block contracts for EKHUFT had recently moved to a payment by result system, this potentially shifted the risk of budget overspend to local CCG's.
- The annual report would be circulated to the members of the Board after the meeting.

7. QUALITY PREMIUM

Adrian Halse, Senior Business Analyst, Thanet CCG presented the report during which it was noted that:

- The quality premium rewards CCG's for achievement of certain measures. Mandatory measures make up 70% of the available award, and 30% is allocated on the basis of achievement of three locally set measures and targets.
- The Board was asked to ratify Thanet CCG's choice of locally set indicators which had been submitted to NHS England for approval.
- The three indicators were chosen because they were highlighted as appropriate by the RightCare data, and were indicators which could be easily measured.
- Payment as a result of achievement of these indicators would be received in December 2017. Payment for the 2015/16 year would be made in December 2016, however payment would be reduced as not all the targets had been met.

The Board agreed to ratify the list of locally set indicators as set out in paragraph 3.5 of the report, namely:

17 - Genito-Urinary - Reported to estimated prevalence of CKD (%)	As noted in our operational plan, Right Care has highlighted cardio vascular disease, and tackling diabetes is also a key concern for the CCG in 2016/17. A key part of this work will be ensuring that more is done in primary care to prevent the need for secondary care interventions. CKD is linked to bother cardio vascular and diabetes and practices will need to continue to achieve high rates of diagnosis as part of this work. The intention is to exceed the national average.
37 - Mental Health - Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression	Mental health outcomes have been highlighted in the RightCare data for Thanet and improving access to psychological therapies is a key part of our operational plans around mental health next year. The intention will be to exceed the national average in terms of access rates.
43 - Mental Health - % of people who are "moving to recovery" of those who have completed IAPT treatment	Mental health outcomes have been highlighted in the RightCare data for Thanet and improving access to psychological therapies is a key part of our operational plans around mental health next year. The intention will be to exceed the national average in terms of recovery rates.

8. THEMATIC QUESTIONS FROM THE THANET LEADERSHIP GROUP

The Chairman introduced the item during which it was noted that:

- Three options had been considered at the recent Thanet Health and Wellbeing Board workshop. The preferred option was to create an Integrated Commissioning Board (ICB) which would adopt some of the work mandated to the Board.
- Similar conversations were taking place across other districts within Kent.
- The intention was to encourage integrated public services at a local level that were tailored to meet local needs.
- A clear proposal and appropriate governance arrangements would need to be established before being bought before Members for decision.

It was agreed that:

- The Chairman would formally speak to Roger Gough, KCC Cabinet Member for Education & Health Reform and Chairman on the Kent Health and Wellbeing Board to express the Board's desire to establish an ICB.
- The Executive Group would meet to consider governance arrangements and develop some challenge questions, proposals for group development would be reported back to the next THWB meeting.
- This topic would be a regular item on future agendas.

9. SERIOUS INCIDENT REPORT

The Board agreed that the public and press be excluded from the meeting for agenda item 9 as it contained exempt information as defined in paragraph 1 of Schedule 12A of the Local Government Act 1972 (as amended).

It was noted that:

- The Thanet CCG would consider how lessons learned information would be disseminated to relevant organisations going forward.
- Madeline Homer would share the lessons learnt with relevant individuals from Housing Services and the Police on this occasion.

10. REPORT FROM LOCAL PARTNERSHIP GROUPS

The Board noted the report.

Meeting concluded: 11.45 am

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