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THANET HEALTH AND WELLBEING BOARD

26 MAY 2016

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 26 May 2016** in the Pugin & Rossetti Rooms, First Floor, Council Offices, Cecil Street, Margate.

Membership:

Dr Tony Martin (Chairman); Hazel Carpenter, Councillor L Fairbrass, Councillor Gibbens, Clive Hart, Madeline Homer, Mark Lobban, Sharon McLaughlin, Colin Thompson and Councillor Wells.

A G E N D A

Item No

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

2. **APOLOGIES FOR ABSENCE**

3. **DECLARATION OF INTEREST**

4. **MINUTES OF THE PREVIOUS MEETING** (Pages 1 - 4)

   To approve the minutes of the meeting held on 24 March 2016, copy attached.

5. **GROWTH AND INFRASTRUCTURE FRAMEWORK** (Pages 5 - 40)

   Robustness of the HWB datasets that underpin the Growth and Infrastructure Framework locally.

6. **THANET CCG ANNUAL REPORT**

7. **QUALITY PREMIUM** (Pages 41 - 50)

8. **THEMATIC QUESTIONS FROM THE THANET LEADERSHIP GROUP**

9. **SERIOUS INCIDENT REPORT** (Pages 51 - 82)

10. **REPORT FROM LOCAL PARTNERSHIP GROUPS** (Pages 83 - 84)

    Declaration of Interests Form

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 24 March 2016 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Clive Hart (Thanet Clinical Commissioning Group), Mark Lobban (Kent County Council), Sharon McLaughlin (Thanet Children's Committee) and Linda Smith (Kent County Council)

In Attendance: Val Miller, Public Health Specialist for Healthy Weight, KCC and Kallie Heyburn, Head of Strategic Planning and Commissioning, Thanet CCG

16. APOLOGIES FOR ABSENCE

Apologies were received from the following Board members:

Colin Thompson, substituted by Linda Smith;
Councillor Gibbens;
Councillor Wells;
Councillor L. Fairbrass;
Madeline Homer, substituted by Penny Button;
Hazel Carpenter.

17. DECLARATION OF INTERESTS

There were no declarations of interest made at the meeting.

18. MINUTES OF THE PREVIOUS MEETING

The minutes were agreed as a correct record of the meeting that was held on 21 January 2016.

19. THANET HEALTHY WEIGHT ACTION PLAN

Val Miller, Public Health Specialist for Healthy Weight, KCC led discussion with a presentation to the Board. She said that the Action Plan was still work in progress and that it was an iterative process as officers were still collating information from partner agencies including KCC. Adult excess weight was prevalent in the county, with two thirds of adult population viewed as being obese. Prevalence of obesity in Year 6 school children was observed as well.

The Board was concerned about children leaving primary school overweight. It was reported that other Health and Wellbeing Boards were working on similar issues using the same action plan template across Kent. The causes of obesity were shared in the 2007 Foresight Report's 108 factors that included genetics, exercise, environment, diet and psychology.

Val Miller said that it was important for organisations to start thinking about workforce development to help address this significant health issue. Providing training to frontline staff to pass on the message on healthy weight would build the confidence of staff to engage residents and raise issues about obesity when providing them with services. It was also essential that adequate resources would need to be commissioned to provide services for weight loss to individuals who require such services.

Concerns were raised about the BME and disability groups being under represented at forums were these issues were debated. There was a need for joined up working and for the Board to use its influence to identify sources of funding that could be shared and accessed for weight loss services.

Communication across agencies was key in order to share information on what different agencies were doing in addressing this health issue. Having an influence over planning, licensing, leisure and environmental services would also help fight obesity for the local communities. Children in the age group 11-19 years did not have as much services to help them with overweight problems. There was a need to consider early health notification and child protection issues when dealing with overweight children. There was a key role to be played by the media, elected Members, local role models and campaigns. It was observed that the sugar tax recently introduced was a step in the right direction by government.

Members suggested that this action plan on healthy weight be made part of the Thanet Health & Wellbeing Board agenda. This plan could include working with schools and nurseries programmes that promote healthy weight for children as well as the diversionary activities by the Justice system that work with children that were picked off streets. It was important to be aware that children from deprived areas and families were more vulnerable and susceptible to obesity problems.

The interventions should therefore aim to reach out to these marginalised individuals and families. Identifying health champions in partner agencies' staff would also be a good start. Attention should be given to creating play spaces when decisions are made by the Council's planning department. Parks and cliff walks should also be promoted. These efforts could be supplemented by sending out subtle messages like promoting smoke free homes for families. The Board should ask difficult questions that would help progress the agenda for healthy weight. This could include challenging the services that were being provided by vending machines in work places, leisure centre leasing conditions and the general food marketing approaches by organisations.

The Board noted the presentation.

20. INTEGRATED COMMISSIONING AND ALIGNMENT

Kallie Heyburn, Head of Strategic Planning and Commissioning, Thanet CCG made a presentation to the meeting. She said that the proposed approach of integrated commissioning and outcomes based commissioning would provide seamless services to patients. A workshop was held on 3 March 2016 with members of the Integrated Commissioning Group together with clinical leads, commissioning manager and chairs of the Local Partnership Groups to start mapping out the services that were currently being offered. The finance picture would need to be clearly identified in order to quantify the efficiency savings whilst improving services being offered. It was hoped that the proposed plan would be implemented in 2017/18.

Board members said that the proposed integrated working should be put at the centre of activities of the partner agencies that are working towards integrated commissioning of health and social care services. There are a number of organisational challenges that would need to be overcome in order to achieve full integration by 2020. These included the current budgetary constraints, budget deficit and efficiency savings.

The other significant challenge is for the integrated commissioning group to establish a new model of integrated working. This would include rewording the terms of reference of the group and bring together the appropriate commissioners to this debate and work out the governance issues leading to an agreed change model that cuts across sectoral interest barriers.

Board members agreed that it would be helpful for the Away Day session that has been planned for early May 2016, be used to develop the Board further and bring in the right professionals to sit on it. This would help ensure that governance arrangements for the commissioning group are set out appropriately in order to move forward the agenda for integrated commissioning.

Some of the questions that would need to be considered are: 'are we seeking to identify a model for service delivery or just to identify the outcomes? Do we want to commission the outcomes or just the model? It was important for the commissioning leadership to identify the model of care and its functionality. What would be the roles and responsibilities between the strategic commissioners and the people who are accountable for the new organisation?'

Members noted the presentation.

21. VERBAL UPDATE ON HEALTH INEQUALITIES IN THANET

Linda Smith, Public Health Specialist for Thanet, KCC introduced the item for discussion.

Thanet Health Inequalities profile
KCC Public Health is taking a new approach to reducing health inequalities in the county, by producing focussed analysis of the most deprived areas. Multivariate segmentation techniques have been used to identify different 'types' of deprivation affecting communities in Thanet:

- Young people lacking opportunities;
- Families in social housing;
- Young people in poor quality housing.

The Health Inequalities Group has met twice and work is underway to develop a Thanet Plan based on these revised Public Health Locality Profiles.

Thanet Child Health Profile
Highlighted for discussions were areas of improvement such as the teenage pregnancy rate in Thanet is at its lowest since records began in 2001. Alcohol-related hospital admissions for those under 18 years are also declining.

The 0-19 year population is set to increase by 3% over the next five years equating to 1000 additional young people in the area by 2020. Wards with relatively high levels of child poverty (50%) are some of the poorest in Kent.

Education attainment and unauthorised absence from school continue to be a key challenge in several wards.

Department of Health Visit
The Department of Health (Equity and Communities) and Public Health England are collaborating and sharing resources to tackle health inequalities. They will be visiting Margate and talking to the various partner agencies Colin Thompson will be coordinating the visit; date to be confirmed.

Dual Diagnosis: Care Improvement
A revised partnership joint working agreement to improve care for individuals with a mental health and a substance misuse condition (dual diagnosis) has been agreed by the Strategic Steering Group for Kent and Medway in March 2016. This will be supported by a Kent and Medway Partnership Trust dual diagnosis policy, a care pathway, training and web-based resources for practitioners. It will be implemented with immediate effect and promoted in the coming months.

The report was noted.

Meeting concluded: 11.20 am

Kent and Medway Growth and Infrastructure Framework (GIF)

A report for the Thanet Health and Wellbeing Board 26th May 2016

This item relates to a paper presented to the Kent Health and Wellbeing Board back in November 2015. That paper and the minutes recorded of the discussion that paper generated within the Kent HWB are presented below in italics.

Today's item (26/05/16) supports a presentation to Thanet Health and Wellbeing Board Members focusing on:

- What data sources does the Thanet HWB believe we should be accessing (whether nationally, regionally or locally held) to ensure Kent and Medway can accurately plan infrastructure going forward?
- Who are the Thanet health and social care stakeholders the HWB would particularly wish to ensure are engaged with the progression of the Growth and Infrastructure Framework – and how does Kent County Council (KCC) best engage them?
- What are the outcomes the West Kent HWB would like to see the GIF evidencing/articulating against, in order to focus county efforts to help achieve them?

This item will be led by Stephanie Holt on behalf of Kent County Council's Environment, Planning and Enforcement Division

By: ***Barbara Cooper, Corporate Director, Growth Environment and Transport, KCC***
Katie Stewart, Director Environment Planning and Enforcement, KCC

To: ***Health and Wellbeing Board***

Date: ***18 November 2015***

Subject: ***Growth and Infrastructure Framework***

Classification: ***Unrestricted***

Summary:
This report provides an overview of the recently launched Kent and Medway Growth and Infrastructure Framework (GIF), and the associated action plan. It also seeks the Board's input to the development of the GIF, with a view to strengthening particularly

the health and social care infrastructure evidence base and using it to help shape health infrastructure provision to support housing growth.

Recommendations:
The Board is recommended to:

a) note the contents and conclusions of the first GIF and its associated action plan;
b) agree to help shape the future of the GIF by contributing robust and timely data and analysis to the next refresh; and
c) agree to use the GIF to help shape discussions about the future shape of health and social care service delivery

1. Background

1.1. Board members will be aware of increasing pressure on local authorities across the UK in delivering housing and economic growth. Within Kent and Medway alone, approximately 160,000 new houses are planned to 2031. In order to deliver such housing numbers, it is vital that the right infrastructure is in place to support that growth – infrastructure including not just roads and rail, but public services required to serve these new communities including education, leisure facilities, and critically health and care services.

1.2. The Kent and Medway ***Growth and Infrastructure Framework (GIF)*** *has been developed to provide a clear picture of housing and economic growth to 2031 and the infrastructure needed to support this growth. It was finalised following its consideration by Kent County Council in July and Kent Leaders in September. The full GIF can be accessed via the following weblink: www.kent.gov.uk/gif.*

1.3. At a time when the Government has prioritised the delivery of housing and economic growth more generally, it is an absolutely critical time for Kent to use the GIF to not only promote Kent and Medway's infrastructure priorities, but also shape a more sustainable approach to funding infrastructure in the long term.

1.4. To this end, the final version of the GIF includes a ***10-point action plan****, which taken together will ensure that the GIF becomes a framework and platform for creating a more sustainable and effective approach to planning, investing and delivering infrastructure to support growth. Please see Appendix for a summary of these actions.*

2. The GIF on health and social care

2.1. As part of the infrastructure to support growth in Kent and Medway, the GIF provides evidence on the provision of healthcare and social care capacity across the area – both current provision and provision that would be required to support the planned housing growth to 2031.

Healthcare provision

2.2. It should be noted that there were challenges in gathering robust data on health infrastructure provision for this first version of the GIF – a challenge which it is hoped can be overcome in working more closely with partners in the sector. The data for existing provision was taken from NHS Choices data, whilst the future requirements and associated costs were derived from modelling that applies population growth to existing provision.

2.3. Specifically, the GIF provides the following data:

Current provision	***Required provision to 2031***

• *Current primary healthcare, including:*
  ○ *Number of GPs*
  ○ *Patient list size*
  ○ *Patients per GP*
  ○ *Population per dentist*
  ○ *Population per pharmacy*
  ○ *Population per optician*
	• *Primary healthcare required to support population growth to 2031*

• *Current provision of hospital capacity, including:* *o Existing acute NHS hospitals* *o Existing community hospitals*	• *Additional beds required to support population growth – including both hospital beds and mental health beds*

2.4. The GIF is based on the existing healthcare model using population growth forecasts to establish level of demand for healthcare services. For acute hospital and mental health beds needed, the current UK bed to person ratios (i.e. steady state) was used and has been applied according to the forecast population growth.

2.5. Future requirements and associated costs and funding assumptions for primary, acute and mental healthcare have been based on benchmark modelling and have not yet, due to time constraints been validated or agreed by the NHS. In most cases of development, after developer contributions have been taken into account, the outstanding costs to deliver necessary infrastructure are usually met by the NHS.

However, given the known funding deficit across public sector organisations including the NHS, it is expected that the NHS may no longer be able to meet the full cost of this funding requirement in future. As such, in the GIF, the proportion of the gap after developer contributions that is funded by the NHS has been reduced down from 100% to 75% in order to give a best estimate of future funding requirements.

Social care provision

2.6. The GIF maps current social care provision across Kent, including provision for people with learning disabilities; people with mental health needs; older people; and people with physical disabilities. The following capacity issues are identified:

Client group needs	***Capacity issues in:***
Learning disabilities	*Ashford* *Dartford* *Dover* *Sevenoaks* *Tonbridge and Malling* *Tunbridge Wells*
Mental health	*Dartford* *Dover* *Tonbridge and Malling*
Older people	*Dartford* *Swale* *Thanet*
Physical disabilities	*Dartford* *Dover* *Gravesham* *Maidstone* *Swale* *Thanet* *Tonbridge and Malling* *Tunbridge Wells*

2.7. Costs and future provision requirements are estimated on the basis of the Social Care Accommodation Strategy which sets out the forecast change in demand for the full range of care clients. This analysis has highlighted the need for considerable investment in older persons nursing and extra care accommodation and also supported accommodation for clients with learning disabilities.

2.8. Given the limitations on the data used for the GIF, there is a clear need to refine the picture of health and care infrastructure to meet future growth in the next and future iterations of the GIF. Nonetheless, whilst the findings of the GIF should be read with caution, they ***highlight a critical challenge in funding health and social care provision to meet future demand****. In particular, the GIF has highlighted challenges in such provision in growth areas where there viability is more marginal.*

3. Developing the health infrastructure of the future for Kent and Medway

3.1. In order to refine our understanding of this challenge and provide as robust an evidence base as possible from which to potentially attract funding and/or explore new delivery models, it is critical that the GIF is shaped by partners, including those around the Health and Wellbeing Board. There is also a clear opportunity to shape this part of the GIF with local Health and Wellbeing Boards moving forward.

3.2. From this work to refine the evidence base, the GIF could give the HWB a platform from which to ***identify priorities for healthcare infrastructure for the future****. In doing so, the HWB is potentially a key partner in the GIF action plan, particularly around raising the profile of the need for better alignment of funding for healthcare infrastructure with growth.*

3.3. Similarly, local partners will ***be using the GIF to engage with London on more proactive management of the impact of London's growth*** *on Kent and Medway. This will form part of a strategic conversation across the Southeast to ensure that where this growth impacts outside of London, the right infrastructure is delivered to support that growth. To broker this engagement, KCC will work through the Southeast Strategic Leaders (SESL) network, as well as Southeast authority officer networks (including a planning policy officers and directors groups).*

3.4. Further, and perhaps more importantly, the GIF is intended to give partners a tool with which ***to test the impact of new delivery models.*** *Within the current GIF, the option of an integrated health and social care model, similar to the Estuary View Medical Centre in Whitstable, is applied to the whole of Kent and Medway. The cost is estimated to be c. £500m, but the impact of revenue savings as a result of more efficient delivery may be deemed to outweigh this initial capital cost in the medium to long term. Further work on exploring the cost of such a model and the potential savings in revenue terms could be undertaken using the GIF as a framework.*

*3.5. Finally, KCC will use the GIF to enable a more **proactive approach to attracting investment** – not only from Government but from potential private sector sources as well. Work will be scoped to explore the potential of institutional investment, as well as to proactively prepare for future rounds of Local Growth Funding and/or other Government funding.*

4. Recommendation

4.1. The Board is recommended to:

a) note the contents and conclusions of the first GIF and its associated action plan;
b) agree to help shape the future of the GIF by contributing robust and timely data and analysis to the next refresh;
c) agree to use the GIF to help shape discussions about the future shape of health service delivery

Report author/Relevant Director:

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Director, Environment, Planning and Enforcement
Directorate Growth, Economy and Transport
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APPENDIX: GIF Action Plan

Action 1: Innovation in financing
Discussions with Government on the shortfall in capital funding growth and work collaboratively to find 'new innovative ways' of closing the funding gap (e.g. Tax Increment Funding (TI F), Institutional Investment, better application of CIL etc).

Action 2: A single Infrastructure Delivery Plan for Kent
Explore the feasibility of producing a single Infrastructure Delivery Plan for Kent and Medway reflecting the robust partnership working with the district authorities and Medway.

Action 3: A stronger relationship with London and the Southeast
Engage with South East Strategic Leaders and the County Councils in the South East on strategic issues and priorities, in particular transport, including linkages to London and radial routes to better connect the wider South East.

Action 4: Reform of CIL and developer contributions
Engage Government, using existing networks such as the County Councils Network where appropriate, to explore means of refining the current CIL and developer contribution mechanisms to better take account of varying viability in different areas of the country, to maximise the potential of CIL

Action 5: The potential for private sector investment
Open discussions with the private sector including the development, pension and insurance sectors, and other investment sectors to explore the feasibility of establishing an 'Institutional Investment' pot for infrastructure and other mechanisms that may help fund infrastructure.

Action 6: A stronger relationship with the utilities
We will collaborate with the utilities sector to seek improved medium to long term planning aligned to the County's growth plans. A key role for the public sector will be to hold utilities companies to account to make the necessary capital investment. Through establishing County Council scrutiny arrangements for utility provision (which have the opportunity to feed into OFWAT, OFGEN, etc) matching utility companies' capital investment plans to the growth plan.

Action 7: Maximise the public estate
We will use the One Public Estate pilot commencing across Kent to seek to ensure we are maximising opportunities to lever in investment opportunities to fund and support growth.

Action 8: Ensuring the GIF is a "go-to" reference for infrastructure priorities
The GIF will be regularly refreshed to reflect the ongoing development of the Kent and Medway Local Plans and to enable refinement of many of the areas of evidence within the framework including costs and future funding assumptions.

Action 9: An integrated approach to planning and delivering growth
Monitor annually on a district-by-district basis:

- *Progress of Local Plans;*
- *Delivery of housing and employment space;*
- *Receipts from developer contributions and CIL;*
- *Public and private sector investment in the county, including into the health*
- *and social care sectors and;*
- *Utility company capital investment.*

Action 10: A robust design agenda for Kent and Medway
Consider how we can build on and refine current activity in the county aimed at ensuring high quality design, including working with Kent Planning Officers' Group and Design South East and updating the Kent Design Guide where required

Agreed Minutes Outlining Discussion at Kent Health and Wellbeing Board 18 November 2015

182. Growth and Infrastructure Framework

(Item 6)

(1) Barbara Cooper (Corporate Director - Growth, Environment and Transport) and Katie Stewart (Director - Environment, Planning and Enforcement) introduced the report which provided an overview of the Kent and Medway Growth and Infrastructure Framework (GIF) and action plan and sought the HWB's input to the development of the GIF to strengthen the health and social care infrastructure evidence base and a commitment to using it to shape health infrastructure provision to support housing growth.

(2) Mrs Cooper said that the development of approximately 160,000 new homes and a population increase of 300,000 were planned for Kent and Medway to 2031 and the GIF and its associated action plan had been developed to become a framework and platform for creating an effective approach to planning and delivering the infrastructure necessary to support growth.

(3) Mrs Stewart said the data for existing health provision had been taken from NHS Choices and future requirements and associated costs were derived from modelling the anticipated population growth to the existing provision. She also said that once developer costs had been taken into account, the NHS currently met the remaining costs of health infrastructure however it was expected that in future the NHS would not be able to meet the full costs. She said input from partners would be very welcome to build the evidence relating to health and social care so the GIF could be used to proactively manage the impact of London's growth on Kent and Medway and attract investment as well as giving partners a tool to test the impact of new delivery models.

(4) During the discussion the need to plan for future health and social care needs was recognised. It was suggested that the growth already taking place in North Kent could be an opportunity to test models of future health and social care provision and of addressing health inequalities however there were also concerns that funding for services might continue to follow population growth.

(5) The need for different models of care and extra-care facilities was mentioned, as well as the need for detailed work at local level to feed into the development of a single infrastructure delivery plan for Kent.

(6) Mrs Stewart said that KCC wished to work collaboratively with health and other partners to ensure maximum benefit from the public estate.

(7) In response to a question Mrs Cooper said that the Kent and Medway Economic Partnership had established a skills commission to identify and plan for future skills needs and she offered to share the notes of the commission relating to the health and social care sectors.

(8) The work that had been done since May was acknowledged and it was suggested that conversations with the accountable officers for each of the CCGs be initiated to ensure all relevant local health data was included in the GIF and kept updated.

(9) Resolved that:

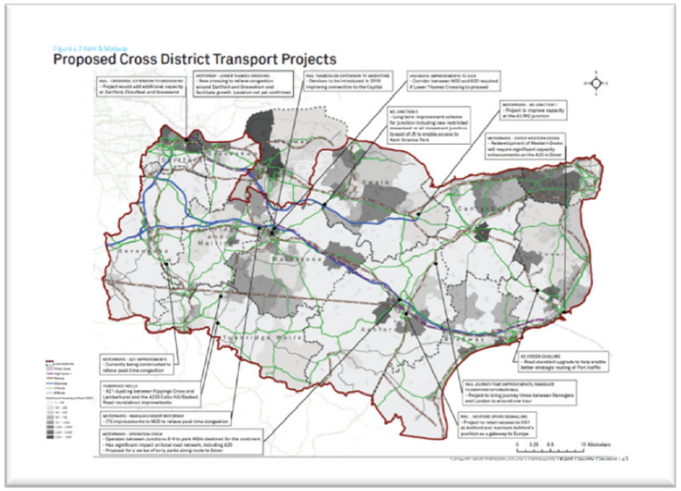
(a) The contents and conclusions of the first GIF and its associated action plan be noted;
(b) It be agreed to help shape the future of the GIF by contributing robust and timely data and analysis to the next refresh;
(c) The GIF be used to help shape discussions about the future shape of health and social care service delivery.

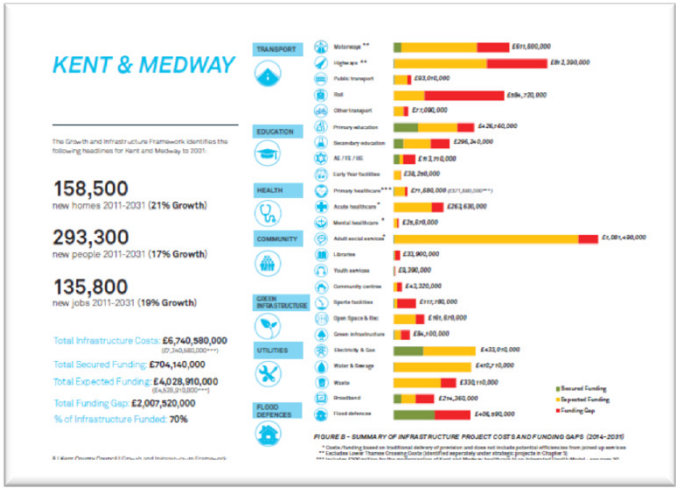
Kent and Medway Growth & Infrastructure Framework

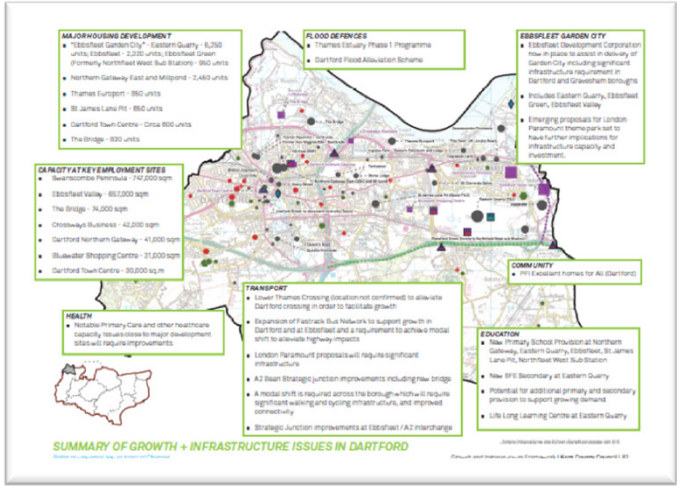
Stephanie Holt

Environment, Planning and Enforcement Division

What is the Growth & Infrastructure Framework?







The benefits of the framework

1. Evidence and support for Local Plans as they are developed

2. Opportunity to co-ordinate planning of new delivery models e.g. health, utilities etc

3. Single, strategic voice for Kent and Medway

4. Evidenced conversation with Government on funding and delivery barriers

5. Evidenced conversation with London on how it will meet its housing need

Kent & Medway – Growth to 2031

The Growth and Infrastructure Framework identifies the following headlines for Kent and Medway to 2031

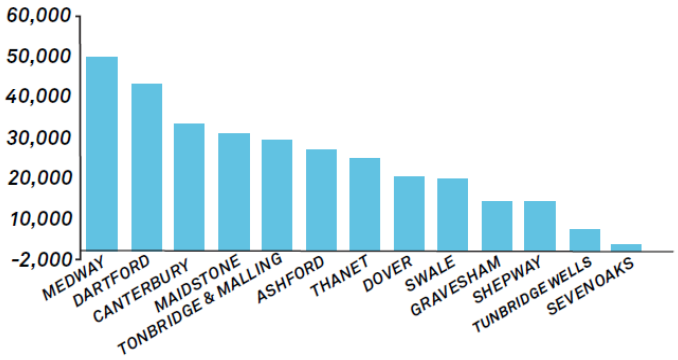
158,500
new homes 2011-2031 (**21% Growth**)

293,300
new people 2011-2031 (**17% Growth**)

135,800
new jobs 2011-2031 (**19% Growth**)

Population Growth

The population growth varies significantly within Kent & Medway, with the greatest increases in Medway, Dartford, Canterbury & Maidstone



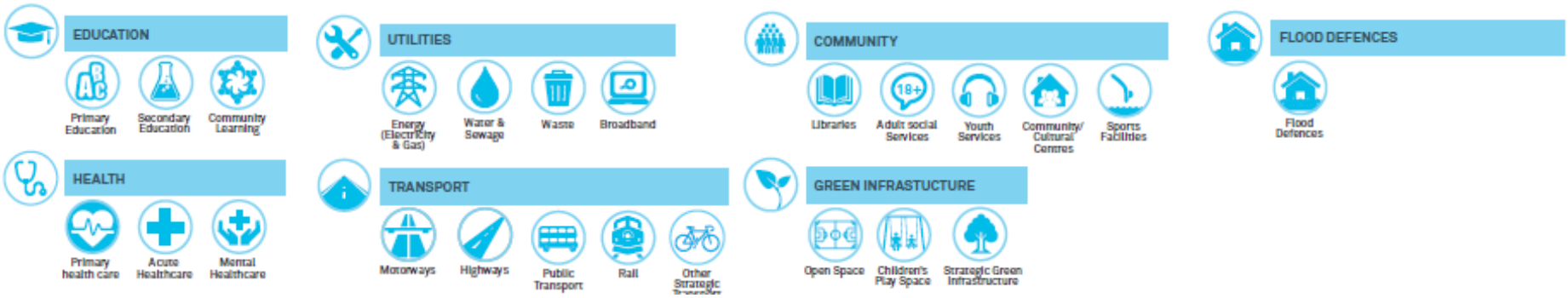
Housing Growth

FIGURE 3.14 - NUMBER OF HOUSING SCHEMES (100+ UNITS) FORECAST FOR EACH LOCAL AUTHORITY

Economic Growth

Kent & Medway – Infrastructure requirement

Statutory Local Government Infrastructure, Public Sector Partnership Infrastructure & Private Sector Infrastructure are necessary pre-requisites to support the scale of growth.



The cost of growth

Total for Kent and Medway	Total Amount	Amount per Annum
Infrastructure Cost from 2014 to 2031	£6.74 billion	£397 million
Secured Funding *	£0.70 billion	£42 million
Expected Funding**	£4.03 billion	£237 million
Funding Gap	**£2.01 billion**	**£118 million**

** Funding that is in the bank or committed via formal agreement* *** Funding that is anticipated to come in via government, developer contributions or private sector.*

The GIF makes abundantly clear that the current mechanisms for delivering growth do not provide the infrastructure needed for that development.

The agenda for infrastructure

Getting the evidence base right

– Explore the potential for a single Infrastructure Delivery Plan for Kent and Medway.

Influencing and attracting new investment

– Health and social care considered on two basis; continuing the existing model of provision, and a modern fit-for-purpose 21st century model

– Explore the potential for private sector investment in infrastructure

– Use the GIF to promote a more robust approach to quality design

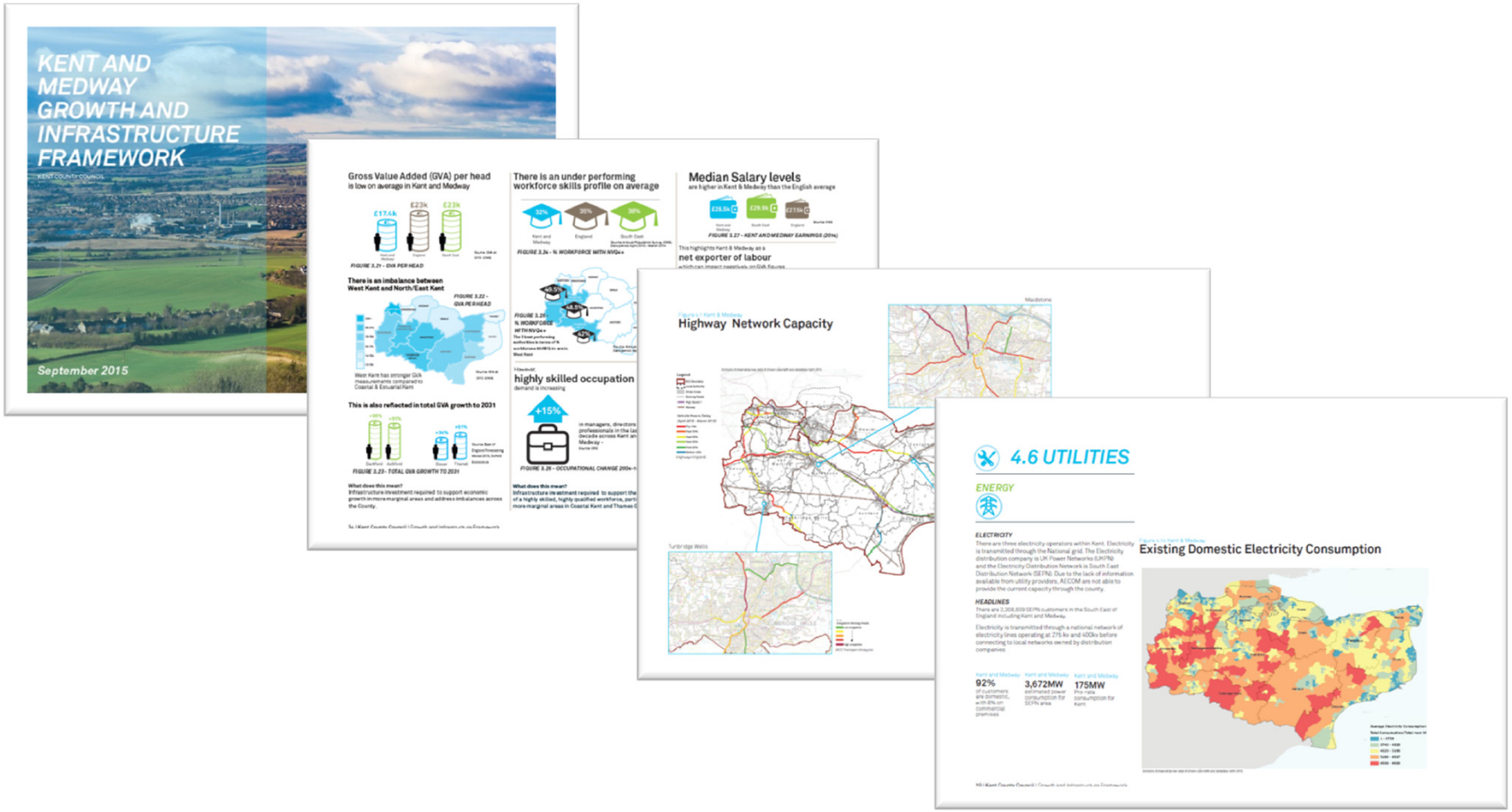
Working more effectively across boundaries to maximise infrastructure investment

– Work with Government to explore innovation in funding of infrastructure including potential reform of CIL

– Maximise the public estate to further support growth through Kent's One Public Estate pilot.

– Develop a stronger relationship with London and the South East

Further development of GIF




www.kent.gov.uk/GIF
GIF@kent.gov.uk
Infrastructure Needs and Requirements;
Chapter 4.3 – Health
Chapter 4.4 – Community
Area Breakdowns;
Chapter 5.11 - Thanet

4.3 HEALTH

PRIMARY CARE SERVICES

Kent & Medway	Kent & Medway	Kent & Medway	Kent & Medway
1040	**833**	**323**	**144**
GPs	dentists	community pharmacies	opticians

CURRENT SITUATION

The Health and Social Care Act 2012 has radically changed the way that primary care services are planned and organised. This has facilitated a move to clinical commissioning, a renewed focus on public health and allowing healthcare market competition for patients.

HEADLINES - GPS

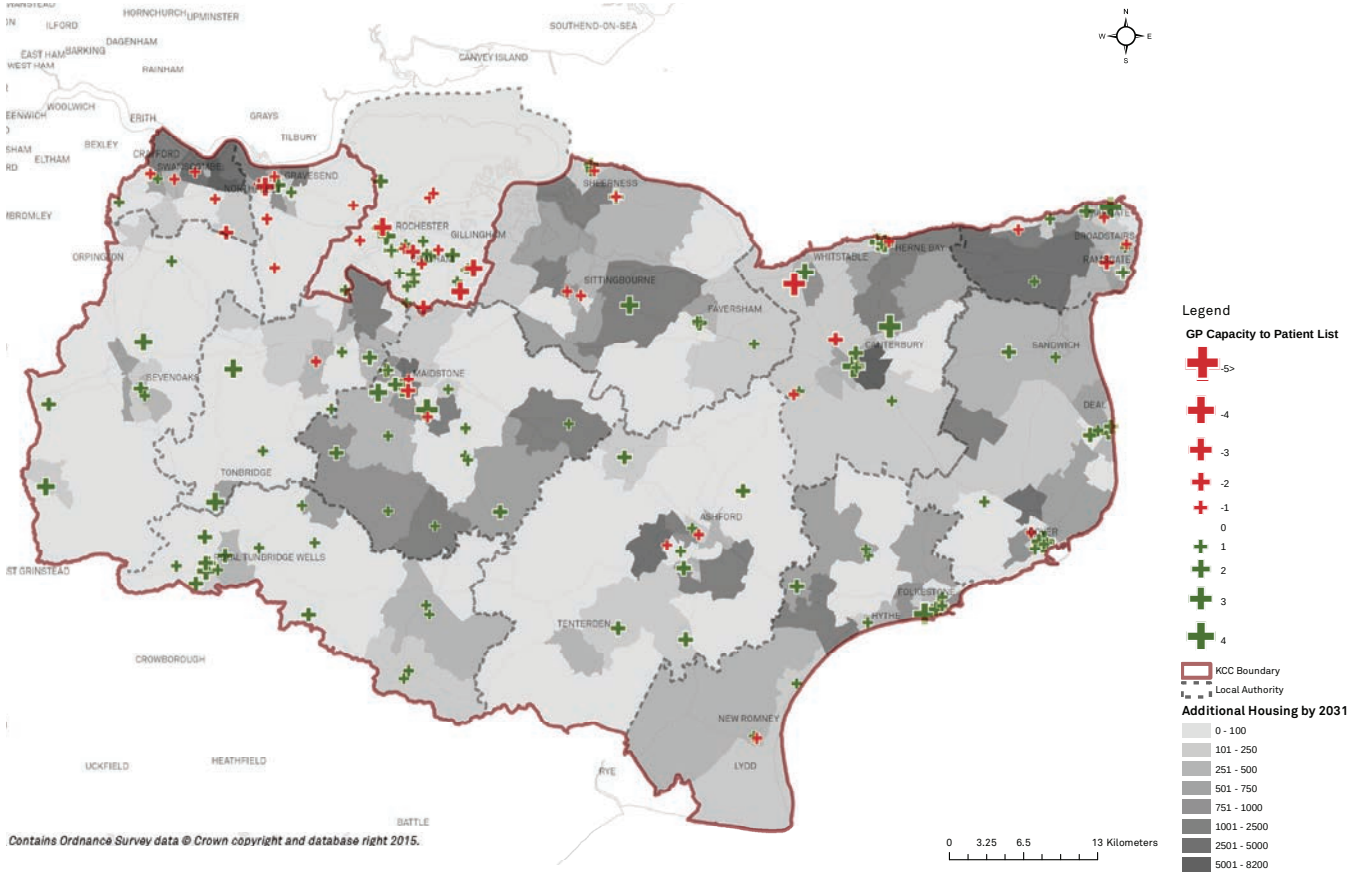
- Dover and Tunbridge Wells have the lowest average patient list sizes to number of GPs
- Average Patient list sizes are below the UK guidelines in Ashford, Canterbury, Maidstone, Sevenoaks, Shepway and Tonbridge & Malling
- Average Patient list sizes are above the UK guidelines in Dartford, Gravesham and Medway
- According to the mapping of provision and GP numbers there is a lack of capacity in proposed growth areas.

HEADLINES - DENTISTS

- The poorest provision in Kent is in Swale with 2,800 people per dentist. Dover also has limited capacity.
- Medway has most capacity at present with 1,680 people per dentist. Canterbury, Dartford, Shepway and Tunbridge Wells also have good provision.

Figure 4.6 Kent & Medway

Primary care capacity against housing growth areas



Primary Care Case Study: Estuary View Medical Centre

In Kent and Medway the picture of existing health services is unsustainable and will require a significant redesign and modernisation to move towards an integrated care strategy. This will place additional pressures on consolidation and refreshing existing healthcare infrastructure.

In recognition of this, there will be additional pressures to consolidate existing healthcare infrastructure. An integrated Health and Social Care model could look like the proposed vanguard development at Estuary View in Whitstable (See Case Study).

The costing for nursing and extra care housing provision is insufficient within Kent and Medway, creating difficulties to meet the adult social care requirement. If we were however to modernise our healthcare model to provide fit for purpose facilities along the lines of the integrated Estuary View model, the cost for Kent and Medway would be approximatly £500 million.

CASE STUDY: ESTUARY VIEW MEDICAL CENTRE, WHITSTABLE

INNOVATIVE ASSET MANAGEMENT FOR HEALTH AND SOCIAL CARE

Estuary View in Whitstable is a combined medical centre providing a precedent example of maximising investment in capital assets. Construction was completed in 2009 at an estimated cost of £4million providing 2,400 sq m of floorspace. It comprises the following co-located facilities:

- Long Term Conditions
- Community Elective Services
- Screening Services
- Day Surgery
- Therapists
- GPSI/Specialist Clinics
- Consultant-led outpatient clinics
- Diagnostics
- Urgent Care

The existing medical centre has already seen reduced costs to the NHS with a 2 year study highlighting £1.6million in savings verses standard NHS tariffs achieved through lower tariffs, use of GPs with a special interest, less outpatient follow-ups and A&E avoidance.

Estuary View is part of the Whitstable Medical Practice (WMP), a super partnership of 19 NHS GPs, serving 34,000 patients from 3 medical centres. WMP has expansion plans to develop the existing Estuary View Medical Centre into a **Community Integrated Health & Social Care Village**. These plans include wider services in addition to the medical centre such as:

- A new, linked community hospital
- Day-centre for care of the elderly, dementia, other patient groups.
- A co-located/linked teaching nursing home
- A co-located extra care facility.
- A co-located base for integrated community nursing and social care teams

It is estimated that the cost of delivering the integrated Health & Social Care Village would be between £20-30 million.

The community hub model also has the potential to deliver council services and complementary social infrastructure including an ambulance response base, dentists, opticians, pharmacies, crèche, library space, Citizens Advice Bureau and meeting rooms.

The “Delivering better health care for Kent” discussion document supports and encourages community integrated health and social care. KCC are considering how the lessons learned from Estuary View can be applied to the delivery of future health and social care facilities in Kent.

Reflecting on the population growth and associated requirements for health and social care facilities set out earlier in this report, the Hub approach provides an opportunity to deliver a proportion of that infrastructure with the cost savings associated with co-location and integrated services. Theoretically, the health and social care village hub is expected to serve a population of between 40 and 50,000 people. The additional 293,900 people forecast in Kent & Medway to 2031 would require the equivalent of 6 to 7 additional Health & Social Care Villages.

Table 4.5 Kent & Medway

Primary healthcare capacity & proposed infrastructure

	PROVISION OF GP PROVISION			PROVISION OF OTHER PRIMARY HEALTHCARE			REQUIREMENT TO SUPPORT POPULATION GROWTH	
	NUMBER OF GP	PATIENT LIST SIZE	PATIENTS PER GP	POPULATION PER DENTIST	POPULATION PER PHARMACY	POPULATION PER OPTICIAN	ADDITIONAL GP	ADDITIONAL DENTISTS
Ashford	71	121,960	1,718	2,191	6,572	11,352	13	11
Canterbury	99	177,896	1,797	1,805	4,964	8,824	15	12
Dartford	52	111,549	2,145	2,054	5,622	9,710	22	18
Dover	76	109,636	1,443	2,770	5,678	11,356	9	7
Gravesham	52	115,881	2,228	2,339	4,577	21,055	6	5
Maidstone	98	154,488	1,576	2,409	7,121	14,890	14	12
Sevenoaks	49	74,502	1,520	2,509	7,860	14,738	1	1
Shepway	72	113,334	1,574	2,083	4,415	11,038	7	6
Swale	77	142,655	1,853	2,822	5,039	14,110	9	8
Thanet	79	142,952	1,810	2,492	4,502	12,688	10	8
Tonbridge & Malling	77	129,642	1,684	2,425	7,005	11,463	14	11
Tunbridge Wells	82	118,694	1,447	1,849	7,279	8,959	4	3
KENT	***884***	***1,513,189***	***1,712***	***2,269***	***5,668***	***11,819***	***123***	***102***
Medway	156	313,143	2,007	1,683	5,019	18,067	23	19
KENT & MEDWAY	***1040***	***1,826,332***	***1,756***	***2,156***	***5,559***	***12,470***	***146***	***121***

SOURCE: PRIMARY HEALTHCARE CAPACITY AND PATIENT LIST SIZE ACCORDING TO NHS CHOICES 2014 DATA

SHADING OF PATIENT / GP PROVISION ACCORDING TO UK BENCHMARK OF 1800 PATIENTS TO 1 GP
SHADING OF OTHER PRIMARY CARE PROVISION ACCORDING TO HIGHER OR LOWER THAN KENT & MEDWAY AVERAGE

Healthcare Analysis Notes:

- Existing primary care baseline figures are based upon NHS Choices data which has limitations and does not represent a 100% accurate record of current provision.
- Future requirements and associated costs and funding assumptions for primary, acute and mental healthcare based upon benchmark modelling and has not been validated or agreed by the NHS.
- Analysis based on a continuation of current models of provision and does not take account of the emerging changes to service delivery set out in the NHS Five year forward view. See Chapter 6 for the potential impacts and savings from joining up health and social care provision.

FUTURE REQUIREMENTS TO MEET GROWTH

Table 4.5 sets out additional primary healthcare facility requirements across Kent and Medway to 2031, this is based on the application of best practise standards per patient list size with the following additional infrastructure required:

- 146 additional GPs and associated premises of 24,100 sq.m
- 121 additional dentists and associated premises of 6,000 sq.m

COSTS AND FUNDING

AECOM has estimated costs based upon a standard multiplier and benchmark costs. It identifies the following costs for Kent and Medway:

Cost = £71,680,000 *(£500,000,000*)*
Secured Funding = £4,000,000
Expected Funding = £56,400,000 *(£556,400,000*)*
Funding Gap = £11,290,000

****ALTERNATIVE SCENARIO COSTS/FUNDING TO MODERNISE EXISTING HEALTH AND SOCIAL CARE TO INTEGRATED MODEL BASED ON VANGUARD ESTUARY VIEW OPERATION***


ESTUARY VIEW MEDICAL CENTRE

HOSPITALS AND MENTAL HEALTH

Kent & Medway
3,115
NHS hospital beds

Kent & Medway
502
mental health hospital beds

CURRENT SITUATION

Kent and Medway include nine acute NHS trust hospitals, 12 community hospitals, one NHS independent sector hospital, nine private hospitals and seven A+E Departments. These are all commissioned by NHS England and the eight CCGs, except the private hospitals.

Mental health trusts provide community, inpatient and social care services for psychiatric and psychological illnesses.

HEADLINES - HOSPITALS

- West Kent has the most acute and hospital beds (30%), followed by East Kent (28%), North Kent (23%) and South Kent (18%)
- 96% of hospital and mental health beds were utilised in Kent and Medway according to 2014 data, compared to 90% in England and Wales
- Dartford, Gravesham, Medway and Canterbury are all near capacity in bed provision, despite facing significant housing growth.
- Higher capacity of beds appears to be available in Sevenoaks, Tunbridge Wells and around Faversham

Figure 4.7 Kent & Medway

Hospitals and Mental Health capacity against housing

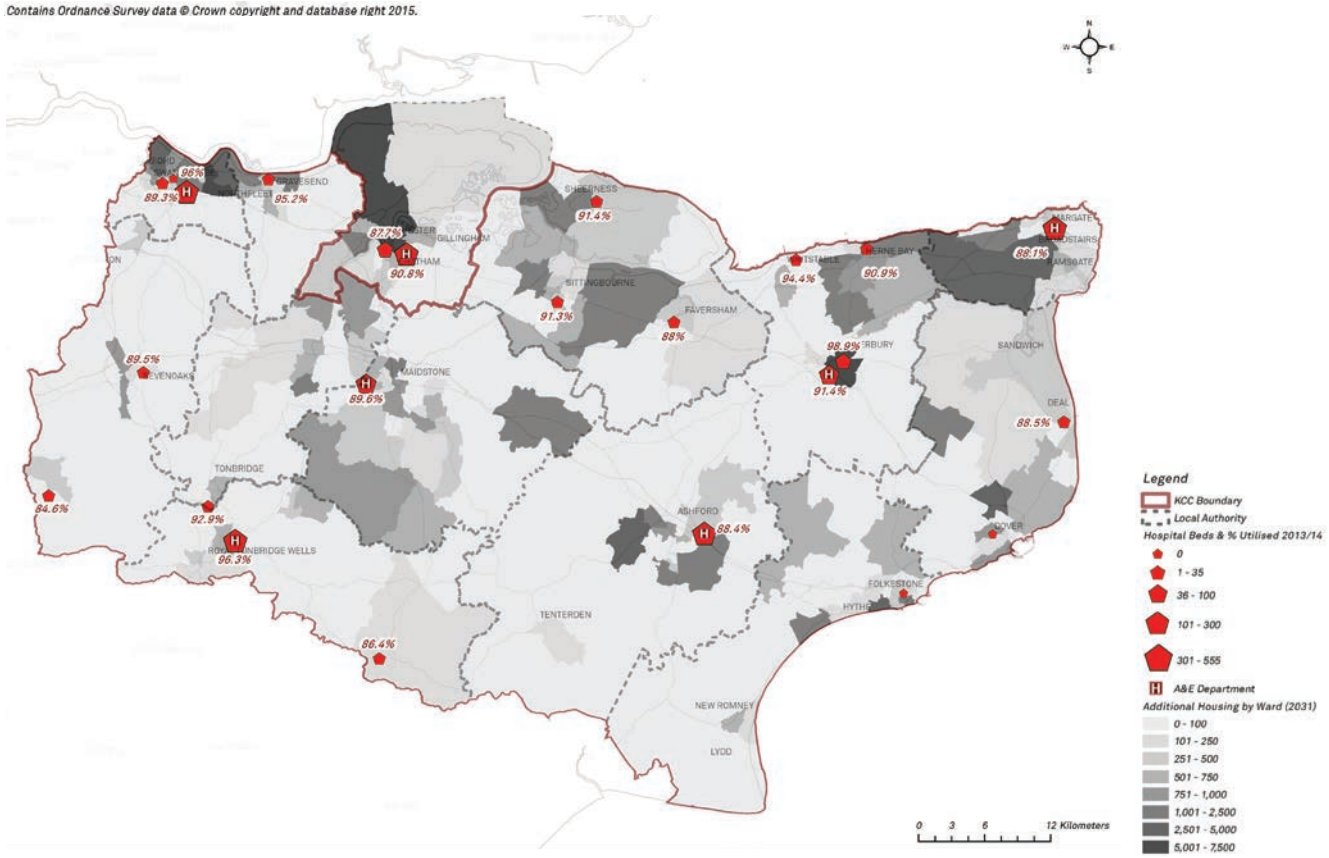


Table 4.6 Kent & Medway

Hospital capacity & proposed infrastructure

	EXISTING ACUTE NHS HOSPITALS		EXISTING COMMUNITY HOSPITALS		ADDITIONAL BEDS REQUIRED TO SUPPORT POPULATION GROWTH	
	BEDS (2014)	OCCUPIED OVERNIGHT (2014 SAMPLE)	BEDS (2014)	OCCUPIED OVERNIGHT (2014 SAMPLE)	HOSPITAL BEDS	MENTAL HEALTH BEDS
Ashford	432	88%	-	-	46	9
Canterbury	255	91%	40	93%	52	11
Dartford	503	96%	28	89%	77	16
Dover	-	-	26	88%	32	6
Gravesham	-	-	21	95%	21	4
Maidstone	289	90%	-	-	50	10
Sevenoaks	-	-	32	88%	3	1
Shepway	-	-	-	-	24	5
Swale	-	-	83	90%	32	7
Thanet	328	88%	-	-	35	7
Tonbridge & Malling	-	-	14	93%	48	10
Tunbridge Wells	431	96%	22	86%	13	3
KENT	***2,238***	***92%***	***266***	***90%***	***434***	***89***
Medway	554	91%	57	88%	81	17
KENT & MEDWAY	***2,792***	***92%***	***323***	***90%***	***515***	***106***

SOURCE: NHS ENGLAND DATA AND AECOM MODELLING (SEE TECHNICAL NOTE 5)

FUTURE REQUIREMENTS TO MEET GROWTH

Table 4.6 sets out forecast growth in terms of acute hospital and mental health beds to 2031. This is based upon application of current UK bed to person ratios to the forecast population growth. This highlights the following key issues:

- The forecast population growth could equate to 515 additional hospital beds across Kent and Medway, with a further 106 additional mental health beds

It is acknowledged that the health service is in the process of change and that future secondary care is more likely to be provided away from acute settings and within the community at local points of contact such as primary care and intermediate facilities. This will have major implications on local healthcare infrastructure.

COSTS AND FUNDING

AECOM has estimated costs based upon a standard multiplier and benchmark costs. It identifies the following combined costs for Acute and Mental Health beds for Kent and Medway:

Cost = £289,300,000
Secured Funding = £0
Expected Funding = £220,740,000
Funding Gap = £68,570,000

4.4 COMMUNITY

ADULT SOCIAL SERVICES

CURRENT SITUATION

Adult social services are provided by Kent County Council's Social Care, Health and Well Being (SCHW) team. The KCC Adult Social Care client groups include: People with learning disabilities; people with mental health needs; older people; and people with physical disabilities people with physical disabilities; and older people (over 65 years).

HEADLINES

Learning disabilities

Capacity issues in 6 Districts

Accommodation Investment priority in Ashford, Dartford, Dover, Sevenoaks, Tonbridge & Malling and Tunbridge Wells

Mental health

Capacity issues in 3 Districts

Accommodation Investment priority in Dartford, Dover, and Tonbridge & Malling

Physical disabilities

Capacity Issues in 8 Districts

Accommodation Investment priority in Dartford, Gravesham, Maidstone, Swale, Thanet, Tonbridge & Malling and Tunbridge Wells

Older people

Capacity Issues in 3 Districts

Accommodation Investment priority in Dartford, Swale and Thanet

Figure 4.8 Kent & Medway

Adult social care facilities

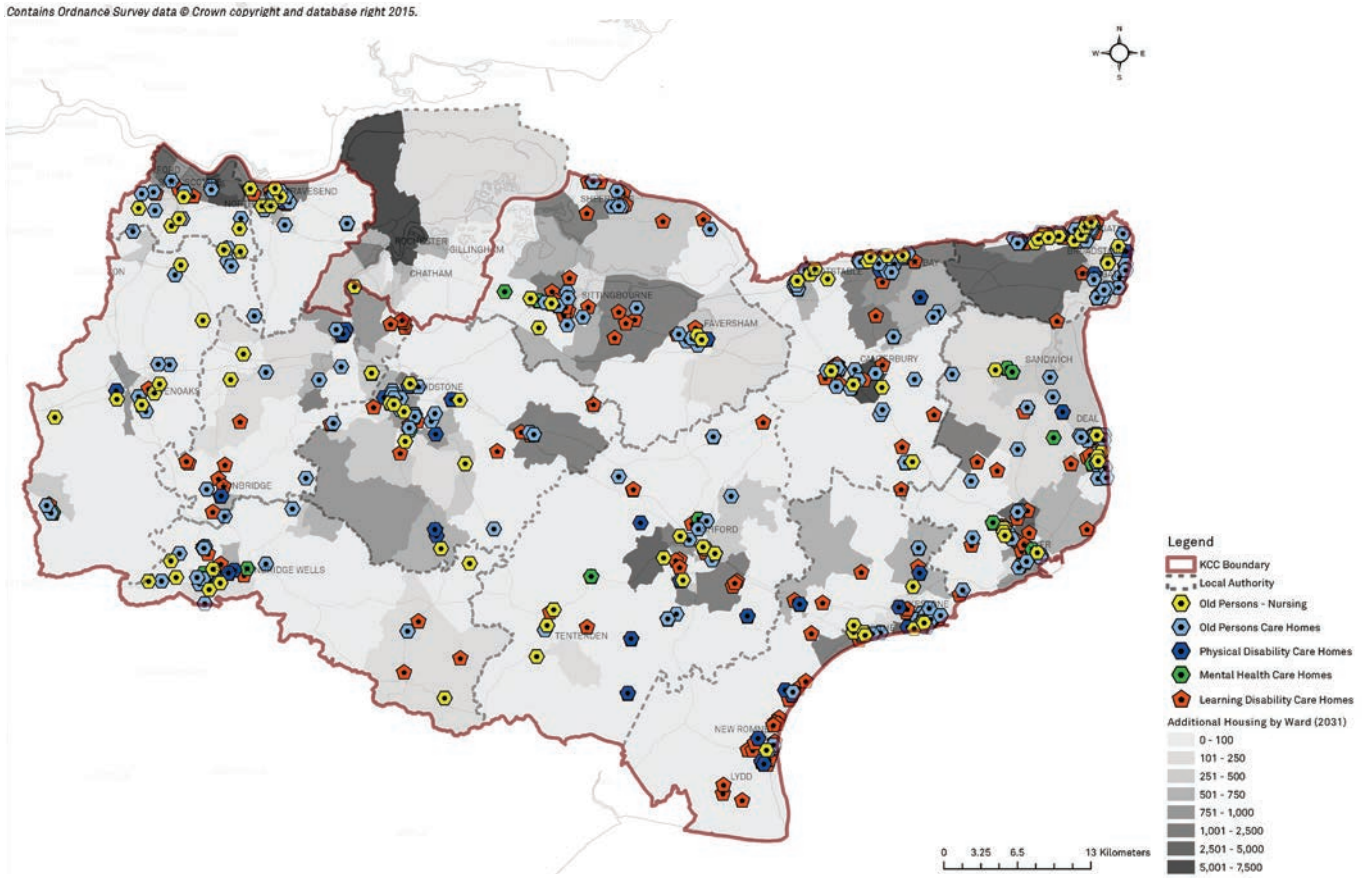


Table 4.7 Kent & Medway

Social care accomodation capacity & infrastructure

	LEARNING DISABILITY	MENTAL HEALTH	PHYSICAL DISABILITY	OLDER PEOPLE
Ashford				
Canterbury				
Dartford				
Dover				
Gravesham				
Maidstone				
Sevenoaks				
Shepway				
Swale				
Thanet				
Tonbridge & Malling				
Tunbridge Wells				

SOURCE: KENT ADULT ACCOMMODATION STRATEGY: EVIDENCE BASE, KENT COUNTY COUNCIL

RED & AMBER SHADING INDICATES REQUIREMENT FOR ADDITIONAL CAPACITY / FACILITIES.

EXAMPLE COMMUNITY CAPACITY PROJECTS PROPOSED

Chilmington Green

Adult social services space in new Chilmington Green Community Hub, Ashford

Lowfield Street, Dartford

New social care hub

Aylesham Health & Social Care Centre

Delivery of new centre in Dover

West Kent Cold Store Site

Delivery of learning disability accommodation within 2 miles of site - Sevenoaks

Development contributions

Contributions from new developments to ensure that new community facilities buildings are suitable for use by commissioned service providers to deliver services to FSC clients:

- Hillborough, South Canterbury and Sturry/Broad Oak - Canterbury
- Whitfield - Dover
- Creekside - Swale
- Land North of Haine Road - Thanet
- Peter's Pit - Tonbridge & Malling

FUTURE REQUIREMENTS TO MEET GROWTH

Kent & Medway
64
Additional Nursing Care Facilities (60 bed)

Kent & Medway
58
Additional Extra Care Facilities (60 bed)

Kent & Medway
39
Additional Learning Disability Support Units

COSTS AND FUNDING

In addition to the community capacity based project requirements to support population growth KCC have also developed a detailed Social Care Accommodation Strategy which sets out the forecast change in demand for the full range of care clients. This has highlighted the need for considerable investment in older persons nursing and extra care accommodation and also supported accommodation for clients with learning disabilities. While KCC is unlikely to directly deliver this future accommodation the cost of the development has been identified but assumed to be funded by private sector and voluntary organisations.

The following costs and funding have been identified for Kent:

Cost = £1,081,490,000
Secured Funding = £3,420,000
Expected Funding = £973,520,000
Funding Gap = £104,540,000

LIBRARY SERVICES

Kent & Medway
115
libraries

CURRENT SITUATION

Figure 4.9 and Table 4.7 set out existing library provision in Kent. Library services in Kent are organised by the County Council's Library, Registration and Archive Service. KCC continues to explore the potential for a charitable trust to deliver the service which will have implications to future service delivery.

HEADLINES

Kent

15.5 sqm
library space for every 1,000 people on average

Thanet - comparatively high level of provision

25 sqm
library space for every 1,000 people
Medway also rates well with 22 sq.m
Dartford and Dover also rate well with 17 sqm

Canterbury - comparatively poor provision

9 sqm
library space for every 1,000 people
Below average provision also in Ashford, Maidstone, Swale, Tonbridge & Malling and Tunbridge Wells

Figure 4.9 Kent & Medway

Library provision against housing growth

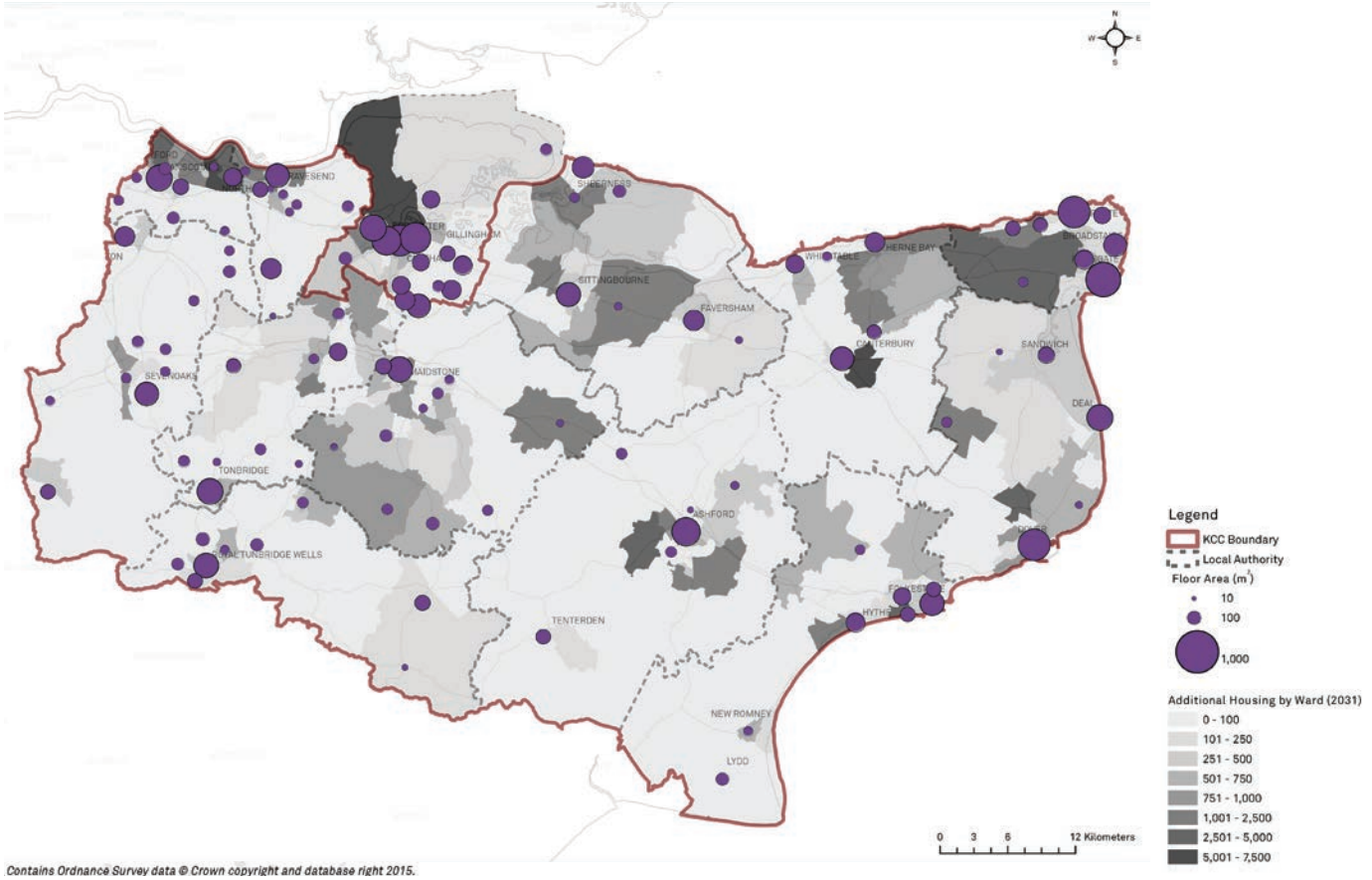


Table 4.8 Kent & Medway

Library capacity and proposed infrastructure

	NUMBER OF LIBRARIES	USABLE FLOORSPACE (SQ.M)	USABLE FLOORSPACE PER 1,000 POPULATION
Ashford	6	1,250	10.2
Canterbury	5	1,379	9.0
Dartford	9	1,712	16.9
Dover	6	1,931	17.2
Gravesham	10	1,594	15.3
Maidstone	11	1,651	10.3
Sevenoaks	11	1,870	15.9
Shepway	8	1,794	16.4
Swale	7	1,673	11.9
Thanet	8	3,482	25.3
Tonbridge & Malling	9	1,582	12.7
Tunbridge Wells	9	1,636	14.0
KENT	***99***	***21,554***	***14.3***
Medway	16	5,983	21.9
KENT & MEDWAY	***115***	***27,537***	***15.5***

SOURCE: KENT COUNTY COUNCIL AND MEDWAY UNITARY AUTHORITY

EXAMPLE INFRASTRUCTURE PROJECTS PROPOSED

The list below sets out key library investments expected to support population growth to 2031:

Chilmington Green
capital cost to build library space in a **new Community Hub** in Ashford, contributions towards **Stanhope Library, Ashford Gateway** and the **mobile library service.**

Library expansion at Queenborough
Development of Library Services in Queenborough and Rushenden - Swale

New Cultural & Learning Hub
New library provision as part of wider redevelopment of existing Museum/Art Gallery/Library/Adult Education Centre

Southborough Community Hub
new library provision as part of wider community space including replacement theatre and town council offices

Ebbsfleet Garden CIty
New library provision to support new community

Sittingbourne
Town centre development - new multi Service centre including library and other KCC and District services

Cranbrook Community Hub
New library as part of wider community space, including town council offices and multi-purpose indoor meeting space

COSTS AND FUNDING

The following costs and funding have been identified for Kent and Medway:

Cost = £33,900,000
Secured Funding = £3,980,000
Expected Funding = £4,480,000
Funding Gap = £25,440,000

YOUTH SERVICES

Kent & Medway

72

youth service providers in total

Includes hubs, youth tutors and commissioned services

CURRENT SITUATION

Youth services in Kent are run either by KCC or on behalf of KCC under contract to a range of commissioned providers with the aim to provide a core offer comprising a 'Hub' youth centre, one street based project and one or more school based workers. This is enhanced through the provision of commissioned youth work activities.

HEADLINES

Kent & Medway

0.46

youth service providers per 1,000 young people

Shepway - good provision

0.67

youth service providers per 1,000 young people

Thanet and Tonbridge & Malling also rate well in comparison to the Kent & Medway average.

Gravesham - poor provision

0.32

youth service providers per 1,000 young people

Ashford, Canterbury and Maidstone also rate poorly in comparison to the Kent & Medway average.

Figure 4.10 Kent & Medway

Youth service provision against housing growth

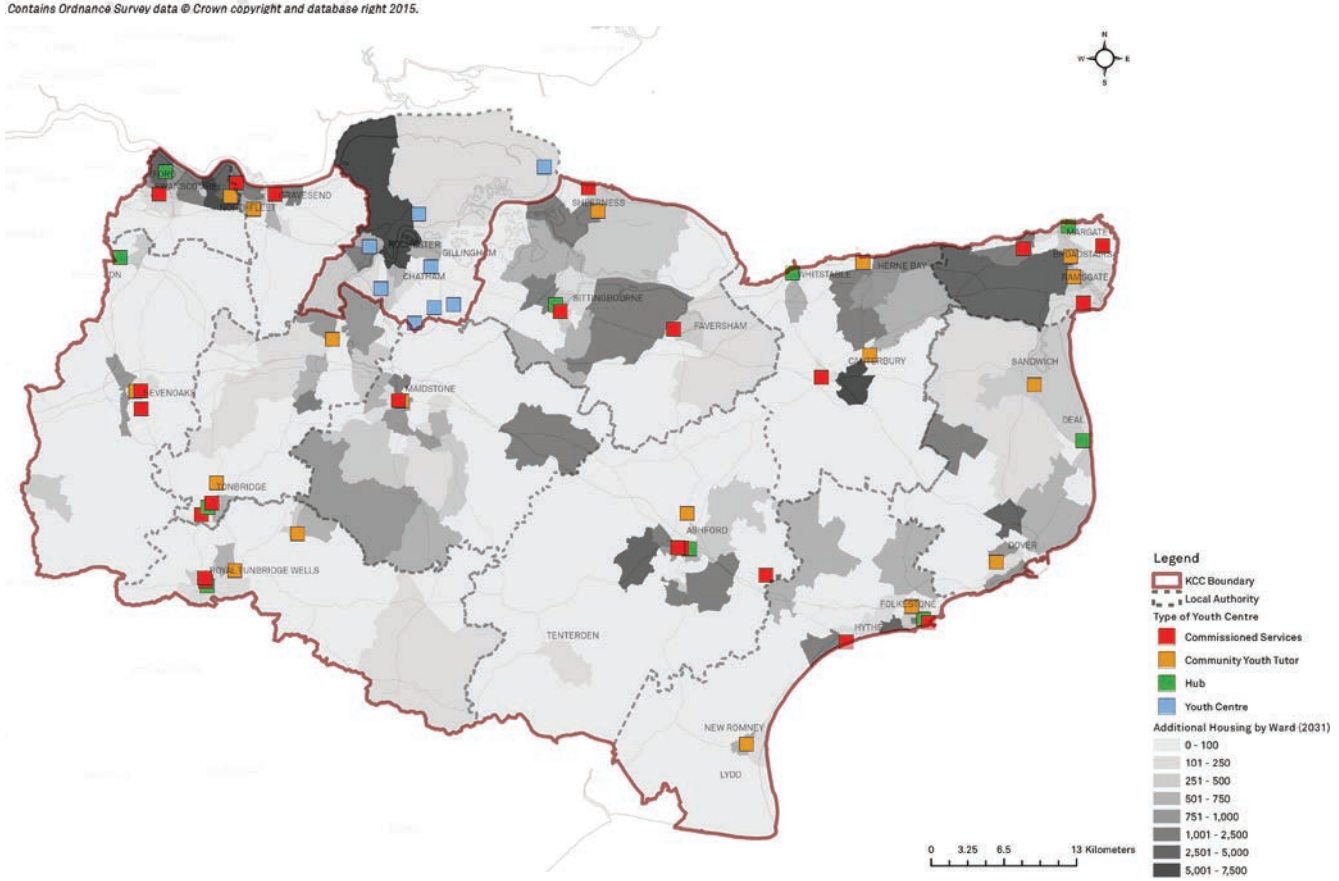


Table 4.9 Kent & Medway

Youth services capacity and proposed infrastructure

	'HUB' YOUTH CENTRE	COMMUNITY YOUTH TUTOR	COMMISSION SERVICES	TOTAL YOUTH SERVICE PROVIDERS	SERVICES PER 1,000 YOUNG PEOPLE
Ashford	1	1	2	4	0.37
Canterbury	1	4	1	6	0.38
Dartford	1	1	2	4	0.48
Dover	1	2	2	5	0.52
Gravesham	1	1	1	3	0.32
Maidstone	1	1	3	5	0.38
Sevenoaks	1	1	3	5	0.52
Shepway	1	2	3	6	0.67
Swale	1	1	3	5	0.40
Thanet	1	2	5	8	0.66
Tonbridge & Malling	1	2	4	7	0.60
Tunbridge Wells	1	2	3	6	0.57
KENT	***12***	***20***	***32***	***64***	***0.48***
Medway	8	-	-	8	0.33
KENT & MEDWAY	***20***	-	-	***72***	***0.46***

SOURCE: INTEGRATED YOUTH SERVICES (KENT COUNTY COUNCIL) AND MEDWAY YOUTH SERVICE

EXAMPLE INFRASTRUCTURE PROJECTS IDENTIFIED

Chilmington Green

Capital cost to build youth service space in a new community hub in Ashford

Riverside & Whitstable

Youth centre expansions in Canterbury

Aylesham Youth Club Grant

funding towards the provision of youth services at Aylesham Youth Centre in Dover

New Deal Youth Centre

New youth centre building in Dover

Queenborough and Rushenden

Delivery of youth services at new developments in Swale

Tonbridge AEC

Enhancement of centre into a youth hub in Tonbridge & Malling

Tunbridge Wells District Youth Hub

New provision for Tunbridge Wells

COSTS AND FUNDING

The following costs and funding have been identified for Kent and Medway:

Cost = £9,390,000
Secured Funding = £4,610,000
Expected Funding = £730,000
Funding Gap = £4,050,000

COMMUNITY & INDOOR SPORTS FACILITIES

Community Facilities

Sports Facilities

CURRENT SITUATION

Community and Indoor Sports facilities in Kent comprise both public and private facilities. Public facilities are provided and funded by the individual districts. This allows for anyone to access the facilities. Private facilities often require membership and payment for the use of those facilities.

HEADLINES

- Swale, Thanet and Gravesham have the largest gaps in indoor sports provision, with the supply below the Kent + Medway average in 4 of the 5 categories.
- There are gaps in current facility distribution against the focus areas of housing growth. This can be seen in Maidstone, Thanet, North East Canterbury and North West Medway.
- Ashford, Canterbury, Sittingbourne and Dartford all have relatively strong provision of indoor sports provision where future housing growth is projected.

Figure 4.11 Kent & Medway

Sports provision against housing growth

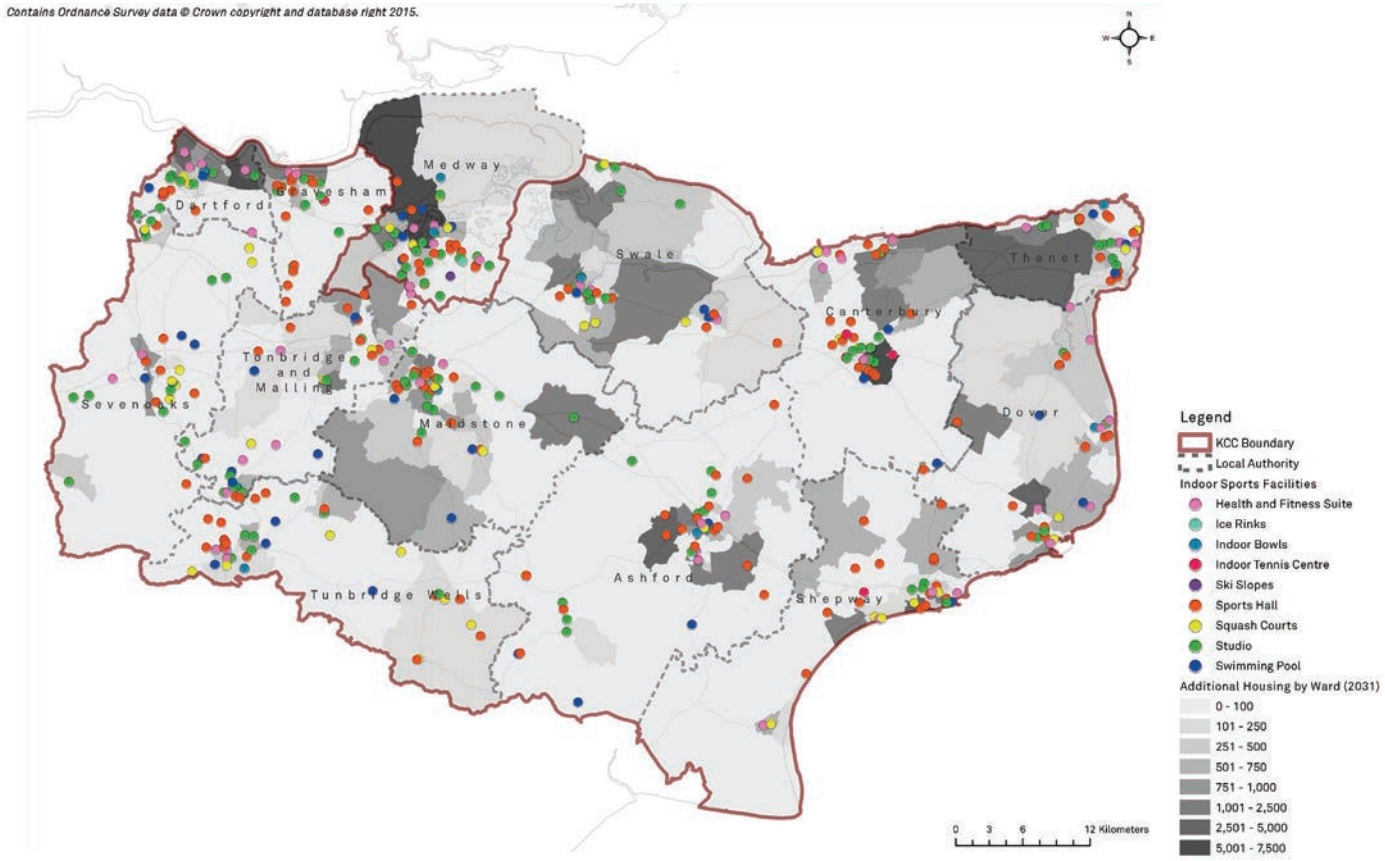


Table 4.10 Kent & Medway

Community / Sports capacity

	SPORTS HALL COURTS	SWIMMING POOL LANES	SQUASH COURTS	GYM STATIONS	INDOOR BOWLS RINKS
Ashford	57	25	6	712	6
Canterbury	101	34	14	918	8
Dartford	49	15	5	637	6
Dover	53	15	10	595	4
Gravesham	66	14	7	403	0
Maidstone	63	31	8	1,044	8
Sevenoaks	58	47	18	326	16
Shepway	43	17	10	702	7
Swale	58	24	10	573	6
Thanet	67	25	8	543	8
Tonbridge & Malling	66	31	12	825	6
Tunbridge Wells	83	42	19	589	6
KENT	***764***	***320***	***127***	***7,867***	***81***
Medway	117	44	12	1,388	14
KENT & MEDWAY	***881***	***364***	***139***	***9,255***	***95***

SOURCE: SPORT ENGLAND FACILITY DATABASE

SHADING INDICATES WHETHER SUPPLY IS ABOVE OR BELOW KENT & MEDWAY AVERAGE SUPPLY TO POPULATION RATIO.

FUTURE REQUIREMENTS TO MEET GROWTH

Kent & Medway
17,100 sqm
new flexible community space

Kent & Medway
13
new swimming pools

Kent & Medway
18
new sports halls

Kent & Medway
3
new indoor bowl centres

INFRASTRUCTURE COSTS

The following infrastructure requirements have been identified based on a combination of those actual planned projects according to the District Authorities and further AECOM analysis using Sport England and best practice standards.

£43,320,000
community facilities

£117,780,000
indoor sport facilities

The following costs and funding have been identified for Kent and Medway:

Cost = £161,100,000
Secured Funding = £3,530,000
Expected Funding = £33,940,000
Funding Gap = £123,630,000

OPEN SPACE AND RECREATION

Open Space & Recreation

Children's Play Space

CURRENT SITUATION

Kent has a wide range of open spaces, outdoor sports pitches, outdoor sports facilities and children's playgrounds. Outdoor sports and playspaces are owned and operated by a mixture of private sector, voluntary organisations and local authorities.

HEADLINES

- Shepway, Swale and Medway have the largest gaps in outdoor sports provision with the supply below the Kent + Medway average supply in 4 of the 5 categories.
- Ashford, Sevenoaks and Tonbridge and Malling have the highest levels of outdoor sport provision, with capacity above the Kent + Medway average in 4 of the 5 categories.
- There are several gaps in outdoor sports provision around future housing development sites, such as developments north of Dover and east of Herne Bay.
- The larger urban centres of Maidstone, Ashford, Canterbury, and northern parts of Dartford and Gravesham all have strong provision of existing outdoor recreational facilities.

Figure 4.12 Kent & Medway

Open Space and Recreation Facilities

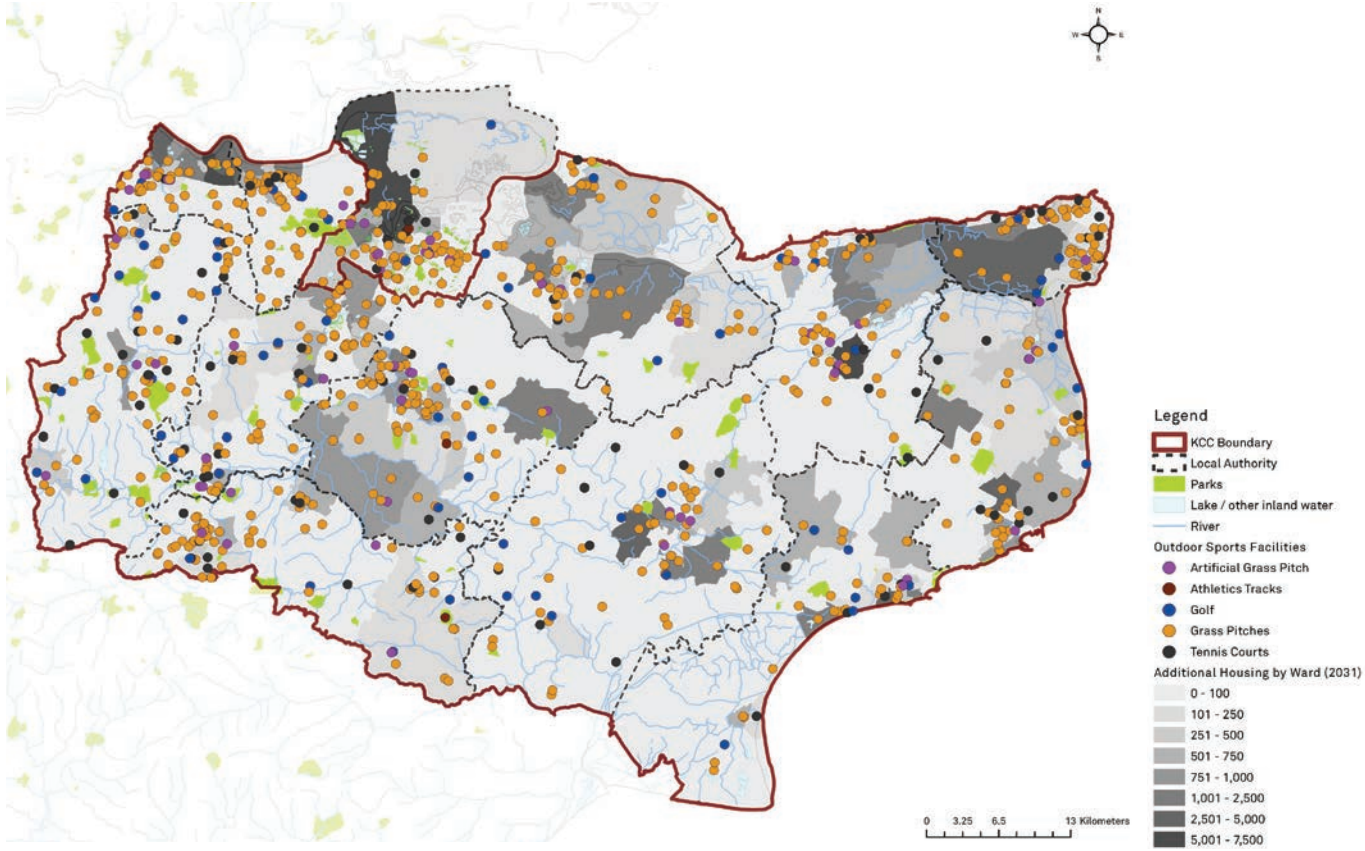


Table 4.11 Kent & Medway

Open space and recreation capacity

	GRASS PITCHES	ARTIFICIAL TURF PITCHES	TENNIS COURTS	ATHLETICS TRACKS	GOLF COURSES
Ashford	182	8	17	8	11
Canterbury	243	15	30	6	5
Dartford	118	19	8	6	5
Dover	186	8	42	7	7
Gravesham	165	9	18	0	6
Maidstone	208	13	22	16	11
Sevenoaks	217	12	49	6	26
Shepway	100	4	15	0	12
Swale	179	7	13	0	12
Thanet	163	13	31	8	10
Tonbridge & Malling	268	10	29	6	15
Tunbridge Wells	292	11	57	6	4
KENT TOTAL	***2,321***	***129***	***331***	***69***	***124***
Medway	220	26	19	14	6
KENT & MEDWAY TOTAL	***2,541***	***155***	***350***	***83***	***130***

SOURCE: NUMBER OF SITES ACCORDING TO SPORT ENGLAND FACILITY DATABASE

SHADING INDICATES WHETHER SUPPLY IS ABOVE OR BELOW KENT & MEDWAY AVERAGE SUPPLY TO POPULATION RATIO.

FUTURE REQUIREMENTS TO MEET GROWTH

Kent & Medway
8
Artificial Turf Pitches

Kent & Medway
315ha
Playing fields

Kent & Medway
42ha
Childrens Playspace

INFRASTRUCTURE COSTS

The follow infrastructure requirements have been identified based on AECOM analysis using Fields In Trust standards cost estimates have been applied using UK benchmarks.

Kent & Medway
£112,130,000
open Space and Recreation

Kent & Medway
£49,530,000
Childrens Playspace

The following costs and funding have been identified for open space, recreation and children's playspace for Kent and Medway:

Cost = £161,670,000
Secured Funding = £0
Expected Funding = £115,980,000
Funding Gap = £45,680,000

5.11 THANET

12,000 new homes **(+18%)**

23,500 new people **(+17%)**

5,000 new jobs **(+11%)**

(2011 to 2031)

EXISTING CAPACITY ISSUES

- ***Transport improvements to allow for evolution of Westwood Cross***
- ***Improved accessibility to London and rest of Kent through reduced rail times and new parkway station***
- ***Regeneration of coastal towns to stimulate wider investment and meet demands from new development***
- ***Investment in Inner Traffic Circuit to address bottlenecks and unlock development***
- ***Need for new secondary school capacity to respond to growth***
- ***Need to recognise variable land values within the district and address their impact on viability***

Total Infrastructure Costs: **£388,170,000**

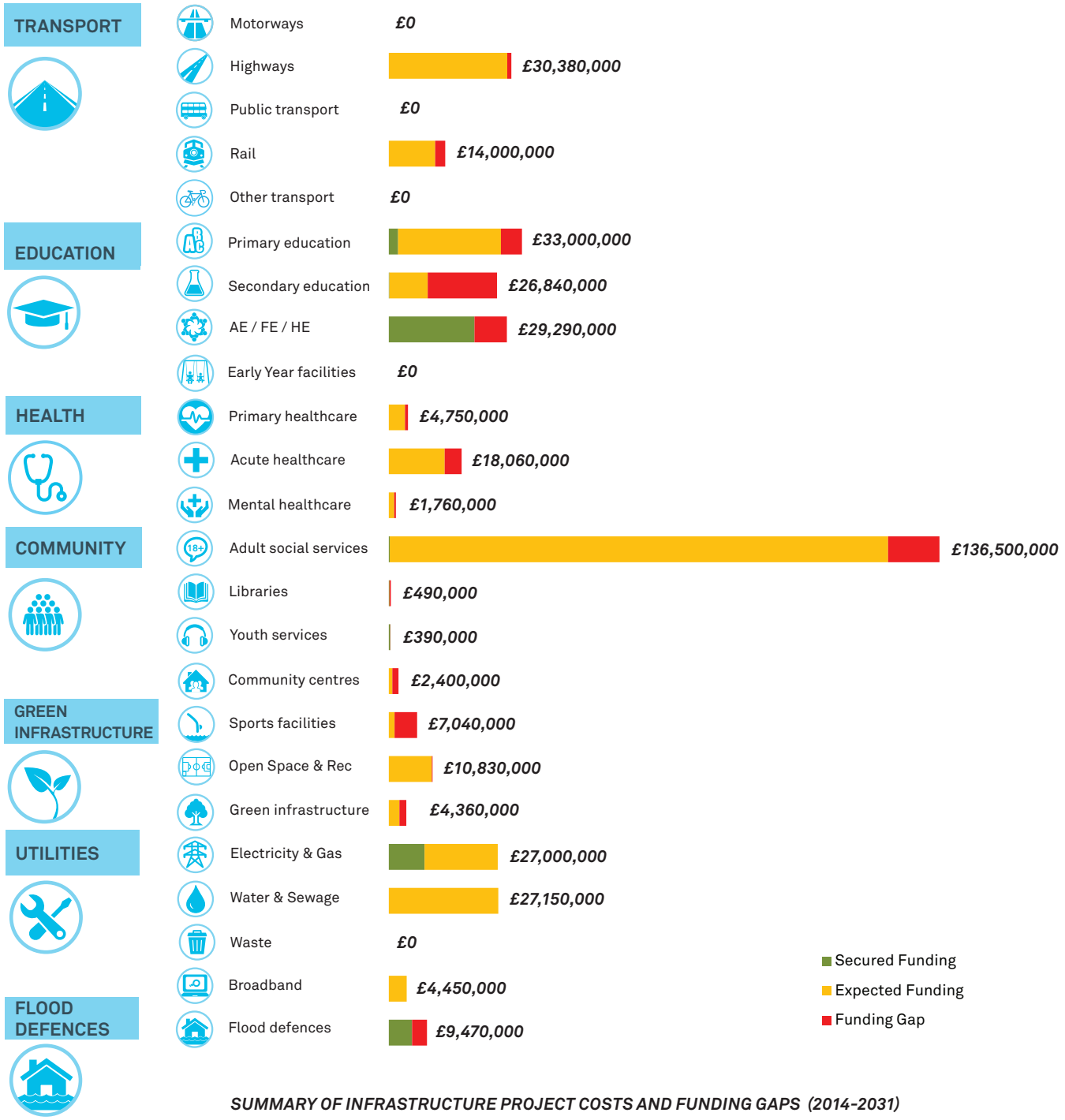
Total Secured Funding: **£39,170,000**

Total Expected Funding: **£283,960,000**

Total Funding Gap: **£65,040,000**

% of Infrastructure Funded: **83%**

(2014 to 2031)



SUMMARY OF INFRASTRUCTURE PROJECT COSTS AND FUNDING GAPS (2014-2031)

HEALTH

- Limited Primary Care capacity across Thanet requiring capacity improvements to support growth

TRANSPORT

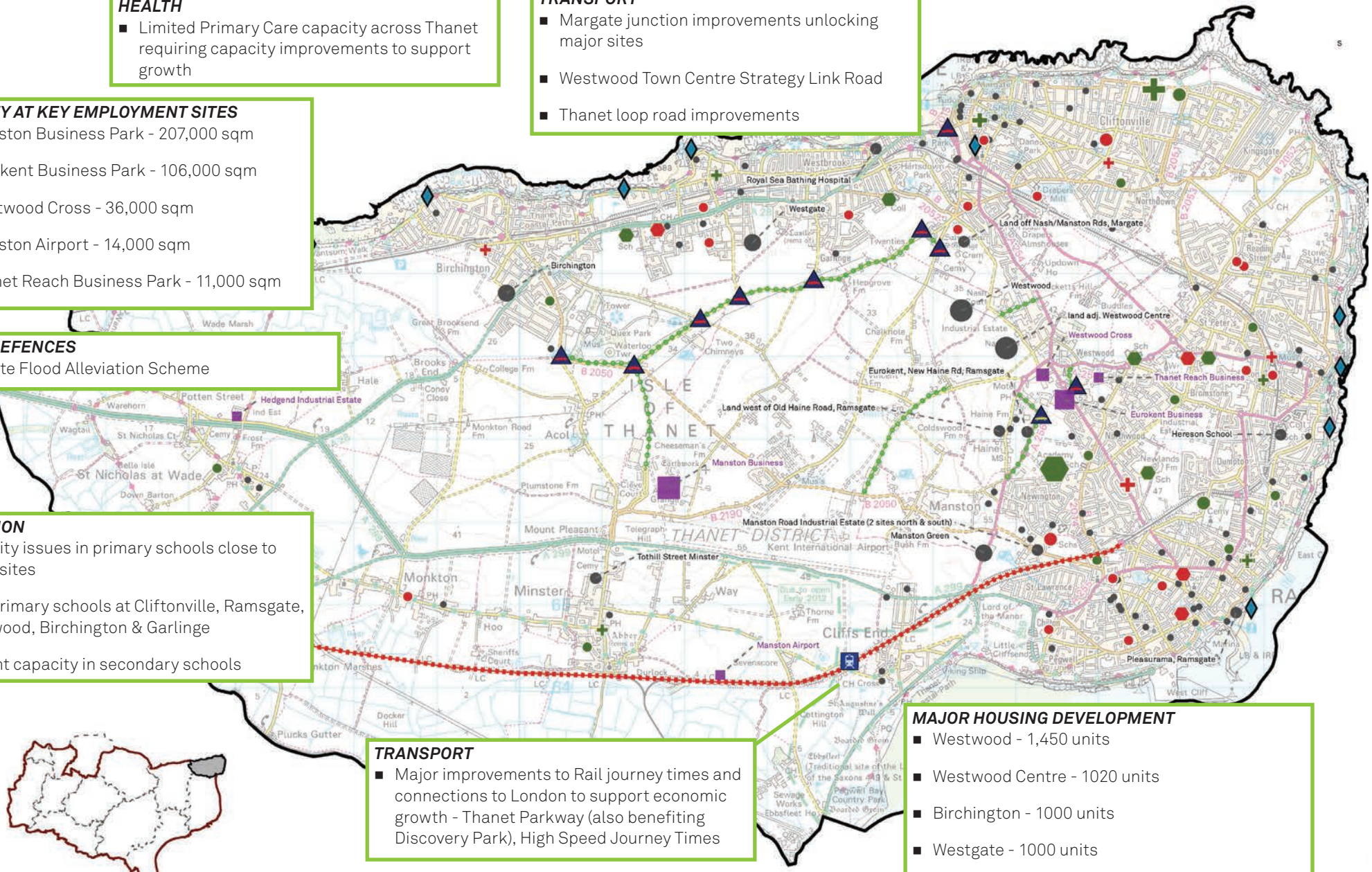
- Margate junction improvements unlocking major sites
- Westwood Town Centre Strategy Link Road
- Thanet loop road improvements

CAPACITY AT KEY EMPLOYMENT SITES

- Manston Business Park - 207,000 sqm
- Eurokent Business Park - 106,000 sqm
- Westwood Cross - 36,000 sqm
- Manston Airport - 14,000 sqm
- Thanet Reach Business Park - 11,000 sqm

FLOOD DEFENCES

- Margate Flood Alleviation Scheme



EDUCATION

- Capacity issues in primary schools close to major sites
- New Primary schools at Cliftonville, Ramsgate, Westwood, Birchington & Garlinge
- Current capacity in secondary schools

TRANSPORT

- Major improvements to Rail journey times and connections to London to support economic growth - Thanet Parkway (also benefiting Discovery Park), High Speed Journey Times

MAJOR HOUSING DEVELOPMENT

- Westwood - 1,450 units
- Westwood Centre - 1020 units
- Birchington - 1000 units
- Westgate - 1000 units
- Manston Green - 700 units

SUMMARY OF GROWTH + INFRASTRUCTURE ISSUES IN THANET

Refer to universal key at start of Chapter

Quality Premium 2015/16

To:	**Thanet Health and Wellbeing Board, 26 May 2016**
By:	**Adrian Halse, Senior Business Analyst, NHS Thanet Clinical Commissioning Group**
Classification:	**Unrestricted**
Ward:	**All wards**

Summary: **This report explains the quality premium and the criteria which will be applied to it in 2016/17. It identifies specific indicators chosen by the Thanet Clinical Commissioning Group and asks the Board to ratify this indicator set.**

For Decision

1.0 Introduction and Background

1.1 The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes.

1.2 The quality premium available to Thanet CCG is theoretically around £700,000, however, the amount achieved is likely to be significantly less than this, due to restrictions on payment.

1.3 Quality Premium payments for achievements in 2016/17 will be paid in 2017/18.

1.4 Quality Premium payments should be used by CCGs to secure improvement in:

a) The quality of health services
b) The outcomes achieved from the provision of health services; or
c) Reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved

1.5 The Quality premium is paid primarily on the CCGs achievement against a set of measures which are each worth a certain percentage of the total premium available. The measures for 2016/17 are set out in section 3.0 below.

2.0 Restrictions on Payment

2.1 There are a number of criteria which may limit the amount available or prevent payment completely. These include:

a) Poor financial management (e.g. qualified audit report or adverse variance at year end): could result in all payment being withheld.

b) Serious quality failure which could result in all payment being withheld.

c) Failure to achieve constitutional targets. This could lead to varying reductions in the amount available as explained in the table below.

NHS Constitution requirement	Reduction to Quality Premium
Maximum 18 weeks from referral to treatment, comprising - incomplete standard.	25%
Maximum four hour waits in A&E departments.	25%
Maximum 14 day wait from an urgent GP referral for suspected cancer.	25%
Maximum 8 minutes responses for Category A (Red 1) ambulance calls.	25%

2.2 At present, East Kent Hospitals University Foundation Trust (EKHUFT) are failing to achieve the 18 week standard and the A&E 4hr wait standard. Recovery plans are in place and progress is being monitored closely.

3.0 Quality Premium Measures

3.1 The quality premium is paid on the basis of achievement of certain measures.

3.2 Mandatory measures make up 70% of the available award. They are listed in the following table:

Measure	% of Quality Premium	Threshold for payment
New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour*)	20%	To earn this portion of the quality premium, CCGs will need to either: 1. Demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar year. Or 2. Achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year.
Proportion of new first outpatient appointment GP referrals into consultant-led services booked through the e-referrals system (all two week waits referrals are also included). This excludes referrals into community services and Mental	20%	To earn this portion of the quality premium, CCGs will need to, either: 1. Meet a level of 80% by March 2017 (March 2017 performance only) and demonstrate a year on year increase in the percentage of referrals made by e-referrals (or achieve 100% e-referrals), or; 2. March 2017 performance to exceed March 2016 performance by 20

Measure	% of Quality Premium	Threshold for payment
Health which are set up as triage or non-consultant led services.		percentage points
The proportion of people who describe their experience of making a GP appointment as very good or fairly good.	20%	To earn this portion of the quality premium, CCGs will need to demonstrate in the July 2017 publication, either: 1. Achieve a level of 85% of respondents who said they had a good experience of making an appointment, or; 2. A 3 percentage point increase from July 2016 publication on the percentage of respondents who said they had a good experience of making an appointment
Reduction in the number of antibiotics prescribed in primary care.	5%	The required performance in 2016/17 must either be: 1. a 4% (or greater) reduction on 2013/14 performance OR 2. equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU
Number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care	5%	Either: 1. to be equal to or lower than 10%, or 2. to reduce by 20% from each CCG's 2014/15 value

3.3 The remaining 30% of the quality premium will be allocated on the basis of achievement of three locally set measures and targets.

3.4 This year, the local element of the quality premium focuses on the Right Care programme.[1] CCGs are expected to identify three measures worth 10% each. The measures must be identified from the Commissioning for Value packs.[2] The full list of these measures is attached as annex 1.

3.5 Thanet CCG has submitted the following three measures and is waiting for approval from NHS England:

[1] The Right Care programme aims to maximise value by tackling unwarranted variation in healthcare outcomes and costs across the country.

[2] Commissioning for Value packs are tools that support the Right Care programme by helping CCGs identify the areas where they are outliers in terms of health outcomes and costs compared to CCGs with similar demographics.

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.

3.6 The Thanet Health and Wellbeing Board is asked to ratify the choice of these indicators.

4.0 Options

4.1 To ratify the list of indicators as set out in 4.2.

5.0 Next Steps

5.1 The list of indicators and suggested targets will be reviewed by NHS England Local Team for Kent Medway, Surrey and Sussex.

5.2 Progress will be monitored throughout the year.

6.0 Recommendation(s)

6.1 That the Board ratifies the list of indicators set out in 4.2.

7.0 Decision Making Process

7.1 The indicators set must ultimately be approved by the NHS England Local Team for Kent Medway, Surrey and Sussex.

Contact Officer:	*Adrian Halse, Senior Business Analyst, NHS Thanet CCG*
Reporting to:	*Ailsa Ogilvie, Chief Operating Officer, NHS Thanet CCG*

Annex List

Annex 1	List of indicators available for use as local measures

Background Papers

Title	**Details of where to access copy**
N/A	

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Annex 1: List of the indicators available for use as local measures

1 - Cancer - Cancer - Breast cancer screening in last 36 months
2 - Cancer - Cancer - Receiving first definitive treatment within two months of urgent referral from GP
3 - Cancer - Cancer - Successful quitters at 4-weeks
4 - Cancer - % of breast cancers detected at an early stage (1 or 2)
5 - Cancer - % of people aged 60 - 69 who were screened for bowel cancer in the previous thirty months
6 - Cancer - % of colorectal cancers detected at an early stage (1 or 2)
7 - Cancer - % of lung cancers detected at an early stage (1 or 2)
8 - Circulation - Circulation - Reported prevalence of CHD on GP registers as % of estimated prevalence
9 - Circulation - Circulation - Reported prevalence of hypertension on GP registers as % of estimated prevalence
10 - Circulation - Circulation - Transient ischaemic attack (TIA) cases with a higher risk who are treated within 24 hours
11 - Circulation - Emergency readmissions to hospital within 28 days for patients: stroke (%)
12 - Circulation - % of patients returning to usual place of residence following hospital treatment for stroke
13 - Endocrine - Additional risk of complication for myocardial infarction among people with diabetes (%)
14 - Endocrine - Additional risk of complication for heart failure among people with diabetes (%)
15 - Endocrine - Additional risk of complication for stroke among people with diabetes (%)
16 - Gastro-intestinal - Gastro-intestinal - Emergency admissions for alcohol related liver disease
17 - Genito-Urinary - Reported to estimated prevalence of CKD (%)
18 - Genito-Urinary - % of people receiving dialysis undertaking dialysis at home
19 - Genito-Urinary - % of patients on Renal Replacement Therapy who have a kidney transplant
20 - Maternity - Maternity - Live births <2500 grams
21 - Maternity - Maternity - Teenage conceptions (aged under 18)
22 - Maternity - % of pregnant women vaccinated for flu
23 - Maternity - Number of women known to be smokers at time of delivery per 100 maternities
24 - Maternity - % of mothers who give their babies breast milk in the first 48 hours after delivery
25 - Maternity - % of infants that are totally or partially breastfed at age 6-8 weeks
26 - Maternity - Rate of emergency admissions for gastroenteritis in infants aged <1 year per 10,000 population aged <1 year
27 - Maternity - Rate of emergency admissions for respiratory tract infections in infants aged <1 year per 10,000 population aged <1 year
28 - Maternity - Children who received 3 doses of DTaP/IPV/Hib vaccine at any time by their second birthday as a % of children reaching age 2 years within the period
29 - Maternity - Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 population aged <5 years

30 - Maternity - % of children aged 4-5 years classified as overweight or obese
31 - Maternity - Children who received 2 doses of MMR vaccine at any time between their first and fifth birthdays as a % of children reaching age 5 years within the period
32 - Maternity - The mean number of teeth per child aged 5 years sampled which were either actively decayed or had been filled or extracted (due to decay)
33 - Mental Health - Mental Health - Emergency hospital admissions for self harm
34 - Mental Health - Mental Health - Improving access to psychological therapies - recovered patients
35 - Mental Health - Mental Health - People with mental illness and or disability in settled accommodation
36 - Mental Health - Mental Health - Reported numbers of dementia on GP registers as a % of estimated prevalence
37 - Mental Health - Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression
38 - Mental Health - Waiting < 28 days for IAPT: % of referrals (in quarter) waiting <28 days for first treatment
39 - Mental Health - Completion of IAPT treatment: Rate completing treatment per 100,000 population aged 18+
40 - Mental Health - % of IAPT patients receiving a course of treatment
41 - Mental Health - % of IAPT patients given a provisional diagnosis
42 - Mental Health - % of IAPT referrals with treatment outcome measured
43 - Mental Health - % of people who are "moving to recovery" of those who have completed IAPT treatment
44 - Mental Health - IAPT reliable recovery: % of people who have completed IAPT treatment who achieved "reliable improvement"
45 - Mental Health - Physical health checks for patients with Serious Mental Illness: summary score (average of the 6 physical health check indicators)
46 - Mental Health - The number of people on Care Programme Approach per 100,000 population aged 18+
47 - Mental Health - Mental health admissions to hospital: Rate per 100,000 population aged 18+
48 - Mental Health - The number of people subject to the Mental Health Act per 100,000 population aged 18+
49 - Mental Health - % of people aged 18-69 on Care Program Approach in employment
50 - MSK - Emergency readmissions to hospital within 28 days for patients: hip replacements (%)
51 - Neurology - Neurological - Emergency admission rate for children with epilepsy aged 0–17 years
52 - Respiratory - Respiratory - Emergency COPD admissions relative to patients on disease register
53 - Respiratory - Respiratory - Reported prevalence of COPD on GP registers as % of estimated prevalence
54 - Respiratory - Emergency admission rate for children with asthma per 100,000 population aged 0–18 years
55 - Trauma and injury - Injuries due to falls per 100,000 population ages 65+
56 - Trauma and injury - Hospital admissions caused by unintentional and deliberate injury for those aged 0-24 per 10,000 population
57 - Trauma and injury - % of patients returning to usual place of residence following hospital treatment for fractured femur
58 - Trauma and injury - Emergency readmissions to hospital within 28 days for patients: hip fractures
59 - Cross-cutting - % of respondents aged 16 and over, with valid responses to the questions, doing less than the required level of activity to count as physically active.

60 - Cross-cutting - % of people aged 18 and over who are self-reported occasional or regular smokers.
61 - Cross-cutting - Rate of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 total population
62 - Cross-cutting - % of the eligible population, aged 40 – 74 years, who have received an NHS Health Check since 1st April 2013
63 - Cross-cutting - % of patients aged 17+ with diabetes, as recorded on practice disease registers
64 - Cross-cutting - % of patients 18+ with depression, as recorded on practice disease registers
65 - Cross-cutting - % of people aged 18 and over self-reporting experiencing three or more long-term conditions
66 - Cross-cutting - % of people aged 18 and over with a long-term condition who report having a written care plan
67 - Cross-cutting - % of people aged 18 and over with a long-term condition who report using their written care plan to manage their day to day health.
68 - Cross-cutting - % of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months
69 - Cross-cutting - % of patients aged 65 years and over using any inpatient services where dementia was mentioned in discharge code
70 - Cross-cutting - Emergency admissions to hospital of people with dementia per 1,000 population aged 65+
71 - Cross-cutting - % of emergency admissions of people aged 65 and over with dementia (mentioned in discharge notes) where the length of stay was of 1 night or less
72 - Cross-cutting - % of people aged 18 and over with a long-term condition who report that they had enough support from local services to help manage their condition(s)
73 - Cross-cutting - Health related quality of life people with long term conditions: average score
74 - Cross-cutting - Difference in the employment rate between those with a long-term health condition and all those of working age
75 - Cross-cutting - Delayed transfers of care from hospital per 100,000 population aged 18+
76 - Cross-cutting - % of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital
77 - Cross-cutting - % of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
78 - Cross-cutting - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population aged 65+
79 - Cross-cutting - Emergency admissions for chronic ambulatory care sensitive conditions for people of all ages per 100,000 total population
80 - Cross-cutting - Emergency admissions to hospital for people aged 75 years and over with length of stay under 24 hours per 100,000 population aged <75

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Thanet Health and Wellbeing Board
Integrated Commissioning: Progress Highlight Report – May 2016

Children: "I want to have the best possible start in life and aspirations for the future"

Frailty: "I want to live a fulfilling life as I age"

Inequalities: "I want the opportunity for me and my family to live a fulfilling life"

Mental Health: "I want to live a fulfilling life and feel a valued member of a caring community"

Key achievements for April

Frailty:

- Drafted Tiers of Care to support development of out of hospital model
- Soft launch of Frailty Unit within QEQM Hospital which aims to prevent admission
- Funding agreed to continue with the Support at Home service delivered by Age UK

Mental Health:

- Established good networking between organisations and willingness of providers to work together.
- Commenced joint working between substance misuse and secondary mental health provider to implement dual diagnosis protocol.
- Agreement that EKHUFT will take forward work to manage frequent users of service.

Inequalities:

- Development of Thanet healthy weight action plan

Key priorities for May/June

Frailty:

- Launch the Hydrate Project in Care Homes which has been proven to reduce falls in the elderly
- Commence work to integrate the Kent Enablement at Home service with the Intermediate Care Team

Mental Health:

- Cross reference and review frequent service users (Mental Health, ambulance and acute) and undertake a 'case conference' with each individual/ organization in order to develop an agreed individualized care plan.

All LPGs:

- Deliver a Thanet wide public engagement event which will capture public/patient views on integration and proposed outcomes
- Review ToR and membership of all LPGs to ensure groups are in a position to drive delivery locally
- Deliver LPG workshops to support the members in their understanding of their unique role and contribution in developing and delivering the integrated model

Issues/Risks:

- Lack of understanding from LPG members in relation to the purpose of the group and their contribution to the meetings/delivery of plans
- All administrative support to the groups is mainly provided by health
- Highlight reports are predominantly health focused rather than system wide which needs to be addressed as a matter of urgency

Items for HWB Board Attention:

- Highlight report not received from the Children's LPG
- Reiterate commitment from all stakeholders to attend LPGs
- To note issues and risks and to suggest how these might be addressed.

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THANET DISTRICT COUNCIL DECLARATION OF INTEREST FORM

Do I have a Disclosable Pecuniary Interest and if so what action should I take?

Your Disclosable Pecuniary Interests (DPI) are those interests that are, or should be, listed on your Register of Interest Form.

If you are at a meeting and the subject relating to one of your DPIs is to be discussed, in so far as you are aware of the DPI, you **must** declare the existence **and** explain the nature of the DPI during the declarations of interest agenda item, at the commencement of the item under discussion, or when the interest has become apparent

Once you have declared that you have a DPI (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote on the matter;
2. Withdraw from the meeting room during the consideration of the matter;
3. Not seek to improperly influence the decision on the matter.

Do I have a significant interest and if so what action should I take?

A significant interest is an interest (other than a DPI or an interest in an Authority Function) which:

1. Affects the financial position of yourself and/or an associated person; or
   Relates to the determination of your application for any approval, consent, licence, permission or registration made by, or on your behalf of, you and/or an associated person;
2. And which, in either case, a member of the public with knowledge of the relevant facts would reasonably regard as being so significant that it is likely to prejudice your judgment of the public interest.

An associated person is defined as:

- A family member or any other person with whom you have a close association, including your spouse, civil partner, or somebody with whom you are living as a husband or wife, or as if you are civil partners; or
- Any person or body who employs or has appointed such persons, any firm in which they are a partner, or any company of which they are directors; or
- Any person or body in whom such persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000;
- Any body of which you are in a position of general control or management and to which you are appointed or nominated by the Authority; or
- any body in respect of which you are in a position of general control or management and which:
  - exercises functions of a public nature; or
  - is directed to charitable purposes; or
  - has as its principal purpose or one of its principal purposes the influence of public opinion or policy (including any political party or trade union)

An Authority Function is defined as: -

- Housing - where you are a tenant of the Council provided that those functions do not relate particularly to your tenancy or lease; or
- Any allowance, payment or indemnity given to members of the Council;
- Any ceremonial honour given to members of the Council
- Setting the Council Tax or a precept under the Local Government Finance Act 1992

If you are at a meeting and you think that you have a significant interest then you **must** declare the existence **and** nature of the significant interest at the commencement of the

matter, or when the interest has become apparent, or the declarations of interest agenda item.

Once you have declared that you have a significant interest (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote (unless the public have speaking rights, or you are present to make representations, answer questions or to give evidence relating to the business being discussed in which case you can speak only)
2. Withdraw from the meeting during consideration of the matter or immediately after speaking.
3. Not seek to improperly influence the decision.

Gifts, Benefits and Hospitality

Councillors must declare at meetings any gift, benefit or hospitality with an estimated value (or cumulative value if a series of gifts etc.) of £100 or more. You **must,** at the commencement of the meeting or when the interest becomes apparent, disclose the existence and nature of the gift, benefit or hospitality, the identity of the donor and how the business under consideration relates to that person or body. However you can stay in the meeting unless it constitutes a significant interest, in which case it should be declared as outlined above.

What if I am unsure?

If you are in any doubt, Members are strongly advised to seek advice from the Monitoring Officer or the Democratic Services and Scrutiny Manager well in advance of the meeting.

DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS, SIGNIFICANT INTERESTS AND GIFTS, BENEFITS AND HOSPITALITY

MEETING……...

DATE…… **AGENDA ITEM** ……

DISCRETIONARY PECUNIARY INTEREST ☐

SIGNIFICANT INTEREST ☐

GIFTS, BENEFITS AND HOSPITALITY ☐

THE NATURE OF THE INTEREST, GIFT, BENEFITS OR HOSPITALITY:

……

……

……

NAME (PRINT): ……

SIGNATURE: ……

Please detach and hand this form to the Democratic Services Officer when you are asked to declare any interests.