Kent Health Commission: Update report

June 2012

Kent Health Commission

We are delighted to present the updated report of the Kent Health Commission in Dover.

These findings are the result of consultation and discussion both locally and nationally and the production of interim reports in December 2011 and February 2012, focussed on ensuring Kent takes full advantage of the reforms set out in *Equity and Excellence: Liberating the NHS.*

Against the backdrop of almost continuous healthcare reform over the last 20 years, we understand local concerns over yet more change. But we believe passionately that by putting GPs and councils in control of local budgets, better patient care and health outcomes for all residents can be achieved.

Using this Kent Health Commission report as a springboard, we will now use the Government pump priming grant for councils aimed at developing integrated services between health and social care to invest in a significant pilot in Dover and Shepway. This work will develop a new comprehensive and clinically-led approach to prevention and local community health.

In undertaking this work, we must be clear what good 'community health' looks like in Kent and how we achieve this. We will look in more detail at the cost of its delivery and the sustainability of the desired 5% shift in activity which we seek from acute to community care. And we will show how integrated commissioning, pooled budgets and integrated health and social care services providing co-ordinated care can bring about a transformation in health and social care leading to better patient care and outcomes.

Local government, we feel, can play a powerful role in this future landscape – offering democratic accountability for the healthcare user at an immediate level, and helping coordinate a more joined-up system which makes the most appropriate use of both acute and non-acute services according to local need.

We believe the reforms to health and social care create an opportunity for local people to own and deliver change within the local health service, shaping future services to meet their needs, rather than delivering them according to a top-down model prescribed from elsewhere. We wish to opt in to change wherever it can positively improve health outcomes and experience for the people of Kent.

We are very lucky in Dover to have some of the most forward thinking GPs in the country who are determined to make the most of the opportunities created by clinically-led commissioning. This report is largely based on their ideas and enthusiasm and that of dedicated health and social care professionals across the county.

We commend it to you.

Paul Carter
Leader of Kent County Council

Charlie Elphicke
Member of Parliament for Dover and Deal

Paul Watkins
Leader of Dover District Council

Dr Joe Chaudhuri
Clinical Lead for Integrated Commissioning and Partnership Working, South Kent Coast Clinical Commissioning Group

Introduction

This update report is based on the findings provided through a process of engagement with local health and social care professionals led by the Kent Health Commission during November and December 2011, and the production of interim reports in December 2011 and February 2012.

The Commission believes that the health and social care system in Kent can be improved, but there is **concern that clinically-driven ambitions could be lost within bureaucratic process**. As the NHS reforms are implemented during this year and the next, the priority of PCTs should be to support clinical commissioning groups (CCGs) to take control of budgets and commissioning decisions.

An initial 5% shift of activity from acute to primary and community health could release at least £59m a year in Kent – an average of £5m per Kent district. This is attainable and should be a year-on-year shift which will lead to a significant cumulative impact.

In order to ensure that the current NHS reforms are truly clinically-led, CCGs should have freedom in seeking commissioning support. To achieve this, **flexibility will be needed to ensure that CCGs can recruit the appropriate resource to meet their needs**. During the period of transition, we recognise there will be tensions inherent in the transfer of existing PCT staff into new CCGs and commissioning support structures, especially the effect of TUPE liabilities in restricting CCGs from making the staffing arrangements best suited to their needs.

In line with this, CCGs should, in time, be able to seek support from external providers of commissioning support, not solely from the PCT cluster. The Department of Health should set out how it intends to stimulate the market in commissioning support across England.

In future as well as choice of commissioning support, **choice of provider will be central to achieving improved outcomes for people in Kent**. That is why we have welcomed commitments that contracts for community services will be for one year only – this is important to ensure that new providers can enter the market.

We believe that there is a role for a primary vendor of services in some areas, supporting the development of a vibrant market for health and care services in Kent. Therefore ensuring consistency in quality and standards of provision.

To ensure that services are designed with the full patient pathway in mind, **we believe that pooled budgets between CCGs and social care should be developed for integrated joint commissioning and provision**. In addition, providers, including acute trusts and community services, and commissioners should work together to consider how more care can be provided in the most appropriate setting, with the goal of achieving a 5% shift in resource from acute settings to community budgets.

Information flowing between providers and commissioners of health and social care services must be accurate, available in a timely manner and used to monitor and improve services for people in Kent. **Full use should be made by health bodies of existing, secure public service information infrastructure** and technology to help make immediate cost savings.

As a result of this local focus which has helped inform the Kent Health Commission the following activity has taken place, more rapidly than originally programmed:

1. Established a Virtual Integrated Commissioning Team in South Kent Coast CCG, including health, social care and District Council representatives.
2. Development of the first integrated commissioning plan to include not just health and social care, but also housing and environmental health; being driven by a bottom up, locality focus. This will form part of each organisations Annual Commissioning Plan for 2013 – 2014.
3. First area in Kent to implement the three strands of Long Term Conditions – Risk Stratification; Self Care and Integration of Services.
4. Facilitated the implementation of the Proactive Care model for Long Term Conditions, based on best practice in Merseyside; population profiling undertaken (a more elderly population) and risk stratification undertaken in first wave GP Practice. Proactive Care model being implemented from April 2012.
5. Integration of Community Health and Social Care to go live in summer 2012; a joint team leader has been appointed.
6. Bid submitted for "fast follower" status for Year of Care Funding Model for Long Term Conditions.
7. Bid in development to access South Coast SHA funding to support innovation in treatment of Long Term Conditions e.g. "Patient Knows Best".
8. Expansion of the Dover Shadow Health and Wellbeing Board to cover the entire South Kent Coast CCG area; will focus on the development and delivery of integrated commissioning. First area in Kent to develop a CCG focussed Health and Wellbeing Board, building on its early implementer status.
9. The work of the Kent Health Commission is being mainstreamed through the Kent County Council Families and Social Care Transformation Plan; the South Kent Coast CCG development and authorisation process; the Kent Shadow Health and Wellbeing Board and the Dover and Shepway Shadow Health and Wellbeing Board.

Recommendations

In a co-ordinated programme to transform preventative community health care in Kent, we will:

Focus on outcomes which matter to patients

1. A local Outcomes Framework for health and social care should be developed which sets the level of ambition for improvements in health and social care services in Kent and provides a measure against which performance of all partners can be assessed.
2. Both the Kent and local Health and Wellbeing Boards should work with CCGs, charities, local HealthWatch and others to assess how information on the quality of services in Kent can best be communicated.

Shift power to patients

3. Access should be put at the heart of NHS planning in Kent, for example through the development of community hospital facilities and services to avoid unnecessary long journeys to acute facilities. We will work closely with East Kent Hospital University Foundation Trust as they develop their planned new facility in Dover.

Place responsibility in the hands of clinicians

4. In order to achieve the 5% shift in activity from the acute to community sectors which Kent County Council has identified in Bold Steps for Kent, clinically-led service redesign will be required. Services should be delivered in a setting which is most convenient to, and appropriate for, patients. As part of this, investment should be made in community services so as to reduce the pressure on the acute sector e.g. community facilities should be utilised where ever possible.
5. CCGs should be free to draw on a range of sources of commissioning support. These arrangements should be developed locally rather than prescribed nationally, in keeping with the spirit of the reforms.
6. While CCG commercial acumen is still developing, local authorities should offer support – either in the form of professional advice, or, where possible, the secondment of staff.

Stimulate competition and integration

7. Subject to evaluation, the use of the Any Qualified Provider (AQP) model should be extended further in Kent. In order to support this – and in the absence of national tariffs for many community services – the Department of Health should set out how areas can move to local tariffs to stimulate the market. Our Year of Care bid should ensure local involvement with the Department of Health in developing this approach.
8. In order to make integrated commissioning a reality, South Kent Coast Clinical Commissioning Group and Families and Social Care services in KCC and Dover and Shepway Councils should develop an integrated commissioning approach supported by a pooled budget. A 'community budget' approach should be encouraged.
9. Commissioners should build on the use of assistive technology e.g. telehealth and telecare (Whole Systems Demonstrator pilot) as part of a wider programme in the management of long term conditions. Efficiency savings identified through this should be used to develop further integrated services to meet population needs.

10. Commissioners in Kent should extend the integrated commissioning arrangements beyond current areas, to include, for example, children and young people and older people. Commissioners should be bold and proactive in aligning the strategic objectives of commissioned adult and children social services with health services.

11. Joint development of the information and communications technology infrastructure in Kent is essential for enabling easier and safer sharing of information between agencies and supporting integrated service delivery. The objective is currently constrained as a consequence of protocols implemented during the Connecting for Health Programme. Information Governance remains a key problem and will need Government intervention to resolve.

Make every contact count

12. Integrated health and social care provision should be implemented as soon as possible, alongside the development and use of risk stratification tools and increased use of self management techniques like telemedicine, telehealth and peer support services. This approach should be evaluated to ensure the efficiency and quality benefits of this approach and, if appropriate, encourage its adoption elsewhere through the use of incentives.

13. Local people should be supported in understanding how to access health services appropriately to reduce unnecessary admissions, emphasising personalised self care.

Enable local government and health to work together

14. In order to ensure that local needs are at the heart of joint commissioning strategies, the Kent Shadow Health and Wellbeing Board should be encouraged to develop locality structures. Local authorities, as the democratic link between people and the health service, should scrutinise the work of the CCGs and champion a more efficient, open system.

15. The Department of Health should work with the Kent Health Commission in developing these proposals, helping establish Kent as an example of how a localist, community-based approach to health and social care can reshape services to improve outcomes.

Have an active and engaged voluntary sector

16. The development of a broker model should be explored to help ensure that the market place is open enough to involve both the private and voluntary sector as service providers, even when their scale of operation is relatively small. For example, Kent Community Health NHS Trust could in the future act as a 'prime vendor,' brokering services provided by the private and voluntary sectors in intermediate care.

17. As part of this brokerage model, supporting access to finance for the voluntary, community and social enterprise sector to take on health and social care delivery is vital, such as through the £3 million Kent Big Society Fund to help support social enterprises.

Reform commissioning, quality and financial sustainability of adult social care

18. Parallel measures must be put in place to improve the commissioning, quality and financial sustainability of adult social care alongside the reforms in health, locally this is being delivered through the Adult Social Care Transformation Programme. The forthcoming social care white paper should apply the same approach taken in the NHS reforms to promoting and rewarding high quality care, learning from local examples such as Kent, but also address the weaknesses and inequities in the way in which adult social care is funded.

The vision for health in Kent

Our vision for Kent is for a system where all those involved in delivering health and social care – commissioners and providers – are focused on delivering the outcomes that matter most to patients and local communities. It is progress on these outcomes – rather than management process measures – which should be the test of whether we have succeeded. Our vision has been developed with Dover and wider South Kent Coast CCG area in mind, but the recommendations and ideas will be of relevance in the rest of Kent and beyond.

Focus on outcomes which matter to patients

In keeping with the move from measuring outcomes rather than process, the way in which services are funded and rewarded should be reoriented around the imperative to deliver quality, rather than simply volume of care. An increasing proportion of the funding that providers receive should be contingent on delivering appropriate quality standards.

Although the people of Kent experience good health outcomes on some indicators, there is much more to do. Research, included as an annex to this report and which will be written up in the full report, provides an overview of the performance of Kent, and particularly Dover, on selected indicators. Some of the key findings are set out in the box below. This, alongside the Joint Strategic Needs Assessment, provides the baseline for the Kent Health Commission's work.

Health outcomes in Kent

- In 2008/09 in the Kent County Council area, 104 per 100,000 older people were helped to live at home or received person-centred care services. This compares to a national average of 95
- 11.42% of discharges from hospital resulted in emergency readmission in Kent in 2009/10 – putting Kent in the upper quartile nationally
- There were 429 emergency admissions due to diabetes in 2009/10 in Kent – almost double the national average of 222
- Across Kent and Medway, nearly 1,500 people on the dementia register in Kent missed out on a dementia care review in 2009/10

Health outcomes in Dover

- Between 2007 and 2009, the age-standardised rate of early deaths from cancer in Dover was 75.4 per 100,000. The lowest rate in the country was 37.9. For heart disease and stroke there were 115.5 early deaths per 100,000 – slightly above the England average of 112.1
- 63.9% of year 1-13 pupils in Dover spent at least 3 hours per week on high quality PE and school sport 2009/10 – above the England average of 55.1%
- The percentage of obese adults in Dover was 26.8% between 2007-09, just above the England average of 24.2%

Power shifted to patients

Power should also be shifted decisively towards patients and local communities, ensuring that they have transparent, timely and relevant information on the quality of local services, as well as the range of options which might be appropriate for them. This information should also ensure that

health services and clinicians are clearly accountable for their performance. Part of shifting power to patients should be about enabling them to make an informed choice about what is best for them. Choices which should be available to the people of Kent include when and where to be treated, as well as what treatment to receive.

Patients should also have a say in how they are treated, enshrining the principle of *'no decision about me without me'* in every interaction between patients and the health service.

Treatment and care should be delivered as close to patients as possible, although centralised where necessary to ensure the appropriate level of specialisation. The guiding principle should be that services are configured around the needs of patients, rather than the organisations that deliver them. In this context, the new EKHUFT Dover facility project should be prioritised.

Achieving a 5% shift in activity in Kent

Ambitious plans have already been set out to achieve a 5% shift in activity from the acute sector towards community services in Kent. This equates to approximately £59 million per year – or approximately £5 million per district in the county. A 5% shift is only the starting point, as there is also opportunity to reduce the overall level of activity by empowering patients to better self manage, alongside integration of services.

Responsibility in the hands of clinicians

In order to achieve this vision, responsibility should be placed in the hands of clinicians, the focus of the current NHS reforms. They will be given the freedom to commission and deliver the services which they feel will best meet the needs of their patients, supported by national standards so that they can be assured that their patients are receiving appropriate levels of care. Clinical commissioning groups, working with the Kent and local Health and Wellbeing Boards, will be the decision-makers on what services are commissioned for their patients, supported by expert clinical networks.

GPs are well-placed to oversee the commissioning of many services because they:

- Are close to the needs and concerns of patients
- Interact with patients at various stages of the pathway
- Take decisions which can incur significant expenditure
- Take decisions which can be critical in determining the overall health outcome of a patient

High quality commissioning is about putting the needs of patients before the convenience of the organisations that exist to support them, creating pathways of care which reflect the realities of ill health, rather than artificial boundaries of care. In addition, real sustainable changes in patient pathways will only be achieved if clinician-to-clinician engagement happens between primary and secondary care. The risk is that this will become embroiled in a bureaucratic process, rather than a clinical process. Facilitating this engagement should be a key aim of the Kent and local Health and Wellbeing Boards.

Integrated commissioning in Kent

A historic weakness in the delivery of services has been the artificial divide between the NHS and social care. For the reforms to succeed, it will be important to remove this barrier, which often gets in the way of the interests of patients, who do not consider themselves to be patients of the NHS or adult social care, but simply as patients with a variety of needs.

A key mechanism for ensuring that services are coordinated will be health and wellbeing boards. The Kent Health and Wellbeing Board has already been established, alongside the development of a locality-based model in Dover, ensuring that the local perspective is represented. The Kent Health and Wellbeing Board will have a key role to play in the following stages of the commissioning cycle:

- Needs assessment and market analysis
- Designing service specifications
- Prioritisation of change required

In addition, the local authority will be able to support procurement and contracting processes.

Work is already underway to implement integrated commissioning with a group of appropriate directors and other senior managers from the PCT cluster, Kent County Council, lead GPs and Dover/Shepway District Councils who are coming together to:

- Review existing arrangements within their respective area
- Agree outcomes to be achieved, linked to the public health, NHS and social care outcomes frameworks
- Consider how the principles of prevention, personalisation, incentivisation and localism can be achieved

The Kent and local Health and Wellbeing Boards will oversee this work. This will focus on where the delivery or commissioning of services overlap between 2 or more of the organisations, and these combined priorities will support the delivery of the Joint Health and Wellbeing Strategy.

GPs in the South Kent Coast CCG area have already demonstrated an enthusiasm for assuming these new responsibilities, as well as a desire to move faster than the timelines set out at a national level. There will naturally be some tensions between those organisations responsible for overseeing the transition and CCGs, which are eager to assume their new responsibilities. It is important that these tensions are managed and that all parties work together to expedite the transition to the new arrangements.

If the reforms are to be successful, it will be imperative that GPs are able to access appropriate forms of commissioning support. GPs in the South Kent Coast CCG area have expressed to us their determination not to be distracted from clinical duties. GPs have expressed concerns about them developing commissioning expertise and capacity, making the point that they will need to become intelligent customers of both commissioning support and healthcare services in a relatively short period of time. Commissioning is a complex process requiring a range of different forms of expertise. For CCGs to have full confidence in the commissioning support they receive, they should be able to choose from the variety of providers available, including:

- Former PCT commissioners, located either within the clinical commissioning group or through arm's length commissioning support organisations
- Local authorities
- Expert clinical networks for conditions which require high levels of specialist expertise and coordination across the pathway, such as cancer
- Independent providers of commissioning support

However, the transition to the new structures creates barriers, particularly with the need for staff from existing commissioning organisations (i.e. PCTs) to be transferred to CCGs. TUPE rules may limit flexibility in developing staffing arrangements that are fit for purpose. The Kent Health Commission believes that it will be important for CCGs to be given the maximum possible flexibility in obtaining the support they need to commission effectively for their populations. GPs and local authorities also expressed concern that their freedom of choice in selecting commissioning support may be restricted due to redundancy liabilities. They expressed a desire to be able to identify staff that they would wish to transfer as soon as possible, as well as for financial resources to be made available to cover the costs of any necessary redundancies.

Competition and integration

Different providers should compete and work together based on the quality of the service they offer. Kent's health and social care system should not be concerned about who provides services. What matters most is the quality and consistency of care, rather than who delivers it. In many cases this will be traditional or NHS providers, but where charities, social enterprises or independent providers can best meet the needs of patients, they should be able to do so, provided they can deliver the service at NHS prices.

The concept of Any Qualified Provider – whereby patients are able to choose any provider who has met the right standards, so long as the service will be delivered according to NHS quality and costs – has the potential to increase the access, convenience and quality of local community services. Part of ensuring the full operation of Any Qualified Provider in Kent will involve taking care throughout the transition that existing organisations are not signed-in to long-term contracts. We welcome the commitments from some providers in Kent that their contracts will be renewed on a yearly basis, as well as their ability to work with other providers to deliver services for people in Kent.

In order to support the development of a market in healthcare provision, the NHS Commissioning Board should take steps to clarify what tools will be available for market stimulation, including the use of local tariffs where national tariffs do not exist.

Developing Any Qualified Provider in Kent

Stakeholders from across Kent have been involved in deciding the priorities for the introduction of Any Qualified Provider in the county. An engagement exercise involving CCGs, the Local Involvement Network, the local authority and healthcare providers led to the selection of three priority areas for piloting Any Qualified Provider:

- Diagnostics
- Musculoskeletal services for back and neck pain
- Primary care psychological therapies

It is envisaged that this will be just the start for Any Qualified Provider in Kent, with many other services being opened up to the process in future years.

Cooperation between different providers and commissioners will also be critical to delivering the improvement in outcomes in Kent which all stakeholders want to see. Although competition has a role to play in providing patients and commissioners with a choice, and so driving up standards, it is critical that all organisations involved in the commissioning and delivery of social care should work together in the interests of patients. Organisational barriers or interests should never come before the needs of patients. Put simply, services should be organised around the needs of patients, rather than patients organised around the convenience of providers.

Community Health and Social Care Integrated Provision

Health and social care commissioners and providers in Kent are working together to:

- Make the system simpler to understand for the public and healthcare professionals
- Reduce the risk of people falling between the gaps of different services
- Generate savings by removing unnecessary duplication

Access to community health and social care will be made through a local Single Point of Access. This will co-ordinate care with:

- An integrated locality team, covering intermediate care and enablement, rapid response as well as health and social care assessment
- Practice-linked multidisciplinary teams, focusing on managing long term conditions and ensuring continuity of care
- Piloting of integrated management arrangements between health and social care services
- Other health, social care, private and voluntary sector provision as appropriate

People will be offered escalating levels of support depending on the complexity of their need.

Making every contact count

Public health, NHS and social care services should work together intelligently to support patients, making every contact with health or social care count in our efforts to improve outcomes. Through its participation in the Whole System Demonstrator pilot programme, which tested how support for people with long-term conditions could be improved and integrated, Kent has a promising track record in encouraging joint working. However, there is much more to do.

Commissioners and providers of public health, NHS and social care will need to work together to ensure that care is not disrupted by organisational boundaries which may seem important in the management of services but which are meaningless to patients (who the services exist to support). A key part of this will involve clinicians designing new approaches to identifying patients who are at risk and ensuring that interventions are made to manage and reduce this risk, utilising every opportunity provided by contact between the patient and health and social care services.

Clinician involvement in risk stratification

Dr Tuan Nguyen, a GP in South Kent Coast CCG, who has recently relocated from Liverpool, was involved in the Pro Active Care Anfield study. This showed that effective risk stratification and intervention in a targeted population reduced:

- Non-elective admissions by 88%
- Non-elective length of stay by 56%
- Non-elective costs by 77%

Furthermore, there was an improvement in quality of life for patients, with:

- A threefold increase in the number of patients who reported having no problems walking about
- An improvement in the number of patients who reported having no problems washing or dressing
- The percentage of patients who reported having no problems with their ability to do usual activities more than doubling
- An improvement in the proportion of patients who reported having no pain or discomfort
- An improvement in the percentage of patients who reported having no anxiety or depression

This model is to be introduced into South Kent Coast CCG alongside other integrated health and social care projects.

Local government and health working together

The Government has made clear that decentralisation is a key part of its overall agenda. This will mean:

- Lifting the burden of bureaucracy, by removing the cost and control of unnecessary red tape and regulation, the effect of which is to restrict local action
- Empowering communities to do things their way, by creating rights for people to get involved with, and direct the development of, their communities
- Increasing local control of public finance, so that more of the decisions over how public money is raised and spent can be taken within communities
- Diversifying the supply of public services by ending public sector monopolies, ensuring a level-playing field for all suppliers, and giving people more choice and a better standard of service
- Opening up government to public scrutiny, by releasing government information into the public domain so that people can know how their money is spent, how it is used and to what effect
- Strengthen accountability to local people, by giving every citizen the power to change the services provided to them through participation, choice or the ballot box

We believe that all these principles can and should apply to the delivery of health and social care services in Kent. Local government has always played a role in the commissioning and delivery of health services and, until 1974, was responsible for public health. A survey by Localis found that many local authorities are eager to take on health responsibilities, with seven in 10 seeing the reforms as either an opportunity or a significant opportunity to ensure better coordination in the delivery of health and social care services. However, there was scepticism about the ability of local government to influence the reforms; less than half of local authorities surveyed perceived the local government sector as being engaged in helping shape the nature of the Government's health reforms, and only one in four authority leaders believing that the local government sector had been

influential in shaping the nature of the health reforms. Furthermore, less than half of local authorities saw their relationship with existing NHS organisations as positive.

A key purpose of the Kent Health Commission is to challenge this scepticism, showing what is possible when local authorities and the NHS work together with other local stakeholders in a partnership with the intention at its core of improving health outcomes. In Kent, there have already been some good examples of the NHS and local authorities working together, providing a platform to build on. Kent County Council has strived to build strong relationships with GPs across the county, and in doing so, has discovered a wealth of energy and innovation among the Kent GPs.

Working together to tackle obesity

Kent Public Health and the Kent Community Health NHS Trust have worked together to commission and provide healthy weight programmes for the local population. The programmes vary, and involve a number of voluntary sector organisations in their delivery. They include:

- MEND 7-13, a healthy lifestyle programme for 7 to 13 year olds who are above a healthy weight. The programme is family-based and involves two hour sessions every week for ten weeks
- The Food Champions programme, which supports employees and volunteers in setting up initiatives so that they can promote healthy eating and set up their own healthy eating initiatives in their organisation
- The exercise referral scheme, which is designed to initiate long-term lifestyle changes by enabling clients to take responsibility for their own health. Individuals engaging with the scheme will receive a 12 week, tailored exercise programme designed by a qualified exercise professional

Working together to improve outcomes and experience for people with mental health problems

Kent County Council and Kent and Medway NHS and Social Care Partnership Trust (KMPT) have together taken steps to improve the outcomes and experience of people with mental health problems in Kent. Health and social care have been integrated in co-located facilities and under the accountability of a single provider, KMPT. Over 350 staff have been seconded from Kent County Council to KMPT.

Through partnership working, improved models of care have been introduced, which have significantly reduced demand in mental health wards and other hospitals in the area. Services include: liaison services in accident and emergency and acute care; crisis resolution; early intervention; and assertive outreach services. A recovery ethos across all services has enabled more people to regain independence.

ICT

Currently the clinical and service outcomes as defined in the report are being compromised by the technical and procurement constraints operated by the national health programme. The focus is currently on two separate services, Health and Social Care which will inhibit the policy outcomes in the short term.

It is perceived that the national health programme is committed to infrastructure services that maintain separation of services rather than joining them up to meet the desired outcomes. This is making the provision of services much more difficult. Whilst it is also recognised that things are changing the procurement contracts that are in force at the moment and which look like remaining in place, especially the issue around the subsidy only available to health organisations using the N3 Service Provider, will again seriously hinder progress to shared service delivery.

At the moment due to the restrictive nature of these national health ICT programme infrastructure contracts and services we are in effect running two motorway services in the region without any bridges connecting them, stopping the sharing of information and services. This means it is difficult for a patient or citizen to transfer from one system to another easily without either loss of information or the need to re-create the information in the new system.

Also to compound these issues we seem to operating these motorways under different highway codes. This is making it extremely difficult to get clinicians and social care professions on the same system using the same services and information. The rules although not too different are not aligned to make sharing easier.

An active and engaged voluntary sector

The voluntary sector already plays a hugely significant and successful role in the life of Kent, particularly in supporting older people and those affected by disability or ill health. There are a number of important examples of how voluntary sector organisations can also either deliver or inform the delivery of public services. For example, we heard from Marie Curie Cancer Care about the critical role that the voluntary sector plays in delivering end of life care services.

Yet we also know that too often voluntary sector organisations feel blocked from playing a full role in supporting efforts to improve health outcomes, either through lack of access to investment to develop services, inflexible commissioning processes or unsuitable procurement policies. Steps are already being taken to address this through the creation of the Kent Big Society Fund (a £3 million loan scheme for new and existing social enterprises in Kent) and discussions about reforming the commissioning and procurement framework in the county. These steps, combined with the recommendations set out in this document, will be an important move towards enabling the potential of the voluntary sector to improve health outcomes to be realised.

Linking the health reforms with changes in social care

Many of our recommendations stress the importance of integrated working between the NHS and social care services, ensuring that the needs of patients are put before organisational boundaries. The health reforms have great potential to promote integration, but this will only be realised if parallel measures are put in place to improve the commissioning, quality and financial sustainability of adult social care. We therefore welcome the recommendations made in the Dilnot Review in 2011 and look forward to the forthcoming social care white paper, which we hope will apply the same approach taken in the NHS reforms to promoting and rewarding high quality care, whilst also addressing the weaknesses and inequities in the way in which adult social care is funded.

By 2015 it is anticipated that as well as delivering significantly improved services through integration and a changed investment profile, the adult social care transformation programme will also release the savings that the local authority is committed to achieving.

The management of long term conditions is expected to play a major part in this. It is anticipated that the comprehensive implementation of all three elements of the LTC strategy (risk stratification, integrated teams and self management) will deliver significant savings to both health and social care as well as a more coordinated and improved service for patients.

The County Council has agreed the following strategic themes as the foundation for the transformation programme, which can only be delivered in partnership with stakeholders:

1. Prevention, independence and wellbeing
2. Supporting recovering and maximising independence
3. Support at home and in the community
4. Place to live
5. Every penny counts
6. Doing the right things well.

The full South East Councils response to the Commons Health Committee Inquiry into Social Care can be found in Annex 3.

The Dover example

Since late 2010, Dover District Council and GP commissioner colleagues have been working together to understand the changing health and social care environment and also to seek innovative new ways of working together. The aim of this joint working has been to improve health and wellbeing outcomes for residents, whilst also addressing the strategic leadership role of local authorities and democratic accountability being embedded into the process.

In March 2011, Dover District Council and Kent County Council were mutually supportive of each other's 'early implementer' bids to establish health and wellbeing boards. The councils were intent on learning together what combinations of functions deliver the most effective outcomes, through the County's strategic co-ordination role and the District's local integration activities. Dover District Council is currently one of only three district councils to be chosen as an early implementer for health and wellbeing boards. This enables both the County and District Council to get to grips with the role of district council engagement in health reform, which is necessary to support improved health outcomes, and is required in areas of two-tier government in a county area as large as Kent.

Working with respective colleagues, the shadow arrangements and strong partnership foundations seek a solution that ensures added-value, streamlines current practices to reduce any potential duplication of effort and also keeps a very strong local dimension to emerging partnerships. The District Council also supported a successful pathfinder application, submitted by the original Dover and Aylesham PBC Consortia, in developing an integrated health and social care model for the future. This involves closer working on the needs of residents, integrated pathways for accessing care and further improvement and evolution of current successful community engagement methods. Examples would include the existing Neighbourhood Forums – a partnership of County, District and Town and Parish Councils – to evolve community engagement and the wider public participation in health (meeting the needs of the whole population).

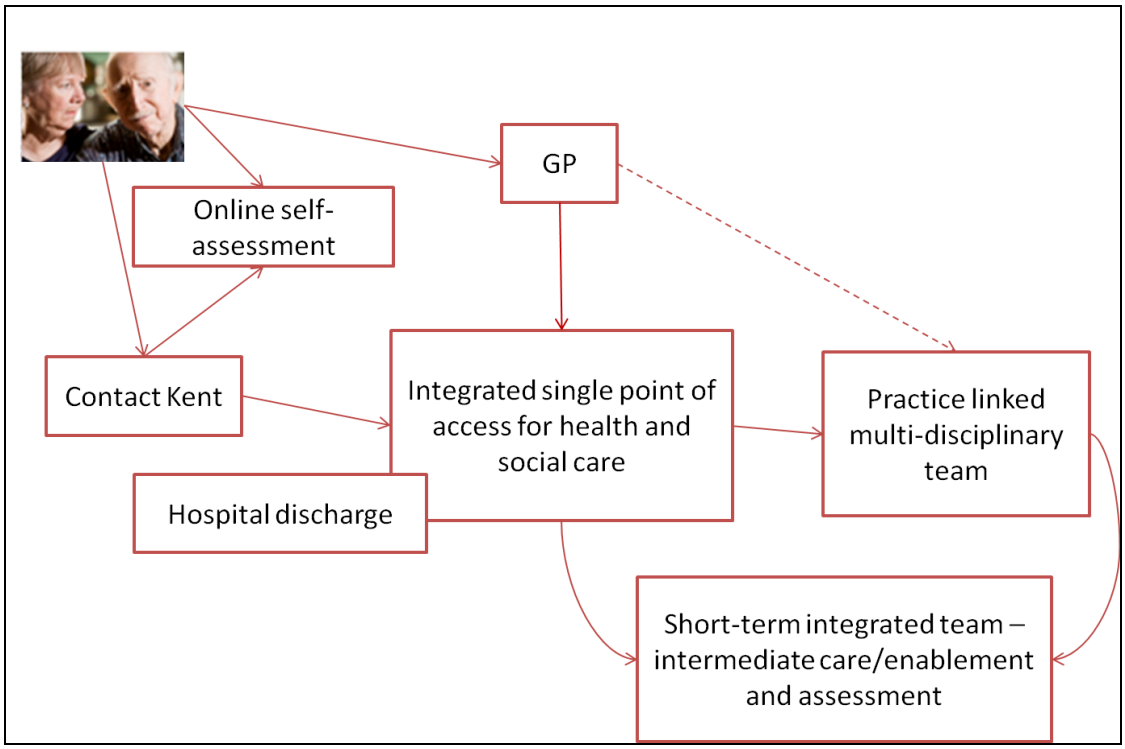
Having also established a Locality Board model with Kent County Council that aims to provide a coherent and co-ordinated (both horizontally and vertically) approach to service prioritisation and reduction in effort and duplication, Dover District area is also characteristic of many coastal areas. The challenges and opportunities presented by the geographical location and health needs alone – lying on a peninsular with a busy port (both passenger and freight), a challenging topography, an increasing ageing population, many regeneration plans underway and a large housing growth proposal – can be used to share lessons across the country.

Dover has been used as an exemplar for the work of the Kent Health Commission because of the tradition of joint working which has already been established in the area. GPs in Dover, working in partnership with other local health and social care stakeholders, have already undertaken considerable work in developing a vision for integrated health and social care in the town, as set out below. South Kent Coast CCG, Kent County Council and health providers are working together to implement the model previously described and shown in the diagram (below). It is anticipated that the new system will be in place from spring 2012.

Local community health and social care staff will be co-located in new integrated teams. Dover residents will benefit by having better experiences of health and social care services. There will be better co-ordination of care and people will get better personal health and social care outcomes.

Unique to this model is that we are working closely with the Mental Health Trust to explore how services for older people can be integrated into new multi-disciplinary team arrangements.

Enablers for changes to local services will include health and social care staff using the same single assessment forms, integrated care pathways and new shared care protocols and care pathways. Integrated Personal Budgets are also being piloted in Dover from February 2012 as part of the Department of Health pilot. Further change will be enabled through mainstreaming telecare and telehealth, a roll-out for which will also be focussing on Dover.



Future Ambitions of South Kent Coast Clinical Commissioning Group

Dr Joe Chaudhuri of South Kent Coast Clinical Commissioning Group describes their future ambitions as:

- Delivering our vision of a high quality sustainable system of care, that removes all boundaries between organisations – keeping the patient at the centre of all that we do
- Working with the local Hospital Trust to develop a new community facility enabling care to be delivered closer to home and helping prevent avoidable emergency admissions
- Provide a co-located intermediate care service with the planned new Dover facility, which would enable earlier discharge from hospital, as well as prevention of hospital admissions. This would enable patients to take time to consider how they would like to be supported in the community, rather than simply pushing them towards residential care homes
- Establish a local urgent care service, providing a supplementary service to A&E, supported by 'telelinks' to A&E consultants

- Create a fully integrated community health/social care service, with 24/7 rapid response teams to enable vulnerable patients to be supported either to stay in their own home or move to a local community facility, minimising emergency admissions

- Employ locally-based health and social care co-ordinators who can respond to patient need in the community and co-ordinate the delivery of required services, freeing-up GP time

- Begin a single assessment process with information which is easily transferable between different organisations, both horizontally and vertically

- Facilitate the implementation of care of older people consultants to work with care homes and groups of GP practices, assisting them in managing high risk older patients who may be particularly susceptible to falls, attendances at A&E and emergency admissions

- Improve advanced care planning, particularly for palliative and end-of-life care, ensuring that the needs and wishes of patients are at the heart of service delivery

These ambitions will best be met through:

- Developing an education and training strategy, to enable the CCG to become a "teaching CCG", focussing on the integration of health and social care. This will enable us to improve our recruitment and retention of high quality staffing resources

- Taking a locality-wide view to the commissioning of health, social care, housing and wider services, coordinated and led through the local health and wellbeing board

- Integrated delivery of health and social care services, bringing health commissioners together with their local authority counterparts to share information, ideas and resources

- Taking a longer term view of health commissioning and delivery, investing in high quality community care as a prerequisite to helping to reduce secondary care activity and costs

- Redesigning care pathways to support the delivery of care closer to home where possible, with access to appropriate specialist support

- Developing partnerships between commissioners and providers to ensure that the needs of patients come first, promoting competition where appropriate within the parameters of an integrated system

Next steps

The interim papers were intended to stimulate discussion and ideas about how health and social care services in Kent can be improved. As a consequence of those discussions, extensive activity has taken place to develop and implement various work streams and in the case of the development of an integrated commissioning model, implement work earlier than originally envisaged. Underlining this activity has been the strengthening of relationships between health and local government across all levels and disciplines. It has seen a strengthening of trust and understanding between organisations which will support the difficult process of health and social care transformation over the coming years. In all of this, the role of the clinician has been at the centre. Mainstreaming of the lessons learnt and new ways of working has already begun, these include:

- Development of Integrated Commissioning between health, social care and District Councils as the way forward for commissioning services, focussed at a locality/CCG level.
- The implementation of all three strands of Long Term Conditions work to expand outside of the first phase areas.

Using the Kent Health Commission as a springboard, we hope to use government 'pump priming' grant for councils aimed at developing integrated services between health and social care to invest in a significant pilot in Dover and Shepway. This work will develop a new comprehensive and clinically-led approach to prevention and local community health. We will also support the submission of bids to appropriate Department of Health, SHA and other funding streams.

In undertaking this work, we must be clear about what good 'community health' looks like in Kent, what will be different and how we can achieve this. We will look in more detail at the cost of its delivery and the sustainability of the desired 5% shift we seek from acute to community care. In particular, we will look at how the funding flows round the system and how the good community health services will be paid for from this activity shift. This will include how new and existing facilities and services such as Children's Centres and new Health visitors are co-ordinated.

We will also show how integrated commissioning, pooled budgets and integrated health and social care services providing coordinated care can bring about a transformation in health and social care leading to better patient care and outcomes. We aim to produce our first truly integrated commissioning strategy, owned by health, social care and the District Councils, by the end of September 2012.

We believe the national reforms to health and social care create an opportunity for local people to own and deliver change within the local health service, as well as to shape future services to meet our needs, rather than delivering them according to a top-down model prescribed from elsewhere. We wish to opt-in to change wherever it can positively improve health outcomes and experience for the people of Kent.

Annex 1: About the Kent Health Commission

As with other parts of the UK, services in Kent face many challenges in caring for local people including a reduction in spending, people living with multiple long-term conditions and the rising costs of new technologies. The Kent Health Commission was set up therefore with the aim of helping – through engaging with local people – to evaluate and develop a new system which is tailored to the needs of patients and service users.

Objectives

The overarching objective of the Kent Health Commission is therefore to:

"Develop a visionary model that demonstrates how the Government's health and care reform agenda can empower GPs and commissioners to deliver better quality care, improve health outcomes and improve patient experience through working with GPs in Dover district as a pilot area."

In delivering on this overarching objective, the Kent Health Commission will explore how:

- Health and social care services can be redesigned according to local need
- The reforms to health and social care can be implemented in a way which improves service quality and health outcomes for the residents of Kent
- Local expertise can be harnessed to improve services in the way which best meets local needs
- Services can be joined up in the interests of patients, enabling easier access
- Local health professionals, including GPs, can be empowered to use their expertise to develop better services that are more accountable to local people
- Stronger and more productive links between different local health and social care providers can be forged, enhancing productive working relationships in the interests of patients
- New commissioning organisations, such as clinical commissioning groups (CCGs), can best be supported to implement change
- Examples of good local practice can be identified, applauded and spread

These objectives will be achieved by bringing together existing best practice from across Kent with the expertise, experience and ideas of health professionals, patients and local people through the Kent Health Commission. This evidence and analysis will enable the Commission to make recommendations which will help drive improvement in health and social care.

Membership

The Commission's membership is:

- Paul Carter, Leader of Kent County Council (KCC)
- Cllr Paul Watkins, Leader of Dover District Council
- Charlie Elphicke, MP for Dover and Deal
- Graham Gibbens, Cabinet member for Adult Social Care and Public Health

- Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform
- Andrew Ireland, Strategic Director of Families and Social Care
- Meradin Peachey, Director of Public Health, KCC and Kent and Medway PCT Cluster
- Joe Chaudhuri, Lead, South Kent Coast Clinical Commissioning Group
- GP representatives from CCGs across Kent
- Mike Birtwistle, Managing Director, MHP Health Mandate
- Alex Thomson, Chief Executive, Localis

The work of Kent Health Commission is supported by Kent County Council and Dover District Council, with input from MHP Health Mandate, a specialist health policy consultancy, and Localis, the local government and localist think tank.

Developing this document

This interim document is based on the findings provided by a process of engagement with local health professionals led by the Kent Health Commission during November and December 2011. As part of the Kent Health Commission process, meetings were held with:

- GPs from the Dover, Shepway and Deal area to gain their insights into the opportunities and challenges created by the reforms.
- Local providers of health services, including NHS Eastern & Coastal Kent, East Kent Hospitals University NHS Foundation Trust, Kent Community Health NHS Trust, and Kent and Medway NHS and Social Care Partnership Trust
- Representatives from the voluntary sector

The list of attendees is set out in Annex 2.

In order to supplement this face-to-face engagement, an engagement process was undertaken with a wider group of GPs in Kent. In addition, a number of GPs, social care and public health professionals also provided additional relevant information to the Commission, either in face-to-face interviews or by email. The responses were analysed and used to inform the content of this report.

Work was also undertaken to assess the attitudes of local authorities to the reforms to health and social care. A short survey undertaken by Localis was sent to every local authority (upper and lower tier) leader and chief executive in England. In total, 85 provided answers – with responses received from every region of the country.

The information and insights captured through this process of engagement were supplemented by desk research and analysis of the health environment in Kent using published information and data disclosed as a result of parliamentary questions tabled by Charlie Elphicke MP.

Annex 2: Attendees at the Kent Health Commission meetings

17th November Inaugural Meeting, Dover District Council

Dr Nicholas Sharvill, GP
Dr Ian Sparrow, GP
Dr Mark Jones, GP
Dr Marc Feeney, GP
Dr Joe Chaudhuri, GP
Dr Gary Calver, GP
Dr Abhijit Banik, GP
Dr Marianne Ford, GP
Dr John Allingham, GP
Dr Tuan Nguyen, GP
Cllr Paul Carter, Leader, Kent County Council
Cllr Roger Gough, Kent County Council
Meradin Peachey, Director of Public Health, Kent County Council
Andrew Ireland, Executive Director Families and Social Care, Kent County Council
Charlie Elphicke, MP Dover and Deal
Cllr Paul Watkins, Leader, Dover District Council
Cllr Pat Heath, Dover District Council
Cllr Sue Chandler, Dover District Council
Alex Thomson, Localis
Mike Birtwistle, MHP Health Mandate
Rupert Gowrley, MHP Health Mandate

1st December Meeting, Dover District Council

Dr Darren Cocker, GP
Dr Joe Chaudhuri, GP
Dr Marianne Ford, GP
Dr Tuan Nguyen, GP
Cllr Paul Carter, Leader, Kent County Council
Cllr Graham Gibbens, Kent County Council
Meradin Peachey, Director of Public Health, Kent County Council
Andrew Ireland, Executive Director Families and Social Care, Kent County Council
Charlie Elphicke, MP Dover and Deal
Cllr Paul Watkins, Leader, Dover District
Cllr Pat Heath, Dover District Council
Cllr Sue Chandler, Dover District Council
Nadeem Aziz. Chief Executive, Dover District Council
Alex Thomson, Localis
Mike Birtwistle, MHP Health Mandate
Ann Sutton, Chief Executive, NHS Kent and Medway
Stuart Bain, Chief Executive, East Kent Hospitals University NHS Foundation Trust
Nick Wells, Chairman, East Kent Hospitals University NHS Foundation Trust
Marion Dinwoodie, Chief Executive, Kent Community Health Trust

David Griffith, Chairman, Kent Community Health Trust
Bob Deans, Chief Executive, Kent and Medway NHS and Social Care Partnership Trust
Andrew Ling, Chairman, Kent and Medway NHS and Social Care Partnership Trust
Chris Mackenny, GP Practice Manager

8th December Meeting, House of Commons Committee Room

Charlie Elphicke, MP Dover and Deal
Damian Collins, MP Folkestone and Hythe
Nick de Bois, MP Enfield North
Cllr Paul Carter, Leader Kent County Council
Cllr Graham Gibbens, Kent County Council
Cllr Paul Watkins, Leader Kent County Council
Cllr Sue Chandler, Dover District Council
Dr Tuan Nguyen, GP
Andrew Ireland, Executive Director Families and Social Care, Kent County Council
Meradin Peachey, Director of Public Health, Kent County Council
Rupert Gowrley, MHP Health Mandate
Richard Carr, Localis
David Shaw, Marie Curie Cancer Care
Alexis Howsam, Marie Curie Cancer Care
Katherine Ward, United Health
Tom Shakespeare, Local Government Association

Annex 3 - Submission to the House of Commons Health Select Committee Inquiry into Social Care

South East Strategic Leaders (SESL), South East Councils Adult Social Care Members (SECASC) and South East England Councils (SEEC)

Submission to the Commons Health Committee Inquiry into Social Care

This submission draws on evidence and views from a number of South East councils and is a joint contribution from the above bodies. Some individual authorities will also be submitting evidence to the Committee.

Summary of key points

- We welcome the Dilnot report on the funding of long-term care and its ambition to clarify how much individuals should pay towards their care by setting a cap on costs. We also support the proposals to raise the means testing threshold to £100,000 and to extend the current deferred payment scheme so that it is a full universal offer across the country.
- It should be recognised, however, that the proposals will require very significant additional capacity for councils to respond to the increased demand for financial and care assessments. The state would, as a consequence of these proposals, have a relationship with a much higher number of individuals who need care than is currently the case.
- The demographic challenges of the South East, with an above-average ageing population, coupled with much higher numbers of self-funders than in other parts of the country, present a particularly stark funding problem which will require significant Government investment. SECASC estimates that councils could face a threefold increase in people needing support in future.
- We support the recommendations of the Law Commission's report, particularly around the potential for sharing assessment arrangements with other agencies; the new duty to assess carers; strengthening safeguarding arrangements and the new lead role for councils in statutory multi-agency adult safeguarding boards; and a clearer definition of NHS continuing care.
- We support the principle of national eligibility and portability of assessments, but building on the Government's localism agenda, individual councils should retain local discretion when commissioning services to meet the distinctive needs of their area.

- Transitional financial protection may be needed for councils who currently support people who may fall below new national eligibility criteria.
- We welcome the opportunities offered by the health reforms to improve integrated commissioning, working with partners and across the tiers of local government to maximise benefits for residents.

1. The practical and policy implications of the Dilnot Commission proposals

1.1 Broadly we welcome the report of the Dilnot Commission, and in particular the profile that it has given to the complex issue of funding long-term care, which needs urgent reform. Dilnot's emphasis on the funding of care being a partnership between the individual and the state is a rational approach, and one that we support. Accordingly, we urge the Government to implement the changes based on the Dilnot proposal as quickly as possible.

1.2 The proposal for a cap on lifetime care costs payable by an individual, which is suggested might be around £35,000, introduces some clarity around the individual's responsibility and would make it easier for people to plan for future care needs. It would also provide greater scope and incentive for the development of more suitable financial products to help people make provision for potential future care needs.

1.3 Local authorities would have a new responsibility under Dilnot's proposals to assess and calculate when a person would become eligible for state funding, which would require significant additional resources in terms of assessment capacity, training and changes to IT systems. In effect, much higher numbers of people would enter the social care system as personal budget holders, albeit that they might be funding up to £35,000 of care themselves in the first instance. This has workforce implications, in that it would lead to a significant increase in the number of people requiring a care assessment.

1.4 Dilnot proposes that the means testing threshold for those entering residential care should be raised from £23,250 to £100,000 which we would support, along with the proposed extension of the current deferred payment scheme so that it is a full universal offer across the country. However, we are concerned that similar arrangements are not suggested for people who remain at home, who may have very high cost care packages, in particular, the high proportion of people falling into what is termed as 'asset rich and cash poor'. There are also, again, implications for capacity, as authorities could see a huge demand in the number of people for whom it would become worthwhile to approach their local authority for help. This would increase the demand for detailed financial assessments, at a time when public sector workers are seeing the biggest job cuts ever. This transactional workload could be significantly reduced if the data sharing clauses in the current Welfare Reform Bill were approved to make financial assessments simpler for people and possibly undertaken electronically.

1.5 Dilnot's report assumes that the funding required to implement the proposals will be passed by Central Government to local authorities, at an estimated cost of £1.7bn in the first year, rising to £3.6bn in the long term. However, work done in a number of SE authorities indicates that the costs are likely to be higher for the SE than the assumptions made in the

report. This is largely linked to the high numbers of self-funders in the region. Although nationally, it is estimated that around 45% of people pay for their own care, in many SE authorities the percentage is much higher. For example, Surrey – due to its relative wealth – estimates that closer to 80% of people fund their own care, whilst Hampshire estimates that around 60% are self-funders. With the additional pressures from self-funders, SECASC estimates that SE authorities could potentially be supporting three times the number of people they do now, before any demographic changes are taken into account. We would encourage the Select Committee to explore the possibility of a shift of 2-5% of NHS secondary care resources to fund key Dilnot proposals.

1.6 The variation in care costs across the country will also mean that an individual's contribution of £35,000 will be spent more quickly in more expensive social care markets, such as the SE where labour and associated costs are higher. Dilnot's proposals also do not appear to take into account the potential impact on the care market. If self-funders have a notional personal budget into which they contribute up to £35,000 of their own money, then they would quite rightly expect to be able to access the same rate for care as someone who was local authority-funded. This is likely to push up provider prices across the board, since it will be harder to justify charging self-funders a higher rate to subsidise local authority clients (as frequently happens at the moment).

1.7 The implementation of the key proposals contained in the Dilnot Commission Report and the Law Commission recommendations imply all social care staff, managers and lawyers in local government will need to be trained to understand and undertake new responsibilities. We would wish to see further information on the mechanisms for rolling this out nationally.

1.8 The public may form high expectations from the headline messages of the Dilnot Commission Report, specifically, matters such as the portability of assessment, national eligibility and capped contributions. Explaining the detailed implications to residents and managing expectations will place real pressures on local authorities at a time of unprecedented cuts in the public sector. For example, portability of assessment does not confer guaranteed replication of the same care package when a person moves from one local authority area to another.

2. Reform of social care law

2.1 The Law Commission's recommendations have been welcomed by social care authorities, and will help greatly to make the legislative framework for adult social care clearer, more modern and more cohesive. Particular aspects of the recommendations we feel will be helpful include:

- The ability of a local authority to authorise others – such as a health professional – to undertake an assessment or aspects of an assessment on their behalf, subject to the local authority retaining overall control of the process (which would allow for joint health and social care assessments to be carried out by the same assessor, for example);
- The new duty to assess carers;
- Strengthening of safeguarding arrangements and a lead role for councils in statutory multi-agency adult safeguarding boards; and
- A clearer universal definition of NHS continuing health care.

2.2 We recognise that the Government has put in place secondary legislation to give effect to the operation of the Social Work Practice Programme pilot which enables the delegation of statutory duties. We would support the expansion of the programme ahead of the fundamental reform of adult social care law.

2.3 The Law Commission's proposal – supported by Dilnot – to allow scope for introducing national eligibility criteria would aid transparency for service users. However SE authorities feel strongly that individual authorities need to retain responsibility at local level for how eligible needs are met, through locally commissioned services and local charging arrangements taking into account of the distinctive needs of each area and its social care market.

2.4 The proposal put forward by Dilnot, building on the Law Commission's report, to base the national eligibility criteria at the substantial level may disadvantage the financial position of those local authorities which have continued to provide services to people who fulfil the moderate level of the current eligibility criteria. If eligibility was made uniform at substantial level and without local discretion, then a significant number of service users in some authorities would have to be reassessed and /or given transitional protection. We believe it is important that the local government funding formula is sensitive to this position, especially against the backdrop of current pressures to deliver Communities and Local Government savings over the next four or five years. In addition, councils have historically spent more on adult social care than is indicated by national government funding levels through subsidies from the council tax. This is a legitimate part of a set of local democratic decisions. All of these concerns would be reduced if the social care and welfare reforms and Dilnot Commission recommendations were supported by adequate funding for local government.

3. Variation in access to and charges for social care/ barriers for social care users who wish to relocate

3.1 Dilnot recommends that assessments should be portable across local authority areas and that there should be a national assessment system. This would be welcomed as a mechanism for introducing greater certainty for service users who wish to relocate. However, local authorities would still need to retain discretion on the services they provide to meet an individual's assessed needs, since the range of services will differ in each area, as they are tailored to meet local needs. This implies that care packages would not be fully portable. In the same way and in line with localism, local authorities should retain responsibility for setting their own contributions (charging) policy.

3.2 The arrangements around Ordinary Residence need further consideration and can provide a barrier to people relocating, particularly where individuals (either as adults becoming more independent or children moving into adulthood) move from a residential setting to a deregistered independent living setting out of county. This can increase costs significantly for authorities who are net importers of clients as is the case for a number of authorities in the South East. We would want to see further clarification on this area especially as the

Law Commission report did not make a recommendation on changing current Ordinary Residence rules.

4. Promoting personalisation

4.1 We welcome the opportunity offered by the Government's agenda of expanding the options available to people who rely on adult social services to exercise greater choice and control. However, it is generally accepted that the existing legal framework is not in step with the fundamental building blocks of the personalisation agenda mainly because of the nature of statutory duties placed on local authorities. In brief, the existing rules constrain local authorities. Piecemeal steps such as the Secretary of State's recent announcement to enable NHS Continuing Healthcare patients to access Personal Health Budgets, Right to Control and Social Work Practices pilot programmes are helpful but available to a limited number of local authorities. We support the drive to put in place further enabling instruments ahead of reform of adult social care law.

4.2 The Committee may wish to reflect on the balance of responsibility between the institutions of the state and the individual, as more people take on the responsibility for decisions about their care and support. There needs to be a clear statement of the limit of the local authority's responsibility in this context. And if local authorities are to be held to account on corporate responsibilities grounds, then this needs to be proportionate to reflect the new arrangements.

4.3 A key consideration in this respect that is worth exploring is who ultimately should bear the financial responsibility of accrued debt, when people choose to exercise choice and control through personal budgets. We would be pleased if this issue was clarified.

5. Economic regulation of the social care system

5.1 There is emerging evidence that some residential care homes for older people are struggling financially, yet the budgetary pressures have made it difficult for councils to re-consider an uplift to care home providers this year. In this situation we are not sure that economic regulation is the answer or even the way forward. In our opinion central government should look to develop initiatives that may help support the financial viability of the good quality, smaller care homes.

5.2 All industries experience cycles of change and continual business exit and entry, therefore the Government needs to be clear about the intended benefits of economic regulation. We do not believe that the Government's discussion paper 'Oversight of the Social Care Market' makes a compelling case for such regulation. Accordingly, the Government should ensure that a competitive market can thrive, and with allocation of sufficient grant to local authorities.

5.3 In light of the recent national media coverage of the quality of care in homes we have greater concerns in relation to CQC regulation of standards and quality in the social care system than with economic regulation. We understand that although the CQC plans to recruit more inspectors it is not on target to inspect all the registered providers in the region within the two year commitment timeframe.

6. Integration between health and social care

6.1 SE authorities are fully engaged in responding to the changes to the health system, working closely with our SHAs, PCT clusters and emerging clinical commissioning groups as well as working together across local government to learn from each other and promote best practice. Good progress is being made on developing the Health and Wellbeing Boards, due to the high numbers of Early Implementers in our area.

6.2 The majority of councils are actively planning and promoting integration between health and social care by focusing on two key areas: - integrated provision/pathways, and integrated commissioning, the aim being to develop a system that can deal more effectively with the anticipated growth in the population and the health and social care pressures arising from it. Adopting this approach will help ensure we rely less on making changes to the formal organisational structures and concentrate more on the frontline managers and commissioning professionals who are taking many of the commissioning decisions in practice.

- **Integrated provision**

  There is a real energy and excitement within health and social care organisations in the region to deliver community health and social care integrated provision.

- **Integrated commissioning**

  Integrated commissioning not only brings together a more coordinated health and social care service but will help ensure patients/service users experience a single system. This will also improve organisational efficiency and effectiveness. However existing integrated commissioning arrangements are too limited to deal with the scale of change. The need for developing clearer and simpler frameworks for the development of integrated commissioning, strengthening locality commissioning and developing new models of working are all key to promoting better integrated services. Effective cross-tier working will be crucial to improving health and wellbeing outcomes for local residents: for example, Housing departments in our unitary and district/borough councils have much to contribute to the integrated commissioning equation, providing services that help to keep people safely at home and developing and providing supported accommodation.

  There are a number of practical implications which need to be considered but should not be seen as barriers:

i. Firstly the need for mechanisms and a willingness to share information across organisations, person held records and access to different systems and development of different data collection for separate performance frameworks.
ii. Secondly, professional boundaries and not understanding different job roles; and developing working relationships across organisations and with GPs.
iii. Thirdly, there are training implications in moving towards single assessment, since NHS care is not chargeable whereas social care is. Also delivering the personalisation agenda

requires training for health staff to understand the way social care professionals undertake assessments and support planning.

iv. Fourthly, there are also questions around management of staff and management structures across organisations, the geographical boundaries of local authority and NHS and co-location of staff across organisations.

v. Finally, the development of a transparent risk sharing framework as a potential vehicle for managing shifting resources from secondary care to primary care as endorsed by the NHS Future Forum.

Cllr David Burbage

Chairman of SESL

Leader of the Royal Borough of Windsor and Maidenhead

Cllr Graham Gibbens

Chairman of SECASC

Cabinet Member for Adult Social Care and Public Health, Kent County Council

Cllr Paul Carter

Chairman of SEEC

Leader of Kent County Council

Annex 4: Profiling Health in Kent

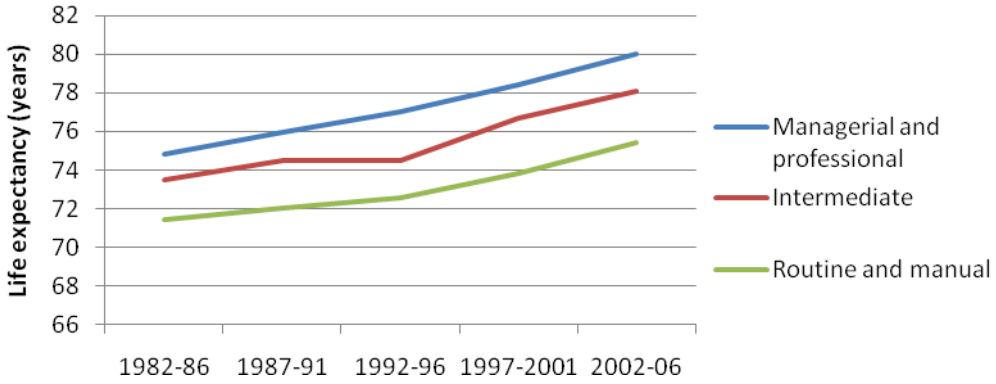
Many of the challenges facing Kent County Council are replicated across the country. The population is growing and people are living longer, budgets are no longer growing and finances are under pressure. Existing organisational structures are not always designed around the needs of patients. This section looks at the context for health and social care services in Kent, focusing in detail on the Dover area.

Population trends

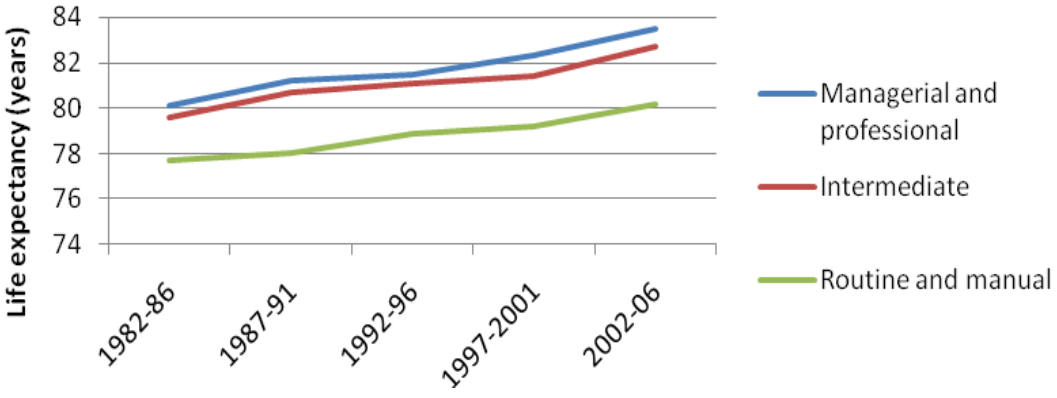
As with elsewhere in the UK, the population in Kent is living longer. As Figure 1 demonstrates, there has been a steady increase in life expectancy in the UK over the last thirty years, although a significant gap remains between different demographic groups. Individuals classed as working in routine and manual professions consistently have a lower life expectancy than those defined as 'intermediate' or 'managerial and professional'. This pattern is repeated in Kent.

Figure 1: Trends in life expectancy at birth[1]

Males



Females

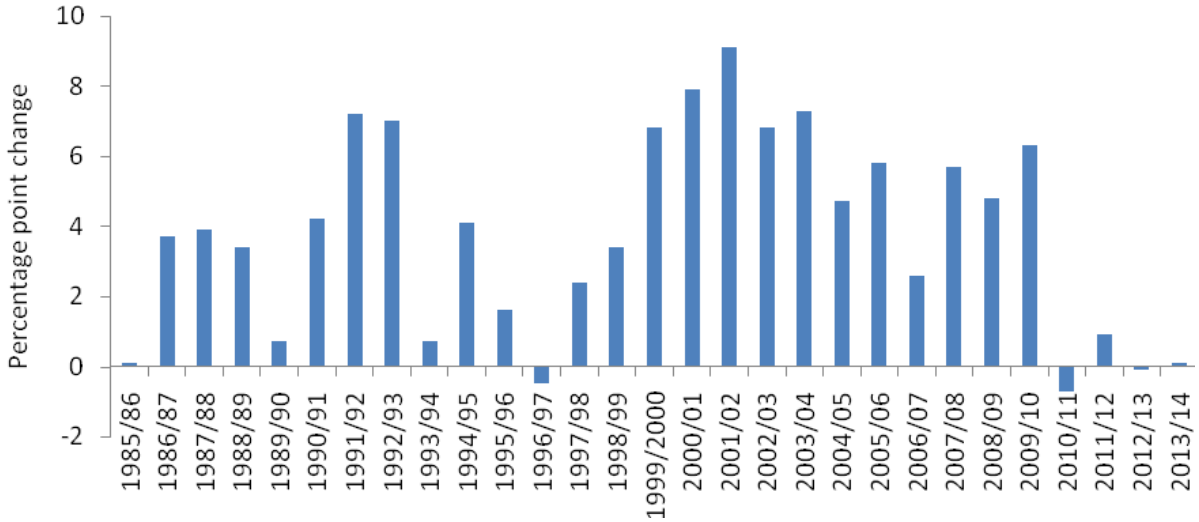


Although the increase in life expectancy is welcome, it does present challenges for health services. As the population ages, more people will live with often multiple long term conditions. The process of delivering care will become more complex and more expensive, particularly as long term conditions become more treatable due to advances in medical technology.

Slowdown in expenditure

These demographic and technological pressures have combined with a slowdown in the rate of increase in NHS expenditure. Figure 2 demonstrates that the projected rate of increase in expenditure is, by historic trends, very small. These small increases in expenditure will seem like a cut to many NHS services.

Figure 2: Real terms change in NHS expenditure[2]



Addressing this challenge requires new ways of working, including using clinical and patient expertise to fundamentally redesign the way that much of care is delivered. This will require improving the support provided to people in the community so as to free up expensive acute capacity.

The challenges in Kent

As set out above, the situation in Kent mirrors that elsewhere in England. It is, however, important to consider the specific circumstances in the county so that solutions and services can be developed to meet the needs of the local population.

There are currently eight clinical commissioning groups working within Kent to improve services and outcomes for patients. As part of their development process, each clinical commissioning group has been asked to develop priority areas for improvement. Those identified range from reducing inequalities to developing an organisational model for an integrated health and social care service. As demonstrated in

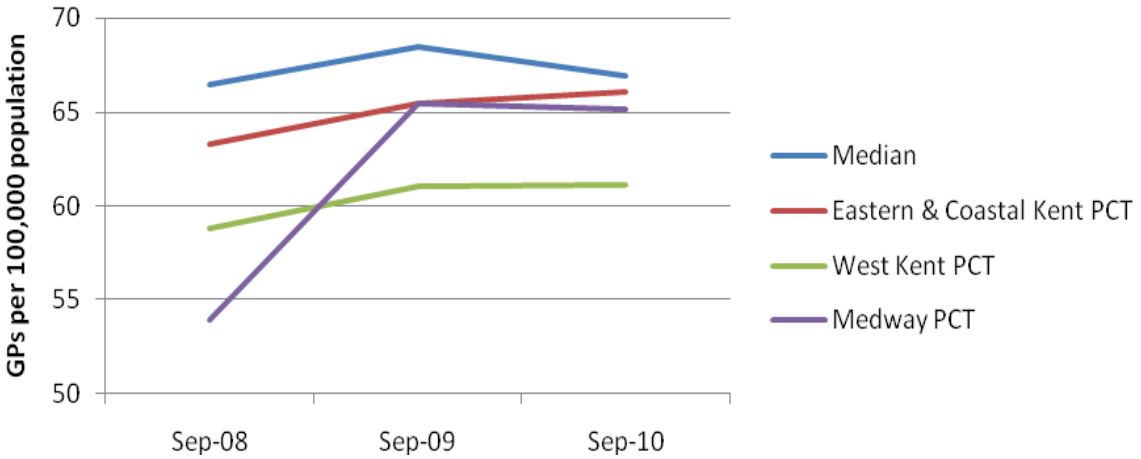
Figure 3, several key themes are apparent across Kent: reducing hospital admissions, providing more services in the community and ensuring integrated services for the local population.

Figure 3: Objectives of, and challenges to, Kent's clinical commissioning groups

In developing commissioning policies to address these priorities, clinical commissioning groups will need to address particular local issues which concern patients and the wider population in Kent, while at the same time addressing issues that drive costs. These clinical commissioning groups are operating in a challenging environment. The national challenges of increased life-expectancy, pressure on social care services, a slow-down in funding increases and services organised around the needs of buildings and staff rather than patients are as relevant in Kent as they are elsewhere. And yet it is important to look at Kent more specifically to identify some of the particular challenges, and indeed opportunities, that will need to be addressed to achieve the vision for integrated patient-centred care across the county.

Kent has a unique geography. With large sections of the county along the coast, particular challenges are faced in terms of access to services and availability of staff. For example, access to GPs in Kent, measured in terms of the number of GPs per 100,000 of population, is consistently and significantly below the national average, as demonstrated in Figure 4.

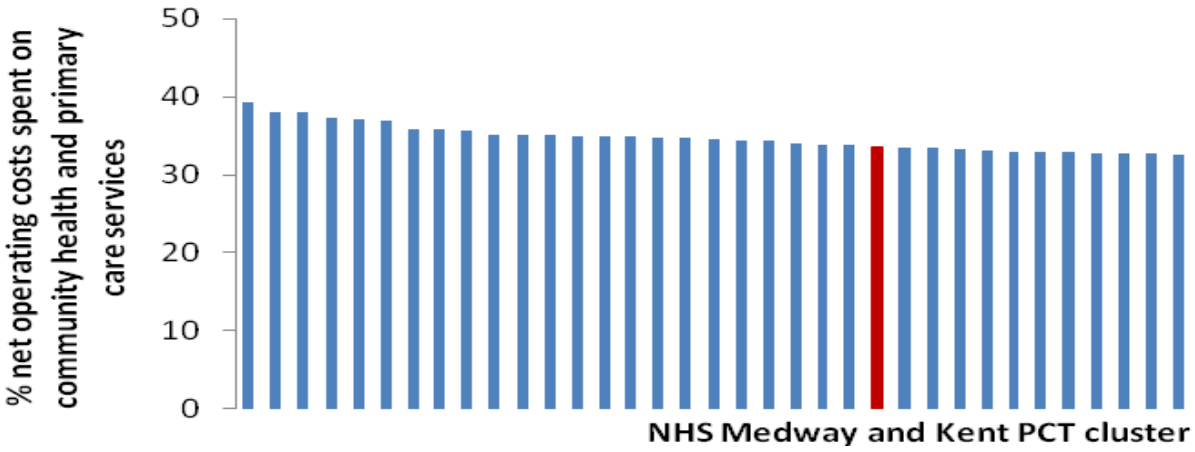
Figure 4: Access to GPs in Kent[3]



The distribution of healthcare expenditure in Kent is broadly similar to the national average. The PCT cluster in Kent, NHS Medway and Kent, spent 34% of its net operating costs on community health and primary care in 2010/11.

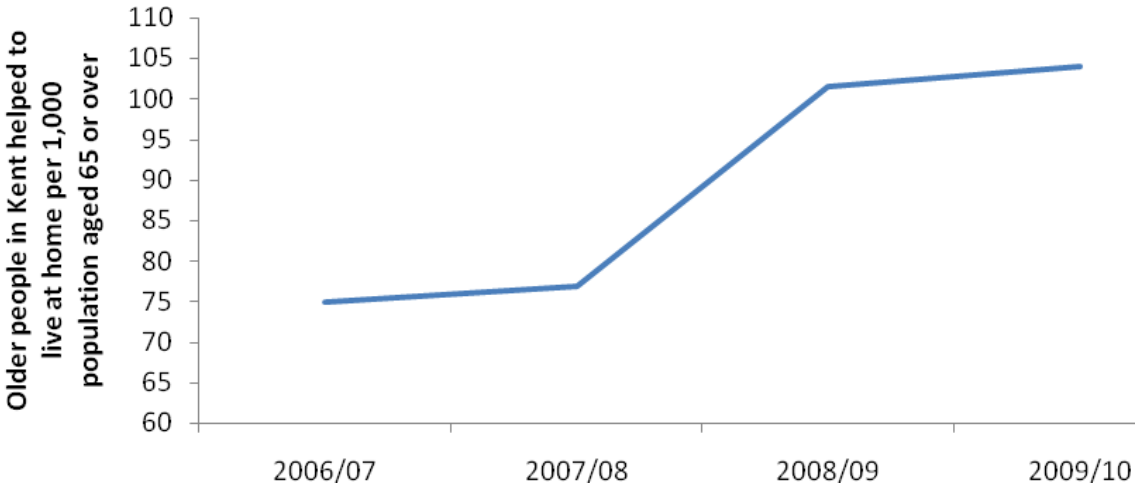
Figure 5 below shows that this is slightly above the average. Across PCT clusters, the allocation spent on community and primary care services remained relatively stable between 2009/10 and 2010/11. This was also the case in NHS Medway and Kent, where there was no increase in the percentage spent on community and primary care services.

Figure 5: Expenditure on community health and primary care as a percentage of net operating costs, by PCT cluster[4]



A key component of reducing healthcare costs and improving outcomes is ensuring that, where possible, patients are supported in their own homes. This reduces expenditure on hospital services and improves patient experience. This is a particular challenge for older people. As demonstrated in Figure 6 below, the number of older people per 100,000 supported to live at home increased significantly in Kent between 2006/07 and 2009/10. This corresponded with a small drop in the number of adults in nursing homes – from 1,515 in 2009 to 1,490 in 2010[5], and is a promising sign that care in the community has improved.

Figure 6: Older people in Kent supported to live at home[6]



Although Kent has done well to increase the number of people supported to live at home, the number of emergency readmissions to hospital within 28 days of discharge from hospital remains above the national average. Figure 7 demonstrates that Kent has consistently been in the upper 25% of upper tier local authorities on this measure, with 11.4% of persons being readmitted in 2009/10[7]. As Figure 8 shows, Kent is also above average in terms of emergency admissions for diabetes – and has been since at least 2006/07[8].

Figure 7: Emergency readmissions to hospital within 28 days of discharge from hospital[9]

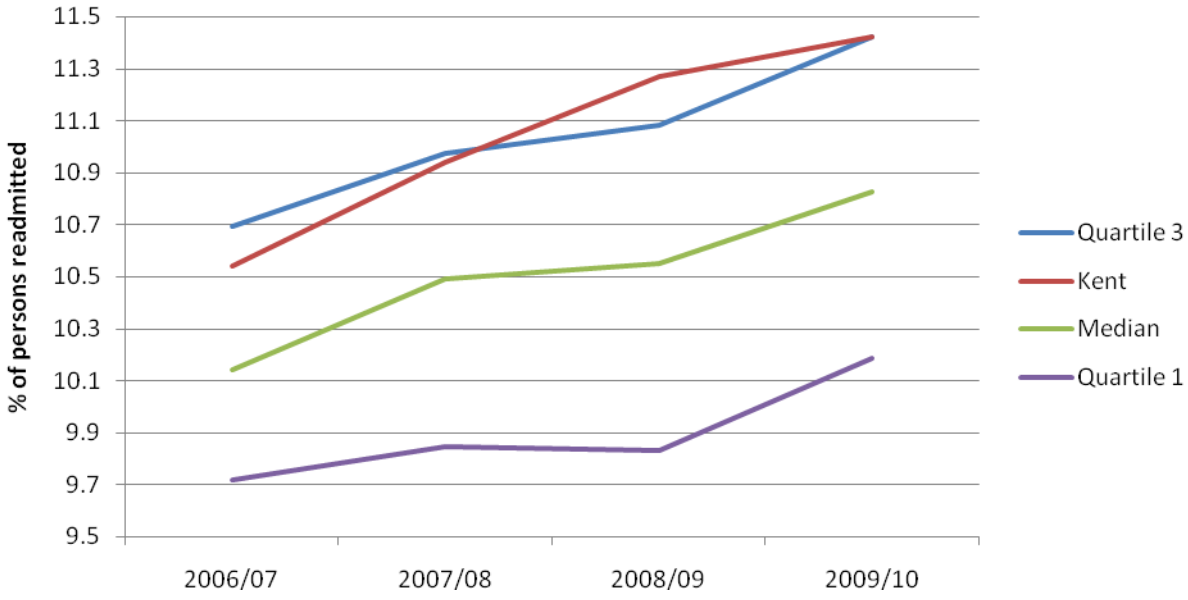


Figure 8: Emergency admissions due to diabetes[10]

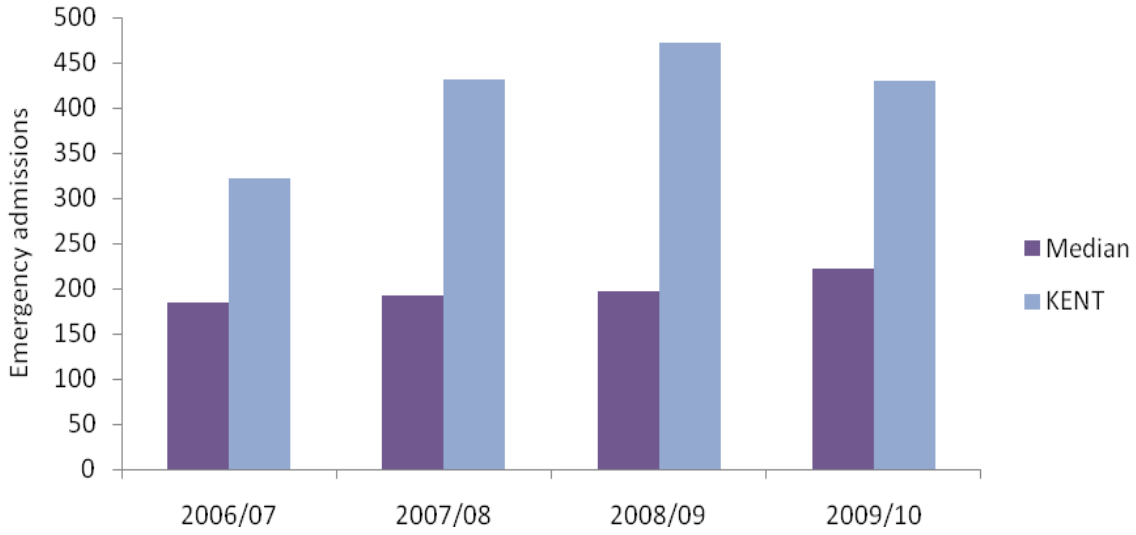
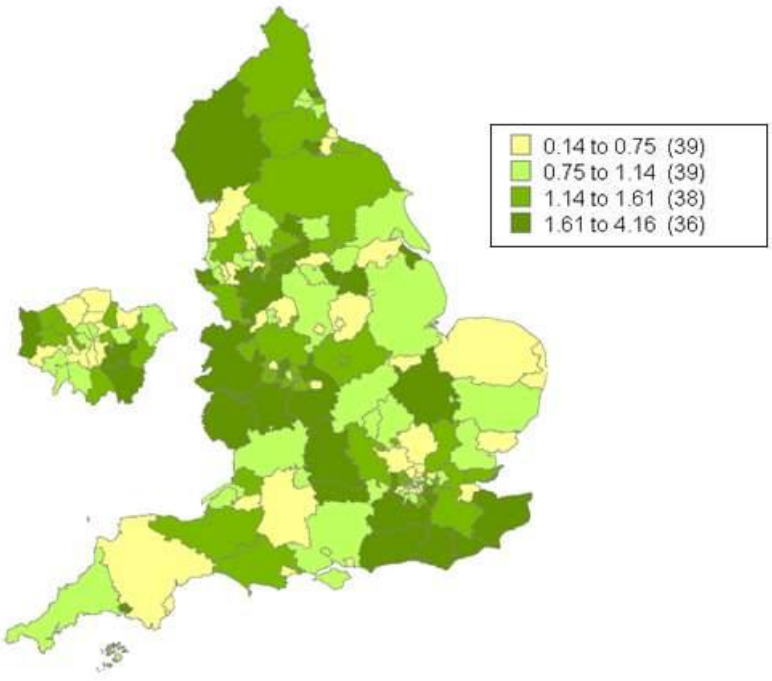


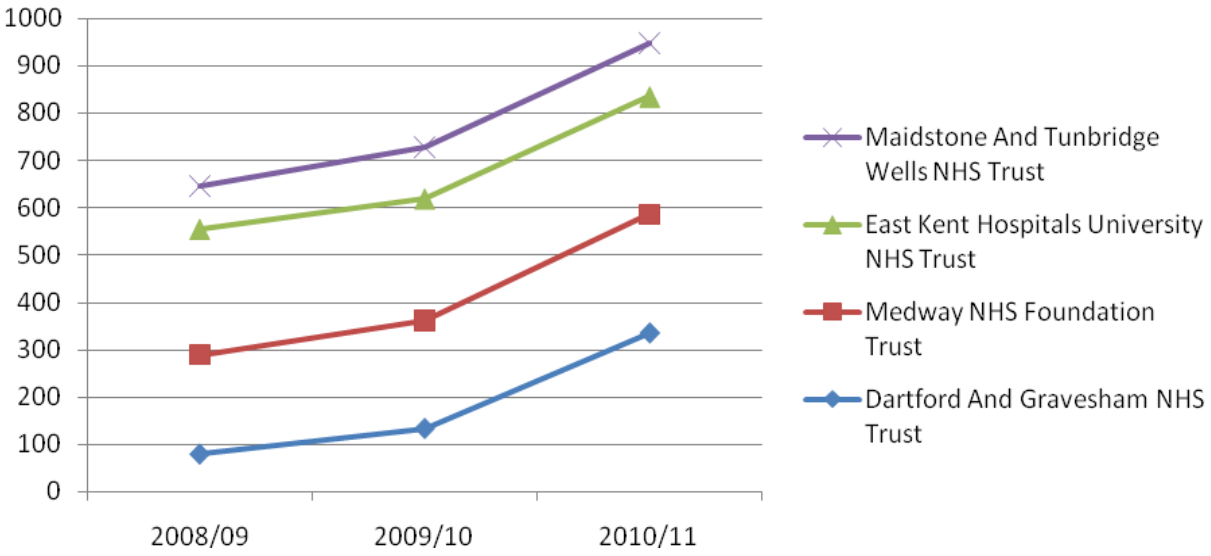
Figure 9 demonstrates that there is also scope to reduce the proportion of people aged 65 and over who are discharged directly from hospital to residential care, rather than supported to return to their own home. Kent has amongst the highest proportion of older people discharged directly to residential care – over 2.5% in Eastern and Coastal Kent PCT compared to 1.1% across the country.

Figure 9: Proportion of 65+ emergency patients discharged directly from hospital to residential care, 2009/10[11]



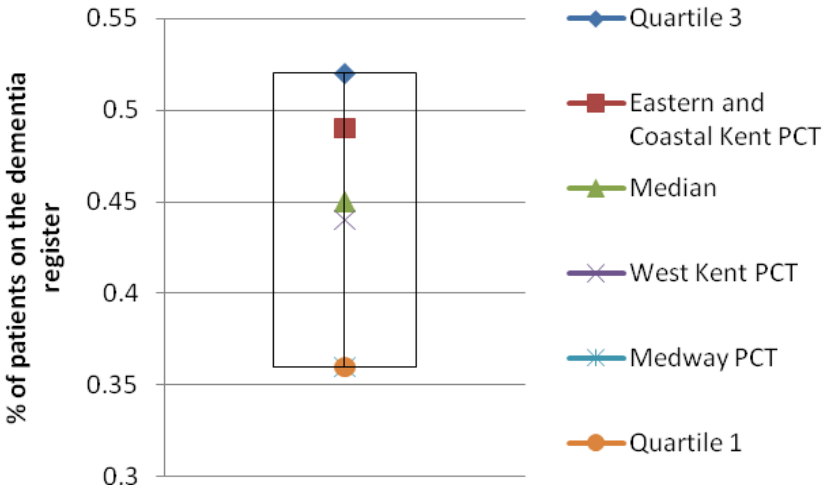
The challenge in supporting older people will only become more significant. As with many health economies, the burden of dementia in Kent is growing. Figure 10 shows that, across major hospital providers in Kent, there has been a steady increase in the number of people with dementia admitted to care.

Figure 10: Trends in admissions, dementia[12]



However, the burden of dementia across the county is not uniform. As Figure 11 demonstrates, Medway PCT and West Kent PCT have a below average percentage of patients on the dementia register, while the rate in Eastern and Coastal Kent is well above the average.

Figure 11: Percentage of patients on the dementia register[13]

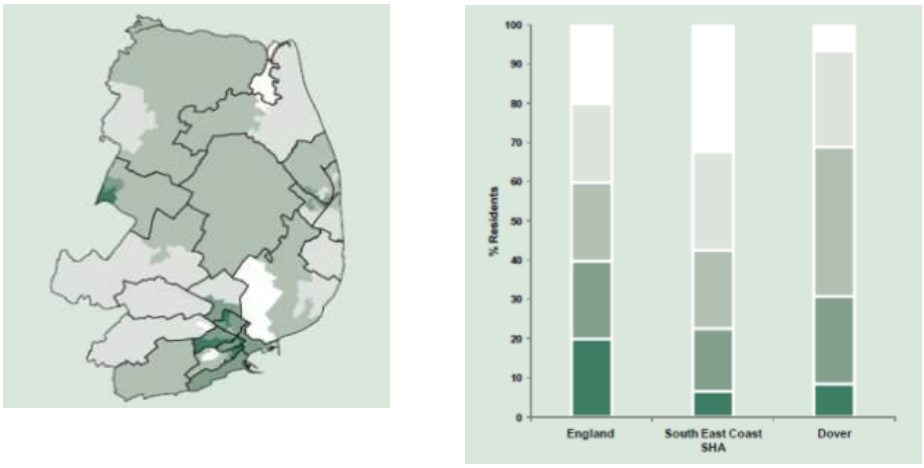


There is also evidence that not everyone is receiving the care they should. For example, official figures suggest that nearly 1,500 people on the dementia register in Kent have missed out on a dementia care review[14].

The challenges in Dover

Kent spans a large cross-section of the country – from rural to urban and from deprived to affluent. Dover, a coastal area of Kent, has its own specific challenges and needs, which must be considered in the design and management of the health service. Within Dover the challenges are diverse as well. Many health issues are linked to deprivation and the Indices of Multiple Deprivation reflect the relationship between poverty and ill-health. Figure 12 demonstrates the differences in deprivation within the Dover area. Although levels of deprivation are slightly lower in Dover than they are in England as a whole, there are pockets of extreme deprivation where residents are within the most deprived quintile in the country. The darkest coloured areas on the map are some of the most deprived areas in England.

Figure 12: Indices of Multiple Deprivation 2010[15]



The health of the population in Dover is also mixed. As demonstrated in

Figure 13**,** there are health indicators on which Dover is achieving better than the national average (such as deprivation, physically active children and proportion of children in poverty). However, there are also indicators where performance is significantly below average (such as smoking in pregnancy, obese adults, people diagnosed with diabetes and male life expectancy).

There are also indicators on which performance could be improved, in order to deliver better health outcomes. On age standardised early deaths from cancer, heart disease and stroke, Dover is slightly below the average, with the rate per 100,000 being nearly double that of the best performer in the country on early deaths from cancer, and 50% higher than the best in England for early deaths from heart disease and stroke. The same is the case for the number of hip fractures among those aged 65 and over; while Dover is achieving better than average rates there is still a gap between the best in England and that in Dover.

Figure 13: Key health and deprivation indicators in Dover[16]

	Dover Value	England Average	England Worst	England Best	England range
Deprivation	8.5	19.9	89.2	0.0	
Proportion of children in poverty	18.9	20.9	57.0	5.7	
Smoking in pregnancy	20.0	14.0	31.4	4.5	
Physically active children	63.9	55.1	26.7	80.3	
Teenage pregnancy	36.4	40.2	69.4	14.6	
Obese adults	26.8	24.2	30.7	13.9	
People diagnosed with diabetes	5.95	5.40	7.87	3.28	
Hip fractures in over 65s	399.4	457.6	631.3	310.9	
Life expectancy - male	77.4	78.3	73.7	84.4	
Life expectancy - female	82.4	82.3	79.1	89.0	
Early deaths: cancer	75.4	70.5	122.1	37.9	
Early deaths: heart disease & stroke	115.5	112.1	159.1	76.1	

Annex 5 – Extract from "Fixing a Broken System", South East England Councils, June 2012

"Fixing a Broken System" is the result of extensive research into levels of funding provided to the 74 local authorities in the South East of England under the existing local government funding system.

While primarily about local government funding, the transfer of public health responsibilities to local councils also offered a timely opportunity to review health funding as part of the major health reforms which will see establishment of GP-led Clinical Commissioning Groups, greater joint commissioning with social care and a desired shift of activity and resource from acute care to preventative services & community health.

An extract from the report is reproduced below.

3. 2 Health funding – South East needs a fairer deal

3.2.1 SEEC members also believe there are significant disparities in funding for health provision, with the South East Primary Care Trusts (PCTs) once again receiving some of the lowest levels of funding per capita in the country due to an opaque and complex system that has little logic and is almost impossible to follow. We are concerned that these inequities have exacerbated the unfairness in the new funding regime for public health responsibilities being transferred to local authorities in 2013 (see table 5) as well as impacting on the delivery of health service provision.

3.2.2 Table 4 below uses data from the Department for Health Annual Report to show the significant disparities in resources. The South East has the lowest per capita spending on health and has seen the lowest percentage increase in spending since 2006-07. This means investment in the health of South East residents is trailing behind spending in other areas and making it almost impossible for PCTs to deliver good quality health provision, particularly in mental health. If, for example, we were to apply the average per capita funding for England to Kent this would equate to an additional £286m per annum. If Kent had the same per capita funding as London this would equate to an additional £726m per annum!

Table 4: Per capita health funding and percentage increases 2006-07 to 2010-11

	2006-07 £ per Head	2010-11 £ per Head	Change
North East	1,619	2,113	30.5%
North West	1,594	2,055	28.9%
Yorkshire and The Humber	1,478	1,907	29.0%
East Midlands	1,329	1,733	30.4%
West Midlands	1,476	1,894	28.3%
East	1,311	1,708	30.3%
London	**1,626**	**2,200**	**35.3%**
South East	**1,337**	**1,687**	**26.2%**
South West	1,351	1,741	28.9%
England	1,456	1,889	29.7%

3.2.3 The analysis in table 4 disguises wide disparity of funding per head between individual PCTs. PCTs in the South East receive among the lowest recurrent funding per head, for example West Berkshire receives £1,300 per capita and Oxfordshire £1,374. At the other extreme London and metropolitan authorities receive the highest funding – for example Islington receives £2,268, Hammersmith & Fulham £2,086, Liverpool £2,098 South Tyneside £1,932.

3.2.4 We recognise that there are some health inequalities and that inner city areas can have greater health needs but, as with local government funding, we are concerned that the additional money invested in health over the past decade has been disproportionately targeted to London and metropolitan areas due to bias in the formula. Does social deprivation and lower life expectancy justify the significant differences in health spending?

3.2.5 There seems to be a reluctance to move resources from one area to another, fearing that funding freezes or reductions could cause more harm than good. However, delaying review simply means preserving existing inequities and cannot be justified. Through the health reform agenda, including disestablishment of PCTs and establishment of Clinical Commissioning Groups (CCGs), now is the perfect time to review the distribution of funding. The Government has proposed an independent NHS Commissioning Board, which we very much support. We propose this body should be responsible for agreeing a more equitable allocation of resources to CCGs and then to local GP consortia and for delivering this change in a meaningful period.

3.2.6 We are concerned that there are no such proposals for an independent body to oversee the allocation of public health funding to local authorities and that significant historical discrepancies in funding will persist. Table 5 below shows the wide disparity in the funding per capita proposed to be transferred to local authorities for public health functions. We contend that the wide disparities are symptomatic of the inequity in resource allocations to PCTs and not a true reflection of need. We urge Ministers to review the methodology for allocating public health resources to ensure a more equitable distribution. We are also keen to see service commissioners retain the freedom to shift spending from primary care to

prevention where they are able to make the case that such spending would be more beneficial, efficient and effective.

Table 5: Public health (PH) spend variations in the South East

	Total PCT Budget £000s	PCT Public Health Budget £000s	Public Health as % of Total spend	Public Health £s per Head	Public Health share to Local Authorities £000s	Public Health share to Commssioning Board £000s
Berkshire West	633,631	25,082	4.0%	25	12,005	12,998
Bracknell Forest/ Slough/Windsor & Maidenhead	574,182	19,073	3.3%	21	8,541	10,422
Brighton and Hove	468,341	19,777	4.2%	47	12,174	7,569
Buckinghamshire	699,972	21,039	3.0%	15	7,793	13,169
East Sussex	898,832	37,225	4.1%	39	20,302	16,899
Hampshire	1,881,715	61,695	3.3%	21	26,829	34,682
Isle of Wight	241,666	8,896	3.7%	33	4,610	4,195
Kent	2,239,753	76,965	3.4%	24	34,668	42,259
Medway	421,543	20,325	4.8%	38	9,882	10,229
Milton Keynes	359,521	14,314	4.0%	23	5,585	8,610
Oxfordshire	925,403	39,504	4.3%	31	19,468	19,901
Portsmouth	345,746	20,246	5.9%	68	14,123	6,077
Southampton	400,662	20,196	5.0%	50	12,073	8,010
Surrey	1,640,256	58,145	3.5%	17	18,524	39,453
West Sussex	1,287,283	47,343	3.7%	28	22,131	24,979
Tower Hamlets (for comparison as highest spending authority).	**519,868**	**36,915**	**7.1%**	**117**	**27,756**	**9,060**

3.2.7 If we carry forward these historic funding disparities it risks a postcode lottery on health. It could also undermine the expected benefits of the new CCGs and Health & Wellbeing Boards and their aim of delivering a better integrated approach to health for all our residents.

References

[1] Trends in life expectancy by the National Statistics Socio-economic Classification 1982–2006

[2] House of Commons, NHS Expenditure - Commons Library Standard Note, September 2011

[3] London Health Observatory, Number of GPs per 100,000 population, by PCT, September 2010

[4] PQ HL13081 Table - Primary Care Trust Expenditure 2009-10 to 2010-11 and 2011-12 revenue allocation

[5] Adult Social Care-Combined Activity Return (ASC-CAR)

[6] London Health Observatory, Older people aged 65 or over helped to live at home (per 1,000 65s or over)

[7] The NHS Information Centre for health and social care, Hospital Episode Statistics NCHOD FY vFeb 2011 and National Statistics, February 2011

[8] The NHS Information Centre for health and social care, Compendium of Clinical and Health Indicators, June 2011

[9] The NHS Information Centre for health and social care, Hospital Episode Statistics NCHOD FY vFeb 2011 and National Statistics, February 2011

[10] The NHS Information Centre for health and social care, Compendium of Clinical and Health Indicators, June 2011

[11] Audit Commission, *Joining up health and social care, Improving value for money across the interface*, December 2011

[12] The NHS Information Centre for health and social care, Compendium of Clinical and Health Indicators, June 2011

[13] The NHS Information Centre for health and social care, Compendium of Clinical and Health Indicators, June 2011

[14] The NHS Information Centre for health and social care, Compendium of Clinical and Health Indicators, June 2011

[15] Health Profile Dover 2011, Association of Public Health Observatories

[16] Health Profile Dover 2011, Association of Public Health Observatories

Deprivation: % of people in this area living in 20% most deprived areas in England 2007

Proportion of children in poverty % children in families receiving means-tested benefits & low income 2008

Smoking in pregnancy: % of mothers smoking in pregnancy where status is known 2009/10

Physically active children: % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10

Teenage pregnancy: Under-18 conception rate per 1,000 females aged 15-17(crude rate) 2007-2009 (provisional)

Obese adults: % adults, modelled estimate using Health Survey for England 2006-2008 (revised)

People diagnosed with diabetes: % of people on GP registers with a recorded diagnosis of diabetes 2009/10

Hip fractures in over 65s: Directly age and sex standardised rate for emergency admission 65+, 2009/10

Life expectancy – male: At birth, 2007-2009

Life expectancy – female: At birth, 2007-2009

Early deaths: heart disease and stroke: Directly age standardised rate per 100,000 population under 75, 2007-2009

Early deaths: cancer: Directly age standardised rate per 100,000 population under 75, 2007-2009