AGENDA

HEALTH AND WELLBEING BOARD (SHADOW)

Wednesday, 30th May, 2012, at 6.30 pm
Pendragon Room, Invicta House, Maidstone
ME14 1XQ

Ask for: **Peter Sass**
Telephone: **(01622) 694002**

Tea/Coffee will be available 15 minutes before the meeting.

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

1.	Chairman's Welcome	6:30-6:45 pm
2.	Substitutes	
	Part One	
3.	Declaration of Interests by Members in Items on the Agenda for this meeting	
4.	Minutes of the Meeting held on 21 March 2012 (Pages 1 - 30)	
5.	Terms of Reference for the Shadow Health and Wellbeing Board - For noting and endorsement (Pages 31 - 36)	
6.	Health and Wellbeing Strategy: Chairman's update	
	Part Two	
7.	Dementia: Improving the lives of people living with dementia (Integrated care pathway, LINk's view and next steps) (Pages 37 - 92)	6:45-7:30 pm
8.	Workshop on Adult Social Care Transformation Plan	7:30-8:30 pm

Peter Sass
Head of Democratic Services
Tuesday, 22 May 2012

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

Delegates

Dr John Allingham	Clinical Lead, Shepway Locality, South Kent CCG
Dr Fiona Armstrong	Joint Clinical Lead, Swale CCG
Dr Bob Bowes	Chair West Kent & Weald CCG
Cllr Andrew Bowles	represented by
Cllr Lesley Ingham	Member, Housing, Health and Wellbeing, Swale BCl
Cllr Paul Carter	Leader of Kent County Council
Dr Sourja Chaudhuri	Clinical Lead, Dover Locality, South Kent CCG
Cllr John Cunningham	Tunbridge Wells Borough Council
Caroline Davis	Strategic Policy Advisor (Health & Wellbeing), KCC
Michelle Farrow	Leadership Support Manager, Dover DC
Cllr Graham Gibbens	Cabinet Member for Adult Social Care and Public Health, KCC
Cllr Roger Gough	Cabinet Member for Business Strategy, Performance & Health Reform, KCC
Andrew Ireland	Corporate Director Families and Social Care
Dr Mark Jones	Chair & Clinical Lead C4 Canterbury CCG
Roger Kendall	Kent LINk
Dr Chee Mah	Clinical Lead, Deal Locality, South Kent CCG
Dr Tony Martin	Chair & Clinical Lead, Thanet CCG
Dr John Neden	Chair & Clinical Lead, East Cliff Commissioning Practice
Meradin Peachey	Director of Public Health
Dr Roger Pinnock	Chair, Ashford CCG
Dr John Ribchester	Chair & Clinical Lead, Whitstable CCG
Dr Garry Singh	Clinical Lead, Maidstone & Malling CCG
Ann Sutton	Chief Executive, Kent & Medway Cluster
Cllr Paul Watkins	Leader, Dover DC
Cllr Jenny Whittle	Cabinet Member for Specialist Children's services, KCC
David Woodhead	Clinical Lead, Gravesham & Swanley CCG

Invited Observer

Colin Tomson	Chair, Kent & Medway Cluster

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD (SHADOW)

MINUTES of a meeting of the Health and Wellbeing Board (Shadow) held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 21 March 2012.

PRESENT: Mr R W Gough (Chairman), Dr B Bowes, Dr M Cantor, Mr P B Carter, Dr S Chaudhuri, Mr A D Crowther (Substitute for Mr A Bowles), Mr G K Gibbens, Mr R Kendall, Cllr M Lyons, Mr K Smith (Substitute for Cllr P Watkins), Ms A Sutton, Mr C Tomson, Mrs J Whittle, Dr D Woodhead and Cllr M Worrall

IN ATTENDANCE: Mr A Ireland (Corporate Director, Families and Social Care), Ms M Peachey (Kent Director Of Public Health) and Mr P D Wickenden (Democratic Services Transition Manager)

UNRESTRICTED ITEMS

30. Welcome
(Item 1)

The Chairman, Roger Gough, Cabinet Member for Business Strategy, Performance and Health Reform (KCC), welcomed everyone to the meeting of the Shadow Health and Wellbeing Board.

31. Substitutes
(Item 2)

The following apologies were received and noted:

Dr Fiona Armstrong, Joint Clinical Lead, Swale CCG – substituted by Dr F M Cantor
Dr Roger Pinnock, Chair, Ashford CCG
Mrs Michelle Farrow, Leadership Support Manager, Dover District Council
Councillor John Cunningham, Tunbridge Wells Borough Council
Councillor Leslie Ingam, Member, Housing, Health and Wellbeing, Swale BCI
Councillor Paul Watkins, Leader, Dover District Council – substituted by Councillor Kit Smith

32. Declaration of Interests by Members in Items on the Agenda for this meeting
(Item 3)

Dr B Bowes declared an interest as his wife works in a Children's Centre which was the subject of discussion at Item 9 on the Board's agenda.

33. Previous Minutes/Action Points - 18 January 2012
(Item 4)

The Board agreed that Minutes of the meeting held on 18 January 2012 were a correct record and that they be signed by the Chairman.

34. Chairman's remarks - the Board's work programme (Oral report)
(Item 5)

(1) The Chairman informed the Board that at the current time there were many unknowns in the development of the Health and Wellbeing Board. These included:-

- Money
- Supply Side
- Patient experience and engagement
- Integration
- Our existing plans, strategies and frameworks

(2) To take the work of the Board forward the Chairman suggested that the Board might wish to consider holding a workshop to look at the following important issues:-

(a) NHS Operating Plan;
(b) Children's Services Improvement Plan; and
(c) Social Care Transformation Plan

(3) The purpose of the proposed workshop would be to look at the interrelationship between these three Plans which would help to inform the Health and Wellbeing Strategy which is being developed.

(4) The suggested timelines were as follows:

Spring-Summer

- A range of meetings to share the understanding of key issues

Summer

- Clinical Commissioning Group authorisation
- Building engagement capacity for Health and Wellbeing Strategy
- Shadow benchmarking of Plans against Health and Wellbeing Strategy

Autumn

Cycle of:-

- Strengthened Joint Strategic Needs Assessment, Health and Wellbeing Strategy
- Public engagement
- New commissioning plans
- Working as a team

(5) Mr Ireland suggested that in addition to the three Plans referred to in sub-paragraph (2) above the Board may wish to consider expanding the issues to include the Children's Centres.

(6) RESOLVED: that the report be noted.

35. Joint Strategic Needs Assessment (JSNA)
(Item 6)

(1) Further to Minute 27 the Shadow Health and Wellbeing Board had before them the latest version of the Joint Strategic Needs Assessment (JSNA).

(2) Mr Gibbens informed the Board that the consultation would be concluded at the end of March 2012. During the debate the following comments were made:

- GP Representatives said that the JSNA has implications for the way in which GPs work. The JSNA needs to reflect more appropriately what is happening on the ground and related to GP practices. Specific reference was made to public health and moving this more to the GP suite. This was acknowledged by the Board as a real challenge between the strategic requirements of a JSNA and what happens at a practice level.
- With regard to Community Engagement the JSNA is a process which should be used as a working tool for dialogue and engagement.
- Citizen and service user engagement is key to ensuring what the NHS and the County Council is putting in place to inform their decisions on service delivery.
- An audit of all the citizen and service user engagements would be completed by early April for inclusion in the JSNA,
- The establishment of a local Healthwatch and the emerging Locality Boards will have key roles moving forward.

36. Health and Wellbeing Strategy: Progress to date and the way forward (Presentation)
(Item 7)

(1) Further to Minute 25 the Chairman informed the Board of the ongoing work in developing the Health and Wellbeing Strategy. It was important to build on the priorities identified by the Board. Consultation with other key partners was key moving forward, it was important to recognise and understand all the opportunities. The Shadow Board acknowledged that it was important that the Strategy had 'real people issues' – not expressed in an operational way but as a 'service user'/'patient'.

(2) The Board acknowledged that the Strategy needed to reflect both the strategic and District needs in what the Strategy was seeking to achieve.

(3) The Strategy would be important in terms of a two way dialogue, e.g. Clinical Commissioning Groups and the Commissioning Plans.

37. Strategic Overview of NHS and Social Care Finance (Presentation)
(Item 8)

(1) The Shadow Health and Wellbeing Board received a presentation by Mr R Smith, Director of Financial Planning and Strategy NHS Kent and Medway PCT, giving an overview of NHS and Social Care Finance. A copy of the presentation is attached as an appendix to these Minutes.

(2) RESOLVED: that Mr Smith be thanked for an excellent, detailed presentation.

38. The Principles and Health & Wellbeing Outcomes of Children's Centres
(Item 9)

(Helen Jones, Head of Commissioning, Families and Social Care, Kent County Council and Linda Denne, Service Commissioning Manager, Consulting Service, NHS Kent and Medway were in attendance for this item)

(1) The Shadow Health and Wellbeing Board had a very comprehensive report which set out for the Board how Children's Centres across Kent had developed and how health services were currently being delivered in these Centres.

(2) The Board acknowledged that there is a variance in current links between Children's Centres and health professionals across Kent, and, in particular, the links between General Practice and Children's Centres.

(3) The Kent Children's Centres outcomes Framework for commissioned services provides an overview of strategic outcomes to guide and support commissioners in developing services within Children's Centres in Kent. This Framework aims to deliver the revised core purpose for Children's Centres which enables and guides services to be targeted at those most in need whilst maintaining availability to all.

(4) The Board noted that Children's Centres contribute significantly to the Public Health Outcomes Framework.

(5) The Health Visitor Implementation Plan 2011-2015 – A Call to Action published in February 2011 sets out the coalition Governments vision to increase the number of Health visitors nationally by 4,200. The Board noted that Kent and Medway have the highest target, 420 new Health Visitors.

(6) The Shadow Health and Wellbeing Board were invited to discuss how the review of the delivery of Children's Centres may further develop joint working and improve outcomes including:

- Should the age range be extended to have a more family focus whilst not diluting the core purpose for 0-5 year olds?
- Could some Children's Centres have specialisms?
- Could more targeted and specialist services be delivered in those areas with the most vulnerable families?

(7) The Shadow Health and Wellbeing Board acknowledged the central role Children's Centres can play in multi agency working to achieve the National Implementation Plan.

(8) Reference was made to the way good work is already taking place in parts of the County to align some health services to Children's Centres.

(9) There was a real opportunity to drive this agenda forward together working collaboratively across the agencies. The opportunity to maximise the use of Children's Centres and align some services provided by GPs to provide a more equitable service across the County. The Leader of the Council sought the views of Health colleagues, GPs and Clinical Commissioning Groups on the value of Children's Centres.

(10) The Shadow Health and Wellbeing Board recognised that the Children's Centres could play a significant role for expectant new parents, public health, children's mental health and those mental health services for children in the community.

(11) The Board asked for a map of where the 97 Children's Centres are located across the County and a description of what each Children's Centre provides in the way of services so gaps can be identified.

(12) The Board acknowledged that the Team were confident that they would be able to achieve the target of 420 new Health Visitors for Kent and Medway. One GP representative, whilst supportive of Health Visitors, expressed the view that it is very difficult to measure services and outcomes for the Health Visitor Team.

(13) Commissioning Services through a mix of commissioners and providers will need to be handled with care and streamlined where possible.

(14) It was important to reflect where local pilots, e.g. Dover and Shepway, fitted into the wider vision.

(15) In conclusion the Board noted that responsibility for the provision of Children's Centres rests with the Local Authority. There would be a core offer of services. The challenge is to ensure that there is the right number of Children's Centres in the right place offering a broader but equitable range of services.

39. Dover Health and Wellbeing Board: Progress Report
(Item 10)

(1) The Shadow Health and Wellbeing Board received a short report seeking approval to the Draft Terms of Reference for the Dover District Shadow Health and Wellbeing Board which was to be established as a Sub-Committee of this Board.

(2) RESOLVED that:

(a) the Terms of Reference for the Dover Shadow Health and Wellbeing Board be approved; and

(b) the development of the Board noted.

40. Date of next meeting - Wednesday 30 May 2012
(Item 12)

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Kent Health and Wellbeing Board

21st March 2012

Strategic Overview Of NHS and Social Care Finance

Rod Smith – Director Of Financial Planning and Strategy

Main Headings

- Annual spending
- Main Financial Drivers
- Medium Term Assumptions?
- Linking Finance with health and outcomes – (a quick Cook's tour)

Annual Spending (2012/13)

- Initial Revenue Limit
  - Kent only, £2.4bn
  - Around £1,720 per weighted person
  - Around £4.70 per person per day

To be delegated to emerging Clinical Commissioning Groups (2012/13)

	£m
• Dartford,Gravesham & Swanley	275
• Swale	123
• Canterbury	245
• Thanet	197
• South East Coast	262
• Ashford	136
• South of West Kent	459
•	1,697

Main Financial Drivers

- Population growth and ageing £15m
- Additional demand £14m
- Tariff/ inflation/efficiency (£15m)
- Quality £15m
- Commissioning Intentions (£41m)
- 1% surplus & 2% Headroom

Medium Term Annual Assumptions?

- NHS may expect small real terms growth >zero and < 0.5%
- Population growth/ageing around 1.5%
- Provider tariff deflator around 0.8%, embedding 4% efficiency and increased quality incentives
- Commissioning Intentions net saving between 0.5% and 1%

Sensitivities

- Relationship between inflation and tariff
  - For 2012/13 2.5% inflation and 4% efficiency assumed resulting in negative 1.5% tariff adjustment.
- Additional demand above level explained by demography.
- Impact of commissioning plans

Expected Impact

- “Smaller/ hotter” acute services
- Services adapting towards community and home settings
- Real time information and risk stratification used to manage patients proactively, with focus on prevention.
- Increased use of innovative technology
- Personalised care, especially long term conditions

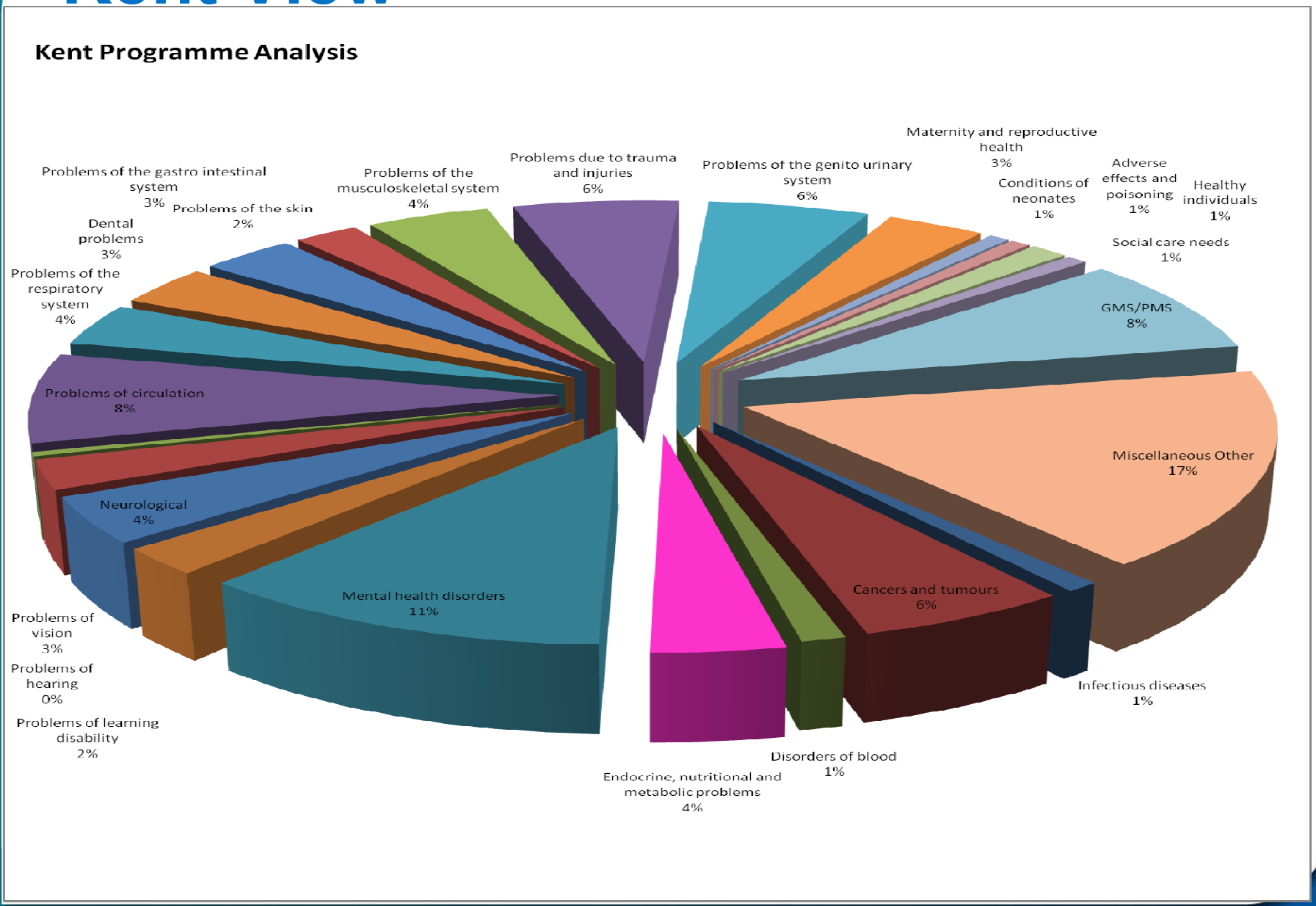
Health and Outcomes…..

Linking £ with health and outcomes

23 Programme Budgeting Categories

1 Infectious Diseases
2 Cancers & Tumours
3 Blood Disorders
4 Endocrine, Nutritional and Metabolic Problems
5 Mental Health Problems
6 Learning Disability Problems
7 Neurological System Problems
8 Eye/Vision Problems
9 Hearing Problems
10 Circulation Problems (CVD)
11 Respiratory System Problems
12 Dental Problems
13 Gastro Intestinal System Problems
14 Skin Problems
15 Musculoskeletal System Problems (excludes Trauma)
16 Trauma & Injuries
17 Genito Urinary System Disorders (except infertility)
18 Maternity & Reproductive Health
19 Neonates
20 Poisoning
21 Healthy Individuals
22 Social Care Needs
23 Other Conditions

Kent View


Kent Programme Analysis
Problems of the gastro intestinal system 3%
Problems of the skin 2%
Problems of the musculoskeletal system 4%
Problems due to trauma and injuries 6%
Problems of the genito urinary system 6%
Maternity and reproductive health 3%
Conditions of neonates 1%
Adverse effects and poisoning 1%
Healthy individuals 1%
Social care needs 1%
GMS/PMS 8%
Miscellaneous Other 17%
Cancers and tumours 6%
Infectious diseases 1%
Disorders of blood 1%
Endocrine, nutritional and metabolic problems 4%
Mental health disorders 11%
Problems of learning disability 2%
Problems of hearing 0%
Problems of vision 3%
Neurological 4%
Problems of circulation 8%
Problems of the respiratory system 4%
Dental problems 3%

Benchmarking tool

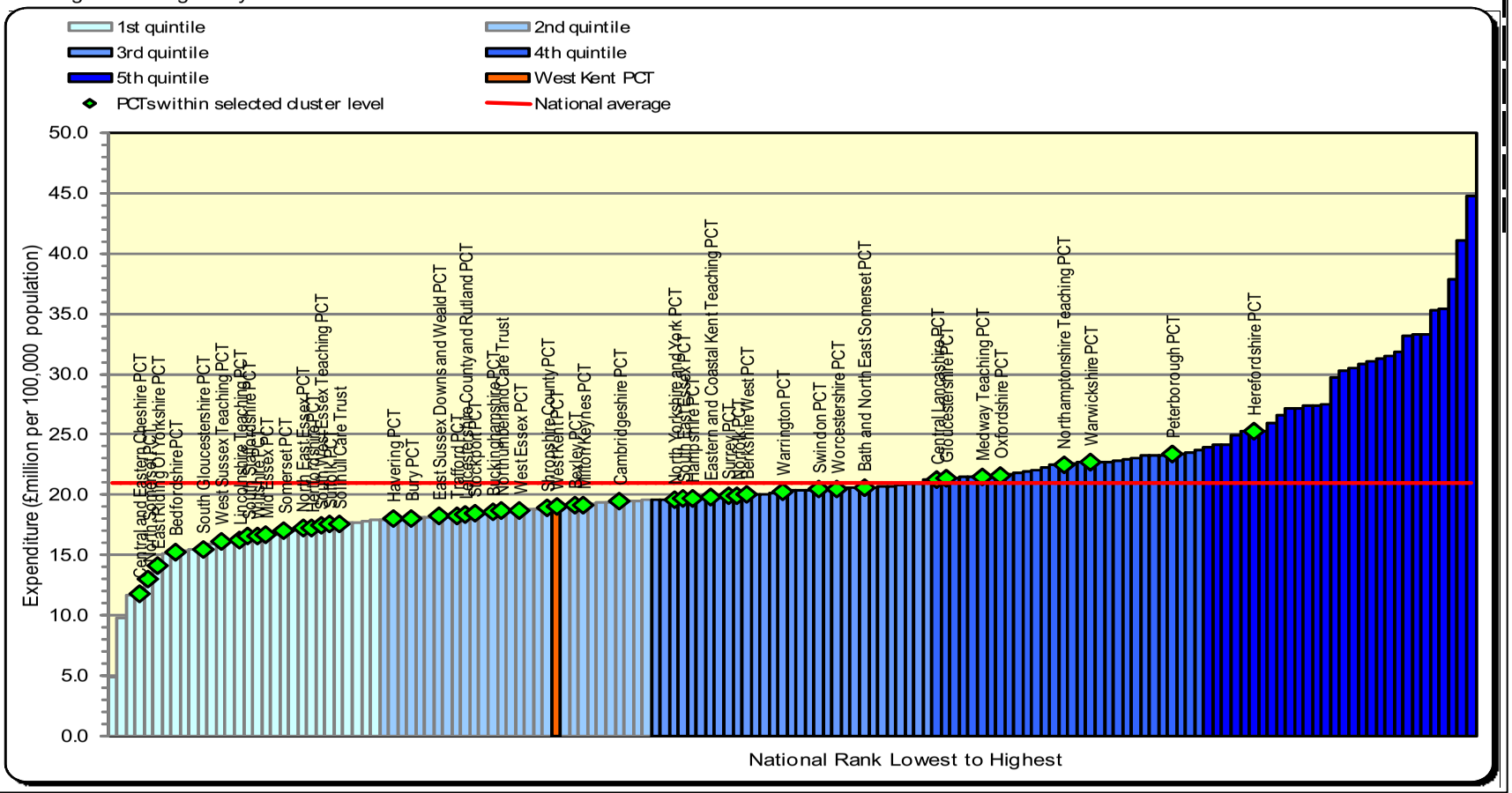
- Start at PCT level
- Select a
  - programme area
  - care setting
  - peer cluster (ONS)
  - weighting (a level of standardisation)
- Example using mental health…

WKPCT 2010/11 Mental Health Expenditure

All PCTs expenditure per 100,000 population

Programme category	05. Mental health disorders	**ONS Cluster level**	1 SUPER (7 groups)
Primary Care Trust	West Kent PCT	**Population weighting**	UNIFIED WEIGHTED POPULATION
Care Setting	14.Total Expenditure	**Benchmark**	National average

Note on interpretation: PCTs with large amounts of expenditure in category 23x for a given care setting may have less expenditure allocated to disease specific categories within that care setting. To aid comparison of expenditure on disease specific categories and within care settings the 'All commissioner chart with 23x' sheet shows the same information as the chart below with additional information on the amount of expenditure in 23x for the chosen care setting on the negative y axis.



What has happened over time?

- Compare since 2006/07

Select commissioner: Q37 West Kent PCT (5P9)

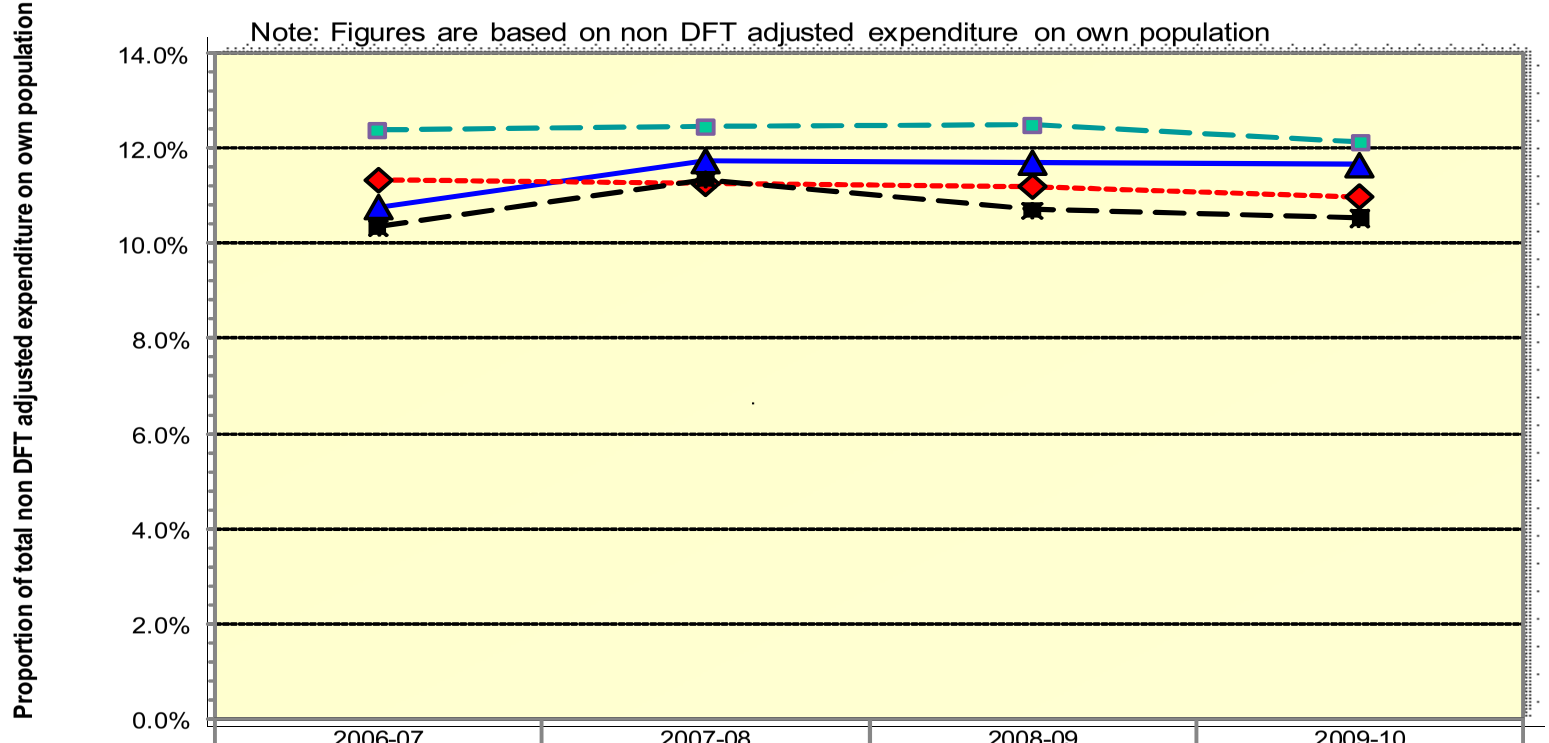
Select programme: 05. Mental health disorders

Select cluster level: 1 SUPER (7 groups)

Cluster description: Prospering UK

Programme spend on own population as a percentage of total spend compared to cluster, SHA and national averages

Note: Figures are based on non DFT adjusted expenditure on own population



	2006-07	2007-08	2008-09	2009-10
Selected PCT	10.76%	11.73%	11.70%	11.64%
Cluster Average	11.33%	11.26%	11.20%	10.99%
Host SHA Average	10.35%	11.34%	10.71%	10.54%
National Average	12.38%	12.45%	12.49%	12.15%

Information at practice level…

- Practice level is the building block for Clinical Commissioning Groups.
- Systems and processes must develop and adapt to produce SMART information at the appropriate level of detail.

WKPCT has a large variation at practice level for reported vs expected prevalence of depression

NHS comparators – depression reported vs Expected Prevalence Aged >=18 – Practice level

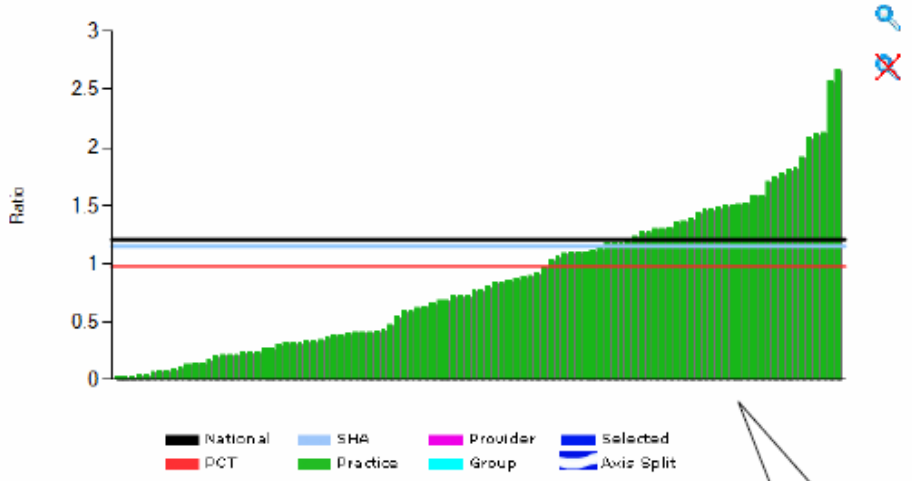
West Kent PCT - Depression Reported vs Expected Prevalence Aged >=18

Period/Year: Rolling Year - 2008/2009; Activity

2007/2008 | 2008/2009

Annual

View | Alerts | Definition | Interpretation



Organisational View

View your organisation at peer group level, above or below:

» National » SHA

Display Other Groupings

View your organisation against a peer group:

◉ Custom ○ Common

Group:

Please select a group...

Graph View Options:

Ranked

Time Series

○ Ratio ○ Expected Count

○ Reported Count ○ Population

Statistics

Type	Org	Ratio	Reported Count >=18	Expected Count >=18	Difference	Population >=18
PCT	5P9	0.98	44,940	45,798	-858	544,386
SHA	Q37	1.15	346,409	300,350	46,059	3,596,013
National		1.21	4,373,974	3,617,391	756,583	42,871,182

Easy to identify high and low spending practices. Can compare practices within groups based on need of population

Spend and Outcomes

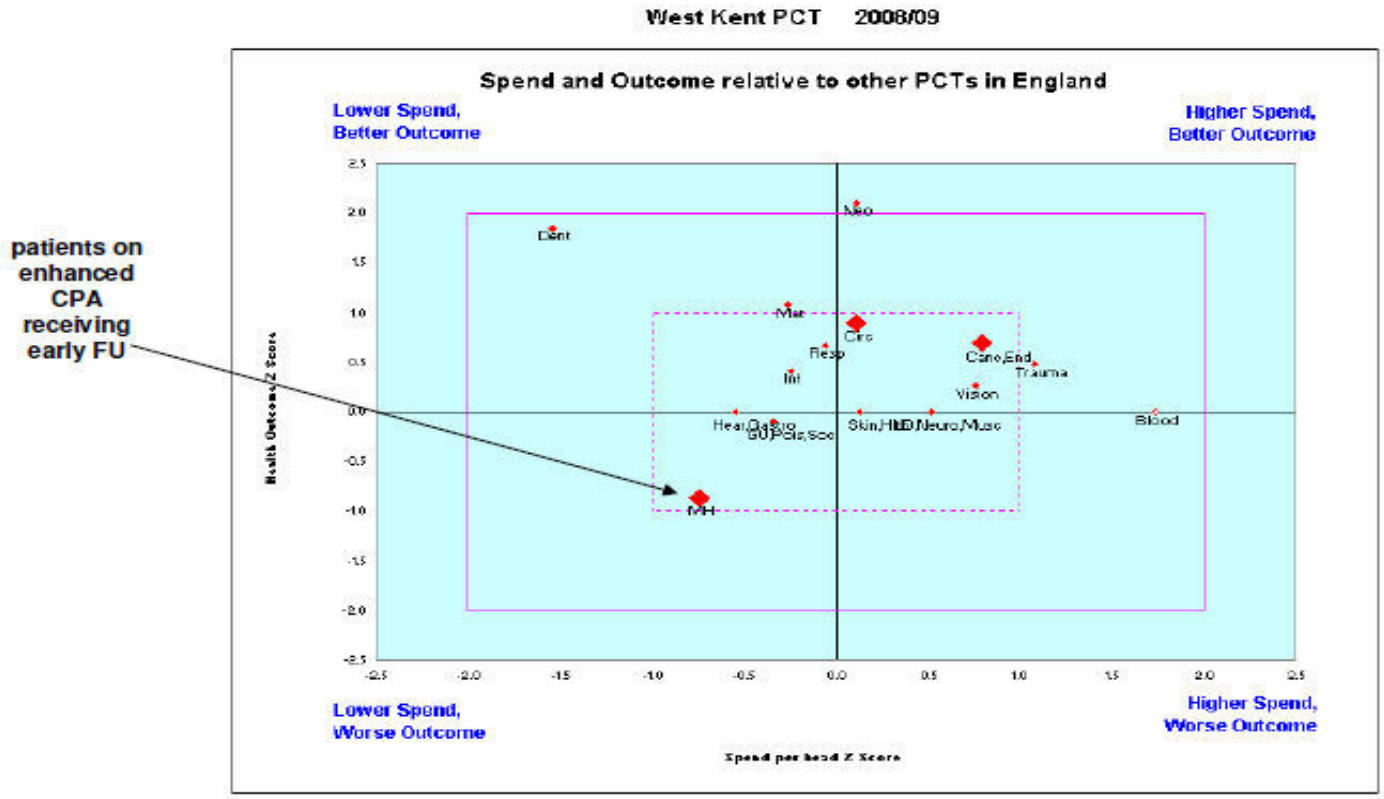
- SPOT (spend and outcomes tool)
- Developed by Association of Public Health Observatories
- Matches spend with available and relevant outcomes for each programme area

WKPCT has a low spend and outcome quadrant for Mental Health disorders when compared to PCTs nationally

Each diamond represents a disease category and shows spend and outcomes compared to PCTS Nationally

2008/2009 APHO Spend and Outcomes Tool – Each diamond represents a disease category and shows spend and outcomes compared to the national average

West Kent PCT has a lower spend and worse outcome for Mental Health disorders when compared to PCTs nationally

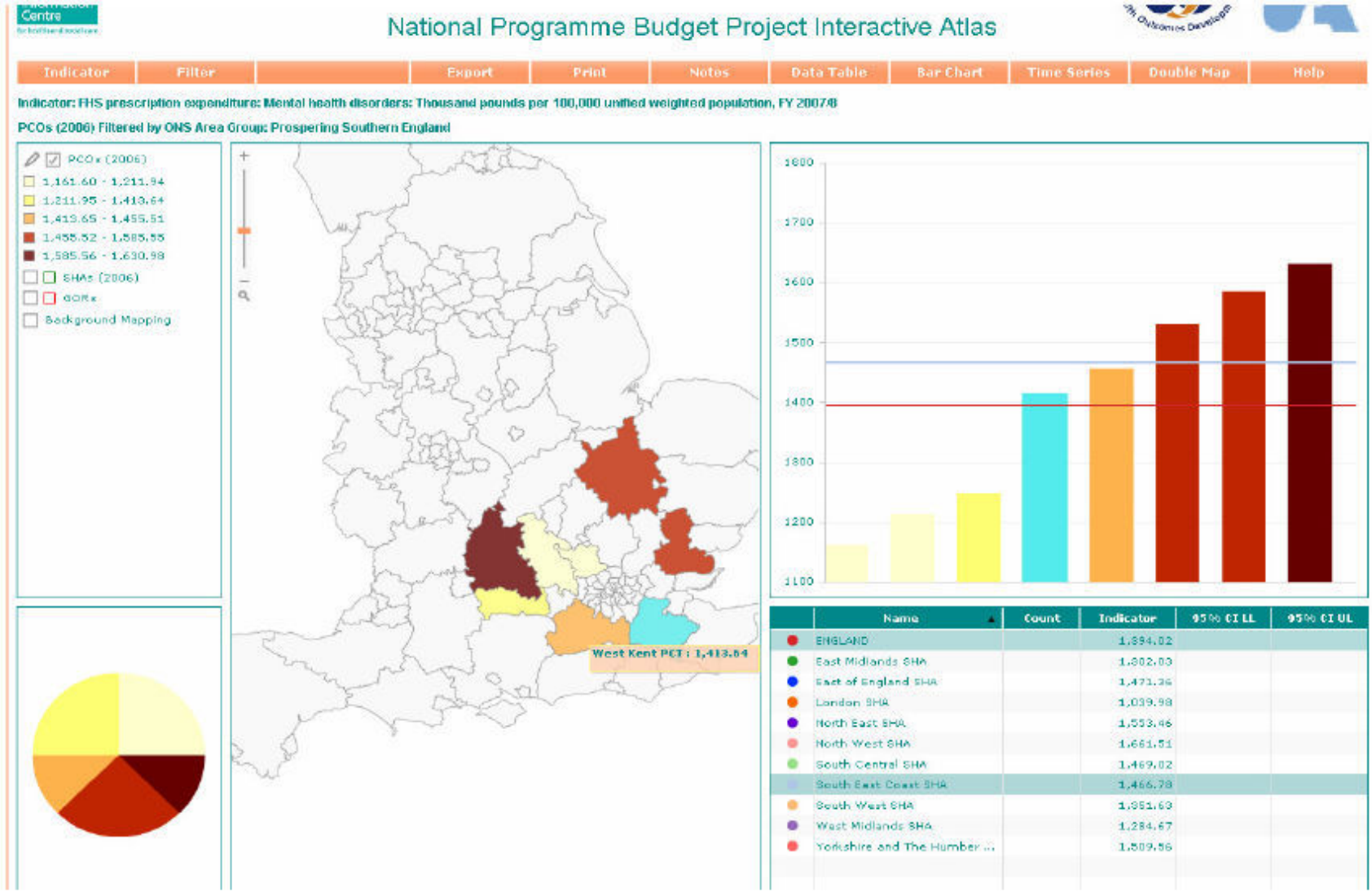


Triangulate using for example Programme Budget Atlas

- Provided on our behalf by the National Centre for Health Outcomes Development, under contract to the NHS Information Centre.
- The Atlas links programme budgeting expenditure data, as presented in the programme budgeting spreadsheet with an array of outcome data.
- By using mapping software, bar charts and correlation plots, the Atlases provides an illuminating and user-friendly way of analysing and presenting data.
- Atlases available via an NHS Net connection from:
  nww.nchod.nhs.uk

WKPCT has an average FHS prescribing expenditure when compared to similar PCTs (Prospering Southern England)

FHS Prescription expenditure : Mental Health. Thousand pounds per 100,000 unified



Where to with programme analysis?

- Department of Health interested in what we have done in Kent.
- Recent two day visit involving GPs, Public Health Directors and Kent County Council.
- Potential to make the approach far more useful.

Thank You

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Appendix A

Kent Shadow Health and Wellbeing Board

Draft Terms of Reference

Role

The shadow Health and Wellbeing Board (HWB) will lead and advise on work to improve the health and wellbeing of the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing,) in order to secure better health and wellbeing outcomes in Kent and better quality of care for all patients and care users. The HWB has a primary responsibility to make sure that health care services paid for by public monies are provided in a cost-effective manner.

The Shadow HWB also aims to increase the local democratic legitimacy in health and provide a key forum for public accountability for NHS, public health, social care and other commissioned services that relate to people's health and wellbeing.

Terms of Reference:

The HWB will:

1. Commission and endorse the Kent Joint Strategic Needs Assessment (JSNA), subject to final approval by relevant partners, if required.

2. Commission and endorse the Kent Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the JSNA, subject to final approval by relevant partners, if required.

3. Commission and endorse the Kent Pharmaceutical Needs Assessment, subject to final approval by relevant partners, if required.

4. Review the commissioning plans for healthcare, social care (adults and children's services) and public health to ensure that they have due regard to the JSNA and JHWS, and to take appropriate action if they consider that they do not (for instance, by writing formally to the local authority leadership, GP consortium or the NHS Commissioning Board as appropriate, drawing attention to their reservations).

5. Consider the totality of the resources in Kent for health and wellbeing and consider how and where investment in health improvement and prevention services could (overall) improve the health and wellbeing of Kent's residents.

6. Endorse and secure joint arrangements where agreed and appropriate; including the use of pooled budgets for joint commissioning (s75), the development of appropriate partnership agreements for service integration, and the associated financial protocols and monitoring arrangements., making full use of the powers identified in all relevant NHS and local government legislation.

7. Facilitate pathway redesign to improve the patient journey and healthcare outcomes.

8. Consider and advise CQC, NHS Commissioning Board, Monitor and Providers in health and social care with regards to service reconfiguration and make recommendations to those providers to enable improved and integrated service delivery.

9. Provide advice (as and when requested) to the County Council on service reconfigurations that may be subject to referral to the Secretary of State on resolution by the full County Council.

10. Be the focal point for joint working in Kent on the wider determinants of health and wellbeing, such as housing, leisure facilities and accessibility, in order to enhance service integration.

11. Discharge its duty to encourage integrated working with relevant partners within Kent (e.g. at locality level).

12. Develop and implement a Key Deliverables Plan, which will support the HWB early implementer status evaluation report, to be submitted to the Department of Health in May 2012.

13. Will report to the full County Council on an annual basis on its activity and progress against the milestones set out in the Key Deliverables Plan.

14. Develop and implement a Communication and Engagement strategy for the work of the HWB; outlining how the work of the HWB will reflect stakeholders views and how the HWB will discharge its specific consultation and engagement duties. Work closely with LINks/Local HealthWatch.

15. Represent Kent in relation to health and wellbeing issues across localities, nationally and internationally.

16. Subject to prior agreement and meeting the HWB's agreed criteria, the HWB may delegate those of its functions it considers appropriate to another committee established by one or more of the principle councils in Kent to carry out specified functions on its behalf for a specified period of time.

Membership

The Chairman will be elected by the HWB.

1. Kent County Council:

- The Leader of Kent County Council and/or their nominee*
- Cabinet Member for Adult Social Care & Public Health
- Cabinet Member for Business Strategy, Performance and Health Reform
- Cabinet Member for Specialist Children's Services
- Corporate Director for Families and Social Services*
- Director of Public Health*

2. Clinical Commissioning Group: up to a maximum of one representative from each consortium or to be determined by the CCG leads*

3. HealthWatch/Link*

4. Three elected Members representing the Kent District/Borough/City councils (nominated through the Kent Forum)

5. PCT Cluster Chief Executive (until 2013)

6. NHS Commissioning Board*

*denotes statutory member.

Kent Health and Wellbeing Board – Terms of Reference

Standing Orders

1. **Conduct.** Members of the HWB are expected to subscribe to and comply with any code of conduct that applies to them. No code of conduct will have precedence over another.

2. **Frequency of Meetings**. The HWB shall meet at least quarterly. The date, time and venue of meetings shall be fixed in advance by the HWB in order to coincide with the key decision-points and Forward Plan.

3. **Meeting Administration.** HWB meetings shall be advertised and held in public and be administered by the County Council. The HWB will consider matters submitted to it by local partners. The County Council shall give at least five clear working days' notice in writing to each member for every ordinary meeting of the HWB, to include any agenda of the business to be transacted at the meeting. Papers for each HWB meeting will be sent out five clear working days in advance. Late papers will be sent out or tabled only in exceptional circumstances. The HWB shall hold meetings in private session when deemed appropriate in view of the nature of business to be discussed. The Chair's decision on this matter shall be final.

4. **Special Meetings.** The Chair may convene special meetings of the HWB at short notice to consider matters of urgency. The notice convening such meetings shall state the particular business to be transacted and no other business will be transacted at such meeting.

   The Chair will be required to convene a special meeting of the HWB if s/he is in receipt of a written requisition to do so signed by no less than [three] of the [Constituent Members/members] of the HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within seven days of the Chair's receipt of the requisition.

5. **Minutes.** The HWB shall cause minutes of all of its meetings to be prepared recording:

   a) the names of all members present at a meeting and of those in attendance
   b) apologies
   c) details of all proceedings, decisions and resolutions of the meeting.

   These minutes shall be printed and circulated to each member before the next meeting of the HWB when they shall be submitted for the approval of the HWB. When the minutes of the previous meeting have been approved they shall be signed by the Chair.

6. **Agenda.** The agenda for each meeting will normally include:

   a. Minutes of the previous meeting for approval and signing
   b. Reports seeking a decision from the committee

c. Any item which a Member of the Committee wishes included on the agenda, provided it is relevant to the terms of reference of the Committee and notice has been give to the Clerk at least nine working days before the meeting.

The Chairman may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. He must state these reasons at the meeting and the Clerk shall record them in the minutes.

7. **Chair and Vice Chair's Term of Office.** The Chair and Vice Chair's term of office shall terminate on 1 April in each year and they shall each be reappointed or replaced by another member, according to the decision of the HWB, at the first meeting of the HWB succeeding that date.

8. **Absence of Members and of the Chair.** If a member is unable to attend a meeting, then the relevant Constituent Member shall, where possible, provide an appropriate alternate member to attend in his/her place. Where possible, the Clerk of the meeting will be notified of any absence and/or substitution within 5 working days of the meeting. The Chair shall preside at HWB meetings if s/he is present. In her/his absence the Vice-Chair shall preside. If both are absent the HWB shall appoint, from amongst its members Acting Chair for the meeting in question.

9. **Voting.** The HWB will operate on a consensus basis. Where consensus cannot be achieved the subject (or meeting) will be adjourned. The matter will then be reconsidered; if at that point a consensus can still not be reached the matter will be put to a vote. All matters to be decided by the HWB shall be decided by a simple majority of the members present, but in the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chair.

10. **Quorum.** A third of [Constituent Members/members] shall form a quorum for meetings of the HWB. No business requiring a decision shall be transacted at any meeting of the HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chair shall either suspend business until a quorum is re-established or declare the meeting at an end.

11. **Adjournments.** By the decision of the Chair of the HWB, or by the decision of a majority of those present at a meeting of the HWB, meetings of the HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the HWB shall decide.

12. **Order at Meetings.** At all meetings of the HWB it shall be the duty of the Chair to preserve order and to ensure that all members are treated fairly. S/he shall decide all questions of order that may arise.

13. **Suspension/disqualification of Members.** At the discretion of the Chair, any body with a representative on the HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive meetings without good reason or with the prior consent of the Chair or they breach the appropriate code of conduct.

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By: Sue Gratton, Deputy Associate Director, Integrated Commissioning, NHS Kent and Medway
Anne Tidmarsh, Director Older People and Physical Disabilities, KCC

To: Kent Health and Well Being Board May 2012

Subject: Progress Report and Commissioning Plans for Dementia 2012-13

Classification: Unrestricted

1. Recommendations

(1) The Health and Well Being Board is asked to note the progress against the Integrated Commissioning Plan for Dementia (appendix 3) to improve the outcomes for people with dementia and their carers.

(2) The Health and Well Being Board is asked to consider what more can be done to meet the Prime Minister's Challenge in particular the challenge to develop dementia friendly communities across Kent

2. Introduction

(1) Dementia is one of the main long term conditions of later life and it has a huge impact on capacity for independent living. Dementia is estimated to cost over £19 billion per year in the United Kingdom and it is predicted that there will be a doubling of the number of people who have dementia in the UK over the next 30 years.

(2) This report aims to update the Health and Well Being Board on:

- Needs analysis in relation to dementia in Kent – appendix
- Achievements to date
- Gaps identified
- The integrated commissioning plan for dementia – appendix 3

(3) The Prime Minister recently published his Challenge on Dementia, this set down a number of areas for action to make life better for people with dementia and their carers. The Challenge focused on three key areas:

- Driving improvements in health and social care
- Creating dementia friendly communities that know how to help
- Better research.

(4) This report will consider how we are addressing these areas in our commissioning plans but will also seek the views of the Health and Well Being Board to see what more we can do in Kent to meet the Challenge.

(5) Whilst considerable progress has been made in redesigning services in order to re-invest in more universal preventative and early intervention support there remains a significant challenge to ensure that the growing number of people who will develop

dementia over the coming years will be well supported and can continue to enjoy life with their dementia.

(6) The plans are in line with the National Dementia Strategy and also take account of the Kent Select Committee on Dementia.

3. Relevant priority outcomes

(1) It is important for the Health and Social Care economy in Kent that plans continue to focus on prevention and early intervention as the consequence of people with dementia and their carers not being well supported leads to earlier admission to residential care and inappropriate hospital admissions which frequently lead to exacerbation of the condition resulting in earlier reliance on either residential or nursing care home provision. The impact of this cycle of events is not only distressing to families but also greater financial cost to the NHS and Kent County Council.

(2) It is also important that dementia is seen and treated as a long term condition which is managed in primary care with access to good quality universal community services with support from specialist services as needed. An integrated approach to the provision of services is fundamental to the delivery of high quality care to people with dementia. The work that is being led through the Health and Social Care Integration Board will be important to ensure integration between heath and social care but equally important is joined up working with the independent and voluntary sector to ensure integrated care across all providers and all stages of the pathway of care.

4. Financial Implications

(1) Both the NHS in Kent and Kent County Council will need to invest in community support to meet the challenge of the increasing demographic needs. The majority of spend in relation to people with dementia is in bed based services, i.e. residential care for the Local Authority and hospital and NHS continuing care for the NHS, in order to make the necessary investments it will be important to take action which will reduce or delay reliance on bed based services.

(2) An estimate of expenditure is given in appendix 2. Due to the low formal diagnosis rates (currently only 38% of people in Kent expected to have dementia have a formal diagnosis) and the lack of use of diagnosis codes which would identify people with dementia using services it is difficult to say with accuracy the actual current cost of services used by people with dementia in Kent. Furthermore this only represents the cost of dedicated dementia services and not the whole range of mainstream services accessed by people with dementia.

(3) Further work would be required to get a more accurate forecast of costs across the health and social care economy.

(4) The financial implications of not taking action are significant, as noted in the Prime Ministers Challenge. Whether or not we can track the costs accurately at this stage in Kent, we know from national studies that people with dementia are likely to occupy 25% of hospital beds (Counting the Cost, Alzheimer's Society) and that when they are admitted to hospital their condition is likely to be exacerbated and end up on average staying much longer than other patients. Depending on the condition being

treated, people with dementia may stay on average between 14 and 29 days longer. Significant savings could be made by reducing the length of stay in hospital. We also know that people with dementia will account for around 40 % of admissions to care homes. A key focus of our commissioning plans is early diagnosis and intervention with easy access to information, advice and range of community support to avoid inappropriate hospital attendance / admission and delay admission to care homes, thus reducing the financial impact of dementia and ensuring that our financial resources can be released to support people to live well with their dementia.

5. Legal Implications

(1) Key areas of legislation that would be important in this area would be the Equality Act 2010 – ensuring that people who receive services are treated equally, currently there is evidence that some older people and particularly those with dementia do not always get treated with the dignity and respect that they deserve (Care Quality Commission – Dignity and Nutrition Inspection in Older People).

(2) Carer's legislation also places a requirement to ensure that carer's needs are assessed and access to appropriate support is available. The plans that are currently being developed jointly by KCC and the NHS for carers services aim to address these areas.

(3) Under the Mental Capacity Act (MCA) it must not be assumed that people with dementia cannot make decisions without a proper assessment of their capacity, thus it is important that services focus on maintaining independence. Organisations have a requirement to ensure their staff is fully aware of the MCA and can make assessments.

6. Purpose of report

This report aims to update the Health and Well Being Board on:

- Needs analysis in relation to dementia in Kent;
- Achievements to date
- Gaps identified
- The commissioning plan
- Consider areas for further action to meet the Prime Minister's Challenge.

6.1 Strategic Vision

The vision for people with dementia in Kent is *that people with dementia receive timely diagnosis and support that promotes their independence and helps them 'live well' with dementia, and that all services and support are provided to the highest possible standards: promoting dignity, choice and respect.*

6.1.1 Needs analysis of dementia in Kent

(1) An extract from the Joint Strategic Needs Assessment is given at appendix 1. This shows that over the 20 year period from 2006 to 2026 the number of people estimated to have dementia will increase from 17.400 to 30,100, a 73% increase in the number of people with dementia in the population of Kent. The largest increase will be in those people aged over 85 who are also likely to have other long term

conditions. It is expected that the >85 yrs population in Kent with Dementia will rise by more than 100% in 2030, ranging from 70% in Thanet to 140% in Swale.

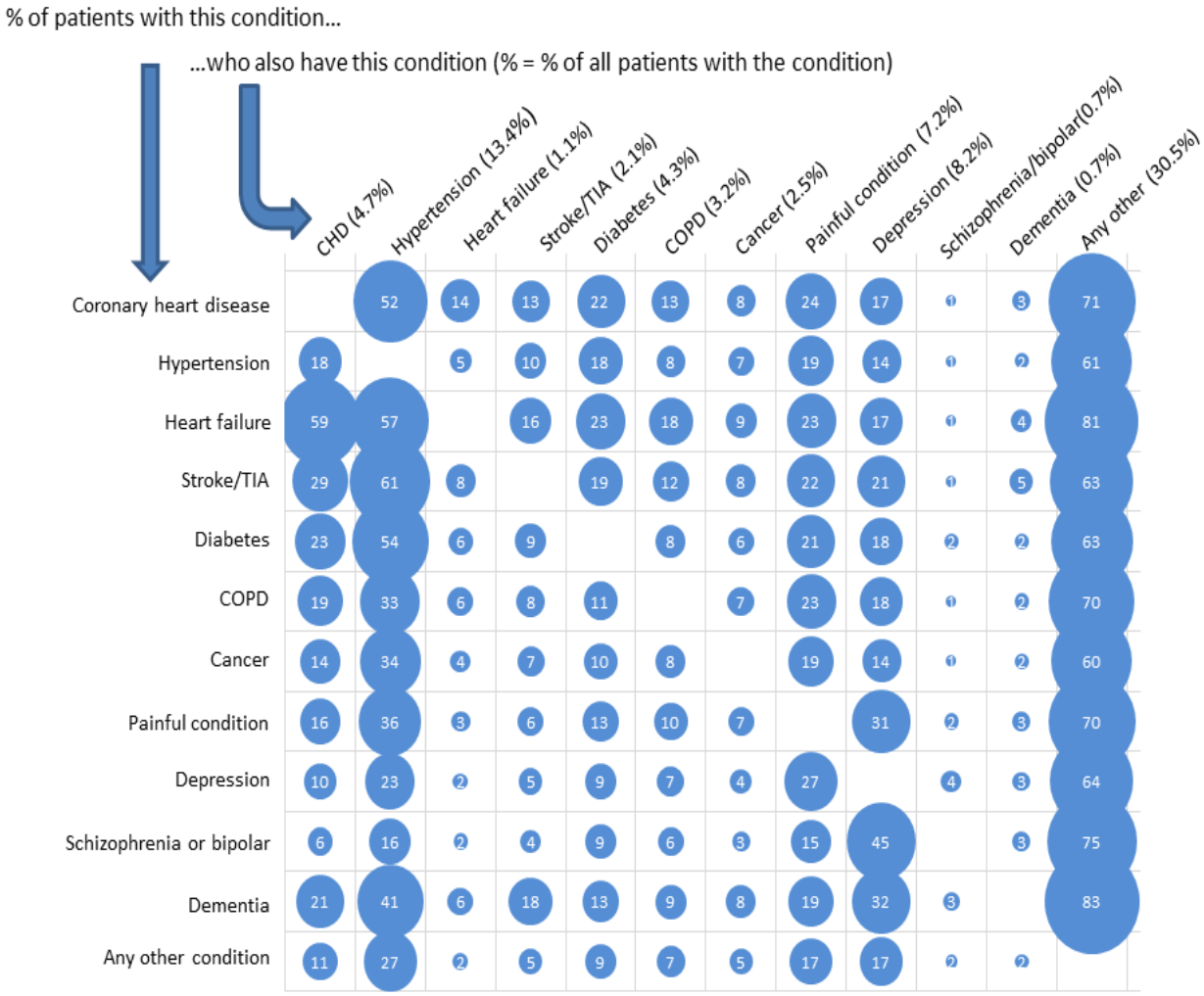
(2) Those districts which will see the largest increases include: Shepway, Swale, Sevenoaks, Tonbridge and Malling and Tunbridge Wells.

6.1.2 Risk stratification to support dementia mapping

(1) The rationale behind developing a methodology for risk stratification which includes patients with Dementia, is to manage long term conditions effectively and improve outcomes for patients.

(2) By managing risk of the most vulnerable people we can then predict who is at risk of emergency admission to hospital and take action to avoid unnecessary and costly secondary care episodes. Traditionally Long Term Conditions (LTC) has not included dementia but there is now a growing body of evidence that is highlighting the need to address co-morbidities rather than just single disease issues.

(3) One of the reasons for this is that the majority of people with LTCs usually have two or more rather than a single condition. For example in a recent Scottish study (Mercer, Guthrie and Wyke, University of Glasgow 2011) it was found that only 5% of people with dementia had only dementia and only 14% of people with diabetes had only diabetes.



(4) There is now overwhelming evidence that people with long term conditions place disproportionate pressure on current health and social care services. People with LTC (around 29% of the population) use 50% of GP appointments; 58% of A&E attendances; 59% of practice nurse appointments; 64% of outpatient appointments; and 70% of inpatient days. (LTC Conference 2012).

(5) Multi-morbidity is becoming the norm, with the majority of over 75's having three or more LTCs. It has also been forecast there will be a 60% increase in people with three or more LTC over the period 2006 – 2016. The expected growth in LTC and in the number of older people in Kent, mean our current system is unsustainable. More positively, better targeted services as a result of risk stratification is associated with improved patient outcomes especially for patients with LTCs that include Dementia. Further, enhanced targeted assessment is associated with improved mortality and physical function after 1 year.

(6) More generally, the potential for financial savings, particularly to health, from an effective LTC strategy combining risk stratification, integrated teams and self management in Kent and Medway would be significant. Thus it is important that dementia is seen and treated as a long term condition.

6.2 Achievements to date

A number of steps have already been taken to set the framework in place for meeting the strategic vision, these are fully documented in appendix 3 in the Integrated Commissioning Plan. Achievements of note include:

Objective	Achievement
To raise public and professional awareness about and reduce stigma associated with dementia in order to encourage people to seek a memory assessment.	Dementia web and 24 hour helpline in place, Web gets approx 5000 visits per month.
To ensure that people with dementia and their carers are well supported in the community and are able to maintain their independence for as long as possible.	Investment in peer support and dementia cafes across the county – now available in every locality.
People feel well supported through a crisis without resorting to unplanned admission to either hospital or care home.	Establishment of crisis support service that will extend across the county. West Kent scheme has supported 260 people in a year. In first year prevented 69 hospital admissions and 92 care home placements. Reduced reliance on acute mental health beds, East Kent beds already reduced from 91 to 61 with further reduction of 16 beds planned. West Kent beds reduced by 57 beds since 2008.

People feel well supported in the community through access to a range of day support and short breaks.	Broadmeadows unit based in Shepway (takes referrals from east Kent). 8 bedded short stay unit and day care (open 7 days a week) helps to maintain people in the community through periods of difficulty and change. In the first 3 months of its operation 20% of the admissions were an alternative to hospital admission and 76% of people returned home.
To ensure that people with dementia who are cared for in care homes receive good quality care and have their privacy and dignity respected.	A range of initiatives have started to support care homes, e.g. training programmes (My Home Life, Dementia Care Mapping) and support around end of life and interventions to reduce hospital admissions.

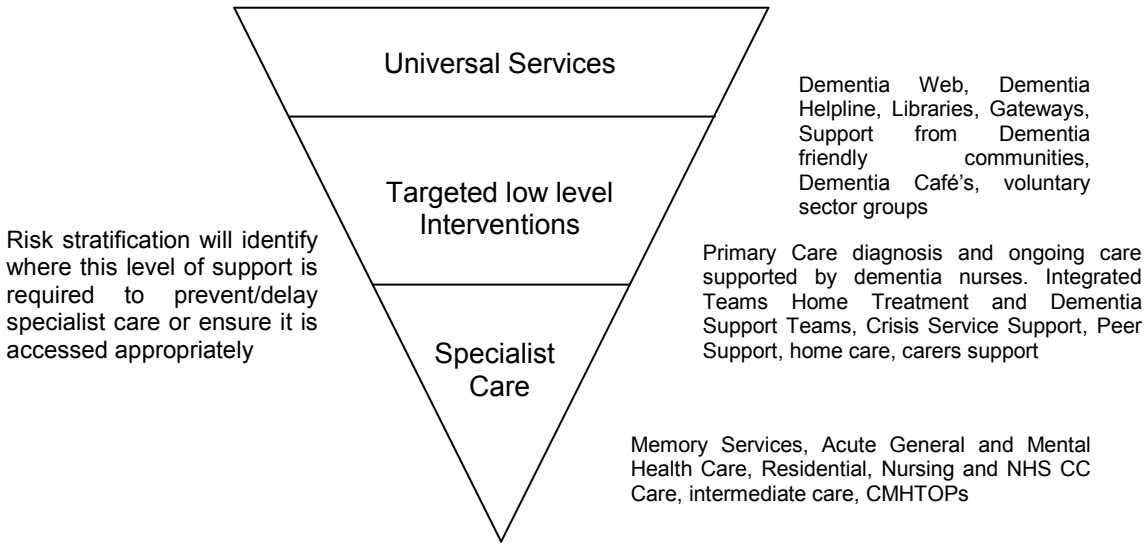
6.3 Pattern of current and future services - shifting the balance from specialist high cost services to universal integrated support

(1) Previously dementia services have been the province of specialist mental health services and whilst these still have an important role to play in sharing their skills and expertise and to provide specialist care for people with acute and complex needs, there is a need to shift the balance to more integrated care in the community close to primary care and care in the home which sees dementia as a long term condition. An integrated approach to the provision of services is fundamental to the delivery of high quality care to people with dementia.

(2) The diagrams in appendix 4 aim to demonstrate the shift that is required and the commissioning plans show the investment that is being made in community support to enable people to feel well supported and to live well with their dementia.

(3) The diagram below shows the alignment of our services to the inversion of the triangle of care described in appendix 4.

The triangle of care



6.4 Action taken to address identified gaps

Various approaches have been taken to gathering the views of people with dementia and their carers about their experiences and views of services:

- Consultations on change of service
- Social Innovation Lab, Kent (SILK) Co-production work
- Care Quality Commission (CQC) Dignity and Nutrition inspection in hospitals
- National Audit of Dementia in hospitals – Royal College of Psychiatrists.

What people want	Gap	Action
Consultations on change have said that people want access to short term breaks and support in a crisis	No crisis service in east Kent Lack of short term breaks	Established a crisis support service in west Kent and plans are in hand to introduce a similar service to east Kent in 2012 Carers workstream to redesign and commission new support arrangements for carers in progress to tender and new pattern in place by 1.4.13. Increasing access to personalised short breaks in partnership with KCC through Carers work.
The SILK work found Some people have reported that their GPs do not understand and that it takes persistency to get referred for diagnosis.	Lack of support for GPs to carry out pre-diagnostic tests in primary care. Current rate of diagnosis is 38% of people expected to have dementia across Kent and Medway.	Working with Kent and Medway Partnership Trust to Clarify the diagnosis pathway under Payment By Results and to shift support to primary care to enable easier access to early diagnosis with aim to increase diagnosis rates to 50% by 2014 and 60% by 2015.
SILK work identified that some people do not feel well supported after their diagnosis	Lack of ongoing support from community groups and access to carers support and guidance	Peer support groups and dementia cafes extended to every locality across Kent from May 2012. Carers education programme to be commissioned by 31.10.12.
The CQC inspection in 2011 found Darenth Valley Hospital in Kent was lacking in the standard of care provided to older people	People with dementia need more support in unfamiliar hospital environments and hospital routines.	Dementia Buddy project being introduced to DVH 01.06.12
All acute Trusts took part in the National Audit of Dementia by the Royal College of	Not all people with dementia identified in hospital and not all their needs being met.	All acute Trusts developed action plans, dementia champions identified, new national dementia CQUIN

Psychiatry which looked at the quality of care and the use of anti-psychotic medication for people with dementia.		(payment for quality and innovation) is being implemented across all Acute and Community Trusts to ensure that all people with dementia identified and referred for diagnosis.
People with dementia stay longer in acute general hospitals, people want good quality care and to be able to move on more quickly.	No shared care wards (i.e. general/OPMH), access to intermediate care limited, need extra support post discharge.	Discussions starting re shared care wards. Intermediate care review will examine barriers to ITC for people with dementia. Dementia Support Service in WK and Active Care Force in EK for post discharge support.
The Prime Minister's Challenge identified the need for dementia friendly communities	How will we identify dementia friendly communities?	Some work in the commissioning plan will contribute to this e.g. work with Libraries. How can the HWB support the development of dementia friendly communities?
A well trained workforce across all health and social care sectors who have the skills and compassion to support people with dementia.	Gaps in the skills of staff are evident across all sectors, especially to support people with complex needs.	Dementia care mapping being extended to care homes, Home Treatment Service in EK being extended to provide guidance to care homes and home care agencies. Dementia awareness programmes started in hospitals.
People want to stay at home for as long as possible and safe to do so.	Use of tele-technology to support people at home.	KCC buying into tele-technology to support people with dementia at home (e.g. Just Checking) but other options as technology advances need to be considered.

6.5 Integrated Commissioning Plan

(1) The plan recognises that dementia requires a multiagency approach to ensure that people have access to a range of treatment, care and support which they need in order to live well with their dementia. Areas of joint working are included in the plan but there will be additional areas e.g. community safety, housing and dementia friendly communities which are not fully covered in the plan.

(2) The Prime Minister's Challenge set out a number of areas where further action is required. This plan includes a range of actions which seek to address these challenges. One such area is the need to increase diagnosis rates, which currently stand at 38% across Kent and Medway, the plan sets out a number of actions which will contribute towards increasing the diagnosis rates, which we are aiming to increase to 50% of prevalence rates by 2014 and 60% by 2015.

(3) The top level objectives in the plan are:

What are we aiming to achieve?	How we will know when it has been achieved.
To ensure that our future plans are robust and take account of the impact of the future increase of dementia on health & social care services and which enable the system to move away from reactive/treatment to pro-active preventive system.	A methodology that will correctly estimate the amount of unscheduled health & social care spend that could be avoided with appropriate investment in primary and community services.
To raise public and professional awareness about and reduce stigma associated with dementia in order to encourage people to seek a memory assessment.	There will be an increase in the number of people being referred to memory services and the number of people appearing on the GP Quality Outcome Framework (QOF) registers will increase.
To increase the number of people with a diagnosis of dementia and to increase the number of people receiving an early diagnosis and treatment.	Increase in number of people with a diagnosis appearing on QOF registers to 50% of prevalence rates by March 2014 and 60% by 2015.
To ensure that people with dementia and their carers are well supported in the community and are able to maintain their independence for as long as possible.	Reduced admissions to care homes and reduced inappropriate admissions to hospitals. Integrated health and social care teams in place supporting people with dementia as part of long term conditions.
To ensure that people with dementia who are cared for in care homes receive good quality care and have their privacy and dignity respected.	Reduction in inappropriate hospital admissions, good reports and reviews.
When a person with dementia is admitted to an acute general hospital, they have their privacy and dignity respected and staff have the right skills to provide good quality care.	Excellent CQC results, CQUIN standard met and Enhancing Quality standards met.
To ensure that people with dementia are well supported through end of life.	Reduction in number of people with dementia dying in hospital.
To ensure that carers of people with dementia are well supported in their caring role and their own needs are met.	Increase in number of carers reporting that they feel well supported.
To ensure that services are able to meet the needs of specific groups,	Range of support options in place to meet different needs.

e.g. • **People with young onset dementia.** • **People from BME communities.** • **People with Down's syndrome.** • **People with sensory loss.**	

(4) The plan has been structured to ensure a holistic and comprehensive approach is taken to addressing all the stages from awareness raising through living well with dementia to ensuring good support at end of life. The plan is consistent with the National Strategy for Dementia and the recommendations of the Kent Select Committee.

(5) The Integrated Commissioning Plan is attached at appendix 3.

7. Consultation and Communication

(1) The Dementia Collaborative is well established in Kent. This forum brings together statutory partners together with the independent and voluntary sector, research and educational representatives. This forum scrutinises plans, shares best practice and developments to ensure that there is multi-agency engagement with dementia plans and developments in Kent.

(2) A range of consultations and communications have either taken place over recent times or are taking place in 2012-13:

- 2009/10 – West Kent PCT consulted on changes to in-patient services and service redesign, which resulted in fewer acute mental health beds for people with dementia and introduction of Crisis Response Service;
- Throughout 2011 – various awareness raising articles in local media;
- July, September and December 2011 – multi-stakeholder workshops preparing for the redesign of services in east Kent;
- October 2011 to Jan 2012 - SILK co-production work;
- March – April and Autumn 2012 – planned media campaign to raise awareness of dementia and support available through all stages;
- April – June 2012 – formal public consultation for the redesign of Older People's Mental Health Services in east Kent;
- Throughout 2011 – various events regarding the Kent Carers plans.

(3) Kent Link have been involved in a number of the events mentioned above and are always consulted on major developments.

(4) It is likely that a continued public awareness campaign will be required over the period of the commissioning plan to reinforce messages. A range of media will be used to gain maximum impact, e.g. news articles, radio presentations, public meetings, GP and Hospital screens, adverts on buses. In addition the Alzheimer's Society's bus has been visiting Tesco stores across Kent.

8. Risk and Business Continuity Management

(1) The key risks of not going forward with the Integrated Commissioning Plan is that Kent will be unprepared for the increase in demand upon its services from the

growing number of people with dementia. Without shifting the balance from high cost bed based services to lower cost universal early intervention services the current pattern of usage and expenditure will not change leading to the risk of unaffordable services which do not meet people's needs.

(2) The Integrated Commissioning Plan attached at appendix 3 to this document offers a way forward to turn around the pattern of support in Kent and to mitigate these risks.

9. Sustainability Implications

The thrust of the strategic direction is focused on sustainable early intervention services that are delivered close to home and encouraging self supporting communities. Together these will reduce reliance on specialist high cost services which are likely to be delivered in centres at a greater distance from people's homes. The longer people can be supported to be independent, e.g. through the use of technology, and remain within their own community will improve the sustainability of the delivery of care.

10. Conclusion

(1) The number of people with dementia is likely to double over the next thirty years, with the greatest increase being experienced by people aged over 85 as the number of people living longer increases. These people are likely to have other long term conditions in addition to their dementia.

(2) There are a number of areas where we need to do more to ensure that people with dementia are offered an early diagnosis, have access to good support to enable them to live well with their dementia in the community, particular areas for action include:

- Diagnosis rates in Kent are low, 38% of expected prevalence – the plan outlines a number of actions which together aim to increase the rate to 50% by 2015.
- People's experience of services is varied and in some sectors e.g. some acute hospitals and care homes is poor. There is a need to increase the skills of the workforce so that the quality of care provided is improved and people have a better patient / care experience, the plan sets out actions across the care sectors to improve this.
- People with dementia stay much longer in acute hospitals than other people with the same condition – a combination of actions between health and social care are required to ensure that people receive good care in hospital, have access to intermediate care and good support on discharge.
- Nationally carers report that 52% of carers do not receive sufficient support (Support, Stay and Save) – the Kent carers plans aim to improve the support available to carers.
- The majority of carers and people with dementia (83%, reported in Support, Stay and Save) want to live in their own homes – continued investment in community support, like the crisis service and Home Treatment Service and tele-technolgy, is required to reduce inappropriate hospital admissions and early admissions to care homes.

(3) The Integrated Commissioning Plan is designed to address all the stages of the pathway to ensure that people have access to appropriate, timely and quality support through their journey with dementia. Many of the actions identified in the plan help to address the commitments made in the Prime Minister's Challenge, particularly in respect of those to improve health and care. The Challenge also sets out to improve research into dementia and Kent will be well placed to respond to the outcomes of this research, the Kent Dementia Collaborative has been active in including research into its remit. With regard to the challenge to create dementia friendly communities, the Health and Well Being Board is asked to consider what more we can do in Kent to achieve this ambition.

(4) The Integrated Commissioning Plan will be a living document and will be regularly reviewed and updated in the light of developments and further national advice and research evidence.

(5) The provision of integrated care across the care pathway and across all providers of care will be critical to the success of managing the future demands, with emphasis on early intervention and maintaining independence in the community through the use of technology and supporting carers.

11. Background Documents

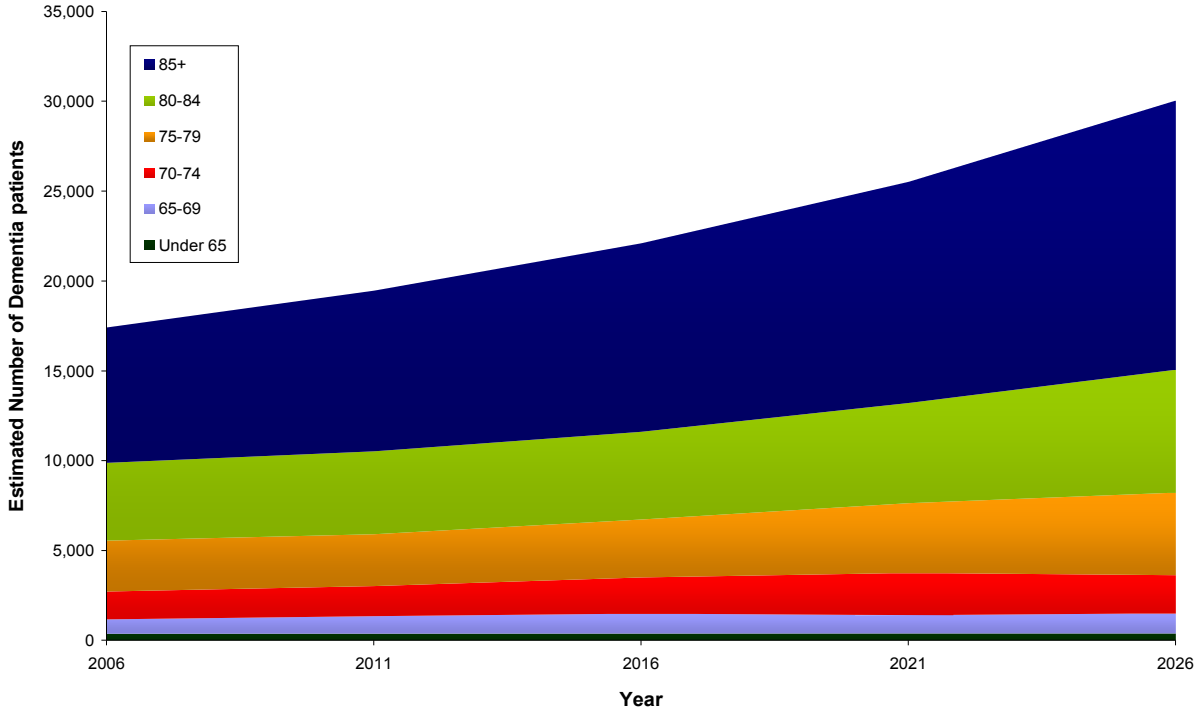
The following documents have been used for reference:

National Dementia Strategy
Public Health Report for Kent 2010
Joint Strategic Needs Assessment for Kent
Dementia UK – Alzheimer's Society 2007
Commission for Care and Quality – Dignity and Nutrition Inspection for Older People – an inspection of 100 hospitals
National Audit of Dementia – Royal College of Psychiatrists
The Prime Minister's Challenge 2012
Support, Stay and Save – Alzheimer's Society 2011
Counting the Cost – Alzheimer's Society 2009

Appendix 1 – Extract from the Joint Strategic Needs Assessment

The table below shows the predicted increase in the cases of dementia until 2026. The highest levels of increase will be in the 85 plus age range. This will bring the additional complications of that age group who are more likely to a have a co-morbidity with other long term conditions, may be living alone or supported by older carers.

Estimated change in the number of dementia patients in Kent between 2006 and 2026



Source: Dementia UK Prevalence estimates applied to South East Plan Strategy-based forecast (July 2010), Research and Intelligence Kent County Council

Estimated prevalence of dementia in Kent between 2006 and 2026 by type with number of patients

Type of dementia	Est. %	Est. number of patients
Alzheimer's	62%	10,800
Vascular dementia	17%	3,000
Mixed dementia	10%	1,700
Dementia with Lewy bodies	4%	700
Fronto-temporal dementia	2%	300
Parkinson's	2%	300
Other form of dementia	3%	500
Total		**17,400**

Source: Dementia UK Prevalence estimates applied to South East Plan Strategy-based forecast (July 2010), Research and Intelligence Kent County Council

Estimated change in the number of dementia patients in Kent between 2006 and 2026 by Local Authority District and Primary Care Trust

	2006	2026	Difference			
	Est. number	Est. prev	Est. number	Est. prev	Number	Percentage
Kent	**17,400**	**1.3%**	**30,100**	**1.9%**	**12,600**	**0.6%**
Ashford	1,300	1.2%	2,500	1.6%	1,300	0.4%
Canterbury	2,100	1.4%	2,900	1.9%	900	0.5%
Dover	900	1.0%	1,700	1.3%	800	0.3%
Shepway	1,500	1.5%	2,600	2.5%	1,100	1.0%
Swale	1,400	1.1%	2,600	1.8%	1,200	0.8%
Thanet	2,100	1.6%	3,000	2.2%	900	0.5%
NHS Eastern & Coastal Kent	**9,200**	**1.3%**	**15,300**	**1.9%**	**6,100**	**0.5%**
Dartford	1,500	1.4%	2,500	2.1%	1,000	0.7%
Gravesham	1,100	1.1%	1,900	1.7%	900	0.6%
Maidstone	1,600	1.1%	3,100	1.8%	1,500	0.7%
Sevenoaks	1,500	1.3%	2,500	2.2%	1,100	0.9%
Tonbridge & Malling	1,200	1.1%	2,400	1.9%	1,200	0.8%
Tunbridge Wells	1,300	1.3%	2,300	2.1%	1,000	0.8%
NHS West Kent	**8,200**	**1.2%**	**14,800**	**2.0%**	**6,600**	**0.7%**

Source: Dementia UK Prevalence estimates applied to South East Plan Strategy-based forecast (July 2010), Research and Intelligence Kent County Council

The above table shows that the estimated number of people with dementia in Kent is likely to increase from 17,400 in 2006 to 30,100 in 2026. The districts which will see the biggest increases include Shepway, Swale, Sevenoaks, Tunbridge and Malling and Tunbridge Wells.

People aged 85+ and over predicted to have dementia, by age and gender, projected to 2030

	2011	2015	2020	2025	2030
Ashford	715	813	986	1,253	1,627
Canterbury	1,016	1,145	1,295	1,596	1,999
Dartford	423	492	666	763	950
Dover	816	891	1,075	1,314	1,637
Gravesham	492	562	735	886	1,064
Maidstone	824	938	1,200	1,539	1,930
Sevenoaks	794	863	1,036	1,290	1,516
Shepway	735	810	942	1,175	1,503
Swale	584	699	849	1,100	1,414
Thanet	1,055	1,108	1,236	1,464	1,810
Tonbridge and Malling	590	688	894	1,117	1,423
Tunbridge Wells	696	771	960	1,209	1,468

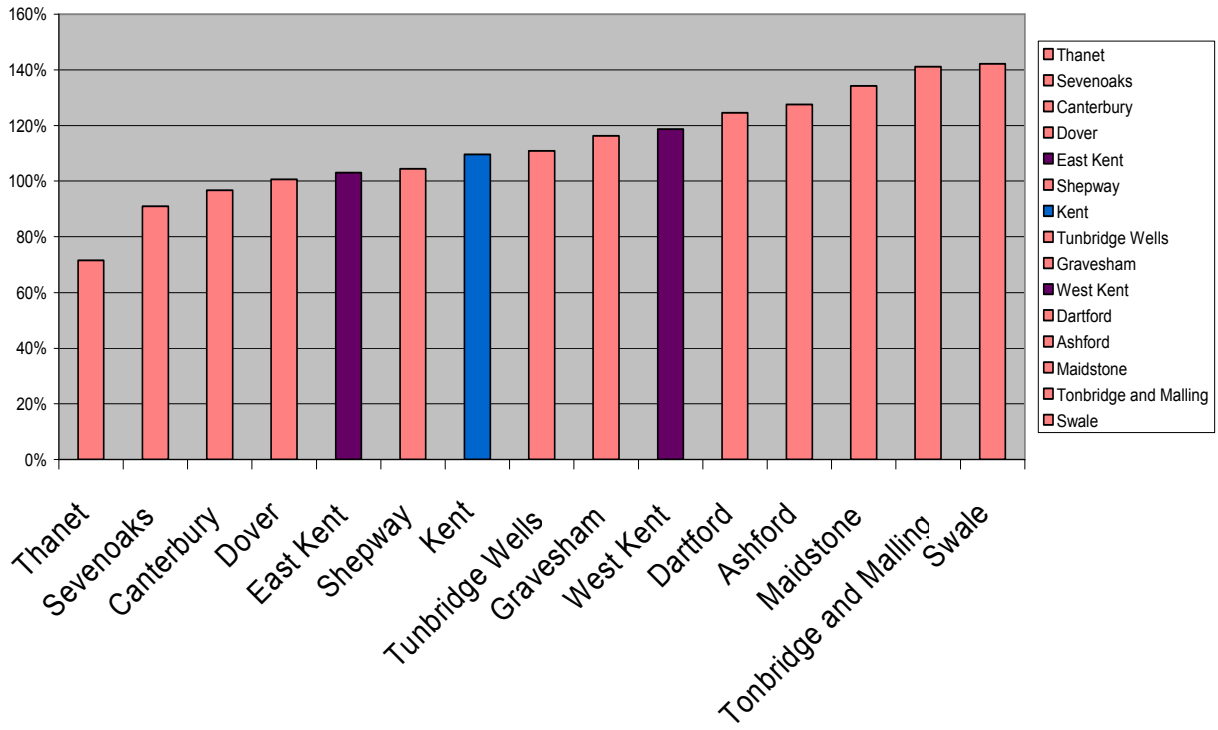
East Kent	4,921	5,466	6,383	7,902	9,990
West Kent	3,819	4,314	5,491	6,804	8,351

Kent	8,765	9,924	11,841	14,688	18,366

Source: Projecting Older People Population Information www.poppi.org.uk 2012

Table 2

% increase in >85yrs popn with dementia from 2011 to 2030



- The proportion of >85 yrs population with dementia compared with all age groups (with dementia) stands roughly around 43% in Kent. This is expected to increase to 50% by 2030.
- It is expected that the >85 yrs population in Kent with Dementia will rise by more than 100% in 2030, ranging from 70% in Thanet to 140% in Swale.
- This increase is similar to the forecast projections outlined in the 2010 Annual Public Health Report on Dementia from 2006 to 2026.
- The report also estimates only one third of this population will have been diagnosed.
- This implies the need for earlier diagnosis of dementia as a essential prerequisite in order to expand and improve services to meet the increase in population.

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Appendix 2 – estimated Spend on services in Kent used by people with dementia.

1. KCC estimated spend

Kent County Council does not categorise service users according to their medical conditions, therefore it is difficult to accurately calculate what percentage of total gross annual budget is attributable to meeting the needs of people living with dementia. The table below takes each budget line and applies a percentage that we conservatively estimate should be attributable to meeting the needs of people with dementia. It does clearly show that the majority of spend on dementia is in the care home sector.

Type of Service	Gross Cost	% of Budget attributed to people living with Dementia	Estimated cost of providing service to people living with Dementia
OPMHN Residential Care	31,602,400	100%	31,602,400
OPMHN Nursing Care	7,675,700	100%	7,675,700
KCC in House Care Home Budget	12,406,600	40%	5,515,200
Other P&V residential and nursing Home Care	73,462,300	40%	32,656,700
KCC Intermediate Care Centres	11,302,500	20%	2,512,200
Domiciliary Care Contracts	47,881,500	40%	21,285,100
Direct Payments	4,981,000	10%	553,600
All Other Older Peoples services including investment in Voluntary and Community Services	19,582,100	40%	8,705,000
Total Gross budget	**£204,958,900**	**Total estimated Dementia Spend**	**£110,505,900**

2. NHS estimated spend in Kent

Most services in the NHS are not dementia specific and additionally the coding of people with dementia using general services is not always complete, thus obtaining accurate costs is difficult. Dementia UK report estimated that NHS expenditure forms 8% of all costs of services and Social Services account for 15%, this would give an estimated spend of £58.7million for NHS. In Surrey it was estimated through the use

of the dementia modelling tool that the annual NHS spend on dementia was £40.2million this represented 2.4% of their total spend applying that proportion to the total spend of Eastern and Coastal Kent and West Kent PCTs this would give an estimated spend of £55.07million. Thus using these two methodologies the estimated NHS spend across east and west Kent on dementia is in the region of £55 - £58.7 million. This is likely to be an underestimate as identifying costs of all services used by people with dementia is difficult.

Appendix 3 – Kent and Medway Dementia Plan 2012-13

KENT & MEDWAY

DEMENTIA PLAN 2012- 13

Document Status	**Draft**
Version	

DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments (i.e. viewed, or reviews, amended, approved by person or committee)**
Version 1	25.04.12	First completed version
Version 2	26.04.12	Added Partner involvement
Version 3	03.05.12	Updated – Sue Gratton
Version 4	11.05.12	Updated – Sue Gratton

Groups or individuals which have been consulted with in the production of document:

Kent and Medway Dementia plan

Introduction

This plan aims to bring together the various initiatives across Kent and Medway into one document and represents the detailed plans that sit behind the projects approved in the Integrated Strategic Operating Plan (ISOP) for 2012-13.

The plan recognises that dementia requires a multiagency approach to ensure that people have access to a range of treatment, care and support which they need in order to live well with their dementia. Areas of joint working are included in the plan but our Local Authority partners have supplementary plans for meeting other housing and social care needs of people with dementia. The plan also recognises that people with dementia are likely to have more than one other long term condition, thus it is critical that dementia is included in the planning for long term conditions.

The Prime Minister's Challenge set out a number of areas where further action is required. This plan includes a range of actions which seek to address these challenges. One such area is the need to increase diagnosis rates, which currently stand at 38% across Kent and Medway, the plan sets out a number of actions which will contribute towards increasing the diagnosis rates, which we are aiming to increase to 50% of prevalence rates by 2014 and 60% by 2015.

Future Planning

Latest forecast estimates suggest the numbers of dementia patients in Kent and Medway will increase by 80% from 21,750 in 2011 to 39,400 in 2030. Our diagnosis rate in primary care stands at around 38% and so therefore needs to be improved considerably in future to meet this trend. However further work is also required to understand how the increase in population will impact on health and social care spend for the growing elderly population and how services in primary and community care (ranging from memory assessment to care home support) will improve on this. For example, unscheduled care hospital spend on dementia is expected to rise from approx £2.4 million in 2011 to £3.5 million in 2025. Thus a detailed mapping exercise is required to understand what services (for dementia patients) are available within and outside the NHS and collect the latest activity figures, explaining how many patients access in and out of these across a continuum of care. This will help build on existing modelling analysis, link into the wider Long Term Conditions Model of Care work, focusing on multiple morbidities and the complex elderly, and correctly estimate the amount of unscheduled health and social care spend that could be avoided if the necessary investment into primary and community services was provided, thus moving away from reactive / treatment system to a pro-active / preventive system and improving quality of patient care.

Updating the plan

This plan is a live document and will be regularly updated through the year and will therefore inform the reporting on progress against the ISOP.

	What are we aiming to achieve?	How we will achieve it.	Lead Orgs	£ Invest in 2012-13	By when	How we will know when it has been achieved.	Achievements to date
1. Future Planning	**To ensure that our future plans are robust and take account of the impact of the future increase of dementia on health & social care services and which enable the system to move away from reactive/treatment to pro-active preventive system.**	**Work with colleagues across the health & Social care economy to develop effective risk stratification and modelling system for long term conditions including dementia, taking account of the increasing prevalence.**				**A methodology that will correctly estimate the amount of unscheduled health & social care spend that could be avoided with appropriate investment in primary and community services.**	
		Implement a risk stratification tool that includes dementia	NHS K&M / CCGs	£60k	Jan 2013	All organisations using a risk stratification tool.	Engaged with LTC workstream.
	Dementia is recognised as a long term condition and services make reasonable adjustments to meet the wider health needs of people with dementia	Ensure the wider health needs of older people with dementia and their carers are included in other local strategies, e.g. intermediate care, end of life and other workstreams – e.g. health and social care integration	NHS K&M / CCGs		Ongoing	Needs of people with dementia reflected in other health and social care plans.	Engaged with integration agenda and Long term conditions work.
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
2. Awareness raising and reduction	**To raise public and professional awareness about and reduce stigma associated with dementia in order to**					**There will be an increase in the number of people being referred to memory services and the number of people**	

of stigma.	**encourage people to seek a memory assessment.**					**appearing on the GP Quality Outcome Framework (QOF) registers will increase.**	
	Ensure people are aware of the Kent and Medway (K&M) Dementia Web site and Dementia Helpline	Every opportunity taken to publicise its existence at any public event, media releases and distribution of leaflets. Review content of web against the SW Web	NHS K&M / KCC/ MC/ Guidepost Trust		Ongoing 31 May 12	Continue to monitor activity on the site and usage of helpline.	Kent and Medway Dementia Web established in 2010 and receives around 5000 hits per month. Provides information about dementia and local services. Kent 24 hour dementia helpline established, receives around 700 calls per year.
	A local campaign which raises public awareness re dementia, our services available and health promoting messages timed to match east Kent consultation.	Liaise with communications department to establish a local public awareness campaign and use local media to highlight the importance of early diagnosis and to promote the message that 'what's good for the heart is good for the head'.	NHS K&M	£26k	March 2012- July 2012	People come to consultation events.	Articles in Health News and press releases to local newspapers, interviews given to local radio.
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	Use Dementia Awareness Week and national Campaigns to raise awareness	Undertake local media campaign During dementia week and link to national campaign planned to begin in Autumn 2012.	NHS K&M / KCC / MC		May 2012 and Autumn 2012	People come to events	Events planned in dementia awareness week to raise awareness and celebrate achievements

	Make libraries dementia – friendly and places which raise awareness.	Agree Action plan with Kent libraries and Kent Gateways to develop a range or resources suitable for people with dementia and also to raise awareness with other people – particularly young people.	KCC		31 Mar 12	Resources available in all libraries	Plans agreed with Kent libraries
	People have access to a range of information in different formats and languages from a variety of locations.	Review range of information and ensure that good quality information about the signs and symptoms of dementia are readily available for individuals, families and professionals and identify opportunities to promote the dementia web and helpline and ensure that information is available in a	NHS K&M / KCC / MC / Vol. Orgs.		Dec 2012	All literature reviewed and updated	Kent Dementia Web in place and range of fliers and leaflets already available
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
		Range of formats and languages. Use KCC gateways and GP surgeries to ensure that information is available on dementia.					
	All stakeholder representatives involved in planning, development	Engage stakeholders through Kent and Medway Dementia Collaborative and	NHS K&M / KCC / MC / Vol. Orgs /		Ongoing	People actively engaged in development of plans	Kent and Medway Collaborative established which

	and evaluation of services	other specific forums.	Universities/ KMPT/ Research orgs. / KMCA				brings together key stakeholders from the statutory sector, voluntary and independent sector and academia to share plans and review progress A Range of programme groups established and operational across Kent & Medway where key stakeholders including service users and carers input to the redesign of services and care pathway.
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
							Engaged with integration agenda and Long term conditions work. Dementia strategy groups operational in majority of Acute Hospitals.
3. Early Diagnosis and Interventio n	**To increase the number of people with a diagnosis of dementia and to increase the number of people**				Apr 2014 Apr 2015	**Increase in number of people with a diagnosis appearing on QOF registers to 50% of prevalence rates by**	Current rate across K&M is 38%.

	receiving an early diagnosis and treatment.					**March 2014 and 60% by 2015.**	
	To encourage people to seek early diagnosis	Utilise the work commissioned through Social Innovation Lab for Kent (SILK) to understand what prevents people seeking diagnosis and develop an action plan to redesign services accordingly. Introduce a checklist of questions to take to the GP.	NHS K&M / KCC / CCGs	£286k	Jul 2012	Action plan agreed and with investment priorities identified.	Research completed by SILK and report received.
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	To ensure a memory assessment and diagnosis are obtained as quickly as possible. Ensure all diagnostic pathways are compliant with NICE standards	Review of memory services pathway under the Payment by Results (PBR) cluster with view to ensuring the specialist services concentrate on the most complex cases and supporting diagnosis uptake in primary care for less complex cases. Monitor work already started in Medway and west Kent to learn and spread	NHS K&M / CCGs / KMPT	£50 EK		Revised PBR pathway agreed Memory assessment and diagnosis taking place in a structured way in primary care with Community Psychiatrist Nurses (CPN)/Admiral nurse working in primary care.	Kent and Medway have more Admiral Nurses than any other county – 13 nurses; they are specialists in dementia care and work collaboratively with other professionals to support people with dementia and family carers in the community.
		Best practice across Kent and Medway (K&M).				Admiral nurse in Thanet permanently funded	Admiral nurses receive 1500 referrals for support p.a.

	People receive appropriate support post diagnosis.	Elements of the pathway – eg post diagnostic counselling and support - will be commissioned in the voluntary sector where appropriate, to release capacity in the memory services to cope with likely increase in demand for their support to primary care. To be linked to SILK recommendations for post diagnostic support.	NHS K&M / CCGs / Vol Orgs	(part of £286k investment see above)		Increased post diagnostic support available	Peer support and dementia cafes already in place.
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	Appropriate use of neuro-imaging to support diagnosis	Explore with East Kent Hospitals Trust (EKHUFT) and Kent and Medway Partnership Trust (KMPT) in conjunction with Clinical Commissioning Groups (CCGs) the efficacy of scans in diagnosis to ensure that neuro-imaging is used where proven to be clinically effective, to release resources and reduce diagnosis times.	NHS K&M / KMPT / EKHUFT / CCGs		04 May 2012 joint meeting arranged	Fewer people undergoing unnecessary scans and clarity of costs for scans.	Information on options shared.
		Explore if a model can be established for roll out across K&M.					

	Maximise opportunities to ensure QOF registers are regularly updated	Monitor Key Performance Indicator (KPI) for Community Mental Health Teams for Older People (CMHTOP)) to establish links with primary care to ensure people known to CMHTOPs with dementia diagnosis appear on QOF registers.	NHS K&M / CCGs / KMPT		31 Mar 13	Number of people on QOF registers regularly checked and increase in numbers seen and tracked.	Dementia QOF registers for 2010/11 show 8266 people recorded
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
		Ensure discharge letters from Acute Trusts and MH Trusts include details of diagnosis and onward actions required.					
	CCGs own the action plan to increase diagnosis rates and plans modified to meet local circumstances	Work with CCGs by the establishment of a dementia reference group to increase GP awareness of dementia and the need to increase diagnosis rates and the support available to their patients. Encourage GPs to ensure that QOF registers are up to date.	CCGs / NHS K&M		July 2012	GP reference group established. CCGs regularly reviewing QOF rates.	Plans in progress to seek membership. Programme management group established to develop whole systems best practice pathways across primary, community, secondary care and social care.
	Ensure that people who meet the criteria of the NICE guideline TA217 receive appropriate drug	Through reference group, develop Shared Care Guidelines for Acetylcholinesterase	NHS K&M / CCGs / KMPT	£1.6m gross – excludes savings	Sep 2012	Shared care guidelines agreed between secondary and primary care and	Currently meet NICE guidelines on prescription and follow up of drugs by

	therapy	Inhibitors in the Treatment of Alzheimer's					
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
4. Living well with Dementia	**To ensure that people with dementia and their carers are well supported in the community and are able to maintain their independence for as long as possible**.					**Reduced admissions to care homes and reduced inappropriate admissions to hospitals. Integrated health and social care teams in place supporting people with dementia as part of long term conditions**	Various workstreams started
	People feel well supported post diagnosis and have a range of support to call upon	Ensure that peer support is available in each locality and can be accessed following early diagnosis Ensure people with dementia and their carers have access to dementia cafes (already commissioned in Kent).	NHS K&M / KCC / MC / Vol Orgs	£90K £90K	2012	Peer support and dementia cafes available in each locality, steering group established to review and monitor quality of services.	8 peer support groups and 11 dementia cafes established across Kent and Medway, peer support groups support 10 people at each session and cafes vary in size and support between 30 – 50 people. Contracts awarded 1.4.12 to increase coverage of peer support and dementia cafes in every locality across Kent
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
		Extend Advocacy service	KCC / Vol	£100k		Advocacy service	Independent Advocacy

		across Kent.	Org			established in East Kent	established in West Kent, 50 people supported with over 100 issues ranging from safeguarding, financial to place of care.
	People feel well supported in the community through access to a range of support and short breaks.	Review range of social opportunities , use of direct payments and short breaks available (also see work under carers support)	KCC / MC / NHS K&M		31 Mar 13	Range of pattern of support reviewed and meeting people's needs	Broadmeadows unit based in Shepway (takes referrals from east Kent). 8 bedded short stay unit and day care (open 7 days a week) helping to maintain people in the community through periods of difficulty and change. In the first 3 months of its operation 20% of the admissions were an alternative to hospital admission and 76% of people returned home.
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	To avoid admission to either acute general or acute mental health hospital unless it will be clinically effective. Avoid or delay admission to a care home where	To ensure that community services are available to support each part of the dementia pathway. Enhance home treatment service in east Kent	NHS K&M / KCC / MC / KMPT / MCH / Vol Orgs	£250k	31 May 12	There will be a reduction in the number of people with dementia who are admitted to mental health and acute trust beds.	Home Treatment Service (east Kent only) provides enhanced support at periods of change, crisis or difficulties to help maintain people either

	possible.						living at home or in care homes and avoid unnecessary hospital admission, also supports discharge. The service supports 376 people per year with a further 120 people with additional investment in team.
	People who are admitted to acute mental health services receive appropriate care and are discharged as soon as clinically effective.	Review and redesign mental health inpatient provision and redirect investment into community support.	NHS K&M / KMPT	-£750k Savings to be reinvested	31 Oct 12	KMPT are achieving their KPIs in relation to: • Occupancy rate. • Length of stay. • Delayed discharges.	Consultation underway proposed redesign of EK OPMH services
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	People feel well supported through a crisis without resorting to unplanned admission to either hospital or care home.	Ensure 24/7 crisis support is available which supports people with dementia and their carers (already commissioned in west Kent and currently being commissioned in east Kent and Medway).	NHS K&M / KCC / MC / Independent sector	£300k EK £194k Med	Interim service by 01 Jun 12 Full by 01 Jan 13	There will be a reduction in the number of people with dementia who are admitted to mental health and acute trust beds, reduction in unplanned admissions to care homes.	Crisis service established in west Kent with evidence of providing effective support in a crisis which has prevented hospital admission or early admission to residential care. West Kent scheme has supported 260 people in a year. In first year prevented 69 hospital admissions and 92 care home placements.

	People with dementia have access to intermediate care where clinically effective for rehabilitation	Link with intermediate care reviews across K&M to ensure intermediate care services have the skills to manage people with dementia	NHS K&M / CCGs	£20k (share of PM costs)	01 May 12 31 Mar 13	Project Manager in post Number of people with dementia accessing intermediate care.	Project Manager appointed for Intermediate Care review
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	Care pathway in Medway provides a range of support through stages of acute, intermediate care, discharge and continuing care	Redesign of pathway in Medway to reduce reliance on acute OPMH beds. Provide access to specialist intermediate care support for people with complex needs. Extend Dementia Support Team. Spot purchase continuing care provision.	NHS K&M / MCG / MCH / KMPT	-£545k £290k Savings to be reinvested	31 Mar 13 01 Apr 12 01 Apr 12 01 Jul 12	KMPT are achieving their KPIs in relation to: • Occupancy rate. • Length of stay. • Delayed discharges Darland House services available through NHSCC spot purchase	Dementia Support Service in Medway provide short term home treatment and support for people with dementia and carers at risk of crisis. The service became operational mid 2011 and to date has received 97 referrals and carried out 160 interventions.
	To ensure that people with dementia who present with behavioural problems are managed with the use of non pharmacological interventions wherever possible. To achieve the national target of a review of people with dementia	Develop action plan in partnership with CCGs to address reduction in anti-psychotic usage, key action points include: - audit of usage of these drugs - support to GPS to undertake reviews - care plans reviewed to ensure appropriate support	NHS K&M / CCGs / KMPT		31 Mar 13 2014	All people with dementia in receipt of anti-psychotic medication have been reviewed A reduction in the number or people with dementia receiving anti psychotic drugs national target 2/3rd reduction by 2014	Action plan in discussions with CCGs Audit undertaken in Medway, plans in discussion with other CCGs

	who are being prescribed anti psychotic drugs and reduce prescribing by two thirds by March 2014.	in place					
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
							Medway audit identified that 160 patients of 1054 on the dementia register were taking low dose antipsychotics. Of these, 84 had complex mental health issues and reviewed by KMPT. New guidance to assist withdrawal developed between KMPT/GPs – 33 patients withdrawn. Clinical Learning events held across Kent & Medway.
	To ensure that health and social care services are provided in an integrated way to reduce duplication of assessment and services and ensure that people with dementia and their families receive a seamless service and the physical needs of people with dementia are also met.	Include OPMH services in the Kent health and social care integration programme, to develop integrated health and social care teams. Develop fully Integrated Health and Social Care teams across Medway.	NHS K&M / CCGs/ KCC / KCHT / KMPT		31 Mar 12	Integrated health and social care teams in place that include support for older people with mental health problems, including dementia.	Engaged with Health & social Care Integration Board.

	What are we aiming to achieve?	How we will achieve it.	Lead Orgs	£ Invest in 2012-13	By when	How we will know when it has been achieved.	Achievements to date
	People have access to appropriate teletechnology to support them with their care and managing their long term conditions	Link with assistive technology programme across Kent & Medway to encourage use for people with dementia.	NHS K&M / KCC	£250k	31 Mar 12	Increase in the number of people with dementia being supported by assistive technology.	Options for investment being considered
5. Care Homes	**To ensure that people with dementia who are cared for in care homes receive good quality care and have their privacy and dignity respected.**	Expand 'My Home Life' programme across K&M. 60 more managers planned to participate in 2012 across Kent.	KCC / NHS K&M / KMPT	£100k	31 Mar 13	**Reduction in inappropriate hospital admissions, good reports and reviews.**	39 home managers have participated in the first phase of training in west Kent –
	To ensure that care home staff have the right skills and support to care for people with dementia.	Establish a programme of dementia care mapping in care homes across Kent – a process to actively engage residents in everyday activities. Carry out a survey of training needs in care homes in Medway.		£50k	30 Jun 12	Training programmes completed and evaluation shows staff have applied learning.	
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	To prevent inappropriate hospital attendance and admission wherever possible.	Enhancement of Home Treatment Service in east Kent to undertake training for care homes and provider support guidelines.	NHS K&M / KMPT	(cost shown above in section3)	May 2012	Reduction in hospital attendances/admissions from care homes. Reduction in prescribing of antipsychotic drugs	Agreed extension to Home Treatment Service in east Kent partly with view to supporting care homes

							in managing people through difficult transitions to avoid hospital admission.
	An integrated approach to quality and performance management of care homes.	Development of an integrated quality dashboard with Kent County Council which highlights those homes who require some form some form of intervention. Develop an integrated quality dash board with Medway Council to identify and prioritise homes that require intervention.	NHS K&M / CCGs / KCC		01 Oct 12	Reduction in number of incidents when homes are closed to admissions due to Adult Protection alerts.	Steering group established
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	Care Homes have clear guidelines on what course of action to follow to support residents with health issues.	Develop, update and publish simple pathways for all care homes across K&M to help them to manage common medical issues, eg urinary tract infections.	NHS K&M / CCGs		Sep 2012	Reduction in hospital attendances/admissions from care homes.	West Kent Care Home project has achieved 523 fewer non-elective admissions from care homes from 2010-11 to 2011-12.
	Care homes know how to access general medical support	Review and evaluate the various current arrangements for medical support to care homes across Kent and Medway to build upon best practice	NHS K&M / CCGs		31 Mar 13	Reduction in hospital attendances/admissions from care homes. Patients' health well managed in care homes.	

	A coordinated approach to supporting care homes to deliver good quality care, particularly through end of life.	Through the project funded by the Regional Innovation fund bring together work programmes that are working with care homes across Kent to share best practice, particularly around end of life care for people with dementia. Appoint project manager to coordinate programme.	NHS K&M / CCGs/ KMCA/ Hospices	£200k	31 Mar 13	Reduction in hospital attendances/admissions from care homes. Reduction in number of people from care homes dying in hospital.	Regional Innovation funding secured for care home programme across Kent and Medway with aim of ensuring people with dementia are well supported in care homes at end of life and are not admitted to hospital unnecessarily.
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
	Improve access to expert advice to care homes by use of technology.	Link pilot care homes through web cams to A&E departments and possibly out of hours GP services. Initiate 'My Clinic' telehealth in nursing homes in Medway to support VMOs	NHS K&M / Acute Trusts / CCGs/ KMCA	(part of RIF funding)	31 Mar 13	Reduction in hospital attendances/admissions from care homes. Reduction in number of people from care homes dying in hospital.	As above
6.Acute Hospital Care	**When a person with dementia is admitted to an acute general hospital, they have their privacy and dignity respected and staff have the right skills to provide good quality care**. Ensure people admitted as an emergency who	Support acute and community trusts to implement and monitor progress with the new national CQUIN which requires anyone over the age of 75 who is admitted as an emergency to be screened for dementia. This is a 3 post CQUIN: 1)Screening question to identify everyone at	NHS K&M / Acute Trusts / KCHT / MCH	£1.4m CQUINS	Apr 2012	**Excellent CQC results, CQUIN standard met and Enhancing Quality standards met** An increase in the number of people with a	CQUIN included in acute and community contracts.

	have a cognitive impairment are appropriately assessed.	risk of dementia. 2)Risk assessment to identify people who require a memory assessment. 3)Referral to GP for further diagnosis.				diagnosis of dementia and an increase in the number of people recorded on QOF registers.	
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved**	**Achievements to date**
	Length of stay in hospital for a person with dementia should be no longer than that for other people with similar physical conditions. People supported to return home post discharge.	Ensure intermediate care review supports discharge arrangements for people with dementia. Enablement services support people with dementia post discharge.	NHS K&M / KCHT/ MCH / CCGs / KCC / MC		31 Mar 13 31 Mar 13	Reduction in length of stay for people with dementia. Reduction in the number of people admitted to a care home following discharge.	Dementia Discharge Support (west Kent only) – provides enhanced support upon discharge to settle people home where risks of going home without support may have led to residential care. 50 people supported and 75% enabled to return home
	To support people who present challenges through the use of non pharmacological interventions when possible and ensure that if anti psychotics are prescribed their use is reviewed on a regular basis and their review is included in the discharge plan.	Review outputs from the enhancing quality programme in relation to the reduction of anti psychotic drugs.	NHS K&M / Acute Trusts / KMPT		31 Mar 13	Reduction in the use of anti psychotics in acute hospital settings.	All general hospital and mental health providers are participating in the Enhancing Quality Programme to be able to demonstrate the improvement in dementia care and reduce anti-psychotic drugs.

	What are we aiming to achieve?	How we will achieve it.	Lead Orgs	£ Invest in 2012-13	By when	How we will know when it has been achieved.	Achievements to date
	All hospitals have a lead for dementia and a group to address quality of care for people with dementia.	Commissioners to participate in dementia strategy groups established in the acute trusts.	Acute Trusts / NHS K&M		Ongoing	Dementia Lead identified, action plan in place.	All hospitals now have action plans to address issues as result of Royal College of Psychiatry Audit to ensure that dementia is recognised and reasonable adjustments are made in the delivery of care.
	Liaison psychiatry services or similar mental health support in place in all acute hospitals	Mental health support to be provided by KMPT to West Kent to provide advice and guidance on managing people with mental health problems including people with dementia.	Acute Trusts / NHS K&M / KMPT	Through KMPT CQUIN	31 Mar 13	Reduction in admissions from emergency attendances.	Liaison service already in place in East Kent and Medway.
	People with dementia are well supported in hospitals, particularly with feeding, drinking and befriending.	Implement and monitor agreed dementia buddy pilot scheme in Darenth Valley Hospital. Implement 'Red Tray' initiative	DVH / KCC / NHS K&M	£30k	01 Jun 12	Improved reported patient experience	Plan prepared Initiative introduced in MMFT to identify patients that require support with feeding and drinking. Increased use of volunteers that are trained to assist with feeding.

	What are we aiming to achieve?	How we will achieve it.	Lead Orgs	£ Invest in 2012-13	By when	How we will know when it has been achieved.	Achievements to date
7. End of Life Care	**To ensure that people with dementia are well supported through end of life.** To enable people to plan for their end of life. To enable people with dementia to die in their place of choice.	Identify and link with opportunities to encourage people to develop advanced care plans, eg Via care homes work (see no 3 above). PEACE project to be implemented in MMFT.	NHS K&M / KMCA / Acute Trusts / CCGs		31 Mar 13 31 Mar 13	**Reduction in number of people with dementia dying in hospital** Increase in the number of people with dementia with advanced care plans, particularly in care homes. Reduction in the number of people with dementia dying in a hospital.	End of Life Facilitators working with care homes in West Kent. Ditto above Consultant Lead in MMFT progressing the development of advance care plans and roll out by Community Geriatrician.
	To ensure that people with dementia and their families have equitable access to palliative care services.	End of life care service developments.	NHS K&M / Hospices / KCHT / MCH / Acute Trusts / CCGs		31 Mar 13	Number of people with dementia recorded on End of Life registers	Joint working with EOL commissioners
	To ensure access to good quality NHS continuing health care facilities as locally as possible. Care home staff skilled in end of life care.	Work with the continuing care team to develop a strategy for NHS continuing health care to agree the type and level of NHS and private provision. Provide access to training on end of life care.	NHS K&M / independent sector NHS K&M / Hospices/ KMCA		31 Mar 13 Ongoing	Market analysis of continuing care undertaken and plan in place to address any gaps in provision. Number of care homes which have accessed training	Training provided to nursing homes in east Kent for Liverpool Care Pathway
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
8. Support	**To ensure that carers of**					**Increase in number of**	

for Carers	**people with dementia are well supported in their caring role and their own needs are met.**					**carers reporting that they feel well supported**	
	Carers are offered education programme to assist with their caring role.	To commission carer's education packages to be provided by the voluntary sector.	NHS K&M / KCC / MC/ Vol Orgs	(part of £286k in 2 above)	31 Oct 13	Number of carers receiving carer's education sessions.	Specifications agreed for education programme.
	To commission a range of support for carers	To continue work with KCC and Medway Council to jointly commission a range of carer's services: • Information and guidance – including carers helpline for emotional support and Kent link to DH carers web • Increase Short breaks. • Carers assessments and support	NHS K&M / KCC / MC/ Vol Orgs/ Independent sector	Share of carers investment: £372k WK £527k EK £322k Med	31 Oct 13	Number of carer's short breaks, assessments and respite. Admission to a care home is part of a care plan; reduction in admissions due to crisis carer breakdown. .	Booklets developed by Carers Support on the range of support available in east Kent, 5000 distributed Dementia Web, Dementia Cafes, Admiral Nurses, Crisis service all provide support to carers.
	What are we aiming to achieve?	**How we will achieve it.**	**Lead Orgs**	**£ Invest in 2012-13**	**By when**	**How we will know when it has been achieved.**	**Achievements to date**
		Ensure that respite services are flexible and can be provided in and away from the home.					
		Extend use of payment for carers to increase personalised support available to carers.				Number of payments to carers	

9. Cross cutting themes.	**To ensure that services are able to meet the needs of specific groups, eg** • **People with young onset dementia.** • **People from BME communities.** • **People with Down's syndrome.** • **People with sensory loss**	Build on work already undertaken in relation to people with Down's syndrome and BME and develop specific action plans to support these areas. Further training sessions for LD support providers	NHS K&M / KCC / Independent sector / KCHT/ Vol Orgs	£20k	31 Mar 13	**Range of support options in place to meet different needs.** KPI for screening people with Downs syndrome at age 30 met	Dementia pathway agreed for people with LD KPI agreed for community LD teams to screen people with downs syndrome at age 30 for dementia Dementia Awareness training sessions held for people working with people with LD.

Key to lead Organisations

NHS K&M	NHS Kent and Medway
KCC	Kent County Council
MC	Medway Council
MCH	Medway community Services
KCHT	Kent Community Health Trust
KMPT	Kent and Medway Partnership Trust
EKHUFT	East Kent Hospitals Trust
DVH	Darenth Valley Hospital Trust
Vol Org	Voluntary Organisations
KMCA	Kent and Medway Care Alliance

Appendix

Kent and Medway Dementia Plan summary of investments for 2012-2013

Dementia investment

Item	£	Source	
Modelling tool	60,000	AOP	
Undertake local media campaign	26,000	AOP	
Utilise the work (SILK) to redesign services accordingly.	286,000	AOP	
admiral nurse EK	50,000	AOP	
Anti dementia drugs	1,600,000	AOP	
Peer support	90,000	ASC KCC	
Dementia cafes	90,000	ASC KCC	
Advocacy	100,000	ASC KCC	
EK Home Treatment Service	250,000	AOP	Reablement 12/13
EK Crisis service	300,000	AOP	ASC 12/13
Medway crisis service	194,000	AOP	Reablement 12/13

Intermediate care review - share	20,000	AOP	Reablement
Assistive technology - est share	250,000	ASC KCC	
Littlestone dementia intermediate care	290,000	AOP	
Care Home training -dem map/ My Home Life	150,000	ASC KCC	
Care Home project	200,000	AOP	Regional Innovation fund
National dementia CQUIN	1,400,000	AOP	
DVH Dementia Buddy	30,000	ASC KCC	
Training LD providers	20,000	ASC KCC	
Carers Support 66% share of carers invest:			
WK - £563k	372,000	AOP	
EK - £798k	527,000	AOP	
Med - £488k	322,000	AOP	
Total investment	**6,627,000**		
Sources of funding			
Annual Operating Plan (AOP)	5,897,000		of which £1,295,000 is from savings form service redesigns in east Kent and Medway
Adult Social Care funding for Health, KCC	730,000		
Total	**6,627,000**		

Appendix 4 – Shifting the balance from specialist to universal services

Current Model

Services for older people can be described as a three tier service model where services are designed to meet need and promote independence. The three broad tiers of service are:

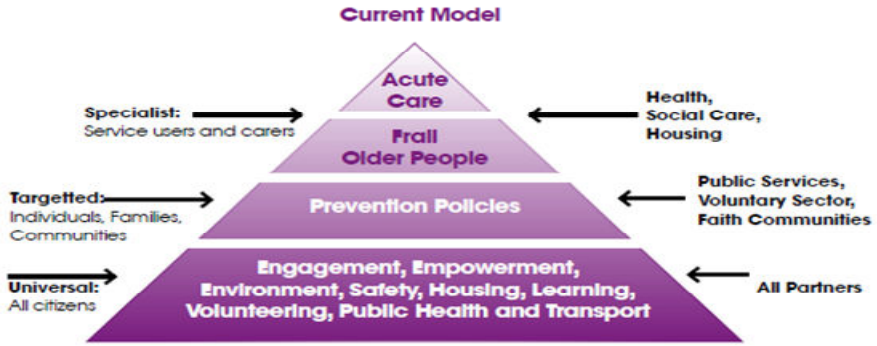
Universal provision: Available to all older people

Targeted provision: To enable older people to maintain their independence and minimise the need for acute services

Specialist provision: For older people who require more intensive support

Traditionally our model of service provision has been one where both investment and focus has primarily been on specified services.

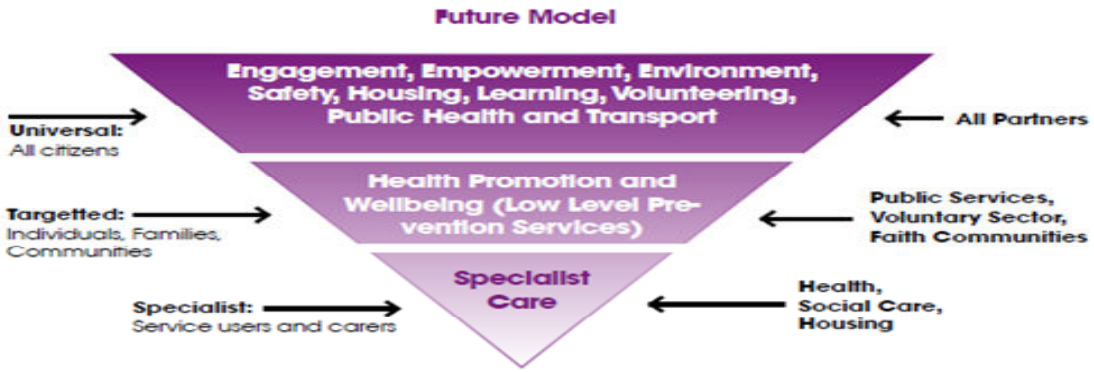
Current focus of service provision



Inverting the triangle

By inverting the focus on specialist services and placing universal services at the top of the triangle we will ensure that our investment and focus is primarily on maximising the independence and choice of older people.

Vision for the future: Inverting the triangle of care.



To do this we will work with our health and social care partners across the system to ensure that we commission services in the right place at the right time.

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By:	Rebecca Barraclough, Healthwatch Development Worker, Kent LINk
To:	Health and Wellbeing Board (Shadow)
Subject:	LINk's view of Dementia services in Kent May 2012
Classification:	Unrestricted

Recommendations

1. Health and Wellbeing Board is asked to receive this report for information.

2. To consider looking into further services for people with dementia, with a particular emphasis on how integration of health and social care services could help patients and carers.

3. To consider leading on and working with others to raise public awareness and education in relation to dementia services.

Introduction

As this is the first formal report that Kent LINk is submitting to the Health and Wellbeing Board (Shadow), we have taken the opportunity to outline the role of the LINk and how it fulfils that role through its volunteers and internal structures, before we comment on dementia services.

1. Introduction to the Kent LINk

The Kent LINk is a network of individual people and organisations who want to help improve health and social care services for the community of Kent. They join the LINk as volunteers. LINk participants play an important role in raising issues about health and social care, identifying which services provide good services, those that need improving and then taking action to make changes. There are a variety of ways people can get involved in the LINk. Participants can get involved as much or as little as they wish; by receiving information on current consultations, taking part in projects or becoming a core group member:

The Governor's Group **-** ensures that the LINk operates within the law and within its budget. The LINk Governance is set by participants and reviewed at the LINk's Annual Meeting. Governors also ensure that as many people as possible have their voices heard, when and where it counts. Each Governor takes the lead on specific areas such as equality and diversity, projects and finance.

The Priorities Panel **-** assesses, against a set of criteria, issues about health and social care services brought to the LINk and recommends how they are taken forward. They do not look at individual complaints but can signpost individuals to the appropriate service.

Authorised Visitors use the LINk's right to enter and view NHS and Social Care settings. To become authorised, the volunteer has to go through a rigorous process of recruitment, selection, references, training and CRB checking. They also undertake project-specific training.

External Representatives ensure the LINk is represented at the decision-making level on organisations across Kent. They use the LINk's (and their own) networks to seek information and views from the public and users of the services. They feed this into the organisations – providers or commissioners - they attend meetings and they feed back to the public via the LINk.

Mystery Shoppers carry out research for the LINk through questionnaires, visits and telephone calls, collecting information about health and social care services as part of LINk projects.

The LINk and its participants are supported by its Host organisation, Kent & Medway Networks Ltd (KMN), which handles administration, community engagement, project development, information and financial management, event organisation, secretariat, and the contact point for the LINk.

The ethos of the Kent LINk is to be a network of networks, expanding the opportunities for people to be involved in improving health and social care. This year the LINk has enhanced its network through setting up further LINk groups and developing partnerships with community / voluntary and public sector stakeholders. These groups and partnerships are forged by LINk participants, supported by Host organisation staff, and enable the LINk to be involved in decision-making within health and social care.

The LINk undertakes a full work programme each year. It consists of a mixture of activities to fulfil the LINks statutory duties, community engagement, LINk projects (that is major pieces of work where the LINk needs to invest resources, time and effort) and issues that have come to the LINk throughout the year.

Ideas for the Work Programme come from individual LINk participants, LINk participant organisations and projects which stem from the LINk's statutory duties. An example of the latter is providing a community response to NHS Trusts' Quality Accounts. The LINk's Annual Work Programme is reviewed and agreed by LINk participants at the LINk's annual meeting.

In addition to the planned programme of work, the LINk receives throughout the year, other items or issues from the public, LINk participants (individuals or

organisations) or LINk stakeholder groups, i.e. the NHS or social care agencies in the county. For an issue to be added to the LINk Annual Work Programme it is considered first by the LINk's Priorities Panel, which takes into account a number of factors. Any issue that appears not to be within the remit of the LINk will be referred to the Governors' Group for decision. In addition, if an issue is to be followed up but will incur LINk resources, the Panel refers it to the LINk's Governors' Group to assess the impact on its budget and other priorities.

The LINk's monthly Bulletin and quarterly newsletter – Kent LINk News – are used to provide and gather information for current issues being investigated by the LINk, promote any events or workshops, provide an opportunity to respond to consultations and update on work being undertaken by the LINk's participants.

The Bulletin and quarterly newsletter are sent to over 200 groups and organisations, providing information and opportunities for involvement. Copies of the Kent LINk newsletter are sent to every Doctors Surgery, Optician, Dentist and Pharmacy across the County, as well as libraries and other public outlets.

2. LINk Participants

The Kent LINk has 1249 participants listed on its database. Of these 1044 are individual people and 205 are organisations. The organisations include voluntary/community groups who bring with them their own membership and networks, meaning the LINk can readily engage with upwards of 6,000 residents in Kent.

The Kent LINk is committed to working with local community organisations and groups through its project work, consultations, community based engagement and information sharing including its Bulletin, website, Facebook and Twitter. The LINk continues to develop links with other groups on any relevant project work and the LINk Development Workers work with others in their communities.

When registering, LINk participants list their areas of interest in NHS and social care and also give the LINk permission to share their contact details, where appropriate, with those within the LINk with similar interests. Those could be around a locality, or a health condition, or other topics such as transport or social care support in people's homes.

For the purpose of this report it is useful to note that, when registering with the LINk, 86 participants have identified Dementia as an area of interest. Given more time it would have been possible to seek their views on Kent dementia services direct.

Dementia Services – Kent LINk comment

3. Kent LINk Projects

The LINk has undertaken several projects in which dementia services have featured, several are due for completion this year:

3.1. *West Kent Enhanced Dementia Crisis (2009*) - The Kent LINk was invited by NHS West Kent and Kent Adult Social Services to contribute to their contract tendering process for the new West Kent Enhanced Dementia Crisis Service (Emergency Support Service). There were two stages where LINK participants were involved: reviewing the written applications, then sitting on the panel for the short listed presentations. LINk Participants that took part had personal experience of caring for someone with dementia. Participants were particularly pleased that someone had given them the opportunity of not only being heard, but being listened to, and thinking that they had something worthwhile to say. The LINk believes this highlights the importance of public/patient involvement when considering commissioning a service and congratulated the commissioners for their approach.

3.2. *A Users Perspective Of Day Centres In East/West Kent (2009-2010)* - In 2009 the Kent Local Involvement Network (LINk) was approached by Kent Adult Social Services (West Kent) with a request to assist them in gathering the views of individuals who use day care services run by Age Concern in the west of the County. This work was then replicated in 2010 in the East of the County. LINk Authorised Visitors were used to visit centres across Kent, hold focus groups with users of centres, and further in-depth interviews. The final report highlighted the use of day centres by people suffering from dementia, which provide not only a lifeline for those users but a welcome respite for families/carers. Service users drew attention to the increasing number of their fellow users suffering from dementia to varying degrees. It was apparent that users also form part of the caring regime for this vulnerable group and tend to "watch out" for them. The extent to which users felt they missed out because of this was not easy to gauge. However, it was apparent that some users are concerned about staffing levels, including the level of volunteers, and about perceived funding problems.

3.3. *Monitoring Quality of Residential Homes in East Kent (2011)* - The Kent LINk was approached by Kent County Council (KCC) and asked to assist with a project being run in conjunction with Older Peoples' Forums to monitor the quality of care in residential homes across East Kent. All care homes across East Kent received information about the LINk, its right to enter and view, the project being undertaken on behalf of KCC and informing them of unannounced visits taking place at a selection of homes in the area. Three homes were nursing homes for older people, eight were nursing homes for people with dementia, sixteen were care homes for older people and nine were care homes for people with dementia. All homes were privately owned but hold contracts with KCC. The LINk was pleased to note that the nursing homes for people with dementia all received positive comments, especially in relation to safety.

3.4. *Monitoring Quality of Residential Homes across Kent (2012)* - Following on from the East Kent project, the Kent LINk has decided to expand its remit to look at homes across Kent using the lessons learnt previously.

Once again, the work will be focused on residential homes for older people specifically and nursing homes and homes catering for people with dementia are included. The information received will be used to make recommendations to Kent County Council and the individual homes visited. The LINk will be happy to share this report with the Health and Wellbeing Board when it is due to be completed in July 2012. In the meantime if any significant issues are raised (such as safeguarding), then the LINk will immediately notify the home owner and Kent County Council.

3.5. *Care of Older People in Hospitals (2012)* - Following several issues raised by members of the public, the aim of this project is to establish local and national best practice with regards to the care of older people in hospitals and establish if patient experience suggests that best practice is being followed in Kent. As part of the project, LINk Authorised Visitors are talking to patients with dementia or their carers. The initial research is being collated now, and a full report will be available in September 2012. Recommendations will be shared with all relevant parties.

Projects included on the 2012/2013 work programme (subject to agreement at the LINk Annual Meeting on 16 May 2012) which may involve dementia as a subject include:

- Health and Social Care Integration
- Discharge from Hospital procedures
- Follow-up to Monitoring Quality of Residential Homes project
- Follow-up to training and supervision of care staff project

4. Kent LINk Monthly Bulletin

Articles on dementia have featured in 18 of the 48 bulletins that have been produced since 2008. This includes:

- National Information regarding dementia
- Advertising Events that relate to dementia services
- Promoting external volunteering opportunities
- Requests for information from LINk participants
- Opportunities to get involved in LINk projects that include looking at dementia services
- Reports from meetings where dementia has been discussed

5. External Representatives

The LINk currently has two participants who sit on the Maidstone and Tunbridge Wells NHS Trust Dementia Strategy Group. To help the LINk External Representatives contribute and take part in the discussion, KMN invites anyone with an interest in the subject to provide views, which can be raised at the meetings. As part of the information sharing and feedback, reports from the

meetings are advertised in the LINk bulletin and on the LINk website. Any recommendations for LINk action are considered by the Governor's Group.

Recently some concern was expressed regarding the reality of availability and extent of supplementary dementia support services. The LINk would support the Health and Wellbeing Board looking into further services, with a particular emphasis on how Health and Social Care Integration can help patients and carers. [**Recommendation Two**]

The LINk also has representation on the Health Overview and Scrutiny Committee. Following the report received from the March 2012 meeting, the LINk has agreed to monitor the recommendation made in the Kent County Council Dementia Select Committee Report.

6. Consultations

LINk participants are kept up to date on consultations that are happening locally, regionally and nationally and are given opportunities to get involved and have their say on the services they use. The consultations are advertised online via the LINk's website or in the LINk's monthly Bulletin.

The LINk has provided the opportunity to get involved in the following consultations related to dementia:

- Nursing Care at Home - Queens Nursing Institute
- Proposed Regulations to Care Quality Commission registrations - Care Quality Commission
- Implementing a 'Duty of Candour'; a new contractual requirement on providers - Department of Health
- Development of the Social Care White Paper - Department of Health
- Preventative Services - Strategic Commissioning Families and Social Care, Kent County Council.

7. Issues raised with Kent LINk

Several issues involving the subject of dementia have been raised with the LINk and considered by the LINks Priorities Panel:

- ID 078 – Tunbridge Wells Hospital issues
- ID 059 - LINk visits to care / nursing homes in West Kent
- ID 057 - Ombudsman Report – Care of Elderly people
- ID 053 - Transport to Pembury Hospital
- ID 048 - Withdrawal of minibuses for the elderly
- ID 045 - Lack of joined up services for vulnerable adults
- ID 034 - Medication Errors in Care Homes for Older People
- ID 032 - User Perspective of Age Concern Day Centres in East Kent
- ID 025 - Input into tender for West Kent Enhanced Dementia Crisis Service
- ID 021 - Eligibility for Continuing Care and Concerns over Neglect

- ID 020 - Failure of NHS West Kent to allocate the funding it has been given to provide carers with short breaks
- ID 009 **-** Financial abuse of self funders and other vulnerable adults

Further details of the issues and outcomes are outlined within the attached appendix. All such issues are considered by the LINk's Priorities Panel against a set of criteria, and they decide what action is the most appropriate for the LINk. Actions range from seeking further information, enquiries or fact-finding from the providers or commissioners to full-scale project work. Where the LINk feels it is unable to offer assistance, the originator is signposted to the most appropriate source.

The LINk has noticed, through issues raised with the Priorities Panel, that there is an increased interest in the care of the elderly. The subject is often reported both nationally and locally, usually in a negative light. The LINk projects that have arisen as a result of these concerns, give opportunities to highlight cases of best practice as well as areas for improvement. The LINk would welcome anyone else to do the same to help increase public awareness and education. [**Recommendation Three**]

8. Conclusion

As highlighted, the LINk has a wide range of mechanisms for involving the patients and public. The way in which the LINk operates will be useful to the Health and Wellbeing Board as a whole, but also to the individual members.

The LINk is able to gain the lay perspective, as required for the Health and Wellbeing Board. This will continue to be an intrinsic and valuable part of Local Healthwatch. The LINk wishes to establish a process for working with the Health and Wellbeing Board, which can then be passed onto Healthwatch as part of its legacy.

As evident above, the LINk has a variety of methods it can employ to gather the intelligence needed, however it should be noted that the LINk does require time in order to be able to fulfil its functions to the best of its ability. The LINk welcomes the opportunity to sit on the Health and Wellbeing Board, with this in mind it might be helpful to give earlier indication for possible future subjects and a time line for submissions as is done by the HOSC, to ensure it can achieve the best value and impact for the committee and , of course, the residents of Kent.

Appendix: Priorities Panel Issue Log

Item No.	ISSUE TITLE (PDW)	Status
ID078	Complaints against Tunbridge Wells Hospital	External Representative to attend MTW Trust meeting and raise concerns
ID 059	LINk visits to care / nursing homes in West Kent	Visits are being scheduled in to the LINk work programme where visits to West Kent will be included in a county wide project.
ID 057	Ombudsman Report – Care of Elderly people	Ombudsman Report on Care of Older People while in the care of the NHS noted. LINk project initiated.
ID 053	Transport to Pembury Hospital	Letter received from Tunbridge Wells Borough Council on 8 September 2011 advising that the NHS and KCC are working together to come to an acceptable resolution and that they do intend to make provisions but these are still under discussion.
ID 048	Withdrawal of minibuses for the elderly, Age Concern	Sent letter of concern about the effects on older people to Sevenoaks District Council. They, are now investigating whether better co-ordination of existing transport services might be possible.
ID 045	Lack of joined up services for vulnerable adults	Sent case study to Director of Social Services and Chief Constable but no response. Have requested this issue be addressed by the Policy Overview and Scrutiny Committee for Adult Social Services.

Item No.	ISSUE TITLE (PDW)	Status
ID 034	Medication Errors in Care Homes for Older People	Guidelines have been issued. No action to be taken immediately, but decision to write to PCTs after deadline for recommendations to establish how recommendations have been implemented.
ID 032	User Perspective of Age Concern Day Centres in East Kent	Approved by Kent LINk Governors as a project.
ID 025	Input into tender for West Kent Enhanced Dementia Crisis Service (or Emergency Support Service)	LINk participants involved in process.
ID 021	Eligibility for Continuing Care and Concerns over Neglect	No further action as constitutes complaint; advice to referrer.
ID 020	Failure of NHS West Kent to allocate the funding it has been given to provide carers with short breaks	Response to West Kent for further clarification as to how this funding is to be used.
ID 009	Financial abuse of self funders and other vulnerable adults	Referred to Governors' Group; issue was raised with Adult Protection Committee, KCC.

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