AGENDA

HEALTH AND WELLBEING BOARD (SHADOW)

Wednesday, 30th January, 2013, at 6.30 pm
Medway Room, Sessions House, County Hall, Maidstone

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. Chairmans welcome
2. Substitutes

Part 1 (6.30 - 7.45 pm)

3. Declaration of Interests by Members in Items on the Agenda for this meeting
4. Minutes of the Meeting held on 21 November 2013 (Pages 1 - 6)
5. Kent Health and Wellbeing Board - Future shape and draft work programme 2013-14 (Pages 7 - 18)
6. Joint Kent Health and Wellbeing Strategy (Pages 19 - 76)
7. Provider Relationships (verbal update)
8. Public Health Outcomes Framework (Pages 77 - 84)
9. Reconfiguration Proposals for East Kent Hospitals (verbal update)
10. Care in the Digital Age (Pages 85 - 90)
11. Tobacco Control in Kent (Pages 91 - 98)

Part 2 (7.45 - 8.30 pm)

12. End of Life Care - presentation
13. Future Meeting Dates 2013

    Please note that the date of the next meeting is on **Wednesday 27 March 2013** at **6:30 pm** in the **Medway Room**, Sessions House, County Hall, Maidstone ME14 1XQ.

Future meeting dates for the rest of the year are as follows:

Wednesday 29 May
Wednesday 17 July
Wednesday 18 September
Wednesday 20 November

Peter Sass
Head of Democratic Services
Tuesday, 22 January 2013

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.

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 BC
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
Cllr Michael Lyons	Shepway District Council
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
Simon Perks	Accountable Officer, Ashford and Canterbury & Coastal CCGs
Dr Roger Pinnock	Chair, Ashford CCG
Dr John Ribchester	Chair & Clinical Lead, Whitstable CCG
Veronika Segall Jones	Local Healthwatch
Dr Garry Singh	Clinical Lead, Maidstone & Malling CCG
Dr Sanjay Singh	Clinical Lead, West Kent 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

This page is intentionally left blank

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD (SHADOW)

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

PRESENT: Mr R W Gough (Chairman), Dr B Bowes, Dr M Cantor, Mr P B Carter, Dr S Chaudhuri, Ms F Cox, Cllr J Cunningham, Ms M Farrow, Mr G K Gibbens, Mr A Ireland, Mr R Kendall, Cllr M Lyons, Ms M Peachey, Dr R Pinnock, Ms V Segall Jones, Mr R Stewart, Dr J Thallon, Mr C Tomson, Cllr P Watkins, Mrs J Whittle and Dr D Woodhead

IN ATTENDANCE: Ms C Davis (Strategic Business Advisor), Ms P Green, Mr A Houlden, Mr A Scott-Clark (Director of Health Improvement (KCC), NHS Kent and Medway), Ms M Varshney, Mr M Wilson, Ms H Wolstenholme and Mr P D Wickenden (Democratic Services Transition Manager)

UNRESTRICTED ITEMS

69. Welcome
(Item 1)

(1) The Chairman, Roger Gough, Cabinet Member for Business Strategy, Performance and Health Reform welcomed everyone to the meeting for the meeting of the Shadow Health and Wellbeing Board. He made particular reference to Veronika Segall Jones who had been appointed to the Shadow Board as the representative for Local Healthwatch.

(2) The Board noted that the invitation to tender for the operation of Local Healthwatch had been sent out the previous week.

(3) The Shadow Board had two more meetings arranged before the Board came into operation on 1 April 2013 as required by the legislation.

(4) An officer team would be meeting shortly to work out a draft programme for the Health and Wellbeing Board for the forthcoming year. The proposed programme would be presented to the Committee at its January meeting.

(5) The Chairman informed the Shadow Board that the County Council were hosting the Communities and Local Government Select Committee next week. The following week the Chairman had been invited to give evidence to the Select Committee on the role being played in the Health reforms.

70. Substitutes
(Item 2)

The following apologies were received and noted.

Dr Fiona Armstrong and Dr Mark Jones

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

There were no declarations of Interest by Members on any items on the agenda for this meeting.

72. Minutes of the Meeting held on 19 September 2012
(Item 4)

RESOLVED that the Minutes of the meeting held on 19 September 2012 are correctly recorded and that they be signed by the Chairman.

73. Update on the draft Kent Joint Health and Wellbeing Strategy
(Item 5)

(1) The Shadow Health and Wellbeing Board were informed of the ongoing stakeholder engagement which concluded on 23 November 2012 and noted the initial comments received.

(2) Following the conclusion of the consultation process the Kent Joint Health and Wellbeing Strategy will be prepared. The Chairman will be asked to approve the Strategy on behalf of the County Council.

(3) The Shadow Health and Wellbeing Board noted that the draft Strategy had been circulated widely. To date 35 responses had been received.

(4) The Shadow Board noted that there had been informative and useful debates at the County Council's Health Overview and Scrutiny Committee and Policy and Resources Cabinet Committee.

(5) Mr Carter stressed the importance of getting the Strategy right. He said that the Strategy should be the catalyst to influence change working with the executives of the Clinical Commissioning Groups and the local Health and Wellbeing Boards.

(6) Dr Pinnock said that the outcomes in the Strategy needed to be achievable. He stressed the importance of the Clinical Commissioning Groups and Social Care Commissioning Strategies and the Local Health and Wellbeing Boards being compatible with the Kent Health and Wellbeing Board Strategy.

(7) The Strategy would be circulated electronically to all Members of the Shadow Board before it is approved.

74. Safeguarding Children and engagement with the Board
(Item 6)

(1) Mrs Blyth Independent Chairman of the Kent Safeguarding Children Board (KCSB) made a presentation to the Shadow Board on its role and purpose.

(2) The presentation provided the opportunity for the Shadow Health and Wellbeing Board to consider the interrelationship with the KSCB and its dual role to influence the Joint Strategic Needs Assessment. As an example Mrs Blyth suggested that the Health and Wellbeing Board should report back to the KSCB on how well early intervention services are embedded in Kent.

(3) Membership of the KSCB was key and Mrs Blyth was particularly interested in how the Clinical Commissioning Groups would be represented on the KSCB.

(4) Mrs Blyth informed the Board that she had met with the Mr Gough and they had discussed the possibility of the Annual report of the Kent Safeguarding and Children Board being submitted to a meeting of the Health and Wellbeing Board in July.

(5) Mrs Whittle stressed the synergy and need to work together with the KSCB citing the opportunities to work together. She added that having a clear and formal reporting line was key moving forward.

(6) Ms Davies expressed the view that within the newly created Clinical Commissioning Groups there was a key issue around the skill set and knowledge for safeguarding issues. She added that historically in the Primary Care Trust infrastructure there was one PCT which had taken the lead on these issues.

(7) Mr Carter emphasised the need for a Communication Strategy for the Health and Wellbeing Board. It was important that CCG Executives identified the “big ticket” items. There needed to be a network to share good practice speedily.

(8) Dr Woodhead said that there needed to be a collaborative approach across Kent and Medway. Having an operational post to ensure the two way communication between the relevant agencies was key and this was acknowledged by Mrs Blyth.

(9) Ms Carpenter said that across Kent there were four Nursing Officers.

(10) Mr Watkins expressed the view that from what had been said there did not appear to be a great deal to do to ensure that the agencies were joined up and working together.

(11) Dr Woodhead said that from a CCG perspective there needed to be the ability to assess what was going on across Kent and Medway.

(12) Mr Ireland said that the “Improvement Notice” which Kent County Council was addressing made it clear that the relationship between the agencies/ boards must be joined up.

(13) Dr Pinnock said in times of immense change there was an opportunity for things to go wrong. Often issues were seen as threatening. He questioned whether existing teams should be dismantled. He added that there should not be a wasteful rethink if improvements could not be achieved.

(14) Mrs Peachey said that there were opportunities here for CCGs. She added that there was a very important report about to be published by a Kent County Council Select Committee which had been looking at the issue of Domestic violence.

(15) The Board AGREED that work should continue around collaboration between the Board and the KCSB; the review of the KCSB annual report should be the bare minimum, and work should continue in areas such as the Common Assessment Framework.

(16) There would be a report back to the Health and Wellbeing Board on 30 January 2013 on the arrangements for collaboration which have been established.

(17) It was agreed that a response should be sent to the letter recently received from David Nicholson following the recent revelations relating to the late Jimmy Saville.

(18) Dr Pinnock asked about the role of the Care Quality Commission (if any in safeguarding issues) bearing in mind the Commission had an oversight role.

75. Update on Long Term Conditions
(Item 7)

(1) Jenny Thomas, Assistant Director – Planned Care (NHS Kent and Medway) Anne Tidmarsh Director of Commissioning and Provision (KCC) and Abraham George (Assistant Director, Public Health Consultant (KCC) made a presentation on long terms conditions.

(2) The Shadow Board discussed how resources could be released and patients supported to prevent hospitalisation.

(3) The Board noted the work which was taking place in South Kent Coast where an Integrated Commissioning Plan was being prepared focussing on long term conditions.

(4) It was agreed that local Health and Wellbeing Boards should look to develop their own programmes of work regarding Long Term Conditions. This should be an item for the Chairman's continuing discussions with CCGs, and progress should be reported back to the Board.

76. Commissioners Role in Tackling Health Inequalities
(Item 8)

(1) Professor Chris Bentley made a thought provoking presentation on tackling health inequalities and evidenced this with some examples across the country. He drew particular attention to how focussing on the right patients in terms of public health GPs and agencies could have a significant impact.

(2) Dr Chaudhuri said that the principles which Professor Bentley had articulated in his presentation would be key in the local health economy setting its priorities and making informed educated decisions. It would be important to have the flexibility between the Local Heath and Wellbeing Board and the Clinical Commissioning Group.

(3) Dr Bowes welcomed Professor Bentley's presentation which he said he would like his CCG Governing Body to see. He added some GPs just "do not get it"

(4) Dr Chaudhuri expressed the view that it was important to look at what is achievable and what is practical.

(5) Dr Pinnock spoke about the sub infrastructure for CCGs and the issue around devolution to local Health and Wellbeing Boards.

(6) Professor Bentley stressed the importance of not neglecting any one group

(7) Mr Ireland said it was key to have the data as local as possible for holding decision makers to account. The relationship between Local Health and Wellbeing Boards and this Board and their respective accountabilities was key.

(8) Mr Tomson said that Clinical Commissioning Group leads understood the issues but this might not be the case for all GPs

(9) It was AGREED that it would be helpful for all areas to identify their local priorities for reporting to the Kent Health and Wellbeing Board.

77. Date of next meeting - 30 January 2013
(Item 9)

This page is intentionally left blank

By: Andrew Scott-Clark, Director of Public Health Improvement

To: Kent Shadow Health and Wellbeing Board – 30 January 2013

Subject: Kent Health and Wellbeing Board – Future shape and draft work programme 2013/14

Classification: Unrestricted

---

1. Introduction

1.1. This paper provides the Kent Shadow Health and Wellbeing Board with feedback from the HWB planning group which met on the 9th January to discuss the future shape of the Board and work programme for the year ahead as it moves from being in "shadow form" to operating as a full committee by the end of March 2013.

2. Developing the work programme

2.1. The HWB is acting as a full KCC committee operating in shadow form until the final legislation detailing the statutory duties of the HWB is enacted. Secondary regulations are due to be published later this month and the Kent HWB will be established as a full committee by the end of March 2013.

2.2. A small KCC officer steering group for the HWB was established last December, tasked with developing a 12 month programme for the Board in wider consultation with health colleagues and the CCGs. `

2.3. It was agreed at the workshop on the 9th January that topics for future Board meetings will be based around the 5 outcomes set out in the HWBS: young people, health & wellbeing, long term conditions, mental health and dementia. The role of the HWB in relation to the sub architecture in Kent was discussed and agreed that the Board will have a performance management role, reviewing where local HWBs are at on a quarterly basis, as well as signing off CCG operating plans and integrated commissioning strategies.

2.4. The proposal is for the Board agendas to have a four fold structure along the following lines:

- deep dive on priorities and outcomes on a rolling basis
- performance management/review of where local HWBs are at on a quarterly basis
- sign off of plans and strategies
- developmental/workshop sessions four times a year

2.5. The Board will continue to meet bi-monthly on a Wednesday evening at 6.30 pm at County Hall, Maidstone. It was agreed that it would be beneficial to have 4 extra workshops/development sessions outside of the formal Board meetings to devote time to specific topics such as a CCG conference, provider engagement and a workshop for commissioners. The attached draft work plan in Appendix A sets out the proposed programme for the year ahead.

3. Operating principles, Terms of Reference and Membership

3.1. The operating principles, ToR and membership of the Shadow Board were also reviewed at the workshop. The attached ToR in Appendix B has been modified to reflect how the HWB has operated over the last 12 months. However, they have been produced before the Secondary Regulations on the establishment of HWBs has been published. Please note that as the HWB is a Committee of the County Council, any ToR and Standing Orders will have to be ratified by a meeting of the full Council.

3.2. The Secondary Regulations will amend or disapply four different Local Government Acts that pertain to the establishment and running of committees. They are likely to impact on the following areas (this is not an exhaustive list): political proportionality, voting, declaration of pecuniary interests and code of conduct. Once the regulations are published, work will be undertaken to ensure that the ToR and Standing Orders for both the Kent HWB and CCG level HWBs are fit for purpose. This will be done in time to establish the Kent HWB as a formal Committee of the Council as of the 1st April 2013.

4. Recommendation

4.1. The Shadow HWB is asked to comment on and approve the proposed work programme for 2013 – 14 and the amended ToR and membership.

Proposed Programme for the Health and Wellbeing Board 2013-14

Timeframe	Strategic Development / Milestone	Outcome	Proposed HWBB agenda item	Key operating principle of HWBB addressed
30th Jan 2013	Focus on future shape of the Board and workshop on End of Life Care	Work programme for 2013/14 agreed	Joint Health & Wellbeing Strategy - sign off final document	To provide collective leadership to improve health and wellbeing across Kent, enable shared decision making and ownership of decisions in an open and transparent way.
			Future shape of the Board and work programme	
			Provider relationships	
			Kent's report on delivery of Public Health Outcomes	Provide Board Assurance on Public Health outcomes.
			Care in the Digital Age (paper for noting, James Lampert)	
			Workshop for HWBB members	
			End of Life Care	
14th March 2013	**Developmental/ workshop session**	**CCG Conference**		
27th March 2013	Authorisation of CCG Operating Plans	CCG Authorisation	Sign off of 7 CCG Operating Plans	Formal review and sign off by the Board
			South Kent Coast Integrated	

			Commissioning Strategy for sign off (the remaining 6 CCG Integrated Commissioning Strategies will be signed off by the Board when they become available) Personal health records - paper on how we jointly procure an electronic personal health record system with recommendation re: risk and ownership (James Lampert)	
29th May 2013	HWBS Outcome 1 - Focus on Young People	Integrated delivery models	Integrated delivery model for CAMHS Integrated delivery model for Sexual Health Pathway Assurance on Integrated multiagency working to reduce Teenage Pregnancy rates Children's Centres, health visitors	To identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources improve local health and well-being in the short, medium and long term. To achieve democratic legitimacy and accountability, and empower local people to take part in decision making.

			School nursing Healthy schools (Helen Jones) JSNA update – changes since the previous year	Update to inform the development of a 3 year HWBS 2014 – 2017
Pre-summer	**Developmental/ workshop session**	**Provider engagement (focus on key strategic issues from providers)**		
31st July 2013	HWBS Outcome 2 – Health and Wellbeing		Assurance Report on collaborative working to tackle wider determinants such as unemployment, housing etc to tackle Children's Health inequalities.	To address health inequalities by ensuring quality, consistency and comprehensive local government services are commissioned and delivered in the area.
25th September 2013	HWBS Outcome 3 – Focus on long term conditions		Risk stratification Integrated care systems Self management Feed into winter planning	
Pre-Christmas	**Developmental/ workshop session**	Performance management – The Board to review how local		

		HWBs are functioning		
27th November 2013	HWBS Outcome 4 - Mental ill health			
29th January 2014	HWBS Outcome 5 - Dementia			
Late March	**Developmental/ workshop session**	**Workshop for Commissioners**		
26th March 2014	Sign off CCG commissioning plans for 2014/15			

Kent Health and Wellbeing Board

Draft Terms of Reference

Please note that these have been amended ahead of the publication of the Secondary Regulations on establishing Health and Wellbeing Boards.

Role

The Kent 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, reduce health inequalities and ensure 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 Kent 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, Clinical Commissioning Group or the NHS Commissioning Board as appropriate, drawing attention to their reservations).

5. Have oversight of the activity of its sub committees (Clinical Commissioning Group level Health and Wellbeing Board); focussing on their role in developing Integrated Commissioning Strategies and Plans at a local level.

6. Work alongside the Health Overview and Scrutiny Committee to ensure that substantial variations in service provision by health care providers are appropriately scrutinised. The Kent HWB itself will be subject to scrutiny by the Health Overview and Scrutiny Committee.

7. 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.

8. Discharge its duty to encourage integrated working with relevant partners within Kent (e.g. at locality level). This may cover endorsing and securing joint arrangements, including integrated commissioning where agreed and appropriate. 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.

9. Work with existing partnership arrangements for example, Children's commissioning, Safeguarding and Community Safety, to ensure that the most appropriate mechanism is used to deliver service improvement in health, care and health inequalities.

10. Consider and advise CQC, NHS Commissioning Board, Monitor and Providers in health and social care with regards to service reconfiguration.

11. Work with Health Overview and Scrutiny and/or 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.

12. 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.

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 principal 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
    - Executive Director for Families and Social Care*
    - Director of Public Health*

2. Clinical Commissioning Group representation: up to a maximum of two representatives from each consortium or to be determined by the CCG leads (e.g. Chair of CCG Board and/or Accountable Officer)*

3. HealthWatch*

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

5. NHS Commissioning Board Local Area Team*

*denotes statutory member.

Kent Health and Wellbeing Board – Terms of Reference

Standing Orders

Please note that these Standing Orders will be revised once the Secondary Regulations have been published.

1. **Conduct.** Members of the HWB are expected to subscribe to and comply with the Kent County Council Code of Conduct. Non elected representatives on the HWB (e.g. GPs and Officers), will be for the purpose of the HWB, co-opted Members and as such, covered by the Kent Code of Conduct for any business they conduct as part of the HWB.

2. **Declaration of Pecuniary Interests.** Section 31(4) of the Localism Act 2011 (pecuniary interest in matters considered at meetings or by a single member), will not be applied to Health and Wellbeing Boards or a sub committee of a Health and Wellbeing Board. However a register of pecuniary interests will be held by the Health and Wellbeing Board, but Health and Wellbeing Board representatives will not have to leave the meeting once a pecuniary interest is declared. This will also apply to any sub committees of a Health and Wellbeing Board.

3. **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.

4. **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.

5. **Meeting Administration of Sub Committees**. Sub Committees will be administered by a Local Authority, in the case of the CCG level Health and Wellbeing Boards, by a District Council in that area. They will be subject to the provisions stated in these Standing Orders.

6. **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.

7. **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.

8. **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.

9. **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.

10. **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.

11. **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.

12. **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.

13. **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.

14. **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.

15. **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.

By: Roger Gough, Cabinet Member for Business Strategy, Performance and Health Reform

To: Kent Shadow Health and Wellbeing Board – 30 January 2013

Subject: Kent Joint Health and Wellbeing Strategy

Classification: Unrestricted

---

1. Introduction

1.1 This paper updates the Kent Shadow Health and Wellbeing Board on the development of the Joint Health and Wellbeing Strategy and presents the final version to the Board.

2. Finalising the Joint Health and Wellbeing Strategy

2.1 The Board is asked to note the following:

- Wider public engagement on a draft strategy took place in the autumn of 2012. A summary of that engagement is attached to this report for information.
- The Joint Health and Wellbeing Strategy has been amended to reflect the comments made during the engagement process and is attached for your information.
- There are a number of places where some further information on targets/outcomes is awaited. In addition, the Board is asked to suggest areas of best practice that they would like to include in the 12 month strategy.
- The Strategy will be signed off by Roger Gough as Cabinet lead, under delegated powers.
- Once the strategy has been signed off, it will then go through the final design phase ahead of a formal launch and publication in March.

Recommendation

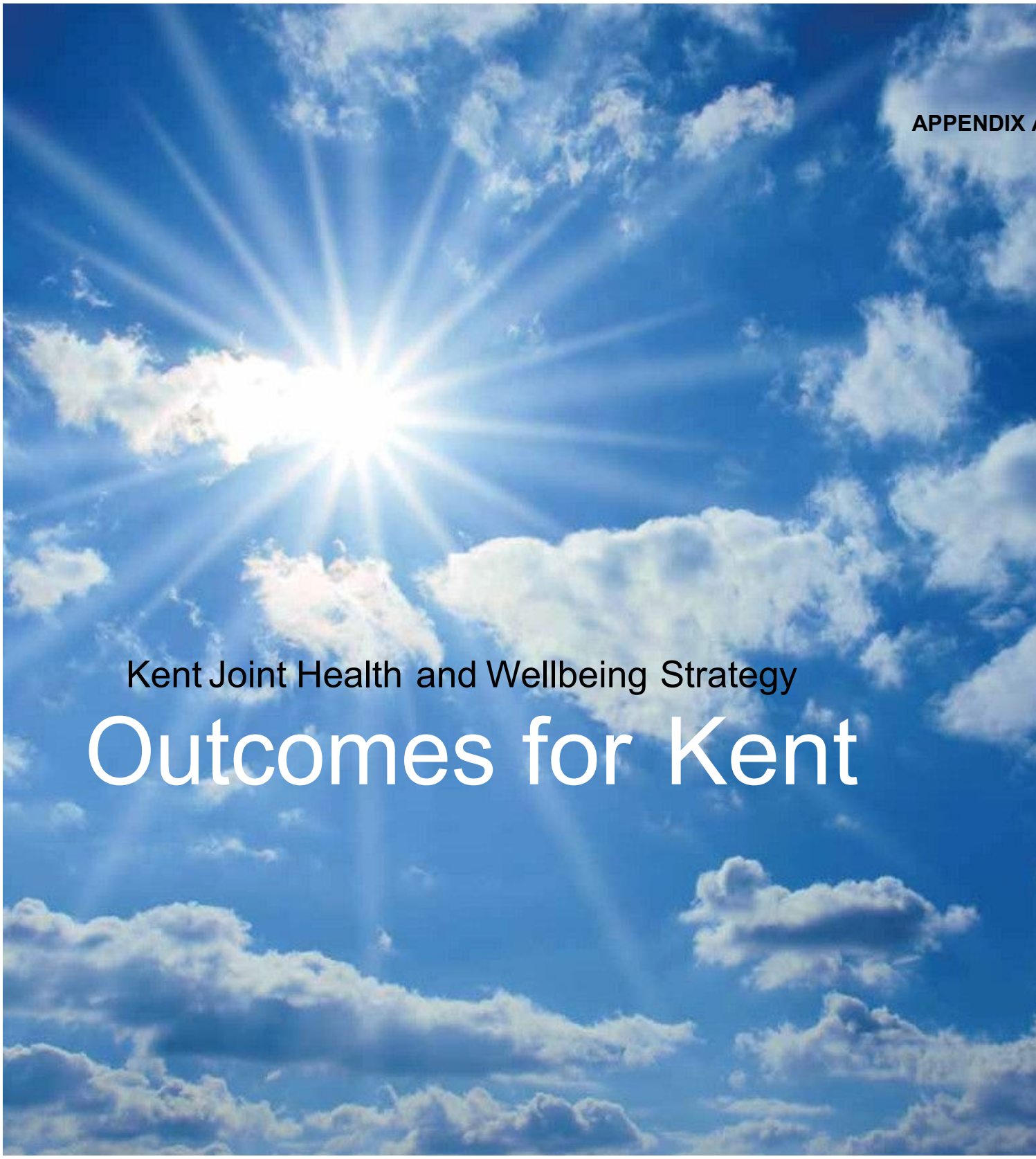
1. To note this report.

2. To suggest areas of best practice to include in the strategy

Appendices:

Appendix A – Kent Joint Health and Wellbeing Strategy
Appendix B – Feedback from the engagement process
Appendix C – Summary Report on the Kent Health and Wellbeing Strategy engagement exercise

This page is intentionally left blank



Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

Joint Health and Wellbeing Strategy for Kent
Kent Shadow Health and Wellbeing Board

This publication is available in other formats
and can be explained in a range of languages
Please call 08458 247 247 or Text Relay 18001 247 247 for details

Foreword

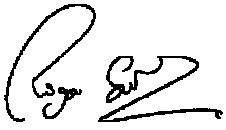
This, the first Kent Health & Wellbeing Strategy, comes at a time of two major changes in health and social care. The first is the introduction of a new partnership between health, led by GPs and local government under the Health and Social Care Act. This offers the chance for people who are locally focused and locally accountable to take responsibility for better care in Kent. This will be delivered through the Kent Health & Wellbeing Board, bringing together GPs, County and District Councillors, senior officers from Social Care and Public Health, as well as representation from Local Healthwatch - for the first time putting the patient and public voice at the heart of commissioning decisions.

The second is the growing pressure of demographic change, generating increased need for health and social care services, at a time of financial stringency. We have to change, and to work together more effectively, if we are to achieve better health outcomes for the people of Kent while staying within budget.

This Strategy aims to confront that challenge, to improve the areas in which - in spite of generally good levels of health - Kent lags behind the country as a whole, and to tackle the significant differences in people's health and wellbeing across the county.

We can do this through a greater focus on prevention, on the social conditions that affect health and wellbeing and on helping people take responsibility for their own health, and through more integrated working between GPs and local government. In all this the role of Public Health, coming back to local government from April 2013, is central. We aim to achieve better care closer to home, while focusing hospital and residential care services on those for whom they are truly essential. The end result must be a better quality of life, health and wellbeing, including mental well being, for the people of Kent.

This 12 month strategy sets out our major priorities. It will be for GP-led Clinical Commissioning Groups, the County and District Councils and other partners to produce more detailed plans on how the issues will be addressed in our local communities



Signed by Roger Gough
Chair of the Shadow Kent Health and Wellbeing Board.

Summary

This is the first Joint Health and Wellbeing Strategy for Kent. Good health and wellbeing is fundamental to living a full and productive life. Overall Kent has a good standard of health and wellbeing, but this hides some significant areas of poorer health and differences in life expectancy (15 years between the healthiest and least healthy wards in Kent).

This overarching strategy aims to identify the health and social care outcomes that we want to achieve for the people of Kent. This document will set out the challenges we face, what we are going to do to address them and what we will see as a result.

We must prioritise what needs most attention so we do not try and take on everything at once. By focusing on key issues we can make the biggest differences. This strategy sets out what we propose to focus on, how we propose to deliver improvements to health and wellbeing in Kent and what outcomes we want to achieve. It has not been developed in isolation, reflecting the evidence base of our Joint Strategic Needs Assessments and other key partner documents and data sources. This is also a high level strategy; our partners have detailed plans on how they plan to deliver improved services in Kent including improving people's health and wellbeing. This strategy will not repeat those documents; it will instead focus on issues we need to tackle together.

The opportunities presented by this new approach to health and wellbeing are significant. For the first time we have clearly identified shared health and care outcomes for Kent. This presents huge opportunities for new ways of working, to ensure that health, care and broader services are aligned to meet people's needs. For example, we will see more health services delivered in the local community, in places that patients find easy to access. We will see a more holistic approach to the patient, looking at their care pathway from prevention to better timed interventions. This will take time to deliver, however we have begun this ambitious programme. This 12 month strategy is the starting point for a long term partnership approach to improving health and reduce health inequalities in Kent.

Our Vision:

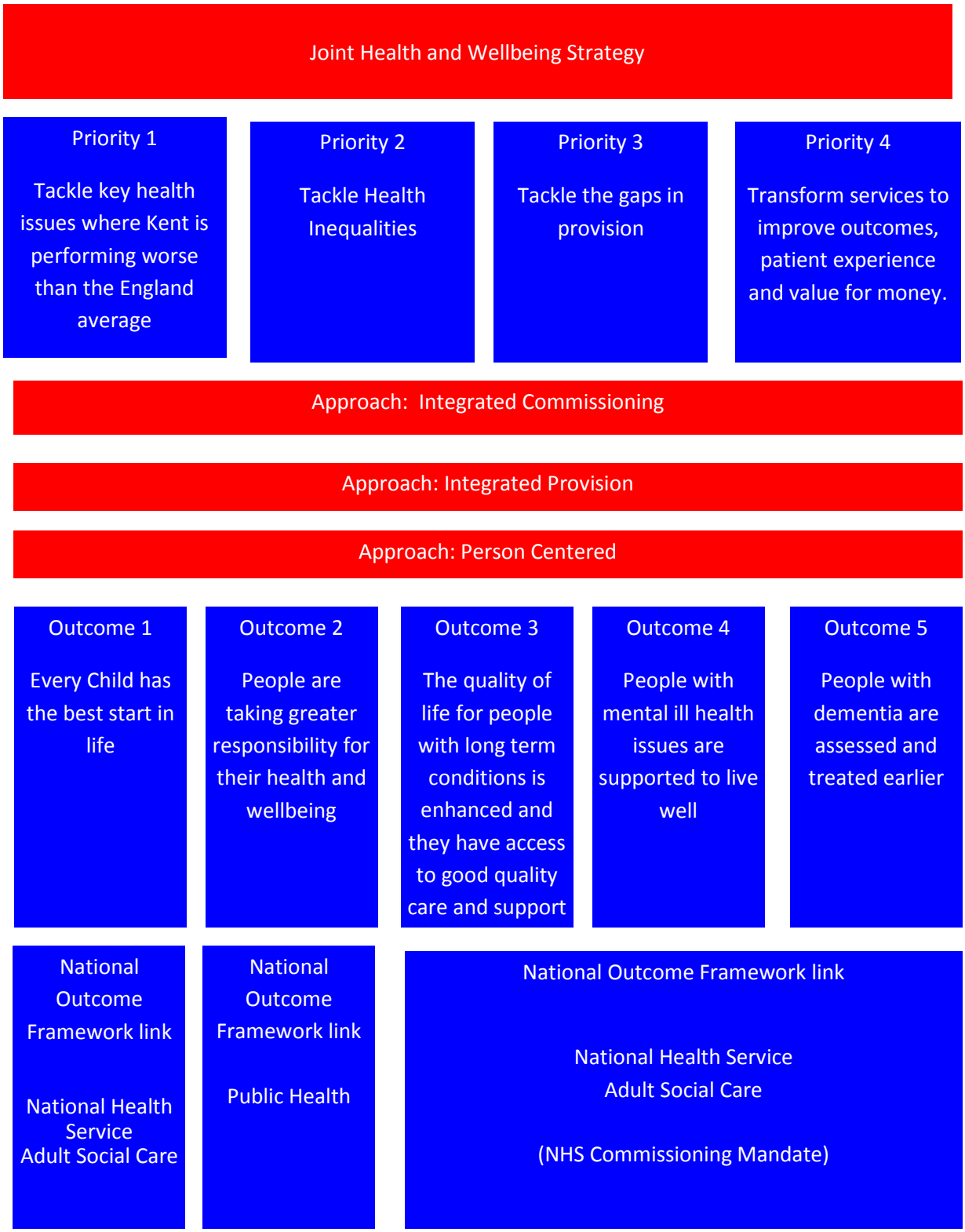
Our vision in Kent is to deliver better coordinated quality care, improve health outcomes, improve the public's experience of integrated health and social care services and ensure that the individual is involved and at the heart of everything we do.

The Health of the people of Kent

This document is based on data and evidence in the Kent Joint Strategic Needs Assessment, the Kent Health Profile 2012, the Kent Health Inequalities Action Plan "Minding the Gap" and guidance from the Department of Health.

Joint Strategic Needs Assessment http://www.kmpho.nhs.uk/jsna/ Kent Health Profile 2012 http://www.healthprofiles.info
Kent Health Inequalities Action Plan: "Mind the Gap" http://www.kmpho.nhs.uk/health-inequalities/?assetdet1118452=228636

The following diagram illustrates the key elements of the Kent Joint Health and Wellbeing Strategy.



The challenges that we face in Kent:

Many factors affect our health and wellbeing; our environment, living and working conditions, genetic factors, economic circumstances, how we interact with our local community and choices we make about our own lifestyles.

Health of the People of Kent

This document is based on data and evidence in the Kent Joint Strategic Needs Assessment, the Kent Health Profile 2012, the Kent Health Inequalities Action Plan and guidance from the Department of Health. These documents can be found at:

Joint Strategic Needs Assessment http://www.kmpho.nhs.uk/jsna/
Kent Health Profile 2012 http://www.healthprofiles.info
Kent Health Inequalities Action Plan: Mind the Gap http://www.kmpho.nhs.uk/health-inequalities/?assetdet1118452=228636

The Joint Strategic Needs Assessment identified the following key priorities that need to be addressed:

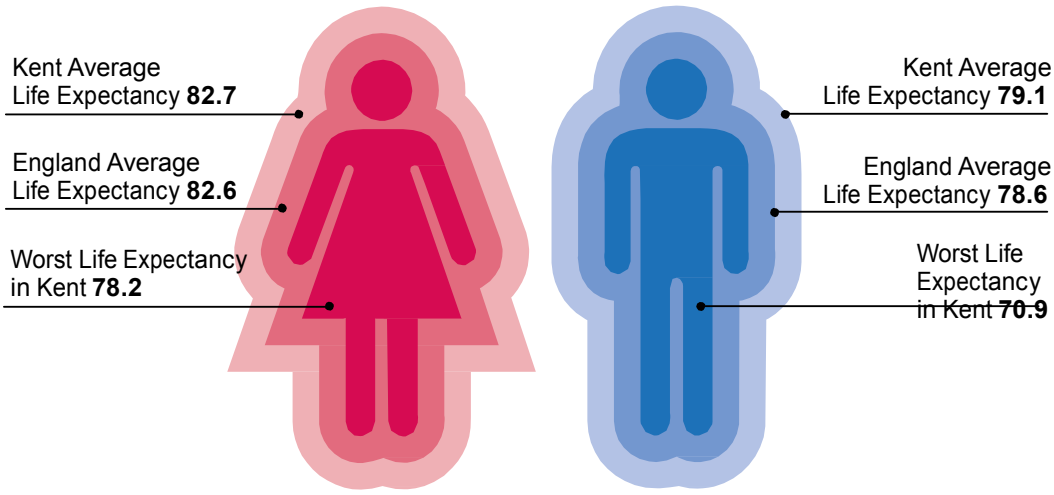
- Improving the health of children in their early years
- Improving lifestyle choices particularly of young people
- Preventing ill health and preventing existing health conditions from getting worse
- Shifting of care closer to home and out of the hospital (including dementia and end of life care) and improving the quality of care
- Tackling Health Inequalities

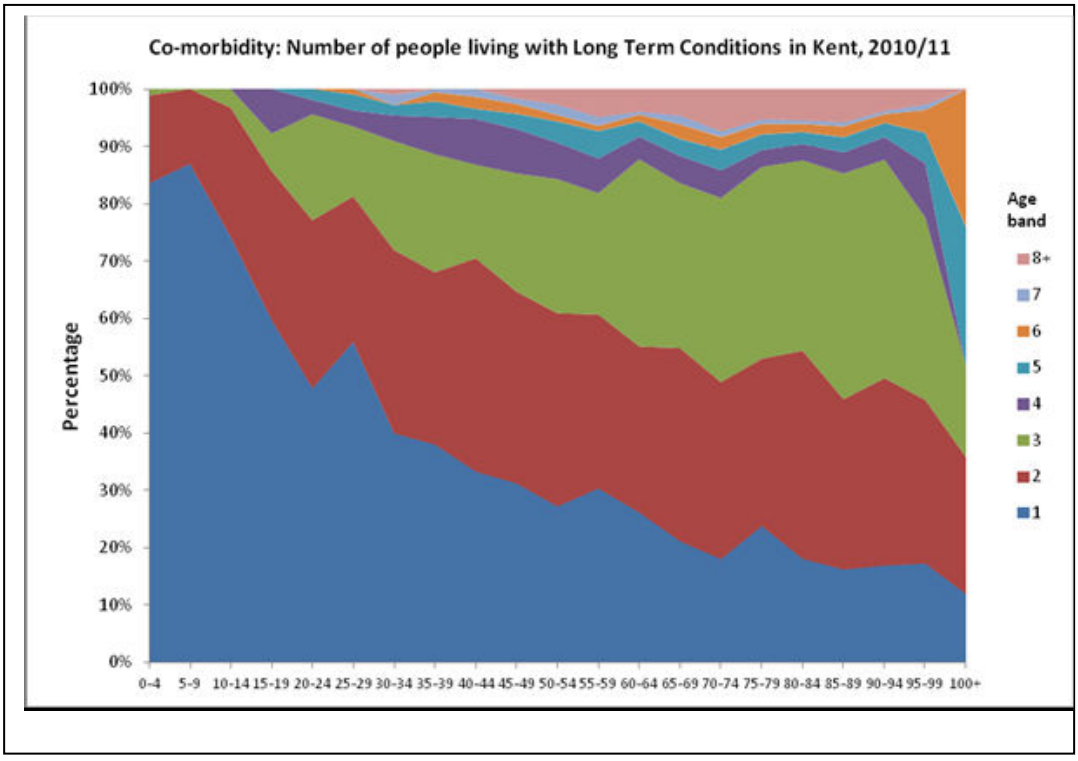
At a strategic level, the following are the challenges that we face in Kent: demographic pressures, poor performance on certain health outcomes and economic and financial pressures.

Demographic Pressures and Health Inequalities

Kent ranks 102 out of 152 county and unitary authorities in the English Indices of Deprivation 2010 (ID2010). This places Kent within England's least deprived third of authorities (a rank of one indicates the most deprived area). However, there are areas within Kent that fall within the 20% most deprived in England, there are a significant number of areas which are very deprived.

Kent has the largest population of all of the English counties, with just over 1.46 million people. The health of the people of Kent is mixed. Life expectancy is higher than the England average for both men and women However, life expectancy is significantly lower in deprived areas, with a man in a deprived area living on average 8.2 years less, giving him a life expectancy of 70.9 years and a woman living on average 4.5 years less, with a life expectancy of 78.2 years.


Kent Average
Life Expectancy 82.7
England Average
Life Expectancy 82.6
Worst Life Expectancy
in Kent 78.2
Kent Average
Life Expectancy 79.1
England Average
Life Expectancy 78.6
Worst Life
Expectancy
in Kent 70.9


Co-morbidity: Number of people living with Long Term Conditions in Kent, 2010/11
Percentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0-4 5-9 10-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75-79 80-84 85-89 90-94 95-99 100+
Age band
8+
7
6
5
4
3
2
1

Just over half of the total population of Kent is female (51.1%) and 48.9% are male. Over the past 10 years Kent's population has grown faster than the national average, growing by 7.8% between 2000 and 2010, above the average both for the South East (6.7%) and for England (6.1%). Kent's population is forecast to increase by a further 10.9% between 2010 and 2026.

Overall the age profile of Kent residents is similar to that of England. However, Kent does have a greater proportion of young people aged 5-19 years and of people aged 45+ years than the England average. Just under a fifth of Kent's population is of retirement age (65+). Kent has an ageing population. Forecasts show that the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026, yet the population aged under 65 is only forecast to increase by 3.8%. 70% of Kent residents describe themselves as being in good health but 16.5% of Kent's population live with a limiting long term illness. Kent's ageing population will place significant pressures on health and social care services.

Where Kent is performing below the national average for health outcomes:

Kent is performing worse than the national average on:

- smoking in pregnancy,
- breast feeding initiation,
- healthy eating among adults and
- obesity in adults worse than the national average.
- Injuries due to falls in women aged 65 and over and in people aged 80+.
- Fractured hips for people over 80
- Diagnosis rates for alzheimers
- First time entrants into the youth justice system
- Number of 16-18 year olds not in employment, education or training
- Rates of Chlamydia diagnoses (15-24 year olds)
- Vaccination rates for HPV and PPV and vaccines and the at risk group for influenza.

Continued poor performance in these areas will have a significant impact on the health of the population over the coming years with smoking and poor diet being a contributory factor in cancer and heart disease and obesity contributing to the increase in type 2 diabetes.

To improve people's long term health we have to improve healthy lifestyles; encourage healthy eating in adults, address the challenges of an ageing population; give every child the best start in life and enhance the quality of life for people with long term conditions, including mental health and dementia. We will need a real focus on differences in outcomes both within and between communities. In addition to this, we will need to look at how we improve people's knowledge of both the symptoms of various diseases such as cancer, and what they can do prevent them e.g. encouraging physical activity. Healthier choices need to become the easier choice to make.

We will also need to address the wider determinants of ill health e.g. lifestyle, access to services, employment status and housing conditions. If these are tackled successfully they will have a significant long term impact on people's health.

Years of life lost by people dying early, which are considered preventable.

A simple way to identify the impact of poor health and lifestyle choices on life expectancy is by looking at how many years of life are lost by people dying prematurely. In Kent, the number of years of life lost by people dying of preventable causes before the age of 75 is **165,576**. The key diseases that have led to the years of life lost are

circulatory disease, cancer and respiratory disease; all of which can be reduced by taking a more proactive approach to health and care. The graphics depict the breakdown of years of life lost by men and women; the types of disease contributing to this and the years of life lost by district.

Economic pressures

We know these are difficult economic times for everybody. Public sector organisations are facing tough decisions, about how to deliver the best, most efficient services within reduced budgets. This is made more challenging by an increase in demand on services such as social care and rising expectations of residents for higher quality services. This strategy is set against the risk of ensuring service sustainability during these times of unprecedented pressure on budgets and increase in need.

We will also focus on doing the right things well. In other words, commissioning the right services that improve health as well as delivering value for money. If a service is best delivered in a community setting rather than in a hospital, we will support this happening. We will focus more on preventing people going into crisis and requiring hospital care, by better use of risk profiling; by moving care out of hospitals into appropriate community settings. We will also need to look at how we make better use of social care, so that we can maintain people's independence for as long as possible.

How we will improve the health of the people in Kent.

With limited resources we need to focus on the key health issues that have been identified through the Joint Strategic Needs Assessment, including moving our focus from treatment to prevention. We will also focus on ensuring more treatment occurs in the community where appropriate. People should be able to access the right treatment, at the right time and in the right place.

We also believe it is important that local communities have a greater role in shaping and influencing services and improving health and wellbeing in communities. This will be supported by the role of democratically elected members and our local Healthwatch representatives (patient representation is an integral part of the Health and Wellbeing Board). Not only do we think this will help us tailor services to meet the needs of local people, we also understand the value of community in improving the health and wellbeing of residents. This will also extend to widening the involvement of the voluntary and community service in delivering health and care services in the community. The voluntary sector already play a crucial role in helping to prevent ill health and providing direct services to help keep people healthy and in their own homes. We must not lose sight of this.

To promote healthier lives for everyone in Kent our **priorities** are to:

- Tackle the key health issues where Kent is not performing as well as the England average. For example tackling the levels of adult obesity
- Tackle Health Inequalities across and within Kent. For example delivering the Kent Health Inequalities Action Plan "Mind the Gap"
- Tackle the gaps in provision and quality of care and support that the people of Kent receive. For example ensuring improved rates of diagnosis for mental health problems and get people into the right services when they need them. This will focus on delivering a number of interventions concurrently, such as medical interventions, improvements in lifestyle behaviours and improvements to social determinants of ill health (poor housing, poverty an worklessness).
- Transform services to improve health and care outcomes, the patient experience and value for money and quality. For example we want to see better community care, moving services closer to home, improving access for patients and carers.

In considering each of these priorities the approaches and the outcomes outlined in the following pages need to be taken into account, as

they are interdependent and their successful delivery is dependent on all elements being delivered.

The following bullet points have been taken from responses to the consultation on the JHWS:

"We need to prioritise tackling the key health issues where Kent is under performing because continued poor performance will have a significant impact on the health of the population in future years. For example, high obesity levels contributing to an increase in type 2 diabetes".

"If we tackle health inequalities we will be addressing all the priorities"

"The most important issue is to identify and tackle gaps in provision and quality of care as this will inevitably result in an efficient service that will be able to reduce inequalities in health and increase Kent's performance standard"

"We need to improve patient experience and outcomes first. This will produce a natural flow to inequalities, gaps in provision. If we get these things right then it is likely we will improve the key issues where we are performing worse?"

"Value for money has to be the main priority, then the gaps can be plugged which in itself will tackle some of the inequalities which should tackle health issues where Kent is performing under average".

"[This priority] is the most important in this era of economic constraint and coinciding with an ageing population with their increased demands for healthcare and social care".

We will deliver our 4 key priorities through the following approaches:

- Integrated Commissioning, leading to
- Integrated Provision (delivering seamless services to the public), which will be;
- Person Centered: we will get better at treating the whole person and not just the condition and improve access to services.

We also want to see a move from treating the condition to treating the patient. Quite often patients will experience more that one health problem, these need to be treated together, rather than separate treatment and appointments for each health problem; saving both patient time and improving clinical outcomes. Patients and the public should experience seamless services;. We know that patients can spend longer in hospital because they cannot go home as a result of their home not having the right adaptations. If we commission services together, we can work towards this sort of thing no longer happening.

The Health and Wellbeing Strategy will inform commissioning decisions made by local partners especially GP led Clinical Commissioning Groups (CCGs), so that they focus on the needs of patients, service users and communities, tackle factors that impact on health and wellbeing across service boundaries and influence local services beyond health and care to make a real impact on the wider determinants of health (e.g. employment, housing and environment). We are already developing a number of new ways of working, and where successful we want to ensure that we implement them across the whole of Kent.

For example:

Connecting Communities - We need to find cost effective ways of working with communities which empowers both local residents and frontline service personnel to improve health, well-being and local conditions in disadvantaged areas. Such an approach elsewhere has shown that it gives people greater control over their own lives, such that they are more likely to adopt health enhancing behaviours, it enables people to cooperate within their own neighbourhood to improve their shared conditions; and it enables people to participate in dialogue and negotiation with public agencies, making those more accountable and responsive.

Pro-Active Care – this programme works with people with at least 2 long term conditions, which have meant they have had to go into hospital in the last 12 months. Selected patients are offered 12 weeks of intensive support led by their GP and involving all the relevant services coming together. An action plan is developed to improve the patient's health and wellbeing. Changes might include a review of medicines, use of different equipment, intensive physiotherapy to support independence. So far patients that have taken part in this programme have seen a reduction in emergency admissions to hospital; if taken to hospital have spent less time there, have needed fewer outpatient appointments and were less likely to be anxious or depressed. It also involves a number of non medical interventions which have led to self reported improvements in quality of life and self confidence.

Patient Records – the governments drive towards more empowered patients with easier access to information is driving a revolution in the way in which patients and their carers access information held about them. Partners in Kent are working with new patient information systems which will enable patients and their carers to have better access to their records, empowering them to let other health and care professionals have access to these records which in turn will lead to more seamless provision of health and care services. We are working to remove the need for people to tell their health and care problems over and over again, rather then telling it once.

Health Visitors - There is currently a programme of work to develop effective universal health visiting services, a key element in improving support to children and families at the start of life. The service will deliver the national Healthy Child programme locally, working with Children's Centres, GPs and other local services.

HASCIP –

Urgent Care Work in C4G –

Year of Care Tariff -

How will we know if we have made a difference?

The earlier pages have described the health and care problems Kent faces, what our priorities are and what approaches we will take to tackle them. We will use outcomes across 5 areas to measure if we have made a difference. The following outcomes have been agreed with all the health and wellbeing partners in Kent:

1. Every Child has the best start in life
2. People are taking greater responsibility for their health and wellbeing
3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
4. People with mental ill health issues are supported to live well
5. People with dementia are assessed and treated earlier

There is already a lot of good work going on across Kent in these areas and this strategy is not intending to duplicate the work already taking place but we do want to ensure we are aware of these areas and make sure we are performing well.

All of this activity will deliver the priorities and targets identified in the National Outcome Frameworks for Public Health, National Health Service and Social Care. This is important as these Outcome frameworks set the national and local priorities for service delivery and outcomes. By identifying what is important for Kent, the Joint Health and Wellbeing Strategy is also the Health and Care Outcomes Framework for Kent.

Outcome 1: Every child has the best start in life

We know that improving health and wellbeing in early life contributes considerably to better outcomes in later life and helps reduce inequalities.

If we do this in Kent the following will happen: Over the next 3 years we will focus on achieving an increase in breast feeding take up, increasing targeted support on healthy eating in families leading to an increase in healthy weight level; and an increase in MMR take up, particularly in east Kent. Kent and Medway will see an additional 421 (whole team equivalents) Health Visitors by 2015 who will support families with young children.

This is what we will do:

1. Better use of Community Assets such as Children's Centres to deliver integrated health and social care to high risk vulnerable families
2. Rolling out Total Child Pilot to schools to help schools identify health and wellbeing problems for pupils
3. Working with families to promote healthy eating and increased physical activity
4. Improving child and adolescent mental health services (CAMHS)
5. Implement the Adolescent support workers programme, to deliver brief interventions as part of a wider team supporting young people and their families
6. Ensure all providers get safeguarding right for Kent
7. Reduce risk taking behaviour in children and adolescents e.g. smoking, sexual health, teenage conception, drugs and alcohol.
8. Ensure there is adequate health provision in Special Needs schools and for children with Special Needs in mainstream schools

We will measure success by:

1. Increasing breast-feeding initiation rates and continuance at 6-8 weeks, until it is at least 50% in all parts of Kent.
2. Improving MMR uptake and improve access to the vaccination particularly for the most vulnerable groups. To attain 95% coverage levels.
3. Promoting healthy weight for children particularly those in deprived areas
4. Ensuring women have access to good information and health and wellbeing in pregnancy and book their maternity care early
5. Working with families to promote healthy eating and increased physical activity
6. Reduce the numbers of pregnant women who smoke through their pregnancies by 50%

"In terms of investment, I believe that outcomes 1 and 2 are the most important – if we can get families with young children to take a greater responsibility for their health and wellbeing then this should have an impact for later life. But I really believe something different has to be done. Children's centres need to be used to really support families ongoing (not just until they are 5) in terms of health outcomes, using experts in their fields. The Children's Centre staff cannot do it all – there has to be a real partnership working with midwives, health visitors as well as colleagues in the voluntary and private sector."

Outcome 2: Effective prevention of ill health by people are taking greater responsibility for their health and wellbeing

We all make decisions which affect our health and wellbeing. We want to ensure we have provided the right environment in Kent for people to make better choices.
We have already got some good examples of where we are working with communities to promote healthy living, diet and exercise such as the Change 4 Life initiative. However, Kent is performing below average on obese adults and healthy eating and we are average on physically active adults. We will work towards ensuring that patients and the public are better informed about symptoms of major diseases such as cancer. We will support the making of healthier choices as easier choices.

Lifestyle choices can cover a wide variety of decisions; such as type and frequency of exercise, the food we eat, whether or not we smoke. They can also be affected by poor access to information about symptoms and awareness, guidance and access to services. Target resources so that levels of provision are proportionate to the levels of need to reduce inequalities (e.g. social gradients of ill health, Mind the Gap looks at this in detail).

If we do this in Kent the following will happen: A continued increase in people accessing treatment for drug and alcohol problems; fewer alcohol related admissions to hospital; an increase in people quitting smoking and staying smoke free; more people supported to manage their own conditions.

This is what we will do:

1. Ensuring there is provision for people with a learning disability living within residential accommodation to engage in physical activity and have a healthy diet
2. Ensuring rehabilitation pathways and screening services are in place and systematically applied so all people eligible are offered a service
3. Ensuring people are aware of symptoms, particularly cancer and encouraged to access services early
4. Ensuring the critical care pathways are in place across the Kent population to manage acute events according to nationally advised guidance (e.g. NICE) e.g. heart attacks and strokes
5. Ensuring that all providers maximise the opportunities to improve people's health e.g. implement the NHS Every Contact Counts initiative.
6. Ensure that where appropriate, specific targeted services are delivered to address specific health and wellbeing issues affecting minority communities.
7. Working with young people, in school settings, particularly those who are vulnerable, to tackle substance misuse, smoking and underage drinking and other risk taking behaviour
8. Ensuring primary preventative strategies are systematically in place locally to address the lifestyle contributory causes of the big killers, e.g. smoking, obesity, alcohol and illegal drugs consumption
9. Ensuring secondary prevention interventions are systematically in place locally and delivered at scale in order to have an impact on life expectancy. e.g. all people eligible for cardiac rehabilitation are offered this in
10. Developing the NHS Health Check programme, so that invites and take up exceeds national averages across Kent.
11. Better information and education so that people can recognise the symptoms of ill health.

We will measure success by:

1. Reducing the levels of inequalities for Life Expectancy
2. Reducing rates of deaths attributable to smoking in all persons, targeting those who are vulnerable or most at risk (focusing on social gradient of smoking)
3. Improving the proportion of our adult population that enjoy a healthy weight, a healthy diet and are physically active
4. Reducing homelessness and its negative impact for those living in temporary accommodation

5. Reducing the numbers of hip fractures and falls for people aged 65 and over, where Kent is currently performing significantly worse than the England average
6. Reduce the under 75 mortality rate from cancer
7. Reduce the under 75 mortality rate for respiratory diseases

"In order to improve health outcomes and reduce costs, particularly in areas where Kent is performing below the national average, it is essential that people are given the tools to take responsibility for their health. For example, any reduction in the incidents of smoking and obesity would enable resources to be targeted to improve health outcomes that prevention cannot address. Improvement on this outcome will have the greatest impact on the other four outcomes"

Outcome 3: The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

We know that our population is ageing and is living longer; we need to focus on not just adding years to life, but life to years. Currently, as we age, we start to experience a number of long term conditions (high blood pressure, COPD, heart problems) and these have a limiting affect on the quality of life and have an impact on resources. We want people with long term conditions to experience well coordinated services which prevent them from being admitted to hospital unnecessarily or experiencing a crisis.

We also want to ensure that high quality end of life care is delivered, which is coordinated around the needs of the individual and their families. This will be done by the systematic identification of patients who are at the end of life, and by providing the appropriate support and co-ordination of care to support patients, carers and their families.

If we do this in Kent the following will happen: More patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reducing number of times patients have to repeat information to professionals (Tell us Once).

This is what we will do:

1. Ensuring risk profiling is carried out consistently across the population of Kent using the same tool and done at scale, using both GP and social care data, which will help to prevent unplanned hospital admissions
2. Ensuring we have multi-professional teams working together, not in silos, so that people who need support from a variety of organisations do not face duplication of assessment and numerous referrals around the system
3. Ensuring people can be supported to live as independently as possible at home
4. Enabling General Practitioners to act as navigators, rather than gatekeepers, retaining responsibility for patient care and experiences throughout the patient journey
5. Enabling Clinical records to be shared across the multi-professional team, by assessing patient record schemes e.g. Patient Knows Best
6. All GP practices in Kent are undertaking risk profiling, working in integrated teams (between health, social care and others) and ensuring a range of self management approaches, e.g.
    - patient and carer education programmes
    - medicines management advice and support
    - the provision of telecare and telehealth
    - psychological interventions (e.g. health trainers)
    - pain management
    - patient access to own records, systematic training for health providers in consultation skills that help engage patients.

We will measure success by:

1. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
2. A 15% reduction in A&E admissions; a 20% reduction in emergency admissions and a 14% reduction in elective admissions.
3. Employment of people with Long Term Conditions
4. Increase the amount of people who are self reporting an increase in their health related quality of life for people with long term conditions/social-care
5. Palliative and end of life care, increase the number of people actively supported during their end of life care.

Outcome 4: People with mental ill health issues are supported to 'live well'

We have been working hard to ensure we deliver the Kent wide integrated strategy (Live it Well) for mental health and wellbeing of people in Kent. We have been putting into place the action plan to deliver high quality services for people with mental ill health issues. We know this can only be achieved by organisations working together across Kent, particularly in primary and secondary care. In addition, we will work with partners to continue to improve mental health service provision and implement "No health without mental health".

If we do this in Kent the following will happen: Early recognition of mental ill health will be increased, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support and early intervention services will see an increase in people reporting an improvement in their own mental ill health and wellbeing. The stigma of mental ill health will be reduced.

This is what we will do:

1. Promoting independence and ensuring the right care and support is available to prevent crisis
2. Awareness raising and access to good quality information
3. Working with the voluntary sector, other provider, carers and families to reduce the social isolation of people with mental health issues
4. Ensuring we have robust audit processes around mental health e.g. suicide prevention.

We will measure success by:

1. Improving rates of recognition and diagnosis in Kent and get people into the right services when they need them
2. Ensuring more people with mental ill health are recovering
3. Ensuring more people with mental ill health have good physical health
4. Ensuring more people with mental ill health have a positive experience of care and support
5. Ensuring more people with mental ill health are supported in employment and/or education
6. Reduction in people reporting feeling socially isolated
7. Employment of people with mental illness/those in contact with secondary mental health services.

Outcome 5: People with dementia are assessed and treated earlier.

There are currently 9200 people living with dementia in Kent, and this figure is set to more than double over the next 30 years. Dementia is a progressive disease (which means it will only get worse) placing a significant strain on services, families and carers (who are often elderly and frail themselves). We have been working hard to ensure we deliver the National Dementia Strategy in Kent. Following Kent County Council's Dementia Select Committee we have been putting into place the action plan to deliver high quality services for people with dementia. We know this can only be achieved by organisations working together across Kent. In addition we will work with partners to continue to improve mental health service provision.

If we do this in Kent the following will happen: Early diagnosis of Dementia will become the norm, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support including housing, supported housing options and dementia friendly communities will lead to patients being able to stay within their own communities for longer. GPs and other health and care staff will be able to have the appropriate conversations with patients and their families about end of life care.

This is what we will do:

1. Improving accommodation and hospital care
2. Working with the voluntary sector, other providers, carers and families to reduce the social isolation of people with dementia
3. Awareness raising and access to good quality information
4. Working with partners to develop dementia friendly facilities and communities in Kent.
5. Delivering the Integrated Dementia Plan
6. Developing an integrated model of care

We will measure success by:

1. Improving the rates of diagnosis in Kent to at least 60% of expected levels (currently 39%) and get people into the right services when they need them
2. Early intervention to reduce care home placements and hospital admission
3. Dementia: effectiveness of post diagnosis care in sustaining independence and improving quality of life.

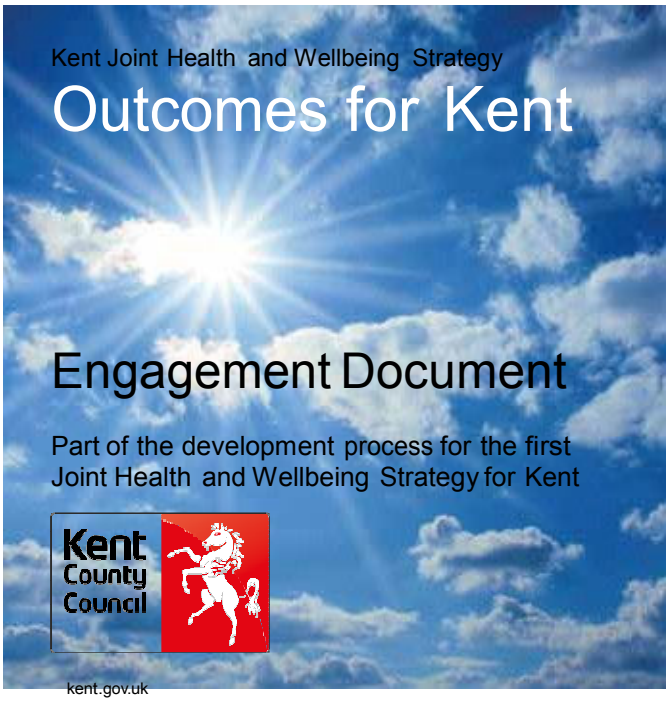
What happens next:

In order to achieve our stated priorities as seen in the approach we take and the outcomes we achieve we will also ensure that we:

- Engage with the community via Healthwatch and other engagement mechanisms
- Halt the widening of health inequality gaps both within and between communities and improving healthy life expectancy
- Focus on prevention and the individual taking more responsibility for their own health and care
- Provide good quality joined up support and care to people with long term conditions, mental ill health and Dementia; preventing unnecessary hospital admissions. By care we mean both health and social care
- Reduce premature deaths by the key killers including: Cancers and respiratory diseases
- Integrate commissioning of health and social care services as well as integrating how those services are provided
- Ensure cost effectiveness and efficiency are not achieved at the cost of quality.

Key to this will be having the right decision makers, making timely decisions based on accurate data about health needs at both a Kent and local level. The Kent Health and Wellbeing Board will have oversight of all the health, care and public health activity across Kent. This is important role will be supported by a series of local Health and wellbeing boards who will determine the local context, by which they will achieve an improvement in the health of the population. These local health and wellbeing boards will use the Joint Health and Wellbeing Strategy to help determine their local health and care priorities and will then work to commission the right services to achieve this.

This strategy has been designed to cover 2013 – 2014. During 2013 work will begin to develop a more comprehensive three year Joint Health and Wellbeing Strategy, which will outline the key health, care and public health needs for Kent until 2017 and what we will do tackle them.


Kent Joint Health and Wellbeing Strategy
Outcomes for Kent
Engagement Document
Part of the development process for the first Joint Health and Wellbeing Strategy for Kent
Kent County Council
kent.gov.uk

This page is intentionally left blank

APPENDIX B

Kent Health and Wellbeing Strategy
Report on the Engagement Exercise conducted in 2012 to inform the development of Kent Health and Wellbeing Strategy

Summary of Response from Engagement Questionnaire

1. Background

2. Methodology and who responded

The engagement document was distributed during November through a broad range of channels. Responses were invited to an enclosed questionnaire.

This document represents a summary of the responses from the 58 completed questionnaires received. In addition, it incorporates feedback received via email or letter during the engagement period.

The 58 respondents to the questionnaire were made up as follows:

57% completed questionnaire as an individual

- 66% were members of the public
- 16% were patients or service users
- 6% were carers
- 12% were 'others'

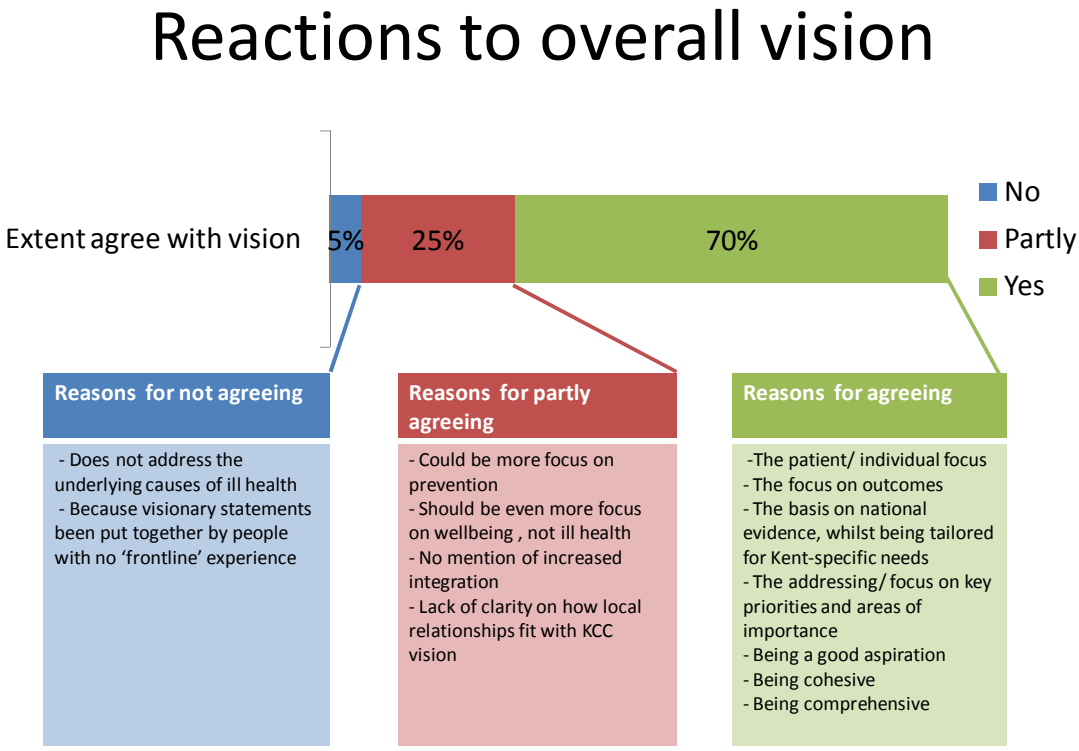
43% completed questionnaire as a group

- 38% were County or District Council Officers
- 13% were involved in the Voluntary, Community or Faith sector
- 13% were NHS Clinicians or Commissioners
- 36% were 'others'

3. Summary Results

3.1. Reactions to the Vision

When asked about the extent of agreement with the overall vision most (70%) are in agreement. The majority of the remainder are in part agreement (25%) with only 5% saying they do not agree with the vision put forward (see chart below).



When asked for the reasons for their positive response to the vision the answers given in descending order of importance were:

- The patient/ individual focus
- The focus on outcomes
- The basis on national evidence, whilst being tailored for Kent-specific needs
- The addressing/ focus on key priorities and areas of importance
- Being a good aspiration
- Being cohesive
- Being comprehensive

- The following comments illustrate these responses:

"Clear easy to understand statement putting individual at the centre of approach"

"It is important that you take into account the client's views and that they are at the heart of the decision making process (I am thinking of young people, vulnerable adults, the elderly) who may feel that things are being done to them. What professionals and friends and family think is a good experience the client may not".

"Support the need to improve health outcomes in particular and to look at all areas that support healthy lifestyles and which will improve health outcomes".

"The vision is sufficiently comprehensive as to take most health issues into account".

"The vision provides a clear focus on areas of importance, in particular on improving health outcomes".
"This follows national evidence and trends but geared to the profile of the Kent population".

"This is a good aspiration".

"We believe that a cohesive strategy, across all of the interested parties is required to ensure meaningful outcomes"

"Well set out and key priorities addressed".

- However, there were comments which stressed that the vision, however positive, would need to be actioned effectively in order to deliver any of its promises:

"As a vision I don't believe that anyone would really say that the statement isn't correct. I am far more interested in the actions of putting those ideals in place".

- There are also those who would like to see a **greater emphasis** upon certain elements within the vision; these include the focus on prevention, the focus on wellbeing rather than ill health, the focus on health outcomes. The comments below are illustrative:

"I think there could be mention of narrowing health inequalities and focusing on prevention rather than cure".

"Improving health outcomes should be the main focus from which the other aspects follow"

"People seem to think they have to be unwell, would be good if we could focus on well being rather than ill health".

- Others would like to see **additional elements** brought into the vision, for example; access to care, delivery of integrated care, a holistic approach, coverage of all patient life-stages. The responses below explain some of these responses in more detail:

"The provision of care is only successful if there is good access to care and we believe this should be highlighted at the beginning of this strategy"

"There's no mention of improving the co-ordination of care through integrated care - a key function of the HWBB"

"I would like to see a commitment to a more holistic approach to health and wellbeing, where the individual is acknowledged to be part of a family unit and services are provided to support not just the person with a health condition but all those impacted by this, i.e. the whole family unit, including anyone providing unpaid care and support".

"The vision could perhaps include – 'improve the public's experience, accessibility and greater understanding of health and social care'".

- Very few respondents (3 in total) said they did not agree with the vision and of those that did the most popular reason given was that the statement did not reference the underlying causes of ill health:

"It does not tackle the underlying causes of ill health, low education attainment, poor housing, poverty, unemployment and barely addresses access to all services".

- One person responded negatively to the vision for the following reason:

"I take exception to visionary statements being made by people who do not work in health and social care i.e. who are not at the frontline of delivery and from what I can see has relatively little experience of working within health and social care".

3.2. Suggested changes to the vision.

When asked what they would like to see changed about the vision, the responses offered were wide-ranging. They are detailed below:

"More help with mental health"

"Accountabilities by managers made very specific to ensure quality is not compromised"

"Our vision in Kent is to deliver better co-ordinated quality care, improve health outcomes, improve the public's experience of integrated health and social care services and ensure that the individual is at the heart of everything we do".

"Could it be about the individual being at the heart and involved in everything we do?"

"There is no reference to addressing the needs of LGBT patients or public, or acknowledgment of inequalities faced by gay, lesbian, bisexual or trans individuals. There is significant evidence that LGBT people are at higher risk across a range of health and wellbeing contexts, and face disproportionate inequalities in terms of access and provision of appropriate services. We would recommend that these inequalities are recognised within the Strategy".

"Outcome 1: We recommend that in reference to focus points, inequalities are specifically addressed with regards to LGBT and questioning young people, particularly with regards to risk taking behaviour"

"Outcome 4: We recommend that there should be specific focus on tackling inequalities within mental health, acknowledging and addressing disproportionate mental health issues within LGBT community and improving access and quality of services for LGBT individuals".

"Give sufficient information to users on self help to reduce the need to keep unnecessary calls on the various providers".

"Improvement with communication between hospital and doctors and then communication between the Doctor and patient. which fall down when the hospitals do not respond to a doctor's letter of request".

“It must become considerably wider in focus and drop the emphasis on individual behaviour - time to stop victim blaming”.

“It would be useful to add a specific reference to mental health. This would support the aspirations set out in the strategy”.

“It would be useful to add a vision of what improvement in these areas looks like, and how it will help to address health inequalities”.

“May be it should be not to ensure that the individual... but "to restate that the council, health and social care providers both voluntary and statutory acknowledges and reinforces that the individual is at the centre of all that is done".

“Maybe something about the individual's views taken into account”

“Need to include information on how you are going to get the voluntary sector involved and how you will support this”

“No private money to be used, this is our NHS not a money making for the Private Sector”.

“Not really , just make it as inclusive as possible”

“Partnership working to address the social determinants of health should be included”.

“Prevent ill health and accidents”

“Services delivered easily accessible, close to home”

“Suggestion: Aims to create a healthy environment that is the best for patients and fantastic to work for.....”

“The approach may need adapting to meet the needs of those with learning disabilities”

“The best quality - researched care”.

“The original NHS pledge: 'from cradle to grave' appended at the end”.

“The vision is well presented - there is a need to build on this to develop the more substantive actions to implement the plan & improve health outcomes”.

“The vision should somehow include the importance of individual and community well-being as key element of preventative and palliative health care”.

“The vision statement should also include Wellbeing”

“The vision statement should be rephrased to put improved health outcomes first”.

“There are quite a few general statements. I am unsure how this is being costed. I am aware the NHS has to achieve almost unachievable savings and am not clear how this affects Council provision of services”.

“To communicate and engage with individuals in a meaningful way, that is workable and effective”.

"Under the dementia heading: ensure that the quality of care that people with dementia receive is of a good standard"

"We assume that ensuring the individual is at the heart of everything we do means working beyond organisational boundaries, in a spirit of co-operation and with an emphasis on co-ordinated pathways of care. Perhaps a phrase could be added to emphasise the need for health and social services to work in an increasingly co-ordinated way".

"We would suggest more emphasis on 'engagement' so as to promote the importance of prevention and increased ownership by the individual of their health and wellbeing profile".

"I would like to see a commitment to provide first class care for the elderly and to radically improve care for people, whatever their age, with mental health issues".

3.3. Health and Wellbeing Strategy Priorities

We can see from the table below that when asked to evaluate the four possible Health and Wellbeing Strategy Priorities the strength of agreement was high for all, but particularly so for Priorities 4 and 3.

Health and Wellbeing Strategy Priorities

Priority	% saying strongly agree	% saying Agree
1. Tackle key health issues where Kent is performing worse than the England average	57%	38%
2. Tackle health inequalities	65%	25%
3. Tackle the gaps in provision and quality	70%	23%
4. Transform services to improve outcomes, patient experience and value for money	74%	23%

When asked if there were priorities they would like to see added, and if so what they could replace, a broad range of responses were given. Those mentioned by more than one person involved:

- A greater emphasis on prevention/ health promotion/ healthy living

"Where possible healthy living should be strongly promoted as it has a massive effect on the health of the populace"

"The idea of promoting 'prevention' should be a cornerstone of any strategy going forward".

- The merging of statements 1 and 2

"Priorities 1&2 appear to be very similar and perhaps could be merged to allow for another, different focus. The priorities as outlined in the strategy seem to be mainly in respect of physical health â€"there is little about mental health promotion. Whilst good physical health clearly impacts on emotional wellbeing, I feel it is important that we tackle both mental and physical health issues in tandem".

"Could merge Priorities 1 and 2. New priority to tackle the single biggest issue facing the health and social care economy, that of Long Term Conditions. This is the biggest challenge faced over the next 10 years and it needs to be a priority".

- The inclusion of specific conditions, e.g. long term conditions generally, diabetes, mental health.

"Raise the mental health agenda in Kent"

"Ensure end of life experience is not sublimated to the poor relation of treatment both in hospitals and the community"

"Ensure Mental Health is recognised as very important - 'No Health without Mental Health'".

- The mention of wider causal factors, e.g. poverty, poor housing.

"Replace Priority 1 with: 'Link up and support and agenda that work towards tackling wider social and environmental factors that impact on health and well-being - such as access to quality green space, air quality, climate change, etc.'"

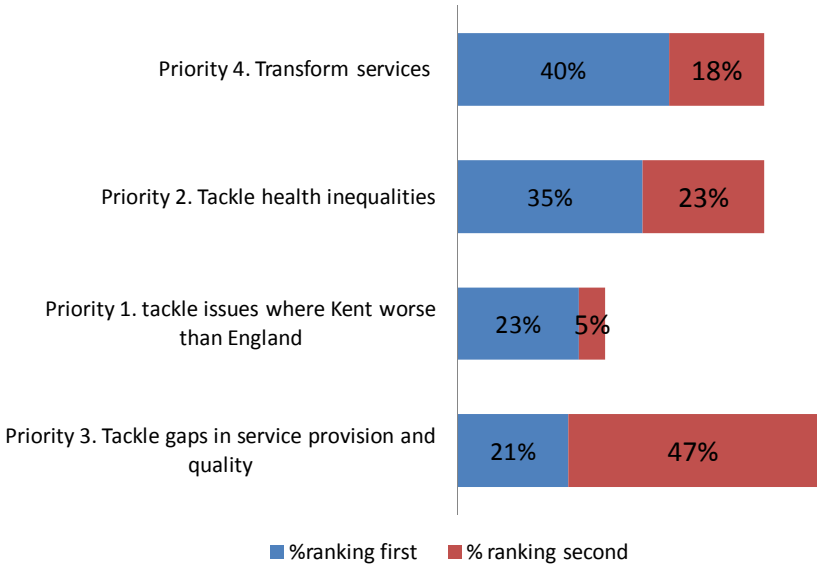
"Improve availability and standard of housing".

3.4. Rank order of proposed priorities in order of importance

Respondents were asked to place the Health and Wellbeing priorities in rank order of importance, in order to try and elicit greater discrimination between them.

We can see from the chart below that Priority 4 is ranked number one most often, by 40% of respondents, followed closely by Priority 2, ranked first by 35%. The order, however, is slightly different when we take into consideration being ranked in the top two and when we consider the priorities being ranked first or second, Priority 3 comes to the fore.

Ranking of priorities



The comments below are illustrative of the reasons given for the rank order choices made in relation to the four Health and Wellbeing Strategy priorities.

Priority 1: Tackle key health issues where Kent is performing worse than the England average.

"We need to prioritise tackling the key health issues where Kent is under performing because continued poor performance will have a significant impact on the health of the population in future years. For example, high obesity levels contributing to an increase in type 2 diabetes".

"The opportunities to affect local outcomes are more relevant than the "macro" issues of service provision and patient experience".

Priority 2: Tackle health inequalities

"If we tackle health inequalities we will be addressing all priorities".

"Health inequalities make the biggest difference to outcomes".

"A difficult task given the importance of all of the priorities. We believe that priority 2 is the foundation for a long term strategy that will have a lasting impact".

"Unless 1 and 2 are tackled, continued poor performance will continue to impact on the overall health of the nation in future years (obesity leading to increases in other illnesses and conditions. I also think that prevention work needs to be emphasised in tackling priority 1"

Priority 3: Tackle the gaps in provision and quality.

"The most important issue is to identify and tackle gaps in provision and quality of care as this will inevitably result in an efficient service that will be able to reduce inequalities in health and increase Kent's performance standard"

"Tackling gaps in provision and quality will lead to reduced health inequalities. Better outcomes for patients and improves Kent's health outcomes".

"Evidence shows health inequalities to be increasing and priority should be given to slowing and ultimately reversing this trend. To effectively tackle health inequalities requires that gaps in provision and quality are filled and consequently requires that priority be given to this. Whilst we should be aware of our performance in relation to national averages, we should not be driven by this and should give priority to tackling those issues of most importance and relevance to communities in Kent".

"Access to and quality of service provision is a top priority first as it will release the necessary savings that can be reinvested into priorities focusing on wider determinants of health improving health inequalities"

Priority 4: Transform services to improve outcomes, patient experience and value for money.

"Each of the priorities are clearly important. However, Priority 4 was ranked as the most important priority as it underpins the other three priorities; health outcomes, health inequalities and gaps in provision and quality can all be improved by enhancing services and in turn ensuring an improved patient experience. For this reason it needs to be clear what services will form the bases of priority 4.

Tackling health inequalities was ranked second as it is a strategic aim for xxxxx Borough Council within the corporate plan and forms the bases of the work the council currently completes in partnership with the PCT (public health). Priority 1 was ranked third as it is vital to improved Kent's outcomes where we are currently performing below average, however within this priority, sub-Kent performance also needs to be taken into consideration as some boroughs may have a particular health issue in their area that could be masked when taken into a Kent context".

"We need to improve patient experience and outcomes first. This will produce a natural flow to inequalities, gaps in provision. If we get these things right then it is likely we will improve the key issues where we are performing worse?"

"Value for money has to be the main priority, then the gaps can be plugged which in itself will tackle some of the inequalities which should tackle health issues where Kent is performing under average".

"Need to do 4 before any of others possible"

"Priority 4 is the most important in this era of economic constraint and coinciding with an ageing population with their increased demands for healthcare and social care".

"If you improve outcomes and patient experience you have probably gone a long way to achieving the other priorities".

- A number of respondents took the opportunity to explain how difficult they found it to rank the priorities at all:

"The priorities are all critically important for the improvement of health through a multi-agency and multi- disciplinary approach. The prioritisation might be informed better via a joint health impact assessment that would demonstrate which priority actions are most effective and can be facilitated best by a multi-agency Health and Wellbeing Board".

"The priorities are not exclusive; they are complementary and cannot be separated".

"It is impossible to prioritise. They should all be addressed".

3.5. Health and Wellbeing Strategy Outcomes

Having evaluated the Health and Wellbeing Strategy priorities, respondents were then asked to consider the Health and Wellbeing Strategy outcomes.

From the table below we see that the vast majority of respondents agreed with each of the outcomes as a means of measuring success. Between 81%-95% either agreed or agreed strongly that this was the case for each outcome, with the highest overall agreement figures being achieved for Outcome 3 and 4.

Health and Wellbeing Strategy Outcomes

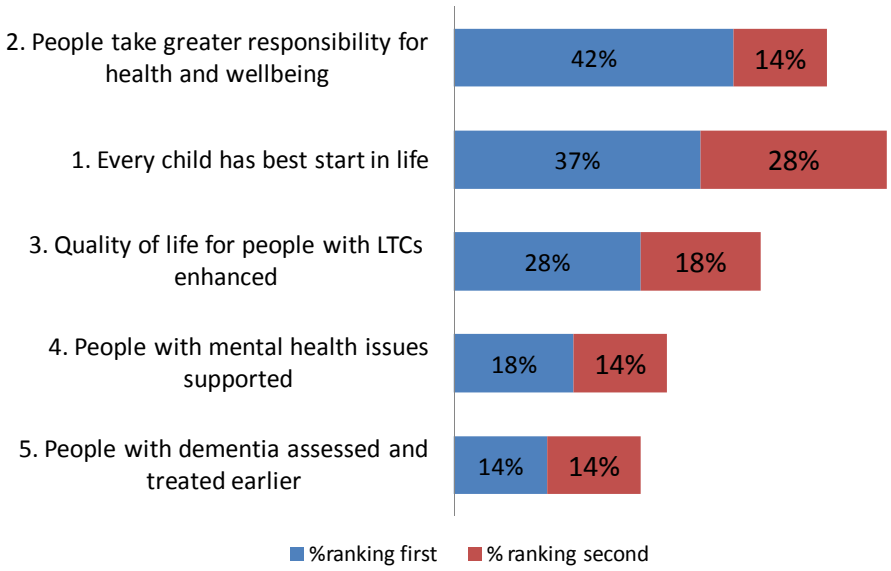
Outcomes	% saying strongly agree as a means of measuring success	% saying strongly agree or agree as a means of measuring success
1. Every Child has the best start in life	63%	89%
2. People are taking greater responsibility for their health and wellbeing	56%	81%
3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support	63%	95%
4. People with mental ill health are supported to live well	58%	95%
5. People with dementia are assessed and treated earlier	60%	91%

The emphasis changes slightly when the outcomes are rank ordered, with outcome 1 and 2 being ranked first by most respondents.

1. Every Child has the best start in life
2. People are taking greater responsibility for their health and wellbeing

3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
4. People with mental ill health are supported to live well
5. People with dementia are assessed and treated earlier

Ranking of outcomes



The comments below are illustrative of the reasons given for the rank order choices made in relation to the five Health and Wellbeing Strategy outcomes.

Outcome 1. Every Child has the best start in life

"Best start in life may ensure best outcome so 1 should be 1st".

"Child health and wellbeing is crucial to later better health and success and infant mortality is linked directly to poverty and deprivation".

"In terms of investment, I believe that outcome 1 and 2 are the most important - if we can get families with young children to take a greater responsibility for their health and well-being then this should have an impact for later life. But I really believe something different has to be done. Children's Centres need to be used to really support families ongoing (not just until they are five) in terms of health outcomes, using experts in their fields. The Children's Centre staff cannot do it all - there has to be real partnership working with midwifes, health visitors as well as colleagues in the voluntary sector and private sector, such as trained counsellors and nutritionists".

Outcome 2. People are taking greater responsibility for their health and wellbeing

"2 Is a given. The financial resources available will not match expectations. People need to take control and live healthily. 1. A good start is important as research has shown that people who have a good start in life usually adopt this throughout their life. 3. Having a long-term condition must be horrid. To have to endure this must be helped by good quality provision and care. 5. Early diagnosis can help sufferers cope with life and help to take actions to delay the condition. 4. Last only because the others seem slightly more important".

"I think outcome 2 is a lovely statement but I would like to see how you would successfully measure this outcome. The same could be said for both 1 and 3. Outcomes 4 and 5 can be measured more easily I would say".

"In order to improve health outcomes and reduce costs, particularly in areas where Kent is performing below the national average, it is essential that people are given the tools to take responsibility for their health. For example, any reduction in the incidents of smoking and obesity would enable resources to be targeted to improve health outcomes that prevention cannot address. Improvement on this priority will have the greatest impact on the other four priorities".

"Above all to help stop increased expense and demand on hospitals and for prescriptions etc, people need to take more responsibility for their lifestyle choices rather than expect the NHS/social services to pick up the pieces that could have been avoided. In this way more resources will be available to tackle the other priority areas identified".

Outcome 3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

"Those with long term conditions deserve support because otherwise they are left to live a miserable existence. Taking responsibility is also important but below my first choice as the long term sick may not have had any choice in acquiring their condition".

Outcome 4. People with mental ill health are supported to live well

"Children have many supports existing whereas some of the others are neglected, such as failure to diagnose earlier those suffering from dementia and the disproportionately low resource on those with mental health issues".

Outcome 5. People with dementia are assessed and treated earlier

"We would like to see 4 and 5 become one 'people with mental illness issues or dementia are assessed and treated earlier and supported to live well'. A fifth outcome would be added ' to improve care and outcomes for older people'. The majority of health costs are incurred in later years and there are some very significant issues relating to the care of older people including quality of care in homes, a bias against treatment based on age rather than suitability for treatment as well as end of life care issues. Research shows that older people are often denied treatment on the basis of age rather than their ability to benefit from it. A culture change is required to support a change in attitudes across ail services

and professionals and we believe this change would benefit from the clear direction from the Health and Wellbeing Board".

- As with the priorities a number of respondents commented that the ranking was very difficult, as all were important. In addition, comments were made about the challenge in comparing outcomes addressing very different sections of the population:

"EVERY OUTCOME IS IMPORTANT. How do we prioritise when there are equal needs - we should not be discriminating".

"I find it near impossible to rank these".

"My interest in getting people to take more responsibility for their health is in line with my hope that by educating & encouraging people to be more pro-active in respect of health care - to understand more - to participate more - we might raise standards of health such that the moneys available could be used to mitigate situations/conditions which cannot be prevented or cured other than by medical intervention.

Obviously giving a child the best start in life - should include encouraging parents - on behalf of their children - to take more interest in good nutrition, exercise - and a generally more healthy life style .

My particular area of interest is actually in patient 'after' care - both post-operatively - and where a patient suffers from long-term conditions. There is at present a good deal of concealed suffering coming about because of the relative poverty of practical caring services - poor interface between the medical (diagnostic/treatment) services and caring service provision - lack of joined up thinking and incoherent care information. This is a crying area of need. It is actually shameful what is going on privately in individual households as they struggle to cope with illness with relatively little support".

"I believe they are all of equal importance. The ranking is based on freeing up resources better to deal with outcomes".

"There is insufficient focus on universalism. It is not enough to target particular groups there is a need to recognise that health services are for all".

"While all these outcomes are relevant they need to be applied in perspective to the whole population pyramid".

- When asked about outcomes that they would like to see added, the range of responses given is shown below:

"A significant gap is a stated improvement in health inequalities across the county"

.

"Actively engaged with agendas that are working towards improving community and individual wellbeing".

"Are you including those with Learning Disabilities like Autism in outcome 3? (this is not very clear)"

"An outcome of better Kent population lifestyles must be added here"

"Emergency treatment is increased for those injured in public areas to reduce demands on ambulance service and A&E"

"Feedback to improve the service and identify issues. All encounters with medical professionals should be evaluated by the end user. It should be possible to accurately evidence good and bad practice. E.g. Experience of A and E, always putting patients in hospitals in incontinence pads instead of putting them on a commode regularly".

"I suggest that something should be added specific to support for the elderly. Outcome 3 could be changed by adding "and the elderly" after "conditions".

"I would like these outcomes to be placed in their respective areas in the population pyramid"

"If tackling inequalities is a priority, it should also be reflected/transferred into an Outcome or at the very least specified across all current outcomes".

"Improvement on communications. As a cancer patient I have had to change hospitals due to the way I was informed I had prostate cancer"

"More help and resources for the elderly".

"More training for GPs on mental health"

"No, however it is important to note the headings used to describe the outcomes are not measurable outcomes and are more statements of intent. Even within each outcome within the strategy, some outcomes listed are not measureable and the document does not make it clear how the outcomes listed (measurable or un-measurable) link with each of the National Outcomes Frameworks in detail. Not an outcome as such but what is the answer to the large number of people who will not take responsibility and their lifestyle choices result in their long term condition?"

"Outcome 3 should be changed - it's not just about quality of life. The outcome should be that people with LTCs experience quality, co-ordinated care and are better able to self manage their LTC so that they can life full and independent lives. Could be linked (but not merged to Outcome 2 as that also relates to the general population)".

"Could merge 4 and 5 together as both relate to mental health. Should have an outcome in there that relates to supporting carers".

"People are given easy access to services, close to home and where people live"

"Reduced waiting times in A & E"

"There is a concern where issues like domestic abuse sit: this may be a "community safety" issue but it has serious and frequently overlooked health impacts as well".

"There is nothing you couldn't agree with but potentially many of the areas need strengthening in terms of outcomes. What we will focus on may not always resonate with the public in terms of 'what it means for me'".

"I would like to see something specific around social inclusion - minority groups. There are specific health inequality issues that relate to BME and LGBT communities that are not addressed. I could not

see an Equality Impact Assessment to support the document?"

"There is limited information about end of life care and what we will do".

"The terms such as lifestyle choices also need a definition, I understand what we mean but not everyone will".

"We would like to see 4 and 5 become one 'people with mental illness issues or dementia are assessed and treated earlier and supported to live well'. A fifth outcome would be added ' to improve care and outcomes for older people'. The majority of health costs are incurred in later years and there are some very significant issues relating to the care of older people including quality of care in homes, a bias against treatment based on age rather than suitability for treatment as well as end of life care issues. research shows that older people are often denied treatment on the basis of age rather than their ability to benefit from it. A culture change is required to support a change in attitudes across ail services and professionals and we believe this change would benefit from the clear direction from the Health and Wellbeing Board".

"We would suggest some specific strategy aimed at Teenage Conception and Diabetes".

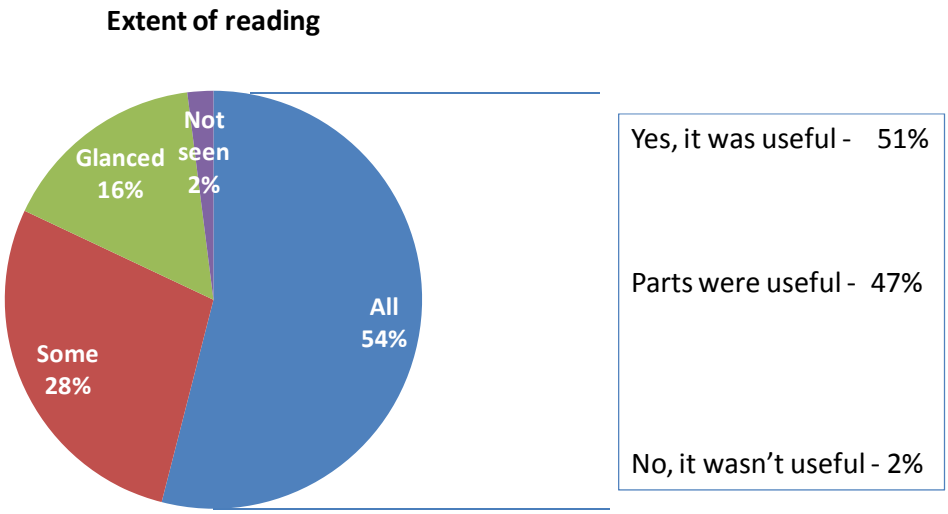
"What about vulnerable groups"

3.6. The Health and Wellbeing Strategy Engagement Document

The majority (82%) of respondents to the questionnaire had read at least some of the Health and Wellbeing Strategy Engagement document in detail, most of these (54%) having read all of it in detail.

One half of those who had read or glanced through the document had found it useful and the vast majority of the remainder had found it useful in parts.

The Health and Wellbeing Strategy Engagement Document



4. Additional non-survey response to the Engagement document

In addition to the responses gathered via the questionnaires, a number of groups (CCGs, Borough and County Councils) and a small number of individuals responded to the engagement document via email and letter.

The content of these responses very largely mirrors that gathered via the questionnaire, albeit in greater detail and from a position of greater knowledge (for the CCGs, Borough and County Council representatives in particular).

Below is a summary of the main points contained in this correspondence, the full responses (anonymised where appropriate) are appended to this report:

Clinical Commissioning Groups

CCGs were generally supportive and welcomed the focus on mental health and long term conditions.

Areas where greater focus or emphasis was requested included:

- Universalism – clarity that health services are for all
- The integration of health and social care
- Recognition that everyone doesn't have the same opportunities, or ability, to access health services
- Regarding the dynamics of health inequalities
- The role that the voluntary sector can and should play

There was also a strong desire articulated for the development of quantifiable indicators of success. This is illustrated by the following comment:

"I would like to suggest some improvements. Our board felt that there need to be more specifics in each of the five areas, based upon clearly defined and mutually understood data so that the CCG, providers and KCC HWB can hold each other to account for delivery against these specifics".

Borough and County Council

KCC representatives were keen to see a 'wider and more specific reference' made to the social and environmental issues which impact health and which can lead to a greater focus upon prevention:

- Poor housing/ living conditions
- Employment status
- Level of involvement in outdoor activities

Interested parties within Borough Councils mentioned a desire to see even greater emphasis upon the following conditions:

- Dementia
- Long term conditions

Appendix 1 – The Questionnaire

Draft Kent Joint Health and Wellbeing Strategy

Engagement Survey

We would like to hear your views on whether the draft Kent Joint Health and Wellbeing Strategy focuses on the right key health, social care and wellbeing issues for people in Kent. Please use this questionnaire to tell us your views.

1. Our Vision

Our vision in Kent is to deliver better quality care, improve health outcomes, improve the public's experience of health and social care services and ensure that the individual is at the heart of everything we do.

Do you agree with our overall vision? (Please tick one)

☐ Yes
☐ Partly
☐ No
☐ Don't know

What was the reason for your answer?

Is there anything you would like to see added to the vision?

Is there anything you would like to see changed about the vision? For example anything you would like to see added, rephrased or removed?

2. Health and Wellbeing Strategy Priorities

The draft strategy identifies the following four priorities for Kent.

To what extent do you agree with each of these priorities?

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
Priority 1: Tackle key health issues where Kent is performing worse than the England average.					
Priority 2: Tackle health inequalities					
Priority 3: Tackle the gaps in provision and quality.					
Priority 4: Transform services to improve outcomes, patient experience and value for money.					

Are there any priorities you would like to see added? If so, which of the current priorities would they replace?

How would you rank the four currently proposed priorities in order of importance? (Please rank them 1-4, with 1 being the most important)

	Priority
Priority 1: Tackle key health issues where Kent is performing worse than the England average.	
Priority 2: Tackle health inequalities	
Priority 3: Tackle the gaps in provision and quality.	
Priority 4: Transform services to improve outcomes, patient experience and value for money.	

Please give your reasons below:

3. Health and Wellbeing Strategy Outcomes

The Kent Joint Health and Wellbeing Strategy aims to identify the health and social care outcomes we want to achieve. To this end, we are proposing to focus on 5 key outcomes. These are:

6. Every Child has the best start in life
7. People are taking greater responsibility for their health and wellbeing
8. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
9. People with mental ill health are supported to live well
10. People with dementia are assessed and treated earlier

To what extent do you agree with each of these outcomes as a means of measuring our success?

~~**Outcome**~~	**Strongly agree**	**Agree**	**Neither agree or disagree**	**Disagree**	**Strongly disagree**
Outcome 1: Every Child has the best start in life					
Outcome 2: People are taking greater responsibility for their health and wellbeing					
Outcome 3: The quality of life for people with long term conditions is enhanced and they have access to good quality care and support					
Outcome 4: People with mental ill health issues are supported to live well					
Outcome 5: People with dementia are assessed and treated earlier					

How would you rank these five outcomes in order of importance? (Please rank them 1-5, with 1 being the most important)

Outcome	**Priority**
Outcome 1: Every Child has the best start in life	
Outcome 2: People are taking greater responsibility for their health and wellbeing	
Outcome 3: The quality of life for people with long term conditions is enhanced and they have access to good quality care and support	
Outcome 4: People with mental ill health issues are supported to live well	
Outcome 5: People with dementia are assessed and treated earlier	

Please give your reasons below:

Are there any outcomes you would like to see added? If so, which of the current outcomes would they replace?

4. Other comments

Which of the following best describes the extent to which you have read the draft Kent Joint Health and Wellbeing Strategy Engagement Document? (Please tick one)

1. ☐ I have read it all in detail
2. ☐ I have read some of it in detail
3. ☐ I have only really glanced through it
4. ☐ I haven't seen the document
5. ☐ Don't know

If you've answered 1, 2 or 3 please answer the following questions:

Did you find the document useful?

☐ Yes
☐ Partly
☐ No
☐ Don't know

Are there any other suggestions or comments you would like to make?

Appendix 2. Non- survey response to the engagement document

Non- survey response to the engagement document

Clinical Commissioning Groups

1. Ashford CCG – Officer's Response

Thank you for giving us the opportunity to respond to the consultation on the Health and Wellbeing Strategy. We recognise that this is work in progress but a lot more work needs to be done on such a strategy, once the Health and Wellbeing Board has full statutory effect and that the CCG receives formal authorisation

Delivery of any strategy requires an effective partnership architecture. The H&W Board has done well to recognise the complexity of Kent and thus the need to devolve. However the impact of the proposed arrangements for partnerships is, as yet, not sufficiently coherent and may get in the way of effective delivery. A more developed strategy needs to be a co-production between all commissioner stakeholders, especially involving CCGs

There are some specific points as regards stated health policy:

- There is insufficient focus on universalism. It is not enough to target particular groups there is a need to recognise that health services are for all.

- There is no acceptance in health that Children's Centres should deliver integrated health and social care to high risk vulnerable families as their prime purpose. This is currently the matter of on-going dialogue within the Children's Centre Working Group. Health services would wish to assure that the prime object of Children's Centres would be the universal offer to all children regardless of whether they come from vulnerable families or not. The NHS is charged with making major investment into health visitor services for that very purpose (which has the personal oversight of the Prime Minister). Children's Centres should not become places for problem families because that will detract from their whole purpose.

- Whilst people should take more responsibility for their health and wellbeing the strategy doesn't recognise that not everyone has the same fortune in life. It is unreasonable to use the same standards for those who are not in work or whose lives contain a disproportionate element of chaos and disruption.

- For the same reason the strategy underplays the dynamics of health inequalities as driven by the social determinants of health. Having a Kent Health Inequalities Action Plan is too little purpose unless it is embedded in a Health & Well Being Strategy. Unlike local government, CCGs having statutory obligation to address inequalities in health and will be called to account annually for their performance in this regard to the NHS Commissioning Board.

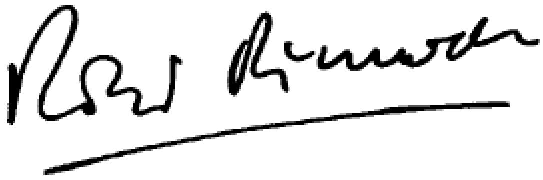
- Reference to mental health and specifically to the National (not Kent) "Live It Well" programme is welcome. However there will be a challenge to resource this and to sustain it.

- A focus on long term conditions is welcome. Clearly much work needs to be undertaken to provide clarity in terms of objectives for this element of the strategy including how all agencies can work better together.

- The strategy underplays the role of the voluntary sector in supporting the delivery of all five objectives

- A lot of work needs to be done developing quantifiable indicators of success which are meaningful locally and can support delivery. The strategy correctly emphasises the relevant Outcomes Frameworks. However these will be produced nationally and we may wish to consider developing more immediate indicators to enable the monitoring of progress between the publication periods that will be specified in the Outcomes methodology.

For all the above issues the general direction of travel is one which in principle this CCG can support. We are with local stakeholders from both the local professional community and representatives of local organisations developing a five year plan. There is a lot of concurrence between the planned aspirations of the CCG and the direction of travel being developed for a Kent Health & Well Being strategy.



Dr Roger Pinnock
Chair

****

2. West Kent CCG

I am writing to formally accept the JHWS. If I may, I would like to suggest some improvements. Our board felt that there need to be more specifics in each of the five areas, based upon clearly defined and mutually understood data so that the CCG, providers and KCC HWB can hold each other to account for delivery against these specifics. It may be that the JSNA is as yet not comprehensive enough in terms of the breadth of illness it covers to properly inform the strategy. It feels a little public health orientated at the moment and perhaps could be more general in terms of predicting demand.

Dr. B. Bowes
Chair

****

3.

This is looking good
As per the strategy, we need to raise the profile of the need to transform services whilst recognising local flexibility regarding implementation

~~~~~~

Kent Joint Health and Wellbeing Strategy
Outcomes for Kent
Response to consultation

We would like to make a few general points and illustrate these by reference to certain details within the strategy and hope this will be constructive. We believe that at this juncture there is a great opportunity to ensure that more integrated working between the NHS and local authorities can address and improve the underlying determinants of health. We welcome the fact that the strategy notes the importance of environment and living/working conditions in determining health and wellbeing.
~~~~~~

Our suggestions:

1. The strategy should place less emphasis on health service improvements as a means of improving health and wellbeing but address and target underlying causes. So in the Forward second paragraph:

   "This document builds on many years of joint working between local government and health, which have delivered improvements in services leading to improvements in people's health"

   We suggest instead:

   "This document builds on many years of joint working between local government and health, which have delivered improvements in services *contributing* to improvements in people's health"

2. We note the challenge of a forecast population growth combined with a greater number of older people against a relatively static budget and wonder why the underlying risk to service sustainability is not addressed more directly. Clearly the emphasis on prevention and personal responsibility in the strategy will help but it needs to be very carefully targeted to deliver financial savings.
3. Where Kent is falling below the national average in some areas it might be helpful to have some understanding of the root cause of this so the actions can be linked. For example is there a link between high obesity levels and our transport infrastructure? Active travel initiatives are being planned and promoted across the county so this link could be more specific. Other initiatives such as the outdoor gym movement have made impacts on obesity levels elsewhere without direct health service involvement. With regards to healthy eating Kent has many opportunities to improve this due to our rich natural environment ideally suited to growing fruit and vegetables. More public engagement in this is planned, for example in Sheppey, with positive impacts on activity levels, local employment and affordability of fresh food.
4. We would hope to see some reference to the excellent work done by the air quality health network to improve air quality as this has direct relevance to reducing premature deaths, particularly respiratory and cardiovascular disease as well as some cancers. As there is now an air quality indicator in the Public Health Outcome framework and our current performance in some parts of Kent is worse than the national average this is an area where more work will need to be done.
5. We consider that some of the outcomes described on page 10 are in fact process measures e.g. "people are taking responsibility for their health and wellbeing". A measureable outcome for this action would be "fewer people die or suffer morbidity from preventable illness related to lifestyle choices". Perhaps the measure could be based on an assessment of disability free life years for which there is a robust methodology?
6. We are concerned on page 10 by the sentence "*Halting the widening* of health inequality gaps both within and between communities and improving healthy life expectancy" which contrast with the objective in Kent's Health inequalities Action Plan *Mind the Gap*: "We will transform health inequalities in Kent *by reducing the gap* in health status between our richest and poorest communities"
7. We believe that given the impact of the environment on health and wellbeing, the risks of harm from flooding, heat waves and other impacts of climate change and the benefits to mental health from contact with the natural environment it is regrettable that there is little mention in the priorities of the joint work being done within the Kent Environment strategy. Some of this work impacts very directly on health and wellbeing, for example the use of the Green Deal partnership to create affordable warmth for vulnerable people and improve housing stock.
8. On page 9 the statement "We also need to focus on doing the right things well. In other words, commissioning the right services that improve health as well as

delivering value for money." While not disagreeing with this we wondered if this might be more appropriate from a commissioning body strategy such as one for a clinical commissioning group.

9. We were surprised to see no reference to working closely with schools and higher education, particularly in relation to children's health, healthy eating and obesity. Similarly no reference of Health Impact Assessments for planners and those involved in designing and improving the built environment might be a missed opportunity, particularly with regard to mental health and tackling inequalities.

In summary we think the strategy would be stronger and have more long term impact on health and well-being if the aims were more holistic and focussed on the underlying determinants of health. Conversely the outcomes chosen need to be specific and measureable. It might help achieve this if reference is made particularly to the Public Health Outcomes Framework and ensure the outcomes chosen are consistent with it and monitored via it. We would both be happy to contribute further if that would be helpful to the shadow board.

Malti Varshney, Consultant in Public Health, Kent
Caroline Jessel, Medical Adviser and Sustainability Lead, NHS Kent and Medway

~~~~~~

Maidstone Borough Council

Communities Overview and Scrutiny Committee
Response to the draft Kent Joint Health and Wellbeing Strategy
21st November 2012

On 21st November 2011 the Communities Overview and Scrutiny Committee at Maidstone Borough Council invited Andrew Scott-Clark, Director of Health Improvement (Public Health) and Malti Varshney, Lead Public Health consultant for Maidstone district, to its meeting. The Committee received a presentation and interviewed Mr Scott-Clark and Mrs Varshney in relation to the draft Health and Wellbeing Strategy under consultation.

Members of the Committee agreed to make individual responses via the online questionnaire. In addition the Communities Overview and Scrutiny Committee would like to raise the following points in its open response:

- The draft strategy refers to an aging population but omits those in long term care or in need of long term care. This Committee understands the national strategy of prevention and the desired outcomes which would enable patients to manage long term conditions. It is vital that those in long term care or in need of long term care can continue to be cared for in their own homes. It is vital this is addressed in the final version of the strategy; and

- This Committee's membership, through its ward member and wider experience, feels strongly that there is an obvious gap in mental health provisions. In order for this to be addressed there must be an improved emphasis within this strategy on mental health services. This must be maintained in future versions of this document to continue to drive the commissioning of ongoing mental health services.

~~~~~~

Individual responses (themes)

1.
Agreement with most of it.
Concern expressed about the rebuild of Buckland Hospital and access. No availability for parking on site and only VERY short term parking in surrounding roads. Or is a Hospital Bus service from town proposed. Or a car park on the Whitfield Industrial Estate.
If these options are not possible then the whole rebuild is a waste of public money and the Health and Wellbeing Strategy will then not apply to the people of Dover/Deal as people will still be unable to access services.

****
2.
Overall a good strategy, well written and clearly presented.
Patient choice: should also emphasise the value of patients being able to choose between different providers, as a way of driving up standards. It would help if patients could choose between GPs – e.g. one who offers better out-of-hours provision or additional services. there should be readily available information about facilities offered by each provider, with customer reviews.
Managing demand: there should be more about the difficulties health services will face in meeting future demand as it escalates, due to ageing population, availability of increasingly expensive and advanced treatments and demand increasing as more made available. The strategy should address hwo growing demand will be managed.
Needs of special groups: more could be included for those with particular needs, e.g. prisoners (high mental health needs); ethnic minorities (e.g. prevalence of diabetes type 2 in people of South Asian descent)
Raising standards of care: the strategy could spell out the need to raise standards and how these will be achieved – in primary and secondary care
Emergency ambulance services: nothing about these services in the strategy despite their important role in the shift to community care
Managing the transition from secondary care to a focus on primary care: it should refer to studies showing how shift to primary-care is likely to produce better health outcomes, at lower cost, with greater user satisfaction. Patients with chronic conditions account for two-thirds of NHS bed days yet better primary and community care could avoid unnecessary and expensive bed days. Set out the objective of putting more resources into primary care. Give a target figure for the percentage of the local health budget that will eventually go into primary and secondary care

Scanned responses

The Consultation Team
Kent County Council,
Room G37
Sessions House,
Maidstone,
Kent ME14 1XQ

Kent Countryside Access Forum
c/o Kent County Council
Countryside Access Service
Invicta House
County Hall
Maidstone
Kent ME14 1XX
Tel: 01622 221568
Fax: 01622 221636

Email: access.forum@kent.gov.uk
Ask for: Benjamin Collins
Your Ref:
Our Ref: KCAF 121118
Date: 18th November 2012

Dear Sir

Joint Health and Well-being Strategy Consultation

With reference to your Consultation on the Joint Health and Well-being Strategy for the people of Kent, this response is made on behalf of the Kent Countryside Access Forum (KCAF). The KCAF is a statutory, independent body made up of volunteers from the local community who represent landowners and land managers (both public and private), access users (such as walkers, cyclists, horse riders, carriage drivers, motorized vehicle users) and other interests (such as health and conservation, access for those with disabilities, the police, parish councils). The purpose of the KCAF is to advise KCC (in particular the Countryside Access Service - CAS) and other relevant organisations on the management, enhancement and promotion of Kent's Public Rights of Way (PRoW) and green spaces for the benefit of the people of Kent and visitors to the County.

The Kent Countryside Access Forum supports the development of a connected network of shared use routes as a means of improving the availability and enjoyment of Kent's PRoW network and green spaces by the public. The KCAF supports shared use routes wherever possible as 'best value' practice, allowing a wide range of people to experience the countryside in a variety of different ways. The KCAF has particular regard to those users who are vulnerable to road traffic (walkers, cyclists, equestrians) and who would benefit most from a connected safe off-road network.

The KCAF recognizes and wholeheartedly supports the positive impact that good access to and opportunity for enjoyment of the Kent countryside has on the health and well-being of the people of Kent and visitors to the county. Spending time in the Kent countryside, using Public Rights of Way, public woodlands and green spaces can have a huge benefit for a person's physical health, fitness and mental well-being. It can help develop social relationships, encourage new friendships and foster a sense of community and identity with the landscape and County.

Access to the Kent countryside is available to people of all ages, male and female, from small children to the elderly, and to all abilities, including those with physical and mental disabilities; it can often be undertaken at virtually no cost and can be experienced alone, with family or friends, in guided groups or as part of organized activities. The chance to volunteer to help with care and management of the Kent countryside and its wildlife brings many benefits, including the satisfaction of 'putting something back', achieving a goal, learning new skills and making new friends. The opportunity to get away from noise and pressures of the urban environment and leave problems behind for a time should not be underestimated. Experiencing the beauty and tranquility of parts of the Kent countryside can be a hugely uplifting experience, the imprint of which remains long after returning home.

We urge that, as a part of your laudable efforts to improve the health, fitness and well-being of the people of Kent, you consider the many positive benefits of encouraging access to and enjoyment of the Kent countryside. At comparatively low cost, it also represents good value for money. The Countryside Access Service (CAS) of Kent County Council can provide information on the many opportunities available for countryside access, as well as supplying references to the numerous studies carried out that link health, fitness and well-being with time spent enjoying countryside activities.

Yours faithfully

A. Beecham

Anne Beecham
Chairman
Kent Countryside Access Forum

Are there any other suggestions or comments you would like to make?

The strategy should explore, explain and seek solutions to the social and environmental elements that impact on wider determinants of health and not over look these preventative measures.

The following extract is taken from the White Paper "The Natural Choice"

"There is increasing interest in the impact of outdoor environments on health and wellbeing. Several reviews, including Sir Michael Marmot's independent review of health inequalities, Fair Society, Healthy Lives, point to the potential of natural environments to improve mental and physical health. A study in the Lancet showed that proximity to green spaces was associated with reduced health inequalities.

Access to nearby attractive public green space and footpaths is likely to increase levels of walking, one of the simplest forms of physical activity that most can enjoy. Studies show that patients recovering from operations are likely to stay in hospital for less time and need less powerful painkillers if they look out onto a natural scene from their hospital bed."

It is noted that the proposed Kent draft has similar objectives to those outlined in the Marmot Study; however appears to have more prescriptive outcomes set for more specific conditions.

It seems the Kent strategy has made an omission in failing to support National Policy, and ignoring the significant evidence in respect of the value of quality access provision and green space to delivering health and well-being.

Marmot Study Objectives;

- **Give every child the best start in life**
- **Enable all children young people and adults to maximise their capabilities and have control over their lives**
- **Create fair employment and good work for all**
- **Ensure healthy standard of living for all**
- **Create and develop healthy and sustainable places and communities**
- **Strengthen the role and impact of ill health prevention**

The final 4 objectives from the study appear to be completely omitted from the local strategy. To be more consistent with the National strategies the inclusion of outcomes that deliver quality access, active lives and green space and environment must be included. There are significant opportunities available in Kent to deliver quality active lifestyles, preventative and curative health care and these must be captured.

KCC's Countryside Access Service has an excellent track record in providing opportunities for the above. Established partnerships, both internal and external have provided low cost opportunities and demonstrable participation in encouraging daily exercise, delivered with, by and for local communities. The Service would welcome the opportunity to assist in the development and delivery of elements to the delivery of this strategy.

APPENDIX C

Kent Joint Health and Wellbeing Strategy

Report on the engagement exercise – December 2012

Introduction

Health and Wellbeing Boards – which will take on their statutory function from April 2013 - will be the focal point for decision making about how best to improve the health and wellbeing of local communities. They will play a key leadership role in bringing commissioners of health and care services together, alongside council members and Local Healthwatch – the independent public voice - to develop a shared understanding of the health and wellbeing needs of their local community.

Kent's Shadow HWB (SHWB) is committed to involving its people and communities from the outset and has recently completed a stakeholder engagement exercise on its first joint Health and Wellbeing Strategy.

The following outlines the process and methodology that was adopted to ensure a wide range of people and communities could provide feedback to inform the final version of the strategy.

Process and methodology

An initial draft Health and Wellbeing Strategy was discussed at the SHWB meeting in July 2012. Feedback from that meeting was incorporated into the next version which was then put on KCC website, with access restricted to SHWB members, CCGs and councils for further feedback up to the end of August.

The comments received were added and the revised version of the draft strategy went out for wider engagement from 18th October to 23rd November 2012.

The strategy, supporting materials and electronic survey were available on-line and key groups/individuals were e-mailed with links to the on-line survey. The strategy, supporting information and word version of the survey were also attached, as an additional option, with the request to cascade as appropriate.

A variety of stakeholders were contacted, including:

- Health and social care commissioners
- Health and social care providers
- Councils
- Voluntary organisations
- Minority groups
- Patient and public engagement leads and groups
- Colleges and universities

Hard copies were also made available and distributed to key access points, such as libraries and Gateways, and distributed at meetings and events (for example, Older People's Forum, Tunbridge Wells; Self Care event, Maidstone).

The distribution list is at Annex A of this summary report.

Response

58 questionnaire responses had been received by the end of the engagement exercise. A number of groups and a small number of individuals also responded via e-mail and/or letter, either instead of or in addition to the questionnaire.

The summary report, which is at Appendix B, has been used to develop the final version of the first Kent Joint Health and Wellbeing Strategy, which will be published at the end of December and will be publicly launched in January 2013.

Conclusion

This was a joint engagement exercise and provided an opportunity for engagement and communication leads across Kent to work together in using their networks to share the draft strategy and ask for feedback.

This experience will be used to further develop the approach for future engagement activities on both the strategy and the joint strategic needs assessment.

Julie Van Ruyckevelt
December 2012

ANNEX A

Kent Health and Wellbeing Strategy – Engagement Process

Distribution list

Groups/organisations
Electronically
KCC website
Kent Health and Wellbeing Board
Kent Health Overview and Scrutiny Committee
CCGs - 7
City, District and Borough Councils - 9
KCC Consultation Directory
FSC – Adults and Children
Maidstone Local Children's Trust Board
Kent LINk
Interim Shadow Local Healthwatch Board
Gateways - 9
Health providers – acute hospitals, community health services, mental health services, ambulance service
Clinical Networks
Patient experience/engagement leads across health providers and PCT cluster
PPG Chairs – West Kent
Patient Networks - HealthNetworks
Minority Community Workers
Diverse and minority groups
Voluntary organisations – wide cascade
Children's Centres
Colleges, Universities, U3A
Libraries
Meetings
Kent Health and Wellbeing Board
Kent Health Overview and Scrutiny Committee
Maidstone Communities Scrutiny Committee
Older People's Forum, Tunbridge Wells
Kenward Trust
Maidstone Voluntary and Community Sector Focus group
Self Care Open Event, Maidstone

This page is intentionally left blank

By: Meradin Peachy, Public Health Director

To: Health and Wellbeing Board – 30 January 2013

Title: Public Health Outcomes Framework

For Information

Background

The Public Health Outcomes Framework centres around 4 key domains

Domain One – Improving the wider determinants of health
Domain Two – Health Improvement
Domain Three – Health Protection
Domain Four – Healthcare public health and preventing premature mortality

This paper sets out the Kent baseline assessment presenting those indicators that Kent is significantly better than England and significantly worse than England.

Brief Overview of Significantly Better Indicators across all domains

Indicator Number	**Indicator**	**Kent authority rank within the South East (1st=Best)**
1.01	Children in poverty	10th
1.12ii	Violent crime (including sexual violence) – violent offences	4th
1.13i	Re-offending levels – percentage of offenders who re-offend	10th
1.13ii	Re-offending levels – average number of re-offenses per offender	7th
1.14i	Percentage of the population affected by noise – number of complaints about noise	12th
1.15i	Statutory homelessness – homelessness acceptances	14th
1.15ii	Statutory homelessness – households in temporary accommodation	8th
2.15	Successful completion of drug treatment	1st
3.02	Chlamydia diagnosis (15-24 yr olds)	8th
3.03iii	Population vaccination coverage – Dtap/IPV/Hib (1yr old)	12th
3.03iii	Population vaccination coverage – Dtap/IPV/Hib (2yrs old)	5th
3.03iv	Population vaccination coverage – Menc	9th
3.03v	Population vaccination coverage – PCV	11th
3.03vi	Population vaccination coverage – Hib/MenC booster	7th

3.03vii	Population vaccination coverage – PCV booster	4th
3.03viii	Population vaccination coverage – MMR for one dose (2 yrs old)	4th
3.03ix	Population vaccination coverage – MMR for one dose (5yrs old)	10th
3.03x	Population vaccination coverage – MMR for two doses (5yrs old)	4th
4.03	Mortality from causes considered preventable	12th
4.04i	Under 75 mortality rate from cardiovascular disease (including heart disease and stroke)	12th
4.05i	Under 75 mortality rate for cancer	12th
4.05ii	Under 75 mortality rate for cancer that is considered preventable	12th
4.06i	Under 75 mortality rate for liver disease	11th
4.06ii	Under 75 mortality rate for liver disease that is considered preventable	8th
4.12i	Preventable sight loss – age related macular degeneration	3rd
4.12iv	Preventable sight loss – sight loss certification	6th

Brief Overview of Significantly Worse Indicators across all domains

Indicator Number	**Indicator**	**Kent authority rank within the South East (1st=Worst)**
1.04	First time entrants to the youth justice system	5th
1.05	16-18 year olds not in education, employment or training	5th
2.03	Smoking status at time of delivery	4th
2.22i	Take up of NHS health Check Programme by those eligible – health check offered	1st
2.22ii	Take up of NHS health Check Programme by those eligible – health check take up	4th
2.23i	Self-reported wellbeing – satisfied with life	9th
2.23ii	Self-reported wellbeing – worthwhile	4th
2.23iii	Self-reported wellbeing – happy yesterday	4th
2.24ic	Injuries due to falls in people aged 65 and over (females)	9th
2.24iii	Injuries due to falls in people aged 65 and over – aged 80+	4th
3.03xii	Population vaccination coverage - HPV	3rd
3.03xiii	Population vaccination coverage – PPV	1st
3.03xv	Population vaccination coverage – Flu (at risk individuals)	2nd
3.05i	Treatment completion for TB	1st
3.05ii	Treatment completion for TB – TB incidence	7th
4.14i	Hip fractures in people aged 65 and over	5th
4.14iii	Hip fractures in people aged 80 and over	3rd

Introduction

The Public Health Outcomes Framework "Healthy lives, healthy people: Improving outcomes and supporting transparency" sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected.

The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

Baseline data, for 39 of the 66 indicators at upper tier local authority level, was published on the 20th November 2012. This report should be read in conjunction with the Kent PHOF Baseline document.

Please note: The data currently published and included in this report are the baselines for the Public Health Outcomes Framework. The baseline period is 2010 or equivalent, unless these data are unavailable or not deemed to be of sufficient quality.

Overarching Indicators

There are two high-level outcomes, or overarching indicators, that headline the Public Health Outcomes Framework (PHOF), these are:

Healthy Life Expectancy

And

Differences in life expectancy and healthy life expectancy between communities

Baseline data for these indicators are not available at this time they will be reported as they become available.

Domain One – Improving the wider determinants of health

The objective of this domain is to monitor improvements against the wider factors which affect health and wellbeing and health inequalities.

Significantly worse indicators in domain one

Baseline figures have been published for 11 of the 19 indicators in this domain. Of these, 2 indicators are significantly higher than the national position.

1.04 First time entrants to the youth justice system' – measured by the rate of juveniles receiving their first reprimand, warning or conviction per 100,000 10-17 year old population.

The Kent value for this indicator is 1,062 compared to a 928 nationally. This ranks Kent as 5th highest authority (out of 19 authorities) in the south east behind Isle of

Wight (1,471), East Sussex (1,256), Medway (1,130) and West Sussex (1,072). Lowest authority in the south east is Windsor & Maidenhead (333).

1.05 16-18yr olds not in education, employment or training (NEETs) - This indicator uses the average proportion of 16-18 year olds NEETs between November and January each year.

The Kent value for this indicator is 6.8 compared to 6.1 nationally. This ranks Kent as 5th highest authority (out of 19 authorities) in the south east behind Reading (8.7), Brighton & Hove (7.9), Southampton (7.4) and Portsmouth (7.2). Lowest authority in the south east is Buckinghamshire (4.1).

Significantly better indicators in domain one

Kent rates as significantly lower than the national average for 6 of the 11 published indicators in this domain, they are;

- 1.01 Child poverty,
- 1.10 Killed or seriously injured on England's roads,
- 1.12ii Violent crime,
- 1.13i & ii Re-offending levels,
- 1.14i Percentage of the population affected by noise and finally
- 1.15i & ii Statutory homelessness acceptances and temporary accommodation.

Domain Two – Health Improvement

The objective of this domain is that people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.

Significantly worse indicators in domain two

Baseline figures have been published for 13 of the 24 indicators in this domain. Of these, 4 indicators are significantly worse than the national position.

These 4 indicators are:

2.03 Smoking status at the time of delivery – the number of women who smoke at the time of delivery per 100.

Kent value is 16.81 compared to 13.52 nationally. This ranks Kent as 4th highest authority in the south east behind Reading (40.9), Brighton & Hove (36.9) and Slough (36.8). Lowest authority in the south east is Wokingham (13.1).

The following indicator is split into two parts:-

2.22i Take up of NHS Health Check Programme by those eligible – health check offered - Percentage of eligible population aged 40-74 offered an NHS Health Check, April 2011 - March 2012.

Kent value is 7% compared to 13.9% nationally. This ranks Kent as one of the lowest in the south east. Best rate in south east is 21.4% in Medway.

And

2.22ii Take up of NHS Health Check Programme by those eligible – health check take up - Percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check. Kent value is 32.8% compared to 51.6% nationally. This ranks Kent as one of the worse authorities in the south east.

Please Note*:* 'Take up' rates are influenced by the 'Offered' rates e.g. the take up rate for Isle of White is 100% but the offered rate is just 1.6%

The following indicator '**2.23 Self-reported wellbeing***'* is split into 4 parts.

ONS are currently measuring individual/subjective well-being based on four questions included in the Integrated Household Survey:

Overall, how satisfied are you with your life nowadays?
Overall, how happy did you feel yesterday?
Overall, how anxious did you feel yesterday?
Overall, to what extent do you feel the things you do in your life are worthwhile?

Responses are given on a scale of 0-10 (where 0 is "not at all satisfied/happy/anxious/worthwhile" and 10 is "completely satisfied/happy/anxious/worthwhile") the first full year data from these questions was published by ONS in July 2012 and are being treated as experimental statistics. In the ONS report, the percentages of people scoring 0-6 and 7-10 have been calculated for this indicator.

Kent has significantly worse outcomes in 3 of the 4 indicators, these are:-

2.23i Self-reported wellbeing – satisfied with life - The percentage of respondents scoring 0-10 to the question "Overall, how satisfied are you with your life nowadays".

Kent value is 21.3% compared to 24.3% nationally. This places Kent as 11th in the south east. The authority with the highest percentage in the south east is Slough at 27.2%.

2.23ii Self-reported wellbeing – worthwhile - The percentage of respondents scoring 0-10 to the question: Overall, to what extent do you feel the things you do in your life are worthwhile?

Kent value is 15.7% compared to 20.1% nationally. This places Kent as one of the worse authorities in the south east. The authority with the highest percentage in the south east is Slough at 24.7%

2.23iii Self-reported wellbeing – happy yesterday. The percentage of respondents scoring 0-10 to the question: Overall, how happy did you feel yesterday?

The Kent value is 26.4% compared to 29% nationally. This places Kent as one of the worse authorities in the south east. The authority with the highest percentage in the south east is Portsmouth at 31.3%.

The last of the 4 significantly worse indicators in this domain is *'**2.24 Injuries due to falls in people added 65 and over**'.* This indicator is split into 5 parts, of these 2 parts are significantly higher than nationally.

2.24ic Injuries due to falls in people aged 65 and over – (Females). Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age-sex standardised rate per 100,000.

The Kent rate is 2,088 per 100,000 compared to 2,014 nationally. This places Kent as the 9th worse authority in the south east. The best authority in the south east is Wokingham with 1,237.

2.24iii Injuries due to falls in people aged 65 and over – aged 80+. Emergency hospital admissions for falls injuries in males/females aged80 and over, directly age standardised rate per 100,000.

The Kent rate is 5,260 per 100,000 population compared to 4,711 nationally. This places Kent as the 5th worse authority in the south east behind Medway (5,796), Milton Keynes (5,796), Portsmouth (5,796) and Brighton & Hove (5,690).

Significantly better indicators in domain two

Kent rates as significantly better than the national average for just 1 of the 13 published indicators in this domain:-

- 2.15 Successful completion of drug treatment

Domain Three – Health Protection

The objective of this domain is to ensure the population's health is protected from major incidents and other threats, whilst reducing health inequalities.

Significantly worse indicators in domain three

Baseline figures have been published for 5 of the 7 indicators in this domain, of these just 1 is significantly worse than the national position. However, the population vaccination indicator is sub-divided into 15 sub-indicators. Of these 15 sub-indicators 3 are significantly worse (9 are significantly better).

The significantly worse indicators in this domain are:-

3.03xii – Population vaccination coverage – HPV – defined as all girls aged 12 to 13 years who have received all three doses of the HPV vaccine within each reporting area (at present PCT responsible population) as a percentage of all girls aged 12 to 13 years within each area.

The Kent value is 76.7% compared to 84.2% nationally. This places Kent the 3rd worse authority in the south east behind Hampshire (75.7%) and Southampton (71.1%). The highest percentage in the south east is found in 90.7% in Oxfordshire.

3.03xiii – Population vaccination coverage – PPV - These data describe pneumococcal polysaccharide vaccine (PPV) uptake for the survey year 2011, for those aged 65 years and over.

The Kent value is 67.5% compared to 70.5% nationally. This places Kent as the worst authority in the south east. The best authority is the Isle of Wight at 75.9%.

3.03xv – Population vaccination coverage – Flu (individuals at risk*)* - Flu vaccine uptake (%) in at risk individuals aged over 6 months to under 65 years (excluding pregnant women), who received the flu vaccination between 1st September 2010 to 28th February 2011.

The Kent value is 47.2% compared to 50.4% nationally. This places Kent as the 2nd worse authority in the south east behind Surrey (45.6%). The best authority in the south east is 53.5%.

3.05i Treatment completion for TB - The percentage of people completing treatment for tuberculosis within 12 months prior to 31st December, of all those whose case was notified the previous year.

The Kent value is 75.5% compared to 84.3% nationally. This places Kent as the worse authority in the south east; the best authority is 98.3% in Oxfordshire

Significantly better indicators in domain three

Kent rates as significantly better than the national for 3 of the 7 published indicators in this domain. However, as stated on the previous page the population vaccination coverage indicator has 15 sub-indicators and of these 9 were significantly better.

- 3.02 Chlamydia diagnosis (15-24 year olds),
- 3.03iii & iv & v & vi & vii & viii & ix & x Population vaccination coverage (Dtap/IPV/Hib for 1 and 2 yr olds, MenC, PCV, Hib/MenC booster, PCV booster, MMR one dose for 2 and 5 year olds and MMR for two doses).

Domain Four – Healthcare public health and preventing premature mortality

The objective of this domain is reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities.

Significantly worse indicators in domain four

Baseline figures have been published for 9 of the 16 indicators, just one indicator is significantly worse than the national position.

4.14 Hip fractures in people aged 65 and over*.* This indicator is split into 3 parts, 2 parts are significantly worse.

4.14i Hip fractures in people aged 65 and over - Emergency Hospital Admission for fractured neck of femur in persons aged 65 and over, directly age-sex standardised rate per 100,000.

The Kent value is 477 per 100,000 population compared to 452 nationally. This places Kent as the 5th highest authority in the south east behind Medway (487), Surrey (494), Windsor & Maidenhead (501) and Milton Keynes (544). The best authority in the south east is Slough with 341 per 100,000.

4.14iii Hip fractures in people aged 65 and over – aged 80+ - Emergency Hospital Admission for fractured neck of femur in persons aged 80 and over, directly age-sex standardised rate per 100,000. The Kent value is 1,619 per 100,000 compared to 1,476 nationally. This places Kent the 3rd worse authority in the south east behind Medway (1,711) and Milton Keynes (1,869).

Significantly better indicators in domain four

Kent rates as significantly better than the national for 5 of the 9 published indicators in this domain.

- 4.03 Mortality from causes considered preventable,
- 4.04i Under 75 mortality from cardiovascular disease that is considered preventable (including heart disease and stroke),
- 4.05i Under 75 mortality from cancer,
- 4.05ii Under 75 mortality from cancer that is considered preventable,
- 4.06i Under 75 mortality from liver disease,
- 4.06ii mortality from liver disease that is considered preventable,
- 4.12i Preventable sight loss – age related macular degeneration
- 4.12iv Preventable sight loss – sight loss certification

Prepared By: Del Herridge, Public Health Data and Product Manager
Natasha Roberts, Head of Health Intelligence

By: Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform

To: Kent Health and Wellbeing Board, 30th January 2013

Subject: Care in the Digital Age

Classification: Unrestricted

FOR INFORMATION

Recommendations

To note the proposed programme of work to explore opportunities for maximising use of digital technologies across the Kent whole system, including health, social care and housing.

Summary

1. (1) The Health and Wellbeing Board have a duty to support and facilitate integrated care. One area where there is value in further work being done is around better use of digital technologies across public, private and voluntary sector organisations – driven by customer requirements.

(2) The Strategic Commissioning division of Families and Social care is proposing to commission a piece of work called "Care in the Digital Age (see Appendix 1 for detail), supported by and engaging with member organisations of the Kent Health and Wellbeing Board. This will provide an opportunity to explore and map opportunities and create a space to learn about and share good practice.

(3) This programme could provide an opportunity to align and connect some of the currently disconnected work that is going on in various parts of our system. This includes:

- KCC Social Media strategy development
- Patient held records (health and social care)
- Developing community capacity / voluntary sector
- Social Media developments
- Patient and public engagement
- Personalisation and co-production – real time conversations with the public and providers
- KCC Customer Service strategy
- Patient / service user feedback
- 3 Million Lives Programme (Kent is a Department of Health pathfinder) - advanced assistive technologies
- Other advanced assistive technologies (telehealth, telecare, web based and smartphone apps, etc)

Next Steps

2. An initial meeting with the Care in the Digital Age team and key stakeholders will be arranged. A work programme will be developed which will include delivery of a Kent wide conference and follow up report, which will be presented back to the Health and Wellbeing Board.

Recommendations

3. To note the proposed programme of work to explore opportunities for maximising use of digital technologies across the Kent whole system, including health, social care and housing.

Background Documents

4. Care in the Digital Age (adapted) – see Appendix 1

Lead Officer:
James Lampert
Commissioning Manager
KCC, Families and Social Care, Strategic Commissioning
James.Lampert@kent.gov.uk or 07725 759541

APPENDIX 1

Care in the Digital Age Programme
(adapted by J Lampert, KCC 15.1.13)

How can the social web and mobile apps help Councils and Health and Well Being Boards improve the delivery of social care services and enhance community resilience? The use of the social web and mobile apps in social care offers considerable opportunities to improve the capacity of local communities to deliver high quality services to care recipients which addresses the challenges of isolation, access to services, health and disabilities.

There are three elements to the Care in the Digital Age programme:

1. Initial meeting with senior managers to explore the opportunities and challenges and map exiting connections across the public, not for profit and private providers which include care, health, housing, education, transport, leisure, economic regeneration and the police can benefit communities.

2. A one day event which brings together stakeholders to share good practice, enhance the skills and knowledge of a diverse workforce and introduces technology innovators working in the sector. The event provides an opportunity for staff from across the authority to showcase their knowledge, skills and innovative practice in the workshops. All workshop facilitators are provided with a briefing note prior to the event.

3. A final report which draws upon the initial discussions and the resources shared at the conference.

Drivers for change

- the economic climate and need for substantial cost savings in the public sector;
- changes in the demographic profile which will increase demands on services and decrease the available pool of labour to deliver them;
- opportunities provided by digital technology to deliver better, more efficient services;
- ongoing skills shortages in specific areas;
- the need for the statutory, private and not for profit sectors to work together for the benefit of people who use services, carers and families;
- the need to involve service users and carers in planning the workforce;
- a philosophical shift in public sector management from ‘command and control’ models to ‘whole systems’ approaches.

The nature and scale of these factors means that the social care workforce of the future will be significantly different from that of today. It will need to embrace change, be more flexible and be more responsive to a dynamic environment. It will also need to be more imaginative in the kinds of services it delivers and the ways in which it delivers them.

Aims of the conference

Integrated working is not only about structures and processes, however important these will be. It will also require individuals to think, and be able to co-operate, outside of their departmental or disciplinary 'silos'. They will need a much better understanding of each others' roles and responsibilities, a more flexible interpretation of their own job description and a shift in focus from service led to service user led approaches.

To support the development of a more connected care workforce who are able to advise and support the use of the social web and mobile apps To explore what is involved in using digital technologies.

To showcase and highlight a range of innovative solutions which will enable care recipients to live more independent and fulfilling lives.

To promote wider understanding of the role of the Health and Wellbeing Board

Outcomes

- Disseminating information and practical skills in the use of digital technology to a diverse workforce.
- Enabling care organisations to network and share best practice amongst themselves and with the County Council
- Providing a learning and development opportunity through social learning and sharing knowledge and expertise.
- Being better able to support families and carers
- Widening access to information and supporting digital inclusion
- Helping participants to understand the potential offered for engagement and support through social media and mobile apps.
- Facilitating the sharing of experiences of using digital technology and areas of concern.

The Care in the Digital Age Team

Shirley Ayres and James Souttar provide a knowledge consultancy working across the care and health sectors which connects purchasers and service providers to research, best practice and social innovation.

Shirley Ayres is a respected commentator with specialist knowledge of the care sector and the use of digital technology and social media. A qualified social worker she holds an MSc in Marketing and academic awards in Ethics,

Criminology and Management. She is the author of “The Future for Personalisation? service users, carers and digital engagement” (Institute for Research and Innovation in Social Services) and “Can online innovations enhance social care?” (Nominet Trust) and the Click Guide to Digital Technology in Care”. Shirley co-presents and produces the Disruptive Social Care podcast a weekly audio discussion programme promoting innovation in the care sector.

James Souttar is a communications specialist with considerable experience of stakeholder engagement, adult learning and developing communications strategy. He has worked with organisations in the governmental, higher education, professional, and not for-profit sectors. In 2005 he was awarded an Honorary Doctorate by Middlesex University for his work in rebranding the University.

The team work with a number of digital technology, social media and care specialists who may also be involved in the conference.

This page is intentionally left blank

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

To: Health and Wellbeing Board (Shadow) – 30 January 2013

Subject: Kent Tobacco Control Programme

Classification: Unrestricted

Summary

This paper proposes developing the Kent Tobacco Control strategy – Towards a Smokefree Generation- and establishing a Tobacco Control Board for Kent to oversee its implementation and realise the cost savings involved.

1. Introduction

a) As of April local authorities and Clinical Commissioning Groups will be assessed on how well they are reducing health inequalities in their area. The Public Health Outcomes Framework includes a number of measures that are directly related to smoking and several that have very strong links. In time this may also determine whether local authorities will be paid the Health Premium supplement to the public health budget.

- Smoking tobacco is the single biggest cause of health inequalities. To reduce health inequalities we need to reduce the number of smokers in Kent.

- Smoking remains the biggest cause of premature death and is responsible for more loss of life than the next four factors (including obesity and alcohol) combined.

- 70% of smokers want to give up.

b) With a smoking prevalence of 21.34% and an adult population of 1,153,000, Kent has an estimated smoking population of 246,071. To reduce the number of smokers in Kent we need to help existing smokers give up and reduce the number of young people that take up smoking

2. Tobacco use

a) Smoking rates amongst adults are declining and tobacco use is increasingly confined to the poorest sectors of our communities.

b) Smoking is the leading preventable cause of death and ill health in our society and is the prime cause of health inequalities as more affluent people continue to give up smoking.

c) Nicotine is a drug which is as addictive as heroin or cocaine.

d) Every year c.200,000 people stop smoking in England – they either die or quit.

e) Every year c. 200,000 young people start smoking tobacco regularly. In Kent c. 5,600 young people will begin smoking this year. Tobacco companies continue to target young people through social media advertising and cigarette packaging.

f) Demand for tobacco fuels the illicit trade in counterfeit and smuggled cigarettes that is conducted by organised crime syndicates that are also involved in people trafficking and drug misuse.

3. Smoking and children

a) Smoking is an addiction of childhood that reduces the ability of young people throughout their lives to manage their health and wellbeing and also their disposable income and in turn the health and wellbeing of their own children.

b) 90% of smokers begin smoking in childhood (13 – 18 years old) and then spend many of their adult years trying to give it up. The legal age for buying tobacco is 18.

c) The effects of smoking are often most serious for children. It is children that start smoking, hardly ever adults, and children that are most likely to be badly affected by smoking in the home and in cars.

d) The greatest influence on young people that will lead to them start smoking is whether their parents smoke - a child from a smoking household is 4 times more likely to begin smoking themselves than a child whose parents do not smoke.

e) Helping parents to give up smoking will directly affect the number of young people that take it up.

f) Every year nearly 10,000 children nationally are admitted to hospital as a direct result of inhaling second-hand smoke.

g) Children from smoking households display difficult behaviour in schools, especially during the afternoons, as a result of nicotine deprivation.

4. The economics of smoking

a) The economic impact of smoking is extremely serious for the smoker, their family and society as a whole.

- An average smoker – 20 a day – will spend £2,500 p.a. on tobacco. Most smokers are now in our poorest communities and can least afford this level of expenditure. Regressive taxation, designed to discourage smoking actually makes the issue worse for individual smokers and their families and encourages the use of illicit tobacco.
- 25% of all house fires are caused by smoking. (Cost £14.5 mil in Kent)
- Cigarette and smoking detritus is the biggest component of street cleaning and costs district councils in Kent £9.8 mil pa.
- Total cost of smoking to the NHS in Kent is estimated to be £77 mil.

b) A return on investment model has been developed by Brunel University and adopted by NICE that illustrates the cost benefits of various levels of intervention and how these can be apportioned to the different agencies involved. Extrapolation of national data to Kent indicates total cost savings of up to £7 mil in two years and over £30 mil in ten years.

5. Tobacco Strategy

a) Government intentions are clear:

b) In March 2011, the Department of Health published *Healthy Lives Healthy People: A tobacco control plan for England.* The plan sets out how tobacco policy fits with the localism agenda and how, together with local partners, the Government will:

- Help smokers to quit
- Reduce exposure to secondhand smoke
- Stop the promotion of tobacco in shops
- Make smoking less affordable
- Regulate tobacco products more effectively
- Protect health policy from the vested interests of the tobacco industry

c) Smoking services have been concentrated on achieving the DH targets for adult quitters. This has resulted in other groups receiving less attention. These include children and young people, and pregnant women who smoke. The Government has recognised these issues and has widened the focus of its objectives.

"By the end of 2015 we will:

- Reduce adult smoking prevalence in England to 18.5% or less by the end of 2015 (Kent rate currently 21.34%)
- Reduce regular smoking among 15 year olds to 12% (Kent rate currently 13%)
- Reduce smoking throughout pregnancy to 11% (E. Kent rate currently 16.8%, W. Kent 12.1%)"

d) The strategy recognises the importance of helping smokers to quit but places emphasis on prevalence rates that will incorporate how to prevent young people taking up smoking, as well as teenage quit rates.

e) Other priorities in the public health outcomes framework will require action on tobacco use to be achieved. These include reducing rates of cardiovascular disease, cancer and respiratory disease as well as the overarching indicators of reducing inequalities in life expectancy and healthy life expectancy. Prioritising tobacco control programmes can therefore also contribute to the QIPP agenda.

6. Doing it differently in Kent

a) Historically Kent has concentrated investment in services to help adults quit smoking. These have achieved significant success - last year (11/12) the Stop Smoking Services in Kent helped 9,314 people quit smoking at a cost of c. £3.3 million. However the agenda is now much wider and Kent has developed a Tobacco

Control Strategy (Towards a Smokefree Generation) that addresses the use of tobacco across the Life-Course (Marmot 2010) and provides a coherent programme of interventions that address the local priorities for Kent. Critically we need to reduce the number of children that start smoking. The Kent strategy has a clear emphasis on engaging and empowering young people to avoid smoking.

6.1 Smoking Cessation

a) Services to support smokers who want to quit are critical to a successful approach. These services will also need the flexibility to engage with the greater number of referrals that will be generated by a wider approach.

b) Five minutes of advice in general practice to middle-aged smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person (King's Fund 2011).

6.2 Reduce prevalence of smoking in pregnancy

a) Audit current Smoking at Time of Delivery (SATOD) activity, to ensure accuracy of data and self-reporting.

b) Redesign pathways and interventions with midwifery and cessation services including the roll out and continuing evaluation in Kent of the successful "Babyclear" programme.

c) Current costs to NHS in Kent of smoking in pregnancy by NICE modelling are estimated to be £2,486,875 pa.

6.3 Reduce children's exposure to tobacco smoke

a) Currently working with professionals and families in Dartford, Gravesham and Swanley to design community based interventions that will reduce children's exposure to second hand smoke in the home and elsewhere.

6.4 Reduce the number of young people who take up smoking

a) Supporting young people's awareness of, and education in, tobacco issues by leading the delivery of "Reframe the Debate" and introducing the Tobacco Education Quality Standard to Kent schools.

b) Developing Youth Advocacy across Kent for young people to assume control of the tobacco control agenda and develop a Kent Youth voice and associated campaigns.

c) Issues identified by young people include the introduction of plain packaging for cigarettes, sales restrictions and enforcement and using the "Truth Campaign" to demonstrate the targeting of young people by the tobacco industry at home and abroad.

6.5 Illicit tobacco

a) Tackle the demand for and supply of cheap and illegal tobacco in our communities and address the criminal activity involved.

6.6 Smokefree business

a) Targeted workplace smokefree initiatives promoting smokefree policies and supporting workers who wish to quit smoking including Kent's Smokefree Business Awards.

6.7 Establish a Tobacco Control Board

a) To coordinate the strategy it is proposed to establish a Tobacco Control Board for Kent. The Board will develop from the existing Tobacco Control Alliance in Kent and membership will include representatives from KCC Public Health, the District Councils (very important in delivering on all aspects of tobacco), CCG's, Stop Smoking Services, Education and youth services, Trading Standards, Environmental Health, Police, Fire and Rescue, Revenue and Customs, and other key stakeholders.

b) The Board would have a specific remit to use the Brunel/NICE return on investment model (see p3) to deliver the cost savings for Kent generated from a comprehensive tobacco control and smoking cessation programme.

c) The Board would also be responsible for the production and implementation of a Kent Health Inequalities Action Plan (Mind the Gap) for Tobacco Control and identifying further ways in which tobacco use in Kent can be "de-normalised" and reduced.

7. Resources

a) The current programmes of activity require an annual budget of c. £655,000. It is proposed that funding continues from the Public Health ring-fenced budget for Kent at this level. This would bring Kent broadly into line with other areas that have funded similar programmes at a rate of 40p per head of population. Staffing and support for the Board would also be required.

8. Recommendation

a) A Tobacco Control Board for Kent, as described above, is established as soon as practical.

b) A comprehensive Tobacco Control strategy comprising the elements listed above should be funded and implemented with a particular focus on preventing young people from starting smoking.

Contact details:
Andrew Scott-Clark
Director of Health Improvement
Andrew.scott-clark@eastcoastkent.nhs.uk
Tel: 01233 658403

References:

Fair Society, Healthy Lives (The Marmot Review) 2010
www.ucl.ac.uk/marmotreview

King's Fund – Transforming our healthcare system – 2011
10 priorities for commissioners

Building the Economic Case for Tobacco Control - 2011
Health Economics Research Group – Brunel University
Queen's Medical Centre – University of Nottingham
London Health Observatory

Kent Tobacco Control Strategy - 2010-2014
Towards a Smokefree Generation
https://shareweb.kent.gov.uk/Documents/health-and-wellbeing/kent-tobacco-control-strategy-2010-2014%20vd1%202.doc

Kent Health Inequalities Action Plan 2012 - 2015
Mind the Gap Building bridges to better health for all
www.kmpho.nhs.uk/health-inequalities

This page is intentionally left blank