HEALTH AND WELLBEING BOARD

Wednesday, 17th July, 2013

6.30 pm

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 17 July 2013 at 6.30 pm
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Ann Hunter**
Telephone: **01622 694703**

Tea/Coffee will be available 30 minutes before the meeting

Webcasting Notice

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

Item No	
1	Chairman's Welcome
2	Substitutes
3	Declarations of Interest by Members in Items on the Agenda for this Meeting
4	Minutes of the Meeting held on 29 May 2013 (Pages 1 - 10)
5	Public Health Priorities (Presentation)
6	Addressing Health Inequalities (Pages 11 - 54)
7	Kent Framework for the Prevention and Management of Falls and Falls Prevention (Pages 55 - 60)
8	Kent Framework for System Assurance (Pages 61 - 68)
9	Integrated Pioneer Programme Bid - Delivering the Vision (Pages 69 - 84)
10	Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategy and Timeline (Pages 85 - 90)

11 Working Arrangements Between Boards (Pages 91 - 100)

12 West Kent CCG - Mapping the Future (Verbal Update)

13 System Leadership - Integrated Commissioning (Verbal update)

14 Kent's Initial Stocktake of Progress against the Winterbourne View Concordat Commitment (Pages 101 - 126)

15 Befriending Services (Pages 127 - 132)

16 Date of Next Meeting 18 September 2013 at 6.30pm

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
(01622) 694002

Tuesday, 9 July 2013

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

HWB Membership

CCG Reps	**Clinical Lead**	**Officer**
Ashford CCG	*Dr Navin Kumta*	*Simon Perks*
Canterbury & Coastal CCG	*Dr Mark Jones*	*Simon Perks*
Dartford/Gravesham/ Swanley	*Dr B Bora*	*Patricia Davies*
South Kent Coast	*Dr Darren Cocker*	*Hazel Carpenter*
Swale	*Dr Fiona Armstrong*	*Patricia Davies*
Thanet	*Dr Tony Martin*	*Hazel Carpenter*
West Kent	*Dr Bob Bowes*	*Ian Ayres*

District Councillor Reps

	Substitute	
Cllr Andrew Bowles	Cllr Lesley Ingham	Swale
Cllr John Cunningham		Tunbridge Wells
Cllr Paul Watkins		Dover

Healthwatch
Veronika Segall- Jones

NHS England

Michael Ridgwell or	*Felicity Cox*

KCC
Paul Carter
Andrew Ireland
Meradin Peachey
Graham Gibbens
Roger Gough
Jenny Whittle

Italics = statutory reps
CCG reps – each CCG rep has one vote

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 29 May 2013.

PRESENT: Mr I Ayres, Mr P B Carter, Ms F Cox, Ms P Davies, Mr R W Gough, Dr D Grice (Substitute), Mr R Kendall, Dr N Kumta, Dr T Martin, Ms M Peachey, Mr S Perks, Cllr K Pugh, Cllr P Watkins and Mrs J Whittle

IN ATTENDANCE: Ms C Davis (Strategic Business Advisor), Mrs J Dixon-Sherreard (Policy Manager), Ms J Ely, Mr A George, Mrs R Henn-Macrae (District Manager), Mr A Scott-Clark (Director of Public Health Improvement) and Mr M Thomas-Sam (Head of Policy and Service Development)

UNRESTRICTED ITEMS

1. Chairman's Welcome

(Item 1)

(1) As chairman of the former Health and Wellbeing Board (Shadow), Roger Gough, Cabinet Member for Education and Health Reform, welcomed everyone to the first meeting of the Health and Wellbeing Board. He confirmed that this meeting and future meetings of the Health and Wellbeing Board would be webcast.

(2) He drew the Board's attention to a flyer for a conference on Integrating Health and Social Care to be held on 19 June 2013 at the Saga Pavilion, Sandgate.

(3) He advised the Board that, at an event on 1 May 2013, the South East Coast Clinical Senate had expressed a strong desire to build a relationship with the Health and Wellbeing Board and it was agreed that he would write to the Senate to initiate this process.

2. Apologies and Substitutes

(Item 2)

(1) Apologies were received from: Dr Fiona Armstrong, Swale CCG; Dr Bob Bowes, West Kent CCG; Ms Hazel Carpenter, South Kent Coast and Thanet CCGs; Dr Darren Cocker, South Kent Coast CCG; Mr Graham Gibbens, Cabinet Member for Adult Social Care and Public Health; Dr Mark Jones, Canterbury and Coastal CCG; Mr Michael Ridgwell, NHS England; and Ms Veronika Segall-Jones, Healthwatch.

(2) The following substitutes were also noted: Dr David Grice for Dr Mark Jones; Mr Andrew Harrison for Ms Hazel Carpenter; Mr Roger Kendall for Ms Veronika Segall-Jones; and Cllr Ken Pugh for Cllr Andrew Bowles.

3. Election of Chairman

(Item 3)

(1) Proposed by Cllr Ken Pugh and seconded by Cllr Paul Watkins that Roger Gough be elected as chairman. There being no other nominations it was

(2) **RESOLVED** that Roger Gough be elected as chairman of the Health and Wellbeing Board.

4. Election of Vice Chairman

(Item 4)

(1) Proposed by Jenny Whittle and seconded by Patricia Davies that Dr Bob Bowes be elected as vice chairman. There being no other nominations it was

(2) **RESOLVED** that Dr Bob Bowes be elected as vice chairman of the Health and Wellbeing Board.

5. Declarations of Interest by Members in Items on the Agenda for this Meeting

(Item 5)

There were no declarations of interest by members of the board on any items on the agenda for the meeting.

6. Minutes of the Meeting of the Health and Wellbeing Board (Shadow) held on 27 March 2013

(Item 6)

RESOLVED that the minutes of meeting of the Health and Wellbeing Board (Shadow) held on 27 March 2013 are correctly recorded and that they be signed by the chairman.

7. Delay in the Statutory Assessment of Children and Young People with Special Educational Needs (SEN)

(Item 7)

(1) The Health and Wellbeing Board considered a report by Roger Gough (Cabinet Member for Education and Health Reform) and Julie Ely (Head of Special Educational Needs) which provided information about the performance against National Indicator (NI 103). This indicator measures the time taken to produce SEN statements and the report said that Performance during 2012 was below target and remained a significant cause of concern in 2013. It also said that an analysis indicated that the root causes of delay were late receipt of professional advice from health contributors to the assessment and placement pressure.

(2) Julie Ely, introduced the report and in particular she made the following statements:

- There is a statutory duty to carry out an assessment of special educational need on children with the greatest learning difficulty and the responsibility of the Designated Medical Officer to coordinate the NHS contribution to the assessment is set out in the SEN Code of Practice;
- Approximately 100 new, first time assessments are initiated every month;
- The time taken to conduct an assessment should not exceed 26 weeks;
- In 2010/11 Kent's performance against NI 103 was 88% compared with the national average of 95% and 98% achievement by statistical neighbours;
- In August 2012 actual performance was 70% for a twelve-month rolling year;
- Improvements to performance were made in 2012/13 but were insufficient to reach the prescribed targets;
- Proposals in the Children and Families Bill will reduce the time allowed for assessments from 26 to 20 weeks;
- 50% of complaints from service users related to dissatisfaction with the assessment process, gaps in provision and/or placement;
- In 2010 Brian Lamb reported meeting parents who battled to get the needs of their child identified and met. The Government had responded to his report with a Green Paper in 2010 proposing transformation, and the draft Children and Families Act which is due in 2014.

(3) During discussion it was agreed that: the tone of the report was not as helpful as it could be and the style felt more like performance management than partnership working. It was also agreed there was a need to share the underlying analysis with the Board; and to monitor progress against agreed actions.

(4) **RESOLVED:**

(a) That the report into the delay and causes be noted;

(b) That the Head of Special Educational Needs circulates a report setting out the issues and background data to the Board;

(c) That the Board receives a report in six months monitoring actions and achievements in addressing the issues.

8. Kent's Pathfinder for the Children and Families Act 2014

(Item 8)

(1) The Health and Wellbeing Board considered a briefing report by Roger Gough (Cabinet Member for Education and Health Reform) and Julie Ely (Head of Special Educational Needs) about the Kent Pathfinder which is testing reforms proposed in the Children and Families Bill. The report also drew attention to an amendment to the bill in March 2013 which will impose a legal duty on clinical commissioning groups to secure the health services that are specified in the Education, Health and Care (EHC) Plans

(2) Julie Ely introduced the report and in particular she made the following statements:

- 20 pathfinders have been invited by the Government to test proposed reforms set out in the Children and Families Bill including Kent which is a member of the SE7 Pathfinder group comprising East and West Sussex, Medway, Surrey, Hampshire and Brighton and Hove;
- The bill introduces a single system from birth to 25 for children with SEN and their families that demands a more streamlined assessment process integrating education, health and care services; offers families and young people with an EHC plan a personal budget; and places a legal duty on clinical commissioning groups to secure health services specified in the EHC plans;
- SE7 is developing a common framework for assessment and a children and family centred plan that focuses on outcomes. In Kent the work has focussed on co-production with parents and carers, developing an understanding of effective key working approaches, the development of the local offer, identifying how multi-agency assessments can be integrated; developing a prototype for integrated EHC plans and piloting the use of personal budgets.

(3) **RESOLVED:**

(a) That the briefing report be noted;

(b) That the proposed statutory duties be noted;

(c) To ensure that a joint commissioning approach is reflected in Pathfinder development;

(d) That the establishment of task and finish groups or other mechanisms be considered to enable each health economy to address the particular issues in its area.

9. Joint Strategic Needs Assessment Update

(Item 9)

(1) The Health and Wellbeing Board considered a report by Roger Gough (Cabinet Member for Education and Health Reform) and Dr Abraham George (Public Health Consultant) which sought approval for the establishment of a project development group to oversee the rolling programme of Joint Strategic Needs Assessment (JSNA) updates as well as approval for the process to be used.

(2) The report was introduced by Abraham George who said there was a statutory duty to undertake a JSNA which in turn informs the Health and Wellbeing Strategy.

(3) There was broad support for the approach outlined but concerns were raised about the blurring of the purposes of the JSNA and HWB Strategy and that the proposed date of 1 September for the production of the overview chapter would be too late to inform the commissioning cycle. For future years the JSNA would need to be completed for the 1 April to fit with the commissioning cycle.

(4) **RESOLVED:**

(a) That the process to update the JSNA be agreed;

(b) That the membership of the JSNA Project Development Group as set out in paragraph 2.2 of the report be agreed;

(c) That Andrew Scott-Clark leads the preparation of a report to a future meeting of the Health and Wellbeing Board setting out the timetable for the development of the JSNA, the Health Wellbeing Strategy and the commissioning cycle.

10. Establishment of Sub Committees
(Item 10)

(1) The Health and Wellbeing Board considered a report by Roger Gough (Cabinet Member for Education and Health Reform) which sought to establish sub committees to be known as CCG level health and wellbeing boards.

(2) Caroline Davis introduced the report and said that the proposed sub committees had been running in shadow format and they now need to be formally established. She also said that Kent was the only area to have taken this approach and that the shadow sub committees had identified local priorities and were working well.

(3) During discussion it was made clear that partners were individually taking responsibility for the achievement of priorities and that the CCGs were not and could not delegate accountability. The need to revise the tone of the example of governance arrangements/terms of reference attached at appendix A to the report was identified.

(4) **RESOLVED:**

(a) That the Kent Health and Wellbeing Board establish a series of sub committees, to be known as CCG level Health and Wellbeing Boards;

(b) That the governance arrangements will follow those set out in the Kent County Council's Constitution and the Kent Health and Wellbeing Board's Terms of Reference. This includes the use of the KCC Elected Members Code of Conduct for all members of the CCG level HWBs;

(c) That minor changes to membership of the CCG level HWBs will not need to be notified to the Kent HWB;

(d) That each CCG HWB will report at least on an annual basis to the Kent HWB, unless otherwise directed.

11. System Performance - Early Indicators for 2013 (Verbal Report)
(Item 11)

(1) The chairman asked the accountable officers from each of the clinical commissioning groups to give an update. The updates will be circulated to members of the Board

(2) Paul Carter suggested having a performance dashboard for "what good looks like". The indicators should be reviewed against the outcomes listed in the Health and Wellbeing Strategy.

(3) **West Kent CCG**

Ian Ayres reported that:

- Performance in West Kent is on track at the end of month one.
- Activity at Maidstone and Tunbridge Wells hospitals is running slightly below plan and finances for the CCG as a whole are at budgeted levels.
- Urgent care performance is the key cause of concern with delays to admissions from A&E failing to meet the four-hour target. This continues a trend seen through the winter and, although overall activity had not increased, patients needing admission were sicker than normal and required longer stays in hospital. Performance has improved over the four weeks and the trust is currently meeting the four-hour target.
- Discharges from hospital to home or into care have continued to be challenging. All agencies have been working together to ensure patients are able to leave hospital and receive rapid and appropriate re-ablement services.

(4) **Dartford, Gravesham and Swanley CCG**

Patricia Davies said that:

- The eight clinical commissioning groups have agreed to take the lead on contracts as follows:
    - DGS are the lead commissioners for Darent Valley Hospital, the North Kent health economy contract with KCHT, Fawkham Manor and London;
    - Swale CCG are the lead commissioners for SECAmb, 111 and host the North Kent Quality Team;
    - Both DGS and Swale CCGs hold contracts with KMPT, MTW, EKHUFT, MFT;
    - Swale CCG holds a contract with MCH;
    - West Kent CCG provides the lead commissioning role for KMPT, MTW;
    - Ashford and Canterbury CCGS provide the lead commissioning role for EKHUFT
    - Medway CCTG provide the lead commissioning role for MFT, MCH and hosts the Safeguarding team for all eight CCGs in Kent and Medway.
- Darent Valley Hospital achieved all of the NHS constitutional targets for 2012/13. For month one the A&E figures were at 93% and in May 2013 was in excess of 97%. It is anticipated that the trust will achieve the quarter one gateway performance of 95% or above.
- Achieving targets relating to cancer treatments remains challenging and work is continuing with the trust to resolve issues.

- Single point of access went live at end of April for both Swale and DGS CCGs and feedback from GPs on the first three weeks of operation had been very positive.

- Medway Foundation Trust had been identified as requiring a review and support following the Francis report. A report on the findings of the review is imminent.

- North Kent CCGs have developed a joint steering group with KCC to monitor Section 75 agreements and jointly agree the commissioning plans for re-ablement and social care funds locally and are looking at opportunities for joint commissioning, streamlining processes and joint working.

(5) **East Kent CCGs**

Simon Perks said that:

- Performance for month one was broadly on track.
- Performance in outpatients in EKHUFT in cancer and children's services is being reviewed.
- Spend is at budgeted levels.
- Work is underway to build greater sustainability into the orthopaedic waiting list position.
- Waits in A&E had exceeded four hours but are now on target.
- There is now a focus on the effective discharge of patients.

(6) **RESOLVED** that a review of performance against the priorities set out in the HWB Strategy be included as a standing item on agendas for the Health and Wellbeing Board.

12. Health and Social Care Integration "Pioneers"
(Item 12)

(1) The Health and Wellbeing Board considered a report by Roger Gough (Cabinet Member for Education and Health Reform) which provided information about Integrated Care and Support: Our Shared Commitment report published on 14 May 2013 and sought endorsement to submit an expression of interest by KCC in partnership with health.

(2) Michael Thomas-Sam, Strategic Business Adviser – KCC, introduced the report and said that becoming a pioneer would create access to external support; provide a sound foundation for flexibility, assist with overcoming barriers to health and social care integration and provide an opportunity to influence national developments. He also outlined the "pioneer approach" and described the selection process and timetable.

(3) During discussion the importance of clarifying the distinction between commissioning and provision as part of the bid was identified as was the need to reflect local input to capture the diversity in different parts of Kent.

(4) **RESOLVED** that the proposal for Kent County Council and Kent Clinical Commissioning Groups to submit an expression of interest application be

endorsed subject to clarifying the distinction between commissioning and provision and reflect local input to capture diversity.

13. Every Day Matters- Kent's Multi-agency Strategic Plan for Children and Young People
(Item 13)

(1) The Health and Wellbeing Board considered a report by Jenny Whittle (Cabinet Member Specialist Children's Services) and Andrew Ireland (Corporate Director, Families and Social Care) which included the final draft of Every Day Matters: Kent Multiagency Strategic Plan for Children and Young People 2013-16 that reflected feedback from a number of individuals and organisations. The Health and Wellbeing Board was asked for any further comments and to endorse its publication.

(2) Jenny Whittle introduced the report and said the strategic plan would shape key priorities for the future and reflected earlier discussions with the Health and Wellbeing Board. She thanked Michael Thomas-Sam and Jenny Dixon-Sherreard for their working in bringing the draft together.

(3) **RESOLVED** that the final draft of Every Day Matters: Kent's Multiagency Strategic Plan for Children and Young People 2013-2016 be endorsed.

14. Disabled Children's Charter for Health and Wellbeing Boards
(Item 14)

(1) Rosemary Henn-macrae introduced the item saying the chairman had received a letter from the Children's Trust Tadworth who had created a Disabled Children's Charter for Health and Wellbeing Boards inviting the Kent Health and Wellbeing Board to sign up to the charter. She said that the commitments in the charter were either already being met or were ones that Kent could aspire to meet and were very similar to the Every Disabled Child Matters Charter to which Kent had been a signatory.

(2) **RESOLVED** that authority be delegated to the chairman to sign the Disabled Children's Charter for Health and Wellbeing Boards.

15. Local Children Services Arrangement
(Item 14a)

(1) The chairman agreed to consider this report which had not been included on the agenda published on the 20 May as a matter of urgency because its consideration could not be deferred to the next meeting of the Health and Wellbeing Board scheduled for 17 July 2013 as the Cabinet Member for Specialist Children's Services will make a decision on this matter before the end of June 2013 having taken into account any views put forward by the Health and Wellbeing Board.

(2) This paper by the Roger Gough (Cabinet Member for Education and Health Reform) and Andrew Ireland (Corporate Director Families and Social Care informs the Health and Wellbeing Board about the proposed local children services arrangement to support the county Children and Young People's Joint Commissioning Board at the CCG Health and Wellbeing Boards level rather than retaining a district-based arrangement.

(3) The paper was introduced by Jenny Whittle who said the core purpose of the proposal was to avoid duplication and to target efforts by working with CCGs.

(4) During discussion questions were raised about whether children's issues should be a standing item on the agendas for the Health and Wellbeing Board or whether there should be a sub-group and how the CCG-level health and wellbeing boards might deal with items relating to children. It was suggested that the existing protocol between the Health and Wellbeing Board and the Joint Commissioning Board be re-circulated.

(5) **RESOLVED:**

(a) That the Health and Wellbeing Board supports the proposal subject to CCG accountable officers being able to resolve how this would work in practice addressing the issues raised in paragraph 3 above.

(b) That the Cabinet Member for Specialist Children's Services will take the decision to approve the local children services arrangement no later than July 2013.

16. Date of Next Meeting - Wednesday 17 July 2013 at 6.30pm
(Item 15)

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

Meradin Peachey, Kent Director of Public Health

To: Kent Health and Wellbeing Board

Subject: Addressing Health Inequalities in Kent

Classification: Unrestricted

Summary

The purpose of this report is to identify geographical areas where Clinical Commissioning Groups (CCGs) and the other local partners can focus their attention for effectively reducing health inequalities, by reducing disease and gender specific under 75 mortality.

Based on the model suggested by Professor Chris Bentley the Kent Public Health department has developed a methodology to identify the number of lives that will need to be saved for effective reduction in health inequalities and where to target resources.

This paper states the number of deaths that will need to be reduced in areas that have mortality rates within the top 20% of death rates for each CCG to achieve average number of deaths across Kent and Medway.

Recommendation(s): The Health and Wellbeing Board are asked to:

i) Note the data reported in this paper

ii) Support CCGs and NHS England to develop action plans to address the identified number of postponed premature deaths targeting the areas with top 20% death rate.

iii) Support the local system in working together through the local Health and Wellbeing Boards. Action planning at a local level to develop local 'Mind the Gap' needs to continue and bring together the District Council and CCG priorities to tackle health inequalities. This should be used as the mechanism to identify contribution from various parts of the system (CCGs, District Councils, KCC, Health Watch and voluntary sector) and address the wider determinants of health, health promotion and preventing poor health.

1. Introduction

Professor Chris Bentley was invited to present his approach to 'Addressing Health Inequalities' at the November 2012 Shadow Health and Wellbeing Board, where he presented a number of tools for assessing variation that contributes to the health inequalities gap. This paper builds on the model developed by Chris Bentley to show CCGs the specific groups of adults most at risk of early deaths. The public health intelligence team have used small areas of geography (Lower level super output areas LSOAs) to help CCGs understand where the avoidable variations are.

Health inequalities are avoidable variations in health status of groups and individuals and are a complex issue. There is evidence that populations in areas with high deprivation experience higher morbidity and mortality than those areas with low deprivation (Marmot strategic review, 2010), however some less deprived areas may contain pockets of high mortality.

By using Lower Super Output Areas high risk communities can be identified in affluent and deprived parts of Kent.
This report presents patterns of premature mortality (under 75) in the Lower Super Output Areas (LSOAs) which contain the highest mortality rates. It further addresses this issue by showing how many lives can be saved if death levels within this top quintile (containing 20% of the population) are reduced to the average level for Kent and Medway at this time (2010-12).

This paper shows one aspect of the inequalities plan where CCGs can help to make a difference.

2. How is "Mind the Gap" being used?

'Mind the Gap, Building bridges to better health for all' is a cross system approved Health Inequalities action plan providing strategic direction, and was produced by KCC in collaboration with District Councils. The action plan is based on the principles of Marmot's life-course approach and has been aligned to the Joint Strategic Needs Assessment (JSNA) priorities and relevant policies and plans.

Kent Public Health team is supporting the Districts in their preparation of local action plans for their contribution to reducing health inequalities. The district level action plans so far have had variable collaboration with CCGs as at the time CCGs were being established.

Professor Chris Bentley has visited a number of Kent Local Authorities and CCGs and endorses the partnership approach of CCGs, Districts and the County Council working together to tackle health inequalities. The plan therefore illustrates a range of actions and initiatives undertaken by Kent County Council (KCC) and partners to address the wider social determinants of health inequalities across Kent. It demonstrates a far-reaching and expansive contribution that District Councils, community enterprises, voluntary sector and other statutory agencies make to improve healthy lifestyles and promote mental and emotional wellbeing among the Kent population, particularly in deprived communities and to the most vulnerable in society.

In addition, the Joint Policy and Planning Board for Housing and Tobacco Control services are finalising separate action plans related to 'Mind the Gap' focussing on Housing and Tobacco Control respectively. The Housing action plan will identify activities that address housing issues that impact upon inequalities (such as decent home standard, homelessness, supporting people to live in their own homes) and Tobacco Control action plan will focus on actions to reduce smoking prevalence in manual and routine workers, smoking in pregnancy and the illicit tobacco trade.

3. How will we know if commissioned services will reduce health inequalities?

To measure effectiveness of action plans these are supported by an Impact Assessment tool designed on a model endorsed by the Department of Health. The tool includes the 13-step approach to the Health Inequalities National Support Team's (HINST) Christmas Tree model for commissioning for the most effective outcomes for inequalities. The tool will be used to assess the impact of the proposed service on health inequalities. In the first phase this tool is being rolled out to all Health Inequalities leads across directorates in Kent County Council and to HI leads in District Councils. The second phase of the roll out will include CCGs.

4. Contribution from CCGs and NHS England (Kent and Medway)

The local level Health and Wellbeing Boards provide opportunities for CCGs and District Councils to work collaboratively to reduce health inequalities. Figure A illustrates the role and contribution needed across the entire system, to ensure that health inequalities are effectively reduced over the short, medium and long term**.**

All partners in the local health and care system have a role to play in prevention of ill health. The Area Team and CCGs are collectively responsible for commissioning services provided through general practice that can make a difference to the early deaths in the 'at risk' groups. Therefore this paper focuses on the short term interventions which can be influenced primarily by the CCGs and assist in reducing health inequalities. Examples of these services include:

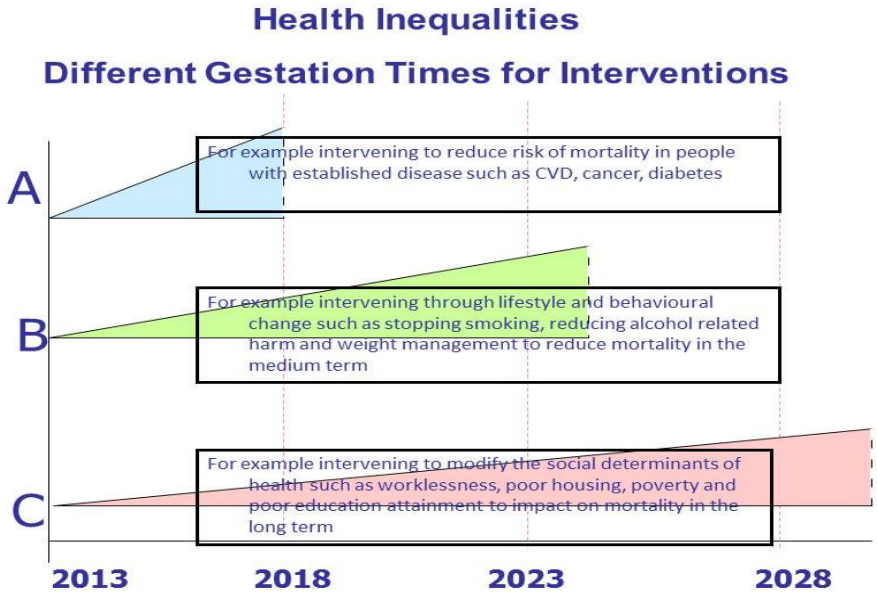
- Reduce differences across practices in Kent on how patients with high blood pressure are effectively identified on a register and managed

- Reduce differences across practices in the number of patients that are known to have diseases compared to those who are expected to have a disease for certain conditions such as diabetes, blood pressure and respiratory diseases (Chronic Obstructive Pulmonary Disease)

- Maximise access to, and use of treatment, for managing clinical conditions such as high blood cholesterol, high blood sugar in the case of known diabetics.

- CCGs and NHSE have a particular role in relation to number A in figure A below.

Figure A:



(adapted from C.Bentley)

5. Identifying target areas for intervention

This paper highlights areas at a small geographical level (lower level super output areas) that experience high rate of deaths for premature deaths (those under 75 yrs) related to:

- circulatory diseases
- respiratory diseases
- cancer

The data analysis highlights that disease specific deaths in under 75 years is higher among males and therefore this briefing paper has information relating to men. Data on premature deaths in females is available in specific reports for the CCGs at electoral ward and LSOA level (Appendices 1-7).

5.1 How did we identify number of lives that can be saved?

To develop a Kent wide picture premature mortality rates (deaths under 75 years) for Kent and Medway population were divided into equal tenths referred to as deciles, with decile 1 (top 10%) representing the highest premature mortality rates.

Premature mortality rates were calculated for small areas of geography (lower level super output areas), for each of the seven CCGs these death rates were ranked from highest to lowest and allocated to decilies.

The top two deciles (20%) of the population in each CCG, and the premature mortality rates for Kent and Medway were compared to identify the number of deaths that would need to be postponed if the mortality rate in the districts followed the same pattern as that for Kent and Medway. These calculations identify that the following numbers of lives would need to be saved.

- circulatory disease –515 lives saved (deaths postponed)
- respiratory disease –306 lives saved (deaths postponed)
- cancer –579 lives saved (deaths postponed)

5.1.1 Circulatory disease related under 75 mortality rates in men

Table 1 highlights number of circulatory related deaths among top 20% of the male population during 2010-2012 compared to death rate across Kent and Medway. **It shows that the death rate in top 20% of the population is nearly twice as high compared to Kent and Medway (189.3 and 83.6 per 100,000 respectively).** The table also highlights that that 20% of the CCG male population in these subsets (top LSOA) experiences 39% of all premature deaths from circulatory diseases (932 out of 2382).

Table 1: Mortality in 20% of population with highest death rates, all circulatory disease, aged under 75, 2010-2012, males, lower super output areas.

Mortality data for all circulatory diseases, aged under 75, 2010-2012 (pooled), males

	Mortality in 20% of population experiencing highest death rates					
Clinical commissioning group	Numbers of deaths in 2010-2012	Directly age-standardised mortality per 100,000	Numbers of deaths in 2010-2012	Directly age-standardised mortality per 100,000	Numbers of deaths which would occur if area experienced same mortality rates as K&M	Numbers of lives which could be saved in highest 2 deciles
NHS Ashford CCG	59	174.8	174	87.9	28	31
NHS Canterbury and Coastal CCG	59	195.2	231	68.3	25	34
NHS Dartford, Gravesham and Swanley CCG	149	191.6	338	86.9	65	84
NHS Medway CCG	150	189.1	359	89.9	66	84
NHS South Kent Coast CCG	139	186.3	349	96.5	62	77
NHS Swale CCG	84	171.1	159	89.5	41	43
NHS Thanet CCG	135	215.0	258	110.8	53	82
NHS West Kent CCG	148	186.6	514	68.7	66	82
Kent & Medway	**923**	**189.3**	**2382**	**83.6**	**408**	**515**

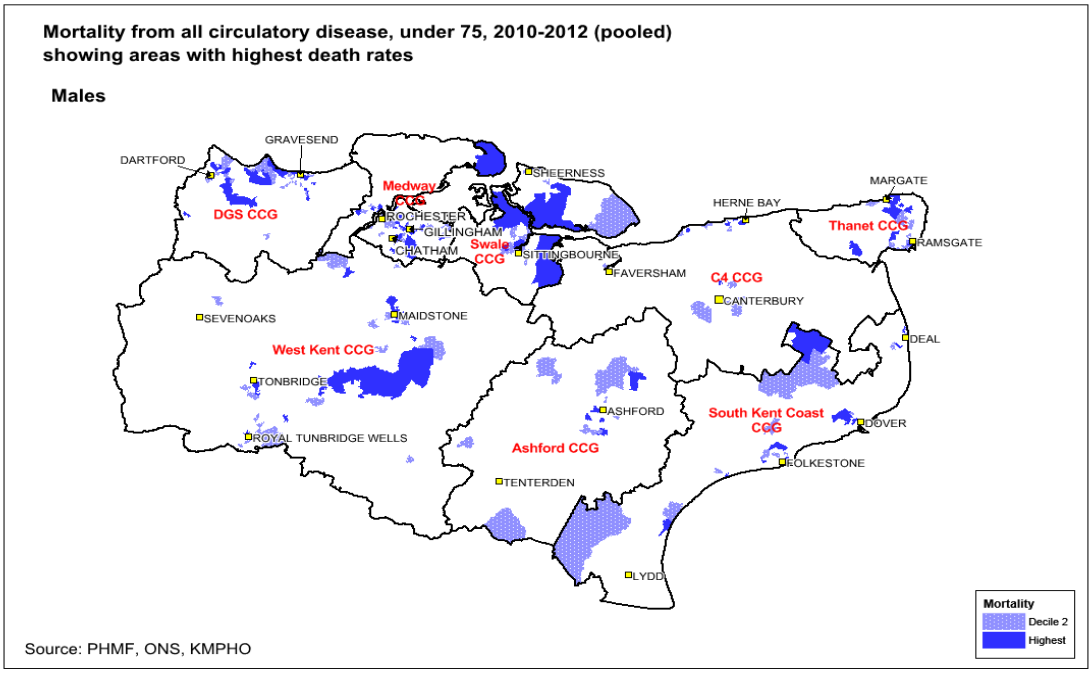
Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may be evident

If each CCG were to aim for reducing their respective death rates in these areas to the same level as Kent and Medway then this would mean a reduction of 515 premature deaths across Kent and Medway in a three- year period.

Figure 1 highlights the geographical distribution in each CCG with premature male deaths experienced in the 20% of the population which have the highest mortality rates related to circulatory disease in Kent and Medway.

Figure 1: Mortality in 20% of population with highest death rates, all circulatory disease, aged under 75, 2010-2012, males, lower super output areas



5.1.2 Respiratory disease related under 75 mortality rates in men

Table 2 highlights number of respiratory disease related deaths among top 20% of the male population during 2010-2012 compared to death rate across Kent and Medway**. It shows that the death rate in top 20% of the population is nearly three times higher compared to Kent and Medway (84.4 and 27.3 per 100,000 respectively)**. The table also highlights that that 20% of the CCG male population in these subsets (top LSOA) experiences 56 % of all premature deaths from respiratory diseases (452 out of a total of 805).

If each CCG were to aim for reducing their respective respiratory disease related death rates in these areas to the same level as Kent and Medway then this would mean that there would be 306 *fewer* deaths in a three-year period.

Lower super output areas with these higher rates are identified in the CCG-specific sections of this report.

Table 2: Mortality in 20% of population with highest death rates, all respiratory disease, aged under 75, 2010-2012, males, lower super output areas.

Mortality data for all respiratory diseases, aged under 75, 2010-2012 (pooled), males

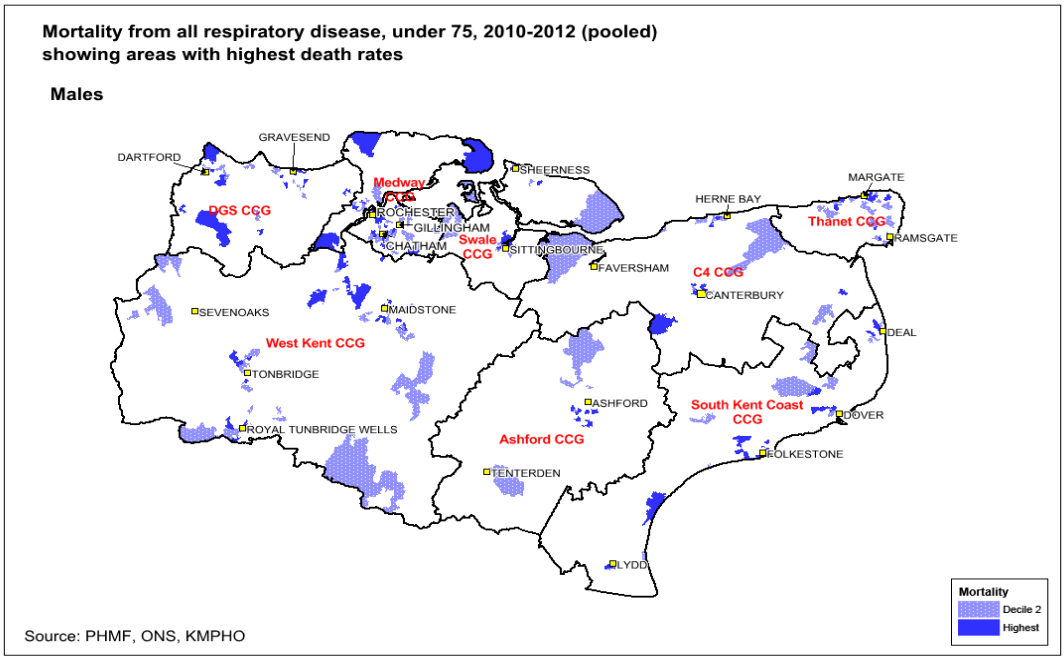
	Mortality in 20% of population experiencing highest death rates					
Clinical commissioning group	Numbers of deaths in 2010-2012	Directly age-standardised mortality per 100,000	Numbers of deaths in 2010-2012	Directly age-standardised mortality per 100,000	Numbers of deaths which would occur if area experienced same mortality rates as K&M	Numbers of lives that could be saved in highest 2 deciles
NHS Ashford CCG	19	95.7	43	21.9	5	14
NHS Canterbury and Coastal CCG	39	73.2	84	23.6	15	24
NHS Dartford, Gravesham and Swanley CCG	52	91.9	98	24.6	15	37
NHS Medway CCG	92	87.8	135	33.5	29	63
NHS South Kent Coast CCG	69	88.9	121	32.1	21	48
NHS Swale CCG	28	89.2	54	30.2	9	19
NHS Thanet CCG	62	82.0	92	36.4	21	41
NHS West Kent CCG	91	80.4	178	23.0	31	60
Kent & Medway	452	**84.4**	805	**27.3**	**146**	**306**

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may be evident

Figure 2 highlights the geographical distribution within each CCG with premature male deaths experienced in the 20% of the population which have the highest mortality rates related to respiratory disease in Kent and Medway.

Figure 2: Mortality in 20% of population with highest death rates, all respiratory disease, aged under 75, 2010-2012, males, lower super output areas



5.1.3 Cancer related under 75 mortality rates in men

Table 3 highlights number of cancer related deaths among top 20% of the male population during 2010-2012 compared to death rate across Kent and Medway. **It shows that the death rate in top 20% of the population is nearly two times higher compared to Kent and Medway (231 and 117.2 per 100,000 respectively).** The table also highlights that that 20% of the CCG male population in these subsets (top LSOA) experiences 35% of all premature deaths from cancer (1176 out of a total of 3369).

If each CCG were to aim for reducing their respective cancer related death rates in these areas to the same level as Kent and Medway then this then there would be 579 *fewer* deaths in a three-year period[i].

Table 3: Mortality in 20% of population with highest death rates, all cancers, aged under 75, 2010-2012, males, lower super output areas.

Mortality data for all cancers, aged under 75, 2010-2012 (pooled), males

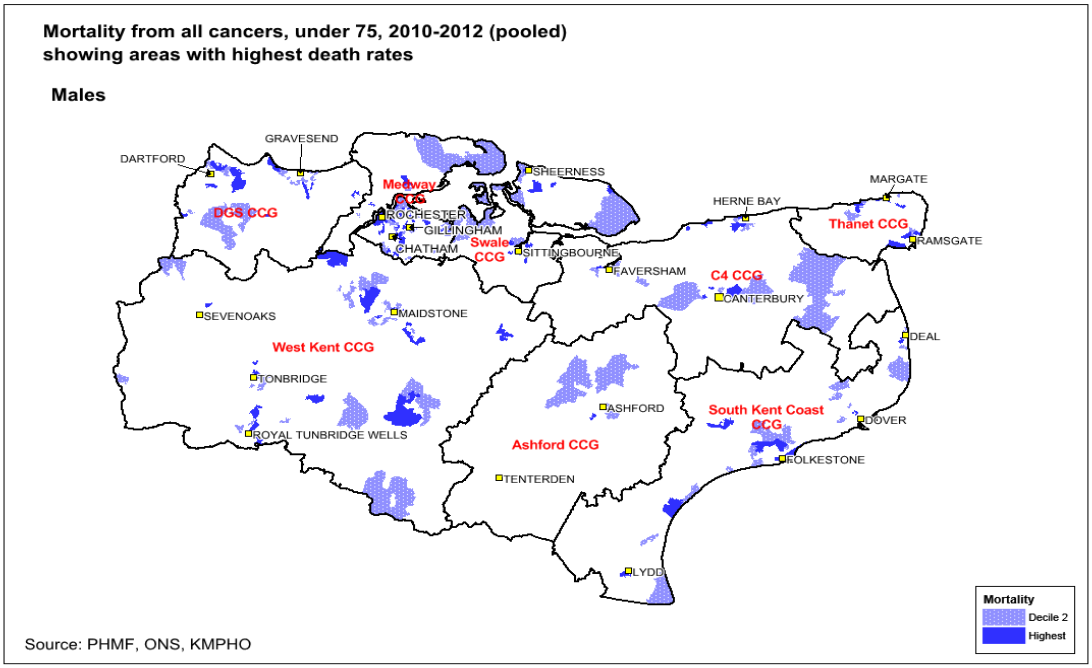
	Mortality in 20% of population experiencing highest death rates					
Clinical commissioning group	Numbers of deaths in 2010-2012	Directly age-standardised mortality per 100,000	Numbers of deaths in 2010-2012	Directly age-standardised mortality per 100,000	Numbers of deaths which would occur if area experienced same mortality rates as K&M	Numbers of lives that could be saved in highest 2 deciles
NHS Ashford CCG	39	214.2	197	99.0	21	18
NHS Canterbury and Coastal CCG	109	213.8	346	99.8	60	49
NHS Dartford, Gravesham and Swanley CCG	147	246.8	453	116.1	70	77
NHS Medway CCG	269	247.6	559	139.6	127	142
NHS South Kent Coast CCG	184	223.3	459	125.3	97	87
NHS Swale CCG	106	229.4	245	134.8	54	52
NHS Thanet CCG	107	247.2	304	127.8	51	56
NHS West Kent CCG	215	220.1	806	107.5	115	100
Kent & Medway	1176	231.0	3369	117.2	**597**	**579**

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may be evident

Figure 3 highlights the geographical distribution within each CCG with premature male deaths experienced in the 20% of the population which have the highest mortality rates related to cancer in Kent and Medway.

Figure 3 Mortality in 20% of population with highest death rates, all cancers, aged under 75, 2010-2012, males, lower super output areas



6. Conclusions

The data in this report identifies, for each CCG area, the number of disease-specific premature deaths that need to be postponed within each CCG area.

This information will assist CCGs and partners to target resources in the areas of most need and contribute significantly to the short-term gains (figure A) in reducing health inequalities. It also provides opportunities for the local system (KCC, CCGs, District Councils and other partners such as social enterprises and voluntary sector) to work together through 'Mind the Gap' action planning and addresses various factors that affect health outcomes. Local action planning provides all partners with an opportunity to work on the short, medium and long-term contributions that are attributable to healthy lifestyles, and also in preventing poor health that potentially results in the onset of preventable diseases and consequently premature mortality.

7. Recommendation(s)

Recommendation(s): The Kent Health and Wellbeing Board are asked to:

i) Note the data reported in this paper

ii) Support CCGs to develop action plans to address the identified number of postponed premature deaths targeting the areas with top 20% death rate.

iii) Support the local system in working together through the local Health and Wellbeing Boards. Action planning at a local level to develop local 'Mind the Gap' needs to continue and bring together the District Council and CCG priorities to tackle health inequalities. This should be used as the mechanism to identify contribution from various parts of the system (CCGs, District Councils, KCC, Health Watch and voluntary sector) and address the wider determinants of health, health promotion and preventing poor health.

8. Contact details

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Appendices:

Please Note that Blue coloured table represents data related to men and Red colour represents data related to women.

Maps for all Districts are being developed and will be provided to CCGs.

Appendix 1 - Ashford CCG district level maps

Appendix 2 - Canterbury CCG district level tables

Appendix 3 - Dartford, Gravesham, Swanley CCG district level tables

Appendix 4 - South Kent Coast CCG district level tables

Appendix 5 - Swale CCG district level tables

Appendix 6 - West Kent CCG district level tables

Appendix 7 – Thanet CCG district level tables

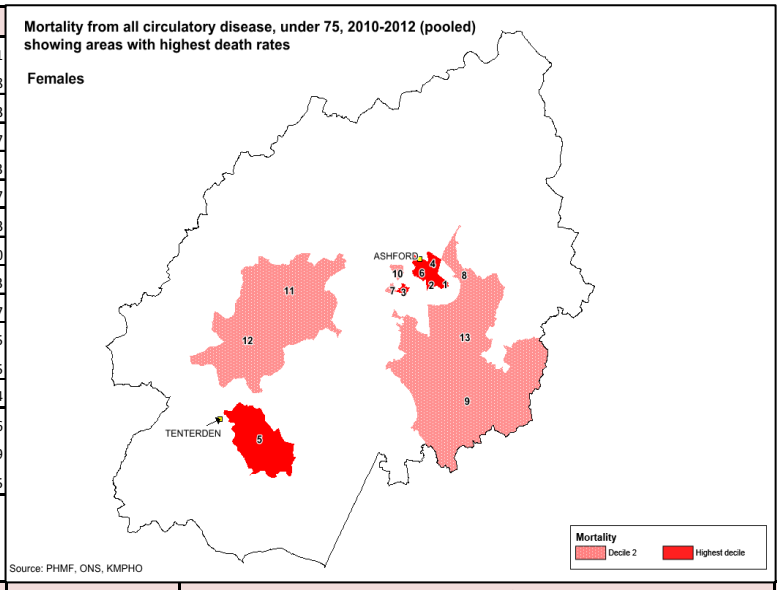
Table / figure Ashford 1

Mortality in females for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Aylesford Green	E01023972	1	Data suppressed	571
		E01023973	2		698
	Beaver	E01023976	3		693
	Stour	E01024023	4		1247
	Tenterden South	E01024026	5		563
	Victoria	E01024027	6		667
2	Beaver	E01023977	7		603
	North Willesborough	E01024004	8		770
	Saxon Shore	E01024014	9		843
	Victoria	E01024028	10		857
	Weald Central	E01024031	11		645
		E01024032	12		775
	Weald East	E01024034	13		1004
Total deaths and population in highest two deciles				35	9936
Total deaths and population in other deciles				36	43689
Total deaths and population in NHS Ashford CCG				71	53625

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred



Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	35	9936	100.2	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	36	43689	21.1	**- resulting in 23 deaths postponed in a three year period**
Total deaths in NHS Ashford CCG	71	53625	35.5	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

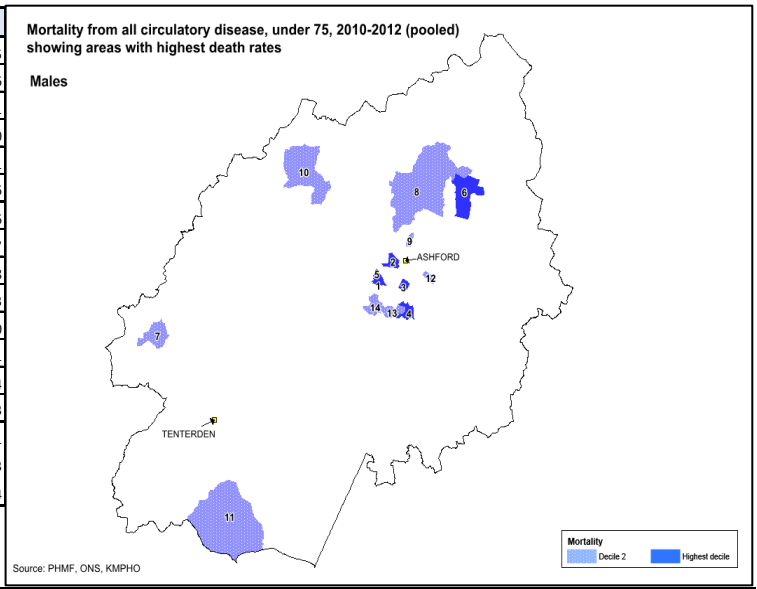
Table / figure Ashford 1a

Mortality in males for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Beaver	E01023974	1	Data suppressed	605
	Godinton	E01023992	2		626
	Norman	E01024002	3		661
	Park Farm South	E01024006	4		670
	Singleton South	E01024016	5		601
	Wye	E01024040	6		466
2	Biddenden	E01023979	7		546
	Boughton Aluph and Eastwell	E01023982	8		1617
	Bybrook	E01023984	9		568
	Charing	E01023986	10		553
	Isle of Oxney	E01023998	11		520
	North Willesborough	E01024005	12		751
	Park Farm North	E01024008	13		1054
	Washford	E01024030	14		1553
Total deaths and population in highest two deciles				59	10791
Total deaths and population in other deciles				115	41673
Total deaths and population in NHS Ashford CCG				174	52464

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred



Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	59	10791	175.9	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	115	41673	65.5	**- resulting in 31 deaths postponed in a three year period**
Total deaths in NHS Ashford CCG	174	52464	106.3	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

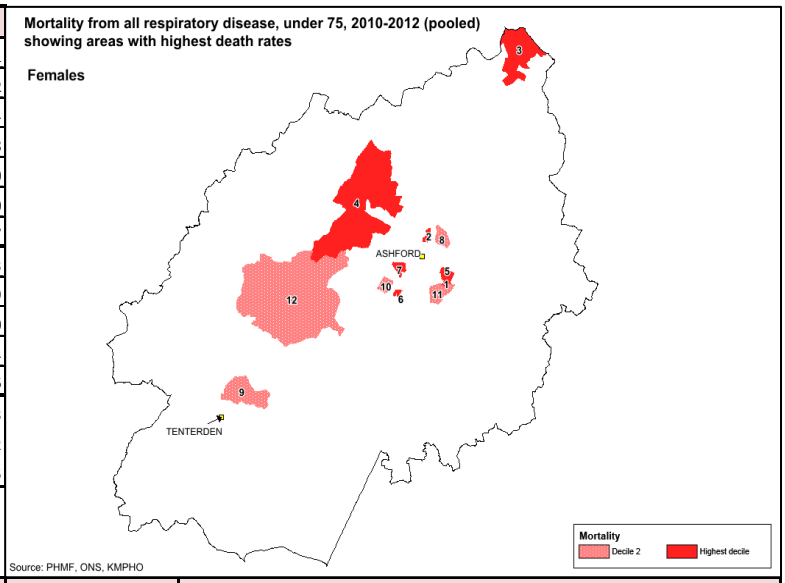
Table / figure Ashford 2

Mortality in females for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Aylesford Green	E01023972	1	Data suppressed	571
	Bybrook	E01023984	2		612
	Downs North	E01023987	3		474
	Downs West	E01023990	4		548
	North Willesborough	E01024005	5		690
	Stanhope	E01024020	6		860
	Victoria	E01024028	7		857
2	Little Burton Farm	E01024000	8		1473
	St Michaels	E01024012	9		489
	Singleton South	E01024017	10		690
	South Willesborough	E01024018	11		1644
	Weald Central	E01024031	12		645
Total deaths and population in highest two deciles				17	9553
Total deaths and population in other deciles				15	44072
Total deaths and population in NHS Ashford CCG				32	53625

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred



Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	17	9553	56.4	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	15	44072	8.3	**- resulting in 11 deaths postponed in a three year period**
Total deaths in NHS Ashford CCG	32	53625	15.6	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

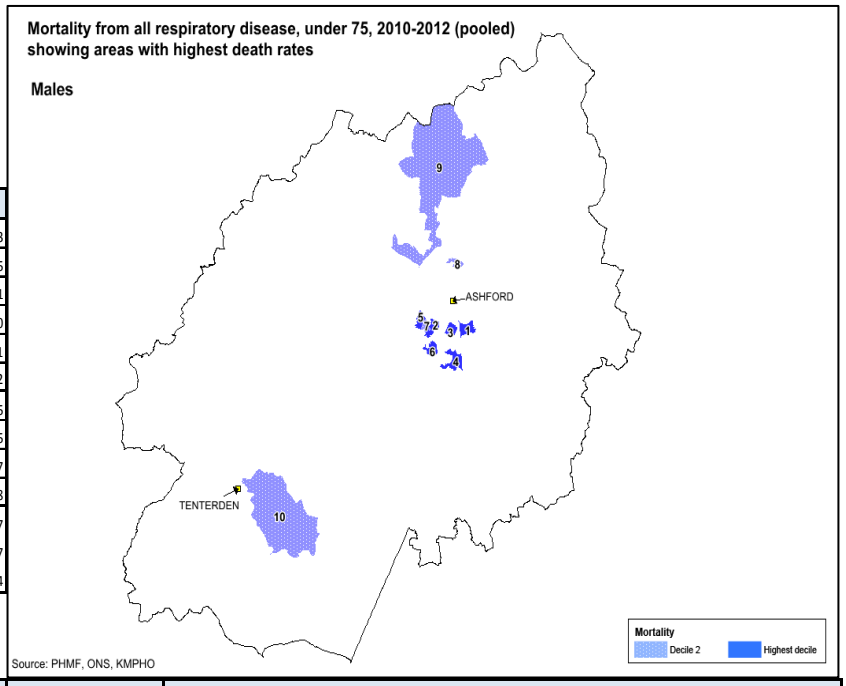
Table / figure Ashford 2a

Mortality in males for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Aylesford Green	E01023973	1	Data suppressed	673
	Beaver	E01023975	2		715
	Norman	E01024002	3		661
	Park Farm South	E01024006	4		670
	Singleton South	E01024016	5		601
	Stanhope	E01024019	6		752
2	Beaver	E01023974	7		605
	Bockhanger	E01023980	8		475
	Downs West	E01023989	9		587
	Tenterden South	E01024026	10		498
Total deaths and population in highest two deciles				19	6237
Total deaths and population in other deciles				24	46227
Total deaths and population in NHS Ashford CCG				43	52464

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred



Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	19	6237	95.7	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	24	46227	13.3	**- resulting in 14 deaths postponed in a three year period**
Total deaths in NHS Ashford CCG	43	52464	26.5	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

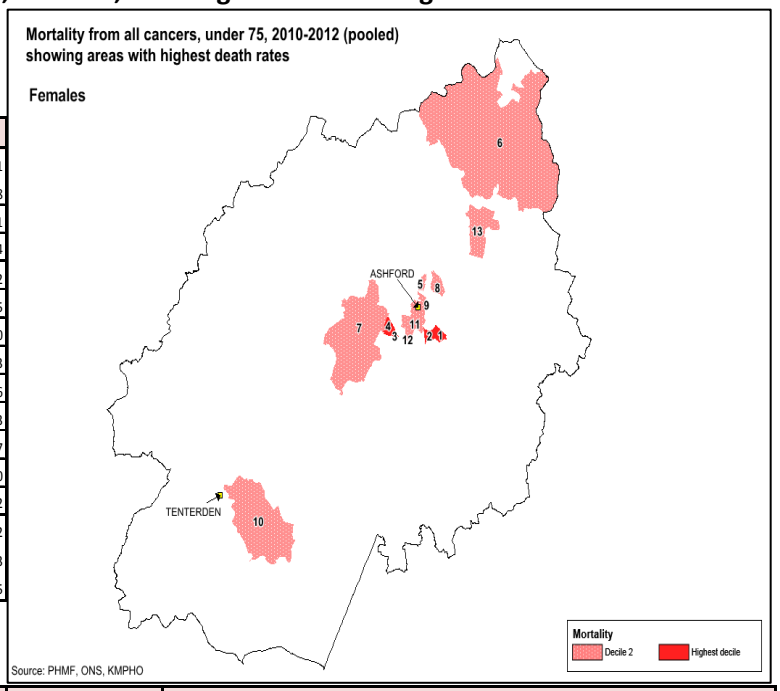
Table / figure Ashford 3

Mortality in females for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Aylesford Green	E01023972	1	Data suppressed	571
		E01023973	2		698
	Beaver	E01023974	3		681
	Singleton South	E01024016	4		604
2	Bybrook	E01023984	5		612
	Downs North	E01023988	6		625
	Great Chart with Singleton North	E01023994	7		1660
	Little Burton Farm	E01024000	8		1473
	Stour	E01024021	9		576
	Tenterden South	E01024026	10		563
	Victoria	E01024027	11		667
		E01024029	12		1070
	Wye	E01024040	13		492
Total deaths and population in highest two deciles				58	10292
Total deaths and population in other deciles				112	43333
Total deaths and population in NHS Ashford CCG				170	53625

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred



Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	58	10292	179.5	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	112	43333	64.6	- resulting in 27 deaths postponed in a three year period
Total deaths in NHS Ashford CCG	170	53625	83.3	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

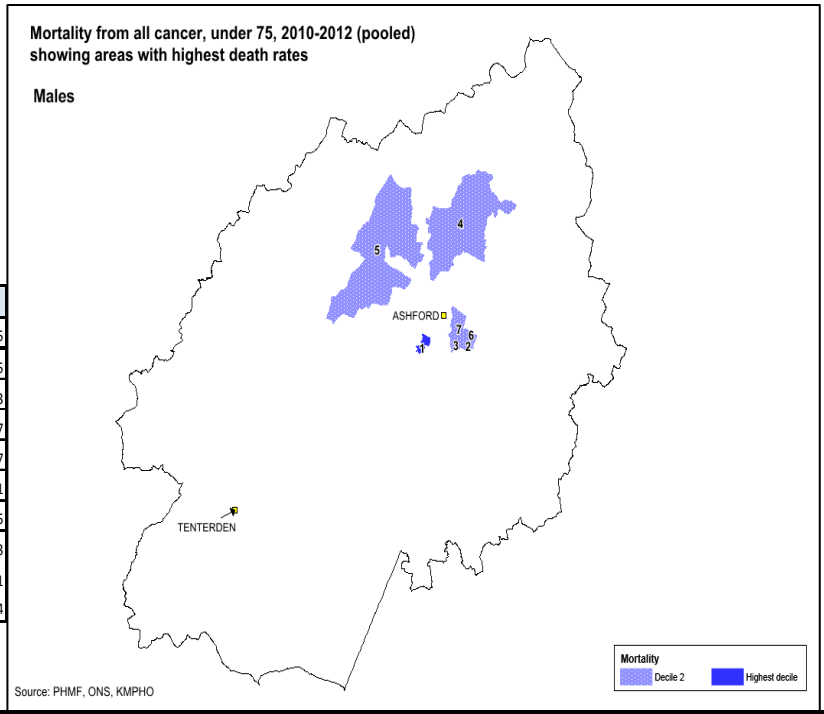
Table / figure Ashford 3a

Mortality in males for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Beaver	E01023975	1	Data suppressed	715
2	Aylesford Green	E01023972	2		585
		E01023973	3		673
	Boughton Aluph and Eastwell	E01023982	4		1617
	Downs West	E01023990	5		507
	North Willesborough	E01024005	6		751
	Stour	E01024023	7		1175
Total deaths and population in highest two deciles				39	6023
Total deaths and population in other deciles				158	46441
Total deaths and population in NHS Ashford CCG				197	52464

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred



Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	39	6023	214.21	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	158	46441	87.39	- resulting in 18 deaths postponed in a three year period
Total deaths in NHS Ashford CCG	197	52464	119.78	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Maps to be added

Table Canterbury 1

Mortality in females for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Blean Forest	E01024051	1	Data suppressed	2901
	Herne and Broomfield	E01024076	2		888
	Northgate	E01024093	3		1087
	Seasalter	E01024108	4		604
	Westgate	E01024126	5		686
	Wincheap	E01024128	6		787
	Watling	E01024627	7		905
2	Barton	E01024047	8		764
		E01024048	9		840
	Gorrell	E01024061	10		716
	Herne and Broomfield	E01024075	11		717
	Heron	E01024078	12		756
	Little Stour	E01024084	13		515
	Northgate	E01024090	14		1091
	St Stephens	E01024101	15		1105
	Wincheap	E01024129	16		816
	Sandwich	E01024242	17		776
	Boughton and Courtenay	E01024555	18		585
Total deaths and population in highest two deciles				42	16539
Total deaths and population in other deciles				82	75148
Total deaths and population in NHS Canterbury CCG				124	91687

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	42	16539	93.6	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	82	75148	23.0	**- resulting in 26 deaths postponed in a three year period**
Total deaths in NHS Canterbury CCG	124	91687	31.5	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Canterbury 1a

Mortality in males for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Harbour	E01024071	1	Data suppressed	738
	Heron	E01024081	2		610
		E01024082	3		602
		E01024083	4		548
	St Stephens	E01024099	5		1081
	West Bay	E01024119	6		710
2	Barton	E01024045	7		629
	Chestfield and Swalecliffe	E01024059	8		619
		E01024066	9		698
	Harbour	E01024070	10		614
	Northgate	E01024091	11		726
	Wincheap	E01024127	12		722
	Davington Priory	E01024563	13		759
Total deaths and population in highest two deciles				59	9056
Total deaths and population in other deciles				172	80533
Total deaths and population in NHS Canterbury CCG				231	89589

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	59	9056	195.2	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	172	80533	55.9	**- resulting in 34 deaths postponed in a three year period**
Total deaths in NHS Canterbury CCG	231	89589	68.3	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Canterbury 2

Mortality in females for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Gorrell	E01024061	1	Data suppressed	716
		E01024062	2		671
	Heron	E01024081	3		591
		E01024083	4		590
	Northgate	E01024090	5		1091
		E01024093	6		1087
	Davington Priory	E01024563	7		712
2	Barton	E01024045	8		638
		E01024049	9		661
	Chestfield and Swalecliffe	E01024059	10		661
	Heron	E01024079	11		669
		E01024080	12		581
	Little Stour	E01024084	13		515
	Northgate	E01024092	14		900
	Reculver	E01024096	15		771
	Sturry North	E01024110	16		524
	West Bay	E01024117	17		668
	Westgate	E01024122	18		641
	Little Stour and Ashstone	E01024206	19		778
		E01024208	20		769
	Boughton and Courtenay	E01024556	21		519
	St Ann's	E01024603	22		573
		E01024605	23		612
	Teynham and Lynsted	E01024622	24		751
Total deaths and population in highest two deciles				41	16689
Total deaths and population in other deciles				26	74999
Total deaths and population in NHS Canterbury CCG				67	91688

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	41	16689	17.0	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	26	74999	8.1	**- resulting in 28 deaths postponed in a three year period**
Total deaths in NHS Canterbury CCG	67	91688	15.6	

Table Canterbury 2a

Mortality in males for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Barton	E01024048	1	Data suppressed	863
	Chartham and Stone Street	E01024052	2		1012
	Greenhill and Eddington	E01024066	3		698
	Heron	E01024079	4		660
		E01024080	5		607
	Northgate	E01024093	6		807
	St Stephens	E01024103	7		763
	Westgate	E01024125	8		1225
	Sandwich	E01024243	9		667
2	Barton	E01024044	10		808
		E01024049	11		922
	Harbour	E01024070	12		614
	Heron	E01024082	13		602
		E01024083	14		548
	Marshside	E01024087	15		587
	West Bay	E01024118	16		790
		E01024120	17		633
	Westgate	E01024121	18		687
	Eastry	E01024202	19		799
	Teynham and Lynsted	E01024622	20		766
Total deaths and population in highest two deciles				39	15058
Total deaths and population in other deciles				45	74530
Total deaths and population in NHS Canterbury CCG				84	89588

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	39	15058	73.2	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	45	74530	14.9	
Total deaths in NHS Canterbury CCG	84	89588	29.6	**- resulting in 24 deaths postponed in a three year period**

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Canterbury 3

Mortality in females for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Barham Downs	E01024043	1	Data suppressed	625
	Gorrell	E01024063	2		725
	Herne and Broomfield	E01024073	3		807
	Herne and Broomfield	E01024075	4		717
	Herne and Broomfield	E01024077	5		696
	Heron	E01024080	6		581
	Seasalter	E01024105	7		675
	Little Stour and Ashstone	E01024207	8		841
	Sandwich	E01024243	9		750
	Boughton and Courtenay	E01024555	10		585
	St Ann's	E01024604	11		624
2	Gorrell	E01024061	12		716
	Harbour	E01024069	13		700
	Heron	E01024078	14		756
	Little Stour	E01024084	15		515
	Marshside	E01024087	16		573
	West Bay	E01024117	17		668
	West Bay	E01024118	18		822
	Wincheap	E01024127	19		722
	Wincheap	E01024130	20		1174
	Little Stour and Ashstone	E01024206	21		778
	Watling	E01024626	22		673
Total deaths and population in highest two deciles				111	15723
Total deaths and population in other deciles				213	75965
Total deaths and population in NHS Canterbury CCG				324	91688

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	111	15723	177.1	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	213	75965	72.0	**'- resulting in 51 deaths postponed in a three year period**
Total deaths in NHS Canterbury CCG	324	91688	91.4	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Canterbury 3a
Mortality in males for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Barton	E01024047	1	Data suppressed	801
		E01024049	2		922
	Chestfield and Swalecliffe	E01024059	3		619
	Greenhill and Eddington	E01024064	4		1103
	Harbour	E01024071	5		738
	Heron	E01024078	6		759
	St Stephens	E01024103	7		763
	Westgate	E01024126	8		679
2	St Ann's	E01024605	9		598
	Harbledown	E01024067	10		479
	Herne and Broomfield	E01024073	11		818
	Heron	E01024079	12		660
		E01024081	13		610
	Little Stour	E01024084	14		499
	Northgate	E01024093	15		807
	Little Stour and Ashstone	E01024206	16		744
		E01024207	17		823
	Abbey	E01024552	18		806
	Boughton and Courtenay	E01024557	19		673
	Watling	E01024627	20		882
Total deaths and population in highest two deciles				109	14783
Total deaths and population in other deciles				237	74806
Total deaths and population in NHS Canterbury CCG				346	89589

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	109	14783	213.8	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	237	74806	78.8	**- resulting in 49 deaths suppressed in a three year period**
Total deaths in NHS Canterbury CCG	346	89589	56.9	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Appendix 3

Table Dartford, Gravesham and Swanley 1
Mortality in females for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Bean and Darenth	E01024135	1	Data suppressed	626
	Newtown	E01024161	2		915
	Stone	E01024170	3		744
		E01024172	4		852
	Swanscombe	E01024176	5		752
		E01024179	6		1247
	Town	E01024181	7		590
	Wilmington	E01024187	8		492
		E01024188	9		543
	Meopham South and Vigo	E01024275	10		682
	Northfleet South	E01024280	11		752
	Painters Ash	E01024285	12		627
		E01024287	13		640
	Pelham	E01024291	14		760
	Singlewell	E01024305	15		652
		E01024306	16		566
	Westcourt	E01024308	17		664
	Whitehill	E01024315	18		748
2	Bean and Darenth	E01024133	19		681
	Littlebrook	E01024155	20		738
	Newtown	E01024162	21		697
		E01024163	22		815
	Princes	E01024165	23		732
	Swanscombe	E01024178	24		817
	Town	E01024182	25		764
	Coldharbour	E01024263	26		743
	Riverside	E01024294	27		1107
		E01024296	28		1131
	Westcourt	E01024309	29		637
	Fawkham and West Kingsdown	E01024435	30		708
	Hextable	E01024445	31		584
		E01024447	32		610
	Swanley St Mary's	E01024476	33		820
	Swanley White Oak	E01024480	34		724
		E01024481	35		750
Total deaths and population in highest two deciles				85	25910
Total deaths and population in other deciles				65	86476
Total deaths and population in NHS Dartford, Gravesham and Swanley CCG				150	112386

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	85	25910	107.1	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	65	86476	18.6	**- resulting in 57 deaths postponed in a three year period**
Total deaths in NHS Dartford, Gravesham and Swanley CCG	150	112386	35.8	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Dartford, Gravesham and Swanley 1a

Mortality in males for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Bean and Darenth	E01024135	1	Data suppressed	578
	Brent	E01024138	2		735
	Castle	E01024140	3		1136
	Greenhithe	E01024141	4		710
	Joyce Green	E01024148	5		755
	Newtown	E01024162	6		808
	Princes	E01024165	7		662
	Swanscombe	E01024176	8		687
		E01024178	9		820
	Central	E01024257	10		844
		E01024258	11		777
	Northfleet North	E01024277	12		864
		E01024278	13		922
	Pelham	E01024289	14		1126
	Singlewell	E01024303	15		706
		E01024305	16		647
	Westcourt	E01024311	17		700
	Swanley St Mary's	E01024477	18		649
2	Brent	E01024139	19		767
	Greenhithe	E01024142	20		1085
	Littlebrook	E01024154	21		613
		E01024155	22		651
	Newtown	E01024163	23		827
		E01024164	24		898
	Princes	E01024166	25		735
	Swanscombe	E01024179	26		1176
	Town	E01024182	27		748
	Coldharbour	E01024262	28		854
	Northfleet North	E01024279	29		793
	Northfleet South	E01024282	30		767
	Painters Ash	E01024288	31		554
	Pelham	E01024291	32		756
	Riverside	E01024296	33		1151
	Singlewell	E01024306	34		555
	Woodlands	E01024318	35		738
	Ash	E01024413	36		737
Total deaths and population in highest two deciles				149	28531
Total deaths and population in other deciles				189	81728
Total deaths and population in NHS Dartford, Gravesham and Swanley CCG				338	110259

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	149	28531	191.6	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	189	81728	60.4	**- resulting in 84 deaths postponed in a three year period**
Total deaths in NHS Dartford, Gravesham and Swanley CCG	338	110259	86.9	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Dartford, Gravesham and Swanley 2

Mortality in females for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Bean and Darenth	E01024133	1	Data suppressed	681
		E01024135	2		626
	Brent	E01024136	3		723
	Heath	E01024146	4		677
	Joyce Green	E01024148	5		780
	Littlebrook	E01024156	6		713
	Princes	E01024165	7		732
		E01024166	8		834
	Stone	E01024172	9		852
	Swanscombe	E01024177	10		778
	West Hill	E01024184	11		819
	Coldharbour	E01024263	12		743
	Singlewell	E01024306	13		566
	Westcourt	E01024311	14		711
	Ash	E01024414	15		798
	Swanley White Oak	E01024481	16		750
2	Joydens Wood	E01024152	17		1312
	Newtown	E01024162	18		697
	Stone	E01024171	19		701
	Wilmington	E01024189	20		690
	Central	E01024257	21		835
	Northfleet North	E01024278	22		890
	Northfleet South	E01024284	23		783
	Painters Ash	E01024287	24		640
	Riverside	E01024294	25		1107
	Singlewell	E01024305	26		652
		E01024307	27		639
	Westcourt	E01024312	28		623
	Farningham, Horton Kirby and South Darenth	E01024434	29		798
	Swanley Christchurch and Swanley Village	E01024472	30		653
	Swanley St Mary's	E01024476	31		820
Total deaths and population in highest two deciles				47	23623
Total deaths and population in other deciles				27	88751
Total deaths and population in NHS Dartford, Gravesham and Swanley CCG				74	112374

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	47	23623	66.7	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	27	88751	7.4	**- resulting in 34 deaths postponed in a three year period**
Total deaths in NHS Dartford, Gravesham and Swanley CCG	74	112374	17.7	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Dartford, Gravesham and Swanley 2a

Mortality in males for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Brent	E01024138	1	Data suppressed	735
	Joyce Green	E01024149	2		1304
	Newtown	E01024164	3		898
	Central	E01024257	4		844
	Coldharbour	E01024264	5		736
	Higham	E01024266	6		470
	Northfleet South	E01024283	7		635
	Riverside	E01024295	8		852
		E01024296	9		1151
	Westcourt	E01024308	10		605
		E01024311	11		700
	Ash	E01024413	12		737
	Farningham, Horton Kirby and South Darenth	E01024433	13		610
	Swanley St Mary's	E01024477	14		649
	Swanley White Oak	E01024482	15		645
2	Brent	E01024139	16		767
	Greenhithe	E01024142	17		1085
	Newtown	E01024162	18		808
	Stone	E01024169	19		693
	Town	E01024181	20		658
	Northfleet North	E01024277	21		864
	Singlewell	E01024304	22		652
		E01024305	23		647
	Woodlands	E01024318	24		738
	Hartley and Hodsoll Street	E01024443	25		556
Total deaths and population in highest two deciles				52	19039
Total deaths and population in other deciles				46	91220
Total deaths and population in NHS Dartford, Gravesham and Swanley CCG				98	110259

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	52	19039	91.9	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	46	91220	13.4	**- resulting in 37 deaths postponed in a three year period**
Total deaths in NHS Dartford, Gravesham and Swanley CCG	98	110259	24.6	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Dartford, Gravesham and Swanley 3

Mortality in females for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Brent	E01024138	1	Data suppressed	803
	Greenhithe	E01024142	2		1140
	Greenhithe	E01024143	3		999
	Joyce Green	E01024148	4		780
	Newtown	E01024162	5		697
		E01024164	6		869
	Stone	E01024172	7		852
	Swanscombe	E01024179	8		1247
	Wilmington	E01024189	9		690
	Central	E01024258	10		770
	Coldharbour	E01024262	11		846
	Riverview	E01024299	12		691
	Ash	E01024415	13		670
	Hartley and Hodsoll Street	E01024442	14		664
	Swanley Christchurch and Swanley Village	E01024473	15		757
2	Bean and Darenth	E01024133	16		681
	Heath	E01024145	17		719
	Littlebrook	E01024156	18		713
	Longfield, New Barn and Southfleet	E01024158	19		687
	Princes	E01024168	20		621
	Stone	E01024170	21		744
	Sutton-at-Hone and Hawley	E01024174	22		494
	Central	E01024257	23		835
	Northfleet South	E01024280	24		752
	Painters Ash	E01024287	25		640
	Riverside	E01024296	26		1131
	Singlewell	E01024307	27		639
	Eynsford	E01024431	28		820
	Hartley and Hodsoll Street	E01024441	29		662
Total deaths and population in highest two deciles				139	22613
Total deaths and population in other deciles				242	89764
Total deaths and population in NHS Dartford, Gravesham and Swanley CCG				381	112377

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	139	22613	191.1	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	242	89764	71.3	**- resulting in 70 deaths postponed in a three year period**
Total deaths in NHS Dartford, Gravesham and Swanley CCG	381	112377	93.0	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Dartford, Gravesham and Swanley 3a

Mortality in males for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Bean and Darenth	E01024133	1	Data suppressed	701
	Joyce Green	E01024148	2		755
	Littlebrook	E01024154	3		613
		E01024156	4		790
	Stone	E01024170	5		700
		E01024171	6		755
	Wilmington	E01024187	7		452
	Higham	E01024266	8		470
	Northfleet North	E01024278	9		922
	Singlewell	E01024303	10		706
		E01024305	11		647
		E01024306	12		555
	Westcourt	E01024308	13		605
	Whitehill	E01024313	14		650
	Hartley and Hodsoll Street	E01024444	15		579
	Swanley St Mary's	E01024476	16		757
2	Newtown	E01024162	17		808
		E01024163	18		827
	Sutton-at-Hone and Hawley	E01024175	19		592
	Town	E01024180	20		652
	Central	E01024260	21		855
	Coldharbour	E01024263	22		713
	Northfleet North	E01024277	23		864
		E01024283	24		635
	Riverside	E01024293	25		768
	Woodlands	E01024317	26		742
	Farningham, Horton Kirby and South Darenth	E01024433	27		610
		E01024434	28		820
	Swanley White Oak	E01024480	29		671
Total deaths and population in highest two deciles				147	20214
Total deaths and population in other deciles				306	90043
Total deaths and population in NHS Dartford, Gravesham and Swanley CCG				453	110257

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	147	20214	214.21	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	306	90043	87.39	**- resulting in 77 deaths postponed in a three year period**
Total deaths in NHS Dartford, Gravesham and Swanley CCG	453	110257	119.78	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table South Kent Coast 1

Mortality in females for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Buckland	E01024193	1	Data suppressed	673
		E01024196	2		685
	Castle	E01024199	3		798
	Middle Deal and Sholden	E01024219	4		576
		E01024220	5		617
	St Radigunds	E01024240	6		764
	Folkestone East	E01024498	7		833
	Folkestone Foord	E01024499	8		687
	Folkestone Harbour	E01024504	9		808
	Folkestone Harvey Central	E01024506	10		585
	Folkestone Harvey West	E01024511	11		586
	Folkestone Park	E01024517	12		649
	Lydd	E01024534	13		686
2	Buckland	E01024194	14		691
	Maxton, Elms Vale and Priory	E01024213	15		623
		E01024215	16		678
	North Deal	E01024229	17		592
	St Radigunds	E01024241	18		929
	Whitfield	E01024254	19		915
	Dymchurch and St Mary's Bay	E01024487	20		579
		E01024488	21		549
	Folkestone Foord	E01024500	22		620
	Folkestone Harvey West	E01024510	23		598
	Hythe Central	E01024524	24		593
	Hythe East	E01024528	25		585
	North Downs West	E01024545	26		630
Total deaths and population in highest two deciles				67	17529
Total deaths and population in other deciles				76	69352
Total deaths and population in NHS South Kent Coast CCG				143	86881

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	67	17529	97.6	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	76	69352	22.9	**- resulting in 43 deaths postponed in a three year period**
Total deaths in NHS South Kent Coast CCG	143	86881	36.6	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table South Kent Coast 1a

Mortality in males for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Aylesham	E01024190	1	Data suppressed	646
	Maxton, Elms Vale and Priory	E01024215	2		670
		E01024216	3		679
	Mill Hill	E01024222	4		680
	North Deal	E01024229	5		627
	St Radigunds	E01024240	6		683
	St Radigunds	E01024241	7		804
	Tower Hamlets	E01024248	8		822
	Dymchurch and St Mary's Bay	E01024487	9		484
		E01024488	10		484
	Folkestone East	E01024496	11		671
	Folkestone Harbour	E01024504	12		769
		E01024505	13		800
	Folkestone Harvey Central	E01024506	14		802
	Folkestone Sandgate	E01024520	15		537
	Hythe Central	E01024522	16		530
	Eythorne and Shepherdswell	E01024203	17		671
		E01024204	18		660
	Mill Hill	E01024223	19		642
	North Deal	E01024228	20		614
	St Radigunds	E01024239	21		699
	Dymchurch and St Mary's Bay	E01024486	22		870
	Folkestone Foord	E01024499	23		664
	Folkestone Morehall	E01024512	24		717
		E01024513	25		689
	Folkestone Park	E01024515	26		600
	Hythe West	E01024531	27		593
	North Downs East	E01024541	28		910
	Romney Marsh	E01024548	29		617
Total deaths and population in highest two deciles				139	19634
Total deaths and population in other deciles				210	64876
Total deaths and population in NHS South Kent Coast CCG				349	84510

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	139	19634	186.3	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	210	64876	72.7	**- resulting in 77 deaths postponed in a three year period**
Total deaths in NHS South Kent Coast CCG	349	84510	96.5	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table South Kent Coast 2

Mortality in females for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Aylesham	E01024191	1	Data suppressed	810
	Buckland	E01024193	2		673
		E01024196	3		685
	Capel-le-Ferne	E01024198	4		1003
	Eastry	E01024201	5		711
	Tower Hamlets	E01024247	6		790
	Whitfield	E01024254	7		915
	Folkestone East	E01024496	8		711
		E01024498	9		833
	Folkestone Harvey Central	E01024506	10		585
		E01024508	11		714
	North Downs West	E01024547	12		590
	Romney Marsh	E01024548	13		546
2	Buckland	E01024195	14		652
	Maxton, Elms Vale and Priory	E01024214	15		665
	Middle Deal and Sholden	E01024219	16		576
	Dymchurch and St Mary's Bay	E01024486	17		834
	Folkestone Cheriton	E01024495	18		820
	Folkestone Harvey Central	E01024507	19		796
	Folkestone Morehall	E01024513	20		728
	Folkestone Sandgate	E01024520	21		630
		E01024521	22		668
	Hythe Central	E01024525	23		570
	Lydd	E01024534	24		686
	Lympne and Stanford	E01024536	25		923
	Romney Marsh	E01024549	26		531
Total deaths and population in highest two deciles				45	18645
Total deaths and population in other deciles				35	68224
Total deaths and population in NHS South Kent Coast CCG				80	86869

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	45	18645	61.5	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	35	68224	10.4	**- resulting in 31 deaths postponed in a three year period**
Total deaths in NHS South Kent Coast CCG	80	86869	20.7	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table South Kent Coast 2a

Mortality in males for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Lydden and Temple Ewell	E01024211	1	Data suppressed	420
	Middle Deal and Sholden	E01024219	2		520
		E01024220	3		637
	St Radigunds	E01024240	4		683
	Tower Hamlets	E01024246	5		855
		E01024247	6		771
	Dymchurch and St Mary's Bay	E01024486	7		870
		E01024487	8		484
		E01024488	9		484
	Folkestone Cheriton	E01024492	10		646
		E01024495	11		874
	Folkestone East	E01024498	12		740
	Folkestone Foord	E01024501	13		725
	Folkestone Harbour	E01024505	14		800
	Folkestone Harvey West	E01024509	15		457
	Folkestone Sandgate	E01024520	16		537
		E01024521	17		618
	Lydd	E01024534	18		693
2	Eythorne and Shepherdswell	E01024205	19		691
	Lydden and Temple Ewell	E01024210	20		573
	Maxton, Elms Vale and Priory	E01024214	21		679
	Maxton, Elms Vale and Priory	E01024215	22		670
	Mill Hill	E01024222	23		680
	Mill Hill	E01024223	24		642
	North Deal	E01024229	25		627
	Whitfield	E01024256	26		622
	Folkestone Harvey Central	E01024507	27		788
	Hythe Central	E01024522	28		530
	Lydd	E01024532	29		654
	North Downs West	E01024547	30		558
Total deaths and population in highest two deciles				69	19528
Total deaths and population in other deciles				52	64981
Total deaths and population in NHS South Kent Coast CCG				121	84509

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	69	19528	88.9	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	52	64981	16.2	**- resulting in 48 deaths postponed in a three year period**
Total deaths in NHS South Kent Coast CCG	121	84509	32.1	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table South Kent Coast 3

Mortality in females for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Buckland	E01024194	1	Data suppressed	691
		E01024196	2		685
	Eythorne and Shepherdswell	E01024203	3		654
	Lydden and Temple Ewell	E01024210	4		592
	Middle Deal and Sholden	E01024218	5		597
	St Radigunds	E01024240	6		764
	Town and Pier	E01024249	7		855
	Folkestone Foord	E01024499	8		687
	Folkestone Harvey Central	E01024506	9		585
	Folkestone Harvey West	E01024509	10		448
	Hythe East	E01024526	11		631
2	Aylesham	E01024190	12		681
	Buckland	E01024195	13		652
	Castle	E01024199	14		798
	Eastry	E01024201	15		711
	North Deal	E01024229	16		592
	St Margaret's-at-Cliffe	E01024238	17		940
	St Radigunds	E01024239	18		664
	Walmer	E01024251	19		691
	Whitfield	E01024256	20		612
	Folkestone Cheriton	E01024495	21		820
	Folkestone Harbour	E01024504	22		808
		E01024505	23		812
	Hythe Central	E01024522	24		580
	Lydd	E01024534	25		686
	North Downs West	E01024546	26		715
Total deaths and population in highest two deciles				124	17951
Total deaths and population in other deciles				245	68916
Total deaths and population in NHS South Kent Coast CCG				369	86867

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	124	17951	184.7	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	245	68916	78.7	**- resulting in 60 deaths postponed in a three year period**
Total deaths in NHS South Kent Coast CCG	369	86867	98.9	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table South Kent Coast 3a

Mortality in males for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Middle Deal and Sholden	E01024218	1	Data suppressed	521
	Tower Hamlets	E01024247	2		771
	Dymchurch and St Mary's Bay	E01024486	3		870
	Folkestone Cheriton	E01024492	4		646
		E01024493	5		614
	Folkestone East	E01024496	6		671
	Folkestone Harbour	E01024503	7		751
		E01024505	8		800
	Folkestone Harvey Central	E01024508	9		701
	Folkestone Park	E01024518	10		763
	Lydd	E01024534	11		693
	North Downs West	E01024547	12		558
2	Buckland	E01024193	13		600
	Lydden and Temple Ewell	E01024211	14		420
	Maxton, Elms Vale and Priory	E01024213	15		630
	North Deal	E01024230	16		539
	Ringwould	E01024232	17		820
	Walmer	E01024250	18		681
	Whitfield	E01024255	19		638
	Dymchurch and St Mary's Bay	E01024489	20		731
	Folkestone Cheriton	E01024494	21		701
	Folkestone East	E01024498	22		740
	Folkestone Sandgate	E01024519	23		1183
	Hythe Central	E01024525	24		575
	Lydd	E01024533	25		483
	New Romney Town	E01024540	26		665
	North Downs East	E01024543	27		1421
Total deaths and population in highest two deciles				184	19186
Total deaths and population in other deciles				275	65322
Total deaths and population in NHS South Kent Coast CCG				459	84508

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	184	19186	223.20	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	275	65322	37.20	**- resulting in 87 deaths postponed in a three year period**
Total deaths in NHS South Kent Coast CCG	459	84508	125.60	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Appendix 5

Table Swale 1

Mortality in females for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Chalkwell	E01024559	1	Data suppressed	565
	Grove	E01024567	2		1332
	Hartlip, Newington and Upchurch	E01024571	3		713
	Kemsley	E01024577	4		655
	Minster Cliffs	E01024588	5		649
	Murston	E01024590	6		717
	Queenborough and Halfway	E01024595	7		677
		E01024597	8		741
		E01024598	9		687
	Roman	E01024599	10		910
	Sheerness East	E01024609	11		575
		E01024610	11		728
	Sheerness West	E01024614	12		727
2	Sheerness East	E01024611	13		702
	Sheppey Central	E01024617	14		1424
		E01024619	15		665
		E01024621	16		564
	West Downs	E01024628	17		686
Total deaths and population in highest two deciles				51	13717
Total deaths and population in other deciles				30	34273
Total deaths and population in NHS Swale CCG				81	47990

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	51	13717	100.2	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	30	34273	22.1	**- resulting in 35 deaths postponed in a three year period**
Total deaths in NHS Swale CCG	81	47990	45.2	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Swale 1 a

Mortality in males for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Grove	E01024567	1	Data suppressed	1291
	Iwade and Lower Halstow	E01024574	2		1460
	Milton Regis	E01024584	3		741
	Sheerness East	E01024610	4		718
	Sheppey Central	E01024620	5		572
		E01024621	6		502
	Teynham and Lynsted	E01024624	7		718
2	Chalkwell	E01024559	8		548
		E01024561	9		573
		E01024562	10		668
	Grove	E01024569	11		734
	Kemsley	E01024577	12		691
		E01024578	13		786
	Leysdown and Warden	E01024580	14		782
	Milton Regis	E01024582	15		690
	Minster Cliffs	E01024585	16		676
	Murston	E01024590	17		799
	Roman	E01024600	18		660
	Sheerness West	E01024614	19		705
Total deaths and population in highest two deciles				84	14314
Total deaths and population in other deciles				75	34864
Total deaths and population in NHS Swale CCG				159	49178

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	84	14314	171.1	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	75	34864	57.9	**- resulting in 43 deaths postponed in a three year period**
Total deaths in NHS Swale CCG	159	49178	89.5	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Swale 2

Mortality in females for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Kemsley	E01024578	1	Data suppressed	814
	Sheerness West	E01024613	2		667
		E01024614	3		727
	Sheppey Central	E01024618	4		795
	Teynham and Lynsted	E01024624	5		712
2	Borden	E01024554	6		1134
	Chalkwell	E01024560	7		594
		E01024562	8		670
	Hartlip, Newington and Upchurch	E01024570	9		857
	Kemsley	E01024576	10		818
	Leysdown and Warden	E01024580	11		752
	Murston	E01024592	12		571
	Sheerness West	E01024615	13		669
Total deaths and population in highest two deciles				22	9780
Total deaths and population in other deciles				15	38211
Total deaths and population in NHS Swale CCG				37	47991

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	22	9780	57.5	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	15	38211	9.8	**- resulting in 15 deaths postponed in a three year period**
Total deaths in NHS Swale CCG	37	47991	19.8	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Swale 2a

Mortality in males for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Chalkwell	E01024559	1	Data suppressed	548
	Kemsley	E01024576	2		827
	Milton Regis	E01024584	3		741
	Murston	E01024590	4		799
	Sheerness East	E01024609	5		604
		E01024612	6		736
	Sheerness West	E01024614	7		705
	Sheppey Central	E01024621	8		502
2	Chalkwell	E01024560	9		559
		E01024561	10		573
	Hartlip, Newington and Upchurch	E01024572	11		627
	Leysdown and Warden	E01024580	12		782
	Roman	E01024601	13		751
	Sheppey Central	E01024619	14		650
Total deaths and population in highest two deciles				28	9404
Total deaths and population in other deciles				26	39772
Total deaths and population in NHS Swale CCG				54	52464

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	28	9404	89.2	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	26	39772	16.9	**- resulting in 19 deaths postponed in a three year period**
Total deaths in NHS Swale CCG	54	52464	30.2	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Swale 3

Mortality in females for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Kemsley	E01024577	1	Data suppressed	655
		E01024579	2		1267
	Minster Cliffs	E01024585	3		653
		E01024588	4		649
	Queenborough and Halfway	E01024596	5		727
		E01024598	6		687
	Sheerness East	E01024609	7		575
		E01024610	8		728
	Sheppey Central	E01024619	9		665
2	Borden	E01024554	10		1134
	Grove	E01024567	11		1332
	Milton Regis	E01024584	12		812
	Minster Cliffs	E01024589	13		670
	Sheerness West	E01024613	14		667
		E01024616	15		741
	Sheppey Central	E01024620	16		577
		E01024621	17		564
	Teynham and Lynsted	E01024624	18		712
	Woodstock	E01024630	19		652
Total deaths and population in highest two deciles				96	14467
Total deaths and population in other deciles				104	33523
Total deaths and population in NHS Swale CCG				200	47990

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	96	14467	179.2	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	104	33523	81.8	**- resulting in 45 deaths postponed in a three year period**
Total deaths in NHS Swale CCG	200	47990	110.4	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table Swale 3a

Mortality in males for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Chalkwell	E01024560	1	Data suppressed	559
	Leysdown and Warden	E01024581	2		704
	Milton Regis	E01024582	3		690
	Murston	E01024593	4		669
	Queenborough and Halfway	E01024595	5		666
	Roman	E01024600	6		660
	Sheerness East	E01024611	7		785
	Sheerness West	E01024614	8		705
	Sheppey Central	E01024621	9		502
2	Hartlip, Newington and Upchurch	E01024572	10		627
	Iwade and Lower Halstow	E01024575	11		562
	Leysdown and Warden	E01024580	12		782
	Milton Regis	E01024583	13		744
		E01024584	14		741
	Queenborough and Halfway	E01024597	15		656
	Roman	E01024599	16		911
	St Michaels	E01024608	17		697
	Sheerness West	E01024613	18		674
		E01024615	19		661
Total deaths and population in highest two deciles				106	12995
Total deaths and population in other deciles				139	36181
Total deaths and population in NHS Swale CCG				245	49176

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	106	12995	229.40	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	139	36181	102.70	**- resulting in 52 deaths postponed in a three year period**
Total deaths in NHS Swale CCG	245	49176	134.80	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Appendix 6

Table West Kent 1

Mortality in females for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Boughton Monchelsea and Chart Sutton	E01024332	1	Data suppressed	531
	Coxheath and Hunton	E01024342	2		716
	East	E01024352	3		757
	Fant	E01024356	4		718
	High Street	E01024370	5		853
	High Street	E01024372	6		860
	Park Wood	E01024389	7		952
	Shepway South	E01024398	8		756
	Shepway South	E01024399	9		535
	Aylesford	E01024717	10		736
	Higham	E01024749	11		690
	Snodland East	E01024771	12		830
	Snodland West	E01024773	13		800
	Paddock Wood East	E01024812	14		740
	Rusthall	E01024831	15		676
	St James'	E01024832	16		747
	Southborough and High Brooms	E01024846	17		721
2	Allington	E01024321	18		785
	East	E01024351	19		698
	Fant	E01024358	20		808
	Heath	E01024369	21		676
	High Street	E01024374	22		729
	Marden and Yalding	E01024381	23		666
	Shepway North	E01024393	24		658
	Shepway North	E01024394	25		636
	South	E01024405	26		879
	Sutton Valence and Langley	E01024410	27		677
	Brasted, Chevening and Sundridge	E01024417	28		692
	Brasted, Chevening and Sundridge	E01024418	29		605
	Leigh and Chiddingstone Causeway	E01024451	30		1106
	Otford and Shoreham	E01024452	31		593
	Sevenoaks Town and St John's	E01024469	32		702
	Westerham and Crockham Hill	E01024485	33		815
	Larkfield South	E01024763	34		647
	Medway	E01024766	35		825
	Snodland East	E01024769	36		684
	Brenchley and Horsmonden	E01024794	37		735
	Broadwater	E01024795	38		685
	Goudhurst and Lamberhurst	E01024805	39		745
	Park	E01024822	40		810
	Park	E01024824	41		742
	Rusthall	E01024830	42		738
	St John's	E01024835	43		925
	Southborough North	E01024849	44		713
Total deaths and population in highest two deciles				102	32592
Total deaths and population in other deciles				117	170641
Total deaths and population in NHS West Kent CCG				219	203233

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	102	32592	85.0	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	117	170641	16.8	**- resulting in 60 deaths postponed in a three year period**
Total deaths in NHS West Kent CCG	219	203233	27.4	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table West Kent 1a

Mortality in males for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Boughton Monchelsea and Chart Sutton	E01024332	1	Data suppressed	529
	East	E01024352	2		794
	High Street	E01024370	3		995
	High Street	E01024372	4		919
	High Street	E01024374	5		692
	Marden and Yalding	E01024379	6		839
	North	E01024383	7		979
	North	E01024384	8		817
	Park Wood	E01024389	9		762
	Medway	E01024766	10		849
	Snodland East	E01024769	11		645
	Snodland East	E01024770	12		484
	Trench	E01024776	13		558
	Culverden	E01024801	14		1043
	Paddock Wood East	E01024813	15		680
	Park	E01024821	16		744
	Pembury	E01024827	17		694
2	Boxley	E01024334	18		486
	High Street	E01024339	19		946
	Coxheath and Hunton	E01024342	20		664
	Fant	E01024358	21		747
	Fant	E01024359	22		1186
	Shepway North	E01024392	23		746
	Sutton Valence and Langley	E01024410	24		619
	Seal and Weald	E01024457	25		524
	Judd	E01024757	26		746
	Snodland West	E01024774	27		1060
	Vauxhall	E01024780	28		782
	Benenden and Cranbrook	E01024790	29		577
	Broadwater	E01024795	30		616
	Paddock Wood West	E01024816	31		604
	Pantiles and St Mark's	E01024819	32		686
	Park	E01024822	33		817
	Sherwood	E01024841	34		875
	Southborough and High Brooms	E01024843	35		704
Total deaths and population in highest two deciles				148	26408
Total deaths and population in other deciles				366	174987
Total deaths and population in NHS Medway CCG				514	201395

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	148	26408	186.6	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	366	174987	54.4	**- resulting in 82 deaths postponed in a three year period**
Total deaths in NHS Medway CCG	514	201395	68.7	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table West Kent 2

Mortality in females for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Allington	E01024322	1	Data suppressed	516
		E01024323	2		614
	High Street	E01024339	3		739
	Detling and Thurnham	E01024348	4		613
	East	E01024352	5		757
	Fant	E01024360	6		739
	High Street	E01024374	7		729
	North	E01024384	8		825
	Park Wood	E01024388	9		1173
		E01024389	10		952
	East Peckham and Golden Green	E01024743	11		819
	Hildenborough	E01024753	12		715
	Judd	E01024758	13		734
	Snodland East	E01024770	14		469
	Trench	E01024777	15		542
	Broadwater	E01024795	16		685
	Capel	E01024798	17		1074
	Sherwood	E01024842	18		715
	Southborough and High Brooms	E01024844	19		749
2	Bearsted	E01024328	20		731
	Harrietsham and Lenham	E01024362	21		817
	Shepway North	E01024391	22		641
	Shepway South	E01024398	23		756
	Dunton Green and Riverhead	E01024423	24		835
	Edenbridge North and East	E01024425	25		679
		E01024428	26		628
	Judd	E01024757	27		745
	Trench	E01024775	28		735
	Wrotham	E01024786	29		853
	Paddock Wood West	E01024815	30		672
	Rusthall	E01024831	31		676
	St John's	E01024835	32		925
	Southborough and High Brooms	E01024843	33		677
		E01024845	34		593
		E01024849	35		713
Total deaths and population in highest two deciles				59	25835
Total deaths and population in other deciles				66	177381
Total deaths and population in NHS West Kent CCG				125	203216

2

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	59	25835	64.7	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	66	177381	8.8	**- resulting in 42 deaths postponed in a three year period**
Total deaths in NHS West Kent CCG	125	203216	15.1	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table West Kent 2a

Mortality in males for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	East	E01024355	1	Data suppressed	928
	High Street	E01024370	2		995
	Shepway North	E01024395	3		654
	Shepway South	E01024400	4		525
	South	E01024403	5		768
	Aylesford	E01024717	6		666
	Blue Bell Hill and Walderslade	E01024722	7		643
	Ditton	E01024735	8		726
	Hildenborough	E01024753	9		672
	Snodland East	E01024769	10		645
		E01024771	11		825
	Trench	E01024777	12		526
	Vauxhall	E01024779	13		772
	West Malling and Leybourne	E01024783	14		629
	Broadwater	E01024797	15		644
	Park	E01024821	16		744
	Rusthall	E01024831	17		659
	St James'	E01024833	18		902
2	Bearsted	E01024330	19		729
	Fant	E01024357	20		782
		E01024358	21		747
	High Street	E01024372	22		919
	Park Wood	E01024388	23		1157
		E01024389	24		762
	Shepway South	E01024397	25		622
	South	E01024405	26		791
	Staplehurst	E01024407	27		680
	Sutton Valence and Langley	E01024411	28		543
	Brasted, Chevening and Sundridge	E01024417	29		699
	Halstead, Knockholt and Badgers Mount	E01024439	30		760
	Westerham and Crockham Hill	E01024485	31		754
	Cage Green	E01024731	32		475
	Castle	E01024734	33		691
	East Malling	E01024741	34		664
	Snodland East	E01024770	35		484
	Trench	E01024776	36		558
	Vauxhall	E01024780	37		782
	Broadwater	E01024796	38		626
	Goudhurst and Lamberhurst	E01024804	39		686
	Hawkhurst and Sandhurst	E01024810	40		747
	Park	E01024823	41		813
	Pembury	E01024827	42		694
		E01024828	43		708
	Southborough and High Brooms	E01024843	44		704
	Speldhurst and Bidborough	E01024851	45		724
Total deaths and population in highest two deciles				91	32224
Total deaths and population in other deciles				87	169170
Total deaths and population in NHS West Kent CCG				178	201394

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	91	32224	80.4	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	87	169170	13.4	**- resulting in 60 deaths postponed in a three year period**
Total deaths in NHS West Kent CCG	178	201394	23.4	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table West Kent 3

Mortality in females for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Bearsted	E01024329	1	Data suppressed	722
	Fant	E01024356	2		718
	Harrietsham and Lenham	E01024363	3		918
	High Street	E01024373	4		765
	South	E01024401	5		625
	Sutton Valence and Langley	E01024411	6		560
	Dunton Green and Riverhead	E01024423	7		835
	Edenbridge South and West	E01024429	8		712
	Otford and Shoreham	E01024454	9		694
	Sevenoaks Northern	E01024466	10		636
	East Malling	E01024742	11		839
	Larkfield South	E01024764	12		562
	Snodland West	E01024773	13		800
	Vauxhall	E01024778	14		781
		E01024780	15		843
	Benenden and Cranbrook	E01024790	16		536
	Paddock Wood West	E01024816	17		565
	Sherwood	E01024840	18		893
	Boxley	E01024335	19		731
	Boxley	E01024337	20		720
	Marden and Yalding	E01024377	21		740
		E01024379	22		796
	Shepway South	E01024398	23		756
	Dunton Green and Riverhead	E01024424	24		656
	Blue Bell Hill and Walderslade	E01024722	25		683
	Ditton	E01024737	26		1041
	Hildenborough	E01024753	27		715
	Medway	E01024767	28		709
	Snodland West	E01024774	29		1092
	Trench	E01024776	30		638
	Goudhurst and Lamberhurst	E01024804	31		745
	Southborough and High Brooms	E01024843	32		677
		E01024847	33		738
Total deaths and population in highest two deciles				160	24441
Total deaths and population in other deciles				501	178772
Total deaths and population in NHS West Kent CCG				661	203213

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	160	24441	192.9	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	501	178772	71.5	**- resulting in 81 deaths postponed in a three year period**
Total deaths in NHS West Kent CCG	661	203213	84.8	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table West Kent 3 a

Mortality in males for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Fant	E01024357	1	Data suppressed	782
	Harrietsham and Lenham	E01024361	2		772
	High Street	E01024370	3		995
	Park Wood	E01024388	4		1157
	Shepway North	E01024391	5		665
		E01024395	6		654
	Staplehurst	E01024406	7		717
	Sevenoaks Eastern	E01024460	8		807
	Aylesford	E01024717	9		666
	Castle	E01024733	10		728
	Snodland West	E01024774	11		1060
	Trench	E01024777	12		526
	Paddock Wood West	E01024816	13		604
	Park	E01024824	14		713
	St James'	E01024832	15		736
		E01024833	16		902
		E01024834	17		951
	Southborough and High Brooms	E01024843	18		704
		E01024847	19		687
2	Bridge	E01024340	20		969
	East	E01024352	21		794
		E01024355	22		928
	Fant	E01024358	23		747
	High Street	E01024374	24		692
	Shepway South	E01024397	25		622
	South	E01024401	26		636
	Staplehurst	E01024407	27		680
	Edenbridge South and West	E01024428	28		572
	Halstead, Knockholt and Badgers Mount	E01024439	29		760
	Aylesford	E01024719	30		974
	Ditton	E01024737	31		983
	East Malling	E01024742	32		792
	Medway	E01024767	33		659
		E01024768	34		710
	Vauxhall	E01024779	35		772
	West Malling and Leybourne	E01024785	36		664
	Brenchley and Horsmonden	E01024794	37		741
	Culverden	E01024800	38		685
	Hawkhurst and Sandhurst	E01024807	39		709
		E01024810	40		747
	Pembury	E01024826	41		656
	St John's	E01024835	42		926
Total deaths and population in highest two deciles				215	32244
Total deaths and population in other deciles				591	169148
Total deaths and population in NHS West Kent CCG				806	201392

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	215	32244	220.1	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	591	169148	90.0	**- resulting in 100 deaths postponed in a three year period**
Total deaths in NHS West Kent CCG	806	201392	107.7	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Appendix 7

Table 1 Thanet

Mortality in females for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Bradstowe	E01024643	1	Data suppressed	532
	Central Harbour	E01024646	2		770
	Dane Valley	E01024663	3		821
	Garlinge	E01024672	4		692
	Margate Central	E01024676	5		659
	Nethercourt	E01024679	6		513
	Newington	E01024683	7		856
	Northwood	E01024687	8		723
	St Peters	E01024693	9		658
	Thanet Villages	E01024704	10		758
	Westgate-on-Sea	E01024713	11		737
2	Beacon Road	E01024633	12		739
	Birchington South	E01024641	13		673
	Central Harbour	E01024645	14		730
	Central Harbour	E01024648	15		687
	Central Harbour	E01024649	16		785
	Dane Valley	E01024664	17		744
	Eastcliff	E01024670	18		728
	Salmestone	E01024695	19		611
	Westbrook	E01024712	20		728
Total deaths and population in highest two deciles				56	14144
Total deaths and population in other deciles				50	46133
Total deaths and population in NHS Thanet CCG				106	60277

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	56	14144	108.0	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	50	46133	22.4	**- resulting in 38 deaths postponed in a three year period**
Total deaths in NHS Thanet CCG	106	60277	40.9	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table 1 a Thanet

Mortality in males for all circulatory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Beacon Road	E01024634	1	Data suppressed	607
	Central Harbour	E01024646	2		731
	Cliftonville West	E01024657	3		854
		E01024658	4		773
		E01024659	5		681
		E01024660	6		706
	Dane Valley	E01024664	7		772
		E01024666	8		776
	Margate Central	E01024676	9		699
		E01024677	10		886
		E01024678	11		764
	Newington	E01024682	12		719
		E01024683	13		779
	Salmestone	E01024694	14		703
		E01024696	15		564
	Thanet Villages	E01024702	16		620
2	Central Harbour	E01024648	17		700
		E01024649	18		625
	Cliffsend and Pegwell	E01024651	19		657
	Eastcliff	E01024667	20		775
		E01024668	21		618
	St Peters	E01024690	22		625
		E01024691	23		571
	Westbrook	E01024710	24		602
		E01024711	25		641
		E01024712	26		673
Total deaths and population in highest two deciles				135	18121
Total deaths and population in other deciles				123	39584
Total deaths and population in NHS Thanet CCG				258	57705

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	135	18121	215.0	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	123	39584	68.1	**- resulting in 82 deaths postponed in a three year period**
Total deaths in NHS Thanet CCG	258	57705	110.8	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table 2 Thanet

Mortality in females for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Birchington South	E01024640	1	Data suppressed	663
	Cliftonville West	E01024657	2		851
	Dane Valley	E01024665	3		775
		E01024666	4		884
	Eastcliff	E01024669	5		814
		E01024670	6		728
		E01024671	7		685
	Garlinge	E01024672	8		692
	Margate Central	E01024676	9		659
	Nethercourt	E01024679	10		513
	Birchington South	E01024641	11		673
2	Bradstowe	E01024642	12		656
		E01024643	13		532
	Cliftonville West	E01024661	14		729
	Dane Valley	E01024663	15		821
		E01024664	16		744
	Margate Central	E01024677	17		817
	Newington	E01024682	18		822
	St Peters	E01024690	19		693
	Thanet Villages	E01024703	20		802
	Westbrook	E01024710	21		501
	Westgate-on-Sea	E01024714	22		557
Total deaths and population in highest two deciles				43	15611
Total deaths and population in other deciles				24	44667
Total deaths and population in NHS Thanet CCG				67	60278

2

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	43	15611	68.8	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	24	44667	10.6	**- resulting in 31 deaths postponed in a three year period**
Total deaths in NHS Thanet CCG	67	60278	24.5	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table 2a Thanet

Mortality in males for all respiratory disease under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Cliftonville East	E01024654	1	Data suppressed	631
		E01024657	2		854
	Cliftonville West	E01024659	3		681
		E01024661	4		694
	Dane Valley	E01024664	5		772
	Margate Central	E01024676	6		699
		E01024677	7		886
	Nethercourt	E01024681	8		722
	Newington	E01024683	9		779
	Westbrook	E01024710	10		602
	Westgate-on-Sea	E01024713	11		660
		E01024715	12		715
2	Beacon Road	E01024633	13		685
		E01024634	14		607
	Birchington South	E01024639	15		639
		E01024641	16		604
	Central Harbour	E01024649	17		625
	Cliftonville West	E01024660	18		706
	Dane Valley	E01024666	19		776
	Eastcliff	E01024670	20		659
	Nethercourt	E01024680	21		697
	Northwood	E01024688	22		648
	St Peters	E01024690	23		625
	Salmestone	E01024695	24		614
	Salmestone	E01024696	25		564
	Viking	E01024709	26		620
	Westbrook	E01024711	27		641
	Westgate-on-Sea	E01024714	28		564
Total deaths and population in highest two deciles				62	18969
Total deaths and population in other deciles				30	38736
Total deaths and population in NHS Thanet CCG				92	57705

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	62	18969	82.0	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	30	38736	16.6	**- resulting in 41 deaths postponed in a three year period**
Total deaths in NHS Thanet CCG	92	57705	36.4	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table 3 Thanet

Mortality in females for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Beacon Road	E01024633	1	Data suppressed	739
		E01024635	2		768
	Central Harbour	E01024646	3		770
		E01024648	4		687
	Dane Valley	E01024663	5		821
		E01024665	6		775
	Eastcliff	E01024670	7		728
		E01024671	8		685
	Margate Central	E01024676	9		659
		E01024678	10		780
	Salmestone	E01024696	11		560
2	Birchington North	E01024637	12		698
		E01024640	13		663
	Birchington South	E01024641	14		673
	Central Harbour	E01024649	15		785
	Garlinge	E01024672	16		692
	Newington	E01024683	17		856
	Northwood	E01024688	18		687
	St Peters	E01024692	19		788
	Sir Moses Montefiore	E01024700	20		889
	Westbrook	E01024710	21		501
Total deaths and population in highest two deciles				118	15204
Total deaths and population in other deciles				170	45075
Total deaths and population in NHS Thanet CCG				288	60279

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate	Target setting
Total deaths in highest two deciles	118	15204	194.2	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	170	45075	85.9	**- resulting in 60 deaths postponed in a three year period**
Total deaths in NHS Thanet CCG	288	60279	112.0	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

Table 3a Thanet

Mortality in males for all cancer under 75, 2010-12, showing LSOAs in the highest two deciles

	Place of residence				
Decile	Electoral ward	LSOA	Map index	Deaths	Population
1	Central Harbour	E01024645	1	Data suppressed	715
	Cliffsend and Pegwell	E01024650	2		674
		E01024651	3		657
	Dane Valley	E01024663	4		751
	Eastcliff	E01024667	5		775
		E01024668	6		618
		E01024670	7		659
	Margate Central	E01024676	8		699
	Sir Moses Montefiore	E01024700	9		852
	Westbrook	E01024710	10		602
	Westgate-on-Sea	E01024713	11		660
		E01024714	12		564
2	Birchington South	E01024641	13		604
	Cliftonville West	E01024660	14		706
	Eastcliff	E01024669	15		740
	Sir Moses Montefiore	E01024699	16		869
	Westgate-on-Sea	E01024715	17		715
Total deaths and population in highest two deciles				107	11860
Total deaths and population in other deciles				197	45844
Total deaths and population in NHS Thanet CCG				304	57704

Source: PHMF, ONS, KMPHO

Note: Errors due to rounding may have occurred

Summary data*		Population	Standardised rate**	Target setting
Total deaths in highest two deciles	107	11860	247.2	Cut mortality in two highest deciles to the Kent and Medway rate of 34.8 deaths per 100,000
Total deaths in other deciles	197	45844	100.7	**- resulting in 56 deaths postponed in a three year period**
Total deaths in NHS Thanet CCG	304	57704	127.8	

* - 2010-2012 combined deaths

** - per 100,000 population, annual average for period

[i] **Reduction in number of cancer related deaths should be interpreted with caution as improvements may take decades to become apparent**

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From:	Andrew Ireland, Corporate Director, Families and Social Care, KCC
	Meradin Peachey, Kent Director of Public Health, KCC
To:	Kent Health and Wellbeing Board, 17 July 2013
Subject:	Kent Framework for Prevention and Management of Falls
Classification:	Unrestricted

Summary:

This is a briefing paper providing background information to stimulate discussion around developing a 'framework' for falls prevention and management for Kent's population. A comprehensive picture across Clinical Commissioning Group (CCG) areas will be presented at the meeting. This will provide platform for further discussion and how this framework can contribute towards reducing A&E attendances, emergency admissions and need for residential care.

Recommendation(s):

The members of Kent Health and Wellbeing Board are asked to consider this report, along with the information that will be presented at the meeting.

Falls prevention and management services should be seen as an important component of integrated services with specific outcomes for reducing the falls related burden of ill health across health and social care sector.

Once agreed, the implementation of the framework should be led locally by commissioners represented at the local Integrated Commissioning Groups, reporting progress to the local Health and Wellbeing Boards.

Commissioners need to work with stakeholders (providers and voluntary sector) to identify 'at risk' population for timely intervention.

1. Introduction

Kent has an aging population, and over the next five years it is anticipated that the population over 65 years will increase by at least 15% (and by more than 20% for >85 years).

Both health and social care organisations are facing unprecedented challenges, and the need to focus on preventative and early measures through joint working has never been greater. A lot of falls especially amongst the older population can be prevented, provided at risk individuals are identified from the first fall, with infrastructure in place to prevent a second fall.

Findings from a scoping exercise in Kent suggest that the current falls prevention pathway across the health and social care system can be better coordinated. The findings also suggest there are currently gaps in the provision of appropriate

services which need addressing for effective prevention and management of falls, especially amongst older people. Therefore, falls as a public health issue should not be seen in isolation and should take into consideration a system wide approach. This methodology can help to reduce the frequency, and effectively improve the management, of falls.

Given current financial constraints across all organisations there is an urgent need to use existing resources more effectively for instance by identifying 'at risk' population across the health and social care system.

This paper therefore introduces the concept of a 'framework' for falls prevention and management, highlighting the elements that should be taken into consideration when commissioning integrated services for at risk population.

2. National and Local context

Falls and fractures are significant public health issues particularly as individuals' age, and it is estimated that one in three people aged 65+ will fall each year and one in two people aged 80+ will fall each year (NHS Confederation, April 2012)[1]. The cost associated with management of falls and fractures is very high, with hip fractures costing the NHS £2 billion per year in England. It is estimated that falls account for approx. 10 to 25% of ambulance callout at £115 per call-out, (NHS Confederation).

Kent is an outlier for falls with hip fractures in the over 65s, significantly worse than the national average, (Health Profile 2012)[2]. The last six years (2006 -2012) have seen a significant increase in the rate of falls amongst over 65s across all CCG areas (detail information will be available at the meeting).

Aside from the obvious importance to the NHS, this is of strategic importance to KCC. In June 2012, at the start of the KCC Adult Social Care Transformation Programme, the Institute of Public Care (Oxford Brookes University) were commissioned to investigate some of the reasons for social care spend. The findings from their review were similar and reinforced prevention of falls as a priority. Effective prevention and management of falls is also part of Public Health's 100 day plan.

[1] http://www.nhsconfed.org/Publications/Documents/Falls_prevention_briefing
[2] http://www.apho.org.uk/ HEALTH_PROFILES

It is well-known that the interaction of biological factors with behavioural and environmental risks increases the risk of falling. For instance the loss of muscle strength leads to a loss of function and to a higher level of frailty, which intensifies the risk of falling due to some environmental hazards. A recent study[3] in Kent identified that reduced mobility and the risk of falls were the most important ('primary') factors for admissions to care homes in Kent. The study also highlighted that falls risk was the primary reason for admission to care homes for 12% of the study population and was secondary factor for 62% of those in care homes at the time. In financial terms almost 50% of the adult social care budget is currently used to fund care home placements.

Suitable accommodation also plays a major role in prevention of falls and a separate paper is available on Kent's approach, from a housing perspective, in prevention and management of falls.

3. Proposed Falls Framework: a system wide commissioning model

The falls framework is proposed following the review of falls service and is based on published evidence.

Nationally the NHS Confederation suggests that a falls prevention strategy could reduce the number of falls by up to 30% and that effective falls prevention schemes can be implemented at little cost with the involvement of professionals working in health, social care and in the community[4]. The report further suggests that prevention by one partner can create efficiencies for others and that when addressing falls and fractures, health and social care organisations should be encouraged to align their own budgets to support joined-up working in this area.

Therefore the Kent framework promotes an integrated multi-agency, multi-disciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009)[5] for developing an Integrated Falls Service. The DH identified four main objectives:

Objective 1	improve patient outcomes and improve efficiency of care after hip fractures through compliance with core standards
Objective 2	respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings
Objective 3	early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries
Objective 4	prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards

[3] The University of Kent, Personal Social Services Research Unit report (September 2012), "Admission Risk to Care Homes – Phase 1, Older People".

[4] Falls prevention: New approaches to integrated falls prevention services (NHS Confederation: Ambulance Service Network / Community Health Services Forum, April 2012)
http://www.nhsconfed.org/Publications/briefings/Pages/FallsPreventionNewApproaches.aspx

[5] Falls and fractures: *Effective interventions in health and social care, Department of Health 2009.*

The overall aim of the proposed 'framework' is to focus on objectives 2 and 3, and improve the quality of life for Kent residents (particularly over 65yrs of age).

The 'framework' also covers the entire spectrum across a range of stakeholders including acute trusts, community health trusts, CCGs, adult social services, district authorities and voluntary organisations (Figure 1).

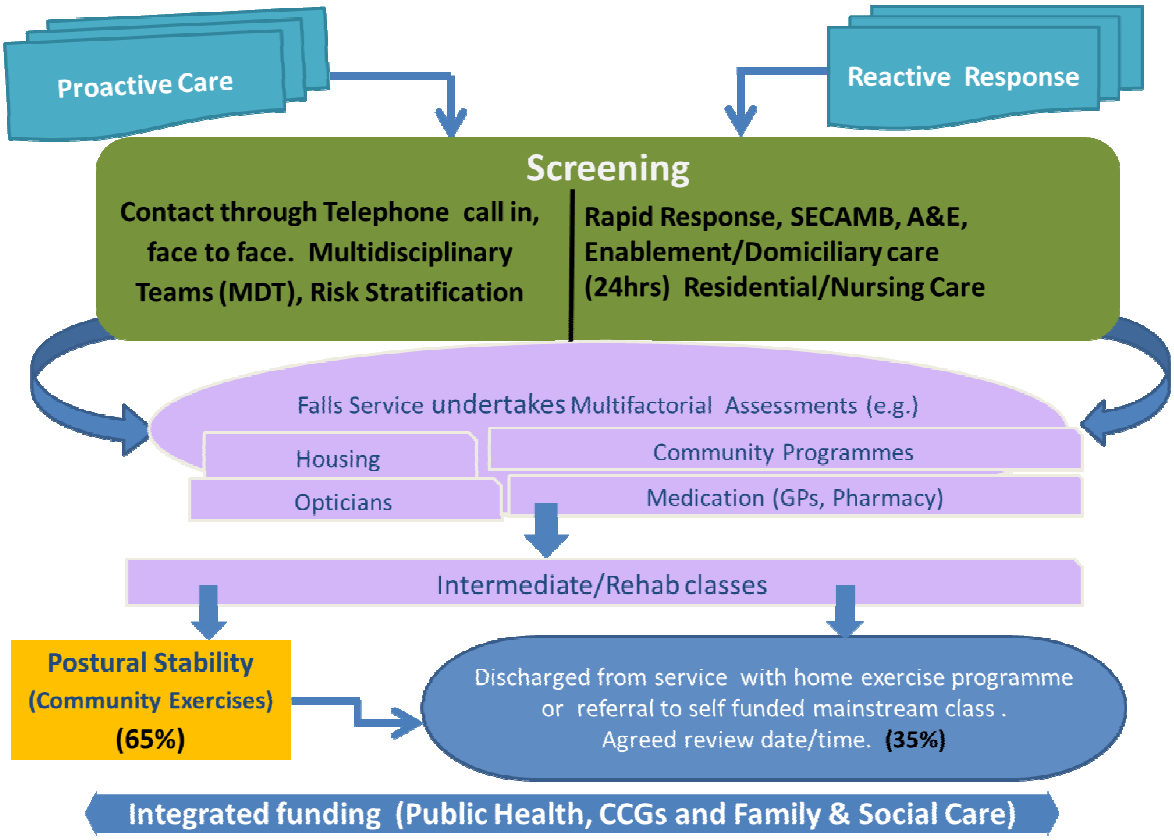
Considering the guidance from NICE and the National Service Framework, the framework recommends following interventions, which if undertaken in a systematic way will prove beneficial at a population level. These include:

1. Screening of adults who are at a higher risk of falls
2. Integrated multi-disciplinary assessment for the secondary prevention of falls and fractures
3. Use of standardised Multifactorial Falls Assessment and Evaluation tool across Kent
4. Availability of community based postural stability exercise classes
5. Follow on community support for on-going maintenance closer to home

These interventions should be available as a "core offer" for the population of Kent if we are to see a reduction in the number of falls related hospital admissions and reductions in numbers of older people living in residential care as a result of falls. KCC and all CCGs are urged to consider the adoption of the framework and implementation at a local level in order to achieve these outcomes. The 'integrated' falls management services in each area should be based on best practice, using a Multidisciplinary Team approach involving trained therapists, geriatricians and social workers.

The model proposes that the 'at risk' person is identified irrespective of their place of residence and receive agreed interventions. However, the location of intervention is based on the reasons that the individual person is 'at risk' for, and takes into consideration the individual needs, for instance an intervention such as exercise programme can be provided in a community or care home setting.

Figure 1



4. Conclusions

The Kent Health and Wellbeing Strategy (2012) highlighted prevention and management of falls as an important issue requiring action from all partners across the health and social care system.

The joint falls prevention and management framework developed between Public Health, Families and Social Care and CCGs should provide system wide approach to ensure that Kent achieves the right outcomes for older people who fall or are at risk of falling.

5. Recommendation(s):

The members of Kent Health and Wellbeing Board are asked to consider this report, along with the information that will be presented at the meeting.

Falls prevention and management services should be seen as an important component of integrated services with specific outcomes for reducing the falls related burden of ill health across health and social care sector.

Once agreed, the implementation of the framework should be led locally by commissioners represented at the local Integrated Commissioning Groups, reporting progress to the local Health and Wellbeing Boards.

Commissioners need to work with stakeholders (providers and voluntary sector) to identify 'at risk' population for timely intervention.

6. Contact details

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Karen Shaw, Public Health Practitioner, KCC, Karen.shaw@kent.gov.uk

Director Lead: Meradin Peachey, Director of Public Health

Meradin.peachey@kent.gov.uk

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

Meradin Peachey, Kent Director of Public Health

To: Kent Health and Wellbeing Board

Subject: Kent Framework for System Assurance

Classification: Unrestricted

Summary:

The Kent Health and Wellbeing Board (KHWB) wishes to develop an assurance framework across the Health and Social care system. It is proposed that indicators from the three national outcomes frameworks, the Kent Health and Wellbeing strategy and KCC Key Performance Indicators are taken as the basis to develop an overview of the health and social care system across Kent. These indicators will form a relatively simple Assurance Dashboard for the KHWB to assess current service effectiveness. In addition it may be useful to identify one or two other indicators within the system that can alert the Board to potentially unsustainable pressures in the component sectors.The Dashboard will also provide assurance on a regular basis if overall status of the indicators is progressing in the right direction.

Recommendation(s):

i) Note the contents of this paper and approve this proposal for developing Kent wide assurance framework.

ii) Make recommendations for alternative indicators including those for potential areas of stress within the system that may be unsustainable without concerted action to address the issues highlighted.

iii) Approve the development and ownership of the dash board for regular monitoring of the agreed indicators.

1. Introduction

At its inaugural meeting in April 2013 the Kent Health and Wellbeing Board (KHWB) received information on how constituent parts of the health and social care system in Kent are performing against national requirements. The KHWB requested this information be available as a standing agenda item and be extended to include primary and community services, acute hospital services, public health and social care.

Currently across the health and social care services a large amount of information is collected and it is important that the KHWB receives the most relevant and appropriate data selected from the myriad available in order to inform its business.

It is also important to ensure that the assurance reports to the KHWB contain data that is already available rather than generating new information and data collection requirements. To be meaningful the data must also be reportable in time-frames relevant to the sitting of the Board rather than annual updating that is required for a number of indicators.

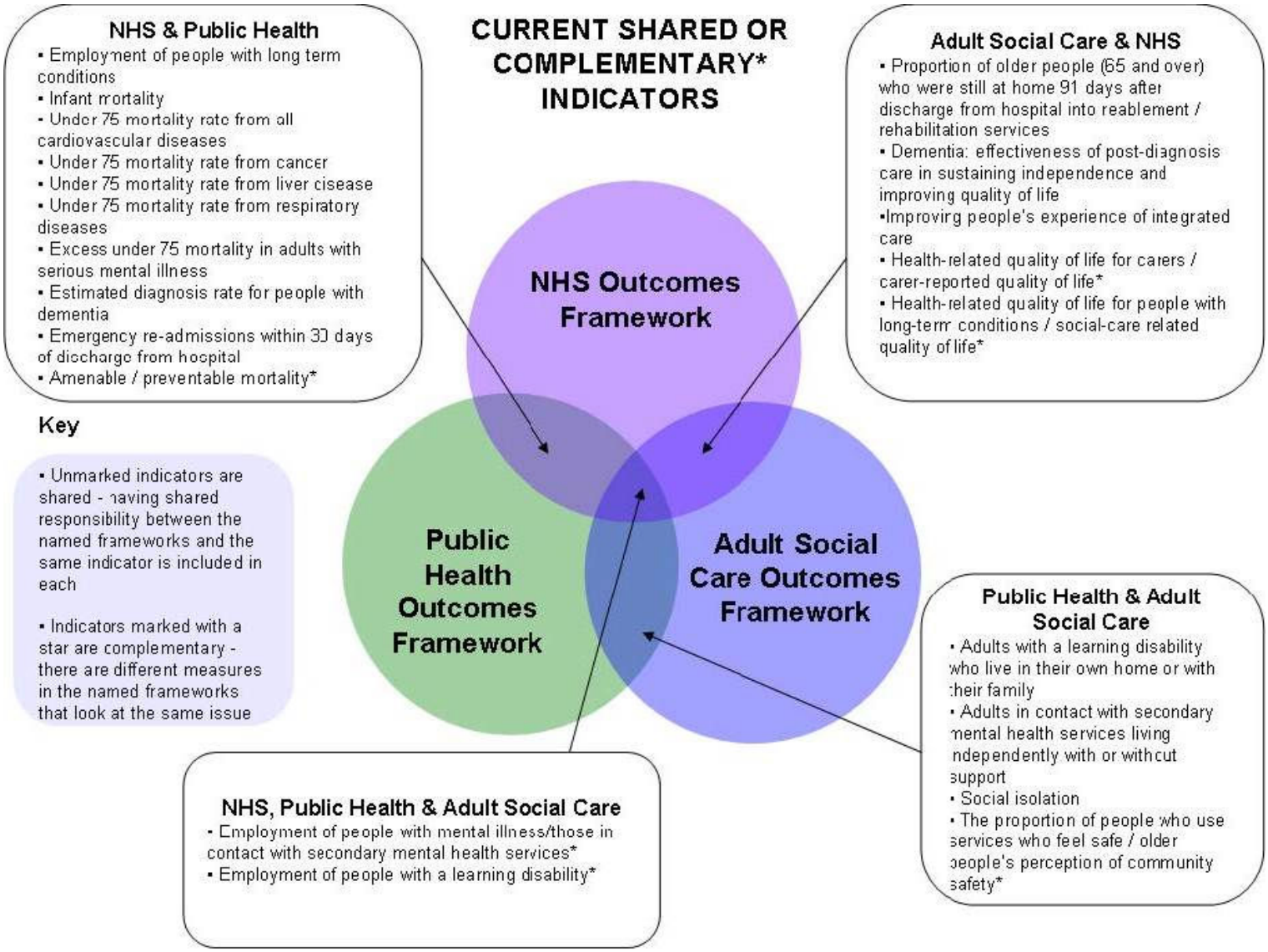
As well as demonstrating how the health and social care system is operating across the County the data supplied should inform the key responsibilities of the Board concerning the promotion of integration and the five outcomes contained in the Health and Wellbeing Strategy. It would also be useful to include indicators that demonstrate potential stress within constituent parts of the system that may require concerted action to alleviate and ensure service sustainability.

2. Current indicators

Nationally the performance of health and social care is assessed through the three Outcomes Frameworks that apply to the NHS, Public Health and Adult Social Care respectively. (Currently there is no corresponding framework specifically applicable to children although some indicators in other frameworks are relevant).

Each of these frameworks operate separately for each part of the system but they share indicators and domains designed to make them complementary to promote cross sector working and partnership towards joint outcomes. There are therefore shared indicators between each and all three of the sectors. The indicators are not intended to form a performance management framework but have been chosen to be indicative of whether key overarching outcomes are likely to be achieved. Some indicators in the Operating Frameworks have yet to be defined and others are collected on an annual basis only and are therefore less useful to the KHWB.

Figure 1



Other indicator sets that can inform the Health and Wellbeing Board include the KCC Key Performance Indicators (KPI's) that are reported on a quarterly basis.

3. Kent wide Assurance Framework

The role of the Kent Health and Wellbeing Board is to provide a system overview and to:

- assess the needs of their local population through the joint strategic needs assessment process
- produce a local health and wellbeing strategy as the overarching framework within
  which commissioning plans are developed for health services, social care, public
  health and other services which the board agrees are relevant
- promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.

To assist the delivery of these functions the members of the Kent Health and Wellbeing Board wish to develop an assurance framework. It is proposed that the Board regularly receives quarterly or 6 monthly reports on a suite of indicators or dashboard as attached at Appendix 1.

The dashboard of indicators that is proposed is designed to incorporate a number those that are shared variously between the national outcomes frameworks, the Kent Health and Wellbeing Strategy and KCC KPI's. Others are included for their particular relevance to the population groups or system sectors concerned.

Some of these overarching indicators such as Under 75 mortality rates for cardiovascular disease, respiratory disease and cancer are only reported on an annual basis. However, applying the analysis and methodology developed by Professor Chris Bentley compliments the report on *Addressing Health Inequalities in Kent*, also before the board today, which highlights small geographical areas (Lower Super Output Areas) with the top 20% premature mortality due to cardiovascular, cancer and respiratory diseases. The high level indicators mentioned in the assurance framework related to premature mortality will have a sub set of detailed indicators which can be monitored on quarterly basis. For instance the indicator on under 75 mortality for all cardiovascular diseases will have a sub indicator of associated risk factors such as that of under-diagnosis of hypertension and smoking cessation in these areas. Similarly the indicator on Cancer can have a subset on uptake of cancer screening services and respiratory can have an indicator on under-diagnosis of Chronic Obstructive Pulmonary Diseases (COPD) and smoking cessation. By monitoring these sub indicators the local health and wellbeing Board will be able to track progress of the named high level indicators.

4. Conclusions

Indicators across the three national outcomes frameworks, the Kent Health and Wellbeing Strategy and KCC KPIs can provide an overview of the status of the health and social care system.

Jointly held indicators can form the basis for a relatively simple Assurance Dashboard that will inform the KHWB of current service effectiveness. In addition it may be useful to identify one or two other indicators for each part of the system that reveal whether the current service levels are sustainable in the longer term. The Dashboard should also demonstrate whether indicators are improving or deteriorating.

Use of the dashboard should enable the KHWB to:

- Have timely indication of areas of concern and improvement across the system with emphasis on those aspects that involve joint responsibility
- Identify potential areas of stress within the system that may be unsustainable without concerted action to address the issues highlighted.

Please see Appendix 1 for a sample dashboard

5. Recommendation(s)

The Health and Wellbeing Board is asked to:

i) Note the contents of this paper and approve this proposal for developing Kent wide assurance framework.

ii) Make recommendations for alternative indicators including those for potential areas of stress within the system that may be unsustainable without concerted action to address the issues highlighted.

iii) Approve the development and ownership of the dash board for regular monitoring of the agreed indicators.

6. Contact details

Report Author

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Appendix 1

Kent Health and Wellbeing Strategy Outcomes

Outcome 1	Every child has the best start in life
Outcome 2	Effective prevention of ill health by people 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 health issues are supported to "live well"
Outcome 5	People with dementia are assessed and treated earlier

Indicator	**Shared Outcomes Framework (OF), Health and Wellbeing Strategy Outcomes, KCC Key Performance Indicators**
U75 mortality rate from cancer (see explanation in section 3)	NHS and Public Health OFs H&WBS Outcome 2
U75 mortality rate from respiratory diseases (see explanation in section 3)	NHS and Public Health OFs H&WBS Outcome 2
U75 mortality rate from all cardiovascular disease (see explanation in section 3)	NHS and Public Health OFs
Employment of people with long-term conditions	NHS & Public Health OFs H&WBS Outcome 3
Estimated diagnosis rate for people with dementia	NHS and Public Health OFs H&WBS Outcome 5
Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Adult Social Care and NHS OFs H&WBS Outcome 3

Dementia: effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Adult Social Care and NHS OFs HAWBS Outcome 5
Adults with a learning disability who live in their own home or with their family	Public Health and Adult Social Care OFs
Reducing the number of people reporting that they feel socially isolated	Public Health and Adult Social Care OFs H&WBS Outcome 4
Employment of people with mental illness/those in contact with secondary mental health services	NHS, Public Health and Adult Social Care OFs H&WBS Outcome 4
Increase breastfeeding initiation rates at 6-8 weeks	Public Health OF H&WBS Outcome 1
Smoking status at time of delivery	Public Health OF H&WBS Outcome 1
First time entrants to the youth justice system	KCC KPI Public Health OF
Under 18 conceptions	Public Health OF
	System sustainability indicators
Acute sector	
Bed occupancy levels in local hospitals	
Waiting times in A&E departments	
Primary care	
Out of Hours service – 111 performance	
Public Health	
Rates of infectious disease	
Seasonal mortality	Public Health OF

Adult Social Care	
Delayed transfers of care and those attributable to social care	Adult Social Care OF H&WBS Outcome 3
Mental Health	
Reducing the number of suicides	Public Health OF H&WBS Outcome 4
Children	
Percentage of children becoming subject to a child protection plan for a second or subsequent time	KCC KPI
Children in care with 3 or more placements in the last 12 months	KCC KPI

From: Andrew Ireland, Corporate Director, Families and Social Care, KCC

To: Kent Health and Wellbeing Board, 17 July 2013

Subject: Integration Pioneer Programme Bid – Delivering the Vision

Classification: Unrestricted

FOR DECISION

Summary:

This paper is accompanied by Kent's joint submission to the Department of Health's Integration Pioneer Programme.

It proposes that work to deliver integrated care and support at scale and pace starts *now* in Kent; there is no need to wait for September's announcement of who the Integration Pioneer sites are. The paper also proposes the creation of a group to lead the work programme and asks how the HWBB can embed this work into future Health and Wellbeing strategies.

Recommendation(s):

The Kent Health and Wellbeing Board is asked to DECIDE to:

4.1 Support the start of the work to deliver the vision described in the Kent Integration Pioneer Bid submission.

4.2 Agree the creation of a whole systems group which will (a) co-ordinate the programme activity associated with achieving integrated care and support (b) report progress to the HWBB. The HWBB are asked to express a preference for the group's status i.e. a sub-committee or a group mandated to report to the board.

4.3 Consider how the integration programme can be supported by future Health and Wellbeing strategies.

1. Introduction

1.1 The Health and Wellbeing Board will now be familiar with the Department of Health's invitation to submit bids for areas to become "Integration Pioneers". Kent's bid submission (see appendix) was submitted on 28th June. Bid results are expected to be announced in September.

1.2 There will be 10 sites selected for the first phase and there is speculation that a further 20 sites will be selected at a later stage.

1.3 Development of the Kent Integration Pioneer bid involved a range of stakeholders, including all the CCGs, the Kent County Council and major health providers. It is recognised that others need to be involved as work progresses on this, including members of the public, district councils, social care providers and the voluntary sector.

1.4 The bid document describes Kent's vision for integrated commissioning and integrated provision and should form the basis of future Health and Wellbeing strategies for the next 5 years. The Health and Wellbeing Board, as a systems leader should have an oversight role to ensure that the ambitions and vision stated in the bid are realised.

2. Delivering the vision for Integrated Health and Social Care

2.1 Whilst we hope that the bid is successful and that Kent is selected to be an integration pioneer site in the first phase, we are realistic that this might not happen. It is recommended that the Health and Wellbeing Board (and local HWBB sub-committees) support and drive forward the ambitions articulated in the bid irrespective of whether or not the Kent bid is chosen.

2.2 There is nothing to stop the organisations in the health and social care system working together in any case to achieve the bid proposals, learning from other areas and contributing to the national debate. With this is mind, it is recommended that the HWBB approves the creation of a whole systems group (commissioners and providers), reporting to the HWBB. The role of the group would be to co-ordinate the integration programme, as defined in the bid. At the time of writing, the formal status of the group needs to be confirmed - whether this group would be a sub-committee of the HWBB or whether it is a group mandated to report to the HWBB.

2.3 Driving this agenda forward will rely on strong clinical leadership and an equal partnership between CCGs and KCC. The Clinical Design Service could be used to support /facilitate the group. Discussion about who should chair the group is encouraged.

3. Conclusions

3.1 Development of the Integration Pioneer bid has been productive in bringing commissioners and providers across Kent together to create a local shared vision and commitment to integrated care and support. Integrating care and support at scale and pace will demand an ongoing, co-ordinated approach to delivery.

3.2 The HWBB has a systems leadership role to play in encouraging an environment for integrated care and support, which can be supported through focussing on this priority in future Health and Wellbeing strategies.

3.3 If, as the bid states, we want to improve the experiences of people and move from a reactive set of services to working with people and our communities in a positive proactive way that improves quality of life, health and wellbeing for everyone, we must start *now*.

4. Recommendation(s):

The Kent Health and Wellbeing Board is asked to DECIDE to:

4.1 Support the start of the work to deliver the vision described in the Kent Integration Pioneer Bid submission.

4.2 Agree the creation of a whole systems group which will (a) co-ordinate the programme activity associated with achieving integrated care and support (b) report progress to the HWBB. The HWBB are asked to express a preference for the group's status i.e. a sub-committee or a group mandated to report to the board.

4.3 Consider how the integration programme can be supported by future Health and Wellbeing strategies.

5. Contact details

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Kent submission for the Department of Health's Integration Pioneer Programme

28 June 2013

Health and Social Care Integration in Kent is focused on improving the co-ordination of care for patients, service users and their families. We already have a coherent story to tell in Kent and will build on this through working in partnerships that support integrated commissioning and deliver the provision of integrated services.

What we will achieve in 5 years:

Integrated Commissioning:

- **Design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of hospital and care home admissions.**
- **The Health and Wellbeing Board will be an established systems leader.**
- **Clinical Design partnerships between the local authority and CCGs with strong links to innovation, evaluation and research networks.**
- **Year of Care tariff financial model and risk stratification will be tested and adopted at scale.**
- **Integrated budget arrangements as the norm alongside Integrated Personal Budgets.**
- **Outcomes based contracts supported by new procurement models will be in place that incentivise providers to work together.**

Integrated Provision:

- **Good person centred integrated care will be evidenced through use of the Narrative**
- **Proactive models of 24/7 community based care, with fully integrated multi-disciplinary teams. The community / primary / secondary care interfaces will become integrated.**
- **A new workforce with skills to deliver integrated care.**
- **Leadership of the integrated workforce with a commitment to 'place'.**
- **Integrated IT systems to improve patient / service user care, underpinned by personal health records that can be accessed by the individual –"Nothing about me, without me".**
- **We will systematise self care so that people with long term conditions can do more to manage their own health and social care needs to prevent deterioration and over-reliance on services.**
- **New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.**

1. Introduction

Kent is totally committed to being part of the first phase of the integration pioneer programme, building on strong foundations but focusing on delivering integration at scale and pace. Kent's geographical size and range of stakeholders presents challenges in rolling out integrated services across the whole area but there is a determination across the whole system to demonstrate that it can be done. With the support of the Pioneer programme, we will develop models that will deliver integration across a population of 1.5 million people, which is an ambitious proposal. If Kent can deliver integrated services to that many people at scale, so can every other area of the country.

Being an Integration Pioneer will make us stronger commissioners and providers of health and social care across the whole system with implementation of improved services at a local CCG level as determined by individual CCGs. Our submission is about integration of both commissioning and provision and is a vision owned by all the major stakeholders.

2. The Vision

We will adopt the National Voices definition of co-ordinated care across our whole system and use these "I statement" outcomes to check that what we do means a real difference to the way people experience health and social care here in Kent. We are already working with users, carers and their families to re-design models of care to achieve this step change.

What we want to achieve in 5 years:

Integrated Commissioning:

- Together we will design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.
- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.
- The Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning based on the year of care funding model, allocating risk adjusted budgets, co-managed and owned by the integrated teams and patients.
- We will see integrated budget arrangements through section 75s as the norm alongside Integrated Personal Budgets.
- New procurement models will be in place, such as alliance, lead provider, key strategic partner and industry contracts, delivering outcome based commissioned services.

Integrated Provision:

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.
- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors.
- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.
- We will systematise self care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.
- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

What the people of Kent say they want:
"I always know who the key worker for my care is and who to contact"
"I am always kept informed"
"There are no gaps in my care"
"I am fully involved in decisions and know what is in my care plan"

We already have a coherent story to tell, with many achievements already that can be learnt from and built upon.

Integrated Commissioning:

- The Kent Health and Wellbeing Board (HWB) has been established and is working across the system on the themes in our joint Health and Wellbeing Strategy. We believe Kent is also unique in developing a sub-committee architecture with local HWBs now operating at local level around CCG boundary areas. These local HWBs also include district / borough councils and some also include voluntary sector representation.
- We have created integrated commissioning groups aligned to the local HWBs where commissioning activities can be co-ordinated. These new groups will be key to local relationships between commissioners and will inform and be informed by the leadership of the local HWBs.
- The Kent HWB has produced a local integrated outcomes framework within the HWB Strategy. We have also reviewed the work of the Kings Fund and the Local Government Association with an aim to develop this further.
- KCC has recently appointed Newton Europe – an operational and financial improvement specialist – to work as Transformation Partner. Their work will focus on better aligning pathways for independent outcomes, streamlining and balancing processes and ensuring best quality and value for money on the services commissioned now and in the future. The four East Kent CCGs are also working with Newton Europe to identify further opportunities for financial efficiencies in their current system.
- KCC wants to push the boundaries of what can be achieved and recognises the importance of clinical leadership in the new commissioning environment. To facilitate dialogue between KCC and clinical leaders in the CCGs, we have engaged our own clinical leader, a respected GP, to deliver a Clinical Design service.
- Public Health has taken a lead role in developing approaches to using risk stratification to inform commissioning decisions. They have the capability to cross match pseudonymised NHS data with a range of social care and health provider records using NHS numbers in order to provide comprehensive analysis for commissioners.

Integrated Provision:

- Kent has a long history of integrated adult provision with joint learning disability and mental health teams being well established already.
- We have a Health and Social Care Integration Programme [HASCIP] that has been in place for the past 2 years aiming to introduce the long term conditions model of care at pace and scale. We currently have separate adult social care teams, community health teams and older people's mental health teams. We are currently working to align them and through the pioneer programme would like to explore opportunities to create true integrated teams with single management structures. We have already been sharing our learning through regional and national conferences. A Compact agreement is already in place between community mental health, community health and social care which describes how we will work together to create integrated care teams.
- NHS numbers are available on the majority of electronic adult social care records now, which provide a means of cross-matching care records.
- Advanced Assistive technology partnership: we were one of the areas contributing to the Whole Systems Demonstrator programme, rolling out telehealth and telecare technologies at scale. 2000 people now benefit from telecare services in Kent provided by KCC. We are a pathfinder for the 3 million lives programme, aiming to have 10,000 people using assistive technologies in Kent within the next 5 years.

- We have 4 integrated care centres in Kent, providing long and short term (intermediate care) beds. Services are delivered within these buildings by integrated health and social care staff teams.
- The innovative "Proactive care" model, led by a local GP, is being rolled out across the South Kent Coast CCG area, already proving reductions in acute care usage.
- Kent has accessed Dementia Challenge Funds to implement projects. These include:
    - 12 Dementia Friendly Communities projects
        - Intergenerational work between schools and care homes for people living with dementia. These include developing "Dementia Diaries" and connecting people through using iPads.
    - A hospital admission prevention / faster discharge scheme – a partnership between Crossroads care West Kent (voluntary organisation) and Maidstone and Tunbridge Wells NHS Trust. This scheme sees Crossroads staff working at Pembury acute hospital and "pulling" the person back home, providing 24 hour care if required.
- Piloting personal health and social care records in Swale and South Kent Coast using "Patients Know Best" (PKB), an internet based networking IT solution that puts the person in control of who can see their shared health and social care anticipatory care plan. An anticipatory care plan has been developed which is now hosted on PKB.
- Developing a new falls response service. South East Coast Ambulance NHS Trust paramedic staff and social care practitioners will work together as a response team in order to respond quickly to 999 calls and prevent avoidable hospital admissions – anticipated go-live first phase October 2013.
- We have piloted personal health budgets and integrated personal budgets as part of the DH Personal Health Budgets programme. This work is now continuing across Kent in relation to continuing health care and the "Going Further, Faster" Integrated Personal Budgets project in South Kent Coast area.

We have a strong track history of integrated working and see our strength in being able to deliver systems change at scale, sharing good practice and ramping up local pilots and projects across a much wider geographic area for the benefit of all.

The following information in the bid goes into some of the detail of ideas already mentioned in the section above.

3. Whole System Integration

Commissioning health and social care services in the public sector is complex. While the county council is largely responsible for adult and children social care services, it currently works in partnership with seven Clinical Commissioning Groups and 12 District Authorities that commission health care and housing services respectively. The provider landscape is also extensive, with 4 acute trusts spread over 7 hospital sites, one pan county community health care trust, one mental health and social care partnership trust and many third sector and voluntary organisations including 4 hospices.

The Kent approach has been to look at whole system integration, rather than working in one area and then moving on to others, we have developed a comprehensive programme which supports integration across the entire health and social care economy.

Developing leadership and robust governance arrangements

Collaboration within the system has helped Kent achieve success to date – our integration models are not based on one design principle, rather we are exploring what best delivers success – be that a vertical or horizontal model, or provider to provider or commissioner to commissioner. We see great strength in this model as this flexibility in exploring whole system integration at local and Kent wide level allows us to share best practice but also ensure we meet local need.

We have also been able to sustain and develop commitment and participation from both mental and physical health, social care, and public health and have begun to further develop our work across other partners including the voluntary and community sector, housing and education. This is evidenced in some key projects for example work with *Crossroads Care* that crosses secondary,

primary care and community boundaries. We are working with schools and education on developing dementia friendly communities.

Designing whole system integrated intelligence

Kent Public Health has been integrating health and social care intelligence by linking and sharing coded data at a citizen level and has just successfully carried out a unique epidemiological study, using a locally developed King's Fund based risk stratification tool, giving commissioners a unique whole system baseline profile of population utilization of health and social care services.

On a local level, areas are starting with risk stratification as the tool to identify those who would further benefit from an integrated approach. Currently this work is focusing on adults, however as an Integration Pioneer Kent would be keen to explore how our approach could be applied to children's and transition services.

What we want to achieve in 5 years:

- Reduced admissions to acute care, having worked in a planned and phased approach, working with the population identified by risk stratification, with integrated Multi-Disciplinary Team Meetings and Neighbourhood Care Teams established ensuring links with acute, mental health, end of life care, pharmacy, voluntary sector and other specialist input as appropriate.
- Reduced length of stay through integrated working in the A&E department to enable improved treatment for patients and support them to return home with effective health and social care support.

Integration based on national LTC Model of Care

The Health and Social Care Integration Programme [HASCIP] has been working within CCG areas to further develop the integrated model between KCC adult social care, KCHT and KMPT regarding a shared desire to integrate community health and social care. Models of care have been flexed to address local needs and local priorities but essentially include the following:

- Integrated contacts and referrals.
- Common assessment framework using FACE.
- Integrated multi-disciplinary teams (MDTs) including the piloting of Health and Social Care Coordinators across West Kent, Canterbury and Swale.
- Closer working arrangements between intermediate care and social care enablement and home care.

What the people of Kent say they want:

"There was a plan in place to help me cope if I thought things were getting worse and make sure"
"I stayed at home and didn't have to go into hospital or long term care".
"My GP knew who she was dealing with in the team"

What we want to achieve in 5 years:

- Everyone coming through an MDT has an integrated anticipatory care plan – this plan not only identifies someone's needs should they go in to crisis but also supports self-care and contingency planning.
- Patient held record – currently in Swale and South Kent Coast CCG the online tool Patients Know Best is being used to pilot an electronic patient held care plan.

Systematising self-care and the use of technology

Self-care and self-management is essential to delivering better outcomes for people. A variety of services, already exist in Kent either as distinct services or as part of broader commissioned care pathways such as expert patient programme, health trainers, care navigators, exercises for falls prevention, advice on diet and nutrition, dementia friendly communities, including dementia cafes and peer support groups and more.

Kent is one of 7 pathfinder sites in to the *3 million lives* programme and is expected to deliver technologies to 10,000 people over the next 5 years. Work is currently taking place to identify an appropriate procurement model, including alliance contracting and single lead provider models that ensure services in locality are coordinated and include a range of methodologies for keeping people at home. This may include in the future financial incentives for providers and industry to work together. We are also part of an EU good practice and research exchange called CASA this is supporting innovation in assistive technologies in Kent.

We are already working with social care providers to test end-to-end care incorporating technology, a monitoring centre and provision of direct care – exploring the opportunities to improve outcomes whilst reducing longer term costs.

What we want to achieve in 5 years:

- Telemedicine and interactive technology used to reduce the need for patient to be in same physical space as carer or clinician before clinical care can take place.
- Through our digital engagement strategy, we will see a vast number of people in our communities benefiting from connected care using readily available technologies (via the television, smartphones and tablet devices), supporting families, carers, young carers, voluntary sector and integrated health and social care providers.
- Development of appropriate procurement model – including alliance contracting and single provider led models.
- Patients with LTCs further down the risk pyramid are fully engaged in self care schemes and may also consider purchasing technology solutions for themselves

Transforming whole system commissioning and redesigning contract and payment mechanisms

Last year the Kent & Medway PCT Cluster applied to be fast follower of the Year of Care programme of which South Kent Coast (SKC) CCG had applied to be the lead CCG. However, in light of the detailed whole population analysis led by Kent Public Health and sharing of the local datasets to the Year of Care team as part of the national analysis, Kent has just been offered this year to join the Programme as an Early Implementer Site. At the time of writing, we are also anticipating notification of early adopter status so that we can rapidly move to testing proof of concept of the new system and development of the 'RRR' tariff. We wish to look at the total cost of care across health and social care.

Following the success of the personal health budget pilot over the past three years, KCC and SKC CCG have widened the scope of Personal Health Budgets to include other patient groups such as NHS Continuing Healthcare patients. SKC CCG area is a "Going Further Faster" site testing integrated personal budgets from April 2013. The innovative Kent Card, which allows people to pay for their own care, will be used for the new integrated scheme where people wish to have integrated direct payments.

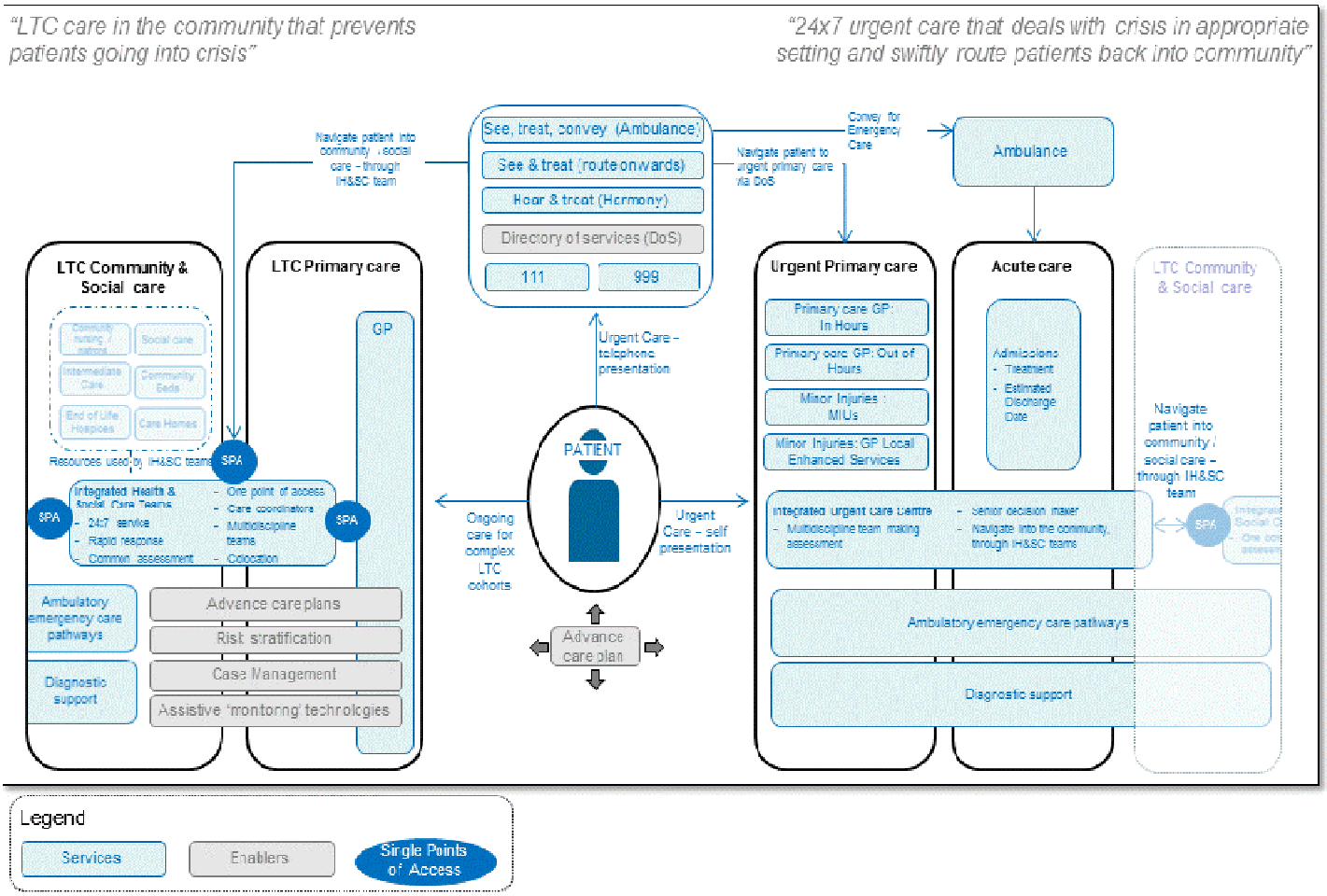
What we want to achieve in 5 years:

- Increased investment in community based support vs. spend on acute and residential care through the creative use of Year of Care Tariff funded care – seeing more people receiving preventative support and reduced admissions to acute care.
- Integrated personal budgets will be widely available across Kent and people will be able to get access to the money quickly without over-complicated procedures. It will be the norm for people to be involved in decisions when developing their care and support plan.

Whole system approach

Kent will use the opportunity as an Integration Pioneer to further explore the use of technology and community based schemes (such as befriending) to improve the outcomes and experience of individuals and carers. We would also like to explore how District Councils could further support work, for example developing specific housing models as alternatives to residential care, or work with CCGs and Adult Social Care in prevention through adaptations and home improvement work.

The diagram below is an example of work that has been done to develop a target operating model for integrated care in East Kent. It illustrates proactive care on the left of the model and integrated urgent care on the right hand side. It incorporates the idea of an integrated urgent care centre, and community based geriatricians who work between community and secondary care. The model will ensure the safe and appropriate removal of urgent care activity from secondary care and will maximise the use of physical, virtual and mobile resources to support individuals when dealing with a crisis. This is replicated in the other health systems, although different models of integrated care are being explored in partnership with providers and the voluntary sector. Specific work around integrated discharge planning with acute trusts and bed management are being worked on to support admission avoidance and ensuring support for patients and carers.



We will look at care across the whole spectrum of care provision, preventing avoidable admissions, ensuring 24/7 care where required and restructuring A&Es to support pioneering urgent care treatment centres. Some aspects of the model around step up/ down facilities have already been tested to ensure services are proactive and responsive to meet demand, supporting both admission avoidance and facilitated discharge; thereby reducing bottlenecks.

Clinical engagement has been positive and the benefits of integrating General Practitioners with specialists, such as community based Consultant Geriatricians, is already proving fruitful. The development of closer working relationships and provision of support and education is helping to keep older people at home or care home, without the need to come to hospital. Short term care can be provided within the home to prevent an avoidable and potentially distressing admission.

Within the proposed model, similar principles would be introduced to support risk stratified high users of secondary care, including patients with long term conditions, neurological conditions or patients requiring a time-limited period of reablement. Consultants and consultant practitioners (non-medical) could work across the pathway to provide specialist advice to community and primary care teams, supported by technology to have a three way consultation with the patient, GP

and themselves within the patient's home or GP practice. We will pool resources and look for opportunities to up skill staff to work across the spectrum of care.

What we want to achieve in 5 years:

- New whole systems models of care across Kent – this might look and feel different in different geographic patches to reflect local population and priorities, but will all deliver better outcomes within the available cost envelope.

4. Integrating Care and Support Across all Stakeholders

As outlined in our introduction our existing integration programme has strong support from all stakeholders within Kent, including the public. The Integration Pioneer bid is supported across CCGs, within organisational corporate management structures, at Cabinet level within KCC (Paul Carter, Leader of KCC is holding a series of Health and Social Care Integration events) and at the Health and Wellbeing Board.

The governance arrangements for integration operate like a cohesive chain, each link providing an important element to achieve success and only as strong as the next connecting link. As an Integration Pioneer the Health and Wellbeing Board would retain oversight of progress and it has been agreed that a sub-group would be established to support partners in delivery. Accountability of progress would remain within the existing governance arrangements of all stakeholders, thus ensuring the chain remains unbroken.

Each CCG area has a robust governance structure that seeks to engage and involve all key area stakeholders including local hospitals, hospices and the ambulance service (SECAMB). This supports the both integrated commissioning and integrated provision through different plans and groups.

Integration does not take place in isolation of the needs of the patient, service user or carer. HASCIP has a robust communication and engagement plan and holds a number of engagement events with public, patients as well as the voluntary and community sector. Many of the CCG area HASCIP Steering Groups have patient representatives, further public involvement takes place via CCG Patient Participation Groups and as an Integration Pioneer we would seek to explore how to embed *Making it Real* and the Narrative as a benchmark to our success and work in partnership with Kent Healthwatch to deliver this. The Dementia Friendly Communities programme has coproduction at the heart and has already delivered.

What the people of Kent say they want:

"I won't have to keep repeating myself to lots of different people"

"I don't need to worry about who is paying for my care, I contact one person and it's all sorted"

To sustainably deliver a future integrated model of provision we need a sustainable supply of staff and the development of skills in the community that can deliver care to the highest standards. We would welcome the opportunity to develop a model with Health Education England and local employers and voluntary organisations which ensures that the workforce plans reflect our vision for care over the next 5 to 10 years. This we believe will require joint approaches to planning, skills development and training in the right setting and with the right rigour around education and training outcomes. The health and care workforce is, to a great extent a local resource and this focus on development could creatively link in our education and academic partners as well as those focusing on employment and regeneration.

There are also employer level HR challenges to implementing integrated provision. This is supported through current developments within HASCIP – a joint HR plan, staff engagement events, a staff guide and an integrated training plan between health and social care. We would welcome further support in exploring the mutual extension of operational roles – so that Community Nurses can assess and implement social care solutions easily and vice versa for Case Managers (especially where Nurse trained).

We also want to explore further the development of a new workforce leadership model through further development of 'Leadership of Place'. This could see a development of common purpose at a CCG/ Local HWB level that enables the local workforce – in its broadest sense to connect to the work of care and health. Thanet CCG – supported by the SEC SHA piloted a programme with local government and provider partners in 2011/12 leading to the development of the 'Big Check' programme. This is being evaluated and will be redesigned to support the work of the Thanet HWB.
Kent is submitting an Integration (Information) bid which will help facilitate much better integrated and co-ordinated services around the individual, improve clinical outcomes and enable providers to communicate real time to improve the "patient" experience. As Integration Pioneers we would welcome the opportunity to share the progress we have made on information governance but also to explore how with multiple stakeholders you can overcome some of the perceived barriers to sharing information.

What we want to achieve in 5 years:

- We have moved from engaging and involving patients and carers to co-production.
- Integrated Commissioning taking place that is outcome based and informed by all key stakeholders including patients, District Councils and Housing.
- There are clear lines of accountability and decision making between member practices, CCGs and partner organisations.
- An interoperability gateway that allows viewing of care record and plans, in a secure controlled and auditable way from clinical systems across all key stakeholders.
- Neighbourhood Care Teams made up of integrated health and social care staff are situated across Kent and 24/7 accessible.

5. Capability and Expertise to Deliver

Kent has a strong track record in delivering transformation projects and providing strong leadership to explore barriers to implementation and innovative solutions – examples include the Whole System Demonstrator programme, implementation of Self Directed Support, personal health budgets and the ongoing development and implementation of Risk Stratification.

Within the Kent Governance structures there are locally based integrated commissioning plans and also local plans for delivering integrated health and social care teams. The Health and Social Care Integration Programme is also supported by a Kent wide Programme Team to act as an additional resource to deliver both local plans and Kent wide initiatives. On a local level each CCG provides strong leadership and are working to further develop their local visions for integrated services. This is supported by a willingness to explore potential barriers not only on a local level but on wider macro-level.

Kent recognises that a willingness to take risk is an important ingredient in innovation. In order to support integration and achieve success we combine our robust governance with system wide leadership, using learning opportunities as they arrive and seeing a role for the local authority and the Kent and Medway Commissioning Support Unit in cross fertilisation of ideas. Work is also taking place to explore opportunities for financial risk sharing models as well as whole system incentives to encourage providers to work together.

What we want to achieve in 5 years:

- A fundamental change in how the health and social care system operates, but also in how practitioners operate within this and how workforce planning needs to accommodate integration.
- Existing pilots completed and evaluated including Year of Care, 3 Million Lives, and Going Further Faster (Integrated Personal Budgets).

6. Sharing lessons across the system.

Kent is committed to sharing learning on integration and has already benefitted greatly from this approach through attendance at conferences, both in presenting our Integration Programme and networking with others. Also through existing networks such as ADASS and Transforming Social Care groups. CCGs are also making use of Protected Learning Time to explore issues around Integration.

Kent is also one of the 8 areas taking part in the Department of Health's System Leadership programme, and is focusing its work on developing a clear and owned definition of what integration means for the Kent Health and Wellbeing Board. This Pioneer work will complement the focus of the System Leadership programme.

Kent is keen to explore further work with the Academic Health Science Network and Clinical Senates, particularly to explore how we can evaluate the success of integration. However we recognise that this is an area where there is always scope to develop further and as an Integration Pioneer we would be keen to link with ICASE, but also see great potential in seeking to develop a local version which could provide learning across Kent and act as a repository for work to date, ensuring access to stakeholders, the health and social care workforce and the public.

In particular Kent is keen to explore further how we link to and further develop the wider health and social care workforce, ensuring everyone understands the importance of integration and we can ensure the changes need to deliver.

What we want to achieve in 5 years:

- A network across Kent that allows sharing of good practice – including the development of a local level ICASE and extension of the current EU Innovation Pioneer network.
- Broad understanding of the principles of integration across the entire health and social care workforce and within the Kent population.

7. Evidence Based Practice and Practice Based Evidence.

Kent would like to be at the forefront of developing a robust evaluation for integration and has begun to explore creating and developing our own evidence base. This has included looking at the work of Professor John Glasby on practice based evidence, as we understand that the traditional norms of evidence based practice are hard to apply within integration. We were pleased that John was able to attend a recent conference that we held for voluntary sector organisations across Kent to explore some of these issues.

A number of small scale local evaluation studies have already taken place. For example evaluation of the Proactive Care programme by LSE, Going Further Faster using POET, and ongoing evaluation on the immediate effects of integration through the Integrated Care Survey through Meridian by KCHT. More detailed surveys have also been designed and delivered, as well as work with the University of Kent to create a framework to evaluate the Year of Care Programme.

Although much work is focused around the known impact of integration – seeking to move money from acute/residential in to community support we are also talking with local providers about what new models of support may mean and working with them to find out what opportunities there are. As an Integration Pioneer this is an area in which we would welcome further support. CCGs are also reviewing services to identify innovative commissioning models for future procurement.

As discussed Kent is also working with National Voices and TLAP *Making it Real* to begin to make use of the 'I Statements'. We would welcome the opportunity as an Integration Pioneer to explore further how we can use the National Voices work and the new Shared Commitment and ensure it is used to frame ongoing work and evaluation.

What we want to achieve in 5 years:

- Increased evidence to support the vision and implementation of integration within Kent.
- A robust evaluation framework that provides both local and Kent wide measures of success.

8. Opportunities to Maximise Success

These are areas we are currently exploring but would relish the opportunity to tackle with the support of the DH and also by learning from others elsewhere. In particular we are keen to look further at:

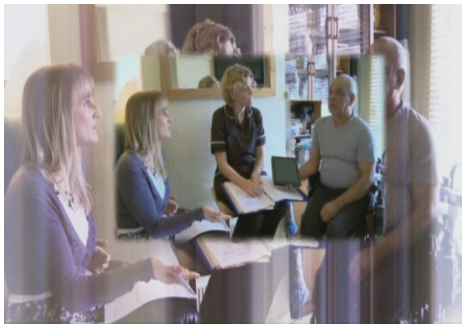
- Improved communication between services, providers and patients. Patients go where it is easiest and they don't always know who to contact. Further work can be achieved in supporting people to access services in the best way for them and through a variety of media.
- Contract design – to develop innovative contracting models such as strategic lead provider or Alliance provider models. The inability between commissioners and providers to agree on a common contracting model will hinder ideal spread of clinical and financial risk of meeting desired patient and service outcomes.
- Flexibility, tariff & pricing – what new models could be implemented?
- Information governance – work is already progressing in Kent to ensure this does not act as a barrier to creating integrated teams. However we would welcome discussing some of the wider national issues and work towards patient held records and work across multiple partners for example Districts, Housing etc.
- I.T. platforms – There is system wide agreement to information sharing. KCC and the Kent CCGs have submitted a bid to the Health and Wellbeing Information Centre to support development of information sharing platform. This will be a significant success to enable integration across health and social care providers – and in a short time also with members of the public. However we would welcome further support in finding lasting solutions to infrastructure differences.
- Develop additional funding streams.

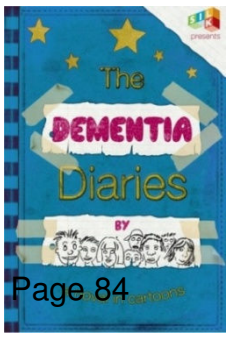
We think that we offer a unique environment to really test out the possibilities that the pioneer programme brings. Our track history and innovative approach to integration at scale sets us in good stead for leading this programme for the nation.

We understand the barriers that exist and are excited to work with other pioneers and the national team to test out new policy, advise on legislative change and push the boundaries on integrated commissioning and provision. Most of all, we really want to improve the experiences that our local people have of our current fragmented health and social care system, moving from a reactive set of services to working with people and our communities in a positive proactive way that improves quality of life, health and wellbeing for everyone.

For further information about this bid, please contact: Jo Frazer, Health and Social Care Integration Programme Manager, Kent County Council jo.frazer@kent.gov.uk 0300 333 5490

Contributing stakeholders include all CCGs (Thanet, South Kent Coast, Ashford, Canterbury and Coastal, West Kent, Swale & Dartford, Gravesham and Swanley), Kent County Council [KCC], Kent and Medway Commissioning Support Unit [KMCS], Kent Community Health NHS Trust [KCHT], Kent and Medway NHS and Social Care Partnership Trust [KMPT], East Kent Hospitals University NHS Foundation Trust [EKHUFT] and Swale Borough Council's Housing Department. We are committed to work with all district councils, housing, the voluntary sector and other health and social care providers in making integration real.





By:	Roger Gough Cabinet Member for Education and Health Reform
	Andrew Scott-Clark Director of Public Health Improvement KCC
To:	Kent Health and Wellbeing Board
Date:	17 July 2013
Subject:	Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategy and Timeline
Classification:	Unrestricted

Summary:
This paper is seeking Kent Health and Wellbeing Board's approval of the timeline within which the Kent JSNA and Kent Joint Health and Wellbeing Strategy will be produced in order to inform future health and care commissioning plans.

1. Introduction

At the last Kent Health and Wellbeing Board a paper was presented that described the Kent Joint Strategic Needs Assessment process, which was agreed, save a further paper and Health and Wellbeing Board discussion in order to agree definitive timelines.

The discussion centred on the demarcation of JSNA and Health and Wellbeing Strategy and the appropriate timeline to ensure the JSNA and Kent H&WB Strategy then informs Clinical Commissioning Groups, NHS England Local Area Team, Kent County Council, other local organisations with a health and care function, in planning for future years

This paper seeks to provide clarification and proposes a timeline.

The paper is based upon guidance issue by the Department of Health entitled "Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies" issued 26th March 2013[1]

2. Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint responsibilities to prepare a Joint Strategic Needs Assessments (JSNA) and Joint

[1] https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/18/files/2013/03/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

Health and Wellbeing Strategy (JHWBS), through the Health and Wellbeing Board. The responsibility falls on the Health and Wellbeing Board as a whole and so success will depend upon all members working together throughout the process.

At the last meeting of the Kent Health and Wellbeing Board we agreed how co-production of the Kent JSNA would be facilitated through the establishment of the JSNA Project Development Group led by the Kent Director of Public Health.

3. The Joint Strategic Needs Assessment (JSNA)

The JSNA is an assessment of the current and future health and social care needs of the local community – these are needs that could be met by the local authority, CCG or the NHS England Area Team. They are produced by the Health and Wellbeing Board and thus are unique to local areas.

In Kent, the population is diverse and has thus led to the concept of the JSNA being developed on the basis of Kent, plus the seven CCGs within the geographical footprint of Kent County Council plus the twelve districts within the geographical footprint of Kent County Council.

Local areas are free to undertake the JSNA in a way best suited to local circumstance.

JSNAs must assess current and future health and social care needs, including protection and upstream prevention of ill health within the health and wellbeing board area. It is important to cover the whole population, and to ensure that mental health receives equal priority to physical health. .

Health and wellbeing boards will need to consider:

- Current demographics of the area, and any reasonably predicted changes within the life of the JSNA. This covers the needs of people of all ages of the life course (Ref Marmot Health Inequalities Report) including how needs vary for people at different ages;
- The JSNA includes needs for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services; and those with complex and multiple needs such as looked after children, children and young people with special educational needs or disabilities, troubled families, offenders and ex-offenders, victims of violence, carers including young carers, homeless people, Gypsies and Travellers, people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging;
- Wider social environmental and economic factors that impact on health and wellbeing- such as access to green space, the impact of climate change, air

quality, housing, community safety, transport, economic circumstances, employment; and

- What health and social care information the local community needs, including how they access it and what support they may need to understand it.

At the last meeting of the Health and Wellbeing Board we outlined that the Kent JSNA will be an on-going process based on prioritisation and review of needs assessments. There will be an annual up-date of the overview chapter highlighting significant change.

4. Joint Health and Wellbeing Strategies (JHWBSs)

The Joint Health and Wellbeing Strategy (JHWBS) is a strategy for meeting the needs identified in the JSNA. As with the JSNA, it is produced by the Health and Wellbeing Board, is unique to the local area, and there is no mandated standard format.

In preparing the JHWBS, Health & Wellbeing Boards must have regard to the Secretary of State's mandate to NHS England which sets out the Government's priorities for the NHS.

The JHWBS should explain what priorities the Health and Wellbeing Board has set out in order to tackle the needs identified in their JSNA. It is envisaged that JHWBSs will not cover every priority at once, but rather identify a small number of strategic priorities for action, that will make a real impact on people's lives. The JHWBS should translate the JSNA findings into clear outcomes the board wants to see achieved through the commissioning strategies of the partners at the board – leading to locally led initiatives that meet those outcomes and address the needs.

5. Timing

JSNAs and JHWBSs are continuous processes, and are an integral part of CCG and local authority commissioning cycles. It is up to local Health and Wellbeing Boards to decide when to update or refresh JSNAs and JHWS or undertake a fresh process to ensure that they are able to inform local commissioning plans over time. They do not need to undertake from scratch every year; however boards will need to assure themselves that their evidence based priorities are up to date to inform relevant local commissioning plans.

6. Proposed Timing for Kent JSNA and JHWBS

Planning for commissioning begins in April for the following financial year, and thus the JSNA refresh and a review of JHWBS will need to be completed and finalised by the end of March of the previous financial year to then inform the commissioning plans which will ultimately be implemented in the following financial year.

Undertaking the work	Time Calendar years	Outputs
Refresh of Kent JSNA.	January (year 0) to December (year 0)	Finalised Kent JSNA
Check and Refresh of Kent Joint H&WB Strategy in line with Kent JSNA.*	January (year 1) to March (year 1)	Finalised Kent H&WB Strategy
CCGs, NHS England Kent Area Team and Kent County Council develop commissioning plans informed by the Kent JSNA and Kent JHWBS.	April (year 1) to March (year 2)	Finalised organisational commissioning plans to be implemented from April in the year following the start of the refresh.
CCGs, NHS England Kent Area Team, and Kent County Council implement Commissioning plans.	April (year 2)	Begin planning for next financial year's commissioning intentions

*NB: Every three years we will potentially need to reproduce the Kent Joint Health and Wellbeing Strategy which will require a longer time frame and run in parallel with the refresh of the JSNA from September to March. In 'off' years (i.e. two out of every three) changes to the Kent JHWBS should, barring major changes in the external environment, be absolutely minimal.

Recommendation

The Kent Health and Wellbeing Board is asked to;

1. **Note the difference between Joint Strategic Needs Assessments and Health and Wellbeing Strategy and**
2. **Approve the proposed timeline for production of both the Kent JSNA and the Kent Health and Wellbeing Strategy**

Contact Officers
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By:	Roger Gough, Cabinet Member for Education and Health Reform
	Andrew Ireland, Corporate Director Families and Social
To:	Health and Wellbeing Board – 17 July 2013
Subject:	**WORKING ARRANGEMENTS BETWEEN BOARDS**
Classification:	Unrestricted

Summary: This report sets out proposals which are intended to help clarify the relationship between boards that have distinctive but complementary roles for promoting health and well being, safety of children and vulnerable adults in Kent.

FOR DECISION

Introduction

1. (1) By virtue of s.194 of the Health and Social Care Act 2012, Health Well Board (HWB) was established in April 2013. Evidence indicates that the HWB will take centre stage in overseeing a range of health and social care activities, including development of strategies, planning and commissioning and service provision. Therefore, clarifying the working relationship between the HWB and existing key partnership boards is paramount.

(2) A meeting took place on 14 November 2012 to discuss this matter, which involved:

(a) Corporate Director of Families and Social Care

(b) Cabinet Member for Business Strategy, Performance and Health Reform

(c) Cabinet Member Specialist Children's Services

(d) Cabinet Member Adult Social Care and Public Health

(e) Director of Governance & Law

(f) Independent Chair of Kent Safeguarding Children Board

(3) The main action from the meeting was that an options paper should be prepared for consideration which, once agreed, will confirm the relationship between the different partnership boards.

(4) For the purpose of this report, partnership boards comprise the following:

(a) Health and Wellbeing Board

(b) Kent Safeguarding Children Board (KSCB)

(c) Kent and Medway Safeguarding Vulnerable Adults Board (KMSVAB)

(d) Kent Children and Young People's Joint Commissioning Board (KCYPJCB)

Two internal KCC boards that will also have an interest in the agreed working arrangements are:

(a) Children's Services Improvement Panel

(b) Integrated Children's Services Board.

(5) The key issues that this report addresses are:

(a) the need to reduce duplication

(b) improving the quality of governance and decision making

(c) promoting integrated working and provision

The examination of each of these issues generates different propositions, which are considered below.

(6) This report also provides an account of the evolving working relationship between similar boards in other areas of England, as a reference. The report also describes three options which relate to the key issues listed in paragraph 1(5) and, makes recommendations which, if accepted, could lead to the development of protocol on working arrangements.

Legal Context

2. (1) The statutory origin of the HWB is found in s.194 of the Health and Social Care Act 2012, which requires that a HWB must be established by a local authority with social services responsibilities. The statutory provisions came into effect as of 1 April 2013.

(2) Children's Trust arrangements are underpinned by the 'duty to cooperate' provision of s.10 of the Children Act 2004 and were established formally under s.12A of the same Act. However, the prescriptive statutory guidance was withdrawn on 31 October 2010. Each area must still have a Children's Trust Board, but how it operates, what it is called and how it will work with the HWB is a matter for local determination. As a result the KCYPJCB has replaced the former Kent Children's Trust.

(3) Kent Safeguarding Children Board, on the other hand, has its statutory underpinnings in s.13 of the Children Act 2004. This requires local authorities to have a Local Safeguarding Children Board. The Department of Education has published revised statutory guidance on the functions of the Local Safeguarding Children Board (Working Together to Safeguard Children, March 2013), which frames how the Board functions.

(4) Kent and Medway Safeguarding Vulnerable Adults Executive Board operates under the s.7 of the Local Authority Social Services Act 1970. The 'No Secrets' guidance issued by Department of Health required local authorities to set up a multi-agency framework to protect vulnerable adults at the risk of abuse. Putting Safeguarding Adults Boards on a statutory footing formed part of the recommendations of the Law Commission review into adult social care law. A clause to this is found in the the draft Care and Support Bill which is before Parliament.

(5) One general observation is that the children's commissioning landscape is complicated but the provision is more straight forward. Compared this to adults commissioning, which is more straight forward but the provider landscape is more complex.

(6) This then, is the backdrop to the accountability and relationship issues that, in the interest of effective working arrangements, the need to save time and make best use of resource, we are keen to resolve. The next section of the paper describes the scene of the evolving landscape in Kent.

Established and emerging relationships in Kent

3. (1) The role of the HWB has been defined as leading and advising 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). It has interest in securing better health and wellbeing outcomes in Kent and better quality of care for all patients and care users. Making sure that health care services paid for by public monies are provided in a cost-effective manner falls within primary responsibility of the HWB. The current membership of the HWB is set in its terms of reference.

(2) The work of the HWB is supported by seven Clinical Commissioning Group level HWBs.

(3) The KCYPJCB's purpose and remit is to improve outcomes for children and young people through the effective commissioning of services in partnership with a range of agencies, ensuring resources are prioritised according to need and where they achieve the most impact. The KCYPJCB functions as the lead commissioning group for the prioritising and coordination of services commissioned for children and young people, and it takes decisions about how resources are allocated across services for children and young people.

(4) The KCYPJCB is supported by four sub-groups which assist the KCYPJCB in discharging its responsibilities. The sub-groups are:

(a) Children Living Away from Home

(b) Early Intervention and Prevention

(c) Emotional Health and Wellbeing

(d) Disabled Children.

Protocols governing the working arrangements between the KSCB and the Kent Children and Young People's Joint Commissioning is in place. In accordance with the agreement the Protocol is reviewed annually.

(5) The key purpose of KSCB is to co-ordinate what is done by each person or body represented on the KSCB for the purposes of safeguarding and promoting the welfare of children in Kent, and to ensure the effectiveness of what is done by each person or body for that purpose. The work of KSCB is regarded as part of the wider context of 'Children's Trust' cooperation arrangements that aim to improve the overall wellbeing of all children in Kent

(6) The KSCB has several working/reporting groups which support it in undertaking its responsibilities, comprising

(a) Quality & Effectiveness

(b) Learning & Development

(c) Serious Case Reviews

(d) Child Death Overview Panel

(e) Health Safeguarding Group

(f) Education Advisory Group

(g) Trafficking Children and Sexual Exploitation

(7) KMSVAB takes a strategic lead on safeguarding matters. It also co-ordinates the safeguarding activities of partner agencies in the two local authority areas. The aim of the Board is to safeguard vulnerable adults living in Kent and Medway through a multi agency approach ensuring their safety, independence and well being. The Board sets priorities, determines resources and oversees performance management framework.

(8) In 2012 the KMSVAB undertook a review of its sub-structure as part of the overall governance review. As a result of the review the Board's sub-group will focus on Serious Case Review, Quality Assurance, Learning and Development, and policy, protocols and procedures.

Evolving relationships in other areas

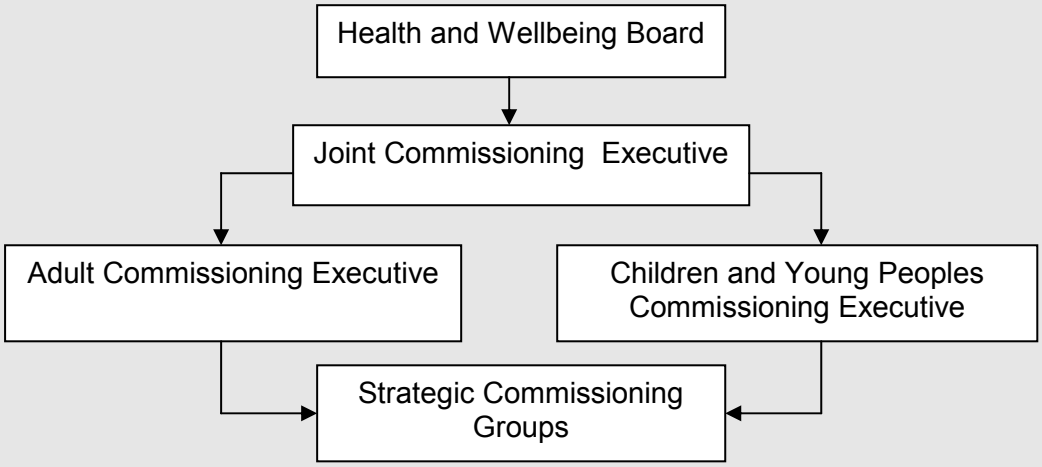
4. (1) As a consequence of the current changes within local authorities, public health and the NHS, it is important to avoid confusion about responsible and accountable bodies. One of the central challenges associated with partnership working, is clarifying the lines of accountability between boards with distinctive but complementary roles. To underline this, the Local Government Association commissioned the National Foundation for Educational Research to investigate local authorities' approaches to their children's trust arrangements and how they are fulfilling their duty to promote cooperation with partners to improve children and young people's health and wellbeing[1].

[1] Easton, C.; Hetherington, M., Smith, R., Wade, P., Aston, H. and Gee, G. (2012). *Local Authorities' Approaches to Children's Trust Arrangements* (LGA Research Report). Slough: NFER. The advice the report gave related to: (1) reviewing existing structures and partnerships to ensure they remain focused relevant and as streamlined as possible, (2) having strong leadership and management within individual organisations and collectively, (3) clearly outlining current and future areas of priority, need and direction of travel, (4) ensuring local authority senior leaders, including Directors of Children's Services and lead members for children's services, are represented on children's and health bodies to ensure issues are discussed and decisions made quickly, (5) developing clear terms of reference for the Health and Wellbeing Board and sharing its focus with other bodies, including the local authorities, CCGs and LSCB, (6) collectively developing a shared vision and priorities, (7) developing a strong evidence base built on robust needs analysis, (8) developing positive relationships with partners based on trust, respect, common understanding, dialogue and a commitment to working together, (9) promoting information sharing between partners and children's and health bodies, (10) understanding and developing the workforces across the local authority, health bodies and partner organisations, (11) embedding children and young people's needs into the JSNA, ensuring it is not perceived as an add-on and (12) raising communities' awareness of the importance of health and wellbeing and early help.

(2) Working arrangements between partnership boards across the country are being approached in a variety of ways. The following examples from other areas have been pulled together to inform the discussions in Kent.

Hertfordshire: Outline Health and Wellbeing Board Governance Structure

The draft constitution provides that "the Board will directly oversee the commissioning of those services where a section 75 agreement between health and social care partners is in place including taking strategic oversight and assume delegated responsibility for all those areas where a Section 75 Agreement is in place for the pooling of commissioning budgets".



Oxfordshire: Outline of the protocol on the working arrangements between the Oxfordshire Safeguarding Adults Board and the Oxfordshire Health and Wellbeing Board[2]

The Oxfordshire HWB and the Oxfordshire Safeguarding Adults Board have an on-going and direct relationship, communicating regularly through identified lead individuals.

The Chair of the Oxfordshire Safeguarding Adults Board attends the HWB annually.

The Independent Chair of the Oxfordshire Safeguarding Adults Board, the Deputy Director of Adult Social Care and the Cabinet Member for Adult Services liaise closely with regards to the effective operation of both bodies.

The Oxfordshire Safeguarding Adults Board provides an annual report to the HWB setting out an honest assessment of local safeguarding arrangements.

If there are any areas of significant concern that cannot be resolved in accordance with the Protocol then a strategy meeting will be held between the Independent Chair of the Oxfordshire Safeguarding Adults Board, the Chair of the Adult Health and Social Care Board, the Deputy Director of Adult Social Care and the Chief Executive of the County Council and any other senior person that is regarded as being required.

Nottinghamshire Integrated Governance between the Health and Wellbeing Board and Children's Trust[3]

[2] There is also protocol on the working arrangements between the Oxfordshire Safeguarding Adults Board and Oxfordshire Children and Young Peoples Partnership Board.

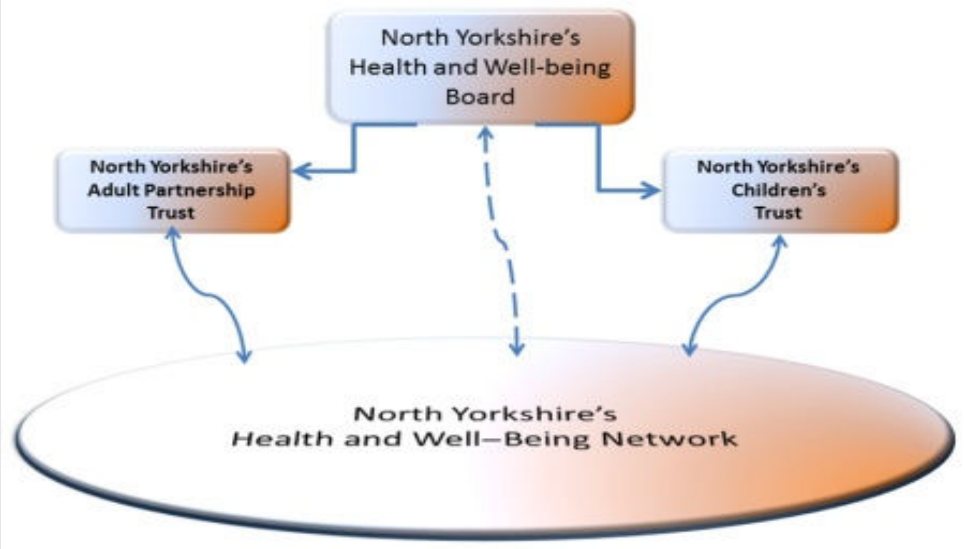
[3] Children and Young People and Health and Wellbeing Boards, Putting policies into practice, June 2012, DH.

In Nottinghamshire, the Shadow HWB was established in 2011 as part of the Government's early adopter programme. The early work on the HWB coincided with a review of the future operating model for the Children's Trust. As a result, the Trust decided that it would be integrated with the governance structure of the HWB . "A key feature is that the chair of the Children's Trust sits on the HWB. The sub-structure implementation group includes the Chair of the Children's Trust and the Independent Chair of the Local Safeguarding Boards (children's and adults).

"One of the most positive outcomes from this collaborative approach is a decision made by the HWB to commission the Children's Trust to provide a report to the Board which 'audits' the current local arrangements for children against key questions and challenges which emerged from the national learning set"

North Yorkshire Health and Wellbeing Board Structure

The HWB has two primary 'doing arms', to drive forward the day-to-day work of the board. One is the North Yorkshire's Children's Trust and the other North Yorkshire's Adult Partnership Trust. The North Yorkshire HWB structure consists of the Board in its leadership role; the two substructures in their action/implementation/doing roles; and the wider health and wellbeing network of boards, partnerships and communities of interest in their shaping, influencing, contribution and calling to accountability roles.



(3) Clearly, there is no one universally applicable model. It would seem that each area has to find the best fit, in the context of local partnership arrangements and other factors. Without a doubt the network of partnership boards must be engaged in arriving at a way forward that best suits the Kent conditions.

Options on working arrangements between boards in Kent

5. (1) In light of the issues outlined above, the options that Kent could consider are as follows:

(a) **Option 1(A):** Merging KMSVAB with the KSCB.

(b) **Option 1(B):** Integrating KMSVAB and the KSCB with the HWB.

(c) **Option 2:** Harmonising the arrangements by securing changes to improve and align the terms of reference of relevant boards, which will be reflected in agreed working protocols with clear reporting lines.

(d) **Option 3:** The HWB with delegated responsibility for all s.75 Agreements.

(2) As stated in paragraph 1(4) above, if reducing duplication in the present arrangements is the overriding concern, the potential options centre on aligning, merging or integrating certain boards would include:

(a) **Option 1(A):** Merging KMSVAB with the KSCB.

(b) **Option 1(B):** Integrating KMSVAB and the KSCB with the Kent Shadow HWB.

(2) Option 1(A) is not without its challenges, in as much as, external scrutiny bodies (particularly Ofsted) have been known to hold a critical view of single adult and children's safeguarding boards. Having said that, there are other areas that operate combined boards. There will be a need to ensure that such arrangements do not lead to dilution of focus, which risks either of the safeguarding responsibilities being effectively discharged.

(3) It is important to take account of the journey that KCC and partners have been on since the Ofsted inspection of 2010 in considering this option. Moving ahead with this option has to be carefully timed even if there is confidence that the necessary conditions are in placed.

(4) The factors that have to be considered under Option 1(B) are not as challenging as those under Option 1(A) based on the evidence from other areas. As shown above with the Nottinghamshire example, it is possible to construct the integration of children's trust arrangements within the HWB structure. The timing, however, has to be right. The HWB was recently established as a statutory body in April 2013, it reasonable to expect the new body to use its first year of operation for embedding its fundamental arrangements.

All the same, option 1(B) should form part of the initial discussion prior to arriving at a settled position.

(5) If, on the other hand, improving the quality of governance and decision making is the main issue to be addressed, the most sensible way forward as we have seen unfolding elsewhere will be the following option:

Option 2: Harmonising the arrangements by securing changes to improve board to board arrangements which will be reflected in agreed working protocols with clear reporting lines.

This will call for the development of, and the agreement to, revised, standardised and complementary governance arrangements and working protocols between the boards listed in 1(4) above. It would be sensible to specify the working arrangements between the HWB and the other three boards in a single working protocol, as has been done in Oxfordshire.

(6) This option has certain inherent attractions. It will lead to the clarification of reporting lines as well as providing the opportunity for working on areas of mutual interest. In addition, the protocol can be developed and gain collective sign-up by the boards within short period of time.

For these reasons, Option 2 is recommended for consideration as the short term solution.

(7) The third option, which perhaps is the most radical of those mentioned above, is based on the understanding that promoting integrated working and provision is the overriding objective. Thus, the option which should be pursued in the long term is the following:

> **Option 3**: The Health Wellbeing Board with delegated responsibility for all s.75 Agreements.

Opting for this option will mean that the Kent HWB will have the authority and responsibility to carry out those functions delegated to it by KCC and others which, where the constituent organisations agree, should be the responsibility of the HWB.

(8) There are compelling reasons for regarding this option as a credible platform for engineering effective pooled commissioning budgets partnership[4]. It has the potential to remove some of the current difficulties that people who rely on services face. It will in effect raise the bar of joint commissioning aspiration that, to date, we have seen given an expression through the Kent Health Commission. It will make the Kent Health Commission, a truly Kent Health Commission enterprise. The HWB would also be familiar with recent government announcement that by 2018 health and social care integration would be the norm[5].

(9) However, any enthusiasm that this option generates would clearly be dampened by counter-factual issues relating to

(a) obtaining buy-in to the direction of travel from all concerned
(b) the development of a clear constitution
(c) a shared vision and priorities and
(d) A positive relationship based on mutual trust and a commitment to joint working.

For these reasons, Option 3 is recommended for consideration as the long term solution.

Conclusion

6. (1) As this report has depicted, as a result of the current changes within local authorities, public health and the NHS, there is a need to avoid confusion about responsible and accountable bodies regarding key activities. A key challenge associated with partnership working is clarifying the lines of accountability between boards with distinctive but complementary roles.

[4] DH Winterbourne View Review Concordate: Programme of Action makes the case that 'the strong presumption will be in favour of supporting this with pooled budgets arrangements with local commissioners offering justification where this is not done.

[5] Integratd Care and Support: Our Shared Commitment, National Collaboration for Integrated Care and Support

(2) This report has drawn on emerging information from other areas to inform the debate in Kent. A number of options have been described which, depending on the appetite for resolution Kent, can move us forward in both the short and long term.

Recommendations

7. (1) The Health and Wellbeing Board consider the contents of this report and a proposed course of action.

(2) ENDORSE the development of a working protocol as outlined in paragraph 5.5 above.

Background Documents

Health and Social Care Act 2012

Easton, C.; Hetherington, M., Smith, R., Wade, P., Aston, H. and Gee, G. (2012). *Local Authorities' Approaches to Children's Trust Arrangements* (LGA Research Report). Slough: NFER

Children and Young People and HWBs, Putting policies into practice, June 2012, DH

Terms of reference of the following boards:

Kent (Shadow) Health and Well Being Board

Kent Safeguarding Children Board

Kent and Medway Safeguarding Vulnerable Adults Executive Board

Kent Children and Young People's Joint Commissioning Board

KCC Children's Services Improvement Panel and

KCC Integrated Children's Services Board.

http://www.hertscvs.org.uk/news.asp?newsID=121, http://www.hertsdirect.org/your-council/hcc/partnerwork/hwb/hwbcyp/

http://www.nhsconfed.org/Publications/Documents/health_and_wellbeing_boards_putting_policies_into_practice210612.pdf

http://nypartnerships.org.uk/index.aspx?articleid=16804 and http://nypartnerships.org.uk/index.aspx?articleid=19041

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From: Andrew Ireland, Corporate Direct Families and Social Care

To: Health & Wellbeing Board

Subject: Kent's Initial Stocktake of Progress against the Winterbourne View Concordat Commitment

Classification: **Unrestricted**

Past Pathway of Paper: Families & Social Care Directorate Management Team, Kent Joint Winterbourne Working Group

Future Pathway of Paper: NHS England, Commission Board and Local Government Association

Electoral Division: All

Summary: The report gives an overview of the Winterbourne View Concordat, Kent's Stocktake of progress against the commitments made in the Winterbourne View Concordant and actions to date

Recommendation(s):

Health & Wellbeing Board is asked to note Kent's Initial Stocktake of Progress against the Winterbourne View Concordat Commitment and note Kent's delivery of the programme to date.

1. Introduction

1.1 In December 2012 the final version of the Winterbourne Concordat was published. The Concordat is a commitment by over 50 Organisations including the NHS and the LGA to reform 'how care is provided to people with learning disabilities or autism who also have mental health conditions or behaviours that are viewed as challenging'. Following Winterbourne there is widespread agreement that the care of this group of vulnerable people requires fundamental change.

Norman Lamb, Minister of State for Care and Support, recently sent a letter to all Health and Wellbeing Boards, stating an expectation that Health and Wellbeing Boards will play a fundamental role in promoting and monitoring the work being undertaken in delivering the vision outlined in the Concordat. The Minister of State stated that the stocktake will provide a local assurance tool for Health & Wellbeing Boards.

2. Financial Implications

2.1 Not Applicable

3. Bold Steps for Kent and Policy Framework

3.1 Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging.

This report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but they are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

The Government's Mandate to the NHS Commissioning Board[1] says:

"The NHS Commissioning Board's **objective** is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people." (para 4.5)

We expect to see a fundamental change. This requires actions by many organisations including government. In summary, this means:

- all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014;
- by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging;
- as a consequence, there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals;
- a new NHS and local government-led joint improvement team, with funding from the Department of Health, will be created to lead and support this transformation;
- we will strengthen accountability of Boards of Directors and Managers for the safety and quality of care which their organisations provide, setting out proposals during Spring 2013 to close this gap;
- CQC will strengthen inspections and regulation of hospitals and care homes for this group of people. This will include unannounced inspections involving people who use services and their families, and steps to ensure that services are in line with the agreed model of care; and with the improvement team we will monitor and report on progress nationally

Source : Transforming care: A national response to Winterbourne View Hospital Department of Health Review

4. The Report

4.1 The Winterbourne View Joint Improvement Programme asked local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

Kent submitted their Initial Stocktake on 5th July 2013, which was agreed by the Chair of the Health & Wellbeing Board, Roger Gough, The Corporate Director of Families & Social care, Andrew Ireland and the , CCG Accountable Officer for Dartford Gravesham & Swanley, Patricia Davies. The Stocktake is attached for the Health and Wellbeing Board to note.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF) for people with Learning Disabilities.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

Penny Southern is the Directorate lead for the Winterbourne Programme in Kent and has established a Kent Joint Winterbourne Working Group (KJWWG), which has representatives from the Local Authority, CCGs, and Health providers and key stakeholders. A draft terms of reference has been developed for the group. The KJWWG will provide regular reports on progress against Kent's action plan.

5. Conclusions

The National Directive has been set for all local areas to complete the stocktake of progress against the commitments by the 5th July 2013. Kent submitted their initial stocktake by the required deadline and has clear a clear governance process in place to deliver the programme of actions.

6. Recommendation(s)

Recommendation(s):

Health & Wellbeing Board is asked to note Kent's Initial Stocktake of Progress against the Winterbourne View Concordat Commitment and note Kent's delivery of the programme to date.

7. Background Documents

7.1 Transforming care: A national response to Winterbourne View Hospital Department of Health Review

7.2. DH Winterbourne Review Concordat: Programme of Action

8. Appendix

8.1 Kent's Stocktake submitted to LGA 5th of July 2013

8.2 Norman Lamb, Minister of State for Care and Support, letter to all Health and Wellbeing Boards

9. Contact details

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Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA website

May 2013

Winterbourne View Local Stocktake June 2013			
1. Models of partnership	**1** There is a good history of joint working between KCC and the NHS in Kent as evidenced by: Section 75 arrangements for the provision of integrated community learning disability teams which is reviewed annually; • Joint programme of work for the re-provision of NHS Campus and subsequent development of supported living options for people utilising the previous assets of the NHS, particularly for those with high support needs. • Joint work to establish the Kent Challenging behaviour Network, that enables providers to share best practice, develop service standards and promote training opportunities; • Joint support and contribution to the Kent Valuing People Board and infrastructure of supporting groups across Kent.	**Good practice example (please tick and attach)** **S75 agreement available on request** **See website** http://kcbn.co.uk/ **See LD Partnership Strategy –** http://www.**kent**.gov.uk/adult_social_services/your_social_ser...	**Support required**
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	**1.1** A proposal to establish a Kent Joint Winterbourne Working Group (KJWWG) that will oversee, co-ordinate and monitor all aspects of the local Winterbourne Programme of Action is being developed at a meeting on 28 June. This will be presented to the Local Authorities and seven CCGs for consideration and decision making and report to the LD		

	Partnership Boards, H&WBs and the NHS Local Area Team for their consideration. There are many issues that require senior level discussion (eg pooled budgets) and it is proposed that all relevant agencies/groups have senior representation on the KJWWG to enable resolution of issues in a timely manner. It is further proposed that the KJWWG is the hub through which all communication, reports, stocktakes etc are ratified.		
1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	**1.2** The above proposal is being developed by commissioners from Kent Local Authorities, CCGs and the Kent and Medway Commissioning Support Unit (KMCS). Additional partners, including housing, advocacy and providers will support the programme as it evolves.		
1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	**1.3** It is proposed that establishment of a Kent and Medway planning function will come under the remit of the KJWWG and will complement existing planning functions such as Health and Wellbeing Strategies, CCG Commissioning Plans, and LD Partnership Strategy. Joint Commissioning Board subgroup for disabled children, Integrated Commissioning themed Divisional Management meeting.	1.3 Draft TOR KJWWG Winterbourne View Project Group Draft T	
1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	**1.4** The LD Partnership Boards will be represented on the KJWWG and the representative will report into the Partnership Board with progress against the action plan.	1.4 LD Partnership Board	

		Winterbourne for LDPB-Jan 2013 - 13 0
1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	**1.5** Yes. The Health & Wellbeing Board Chair has signed the initial stocktake and the stocktake is being noted at the H&WB in July 2013	
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	**1.6** Yes, we use existing arbitration protocols	
1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards.	**1.7** Yes. The Draft JKWWG terms of reference detail the partnerships accountabilities, ensuing the relevant bodies are represented at the group and local, regional and national bodies are provided with reports from the JKWWG as required.	1.6 Draft TOR KJWWG in 1.3
1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	**1.8** Yes, there is a OR protocol and guidance in place, which is monitored via performance. A report on the current OR issues in Kent was presented to the KCC Cabinet.	1.8 Internal KCC policy guidance & policy available on request
1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	1.9 Yes – A group of patients currently in NHSE low secure services have been identified as needing bespoke community support arrangements to enable their discharge. This represents a significant cost pressure to CCGs and LAs if money does not follow the patients from secure services to the local health economy and may prevent progress with developing community based support and specialist communi9ty services. Neither Transforming Care nor the	**1.9 Support required**

	Winterbourne Concordat are specific in terms of defining either the patient group or the care settings across which they apply. Such clarification would be a significant enabler in progressing recommendations.		
2. Understanding the money **2.1** Are the costs of current services understood across the partnership. **2.2** Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.	**2.1** Each CCG and Local authority is aware of costs of their current placements and aware of the different cohorts of services within Kent. It is expected that the proposed KJWWG will take a Kent and Medway perspective on total costs across health and social care. **2.2** Yes. Specialist Commissioning: NHS England is the responsible commissioner for specialised mental health services, as described by the Specialised Services Manual, and including secure mental health services. Within Kent specifically there are x 2 units for which NHS England is the responsible commissioner: - Tarentfort Centre – Low Secure NHS. Contract held by NHS Surrey & Sussex Area Team (on behalf of NHS England) - Cedar House – Private Sector Low secure in-patient Learning Disability Forensic Service, contract held by Birmingham & Blackcountry Area Team (on behalf of NHS England). Continuing Health Care and NHS and Social		

	Care: Agreed processes are in place across health and social care to facilitate the assessment of a patient's care needs to determine funding requirements to meet their care needs. The National Framework for determining eligibility for NHS continuing healthcare and for NHS-funded nursing care is adhered to across Kent & Medway. Patients not eligible for NHS continuing healthcare are assessed jointly by health and social care utilising the Camberwell Assessment of Need tool (CANDID / CANFOR) to understand their health and social needs.		
2.3 Do you currently use S75 arrangements that are sufficient & robust.	**2.3** Yes – The integrated Community Teams are managed under a Section 75 arrangement which is reviewed annually. There is also a SLA with providers that is also review annually.	2.3 Section 75 framework monitoring tool -  Review framework KCC KHCT Final Draft	
2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	**2.4** No – These discussions will come under the remit of the proposed KJWWG. The decisions will be made by the CCGs and LA.		
2.5 Have you agreed individual contributions to any pool.	**2.5** No		
2.6 Does it include potential costs of young people in transition and of children's services.	**2.6** No		
2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future	**2.7** No – These discussions will come under the remit of the proposed KJWWG		

investment and potential for savings.			
3. Case management for individuals **3.1** Do you have a joint, integrated community team.	**3.1** Yes – A clear service specification is in place with clear governance arrangements through a Section 75.		
3.2 Is there clarity about the role and function of the local community team.	**3.2** Yes there is clarity about the role and function of the local integrated team, the team undertake placement reviews in addition to the normal requirements of Care Programme Approach or as dictated by patients progress. There is confidence that the systems in place for placement review and management of Kent and Medway patients are adequate to ensure patients progress along the care pathway in timely manner.	SLA between providers of integrated Community teams available on request	
3.3 Does it have capacity to deliver the review and re-provision programme.	**3.3** Once the action plan details the requirement of the teams, work will take place to look at the capacity required to deliver the key actions and ensure the teams have a greater understanding of the programme.		
3.4 Is there clarity about overall professional leadership of the review programme.	**3.4** Within Kent and Medway statutory agencies there are a number of people whose remit specifically includes the Winterbourne Programme of Action. overall professional leadership of the review programme will be undertaken by the KJWWG and monitored via the Joint Integrated Divisional Management Team meeting.		

3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.	**3.5** Yes – Each patient on the CCG LD register has a named worker from their locality community team. Access to advocacy is a requirement of the contract with providers and therefore is available as required for Kent residents.		
4. Current Review Programme **4.1** Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	**4.1** Yes. The number of <u>current in-patients</u> (in hospital but not NHS England funded placements) affected who come from Kent is known. Where discharge plans are in place, people and their families are involved and supported. We are aware of the Social care and Continuing Health care individuals but are not aware of NHS England patients, and we have approached NHS England for this information and are inviting them to be part of the JKWWG. Liaison with the national project team co-ordinating the stocktake exercise confirmed that Transforming Care and the Concordat do not define either the patient groups or care locations precisely. It is also the case that the commitment to end care and support in inappropriate settings will result in a broadening of care locations where people with learning disabilities or autism who have mental health conditions or behaviours described as challenging will potentially be receiving care. The above given our initial local approach has been to take a broad and inclusive approach		

	to the identification of this patient group to ensure comprehensive capture of people.	
4.2 Are arrangements for review of people funded through specialist commissioning clear.	**4.2** Not currently clear but engaging within them to get clarification and to ensure they are included in the remit of the JKWWG.	
4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	**4.3** The Learning Disability Partnership Board, carers groups and Health Watch are aware of the requirements. Contracts are in place with Advocacy Providers and advocacy is available to individuals when needed. Formal arrangements are proposed – See 1.1 above	
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	**4.4** We understand numbers and needs of people with behaviour that challenges. We do not have a register in Kent and have no plans to develop this type of register.	
4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	**4.5** Each of the seven CCGs has a register of placements. These registers do not currently include NHS England commissioned secure LD placements or Local Authority or joint funded community placements. Chief operating officer in the CGGs and Care Managers are the first point of contact for each individual.	
4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	**4.6** Yes. Access to Advocacy is a requirement of CCG and NHSE contracts with providers and Kent have a countywide advocacy contract which is available to all residents in Kent.	 Advocacy monitoring Report Jan - Mar 201 4.6
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	**4.7** We have a CPA review process in place, that is multiagency. We also look at best practice case management. There has been no audit of the quality of reviews and there	

4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations	has not been any specific training on how to conduct a review within in-patient settings and this is a crucial for our local joint plan. **4.8** We do complete reviews but the quality is varied so we will be completing an audit of reviews and seeking to improve quality as a result.		
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed	**4.9** Each patient on the CCG LD registers has been reviewed within the required timeframe. Discussions are being held within the Area Team regarding carrying out reviews of patients in LD secure services.		
5. Safeguarding **5.1** Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	**5.1**. Kent has relatively few people placed outside Kent and these people have dedicated case managers allocated to them who review the placements regularly and are, where appropriate, engaged in the local safeguarding and mental capacity / DOLs Services in line with ADASS protocols		
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	**5.2** – a) On a strategic level much of the work around risk is being developed through the new Quality Assurance Group of the SVA Board – this is a joint Board with Medway. This group has been developed from a full governance review of the Board Strategic Commissioning have taken the lead on engaging with providers. In Kent there is a strong working relationship with providers , including Housing both on a local and strategic basis		

	Another key element in the local network are the local partnership groups		
5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	**5.3** We do have regular meetings at a strategic level with CQC and as a rule we are informed when inspections have taken place and have worked together on joint action plans. However, there have been difficulties in CQC sharing information even when there are safeguarding alerts raised. Furthermore there have been issues when CQC have made public some of their concerns – but have not shared this with FSC. These issues are being taken up through discussions with the regional manager.		
5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	**5.4** There are good links with the 2 Boards through workplans, membership and other working groups which sit outside the Board. A major conference was hosted by the safeguarding Board in March 2013, which 300 frontline staff and providers attended. The conference had major speakers including Prof Hilary Brown and Margaret Flynn who was the author of the Winterbourne SCR. Enclosed is the conference agenda and web link. A further area of work where the Winterbourne issues are considered across adults and children is the workings	5.4 Conference Programme Programme for Conference v2.doc Preventing institutional abuse Ke http://www.kent.gov.uk/adult_social_services/information_for_professionals/service_information/adult_protection/documen	

	of the LA Central Referral Unit. The CRU is a multi agency hub where allegations of abuse are assessed and evaluated across adults and children. The CRU have been used to ensure there is a strategic oversight of safeguarding activity across children and adults in units with similar functions to those which were attributed to Winterbourne View Hospital	ts_library/presentations.aspx
5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.	**5.5** There are agreed roles – across Kent and Medway led by the DOLS Office and monitored by the multi agency DOLS Board which is chaired by the Strategic Director. There is comprehensive training programme for staff in all agencies in respect of MCA / DOLS	5.5 Post Winterbourne Safeguarding Adults Conference  Delegate List.pdf
5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	**5.6** There are information protocols which support this across Kent which compliment each other and supported by all agencies. For example built in to the Kent and Medway Adult Safeguarding policies and procedures are comprehensive guidance on information sharing procedures , which are re-inforced in multi agency training. All health and social care staff in Kent are expected to attend safeguarding training	5.6 https://shareweb.kent.gov.uk/Documents/adult-Social-Services/adult-protection/adult-protection-policies-protocols-and-guidance.pdf
5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability	**5.7** Community Safety Partnerships are fully engaged in supporting people with learning disability – on the ground these partnerships	

living in less restrictive environments.	are being organised into multi-disciplinary hubs and are supportive of vulnerable people at risk of abuse. For example - Hate crime and Domestic violence initiatives offer support to people with Learning Disabilities		
5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	5.8. CQC have been invited to be part of the Board and have been involved in work such as SCR's On the ground there are good links between CQC and local managers. As already stated there are regular strategic meetings w CQC chaired by the Director of Strategic Commissioning. Formal working arrangements are in place and reviewed by the strategic group noted above.		
6. Commissioning arrangements			
6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	**6.1** Yes. Discussions have been held with providers with regard to patient needs and service specifications for community support. Discussions have also been held with the Local Authority about joint commissioning packages of support although no agreement has been reached on how this will be funded.		
6.2 Are these being jointly reviewed, developed and delivered.	**6.2** No. There is not yet agreement on how these commissioning requirements can be funded and no involvement from NHS England specialist commissioning, however through the work of the JKWWG we expect to address this.		
6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and	**6.3** Each agency has data on each placement they fund or contribute to. This data is not routinely shared across agencies and has not yet been shared or centralised to inform the		

those jointly supported by health and care services.	JKWWG.		
6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	**6.4** Yes, this will form the basis of the local commissioning strategy.		
6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	**6.5** No. There is no agreement on how the commissioning requirements can be funded and no involvement from NHS England specialist commissioning. This will come under the remit of the KJWWG		
6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	**6.6** Some work is ongoing to establish costs, however there is no agreement on how the commissioning requirements can be funded. This will come under the remit of the KJWWG		
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	**6.7** Yes. Advocacy support is sufficient for the number of people that would be involved.		
6.8 Is your local delivery plan in the process of being developed, resourced and agreed.	**6.8** Yes, however it is not yet clear how delivery of the commissioning requirements can be funded and no involvement from NHS England specialist commissioning. however through the work of the JKWWG we expect to address this.		
6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	**6.9** This will be challenging and we will report later in the year about reaching the target.		

6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).	**6.10** Kent has the correct governance in place to support the delivery of the plans. However there are risks in regards to the speed in which decisions will be taken, capacity of providers to develop services and the Financial issues if money does not follow patients from NHSE secure LD services back to the local health economy The access to confidential information could be a problem. As commissioners are no longer allowed to access patient confidential information for commissioning purposes – this could have implication on the programme		**6.10 support required**
7. Developing local teams and services			
7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	**7.1** Yes – Discussions have been held with providers with regard to patient needs and service specifications for community support. KJWWG has met and this is part of the action plan.	7.1 Discharge Planning Project Discharge Planning Project DivMT Report	
7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.	**7.2** Yes it is monitored via KCCs strategic commissioning unit and the contract is reviewed annually		
7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	**7.3** Yes there is a bank of best interest assessors across Kent if required. Practitioners within the integrated teams are also used to managing best interest decisions.		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies			
8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	**8.1** Yes, the proposal includes steps to avoid admission by improving local services and to develop and commission crisis responses. An intensive support service also forms part of		

	the commissioning strategy for children's services		
8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	**8.2** Yes. The commissioning proposal includes steps to avoid admission by improving local services and to develop and commission crisis responses. The proposal involves reinvesting in-patient expenditure on community based services in collaboration with Local Authorities.		
8.3 Do commissioning intentions include a workforce and skills assessment development.	**8.3** This has been considered but not detailed as it is not yet clear how delivery of all of the commissioning requirements can be funded, however it is crucial this happened so will be part of the action plan.		
9. Understanding the population who need/receive services			
9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges.	**9.1** Yes. We work proactively with providers to ensure there is support for people with behaviour that challenges. Sufficient supply is not always reliably available due to silting up of the better services. Our commissioning strategies would address this situation by increasing supply, developing a move-on culture and encouraging outreach from more specialist providers.		
9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	**9.2** Yes. A Person Centred approach is central to the planning of future care services.		

10. Children and adults – transition planning 10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults. 10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	**10.1** Yes. The Local Authority has a newly formed Strategic Commissioning Team which covers Adults and Children's Commissioning, and there are identified leads for transition planning. There are also a number of Forums where transition planning is discussed in regards to commissioning arrangements, including the Transition Steering Group, Disabled Children's Commissioning sub group, LD Commissioning Divisional Management Team meeting. **10.2** Yes, we have a Joint Children's Commissioning Board and we regularly review young people coming through transition. We will use existing governance arrangements to tighten the work up around this specific client group.		
11. Current and future market requirements and capacity **11.1** Is an assessment of local market capacity in progress. **11.2** Does this include an updated gap analysis. **11.3** Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.	**11.1** Yes. An assessment of the market is in progress. This is difficult to manage or predict because of the influence of into-area placements. **11.2** Yes. The assessment will look for any gaps in capacity for a variety of service types. **11.3** Yes. The holly Lodge Project is an example of local innovation and is being shared via networks and academic studies. The Kent Challenging Behaviour Network (www.kcbn.org.uk) is a network of LD commissioners and providers that works to improve services by sharing best practice.	11.3 Good Practice Project - Holly Lodge	

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

This document has been completed by

Name……Penny Southern, Director of Learning Disability and Mental Health

Organisation……Kent County Council

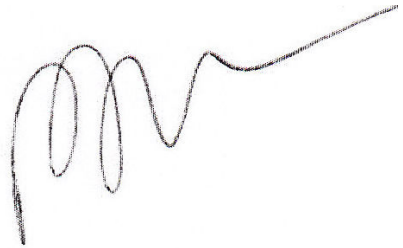
Contact……penny.southern@kent.gov.uk

Signed by:

Chair HWB - Rough Gough, Cabinet Member for Business Strategy, Performance & Health Reform

LA Chief Executive – Andrew Ireland KCC Corporate Director - Families and Social Care

CCG rep - Patricia Davies, Accountable Officer for Dartford Gravesham & Swanley



From Norman Lamb MP
Minister of State for Care and Support

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

To: Chairs, Health and Wellbeing Boards
Cc: Council Leaders and Chief Executives
Chairs and Chief Operating Officers, GGCs

Dear Colleague,

Delivery of the Winterbourne View Concordat and review commitments

I am writing to you at the start of your taking on your statutory functions to stress the pivotal local leadership role that Health and Wellbeing Boards can play in delivering the commitments made in the Winterbourne View Concordat[1] which represents a commitment by over 50 organisations across the sector – including the Local Government Association, NHS England, the NHS Confederation, Royal Colleges and third sector organisations – to reform how care is provided to people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. There is widespread agreement across the sector that the care of this group of vulnerable people requires fundamental change.

The abuse of people at Winterbourne View hospital was horrifying. For too long and in too many cases this group of people received poor quality and inappropriate care. We know there are examples of good practice. But we also know that too many people are ending up in hospital unnecessarily and they are staying there for too long.

NHS England, NHS Clinical Commissioners, the Local Government Association, the Association of Directors of Adult Social Services and the Association of Directors of Children's Services each committed to working collaboratively with CCGs and Local Authorities to achieve a number of objectives by 1 June 2014, including that from April 2013, health and care commissioners will set out:

> *"a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of children, young people and adults with challenging behaviour in their area.*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf.pdf

This could be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) process;

- *The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.*
- *We will promote and facilitate joint and collaborative commissioning by local authorities and CCGs to support these objectives.*

Health and wellbeing boards have an opportunity through their role in agreeing the CCG and Local Authority Joint Plans to challenge the level of ambition in the plan and ensure that the right clinical and managerial leadership and infrastructure is in place to deliver the co-produced plan.

Health and wellbeing boards will, no doubt, also want to take an active interest in how far the other commitments in the Concordat, particularly those relating to care reviews having been completed by June 2013, have been achieved, as well as satisfying themselves that commissioners are working across the health and social care system to provide care and support which does not require people to live in inappropriate institutional settings.

It will only be through creative local joint commissioning and pooled budgets working with people who use services, their families, advocacy organisations and carers and other stakeholders (including providers) that we will deliver more joined-up services from the NHS and local councils in the future and see real change for this very vulnerable group.

Health and wellbeing boards are well placed to agree when a pooled budget will be established (if not already) and how it will promote the delivery of integrated care – care that is coordinated and personalised around the needs of individuals; which is closer to home and which will lead to a dramatic reduction in the number of inpatient placements and the closure of some large in-patient settings.

The Department of Health has supported the establishment of an NHS England and Local Government Association-led Winterbourne View Joint Improvement Board. This Board will be working closely with a range of partners to develop and implement a sector-led improvement programme working with local health and social care communities to deliver real and lasting change in the support and

care for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. It will shortly be in touch with you separately to take stock of progress in your area so that any appropriate level of support can be arranged.

Due to the very public nature of these failures in care, I am sure that you will want to ensure that your health and wellbeing board is able to provide transparent public information and assurance on progress locally.

Further information about the work of the improvement programme, including a recently issued framework for conducting reviews of care locally, is available on the LGA website. If you have any innovative practice to share, or views on how the programme can be designed and developed to ensure rapid progress and real and lasting change, please contact the programme chair via Chris.Bull@local.gov.uk

Yours sincerely,

NORMAN LAMB

We hope to publish progress around the country in reaching the commitments made in the Concordat in the Summer.

Thanks so much for your work on this incredibly important issue!

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

Andrew Ireland, Corporate Director, Families and Social Care

To: Health and Wellbeing Board

Subject: Befriending Services

Classification: Unrestricted

Summary: This paper sets out a response to the research published by Campaign to End Loneliness in which Kent was awarded a Bronze status for its approach to reduce social isolation and loneliness.

The paper describes the prevalence of social isolation within Kent and the impact that it can have on individual physical and emotional health. It identifies the approach that Adult Social Care are taking to address social isolation across the county, namely through the development of a core offer of community based services, which includes befriending. The paper outlines the business case for investment in befriending both in terms of improved outcomes for the individuals receiving the support and in financial terms for health and social care.

Recommendation(s):

This paper is presented for information purposes only.

1. Introduction

1.1 This paper sets out a response to the research published on 19th June 2013 by the Campaign to End Loneliness which reviewed the early progress by health and wellbeing boards to tackle loneliness and social isolation.

1.2 Of the 128 strategies reviewed, 61 acknowledged loneliness and / or social isolation as a serious issue, with 8 reaching a gold standard. 53% had not recognised social isolation as an issue needing to be addressed.

1.3 The Kent Health and Wellbeing Board were awarded a Bronze award.

2. Financial Implications

2.1 During 2013-14 KCC Families and Social Care are already committed to investing £220k in befriending services. This existing provision is funded by locality budgets from Older People / Physical Disability teams and supports socially isolated individuals age 55 years and over. It has been accounted for in budgets for 2012-13.

2.2 The additional £380k investment is to ensure that services are more consistent across Kent and to expand the service to all socially isolated and vulnerable adults, not just those over 55 years. The additional investment is from health monies.

3. Bold Steps for Kent and Policy Framework

3.1 The additional investment in befriending services will support Bold Steps for Kent by:

- Helping the Kent economy grow: additional investment in the voluntary sector supports the future sustainability of this sector.
- Putting the citizen in control: socially isolated individuals are supported to build confidence and engage in socially meaningful relationships, giving them more control over their live and the opportunity to participate in their community. In addition, volunteering opportunities to befriend benefit individuals and support the development of Big Society.
- To tackle disadvantage: by supporting individuals to rejoin and participate in their communities, befriending prevents socially isolated individuals becoming disadvantaged and ostracised from daily life.

3.2 The investment in befriending services supports the Transformation of Adult Social Care Programme by avoiding the use of traditional services, such as domiciliary or residential care, to alleviate the emotional and physical symptoms of social isolation. It will enable individuals to remain in their own homes and communities, resulting in a shift of resources out of expensive long term care, making care home admission a last resort and supporting choice and control for the individual.

4. The Report

4.1 The impact and prevalence of social isolation / loneliness

4.1.1 A large body of psychological research has demonstrated a robust association between social isolation and worse health, including cardiovascular disease, increased morbidity, depression and cognitive decline.

4.1.2 One American study showed that loneliness is a predictor of hospital A&E use independent of chronic illness. It found a statistically significant correlation between loneliness score and total hospital emergency visits.

4.1.3 In Kent, it is estimated that across the present population aged 65 and over, between 5 and 16 per cent report loneliness, while 12 per cent feel socially isolated (SCIE briefing 30 Oct 2011)

4.1.4 That means of the people in Kent aged 65+ between 13,000 and 42,000 would say they were lonely and 31,000 would be feeling socially isolated (using Kent Census Data 2011).

4.1.5 We also know that 88,200 people in Kent over the age of 65 live on their own, which can be a proxy indicator for loneliness (Kent Facts and Figures 2010)

4.1.6 Early results from the 2011 Adult Social Care User Experience survey (893 people in Kent).

- 25% of respondents say they do not have enough social contact.

- 66% of these lived in the community
- 75% of those 65+ who are living in the community say they do not do anything they value or enjoy with their time.

4.1.7 Communication difficulties can lead to feelings of loneliness. For people with learning disability or autism a lack of social skills and inability to engage in social small talk can affect ability to connect with a community.

4.1.8 For people with sensory impairments feeling cut off from society is a reality shared with commissioners. RNID research found that people with hearing impairment are likely to withdraw from social activities which involve large groups of people and in situations where they do take part.

4.1.9 Additional RNID research has found that feelings of loneliness and in turn, frustration, can affect partners of people who are deaf (RNID, In It Together 2010 cited in Action on Hearing Loss 2011b). (Draft Kent Sensory Needs Assessment 2012)

4.2 Kent's approach to reducing social isolation / loneliness

4.2.1 Many other voluntary sector organisations funded by Adult Social Care, such as Age UK and Carers Support Organisations, combat social isolation by providing services such as day opportunities, befriending and peer support.

4.2.2 For example, KCC has invested £180k per year to ensure that there are Dementia Cafes and Peer Support Groups in every district, offering social opportunities for people living with dementia and their carers to meet other living with the disease and gain access to high quality advice and information.

4.2.3 A key strategic objective for Adult Social Care is to build community capacity. This will enable KCC to invest in a range of community services that tackle social isolation holistically, rather than relying on specific types of service working in isolation. We will build community capacity by investing in:

- Befriending
- Day opportunities
- Care navigators
- Improved access to community spaces and services

4.2.4 Development of 12 Dementia Friendly Communities and Intergenerational Projects across the county will reduce social isolation as communities become more 'friendly' and accessible to all vulnerable adults, not only those living with dementia.

4.3. The case for befriending

4.3.1 Befriending can result in wider societal benefits in building social capital and promoting self care. For the individual it can enable them to better self care as social relationships can lead to improvements in their emotional and

physical well being and in doing so promote and maintain good health and overall quality of life, self resilience and control.

4.3.2 Community Based Prevention Initiatives has been piloted and evaluated within the last 10 years through a range of programmes.

4.3.3 Kent Brighter Future Group (BFG) project evaluation report August 2009, of 60 users of BFG befriending services. The great majority (70%) felt the service had improved their lives and half felt it had made them feel much better. Around half also thought their health had improved as a result. About half felt it had made them more independent, for instance through learning how to deal with a fall.

4.3.4 The Partnerships for Older People (POPP) evaluation has shown that small services providing practical help and emotional support to older people can significantly affect their health and well-being, alongside more sizeable services expressly directed to avoiding their need for hospital. Most of the older people using POPP services had relatively high levels of need, but they nonetheless experienced improved outcomes and reported greater satisfaction than the comparison group, as a result of using these services (PSSRU1). Services might include befriending, care navigation, information and advice.

4.4 Social return on investment

4.4.1 The estimates of need and the findings on prevention of the Social Exclusion Unit show that :

- reducing age-specific dependency rates by 1 per cent per year would reduce public expenditure by £940m per year by 2031
- reducing the rate of institutionalisation by 1 per cent a year could save £3.8bn

4.4.2 POPP projects appeared to have the following outcomes:

- a significant effect on emergency bed days: an additional investment of £1 in POPP services would produce greater than £1 savings on emergency bed days.
- Overnight hospital stays reduced by 47%
- Use of A&E Departments reduced by 29%.
- There were also fewer physiotherapy/occupational therapy and clinic or outpatient appointments, with a cost reduction of £2166 per person.
- A 12% increase in health-related quality of life was found for those individuals receiving practical help.

4.4.3 Evaluation of Kent Invoke project showed that changes in service use by those in the POPP programme resulted in a cost reduction of £180 per person.

4.4.4. The Volunteering England website states that research evaluation in 12 small UK social welfare voluntary organisations showed returns of between £2 and £8 for each pound invested.

5. Conclusions

This paper summarises the investment that adult social care is making in befriending services in order to reduce the level of loneliness and social isolation amongst adults in Kent.

Social isolation can have a significant impact on the physical and emotional health of individuals, resulting in a poor quality of life for individuals, but also costly care packages for health and social care.

Befriending services can reduce social isolation resulting not only in improvements in the quality of life for individuals, but also financial savings to health and social care.

6. Recommendation(s)

Recommendation(s): This report is for information only

8. Contact details

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