AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 16th July, 2014, at 6.30 pm Ask for: **Ann Hunter**

Darent Room, Sessions House, County Hall, Maidstone Telephone **01622 694703**

Refreshments will be available 15 minutes before the start of the meeting

Membership

Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Mr A Bowles, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Cllr J Cunningham, Ms P Davies, Mr G K Gibbens, Mr E Howard-Jones, Mr S Inett, Mr A Ireland, Dr M Jones, Dr L Lunt, Dr N Kumta, Dr T Martin, Mr P J Oakford, Mr S Perks, Dr R Stewart and Cllr P Watkins

UNRESTRICTED ITEMS

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

1 **Chairman's Welcome**

2 **Apologies and Substitutes**

To receive apologies for absence and notification of any substitutes present

3 **Declarations of Interest by Members in Items on the Agenda for this Meeting**

In accordance with the Members' Code of Conduct, members of the board are requested to declare any interests at the start of the meeting. Members are reminded to specify the agenda item number to which it refers and the nature of the interest being declared

4 **Minutes of the Meeting held on 28 May 2014** (Pages 5 - 10)

To consider and approve the minutes as a correct record

5 **Dementia Care and Support in Kent** (Pages 11 - 24)

The Health and Wellbeing Board is asked to receive the report and agree the recommendations

6 **Kent Fire and Rescue Service - Presentation** (Pages 25 - 34)

The Health and Wellbeing Board is asked to receive a presentation from the Director of Operations – Kent Fire and Rescue Service

7 **Kent Health and Wellbeing Strategy - 2014-2017** (Pages 35 - 74)

The Kent Health and Wellbeing Board is asked to approve the revised Joint Health and Wellbeing Strategy for Kent

8 **Better Care Fund: National Review** (Pages 75 - 78)

The Kent Health and Wellbeing Board is asked to consider and comment on the report

9 **Potential Merger of Ashford Clinical Commissioning Group and Canterbury & Coastal Clinical Commissioning Group** (Pages 79 - 88)

The Health and Wellbeing Board is asked to note the intention to take a vote on merging the CCGs' membership in July 2014.

10 **Assurance Framework** (Pages 89 - 126)

The Health and Wellbeing Board is asked to consider a report on the Assurance Framework and agree the recommendations

11 **First HWBB Report of the JSNA/JHWS Steering Group for Kent** (Pages 127 - 130)

To note the report and comment on the future activity of the sub-group

12 **Date of Next Meeting** - 17 September 2014

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, 8 July 2014

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, 28 May 2014.

PRESENT: Mr R W Gough (Chairman), Dr B Bowes (Vice-Chairman), Ms H Carpenter, Mr P B Carter, CBE, Mr E Howard-Jones, Mr A Ireland, Dr L Lunt, Dr N Kumta, Dr T Martin, Mr P J Oakford (Substitute for Mrs J Whittle), Mr S Perks, Mr A Scott-Clark, Mr C P Smith and Cllr P Watkins

IN ATTENDANCE: Mr M Chrysostomou (Head of External Communications), Mr M Lemon (Strategic Business Adviser), Mr M Lobban (Director of Commissioning), Ms K Sharp (Head of Public Health Commissioning), Ms M Varshney (Consultant in Public Health) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

75. Chairman's Welcome
(Item 1)

(1) The chairman welcomed those present and obtained agreement that the Kent Health and Wellbeing Strategy Update and Engagement listed on the agenda as item 7 be brought forward and considered following consideration of the minutes of the meeting held on 26 March 2014.

(2) The chairman welcomed Mr Oakford to the meeting and advised the HWB that he would be taking over from Mrs Whittle with effect from 2 June 2014.

(3) The chairman said he had received a letter from the Martello Medical Practice, Dymchurch, seeking a view on the way forward for the practice following the retirement of the sole GP. The chairman said he had consulted with the relevant CCG, Healthwatch and others and would circulate his draft response to members of the HWB.

(4) The chairman said the Dr Abraham George and Mr Shakeel Mowla continued to develop integrated intelligence to aid the strategic commissioning process. They had already been in contact with some partner organisations and were suggesting that each local health and wellbeing board nominated a priority area. Further discussions would continue in June with a view to presenting a proposal to the HWB at its next meeting on 16 July 2014.

(5) The chairman said that, in addition to strong patient input, the Healthwatch Reference Group would welcome clinical input in its work overseeing the work of Healthwatch.

76. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Dr F Armstrong, Cllr A Bowles, Dr D Cocker, Mr G Gibbens, Dr M Jones, Mr S Inett and Mrs J Whittle. Cllr K Pugh, Mr C Smith and P Oakford attended as substitutes for Cllr A Bowles, Mr G Gibbens and Mrs J Whittle respectively.

77. Declarations of Interest by Members in Items on the Agenda for this Meeting
(Item 3)

There were no declarations of interest.

78. Minutes of the Meeting held on 26 March 2014
(Item 4)

Resolved that the minutes of the meeting of the Kent HWB held on 26 March 2014 are correctly recorded and that they be signed by the chairman.

79. Kent Health and Wellbeing Strategy Update and Engagement Plan
(Item 7)

(1) Marcus Chrysostomou (Head of External Communications), Malti Varshney (Consultant in Public Health) and Mark Lemon (Strategic Business Adviser) introduced the report which said the current Kent Health and Wellbeing Strategy had been agreed by the Shadow HWB on 30 January 2013 and that it was now due for renewal. A new strategy would be presented to the next meeting of the Kent HWB on 16 July 2014 and this would enable the final strategy to be endorsed in time to inform the next round of commissioning that would start in autumn 2014.

(2) Mrs Varshney said a workshop had been held with key stakeholders on 30 April and the key issues to emerge were: a need for strategic alignment across the system; the identification of priorities and their connection with outcomes; the need to be more specific about children's issues and a clear statement of the case for change. She drew the HWB's attention to the key points of the refreshed strategy which were: to provide a strategic platform for change across the system; a revision to the wording of Outcome 5 to reflect holistic support for people with dementia and the stronger connections between outcomes and priorities. She also said the strategy took into account the views of Kent residents about the changes they would expect such as: timely access to support; and improvements to professional communication. She also sought the views of the Board on whether to use national targets and benchmarking or to set stretch targets.

(3) The Kent HWB supported the approach outlined in the report and emphasised the need for this strategy to be a high-level strategic document that would inform the commissioning plans of partner organisations which, in turn, would include detailed targets. It was suggested that it was important: to make strong links with the Joint Strategic Needs Assessment; to be very explicit about the quality of outcomes for both existing services and for services that

would be integrated through Better Care Fund initiatives and to explain that different priorities might be identified at the local level. It was also suggested that a simplified version of the Health and Wellbeing Strategy be produced for residents and patients,

(4) Mr Chrysostomou outlined the plans for engagement with the public and stakeholders including publication of the strategy on-line, appropriate press releases, use of social media, simplifying the document and seeking feedback from the public on the accessibility of the document.

(5) It was recognised that this was a key opportunity to engage with residents and stakeholders about the future of health and social care and the intention to provide services around the user and closer to home.

(6) Resolved that:

(a) The first draft of the Kent Health and Wellbeing Strategy be taken to wider engagement and consultation;

(b) The proposal for communications and engagement and the associated key messages for all stakeholders be endorsed;

(c) The final draft version of the strategy be received at the next meeting of the HWB on 16 July 2014;

(d) Progress against the strategy be reviewed at a workshop to be convened c. June 2015;

(e) Reports from the local Health and Wellbeing Boards on how they were engaging local populations be received by December 2014.

80. Public Health Commissioning Plan
(Item 5)

(1) Andrew Scott-Clark (Interim Director of Public Health) and Karen Sharp (Head of Public Health Commissioning) introduced the report which set out the commissioning programme for public health in 2014/15 and asked the HWB to comment on the plan. They also gave a presentation which set out information about the context and legacy of public health, the transition of public health from the NHS to Kent County Council during 2013-2014 and priorities for future commissioning. They said the approach to be adopted for future commissioning was based on four key principles: working in partnership through a whole system approach; making the best use of the public health grant; effective communications with the public, workforces and targeted campaigns; and having evidence-based, locally flexible and targeted services with maximum integration.

(2) The HWB considered it important that: the commissioning plan made strong connections between inputs and outcomes; expenditure was properly evaluated and demonstrated clear changes in behaviour; programmes commissioned county-wide were delivered and integrated locally; the need to invest more in disadvantaged communities in order to bring about change be

recognised; and acknowledged that the local health and wellbeing boards had an important role to play in setting local priorities, facilitating conversations with local champions and integrating service delivery.

(3) Resolved that the Public Health commissioning intentions for 2014-15 be noted.

81. Children's Commissioning Plan
(Item 6)

(1) The chairman, in his introductory comments on the plan, said that at this stage the plan was a KCC focussed document as the levels of integration in children's services were not as well developed as those for adult social care. However he also thought it was important that the HWB viewed this as a first step towards fuller service integration.

(2) Mark Lobban (Director of Commissioning) introduced the report which presented the Children's Commissioning Plan. The purpose of the report was to present high-level information about the Children's Commissioning Plan as part of a review of commissioning plans being undertaken by the HWB. He referred to the overarching strategic document "Every Day Matters" which set out four key outcomes and strategic priorities for the Health, Social Care and Wellbeing Directorate and the Education and Young People's Directorate.

(3) Concerns were expressed that the Children's Commissioning Plan did not adequately define outcomes to enable commissioning to take place. Views were also expressed that: it was important to streamline services which were currently fragmented; work on the development of the Joint Strategic Needs Assessment in relation to children's services had been key to providing evidence of need; the establishment of task and finish groups to address concerns regarding mental health services for children and adolescents as well as discussions regarding the establishment of an integrated commissioning body and the establishment of a children's health and wellbeing board would all contribute to service transformation and integration.

(4) Resolved:

(a) That the Children's Commissioning Plan be noted

(b) That a report on the integrated commissioning of health, social care and children's services be consider at a future meeting of the HWB.

82. Accommodation Strategy - Presentation
(Item 8)

(1) Mark Lobban (Director of Commissioning) gave a presentation on the Accommodation Strategy which covered the rationale for having a strategy, an overview of the strategy, an analysis of the accommodation needs of older people and the next steps.

(2) Comments were made about the gap between the current position and the delivery of the strategy, the need to involve all members of the HWB in any launch to the market and in efforts to communicate planned changes in service provision to the public as well as the implications for quantitative and qualitative provision of nursing in the community and in care homes.

(3) Resolved that the proposed Accommodation Strategy be endorsed.

83. Assurance Framework
(Item 9)

(1) Malti Varshney (Consultant in Public Health) introduced the report which provided a summary of the assurance framework indicators where concerns or improving performance had been noted and asked the HWB to make decisions on the points raised in section 3.

(2) Resolved that:

(a) The establishment of a multi-agency group responsible for proposing and reviewing targets and where analysis of the data and context can be discussed at monthly meetings be endorsed;

(b) The proposed set of stress indicators for children's services including CAMHS and SEN be endorsed for inclusion in Section 6 - Stress Indicators;

(c) The alternative metrics for Outcome 5 (people with dementia are assessed and treated earlier) be endorsed;

(d) CCG members discuss with their constituent members the importance of complete data collation and timely submissions of infant feeding continuation statistics;

(e) Assurance be sought from Public Health England/ NHS England about plans to improve the uptake of flu vaccinations in 2014/15.

(f) The availability of reports in July 2014 for local Health and Wellbeing Boards, with indicators at a lower geographical area, be noted;

(g) The discussions within the Social Care, Health and Wellbeing Directorate to ensure the most relevant and appropriate metrics are being used be noted and that indicators associated with and from the ASCOF might be subject to amendment;

(h) In accordance with the HWB's previous recommendations, the inclusion of new metrics on excess weight in children and adults, and physically active adults in Outcomes 1 and 2 be noted;

(i) The addition of statistics for Medway Foundation Trust to indicators 6.8 and 6.9 surrounding bed occupancy rates and A&E attendances due to the identification of Swale residents accessing Medway Hospital be noted.

84. Date of Next Meeting - 16 July 2014
(Item 10)

By:	Sue Gratton, Associate Partner, KMCS (working on behalf of CCGs) Emma Hanson, Head of Strategic Commissioning, KCC
To:	Kent Health and Wellbeing Board,
Subject:	Dementia care and support in Kent
Classification:	Unrestricted

Recommendations:

That Dementia is viewed as a long term condition with primary care taking an active role to promote timely diagnosis and the coordination of integrated care. Improving Dementia support is an integral element of Kent's Pioneer Programme.

The Health and Well Being Board notes the progress and endorses the continuation of work to reduce the stigma of a diagnosis of dementia and continues to increase support available to people affected by dementia, so people feel able to come forward to seek a diagnosis and when doing so can be well supported through the process.

That the Kent Health and Well Being Board supports the ***Dementia Call to Action*** and ensures that CCGs and local authorities, working with their partners and local communities, fulfil the ambition that 67% of people with dementia have a diagnosis and access to appropriate post-diagnosis support by 2015.

The Health and Well Being Board tasks Kent's carers' organisations together with KCC and the CCGs to review their plans in the light of the recently published ***Call to Action for Carers*** of people with Dementia to understand where further improvements can be made.

The Health and Well Being Board recommends a full review of the acute pathway and supports the development of different models of care with increased skills and breadth of services in the private and voluntary sector in order to avoid unnecessary admission and support timely discharges.

The Health and Well Being Board makes sure that there is a recognised formal link between the Kent Health and Well Being Board and the Kent Dementia Action Alliance and that this is replicated by local HWWBs and their local DAAs, so that the contribution of the wider partnership to improve support to people with dementia and their carers can be acknowledged.

Executive Summary

The aim of Kent's Health and Wellbeing Strategy is to support people to live well with dementia. It is known that the majority of people with dementia wish to live within their own home in their community for as long as possible; that they wish to be treated with dignity and respect and value the care and support they receive from their families and

carers most highly. It is important that partner agencies recognise this and work together to ensure this is achieved.

This report provides an overview of the wide range of initiatives which are currently underway across Kent to help improve access to a timely diagnosis of dementia and to ensure that people affected by dementia, both patients and carers, are supported to live well with dementia and avoid unnecessary crisis events.

It is known that the number of people living with dementia is set to increase as the population lives longer. The average diagnosis rate in Kent is currently at 42% and is below the national average of 48%. A number of projects are aimed at increasing awareness (of both staff and patients / carers) of the benefits of the support available, reducing stigma attached to dementia and making it easier to get a diagnosis, with the expectation that over time this will increase diagnosis rates. The national ambition is to reach 67% diagnosis rate by April 2015, however a number of CCGs in Kent have set lower targets in recognition of the difficulties in reaching this target.

The report highlights combined efforts across the health, social care, private and voluntary sector to increase the range of support available, including raising awareness and reducing stigma, more support for carers, assistive technology and improved care in the community, care homes and the hospitals in Kent.

The work on risk stratification and integration of care will bring benefits for people with dementia as increasingly dementia will be seen and treated alongside other long term conditions.

The implementation of the Care Act will positively impact on the range and type of services available to support people living with Dementia. The act ensures there is a renewed focus on wellbeing and prevention, it requires local authorities to ensure the provision or arrangement of services, facilities or resources to help prevent, delay or reduce the development of needs for care and support. This prevention duty extends to all people in a local authority's area, including carers, regardless of whether they have needs for care and support, or whether someone has had a needs or carer's assessment.

1. Introduction

This report gives an update on the progress that has been made with improving dementia care in Kent since the Prime Minister's Challenge which was published in March 2012. The Shadow Health and Well Being Board last had an update regarding Dementia on 30 May 2012.

Key aims of national and local policy have focused on the following areas:

- Increasing awareness of dementia, reducing stigma and fear of dementia; Dementia Friends and Dementia Friendly Communities are important initiatives contributing to this aim.
- Supporting people to live well with their diagnosis through the provision of good quality and timely advice, information and advocacy and a range of supportive community based services such as peer support groups and dementia cafes.
- Improving diagnosis rates, the national average is currently 48% and Kent is 42% against a national ambition to reach 67% by March 2015.
- Supporting people to live well with their dementia both in the community and in care homes, it is estimated that two thirds of the residents in care homes

will have dementia, but two thirds of people with dementia live in their own homes.

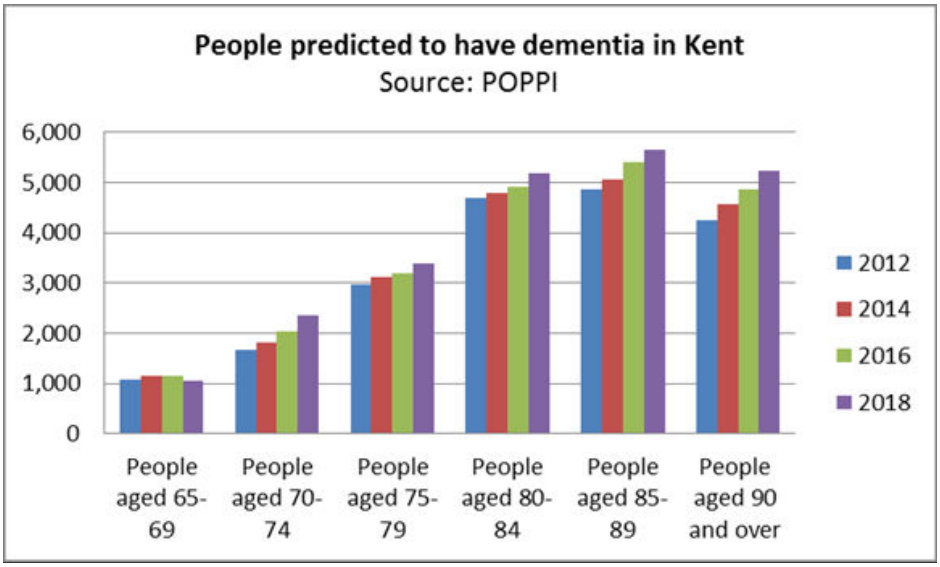
- Improving acute hospital care where it is estimated that up to 25% of acute adult beds will be occupied by patients with dementia, who are more likely to stay in hospital longer and have poorer outcomes than people without dementia.
- Support for carers. There are around 550,000 carers of people with dementia in England. The Dementia Action Alliance launched a Call for Action for carers of people with dementia on 20th November 2013.
- Improved End of Life care to ensure that people are well supported through end of life and that their wishes are respected.

2. Joint Needs Assessment

The population of Kent and Medway is aging and there will be a significant increase in the older population. As the population ages more people will be living with long term conditions, such as diabetes and COPD, which may affect quality of life leading to more health and social care services required to meet the increase in need. These long term conditions will be concomitant with dementia therefore it is crucial that dementia needs are considered as part of the long term conditions agenda and not seen as separate.

Projections from the Office of National Statistics predict dramatic increases in the elderly population over the next 15 years. By 2026 Kent will have significant rises in its population of over 85 year olds, but will see a slightly bigger rise in its 65-84 year olds then the national average. Overall, the population in Kent is growing at a slightly slower rate than the England average but is aging. The expected number of elderly people >65 yrs and over with a limiting long term illness is expected to increase from 120,000 in 2012 to 145,000 in 2020.

Over 19,500 people aged over 65 are estimated to have dementia in Kent. By 2020 it is predicted that this figure will increase to 24,314 with over 5,000 people being over the age of 90 (Information taken from PANSI = Projecting adult needs and service information, POPPI = Projecting older people population information system).



3. Increasing Awareness – Dementia Friendly Communities

A number of initiatives are underway to increase awareness in the community about dementia and to reduce the stigma associated with dementia. Dementia is still one of the most feared diagnoses and consequently people do not seek help early enough. As awareness increases of the support available to it is hoped that people will be encouraged to seek help and thus prevent a crisis event from occurring.

To raise awareness, the second year of a programme to support Kent to become more Dementia Friendly has started. This programme focuses on improving the quality of life for people living with dementia along with their family, friends, and carers. Awareness and understanding are key elements of the work; to this end Dementia Champions are trained to deliver Dementia Friends training. There are over 40 Dementia Champions in Kent who have delivered training and recruited over 1,000 Friends with the numbers growing weekly. We will continue to recruit champions and train friends.

Another element of this approach to develop Kent to be more Dementia Friendly has been the establishment of a Kent Dementia Action Alliance. The Alliance is a collection of stakeholders brought together to improve the lives of people with dementia in their area. It includes local authorities, CCGs, Acute Trusts, Fire and Rescue services, charities, community groups, businesses, care providers, and people living with dementia and their carers. The purpose of the Alliance is to transform the quality of life of people with dementia and their carers within Kent through promoting the National Dementia Declaration and delivering on the Action Plans submitted by Alliance members and informing commissioning decisions and development of services for people with dementia and their carers

The Action Alliance provides the structure for Kent to work towards becoming recognised as a dementia friendly community and is intended to be self-supporting, working for local people with dementia and their carers with all members being equal partners and is able to work with Health and Well Being Boards in delivering Kent strategies for people with dementia and their carers.

Recommendation: Kent Health and Well-Being Board encourages their constituent organisations to consult with their local Alliances on issues relating to dementia and that local Health and Well Being Boards are encouraged to make formal links with their local Dementia Action Alliance.

Intergenerational Work - Copies of the Dementia Diary which has been developed from young people's stories are now available to purchase and provide friendly way to share experiences and prompt discussion. The Diary has been available to all schools across Kent and work is underway to influence learning in schools and community settings so that future generations are better informed and aware about dementia, at the same time developing the workforce of the future. The ultimate goal is to develop a resource that is flexible for different learning environments that meets the requirements of the teacher/ educator but also in a format that meets the needs and aspirations of the people who are learning.

4. Diagnosis Rates

4.1 Diagnosis Rate Headlines

	2010/11	2011/12	2012/13
Swale	39.19%	42.67%	44.92%
Dartford Gravesham & Swanley	43.44%	43.83%	44.17%
Canterbury	40.51%	39.21%	43.09%
Ashford	36.08%	41.13%	43.02%
West Kent	39.08%	40.05%	42.57%
South Kent Coast	37.86%	37.26%	38.65%
Thanet	34.60%	32.99%	34.56%

The table above shows the variation in diagnosis rates across Kent. The dementia diagnosis rates are based on those taken from the National Dementia Tool V3.

For each practice and then by CCG, the diagnosis rate is based on those patients registered on GP QOF registers (Quality Outcome Framework registers) as having dementia set against the expected number of patients with dementia by practice and CCG according to the Alzheimer's Society figures. Those estimates are then enhanced by adding in patient numbers in care homes, as by default more people in care homes tend to have dementia than in the community. GP practices can then register with the tool to update their practice list size and numbers of patients in care homes, although few practices have chosen to do this to date. This process helps refine the tool to give a more accurate picture of the dementia diagnosis rates.

In 2012/13 (most recent data available) the national average dementia diagnosis rate in England was **48.44%** - all Kent CCGs are below this average. In the South of England for the same period the rate was **45.52%** and in Kent **41.51%**.

Within Kent the figures range from Thanet at **34.56%** to Swale at **44.92%.**

Across the South of England the diagnosis rate average went up by 3.8% compared to an increase in Kent of 2.89%.

Locally, the most notable increases over the last three years by CCG were Swale at 5.7%, Canterbury at 2.6% and Ashford at 6.9%.

Thus although there is still much to do to improve diagnosis rates there has been a general increase across Kent.

4.2 Diagnosis Action Plans

The ***Dementia Call to Action*** requests support from CCGs and local authorities, working with their partners and local communities, to fulfil the ambition that 67% of people with dementia have a diagnosis and access to appropriate post-diagnosis support by 2015. Across Kent there is local variation in diagnosis rates, as can be seen from above, and the CCGs have set differing ambition rates in recognition of their starting point. Most CCGs have chosen to set a lower ambition rate to achieve in 2015, with action plans to strive towards the national ambition rates in subsequent years.

There has been a significant increase in the number of referrals to memory services over the past three years as detailed in the table below which are in line with various initiatives which have been introduced to increase diagnosis rates, e.g. the National Dementia Cquin implemented by acute trusts to identify people who may have dementia and the Direct Enhanced Scheme operated by GPs to screen patients who may be at higher risk of developing dementia. However, GP dementia registers in Kent do not appear to have increased at the same rate of increase in referrals to memory services. A widely held belief is that people are being referred earlier when it is more difficult to reach a conclusive diagnosis of dementia and more people are being diagnosed with Mild Cognitive Impairment, many of whom will go on to develop dementia. If this is the case then dementia diagnosis rates in Kent should rise in the next few years. Further data is being collected to see if this assumption is correct.

It is acknowledged that the benefits of a timely, high quality diagnosis of dementia for the person, their families and carers are compelling and that diagnosis is not an end in itself, but a gateway to making informed personal life choices. Through our Dementia Friendly Communities work people have reported that once they have a diagnosis they found it much easier to access services, once they "were in" the support was good.

The integration of health and social care provides an opportunity for a joint approach to coordinate the interventions required to build the resilience of people with dementia and their carers in the community and achieving an early diagnosis is critical to this programme so that crises are avoided and active care planning is in place. The majority of CCGs in Kent have produced action plans to improve the diagnosis rate and are also working with Kent and Medway Partnership Trust (KMPT) who have aligned Mental Health Nurses to support GPs in identifying people with cognitive impairment.

Bespoke Clinical Training Programme has been developed by local KMPT Consultants to support GPs with the overall management of people with dementia and this is being rolled out across Kent throughout the summer.

GP Checklist has been designed by Kent County Council's Social Innovation Lab for Kent (SILK) in partnership with patients and carers. The idea for a checklist came as a response to the conversations had with people living with dementia and carers who said they found it difficult getting a diagnosis. Many people described how they had to visit their GP on a few occasions before getting referred to the Memory Clinic for further investigation. It was often described as a 'battle'. The checklist aims to give patients support in asking the right questions when they approach their GP with concerns about their memory. It is planned to roll this out across Kent.

Cantabmobile Dementia Screening Tool (a screening App used on an IPad) has been piloted by 18 practices across Kent. These practices have screened 1,063 patients from July 2013 to June 2014 and found 366 patients testing 'red' which means they were very likely to have dementia and required further assessment, usually by referral to a memory clinic.

This equates to 34% of the people tested identified as likely to have dementia against an expected rate of 20% for the tool nationally, which is primarily due to the fact most practices are pre-screening patients and only testing those most suitable.

This rate has been exceeded by Bridge Health Centre with a rate of 46%, West Gate in Thanet with 53% and East Cliff, also in Thanet with 52%.

Since the start of the pilot and up until May 2014, the practices taking part in the pilot have seen increases in their diagnosis rates, ranging from less than 1% up to 12%.

Not all practices' data is available and further information will be provided in the evaluation due in September 2014.

5. Supporting people to live well with dementia

5.1 In the Community:

Following a diagnosis of dementia it is critical that there is access to high quality advice and information and a range of care and support services.

Community Capacity Building Programme – KCC is redesigning its community and voluntary sector services to ensure that there is a sustainable model fit for the future the objective of which is to support the transformation of adult social care and ensure the council is able to respond fully to the requirement of the Care Act. KCC recognises that a different approach is needed if we are to succeed in a context of increasing demand, rising public expectations and less funding. Along with other measures this means adopting an asset based approach which empowers individuals, families/carers and communities to meet their own needs outside of a social care model of support.

The community capacity building programme will require the decommissioning and recommissioning of current voluntary sector services to deliver a consistent menu or 'core offers' of services. All services need to support independence, resilience, self-care and wellbeing, diverting people away from formal social care systems and providing an alternative to, or supplementing, traditional care packages.

Services will be generic where possible and specialist where proven necessary, commissioners are looking to ensure that the specialist dementia elements are identified and commissioned consistently as there is local variation about the type of services on offer. The programme will be built on the principles of self-care and self-management, it is intrinsic to our Integration Pioneer Programme and KCC is working to secure joint investment with Public Health and Kent Clinical Commissioning Groups.

New Home Care Contracts – KCC has commissioned new Home Care Contracts and in doing so has rationalised the market from 130 plus contracted providers to 23. Through this commissioning strategy KCC will be able to work much closer with providers to ensure services are flexible and responsive, and are of the highest quality possible and designed to support independence and recovery.

Post Diagnostic Support – KMPT offer a range of clinical post diagnostic support to both the patient and carer as part of the Memory Assessment Service. At the end of this course people are signposted to the support provided by the voluntary sector, described below.

Dementia Cafes and Peer Support Groups – KCC commissions a range of organisations in the voluntary sector to provide proactive peer support for people with dementia. There is a Cafe and Peer Support Group in every local authority district in Kent. These groups provide the opportunity for people with dementia and their families/carers to meet, share experiences, gain support and access to a range of health professionals. They can also obtain information and support about services and support available to them.

Dementia Helpline – The Kent 24hr Dementia Helpline takes calls for a wide variety of reasons to offer advice, information and guidance for people living in Kent whose lives have been touched by dementia. They help people with emotional support and practical advice including access to local services and support. The helpline supports on average 80 people per month.

A new Web Platform 'Dementia Friendly Kent' is currently being developed in collaboration with people with dementia and their carers it will play a crucial role supporting and signposting people to Living Well with Dementia in Kent. The platform will also be where all dementia friendly Kent projects and resources will be available for reference and will enable different local Dementia Action Alliances to share information and ideas.

Kent Community Healthcare Trust (KCHT) has employed three dementia support nurses to deliver training to all staff. The training package which they developed received accreditation from within the organisation. Environmental assessments were also undertaken in community hospitals and action plans were developed to implement the changes. The Butterfly Scheme, a nationally recognised scheme for supporting people with dementia, was also introduced into the community hospitals.

Shared Lives - West Kent is a pilot site to test out the use of 'Shared Lives' for people with dementia. Shared Lives was formerly called the Adult Placement Scheme and it was predominantly used for adults with learning disabilities. Shared Lives host families are recruited to offer either long or short term placements to people with dementia as a viable alternative to care home placements. We are in the second year of the project which is being evaluated and later in the year decisions will be made about its long term future.

Assistive Technology - For people eligible for support from social care, telecare options are considered as part of their care plan to enable them to continue to live at home. KCC plans to double the number of people benefiting from telecare by April 2015. More complex telecare solutions will be used, including things like GPS tracking and systems like "Just Checking" which can inform assessments and improve the design of community based care packages. There is an evolving role for digital technologies to support people to connect with their families and communities. Commissioners need to understand how these kinds of technologies should be built into care pathways.

5.2 In Care Homes and Other Support Accommodation:

Accommodation Strategy for Adult Social Care identifies how the provision, demand and aspiration for housing, care and support services will be met for adult social care clients should they need to move to access care. People with dementia should live independently in their own home receiving the right care and support. However, if that option is no longer suitable, the right accommodation solutions have to be in the right places across the county, and they have to be the right type, tenure and size.

KCC is working with Housing and Care Home Providers and developers to consider and incorporate Dementia Friendly designs into new build and remodelled accommodation for older people. As well as working with providers to make sure their model of care is future proofed and accommodates people at different stages of the disease, ensuring there are flexible dementia focused services in appropriate settings.

Design standards for Housing for Older People that include Dementia Friendly Designs are contained within the KCC Accommodation Strategy.

Challenging Behaviour Service - The aim of this project was to develop and implement a model of care for complex behaviour in care homes, which would increase quality of life and reduce distress, reduce the prescribing of anti-psychotic medication and prevent unnecessary admissions and transfers of residents displaying complex

behaviour to alternative care settings. Work is in progress between KMPT and KCHT to develop this support further through the Enhanced Rapid Response Team

Excellence in Kent - This programme of training was delivered by Bradford University and the main aim was to improve care staff knowledge and skills in person centred care.

The programme consisted of four elements:

- Person centred dementia training.
- Leadership training.
- Dementia care mapping (DCM).
- Advocacy training

Some of the developments and improvements from the programme included:

- The introduction of doll therapy.
- Use of life stories.
- Environmental changes, including the establishment of a garden.
- Improved quality of care plans.

Twelve care facilities took part in the first programme with a further ten benefitting from the second cohort.

Geriatrician Outreach – A variety of schemes have been introduced in different areas providing Geriatrician outreach support to care homes, frequently involving joint visits between the GP and consultant. This enhances the knowledge and advice provided to the Care Home, reduces the need to see patients in hospital settings, supports medication reviews and encourages the development of anticipatory care plans.

6. Acute Hospital Care

All acute trusts in Kent (and Medway) received funding to deliver three projects:

- A training programme for all staff.
- Environmental changes.
- A buddy scheme (also called befriending or dementia visitor scheme) to support people with dementia

The trusts have established training programmes for all staff. A range of environmental changes have also been made which include changes to signage, introduction of large clocks, introduction of red trays and beaker lids, development of a specially designed café area for people with dementia and their carers.

All Acute Trusts now have a scheme in place with various voluntary sector providers. The scheme provides trained volunteers to support patients with dementia in a range of social activities whilst they are in hospital, with the aim of reducing their confusion and improving their patient experience.

The projects are in the progress of being formally evaluated by Greenwich University. However, the trend in reducing the length of stay for people with dementia in acute hospitals would indicate that these initiatives have made a positive contribution.

7. Support for Carers

7.1 Carers Assessment and Support

Carers Assessment and a range of support services have been jointly commissioned by KCC and all CCGs since April 2013. This has seen an increased investment in the support available to carers. A key element of the new contract is the identification of new carers in 2013/14; 3563 new carers were identified and supported. 1070 carers received a full statutory carers' assessment, a KCC responsibility that was delegated to the carers' organisation via this contract.

Another element of this new contract, a rapid response service, has been provided to GP practices for patients whose caring role is placing their health at risk and are identified as in urgent need of support. The carers' organisations have access to budget to provide support tailored to the individual's needs. This service has proved difficult to establish but there are some excellent examples of where this has helped to prevent carer breakdown. This is being reviewed to ensure the support offered to carers at times of additional stress, e.g. discharge from hospital of either the "cared for" or the carer.

7.2 Carers' Short Breaks and Crisis Support

KCC has a range of agreements to provide shortbreak support for carers, through these agreements approximately 1,200 carers receive support with on average a carer receiving a weekly 3 hour sitting service to allow them to take a break from their role. Through these contracts the largest provider Crossroads delivers over 180,000 hours of care per year.

However, agreements were historic and long waiting lists had developed. KCC secured additional carers' shortbreaks services with three desired outcomes:

1 Planned shortbreaks or sitting service
2 Support for carers to look after their own health and be able to attend medical appointments
3 Carers Crisis or emergency support

The new contract was awarded to Crossroads and put in place in November 2013. By the end of April there had been 3842 episodes of care delivered totalling an additional 31,323 hours of service delivered.

National Dementia Action Alliance 'Carers Call to Action' - recommends that carers of people living with Dementia:

- have recognition of their unique experience - 'given the character of the illness, people with dementia deserve and need special consideration... that meet their and their caregivers needs' (World Alzheimer Report 2013 Journey of Caring)
- are recognised as essential partners in care - valuing their knowledge and the support they provide to enable the person with dementia to live well
- have access to expertise in dementia care for personalised information, advice, support and co-ordination of care for the person with dementia
- have assessments and support to identify the on-going and changing needs to maintain their own health and well-being
- have confidence that they are able to access good quality care, support and respite services that are flexible, culturally appropriate, timely and provided by skilled staff for both the carer and the person for whom they care

Recommendation: Kent's carer's organisations together with KCC and the CCGs review their plans in the light of the recently published ***Call for Action for Carers*** of people with dementia to see where further improvements can be made.

KCC is leading the work with multi-agency partners necessary to refresh the Kent Carer's Strategy for anticipated publication in March 2015.

8. End of Life

CCGs are working on a range of initiatives to improve the quality of care through end of life to ensure that the person's wishes are respected and can be supported to die in their place of choice. Training for primary care staff and care homes, sharing records and encouraging anticipatory care plans are among the initiatives.

9. Next Steps

9.1 Integrated Care

Kent is one of 14 sites in England selected by the Department of Health to lead on the integration of care at pace and scale, with a focus on breaking barriers to the delivery of co-ordinated care. The needs of people living with dementia will be better met through some of the shared ambitions which will deliver better co-ordinated care.

All CCGs have contracted to develop integrated care pathways for people with dementia and to develop integrated care plans including plans to avert crisis admissions.

9.2 Commissioning of Integrated Care Using Risk Stratification

Apart from identifying patients at high risk of rehospitalisation, risk stratification should be used to help understand how patients with multiple morbidities impact on use of all health and social care services (including those for dementia). This will in turn transform commissioning and contracting of these services using new payment mechanisms and tariffs that will incentivise proactive, preventative integrated care and empower to self-care and self management. Kent is already an Early Implementer Site for the National Year of Care programme which is expected to develop and test a new system over the next 2 to 3 years.

9.3 Commissioning for Quality

A major focus for KCC and CCGs will be the quality of care delivered by providers to ensure that people receive good person centred care that treats them with dignity and respect. We will work together to ensure that vulnerable adults are protected from harm and that there is clear accountability, roles and responsibilities for helping and protecting those at risk of or who are experiencing abuse or neglect. This will include ensuring understanding and use of the Mental Capacity Act is promoted across Kent.

9.4 Increasing Community Capacity and Self-Management

The Dementia Friendly Communities Programme sits within the strategic commissioning unit of KCC and is part of the wider Building Community Capacity Programme. It is aimed to continue to build upon the work of the Dementia Friendly Communities to nurture and maximise the natural support that exists in local communities in order that people affected by dementia can be well supported. The Dementia friendly communities programme will influence and inform the wider community capacity building programme and ensure that the right menu or core offer

of services are commissioned to support individual and family/carers resilience and enable people to live well with dementia.

9.5 Continuing to Improve Diagnosis Rates

Work should continue to reduce the stigma of a diagnosis of dementia and continue to increase support available to people affected by dementia so people feel able to come forward to seek a diagnosis and when doing so can be well supported through the process. The relationship between rate of referrals to memory assessment services and the lower rate of increase of dementia diagnosis rates needs to be further investigated and understood so that future plans can be informed.

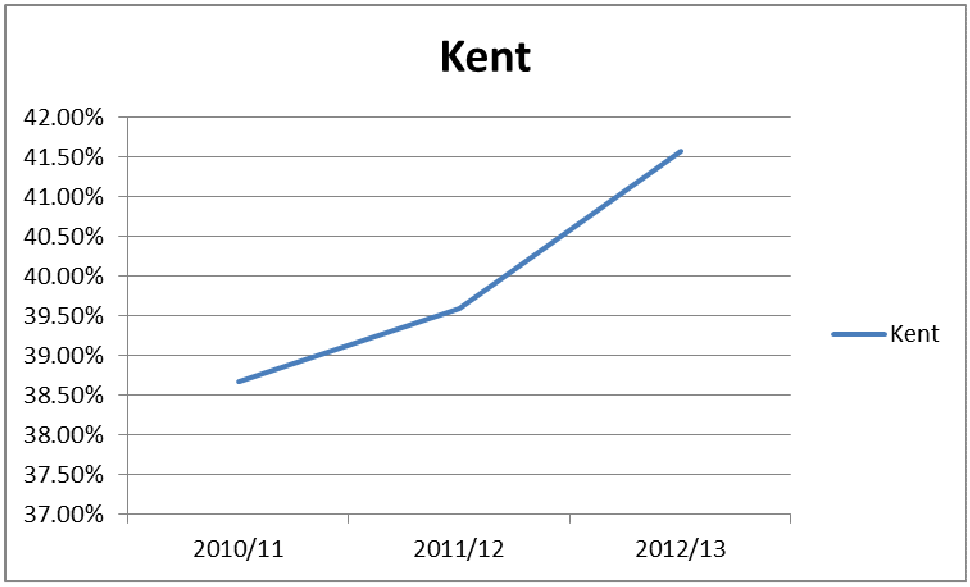
10 Conclusion

This report shows the breadth of work being undertaken across Kent to improve access to a timely diagnosis and a range of good support in all care settings. There is still more work to be done but an excellent foundation has been established upon which to build further improvements in order to achieve the vision for the future:

Vision for the Future

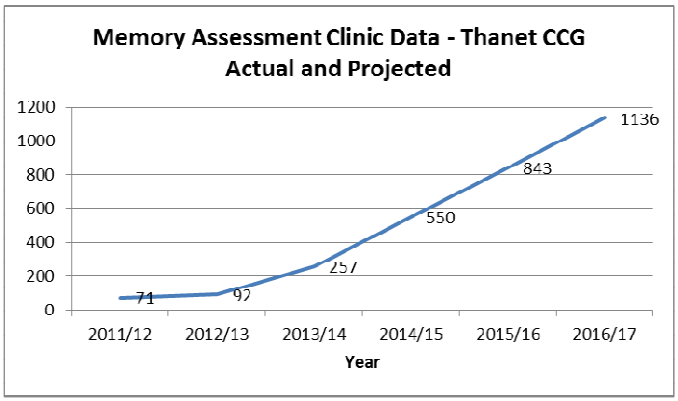
The vision for dementia care in Kent is one where people receive a timely diagnosis so they can be well supported and enabled to make plans for their future and can continue to live well in their local community for as long as possible. It is also one where dementia is seen as a long term condition and managed effectively in primary care alongside people's other conditions through integrated care with access to specialist help and advice as appropriate.

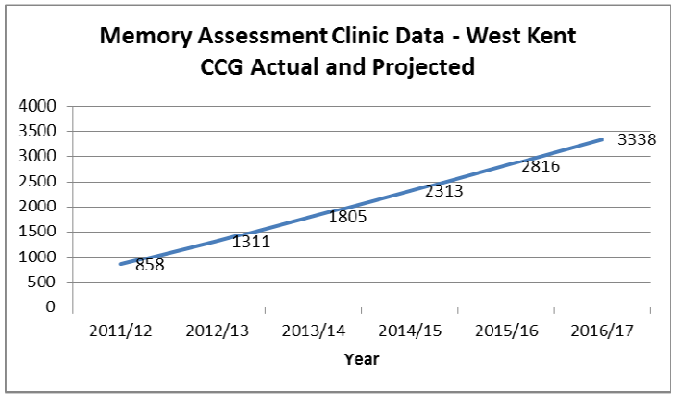
Appendix 1 Trends in diagnosis rates across Kent

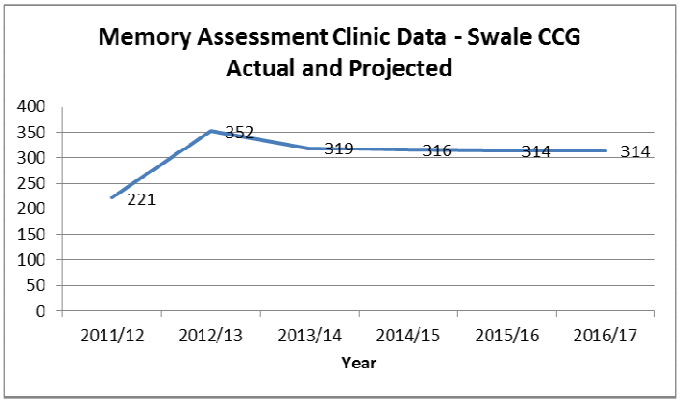


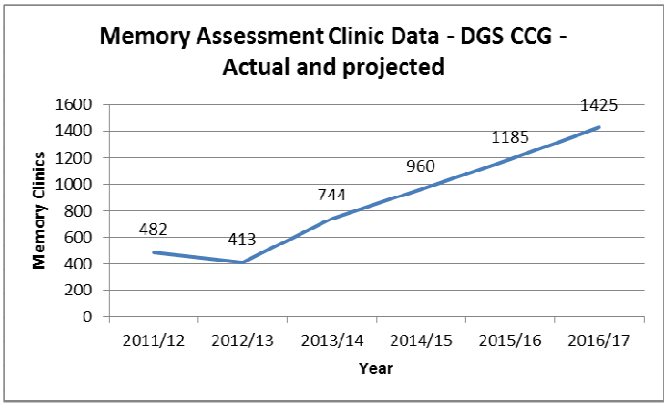
This shows a 2.89% increase in diagnosis rates over 3 years.

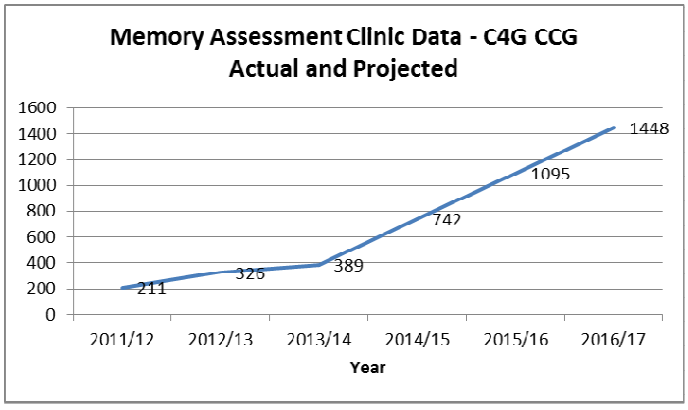
Appendix 2 Trends in referrals to memory assessment services

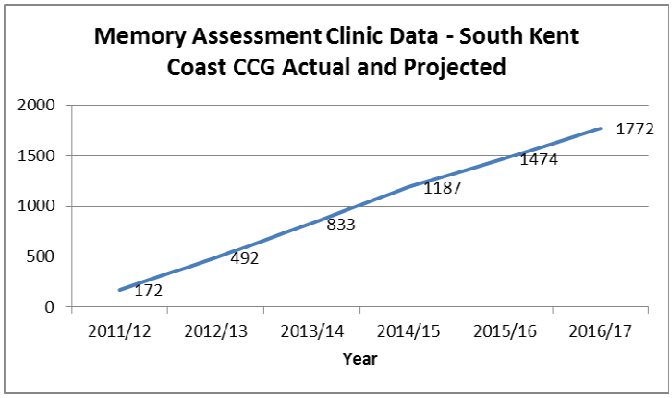


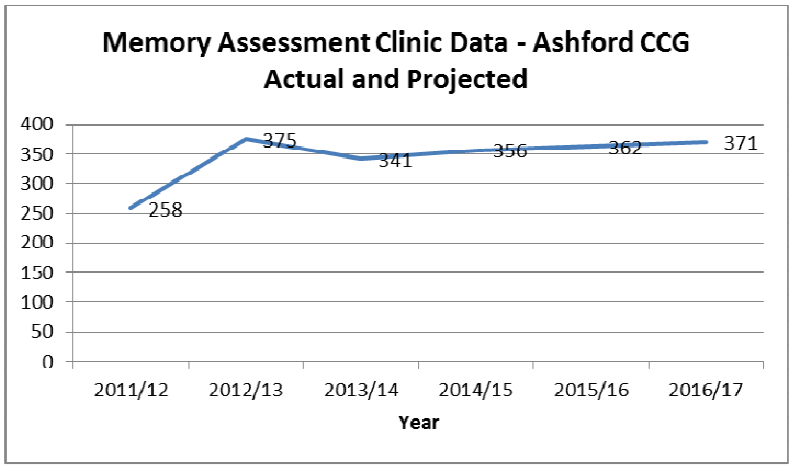












How Kent Fire & Rescue Service adds value to the Health & Wellbeing of Kent

Sean Bone-Knell

Director Operations

Kent Fire & Rescue Service

The Missing link

Common feedback

- Great idea but…
- I can really see how this could work…
- We must look into this…
- I had never thought Fire could do this…
- We must talk about how we can work together…
- Silence

What we do

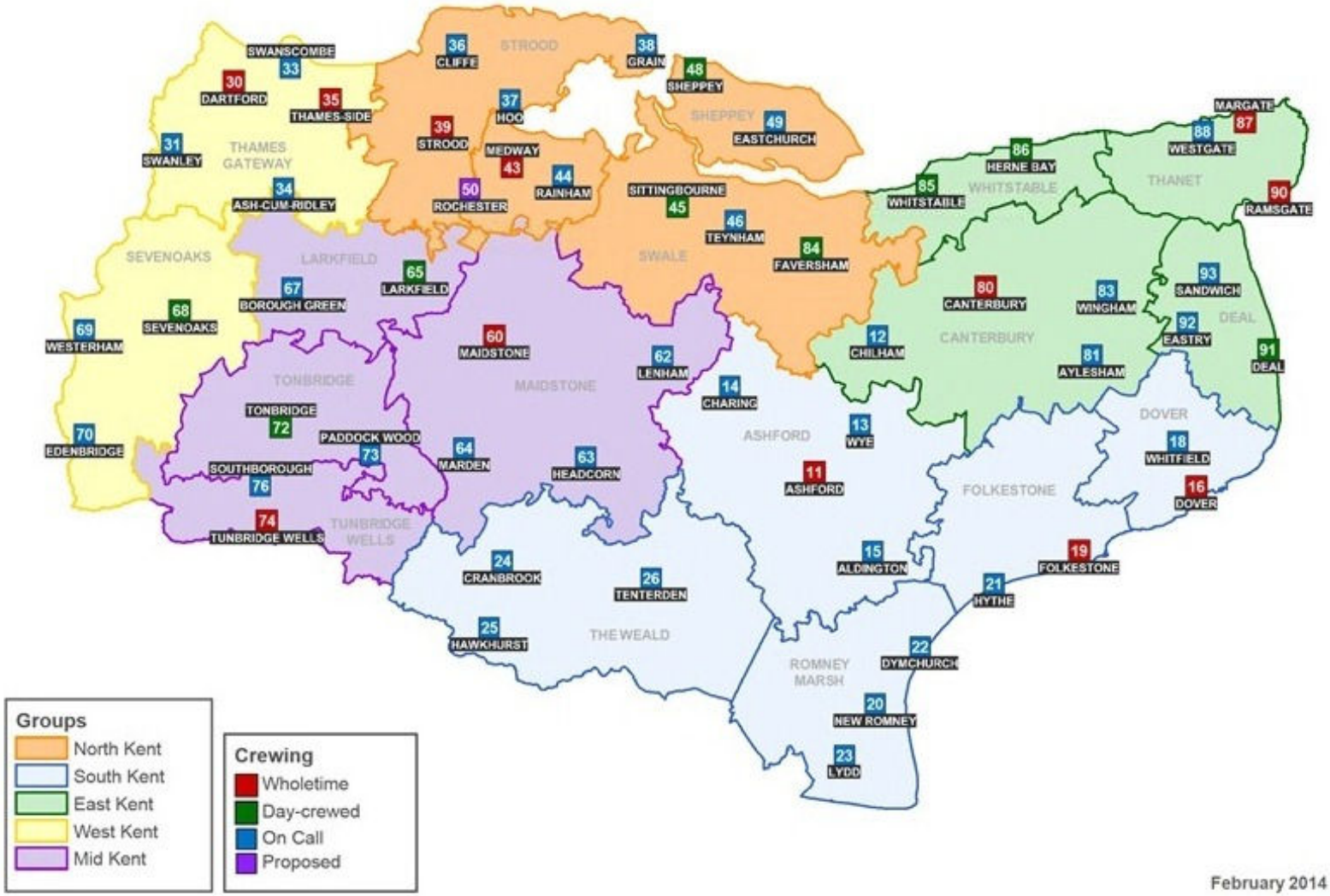
- Prevention
- Fires
- Road Traffic Collisions
- Specialist Rescue
- When all else fails…….call fire

Kent Fire & Rescue Service

Prevention

- Our history of effective prevention
- Sir Ken Knight Review 2013
- Vulnerable people - age, disability, mental illness, focus on dementia, domestic violence, child safety, fire-setters…… much more we can do.
- Home safety
- Schools education
- Business Safety

Our outlets!


SWANSCOMBE
33
36
CLIFFE
STROOD
38
GRAIN
48
SHEPPEY
30
DARTFORD
35
THAMES-SIDE
37
HOO
39
STROOD
MEDWAY
43
44
RAINHAM
50
ROCHESTER
SHEPPEY
49
EASTCHURCH
31
SWANLEY
THAMES GATEWAY
34
ASH-CUM-RIDLEY
SITTINGBOURNE
45
46
TEYNHAM
84
FAVERSHAM
SWALE
SEVENOAKS
LARKFIELD
65
LARKFIELD
67
BOROUGH GREEN
68
SEVENOAKS
69
WESTERHAM
60
MAIDSTONE
62
LENHAM
MAIDSTONE
TONBRIDGE
TONBRIDGE
72
70
EDENBRIDGE
PADDOCK WOOD
73
SOUTHBOROUGH
76
64
MARDEN
63
HEADCORN
74
TUNBRIDGE WELLS
TUNBRIDGE WELLS
24
CRANBROOK
26
TENTERDEN
25
HAWKHURST
THE WEALD
ROMNEY MARSH
22
DYMCHURCH
20
NEW ROMNEY
23
LYDD
14
CHARING
ASHFORD
13
WYE
11
ASHFORD
15
ALDINGTON
21
HYTHE
19
FOLKESTONE
FOLKESTONE
DOVER
18
WHITFIELD
16
DOVER
MARGATE
87
88
WESTGATE
86
HERNE BAY
85
WHITSTABLE
WHITSTABLE
THANET
90
RAMSGATE
80
CANTERBURY
83
WINGHAM
CANTERBURY
12
CHILHAM
81
AYLESHAM
93
SANDWICH
DEAL
92
EASTRY
91
DEAL
Groups
North Kent
South Kent
East Kent
West Kent
Mid Kent
Crewing
Wholetime
Day-crewed
On Call
Proposed
February 2014

Kent HWB Strategy

- How can we work together – we all share the same customers
- What are the blockages
- Where can we integrate
- Where can we use the Fire Brand
- What does the future look like

Kent Fire & Rescue Service

Key Areas

- Vulnerable people
- Slips trips falls – preventing admission to hospitals
- Business Community
- Fire fit – Obesity, elder fitness, youth engagement
- Role models/ mentors

Summary

- Improved service for public of Kent & Medway
- Use the Fire brand for commissioned work which can be targeted and evaluated
- We will continue to drive our prevention strategy – but we can do more together

Kent Fire & Rescue Service

Questions

Kent Fire & Rescue Service

This page is intentionally left blank

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

To: The Kent Health and Wellbeing Board - 16 July 2014

Subject: **Kent Joint Health and Wellbeing Strategy**

Classification: Unrestricted

Summary

The Kent Health and Wellbeing Board is required to ensure that a Health and Wellbeing Strategy for the Kent area is produced and that it reflects the issues identified in the Joint Strategic Needs Assessment. The first draft of a revised strategy for 2014-2017 was considered by the board at its meeting on the 28 May. This version was issued for public comment and the subsequent responses have informed the final draft version submitted to this meeting of the Kent Board for final approval.

The initial draft of the revised strategy has been well received and the general approach and structure of the strategy has been welcomed.

Suggestions for changes to the text have been incorporated where appropriate. Outcome 4 – People with mental health issues are supported to "live well" has been revised. Changes to the proposed metrics and measurements have also been made where useful suggestions have been made.

Recommendations

The Kent Health and Wellbeing Board is asked to:

1. Approve the revised Joint Health and Wellbeing Strategy for Kent

2. Agree the revised engagement and communications programme

3. Task the local Health and Wellbeing Boards to report back in November 2014 on how they are engaging local populations in the discussions concerning implementation of the strategy in their local areas

4. Require the local Health and Wellbeing Boards to ensure local plans demonstrate how the priorities, approaches and outcomes of the Kent Joint Health and Wellbeing Strategy will be implemented at local levels and report this assurance to the Kent Board in November 2014.

1. Introduction

The revised strategy was discussed at the Kent Health and Wellbeing Board at its meeting of the 28 May 2014. The Board agreed that the strategy be published for public comment until 27 June and responses incorporated into a final draft of the strategy to be presented to the Kent Health and Wellbeing Board on 16 July. The final draft also includes suggestions from the Health and Wellbeing Board discussion relating to a greater emphasis on the patient experience and quality of care and more explicit links to the JSNA.

2. Communication and Engagement

Engagement and communication with the public and stakeholders is crucial to the acceptance of the strategy as the basis for health and social care commissioning in Kent. The communications and engagement plan recognises that this process will continue after the strategy has been finally published to ensure that it is properly promoted and understood.

To date the revised strategy has been generally warmly welcomed by the professional organisations and others that have responded. There has been limited response from local media.

Following the publication of the draft revised strategy we received 13 e-mail responses that contained a number of suggestions as to how the document could be improved. All of these have been carefully considered and the majority have been reflected in the final draft before the Board today.

3. Main amendments to first draft

The suggestions received have led to the revision of Outcome 4 – People with mental health issues are supported to “live well”. There is also an increased emphasis on wellbeing as opposed to a more “health” perspective.

A number of respondents highlighted the need for the strategy to be delivered at a local level and the need for existing local plans (Mind the Gap – Inequalities Action Plan, CCG, Public Health and others’ commissioning plans) to reflect the strategy. Local plans should also allow for local priorities to be adopted in the implementation of the strategy. Where local plans do not fully include the key priorities and outcomes of the strategy they should be adjusted accordingly. The issue of availability of resources to achieve proper implementation has also been raised.

The need to be more explicit about the CAMHS service being consistent across the county has been raised and incorporated into the final version. Other measures and metrics have been refined further.

We received some comments about the inequalities that arise from some specific conditions such as HIV and also specific groups such as Gypsies and Travellers. No specific amendments have been made on the basis of these as

the strategy refers to inequalities more generally and these specific issues should be covered in the inequality action plans for the relevant area.

4. Measurement and Metrics

Following consideration by a wide range of stakeholders at a workshop it was agreed that a new set of indicators should be designed to more clearly reflect progress against the outcomes. These have been further refined during the public engagement period.

Targets and indicators will be discussed and further refined over the next six months and further definition will be reported to the Board at the January 2015 meeting.

5. Local Delivery

The size and complexity of Kent means that to be useful the strategy needs to be relevant and able to be applied at district authority, CCG and the three health and care economy levels. Therefore, local Health and Wellbeing Boards should develop their own action plans designed to achieve the outcomes in ways most relevant to their own populations supported by data and information aggregated to the appropriate level.

6. Review and Monitoring of Progress

Ongoing monitoring of the indicators associated with the strategy will be provided through the regular assurance report to the Kent Health and Wellbeing Board.

7. KCC Committee cycle

The revised Health and Wellbeing Strategy is scheduled to be considered at a number of KCC Cabinet committees and the Health Overview and Scrutiny Committee. These committees meet/met on the following dates:

Health Overview and Scrutiny	**18th July 2014**
*Cabinet committees***:**	
Children's Social Care and Health	**9th July 2014**
Adult Social care and Health	**11th July 2014**
Education and Young People's Services	**23rd July 2014**

8. Recommendations

The Kent Health and Wellbeing Board is asked to:

1. Approve the revised Joint Health and Wellbeing Strategy for Kent.

2. Agree the revised engagement and communications programme

3. Task the local Health and Wellbeing Boards to report back in November 2014 on how they are engaging local populations in the discussions concerning implementation of the strategy in their local areas.

4. Require the local Health and Wellbeing Boards to ensure local plans demonstrate how the priorities, approaches and outcomes of the Kent Joint Health and Wellbeing Strategy will be implemented at local levels and report this assurance to the Kent Board in November 2014.

Appendix: Revised communications and engagement plan

Background Documents

Kent Joint Health and Wellbeing Strategy – Outcomes for Kent Report to Kent Health and Wellbeing Board 30th January 2013

Kent Joint Strategic Needs Assessment - http://www.kmpho.nhs.uk/

Kent "Mind the Gap" – Health Inequalities Action Plan http://www.kmpho.nhs.uk/

Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategy and Timeline – Report to Kent Health and Wellbeing Board 17 July 2013

Better Care Fund plans – report to the Kent Health and Wellbeing Board 26 March 2014

CCG Commissioning Plans - report to the Kent Health and Wellbeing Board 26 March 2014

Kent Health and Wellbeing Strategy – report to the Kent Health and Wellbeing Board 28th May 2014.

Contact details

Mark Lemon – Strategic Business Advisor – Health

Email: mark.lemon@kent.gov.uk Tel: 01622 696252

Malti Varshney – Consultant in Public Health

Email: Malti.varshney@kent.gov.uk Tel: 0300 3335919

Wayne Gough – Business Planning and Strategy Manager

Wayne.gough@kent.gov.uk Tel: 01622 221960

Tristan Godfrey – Policy Manager (Health)

Tristan.godfrey@kent.gov.uk Tel: 01622 694270

This page is intentionally left blank

2014 – 2017

Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

Draft

Published by Kent County Council on behalf of the Kent Health and Wellbeing Board

Kent County Council
kent.gov.uk

Contents

This document is available in alternative formats and can be explained in other languages. Please call 03000 41 41 41

Foreword

I have been pleased with the progress that the Kent Health & Wellbeing Board has made since its launch in April 2013 – bringing together GPs, County and District Councillors, senior officers from the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from the Local Healthwatch. We have collectively settled into our role, and the Board provides an effective body where commissioners, patient representatives and elected officials can come together to take an overview of the health and care system in Kent. We continue to align our work, and share our commissioning plans and good practice. This stands us in good stead to tackle the challenges of, and seize the opportunities offered by, the changes that will face us over the coming years.

Just over twelve months ago the Kent Health and Wellbeing Board agreed its first strategy, identifying the outcomes that we, as a health economy in Kent, would collectively be looking to deliver, and we identified the priorities that we felt would enable us to achieve our aims. We took the decision that in a rapidly changing health and social care landscape that it would be prudent to revisit our strategy after twelve months to assess whether it was still applicable, and whether we had started to make progress. It is fair to say that in twelve months the major challenges facing Kent haven't changed a great deal, and for that reason, the board and our colleagues across the health and care system agreed to retain the five outcomes and four priorities we agreed last year.

As you will see over the following pages, the growing pressure of demographic change, generating increased need for health and social care services, at a time of financial stringency is still with us. We have to change, and to work together more effectively, if we are to achieve better health outcomes for the people of Kent while staying within the financial resources budget. The past year has seen the advent of the 'Better Care Fund' which offers us the opportunity to increase the scale of change that we identified was needed in last year's strategy. Kent is also an Integration Pioneer, giving us opportunity to be innovative and develop joined up services faster.

During the development of the refreshed strategy it became clear that one of the key issues that we need to tackle is that of public awareness of the changes that will be taking place over the coming years, namely the move to more care being delivered in local communities and away from acute hospitals. This will inevitably mean major changes to our big hospitals, with the creation of specialist hospitals where good quality care can be provided with specialist trained staff, with general services provided in the community or at a local hospital as clinically appropriate. This may mean an increase in journey times to access specialist provision for some people, but conversely allowing people to access much more of the care they need in community settings. It is the job of the Health and Wellbeing Board, and its constituent members to begin the conversation with the public, ensuring that they understand the implications, and that they can influence the long term decision making to the same extent that they currently influence specific service developments.

The Joint Kent Health & Wellbeing Strategy will only be effective if the plans of GP-led Clinical Commissioning Groups, the County and District Councils and other partners align with the outcomes and priorities identified here, using them as a set of core values by which to design system and service development.

Chair of the Kent Health and Wellbeing Board

Summary

People's need for care, and their lives, has changed radically. But the health service largely operates as it did decades ago, when the predominant need/ expectation was treating episodic disease and injury rather than providing long-term, often complex care. The health and care system needs to redesign services so that care becomes more integrated, person-centred, coordinated, community-based, and focused on supporting people's well-being and preventing crises. The 2015 Challenge Declaration – NHS Confederation

The challenge to the health and care system is clear. Kent, like the rest of England, has an ageing population that will put increasing demands on the system, and will require long-term complex care. This, along with unhealthy lifestyle behaviours, and the rising cost of technology means that nationally the NHS faces a £30bn funding gap by 2021, unless the system of health and social care can be transformed.

To meet this challenge in Kent, the Health and Wellbeing Board have developed this strategy to lead the system as it changes over the coming three years. The constituent members of the Health and Wellbeing Board will use this strategy to guide their plans, and will also use the strategy as a way to start a conversation with the public about the major changes that will be taking place over the coming years.

They will need to build an understanding about the changes that will happen to large hospitals when 15% of their business moves to community based settings. These changes will see some hospitals become more specialised and the journey times for some treatments may increase to provide this better quality specialist care. Some hospital and care settings may, become smaller, with services redesigned to provide care closer to home.

Services closer to home will be provided by multidisciplinary teams that will have preventative, as well as responsive components to them. Integrated teams will provide active support in the community to enable patients to look after themselves. In local areas this could potentially mean that integrated care is provided through community health, mental health, and social care teams, with GP leadership. Where necessary the services will be responsive to provide an integrated 24/7 service that has a full range of out of hospital urgent health

and social care services to support individuals in the community and avoid hospital admission. This would also mean that there will be increased support to help people at the end of their life to die in the place of their choice and with dignity.

These changes will provide the opportunity to build person centred, integrated services and the advantages of these changes need to be communicated over the coming years.

To realise the full potential of these opportunities and to benefit the people of Kent it is paramount that all constituent agencies in the system (i.e. social care, acute hospitals, ambulance services etc.) work together and develop a common vision and complimentary strategies to address these challenges. Collaborative work between agencies will allow the people of Kent to get a complete service and not just one individual service.

Within Kent County Council, the Adult Social Care Transformation portfolio is putting a stronger emphasis on prevention, early intervention and integrated service delivery and commissioning as a way to realise the vision of a sustainable model of integrated health and social care by 2018. This will improve outcomes for people across Kent by

maximising people's independence and promoting personalisation. It will involve KCC working with partner organisations across the public health, health, housing and social care economy. For instance from September 2015 the Council will also be responsible for commissioning of health visitors which will provide increased opportunities to undertake integrated commissioning.

We have tested last year's Joint Health and Wellbeing Strategy (JHWS) against the many developments over the past twelve months, namely the challenges arising from the failures in care at Mid-Staffordshire Hospital and Winterbourne View, alongside the Call to Action, the resulting Better Care Fund, and Kent's status as an Integration Pioneer. The vision, outcomes, priorities and approaches that were developed are still appropriate, and our vision is just as relevant. Therefore we have developed this strategy to achieve our vision:

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

To deliver our vision the **outcomes** we seek, as informed by the Joint Strategic Needs Assessment (JSNA), are:

- Every child has the best start in life
- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental health issues are supported to 'live well'
- People with dementia are assessed and treated earlier, and are supported to live well

Each of these outcomes is discussed in detail over the coming pages, with each one being examined through the prism of our four identified priorities which are to:

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

In all of the work that takes place over the coming years, all developments should test themselves against the three approaches that we identified last year, namely that we should ensure that all services are **Person Centred,** that they are part of **Integrated Provision,** procured by **Integrated Commissioning.**

So that we know we are on track to delivering our strategy, we have identified existing measurements that we will monitor. These are identified in the Outcome sections, and have been adjusted from last year, so that they truly measure how we are delivering against our priorities in each outcome.

Given the size and complexity of Kent, and the scale of the health and care system, it is very difficult for any strategy to provide answers at district, Clinical Commissioning Group and health/care economy (north, east and west) levels. Therefore, it is important that Local Health and Wellbeing Boards test their existing plans (those of GP-led Clinical Commissioning Groups, District Councils and other partners) against the outcomes, priorities and values laid out in this strategy. Where necessary they should develop additional actions to address local priorities, in order to achieve the outcomes in ways most relevant to their own populations and supported by data and information at their local area level.

Context

Overall, it is a positive message that people are living longer, but unfortunately not all are enjoying good health and wellbeing and many suffer from one or more long-term conditions. Often the causes of long term conditions are related to the lifestyles we live and are largely preventable. The increasing number of long term conditions has changed the nature of the need for health and social care, which has meant that the needs of our population are often complex, requiring agencies to work in partnership to provide a desired outcomes for our population. This strategy embraces these challenges and provides strategic direction to address the issues facing our population in Kent.

Demographics

Kent has the largest population of all of the English counties, with just over 1.46 million people. Just over half of the total population of Kent is female (51.1%) and 48.9% is male. Across the population there are diverse outcomes. Life expectancy is higher than the England average for both men and women. However, life expectancy is significantly lower in deprived areas, with a man in a deprived area living on average 8.2 years less, giving him a life expectancy of 70.9 years and a woman living on average 4.5 years less, with a life expectancy of 78.2 years (based on average aggregated Kent data for people living in all the deprived areas of Kent).

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

Overall the age profile of Kent residents is similar to that of England. However, Kent does have a greater proportion of young people aged 10-19 years and of people aged 45+ years than the England average and just under a fifth of Kent's population is of retirement age (65+). However looking ahead, Kent has an ageing population and forecasts show that the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026, yet the population aged below 65 is only forecast to increase by 3.8%. This will mean that Kent will have a relatively smaller population aged 20-49 years and considerable pressures on health and social care services as a result of services required for an aging population.

What has changed in the past 12 months

Although the challenges we face as we transform the health and care system are not new, the past year has seen several developments which will help us bring about this change.

April 2013 marked the beginning of a new era of public health within local government. Moving responsibility for the public's health out of the National Health Service (NHS) into local government offers a greater opportunity to focus on preventing ill health, by building on the partnerships developed within the NHS and concentrating on the primary factors that can change an individual's ability to live a healthy life.

The Health and Wellbeing Board has settled into its role, and started to lay the foundations for the integration of the health and social care system. Broadly speaking there are two main work streams of the Health and Wellbeing Board which are not mutually exclusive, namely prevention of ill health and integration of the health and care system. Public health activity is embedded throughout partner plans including KCC business plans, district plans including Mind the Gap, Clinical Commissioning Group and NHS England strategic plans. Public Health activity is also a core part of both the Better Care Fund and Integration Pioneer programmes. Kent County Council is now responsible for commissioning of public health programmes and these are an integral part of whole system activity to improve the health of the population of Kent.

We have created local Health and Wellbeing Boards that mirror the boundaries of local clinical commissioning groups, bringing together partners at that level to influence local delivery. These groups are complemented by Integrated Commissioning Boards that bring together the people in those areas who decide how the available money is spent on health services. The commissioning plans are also considered by the countywide Health and Wellbeing Board

Failures of care

Sadly there have been some very public failures of care in England, and the reports into Mid Staffordshire Hospital and Winterbourne View have led to widespread agreement that fundamental changes are required across health and social care. There is a greater focus on quality of care with the experience of the patient or service user necessarily being at the centre of everything we do. As a result of the report into Winterbourne View, a series of changes have been made to improve the quality of care for vulnerable people, specifically for people with learning disabilities or autism who also have mental health conditions or behavioural problems.

The Francis Report, examining the tragic events at Mid-Staffordshire Hospital Trust, contained 290 recommendations covering everything from organisational culture to the role of patient and public representative bodies. One of the key warnings arising from the report was the danger of prioritising finance and targets over the quality of care. A lot of work is being taken forward locally and nationally in response to these reports, including Sir Bruce Keogh being asked to conduct an investigation into hospitals with the highest mortality rates (which included one of the main hospitals serving people in Kent) and the Berwick Report into NHS patient safety. This strategy will look to ensure the lessons learnt from this work are incorporated into its delivery.

Continually Improving Quality to Achieve Good Outcomes

Improving quality and outcomes remains the core purpose of all public funded care and is the responsibility of everyone working in the health and care system. Ensuring that patients and families are empowered to influence quality improvements is key to improving delivery. Alongside the professional regulators who are tasked with seeing that quality standards are maintained and improved, the commissioners of health and care services have a duty to ensure the services they commission are safe. Quality improvement therefore is dependent on effective collaboration amongst health and care providers, service commissioners, education providers, regulators, professional bodies and other partners to ensure patients receive high quality care.

The local Quality Surveillance Group is well positioned to pull together information from commissioners, the regulators and Healthwatch. Drawing on the work of this group will enable the Kent Health and Wellbeing Board and its members to work across the system and achieve the collective objectives of ensuring that the essential standards of quality and safety are maintained; and that all services drive continuous improvement in quality and outcomes.

Call to Action

In July 2013, NHS England published *The NHS belongs to the people: a call to action*. This paper set out a range of challenges facing the NHS. This included the fact that more people are living longer and often have more complex conditions. This increases costs for the NHS at a time when funding remains flat but expectations as to the extent and quality of care continue to rise. As things are, a funding gap of £30 billion has been predicted between 2013/14 and 2020/21; this is on top of the £20 billion of efficiency savings the NHS is already working towards meeting.

After the report was published, specific work developing different strands within the Call to Action has been commenced with work on improving general practice, community pharmacy services, dental services and others.

The key point of the Call to Action is that the health and care system needs to do things differently and challenge the status quo. There is a need to embrace new technologies and treatments, but there is a cost attached and thought needs to be given to delivering services in a different way with less focus on buildings and more on patients and services. Kent's participation in the Integration Pioneer programme and Better Care Fund are examples of how different approaches are being developed to meet the challenge locally, and more broadly this strategy shares the same goals as the Call to Action.

Also important is Sir Bruce Keogh's review into transforming urgent and emergency services, arising out of NHS England's Everyone Counts:

Planning for Patients 2013/14. The end of phase 1 report was published in November 2013. This report supported the idea that people with urgent but non-life threatening needs must be provided with effective and personalised services outside of hospital. The report also proposes two levels of hospital based emergency care – 'Emergency Centres' and 'Major Emergency Centres' with those patients with the most serious needs being seen in specialist centres. To support the substantial shift of care out of hospitals, new services will be created but some old services will no longer be required.

Parity of Esteem

In February 2011, the Government published its mental health strategy, No Health Without Mental Health. This emphasised giving equal weight to both physical and mental health, with mental health outcomes being seen as central to the three outcomes frameworks. The implementation framework of the strategy suggested local mental health needs needed reflecting in JSNAs and JHWSs. The idea of parity of esteem between physical and mental health is not new, but was made an explicit duty on the Secretary of State through the Health and Social Care Act 2012. In March 2013, the Royal College of Psychiatrists published a report into achieving parity, writing that a "parity approach should enable NHS and local authority health and social care services to provide a holistic, 'whole person' response to each individual, whatever their needs."

Against this backdrop, the Mental Health Crisis Care Concordat was launched in February 2014 with the aim of making certain that people experiencing a mental health crisis get as good a response from an emergency service as those in need of urgent and emergency care for physical health conditions.

Integration Pioneer & Better Care Fund

Following the 'call to action', the Better Care Fund was created, supporting the full integration of services by 2018, with challenging targets to be achieved by 2016. This has accelerated the pace and scale of integration that KCC had already begun and will continue through our Pioneer work.

Kent was chosen as a Pioneer area in the Department of Health's Integration Pioneer Programme, which will establish new ways of delivering coordinated care. Through the Pioneer work, over the next five years, we will re-design models of care to put the citizen more in control of their health and make a real difference to the way people experience health and social care in Kent. By bringing together CCGs, KCC, District Councils, acute services and the voluntary sector, we will move to care provision that will promote greater independence for patients, whilst reducing hospital and care home admissions. In addition, a new workforce with the skills to deliver integrated care will be recruited and developed. Through the Kent Better Care Fund proposal, a pooled fund of £127 million from existing resources has been identified to support integration in the county.

The integrated model of care that we are moving towards contrasts with the current situation where the majority of commissioning and provision of services is standalone, and although best efforts are made to align services to benefit service users, there is room for improvement. The current situation creates a complex system for users to navigate, often leaving them frustrated with the care they receive.

In the future, patients will have access to 24/7 community based care, ensuring they receive quality care, closer to home, and do not need to go to hospital. A patient-held care record will put the patient in control of their own information. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services.

We will use innovative approaches to identify those who are at a higher risk of hospital admission and new ways of identifying payment mechanisms such as 'Year of Care' commissioning for long-term conditions. Through better integration we can deliver comprehensive, 24/7 community health services, reducing demand on hospitals. By shifting just 10% of funding from acute to community care in Kent, we can free up £170 million a year to invest in community services.

Integrated intelligence

A key element in delivering a joined up health and social care system is ensuring that every partner is working towards common outcomes, and that they are informed by a consistent intelligence that is drawn from as wide a range of information sources as possible. We are embarking upon developing an Integrated Intelligence capability that will enable Kent stakeholders (service users, commissioners and providers) to understand user experiences and outcomes as they journey through the health, social and care system. The purpose of this capability will be to understand how to improve value (outcomes) for money and link these efforts to the priorities and focus of commissioners, providers and patients. This capability will be grounded within an enhanced approach to Integrated Commissioning that will enable multiple agencies to make well-informed, well-supported, practical decisions on how to evolve integration of services. Accordingly, the Integrated Intelligence capability will also allow us to monitor the effectiveness and efficiency of on-going improvements from the perspective of patients and their outcomes.

Specifically, this capability will allow us to:

- truly understand the impact of all health and well-being services, their interplay, and behaviours on the outcomes for individuals
- think across agencies and across agency budgets to identify the most effective ways of driving efficiency and value for money in creating the best short, medium and long term outcomes
- understand behaviour of service users and adapt the whole system to enable them to participate in their optimal outcomes

Applying and demonstrating these capabilities will be done at an aggregated/whole population level. This will generate more accurate and robust information for commissioners to design and create higher value models of care to enable whole system transformation.

Joint Strategic Needs Assessment

Our priorities for Joint Health and Wellbeing Strategy in 2012-2013 were informed through the Joint Strategic Needs Assessment (JSNA) which is a 'live' document and as such is under constant review and updates. To inform the current strategy each of the existing needs assessments that support the current JSNA have been reviewed and updated, to reflect the latest policy, guidance and data trends. Updated information was reported as an exception paper to the Health and Wellbeing Board in January 2014.This process will be undertaken each year for the lifetime of the Health and Wellbeing Strategy. At the end of the HWBS term a full review of the JSNA summary document will take place.

It was in light of the above developments that we assessed the 2013/14 strategic vision, outcomes, priorities and approaches. We feel that they still fit the challenge, and provide the common values that should be applied by all commissioners, providers and organisations that impact upon peoples' health and social care. It is important that all partners support these principles and align their plans to the Health and Wellbeing Strategy for Kent, as illustrated in Figure 1.

Figure 1

Our vision:

As outlined above our vision has not changed and we are still determined to improve health and wellbeing outcomes, deliver better coordinated quality care, improve the public's experience of integrated health and social care services and ensure that the individual is involved and at the heart of everything we do.

Outcomes

To achieve our vision the outcomes we seek, as informed by the Joint Strategic Needs Assessment, are:

- Every child has the best start in life
- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental health issues are supported to 'live well'
- People with dementia are assessed and treated earlier, and are supported to 'live well'

Each of these outcomes is discussed in detail over the coming pages, and the diagram below shows how we will apply our approaches and priorities to each of these outcome areas.

The outcomes will be delivered by focusing on our priorities within each of the outcome areas, whilst ensuring that any intervention is informed by the three approaches, i.e. that it is centred around the person (see diagram below to understand what person centred care would look like as described by our citizens receiving care), that it is provided in a joined up way, and where appropriate it is jointly commissioned.

Joint Health and Wellbeing Strategy

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

Approach: Integrated Commissioning

Approach: Integrated Provision

Approach: Person Centered

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

What should good, person centred, care feel like

We asked the people of Kent and this is what they told us

"I have the information and support I need in order to remain as independent as possible and manage my own conditions."

"I tell my story once. I have one first point of contact. They understand both me & my condition(s). I can go to them with a question at any time."

"I can decide the kind of support I need and when, where and how to receive it."

"I feel safe, I can live the life I want and I am supported to manage any risks. I know what is in my care & support plan and I know what to do if things change or go wrong."

"I have as much control of planning my care & support as I want."

"I am in control of planning my care and support. I can decide the kind of support I need & how to receive it."

"All my needs as a person are assessed & taken into account; I am listened to about what works for me, in my life."

"I am not left alone to make sense of information. I have help to make informed choices if I need and want it."

"Information is given to me at the right times. It is appropriate to my condition & circumstances. And is provided in a way that I understand."

"I have good information and advice on the range of options for choosing my support staff."

"I feel that my community is a safe place to live and local people look out for me and each other."

"I have considerate support delivered by competent people. They help me to make links in my local community."

"I have a clear line of communication, action and follow up. When something is planned, it happens."

I am supported to understand my choices & to set & achieve my goals."

"I have access to easy-to-understand information about care and support, which is consistent, accurate, and accessible, up to date. I am supported to use it to make decisions & choices about my care & support".

"I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a 'personal budget' from the council or NHS)."

"I have care and support that is directed by me, I am as involved with discussions & decisions about my care support & treatment, and it is responsive to my needs."

"I have regular reviews of my care & treatment including comprehensive reviews of my medicines, & of my care & support plan."

"I can speak to people who know something about care and support and can make things happen. I am told about the other services that are available to someone in my circumstances, including support organisations."

"I can get access to the money quickly without having to go through over-complicated procedures."

"I have help to make informed choices if I need & want it; my family or carer is also involved in these decisions as much as I want them to be.

"I can plan ahead and have systems in place to keep control in an emergency or crisis."

"I know where to get information about what is going on in my community."

"I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers."

"I always know who is coordinating my care."

"I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this."

"My support is coordinated, co-operative and works well together. The professionals involved with my care talk to each other. We all work as a team."

"I work with my team to agree a care & support plan; my care plan is clearly entered on my record."

"My carer/family have their needs recognised & are given support to care for me."

"I feel valued for the contribution that I can make to my community."

When I use a new service, my care plan is known in advance & respected.

"I have access to a range of support that helps me to live the life I want and remain a contributing member of my community."

"I have a network of people who support me – carers, family, friends, community and if needed paid support staff."

"The professionals involved with my care talk to each other. We all work as a team; I am kept informed about what the next steps will be."

"I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities."

I can see my health & care records at any time. I can decide who to share them with. I can correct any mistakes in the information."

Outcome 1

Every child has the best start in life

The early years of a child's life are critical for ensuring they develop well and they do not fall behind in a way which means they have poorer outcomes throughout life. The focus will be on supporting families, communities and universal settings within local districts to support all children and young people to do well and to stay safe. The aim will be to provide additional local services that can be accessed easily, at the right time in the right place, to ensure more targeted early help is available to meet the needs of children and young people in a way that avoids problems becoming more serious.

Our Vision is that every child and young person, from pre-birth to age 19, who needs early help services will receive them in a timely and responsive way, so that they are safeguarded, their educational, social and emotional needs are met and outcomes are good, and they are able to contribute positively to their communities and those around them now and in the future, including their active engagement in learning and employment.

Whilst developing this refresh, one area where there was a consensus of opinion was that there is a need to recognise that just as outcomes 2-5 deal with different levels of need of the adult population, it was necessary to deal with the population of young people in a similar way. The identification of needs is based on an assessment of the child and family's circumstances. The three agreed multi-agency 'Levels of Need' are:

Level 1: Universal, where needs are met through engagement with universal services such as schools, GP services, youth clubs and where prevention is a priority.

Level 2: Targeted, where early help is available to address emerging or existing problems which, if not addressed, are likely to become more serious and need more specialist input.

Level 3: Specialist, where needs have become serious and there is a greater likelihood of significant harm, requiring the intervention and protection of statutory services.

We will work across the system to improve educational, health and emotional wellbeing outcomes for all of Kent's children and young people, whilst taking account of the additional needs of those young people who are disabled, or who have Special Educational Needs (SEN).

Over the coming years we will also see a much greater integration in services for children from pre-birth to 19 and implementation of Healthy Child Programme. In October 2015 Health visitors will become a part of the public health responsibilities of Kent County Council, and will complement the responsibility to support breast feeding, and reduce smoking in pregnancy. KCC is in the process of developing a joined up preventative services approach for 0-19 year olds. Meanwhile, a new School Health service specification is currently being developed with the intention that a new service is in place by April 2015.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average

In order to tackle key health issues in this outcome we need to deliver:

- A reduction in the number of pregnant women who smoke at time of delivery
- An increase in breastfeeding Initiation rates
- An increase in breastfeeding continuance 6-8 weeks
- A reduction in the proportion of 4-5 year olds with excess weight
- A reduction in the proportion of 10-11 year olds with excess weight

Priority 2 – Tackle health inequalities

The UK is one of the richest OECD countries but one of the most unequal in health terms, which has a direct impact on children's wellbeing. We have seen a rapid rise in mental health problems in children, an increase in sexually transmitted diseases and an epidemic of childhood obesity. Inequalities in health and emotional wellbeing are striking. Poorer children are more likely to be born too early and too small, and are less likely to be breastfed or immunised.

To address health inequalities for children and young people in Kent we will:

- Improve Breast feeding rates by promoting Unicef's Baby Friendly accreditation and implementing the infant feeding action plan in place. This requires partnership working through maternity units, hospitals, children centres, midwives and Health Visitors in a range of medical and community settings
- Prevalence of obesity in children is higher in more deprived areas. We will promote healthy weight for all children, particularly in areas where the need is greater; working with families to promote healthy eating and increase physical activity
- reduce smoking in pregnancy by strengthening midwifery and smoking cessation resources and provide a whole systems approach to engaging with and supporting pregnant smokers.
- ensure vulnerable and disadvantaged children access and participate in good quality childcare and education and achieve good outcomes.

Priority 3 – Tackle the gaps in service provision

The delivery of Speech and Language Therapy is critical to children and young people accessing and benefiting universal, targeted and specialist services. Speech and Language Therapy (SALT) implementation has system wide benefits. During the life of this strategy we will be working towards implementation of the SALT Framework.

We will continue to work with our partners across the health and care system to ensure that children and young people with short term acute conditions and complex health needs are able to receive high quality, locally accessible community based support, avoiding where possible the need to attend hospital.

The Common Assessment Framework (CAF) will continue to be a key tool for carrying out an early help assessment and planning the necessary actions to improve children's outcomes and support their additional needs. There is also support for parents experiencing physical and mental health issues.

We will continue to work towards strengthening our commissioning and provision of child and adolescent emotional wellbeing and mental health services so that we can achieve greater availability of support for emotional resilience and treatment where needed.

The Children's Health and Wellbeing Board will shortly be developing an Emotional Health and Wellbeing (EMHW) Strategy for 0-25 year olds in Kent to support this outcome.

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

It is essential that there is a seamless flow between universal, targeted and specialist services, and that transition between each level of service is well managed and simple for the children, young people and their families. It is important to recognise that needs change over time, and that the step up, or step down between levels of service is a particularly fraught time for everyone involved, and a time when the risk of gaps appearing are at their greatest.

Agencies in the health and care system will work collaboratively to implement the Kent Integrated Family Support Services (KIFSS) for pre-birth to 11 years' services and Kent Integrated Adolescent Support Services (KIASS) for 11-19 years' services. These key services include Children's Centres, Early Intervention Teams and Family Support workers, Attendance and Inclusion services, Connexions workers to provide targeted support for NEETs, Youth Offending workers, Troubled Families workers, Adolescent Social Work Assistants, Pupil Referral Units and Alternative Curriculum Provision, agencies involved in CAF and commissioned support services and health services for children and young people and Gypsy, Roma, Traveller and minority outreach workers. Schools, children's centres and early years settings are at the heart of this new way of working at district level. By establishing a 'team around the school', it is expected that children, young people and their families will be able to access services in a more timely, effective and appropriate manner so that early help activity agreed will significantly improve outcomes for the child, young person and their family.

Keeping track of our progress in delivering Outcome 1

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

- A reduction in the number of pregnant women who smoke at time of delivery
- An increase in breastfeeding Initiation rates
- An increase in breastfeeding continuance 6-8 weeks
- A reduction in conception rates for young women aged under 18 years old (rate per 1,000)
- An improvement in MMR vaccination uptake two doses (5 years old)
- An increase in school readiness: all children achieving a good level of development at the end of reception as a percentage of all eligible children
- A reduction in the proportion of 4-5 year olds with excess weight
- A reduction in the proportion of 10-11 year olds with excess weight
- An increase in the proportion of SEN assessments within 26 weeks
- A reduction in the number of Kent children with SEN placed in independent or out of county schools
- A reduction, in every part of Kent, in CAMHS average waiting times for routine assessment from referral
- A reduction, in every part of Kent, in the number waiting for a routine treatment CAMHS
- In every part of Kent, an appropriate CAMHS caseload, for patients open at any point during the month
- A reduction in unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 100,000)
- A reduction in unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 100,000)
- A reduction in unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 100,000)

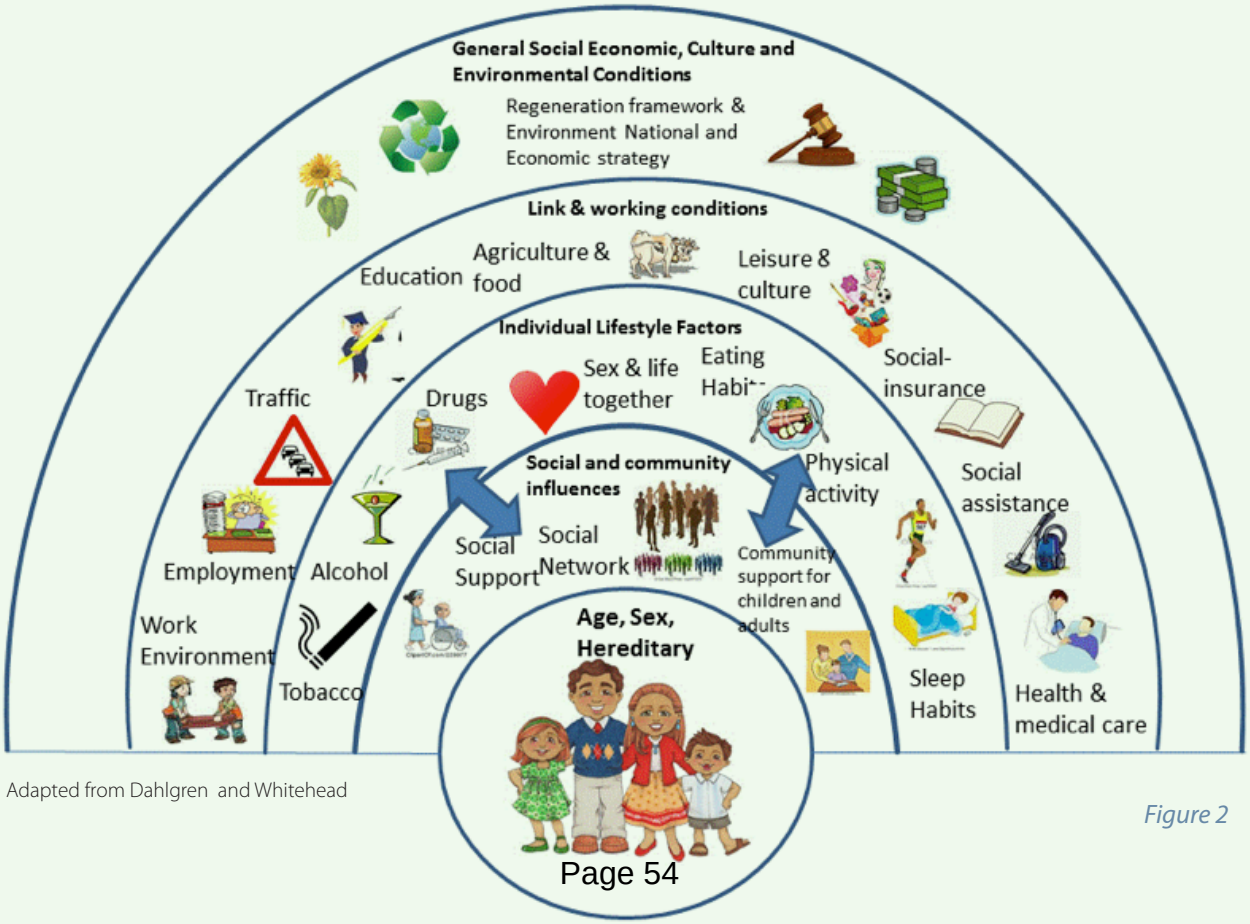
Outcome 2

Effective prevention of ill health by people taking greater responsibility for their health and wellbeing

To improve people's long term health we have to improve healthy lifestyles, encourage healthy eating in adults, and reduce levels of smoking. In addition to this, we will need to look at how we improve people's knowledge of the symptoms of various diseases such as cancer and what they can do prevent them, for example by encouraging physical activity.

A sustainable health and care system requires an integrated approach. It should consider the economic, social and environmental impacts of our decision making to ensure that the delivery of health and social care in Kent is sustainable and equitable, with outcomes benefitting residents now and into the future.

Figure 2 illustrates how we see the health and care system working in collaboration to support local communities. It is acknowledged that for a robust delivery of the strategy wider factors affecting short and long term physical and mental health need to be considered, such as access to green space, climate change resilience, air quality, housing, transport, inequality and employment . To address this, Kent partners have developed a Sustainability Needs Assessment as part of the Joint Strategic Needs Assessment (JSNA). The recommendations identified, in combination with ongoing delivery of the Kent Environment Strategy, underpin our approach to ensuring a sustainable health and care system Through a joined-up, or integrated, approach Kent County Council will make sure that the people of Kent have access to a good standard of education, a clean, safe and sustainable environment in which to live, with good employment opportunities, and will work with local businesses to ensure good workplace health.



Adapted from Dahlgren and Whitehead

Figure 2

The local level Health and Wellbeing Boards provide opportunities for colleagues in Primary Care, Clinical Commissioning Groups and District Councils to work collaboratively to promote prevention of ill health and reduce health inequalities. Figure 3 illustrates the role and contribution needed across the entire system, to promote prevention of ill health and how health inequalities are effectively reduced over the short, medium and long term. For instance in the short term Primary Care services have a major role to play in reducing the risk of people dying prematurely through interventions that control high blood pressure and high blood cholesterol.

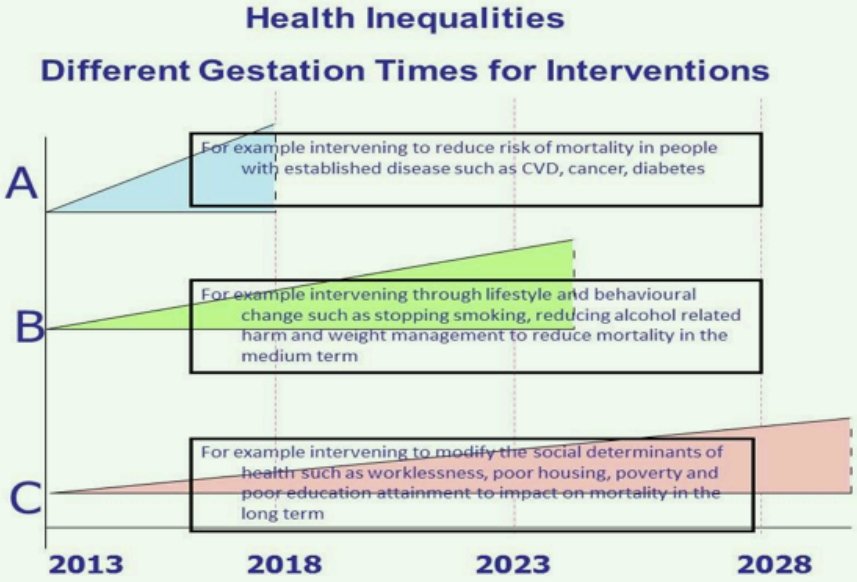
To influence medium term interventions we will ensure that commissioning of public health programmes deliver a transformed and integrated approach to public health, ensuring locally appropriate services and campaigns. Services will be based on "proportionate universalism" principles to ensure that there is the right balance of

- Whole population approaches that inspire citizens to take a much more active part in their immediate and long term health and wellbeing
- Effective screening of the population to identify intervention needs at the earliest time.
- Interventions which are targeted to small populations of high risk groups, particularly in relation to unhealthy behaviours such as, smoking, drinking and being physically inactive.

To influence long term interventions we will work with our colleagues in District Councils, Education system, Local Businesses etc. to support our local communities. Communities play an important part in our health and wellbeing and are crucial to people because fundamentally we are social creatures that thrive on social interactions. The influences on people's health are diverse and through this strategy we aim for the health and care system to support individuals and communities by providing an environment to make healthier choices as easier choices.

For instance Kent, the Garden of England, with miles of coastline, many country parks and green spaces, provides opportunities for improving physical activity, helping people feel connected with the environment that they live in. Public health traditionally assesses need by looking at what we lack – be it health or access to services. In Kent we want to focus on an 'asset' approach turns this on its head and which looks at all the positive and useful things available to us – from buildings, services, communities and networks that we can use along our health journey.

Shaping the physical environment of the community so that it can better promote healthier lifestyles is central to districts' regulatory health improvement role. The new National Planning Policy Framework highlights the role of the planning system in



(Figure 3 adapted from C.Bentley)

facilitating social interaction and creating healthy, inclusive communities. This includes measures aimed at reducing health inequalities, improving access to healthy food and reducing obesity, encouraging physical activity, improving mental health and wellbeing, and improving air quality to reduce the incidence of respiratory diseases.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average

Within this outcome the areas we need to focus on are:

- Reducing the proportion of adults with excess weight
- Increasing take up of NHS Health Checks

Priority 2 – Tackle health inequalities

The partners in the health and care system acknowledge the 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. Tackling health inequalities remains at the heart of preventative work, and we have published 'Mind the Gap', Kent's health inequalities action plan, which is driving improvements in all areas that affect people's health, including work, housing, access to health services and a healthy start for all children. It has excellent support from partners and has been complemented by a series of District level plans. . Kent has also developed a specific action plan 'Think Housing First' to address housing related health inequalities.

Local Health and Wellbeing Boards will continue to work with partners in the system to address health inequalities.

Another example is that of people with learning disabilities as they have poorer health outcomes than other population groups, because they may not be accessing routine screening or health support as consistently as other population groups. The Confidential Inquiry into premature deaths of people with intellectual disabilities (CIPLOD) in England provides evidence of the substantial contribution of factors relating to the provision of care and health services to the health disparities between people with and without intellectual disabilities.

It highlights a need to examine care and local service provision for this population as potentially contributory factors to their deaths—factors that can largely be ameliorated. For instance compared to other areas Kent has low uptake of annual health checks for people with learning disabilities. To address this low uptake, everyone known to have a learning disability will be offered a baseline Health Profile and a Health Action Plan will be developed.

Each GP surgery will have a link LD Nurse who will support them to understand the needs of people with a learning disability, and who can provide advice, guidance and education to GPs to ensure they can deliver an annual health check.

Priority 3 – Tackle the gaps in service provision

The introduction of integrated commissioning groups to support the work of each local Health and Wellbeing board has created a joint space where local plans can be discussed to ensure that they are joined together and can identify where gaps exist. The Public Health team are working to review all the services delivered by the Public Health grant to ensure that they are complimentary to other interventions, working to ensure that the patient journey is seamless.

All partners in the local health and care system have a role to play in prevention of ill health and we will continue to work across the system to understand areas that require improvement. For instance 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. There are short term interventions which can be influenced chiefly by primary care and assist in reducing health inequalities. Examples of the improvements needed to these services include:

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

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

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

We will locally translate principles recommended by Professor Chris Bentley (former national lead for the National Support Team for Health Inequalities). This would mean that we will work across the system to understand needs of our local population (CCG and district level) and industrialise evidence based cost effective interventions. For instance brief interventions for smoking and alcohol are both evidence based and cost effective and working through partners in the system we will work towards implementing 'every contact counts'

Keeping track of our progress in delivering Outcome 2

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

An increase in Life Expectancy at Birth

- An increase in Healthy Life Expectancy
- A reduction in the Slope Index for Health Inequalities
- A reduction in the proportion of adults with excess weight
- An increase in the number of people quitting smoking via smoking cessation services
- An increase in the proportion of people receiving NHS Health Checks of the target number to be invited
- A reduction in alcohol related admissions to hospital
- (Breast Cancer Screening) An increase in the proportion of eligible women screened adequately within the previous 3.5 or 5.5 years on 31st March
- (Cervical Cancer Screening) An increase in the proportion of eligible women screened adequately within the previous 3 years on 31st March
- A reduction in the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000)
- A reduction in the under-75 mortality rate from cancer (rate per 100,000)
- A reduction in the under-75 mortality rate from respiratory disease (rate per 100,000)
- A reduction in the under-75 mortality rate from cardiovascular disease (rate per 100,000).

Outcome 3

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

Nearly 16.5% of Kent's population live with a limiting long term illness, and in most cases they have multiple long term conditions (Figure 3), and need complex support and treatment.The numbers of those affected by multiple long term conditions are set to grow sharply. To improve outcomes for our population we need to shift our focus from treating individual illnesses to addressing the needs of the person as a whole person. This requires a rethinking of how care is commissioned and provided.

Care is often still organised according to 'physical healthcare' and 'social care', with each often delivered by separate organisations and groups of professionals. People do not recognise these distinctions, frequently have need of all … forms of support, and often end up required to do all the work as their own 'service integrator'.

The 2015 Challenge Declaration – NHS Confederation

There is widespread agreement across the health and social care system that things need to change, and that an integrated approach to care is needed if we are to meet this challenge. The journey has begun, and through the Better Care Fund, and Kent's status as an Integration Pioneer, we are in an excellent place to deliver. During the course of this strategy we will begin to see the emergence of a team around the patient with the GP taking the lead for their patient, treating the whole person, rather than each separate ailment. Delivery will generally be in community hubs, with technology increasingly playing a role in linking patients to their care providers, whilst allowing everybody involved, including the patient to see and adjust the same information.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average

Within this outcome, recent data highlights that in Kent we need to:

- Increase the percentage of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family (Persons/Male/Female)
- Increase early identification of diabetes
- Reduce the number of hip fractures for people aged 65 and over (rate per 100,000)

Priority 2 – Tackle health inequalities

From *Mind the Gap, Kent Health Inequalities Action Plan* the following areas have been identified as those in which inequalities have an impact on people's health. Under this priority we will:

- Support older people to live safe, independent and fulfilled lives and support disabled people to live independently at home
- Support self-management of long term conditions
- Deliver effective local services for falls, falls prevention and fractures and reduce the incidence of hip fractures in people aged 65 and over.
- Support people with Learning Disabilities with housing, employment, access to health services and leisure activities.
- Provision of adaptations and equipment to the home to prevent accidents with associated costs, and improve quality of life of recipients and carers.

The graph below shows that the top 0.5% (Band 1) of the Kent population who have been identified as having the highest risk of re-hospitalisation are patients who have at least 3 or more long term conditions, indicating that multi morbidity is the norm, not the exception. For example, only 5% of patients with dementia had only dementia, and only 1% of patients with COPD had only COPD.

Number of conditions experienced by band 1 patients with long Term Conditions in Kent, 2010/11

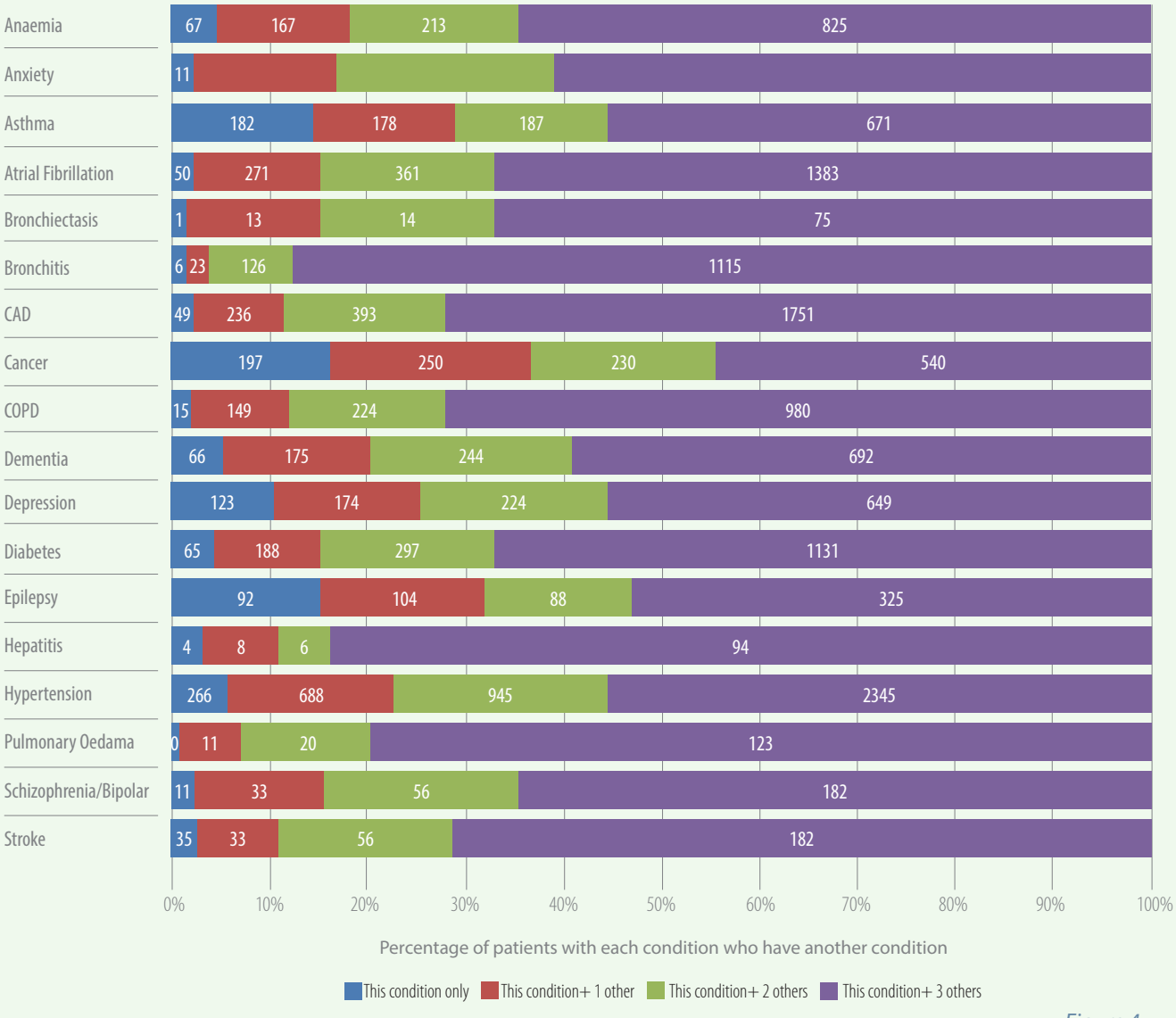


Figure 4

In this outcome the overriding delivery of Priorities 3 and 4 will be focussed around the work on the Better Care Fund

Kent will continue to be bold in developing new and different solutions to the challenges facing health and social care and as Integrated Care and Support Pioneers continue to work through partnerships that support integrated commissioning and deliver the provision of integrated services. 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.

To reflect the complex picture of health and social care within Kent the Better Care Fund is built up from the local level, with 7 area plans, across 3 care economies – giving a complete Kent plan. We will use the Better Care Fund to continue providing us with the opportunity to go further faster and start the longer programme of transformation provided by being a Pioneer. It will drive forward our integration programme, developing more community based services alongside the re-design and commissioning of 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 improves outcomes for people and means the reduction of hospital and care home admissions.

Priority 3 – Tackle the gaps in service provision and Priority 4 – Transform services to improve outcomes, patient experience and value for money

We know that our population is ageing and living longer; we will aim to focus on not just adding years to life, but also adding life to years. Management of long-term conditions requires a structured and consistent approach across the system, particularly around matching care to need.

We will work with our partners to implement a risk prediction approach, which will make it possible to identify those people who are the most regular users of hospital services (and are at risk of re-admissions), stratify them according to complexity of need and commission services to meet those needs. This is an approach that works equally for people with single diseases or multiple co-morbidities.

We will address gaps in current service provision and also work towards transforming services by commissioning and providing these in new ways. To do this we will work with health and social care providers (hospitals, primary care [General Practitioners, Community Pharmacists], social care and and community) to develop 24/7 access of good quality services that are delivered in the right place, at the right time.

Partners across the system will work in a coordinated manner to support implementation of primary care support for those 75 and over and those with complex health and social care needs. We will work with our partners to create a health and care system that supports people to live as independently as possible at home and ensures they receive good quality end of life care as and when needed.

We want to ensure that people using services have as much choice and control as possible when building their support package and are able to access services at the right time and place. We will work with our statutory partners and with community and voluntary sector partners to create systems to empower our citizens to be in control so that they are able to make informed choices about when, how and where to get their support. We want to ensure that services to our citizens are easily accessible, tailored to individual's needs, proactive and designed

to support self-management; for instance through the use of telecare.

Falls and fractures continue to be a significant public health issue particularly as an individual ages. 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. We will continue to work with our partners to address gaps in service commissioning and provision of falls prevention and management.

This will also mean addressing gaps in work force and skills issues, including those of carers. For instance many people with learning disability also have difficulties with communication and may need Speech and Language Therapy to work with carers to teach them different methods of communication. Also for people with learning disability, the aim of the integrated service is to provide quality services in a personalised way so that individuals (and carers) can receive the support they need in a way that enhances their independence. The teams will continue to support people with learning disabilities to live full and active lives within their local communities.

We will ensure that everyone who needs it will have a person centred support plan and help to find the best support to meet their individual needs. Everyone who has social care needs will have a personal budget and will be offered a Direct Payment.

Keeping track of our progress in delivering Outcome 3

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

- An increase in clients with community based services who receive a personal budget and/or direct budget
- An increase in the number of people using telecare and telehealth technology
- An increase in the proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services
- A reduction in admissions to permanent residential care for older people
- An increase in the percentage of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family (Persons/Male/Female)
- An increase in the percentage of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support. (Persons/Male/Female)
- A reduction in the gap in the employment rate between those with a learning disability and the overall employment rate
- An increase in the early diagnosis of diabetes.
- A reduction in the number of hip fractures for people aged 65 and over (rate per 100,000).

Outcome 4

People with mental ill health issues are supported to " live well".

Mental Health covers many separate conditions that vary in duration and severity. Common Mental Health conditions which can impact 1in 5 of the population, include depression and anxiety disorders. Severe mental disorders include psychosis and bi-polar disorder and can impact on around 1 in 2000 people per year. However there are many separate conditions that fall between these categories such as eating disorders. In addition mental illness can co-occur with learning/ physical disability and substance misuse.

We must also be mindful that suicide is a particularly traumatic consequence of mental distress. A large proportion of those committing suicide are not people with a chronic or severe mental illness. However the main cause of deaths for people with a mental health condition are cardiovascular disease, cancer and pulmonary disease and they die on average 20 years earlier than a person with no mental illness. This is an unnecessary and unfair inequality we will tackle as part of this strategy.

Therefore, in addition to ensuring that people with a mental health condition get high quality care, they must also have good quality physical health care. Also people with physical health problems can experience emotional consequences of their condition e.g association between psychological aspects of obesity or depression after an operation. Therefore 'health' and mental health are not separate issues and both need to be treated with equal 'esteem'.

The issue of mental wellbeing, mental illness and mental distress are all interlinked and there is also a clear link between loneliness and poor mental and physical health. Kent has detailed local strategies and plans associated with them and a key element of our local strategies is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. Although the commissioning of the services is shared between KCC, CCGs and NHS England, the outcomes are the responsibility of a far wider range of agencies including the public.

The outcome chosen for this overarching strategy is 'supporting those with a mental health issues to 'live well" and this involves helping people to keep themselves mentally and physically well, make the most of their communities and community resources, access the appropriate care and support and recover from their distress.

Priority 1. Tackle areas where Kent is performing worse than the England average:

In Kent we need to deliver:

- A reduction in the rates of suicides and support the families affected and we have a detailed suicide reduction strategy that will tackle this.
- An increase the percentage of people(using adult social care services) having as much social contact as they would like according to the Adult Social Care Users Survey
- An increase in the percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey
- An increase in the percentage of respondents who, according to the survey, are satisfied with their life, who are not feeling anxious, and who feel their life is worthwhile.

Priority 2. Tackle the health inequalities related to people who have mental health conditions.

- We will ensure that there is equity of access to mental health services for all people – starting with psychological therapies.
- We will use both needs and assets in understanding how to deliver good wellbeing support to local people. This means understanding the best way to utilise local buildings, services, groups and people to enhance a communities wellbeing.
- We will find better ways to engage people into their own care and support.
- We will get behind the 'Time to Change' campaign to tackle stigma and discrimination that often prevents people seeking help or giving help.
- We will work to Improve opportunities for people who have suffered mental health problems to train and return to employment.
- We will promote programmes that improve 'resilience' and recovery – particularly in areas in of greatest deprivation.
- We will target people from vulnerable groups e.g ex-military, ex-offenders and victims of violence to access the appropriate services and keep them well.

Priority 3. Tackle the gaps in provision and quality

- We will ensure that our data and information that we use for commissioning and providing care is of the highest quality possible.
- We will improve the quality of care for people with long term and chronic mental health conditions by sharing care between social care, secondary care and primary care.
- We will ensure that there are places of safety for people in distress
- We will improve the services and outcomes for young people transitioning from child to adult services.
- We will improve the chances of recovery for people with mental health conditions in primary care by reviewing medication and signposting effectively.
- We will continue the improvements made in assertive outreach and early intervention for psychosis.
- We will work with our front line workforce to raise awareness of mental health via high quality training.

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

- We will have a new and modern approach to supporting people with mental illness to stay well in the community- led by service user views.
- We will engage with the public, those both known and not known to services to fully understand what people want future services and support to look like.
- We will make the best use of public sector assets such as libraries and gateways to enable people to have access to stigma free and healthy environments.
- We will have a fully resourced public mental health programme- including campaigns and promotion that is on parity with other public health programmes, for example 'six ways to wellbeing' campaign.
- We will place recovery at the heart of all mental health services we commission.
- We will empower clinical staff to use their expertise and knowledge to improve services.
- We will improve the quality of services in primary mental health care.
- We will work with employers to reduce the stigma of mental illness and improve workplace wellbeing.

- Ensure that we have good emergency plans that minimise the impact of environmental events e.g floods on people's emotional wellbeing.

How we will Keep track of our progress in delivering Outcome 4

We have attempted to pick outcomes where we can measure our success. We know that we will have to improve our quality of data and in some cases – we will need to find new indicators of success. There are also national surveys which show Kent how we are progressing on our 'Wellbeing Index" and there is a National dataset of indicators and some of the following will help us track our progress.

- An increased crisis response of A&E liaison within 2 hours – urgent
- An increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours
- An increase in access to IAPT services
- An increase in the number of adults receiving treatment for alcohol misuse
- An increase in the number of adults receiving treatment for drug misuse
- A reduction in the number of people entering prison with substance dependence issues who are previously not known to community treatment
- An increase in the successful completion and non-representation of opiate drug users leaving community substance misuse treatment
- An increased employment rate among people with mental illness/those in contact with secondary mental health services
- A reduction in the number of suicides (rate per 100,000)
- An increase in the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey
- An increase in the percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey
- An increase in the percentage of respondents who, according to the survey, are satisfied with their life, who are not feeling anxious, and who feel their life is worthwhile.

Outcome 5

People with dementia are assessed and treated earlier and are supported to live well.

In Kent we will support people to live well with dementia. We know that the majority of people wish to live within their own home in their community for as long as possible; that they wish to be treated with dignity and respect and value the care and support they receive from their families and carers most highly. We will work with partner agencies to recognise this and work together to ensure this is achieved.

We are entering the second year of a programme to support Kent to become more Dementia Friendly, which focuses on improving the quality of life for people living with dementia along with their family, friends, and carers. Raising awareness and understanding is a key element of the work; to this end Dementia Champions are trained to go on and deliver Dementia Friends training. We have at least 27 Dementia Champions in Kent who have delivered training and recruited over 1,000 Friends.
Another key element of our approach to develop Kent to be more Dementia Friendly has been the establishment of a Kent Dementia Action Alliance. We will continue to promote the development of Alliances across the 12 Districts in Kent. We will ensure that the local and county Health and Wellbeing Boards regularly have Dementia Friendly Communities on their agendas to consider the themes from local Action Alliance member's action plans.

Priority 1 Tackle areas where Kent is performing worse than the England average

The national diagnosis rate for expected number of dementia cases is 48% and in Kent it is around 42%. One of our key objectives is to increase this rates to 67% by 2015. The two areas with the lowest levels of diagnosis are South Kent Coast CCG at 39% and Thanet CCG at 34.5%. We will be working with partners in the health and cares system to improve our diagnostic rates.

Priority 2 Tackle Health Inequalities

We will work with GP colleagues to address health inequalities through the use of the GP dementia enhanced scheme, which prioritises the assessment of people from high risk groups:

- Patients aged 60 and over with cardiovascular disease, stroke, peripheral vascular disease or diabetes;
- Patients aged 40 and over with Down's syndrome;
- Other patients aged over 50 with learning disabilities;
- Patients with long term neurological conditions e.g. Parkinson's Disease.

Due to the high incidence among people with Down Syndrome the community learning disability teams will screen people for dementia from the age of 30.

Priority 3: Tackle the Gaps in Provision and Quality

We will

- Address gaps in service provision of community Dementia Nurses.
- Ensure that dementia crisis service is available across the county.
- Continue to work with carers' organisations to monitor and refine joint health and social services investment in carers support
- Continue to train and up skill the workforce across all sectors.
- Ensure all acute trusts have trained dementia volunteer schemes to support people in hospital with social activities.
- Ensure all acute and community trusts have improved their hospital environments to make key areas in their hospital more dementia friendly.

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

We will achieve this by:

- Continuing a person-centred and integrated approach to care planning in hospital
- Improving access to diagnosis - the memory assessment pathway has been reviewed and updated and changes will be implemented during 2014-15 to bring closer working between primary and secondary care, making it easier to get a diagnosis.
- Improving Integration of Care - Kent is an Integration Pioneer and all CCGs have contracted for an integrated care pathway in 2014-15 to provide joined up and integrated care plans, including a crisis plan. Ensuring people are well supported following diagnosis and have access to appropriate support when required to avoid crisis admissions.
- Improving Urgent Care – a dementia crisis service has been introduced to help avoid unplanned admissions and help people through urgent care situation whilst maintaining people in their own homes.
- Ensuring Better Support for Carers – Kent County Council and all Kent CCGs have significantly increased funding into Carers Assessment and Support including a new rapid access to support for carers introduced across all CCGs to improve the health and wellbeing of carers, will be further developed and expanded in 2014.
- Improving discharge from hospital – support various schemes around discharge across the county using not for profit organisations including a bridging scheme provided by Alzheimer's and Dementia Support Services to support Darent Valley discharges and a Crossroads supported discharge scheme in all East Kent acute hospitals to support people to be discharged in a safe and timely manner and reduce excess bed days.

Keeping track of our progress in delivering Outcome 5

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

- An increase in the reported number of patients with Dementia on GP registers as a percentage of estimated prevalence
- A reduction in the rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000
- A reduction in the rate of admissions to hospital for patients older than 74 years old with a secondary diagnosis of dementia, rate per 1000
- A reduction in the total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000
- A reduction in the total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000
- An increase in the proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who
  a. have been identified as potentially having dementia
  b. who have been identified as potentially having dementia, who are appropriately assessed
  c. who have been identified as potentially having dementia, who are appropriately assessed, referred on to specialist services in England (by trust)
- A reduction in the proportion of people waiting to access Memory Services - waiting time to assessment with MAS.
- An increase in the proportion of patients diagnosed with dementia whose care has been reviewed in the previous 15 months
- A reduction in care home placements.

What is the Health and Wellbeing Board?

The Kent Health and Wellbeing Board was established by the Health and Social Care Act 2012. With effect from 1 April 2013 it became a committee of Kent County Council.

The board brings together County and District Councillors, senior officers from the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from the Local Healthwatch. It provides an effective body where commissioners, patient representatives and elected officials can come together to take an overview of the health system in Kent, align their work, and share commissioning plans and good practice.

The Board's statutory functions are to:

- Prepare a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy.
- Encourage integrated working between health and social care commissioners including making arrangements under Section 75 of the National Health Service Act 2006

Prior to April 2013 the Health and Wellbeing Board operated in a shadow form.

The Health and Wellbeing Board has established a series of sub-committees known as local Health and Wellbeing Boards. The local Health and Wellbeing Boards lead and advise on the development of Clinical Commissioning Group level integrated commissioning strategies and plans, ensure effective local engagement and monitor local outcomes. They focus on improving the health and wellbeing of people living in their CCG area through joined up commissioning across the NHS, social care, district councils, public health and other services to secure better health and wellbeing outcomes in their areas and better quality of care for all patients and care users.

Further information about the Health and Wellbeing Board, including its membership, can be found here: https://democracy.kent.gov.uk/mgCommitteeDetails.aspx?ID=790

Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

This page is intentionally left blank

Milestones	Actions	Timescale	Lead(s)
Develop draft-for engagement version of the Strategy	Draft the strategy document.	by 14th May	P&SR
	Artwork document	14 – 19 May	Comms
	Publish draft "for engagement" document with Board papers	19 May	Democratic Services
Agree version of Health and Wellbeing Strategy to go out for engagement	Draft considered by the Health and Wellbeing Board, with feedback / amendments provided	28 May	P&SR
	Changes to document made.	28-30 May	Comms
Complete equality impact assessment	Complete initial assessment to assist with identifying potential stakeholders and methods	By 2/6/14	P&SR
Identify key stakeholders	Complete mapping exercise of stakeholders	By 2/6/14	P&SR
Engagement starts	Press and media - press release	w/c 2/6/14	Press Office
	Press briefings with Roger Gough	w/c 2/6/14	Press Office
	Publication of draft Health and Wellbeing Strategy for Kent on kent.gov.uk	w/c 2/6/14	Comms
	Social media activity (Twitter) to inform public.		Comms
Publish survey to gather stakeholder feedback on the draft strategy	Draft survey based on key questions identified by public health.	By 2/6/14	P&SR &
	Survey to be made available on-line and hard copies available in key public areas (tbc)	From 2/6/14	Comms

	Circulate questionnaire to stakeholders: • CCG leads (will require direct targeting and personal approach) • District/Borough council • Providers • Healthwatch Kent • Voluntary & Community Sector (VCS) • KCC • Patient/service user and carer groups • Specific interest groups	From 2/6/14	To confirm
	Work with CCGs to promote through surgeries and other health settings.		P&SR and Comms
Attend public meetings to promote draft strategy and gather feedback	Raise at existing meetings, including patient and user groups across health and social care subject to timescales.	From 2/6/14	tbc
Maximise use of internal/external newsletters	Communicate via existing newsletters, including Healthwatch Kent	From 2/6/14	tbc
Closing date of formal engagement	Issue reminder press release a week before consultation closes with one page version of strategy	w/c 16 June	Press Office
	Increase Twitter activity	w/c 16 June	Comms
Data analysis	Analyse responses from consultation – analyst to be identified	From 1/7/14	tbc
Engagement report	Full report completed and published, alongside final version of HWB Strategy	By 16/7/14	tbc
Engagement	Continue engagement activity and capture feedback until HWB meets	To 16/7/14	

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

To: Health and Wellbeing Board, 16 July 2014

Subject: **Better Care Fund: National Review**

Classification: Unrestricted

Summary: This paper presents a summary of the recent Government announcement about the Better Care Fund.

Recommendation(s):

The Kent Health and Wellbeing Board is asked to consider and comment on the report.

1. Introduction

(a) The Department of Health and Department for Communities and Local Government has reviewed the first set of local plans for the Better Care Fund. A series of changes aimed at improving the Better Care Fund (BCF) was set out in a Government press release on 5 July 2014.[1]

(b) This release included the announcement that revised guidance for the development of the local BCF plans will be issued shortly. A new BCF programme director will also be appointed with a larger team working across the system.

(c) The changes relate to financial management of the risks associated with failure to reduce emergency admissions.

2. Reducing Accident and Emergency Admissions

(a) For Health and Wellbeing Boards, the key paragraph in the release is:

> "Up to £1 billion of the Better Care Fund will be allocated to local areas to spend on out-of-hospital services according to the level of reduction in emergency admissions they achieve. Local areas will agree their own ambition on reducing emergency admissions and they will be allocated a portion of the £1 billion performance money in the fund in accordance with the level of performance against this ambition. The remaining money from the performance pot not earned through reducing emergency admissions will be used to support NHS-

[1] https://www.gov.uk/government/news/better-care-plans-to-provide-dignity-independence-and-reduce-ae-admissions

commissioned local services, as agreed by Health and Wellbeing Boards."

(b) What this means in practice is as yet unclear. The guideline reduction in unplanned admissions is to be 3.5%, equating to around 185,000 fewer admissions nationally per year. Local areas will be expected to agree their own ambition for reducing emergency admissions.

(c) The more local areas are successful in achieving their target, the more money will be released which will be able to be spent on other services. However, the money will be retained to pay for the unplanned admissions which still occur short of the target. The paragraph above also suggests that the entire £1 billion will effectively be ring-fenced within BCF budgets for spending on NHS-commissioned services – either held back to pay for unplanned admissions to acute hospitals or on other locally commissioned services.

(d) It is also unclear whether the money held back will be paid directly to the acute Trusts or whether CCGs will be directed to pay them.

(e) Commentary in the Local Government Chronicle[2] suggests that a 3.5% cut in accident and emergency admissions equates to savings nationally of around £400 million. This leaves £600 million to be definitely spent on other NHS-commissioned services. The precise impact on Kent will depend on the target determined locally and the current levels of unplanned admissions.

(f) The Health and Social Care Information Centre produce annual figures for accident and emergency admissions. The 2013/14 report is not available but it is possible that Kent figures will be available in some form for the meeting.

(g) This still leaves £2.8 billion nationally, from the original BCF of £3.8 billion, to be spent as local areas determine. However, the original guidance out conditions on the whole budget and there may be more details about the rest of the budget in the final guidance.

3. Progress of the BCF Nationally

(a) 80% of the 151 local BCF plans have been identified as being on course to transform out-of-hospital services. In addition, 14 areas have been identified as being able to fast track the completion of their plans. These are: Dudley; Hammersmith and Fulham; Kensington and Chelsea; Westminster; Greenwich; Leeds; Liverpool; Nottinghamshire; Reading; Sunderland; Rotherham; and Torbay.

(b) Although the integration pioneers in many cases cover a wider geography than BCF plans, there are three pioneer areas on this list – Greenwich, Leeds and South Devon and Torbay.

[2] http://www.lgcplus.com/5072695.article

(c) All Better Care Funds plans are expected to launch on 1 April 2015, following a further process on assurance and ministerial sign off of the revised plans that are expected to be submitted later in the summer.

(d) The Government press release also confirms that the BCF will become an established feature of the health and care system in the future.

4. Next Steps

(a) A final decision on next steps may need to wait upon the revised guidance, but consideration will need to be given as to the local target for reduced unplanned admissions. It would also be appropriate to consider how progress can best be measured against this target locally and at what level (County, health economy or CCG) along with the most appropriate mechanisms for determining what actions to take in the case of non-delivery against this target.

(b) There are a number of issues which will need settling before any final decision can be made, including:

1. Are there any perverse incentives with setting a target which will need to be guarded against?

2. What figure will the reduction be counted against and how will responsibility be divided across multiple CCGs and a complex geography? For example, what will happen if one acute Trust reaches the target and another one does not, will money be withheld to pay for the admissions at the Trust which does not?

Recommendation(s)

The Kent Health and Wellbeing Board is asked to consider and comment on the report.

Background Documents

None.

Contact Details

Mark Lemon
Strategic Business Advisor
Mark.lemon@kent.gov.uk
Internal: 6252
External: 01622 696252

Tristan Godfrey
Policy Manager (Health)
Tristan.godfrey@kent.gov.uk
Internal: 4270
External: 01622 694270

This page is intentionally left blank

By: NHS Ashford and NHS Canterbury and Coastal CCGs

To: Kent Health and Wellbeing Board – 16 July 2014

Subject: Potential merger of Ashford Clinical Commissioning Group and Canterbury and Coastal Clinical Commissioning Group

Classification: Unrestricted

Summary: Ashford Clinical Commissioning Group (CCG) and Canterbury and Coastal CCG are exploring the benefits of a potential merger. The CCGs' memberships will vote on whether they should merge in July 2014. Should the votes give approval for a merger to progress, evidence will need to be submitted to NHS England Local Area Team, Regional Team and central office. Without a supportive majority vote from the membership a merger will not progress. The attached slide pack contains further information on the rationale for merging.

Recommendations: The Health and Wellbeing Board is asked to note the contents of the attached slide pack and the intention to take a vote on merging the CCGs' membership in July 2014. Should the outcome of the vote be in favour of merging, further information will be circulated to the Health and Wellbeing Board members for comment during the summer. Additionally a view is now being sought from the HWB on the structure of local HWBs in the event of a vote to proceed with the merger.

Background

Ashford and Canterbury and Coastal CCGs share a joint leadership team and over the past 17 months have developed close working relationships and resources on shared projects. Their emerging business strategies, governance and ways of working are very similar.

Over the last year the Operational Leadership Team have begun to make assumptions about the benefits of a possible merger and wanted to explore this further.

Following positive discussions at Governing Body level, the member practices agreed to explore a merger between the two CCGs ahead of a formal vote on this in July 2014.

This document is intended to update the Health and Wellbeing board on the status of the project and request a view on the future structure of local HWBs in the event of a vote to proceed with a merger by the CCG membership.

Four elements of this are explored in this pack:

1. Benefits of merging
2. Financial case for merging
3. Proposed merged organisational design
4. Frequently asked questions

This page is intentionally left blank

Kent Health and Wellbeing Board
Merger Discussion Pack

NHS Ashford Clinical Commissioning Group

NHS Canterbury and Coastal Clinical Commissioning Group

July 2014

Project background

Ashford and Canterbury and Coastal CCGs share a joint leadership team and over the past 17 months have developed close working relationships and resources on shared projects. Their emerging business strategies, governance and ways of working are very similar.

Over the last year the Operational Leadership Team have begun to make assumptions about the benefits of a possible merger and wanted to explore this further.

Following positive discussions at Governing Body level, the member practices agreed to explore a merger between the two CCGs ahead of a formal vote on this in July 2014.

This document is intended to update the Health and Wellbeing board on the status of the project.

Four elements of this are explored in this pack:

1. Benefits of merging
2. Financial case for merging
3. Proposed merged organisational design
4. Frequently asked questions

Three key benefits of merging

1. Stronger clinical input

- At the moment the two CCGs are finding it difficult to fill all clinical lead positions
- There is currently duplication of effort between Ashford's and C&C's clinical leads
- A merged CCG will enable the CCGs to fulfil all clinical lead positions and give clinical leads more time to focus on our most important issues.

1. Merged CCG leadership and commissioning teams would operate more efficiently and improve focus on delivery

- Leadership time is currently too heavily weighted on running and administering two sets of the same meetings
- Currently two teams could work on the same project even though the end goals are the same
- A merged CCG will allow our leadership and commissioning teams to spend more time on project delivery and communicating with our member practices.

1. Future financial risks would be mitigated

- All CCGs have been asked to make 10% internal cost savings in 2015 and the merger will allow us to do this whilst increasing our focus on our localities and member practices
- A merged CCG would help both CCGs manage the risks associated with their commissioning budgets and targets

Benefits of merging: further points

- Care closer to home and work to take place at a very local level
  - staff will be re aligned to community networks as part of internal re-organisation which will transform local health and social care services

- Increased commissioning power
  - e.g. one larger CCG has more leverage over its providers than a smaller CCG

- Improvements for providers
  - as less of their time will need to be focused on meetings with two sets of commissioners.

- Enable delivery of Kent Health and Wellbeing board strategy
  - Management time will be freed up to help focus on delivery and provide a single point of contact for our partner organisations.

Financial case for merging

- It is estimated that merging presents opportunities to better manage the corporate budget - this will prove very difficult to achieve if the status quo is maintained.
- Increases in costs expected as a result of a merger are expected to be nil.
- The estimated, anticipated savings in terms of cash and resource are as follows:

Cash Saving Description	£'000
Clinical Input	121
Internal Audit	40
External Audit	50
External Commissioning Support	320
Total	**531**

Resource Saving Description	Whole Time Equivalent	£'000
Executive team	0.93	104
Commissioning team shared posts	0.66	43
Commissioning team CCG specific posts	0.26	11
Finance team	1.94	44
Health economy as a whole	0.54	29
Total	**4.33**	**231**

Proposed organisational design: overview

•Staff will be allocated across across key strategic projects e.g. Community Networks and Integrated Urgent Care Centre.

•The merged CCG will additionally implement three localities instead of the current two to increase locality focus i.e. 1 x Ashford and 2 x Canterbury localities.

•Each locality will have a named lead to pick up local issues and drive change at a local level.

•The named lead will dedicate an agreed % of their time to the project and the locality to which they are allocated

•This will help to flesh out locally designed plans and help bring these to fruition.

•The current preference is to keep two local health and wellbeing boards to maintain a local focus. However it would be useful to understand the Kent HWB view on this.

Frequently asked questions

Question	Response
1) Is the merger a done deal?	No. At the moment we are exploring the possibility of a merger. We need to ensure any benefits would clearly outweigh any potential drawbacks and that our practices are supportive of the idea. Only then will we 'officially' progress the merger with NHS England. NHS England has the final say as to whether a merger could go ahead.
2) What about merging with other CCGs? Why just NHS Ashford CCG and NHS Canterbury and Coastal CCG?	NHS Ashford CCG and NHS Canterbury and Coastal CCG are closely aligned organisations which already share an Operational Leadership Team (OLT) and some CCG staff. The OLT felt it natural that in the first instance any exploration of a merger would be between these two organisations. As part of our engagement work we will speak to our neighbouring CCGs to make them aware of the potential plans. We think it's unlikely that any other CCG will want to look at a possible merger. If they do express an interest, we will of course take this into account and make all the relevant parties aware.
3) What would happen if the CCGs continue as separate organisations?	We are certain that we will all be facing financial pressures over the coming years. We are already aware that we have been asked to make a 10 per cent internal cost saving next year. It seems sensible to take a proactive approach to mitigating any potential issues or difficulties now, rather than waiting for them to happen. We believe a merger will help to protect the long-term future of our CCGs as the organisations responsible for planning and paying for the majority of people's healthcare. If we are able to reduce the amount of duplication we will be able to focus more on the delivery of our commissioning intentions which will further help to sustain the organisation.
4) If we did merge, how would we retain a sense of localism?	If the merger goes ahead we believe it will allow us more time to focus on our overarching plans to develop community networks. We envisage the networks being based around natural communities with GP practices as the cornerstone. The proposed locality structure detailed earlier in this document will also ensure staff are focused on moving forward locally-seeded ideas.

This page is intentionally left blank

By:	Roger Gough Cabinet Member for Education and Health Reform
To:	Kent Health and Wellbeing Board -
Date:	16 July 2014
Subject:	Summary Assurance Framework
Classification:	Unrestricted

1. Introduction

This report aims to provide the Kent Health and Wellbeing Board with a summary of the assurance framework indicators where there are concerns identified or increasing good performance at four levels, namely, Kent, District and CCGs and Trusts. The board members are also asked to make a decision on the points raised in section 3.

2. Indicator summary for noting

Please refer to the full Assurance Report and Appendix 1 for the full figures.

Outcome 1: Every child has the best start in life.

- Local Data on **smoking status at time of delivery** (SATOD) continues to show Kent as having a higher proportion when compared to the national status, The national proportion was 12.7% in 2012/13 and local Kent data has 13.1% in 2013/14; there were 3 CCGs above the Kent proportion, with Swale the highest at 20.6%, Thanet at 17.0% and South Kent Coast at 16.5%.
- Kent level figures for **unplanned hospitalisation** are improving, **epilepsy** rates have decreased from 9.4 to 8.8, **asthma** from 14.8 to 14.6 and **diabetes** from 7.6 to 7.3. However there are increases for epilepsy rates in Ashford, Swale and Thanet; for asthma in Ashford, Canterbury & Coastal and South Kent Coast; for diabetes in South Kent Coast, Swale and West Kent (all 2012/13 to 2013/14).
- Kent is also decreasing and below national rate for **under 18 conception** rate in 2012 (25.9 per 1,000 for Kent and 27.7 national) however there is variety across the districts, from 13.5 in Tunbridge Wells to Thanet at 36.1 and Swale at 35.6. It should be noted though that most of the districts had decreased from 2011 except for Dartford (increased by 4.5) and Tonbridge & Malling (increased by 4.3).
- Kent is currently not an outlier on either of the **excess weight in children** metrics (4-5 years old 21.7% and 32.7% for 10-11 year olds, 2012/13) being not significantly different to the national (22.2% and 33.3% respectively). By district those aged 4-5 years old with excess weight ranged from 19.2% in Sevenoaks to 24.4% in Maidstone; whereas for 10-11 year olds with excess weight the lowest proportion was 29.8% in Canterbury to 36.4% in Gravesend. 2013/4 will be the first year where cohort comparisons can be made and the changes between those measured when they were 4-5 and now 10-11.

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

- The **under-75 mortality rate for cancer** (2010-12) ranges between 111.43 per 100,000 for Ashford CCG to 147.87 at South Kent Coast. For respiratory disease Thanet was the highest at 40.17 per 100,000 and Swale was the lowest at 23.56. In addition to Swale being the lowest in 2010-12, it should be noted that 2 years ago Swale CCG had the highest mortality rate compared to the other Kent CCGs.
- There has been improved performance in both the **NHS Health Check** take-up and the number of people quitting smoking via the smoking cessation services in Q4 2013/14; however Public Health will continue to monitor these services closely.
- The **hip fracture rate** for Kent has gradually been increasing; local data shows an increase from 2010/11 at 410.15 per 100,000 to 2013/14 at 480.47. 2012/13 varies between 397.7 per 100,000 in West Kent CCG to 559.6 in Swale CCG. Swale CCG was the only area to decrease from 2012/13 to 2013/14, with a decrease from 770.77 to 559.60. Work at local CCG level has commenced to address this increase in rate.
- The proportion of **adults with excess weight** in Kent is 64.6% this is similar to the national proportion of 63.8%; Canterbury District has the lowest proportion at 54.2% whereas Swale has the highest at 68.8% followed closely by Thanet at 68.4%.
- Ashford district had the lowest proportion of **physically active adults** 48.7%; Kent did not differ greatly from the national percentage with 57.2% compared to 56.0%. Tunbridge Wells was the highest district at 64.8%.

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

- There has been a further drop in the proportion of people receiving a **personal budget and/or direct budget**, this is due to more people receiving a short term service such as enablement or telecare and would not therefore be eligible for a personal budget or direct payment.
- There have been further increases in the number of people using **telecare and telehealth technology** and to February 2014 there were 2,992 clients, which is far exceeding the target of 2,125.
- CCG level figures on both Outcome 3 indicators will be presented in the next report.

Outcome 4: People with mental health issues are supported to "live well".

- The proportion of **A&E referrals** to liaison psychiatry assessment within 2 hours for Kent has decreased from Q1 to Q3 2013/14, from 84.7% to 73.5%; there is variance between the CCGs in Q3 with DGS at 90.8% within 2 hours and SKC at 57.5%; SKC experienced low percentages specifically in November and December. All CCGs had 100% being seen within 24 hours.
- The rate of **successful completion and non-representation** back into treatment services within 6 months of opiate drug misusers in Kent has fallen from 14.4% in 2011/12 to 10.0% in 2012/13; however Kent still remains above national figures of 8.1%.

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

- The reported number of **dementia patients on GP registers** as a proportion of estimated prevalence in 2012/13 varied from 34.6% in Thanet to 44.8% in Swale; all CCGs have increased from 2011/12. The Kent proportion for 2012/13 was 41.5%.

- **Admission rates for 64 year olds** and over with a secondary diagnosis of dementia was between 20.5 per 1,000 in Ashford and 28.8 in Canterbury (2013/14).
- This is mirrored in the rate for **over 74 year olds** with Ashford lowest at 43.3 and Canterbury highest at 56.6 (2013/14).
- **Bed-days in hospital for over 64 year olds** with secondary diagnosis of dementia varied greatly across the CCGs, Kent was 225.7 per 1,000, the lowest CCG was SKC at 183 and the highest was DGS at 342.8 (2013/14).
- The number of **bed-days increased for over 74 year olds** with 327 per 1,000 at Canterbury to 673.0 per 1,000 at DGS (2013/14).
- The dementia indicator that looks into **identification, assessment and referrals** by trust has Medway NHS Foundation Trust was below target in Q4 2013/14 on identification and assessment. The figures do not disaggregate between Kent and Medway residents, and Swale residents access Medway Hospital.

Stress Indicators

- Overall for Kent the number of people waiting for routine treatment with **CAMHS** has been decreasing since December 2013; the highest number of people waiting for treatment is between 7 and 13 weeks and includes the time they waited to assessment. The waiting list is clinically-led and those presenting with high/complex needs are moved into treatment as a priority.
- **Overnight bed occupancy rates** for quarter 4 2013/14 vary between 92.3% at East Kent Hospitals University NHS Foundation Trust to 96.7% at DGS NHS Trust. Trend data indicated that DGS, EKHUFT, MTW and KMPT all have a gradual upward trend; for MFT it is indicated that there has been no overall increase or decrease.
- **A&E Attendances within 4 hours** from arrival also varies from 83.2% in Medway NHS Foundation Trust to 97.9% in DGS NHS Trust. These figures relate to the week ending 25/05/2014. Trend data indicated stable lines for EKHUFT and MTW, DGS experienced a gradual increase and MFT a downward trend.
- There was a reduction in the number of **admissions to permanent residential care** for older people in April 2014 of 100 from 127 people in March, and is now below the 130 target (maximum target).

3. Points for decision

The Board are asked to note and agree the following proposals.

- Further discuss at local boards the areas of variance between CCGs or districts in the metrics outlined above.

- Seek assurances that plans are in place regarding the reductions surrounding successful treatment exits and non-representations in substance misuse services.

- Local Assurance framework reports are in development and will be presented to Local H&W Boards over the next quarter

Report Prepared by

Malti Varshney, Consultant in Public Health
Malti.varshney@kent.gov.uk

Helen Groombridge, Performance Officer Public Health
Helen.groombridge@kent.gov.uk

Mark Gilbert, Commissioning and Performance Manager Public Health
Mark.gilbert@kent.gov.uk

Mark Lemon, Strategic Business Advisor, Business Strategy and Support
Mark.lemon@kent.gov.uk

Appendix 1: CCG Level Figures

Please note that only metrics with CCG level figures are included in these tables, these will be developed to include District and Trust level data. All CCG level data has been either sourced from the Kent and Medway Public Health Observatory or from KMCS and may differ from those published in the PHOF or elsewhere due to differences in methodology. RAG rating is in comparison to Kent.

Outcome 1: Every child has the best start in life – CCGs									
Indicator - Targeted	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
1.4 No. of pregnant women with a smoking status at time of delivery	2013/14	13.1%	10.9%	12.8%	12.9%	16.5%	20.6%	17.0%	9.4%
Indicator - Associated									
1.5 Unplanned hospitalisation for asthma under 19s (rate per 10,000)	2013/14	14.6	16.6	11.5	16.5	18.0	16.3	14.8	12.3
1.6 Unplanned hospitalisation for diabetes under 19s (rate per 10,000)	2013/14	7.3	4.7	7.9	6.2	9.6	10.2	11.9	5.5
1.7 Unplanned hospitalisation for epilepsy under 19s (rate per 10,000)	2013/14	8.8	8.1	8.2	9.9	6.4	13.6	15.7	6.5

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing – CCGs									
Indicator - Targeted	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
2.1 under 75 mortality rate from cancer (rate per 100,000)	2012	135.5	111.4	121.0	128.5	147.9	133.8	140.0	145.2
2.2 under 75 mortality rate from respiratory disease (rate per 100,000)	2012	30.7	28.1	26.8	30.1	34.8	23.6	40.2	30.0
2.3 proportion of people receiving NHS Health Checks (where GP practice can be linked)	2013/14	36.1%	38.7%	40.1%	15.9%	33.6%	28.3%	29.2%	27.8%
2.4 number of people quitting smoking	2013/14	5254	420	630	834	957	518	930	965
2.5 number of hip fractures people aged 65+ (rate per 10,000)	2013/14	480.5	459.7	562.5	554.9	431.5	559.6	540.9	397.7
2.6 deaths attributable to smoking persons aged 35+ (rate per 100,000)	2010-12	295.5	245.3	270.4	287.7	301.7	334.8	333.9	299.2

Outcome 4: People with mental health issues are supported to 'live well' – CCGs									
Indicator - Associated	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
4.3 crisis response of A&E liaison within 2 hours - Urgent	Q3 13/14	73.5%	**65.4%**	**67.6%**	**90.8%**	**57.5%**	**86.0%**	**80.9%**	**81.0%**
4.4 crisis response of A&E liaison, all urgent referrals to be seen within 24 hours	Q3 13/14	100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Outcome 5: People with dementia are assessed and treated earlier – CCGs									
Indicator - Targeted	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
5.1 reported no. of dementia patients on GP registers as a % of estimated prevalence	2011/12	**39.4**	**41.1**	**39.2**	**43.8**	**37.3**	**42.4**	**33.0**	**40.1**
	2012/13	**41.5**	**43.0**	**43.2**	**44.2**	**38.7**	**44.8**	**34.6**	**42.6**
	Direction of travel	⇧	⇧	⇧	⇧	⇧	⇧	⇧	⇧
5.2 admissions to hospital for patients 64+ with a secondary diagnosis of dementia (rate per 1000)	2012/13	**25.0**	**19.9**	**28.5**	**28.8**	**25.4**	**20.5**	**26.2**	**23.0**
	2013/14	**25.1**	**20.5**	**28.8**	**27.0**	**25.1**	**21.3**	**26.1**	**24.1**
	Direction of travel	⇩	⇩	⇩	⇧	⇧	⇩	⇧	⇩
5.3 admissions to hospital for patients 74+ with a secondary diagnosis of dementia (rate per 1000)	2012/13	**49.9**	**40.7**	**57.3**	**56.5**	**50.0**	**45.9**	**49.6**	**46.3**
	2013/14	**50.5**	**43.3**	**56.6**	**53.3**	**50.3**	**48.7**	**50.2**	**48.5**
	Direction of travel	⇩	⇩	⇧	⇧	⇩	⇩	⇩	⇩
5.4 Total bed-days in hospital per population for patients 64+ with a secondary diagnosis of dementia (rate per 1000)	2012/13	**231.8**	**177.3**	**192.5**	**303.9**	**191.0**	**225.4**	**201.2**	**262.3**
	2013/14	**225.7**	**187.6**	**168.1**	**342.8**	**183.0**	**257.4**	**193.0**	**231.4**
	Direction of travel	⇧	⇩	⇧	⇩	⇧	⇩	⇧	⇧

Outcome 5: People with dementia are assessed and treated earlier – CCGs									
Indicator - Targeted	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
5.5 Total bed-days in hospital per population for patients 74+ with a secondary diagnosis of dementia (rate per 1000)	2012/13	**464.0**	**351.4**	**392.8**	**592.1**	**370.7**	**514.9**	**385.8**	**529.3**
	2013/14	**452.5**	**382.4**	**327.1**	**673.0**	**363.9**	**573.1**	**383.1**	**467.7**
	Direction of travel	⇧	⇩	⇧	⇩	⇧	⇩	⇧	⇧

Stress Indicators – Children's Services CCG									
Indicator - Targeted	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
6.1 Decrease the number waiting for routine treatment after assessment – CAMHS (number)	April 2014	565	16	0	216	120	69	49	95
6.2 The number of people on the CAMHS Caseload (excluding Medway and Out of Area)	April 2014	8523	724	1206	1432	1347	531	1250	2033

This page is intentionally left blank

By:	Roger Gough Cabinet Member for Education and Health Reform
To:	Kent Health and Wellbeing Board
Date:	16th July 2014
Subject:	Assurance Framework
Classification:	Unrestricted

Summary: This section outlines changes for some of the indicators and highlights those raising concerns or showing increasing good performance.

Outcome 1: Every child has the best start in life.

- Local Data on smoking status at time of delivery (SATOD) continues to show Kent as having a higher proportion when compared to the National status, The National proportion was 12.7% in 2012/13 and local Kent data has 13.1% in 2013/14.; there were 3 CCGs above the Kent proportion, with Swale the highest at 20.6%, Thanet at 17.0% and South Kent Coast at 16.5%.
- Kent level figures for unplanned hospitalisation are improving, epilepsy rates have decreased from 9.4 to 8.8, Asthma from 14.8 to 14.6 and diabetes from 7.6 to 7.3. However there are increases for Epilepsy rates in Ashford, Swale and Thanet; for Asthma in Ashford, Canterbury & Coastal and South Kent Coast; for Diabetes in South Kent Coast, Swale and West Kent. (all 2012/13 to 2013/14).
- Kent is also decreasing and below national rate for under 18 conception rate in 2012 (25.9 per 1,000 for Kent and 27.7 National) however there is variety across the districts, r from 13.5 in Tunbridge Wells to Thanet at 36.1 and Swale at 35.6. It should be noted though that most of the districts had decreased from 2011 except for Dartford (increased by 4.5) and Tonbridge & Malling (increased by 4.3).
- Kent is currently not an outlier on either of the excess weight in children metrics (4-5 years old 21.7% and 32.7% for 10-11 year olds, 2012/13) being not significantly different to the National (22.2% and 33.3% respectively) By District those aged 4-5 years old with excess weight ranged from 19.2% in Sevenoaks to 24.4% in Maidstone; whereas for 10-11 year olds with excess weight the lowest proportion was 29.8% in Canterbury to 36.4% in Gravesend. 2013/4 will be the first year where cohort comparisons can be made and the changes between those measured when they were 4-5 and now 10-11.

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

- The under-75 mortality for cancer (2010-12) ranges between 111.43 per 100,000 for Ashford CCG to 147.87 at South Kent Coast. For respiratory disease Thanet was the highest at 40.17 per 100,000 and Swale was the lowest at 23.56. In addition to Swale being the lowest in 2010-12, it should be noted that 2 years ago Swale CCG had the highest mortality rate compared to the other Kent CCGs.
- There has been improved performance in both the NHS Health Check take-up and the number of people quitting smoking via the smoking cessation services in Q4 2013/14; however Public Health will continue to monitor these services closely.
- The hip fracture rate for Kent has gradually been increasing; local data shows an increase from 2010/11 at 410.15 per 100,000 to 2013/14 at 480.47. 2012/13 varies between 397.7 per 100,000 in West Kent CCG to 559.6 in Swale CCG. Swale CCG was the only area to decrease

from 2012/13 to 2013/14, with a decrease from 770.77 to 559.60 (KMPHO) Work at local CCG level has commenced to address this increase in rate.

- The proportion of adults with excess weight in Kent is 64.6% this is similar to the National proportion of 63.8% ; Canterbury District has the lowest proportion at 54.2% whereas Swale has the highest at 68.8% followed closely by Thanet at 68.4%.
- Ashford district had the lowest proportion of physically active adults 48.7%, Kent did not differ greatly from the National percentage with 57.2% compared to 56.0%. Tunbridge Wells was the highest district at 64.8%.

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

- There has been a further drop in the proportion of people receiving a personal budget and/or direct budget, this is due to more people receiving a short term service such as enablement or telecare and would not therefore be eligible for a personal budget or direct payment.
- There have been further increases in the number of people using telecare and telehealth technology and to February 2014 there were 2,992 clients, which is far exceeding the target of 2,125.
- CCG level figures on both Outcome 3 indicators will be presented in the next report.

Outcome 4: People with mental health issues are supported to "live well".

- The proportion of A&E referrals to liaison psychiatry assessment within 2 hours for Kent has decreased from Q1 to Q3 2013/14, from 84.7% to 73.5%; there is variance between the CCGs in Q3 with DGS at 90.8% within 2 hours and SKC at 57.5%; SKC experienced low percentages specifically in November but also in December. All CCGs had 100% being seen within 24 hours.
- The rate of successful completion and non-representation back into treatment services within 6 months of opiate drug misusers in Kent has fallen from 14.4% in 2011/12 to 10.0% in 2012/13; however Kent still remains above national figures of 8.1%.

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

- The reported number of dementia patients on GP registers as a proportion of estimated prevalence in 2012/13 varied from 34.6% in Thanet 44.8% in Swale; all CCGs have increased from 2011/12. The Kent proportion for 2012/13 was 41.5%
- Admission rates for 64 year olds and over with a secondary diagnosis of dementia was between 20.5 per 1,000 in Ashford and 28.8 in Canterbury (2013/14).
- This is mirrored in the rate for over 74 year olds with Ashford lowest at 43.3 and Canterbury highest at 56.6 (2013/14).
- Bed-days in hospital for over 64 year olds with secondary diagnosis of dementia varied greatly across the CCGs, Kent was 225.7 per 1,000, the lowest CCG was SKC at 183 and the highest was DGS at 342.8 (2013/14).
- The number of bed-days increased for over 74 year olds with 327 per 1,000 at Canterbury to 673.0 per 1,000 at DGS (2013/14).
- The dementia indicator that looks into identification, assessment and referrals by trust has Medway NHS Foundation Trust as below target in Q4 2013/14 on identification and assessment. The figures do not disaggregate between Kent and Medway residents, and Swale residents access Medway Hospital.

Stress Indicators

- Overall for Kent the number of people waiting for routine treatment with **CAMHS** has been decreasing since December 2013; the highest number of people waiting for

treatment is between 7 and 13 weeks and includes the time they waited to assessment. The waiting list is clinically managed and those presenting with high/complex needs are moved into treatment as a priority.

- Overnight bed occupancy rates for quarter 4 2013/14 vary between 92.3% at East Kent Hospitals University NHS Foundation Trust to 96.7% at DGS NHS Trust. Trend data indicated that DGS, EKHUFT, MTW and KMPT all have a gradual upward trend; for MFT it is indicated that there has been no overall increase or decrease.
- A&E Attendances within 4 hours from arrival also varies from 83.2% in Medway NHS Foundation Trust to 97.9% in DGS NHS Trust. These figures relate to the week ending 25/05/2014. Trend data indicated stable lines for EKHUFT and MTW, DGS experienced a gradual increase and MFT a downward trend.
- There was a reduction in the number of admissions to permanent residential care for older people in April 2014 of 100 from 127 people in March and is now below the 130 target (maximum target).

For Decision: The Health and Wellbeing Board is asked to:

- Further discuss at local boards the areas of variance between CCGs or districts in the metrics outlined above.

- Seek assurances that plans are in place regarding the reductions surrounding successful treatment exits and non-representations in substance misuse services.

- Local Assurance framework reports are in development and will be presented to Local H&W Boards over the next quarter

1. Introduction

This report aims to provide the Kent Health and Wellbeing Board with performance figures on a suite of indicators based on Kent's Health and Wellbeing Strategy; it is arranged on the 5 Outcomes with additional stress indicators. Dementia is on the agenda for this Board meeting. To avoid duplication data on dementia is reported as an integral part of the Dementia paper and not included in this report.

The report has also begun to incorporate CCG and District level data; this will allow further analysis and action identification. CCG level data and corresponding Kent figures have all been sourced either direct from provider or commissioning agency or though the Kent and Medway Public Health Observatory, please note they may differ from the main indicators which are sourced from published frameworks. Only CCG level data is presented in additional tables, District data will be tabled in the next report.

2. Progress since the last report

Since the last Health and Wellbeing Board meeting with a performance paper held in May 2014, a number of discussions and developments have taken place, the Board are asked to note these.

- Scoping work has continued to assess the availability of the indicators at a lower geographical area to ensure reports to the local Health and Wellbeing Boards are meaningful.

- Partner agencies are meeting monthly to analyse the data and provide more narrative to the report, these have been well attended.

Key to KPI Ratings used

GREEN	Target has been achieved or exceeded, or in comparison to Kent
AMBER	Performance was at an acceptable level within the target or in comparison to Kent
RED	Performance is below an acceptable level, or in comparison to Kent
⇧	Performance has improved relative to the previous period
⇩	Performance has worsened relative to the previous period
⇔	Performance has remained the same relative to the previous period

Data quality note: All data is categorised as management information. All results may be subject to later change.

Report Prepared by

Malti Varshney, Consultant in Public Health
Malti.varshney@kent.gov.uk

Helen Groombridge, Performance Officer Public Health
Helen.groombridge@kent.gov.uk

Mark Gilbert, Commissioning and Performance Manager Public Health
Mark.gilbert@kent.gov.uk

Mark Lemon, Strategic Business Advisor, Business Strategy and Support
Mark.lemon@kent.gov.uk

3. Indicator executive summary

The following tables provide a visual summary of the indicators within each outcome domain. Where an indicator has not been RAG rated this indicates that there is no current specified target at this stage. If there has been no change in the data since the previous report then a (nc) symbol will be present in the 'recent time period' field.

Outcome 1: Every child has the best start in life

There have been changes or updates in the data for unplanned hospitalisation rates, however no other metrics have had any planned data releases since the previous report in May.

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
1.1 Increasing breastfeeding Initiation Rates	72.5%	72.1%	⇩	2012/13 (nc)
1.2 Increasing breastfeeding continuance 6-8 weeks	*	40.8%	-	2012/13 (nc)
1.3 Improve MMR vaccination uptake – two doses (5 years old). **Target 95%**	90.5%	92.2%	⇧	2012/13 (nc)
1.4 Reduction in the number of pregnant women with a smoking status at time of delivery (SATOD)	16.8%	15.2%	⇧	2011/12** (nc)

*Previous year figures suppressed due to not meeting the data completion threshold

**currently no Kent figures for 2012/13 due to data quality

Indicator Description - Associated	Previous status	Recent status	Direction of travel	Recent time period
1.5 Unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 10,000)	14.8	14.6	⇧	2013/14
1.6 Unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 10,000)	7.6	7.3	⇧	2013/14
1.7 Unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 10,000)	9.4	8.8	⇧	2013/14
1.8 Reduction in conception rates for young women aged under 18 years old (rate per 1,000)	31.0	25.9	⇧	2012 (nc)
1.9 Decrease the proportion of 4-5 year olds with excess weight	21.7%	21.7%	⇔	2012/13 (nc)
1.10 Decrease the proportion of 10-11 year olds with excess weight	32.7%	32.7%	⇔	2012/13 (nc)

Outcome 1: Every child has the best start in life – CCGs									
	Time Period	Kent	Ashford	Canterbury	DGS	SKC	Swale	Thanet	WK
1.4 No. of pregnant women with a smoking status at time of delivery (SATOD)	2013/14	13.1%*	10.9%	12.8%	12.9%	16.5%	20.6%	17.0%	9.4%
1.5 Unplanned hospitalisation for asthma under 19s (rate per 10,000)	2013/14	14.6	16.6	11.5	16.5	18.0	16.3	14.8	12.3
1.6 Unplanned hospitalisation for diabetes under 19s (rate per 10,000)	2013/14	7.3	4.7	7.9	6.2	9.6	10.2	11.9	5.5
1.7 Unplanned hospitalisation for epilepsy under 19s (rate per 10,000)	2013/14	8.8	8.1	8.2	9.9	6.4	13.6	15.7	6.5

* Locally provided figures for 1.4 Kent and all CCG Data. Source: KMPHO

Local Data on SATOD continues to show Kent as having a higher proportion (13.1% in 2013/14) when compared to the national status (12.7% in 2012/13); there were 3 CCGs higher than Kent - Swale at 20.6%, Thanet at 17.0% and South Kent Coast at 16.5%.

Although Kent level figures for unplanned hospitalisation are improving, epilepsy rates have decreased from 9.4 to 8.8, Asthma from 14.8 to 14.6 and diabetes from 7.6 to 7.3 there are increases for Epilepsy rates in Ashford, Swale and Thanet; for Asthma in Ashford, Canterbury & Coastal and South Kent Coast; for Diabetes in South Kent Coast, Swale and West Kent. (2012/13 to 2013/14)

Kent is decreasing and below national rate for under 18 conception rate in 2012 (25.9 per 1,000 for Kent and 27.7 National) however there is variety across the districts, from 13.5 in Tunbridge Wells to Thanet at 36.1 and Swale at 35.6. It should be noted though that most of the districts had decreased from 2011 except for Dartford (increased by 4.5) and Tonbridge & Malling (increased by 4.3).

Kent is currently not an outlier on either of the excess weight in children metrics (4-5 years old 21.7% and 32.7% for 10-11 year olds, 2012/13) being not significantly different to the National (22.2% and 33.3 respectively) By district those aged 4-5 years old with excess weight ranged from 19.2% in Sevenoaks to 24.4% in Maidstone; whereas for 10-11 year olds with excess weight the lowest proportion was 29.8% in Canterbury to 36.4% in Gravesend. 2013/4 will be the first year where cohort comparisons can be made and the changes between those measured when they were 4-5 and now 10-11.

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

There are updated figures for NHS Health Checks and Smoking Cessation Services, the smoking attributable deaths metric has been amended to reflect the recent Public Health Outcomes framework release.

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
2.1 Reduction in the under-75 mortality rate from cancer (rate per 100,000)	142.9	138.0	⇧	2010-12 (nc)
2.2 Reduction in the under-75 mortality rate from respiratory disease (rate per 100,000)	33.2	31.4	⇧	2010-12 (nc)
2.3 Increase in the proportion of people receiving NHS Health Checks of the target number to be invited (proxy for under-75 mortality from cardiovascular disease). **Target 50%**	30.4%	46.9%	⇧	Q4 2013/14
2.4 Increase in the number of people quitting smoking via smoking cessation services (number. proxy for under-75 mortality). **Target 9,249**	1,488	1,653	⇧	Q4 2013/14
2.5 Reduction in the number of hip fractures for people aged 65 and over (rate per 100,000)	599.0	544.0	⇧	2012/13 (nc)
2.6 Reduction in the rates of estimated deaths attributable to smoking, persons aged 35+ (rate per 100,000)	296.2	285.2	⇧	2010-12

Indicator Description - Associated	Previous status	Recent status	Direction of travel	Recent time period
2.7 Decrease the proportion of adults with excess weight	n/a	64.6%	-	2012 (nc)
2.8 Increase the percentage of physically active adults	n/a	57.2%	-	2012 (nc)

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

	Time Period	Kent	Ashford	Canterbury	DGS	SKC	Swale	Thanet	WK
2.1 under 75 mortality rate from cancer (rate per 100,000)	2012	135.5	111.4	121.0	128.5	147.9	133.8	140.0	145.2
2.2 under 75 mortality rate from respiratory disease (rate per 100,000)	2012	30.7	28.1	26.8	30.1	34.8	23.6	40.2	30.0
2.3 proportion of people receiving NHS Health Checks (where GP practice can be linked)	2013/14	36.1%	38.7%	40.1%	15.9%	33.6%	28.3%	29.2%	27.8%
2.4 number of people quitting smoking	2013/14	5254	420	630	834	957	518	930	965
2.5 number of hip fractures people aged 65+ (rate per 10,000)	2013/14	480.47	459.7	562.5	554.9	431.5	559.6	540.9	397.7
2.6 deaths attributable to smoking persons aged 35+ (rate per 100,000)	2010-12	295.5	245.3	270.4	287.7	301.7	334.8	333.9	299.2

The under-75 mortality for cancer (2010-12) ranges between 111.43 per 100,000 for Ashford CCG to 147.87 at South Kent Coast. For respiratory disease Thanet was the highest at 40.17 per 100,000 and Swale was the lowest at 23.56. In addition to Swale being the lowest in 2010-12, it should be noted that 2 years ago Swale CCG had the highest mortality rate compared to the other Kent CCGs.

There has been improved performance in both the NHS Health Check take-up and the number of people quitting smoking via the smoking cessation services in Q4 2013/14; however Public Health will continue to monitor these services closely.

The hip fracture rate for Kent has gradually been increasing; local data shows an increase from 2010/11 at 410.15 per 100,000 to 2013/14 at 480.47. 2012/13 varies between 397.7 per 100,000 in West Kent CCG to 559.6 in Swale CCG. Swale CCG was the only area to decrease from 2012/13 to 2013/14, with a decrease from 770.77 to 559.60

The proportion of adults with excess weight in Kent is 64.6%, similar to the national proportion of 63.8%; Canterbury District has the lowest proportion at 54.2% whereas Swale has the highest at 68.8% followed closely by Thanet at 68.4%.

Ashford district had the lowest proportion of physically active adults 48.7%, Kent did not differ greatly from the National percentage with 57.2% compared to 56.0%. Tunbridge Wells was the highest district at 64.8%

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

Both metrics have been updated from the previous report with information provided by Adult Social Care.

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
3.1 Clients with community based services who receive a personal budget and/or direct budget. **Target for February 88.3%**	71%	67%	⇩	February 2014
3.2 Increase the number of people using telecare and telehealth technology (number). **Target for February 2,125**	2,754	2,992	⇧	February 2014

There has been a further drop in the proportion of people receiving a personal budget and/or direct budget, this is due to more people receiving a short term service such as enablement or telecare and would not therefore be eligible for a personal budget or direct payment.

There have been further increases in the number of people using telecare and telehealth technology and to February 2014 there were 2,992 clients, which is far exceeding the target of 2,125.

CCG level figures on both Outcome 3 indicators will be presented in the next report.

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

There have been updates to metrics 4.5 and 4.6 on those accessing structured treatment for substance misuse.

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
4.1 Reduction in the number of suicides (DASR per 100,000)	8.4	8.1	⇧	2010-12
4.2 Increased employment rate among people with mental illness/those in contact with secondary mental health services	-	7.4%	-	2012/13 (nc)

Indicator Description - Associated	Previous status	Recent status	Direction of travel	Recent time period
4.3 Increased crisis response of A&E liaison within 2 hours – Urgent	76.7%	73.5%	⇩	Q3 2013/14 (nc)
4.4 Increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours. **Target 100%**	100%	100%	⇔	Q3 2013/14 (nc)
4.5 Number of adults receiving treatment for drug misuse (primary substance) number – New Treatment Journeys	1,352	1,248	⇩	March 2014 YTD
4.6 Number of adults receiving treatment for alcohol misuse (primary substance) number	-	1,945	-	March 2014 YTD
4.7 Increase in the successful completion and non-representation of opiate drug users leaving community substance misuse treatment	14.6%	10.9%	⇩	2012
4.8 Decrease the number of people entering prison with substance dependence issues who are previously not known to community treatment	Awaiting indicator development and reporting from Public Health England			

Outcome 4: People with mental health issues are supported to 'live well' – CCGs									
	Time Period	Kent	Ashford	Canterbury	DGS	SKC	Swale	Thanet	WK
4.3 crisis response of A&E liaison within 2 hours - Urgent	Q3 2013/14	73.5%	65.4%	67.6%	90.8%	57.5%	86.0%	80.9%	81.0%
4.4 crisis response of A&E liaison, all urgent referrals to be seen within 24 hours	Q3 2013/14	100%	100%	100%	100%	100%	100%	100%	100%

The proportion of A&E referrals to liaison psychiatry assessment within 2 hours for Kent has decreased from Q1 to Q3 2013/14, from 84.7% to 73.5%; there is variance between the CCGs in Q3 with DGS at 90.8% within 2 hours and SKC at 57.5%; SKC experienced low percentages specifically in November but also in December. All CCGs had 100% being seen within 24 hours.

The rate of successful completion and non-representation back into treatment services within 6 months of opiate drug misusers in Kent has fallen from 14.4% in 2011/12 to 10.0% in 2012/13; however Kent still remains above national figures of 8.1%.

Outcome 5: People with dementia are assessed and treated earlier

This is the first report where dementia metrics have been presented; this has been through partnership work with KMCS and will continue to evolve to look at trend data.

Indicator Description – Targeted		Previous status	Recent status	Direction of travel	Recent time period
5.1 Increase in the reported number of dementia patients on GP registers as a percentage of estimated prevalence		39.4%	41.5%	⇧	2012/13
5.2 Reduce the rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)		25.0	25.1	⇩	2013/14
5.3 Reduce the rate of admissions to hospital for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)		49.9	50.5	⇩	2013/14
5.4 Reduce the total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)		231.8	225.7	⇧	2013/14
5.5 Reduce the total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)		464.0	452.5	⇧	2013/14
5.6 Increase the proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been:					
Dartford and Gravesham NHS Trust	(a) identified as potentially having dementia	93%	92%	⇩	Q4 2013/14
	(b) who are appropriately assessed	100%	100%	⇔	
	(c) and, where appropriate, referred on to specialist services in England	97%	100%	⇧	
East Kent Hospitals University NHS Foundation Trust	(a) identified as potentially having dementia	99%	100%	⇧	Q4 2013/14
	(b) who are appropriately assessed	95%	94%	⇩	
	(c) and, where appropriate, referred on to specialist services in	100%	100%	⇔	

Indicator Description – Targeted		Previous status	Recent status	Direction of travel	Recent time period
	England				
Maidstone and Tunbridge Wells NHS Trust	(a) identified as potentially having dementia	99%	99%	⇔	Q4 2013/14
	(b) who are appropriately assessed	99%	99%	⇔	
	(c) and, where appropriate, referred on to specialist services in England	100%	100%	⇔	
Medway NHS Foundation Trust	(a) identified as potentially having dementia	69%	78%	⇧	Q4 2013/14
	(b) who are appropriately assessed	97%	88%	⇩	
	(c) and, where appropriate, referred on to specialist services in England	85%	91%	⇧	
Indicator Description – Targeted		**Previous status**	**Recent status**	**Direction of travel**	**Recent time period**
KMPT	5.7 Decrease the % of people waiting longer than 4 weeks to assessment with Memory Assessment Services	21.0%	23.4%	⇩	Q4 2013/14

Outcome 5: People with dementia are assessed and treated earlier – CCGs									
	Time Period	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
5.1 reported no. of dementia patients on GP registers as a % of estimated prevalence	2011/12	**39.4**	**41.1**	**39.2**	**43.8**	**37.3**	**42.4**	**33.0**	**40.1**
	2012/13	**41.5**	**43.0**	**43.2**	**44.2**	**38.7**	**44.8**	**34.6**	**42.6**
	direction of travel	⇧	⇧	⇧	⇧	⇧	⇧	⇧	⇧
5.2 admissions to hospital for patients 64+ with a secondary diagnosis of dementia (rate per 1000)	2012/13	**25.0**	**19.9**	**28.5**	**28.8**	**25.4**	**20.5**	**26.2**	**23.0**
	2013/14	**25.1**	**20.5**	**28.8**	**27.0**	**25.1**	**21.3**	**26.1**	**24.1**
	direction of travel	⇩	⇩	⇩	⇧	⇧	⇩	⇧	⇩
5.3 admissions to hospital for patients 74+ with a secondary diagnosis of dementia (rate per 1000)	2012/13	**49.9**	**40.7**	**57.3**	**56.5**	**50.0**	**45.9**	**49.6**	**46.3**
	2013/14	**50.5**	**43.3**	**56.6**	**53.3**	**50.3**	**48.7**	**50.2**	**48.5**
	direction of travel	⇩	⇩	⇧	⇧	⇩	⇩	⇩	⇩
5.4 Total bed-days in hospital per population	2012/13	**231.8**	**177.3**	**192.5**	**303.9**	**191.0**	**225.4**	**201.2**	**262.3**

Outcome 5: People with dementia are assessed and treated earlier – CCGs									
	Time Period	Kent	Ashford	Canterbury	DGS	SKC	Swale	Thanet	WK
for patients 64+ with a secondary diagnosis of dementia (rate per 1000)	2013/14	**225.7**	**187.6**	**168.1**	**342.8**	**183.0**	**257.4**	**193.0**	**231.4**
	direction of travel	⇧	⇩	⇧	⇩	⇧	⇩	⇧	⇧
5.5 Total bed-days in hospital per population for patients 74+ with a secondary diagnosis of dementia (rate per 1000)	2012/13	**464.0**	**351.4**	**392.8**	**592.1**	**370.7**	**514.9**	**385.8**	**529.3**
	2013/14	**452.5**	**382.4**	**327.1**	**673.0**	**363.9**	**573.1**	**383.1**	**467.7**
	direction of travel	⇧	⇩	⇧	⇩	⇧	⇩	⇧	⇧

The reported number of dementia patients on GP registers as a proportion of estimated prevalence in 2012/13 varied from 34.6% in Thanet 44.8% in Swale; all CCGs have increased from 2011/12. The Kent proportion for 2012/13 was 41.5%

Admission rates for 64 year olds and over with a secondary diagnosis of dementia was between 20.5 per 1,000 in Ashford and 28.8 in Canterbury.

This is mirrored in the rate for over 74 year olds with Ashford lowest at 43.3 and Canterbury highest at 56.6. (all 2013/14)

Bed-days in hospital for over 64 year olds with secondary diagnosis of dementia varied greatly across the CCGs, Kent was 225.7 per 1,000, the lowest CCG was SKC at 183 and the highest was DGS at 342.8 (2013/14). The number of bed-days increased for over 74 year olds with 327 per 1,000 at Canterbury to 673.0 per 1,000 at DGS (2013/14)

The dementia indicator that looks into identification, assessment and referrals by trust has Medway NHS Foundation Trust as below target in Q4 2013/14 on identification and assessment. The figures do not disaggregate between Kent and Medway residents, and Swale residents access Medway Hospital.

Stress indicators

Children's Services	Previous status	Recent status	Direction of travel	Recent time period
6.1 Decrease the number waiting for routine treatment after assessment – CAMHS	701	565	⇧	April 2014
6.2 CAMHS Caseload, for patients open at end of the month	8,928	8,523	⇧	April 2014
6.3 Increase proportion of SEN assessments within 26 weeks. **Target 90%**	94.5%	94.5%	⇔	March 2014 (nc)
6.4 SEN Kent children placed in independent or out of county schools (number)	578	583	⇩	March 2014 (nc)

Stress Indicators – Children's Services CCG									
	Time Period	Kent	Ashford	Canterbury	DGS	SKC	Swale	Thanet	WK
6.1 Decrease the number waiting for routine treatment after assessment - CAMHS	April 2014	565	16	0	216	120	69	49	95
6.2 CAMHS Caseload (excluding Medway and Out of Area)	April 2014	8523	724	1206	1432	1347	531	1250	2033

Public Health	Previous status	Recent status	Direction of travel	Recent time period
6.5 Population vaccination coverage – Flu (aged 65+) (NEW). **Target 75%**	73.1%	71.4%	⇩	2012/13 (nc)
6.6 Population vaccination coverage – Flu (at risk individuals) (NEW). **Target 75%**	46.3%	48.7%	⇧	2012/13 (nc)

Acute/Urgent	Previous status	Recent status	Direction of travel	Recent time period
6.7 Bed occupancy rates, overnight				
Dartford and Gravesham NHS Trust	96.6%	96.7%	Refer to section 6.7	Q4 2013/14
East Kent Hospitals University NHS Foundation Trust	90.8%	92.3%		
Maidstone and Tunbridge Wells NHS Trust	90.3%	93.6%		
Medway NHS Foundation Trust	88.5%	94.3%		
Kent and Medway NHS and Social Care Partnership	90.2%	94.1%		
6.8 A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge				
Dartford and Gravesham NHS Trust (all)	96.6%	97.9%	Refer to section 6.8	Week ending 25/05/2014
East Kent Hospitals University NHS Foundation Trust (all)	95.3%	93.5%		
Maidstone and Tunbridge Wells NHS Trust (all)	94.4%	96.9%		
Medway NHS Foundation Trust (all)	83.0%	83.2%		
6.9 Number of emergency admissions	To be further discussed and developed with NHS England and KMPHO			

Primary Care	Previous status	Recent status	Direction of travel	Recent time period
6.10 GP attendances	Awaiting information from NHS England and indicator development			

Primary Care	Previous status	Recent status	Direction of travel	Recent time period
6.11 Out of Hours activity	Awaiting information from KMCS and indicator development			
6.12 111 NHS Service	Work ongoing with KMCS to shape and define			

Social care / Community care	Previous status	Recent status	Direction of travel	Recent time period
6.13 The proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services **BCF.**	Under review by Adult Social Care			
6.14 Number of delayed days, acute and non-acute for Kent **BCF**	2,148 days	2,170 days	Refer to section 6.14	April 2014
6.15 Infection control rates	Work ongoing with NHS England to shape and define			
6.16 Percentage of people with short term intervention that had no further service	Under further development with Adult Social Care			
6.17 Admissions to permanent residential care for older people (number) **BCF Target 130**	127	100	⇧	April 2014

Overnight bed occupancy rates for quarter 4 2013/14 vary between 92.3% at East Kent Hospitals University NHS Foundation Trust to 96.7% at DGS NHS Trust.

A&E Attendances within 4 hours from arrival also varies from 83.2% in Medway NHS Foundation Trust to 97.9% in DGS NHS Trust. These figures relate to the week ending 25/05/2014.

There was a reduction in the number of admissions to permanent residential care for older people in April 2014 of 100 from 127 people in March and is now below the 130 target (maximum target).

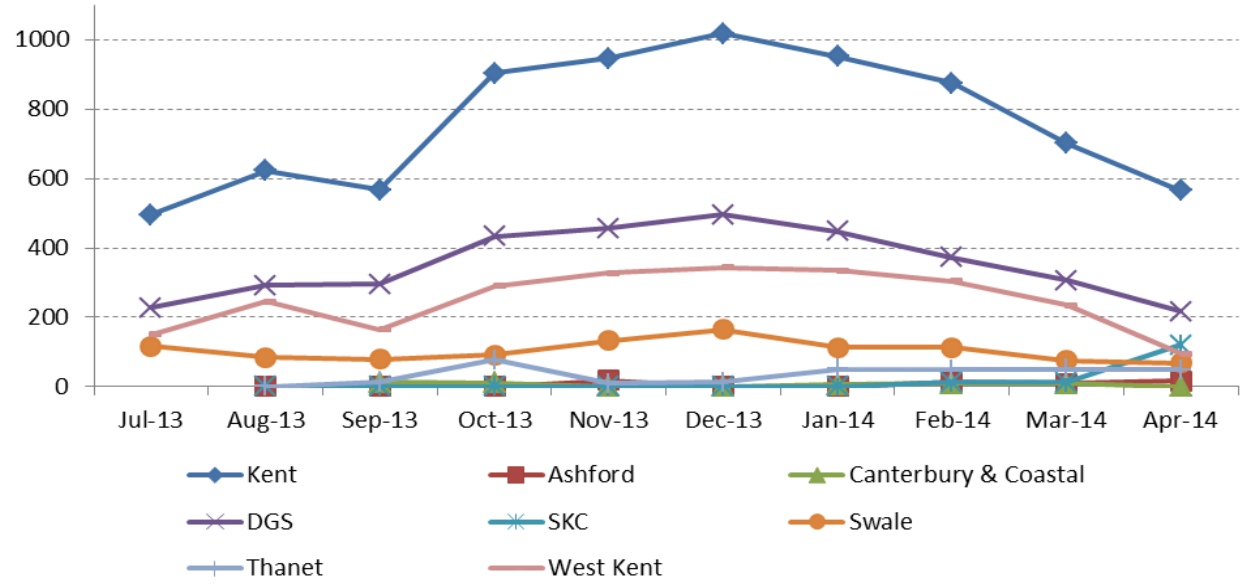
4. Better Care Fund (BCF) Metrics

Better Care Fund (BCF) Metrics*		BCF Definition*	Related Assurance Framework Metric	Direction of Travel
1	Permanent admissions to residential and care homes	Reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care	Metric 6.17 Admissions to permanent residential care for older people – Stress Indicator	⇧
2	Effectiveness of reablement – those 65+ still at home 91 days after discharge	Range to be between 82-88% and not show a reduction over 2 years	Metric 6.13 Proportion of older people still at home 91 days after discharge – Stress Indicator	-
3	Delayed transfers of care	Reduction in DTOC using total number of delayed transfers of care for each month	Metric 6.14 Number of delayed days, acute and non-acute for Kent – Stress Indicator	⇩
4	Avoidable emergency admissions	Up to 15% reduction in admissions	Metric 6.9 under development	-
5	Patient / Service user experience	Kent will use the national metric implemented in 2015/16	Under development following meetings with HealthWatch	-
6	Social Care Quality of Life (Local Metric)	Further local metrics may be used at CCG level; however as part of the Kent HWB dashboard improvements will be required in quality of life and reduction in injuries due to falls.	Not currently reflected	-
7	Injuries due to falls in people aged 65 and over (Local Metric)		Not currently reflected	-

(*Source: BCF Paper to Kent Health & Wellbeing Board, 26th March 2014)

5. Stress indicators

Children's Services
6.1 Decrease the number waiting for routine treatment after assessment – CAMHS



This metric addresses the number waiting for a routine treatment, where the treatment has not yet taken place. The highest number of people waiting for treatment is between 7 – 13 weeks, it should be noted that this includes the waiting time to assessment as well as the time to treatment. The highest number by presenting problem was for "partnership" category. The waiting list is managed by a clinically-led priority based allocation system and those that present with serious/complex needs are moved off the waiting list as a priority.

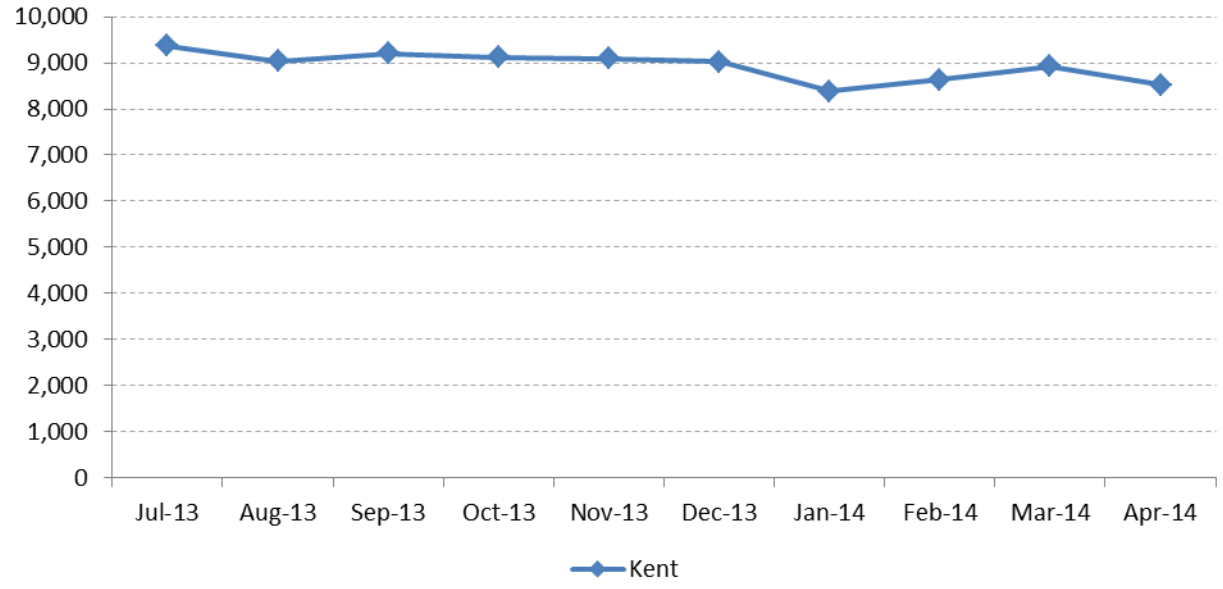
This does not include those from Medway CCG or any out-of-area clients.

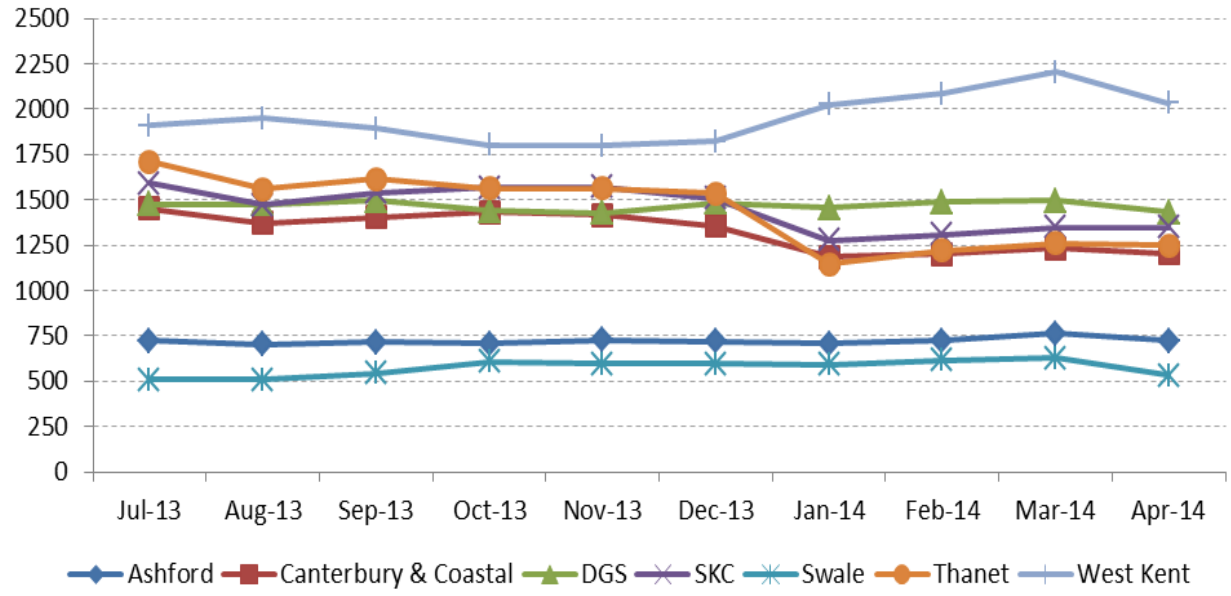
Overall there was a decrease in the number of children waiting for routine treatment with West Kent and DGS showing a sustained decrease from December 2013 onwards.

South Kent Coast experienced the largest increase of children waiting for routine treatment, having 13 in March to 120 in April.

Source: KMCS: Performance Report Children and Young People Service in Kent and Medway April 2014.

6.2 CAMHS Caseload, for patients open at the end of the month





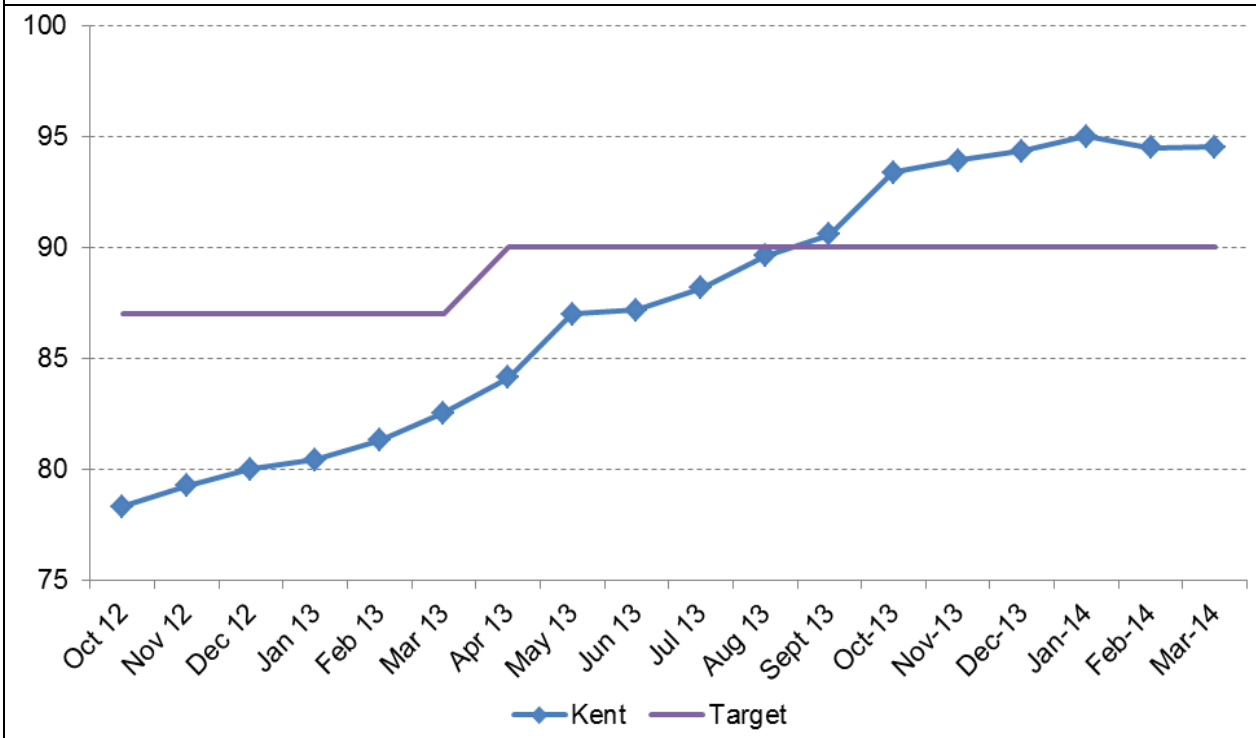
This metric shows the number of clients currently on the caseload by CCG area and Kent as a whole.

This does not include those from Medway CCG or any out-of-area clients.

The caseload for Kent as a whole has remained around 9,000 clients; The CCGs have also remained relatively stable with the exception of West Kent which experienced increases from December 2013 and Thanet which decreased notable in January. Canterbury & Coastal has also decreased.

Source: KMCS: Performance Report Children and Young People Service in Kent and Medway April 2014.

6.3 Increase proportion of SEN assessments within 26 weeks



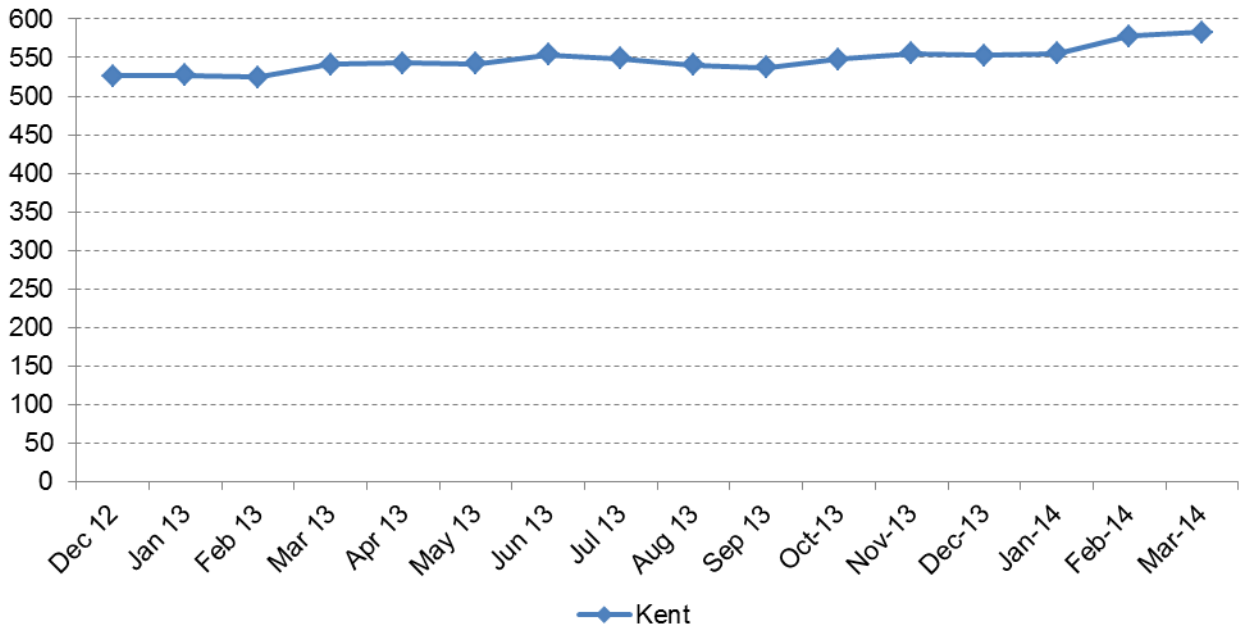
There is considerable evidence of the benefits of early and timely intervention to address children's Statement of Educational Need (SEN). Parents are concerned that SEN statements should be completed within the statutory time limit so that appropriate intervention to meth their children's SEN can begin.

(DOE:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/219452/main_20text_20osr192011.pdf)

The proportion of SEN assessments has remained above target and around 95% over the last 4 months; although CCG level data is currently not available, District figures indicate lower proportions than the target in Dartford (78.3%) and Dover (80.0%).

Target: 90% within 26 weeks (excluding exceptions)
Source: Management Information Unit, Kent County Council

6.4 SEN Kent children placed in independent or out of county schools



Increases are expected during the school year as more children are identified and receive a statement of SEN which in turn requires appropriate school placements to be found; the numbers then reduce at the end of the school year as children reach end of statutory school age.

Kent County Council has put into place a 3-year plan, the aims of which are:

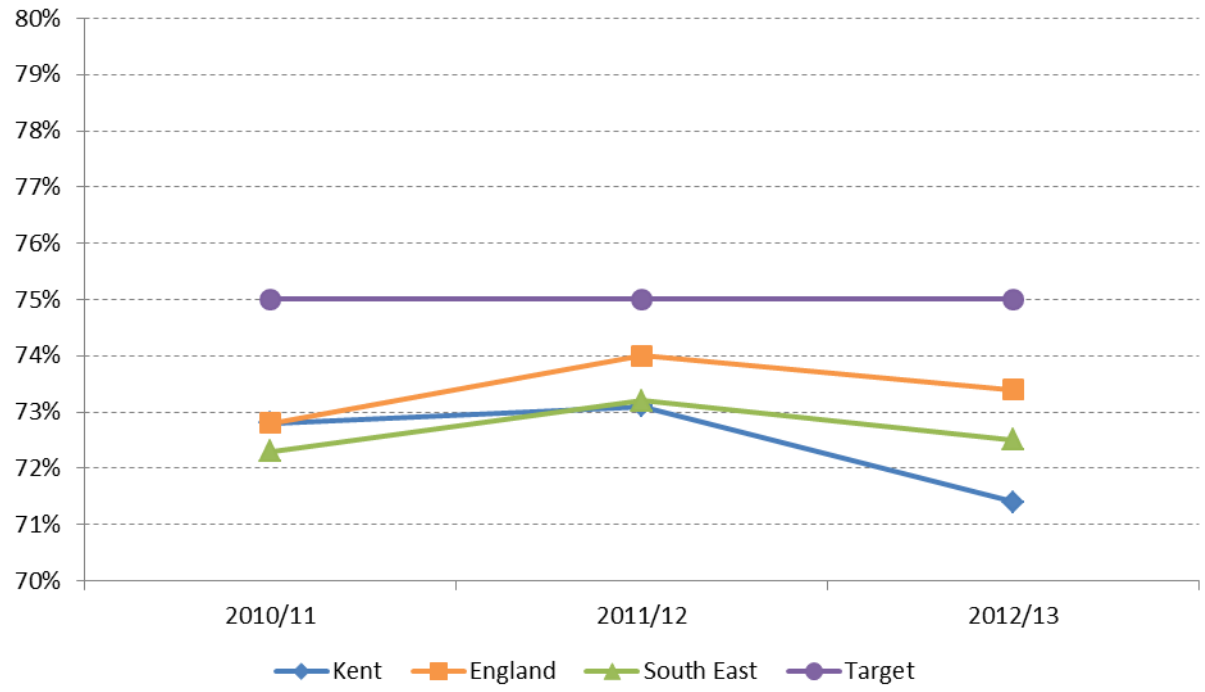
- To increase internal capacity at Kent schools
- Create 200 places in state-maintained Kent special schools
- To increase capacity in mainstream schools to have adequate provision for those with low level need

SEN is monitored by Education and Young People's Services and Education and Young People's Cabinet Committee (KCC)

Source: Management Information Unit, Kent County Council

Public Health

6.5 Population vaccination coverage – Flu (aged 65+)



Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely related to levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise (PHOF)*

A decrease in the percentage would indicate lower levels of immunity; increasing incidence of Flu can put additional seasonal stress on the health system. Other metrics that could display the effect of this would be GP attendances, out of hour's activity/111 call volumes, A&E attendances, emergency admissions and bed occupancy rates.

Target: 75%

Source: Public Health Outcomes Framework: Indicator 3.03xiv

*http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/6/par/E12000004/are/E06000015

6.6 Population vaccination coverage – Flu (at risk individuals)

Studies have shown that flu vaccines provide effective protection against the flu. The flu vaccination is offered to people in at-risk groups such as pregnant women and elderly people. These people are at greater risk of developing serious complications, such as bronchitis and pneumonia if they catch flu. (PHOF)*

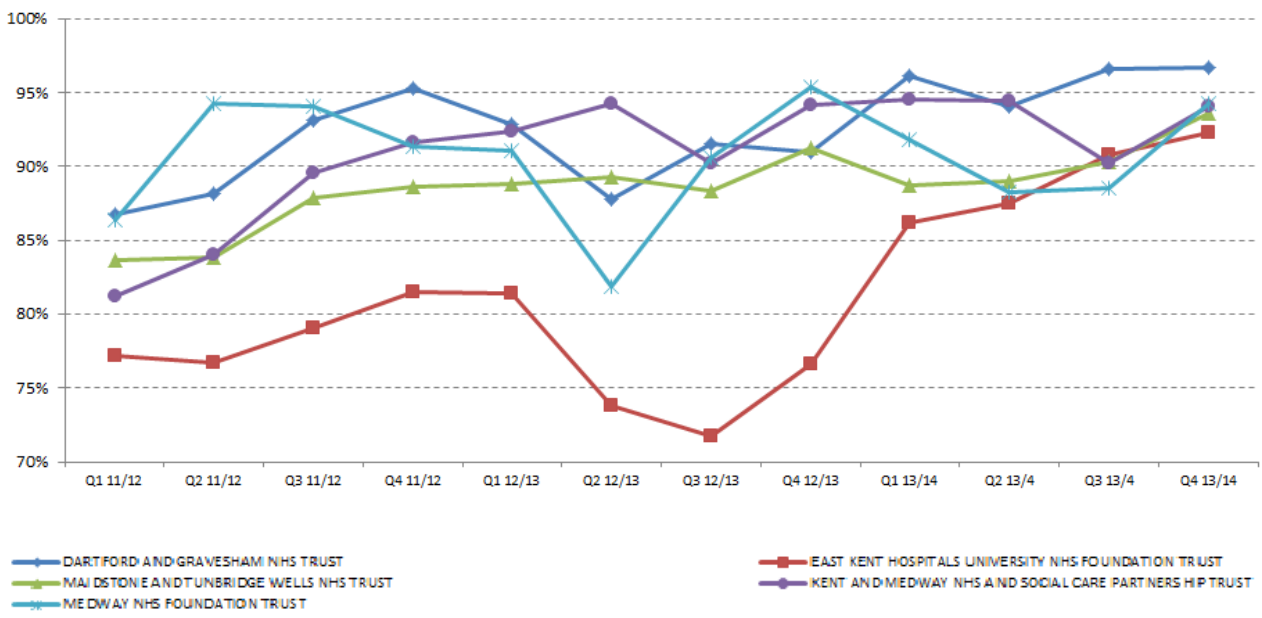
A decrease in the percentage would indicate lower levels of immunity; increasing incidence of Flu can put additional seasonal stress on the health system. Other metrics that could display the effect of this would be GP attendances, out of hour's activity/111 call volumes, A&E attendances, emergency admissions and bed occupancy rates.

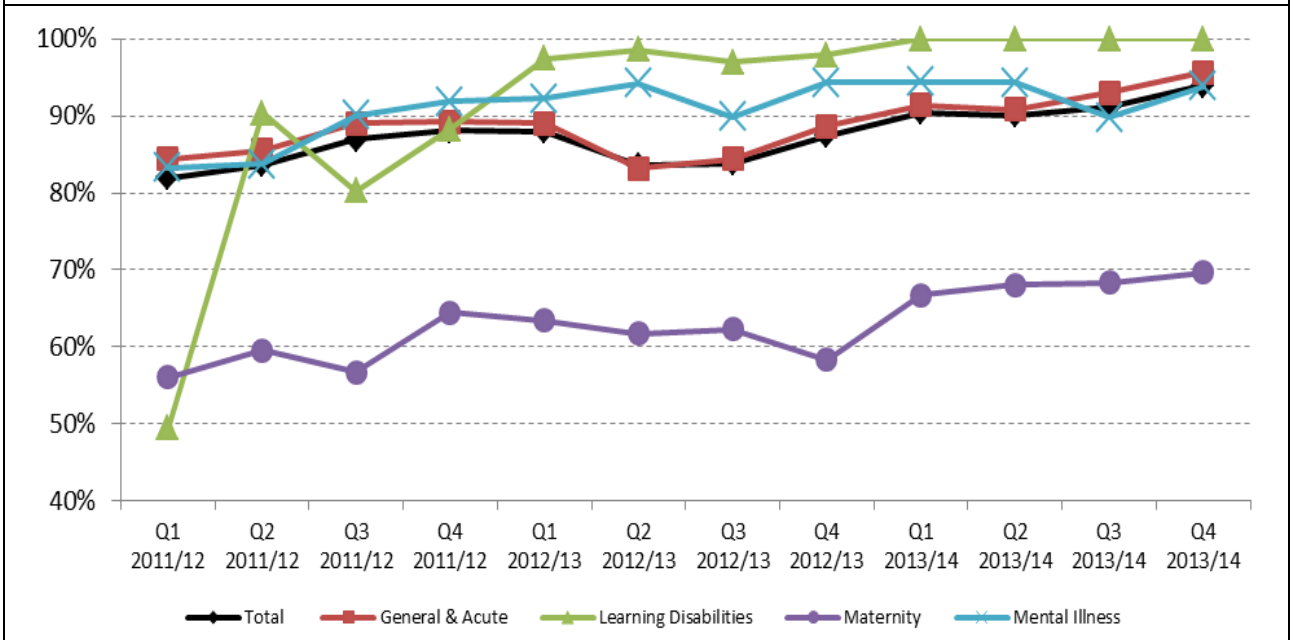
Target: 75%

Source: Public Health Outcomes Framework: Indicator 3.03xv
*http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/6/par/E12000004/are/E06000015

Acute/Urgent

6.7 Bed occupancy rates





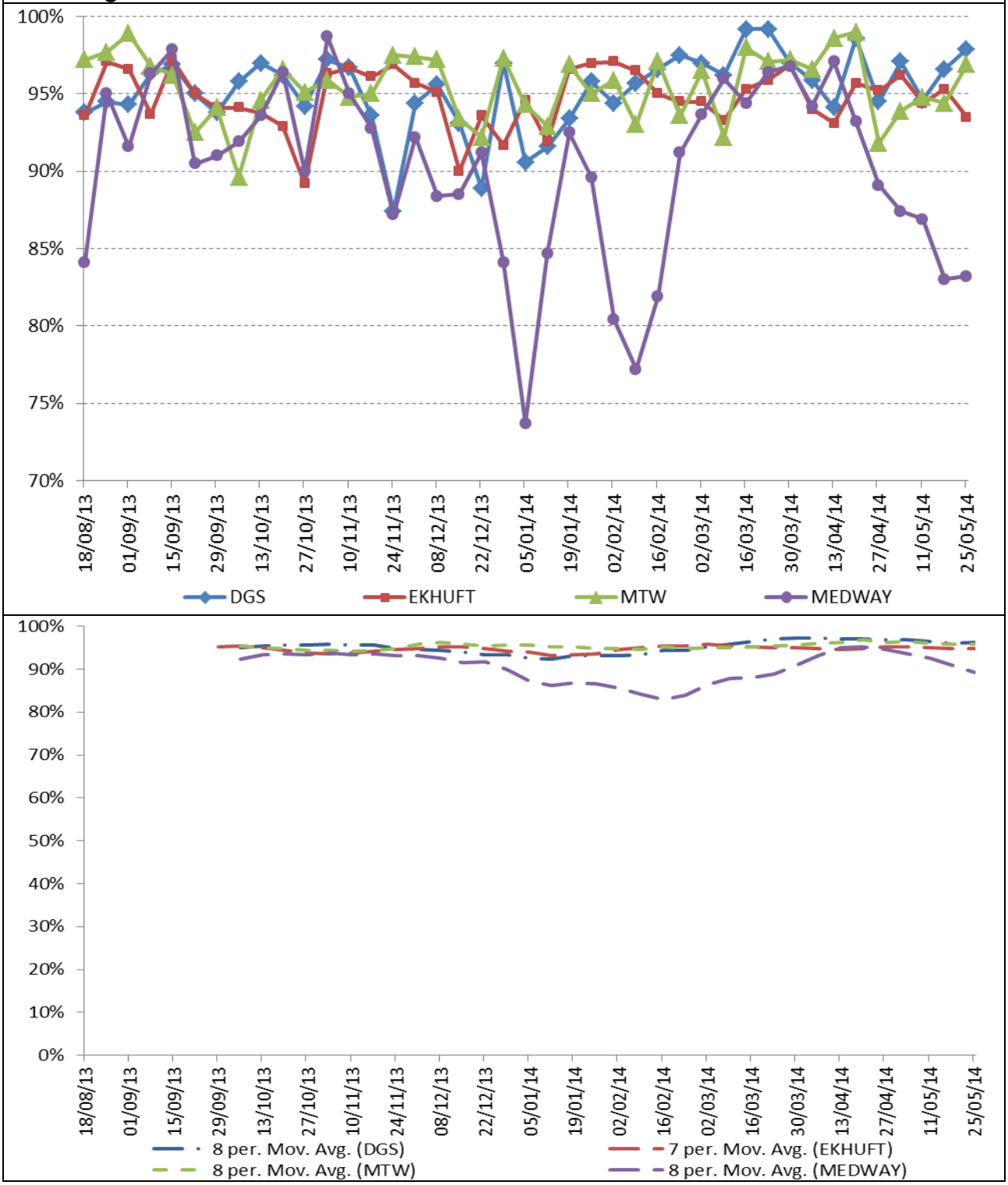
Percentage of occupied beds open overnight only by consultant main specialty and by Trust. Medway Foundation Trust has been added to account for Swale residents.

All Trusts experienced increases in occupation from Q3 to Q4 however the largest increase was for Medway NHS Foundation Trust. East Kent has continued to increase after experiencing a dip in Q3 2012/13. Bed occupancy for maternity speciality has continued to increase gradually across 2013/14. Learning Disability remains at 100% occupancy.

The trends from Q1 2011/12 to Q4 2013/14 indicated that DGS, EKHUFT, MTW and KMPT all have a gradual upward trend; The trend for MFT indicated that there had been no overall increase or decrease.

Acute/Urgent
To understand system wide issues this indicator could potentially be seen in conjunction with other indicators such as A&E transfers and delayed days. **Source:** NHS England. June 2014 http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

6.8 A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge



Numbers/proportions of people being in A&E more than 4 hours can indicate stressors on A&E and the staff with less flexibility to deal with any influxes/general arrivals and a 'blocking' situation could arise.

Taking the rolling 8-week average, all trusts are shown to be relatively stable, Medway experiences more variety but remains near the other trusts.

The trends from 18/08/2013 to 24/05/2014 show stable lines for EKHUFT and MTW; DGS experienced a gradual increase and Medway a downward trend.

Source: NHS England. AE SitRep June 2014.

http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/

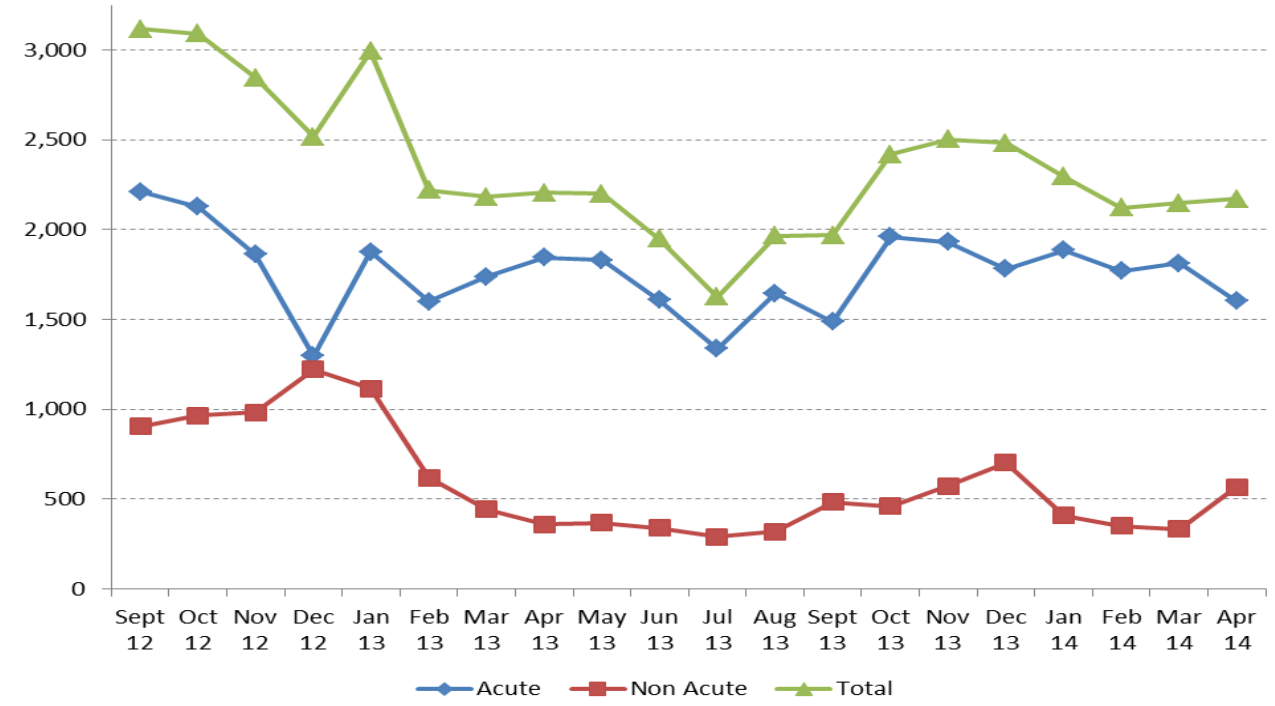
6.9 Number of emergency admissions
To be further discussed and developed with NHS England

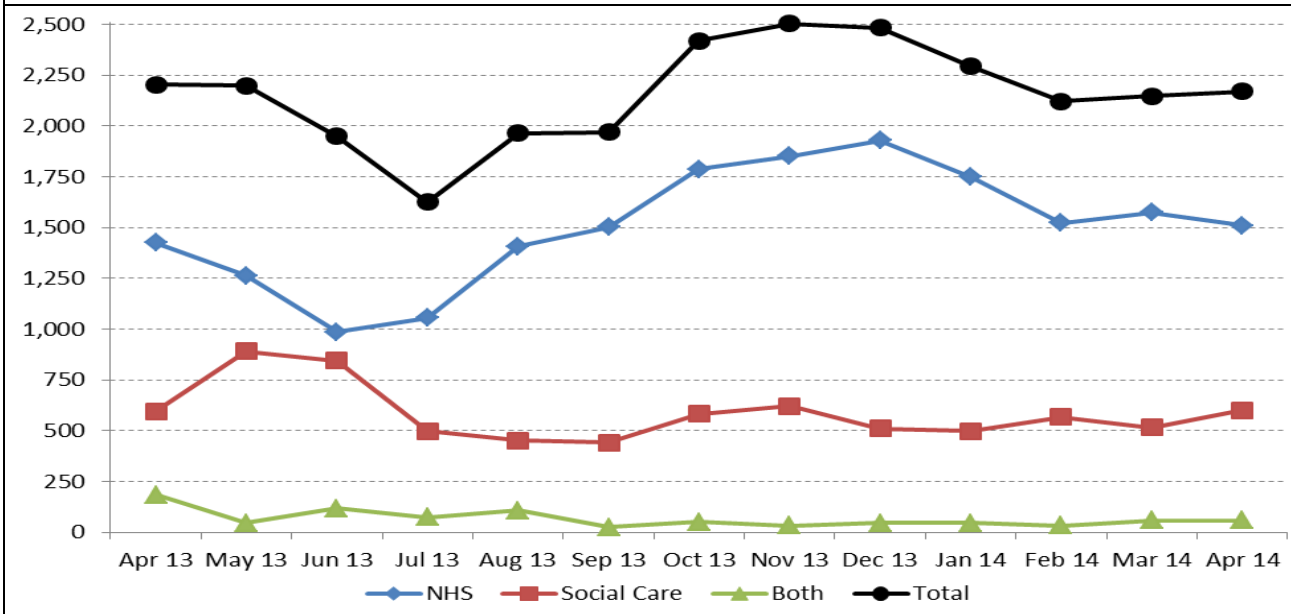
Primary Care
6.10 GP Attendances
Awaiting information from NHS England and indicator development
6.11 Out of Hours activity
Awaiting information from KMCS and indicator development
6.12 111 NHS Service
Work ongoing with KMCS to shape and define

Social Care / Community Care	
6.13 Proportion of older people still at home 91 days after discharge	**BCF**
Currently under review by Adult Social Care	

6.14 Number of delayed days, acute and non-acute for Kent

BCF





The above graphs show the number of delayed days per month, the first by acute and non-acute, the second by responsible authority.

Delayed days are when a patient is ready for transfer from a hospital bed but has not been moved, either for delays occurring by the NHS or Social Services. Increases in the number of delayed days could indicate blockages within the hospital/social care and have an impact on other patients receiving the care they need.

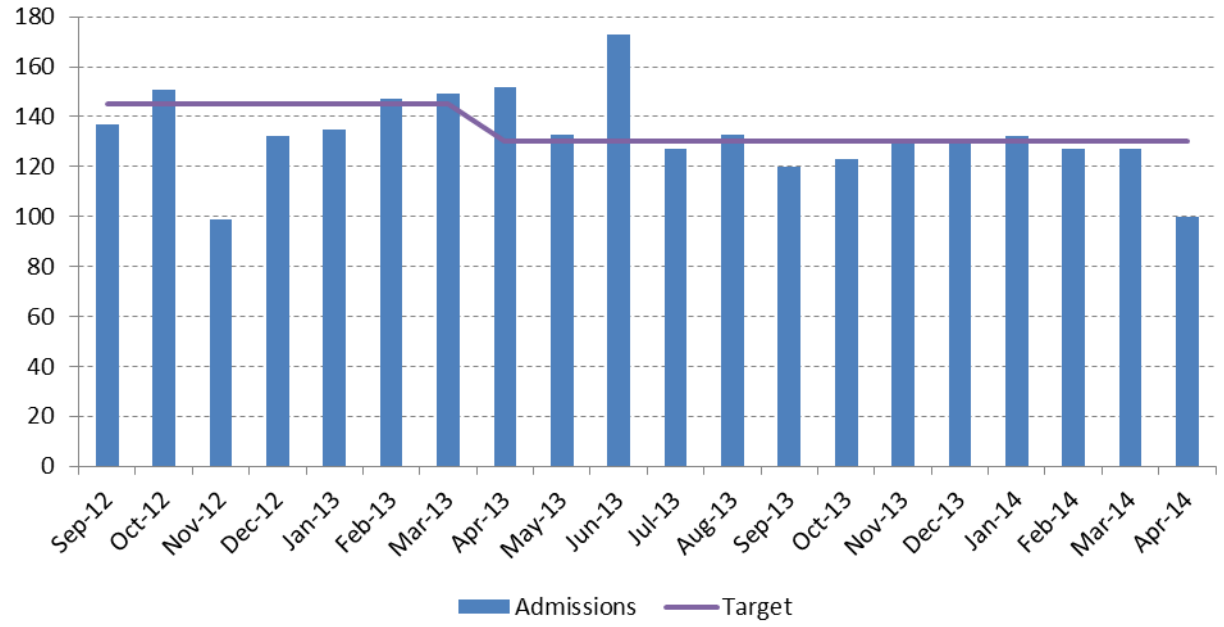
NHS reasons continue to account for the majority of delayed days, however there has been a decrease from December 2013 where the number was at its peak.

Source: NHS England. http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

6.15 Infection control rates
Work ongoing with NHS England to shape and define

6.16 Percentage of people with short term intervention that had no further service
Under further development with Adult Social Care

6.17 Admissions to permanent residential care for older people BCF



Many admissions are linked to hospital discharges, or specific circumstances or health conditions such as breakdown in carer support, falls, incontinence and dementia. (ASC Dashboard September 2013)

A reduction in permanent admissions is desirable and an aim of adult social care; falls prevention support forms part of the analysis into monitoring permanent admissions. Self-management and the ability to stay in their own homes are important for both residents and health services. This reduction in permanent residential care can be potentially attributed to many factors such as better reablement support at home, and improved telecare/telehealth facilities and take-up.

Target: 2012/13 Target of 145 with a reduction in 2013/14 to 130.

Source: Adult Social Care Dashboard, Social Care & Public Health Cabinet Committee and Performance Manager ASC.

Appendix 1: CCG Level Data Tables

Outcome 1: Every child has the best start in life									
Indicator Description - Targeted	**Time Period**	**Kent**	**Ashford CCG**	**Canterbury CCG**	**DGS CCG**	**SKC**	**Swale CCG**	**Thanet CCG**	**West Kent**
1.4 Reduction in the number of pregnant women with a smoking status at the time of delivery	2013/14	13.1%	10.9%	12.8%	12.9%	16.5%	20.6%	17.0%	9.4%
Indicator Description - Associated									
1.5 Unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	14.6	16.6	11.5	16.5	18.0	16.3	14.8	12.3
1.6 Unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	7.3	4.7	7.9	6.2	9.6	10.2	11.9	5.5
1.7 Unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	8.8	8.1	8.2	9.9	6.4	13.6	15.7	6.5

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing									
Indicator Description - Targeted	**Time Period**	**Kent**	**Ashford CCG**	**Canterbury CCG**	**DGS CCG**	**SKC**	**Swale CCG**	**Thanet CCG**	**West Kent**
2.1 Reduction in the under 75 mortality rate from cancer (rate per 100,000)	2012	135.5	111.4	121.0	128.5	147.9	133.8	140.0	145.2
2.2 Reduction in the under 75 mortality rate from respiratory disease (rate per 100,000)	2012	30.7	28.1	26.8	30.1	34.8	23.6	40.2	30.0
2.3 Increase in the proportion of people receiving NHS Health Checks of the target number to be invited	2013/14	36.1%	38.7%	40.1%	15.9%	33.6%	28.3%	29.2%	27.8%
2.4 Increase in the number of people quitting smoking via smoking cessation services	2013/14	5254	420	630	834	957	518	930	965

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing									
Indicator Description - Targeted	**Time Period**	**Kent**	**Ashford CCG**	**Canterbury CCG**	**DGS CCG**	**SKC**	**Swale CCG**	**Thanet CCG**	**West Kent**
2.5 Reduction in the number of hip fractures for people aged 65 and over (rate per 10,000)	2013/14	480.5	459.7	562.5	554.9	431.5	559.6	540.9	397.7
2.6 Reduction in the rates of the deaths attributable to smoking persons aged 35+ (rate per 100,000)	2010-12	295.5	245.3	270.4	287.7	301.7	334.8	333.9	299.2

Outcome 4: People with mental health issues are supported to 'live well'									
Indicator Description	**Time Period**	**Kent**	**Ashford CCG**	**Canterbury CCG**	**DGS CCG**	**SKC**	**Swale CCG**	**Thanet CCG**	**West Kent**
Indicator Description - Associated									
4.3 Increased crisis response of A&E liaison within 2 hours - Urgent	Q3 2013/14	73.5%	65.4%	67.6%	90.8%	57.5%	86.0%	80.9%	81.0%
4.4 Increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours	Q3 2013/14	100%	100%	100%	100%	100%	100%	100%	100%

Outcome 5: People with dementia are assessed and treated earlier									
Indicator Description - Targeted	**Time Period**	**Kent**	**Ashford CCG**	**Canterbury CCG**	**DGS CCG**	**SKC**	**Swale CCG**	**Thanet CCG**	**West Kent**
5.1 Increase in the reported number of dementia patients on GP registers as a percentage of estimated prevalence	2012/13	**41.5**	**43.0**	**43.2**	**44.2**	**38.7**	**44.8**	**34.6**	**42.6**
5.2 Rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	2013/14	**25.1**	**20.5**	**28.8**	**27.0**	**25.1**	**21.3**	**26.1**	**24.1**
5.3 Rate of admissions to hospital for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	2013/14	**50.5**	**43.3**	**56.6**	**53.3**	**50.3**	**48.7**	**50.2**	**48.5**

Outcome 5: People with dementia are assessed and treated earlier									
Indicator Description - Targeted	**Time Period**	**Kent**	**Ashford CCG**	**Canterbury CCG**	**DGS CCG**	**SKC**	**Swale CCG**	**Thanet CCG**	**West Kent**
5.4 Total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	2013/14	**225.7**	**187.6**	**168.1**	**342.8**	**183.0**	**257.4**	**193.0**	**231.4**
5.5 Total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	2013/14	**452.5**	**382.4**	**327.1**	**673.0**	**363.9**	**573.1**	**383.1**	**467.7**
Trust Level Data									
	Time Period	**D&G NHS Trust**		**EKHUFT**		**MTW**		**Medway**	
5.6 The proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been:									
(a) identified as potentially having dementia	Q4 2013/14	**92%**		**100%**		**99%**		**78%**	
(b) who are appropriately assessed		**100%**		**94%**		**99%**		**88%**	
(c) and, where appropriate, referred on to specialist services in England		**100%**		**100%**		**100%**		**91%**	

Stress Indicators									
Indicator Description - Targeted	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
Children's Services									
Decrease the number waiting for routine treatment after assessment - CAMHS	April 2014	**565**	**16**	**0**	**216**	**120**	**69**	**49**	**95**
CAMHS Caseload, for patients open at any point during the month (excluding Medway and Out of Area)	April 2014	**8523**	**724**	**1206**	**1432**	**1347**	**531**	**1250**	**2033**

This page is intentionally left blank

From:	Roger Gough, Cabinet Member for Education and Health Reform Andrew Scott Clark, Acting Director of Public Health
To:	Kent Health and Wellbeing Board – 16 July 2014
Subject:	**First HWBB report of the JSNA / JHWS steering group for Kent**
Classification:	Unrestricted

Summary:

This is the first in a series of progress reports to the Kent HWBB concerning the JSNA / JHWS development process for Kent. This report describes how the JSNA / JHWS steering group was set up, its terms of reference and its sub groups and some of the topic areas discussed.

Recommendations:

The Health and Wellbeing Board is asked to note the contents of the report and to comment on what the sub-group should be covering going forward.

1. Background

The Joint Strategic Needs Assessment for Kent (JSNA) is a statutory requirement by the Kent Health and Wellbeing Board and describes population needs at a Kent and sub Kent levels. The Kent JSNA is currently reported across a number of formats, which are updated at different intervals (please refer to www.kmpho.nhs.uk/jsna for further details). The most important is the Kent JSNA Overview Summary document which is refreshed every 3 years (the next refresh will be in 2015).

Recommendations made within the JSNA are taken forward for consideration for the development of Joint Health and Wellbeing Strategy (JHWS). The Health and Wellbeing Strategy 2014 will be a three year strategic document covering the period 2014-2017. This process is aligned with partner organisations commissioning processes. In future, a prioritisation process will ensure that recommendations are included in JHWS in a robust manner.

Between May to September 2013 the Kent Health and Wellbeing Board considered several reports and sought approval for the establishment of a development group that would oversee the rolling programme for the refreshing of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy.

A decision was also made to combine the existing JSNA and HWBS steering groups. The first meeting of this joint group took place on 11th October 2013 and subsequently met three more times till date.

2. Terms of reference

The following terms of reference were summarised from a synthesis of TORs from JSNA and JHWS groups, before they were merged. These were agreed at the first joint meeting in October:

2.1 Overarching terms for both groups

- Ensure a robust JSNA and JHWS are produced in Kent to set commissioning priorities at all levels and for all health and social care commissioning organisations for the period 2014 to 2017.
- Evaluate and monitor the usage of the JSNA and H&WS in commissioning plans and intentions on behalf of the Kent Health and Wellbeing Board.
- Ensure all requirements for public consultation and engagement are met and contribute effectively to the production of the JSNA and the H&WS.
- Ensure that the JSNA properly informs the priorities of the JH&WS.

2.2 Structure and reporting

Chair: Roger Gough (Cabinet Member for Health Reform)
Vice Chair (HWBS): Andrew Scott-Clark (Acting Director Public Health)
Vice Chair (JSNA): Abraham George (Assistant Director of Public Health)

2.3 Frequency of meetings

The group meets every 6 weeks. The next two meetings are on 9th July 2014 and 21st August 2014.

2.4 Governance

The joint steering group currently reports to the Kent Health and Wellbeing board.

2.5 Membership

JSNA and HWBS:

- KCC Families and Social Care
- KCC Policy and Planning
- KCC Public Health (including KMPHO)
- CCG AOs (or their representative)
- Kent Healthwatch
- KCC Comms & Engagement
- District Council representatives
- Business Intelligence, KCC
- NHS England
- Public Health England
- Kent and Medway Commissioning Support services (Business Intelligence Team and Patient Engagement team)
- Kent Police
- Kent Fire & Rescue

3. Sub-groups

A number of task and finish subgroups report to the joint JSNA/JHWS steering group. They have been established to support the delivery of the JSNA and HWBS:

3.1 Communications

This is to be led by KCC Comms and Engagement team. The purpose is to provide adequate public engagement of the JSNA and HWBS development process. This will also include discussions on internal and external communications insight and engagement, website development and KNet presence.

3.2 Evaluation

An outline framework was discussed and agreed at the April 2014 JSNA/JHWS steering group meeting, examining how the Kent JSNA and JHWS are applied in local commissioning strategies and plans. For example, at the last Kent HWBB, a comment was made to ensure that the excerpts of the JSNA were properly referenced in the latest draft of the JHWS, to substantiate key priorities and outcomes, where applicable. At the next meeting, a detailed report will explain the progress of the JSNA refresh for 13/14 including list of new needs assessments and other products completed.

3.3 Prioritisation

A prioritisation workshop led by academic colleagues, was held on 13th March 2014, was attended by members of the Kent HWBB and the JSNA/JHWS steering group. Its purpose was to test proof a local developed tool (scoring matrix) and determine how it could be used to systematically prioritise recommendations from the JSNA onto the JHWS. Much of the group work discussion focused on 3 themes in 3 sub Kent areas – Long Term Conditions, Lifestyles and Children & Young People.

3.3 Transformation

The Transformation sub-group agreed a report to the Steering Group that described how elements of the JSNA and the existing Health and Wellbeing Strategy had been reflected in the Better Care Fund plans submitted to the Kent Health and Wellbeing Board.

3.4 Health and Social Care Maps

The Health and Social Care Maps, developed by the Kent & Medway Public Health Observatory (http://www.kmpho.nhs.uk/health-and-social-care-maps/) reports regular information and intelligence across 200 indicators which are largely based on the national JSNA Core Dataset. The maps are currently described as District profiles in pdf formats, but will soon also be reported as Instant Atlases and on CCG boundaries. A cross organisation group is to be convened soon to oversee the development process.

3.5 Overall progress

- The JSNA / JHWS group has established itself as a key forum where a wide range of stakeholders including KCC, District Councils, Fire and

Rescue, CCGs and Healthwatch are involved in the further development of the JSNA, JHWS and associated activity.

- Overseen the 13/14 refresh of the JSNA and continued development of the 14/15 refresh.
- Informed and monitored the development of the refreshed JHWS including the engagement and communications strategy.
- Established ongoing working groups to deliver key activities such as assurance around compliance of the Better Care Fund plans with the JHWS, evaluation, and development and promotion of a prioritisation tool for the JSNA.

4. Work plan for the next six months

As a matter of routine all sub groups are expected to feedback at every meeting their progress on their respective work streams, where applicable. In addition, the following items have also been suggested for discussion and consideration:

21st August 2014	Progress report on JSNA refresh 13/14
7th October 2014	Demonstration of KIASS and Health and Social Care Maps
18th November 2014	JHWS Communications and engagement progress and follow up stakeholder event proposal

5. Report Authors

Dr Abraham P George - Consultant in Public Health Kent County Council
abraham.george@kent.gov.uk

Mark Lemon - Strategic Business Advisor, Policy and Strategic Relationships, Kent County Council
Mark.lemon@kent.gov.uk