Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

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

Kent County Council
kent.gov.uk

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Foreword

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

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

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

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

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

Signed by Roger Gough
Chair of the Shadow Kent Health and Wellbeing Board
Cabinet Member for Business Support & Health Reform

Summary

This 12-month strategy is the starting point for a long term partnership approach to improve health and care services whilst reducing health inequalities in Kent.

Good health and wellbeing is fundamental to living a full and productive life. Although overall Kent has a good standard of health and wellbeing, this hides some significant areas of poorer health and differences in life expectancy (15 years between the healthiest and least healthy wards in Kent).

This is the first Joint Health and Wellbeing Strategy for Kent, and it aims to identify the health and social care outcomes that we want to achieve for the people of Kent. This document will set out the challenges we face, what we are going to do to overcome them and what we will see as a result.

We have made sure that this strategy reflects the evidence base of our current Joint Strategic Needs Assessment and other key data sources and documents that we have already developed with our health and care partners.

The purpose of this strategy is to give an overview and to focus on the issues we need to tackle together without repeating plans that already exist. Our partners already have detailed plans in place for how they will improve health and wellbeing in Kent, including developing new ways of working and spreading best practice across the whole county.

The opportunities presented by this new approach to health and wellbeing are significant. For the first time we have clearly identified shared health and care outcomes for Kent, presenting huge opportunities for new ways of working to ensure that health, care and broader services are aligned to meet people's needs.

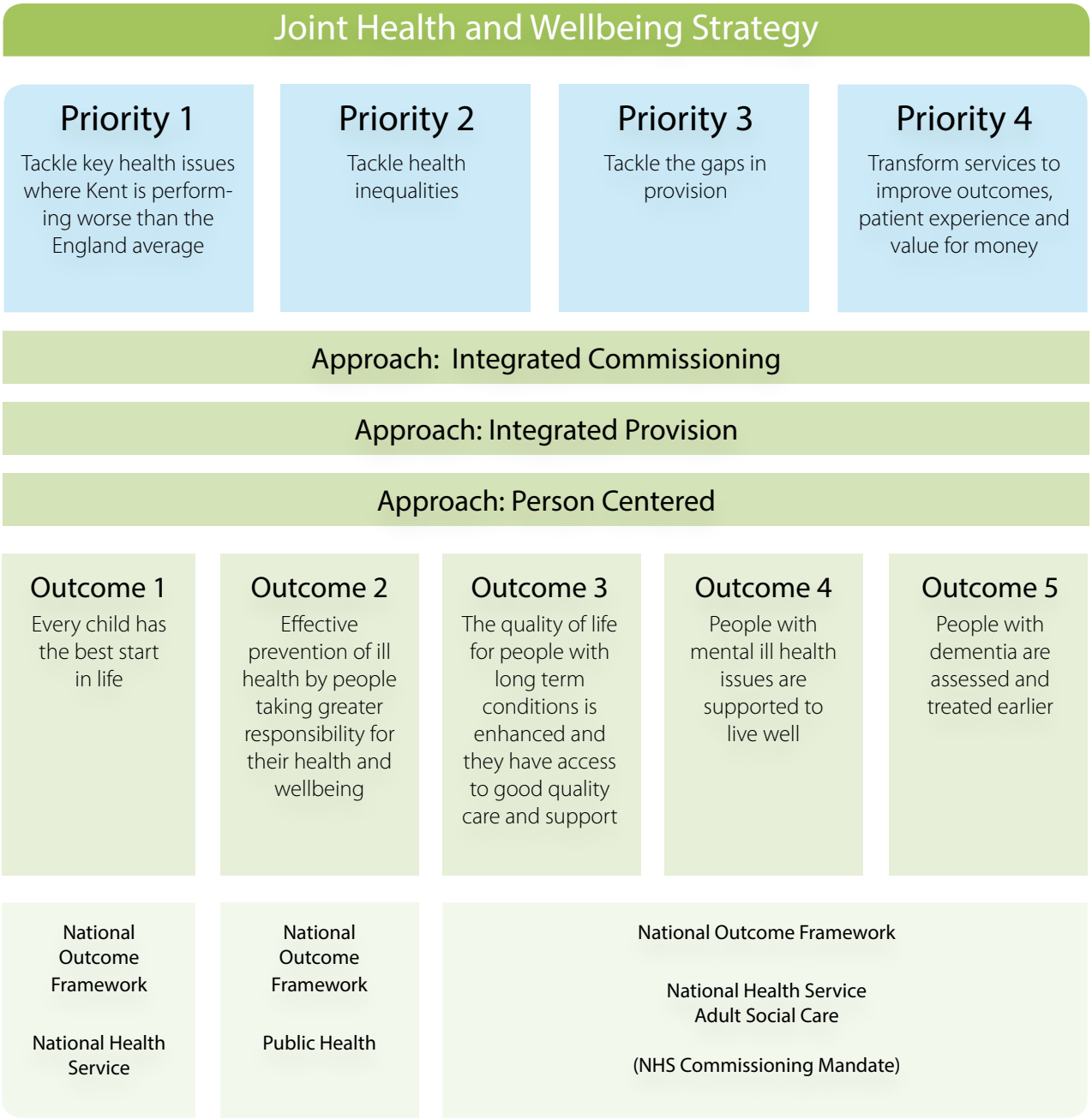
We will make better use of our resources by expanding the integration of health and social care services to provide seamless care, which in turn will support the shift of resources from the acute sector into the community, providing better care, closer to home.

We will act as system leaders and ensure that the residents of Kent have access to high quality care and support wherever they live. We will work to ensure that the health of all the people of Kent will

Our vision:

Our vision in Kent is to improve health 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.

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



Challenges that we face in Kent

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

The evidence base

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

Joint Strategic Needs Assessment
www.kmpho.nhs.uk/jsna/

Kent Health Profile 2012
www.healthprofiles.info

Kent Health Inequalities Action Plan: Mind the Gap
www.kmpho.nhs.uk/health-inequalities/?assetdet1118452=228636

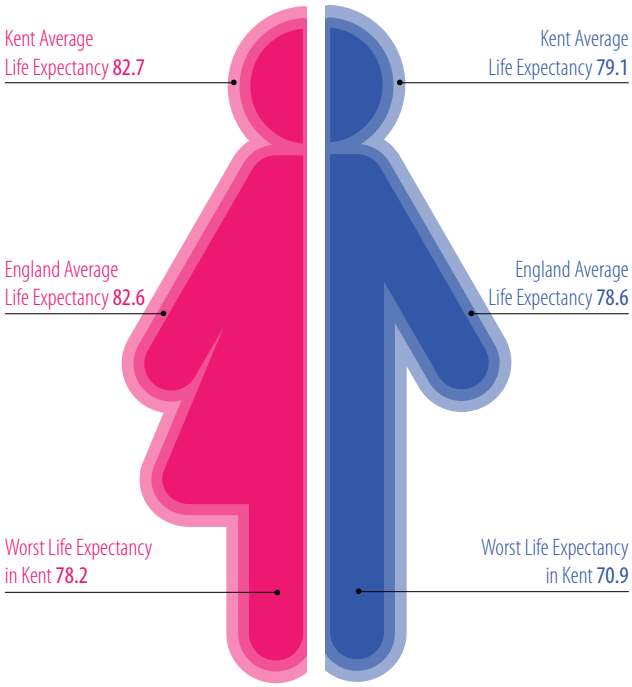
The Joint Strategic Needs Assessment identified the following key priorities that need to be addressed:

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

Demographic pressures and health inequalities

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

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



Just over half of the total population of Kent is female (51.1%) and 48.9% are male. Over the past 10 years Kent's population has grown faster than the national average, growing by 7.8% between 2000 and 2010,

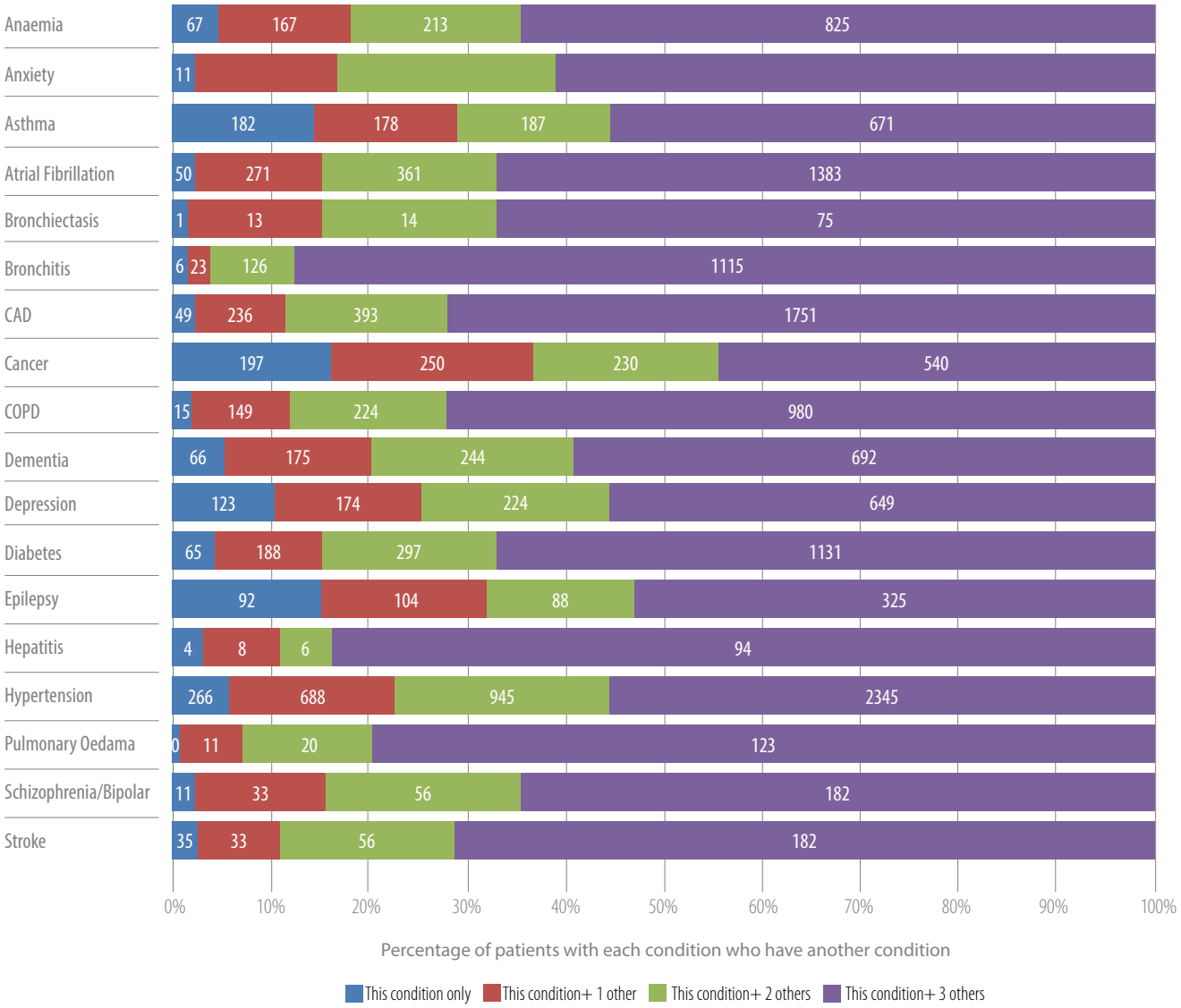
this is above the average both for the South East (6.7%) and for England (6.1%). Kent's population is forecast to increase by a further 10.9% between 2010 and 2026.

Overall the age profile of Kent residents is similar to that of England. However, Kent does have a greater proportion of young people aged 5-19 years and of people aged 45+ years than the England average. Just under a fifth of Kent's population is of retirement age (65+). Kent has an ageing population and forecasts show that the number of people over 65 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%. Kent's ageing population will place significant pressures on health and social care services.

70% of Kent residents describe themselves as being in good health but 16.5% of Kent's population live with a limiting long term illness, and in most cases they have multiple long term conditions (please see the graph below). We need to shift our focus from treating individual illnesses to treating the whole person.

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 experiecned by band 1 patients with long Term Conditions in Kent, 2010/11



The health of the people of Kent

Overall the health of the people of Kent is mixed compared to the England average. We are performing better than the national average in the following areas:

- Obese children (Year 6)
- Hospital stays for alcohol related harm
- Drug misuse
- Infant deaths
- Early deaths from heart disease, strokes and cancer
- Acute sexually transmitted infections
- Teenage pregnancy
- Proportion of children in poverty

Where Kent needs to do better

Kent is performing worse than the national average in the following areas:

- Smoking in pregnancy
- Breastfeeding initiation
- Healthy eating among adults
- Obesity in adults
- Injuries as a result of a fall in women aged 65 and over and in people aged 80 and over
- Fractured hips (among people over 80)
- Diagnosis rates for Alzheimer's disease
- First time entrants into the youth justice system
- Number of 16-18 year olds not in employment, education or training
- Rates of chlamydia diagnosis (15-24 year olds)
- Vaccination rates for HPV and PPV and vaccination rates of the atrisk group for influenza

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

To improve people's long term health we have to improve healthy lifestyles; encourage healthy eating in adults; address the challenges of an ageing population; give every child the best start in life, and; enhance the quality of life of people with long term conditions, including mental health and dementia. We will need a real focus on differences in outcomes, both within and between communities. In addition to this, we will need to look at how we improve people's knowledge of the symptoms of various diseases such as cancer and what they can do to prevent them, for example by encouraging physical activity. Healthier choices need to become the easier choices to make. For example, people with learning disabilities have poorer health outcomes than other population groups, as they may not be accessing routine screening or health support as consistently as the mainstream population.

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

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

A simple way to identify the impact of poor health and lifestyle choices on life expectancy is by looking at how many years of life are lost by people dying prematurely. In Kent, the number of years of life lost by people dying of preventable causes before the age of 75 is 165,576. The key diseases leading to this are circulatory disease, cancer and respiratory disease, all of which can be reduced by taking a more proactive approach to health and care.

Economic and financial pressures

These are difficult economic times for everybody. Public sector organisations are facing tough decisions about how to deliver the best, most efficient services with reduced budgets. The challenge is made greater by increased demand

across services and increased expectations of higher quality services among residents.

This strategy is set against the risk of ensuring service sustainability during these times of unprecedented pressure on budgets and increase in need.

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

How we will improve the health of the people in Kent

With limited resources, we need to focus on the key health issues that have been identified through the Joint Strategic Needs Assessment, including moving our focus from treatment to prevention. Key to this will be a sustained shift in resources out of the acute sector (e.g. hospitals with emergency services) into community health services (e.g. nurse-led clinics). Whilst hospitals are the best place for certain types of treatment, they are not the best place for many people with long-term conditions, dementia and other illnesses that can be better treated in the community. We would like to see an annual and ongoing shift of 5% of resources from hospitals into community services, leading to more community nursing, more preventative services and better, joined-up services. To achieve this we will ensure that the integration of services between health and care is the norm, that we make the difficult resourcing decisions together and that we will promote innovative services to improve care and health in Kent.

People should be able to access the right treatment, at the right time and in the right place, so we will also focus on ensuring that more treatment occurs in the community where it is appropriate. In the light of the recent report into Mid Staffs (the Francis Report), we will work with all partners to ensure that services are safer, patient, focussed, of a high quality and that we respond to patient concerns.

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

We will also work closely with the Academic Science Network and Kent Universities to learn from recent research and evaluated practice to support the implementation of best practice in health and social care in Kent.

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

- Tackle the key health issues where Kent is not performing as well as the England average, for example tackling the levels of adult obesity
- Tackle health inequalities within Kent, for example delivering the Kent Health Inequalities Action Plan "Mind the Gap"
- Tackle the gaps in the provision and quality of care and support that the people of Kent receive. In particular we will focus on the adequacy of provision and preventative work in areas of high need. This may involve delivering a number of measures at any one time such as medical interventions, improvements in lifestyle behaviours and improvements to social factors that may cause ill health (poor housing, poverty and unemployment)
- Transform services to improve health and care outcomes, the experience for patients/service users, value for money and quality, for example we want to see better community care, moving services closer to home and improving access for patients and carers

In considering each of these priorities, the approaches and the outcomes outlined in the following pages need to be taken into account, as their success is dependent on all of the elements being delivered.

What the consultation told us:

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

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

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

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

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

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

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

- **Integrated commissioning,** leading to
- **Integrated provision** (delivering seamless services to the public)
- **Person Centred,** focused on treating the whole person and not just the condition; easier to access, supportive, enabling people to help themselves

We want to see a move from treating the condition to treating the whole patient. Quite often patients will experience more than one health problem. These need to be treated together, rather than having a separate treatment and appointment for each health problem, saving patients' time and improving clinical outcomes. The public should experience seamless services. We know that patients sometimes spend longer in hospital than they need to because their home may not have the right adaptations. If we commission services together (integrated commissioning), we can work towards this no longer happening.

The Health and Wellbeing Strategy will inform commissioning decisions made by local partners, especially GP led Clinical Commissioning Groups (CCGs), so that they focus on the needs of patients, service users and communities, tackle factors that impact on health and wellbeing across service boundaries and influence local services beyond health and care to make a real impact on the wider determinants of health (e.g. employment, housing and environment). We will make better use of money to enhance and develop integrated preventative services in the community.

By integrating provision of services we will see more examples of different disciplines working together in one team or in one place. For example, joint teams of district nurses and social care workers will become the norm, meaning that the patient will only have one assessment and it will be easy for them to access support. This will also lead to a more person-centred approach, giving patients and their families the right tools to look after themselves at home. This might be through personal budgets, telehealth, training on self-management of a condition or better access to services in the community.

We are already developing a number of new ways of working, and where successful we want to ensure that they are implemented across the whole of Kent. We see it as a key task of the Health and Wellbeing Board to build on these initiatives and diffuse successful best practice across the whole of the County. In identifying which projects and pilots we should support on a larger scale across the whole of Kent, we will balance a focus on statistical evidence and value for money with "doability" and importance to the health of the people of Kent.

The following initiatives are already starting to provide more opportunities to improve health outcomes:

Annual Health Check for People with Learning Disability (Kent wide) – this is enhanced funding to ensure people with a learning disability get an annual health check. This project is monitored by the Learning Disabilities Partnership Board through the Good Health Delivery Group. Kent has a very active Learning Disability Partnership Board and has recently published the Partnership Strategy for Learning Disability in Kent 2012 - 2015

Connecting Communities (Thanet) – Based on the Beacon project in Cornwall, this is a new approach to community development and empowerment. It promotes the idea of problem solving by working together through agencies and tenants and residents. The aim of it is to get all the people in that area to get together to look at what the problems are and try to find a way forward. (www.healthcomplexity.net). The outcomes in the Beacon project saw a reduction in child asthma rates by 46%, post natal depression down by 70% educational attainment of 10-11 year old boys (achieving level 4 at key stage 2) was up by 100%. We hope to replicate some of these successes with the community of Newington in Ramsgate.

Pro-Active Care (Folkestone) – This programme works with people with at least two long term conditions, which have meant they have had to go into hospital in the last 12 months. Selected patients are offered 12 weeks of intensive support led by their GP, but involving all the relevant services coming together. An action plan is developed to improve the patient's health and wellbeing. Changes might include a review of medicines, use of different equipment or intensive physiotherapy to support independence. So far, patients that have taken part in this programme have seen a reduction in emergency admissions to hospital, if taken to hospital have spent less time there, have needed fewer outpatient appointments and were less likely to be anxious or depressed. It also involves a number of non-medical interventions which have led to self reported improvements in quality of life and self confidence. The initial work led to a 15% reduction in A&E attendances and a 55% reduction in A&E admissions.

Patient Records (across Kent) – Partners across the health system in Kent are working with new patient information systems which will mean that patients and their carers have better access to their records, and if they choose, can let other health and care professionals access their information making it easier and quicker to provide them with health and care services. We are working to remove the need for people to explain their health and care problems over and over again, in line with the Government's drive to empower patients.

Health Visitors (across Kent) - There is currently a programme of work in place to develop effective universal health visiting services, a key element in improving support to children and families at the start of life. The service will deliver the national Healthy Child programme locally, working with Children's Centres, GPs and other local services. Eventually Kent will have the equivalent of over 420 health visitors.

Children's Centres (across Kent) – These offer significant opportunities for integrated working and a team to work with families to improve children's health by ensuring families are able to access wrap around support, services and information so that their children have the opportunity to reach their full potential. Key to this is the wide range of support services available to improve health (reducing smoking in pregnancy, reducing infant mortality, improving healthy eating) These services will work better when supported by primary care services such as GPs, Health Visitors and community based healthcare. We want to see integrated health and care teams focussed on the family. Work is underway to deliver enhanced provision between Children's Centres and GPs.

Integrated Adolescent Support Service (Thanet, Dartford, Ashford and Tunbridge Wells) - The Integrated Adolescent Support Service provides the model for early intervention and prevention services for young people aged 11-19 in the four pilot areas above. The model involves the integration of the work of professionals working with young people in the following agencies: health, education, social care, Connexions, the youth service and youth offending service, the police and schools. The service aims to improve educational outcomes, improve mental health and emotional wellbeing and reduce levels of drug and alcohol abuse.

Integrated Health and Social Care Teams (Kent wide, with a specific focus on Dover and Shepway) - At the centre of health and social care integration is the vision to make life-changing improvements to the experience and outcomes of people using health and social care services in Kent.

This is being delivered through the identification of those people most at risk of admission to long term care and hospital and who may need support. Integrated neighbourhood care teams, together with the patient/service user and their GP, are developing (self) care and support plans, which will identify what the best response to the care needs will be, including the use of teletechnology. In Shepway and Dover this will include the use of integrated personal budgets. Health and social care providers (including GPs) are working with service users, carers and the voluntary sector to strengthen people's ability to manage their own conditions better, at home and in the community. This will reduce unplanned admissions, ensuring people know how and where to seek support, and when support is provided it will be of the highest quality.

Health and Social Care Coordinators (Kent wide with specific focus in West Kent, Canterbury and Swale) – A bespoke model to meet local needs, delivered through a single point of access 7 days a week. People will only have to undertake one assessment and will be supported by health and social care coordinators. Community emergency/ crisis response, enablement services and dementia responses will be highest quality and personalised to meet the needs of the individual and carers.

Assistive Technology (across Kent) – Kent is part of the National Commissioning Board's "3 Million Lives" programme. The aim is to use Telecare, Telehealth and new technologies to support people to manage their own condition, to connect with the community and to receive direct support at home. This will be carried out across Kent, but new ways of working with teletechnology will be explored in Dartford, Gravesham, Swanley, Swale, Shepway and Dover.

CASE STUDY

"Telecare Case Study: *Mrs. K: "I can't enthuse about the system enough, I tell everybody who visits! I was a bit uppity at first, didn't want things in my house, but it has been a God-send and we've used it on about three occasions. It's easy to use, you don't have to phone an ambulance or anything, and the people are so helpful. We had a chap here the other day to change the batteries."*

Urgent Care Work (East Kent) – The development and delivery of integrated Urgent Care and Long Term Condition services is considered as a priority across East Kent. It has been agreed that the four East Kent CCGs will work with social care commissioners and key providers to understand the vision of Integrated Urgent Care and Long Term Conditions, and to design an overall clinical system model that optimises cost effective patient care, and across primary and secondary care interfaces (GPs and Hospitals). This will mean patients and client needs will be met holistically, with the right care and support being put in place when it is needed.

Year of Care Tariff (across Kent) – Kent is playing a leading role as part of a national programme to support the integration of health and social care teams in integrating care, by better aligning funding flows. The work aims to improve outcomes

and deliver a more effective use of resources by moving towards person-centred care irrespective of organisational boundaries.

Integrated Care Around the Family - Part of the development of the Common Assessment Framework and the Team Around the Family aims to provide more integrated care to families at the earliest possible stage. It provides a simple process of the assessment of a family's strengths and weaknesses. The Team Around the Family provides a coordinated service provision as well as more timely support before issues worsen. Initiatives such as Troubled Families and Kent Integrated Adolescent Support Service underpin this integrated approach.

How will we know if we have made a difference?

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

- 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

There is already a lot of good work going on across Kent in these areas. This strategy is not in place to duplicate the work already taking place, but rather to help spread best practice across the county.

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

CASE STUDY

Health and Social Care Coordinators [HSCC] work with local GPs to provide an improved link into community health and social care services.

Tom is 71 years old and was referred to a HSCC by his GP. He presented with BMI of 44, which placed him in the morbidly obese range, and has complex health problems which include heart disease. Due to his size personal hygiene is problematic and the referral was to find alternative bathing facilities.

The HSCC was able to work with health and social care colleagues to pull all existing information together to prevent reconsideration of any solutions which had already been explored. This meant that it was known that the house was too small for adaptation and that suitable bariatric equipment was not available.

In order to help ensure that Tom stays in his own home and doesn't end up in hospital or residential care the HSCC makes sure that the local Neighbourhood Care Team [NCT], which brings together Health and Social Care staff, have a discussion about what could be done to help him. At the meeting a revised care pathway was agreed for Tom. This included access to appropriate equipment, while an alternative place for bathing was also identified and transport to the bathing facilities was also sorted out.

The HSCC then makes sure that everyone follows the plan and updates the GP so they know what is happening with Tom and can monitor any follow-ups as required.

Outcome 1

Every child has the best start in life

We know that improving health and wellbeing in early life contributes considerably to better outcomes in later life and helps reduce inequalities. We need to focus on both physical and emotional and psychological wellbeing. By continuing to take a holistic approach to the child, working with them in the best settings (e.g. schools and children's centres) we can provide a firm foundation for lifelong health and wellbeing. We also want to ensure that every child, including those with a learning disability, has the best start in life.

In pursuing this, we will focus on achieving an increase in mothers breastfeeding their babies, increasing targeted healthy eating support for families leading to an increase in healthy weight level, and an increase in MMR vaccination take up, particularly in East Kent. Kent and Medway will see an additional 421 (whole time equivalent) Health Visitors by 2015 who will support families with young children.

This is what we will do:

- Achieve our ambition of having fully integrated children's services for children aged 0 – 11
- Ensure better use of community assets such as Children's Centres to deliver integrated health and social care to high risk vulnerable families
- Roll out Total Child Pilot to schools to help schools identify health and wellbeing problems for pupils
- Work with families to promote healthy eating and increased physical activity
- Improve child and adolescent mental health services (CAMHS)
- Implement the adolescent support workers programme, to deliver brief interventions as part of a wider team supporting young people and their families
- Ensure all providers get safeguarding right for Kent
- Reduce risk taking behaviour in children and adolescents e.g. smoking, sexual health, teenage conception, drugs and alcohol
- Ensure there is adequate health provision in Special Schools and for children with Special Educational Needs in mainstream schools, including access to Multi Agency Specialist Hubs (MASH)
- Work with partners to improve the uptake of Antenatal and Newborn Screening services

We will measure success by:

- Increasing breastfeeding initiation rates and continuance at 6-8 weeks, until they are at least 50% in all parts of Kent
- Improve MMR vaccination uptake and improve access to the vaccination, particularly for the most vulnerable groups, to attain 95% coverage levels
- Promoting healthy weight for children, particularly those in deprived areas
- Ensuring women have access to good information about health and wellbeing in pregnancy and book their maternity care early
- Working with families to promote healthy eating and increased physical activity
- Reducing the number of pregnant women who smoke through their pregnancies by 50%

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

(Joint Health and Wellbeing Strategy Consultation Response)

Outcome 2

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

We all make decisions which affect our health and wellbeing. We want to ensure we have provided the right environment in Kent for people to make better choices to improve their own health and prevent ill health occurring. By combining the availability of preventative services with increased personal responsibility for healthier choices, we will begin to see the health of the population improve.

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

Kent is performing below average on obese adults and healthy eating and we are average on physically active adults. We have already got some good examples of where we are working with communities to promote healthy living, diet and exercise such as the Change4Life initiative. We will work towards ensuring that patients and the public are better informed about symptoms of major diseases such as cancer. We will support the making of healthier choices as easier choices.

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

This is what we will do:

- Develop the NHS Health Check programme, so that invitees and take up exceed national averages across Kent
- Work with young people in school settings (particularly those who are vulnerable) to tackle substance misuse, smoking and underage drinking and other risk taking behaviour
- Provide better information and education so that people can recognise the symptoms of ill health
- Implement the NHS Every Contact Counts initiative
- Ensure that, where appropriate, targeted services are delivered to address specific health and wellbeing issues affecting minority communities
- Ensure that people are aware of early symptoms, particularly of cancer, and encouraged to access services early
- Ensure that across the health care system, collaborative work will be undertaken to ensure that mainstream health services (including preventative services) are equipped to meet the needs of people with learning disabilities
- Ensure that rehabilitation pathways and screening services are in place and systematically applied so all people eligible are offered a service

- Ensure that the critical care pathways are in place across the Kent population to manage acute events according to nationally advised guidance (e.g. NICE) such as heart attacks and strokes
- Ensure that all providers maximise the opportunities to improve people's health
- Ensure primary preventative strategies are systematically in place locally to address the lifestyle contributory causes of the big killers, e.g. smoking, obesity, alcohol and illegal drugs consumption
- Ensure that secondary prevention interventions are systematically in place locally and delivered at scale in order to have an impact on life expectancy- e.g. all people eligible for cardiac rehabilitation are offered this

We will measure success by:

- Reducing the levels of inequalities for life expectancy
- Reducing the mortality rate of people with learning disabilities
- Reducing the rates of deaths attributable to smoking in all persons, targeting those who are vulnerable or most at risk (focusing on social gradient of smoking)
- Improving the proportion of our adult population that enjoy a healthy weight, a healthy diet and are physically active
- Reducing homelessness and its negative impact for those living in temporary accommodation
- Reducing the numbers of hip fractures and falls for people aged 65 and over, where Kent is currently performing significantly worse than the England average
- Reducing the under-75 mortality rate from cancer
- Reducing the under-75 mortality rate from respiratory diseases

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

Outcome 3

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

We know that our population is ageing and is living longer; we need to focus on not just adding years to life, but life to years. Currently, as we age, we start to experience a number of long term conditions - high blood pressure, COPD (Chronic Obstructive Pulmonary Disorder), and heart problems. These have a limiting effect on quality of life and have an impact on resources.

We want people with long term conditions to experience well-coordinated services which prevent them from being admitted to hospital unnecessarily or experiencing a crisis.

We also want to ensure that high quality end of life care is delivered, which is coordinated around the needs of the individual and their families. This will be done by the systematic identification of patients who are at the end of life, and by providing the appropriate support and coordination of care to support patients, carers and their families.
If we do this in Kent we should start to see the following: more patients and their carers being supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improved access to patient information and; a reduction in the number of times patients have to repeat information to professionals (Tell Us Once).

This is what we will do:

- Work with health and social care providers in hospitals and in the community to develop 24/7 access and community based health and social care services, ensuring that the right services are delivered in the right place, at the right time
- Take a person centred approach, including personal budgets, for people with multiple long term conditions, learning disabilities or mental ill health
- Ensure equitable access to health services for people with learning disabilities
- Ensure all agencies who are working with people most at risk of admission to hospital and long term care have access to anticipatory and advanced care plans and 24/7 crisis response services in order to provide the support needed
- Develop a minimum level of service we expect to be available for vulnerable people in the community
- Ensure we have multi-professional teams working together, so that people who need support from a variety of organisations do not face duplication of assessment and numerous referrals around the system

- Ensure people can be supported to live as independently as possible at home and are receiving good quality end of life care as and when needed - currently 62% of people in Kent would prefer to die at home, but only 19% are supported to do so
- Enable General Practitioners to act as navigators, rather than gatekeepers, retaining responsibility for patient care and experiences throughout the patient journey
- Enable clinical records to be shared across the multi-professional team, by accessing patient record schemes e.g. Patient Knows Best
- Deliver the Kent Carers' Strategy
- Ensure all GP practices in Kent are undertaking risk profiling, working in integrated teams (between health, social care and others) and ensuring a range of self management approaches, e.g.
  - Patient and Carer education programmes
  - Medicines management advice and support
  - Provision of Telecare and Telehealth
  - Integrated Personal Budgets
  - Psychological interventions (e.g. Health Trainers)
  - Pain management
  - Patient access to own records, systematic training for health providers in consultation skills that help engage patients
- Ensure risk profiling is carried out consistently across the population of Kent using the same tool and done at scale, using both GP and social care data, which will help to prevent unplanned hospital and long term care admissions

We will measure success through:

- The proportion of older people (65 and over) 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
- The amount of reablement and rehabilitation services accessed 24/7 and services put in place, avoiding admissions
- The number of anticipatory/ advanced care plans in place on an accessible patient information system
- A reduction in average acute bed days for emergency admissions
- A reduction in the number of medically fit patients on an acute bed awaiting a social care assessment or placement
- Integrated health and social care teams being established in all CCG areas in Kent. These teams will undertake single assessments and care planning , using teletechnology and integrated personal budgets
- An increased employment of people with Long Term Conditions
- Increase in the number of people with long term conditions and, or social care needs who are self reporting an improvement in their quality of life
- An increase in the number of people actively supported during their end of life care.
- Increasing the number of people who are able to choose where they want to be at the end of their life

CASE STUDY

Integrated Personal Budgets

Jo received a social care direct payment through the Kent card. It was then agreed that health and social care would jointly fund the package in order to meet Jo's complex needs.

Jo stated that his family and independence were very important and therefore wanted to remain in control of the care and support he received. Working with an independent health care broker, Jo developed an integrated support plan looking at how he will use the estimated budget to meet his assessed health and social care needs. Jo decided upon a mixed budget (direct payments and commissioned services). He wanted to keep the social care budget as a direct payment enabling him to continue to employ Personal Assistants (PAs) to access social activities and complete domestic duties.

For the rest of the package, Jo wanted the NHS to directly commission the service. For the direct payment monitoring it was agreed that the KCC Personalisation Coordinator would take the lead to reduce duplication and provide continuity.

Outcome 4

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

Annually we invest over £126 million in adult mental health services in Kent which is delivered through the Kent wide integrated strategy (Live it Well) for mental health and wellbeing of people in Kent. We have been putting into place the action plan to deliver high quality services for people with mental ill health issues. We know this can only be achieved by organisations working together across Kent, particularly in primary and secondary care. In addition, we will work with partners to continue to improve mental health service provision and implement "No health without mental health".

The three key drivers for the next three years are increased personalisation, partnership working and better use of primary care. Personalisation will see more people in charge of their care plans, fundamentally changing the relationships between service users and mental health staff. No single organisation owns mental health; each organisation must be seen as equally important if holistic, non-stigmatising services are to happen. Primary care has a key role to play in mental health services; over 90% of people with mental health problems are treated exclusively within primary care. By moving resources such as mental health social care staff into primary care, we will help people earlier, before mental health problems become too difficult to manage.

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

This is what we will do:

- Promote independence and ensure the right care and support is available to prevent crisis
- Lessen the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services
- Ensure that all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours
- Improve awareness raising and access to good quality information
- Work with the voluntary sector, other providers, carers and families to reduce the social isolation of people with mental health issues
- Ensure we have robust audit processes around mental health e.g. suicide prevention
- Use the Safeguarding Vulnerable Adults competency framework to evidence that all staff that come into contact with vulnerable adults are competent to do so

We will measure success by:

- The proportion of older people (65 and over) mostly at risk of long term care and hospital admission, who are still at home 91 days after discharge from hospitals in reablement / rehabilitation services
- The amount of reablement and rehabilitation services accessed 24/7, and services put in place, avoiding admissions
- The number of anticipatory/ advanced care plans in place on an accessible patient information system
- A reduction in average acute bed days for emergency admissions
- A reduction in the number of medically fit patients on an acute bed awaiting a social care assessment or placement
- Integrated health and social care teams being established in all CCG areas in Kent. These teams will undertake single assessments and care planning , using teletechnology and integrated personal budgets
- Increased employment of people with Long Term Conditions
- An increase in the number of people with long term conditions and or social care needs who are self-reporting an improvement in their quality of life
- An increase in the number of people actively supported during their end of life care
- Increasing the number of people who are able to choose where they want to be at the end of their life
- Improving rates of recognition and diagnosis in Kent and getting people into the right services when they need them
- Ensuring more people with mental ill health are recovering
- Ensuring more people with mental ill health have good physical health
- Ensuring more people with mental ill health have a positive experience of care and support, including housing
- Ensuring more people with mental ill health are supported in employment and/or education
- Reducing the number of suicides
- Reducing the number of people reporting that they feel socially isolated
- Increasing the employment rate among people with a mental illness/those in contact with secondary mental health services
- Ensuring that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) get the appropriate support and treatment.

Outcome 5

People with dementia are assessed and treated earlier

There are currently 9,200 people living with dementia in Kent, and this figure is set to more than double over the next 30 years. Dementia is a progressive disease (which means it will only get worse) placing a significant strain on services, families and carers, who are often elderly and frail themselves. We have been working hard to ensure we deliver the National Dementia Strategy in Kent. Following Kent County Council's Dementia Select Committee, we have been putting into place the action plan to deliver high quality services for people with dementia. We know this can only be achieved by organisations working together across Kent. In addition we will work with partners to continue to improve mental health service provision for dementia patients with specific needs.

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

This is what we will do:

- Work with partners to develop dementi-friendly facilities and communities in Kent
- Improve awareness-raising and access to good quality information to reduce stigma and improve early diagnosis rates, particularly in primary care. A key focus will be on increasing earlier diagnosis by GPs, through better training. This will be linked to greater awareness of support services
- Work with carers and families, health and social care providers and the voluntary sector to reduce the social isolation of people with dementia and their carers
- Invest in the right services in the right place at the right time, focusing on investing in universal services to maximise independence of older people
- Improve the quality of long term care for people with dementia, including the quality of accommodation
- Deliver the Integrated Dementia Plan and KCC Select Committee action plan including specific support for people with learning disabilities and dementia
- Develop an integrated model of care

We will measure success by:

- Improving the rates of diagnosis in Kent to at least 60% of expected levels (currently 39%)
- Identifying information points which deliver high quality information for people with dementia and their carers
- Increased number of peer support groups and dementia cafes across the county
- Increasing effectiveness of post diagnosis care in sustaining independence and improving quality of life for an increased number of people, including early intervention and crisis services in place, reduced care home placements and hospital admissions, an increased number of people supported by these new services
- Increased access to training and development for the health and social care workforce and identified improvements in the hospital environment and long term care establishments
- Reduced reliance on acute mental health beds and reduction in preventable hospital admissions and care home placements
- Integrated hospital and community health and social care teams to include dementia specific support

What happens next?

The Kent Health and Wellbeing Board will have oversight of all health, care and public health activity across Kent. In addition, a series of local Health and Wellbeing Boards reflecting the geography of Clinical Commissioning Groups will use the Joint Health and Wellbeing Strategy to help determine their local health and care priorities and will then work to commission the right services to achieve these.

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

The Kent Health and Wellbeing Board will use the opportunities of the health reforms to make a real difference to people's lives, with the funding that we have available to us. We will see this through the transformation of community services, through better use of resources, and by ensuring that the patient's voice is heard and that we do not lose sight of delivering high quality services to people who are most in need.

Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

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and can be explained in a range of languages

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