

2014 – 2017

# Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

Draft



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Kent Health and Wellbeing Board

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# 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

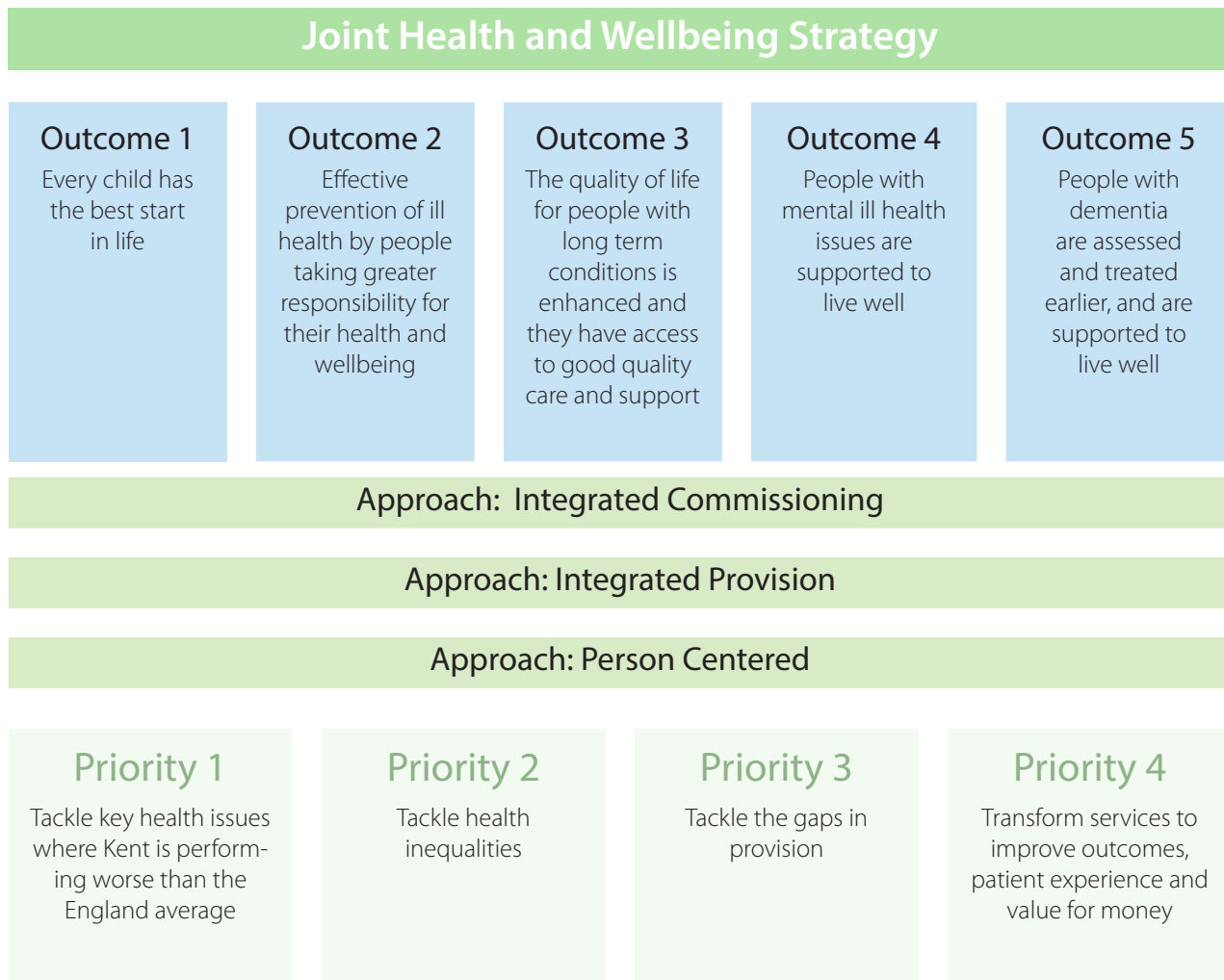
To achieve our vision the outcomes we seek, as informed by the Joint Strategic Needs Assessment, are:

- 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.



## 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.

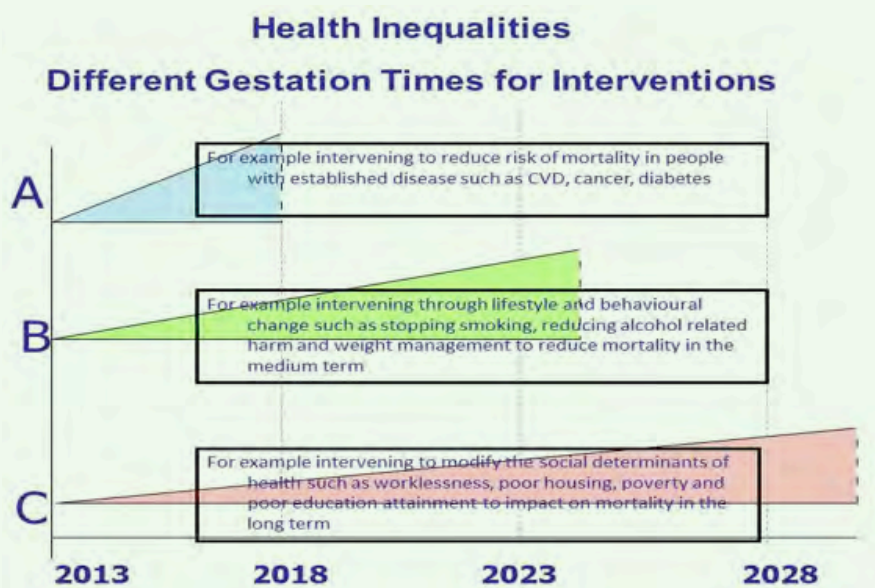
To influence medium term interventions we will ensure that commissioning of public health programmes deliver a transformed and integrated approach to public health, ensuring locally appropriate services and campaigns. Services will be based on “proportionate universalism” principles to ensure that there 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 (CIPLD) 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**

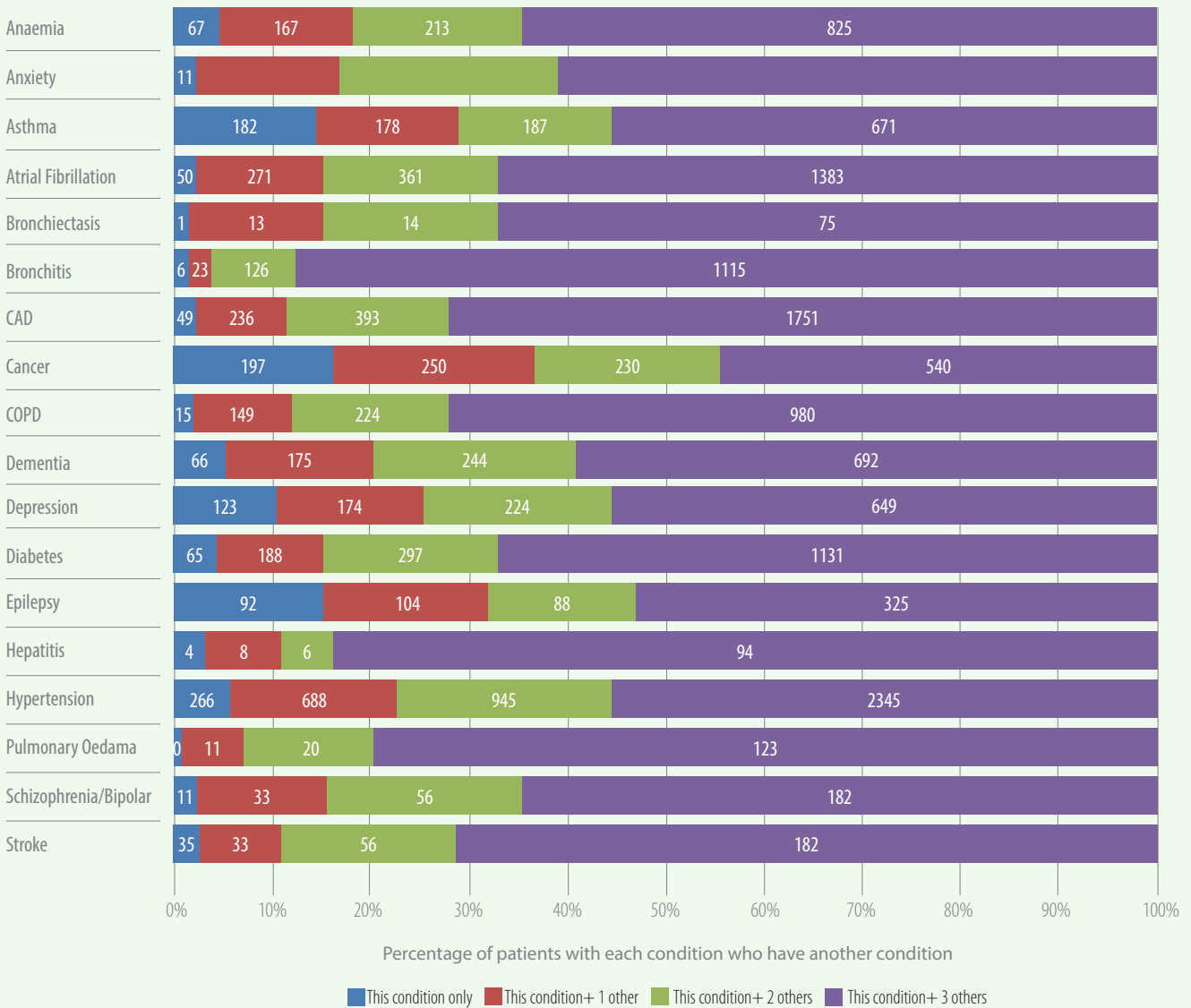


Figure 4



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 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 1 in 5 of the population, include depression and anxiety disorders. Severe mental disorders include psychosis and bipolar 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 as 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 care 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