Canterbury and Coastal Health and Wellbeing Board
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Roger Gough
Chairman, Kent Health and
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SENT BY E-MAIL

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Dear Roger

The Kent Health and Wellbeing Strategy informs the commissioning plans overseen through the Canterbury Health and Wellbeing Canterbury & Coastal CCG commissioning plans enabling us to focus on the needs of 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).

In line with our firm commitment to stakeholder engagement, we embarked on a process of engaging with practices, patients, carers, the public and other stakeholder groups in developing our commissioning priorities. These events focused on information giving, updating stakeholders on our role and activities, and information gathering, enabling us to interact with our 'Patient and Public' and 'organisational' stakeholder groups in a structured way to secure their input into this strategic commissioning plan.

From these efforts, come five key outcomes against which we will measure our success in improving the health of the people of Kent. These key outcomes are:

- **Every Child has the best start in life –**
  - Over the next 3 years we would hope to see an increase in breast feeding take up. We would also like to see targeted support on healthy eating in families leading to an increase in healthy weight levels. There will also be an increase in MMR take up and additional Health Visitors who will support families with young children.
- **People are taking greater responsibility for their health and wellbeing –**
  - This is designed to promote 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.
- **The quality of life for people with long term conditions is enhanced and they have access to good quality care and support**
  - More patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reduce number of times patients have to repeat information to professionals (Tell us Once). More importantly this will lead to a 45% reduction in the rates of people dying earlier than expected.

- **People with mental ill health are supported to live well**
    - Early diagnosis of mental ill health will be increased, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support and early intervention services will see an increase in people reporting an improvement in their own mental ill health and wellbeing. The stigma of mental ill health will be reduced.
- **People with dementia are assessed and treated earlier**
    - 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.

A number of projects are being lead through a Public Health approach, as detailed in the attached Action Plan, however these run across Kent as a whole and are not specific to the needs to Canterbury.

Additionally, within the Health and Social Care commissioning plans **"Community Networks"** is the title given to a number of projects leading towards an overall strategic aim. The component projects, which also form part of the Better Care Fund initiative, are detailed individually below**:**

1. Integrated Urgent Care Centre

Scheme 1 is the integration of urgent care services to ensure that patients receive the same standards of care, entering the same pathways, regardless of which point they access the Urgent Care system.

It will achieve this by providing rapid access to key health economy services which include:

- General Practitioners
- Community Support Services
- Social Services
- Psychiatric Services
- Secondary Care Consultants (including Geriatricians)

The smooth flow of patients through the health and social care system is fundamental to meeting patients' expectations of urgent care services. It is apparent that a significant proportion of urgent and emergency demand could more appropriately be classified as "primary care related" and undertaken by GPs or practice and community nursing.

2. Mental Health Services

We recognise that like physical health related long term conditions, mental illness has a huge impact on the quality of life for the patients and their carer. The CCG will work with all partners to deliver improved mental health services for all age ranges to support:

- Increased schemes to support health minds and early interventions
- Crisis support within all pathway
- Integrated models for all pathways to support patients within range of pathway
- Systematised self-care/self-management through assistive technologies
- Improved care navigation
- The development of Dementia Friendly Communities and
- To facilitate access to other support provided by the voluntary sector.

3. Support for Care Homes

This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions.

4. Health and Social Housing

To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their disability in a safe home environment.

5. Falls Prevention and Management

The intention is to work with partners to develop an integrated multi-agency, multi-disciplinary falls service across Ashford and Canterbury. This will focus predominantly on those aged over 65 years.

The Kent Health and Wellbeing Board have agreed a framework which promotes an integrated multi-agency, multidisciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009) for developing an Integrated Falls Service.

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

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

1. Screening of adults who are at a higher risk of falls

2. Integrated multi-disciplinary assessment for the secondary prevention of falls and fractures

3. Use of standardised Multifactorial Falls Assessment and Evaluation tool

4. Availability of community based postural stability exercise classes

5. Follow on community support for on-going maintenance closer to home

These interventions should be available as a "core offer" for the population if we are to see a reduction in the number of falls related hospital admissions and reductions in numbers of older people living in residential care as a result of falls.

A scoping exercise has been undertaken to review the existing pathways (re-active and pro-active) and services identifying what works well, what requires further development and gaps in existing provision. The outputs of this will be reviewed by the falls task and finish group to support the move to an integrated service.

6. **Integrated Health and Social Care Team**

We will continue to develop our integrated health and social care team to ensure that they will be available 24 hours a day seven days a week and will be contactable through a single access points. The team will be focussed on both ends of the patient journey, through supporting patients, carers, social services and clinicians to avoid the need for patients to be admitted to hospitals, however where this is necessary the team will mobilise to ensure timely discharge of the patient.

These teams will ensure wider integration with other community and primary care based services, including voluntary sector provided services, as well as hospital specialists working out in the community. The ultimate aim is to enable people to be cared for in their own homes or within their own community. The aim of team is to support people to self-manage and to be independent in their own homes.

Yours sincerely

Mark Jones
Chair, Canterbury and Coastal Health and Wellbeing Board