Local health and wellbeing boards be tasked to report in November 2014 on how local populations are being engaged in discussions concerning the implementation of the Health and Wellbeing strategy in their local areas;

Tunbridge Wells' Borough Council is committed to engaging local communities, businesses, officers and VCS in conversations concerning the implementation of the JHWBS for Kent. This achieved through utilising existing tools and resources including:

•**Communications:** Dissemination of important messages via Tunbridge Wells' Local Magazine and Healthy Weight Team Newsletter – this may include publicising community consultations or promoting new strategies and campaigns.

•**Social Media:** Promoting key messages on Facebook and Twitter pages.

•Tunbridge Wells Borough Council Website: promoting health initiatives and campaigns via our website and links to other relevant health sites/ minutes/ consultations and documents via the website

•**Member engagement:** Housing and health officers working closely with portfolio holder for housing and health. Providing information to members and OSC.

•**Tunbridge Wells Health Action Team:** Dissemination of important information, such as consultations to key partners/ stakeholders via the Health Action Team meetings and regular email updates.

•**Engagement:** Utilising engagement initiatives with partners which demonstrate a commitment to the Health and Wellbeing agenda and promoting local services. A range of methods have been used, including, resident engagement through social prescribing in Sherwood through the Sherwood partnership, health checks and community health days.

•**PPGs and GP surgeries:** We have good links with post of the GPs and some for the PPGs so information regarding consultations and important documents is also shared via these mechanisms.

Tunbridge Wells Borough Council

Local health and wellbeing boards be required to ensure local plans demonstrate how the priorities, approaches and outcomes of the Kent Joint Health and Wellbeing Strategy will be implemented at local levels and report this assurance to the Kent Health and Wellbeing Board in November 2014

Outcome 1: Every child has the best start in life

Priority 1

- the number of pregnant women who smoke at time of delivery
- breast feeding initiation rates
- breast feeding continuance at 6-8 weeks
- the proportion of 4-5 year olds with excess weight
- the proportion of 10-11 year olds with excess weight

Priority 2

Tackle health inequalities:

- Implementing the infant feeding action plan (partnership working).
- Children's healthy weight services in priority areas
- Smoking in pregnancy by strengthening resources/ whole systems approach
- Mindful of vulnerable and disadvantaged groups

Priority 3

Tackle the gaps in service Provision achieved through partnership working, monitoring and evaluation of services and the initiation of Task and Finish Groups with recommendations to the commissioners. Community consultations and common assessment framework.

Priority 4

Transform services to improve outcomes, patient and value for money achieved through patient feedback exercises and economic impact assessments.

Local Authority's Actions to support outcome 1

The following are targeted in our most deprived wards to support improvement in health outcomes for the poorest fastest:

- A range of campaigns & health events to raise awareness of the importance of breast feeding (working closely with PSB)
- Work with local businesses and workplaces to encourage and promote breast feeding (Kent Healthy Business Awards and environmental health roll out to food premises)
- Support the baby be clear scheme by working with KCHT SSS.
- Kent healthy business awards – providing safe spaces in the workplace for women to breastfeed
- Little Stirrers Programme delivered for under 5's in children's centres
- Cook and Eat Programme delivered in schools for 7-11 year olds
- LEAP programme delivered in school for 7-11 year olds
- Healthy eating lessons and events delivered in schools
- Healthy mums, healthy bumps programme delivered in partnership with midwives
- Troubled Families Programme – team around the whole family to support with issues including health, emotional wellbeing, ASB and school attendance.
- Linking to the Emotional Health and Wellbeing Strategy (0-25)
- Statutory Duty to carrying out assessments for the Housing Hazard Health and Safety Rating, which will identify the safety of the child's home.
- Areas of green/ open space are allocated and protect through the local plan.
- The development of parks and recreational space is supported through planning applications.
- All new development links in existing and new footpaths and cycle ways – sustainable and active transport

Implementation of the health and wellbeing strategy continued

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

Priority 1

- the proportion of adults with excess weight
- the take up of NHS health checks

Priority 2

Tackle health inequalities

- Whole population approaches
- Effective screening –early identification
- Targeted at small populations of high risk groups

Priority 3

Tackle the gaps in service Provision achieved through partnership working (county, CCG level and local HWB) monitoring and evaluation of services and the initiation of Task and Finish Groups with recommendations to the commissioners. Community consultations. Monitored through the Mind The Gap plan imbedded within local health action team.

Priority 4

Transform services to improve outcomes, patient and value for money achieved through patient feedback exercises and economic impact assessments.

Local Authority's Actions to support Outcome 2

The following are delivered by our health team in community settings with a particular focus on deprived areas

- Weight It programme – 10 week healthy weight course
- Exercise Referral – 10 weeks of physical activity
- Move Eat Grow Programme for people with learning disabilities
- Community Conservation and Volunteering - PA
- Delivery of NHS Health Checks
- Healthy Mums, Healthy Bumps course
- Support a reduction in the number of smokers
    - Referrals to KCHT SSS,
    - Organisation and delivery of health events in partnership with KCHT SSS
    - Support for campaigns such as stoptober
    - Delivery of the Kent Healthy Business Awards – theme on smoking
    - Smoke free policy
    - TW has also made a commitment to increasing referrals by promoting smoking cessation clinics in place of paying a FPN for dropping cigarette butts.
- Man up, Shape up – Exclusively for men weight management group

The following are co-ordinated through the CSU with a focus on reducing alcohol related hospital admissions:

- Safe Socialising policy
- Late Night Levy
- KCAP – challenging underage sales
- Public Spaces Protection Orders (still under consultation) to include drinking in public spaces
- Best Bar None Safer Socialising Award
- Winter shelter funded by the CSU and delivered via Churches together
- Sherwood partnership and social prescribing
- Council's Green infrastructure plan

Implementation of the health and wellbeing strategy continued

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

Priority 1

•□ the percentage of adults with a learning disability known to the LA, who are recorded as living independently or with family

•□ in early identification of diabetes

•□The number of hip fractures for people aged 65+

Priority 2

Tackle health inequalities

•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 □ the incidence of fractures of people aged 65+

•Support people with Learning disabilities with housing, employment, access to health services and leisure activities.

Priority 3

Tackle the gaps in service Provision achieved through monitoring and evaluation of services and the initiation of Task and Finish Groups with recommendations to the commissioners. Community consultations. Monitored through the Mind The Gap plan imbedded with local health action team.

Priority 4

Transform services to improve outcomes, patient and value for money achieved through patient feedback exercises and economic impact assessments.

Local Authority's Actions to support Outcome 3

•Monthly tea dances for older persons to encourage flexibility and physical activity.

•Working in partnership with the Good Neighbour Project who run falls prevention/ postural stability classes in Tunbridge's Wells.

•Tailored Weight Management programme; Move, Eat, Grow delivered as a close group for people with learning disabilities

•**Winter Warmth Programme – Excess winter deaths is one of only two indicators where TW is performing worse than the England average; therefore this is one of our Key Priorities.**

•Community Wardens carry out wellbeing assessments for the elderly

•Incidence of falls included within the Mind The Gap Plan

•Move Eat Grow Weight Management Programme exclusively for people with learning disabilities

•Disable Facilities Grants

•Falls referral pathway delivered via housing teams

•Handy Person Services

•Register of properties that have been adapted with disabled facilities

•Assistance, help and signposting where persons aren't eligible for a grant.

Implementation of the health and wellbeing strategy continued

Outcome 4: People with Mental Ill Health issues are supported to Live Well

Priority 1

•□ in the % of people using adult social care services having as much social contact as they would like according the Adult Social Care Users Survey

•□ in the % of adult carers who have as much contact as they would like according to the ASCUS.

•□ in the % 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 health inequalities

•.Suicide reduction strategy

•Equity of access for all

•Understanding local needs

•Engaging people in their own care

•Improve opportunities for returning to employment

•Promoting programmes to improve resilience and recovery

•Targeting vulnerable groups

Priority 3

Tackle the gaps in service Provision achieved through monitoring and evaluation of services and the initiation of Task and Finish Groups with recommendations to the commissioners. Community consultations. Monitored through the Mind The Gap plan imbedded with local health action team.

Priority 4

Transform services to improve outcomes, patient and value for money achieved through patient feedback exercises and economic impact assessments.

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Local Authority's Actions to support Outcome 4

•Delivery of the 9 week Headspace and Jasmine Programmes for people with moderate mental health and wellbeing issues. In partnership with MIND.

•Exercise Referral for people with mental health conditions

•Event for World Mental Health Day

•Signposting and events to promote the live it well website and the six ways to wellbeing to improve emotional resilience.

•Monthly Tea dances to reduce social isolation for older people

•SAFE – youth led project delivered in schools to raise awareness of mental health and suicide.

•DAVSS - support for male and female victims experiencing domestic abuse; funded by KCC public health and CSU

•Community Liaison Officer of the CSU makes referrals to mental health services

•KHWP- community conservation and volunteering to improve mental health through green exercise and social interaction

•Working in partnership with DPG and TWMHRC

•Men's shed (awaiting grant and project proposal approval)

•Linking with and supporting the time to change campaign

•Brief assessments and advice related to alcohol – promotion of alcohol support services through our programmes and WellPoint machine

Implementation of the health and wellbeing strategy continued

Outcome 5: people with dementia are assessed and treated earlier and are supported to 'live well'

Priority 1

Working with partners to improve early diagnosis

Priority 2

Tackle health inequalities – prioritising assessment for high risk groups

- Patients 60+ with CVD, stroke, peripheral vascular disease or diabetes
- Patients 40+ with downs syndrome
- Other patients 50+ with LD
- Patients with long term neurological conditions

Priority 3

Tackle the gaps in service Provision achieved through monitoring and evaluation of services and the initiation of Task and Finish Groups with recommendations to the commissioners. Community consultations. Monitored through the Mind The Gap plan imbedded with local health action team.

Priority 4

Transform services to improve outcomes, patient and value for money achieved through patient feedback exercises and economic impact assessments.

Local Authority's Actions to support Outcome 5:

- Delivery of NHS health checks to identify the risk factors of cardiovascular disease early
- Supporting development of dementia friendly communities through events, customer consultation exercises and attending West Kent and TW dementia forums.
- Promoting the dementia helpline and dementia friendly Kent web
- Commitment to identify front line staff who will become dementia champions.