Ashford Health and Wellbeing Board

ASHFORD
BOROUGH COUNCIL

Notice of a meeting, to be held in Committee Room No. 2 (Bad Münstereifel Room), Civic Centre, Tannery Lane, Ashford, Kent TN23 1PL on Wednesday, the 23rd July 2014 at 12.00 noon

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Under the Council's Public Participation Scheme, members of the public can submit a petition, ask a question or speak concerning any item contained on this Agenda (Procedure Rule 9 Refers).

KRF/VS
15th July 2014

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Declarations of Interest (see also "Advice to Members" below)

(a) **Disclosable Pecuniary Interests (DPI)** under the Localism Act 2011, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares a DPI in relation to any item will need to leave the meeting for that item (unless a relevant Dispensation has been granted).

(b) **Other Significant Interests (OSI)** under the Kent Code of Conduct as adopted by the Council on 19 July 2012, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares an OSI in relation to any item will need to leave the meeting before the debate and vote on that item (unless a relevant Dispensation has been granted). However, prior to leaving, the Member may address the Committee in the same way that a member of the public may do so.

(c) **Voluntary Announcements of Other Interests** not required to be disclosed under (a) and (b), i.e. announcements made for transparency reasons alone, such as:

- Membership of outside bodies that have made representations on agenda items, or
- Where a Member knows a person involved, but does not have a close association with that person, or
- Where an item would affect the well-being of a Member, relative, close associate, employer, etc. but not his/her financial position.

[Note: an effect on the financial position of a Member, relative, close associate, employer, etc; OR an application made by a Member, relative, close associate, employer, etc, would both probably constitute either an OSI or in some cases a DPI].

Advice to Members on Declarations of Interest:

(a) Government Guidance on DPI is available in DCLG's Guide for Councillors, at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/240134/Openness_and_transparency_on_personal_interests.pdf

plus the link sent out to Members at part of the Weekly Update email on the 3rd May 2013.

(b) The Kent Code of Conduct was adopted by the Full Council on 19 July 2012, with revisions adopted on 17.10.13, and a copy can be found in the Constitution at http://www.ashford.gov.uk/part-5---codes-and-protocols

(c) If any Councillor has any doubt about the existence or nature of any DPI or OSI which he/she may have in any item on this agenda, he/she should seek advice from the Head of Legal and Democratic Services and Monitoring Officer or from other Solicitors in Legal and Democratic Services as early as possible, and in advance of the Meeting.

Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **23rd April 2014**

Present:

Councillor Michael Claughton – Chairman, Cabinet Member ABC;
Navin Kumta – Vice-Chairman, Clinical Lead, Ashford CCG

John Bunnett – Chief Executive, ABC
Paula Parker – Families and Social Services Representative, KCC
Marion Gibbon – Public Health, KCC
Dr Anne Imkampe – Public Health Registrar, KCC
Sheila Davison – Public Health Representative, ABC
Neil Fisher – Head of Strategy and Planning, Ashford CCG
Simon Perks – Accountable Officer, CCG
Lillian Ndawula – Health Watch Representative
Caroline Harris – Health Watch Representative
Mark Lemon – Policy and Strategic Relationships, KCC
Stephen Bell – Local Children's Trust
Tracy Dighton – Voluntary Sector Representative
Tracey Kerly – Head of Community and Housing, ABC
Richard Robinson – Housing Improvement Manager, ABC
Sharon Williams – Housing Operations Manager, ABC
Sylvia Roberts – Senior Housing Options Officer, ABC
Christina Fuller – Cultural Projects Manager, ABC
Keith Fearon – Member Services and Scrutiny Manager, ABC
Belinda King – Management Assistant, ABC

Also Present:

Councillor Mrs Dyer

Apology:

Martin Harvey – Patient Participation Representative, Lay Member CCG

1 Introduction

1.1 The Chairman welcomed all those present to the meeting. He advised that he had received notification from Penny Southern that due to clashes with her other work commitments, in future Mairead MacNeil would attend meetings on her behalf.

2 Notes of the Meeting of the Board held on the 22nd January 2014

2.1 Tracey Dighton referred to paragraph 4.6 and clarified that t meaningful consultation had not taken place over the Better Care Fund. Marion Gibbon clarified that paragraph 10.2 related to new guidance issued by NICE rather than a change in policy.

2.2 In terms of the recommendations in Item 3 Mental Health Provision – Progress Towards Kent Joint Health and Wellbeing Strategy – Outcome for Ashford, Navin Kumta said the proposed Ashford based summit was still under discussion. He also explained that Paula Parker and Sue Luff were in the process of developing a strategic direction for mental health in Ashford with an anticipated delivery date of June this year.

2.3 Subject to the updates and clarifications shown above the Minutes were agreed as a correct record.

3 Lead Officer Group Quarterly Report April to June 2014

3.1 Christina Fuller introduced herself to the Board and explained that she was the Cultural Projects Manager at Ashford Borough Council and managed the team which was involved with various aspects of health intervention work. She explained that since the last meeting of the Board a Lead Officer Group (LOG) had been established with the aim of providing support to the Board. The report set out in detail the organisations/service areas comprising the LOG and also the principle purpose which was to push through the initiatives being undertaken by key delivery partners. The report also requested that the Chairman of the LOG become a member of the AHWB.

3.2 Set out within paragraph 8 of the report were the LOG's views on which areas should become priority areas for the AHWB. These were:-

- Independent living and self-management for those with long-term conditions.
- Dementia.
- Homelessness.
- Obesity.
- Falls prevention.
- Sustainable Development for health and wellbeing.

3.3 In terms of making progress against priorities, Christina Fuller said it was necessary to focus together on those projects' initiatives which would have the greatest chance of improving the health and wellbeing of residents within the community.

3.4 The Chairman commented that whilst there were six priorities set out, he considered that mental health was relevant to several if not all of the priorities. He also referred to the appendix to the report and in particular to the section on demographics, and highlighted the cost factor associated with the increasing need for health and social care for the elderly either at home or in care homes.

3.5 Tracy Dighton referred to the issue of mental health and in particular to the resulting inequalities suffered by people with mental health and said she had concerns that it did not appear to be at the forefront of suggested priorities. In response Christina Fuller said she believed that there were so many threads across mental health issues within all of the priorities, but in particular those associated with dementia.

3.6 Marion Gibbon said she believed that as Ashford grew, particularly in terms of new developments, it was important that they catered for issues associated with mental health, and therefore it was a cross-cutting issue. Tracy Dighton confirmed that in her view she would expect mental health to be clearly stated as a cross-cutting issue. The Chairman said that this would be incorporated within the overall work of the Board.

3.7 Mark Lemon commented that given the scale of the Better Care Fund hardly any issues could be dealt with outside of the BCF Framework.

The Board agreed that:

a) the membership, purpose and reporting arrangements of the Lead Officer Group be approved.

b) the quarterly update templates provided by partners be noted.

c) that the Chair of the LOG becomes a non-voting member of the AHWB.

d) The six local priorities for 2014/15 as set out within the report be agreed.

e) The LOG identify the "must do projects" linked to the AHWB priorities and present these for approval at the next meeting.

f) Future meetings be focused on each priority area to enable debate and further joined up working.

4 Partner Updates

4.1 Included in the Agenda were A4 templates submitted by partners. Comments at the meeting made in respect of the following individual updates are set out below.

a) Clinical Commissioning Group (CCG)

Simon Perks said he wished to give an update into how the CCG was organised and in particular the prospect of the Ashford CCG merging with the Canterbury CCG in 2015. He explained that both CCG's had given approval to continue to work on the proposals.

Simon Perks explained that at the current time both CCG's worked very closely in that he advised both groups and Neil Fisher in his role covered both the Ashford and Canterbury areas. He said that the proposals were not intended to change the nature of the Health and Wellbeing Boards and Patient Participation Groups.

Simon Perks summarised the principle reasons driving the proposals for the merger and said that in terms of clinical leadership a merge would provide better shared leadership in terms of focusing on primary care under the Better Care Fund. He said that Ashford knew how best to provide for the health needs of the area which would involve care being undertaken in the communities by the development of community hubs. In financial terms both CCG's were relatively small when compared to others in England which had, for comparison, populations of in the region of 400,000. He said that the 2015/16 financial year would be challenging and by shaping the CCG's more efficiently this would help to address any reductions in funding which might follow in due course.

Mark Lemon said that there would be a need for further discussions on this issue as the Health and Wellbeing Board was currently based on CCG boundaries and its Constitution would need to be examined if this was to change. Simon Perks commented that if it was not possible to have individual Ashford Health and Wellbeing Boards in Canterbury and Ashford this would be the stopping point in terms of taking forward the proposal.

b) Kent County Council

Paula Parker explained that KCC were currently undergoing a Transformation Programme which set out their response to the increasing financial pressure Local Government faced as public sector austerity continued beyond 2015. She summarised the success stories since the last update which included workshops on the KCC Accommodation Strategy; the Homecare Tender; the Telecare Tender

and advised that Kent had been made an agreed pilot site to tackle malnutrition in older people. Work was also progressing on the Dementia Friendly Alliance and the Better Care Fund had been agreed in principle by the Kent Health and Wellbeing Board. For the next quarter work would be focused on malnutrition, falls and residential relet.

In response to a question Paula Parker confirmed that malnutrition would be focused on the 65+ age group with the issue of obesity and malnutrition being picked up later.

In response to a question about work with the voluntary sector, Paula Parker explained that in June an event was being organised regarding engagement with the voluntary sector and she undertook to provide details of that event in due course.

Tracy Dighton said in terms of responses to consultations from the voluntary sector it would be likely that responses would be different from organisations which had obtained a grant, and from those that did not.

Sharon Williams said that Ashford Borough Council was looking to understand what the voluntary sector could offer, particularly in terms of homelessness and she said it would be useful to co-ordinate the work of both Authorities. The Chairman suggested that the Officers liaise directly on this outside of the meeting.

c) Public Health (KCC)

Marion Gibbon summarised the work currently underway which included a healthy weight review; smoking and tobacco control review; harm reduction pilot; smoking in pregnancy work; and procurement of breastfeeding support. In terms of success stories since the last update, Marion Gibbon explained that there were new plans for the Healthy Club which supported people to be more active, and also that health check invitation targets had been met, although there had only been a 37% take up rate. In response to a question she agreed to examine the statistics to find out the percentage rate as it applied to Ashford. Future works included a new strategy for stop smoking and tobacco control and work with the Jasmin Vardimon Dance Company.

The Chairman explained that the issue of eating disorders would be the focus of the October meeting of the Board.

d) Local Children's Trust

Stephen Bell advised that they had received formal notification of Kent County Council's decision to disband the Local Children's Trusts across Kent. In view of this he said that it was important not to lose sight of groups during the transformation process. In terms of mental

health and children he said that research showed the prevalent age group was the 11 to 19 year age group but he stressed that if early intervention was achieved in the years 6 to 11 it could reduce the later development of mental health issues. Stephen Bell then summarised the areas the Trust was focusing on for the next quarter which included working with young people in Stanhope which showed particular spikes of need. In terms of welfare reform he considered that there was a need to monitor this closely, particularly in terms of malnutrition.

Sharon Williams explained the work Ashford Borough Council had undertaken in terms of the Welfare Agenda and in particular work to address issues caused by homelessness. This included signposting ways for assistance to help people move out of circumstances which could lead to homelessness such as working with Job Centre Plus and the Voluntary Sector. She also explained that banks were now visiting the Ashford Gateway to give advice to those persons who needed help in terms of setting up a bank account. In conclusion she said that in terms of the increased use of food banks, there was a need for further analysis of who was using that facility.

e) Ashford Borough Council Quarterly Update

John Bunnett referred to the update set out within the Agenda and drew particular attention to the fact that Ashford Borough Council had now purchased International House. Further developments within the town included the likely submission of a planning application for a cinema and eateries; the expansion of the Designer Outlet and the work Hadlow College would be undertaking in terms of the new campus for K College. He said that the initiatives he had outlined would bring benefits in terms of employment and thereby a link to public health improvement. Furthermore Ashford was on course to achieve the delivery of in the region of 800 new homes throughout the year and the planning application for Chilmington Green would be likely to be considered in the autumn of this year. John Bunnett urged members of the Board to engage with the Council over the various developments in order to maximise health gain.

Navin Kumta said it was important in terms of strategic work to know about the new developments in terms of their scale and likely infrastructure. John Bunnett said he was sure that colleagues from the Planning Department would welcome input from the various agencies involved in the provision of health as there would be opportunities for such information to influence Section 106 Agreements in terms of infrastructure which the developer would be required to contribute towards as part of their development.

5 Focus on Homelessness

5.1 The covering report for this part of the meeting explained that the priority theme for this meeting was Homelessness and three presentations would be

given. The covering report summarised the main points of the presentations and contained recommendations which would be considered following the individual presentations.

a) Think Housing First

Included within the Agenda for the meeting was a report titled "Think Housing First" which presented the strategy to reduce health inequalities in Kent through access to good quality and affordable housing.

Richard Robinson, the report author, explained that it set out the positive work undertaken by the housing team at Ashford to address health issues. He drew particular attention to the Action Plan which contained five objectives which were:-

- Reduce the negative impact of homelessness on health;
- Encourage people to live in homes with good air quality;
- Ensure homes are warm, dry and free from hazards;
- Develop our neighbourhoods to be healthy places;
- Strengthen the role housing played in ill-health prevention.

Richard Robinson then referred to the work the Borough Council was undertaking on re-modelling of the Farrow Court Sheltered Housing Unit and advised that in addition to residential provision, there would be support and care services which included support services for Dementia. He believed that the Council had an enabling role in influencing the design of new dwellings. The Chairman said he was particularly grateful for the work Ashford Access had done in conjunction with the Borough Council in terms of improving the design and accessibility of housing and public buildings.

Tracy Dighton referred to the role of the voluntary sector and the important role it could play in this sector. She said people often needed a shoulder to cry on or help with filling out forms and these were roles which could be undertaken by the voluntary sector. She considered that for a relatively small amount of money a great deal of assistance could be obtained from the sector and it was a resource wasted if investment was not made. Richard Robinson said he would be pleased to forge a better working relationship with the voluntary sector. Sharon Williams commented that due to cuts in Government funding it was not always possible to provide funding for certain groups. Christy Holden said she saw a real advantage of joined up working between the voluntary sector and the Borough Council and the County Council.

Stephen Bell referred to funding available from the DWP "Fair Chance" which was a payment by results scheme in terms of getting young adults into employment.

b) Ashford Homelessness Strategy

Included with the Agenda Papers was a report entitled "Homelessness Strategy", which gave an outline of Ashford Borough Council's Homelessness Strategy and identified current operational practices.

Sharon Williams, the report author gave a presentation and explained that it was important to understand and identify the need for early intervention in terms of potential homelessness situations. The strategy showed how the Council worked with all agencies on this issue. The strategy was due for review which would shortly be undertaken and would be taken through the Lead Officer Group process. A major aspect of the team's work was to prevent evictions and therefore to directly try to address issues which may be occurring in the home of the potentially homeless person. It was also the aim to identify clear housing pathways for persons leaving prison or from hospital, to ensure homelessness did not arise. She also referred to the problem of alcohol addiction which was a major cause of family breakdown and the fact that under the Welfare Reform Agency persons aged under 35 and in receipt of benefit, had no other choice but to take accommodation in a House in Multiple Occupation in order to maintain their benefit level. In terms of young people there was a need to develop rapid response with services such as Social Services, particularly when the person may have been excluded from home. Further work needed to be developed on this.

Sylvia Roberts explained in terms of handling the homelessness issue, the Housing Department had changed its working practices to deal with the demand and she advised that four Housing Option Officers were currently employed within this service. The service hoped to offer an immediate telephone appointment with the person concerned which would be followed up via a visit in the home. Arising from this she advised that parental evictions had reduced and overall the number of acceptances of homelessness was down and therefore the incidence of prevention had increased.

c) KCC Accommodation Strategy

Included with the Agenda Papers were copies of the slides used by Christy Holden in giving her presentation on the Accommodation Strategy.

Christy Holden gave the presentation and expanded on the various points presented in each slide. She drew particular attention to the slide headed "Ashford Provision" and in terms of extra care explained

that the figures in brackets under the heading “OP” should read (5/262) and not (4/215).

In terms of the slide headed “Some Conclusions” Navin Kumta asked whether the bullet points were in priority order. In response Christy Holden advised that they were not.

In response to a question about respite care, Christy Holden responded that there was a need to look at the different models of how such care was managed.

Tracey Kerly referred to the issue about the “appropriateness” of the home. For example if the home was too big or the person living in the home could no longer get upstairs it was an issue about making available accommodation which would best suit their needs.

The Chairman thanked all of the presenters for their presentations and then put the recommendations to the Board.

The Board:

Approved the following recommendations:-

a) the implementation and delivery of the “Think Housing First” be supported and a further report be presented to the Ashford HWB where detailed costs and benefits of delivering the Action Plans are presented together with recommendations as to how Ashford intended to take the actions forward.

b) The information provided within the KCC Accommodation Strategy be noted.

c) The implementation and delivery of the Homelessness Strategy be supported and be addressed as part of that process with the issues highlighted within the report. Progress to be reported to a future Ashford HWB.

6 Next Meeting

6.1 The Chairman advised that the main topic of the next meeting would be Dementia. The next meeting would be held on 23rd July 2014.

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Report from:

The Kent Health and Wellbeing Board meeting of 28th May 2014

Presented to:

Ashford Health and Wellbeing Board 23rd July 2014

Mark Lemon

Strategic Business Advisor KCC

1. Introduction

The last meeting of the Kent Health and Wellbeing Board was held on the 28th May.

The agenda and reports are available at:

https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=5466&Ver=4

This includes access to the webcast of the proceedings.

The minutes are available at:

https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=5467&Ver=4

2. Kent Health and Wellbeing Board agendas

The agendas of the Kent health and Wellbeing Board usually consist of a number of major items with other reports for less detailed consideration or for noting.

The main items at the meeting on **28th May 2014** were:

- The Joint Health and Wellbeing strategy
- The Accommodation Strategy (presentation)
- Public Health Commissioning Plan

- Children's Commissioning Plan

Every meeting of the Kent Board also receives a report on the Assurance Framework. The meeting held on the 28th May received a summary report on some of the key indicators on the framework and progress on developing the framework further. Later meetings will receive a fuller report (see that for the meeting of 16th July for further update).

3. Update for the Ashford Board

The Health and Wellbeing strategy is being considered on the agenda as a separate item.

The Ashford Health and Wellbeing Board received a presentation on the Accommodation strategy at an earlier meeting.

The Public Health Commissioning Plan should reflect the priorities of the local board areas amongst those at the overarching County level and the Ashford Board may wish to consider how their priorities are reflected in the overall plan.

The Kent Board considered the Children's Commissioning Plan to be mainly KCC focussed and requested that it receive a report on the integration of commissioning by health, social care and children's services at a future meeting.

The Assurance Framework report was considered and a number of suggestions were made for the further development and refinement of the indicators within the framework.

Mark Lemon

Strategic Business Advisor

10/07/14

2014 – 2017

Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

Draft

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

Kent County Council
kent.gov.uk

Contents

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

Foreword

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

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

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

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

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

Signed by Roger Gough
Chair of the Shadow 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 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 specialist care. Some hospital and care settings may, become smaller, with services redesigned to provide care closer to home. 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 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,** delivered 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 develop their own action plans, using the vision and values laid out in this strategy, to achieve the outcomes in ways most relevant to their own populations supported by data and information relevant 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 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.

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. 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 majority of current commissioning and provision of services is standalone and although efforts are made to align services to benefit service users, there is still room for improvement. Single commissioning, and service provision, creates a very complex system for users to navigate often, leaving them dissatisfied. Through the Boards' work we aim to improve the experience for our service users.Kent was chosen as a Pioneer area in the Department of Health's Integration Pioneer Programme, which aims to establish new ways of delivering coordinated care. Through the Pioneer work, over the next five years, we aim to 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, the aim is to 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.

The integration of service will mean that people get the care they need at the right time and in right place and where possible closer to home. Shifting care closer to home will have an impact on the way hospitals operate, and they may not stay the same size, with more specialist work being centralised on fewer sites.

Patients will have access to 24/7 community based care, ensuring they are looked after well closer to home and do not need to go to hospital. A patient-held care record will ensure the patient is in control of the information they have to manage their condition in the best way possible. 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.

It was in light of these 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.

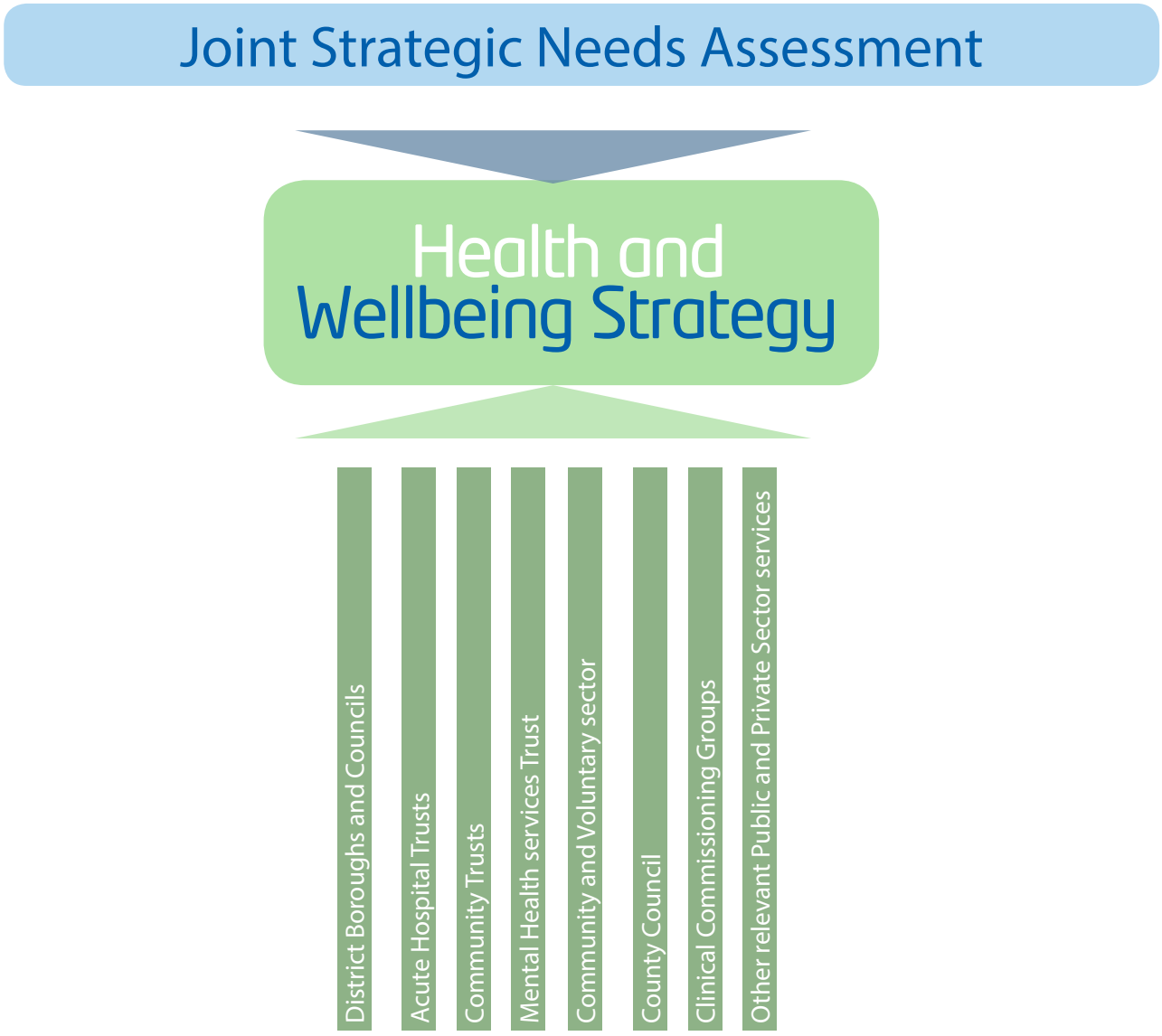


Figure 1

Our vision:

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

Outcomes

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

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

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

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

Joint Health and Wellbeing Strategy

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

Approach: Integrated Commissioning

Approach: Integrated Provision

Approach: Person Centered

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

What should good, person centred, care feel like

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"I always know who is coordinating my care."

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

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

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

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

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

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

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

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

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

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

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

Outcome 1

Every child has the best start in life

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

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

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

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

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

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

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

Over the coming years we will also see a much greater integration in services for children from pre-birth to 19. 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:

- Reduction in the number of pregnant women who smoke at time of delivery
- Increasing breastfeeding Initiation rates
- Increasing breastfeeding continuance 6-8 weeks
- Decrease 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 teenage pregnancies and 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)

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 health 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 the universal, targeted and specialist levels are seen as being parts of a continuum of support available to meet assessed need, and at any particular point in time. Children, young people and their families have different levels of need and their needs change over time depending on their circumstances. The services will be working with universal and specialist provision,

ensuring that targeted support is available to those who need it, in whichever setting, and when they need it most. The service will be helping to ensure that children and families have a well-coordinated experience throughout the pathways of care and support they receive.

The services will aim to provide families with information, advice and support to prevent their needs escalating and to enable them to be supported at the lowest level of need, and where possible to become more self-reliant.

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 CAMHS average waiting times for routine assessment from referral
- A reduction in the number waiting for a routine treatment CAMHS
- 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.

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

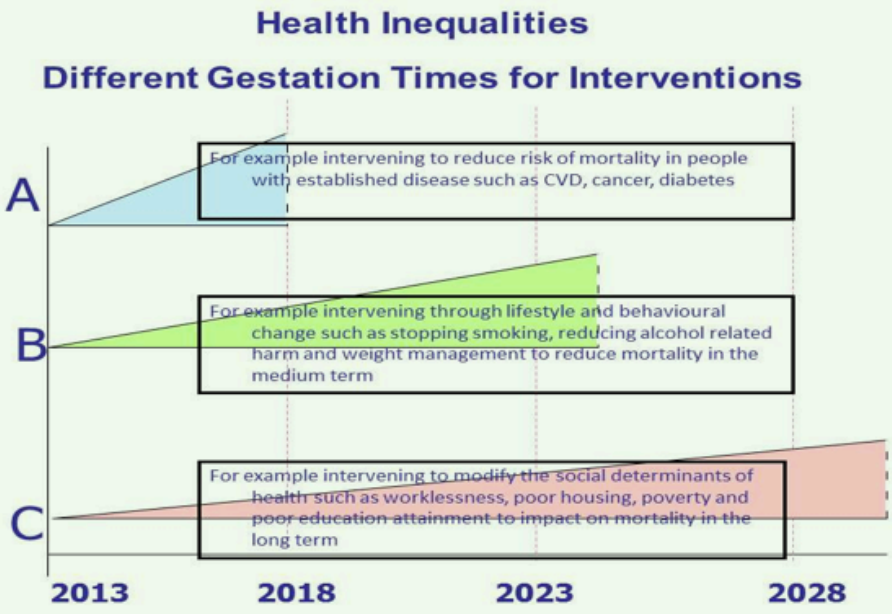


Figure 3
(adapted from C Bentley)

Priority 2 – Tackle health inequalities

The partners in the health and care system acknowledge 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.

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

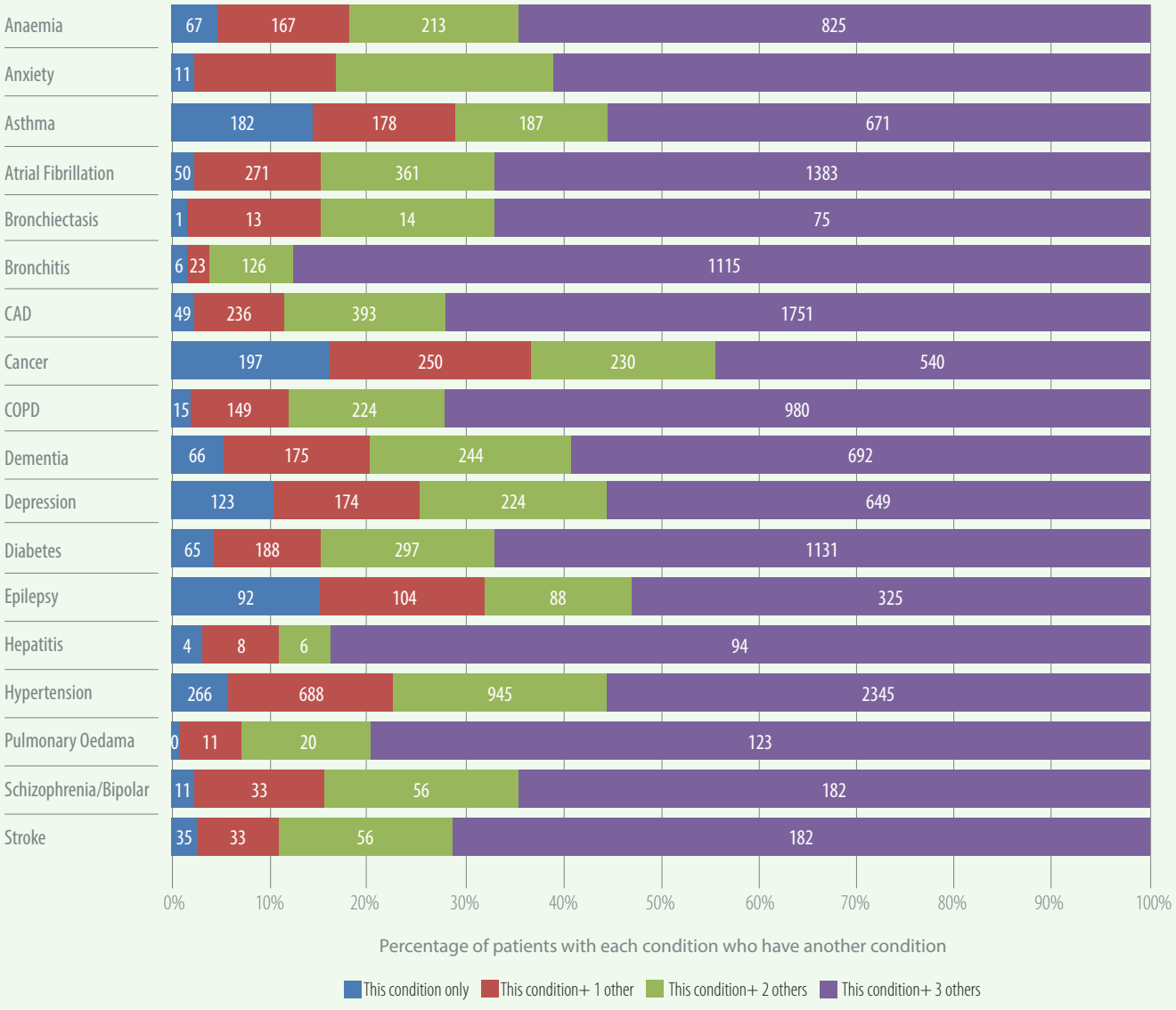


Figure 4

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

Falls and fractures continue to be a significant public health issue particularly as individuals age, and 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.

Another example is that of people with learning disabilities. They have poorer health outcomes than other population groups, as they may not be accessing routine screening or health support as consistently as the mainstream population. To address low uptake of annual health checks for people with Learning Disability everyone known with Learning Disability will be offered a baseline Health Profile and a Health Action Plan will be developed.

For people with learning disability each GP surgery we will have a link LD Nurse who will support them to understand the needs of people with a learning disability and support an annual health check.

Many people with learning disability also have difficulties with communication and may need Speech and Language Therapy support to work with carers to teach them different methods of communication.

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

We know that our population is ageing and is living longer; we will aim to focus on not just adding years to life, but also adding life to years. We will work with health and social care providers in hospitals, primary care (General Practitioners, Community Pharmacists) and in the community to develop 24/7 access and community based health and social care services, ensuring that the good quality right services are delivered in the right place, at the right time. 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 are receiving 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.

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 can be described in two parts, Common Mental Health Disorders and Severe Mental Health Disorders. Common Mental Health conditions are depression are generalised anxiety disorder. Severe mental disorders include psychosis and bi-polar disorder. People with illness related to mental health often have other conditions that can further affect their mental wellbeing. Our focus will be to prevent mental illness and promote positive mental "wellbeing".

We will achieve the outcome through:

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

In Kent we need to deliver:

- A reduction in the number of suicides (rate per 100,000)
- An increase in the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey
- An increase in the percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey
- An increase in the percentage of respondents who, according to the survey, are satisfied with their life, who are not feeling anxious, and who feel their life is worthwhile.

Priority 2. Tackle health inequalities

To tackle inequalities in mental health:

- We will improve health & wellbeing and resilience for the people of Kent by promoting the Six ways to wellbeing, particularly to the most deprived communities
- We will reduce the numbers of hospital stays for self-harm by supporting programmes that work with young people who self-harm or who are at risk of self-harm.
- We will work in partnership to improve access to psychiatric services for people with learning disabilities and for those living in deprived areas.
- We will promote the mental wellbeing impact assessment toolkit and deliver the toolkit in key locations to ensure that the mental wellbeing agenda is addressed across all major services.

Priority 3. Tackle the gaps in provision and quality

Nearly one third of GP consultations are related to mental health problems and approximately one in four people will have a common mental illness such as anxiety and depression during their lifetime and one in six people will have a mental health problem at any given time (point prevalence). One in seven people will have two or more mental health problems at any point in time. We will address this through working across the health and care system including voluntary and community sector. The wellbeing approach set out in this Joint Health and Wellbeing Strategy focusses on holistic wellbeing, and emphasises assets such as an individual's strengths and abilities (rather than deficits) and the networks and associations in communities that people draw on that can grow their mental wellbeing and prevent mental illness. There is evidence to suggest that poor mental wellbeing has impact on physical health. Conditions like heart problems, diabetes are exacerbated by mental health. Therefore in addition to preventing ill health, Primary Care Based services to address problems early will be

a focus of growth this year as we seek to reduce urgent referrals to secondary services and provide a coordinated way for those whose long term condition can be managed closer to home.

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

A key pillar of our approach is the Six Ways to Wellbeing Campaign which seeks to share the knowledge of the six themes for positive action. Kent Public Health aspires to help the population to adopt behaviours that can improve and sustain their mental wellbeing; these behaviours fall into the following themes of the Six Ways to Wellbeing campaign:

Promoting Six Ways to Wellbeing

1. Connect with the people around you
2. Be Active
3. Give
4. Keep Learning
5. Take Notice
6. Grow your World

Keeping track of our progress in delivering Outcome 4

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

- An increased crisis response of A&E liaison within 2 hours – urgent
- An increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours

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

Outcome 5

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

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

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

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

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

Priority 2 Tackle Health Inequalities

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

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

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

Priority 3: Tackle the Gaps in Provision and Quality

We will

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

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

We will achieve this by:

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

Keeping track of our progress in delivering Outcome 5

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

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

What is the Health and Wellbeing Board?

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

The board brings together 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. 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

Focus on Dementia **Agenda Item 6a**

Introduction and Covering Report (Councillor Claughton)

1. The priority theme for today's meeting is dementia. Three presentations are being given. In order to help members to prepare for the meeting, a brief summary of each presentation is provided below along with specific recommendations for the Ashford Health & Wellbeing (HWB).

2. The purpose of the presentations is to help the Ashford HWB identify progress and gaps in service provision and to question how the information provided can be used to influence future projects and inform commissioning decisions.

3. Appendix A provides members with trend information relating to dementia specifically focusing on Ashford. This information was kindly provided by the Kent & Medway Public Health Observatory. Key local data (and predictions) are presented along with references and further reading.

4. On the 16 July 2014 the Kent Health and Wellbeing Board received the paper 'Dementia Care and Support in Kent'. This highlighted the continued work to reduce the stigma of a diagnosis and indicated the desire to increase support available to people affected by dementia. A goal of achieving by 2015 a 67% diagnosis rate and access to appropriate post-diagnosis support was outlined.

5. The Kent HWB tasked Kent's carers' organisations together with KCC and the CCGs to review their plans in the light of the recently published Call to Action for Carers of people with Dementia to understand where further improvements can be made. The Kent Board recommended a full review of the acute pathway and supports the development of different models of care with increased skills and breadth of services in the private and voluntary sector in order to avoid unnecessary admission and support timely discharges.

6. The Kent Board recognised a need for a formal link with the Kent Dementia Action Alliance and that this is replicated by local HWBs and their local DAAs, so that the contribution of the wider partnership to improve support to people with dementia and their carers can be acknowledged.

7. In addition to the above report, Members may also wish to refer to the draft Kent Joint Health and Wellbeing Strategy (also being presented at this meeting) which includes a specific section on dementia and the desire to increase diagnosis rates, treat earlier and to support those with dementia to live well.

8. Members are asked, in advance of the meeting, to consider how the subject of dementia links to their sphere of influence, to ask what more they believe could or should be done and to think about how the Lead Officer Group might assist the Board in terms of this priority.

Dementia Alliance (Peter Marsh, Project Officer - 'Dementia Friendly Communities' Social Care Health and Well Being, Kent County Council)

9. This presentation covers the Dementia Friendly Communities programme which focuses on improving inclusion and quality of life for people living with dementia across Kent.

10. In these communities, people will be aware of and understand more about dementia, people with dementia and their carers will be encouraged to seek help and support and people with dementia will feel included in their community, be more independent and have more choice and control over their lives.

11. At the facilitated event held in Ashford on the 18th June, attendees pledged to undertake a number of personal actions to achieve this, they also identified a number of areas that the recently formed Ashford Dementia Action Alliance could include within their own action plan. The Alliance would like to seek the support of the Health and Well Being Board in working towards achieving progress in a number of areas.

Dementia – An Ashford CCG Perspective (Sue Luff, Head of Commissioning Delivery, Ashford Clinical Commissioning Group)

12. This presentation reports on CCG dementia activities and the outcome of an engagement event. The presentation addresses gaps in provision that have been identified covering Admiral Nurses, earlier access to diagnosis, affordable day care for dementia patients and information for patients and their carers.

13. Members attention is also drawn to the section on dementia within the Ashford CCG Clinical Commissioning Plan as presented to the Board (refer to page 9).

Dementia Carer (Keeley Taylor, Carers' Support)

14. In this presentation Keeley will talk about the services and activities that Carers' Support offer to support unpaid family members, friends and neighbours who are looking after someone else at home. She will explain the benefits of engaging with Carers' Support and how the organisation can be contacted.

15. There are 6.5 million unpaid carers in the UK, not including those who don't realise they are carers. Carers' Support aim to raise awareness and identify hidden carers. Identifying carers early on can significantly reduce the impact that long term caring can have on a carers' health and reduce the time and money spent through Primary Care.

Dementia Recommendations

The AHWB is asked to:

a) Receive from the Ashford Dementia Action Alliance an action plan for subsequent consideration and adoption by the Board.

b) Work towards the provision of additional affordable dementia day care provision for the residents of Ashford. It is suggested that this becomes an Ashford HWB's 'must do' project.

c) Endorse those strategies that promote earlier diagnosis for people with dementia.

d) Actively promote Carers' Support services alongside support for patients.

Appendix A

Ashford – trends in Dementia

Dementia mainly affects older people, although there is a growing awareness of cases starting before the age of 65. After 65, the likelihood of developing dementia roughly doubles every five years.

Escalating costs and hidden costs

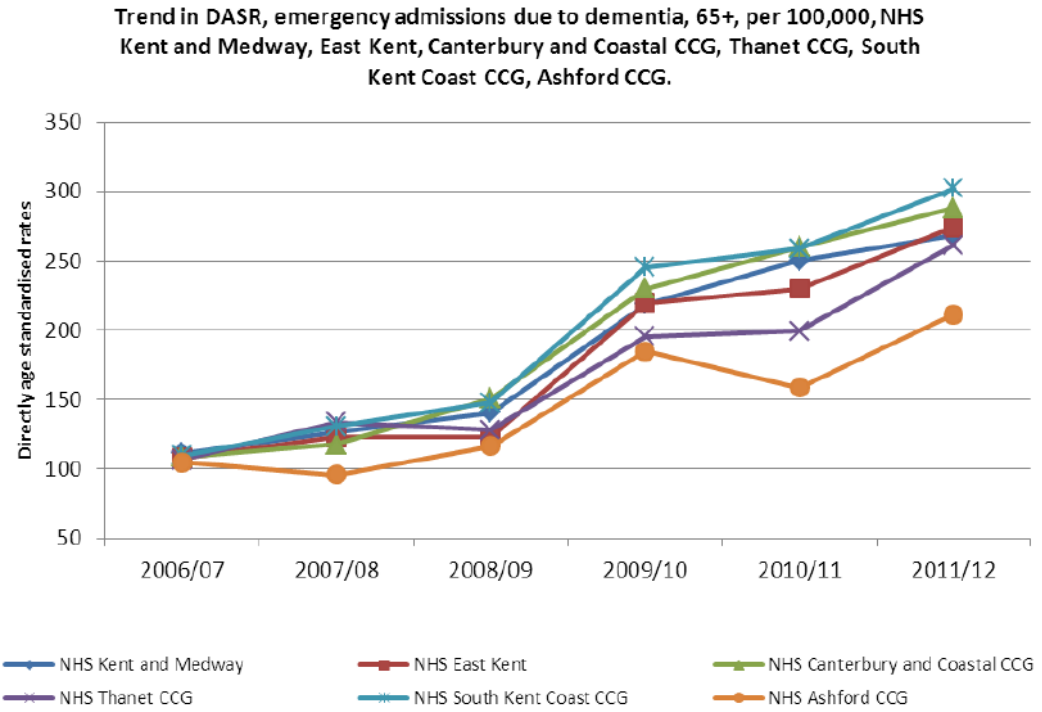
At the moment much dementia goes undetected (Kent Dementia JSNA 2013/14)
The observed prevalence of dementia (number of dementia patients on QOF registers) is approximately 37% of the expected prevalence across Kent. One of the key objectives within the Kent and Medway strategic plan is to increase detection to 60%.

Table 3: Estimates of prevalence of dementia aged 30+, at varying levels of ascertainment, 2010/11 - 2015 (projected) by CCG

Estimates of prevalence of dementia, aged 30+, at varying levels of ascertainment, 2013 - 2015 (projected)

	Current situation			2015 - showing expected numbers at different levels of ascertainment						
District	Poppi estimates - 2011	On QOF register- 2013	Percentage ascertained	Poppi estimates	At 2013 QOF level	50%	60%	70%	80%	90%
Ashford	1,502	604	40.2	1,700	684	850	1,020	1,190	1,360	1,530

High hospital costs
Current intermediate care services face challenges in responding effectively to the needs of people with dementia, resulting in higher risk of hospitalisation. Once admitted their length of stay is considerably longer. People with dementia are also more likely to be admitted to long term care after an acute hospital admission and not given the opportunity to return home with support.



- The top 0.5% (Band1) of the Kent & Medway risk stratified population with the highest risk scores for rehospitalisation generated up to 20% of the total unscheduled care spend for the whole

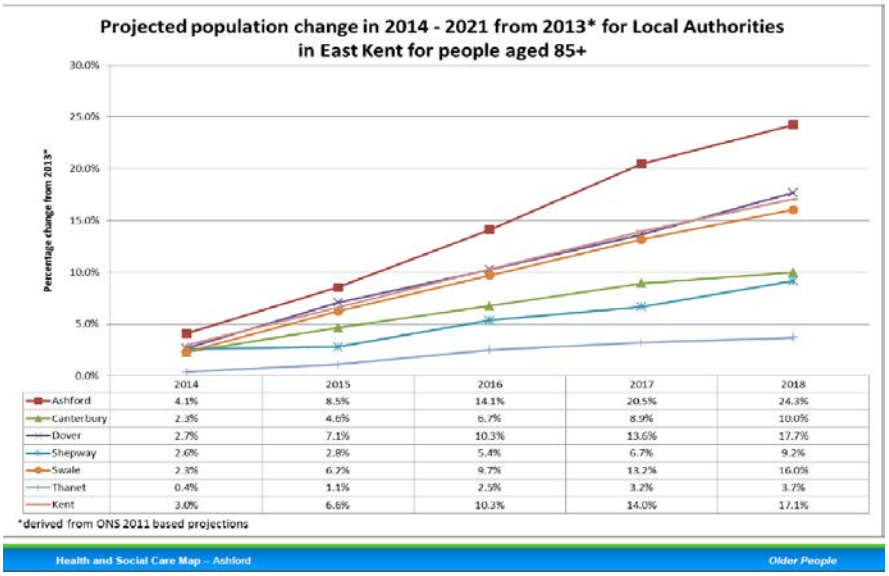
population

- People with only dementia is as low as 5%, while the remaining 95% of persons with dementia have at least one other chronic condition
- The numbers of people with severe dementia are set to increase by 83 per cent. These are the people most likely to require care in specialist care homes.

About one third of people with dementia live in residential care, while about two thirds of people who live in care homes are thought to have dementia. ” (Kent Dementia JSNA 2013/14).

A growing number of elderly at risk of dementia in Ashford

In Kent , from 2012 to 2020, the expected number of elderly people >65 yrs and over with a limiting long term illness is expected to increase by 21%. Of these, the expected number of elderly people with dementia is expected to increase by 25%. (Kent Dementia JSNA 2013/14). Over the next 7 years the population aged 65-84 in the Ashford area is expected to increase in line with the Kent average, but the numbers over 85 are projected to increase more than proportionately. This is the group most susceptible to dementia.

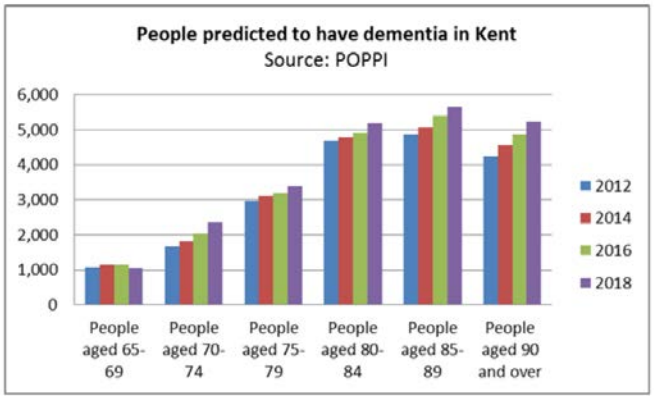


Health and Social Care Maps http://www.kmpho.nhs.uk/health-and-social-care-maps/ashford/

Table 1 - Estimates of prevalence of dementia by age and sex

Age	Women	Men	Combined
65-69	1.0%	1.5%	1.3%
70-74	2.4%	3.1%	2.9%
75-79	6.5%	5.1%	5.9%
80-84	13.3%	10.2%	12.2%
85-89	22.2%	16.7%	20.3%
90-94	29.6%	27.5%	28.6%
95+	34.4%	30.0%	32.5%

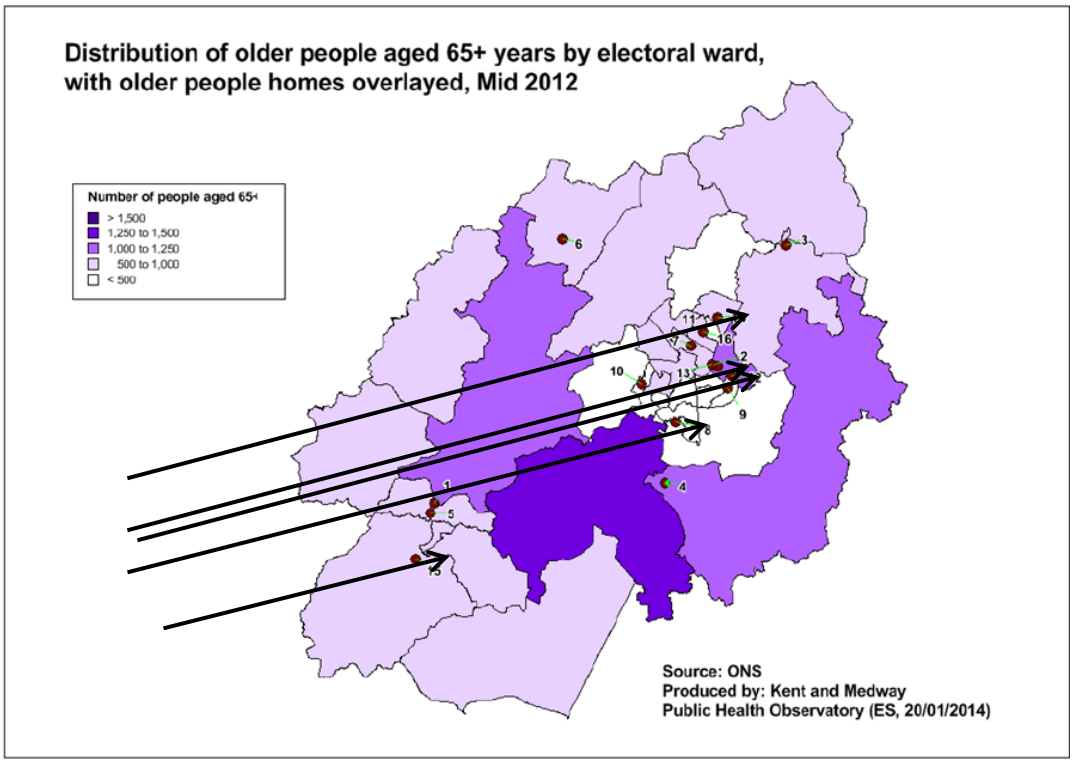
Source: Dementia UK: Full report. Alzheimer's Society 2007



(Kent Dementia JSNA 2013/14)

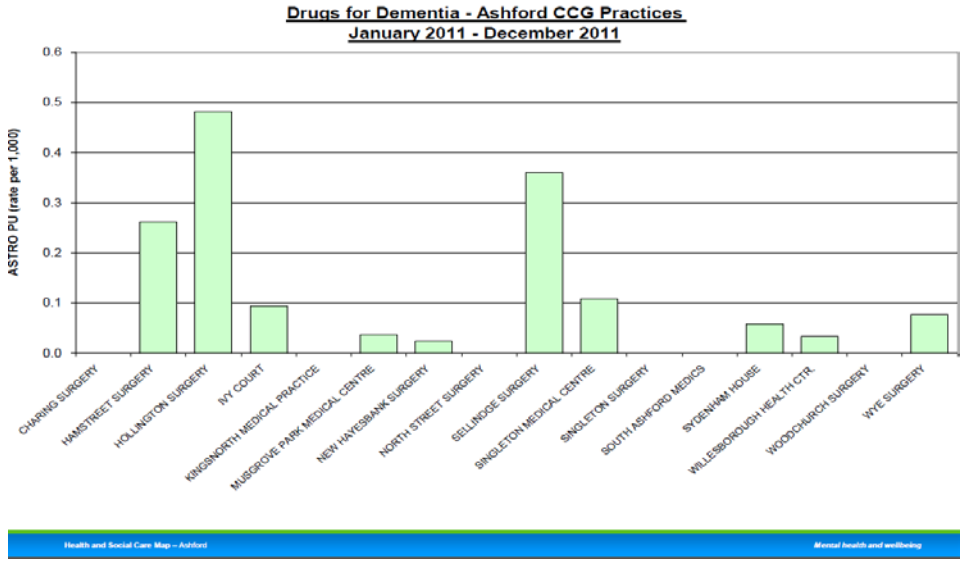
Dementia care in Ashford

The areas in Ashford current providing most dementia services are:



Residential homes: Five homes, offering 300 places overall, have the capacity to cater for residents with dementia (2, 8, 11 and 13, and 15).

GP surgeries: 3 surgeries offer the bulk of care at TN26 2NJ, TN24 8UN, TN25 6JX.



Dementia within particular groups

In 2013/14 a Direct Enhanced Service was introduced for primary care which define " 'at-risk' patients as:

- Patients aged 60 or over with cardiovascular disease, stroke, peripheral vascular disease or diabetes
- Patients aged 40 or over with Down's syndrome
- Other patients aged 50 or over with learning disabilities

- Patients with long-term neurological conditions which have a known neurodegenerative element,
  for example Parkinson's disease.

Early onset: In Kent there are approximately 400 people currently estimated to have young onset dementia. However, according to the Alzheimer Society's 2007 report 'Dementia UK: Full Report' the prevalence of early onset dementia could be up to three times higher as it is often missed or undiagnosed.

Dementia and learning disability: People with Down's Syndrome have an increased risk of developing Alzheimer's disease. The prevalence of dementia in people with other forms of learning disability is also higher than in the general population." (Kent Dementia JSNA 2013/14).

Black and minority ethnic (BME) population: Currently prevalence rates for dementia in people from black, Asian and minority ethnic communities in the UK have not been identified. Six per cent experience early onset dementia compared with only 2.2 per cent for the population as a whole, reflecting the younger age profile of these communities. Evidence shows that certain communities such as those from South Asia, African and Caribbean backgrounds have higher incidence and prevalence of cardiovascular disease." (Kent Dementia JSNA 2013/14).

References and further reading

http://www.kmpho.nhs.uk/health-and-social-care-maps/ashford/ Health and Social Care Maps, Kent and Medway Public Health Observatory website

http://www.kmpho.nhs.uk/disease-groups/mental-health/?assetdet973403=372176
JSNA on Dementia 2013-14, Kent and Medway Public Health Observatory website

Department of Health (2009) **Living well with dementia: a national dementia strategy.** At: https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

Department of Health (2012) **Dementia Challenge**. At: http://dementiachallenge.dh.gov.uk/

Department of Health (2012) **The Prime Minister's Challenge on Dementia: delivering major improvements in dementia care and research by 2015: Annual report of progress**. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200030/9535-TSO-2900951-PM_Challenge_Dementia_ACCESSIBLE.PDF

NICE/Social Care Institute for Excellence (2006) **CG42 Dementia: supporting people with dementia and their carers in health and social care** At: http://www.nice.org.uk/nicemedia/live/10998/30318/30318.pdf

Quick reference guide: http://www.scie.org.uk/publications/misc/dementia/dementia-qrg.pdf

NICE (2010) **End of life care for people with dementia: commissioning guide: implementing NICE guidance** http://www.nice.org.uk/media/0A2/66/CommissioningGuideEoLDementia.pdf

“Guess what?

You can still live well with dementia”

People living with dementia would like to:

Live the life we had before diagnosis

Find our way around and be safe

Access local facilities as we used to

Maintain our social networks so we feel we belong in the community

Pursue hobbies and interests and “go out” more

Support others in their community by volunteering

Can you tell us a little about how your family and the person with dementia have been affected

What's the solution?

Dementia friendly communities are where we want to be

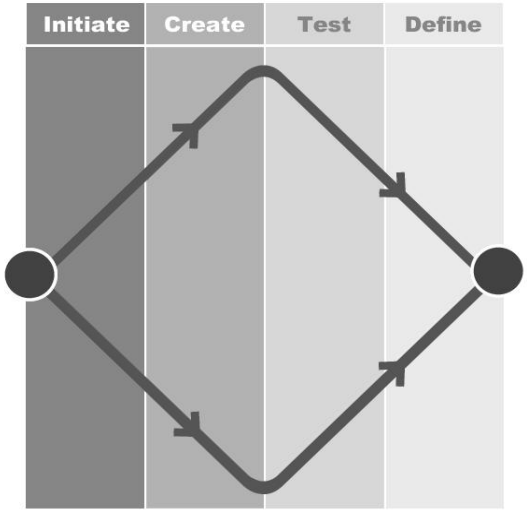
Local Dementia Action Alliances are how we get there

Dementia Friendly Communities

KENT

Health and Wellbeing Board
Kent Dementia Action Alliance

Continuous dialogue to ensure all improvement is grounded in the needs and aspirations of people living with dementia in Kent



Building on existing good practice

Training and awareness

New ways of working

LOCAL

Health & Well-Being Boards

Local Alliance	Local Alliance	Local Alliance	Local Alliance	Local Alliance	Local Alliance	Local Alliance	Local Alliance	Local Alliance	Local Alliance	Local Alliance	Local Alliance

Refreshed web platform

Local Alliances

In this section

Local Alliances

East Midlands

East of England

London

North East

North West

South East

South West

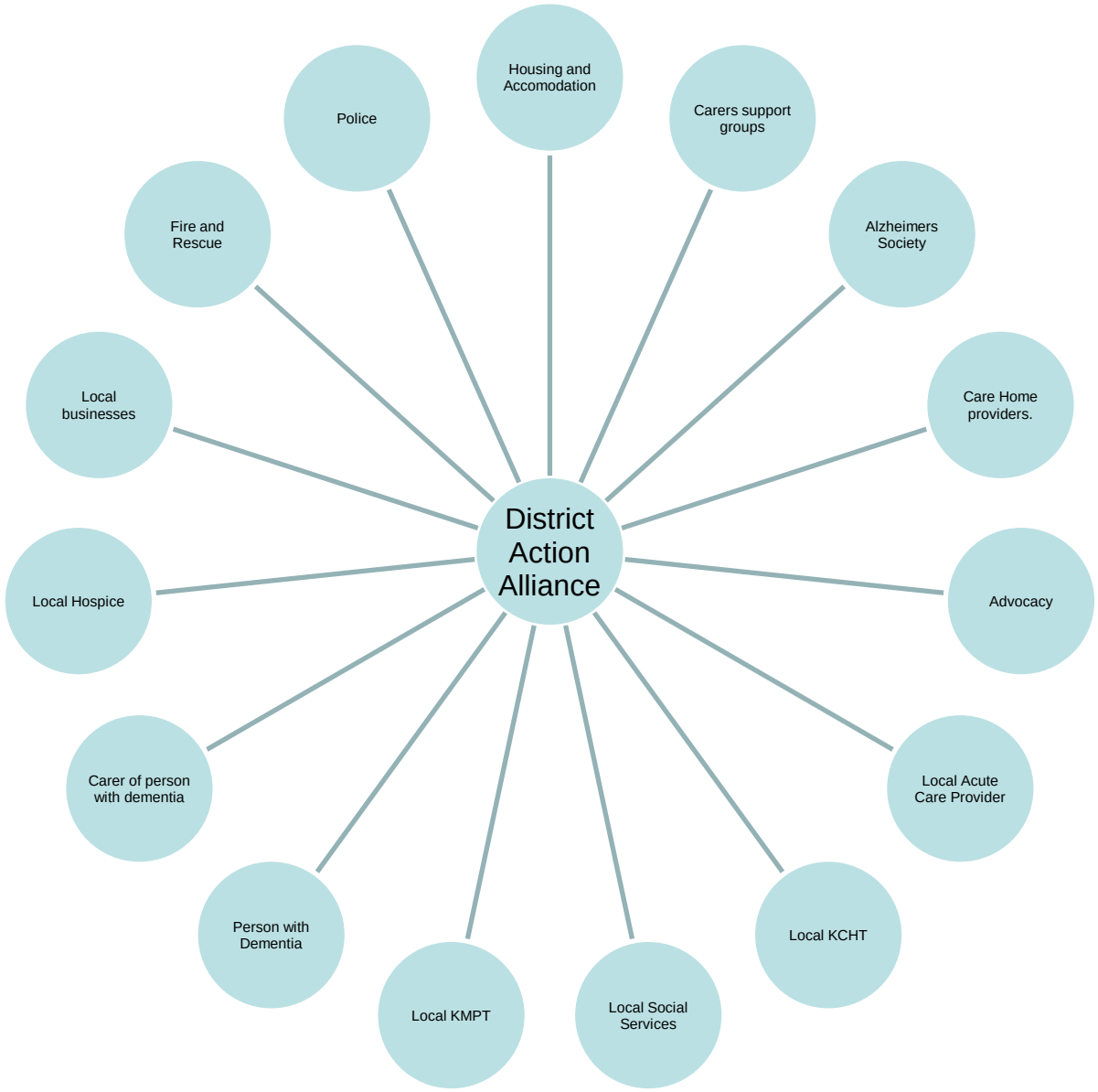
Kent Dementia Action Alliance

The Kent Dementia Action Alliance has evolved from a community necessity to better meet the needs of people with dementia. It had its roots in a Whole System collaborative and a desire to integrate social care and mental health services. In recognising the need for people to Live Well with Dementia it subsequently identified the need to involve a wider range of partners including police forces, fire and rescue services, local authorities, local transport, charities, community groups, businesses, care providers, health trusts, and people living with dementia and their carers.

Desired outcomes delivered by individual member's action plans range from ensuring people with dementia have choice and control over decisions about their lives, to feeling a valued part of family, community and civic life. It is not a statutory body and has no legal authority. Accountability for dementia services remains through the existing legal process of each organisation

Alliance Members

- Academy FM Folkestone
- Age UK Hythe and Lyminge
- Alzheimer's & Dementia Support Services
- Alzheimer's Society
- Darent Valley Hospital, Dartford & Gravesham NHS Trust
- East Kent Hospitals University NHS Trust
- Furley Page LLP
- Home Instead Senior Care (Dover)
- Kent County Council
- NHS Ashford Clinical Commissioning Group



Developing Kent into a 'Dementia Friendly Community'

Ashford

- Community event 18-06-14
- Ashford Dementia Action Alliance
- Farrow Court Dementia Friendly
- Dementia Friendly Shopping
- Ashford Borough Council Dementia Friends
- CCG gap analysis commissioning plan and Z cards

DFC Projects

THANET | Intergenerational Art Installation | East Kent College fundraising, Friends and Dementia Diaries | Minnis Bay Day Centre

CANTERBURY iPad project | Film Project | Solicitors Friends sessions | Whitstable and H-bay working group established.

DOVER Eastry Community | Sandwich GP Surgery Friends Sessions | Pfizer UK donation to Age UK | Community event | Faith communities

SHEPWAY Intergenerational Dance project | Multiagency working group | Academy FM Radio Project | BrightShadow and Broadmeadow

DFC Projects

DARTFORD Dartford Council frontline staff Friends sessions **|** 'Dementia Friendly' Asda | DASco School work | 'Dementia Friendly' Bluewater commitment to Shop Safe and Friends sessions
GRAVESHAM Council have Champion and commitment to sessions **|** Intergen Life Story Project

SWANLEY Orchard School hosting community 'drop in' | 'Teen' social media presence by DofE volunteers | Leisure centre healthy mind/body | WKHA Friends sessions | Social care students Rural Age UK ADSS project

TUNBRIDGE WELLS Faith groups Friends session | TW Care centre Open Day | Dementia Themed over 50s Forum

TONBRIDGE & MALLING Dementia Friendly Village | Libraries & Shared Lives project

SEVENOAKS (Excl Swanley) Dementia Friendly DC | Community leisure services

MAIDSTONE High street Shop Experience | DofE Care Home project

www.socialinnovation.typepad.com/silk

SILK.team@kent.gov.uk

01622 694639

@SILKteam

#dementiaKent

Facebook

Developing Kent into a 'Dementia Friendly Community'

Ashford Clinical Commissioning Group

Dementia - An Ashford CCG Perspective

Dr Caroline Ruaux
Long term conditions lead

Dementia

- First Ashford CCG dementia engagement event – May 2013.
- Development of dementia task and finish group.
- Scoping of dementia services – assessment of current services.
- Identify gaps in services.

What we found out

- There is a wealth of services already available in the Ashford area for dementia.
- We have good availability of dementia cafes and support groups.

Where are the gaps?

Admiral nurses.

Earlier access to diagnosis

Affordable day care for dementia patients.

Information for patients and their carers.

Admiral Nurses

- Admiral nurses linking in with our integrated care teams.
- Business case approved for an increase in admin support to our Admiral nurse to allow more time with families.
- Over the course of the next year, we will assess whether there is a need for additional capacity within the service.

Community Mental Health Teams for Older People

- Alignment of staff from CMHTOP to practices and to integrated care teams to provide support and advice.
- Development of integrated pathways for dementia patients with more diagnosis and support in primary care.

In GP Practices

- Dementia awareness training to all clinical staff.
- Better communication with CMHTOP
- Promote early diagnosis - use of Cantab mobile.
- Development of anticipatory care plans.

Dementia Action Alliance

- Ashford CCG has joined the Dementia Action Alliance and is committed to developing a dementia friendly Ashford.
- Working in partnership with other organisations towards this.

Challenges Ahead

- We have made good progress in the last year but there is still lots more to be done.
- Our population is growing and the proportion of older people is increasing.
- What next…….

carers' support

SUPPORTING CARERS IN ASHFORD, SHEPWAY & SWALE

Norman House
Beaver Business Park
Beaver Road,
Ashford
Kent
TN23 7SH

Tel. 01233 664393
www.carers-ashford.org.uk

Reg. Charity No. 1061475

Carers, who are they and what to they do?

Saving the government £119 billion a year

Who is a carer and what do they do?

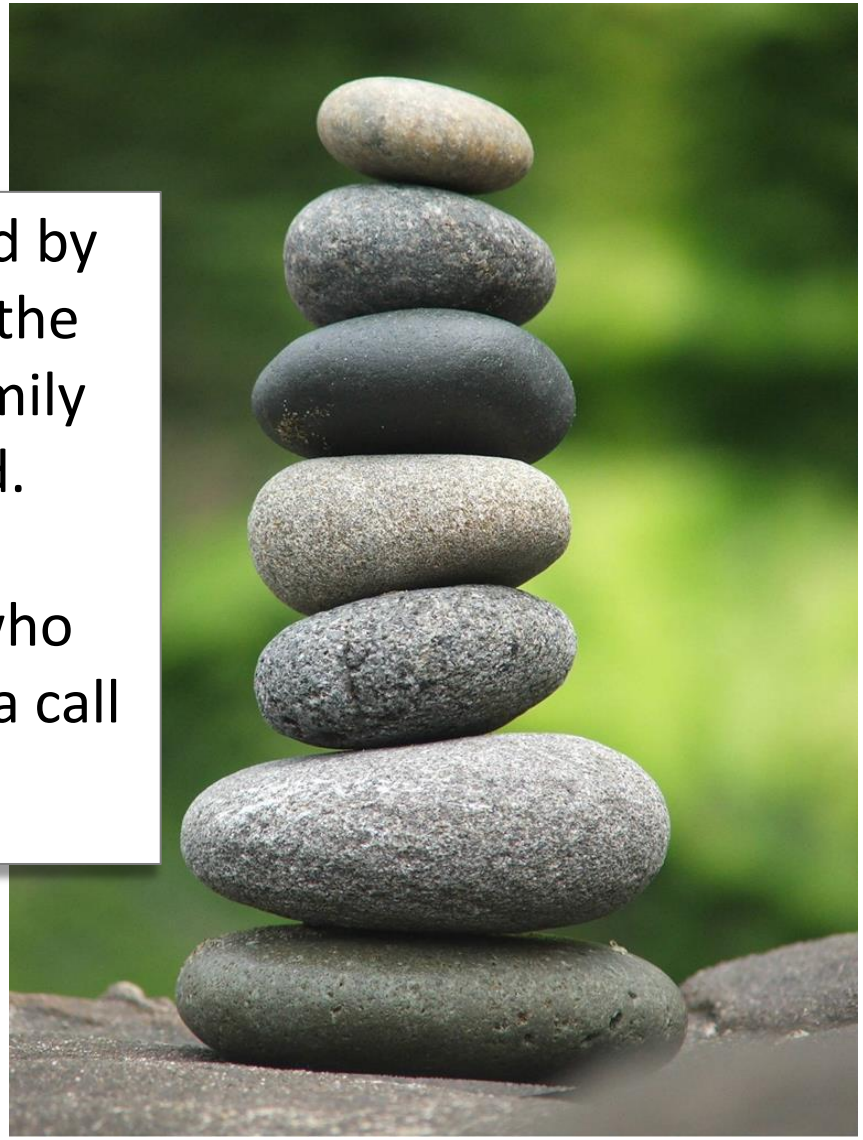
What do we do?

Preventing admissions and readmissions

Enabling carers to have a choice

You have been given this card by someone who understands the challenges of caring for a family member, partner or friend.

If you look after someone who depends on you then give us a call on the number overleaf.



Carers
need
a
break

Kent Carers' Emergency Card

ATTENTION: I look after someone who depends on me, in an emergency please call

08458 247 105

Quote this number
00000000000000

Kent County Council

Promoting awareness and fundraising

Proactive and Interactive

Emotional and practical support

Approved provider for

Kent County Council
kent.gov.uk

carerstrust
a Network Partner

NHS

PQASSO
QUALITY MARK
level 1
Charities Evaluation Services

carers' support

SUPPORTING CARERS IN ASHFORD, SHEPWAY & SWALE

Norman House
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Ashford Health & Wellbeing Board (AHWB)

AGENDA ITEM 7 – Lead Officer Group (LOG) Report (Christina Fuller, Chair)

What have we been up to since the last update?

1. The Board will recall that the LOG was recently set up to support joined up progress and alert the Board to any risks and changes of the agreed local health and wellbeing priority areas (refer appendix A). The LOG was charged with identifying the 'must do' projects linked to these AHWB priorities. This report introduces the suggested projects for discussion and agreement by the Board.

2. As previously agreed the 'must do' projects must respond to the priority areas and provide a long term impact. They should include opportunities for integrated commissioning and involvement from a number of agencies. When considering these projects the Board is asked to note that individually most support more than one local priority.

3. The LOG will monitor an action plan for each agreed 'must do' project and support the lead partner to meet key milestones. The level of impact will be monitored using performance indicators for each project. The Board will receive a progress report with any risks to delivery.

4. The Board is asked to note that a significant amount of other initiatives and projects are being delivered to support local priorities and other areas of concern such as domestic violence, smoking, mental health, etc. Such work is summarised in the Partner Updates.

What are the 'must do' projects?

a) Community Networks (lead CCG)

There is a strong and growing body of evidence that community based approaches to improving health and providing sustainable care and support can be cost effective, deliver better outcomes and help to prevent health and social care needs arising. These are the key principles behind Community Networks which for Ashford includes three area hubs – Ashford South, Rural and Ashford North.

Each hub area will include tailored community based services such as outpatient support, specialist diagnostics etc, as well as core community based health and social care services for example, community nursing, minor injuries, sexual health, carer support, counselling services etc. They will be designed and provided to support the needs and demands of each area.

There will be a multitude of projects and commissioning programmes for each hub. For example a Stanhope health space is being looked at that will support community based services and help promote health and wellbeing services to local residents particularly but not exclusively, in this case, local young people.

Community Networks impact on all the local priorities and demands a multi-agency delivery approach.

b) Farrow Court (lead ABC)

The remodelling of Farrow Court has a total estimated cost of £15.542m. The scheme occupies a prominent location on the entrance to the Stanhope estate and the design proposed aims to create a landmark feature.

The proposal for Farrow Court which is overwhelmingly supported by all partner agencies is to offer independent accommodation to a group of older and vulnerable residents with varying needs of support. The proposal is to create facilities offering a community focus, not only within the scheme itself, but also for people in the surrounding area who will be actively encouraged to make use of the facilities.

The scheme has been designed as a dementia friendly scheme and includes a day centre, restaurant, communal lounge and gardens, a mix of 104 one and two bedroom care ready apartments, including 12 learning disability flats and 8 recuperative care flats, a shop, hairdressers and therapy room. Various services, delivered by different partners, will complement the scheme itself, such as extending work in the day centre to seven days a week with a particular focus on supporting people with dementia at the weekends and having site based care staff.

The Farrow Court Project Board is chaired by Tracey Kerly and the membership includes Members, ABC Officers, KCC Officers, Director of Older People & People With Disability Service, Accommodation Solutions, Head of Adult Services - Ashford Locality, Age UK – Ashford, and various reps from contractor partners and managing agents.

This project particularly supports independent living and dementia but has a community based approach and as such plays a major part in supporting the health and social care activity in South Ashford, supporting the Community Network strategy.

c) Rough Sleeping (lead ABC)

This project supports the ‘Think Housing First’ agenda and homelessness priority. It focuses on tackling the causes and impacts of rough sleeping. The project will target known rough sleepers to ensure that they are engaged with health services and specific specialist services such as drug and alcohol services.

The project will aim to link with health and other relevant agencies to help rough sleepers or those in danger of becoming rough sleepers to tackle the root causes of their homelessness and identify a safe environment for assessment of their needs. This will involve targeted help to support the rough sleeper in accessing accommodation and relevant support.

The service should be up and running by the Autumn and will need identified contacts from health and social services to develop the proposals which will also aim to incorporate the ‘Think Housing First’ objectives and also the governments ‘No second Night Out’ targets.

This project supports a significant element of the homelessness strategy and priority areas. It requires a joined up approach from a range of preventative and targeted services.

d) Dementia Friends/Day Care (Dementia Alliance)

The Board will have received a set of presentations that will help determine the 'must do' project.

e) Healthy Weight – Obesity (lead KCCG)

The key stakeholders that are both commissioning and providing services in support of local adult and children weight management and promotion are meeting to discuss in more detail local priority projects.

The Public Health Observatory is analysing up to date data on obesity rates and agencies are assessing the impacts of current programmes to ensure that resources are targeted to provide the most effect results particularly when looking at the pathway for improved healthy weight. KCC's current consultation on the future provision of healthy weight programmes finishes on 18 August 2014. The link to the consultation directory is: http://consultations.kent.gov.uk. There is a short questionnaire so that KCC can provide services in the ways that people say they want to use them.

At the next Board meeting in October this analyses and other data will be presented along with examples of successful interventions and a 'must do' project identified.

f) Infrastructure Planning (Lead ABC)

An Infrastructure Working Group with ABC planners, NHS England, Chair of CCG, CCG commissioners and KCC has started work on current needs and growth demands to determine what is needed in physical health infrastructure.

The NHS has recently commissioned an audit of surgery provision, looking at their capacity and potential for growth. This work will feed into the Local Plan which will help support the planning of health and social care provision i.e. GP practices, health centres, care homes and community spaces.

A number of specific projects will also be discussed to help better plan current provision. The group is due to meet again in September.

This planning work is a 'must do' given that sustainable development for health & wellbeing is a priority for Ashford as a growth area.

The AHWB is asked to:

- **Approve the above 'must do' projects that support the AHWB priority areas and agree that the LOG monitor progress and reports quarterly to the Board.**

Appendix A

Why are these areas a priority? (agreed by AH&WB April 2014)

1. **Independent living & self-management for those with long-term conditions** is highlighted as a priority for several reasons. Our population is ageing and therefore there is an increasing need for health and social care for the elderly. While emergency admissions are lower than the rest of Kent, more can be done to avoid admissions. Encouraging self-management of those with long-term conditions and ensuring good access to primary care including out-of-hours is vital. Our aim needs to be the development of projects where health and social care services work together to support people.
2. **Dementia** is increasing as our population ages. There is a need to improve rates of recognition and diagnosis and getting people into the right services when they need them. Improved access to community support including housing, supported housing options and dementia friendly communities is crucial in enabling patients to stay within their own communities for longer.
3. **Homelessness** is high within Ashford compared to the England average and getting worse. Those who are homeless have disproportionately more health problems compared to the general population. Hospital services are used more frequently and the health needs of homeless people are currently not met and access to primary care and prevention programmes need to improve.
4. **Healthy Weight/Obesity** is a significant problem for Ashford which starts when people are young. In Year 6 (i.e. the last year of primary school) almost 1/5th of Ashford's children are classified as obese. Ashford also performs particularly badly in terms of adult inactivity which is clearly contributing to a picture of Ashford adult obesity that is worse than the England average. Obesity prevalence in Ashford is higher in high deprivation areas, with 25-30% of the population being classified as obese. Obesity, however, is not confined to areas of high deprivation. In most wards the percentage of people being obese is also high, with 20-25%.
5. **Falls prevention - r**ates of hip fractures are high in some Ashford wards. Access to falls prevention services needs to focus on worst wards.
6. **Sustainable development for health & wellbeing** has to be a priority for an area such as Ashford which is growing rapidly and will continue to do so for many years. There is a need to not only ensure access to primary care for new communities but as a need to ensure that new residents are able to access preventative health programme.

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from(delete as applicable)	CCG / KCC / Public Health / Children's Operational Group / ABC
Quarter concerned (delete as applicable)	April to June 2014
What's going on in our world	Joint workshop held with KCC to discuss implementation of the community networks. Networks across CCG identified and in process of agreeing core services. Dementia engagement held in partnership with KCC Working with partners to develop Children's and Young People strategy Proposal to merge CCG Mental Health working group and LMPG into one meeting which will be discussed on 17th July
Success stories since last AHWB	Continued development of integrated services to support 7 day working at practice within Tenderton Sign off of the Local Referral Unit business case which includes social services Falls pathway agreed at multiagency engagement event
What we are focusing on for the next quarter specific to the key projects	Implementing community network over winter period to test model assumptions Implementing revised specification for Westview to support creating of capacity for GP beds and non-weight bearing patients
Anything else relevant to AHWB priorities NOT mentioned above	
Strategic challenges & risks including horizon scanning?	Ensuring that implementation of community networks is balanced with current demands of capacity
Any thing else the Board needs to know	
Signed & dated	

REMINDER - AHWB key projects are:

- Community Network
- Dementia day centre provision
- Obesity (specific project TBC)
- Farrow Court
- Stanhope area focused wellbeing project
- Homelessness (specific project TBC)

REMINDER - AHWB priorities are:

- Independent living & self management for those with long-term conditions
- Dementia
- Homelessness
- Obesity
- Falls prevention
- Sustainable development for health & wellbeing

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from	KCC
Quarter concerned	July to September 2014
What's going on in our world	• Continuing with KCC Transformation • Home Care tender –in mobilisation stage • Teletechnology, new provider in place • Community Equipment tender, meet the market event 30/06/14 • Voluntary Sector conference 27/06/14 • 'Meet the market' event in order to launch the Kent Accommodation Strategy 'Better Homes: Greater Choice'. The event will be held on 2 July 2014 at the Mercure Hotel (Great Danes), Hollingbourne, Maidstone between 9.30am and 12pm. • Developing Core Offer for Mental Health Services in the community • Falls workshop 24/06/14 • Support for Winter workshop 16/06/14 • Integrated Discharge workshops
Success stories since last AHWB	• Chamberlain Manor extra care- Under construction. Landlord Housing 21, 67 units of rented and shared ownership. • Young persons supported housing- The Limes – planning permission granted March 2014 for high support scheme, landlord Golding Homes, support provider to be tendered for.
What we are focusing on for the next quarter <u>specific to the key projects</u>	• Working with CCG to develop Community Networks • Our Place (Wye and Hixhill, supporting a community to be self-sufficient) • Mobilisation of Home care providers • Working with Westview Integrated care centre to understand their nutritional policy • Farrow court- Sheltered scheme undergoing remodelling to extra care, will provide 84 older persons fats, 12 LD and 8 recuperative care • Charing- Feasibility underway for extra care scheme and bungalows as part of larger residential development.
Anything else relevant to AHWB priorities NOT mentioned above	KCC Transformation programme
Strategic challenges & risks including horizon	

scanning?	No
Any thing else the Board needs to know	No
Signed & dated	Paula Parker

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Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from(delete as applicable)	Public Health
Quarter concerned (delete as applicable)	April to June 2014
What's going on in our world	Adult Healthy Weight tiers 1 & 2 Services to be re-contracted with effect from 1st April 2015, covering tiers 1 & 2 services. Public consultation is imminent. Going to tender in the Autumn. Breastfeeding services Contracts are being awarded by the end of June to start by 1st October. Falls - county wide contracts to deliver postural stability classes in community settings are being commissioned for 3 x 36 week courses (circa. 2 years) with possible extensions. Contracts will be let in September, awarded in October/November and let on a CCG basis. Potentially 3 classes will run within Ashford CCG area with potential for expansion linked to BCF monies. Referrals to be managed by KCC's Access to Resources team in conjunction with other partners involved in the Falls Framework. In the short term Voluntary Action Maidstone (Brighter Futures) have been commissioned to deliver some short-term 12 week courses in east Kent – a class is recently underway in Tenterden. Contact VAM for more info. Health Inequalities – Ashford is developing a health inequalities plan alongside Kent Mind the Gap to identify issues and prevalence of inequalities across the Borough. It will also map activity and programmes that are being delivered to address inequalities in the area. Tobacco Control – a range of programmes that include smoking cessation, harm reduction, smoke free policies in hospitals, maternity and mental health units, smoke free homes and smoke free family areas are being delivered. Ashford is being considered for piloting smoke free family areas, gaining insights from local people to promote voluntary smoke free outdoor family places, such as parks.
Success stories since last AHWB	Mental Wellbeing - Mens Sheds are now up and running. Groundwork leading the project. Bids for funding is available for an Ashford Mens shed, available from www.Kentsheds.org.uk

	Self-Harm programme for young people – we are pleased to report that Ashford Borough Council have organized excellent training to front line professionals to respond to early signs of young people self-harming. This has led to a pilot drop-in facility for young people in the Ashford HOUSE site. The pilot programme will be evaluated throughout the year.
What we are focusing on for the next quarter <u>specific to the key projects</u>	Adult Healthy Weight – tender process will have started (see above) Mental Health First Aid Training – we will be commissioning services to train front line staff in mental health awareness.
Anything else relevant to AHWB priorities NOT mentioned above	Healthy Living Pharmacies – The programme is being launched to promote Healthy Living Pharmacy status to pharmacies: an accreditation that demonstrates their competency to deliver health improvement services in the community. 67 Pharmacists and their staff attended the East Kent Launch on the 3rd June and Ashford have 16 pharmacies currently signed up to the programme.
Strategic challenges & risks including horizon scanning?	Funding is currently being secured for Smoke free places initiatives.
Any thing else the Board needs to know	
Signed & dated	24th June 2014 Deborah A. Smith

REMINDER - AHWB key projects are:

- Community Network
- Dementia day centre provision
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- Stanhope area focused wellbeing project
- Homelessness (specific project TBC)

REMINDER - AHWB priorities are:

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Ashford Health & Wellbeing Board (AHWB) - Ashford Borough Council Partner Quarterly Update

Update from	Ashford Borough Council
Quarter concerned	July to September 2014
What's going on in our world	• **Strategic projects** o Funding for SELEP Growth Deal £632.1m package to 2021 plus £64.6m new funding for 15/16. Full details unknown but for Ashford £35.7m for M20 Jn10a (full scheme – plus Highway Authority funding. Also £9m to improve Chart Road (A28 link to Chilmington Green development) o Jasmin Vardimon International Dance Academy – Flagship centre for dance and dance training plus provision of a hub for creative enterprise. Successful £362K capital bid secured from Arts Council with 'in principle' £3m contribution. Additional funding from Council & KCC. o ABC now own and managing International House. New office development proposed Dover Place. o Elwick Place plans progressing to mixed retail, leisure, office and residential (estimated 600 jobs) o International College Campus (Elwick Road). New operator procured (Hadlow College) phase 1 construction by end 2016 o Continued progress regarding Designer Outlet Expansion, International Station (finding signalling solutions to enable future interoperability for all international service providers and Chilmington Green (development based on Garden City principles (1000 jobs and 5,750 houses).
Success stories since last AHWB	• **Safety In Action** – Over 1,200 year six pupils participated in a practical workshop covering a wide range of safety issues including drug aware and accident prevention. • **Self Harm Project** – aimed at improving mental wellbeing for young people. Key elements were a training programme for front line professionals and curriculum sessions and activities at HOUSE. Training completed other elements of programme ongoing. • **Active Green Travel Project** - encourages primary school children to use an active travel method to get to and from school estimated 12,000 journeys saved already. Project schedule to continue to end of year. • **Dementia Kent Action Alliance** – Ashford BC signed up. Training sessions in July & August with more planned. • **Homelessness** – New process developed as a direct recommendation from the 'Think Housing First Action Plan' linking those in temporary accommodation to GPs. • **Mind the Gap** – Graduate EHO documenting Council

	inequality work • **Community Safety Partnership** – Strategic Assessment Complete and Tactical Delivery Plan agreed.
What we are focusing on for the next quarter <u>specific to the key projects</u>	• **Community Network** and in particular the South Ashford hub. Meetings planned with CCG in order to establish how Council services and aspirations dovetail with the concept • **Dementia -** Detailed discussions continue with ABC, Social Services and Age UK about the arrangements for making the Day Centre at the new Farrow Court facility a centre of excellence. The discussions include aiming to deliver services seven days a week with a specific focus on dementia clients at weekends. • **Healthy weight** – Preparation for the September Board meeting and the focus on obesity. This meeting needs to establish local priorities and service required. Need to establish whether focus is on adults or children. Scoping with key partners. • **Farrow Court** – building work continues on site with dwellings in phase 1 due for completion in March 2015 and communal facilities in April/ May 2015. Once phase 1 is complete phases 2 and 3 will commence in May/June 2015 with anticipated completion of these in late 2016 • **Homelessness** – refer to Lead Officer Group report
Anything else relevant to AHWB priorities NOT mentioned above	• Promoted food safety week • PopUpAshford – extends stay until end of year. Project for start-up businesses • Conningbrook – progress legal agreements with various stakeholders
Strategic challenges & risks including horizon scanning?	Responding to issues raised by future population and housing growth in the Borough, including engagement with the council on the emerging Local Plan to 2030.
Any thing else the Board needs to know	Public health funding of about £10K per local authority available but likely to be earmarked for a specific health issue. Suggested that self-harm and expanding the Ashford project would be appropriate.
Signed & dated	Sheila Davison - 11 July 2014

REMINDER - AHWB key projects are:

- Community Network
- Dementia day centre provision
- Healthy weight
- Farrow Court
- Stanhope area focused wellbeing project
- Homelessness Rough Sleeper Project

REMINDER - AHWB priorities are:

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- Dementia
- Homelessness
- Healthy weight
- Falls prevention
- Sustainable development for health & wellbeing

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update Template

Update from(delete as applicable)	LCT/Children's Operational Group
Quarter concerned (delete as applicable)	April to June 2014
What's going on in our world	The ACHWB has still yet to have its inaugural meeting due to diary clashes and holidays and identifying the right representative for each area following restructures in KCC and the NHS. A meeting has now been set for early September
Success stories since last AHWB	A mental health summit has been held in early July to develop a five year strategy for young people's emotional health and mental wellbeing, this provides a clear indication that KCC and the CCG's hold this as a key priority.
What we are focusing on for the next quarter specific to the key projects	The ACHWB will be aligning its strategy to the AHWB priorities namely - Sustainable development for health and wellbeing, homelessness and obesity
Anything else relevant to AHWB priorities NOT mentioned above	n/a
Strategic challenges & risks including horizon scanning?	KCC support for the ACHWB both in officer attendance and admin support.
Anything else the Board needs to know	
Signed & dated	Stephen Bell Chair 14/7/14

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Ashford Clinical Commissioning Group

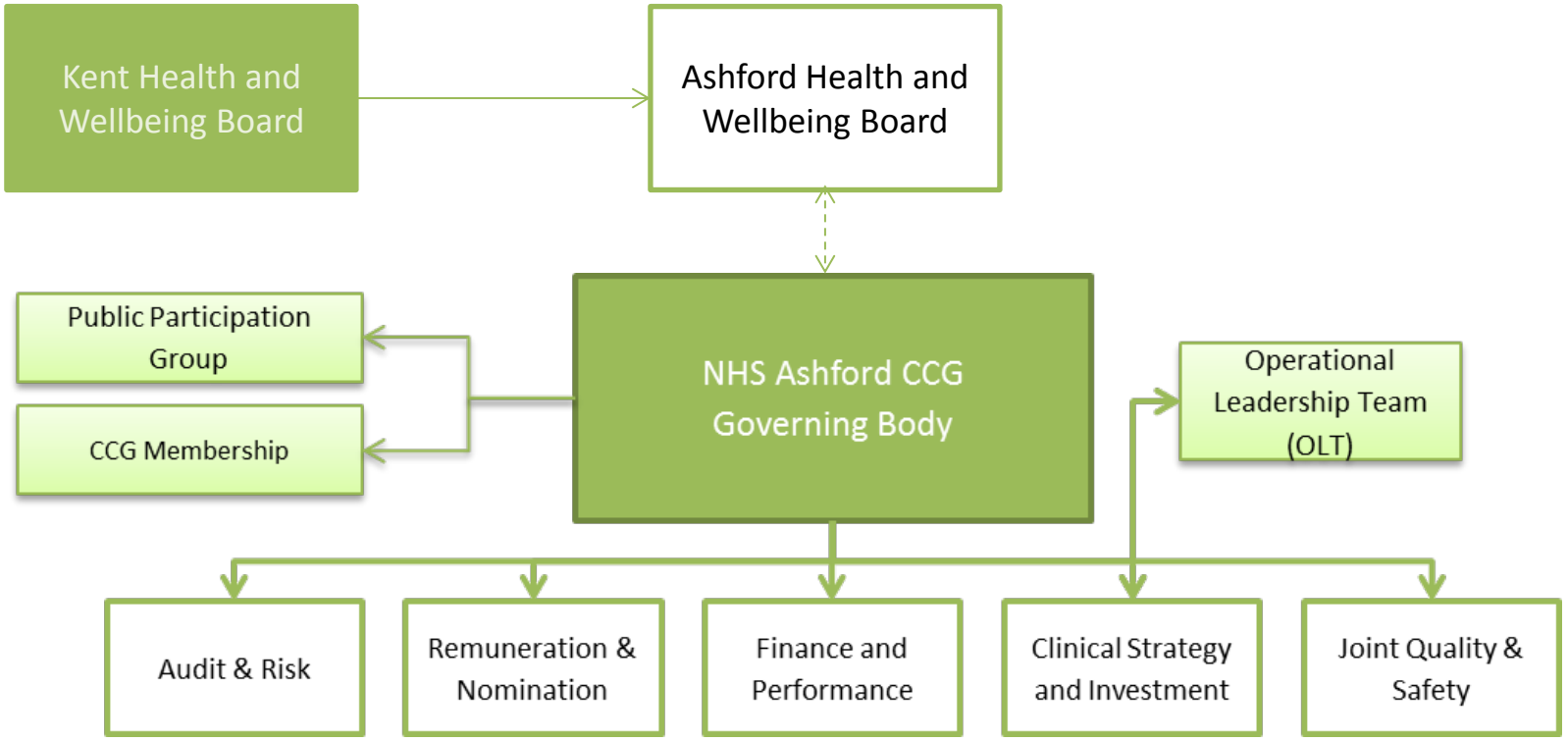
The Changing Face of NHS Ashford

Bill Millar – Chief Operating Officer
Neil Fisher – Head of Strategy and Planning

"The CCG is the practices and the practices are the CCG. There is no separate CCG to the member practices."

- Dame Barbara Hakin

How your CCG works



- Governing Body operates under mandate from 15 member practices
- Governing Body membership is:
  - 6 GPs, 1 x Chief Nurse, 1 x Registered Nurse, 1 x Hospital Consultant, 2 x Lay Members,
  - 4 x CCG officers (including Accountable Officer and Chief Finance Officer)

Local Health Profile

Life Expectancy	The average life expectancy in Ashford is 83.4 years for females compared to males at 80.7 The lowest life expectancy figures are in the wards of St Michaels and Weald East and Weald North, with the highest figures in Park Farm North and Washford. The difference in the number of years between the highest and lowest life expectancy at
Cause of Death	Circulatory Disease is now the main cause of death (34% of deaths), followed by Cancer (26%), and respiratory disease (15%).
Lifestyles	Smoking leads to cardiovascular disease, respiratory disease and cancer. NICE highlight that smoking is the "leading cause of health inequalities in the UK today and the principal reason for inequalities in death rates between rich and poor." In Ashford, almost 35% of people in the most deprived wards are smokers which compares to less than 20% in more affluent wards. The prevalence of adult obesity has been mapped across electoral wards in Ashford. The wards with the highest prevalence (estimated to be between 26% and 30%) are Beaver, Stanhope, Norman and Aylesford Green. All these four wards are found in the
Long-Term Conditions	There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having
Dementia	Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65.
Mental Health	Age specific adult mental health rates are seen to correlate with areas of deprivation, with high rates seen in Stanhope, Beaver, Norman, South Willesborough, Aylesford Green and Victoria Wards. Lowest rates are seem in Weald North.

Improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs and community services.

Care Home project continues and recognised with National Award (Health Service Journal)

- Risk stratification in place across all practices
- Integrated teams organised into Cluster teams
- Review of Westview implemented
- Shared care protocol for management of dementia drugs in primary care

What your CCG has delivered in 13/14

- Introduced Carpal Tunnel pre referral splinting
- CCG based Surgery in Primary Care service introduced to avoid patient's need to travel
- Joint injections pathway implemented so that patients are treated in primary care and not referred to secondary care
- In house services – specifications agreed and new contracts issued

What the CCG has delivered in 13/14

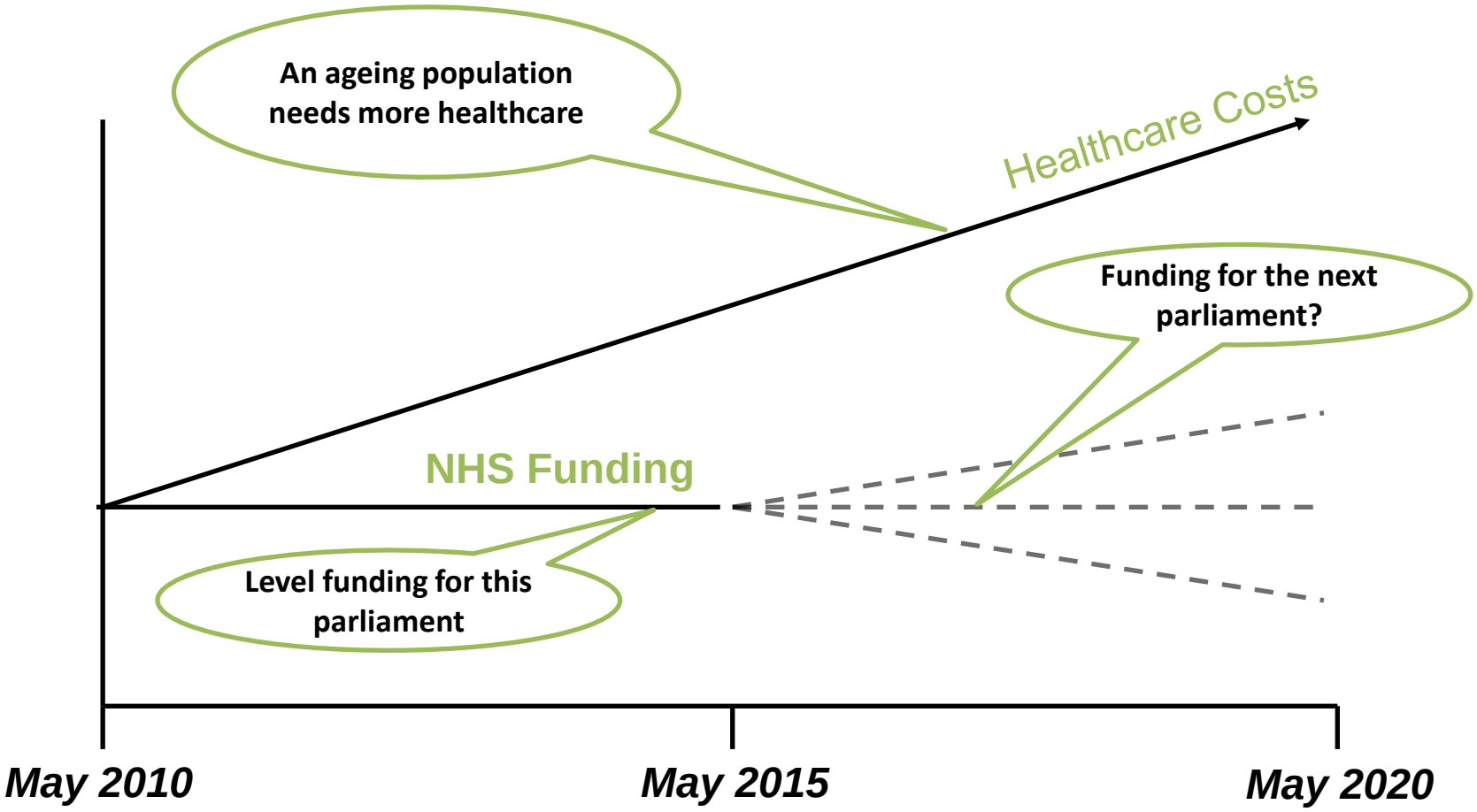
- GP in A/E extended to 7 day service
- Primary Care Foundation standards implemented within practices
- Pilot for 7 day primary care service in place
- MIU local enhanced service reviewed and new specification agreed
- Improved waiting times for IAPT services

Ashford Clinical Commissioning Group

Moving Forwards

The Next Five Years

The Efficiency Challenge

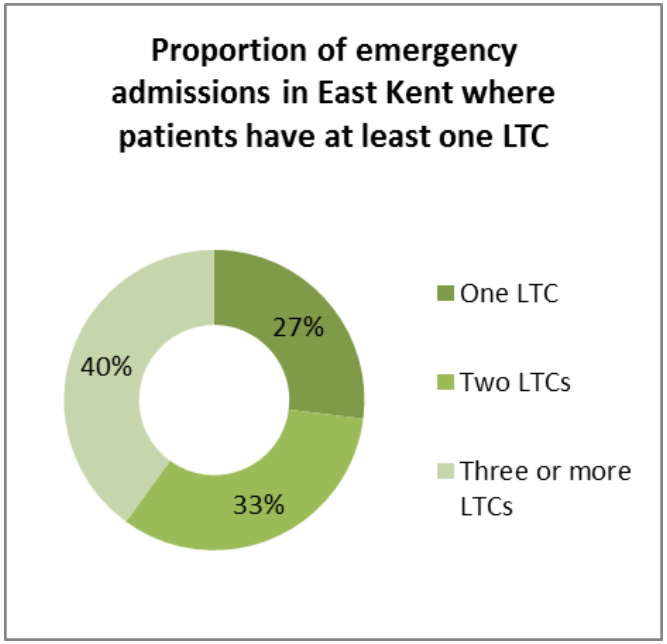


The View in East Kent: Financial Challenge

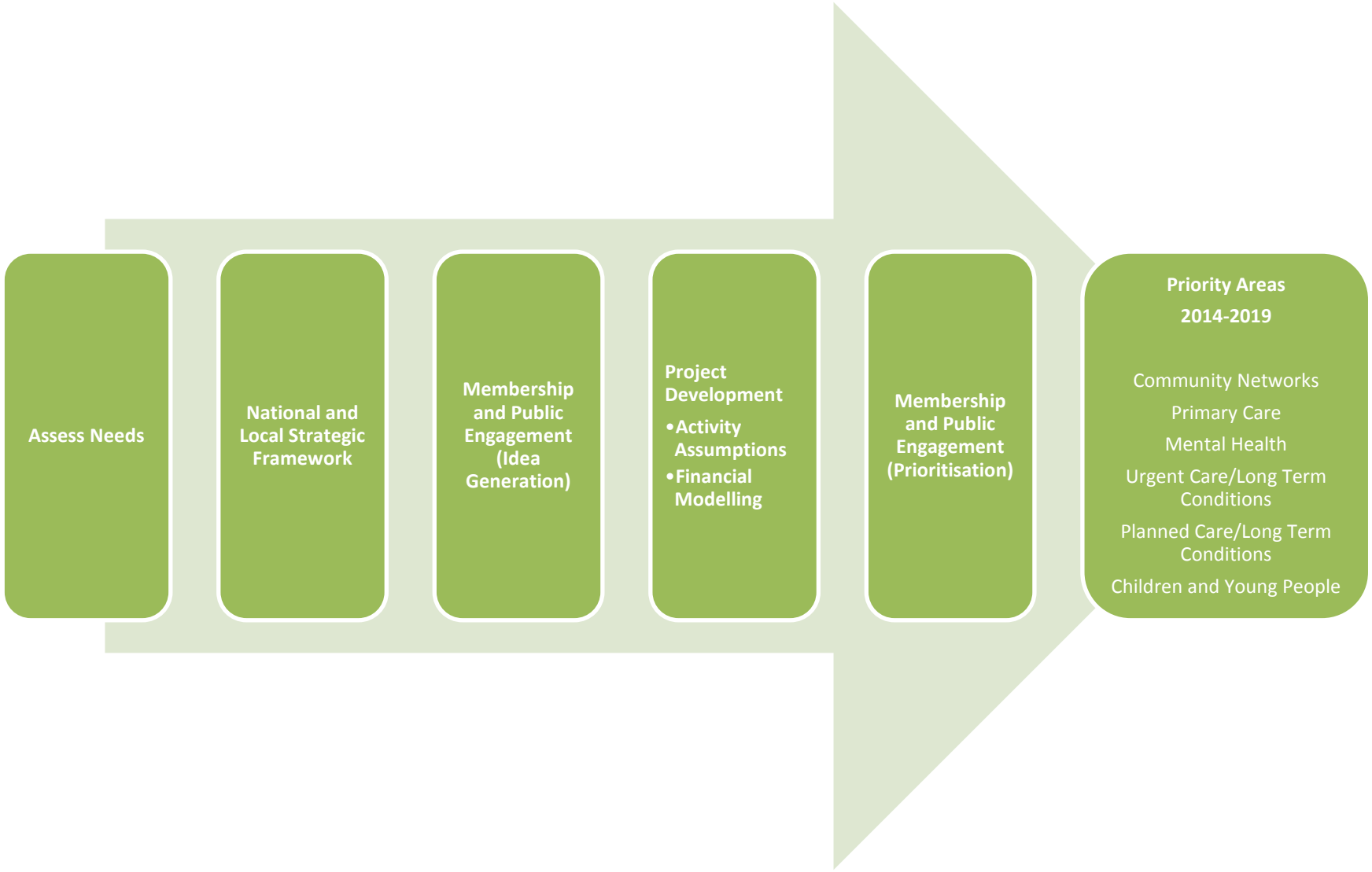
	2018/19 Gap (Budget Share)	2018/19 Gap (Demographic Forecast)
NHS Ashford CCG	£24 million	£27 million
NHS Canterbury & Costal CCG	£44 million	£49 million
NHS South Kent Coast CCG	£47 million	£52 million
NHS Thanet CCG	£35 million	£40 million
East Kent Total	£151 million	£168 million

What are the pressure points?

- Increasing use of emergency services
  - GP, Minor Injuries, Accident and Emergency
- Increase in long term conditions
  - Older patients tend to have longer spells and are readmitted more frequently after a first hospital spell
  - Ageing is a fundamental factor, as the prevalence of LTCs is up to 6 times higher in over 65s than in under 65s
  - Patients with LTCs have been recently estimated to account for 70% of the total health and care spend in England
- Public Expectation
  - Faster, better, more



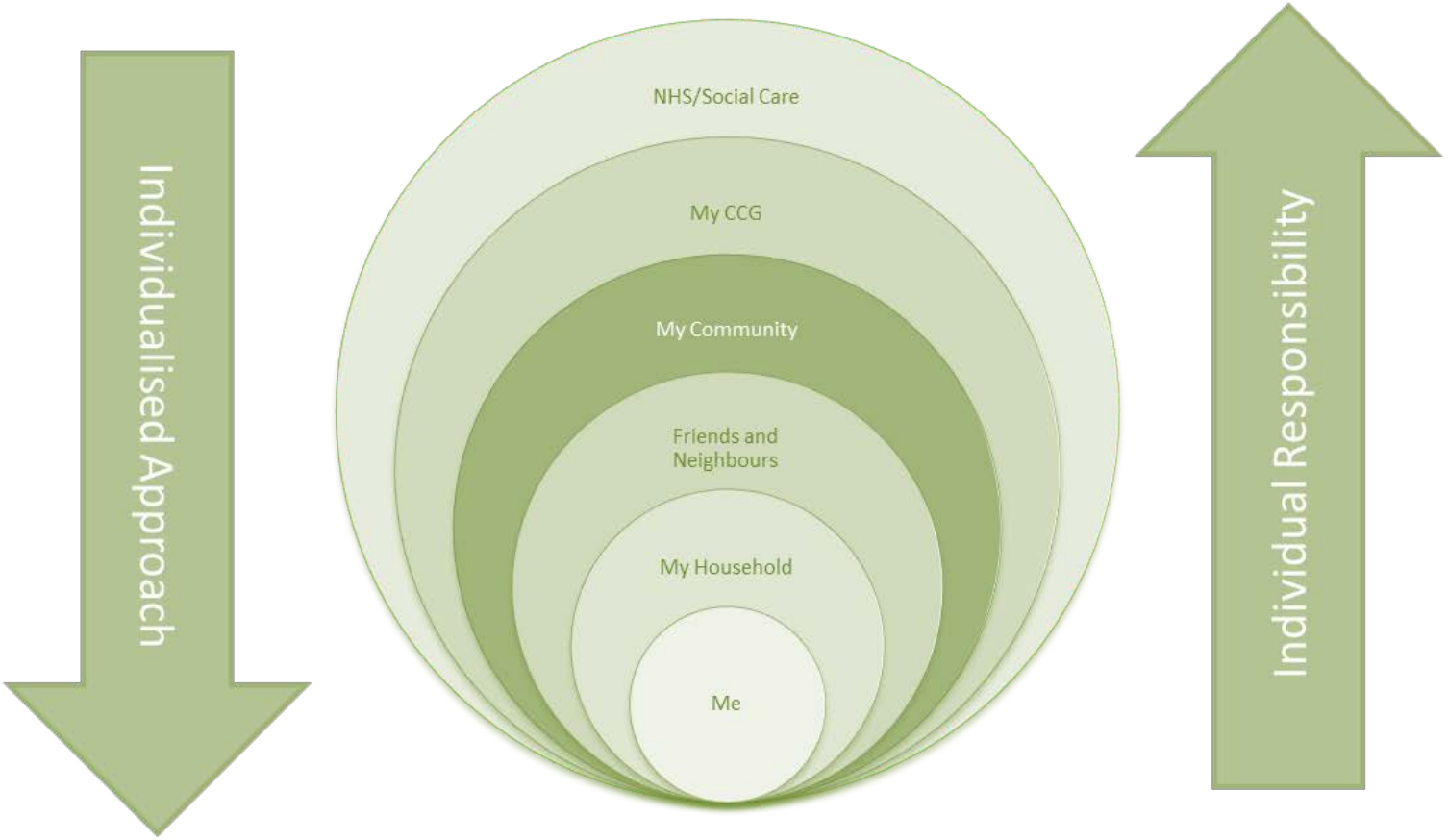
Developing Plans for the Future



View from Public and Membership Events

- Support preventative care
- Enhanced primary care
- Earlier diagnosis for Long Term Conditions including Dementia
- Anticipated care planning
- Integration – social care, primary care, community – improve communication
- Urgent Care needs to include children and Mental Health/Dementia crisis

Localism, Personalisation and Individual Responsibility



Our Vision

Primary Care

We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.

Community Networks

Primary and community care services working closer together, along with voluntary organisations and other independent sector organisations.

Mental Health

We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities

Urgent Care

We want care that crosses the boundaries between primary, community, hospital and social care.

Maternity and Young People

We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation

Planned Care

We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.

Integration

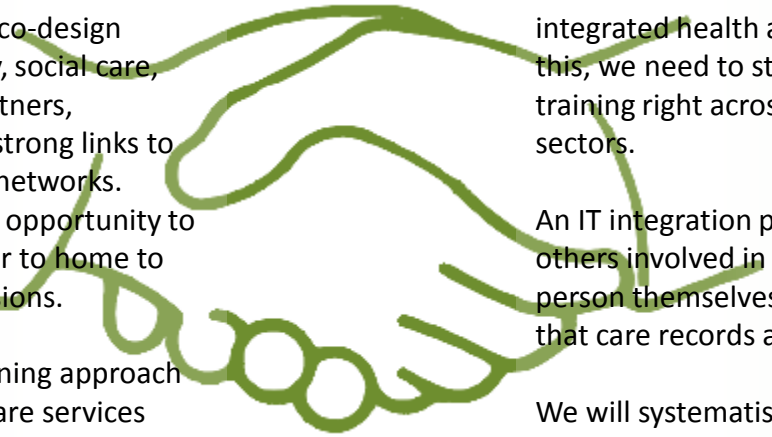
Integrated Commissioning

We will design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services by apply a proactive, rather than a reactive, model that means the avoidance of hospital and care home admissions.

We will introduce community based co-design partnerships between local authority, social care, patients, carers, voluntary sector partners, healthcare providers and CCGs with strong links to innovation, evaluation and research networks. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.

We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense, achieving the shift from spend and activity in acute and residential care to community services

New procurement models will be in place, such as alliance, lead provider, key strategic partner and industry contracts, delivering outcome based commissioned services incentivising providers to work together.



Integrated Provision

A model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community, primary & secondary care interfaces will become integrated.

We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors.

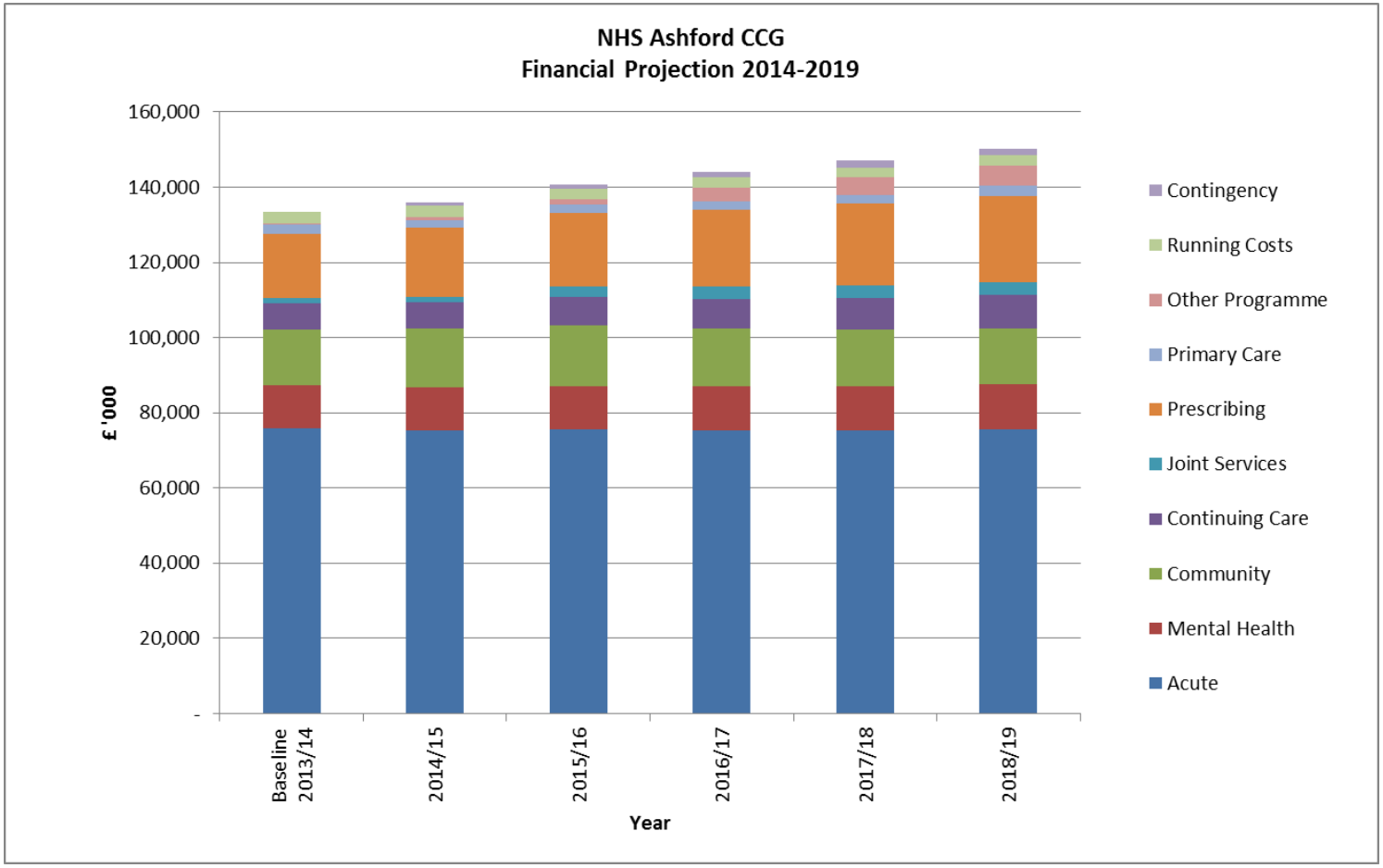
An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless.

We will systematise self care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.

Laying the Foundations

- Joint Projects:
  - Integrated Health and Social Care Team
  - Accommodation Strategy
  - Falls Prevention
  - Integrated Urgent Care Centre
  - Mental Health
  - Care Homes Support
  - West View
  - Medical Interoperability Gateway (IT Integration!)
  - Joint Voluntary Sector Support
- CCG Specific Projects
  - Enhanced Primary Care
  - Community Fund
  - 7-Day Working

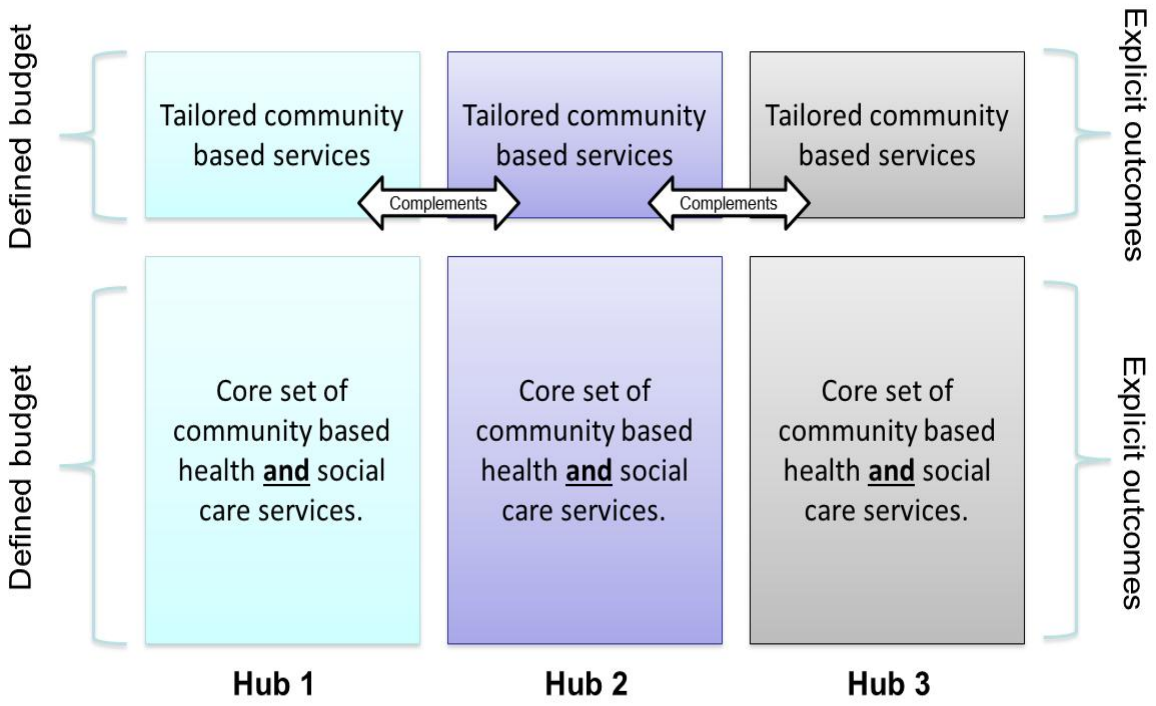
Your CCG Budget



- *Total Budget £133m,*
  - *or £364,000 per day*
  - *or £1100 per patient*

- *Context*
  - *One hip replacement = £5k-6k*
  - *Cataract replacement = £704*
  - *Birth (caesarean) = £2-3k*

Community Networks



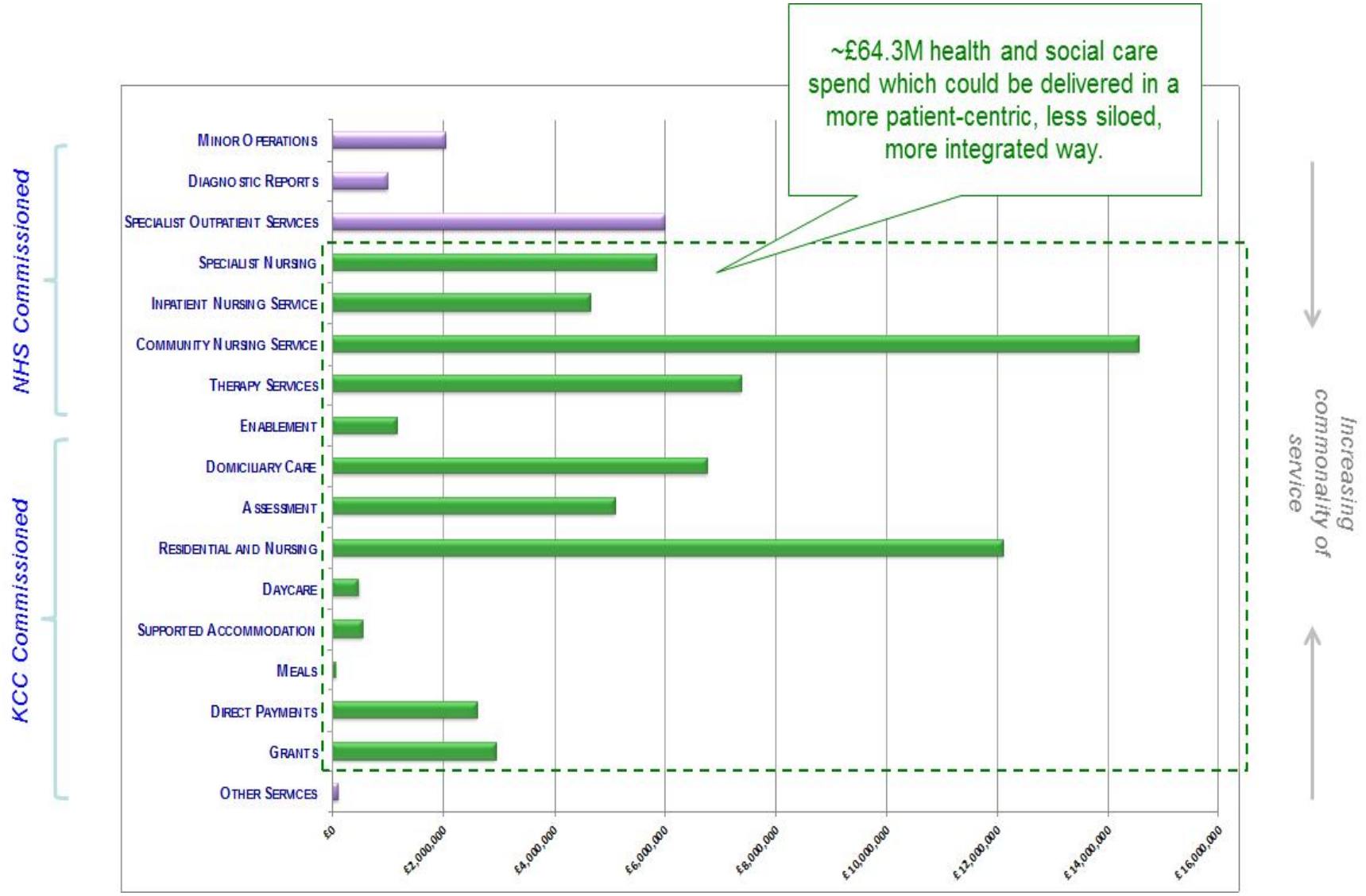
Tailored community based services
e.g. :

- Outpatients
- Specialist Diagnostics
- Addiction Services

Core community based health and social care services
e.g. :

- Assisted Living
- Befriending
- Care Homes
- Care Planning
- Carer Support
- Citizen's Advice
- Community Equipment
- Counselling Services
- Community Nursing
- Dementia Support
- End of Life Care
- General Practice
- Home Support Assessment
- Inpatient Beds (Step-Up and Step-Down)
- Meals-on-Wheels
- Minor Injuries
- Physiotherapy
- Pharmacy
- Respite Care
- Sexual Health

Using the Better Care Fund



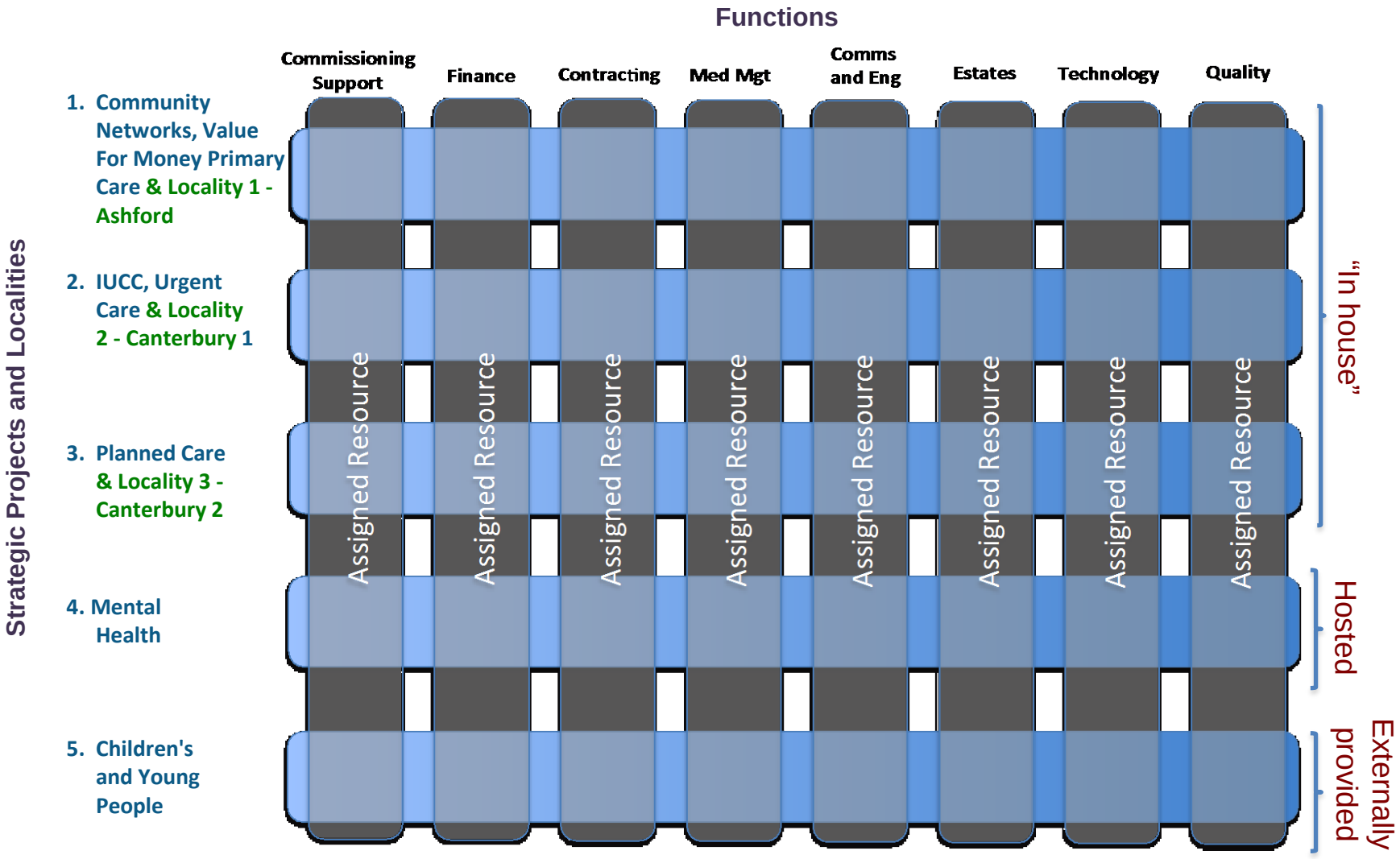
Ashford Clinical Commissioning Group

An Organisation Fit for the Future

Why we are considering CCG merger?

- Stronger clinical input
  - At the moment the two CCGs are finding it difficult to fill all clinical lead positions
  - There is currently duplication of effort between Ashford's and C&C's clinical leads
- Merged CCG leadership equals more efficiency and improved focus on delivery
  - Leadership time is currently too heavily weighted on running and administering two sets of the same meetings
- Future financial risks would be mitigated
  - All CCGs have been asked to make 10% cost savings in 2015 and the merger will allow us to do this whilst increasing our focus on our localities and member practices
- Care closer to home and work to take place at a very local level
  - staff will be re aligned to community networks as part of internal re-organisation which will transform local health and social care services
- Increased commissioning power and improvement for providers
  - One larger CCG has more leverage over its providers than a smaller CCG
  - Time focused on meetings with a single commissioner instead of two

Proposed, draft organisational design schematic



Thank you.

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