

Kent Joint Health and Wellbeing Strategy

Outcomes for Kent



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

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We have extended this strategy until 2021 to take account of the creation of the Kent and Medway Health and Wellbeing Board in partnership with Medway Council and the work of the Sustainability and Transformation Partnership.

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Foreword



I have been pleased with the progress that the Kent Health & Wellbeing Board has made since its launch in April 2013 – bringing together GPs, County and District Councillors, senior officers from the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from 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 it would be prudent to revisit our strategy after twelve months to assess to what extent 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 work together more effectively, if better health outcomes are to be achieved 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 will allow 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 Kent Health and Wellbeing Board

Summary

People's need for care, and their lives, has changed radically. But the health service largely operates as it did decades ago, when the predominant need/ expectation was treating episodic disease and injury rather than providing long-term, often complex care. The health and care system needs to redesign services so that care becomes more integrated, person-centred, coordinated, community-based, and focused on supporting people's well-being and preventing crises. The 2015 Challenge Declaration – NHS Confederation

The challenge to the health and care system is clear. Kent, like the rest of England, has an ageing population that will put increasing demands on the system, and will require long-term complex care. This, along with unhealthy lifestyle behaviours and the rising cost of technology means that nationally the NHS faces a £30bn funding gap by 2021, unless the system of health and social care can be transformed.

To meet this challenge in Kent, the Health and Wellbeing Board has developed this strategy to lead the system as it changes over the next three years. The constituent members of the Health and Wellbeing Board will use this strategy to guide their plans, and will also use the strategy as a way to start a conversation with the public about the major changes that will be taking place over the coming years.

They will need to build an understanding about the changes that will happen to large hospitals when 15% of their business moves to community based settings. These changes will see some hospitals become more specialised and the journey times for some treatments may increase to provide this better quality specialist care. Some hospital and care settings may become smaller, with services redesigned to provide care closer to home.

Services closer to home will be provided by multidisciplinary teams that will have preventative as well as responsive components to them. Integrated teams will provide active support in the community to enable patients to look after themselves. In local areas this could potentially mean that integrated care is provided through community health, mental health, and social care teams, with GP leadership. Where necessary, the services will be responsive and provide an integrated 24/7 service that has a full range of out of hospital urgent health and social care



services to support individuals in the community and avoid hospital admission. This would also mean that there will be increased support to help people at the end of their life to die in the place of their choice and with dignity.

These changes will provide the opportunity to build person centred, integrated services and the advantages of these changes need to be communicated over the coming years.

To realise the full potential of these opportunities and to benefit the people of Kent it is paramount that all constituent agencies in the system (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 programme 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 2021. 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 public health, health, housing and social care.

We have tested last year's Joint Health and Wellbeing Strategy (JHWS) against the many developments over the past twelve months, namely the challenges arising from the failures in care at Mid-Staffordshire Hospital and Winterbourne View, alongside the Call to Action, the resulting Better Care Fund, and Kent's status as an Integration Pioneer. The vision, outcomes, priorities and approaches that were developed are still appropriate, and our vision is just as relevant. Therefore we have developed this strategy to achieve our vision:

To improve health and wellbeing outcomes, deliver better coordinated quality care, improve the public's experience of integrated health and social care services, and ensure that the individual is involved and at the heart of everything we do.

To deliver our vision the outcomes we seek, as informed by the Joint Strategic Needs Assessment (JSNA), are:

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



Each of these outcomes is discussed in detail over the coming pages, with each one being examined through the prism of our four identified priorities which are to:

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

In 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 services are Person Centred, that they are part of Integrated Provision, procured by Integrated Commissioning.

So that we know we are on track to deliver our strategy, we have identified existing measurements that we will monitor. These are identified in the Outcome sections, and have been adjusted from last year so that they truly measure how we are delivering against our priorities in each outcome.

Given the size and complexity of Kent, and the scale of the health and care system it is very difficult for any strategy to provide answers at district, Clinical Commissioning Group and health/care economy (north, east and west) levels. Therefore, it is important that Local Health and Wellbeing Boards test their existing plans (those of GP-led Clinical Commissioning Groups, District Councils and other partners) against the outcomes, priorities and values laid out in this strategy. Where necessary they should develop additional actions to address local priorities in order to achieve the outcomes in ways most relevant to their own populations and supported by data and information at their local area level.

Context

Overall it is a positive message that people are living longer, but unfortunately not all are enjoying good health and wellbeing and many suffer from one or more long-term conditions. Often the causes of long term conditions are related to the lifestyles we live and are largely preventable. The increasing number of long term conditions has changed the nature of the need for health and social care. It has meant that the needs of our population are often complex, requiring agencies to work in partnership to provide the 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).

Between 2000-2010 Kent's population has grown by 7.8% which is above the national average (6.1%) and also for the South East average (6.7%). Overall the age profile of Kent residents is similar to that of England, but there are some key differences:

- Kent has a greater proportion of young people aged 10-19 years and of people aged 45+ years than the England average
- Nearly a fifth of Kent's population is of retirement age (65+)
- Population forecasts between 2010 and 2026 highlight that the number of 65+ year olds is to increase by 43.4% 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 ageing 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 public 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, prevention of ill health and integration of the health and care system. These are not mutually exclusive. 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 Groups 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 the quality of care with the experience of the patient or service user necessarily being at the centre of everything we do. As a result of the report into Winterbourne View, a series of changes have been made to improve the quality of care for vulnerable people, specifically for people with learning disabilities or autism who also have mental health conditions or behavioural problems.

The Francis Report, examining the tragic events at Mid-Staffordshire Hospital Trust, contained 290 recommendations covering everything from organisational culture to the role of patient and public representative bodies. One of the key warnings arising from the report was the danger of prioritising finance and targets over the quality of care. A lot of work is being taken forward locally and nationally in response to these reports, including Sir Bruce Keogh being asked to conduct an investigation into hospitals with the highest mortality rates (which included one of the main hospitals serving people in Kent) and the Berwick Report into NHS patient safety. This strategy will look to ensure the lessons learnt from this work are incorporated into its delivery.

Continually improving quality to achieve good outcomes

Improving quality and outcomes remains the core purpose of all publicly funded care and is the responsibility of everyone working in the health and care system. Ensuring that patients and families are empowered to influence quality improvements is key to improving delivery. Alongside the professional regulators who are tasked with seeing that quality standards are maintained and improved, the commissioners of health and care services have a duty to ensure the services they commission are safe. Quality improvement is dependent on effective collaboration amongst health and care providers,

service commissioners, education providers, regulators, professional bodies and other partners to ensure patients receive high quality care.

The local Quality Surveillance Group is well positioned to pull together information from commissioners, the regulators and Healthwatch. Drawing on the work of this group will enable the Kent Health and Wellbeing Board and its members to work across the system and achieve the collective objectives of ensuring that the essential standards of quality and safety are maintained; and that all services drive continuous improvement in quality and outcomes.

Call to Action

In July 2013, NHS England published "The NHS belongs to the people: a call to action". This paper set out a range of challenges facing the NHS and includes 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 in addition to 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 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 ensuring local mental health needs were reflected 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 in crisis because of a mental health condition are kept safe and helped to find the support they need.

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. The intention of the BCF is to complement the work that KCC had already begun and will continue through its Pioneer work.

Kent was chosen as a Pioneer area in the Department of Health's Integration Pioneer Programme, which will establish new ways of delivering coordinated care. Through the Pioneer work, over the next five years, we will re-design models of care to put the citizen more in control of their health and make a real difference to the way people experience health and social care in Kent. By bringing together CCGs, KCC, District Councils, acute services and the voluntary sector, we will move to care provision that will promote greater independence for patients, whilst reducing hospital and care home admissions. In addition, a new workforce with the skills to deliver integrated care will be recruited and developed. Through the Kent Better Care Fund proposal a pooled fund of £127 million from existing resources has been identified to support integration in the county.

The integrated model of care that we are moving towards contrasts with the current situation where the majority of commissioning and provision of services is standalone, and although best efforts are made to align services to benefit service users, there is room for improvement. The current situation creates a complex system for users to navigate, often leaving them frustrated with the care they receive. The new system will also include elements of the recent Care Act 2014. These requirements of the Care Act will be implemented from April 2015 on and will become the new policy framework for social care.

In the future, patients will have access to 24/7 community based care, ensuring they receive quality care closer to home, and do not need to go to hospital. A patient-held care record will put the patient in control of their own information. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services.

We will use innovative approaches to identify those who are at a higher risk of hospital admission and new ways of identifying payment mechanisms such as 'Year of Care' commissioning for the care of 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 within the health and care system 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 will investigate the possibility of developing an Integrated Intelligence capability. This will enable Kent stakeholders (service users, commissioners and providers) to understand how services are used and provide capability to undertake Joint Strategic Needs Assessment across multiple agencies. This will also generate more accurate information for commissioners to design and create higher value models of care to enable whole system transformation and inform future integrated commissioning. From the perspective of service users this will allow us to monitor the effectiveness and efficiency of on-going improvements across various services.

Joint Strategic Needs Assessment

Our priorities for Joint Health and Wellbeing Strategy in 2012-2013 were informed through the Joint Strategic Needs Assessment (JSNA) which is a 'live' document and as such is under constant review. To inform the current strategy each of the existing needs assessments that support the current JSNA have been reviewed and updated to reflect the latest policy, guidance and data trends. Updated information was reported as an exception paper to the Health and Wellbeing Board in January 2014. This process will be undertaken each year for the lifetime of the Health and Wellbeing Strategy. At the end of the HWBS term a full review of the JSNA summary document will take place.

It was in light of the above developments that we assessed the 2013/14 strategic vision, outcomes, priorities and approaches. We feel that they still fit the challenge, and provide the common values that should be applied by all commissioners, providers and organisations that impact upon peoples' health and social care. It is important that all partners support these principles and align their plans to the Health and Wellbeing Strategy for Kent, as illustrated in Figure 1.



Figure 1

Our Vision

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

Outcomes

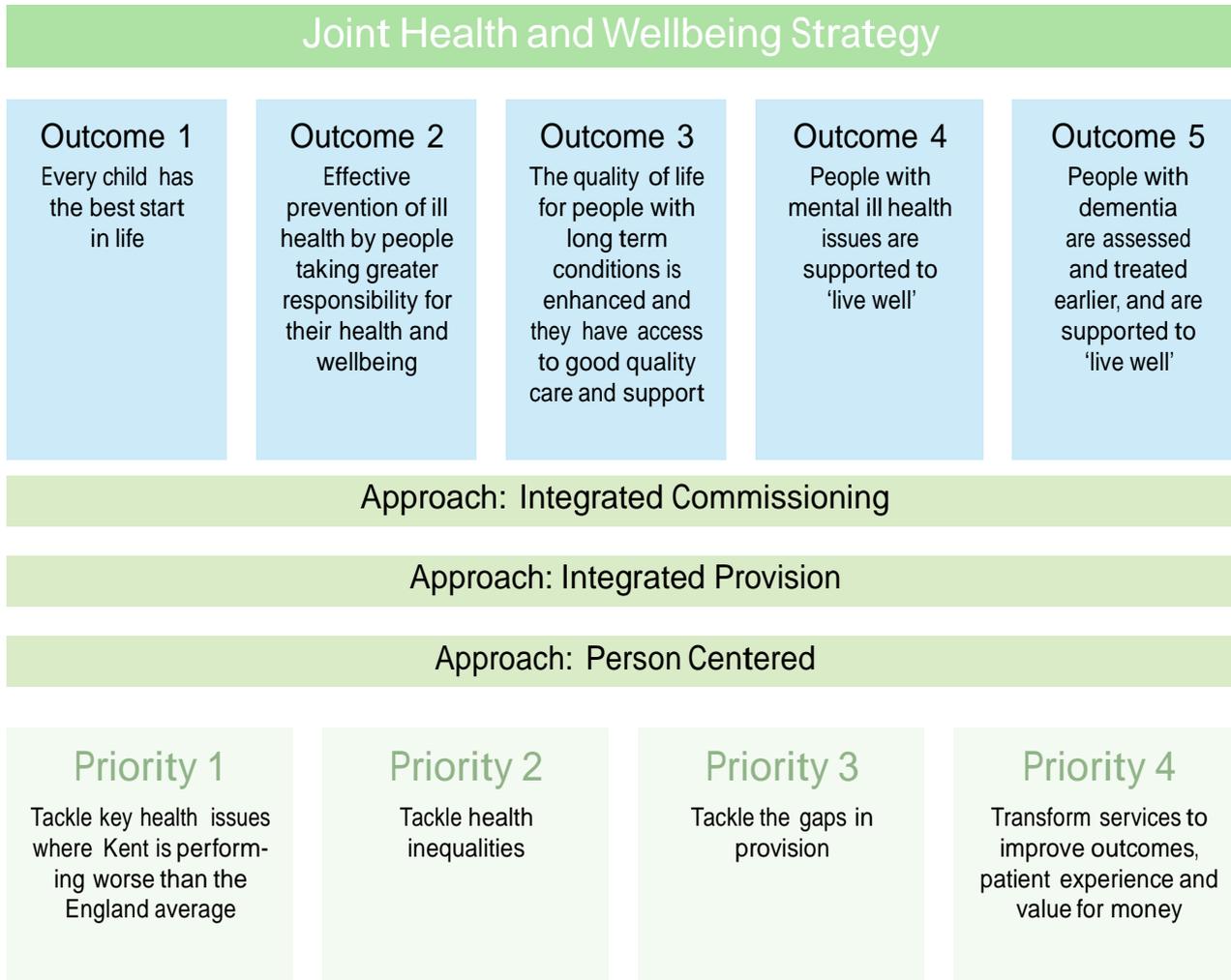
To achieve our vision the outcomes we seek, as informed by the Joint Strategic Needs Assessment, are:

- 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.

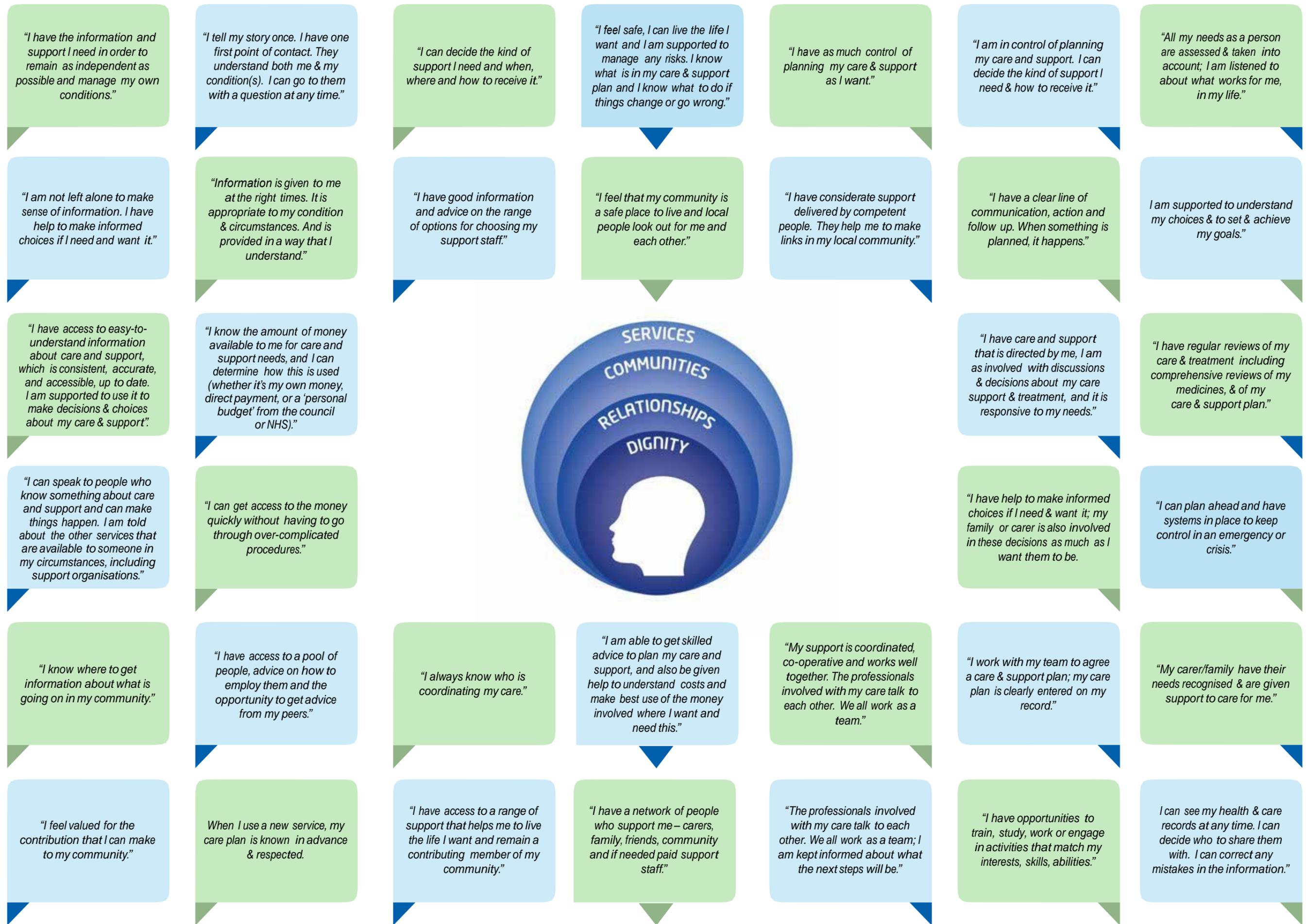
- Every child has the best start in life
- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing

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



What should good, person centred, care feel like

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



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 and in the right place. This will 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. We also need to ensure that children and young people experience a seamless transition when they move between services.

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 safe, 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 and Disabilities (SEND).

Over the coming years we will also see a much greater integration in services for children from pre-birth to 19, or 25 in some circumstances, and implementation of the Healthy Child Programme. In October 2015 Health visitors will become a part of the public health responsibilities of Kent County Council, and will complement the responsibility to support breast feeding, and reduce smoking in pregnancy. KCC is developing a joined up preventative services approach for 0-19 year olds. Meanwhile, a new School Health service specification is currently being developed with the intention that a new service is in place by April 2015.



Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average

In order to tackle key health issues in this outcome we need to deliver:

- A reduction in the number of pregnant women who smoke at time of delivery
- An increase in breastfeeding Initiation rates
- An increase in breastfeeding continuance of 6-8 weeks
- A reduction in the proportion of 4-5 year olds with excess weight
- A reduction in the proportion of 10-11 year olds with excess weight

Priority 2 – Tackle health inequalities

The UK is one of the richest OECD countries but one of the most unequal in health terms, which has a direct impact on children's wellbeing. We have seen a rapid rise in mental health problems in children, an increase in sexually transmitted diseases and an epidemic of childhood obesity. Inequalities in health and emotional wellbeing are striking. Poorer children are more likely to be born too early and too small, and are less likely to be breastfed or immunised.

To address health inequalities for children and young people in Kent we will:

- Improve breast feeding rates by promoting Unicef's Baby Friendly accreditation and implementing the infant feeding action plan in place. This requires partnership working through maternity units, hospitals, children centres, midwives and Health Visitors in a range of medical and community settings

- Prevalence of obesity in children is higher in more deprived areas. We will promote healthy weight for all children, particularly in areas where the need is greater; working with families to promote healthy eating and increase physical activity
- reduce smoking in pregnancy by strengthening midwifery and smoking cessation resources and provide a whole systems approach to engaging with and supporting pregnant smokers.
- ensure vulnerable and disadvantaged children access and participate in good quality childcare and education and achieve good outcomes.

Priority 3 – Tackle the gaps in service provision

The delivery of Speech and Language Therapy is critical to children and young people accessing and benefiting universal, targeted and specialist services. Speech and Language Therapy (SALT) implementation has system wide benefits. During the life of this strategy we will be working towards implementation of the SALT Framework.

We will continue to work with our partners across the health and care system to ensure that children and young people with short term acute conditions and complex health needs are able to receive high quality, locally accessible community based support, avoiding where possible the need to attend hospital.

The Common Assessment Framework (CAF) will continue to be a key tool for carrying out an early help assessment and planning the necessary actions to improve children's outcomes and support their additional needs. There is also support for parents experiencing physical and mental health issues.

We will continue to work towards strengthening our commissioning and provision of child and adolescent emotional wellbeing and mental health services so that we can achieve greater availability of support for emotional resilience and treatment where needed.

The Children's Health and Wellbeing Board will shortly be developing an Emotional Health and Wellbeing (EMHW) Strategy for 0-25 year olds in Kent to support this outcome.

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

It is essential that there is a seamless flow between universal, targeted and specialist services, and that transition between each level of service is well managed and simple for the children, young people and their families. It is important to recognise that needs change over time, and that the step up, or step down between levels of service is a particularly fraught time for everyone involved, and one where the risk of gaps appearing are at their greatest.

Agencies in the health and care system will work collaboratively to implement the Kent Integrated Family Support Services (KIFSS) for pre-birth to 11 years' services and Kent Integrated Adolescent Support Services (KIASS) for 11-19 years' services. These key services include Children's Centres, Early Intervention Teams and Family Support workers, Attendance and Inclusion services, Connexions workers to provide targeted support for NEETs, Youth Offending workers, Troubled Families workers, Adolescent Social Work Assistants, Pupil Referral Units and Alternative Curriculum Provision, agencies involved in CAF and commissioned support services and health services for children and young people and Gypsy, Roma, Traveller and minority outreach workers. Schools, children's centres and early years settings are at the heart of this new way of working at district level. By establishing a 'team around the school', it is expected that children, young people and their families will be able to access services in a more timely, effective and appropriate manner so that early help activity agreed will significantly improve outcomes for the child, young person and their family.

Keeping track of our progress in delivering Outcome 1

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

- A reduction in the number of pregnant women who smoke at time of delivery
- An increase in breastfeeding initiation rates
- An increase in breastfeeding continuance 6-8 weeks
- A reduction in conception rates for young women aged under 18 years old (rate per 1,000)
- An improvement in MMR vaccination uptake two doses (5 years old)
- An increase in school readiness: all children achieving a good level of development at the end of reception year 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 SEND assessments within 26 weeks
- A reduction in the number of Kent children with SEND placed in independent or out of county schools
- A reduction, in every part of Kent, in CAMHS average waiting times for routine assessment from referral
- A reduction, in every part of Kent, in the number waiting for routine CAMHS treatment
- In every part of Kent, an appropriate CAMHS caseload, for patients, open at any point during the month
- A reduction in unplanned hospitalisation for asthma (primary diagnosis) in people aged under 19 years old (rate per 100,000)
- A reduction in unplanned hospitalisation for diabetes (primary diagnosis) in people aged under 19 years old (rate per 100,000)
- A reduction in unplanned hospitalisation for epilepsy (primary diagnosis) in people aged under 19 years old (rate per 100,000)

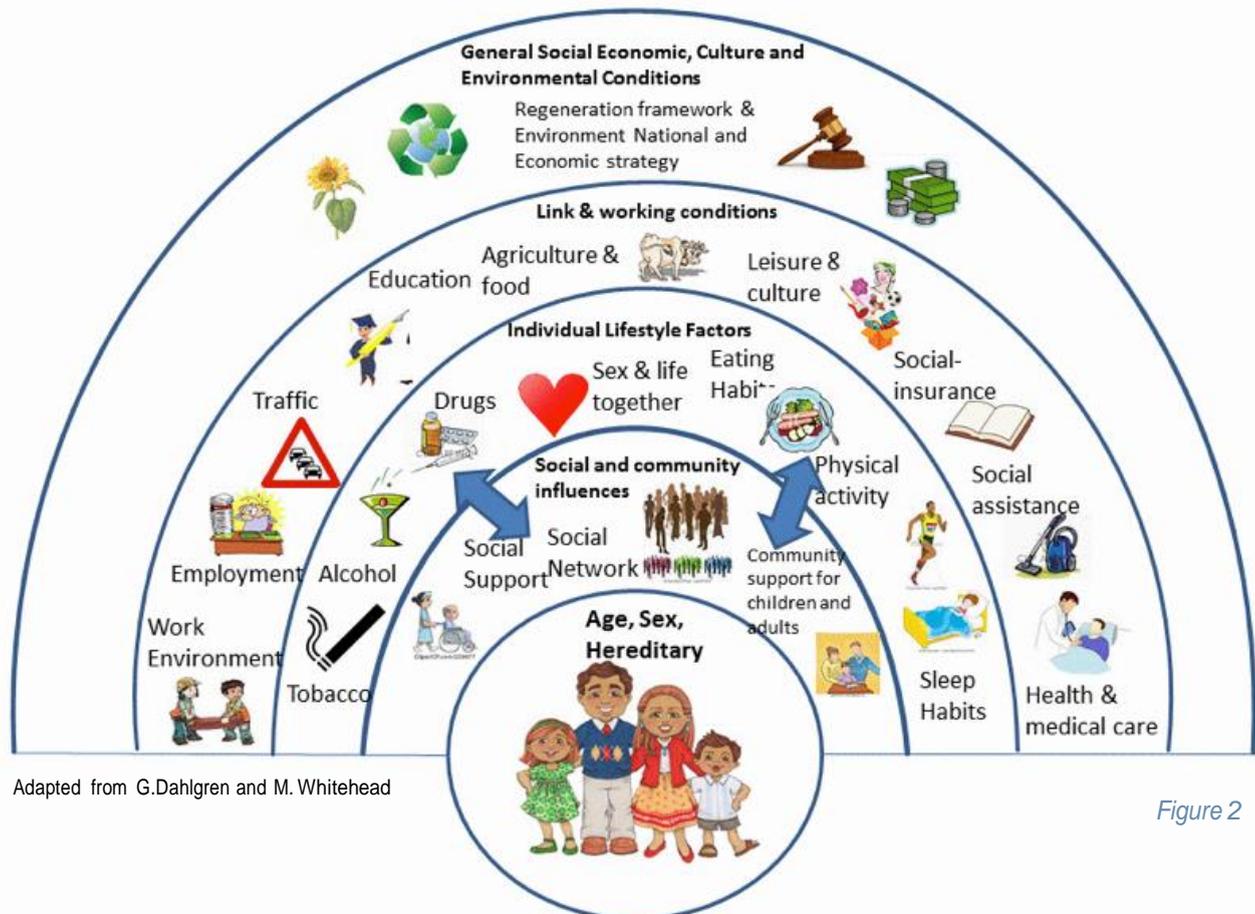
Outcome 2

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 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 an 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 G.Dahlgren and M. Whitehead

Figure 2

Addressing health inequalities will require all partners to effectively contribute to improving access to services so that overall health equity can be improved. The local level Health and Wellbeing Boards provide opportunities for colleagues in Primary Care, Clinical Commissioning Groups and Borough/City/District Councils to work collaboratively to promote equitable provision of services, particularly in prevention of ill health and in reducing 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.

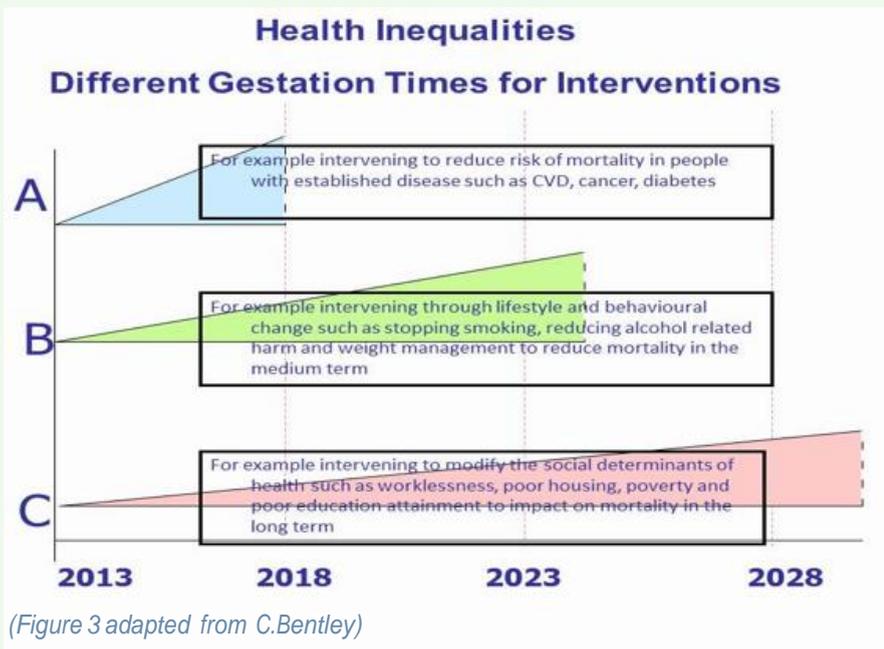
To influence medium term interventions we will ensure that commissioning of public health programmes deliver a transformed and integrated approach to public health, ensuring locally appropriate services and campaigns. Services will be based on “proportionate universalism” principles to ensure that there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

To influence long term interventions we will work with our colleagues in Borough/City/District Councils, education, 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 that turns this on its head and looks at all the positive and useful things available to us – from buildings, services, communities and networks that we can use along our health journey.



Shaping the physical environment of the community so that it can better promote healthier lifestyles is central to borough/city/district councils' regulatory health improvement role. The new National Planning Policy Framework highlights the role of the planning system in facilitating social interaction and creating healthy, inclusive communities. This includes measures aimed at reducing health inequalities, improving access to healthy food and reducing obesity, encouraging physical activity, improving mental health and wellbeing, and improving air quality to reduce the incidence of respiratory diseases.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average

Within this outcome the areas we need to focus on are:

- Reducing the proportion of adults with excess weight
- Increasing take up of NHS Health Checks

Priority 2 – Tackle health inequalities

The partners in the health and care system acknowledge the far-reaching and expansive contribution that Borough/City/District Councils, community enterprises, the voluntary sector and other 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 Borough/City/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. An example here is that of people with learning disabilities as they have poorer health outcomes than other population groups, because they may not be accessing routine screening or health support as consistently. The Confidential Inquiry into premature deaths of people with intellectual

disabilities (CIPLD) in England provides evidence of the substantial contribution of factors relating to the provision of care and health services to the health disparities between people with and without intellectual disabilities.

It highlights a need to examine care and local service provision for this population as potentially contributory factors to their deaths—factors that can largely be ameliorated. For instance compared to other areas Kent has low uptake of annual health checks for people with learning disabilities.

To address this low uptake, everyone known to have a learning disability will be offered a baseline Health Profile and a Health Action Plan will be developed.

Each GP surgery will have a link LD Nurse who will support them to understand the needs of people with a learning disability, and who can provide advice, guidance and education to GPs to ensure they can deliver an annual health check.

Priority 3 – Tackle the gaps in service provision

The introduction of integrated commissioning groups to support the work of each local Health and Wellbeing board has created a joint space where local plans can be discussed to ensure that they are joined together and identify where gaps exist. The Public Health team are working to review all the services funded by the Public Health grant to ensure that they are complementary 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 NHS England 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 concerning 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, and 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 use information across the system to understand the 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'.

To ensure that the prison population receives appropriate care and support as required by the Care Act 2014, the Local Authority will work with the Prison Services and NHS England.

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. This requires rethinking 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

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

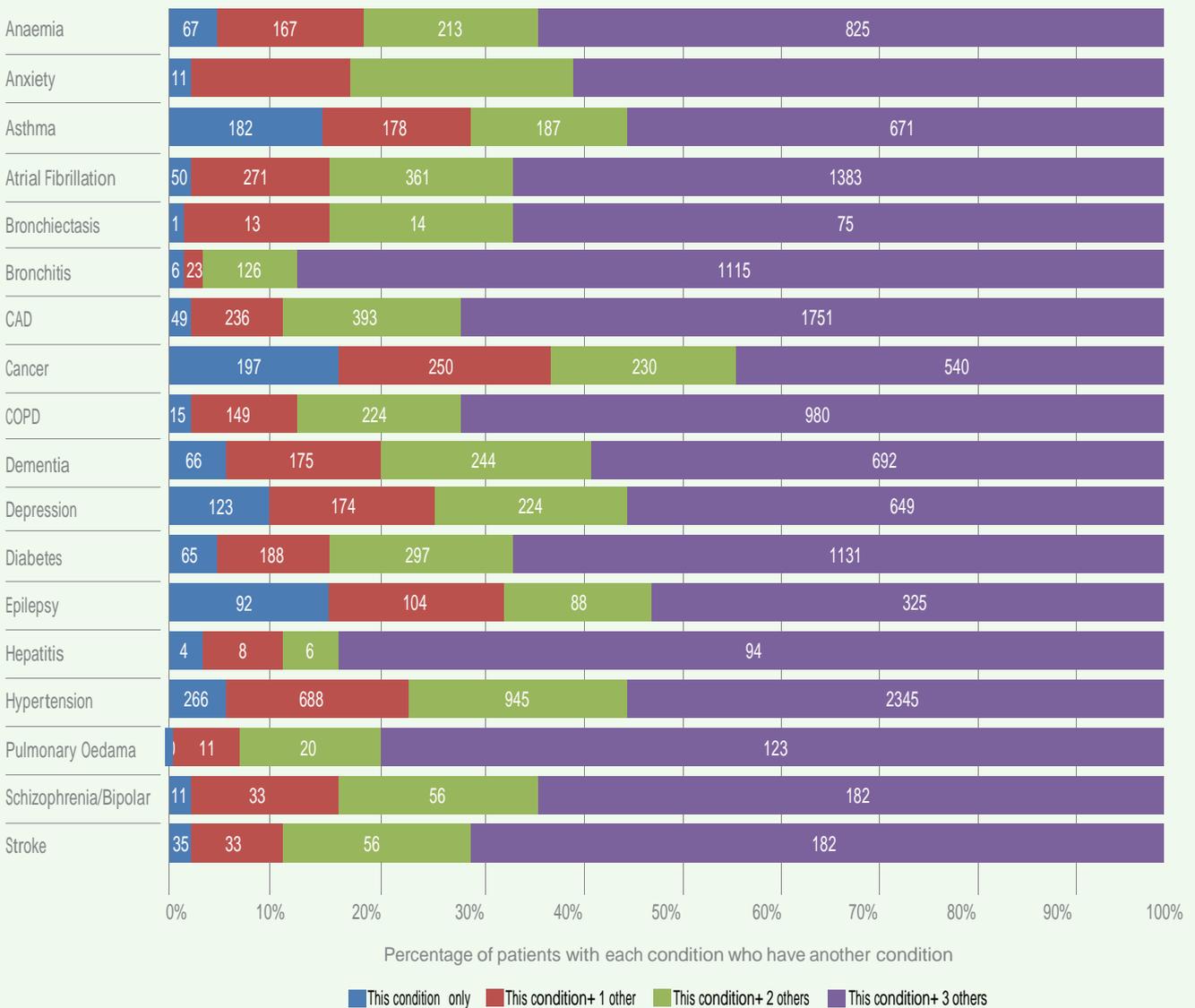


Figure 4



In this outcome the overriding delivery of Priorities 3 and 4 will be fulfilled by the work undertaken through the Integration Pioneer Programme and wider streams of work in this area.

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 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. The intention is that the Better Care Fund will help support the longer term delivery of the integration programme. As set out above, this will help us develop more community based services alongside the re-design and commissioning of new system-wide models of care that ensure the financial sustainability of health and social care services. Overall, the aim is for a proactive, rather than a reactive model that improves outcomes for people and means the reduction of hospital and care home admissions.

Priority 3 – Tackle the gaps in service provision and Priority 4 – Transform services to improve outcomes, patient experience and value for money

We know that our population is ageing and living longer; we will aim to focus on not just adding years to life, but also adding life to years. Management of long-term conditions requires a structured and consistent approach across the system, particularly around matching care to need.

We will work with our partners to implement a risk prediction approach which will make it possible to identify those people who are the most regular users of hospital services (and are at risk of re-admissions), stratify them according to complexity of need and commission services to meet those needs. This is an approach that works equally for people with single diseases or multiple co-morbidities.

We will address gaps in current service provision and also work towards transforming services by commissioning and providing these in new ways. To do this we will work with the whole range of health and social care providers (including hospitals, primary care [General Practitioners, Community Pharmacists] etc.) to develop 24/7 access to good quality services that are delivered in the right place, at the right time.

Partners across the system will work in a coordinated manner to support implementation of primary care support for those aged 75 and over and those with complex health and social care needs. We will work with our partners to create a health and care system that supports people to live as independently as possible at home and ensures they receive good quality end of life care as and when needed.

We want to ensure that people using services have as much choice and control as possible when building their support package and are able to access services at the right time and place. We will work with our statutory partners and with community and voluntary sector partners to create systems to empower our citizens to be in control so that they are able to make informed choices about when, how, and where to get their support. We want to ensure that services to our citizens are easily accessible, tailored to individual's needs, proactive and designed to support self-management, such as through the use of telecare.

Falls and fractures continue to be a significant public health issue particularly as an individual ages. It is estimated that one in three people aged 65+ will fall each year, and one in two people aged 80+ will fall each year. We will continue to work with our partners to address gaps in service commissioning and provision of falls prevention and management.

This will also mean addressing gaps in workforce and skills issues, including those of carers. For instance many people with learning disabilities also have difficulties with communication and may need Speech and Language Therapy to work with carers to teach them different methods of communication. Also for people with learning disabilities, 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 (including Independent Personal Budgets for those who fund their own care and support)
- An increase in the number of people using telecare and telehealth technology
- An increase in the proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/rehabilitation services
- A reduction in admissions to permanent residential care for older people
- An increase in the percentage of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family (Persons/Male/Female)
- An increase in the percentage of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support (Persons/Male/Female)
- A reduction in the gap in the employment rate between those with a learning disability and the overall employment rate
- An increase in the early diagnosis of diabetes
- A reduction in the number of hip fractures for people aged 65 and over (rate per 100,000)

Outcome 4

People with mental ill health issues are supported to “live well”

Mental Health covers many separate conditions that vary in duration and severity. Common mental health conditions can impact 1 in 5 of the population, and include depression and anxiety disorders. Severe mental disorders include psychosis and bipolar disorder and can impact on around 1 in 2000 people per year. However there are many separate conditions that fall between these categories such as eating disorders. Another traumatic consequence of mental distress can be suicide, however a large proportion of those committing suicide are not people with a chronic or severe mental illness.

Amongst the main causes of death for people with a mental health condition are cardiovascular disease, cancer and pulmonary disease. Those affected by these conditions die 20 years earlier than a person with no mental illness on average. This is an unnecessary and unfair inequality and we will address this as part of this strategy.

Mental illness can co-occur with learning/physical disability and substance misuse. Therefore, in addition to ensuring that people with a mental health condition receive high quality care, they must also have good quality physical health care. Also people with physical health problems can experience emotional consequences of their condition e.g. association between psychological aspects of obesity or depression after an operation. Therefore health and mental health are not separate issues and both need to be treated with equal esteem.

The issues of mental wellbeing, mental illness and mental distress are all interlinked and there is also a clear link between loneliness and poor mental and physical health. Due to this connectedness, all sectors have essential parts to play. This includes primary care which has a pivotal role in the early diagnosis and ongoing treatment of mental health conditions.

To ensure we take a joined up approach, Kent has developed detailed local plans and strategies. A key element of our local plans is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family.

The outcome chosen for this overarching strategy is “supporting those with a mental health issues to ‘live well’” and this involves helping people to keep themselves mentally and physically well, make the most of their communities and community resources, access the appropriate care and support and recover from their distress.

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

In Kent we need to deliver:

- An increase in the percentage of people using adult social care services having as much social contact as they would like according to the Adult Social Care Users Survey
- An increase in the percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey
- An increase in the percentage of respondents who, according to the survey, are satisfied with their life, who are not feeling anxious, and who feel their life is worthwhile

Priority 2 - Tackle the health inequalities related to people who have mental health conditions.

- We will have a detailed suicide reduction strategy to reduce the rate of suicide and provide better support for the families affected
- We will ensure that there is equity of access to mental health services for all people – starting with psychological therapies
- We will use both needs and assets in understanding how to deliver good wellbeing support to local people. This means understanding the best way to utilise local buildings, services, groups and people to enhance a community's wellbeing
- We will find better ways to engage people into their own care and support
- We will support the 'Time to Change' campaign to tackle stigma and discrimination that often prevents people seeking or giving help
- We will work to improve opportunities for people who have suffered mental health problems to train and return to employment
- We will promote programmes that improve 'resilience' and recovery – particularly in areas of greatest deprivation
- We will target people from vulnerable groups e.g. ex-military, ex-offenders and victims of violence to access the appropriate services and keep them well

Priority 3 - Tackle the gaps in provision and quality

- We will ensure that the data and information that we use for commissioning and providing care is of the highest quality possible
- We will improve the quality of care for people with long term and chronic mental health conditions by sharing care between social care, secondary care and primary care
- We will ensure that there are places of safety for people in distress
- We will improve the services and outcomes for young people transitioning from child to adult services
- We will improve the chances of recovery for people with mental health conditions in primary care by reviewing medication and signposting effectively

- We will continue the improvements made in assertive outreach and early intervention for psychosis
- We will work with our front line workforce to raise awareness of mental health through high quality training



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

- We will have a new and modern approach to supporting people with mental illness to stay well in the community, led by service user views
- We will engage with the public, those both known and not known to services to fully understand what people want future services and support to look like
- We will make the best use of public sector assets such as libraries and Gateways to enable people to have access to stigma free and healthy environments
- We will have a fully resourced public mental health programme, including campaigns and promotion that is on a par with other public health programmes, for example the 'six ways to wellbeing' campaign
- We will place recovery at the heart of all mental health services we commission
- We will empower clinical staff to use their expertise and knowledge to improve services

- We will improve the quality of services in primary mental health care
- We will work with employers to reduce the stigma of mental illness and improve workplace wellbeing
- Ensure that we have good emergency plans that minimise the impact of environmental events e.g. floods on people's emotional wellbeing
- 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

How we will keep track of our progress in delivering Outcome 4

We have attempted to pick outcomes where we can measure our success. We know that we will have to improve our quality of data and in some cases we will need to find new indicators of success. There are also national surveys which show Kent how we are progressing on our 'Wellbeing Index' and there is a National dataset of indicators and some of the following will help us track our progress.

- An increased crisis response of A&E liaison within 2 hours
- An increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours
- We will increase in access to IAPT (Increasing Access to Psychological Therapies) 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-re-presentation of opiate drug users leaving community substance misuse treatment
- An increased employment rate among people with mental illness/those in contact with secondary mental health services
- A reduction in the number of suicides (rate per 100,000)
- An increase in the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey
- An increase in the percentage of adult carers who have as much social contact as they would like according to the Personal Social Services Carers survey

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 and do all we can to ensure that people who need help and support receive it at the right time, in the right place and in the right way for them. 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 must develop more closely integrated services, more holistic forms of care and support and a greater awareness and understanding of the needs and aspirations of people with dementia and those close to them, such as their families, friends and carers. Early diagnosis is a core part of the approach being taken in Kent and one in which all sectors have their parts to play. Alongside the work of health professionals in this area, the voluntary sector and communities at large will play an important role in early diagnosis and providing ongoing support to people with dementia and their families.

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.

We need a change in attitudes and behaviours. This requires a society in which all people are treated with the dignity and respect they deserve, and can access easily the help and support they need.

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 rate to 67% by 2015. The two areas with the lowest levels of diagnosis are South Kent Coast CCG at 39% and Thanet CCG at 34.5%. We will be working with partners in the health and care system to improve our diagnostic rates.

Priority 2 Tackle Health Inequalities

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

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

Due to the high incidence among people with Down's 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 a dementia crisis service is available across the county
- Review existing Carers Services against the Call to Action for Carers and 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
- Improve training for those delivering care (professionals and families/Carers) and increase awareness amongst young people in schools and community settings to reduce stigma and prepare a workforce for the future
- Develop Kent to be more Dementia Friendly and drive service improvements through the voices of people living with dementia as key partners
- Develop Dementia Friendly Communities in every District across Kent and co-produce innovative projects based on local needs and aspirations
- Ensure all acute hospital 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 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 obtain 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 them in their own homes
- Ensuring Better Support for Carers – Kent County Council and all Kent CCGs have significantly increased funding for Carers Assessment and Support including new rapid access to support for carers introduced across all CCGs to improve their health and wellbeing. This 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 Hospital 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
- Supporting Intergenerational Projects to raise awareness of Dementia with young people. We will continue to build on the success of the award-winning Dementia Diaries which is now in every school in Kent. We will also develop a curriculum accredited learning resource pack for schools in Kent and beyond, with support from Dementia4School
- Improving awareness and access to good quality information about how to live well with Dementia via a 24 Hour Dementia Helpline and on the new Dementia Friendly Kent web platform co-owned by the Kent Dementia Action Alliance

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 Assessment Services (MAS) - 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 and nursing home placements, especially those made at a time of crisis and/or from an acute setting
- Increase in numbers of carers assessments and carers accessing shortbreaks
- Increase in attendance at Dementia Peer Support Groups by establishing clear pathway with post diagnostic support
- Increase in local number of Dementia Champions in order to recruit and train Dementia Friends

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. Prior to April 2013 the Health and Wellbeing Board operated in a shadow form.

The board brings together County and District Councillors, senior officers from the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from the Local Healthwatch. It provides an effective body where commissioners, patient representatives and elected officials can come together to take an overview of the health system in Kent, align their work, and share commissioning plans and good practice.

The HWB is responsible for producing a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS). JSNAs are assessments of current and future health and social care needs in a particular area alongside an identification of the assets the local community has to meet the identified need. The JHWS set out how the needs will be met, in the context of identified priorities, as well as enabling the HWB to encourage integrated working between health, public health and social care commissioners. Both documents are to inform local authority and NHS commissioning plans. Where plans are not in line, an explanation must be provided.

It is also responsible for the production of the Pharmaceutical Needs Assessment (PNA).

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