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Date: 5 November 2014
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THANET HEALTH AND WELLBEING BOARD

13 NOVEMBER 2014

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 13 November 2014** in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Membership:

Dr Tony Martin (Chairman); Councillors: Johnston (Vice-Chairman), Hazel Carpenter, Dominic Carter, Esme Chilton, Councillor Gibbens, E Green, Madeline Homer, Mark Lobban and Andrew Scott-Clark

A G E N D A

Item No | Subject

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATION OF INTERESTS**

   To receive any declarations of interest. Members are advised to consider the advice contained within the Declaration of Interest form attached at the back of this agenda. If a Member declares an interest, they should complete that form and hand it to the officer clerking the meeting and then take the prescribed course of action.

3. **MINUTES OF PREVIOUS MEETING** (Pages 1 - 4)

   To approve the minutes of the meeting held on 28 July 2014, copy attached

4. **ASPIRATIONS FOR THANET** (Pages 5 - 32)

5. **ASSURANCE FRAMEWORK** (Pages 33 - 50)

6. **KENT TEENAGE PREGNANCY STRATEGY 2015-2020** (Pages 51 - 66)

7. **NHS STATEMENT OF SUPPORT FOR TOBACCO CONTROL** (Pages 67 - 68)

8. **RECOMMENDATIONS OF KCC HEALTH & WELLBEING BOARD AT ITS MEETING ON 16 JULY 14**

8a **ENGAGEMENT WITH THE KENT FIRE AND RESCUE SERVICE, PARTICULARLY IN RELATION TO FALLS AND DEMENTIA**

Item No	Subject
8b	**ENSURE THAT THE KENT JOINT HEALTH AND WELLBEING STRATEGY IS REFLECTED IN ALL PUBLIC ENGAGEMENT ACTIVITIES**
8c	**DEMONSTRATE HOW THE PRIORITIES, APPROACHES AND OUTCOMES OF THE JOINT STRATEGY WILL BE IMPLEMENTED AT LOCAL LEVELS**
9.	**THE THANET PLAN** Power point presentations now published on the website, as part of the details for this meeting
10.	**AGENDA TOPICS FOR THE NEXT MEETING, TO BE HELD AT 10.00 AM ON THURSDAY, 12 FEBRUARY 2015**

Declaration of Interests Form

THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 28 July 2014 at 5.00 pm in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Councillors Ailsa Ogilvie (Thanet Clinical Commissioning Group), Esme Chilton (Thanet Children's Board), Councillor Gibbens (Kent County Council), E Green (Thanet District Council), Madeline Homer (Thanet District Council) and Andrew Scott-Clark (Kent County Council)

52. APOLOGIES FOR ABSENCE

Apologies for absence were received from Hazel Carptenter *(for whom Ailsa Ogilvie was substituting)*, Dominic Carter, Councillor Johnston, Mark Lobban and Sue McGonigal *(for whom Madeline Homer was substituting)*.

53. DECLARATIONS OF INTERESTS

There were no declarations of interests.

54. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 8 May 2014 were approved and signed by the Chairman.

55. PUBLIC HEALTH COMMISSIONING INTENTIONS

Andrew Scott-Clark presented his report, making particular reference to the work streams as set out in the diagram at paragraph 4.10 of the report. He stressed that getting commissioning right at a local level was of fundamental importance.

He added that conversations and meetings were taking place with NHS England to ensure that Public Health was ready to inherit the Health Visiting Commissioning Programme on 1 October 2015.

In response to a query from Esme Chilton regarding certain aspects of children's and young people's services, Andrew Scott-Clark stated that Karen Sharp, Head of Public Health Commissioning, would be responsible for ensuring that those bits of work were carried out.

It was noted that he and Hazel Carpenter would be meeting with Patrick Leeson, Corporate Director of Education, Learning Skills, KCC in order to fully understand the nature of work carried out by other service providers, particularly Kent Integrated Family Support (KIFSS) and Kent Integrated Adolescent Support Services (KIASS), and to enable greater alignment and integration of services to take place.

The report was NOTED and WELCOMED.

56. ASPIRATIONS FOR THANET

Andrew Scott-Clark reported that the only direct comment that he had received since the last meeting had been from Esme Chilton. In accordance with her request, safeguarding of children had been added as an aspiration.

In answer to a query from Councillor Gibbens, Andrew Scott-Clark stated that he believed that the aspiration to achieve a 5% reduction in smoking in pregnancy over the next five years was realistic and deliverable. He referred to the success of the "Baby Clear" initiative at the QEQM hospital, aligned with the cessation of smoking service.

It was RESOLVED:

1. THAT the aspirations, as set out at Annex 1 to the report, be APPROVED;

2. THAT the Board be provided with periodic dashboard reports setting out milestones in relation to each of the aspirations and progress achieved.

Andrew Scott-Clark stated that plans *(similar to that for Alcohol on the agenda for this meeting)* would be brought to the Board meeting in November 2014 and that detailed work would be carried out in relation to the aspirations for long term conditions.
NOTED.

57. ALCOHOL STRATEGY FOR THANET

Linda Smith, Public Health Specialist, presented the report and a series of slides *(now published on the website).*

She described what the 6-month project to deliver an Alcohol Integrated Care Pathway (ICP) would involve, particularly in relation to the roll out of IBA's (Identification and Brief Advice). Identification and Brief Advice (IBA) or 'screening and brief advice', has been shown to lead to 1 in 8 people reducing their drinking; IBA is one of the most effective health interventions available to reduce alcohol related harm.

She outlined the other key elements of the project:

a) Understand current gaps in preventing and managing alcohol harm and dependence services in Thanet and South Kent Coast CCGs;

b) Outline clearer integrated pathway across current services and propose solutions to any gaps;

c) Ensure the pathway and new services are evidence based and realistic.

She highlighted the 4 key streams of the Alcohol ICP – *set out in Slide No. 10* – (1) Prevention of harm; (2) Screening and early ID; (3) Support and Risk Management; (4) Specialist Treatment and explained how different levels of information on each of those elements would be accessible by the wider workforce via an online system and mass population screening via IBA scratchcards.

She also made reference to the ICP Stakeholder meeting which would take place in Sandwich on 7 August 2014. She encouraged all present at the meeting to attend and to circulate as appropriate.

Andrew Scott-Clark pointed out that another important element of the ICP was having designated alcohol nurses at the QEQM hospital and referred to the need to involve the Thanet Community Safety Partnership in the implementation of the ICP.

He also suggested that Public Health intelligence might be of assistance to Thanet Council in relation to licensing matters - welcomed by Madeline Homer.

It was RESOLVED:

THAT the Board supports the Alcohol ICP for Thanet, including the Stakeholder event on 7 August 2014 and the setting up of a Task and Finish Group (including Thanet Community safety Partnership), to create a local alcohol action plan for Thanet to act upon the six pledge elements and seven High Impact Steps of the Kent Alcohol Strategy (2014-16).

58. FUNDING FOR THE SPORTS AGENDA

On behalf of Councillor Johnston, Madeline Homer asked if there were any pots of money available for activities associated with the sports agenda.

Andrew Scott-Clark stated that he would be willing to have discussions on funding for targeting inactive or obese children, families and adults. However, money would not be available for promoting sports activities for children who were already active and healthy.

He outlined the elements of funding in the KCC's model of care, as follows:

Tier 1 – preventative

Comprising:

i. Health Walks: very popular, providing not only exercise, but also social benefits;
ii. Community Chef: helping communities to understand the science around food; how to shop for fresh food etc;
iii. Campaign around "Kent Moving"

Tier 2 – Support for obese children and adults

Encouraging people to change their lifestyle.

Tier 3 – Helping the morbidly obese

Trying to prevent the need for bariatric surgery.

Madeline Homer thanked Andrew Scott-Clark for this feedback.

In answer to a query from Dr Martin, Andrew explained that the objectives of geriatric gyms were the promotion of postural stability and the prevention of falls.

59. FEEDBACK ON "OUR CHILDREN, OUR FUTURE" WORKSHOP

As well as outlining the points covered in the report, Esme Chilton reported that:

1. Suitable persons had now been identified for appointment to the new Children's Board;
2. It was intended to hold Children's Board meetings four times a year and also to have sub task and finish groups; the inaugural meeting of the Children's Board was likely to take place either late September or early October.
3. It was proposed to align meetings of Children's Board with those of the Health & Wellbeing Board meeting, although it was still unclear whether to hold these in the lead-up to the parent meetings or as a follow-up.

The report and verbal update were NOTED.

60. UPDATE ON THE MENTAL HEALTH SUMMIT

Dr Andrew Walton referred to the successfulness of the summit, particularly in terms of bringing so many different stakeholders together. He said that he hoped that the CCG could find innovative ways to go forward.

During an ensuing discussion, it was noted that the integration of providers of mental health services, with each having an understanding of its "bit of the pathway", was of primary importance.

It was further noted that, following the transfer of services from the NHS, Public Health had invested separately in mental health, recognising it as one of its key priorities.

In answer to a query from Councillor Elizabeth Green, Andrew Scott-Clark agreed that the "Task Force" for Margate should be rolled out across the district, particularly to encompass Ramsgate (Central Harbour; Eastcliff and Newington), the Villages and Birchington.

The report was NOTED.

61. UPDATE ON THE OVER 75S SUMMIT

Ailsa Ogilvie presented the report on behalf of Dr John Neden, who had sent his apologies for absence, commenting on the enthusiastic participation of attendees.

She referred to out of hospital work, which was currently on-going.

The report was NOTED.

62. AGENDA ITEM FOR NEXT MEETING - THURSDAY, 4 SEPTEMBER 2014, AT 9.45 AM

Dr Tony Martin outlined the purpose of this meeting – to provide reassurances in relation to the various plans, intentions and work streams.

It was AGREED that an alternative venue should be considered for this meeting.

Meeting concluded : 6.20 pm

Aspirations for Thanet

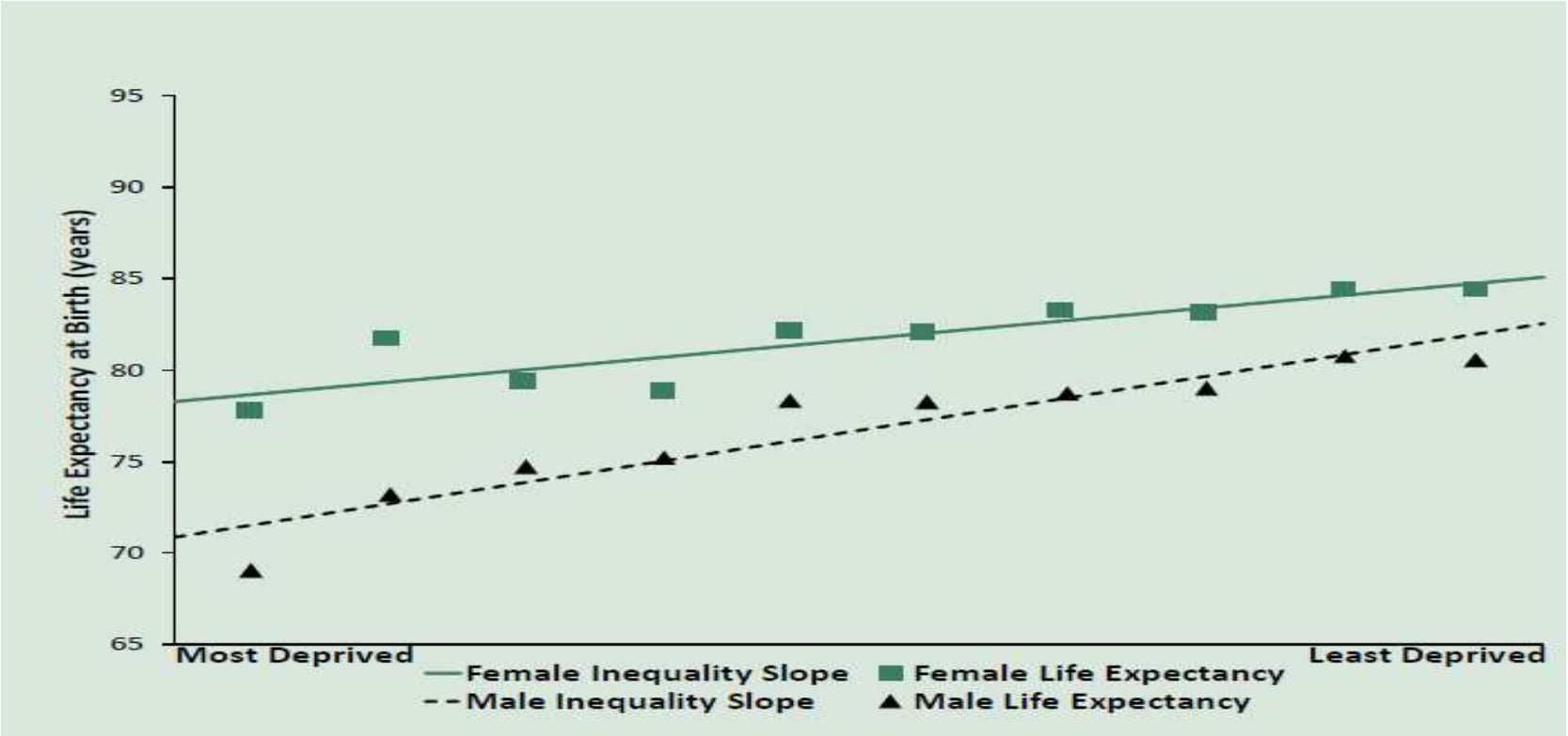
Thanet Health and Wellbeing Board

Andrew Scott-Clark
Acting Director of Public Health
23rd January 2013 and 08th May 2014
Progress November 2014

Outcome for Kent

- Every Child has the best start in life
- Effective prevention through people taking greater responsibility for their health and wellbeing
- Improved quality of life for people with Long Term Conditions (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

Life Expectancy



Based upon pooled 2006-2010: Thanet males have 11.7 years difference in life expectancy
Thanet females have a 6.8 years difference in life expectancy

Aspirations for Thanet: Children

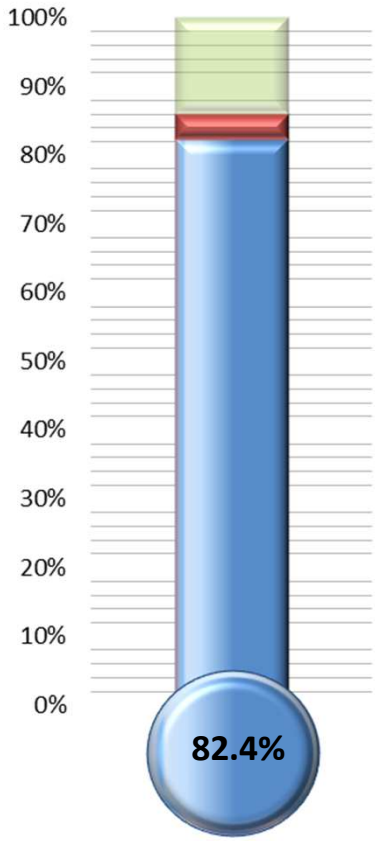
- Reduce smoking prevalence of smoking mothers
- Increase the prevalence of breast feeding
- Reduce alcohol specific stays in hospital of the under 18s
- Reduce teenage conception rates
- Deliver the universal child health programme to the whole Thanet children population.

Smoking in Pregnancy

- Between 2008 and 2012 the percentage of mothers that smoked during pregnancy reduced from 20.1% to 19.0% (England average reduced from 16.1 to 13.7%)
- Likely to be an underestimate.

- Thanet aspiration is to achieve a 5% reduction in next five years.

Women not smoking in pregnancy



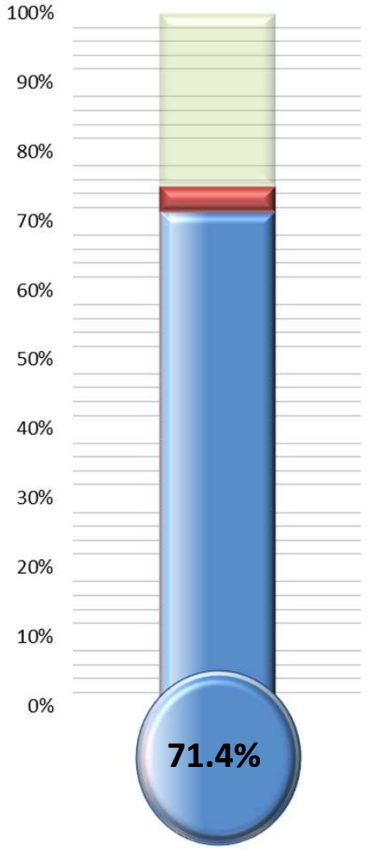
- 2012/13 figures show that 82.4% of women did not smoke at time of delivery.
- Thanet's 5% reduction over 5 years equates to 85% of women not smoking.
- Nationally, 87.3% are not smoking.

Breast Feeding Initiation

- Between 2008 and 2012 breast feeding initiation rates increased from 68.8 % to 70.8% in 2012 (England average increased from 69.2% to 74.5%)

- Thanet aspiration is to increase initiation rates to 75% in five years and maintain at least 50% breast feeding over six to eight weeks.

Women initiating breast feeding



- Thanet's target is to increase initiation rates to 75% by 2015/16.
- Thanet has already increased the rate to 71.4% at the most recent figures for 2012/13.
- Thanet is just below the rate for Kent as a whole (72.1%) and National (73.9%)

Reduce alcohol specific stays in hospital

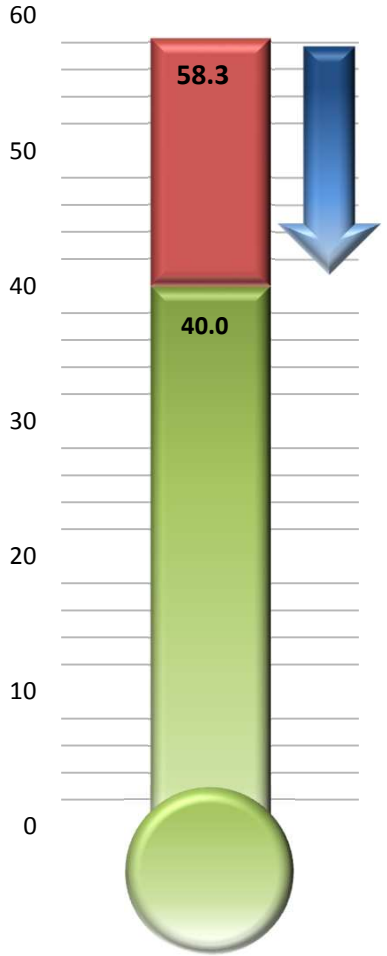
- Rate of alcohol specific stays (under 18) in Thanet was 100.3 (England average 61.8)

  persons under 18 admitted to hospital due to alcohol specific conditions
  crude rate per 100,000 population

- Not measured previously although alcohol profiles suggest a reduction already in Thanet to 58.3

- Thanet aspiration is to reduce rate to below 40.0 in five years.

Reduce alcohol specific stays in hospital



- The 2014 Health has Under 18 years olds admitted to hospital due to alcohol specific conditions has Thanet at 58.3 per 100,000.
- Thanet has an aspiration to reduce this rate to below 40.0 in five years (2017)
- The National rate is 44.9 per 100,000

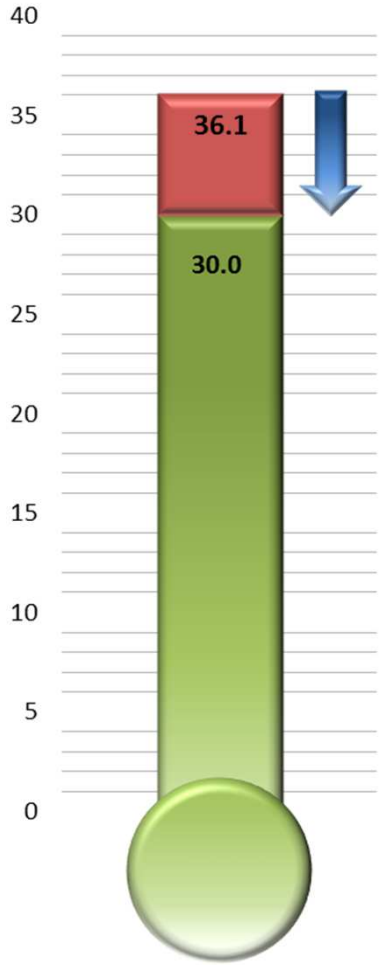
Reduce teenage conceptions

- Between 2008 and 2012 the teenage conception rate reduced from 55.4 to 53.8 (although in between these times the rate actually increased)

- The rate of conceptions continues to reduce in Thanet although rates in Thanet's two most deprived wards remain well above 100.

- Thanet's aspiration is to reduce this rate to below 30 in the next five years

Reduce teenage conceptions



- Thanet's target is to reduce the teenage conception rate to 30.0 per 100,000
- The most recently available figures (2012) place Thanet at 36.1 per 100,000
- Currently Thanet has a higher rate than both Kent (25.9) and National (27.7)

Deliver universal child health programmes

- KCC Public Health to commission all appropriate elements of the Child Health programme 0-18 for all children in Thanet
  - School Nursing
  - Healthy Schools
  - Health Visitors
  - Family Nurse Partnership

Aspirations for Thanet: Prevention

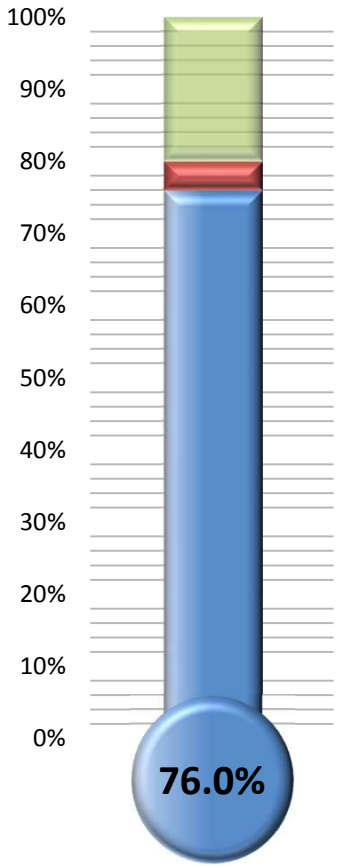
- Reduce the prevalence of smokers
- Ensure at least 50% of people invited for a health check take up the invitation.
- Reduce early deaths from cardiovascular disease
- Reduce the number of falls that lead to hip fractures

Reduce prevalence of adult smokers

- Between 2008 and 2012 the estimated prevalence of adults smokers reduced from 27.7% to 26.9% (England average reduced from 24.1% to 20.7%)

- Thanet aspiration is to reduce the figure to 20% over the next five years.

Adults not smoking



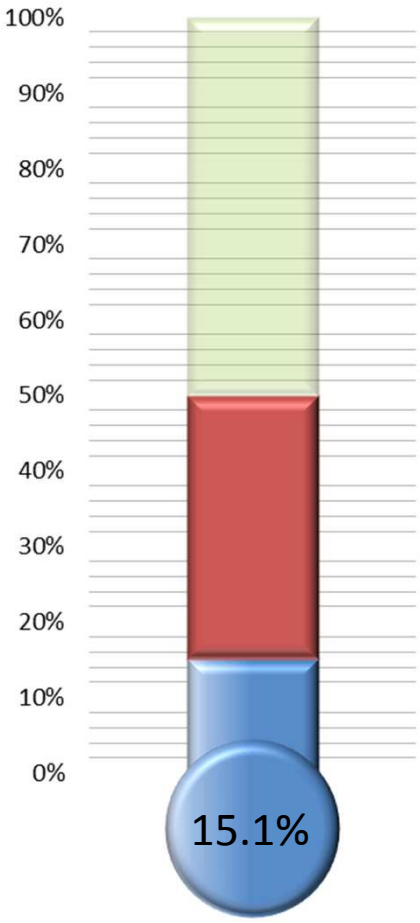
- Thanet's target is to reduce the proportion smoking to 20%
- The most recent figures show 24% smoking, this equates to 76% not smoking
- Nationally, 19.5% of adults are smoking

NHS Health Checks

- Current figures for Thanet are not yet available; however the following must be our aspiration

- All eligible population invited for a health check (100%)
- By end of current financial year 50% of eligible cohort have received a NHS Health Check

NHS Health Checks



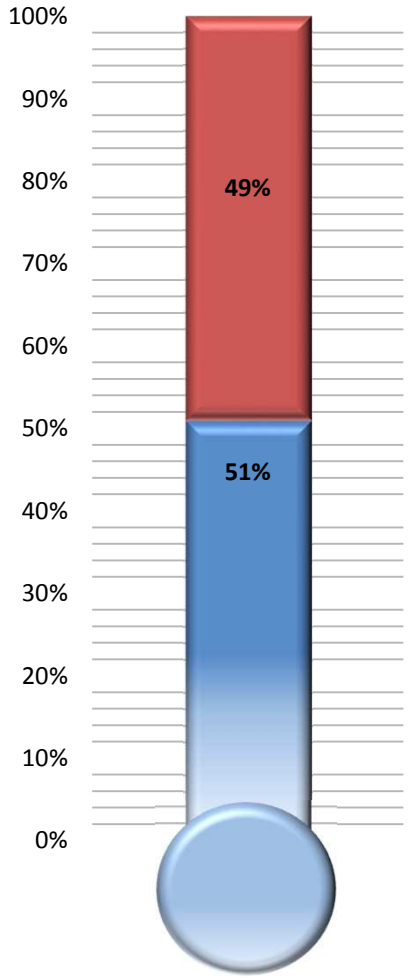
- From April to August 2014, 63.4% of NHS Health Checks invites had been sent the eligible Thanet residents.
- And 15.1% of the eligible population have received their NHS Health Check.
- The target is 50% to receive a NHS Health check

Kent County Council kent.gov.uk

Early deaths from heart disease and stroke

- Between 2008 and 2012 the rates of premature mortality reduced from 88.9 to 77.2 compared with England rate the reduced from 84.2 to 67.3
- Thanet changed from comparable to the England rate in 2008 to being statistically significantly worse than England average.
- Thanet aspiration to get to 50 in the next five years
- This equates to preventing **44** people in Thanet dying prematurely.

Early deaths from heart disease and stroke (option)

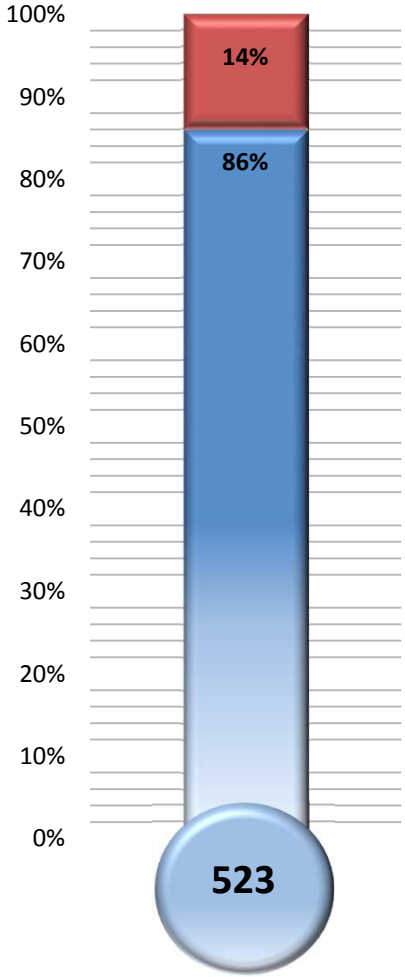


- Measures around early death have been amended with the introduction of the PHOF. The closest equivalent to early death from heart disease and stroke is the Under-75 mortality rate from Cardiovascular disease.
- Most recent data have Thanet at 97.3 per 100,000 population (2011-12) and would need a reduction of 49% to reach target.
- Thanet aspiration was to get to 50 in the next five years for early deaths from heart disease and stroke

Hip Fracture rates

- Between 2008 and 2012 the Thanet rate of Hip fractures in 65 yrs. and over increased from 503.2 to 523 whilst at the same time the England average reduced from 479.8 to 452.
- Whilst Thanet is not statistically worse than the English average, the trend suggests that it will become so.
- Thanet aspiration is to reverse the trend and achieve a rate below 450 in five years…which equates to more than 30 hip fractures prevented.

Hip Fracture rates



- Between 2008 and 2012 the Thanet rate of Hip fractures in 65 yrs. and over increased from 503.2 to 523 whilst at the same time the England average reduced from 479.8 to 452.
- Whilst Thanet is not statistically worse than the English average, the trend suggests that it will become so.
- Thanet aspiration is to reverse the trend and achieve a rate below 450 in five years…which equates to more than 30 hip fractures prevented.
- Figures from 2014 indicate that Thanet has actually increased to 548.2 per 100,000, widening the decrease needed to meet the aspiration.

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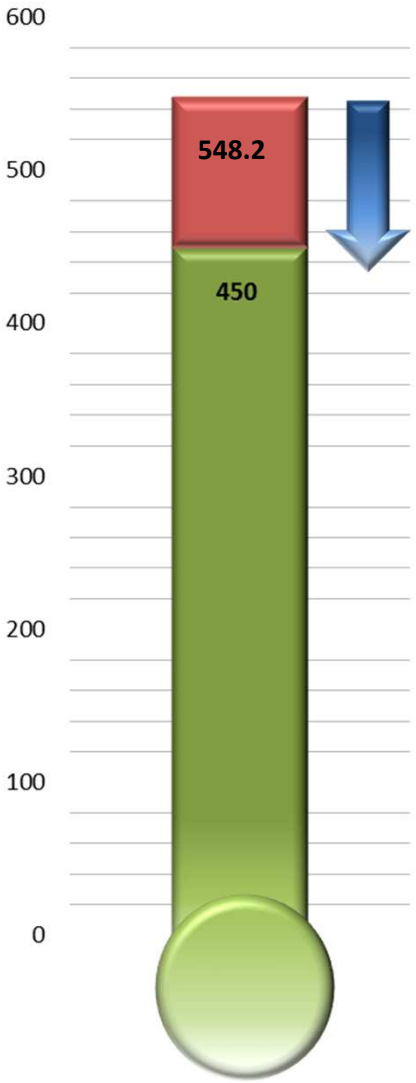
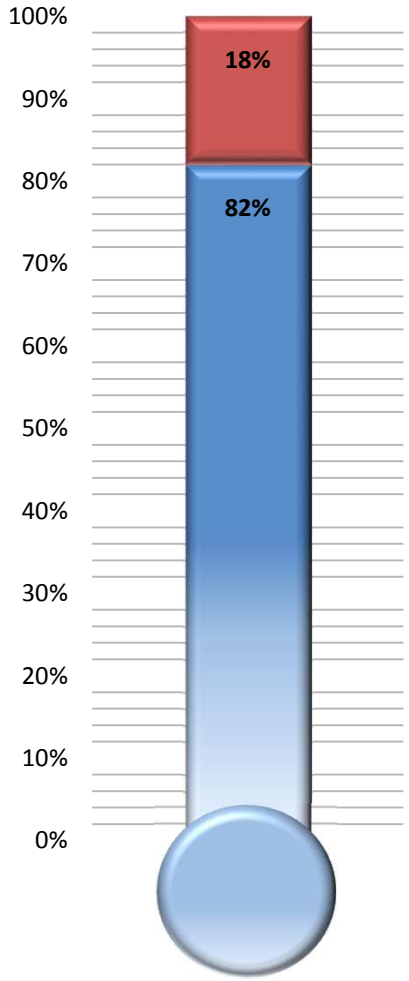
Hip Fracture rates



- The Thanet rate of Hip fractures in 65 years and over, is 548.2 per 100,000. Thanet's target is to achieve a rate below 450.
- This is an increase on the figure previously reported here, however the Public Health Outcomes Framework shows this as a decrease on previous years.
- The National rate is 568.1 per 100,000 which is higher than Kent.

Hip Fracture rates (Option 2)



- The Thanet rate of Hip fractures in 65 years and over, is 548.2 per 100,000. Thanet's target is to achieve a rate below 450.
- To achieve the 450 target, Thanet would need to reduce the 548.2 rate by 18%
- This is an increase on the figure previously reported here, however the Public Health Outcomes Framework shows this as a decrease on previous years.
- The National rate is 568.1 per 100,000 which is higher than Kent.

Aspirations for Thanet: LTC

- Oversee the delivery of a new model of integrated health and social care for the population of Thanet.
  - Integrated health and social care teams operating in every practice in Thanet
  - Risk profiling being done systematically
  - EKHUFT and KCHT fully participating
    - Reduction in inappropriate A&E attendances
    - Length of Stay by Thanet residents in hospital reduced
    - Hospital Consultants practicing in community settings

Aspirations for Thanet: Mental Health

- Mental Health Summit to consider?

- Zero tolerance on long waiting lists for both adult mental health and child and adolescent mental health services
- Services reviewed and commissioned to ensure demand is equalled by capacity.
- Low level and preventative mental health services mapped.

Aspirations for Thanet: Dementia

- Dementia diagnosis rates are increased to ensure the estimated prevalence of dementia is known to local service.
- Integrated service provision specifically includes dementia pathways and meets all national guidance.

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Report Subject: Thanet Health and Wellbeing Board – Assurance Framework

Date: 13th November 2014

Summary:

The Kent Health and Wellbeing Board (KHWB) has developed an assurance framework that includes a range of activity and outcome indicators from across the health and social care system in Kent. This report presents a specific Thanet overview of these indicators.

Recommendations:

The Thanet Health and Wellbeing Board is asked to:

- Note the contents of the report and seek assurance from relevant committees for actions plan to address areas that require further attention.
- Approve ownership of the framework for regular monitoring of the agreed indicators

1. Introduction

This report aims to provide the Thanet Health and Wellbeing Board with an overview of a range of activity and outcomes indicators based on Kent's Health and Wellbeing Strategy and a series of other stress indicators.

As agreed at the KHWB, the indicators have been drawn from a number of existing frameworks and responsible agencies across Kent and England:

- Kent Public Health and the Public Health Outcomes Framework (PHOF)
- NHS Outcome Framework
- KCC Social Care
- Adult Social Care Outcome Framework
- NHS England South Escalation Framework

2. Background to the report

The Kent Health and Wellbeing Board Assurance Framework was developed to provide the Board with an overview of activity and outcomes across the Kent Health and Social Care System.

Many of the indicators in the framework have been included in the revised draft Health and Wellbeing Strategy and will be used to assess progress and impact of the strategy. Others have been derived from the NHS England South Escalation Framework to provide assurance or highlight potentially unsustainable pressures in the component sectors.

The framework aims to provide updates on a regular basis to highlight whether indicators are progressing in the right direction. At the February KHWB meeting, members recommended that the assurance framework should be replicated for local Health and Wellbeing Boards.

The KHWB meeting held in November 2013 decided that the assurance framework should:

- Contain national metrics stated in the Better Care fund; in most cases these metrics were already present in the framework. Metrics on avoidable emergency admissions and patient/service user experience are to be defined and developed in future reporting.

- Add indicators to reflect the evolution of local and national data sets. These are highlighted within the report.

- Following discussions with the Area Team (NHS England) reflect stress indicators across the different components of the system – Public Health, Acute/Urgent, GP and Social Care. Work is on-going to ensure the most appropriate indicators have been identified.

Key to KPI Ratings used

GREEN	Better than Kent Status
AMBER	Similar to Kent Status
RED	Worse than Kent Status
⇧	Performance has increased relative to previous levels (not related to target)
⇩	Performance has decreased relative to previous levels (not related to target)
⇔	Performance has remained the same relative to previous levels (not related to target)

Data quality note: All data is categorised as management information. All results may be subject to later change.

Report Prepared by

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3. Strategy Indicators

The following tables provide an overview of the indicators outcome group in the Kent Health and Wellbeing Strategy. The direction of travel refers to the movement from the last time period. The RAG rating relates to the comparison with the overall Kent value.

A breakdown of the indicator values for each local health and wellbeing board area in Kent is included at Appendix A.

Outcome 1: Every child has the best start in life

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
1.1 Reducing the number of pregnant women with a smoking status at time of delivery (PHOF)	12.8%	17.0%	16.7%	⇩	Q3 2013/14
1.2 Increasing breastfeeding initiation rates (NHS England)	71.3%	-	67.4%	-	2013/14
1.3 Increasing breastfeeding continuance at 6-8 weeks	35.2%	-	21.3%	-	2013/14
1.4 Reducing conception rates for young women aged under 18 years old (rate per 1,000)	25.9	-	36.1	⇧	2012
1.5 Improving MMR vaccination update of two doses 5 years old, (NHS England)	89.3%	-	87.5%	-	2013/14
1.6 Increasing school readiness: all children achieving a good level of development at end of Year R (% of all eligible children)	63.4%	Not currently available		-	2012/13
1.7 Reducing the proportion of 4-5 year olds with excess weight	21.7%	-	21.6%	⇩	2012/13
1.8 Reducing the proportion of 10-11 year olds with excess weight	32.7%	-	33.0%	⇧	2012/13
1.9 Increasing the proportion of SEND assessments within 26 weeks **(Stress)**	92.4%	93.9%	92.2%	⇩	August 2014
1.10 Reducing the number of Kent children with SEND placed in independent of out of county schools **(Stress)**	599	66	63	⇧	August 2014

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
1.11 Reducing CAMHS average waiting times from routine assessment from referral **(Stress)**	9 weeks	-	6 weeks	⇩	August 2014
1.12 Reducing the number waiting for routine CAMHS treatment **(Stress)**	196				August 2014
1.13 Having an appropriate CAMHS caseload for patients, open at any point during the month **(Stress)**	7,320	1250		-	August 2014
1.14 Reducing unplanned hospitalisation rates for asthma (primary diagnosis) in people aged under 19 years old (rate per 10,000, KMPHO)	14.6	-	14.8	⇧	2013/14
1.15 Reducing unplanned hospitalisation rates for diabetes (primary diagnosis) in people aged under 19 years old (rate per 10,000, KMPHO)	7.3	-	11.9	⇧	2013/14
1.16 Reducing unplanned hospitalisation rates for epilepsy (primary diagnosis) in people aged under 19 years old (rate per 10,000, KMPHO)	8.8	-	15.7	⇩	2013/14

Exception items:

- Thanet has the second highest proportion of women with a smoking status at time of delivery. At 17% in 2013/14; Swale was the highest at 20.6%
- For unplanned hospitalisation rate of people aged under 19 for asthma there has been a year on year decrease since 2009/10, with Thanet having one of the highest rates amongst CCGs to being in the middle.
- Thanet has consistently had the highest rate for unplanned hospitalisation on diabetes since 2008/09; the highest was at 13.5 in 2012/13 which decreased to 11.9 in 2013/14.
- Thanet also had the highest rate for unplanned hospitalisation for epilepsy across the CCGs and Kent at 15.7 in 2013/14 compared to Kent at 8.8.

- Thanet experienced a decrease in the under 18 conception rate for 2011 at 45.6 per 1,000 to 36.01 per 1,000 in 2012 from 45.6 in 2011; however, this is still above the Kent average.

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

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
2.1 Increasing life expectancy at birth (PHOF) Years					
Male	79.9	-	77.6	⇧	2010/12
Female	83.4	-	82.5	⇧	2010/12
2.2 Increasing healthy life expectancy	63.5	Not currently available			2010/12
2.3 Reducing the slope index for health inequalities		Not currently available			2010/12
Male	7.1				2010/12
Female	4.8				2010/12
2.4 Reducing the proportion of adults with excess weight (PHOF)	64.6%	-	68.4%	-	Q1 2014/15
2.5 Increasing the proportion of people quitting having set up a quit date with smoking cessation services	51%		49.8%		Q1 2014/15
2.6 Increasing the proportion of people receiving a NHS Check of the eligible population	11.3%	-	%	-	2013/14
2.7 Reducing alcohol related admissions to hospital	Placeholder to be defined				
2.8 Increasing the proportion of eligible women screened adequately in the breast cancer screening programme	78.2%	-	76.3%	⇧	2013
2.9 Increasing the proportion of eligible women screened adequately in the cervical cancer screening programme	77.2%	-	75.2%	⇧	2013
2.10 Reducing the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000, KMPHO)	295.5	-	333.9	⇧	2010/12
2.11 Reducing the under-75 mortality rate from cancer (rate per 100,000, KMPHO)	135.5	148.27	140.43	⇧	2012

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
2.12 Reducing the under-75 mortality rate from respiratory disease (ASR per 100,000, KMPHO)	30.7	35.00	31.94	⇧	2012
2.13 Reducing the under-75 mortality rate from cardiovascular disease (rate per 100,000)	77.6	-	97.3%	-	2012

Exception items:

- Adults with excess weight is a new indicator and only one year is currently available, no direction of travel can be presented; district-level data is available and shows Thanet to have higher proportions than Kent.

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

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
3.1 Increasing clients with community based services who receive a personal budget and/or direct budget (**)	67%	Not currently available			February 2014
3.2 Increasing the number of people using telecare and telehealth technology	2,992				February 2014
3.3 Increasing the proportion of older people (65+) 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 **(Stress) BCF**	84.1%				
3.4 Reducing admission to permanent residential care for older people **(Stress) BCF**	120				

3.5 Increasing 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)**	70.1%	Not currently available			2012/13
Male	68.7%				2012/13
Female	72.0%				2012/13
3.6 Increasing the percentage of adults who are receiving secondary mental health services on the care programme approach recorded as living independently, with or without support **(Persons, Male, Female)**	81.5%%				2012/13
Male	79.8%				2012/13
Female	83.5%				2012/13
3.7 Reducing the gap in employment rate between those with a learning disability and the overall employment rate	66.5%				2011/12
3.8 Increasing the early diagnosis of diabetes	6.0%	-	6.94%	-	2012/13
3.9 Reducing the number of hip fractures for people aged 65 and over (rate per 100,000)	544.0	-	540.9	⇩	2012/13

Exception items:

- There has been a further drop in the proportion of people receiving a personal budget and/or direct budget, this is due to more people receiving a short term service such as enablement or telecare and would not therefore be eligible for a personal budget or direct payment.

- There have been further increases in the number of people using telecare and telehealth technology and to February there were 2,992 clients, this far exceeds the target of 2,125.

- Local health and wellbeing board area figures on both metrics will be available for the next report.

Outcome 4: People with mental health issues are supported to "live well"

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
4.1 Increasing the crisis response of A&E liaison within 2 hours (KMCS)	85.0%	-	80.9%	⇔	Q1 2014/15
4.2 Increasing the crisis response of A&E liaison, all urgent referrals to be seen within 24 hours (KMCS)	100%	-	100%	⇔	Q3 2013/14
4.3 Increasing access to IAPT (Increasing Access to Psychological Therapies) services	Not currently available				
4.4 Increasing the number of adults receiving treatment for alcohol misuse (KDAAT)	Currently under review				
4.5 Increasing the number of adults receiving treatment for drug misuse (KDAAT)					
4.6 Reducing the number of people entering prison with substance dependence issues who are previously not known to community treatment (PHOF)	Not currently available				
4.7 Increasing the successful completion and non-representation of opiate drug users leaving community substance misuse treatment services (PHOF)	10.9%	Not currently available		-	2012
4.8 Increasing the employment rate amongst people with mental illness/those in contact with secondary mental health services (ASCOF)	6.2%	Not currently available		-	2012/13
4.9 Reducing the number of suicides (rate per 100,000 KMPHO)	5.3	-	5.86	⇧	2011/13
4.10 Increasing 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	44.0%	Not currently available		-	2012/13
4.11 Increasing the percentage of adult social carers who have as much social contact as they would like according to the Personal Social Service Carers Survey	33.9%	Not currently available		-	2012/13

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
4.12 Increasing the percentage of respondents who according to the survey are:					
Satisfied with their life	5.6%	Not currently available		-	2012/13
Who are not feeling anxious	21.7%	Not currently available		-	2012/13
Who feel their life is worthwhile	4.0%	Not currently available		-	2012/13

Exception items:

- Although the Thanet rate for suicide is above Kent, it has decreased from 6.73 per 100,000 in 2010/12 to 5.86 in 2011/13 and is not the highest rate across Kent.

- Further work is needed on the substance misuse metrics (4.5, 4.6, 4.7 and 4.8) with the aim to provide figures for the next report.

Outcome 5: People with dementia are assessed and treated earlier

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
5.1 Increasing the reported number of dementia patients on GP registers as a percentage of estimated prevalence (KMCS)	41.5%	-	34.6%	⇧	2012/13
5.2 Reducing rates of hospital admissions for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000, KMCS)	25.1	-	26.1	⇧	2013/14

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
5.3 Reducing rates of hospital admissions for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000, KMCS)	50.5	-	50.2	⇩	2013/14
5.4 Reducing total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	225.7	-	193.0	⇧	2013/14
5.5 Reducing total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	452.5	-	383.1	⇧	2013/14

5.6 Increase the proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been:

Indicator Description		Previous Status	Recent Status	DoT	Time Period
Dartford and Gravesham NHS Trust	(a) identified as potentially having dementia	93%	92%	⇩	Q4 2013/14
	(b) who are appropriately assessed	100%	100%	⇔	
	(c) and, where appropriate, referred on to specialist services in England	97%	100%	⇧	
East Kent Hospitals University NHS Foundation Trust	(a) identified as potentially having dementia	99%	100%	⇧	Q4 2013/14
	(b) who are appropriately assessed	95%	94%	⇩	
	(c) and, where appropriate, referred on to specialist services in England	100%	100%	⇔	
Maidstone and	(a) identified as potentially having dementia	99%	99%	⇔	Q4

Tunbridge Wells NHS Trust	(b) who are appropriately assessed	99%	99%	⇔	2013/14
	(c) and, where appropriate, referred on to specialist services in England	100%	100%	⇔	
Medway NHS Foundation Trust	(a) identified as potentially having dementia	69%	78%	⇧	
	(b) who are appropriately assessed	97%	88%	⇩	
	(c) and, where appropriate, referred on to specialist services in England	85%	91%	⇧	

Indicator Description	**Kent Status**	**Thanet Status**	**DoT**	**Time Period**
5.7 Decreasing the percentage of people waiting longer than 4 weeks to assessment with Memory Assessment Services	21.03%	Not currently available	⇧	Q4 2013/14
5.8 Increasing the proportion of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	Currently being reviewed with Adult Social Care and KMCS			
5.9 Reducing care and nursing home placement, especially those made at a time of crisis and/or from an acute setting				
5.10 Increasing numbers of carers assessments and carers assessing short term breaks				
5.11 Increasing attendance at Dementia Peer Support Groups				
5.12 Increasing number of Dementia Champions				

Exception items:

- There has been an increase in the number of dementia patients on GP registers for all areas and Kent as a whole; however Thanet for 2012/13 has the lowest percentage across Kent.

Stress Indicators

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
1.9 Increasing the proportion of SEND assessments within 26 weeks (Stress)	92.4%	93.9%	92.2%	⇩	August 2014
1.10 Reducing the number of Kent children with SEND placed in independent of out of county schools (Stress)	599	66	63	⇧	August 2014
1.11 Children's Reducing CAMHS average waiting times from routine treatment from referral – CAMHS (KMCS)	9 weeks	-	6 weeks	⇩	August 2014
1.12 Children's Reducing the number waiting for routine CAMHS treatment	196	-	38	-	August 2014
1.13 Children's Having an appropriate CAMHS caseload for patients, open at any point during the month	7,320	-	1152	-	August 2013
6.5 Public Health Increasing the population Flu vaccination coverage for those aged 65+. (PHOF) Target: 75%	71.4%	not currently available		-	2012/13
6.6 Public Health Increasing the population Flu vaccination coverage for those at risk individuals, PHOF Target: 75%	48.7%	not currently available		-	2012/13
6.7 Acute/Urgent and Primary Care Bed Occupancy Rates - Overnight					
Dartford and Gravesham NHS Trust	96.7%			-	Q4 2013/14
East Kent Hospitals University NHS Foundation Trust	92.3%			-	Q4 2013/14
Maidstone and Tunbridge Wells NHS Trust	93.6%			-	Q4 2013/14

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
Medway NHS Foundation Trust	94.3%			-	Q4 2013/14
6.7 Acute/Urgent and Primary Care Bed Occupancy Rates - Overnight					
Kent and Medway NHS and Social Care Partnership	-	-		-	-
6.8 Acute/Urgent A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge					
Dartford and Gravesham NHS Trust (all)	97.9%			-	Week ending 25/05/2014
East Kent Hospitals University NHS Foundation Trust (all)	93.5%			-	Week ending 25/05/2014
Maidstone and Tunbridge Wells NHS Trust (all)	96.9%			-	Week ending 25/05/2014
Medway NHS Foundation Trust (all)	83.2%			-	Week ending 25/05/2014
Kent and Medway NHS and Social Care Partnership (all)	-			-	-
6.9 Acute/Urgent Number of emergency admissions	To be discussed further and developed with NHS England				
6.10 Primary Care GP Attendances	Awaiting information from NHS England and indicator development				

Indicator Description	Kent Status	Thanet Status		DoT	Time Period
		Previous	Recent		
6.10 Primary Care Out of Hours activity	Awaiting information from KMCS and indicator development				
6.11 Primary Care 111 NHS Service	Work ongoing with KMCS to shape and define				
3.3 Social/Community Care Increasing the proportion of older people (65+) 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	Under review by Adult Social Care				
6.12 Social/Community Care Decreasing the number of delayed days (acute and non-acute) **BCF**	2170	Not currently available		-	April 2014
6.13 Social/Community Infection control rates	Work ongoing with NHS England to shape and define				
3.4 Social/Community Care Reducing admissions to permanent residential care for older people **BCF**	100	Not currently available		-	April 2014

Exception items:

- There has been a gradual increase in the percentage of SEN assessments for Thanet across 2012/13 however this has remained above 90%.
- Currently metrics on Flu vaccinations are not available at CCG level, however alternatives are being investigated.
- Overnight bed occupancy rates for Q4 2013/14 vary between 92.3% at EKHUFT to 96.7% at Dartford and Gravesham NHS Trust (D&G NHS Trust).
- A&E attendances within 4 hours from arrival also varies from 83.2% in Medway NHS Foundation Trust to 97.9% in D&G NHS Trust. These figures relate to the week ending 25/05/2014.
- Work is ongoing to either define or find suitable current metrics for those listed above; monthly data meetings are held that include KMCS and NHS colleagues where discussions are ongoing.

- There was a reduction in the number of admissions to permanent residential care for older people in April 2014 of 100 people from 127 people in March and is now below the 130 target (maximum number). This metric will be presented at local health and wellbeing board level in the next report following work by Adult Social Care.

Appendix A: Local area indicators

Outcome 1: Every child has the best start in life									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
1.1 Reducing the number of pregnant women with a smoking status at the time of delivery	Q3 2013/14	13.1%	9.0%	13.7%	15.0%	17.5%	9.1%	16.7%	9.7%
1.11 Reducing CAMHS average waiting times from routine assessment from referral **(Stress)**	April 2014	9 weeks	10 weeks	8 weeks	7 weeks	10 weeks	11 weeks	6 weeks	10 weeks
1.12 Reducing the number waiting for routine CAMHS treatment **(Stress)**	August 2014	196	11	0	58	28	41	38	20
1.13 Having an appropriate CAMHS caseload for patients, open at any point during the month	April 2014	7,320	700	960	1,205	1,268	479	1152	1,556
1.14 Reducing unplanned hospitalisation rates for asthma (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	14.6	16.6	11.5	16.5	18.0	16.3	14.8	12.3
1.15 Reducing unplanned hospitalisation rates for diabetes (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	7.3	4.7	7.9	6.2	9.6	10.2	11.9	5.5
1.16 Reducing unplanned hospitalisation rates for epilepsy (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	8.8	8.1	8.2	9.9	6.4	13.6	15.7	6.5

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
2.5 Increasing the proportion of people quitting having set a quit date with smoking cessation services	Q1 2014/15	51%	49.2%	60.9%	48.8%	48.4%	59.6%	49.8%	53%
2.10 Reducing the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000)	2010-12	295.5	245.3	270.4	287.7	301.7	334.8	333.9	299.2
2.11 Reduction in the under 75 mortality rate from cancer (rate per 100,000)	2012	135.5	111.4	121.0	128.5	147.9	133.8	140.0	145.2
2.12 Reduction in the under 75 mortality rate from respiratory disease (rate per 100,000)	2012	30.7	28.1	26.8	30.1	34.8	23.6	40.2	30.0

Outcome 4: People with mental health issues are supported to 'live well'									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
4.1 Increasing the crisis response of A&E liaison within 2 hours – Urgent	Q1 2014/15	85%	**85.5%**	**78.4%**	**96.9%**	**85.2%**	**87.5%**	**88.2%**	**80.5%**

Outcome 5: People with dementia are assessed and treated earlier									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
5.1 Increasing the reported number of dementia patients on GP registers as a percentage of estimated prevalence	2012/13	**41.5**	**43.0**	**43.2**	**44.2**	**38.7**	**44.8**	**34.6**	**42.6**
5.2 Reducing rates of hospital admissions for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	2013/14	**25.1**	**20.5**	**28.8**	**27.0**	**25.1**	**21.3**	**26.1**	**24.1**
5.3 Reducing rates of hospital admissions for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	2013/14	**50.5**	**43.3**	**56.6**	**53.3**	**50.3**	**48.7**	**50.2**	**48.5**
5.4 Reducing total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	2013/14	**225.7**	**187.6**	**168.1**	**342.8**	**183.0**	**257.4**	**193.0**	**231.4**
5.5 Reducing total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	2013/14	**452.5**	**382.4**	**327.1**	**673.0**	**363.9**	**573.1**	**383.1**	**467.7**

Trust Level Data					
	Time Period	**D&G NHS Trust**	**EKHUFT**	**MTW**	**Medway**
5.6 The proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been:					
(a) identified as potentially having dementia	Q4 2013/14	**92%**	**100%**	**99%**	**78%**
(b) who are appropriately assessed		**100%**	**94%**	**99%**	**88%**
(c) and, where appropriate, referred on to specialist services in England		**100%**	**100%**	**100%**	**91%**

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Kent Teenage Pregnancy

Strategy 2015 -2020

Kent County Council
kent.gov.uk

Foreword

The reduction of teenage pregnancies is one of the success stories of the last decade in the public health field that I warmly welcome. The under 18 conception rate has fallen by a third. Nonetheless, more work is needed to bring it down to those seen in other western European countries. National government has called on local authorities to continue working with partners to 'keep the momentum going'. Kent County Council will continue to lead the effort to reduce rates further across Kent. In this context, Kent County Council has published the Kent teenage pregnancy strategy and we are looking forward continuing our collaboration with all our partners, building on our successes and becoming even more effective in tackling teenage pregnancy.

Foreword by Councillor R Gough
(Cabinet Member for Education & Health Reform)

Councillor G Gibbens
(Cabinet Member for Adult Social Care & Public Health)

Introduction - what we want to achieve

- We want young people to thrive, to be resilient and lead fulfilled lives, able to become responsible and contribute positively to their communities and those around them now and in the future.

- We want to ensure that young people have access to the information, services and early help that they need to be able to take control of their lives, make positive choices for themselves in relation to the sexual relationships that they have and when they start a family.

- When young people make a positive choice to conceive and have a child, we want to make sure that they have access to the services that they need to ensure the best possible outcome for them and their children.

We recognise that teachers, parents, health and social care professionals and young people themselves will all need to be engaged and work together if we are going to achieve our aims.

Local context

Facing the Challenge is a Kent County Council strategic document, which provides a framework for transforming the way in which services are delivered in Kent and a change in the interface between residents and the County Council. For children and young people's services, this includes the development of a Preventative Services Directorate within Kent County Council, which will progress the integrated commissioning and delivery through Early Help and Preventative Services. [1|2]

Kent Joint Health and Wellbeing Strategy is the guiding document for all health and care services across Kent. It identifies three approaches to ensure that services meet the needs of local people; namely integrated commissioning and provision to deliver person centred services. One of the strategy outcomes is that 'Every Child Has the Best Start in Life' that will be achieved by working on four priority areas; tackling issues where Kent is worse than England average, health inequalities, gaps in provision and transforming services to improve patient experience, outcomes and value for money.

National context

The key national strategic drivers (see Annex 1) are identified by the Children and Young People's Health Outcomes Forum report.[3] This report introduces an integrated outcomes framework for children and young people. It recognises the need to take a more asset based approach to children and young people's health and wellbeing and ensure that children and young people health and wellbeing is embedded within health and wellbeing structures.

[1] Early Help and Preventative Services Prospectus Kent Integrated Family Support Service and Kent Integrated Adolescent Support Service (May 2014) **www.kent.gov.uk/data/assets/pdf_file/0006/13965/Early-help-preventative-services.pdf**

[2] One year plan, Early Help and Preventative Services Kent Integrated Family Support Service and Kent Integrated Adolescent Support Service (July 2014)

[3] Children & Young People's Public Health Outcomes Forum: Report of the Public Health & Prevention Subgroup HYPERLINK **www.gov.uk/government/uploads/system/uploads/attachment_data/file/216854/CYP-Public-Health.pdf**

A Framework for Sexual Health Improvement for England[4] prioritises the need to continue efforts to reduce the rates of under 18 and under 16 conceptions. It identifies that young people should receive appropriate information and education to make the right choices in their sex lives.

Positive for Youth - a new approach to cross-government policy for young people aged 13 to 19[5] introduces a new partnership approach to driving up participation in education and training and improve attainment of children and young people. It recognises the need to listen to the voice of the young people.

No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages[6] prioritises preventing mental ill health and poor mental wellbeing across all ages.

You're Welcome Standards[7] sets out 10 criteria for the delivery of effective children and young people friendly services. It includes the need to provide comprehensive sexual health services, ensuring confidentiality and consent, making services accessible and ensuring children and young people participate in their design, delivery and review.

Chief Medical Officer's report 2012[8] focuses on the health and wellbeing of children and young people. Its recommendations include the need to focus on early help, to undertake research which links personal, health, social education (PSHE) to attainment, to take resilience based approach and to better understand how to build resilience in young people and to address gaps in attainment in education for young people as a means to reduce child poverty.

[4] A Framework for Sexual Health Improvement in England. DH & Cross Government, 2013
www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

[5] Positive for Youth: A new approach to cross-government policy for young people aged 13 to 19. Cabinet Office and Dept. for Education, 2010
www.gov.uk/government/uploads/system/uploads/attachment_data/file/175496/DFE-00133-2011.pdf

[6] No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. HMG/DH, 2011
www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

[7] You're Welcome: Quality Criteria for Young People Friendly Health Services. DH 2011
www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf

[8] Our Children Deserve Better: Prevention Pays. Chief Medical Officer's annual report, 2012
HYPERLINK "file:///C:\Users\LZ\Desktop\Alexis\Kent\Kent\TP\www.gov.uk\government\publications\chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays" **www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays**

Teenage pregnancy nationally

The Social Exclusion Report on Teenage Pregnancy (1999) highlighted the health and social impact of teenage conception. This report, given the high rates of teenage conception in comparison to European neighbours, was the catalyst for the National Teenage Pregnancy Strategy 2001-2011.

The aim of the strategy was twofold:

- to reduce teenage pregnancy rates by 50% by 2011
- to increase the number of young parents engaged in education and training

The majority of local authorities have yet to achieve a 50% reduction.[9] However, according to 2012 data, England has the lowest teenage pregnancy rate for 30 years. Although this trend is promising and reflects a significant effort in reducing teenage pregnancies, there is clearly still further work to be undertaken to achieve the target of 50% reduction.

[9] Teenage Pregnancy Strategy: Beyond 2010. DfES and DH, 2010 **www.education.gov.uk/consultations/downloadableDocs/4287_Teenage%20pregnancy%20strategy_aw8.pdf**

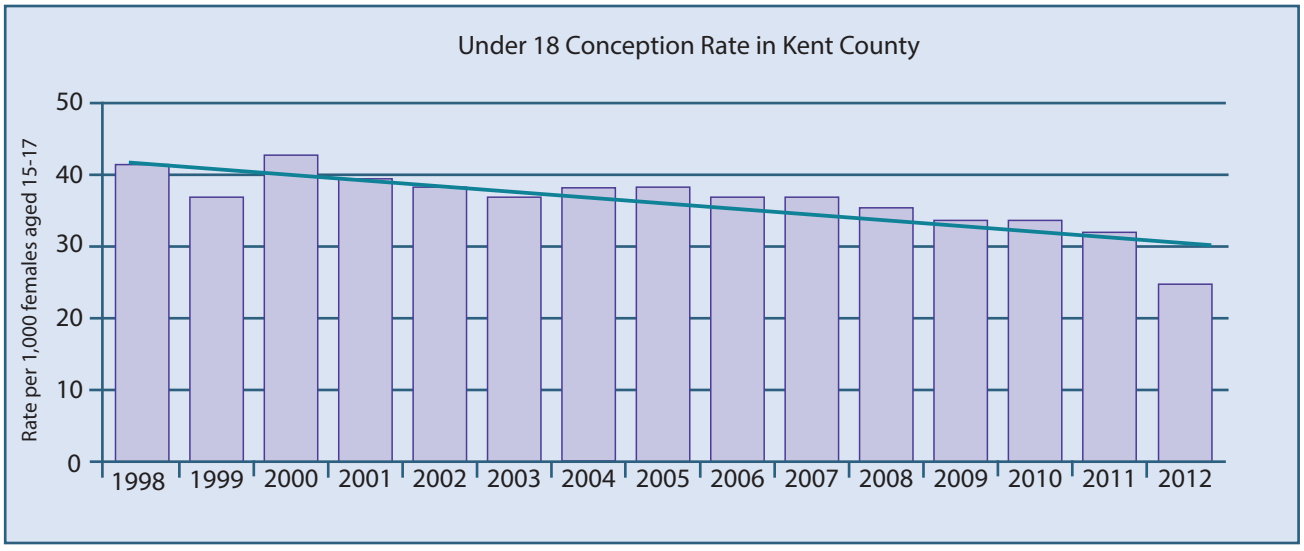
What we are seeing in Kent – the facts

The under 18 conception rate in Kent (2012) is 25.9 per 1000 females aged 15-17, that is lower than the rate for England (27.7).

However, the rates and trends vary significantly across Kent.[10] There is clearly a need for continued efforts for reduction of teenage pregnancies in those areas where rates have not improved as much as it would have been expected. This is a key factor in addressing inequalities for young people across Kent.

As well as improving the information, advice and support, we provide to all young people and introducing measures so that sexually active young people can access contraception easily and use it effectively, our success in reducing teenage pregnancy rates will also depend on how effectively we tackle the underlying factors that increase the risk of teenage pregnancy – such as poverty, low educational attainment, poor attendance at school, non-participation in post-16 learning and low aspirations. Offering appropriate support to young people who are experiencing these underlying risk factors will help to build their resilience and raise their aspirations and so reduce the likelihood that they experience a range of poor outcomes, including teenage pregnancy.

Figure 1 Under 18 conception rates in Kent (1998-2012)



[10] District level information is available from Kent & Medway Public Health Observatory teenage pregnancy dashboard **www.kmpho.nhs.uk/EasysiteWeb/getresource.axd?AssetID=362914&type=Full&servicetype=Attachment**

Termination of pregnancy

Not all young women who become pregnant will complete the pregnancy. In Kent, in 2012, 45.8% of under 18 conceptions lead to a termination. This compares to a figure of 49.1% in England.

Education, employment and training for young parents

Current data indicates that 66% of 16-19 year olds in a parenting cohort are not in education, employment or training (NEET). In January 2014, only 9% of young women under the age of 20 who were parents applied for 'Care to Learn' funding. This programme provides financial support for childcare to parents under the age of 20, who wish to take up training or return to education.

Sexual activity amongst young people

We need to be aware and respond to new evidence about what is happening in young people's relationships, so the advice and support we provide is up to date and relevant. For example, an NSPCC survey[11] reported the levels of violence within teenage relationships; a quarter of girls aged 13 to 17 had experienced physical violence from a boyfriend and a third had been pressured into sexual acts they did not want. The Office of Children's Commissioner[12] highlighted the importance of addressing access to pornography in reducing violence in young relationships. The consequences of violence and coercion can be the early initiation of sexual activity without using contraception. There is also a better understanding of the prevalence of child sexual abuse and its impact on sexual and future emotional health.

[11] Partner exploitation and violence in teenage intimate relationships. NSPCC, 2009
http://www.nspcc.org.uk/Inform/research/findings/partner_exploitation_and_violence_report_wdf70129.pdf

[12] "Basically...porn is everywhere" A Rapid Evidence Assessment on the Effects that Access and Exposure to Pornography has on Children and Young People. Office of Children's Commissioner, 2013
www.childrenscommissioner.gov.uk/content/publications/content_667

Vulnerable young people

Many adolescents experience significant life events and expose themselves to risks, but most of them will bounce back or find their way to the appropriate services. Vulnerable young people (particularly children in care or leaving care, children with learning difficulties and disabilities, young offenders, or those not engaged in education, employment or training) have an increased likelihood acquiring a sexually transmitted infection, becoming pregnant and as a result becoming young parents, having unhealthy relationships and low self-esteem or confidence. Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three. It is therefore critical that practitioners working with vulnerable young people – girls and boys – are aware of these issues, when promoting sexual health. This applies particularly to those supporting children in care and care leavers.

AMBITION 1

Reducing under 18 conceptions requires strong leadership and joined-up working

The development of a Kent Health and Wellbeing board, as well as local CCG Health and Wellbeing boards, provides the multi-agency leadership required. It is widely recognised that local strong leadership is critical for effective action.

The Health and Wellbeing strategy recognises the need for greater integration of the children and young people's workforce around the needs of children and their families. It also recognises the need for greater joint commissioning, which is required to ensure that services are in place for the right young people at the right time, and that provision is not duplicated.

AMBITION 1: Strong leadership and joined-up working
Seek Health and Wellbeing board leadership and accountability for the strategy
Develop CCG level Health and Wellbeing board action plans, which are smart and their implementation is regularly monitored and evaluated
Develop CCG level and district level integrated performance framework for the strategy

AMBITION 2

Building emotional health and resilience and providing universal access to high quality personal, social andhealth education (PSHE) to all children and young people

Emotional health and resilience is the foundation for positive health, social and education[13] outcomes for children and young people. Nationally, evidence is emerging as to how emotional health and wellbeing can be improved, but there is much to learn. The virtual world brings particular risks and challenges, which need to be understood and incorporated into learning opportunities for children and young people.

Underpinning our approach to emotional health and resilience must be an approach to working with children and young people and their families, which emphasises the strengths that they have and can build on. The HeadStart Kent programme[14] will promote a new approach to building resilience. Working with partners, we will develop a new strengths based model that will support vulnerable groups to better cope with life challenges. This programme has been developed using best available evidence and integrating techniques and methods of work that are responsive to the needs of young people and their families.

The Chief Medical Officer has identified that relationships and sex education (RSE) in the context of PSHE is critical. Provision of good quality PSHE is understood to be a key driver in the reduction of under 18 conceptions. Children and young people in Kent must have the information, support and be confident to make the right choices about relationships and when to become sexually active. They need to be given opportunities to develop the knowledge and the understanding of acceptable norms that will safeguard them if adults attempt to sexually exploit them.

[13] Childhood Wellbeing Research Centre (2012). 'The impact of Pupil Behaviour and Wellbeing On Educational Outcomes' **www.gov.uk/government/publications/the-impact-of-pupil-behaviour-and-wellbeing-on-educational-outcomes**

[14] HeadStart Kent programme **www.kent.gov.uk/education-and-children/headstart**

Ofsted has identified that PSHE in England is not 'good enough' in a third of the schools that were inspected.[15] The report identifes this as a concern as it may leave children and young people vulnerable to inappropriate sexual behaviours and sexual exploitation. This is because they have not been taught the appropriate language or developed the confidence to describe unwanted behaviours or know where to go to for help. The ambition is that delivery of PSHE becomes 'outstanding'.[16] It is not only in schools[17] that PSHE can be delivered. Youth and faith settings, between peers and in the family, are places where PSHE messages can be delivered and reinforced.

Young people also want to contribute in the improvement of PSHE. Kent Youth County Council has made the delivery of PSHE one of their priorities. We plan to design together with young people, their parents, schools and the voluntary sector, a new curriculum for life.

We will use peer led social marketing (in collaboration with the PHE 'Rise Above') and target interventions to support young people to make better choices and develop coping strategies for improved positive relationships. We will utilise young health champions to deliver SRE in schools, in the community and through digital media, so that young people can become good parents in the future.

AMBITION: 2 Building emotional health and resilience of the children and young people

Apply whole school approaches to build emotional health and resilience through PSHE and HeadStart Kent

With the active involvement of young people, develop and implement a Kent framework for relationship and sex education

Develop a curriculum for life that builds upon the 'Six Ways to Wellbeing'[18] and is a central component of early help

Develop and implement a workforce development strategy for emotional health and resilience

[15] OFSTED (2013). ' Not Yet Good Enough' **www.ofsted.gov.uk/resources/not-yet-good-enough-personal-social-health-and-economic-education-schools**

[16] OFSTED (2013). 'Supplementary Subject Specific Guidance for PHSE Education' **www.ofsted.gov.uk/resources/generic-grade-descriptors-and-supplementary-subject-specific-guidance-for-inspectors-making-judgement**

[17] 'Schools' denotes all education settings such as schools, colleges, pupil referral units and alternative curriculum settings

[18] Live it well. Six ways to wellbeing HYPERLINK **www.liveitwell.org.uk/ways-to-wellbeing/six-ways-to-wellbeing**

AMBITION 3

There is concern that some children and young people are not reaching their full potential and are not being proactively identified and supported early enough or at key transition stages.

For some cultures, communities and families, parenting at a young age is the social norm. Breaking this cycle requires the building of aspirations for communities and families alongside individual young people. Building on work with particular communities in Kent can be used to build effective interventions with children, young people and their parents; for example with gypsy traveller young people.

As children and young people build their aspirations, schools and colleges will need to offer innovative and accessible training programmes. For those young people who become young parents, we need to embed progression planning as part of the holistic plan early into the pregnancy to ensure that they become economically active citizens.

AMBITION 3: Building the aspirations for young people
Build the capacity of universal services to provide early help, ensuring that all young people are supported to make successful transition into adulthood
Identify the underlying causes of disengagement from education
Provide early help through the use of the early help assessment, targeted interventions, engagement on social action initiatives and positive activities

AMBITION 4

Children and young people playing an active role in shaping the world around them

Children and young people want to play an active role in shaping the world around them and their futures. Their participation is not only their right, but evidence also shows that it results in better service design and delivery. By being involved, their confidence increases. Furthermore, they welcome the increased responsibility and share their energy, enthusiasm and knowledge through their own friendship groups and networks.

We need to systematically and proactively engage young people by building on existing participation in Youth Health Champions, the County Youth Council and school councils, through social action, applying the 'You're Welcome standard' across children and young people services as well as primary and secondary health care. We need to draw this work together in a network and ensure that all children and young people are included, irrespective of age, gender, ethnicity, ability or sexuality. In this way we can maximise our contact with children and young people and ensure that they have access to information and can be actively engaged in shaping, delivering and reviewing services.

AMBITION 4: Children and young people playing an active role in shaping the world around them
Build on existing approaches to the participation of children and young people and extend them to make sure that all children have the chance to shape, deliver and review services
Implement ' You're Welcome Standards ' in all children and young people's services
Implement a Kent wide peer to peer social marketing campaign around children and young people's emotional health and resilience which makes links with national campaigns to maximise effect
Link with Kent's programme of social action in order to increase their engagement with young people who require early help and to build capacity to enhance aspirations and emotional resilience
Build on and extend Youth Health Champions involvement in the delivery of PSHE

AMBITION 5

Improving sexual health for young people

Sexual health services are valued by the wider children and young people's workforce, but need to be more visible and take a more integrated approach. They are not equitable and it is not clear that they meet the needs of the most vulnerable young people. Young people have a great deal to contribute to achieve better sexual health outcomes. Young men, in particular, may not be accessing services as they could be.

We need to make sure there is effective communication with and by young people and the wider children and young people's workforce about where services are, what is available and when. This needs to include the full range of contraception available to young people.

AMBITION 5: Improving sexual health for young people
Implement a new model for the delivery of sexual health services for young people which is equitable in relation to geographical and vulnerable young people's needs
Ensure that the location and times of services are communicated to young people, their parents and carers and the professionals
Ensure the sexual health needs of young men are being met

AMBITION 6

Improving emotional, physical, educational and economic wellbeing for young parents

Young parents are vulnerable to poverty and poor emotional and physical health. Many young parents leave education or training to support their families and find hard to return to education or the workplace. We need to learn from resilient young parents and share that learning, so that all young parents can become resilient and keep themselves and their children safe.

There are programmes such as Family Nurse Partnership and Children's Centres already operating in Kent. However, the existing pathway for young parents to a range of services varies across Kent and is not always up to date.

AMBITION 6: Improving emotional, educational and economic wellbeing for young parents
Ensure that the needs and contribution of young parents is considered across all the ambitions of the strategy
Actively engage and learn from young parents and their families
Review and implement a pathway for young parents in Kent ensuring that they remain engaged in education and employment and become economically active citizens

The way forward

Once the strategy is published, it is expected to come to life through the local health and wellbeing partnerships that will develop local action plans, continuing to build on their successes and becoming even more effective in tackling teenage pregnancy. These plans will be coordinated by Kent County Council.

Annex 1 Children and Young People's Health Outcomes Forum

Current national policy drivers				
Teenage Pregnancy (DH)	Chlamydia (PHE)	HIV (NHS England and PHE)	STIs (DH and PHE)	Cross government Building Resilience
Sexual violence (Home Office and DH)	Child Sexual Exploitation (OCC. DH, LGA)	Sexualisation and commercialisation (No.10)	Online Porn (No.10/DCMS)	Homophobic bullying (DfE/GEO)
Body Image (GEO)	Evidence Base for PSHE/ Contraception	You're Welcome (PHE/ DH - CMO report)	Volunteering and social action (Cabinet Office)	PSHE/SRE (DfE)
Children & young people's health outcomes forum				

Teenage Pregnancy Strategy 2015-2020

This publication is available in other formats
and can be explained in a range of languages

24 hour helpline: 0300 333 5540
Text Relay: 18001 0300 333 5540

NHS
Newcastle Gateshead Alliance
NHS Gateshead Clinical Commissioning Group
NHS Newcastle North and East Clinical Commissioning Group
NHS Newcastle West Clinical Commissioning Group

NHS
Somerset
Clinical Commissioning Group

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Dr Tony Martin
NHS Thanet CCG
Thanet District Council
Cecil Street
Margate
Kent
CT9 1XZ

27th August 2014

Dear Dr Martin

NHS Statement of Support for Tobacco Control

In the next few weeks Clinical Commissioning Groups in Somerset, Hartlepool and Newcastle will sign the NHS Statement of Support for Tobacco Control, setting out our commitment to tackle the harm smoking causes our communities. This is a document for local organisations to sign up to in partnership with their local Health and Wellbeing Board. The Statement has been endorsed by, among others, the Public Health Minister, NHS England, Public Health England, the Care Quality Commission and the British Medical Association. We would encourage your organisation to consider signing this important Statement.

The Statement commits NHS organisations to:

- Actively support local work to reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Play a role in tackling smoking through appropriate interventions such as 'Make Every Contact Count'
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Support Government action at national level
- Participate in local and regional networks for support
- Join the Smokefree Action Coalition (SFAC).

The Statement has been developed following the creation of the Local Government Declaration on Tobacco Control in May 2013. The Declaration commits councils to take comprehensive action to address the harm from smoking and to work with local partners. As of August 2014 this has been signed by over 70 councils across the country.

Through signing this Statement we have made a clear commitment to support effective local approaches to tobacco control in line with NICE guidance. Although there have been changes in the public health system there continues to be an important role for the NHS as local partners in tackling tobacco, as demonstrated by commitments in the Tobacco Control Plan for England and the recent NICE Guidance on Smoking Cessation in Secondary Care.

Despite many years of progress, tobacco remains one of the enduring public health challenges and is the leading cause of premature death and health inequalities in England. Smoking is responsible for 5% of all hospital admissions in those over 35 and the cost of

NHS Statement of Support for Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people; two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

We welcome the:

- Commitment from local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Opportunity to support partnership working with local government as part of delivering local tobacco control in line with NICE guidance;
- Endorsement of this statement by central government, Public Health England, NHS England and others.

We, ..., commit from the date ..... to:

- Continue to actively support work at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reducing the harm caused by tobacco;
- Work with our partners and local communities to address the causes and impacts of tobacco use, according to NICE guidance on smoking and tobacco control;
- Play our role in tackling smoking through appropriate interventions such as 'Make Every Contact Count';
- Protect our work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities; and
- Participate in local and regional networks for support.

Signatories

Local NHS leader | **Chair of the Health and Wellbeing Board** | **Director of Public Health**

Endorsed by

Jane Ellison, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Simon Stevens, Chief Executive, NHS England

Sir Richard Thompson, President, Royal College of Physicians

Dr Hilary Cass, President, Royal College of Paediatrics and Child Health

Dr Janet Atherton, President, Association of Directors of Public Health

Professor John Ashton CBE, President, UK Faculty of Public Health

David Behan, Chief Executive, Care Quality Commission

Baroness Hollins, Chair, BMA Board of Science

Dr Maureen Baker, Chair, Royal College of General Practitioners

Department of Health | Public Health England | NHS England | Royal College of Physicians | BMA | Care Quality Commission | Royal College of General Practitioners | RCPCH

THANET DISTRICT COUNCIL DECLARATION OF INTEREST FORM

Do I have a Disclosable Pecuniary Interest and if so what action should I take?

Your Disclosable Pecuniary Interests (DPI) are those interests that are, or should be, listed on your Register of Interest Form.

If you are at a meeting and the subject relating to one of your DPIs is to be discussed, in so far as you are aware of the DPI, you **must** declare the existence **and** explain the nature of the DPI during the declarations of interest agenda item, at the commencement of the item under discussion, or when the interest has become apparent

Once you have declared that you have a DPI (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote on the matter;
2. Withdraw from the meeting room during the consideration of the matter;
3. Not seek to improperly influence the decision on the matter.

Do I have a significant interest and if so what action should I take?

A significant interest is an interest (other than a DPI or an interest in an Authority Function) which:

1. Affects the financial position of yourself and/or an associated person; or
   Relates to the determination of your application for any approval, consent, licence, permission or registration made by, or on your behalf of, you and/or an associated person;
2. And which, in either case, a member of the public with knowledge of the relevant facts would reasonably regard as being so significant that it is likely to prejudice your judgment of the public interest.

An associated person is defined as:

- A family member or any other person with whom you have a close association, including your spouse, civil partner, or somebody with whom you are living as a husband or wife, or as if you are civil partners; or
- Any person or body who employs or has appointed such persons, any firm in which they are a partner, or any company of which they are directors; or
- Any person or body in whom such persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000;
- Any body of which you are in a position of general control or management and to which you are appointed or nominated by the Authority; or
- any body in respect of which you are in a position of general control or management and which:
  - exercises functions of a public nature; or
  - is directed to charitable purposes; or
  - has as its principal purpose or one of its principal purposes the influence of public opinion or policy (including any political party or trade union)

An Authority Function is defined as: -

- Housing - where you are a tenant of the Council provided that those functions do not relate particularly to your tenancy or lease; or
- Any allowance, payment or indemnity given to members of the Council;
- Any ceremonial honour given to members of the Council
- Setting the Council Tax or a precept under the Local Government Finance Act 1992

If you are at a meeting and you think that you have a significant interest then you **must** declare the existence **and** nature of the significant interest at the commencement of the

matter, or when the interest has become apparent, or the declarations of interest agenda item.

Once you have declared that you have a significant interest (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote (unless the public have speaking rights, or you are present to make representations, answer questions or to give evidence relating to the business being discussed in which case you can speak only)
2. Withdraw from the meeting during consideration of the matter or immediately after speaking.
3. Not seek to improperly influence the decision.

Gifts, Benefits and Hospitality

Councillors must declare at meetings any gift, benefit or hospitality with an estimated value (or cumulative value if a series of gifts etc.) of £100 or more. You **must,** at the commencement of the meeting or when the interest becomes apparent, disclose the existence and nature of the gift, benefit or hospitality, the identity of the donor and how the business under consideration relates to that person or body. However you can stay in the meeting unless it constitutes a significant interest, in which case it should be declared as outlined above.

What if I am unsure?

If you are in any doubt, Members are strongly advised to seek advice from the Monitoring Officer or the Democratic Services and Scrutiny Manager well in advance of the meeting.

DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS, SIGNIFICANT INTERESTS AND GIFTS, BENEFITS AND HOSPITALITY

MEETING……...

DATE…… **AGENDA ITEM** ……

DISCLOSABLE PECUNIARY INTEREST □

SIGNIFICANT INTEREST □

GIFTS, BENEFITS AND HOSPITALITY □

THE NATURE OF THE INTEREST, GIFT, BENEFITS OR HOSPITALITY:

……

……

……

NAME (PRINT): ……

SIGNATURE: ……

Please detach and hand this form to the Democratic Services Officer when you are asked to declare any interests.