Date: **3 June 2015**
Our ref: **Health & Wellbeing Board/Agenda**
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thanet district council

THANET HEALTH AND WELLBEING BOARD

11 JUNE 2015

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 11 June 2015** in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Membership:

Dr Tony Martin (Chairman); Hazel Carpenter, Dominic Carter, Esme Chilton, Councillor Fairbrass, Councillor Gibbens, Madeline Homer, Mark Lobban, Colin Thompson and Councillor Wells.

A G E N D A

Item No | Subject

1. **APPOINTMENT OF CHAIRMAN AND VICE CHAIRMAN FOR 2015/16**

2. **MINUTES OF THE PREVIOUS MEETING** (Pages 1 - 4)
   To approve the minutes of the meeting held on 12 February 2015, copy attached.

3. **DEVELOPMENT OF THE THANET HEALTH AND WELLBEING BOARD**
   Report to follow.

4. **DEMENTIA BRIEFING** (Pages 5 - 8)

5. **AGE UK SUPPORT** (Pages 9 - 28)

6. **QUALITY PREMIUM 2015/16** (Pages 29 - 36)

7. **EKHUFT POSITION STATEMENT**
   Report to follow.

8. **ADULT SOCIAL CARE TRANSFORMATION** (Pages 37 - 48)

9. **HEALTH INEQUALITIES IN THANET** (Pages 49 - 52)

10. **AGENDA TOPICS FOR THE NEXT MEETING**

    Declaration of Interests Form

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 12 February 2015 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Councillors Johnston (Thanet District Council), Hazel Carpenter (Thanet Clinical Commissioning Group), Esme Chilton (Future Creative), E Green (Thanet District Council), Madeline Homer (Thanet District Council) and Mark Lobban (Kent County Council)

In Attendance: Jonathan Bates (Thanet Clinical Commissioning Group); Penny Button (Thanet District Council); Linda Smith (Kent County Council)

1. APOLOGIES FOR ABSENCE

Apologies were received from Andrew Scott-Clark, for whom Linda Smith was present as substitute. Apologies were also received from Mark Elliot and Councillor Gibbens.

2. DECLARATION OF INTERESTS

No declarations of interest were received.

3. MINUTES OF THE PREVIOUS MEETING

Esme Chilton noted that the second to last paragraph of page two which referred to safeguarding children, should be moved to the end of the agenda item to avoid confusion with hip fractures.

The minutes of the previous meeting held on 13 November 2014 were agreed subject to the amendment.

4. ALCOHOL STRATEGY: LOCAL PLAN PROGRESS REPORT

Linda Smith, Public Health Specialist, Kent County Council, provided a progress update on the Thanet Alcohol Plan (2014-16) which implemented the Kent Alcohol Strategy (2014-16) at a local level.

In response to comments and questions, it was noted that:

- the plan was in an early stage of design and was publically available. The document would be updated and developed as a result of feedback.
- it was the intention to develop electronic scratch cards which, like the paper versions, would encourage people to think about how much they drank. The electronic scratch cards could be available on intranet sites for access by employees.
- an important element of the alcohol strategy for Kent was early intervention with a focus on partnership working.
- while progress had been made in the under 25's age category, the age group drinking the most appeared to be the over 55's. It was suggested that this could be for a number of reasons including bereavement and loneliness.

The report was noted.

5. INTEGRATED CARE ORGANISATION

Hazel Carpenter, Accountable Officer, Thanet Clinical Commissioning Group, presented the report noting that the need for change was generated from a number of pressures including an increasing demand for care, reduced funding and fragmented services. Hazel added that depending on the result of the upcoming general election, the Health and Wellbeing Board may take a more active role in the future.

In response to questions and comments Hazel responded that:

- integrated care included in hospital and out of hospital care, as well as long and short term care;
- there was acknowledgement that mental health support was not always available when needed;
- patients would have access to their own medical notes from 1st April 15, this would be a complex process to put in place, and there were concerns about how patients would use the information;
- it was recognised that whilst there is a shared vision, every component within the organisation would have their own challenges in reaching that goal.

The report was noted.

6. BETTER CARE FUND

Jonathan Bates, Chief Finance Office, Thanet Clinical Commissioning Group, gave a report noting that the Government wished to further integrate health and social care. In order to encourage this, the budgets for health and social care would be merged from the 1st April 2015, and as a result, legal and financial frameworks had been produced.

Jonathan added that Local Health and Wellbeing Boards should look at how services could work together to reduce gaps and duplication in service provision. While legal oversight would remain with Kent County Council and the Clinical Commissioning Group, in practice local Health and Wellbeing Boards would drive and formulate the change.

A Member suggested that some training or a workshop might be useful for THWB Members in order to prepare for this.

7. DEVELOPMENT OF THE THANET HEALTH AND WELLBEING BOARD

Madeline Homer, Acting Chief Executive and Director of Community Services, Thanet District Council, advised that there would be an executive group that would support the Thanet Health and Wellbeing Board. Feedback from this executive group would be provided at the next THWB meeting.

8. AGENDA TOPICS FOR THE NEXT MEETING

It was suggested that the following items be included on the next Thanet Health Wellbeing Board meeting agenda:

- Development of the Thanet Health and Wellbeing Board.
- Report on the work of the Children's Board.

- Report on Dementia.

Meeting concluded : 11.30 am

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DEMENTIA BRIEFING

To: **Thanet Health and Wellbeing Board – 11 June 2015**

From: **Colin Thompson, Consultant in Public Health**

Subject: **Dementia briefing**

Classification: **Unrestricted**

Summary: Dementia predominantly affects older people and has a devastating impact on the citizens who develop it and the families who care for them. There are a number of types of dementia that include Alzheimer's and Vascular Dementia, which are caused by different diseases of the brain. Obtaining an early diagnosis can help to improve the quality of life for the individual and their family. There has been an extensive improvement in the diagnosis rate in Thanet over the last twelve months, although there is still considerable progress to be made.

For Information

1.0 Introduction and Background

1.1 Dementia is a global term used to describe a range of neurological disorders characterised by a decline in intellectual and other mental functions. It can affect people of any age, but is most common in older people and age is the greatest risk factor for dementia.

1.2 Dementia affects one in fourteen people over the age of 65 and one in six over the age of 80. However, dementia is not restricted to elderly people: there are 15,000 people under the age of 65 with dementia in the UK, although this figure is likely to be an underestimate.

1.3 There are a number of types of dementia which are caused by different diseases of the brain. These different types of dementia are associated with different risk factors. The most common type is Alzheimer's disease, affecting about 62% of those with dementia. Vascular dementia (17%) is the next most common forms as well as mixed presentations. About 10% of people with dementia have both Alzheimer's disease and vascular dementia.

1.4 Obtaining an early diagnosis enables a person with dementia and their family to receive help in understanding and adjusting to the diagnosis and to prepare for the future in an appropriate way. This might include making legal and financial arrangements, changes to living arrangements, and finding out about aids and services that will enhance quality of life for people with dementia and their family and friends. Early diagnosis can allow the individual to have an active role in decision making and planning for the future while families can educate themselves about the disease and learn effective ways of interacting with the person with dementia. There is evidence that the currently available medications for Alzheimer's disease may be more beneficial if given early in the disease process. These medications can help to maintain daily function and quality of life as well as stabilise cognitive decline in some

people. Early diagnosis allows for prompt access to medications and medical attention.

2.0 The Current Situation

2.1 There have been considerable improvements in the diagnosis rate over the last twelve months. The CCG's diagnosis rate in April 2014 was 40.38% of the expected prevalence and this had risen to 48.27% in March 2015. There was an expectation that CCGs would have achieved a diagnosis rate of 67% by April 2015, but Thanet CCG expects to achieve this by March 2016. There has been good engagement from the practices to achieve this improvement. A large proportion of the increase which has been delivered during the last twelve months has been achieved by the data harmonisation of GP practice data. Further work is required during 2015/16 to increase diagnosis of people in nursing homes.

2.2 There is now an active dementia action alliance established in Thanet with representatives from a number of statutory and voluntary sector organisations. During the recent dementia awareness week, Age UK hosted a dementia awareness day which was attended by a number of organisations able to provide help and support to people with dementia and their families. The day also included other events, such as reminiscence groups and dancing and singing.

2.3 There are also a number of other organisations providing support to people with dementia and their families. East Kent Independent Dementia Support (EKIDs) provide a number of dementia cafes where people with dementia and their carers can obtain support and advise and also meet other people who have dementia or care for someone with dementia.

2.4 There are a number of Cogs clubs running in Thanet. This a programme of activity and stimulation designed for people with mild to moderate dementia and is based on cognitive stimulation therapy (CST) which is recommended by NICE as a non-drug related treatment for memory problems.

2.5 Sunshine Saturday is a dementia intergenerational project which takes place at Age UK in Margate every Saturday morning. This brings together younger and older people to share experiences and participate in activities and is very well attended. A successful intergenerational project was also run with the Marlowe Academy.

2.6 Dementia friends sessions have been delivered to a number of different groups across Thanet, including to a local cubs group.

2.7 Forget Me Nots are a group of people with dementia who are supported by the Kent and Medway Partnership Trust (KMPT) and work to raise awareness of dementia. They have also established a national profile, including taking part in the House of Lords consultation on the Mental Health Act. A number of the group have also contributed to a book, 'Welcome to our World' which is a collection of life stories before a diagnosis of dementia, as well as thoughts on living with dementia.

2.8 Thanet CCG also recently commissioned dementia awareness sessions for GP administration staff. The sessions were supported by the voluntary sector and members of the 'Forget Me Nots' and were very well received by the participants. A further session is planned in September.

2.9 A second edition of Dementia Focus has recently been published. This is a Kent wide publication which aims to showcase some of the good practice which is taking place across the county.

3.0 Recommendation

3.1 Board members are asked to note the briefing paper.

4.0 Background Papers

4.1 None

5.0 Contact details

Report Author

Colin Thompson, Consultant in Public Health, Kent County Council
Linda Caldwell, Commissioning Officer, Thanet Clinical Commissioning Group
Colin.thompson@kent.gov.uk, linda.caldwell@nhs.net

Relevant Director

Andrew Scott-Clark: Director of Public Health, Kent County Council
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Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Support at Home Service

Presentation by

Diane Aslett and Nicola Parish

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Introduction

Thanet CCG are committed to the delivery of improved healthcare outcomes for the population of Thanet.

- Increasing the proportion of older people living independently at home following discharge from hospital.
- Improving the health related quality of life of people with one or more long-term condition, including mental health conditions.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Background

- Older people represent **60%** of all hospital admissions
- Most want to live independently and healthily at home for as long as possible.
- And to have choice and control over the services they need.
- But older people are often going into hospital 'in crisis' and because they can't get the right care and support at home
- 14 m people 60yrs+; 50+% increase projected in 25 years.

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

- The current health and social care system focuses on helping people in crisis – “the ambulance at the bottom of the cliff”

- But identifying older people at risk of developing major health problems before a crisis, and working with them to bring together the services they need is better for them and a much more effective use of resources – “community based services at the top of the cliff

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Support at home service

- Commenced Nov 14
- Funded through ORCP monies
- Joint initiative with TCCG and KCC

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

This is Age UK Territory

- Many determinants of health sit outside formal health and care responsibilities

  Cold homes
  Loneliness
  Malnutrition
  Dehydration
  Poverty and fuel poverty
  Lack of family support

- Trusted assessor –including request for telecare.

Age UKs in Kent Consortium

- **Supporting older people and reducing pressure in hospitals**
- Building on existing Age UK services (Befriending and Home from Hospital) Evaluation
- Co designed with KCC and CCG and supported by Urgent Care Working Group

Age UKs in Kent Consortium

- Type of support

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Service so far…

- Commenced November 2014
- Referrals to end of May 2015 - 207 which is on target for 440 for the year.
- Referral source – links with over 75s scheme at Westgate, Garlinge and Birchington Surgeries, QEQM Integrated Discharge team and Care Navigator Team, KCC Adult Services, Family Mosaic, Private agencies and self referrals
- The cost for our target of 300 clients over a 12 month period is £71,440.

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Case study Mrs S

- 70 year old lady
- Suffers with chronic COPD dependant on oxygen 24/7
- Given 1 year to live
- Main carer for 40 year old son who has learning disability and epilepsy

Case study Mr L

- 85 year old man
- Lives alone
- Disabled due to a stroke
- Son is main carer but has had a total breakdown
- Needs help and advice

Case study Mr M

- 85 year old man
- Lives alone
- No heating
- No hot water
- Poor living conditions
- Struggles to get up stairs

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Comments from the Over 75 schemes in Westgate Birchington and Garlinge

- Very beneficial,
- Very good Response time
- Patients grateful of the support
- Patients have access to a better quality of life knowing that there is free help available whilst they are going through a difficult time.
- Valued befriending service no other service that is available to carry this out
- Equipment requests, have been responded to quickly as there is not waiting list so pressure relief is delivered very quickly hence this prevents skin breakdown

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

I think you all deserve a medal, it's nice to know there are people to talk to and a service to help me'

"Having these weekly visits with Sandra gives me something to look forward to. Sandra is so friendly and I don't want to lose you."

This service has been very appreciated by me and will make the future more positive'

Thank you for what you have done for me, there needs to be more of you I'm sure

Very friendly, service is brilliant, very good service helped me to regain confidence'

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Living Well in Cornwall

- **Programme in Cornwall that delivers similar front line support as Support at Home**

- Evaluation in 2014 showed

  - 49% reduction in non elective admissions
  - 36% reduction in A&E attendance
  - 20% improvement in mental well being
  - 8% reduction in social care costs

  Support at Home may be delivering similar cost savings but not measured

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Considerations…Next steps

- Expansion of service across Thanet
- Ongoing funding beyond Nov 2015 would enable more people in Thanet to be reached.
- Estimated total cost would be approximately £140,000 which would provide support for approximately 850 people
- Possible future opportunities linking with IDT take home and settle service
- http://youtu.be/V5VsqSiHYVY

Age UKs in Kent Consortium

Thanet Clinical Commissioning Group

Any questions ?

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Quality Premium 2015/16

To:	**Thanet Health and Wellbeing Board - 11 June 2015**
By:	**Adrian Halse, Senior Business Analyst, NHS Thanet Clinical Commissioning Group**
Classification:	**Unrestricted**
Ward:	**All wards**

Summary: **This report explains the quality premium and the criteria which will be applied to it in 2015/16. It identifies specific indicators chosen by the Thanet Clinical Commissioning Group and asks the Board to ratify this indicator set.**

For Decision

1.0 Introduction and Background

1.1 The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes.

1.2 The quality premium available to Thanet CCG is theoretically around £700,000, however, the amount achieved is likely to be significantly less than this.

1.3 Quality Premium payments for achievements in 2015/16 will be paid in 2016/17.

1.4 Quality Premium payments should be used by CCGs to secure improvement in:

a) The quality of health services
b) The outcomes achieved from the provision of health services; or
c) Reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved

1.5 The Quality premium is paid primarily on the CCGs achievement against a set of measures which are each worth a certain percentage of the total premium available. The measures for 2015/16 are set out in section 3.0 below.

2.0 Restrictions on Payment

2.1 There are a number of criteria which may limit the amount available or prevent payment completely. These include:

a) Poor financial management (e.g. qualified audit report or adverse variance at year end): could result in all payment being withheld.

b) Serious quality failure which could result in all payment being withheld.

c) Failure to achieve constitutional targets. This could lead to varying reductions in the amount available as explained in the table below.

NHS Constitution requirement	Reduction to Quality Premium
Maximum 18 weeks from referral to treatment, comprising: • 90% Completed Admitted standard; • 95% Completed Non-admitted standard; • 92% Incomplete standard.	30% total, (comprising 10% for each standard, separately assessed)
Maximum four hour waits in A&E departments-95% standard	30%
Maximum 14 day wait from an urgent GP referral for suspected cancer-93% standard	20%
Maximum 8 minutes responses for Category A (Red 1) ambulance calls-75% standard	20%

2.2 At present, East Kent Hospitals University Foundation Trust (EKHUFT) are failing to achieve two of the 18 week standards and the A&E 4hr wait standard. Recovery plans are in place but they do not forecast compliance in the early part of the year. This means that it is very unlikely that these standards will be achieved for the year as a whole. This would bring the maximum quality premium available to Thanet CCG down to £350,000.

3.0 Quality Premium Measures

3.1 The quality premium is paid on the basis of achievement of certain measures. Some measures are mandatory but there is some flexibility around measures for urgent and emergency care and mental health. There is also a requirement to identify 2 local measures which must be taken from, or link closely to the CCG Outcomes Indicator Set (see Annex 1).

3.2 The following table explains how the various quality premium measures are used to calculate payment of the quality premium.

Measure	% of Quality Premium	Threshold for payment	Comments
Reducing potential years of life lost			
Reducing potential years of lives lost through causes considered amenable to healthcare.	10%	Achieve reduction agreed with H&W Board and NHS England Local Area Team.	This measure is compulsory.
Urgent and emergency care			
Avoidable emergency admissions.	30% - CCGs can choose one, two or three of these indicators and specify how much of the percentage total applies to each one.	Reduction or 0% change in annualised 4yr trend over 2012/13 to 2015/16 or less than 1,000 per 100,000 population.	The CCG expects to see improvements this year, but it is not currently clear whether they would be significant enough to alter the annualised 4yr trend.
Delayed transfers of care which are NHS responsibility.		Reduction on 2014/15 actual.	The CCG's performance is calculated as a percentage of the Kent County Council figures rather than the EKHUFT figures so would be dependent on improvements in the other Acute Hospital Trusts as well as EKHUFT.

Measure	% of Quality Premium	Threshold for payment	Comments
Number of non-elective patients who are discharged at weekends or bank holidays.		At least 0.5% points higher in 2015/16 than 2014/15.	With the continuation of the Integrated discharge team and the intended implementation of discharge to assess, this is an area that we could expect an improvement.
Mental Health			
Proportion of A&E patients with a primary diagnosis of mental health-related needs spending more than 4 hours in A&E AND Proportion of A&E diagnosis codes at A&E with a valid code.	30% - CCGs can choose one, two, three or four of these indicators and specify how much of the percentage total applies to each one.	90% with correct code and MH A&E performance same as or better than overall A&E performance (or better than 95%).	Currently EKHUFT do not report the primary diagnosis code so it would not be possible to achieve this in 2015/16.
Number of people with severe mental illness who are currently smoking.		Reduction between 31 March 2015 and 31 March 2016.	Kent and Medway Partnership Trust (KMPT) have a plan to improve smoking cessation among patients over the coming year. Public Health are looking to target smoking in general over the coming year. The data is based on GP records rather than KMPT data and may require additional work to improve data quality.
Proportion of adults in contact with secondary mental health services who are in paid employment.		Reduction between Q4 2014/15 and Q4 2015/16.	KMPT does not have confidence that a reduction could be delivered this year.
Health related quality of life for people with a long term mental health condition.		A reduction in difference between the health related quality of life for people with any long term conditions compared to those with a mental health long term condition.	There are concerns that the small number of respondents to the survey who state that they have a long term mental health condition could skew the figures making this an unreliable measure of performance.
Improving antibiotic prescribing			
Number of antibiotics prescribed in primary care.	5%	1% reduction from 2013/14 value.	This measure is compulsory.
Proportion of broad spectrum antibiotics prescribed in primary care.	3%	10% reduction from 2013/14 value or below 2013/14 median for all English CCGs.	This measure is compulsory.
Secondary care providers validating their total antibiotic prescription data.	2%	Providers with 10% or more of their activity commissioned by TCCG have validated their total antibiotic prescribing data as certified by PHE.	This measure is compulsory.
Local measures			
CCG must choose 2 local measures based on local priorities.	20% (10% for each measure)	Depends on the measure. Must be agreed with NHS England Local Area Team	Local measures must be taken from or link closely to the CCG Outcome Indicators Set (Annex 1).

Measure	% of Quality Premium	Threshold for payment	Comments
		and Health and Wellbeing Board.	

4.0 Measures identified by the CCG

4.1 The CCG has been advised to choose measures which link to local priorities and where a positive impact is expected over the coming year.

4.2 Thanet CCG's Clinical Leadership Team identified the following indicators for those areas where there is a choice:

Urgent and Emergency Care	30% aligned to *Number of non-elective patients who are discharged at weekends or bank holidays*.
Mental Health	30% aligned to *Number of people with severe mental illness who are currently smoking*.
Local Priorities	10% aligned to *C2.5 People with diabetes diagnosed less than a year who are referred to structured education*. 10% aligned to *C3.12 Hip fracture: timely surgery*.

4.3 The Thanet Health and Wellbeing Board is asked to ratify the choice of these indicators.

5.0 Options

5.1 To ratify the list of indicators as set out in 4.2.

6.0 Next Steps

6.1 The list of indicators will be discussed with the NHS England Local Area Team and specific targets will be agreed as required.

6.2 Progress will be monitored throughout the year.

7.0 Recommendation(s)

7.1 That the Board ratifies the list of indicators set out in 4.2.

8.0 Decision Making Process

8.1 The indicators set must ultimately be approved by the NHS England Local Area Team.

Contact Officer:	Adrian Halse, Senior Business Analyst, NHS Thanet CCG
Reporting to:	Ailsa Ogilvie, Chief Operating Officer, NHS Thanet CCG

Annex List

Annex 1	CCG Outcomes Indicator Set

Background Papers

Title	Details of where to access copy
None	N/A

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Annex 1: CCG Outcome Indicator Set

Measure
C1.1 Combined indicator on potential years of life lost (PYLL) from causes considered amenable to healthcare adults children and young people.
C1.2 Under 75 mortality rate from cardiovascular disease
C1.3 Cardiac Rehabilitation Completion
C1.4 Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes
C1.5 Mortality within 30 days of hospital admission for stroke
C1.6 Under 75 mortality from respiratory disease
C1.7 Under 75 mortality rate from liver disease
C1.8 Emergency admissions for alcohol-related liver disease
C1.9 Under 75 mortality rate from cancer
C1.10 One year survival from all cancers
C1.11 One year survival from breast, lung and colorectal cancers
C1.12 People with severe mental illness who have received a list of physical checks
C1.13 Antenatal assessments <13 weeks
C1.14 Maternal smoking at delivery
C1.15 Breast feeding prevalence at 6-8 weeks
C1.16 Cancer: diagnosis via emergency routes (aim to reduce this by earlier diagnosis)
C1.17 Cancer: record of stage at diagnosis
C1.18 Cancer: early detection (proportion of cancers diagnosed at stage 1 or 2 at initial diagnosis)
C1.19 Lung cancer: record of stage at diagnosis
C1.20 Breast cancer: mortality
C1.21 Heart failure: 12 month all-cause mortality
C1.22 Hip fracture: incidence
C2.1 Improved health-related quality of life for people with long-term conditions
C2.2 A greater proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition
C2.3 People with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 referred to a pulmonary rehabilitation programme.
C2.4 People with diabetes who have received all nine care processes.
C2.5 People with diabetes diagnosed less than a year who are referred to structured education.
C2.6 Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions (adults
C2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s).
C2.8 Complications associated with diabetes, including emergency admission for diabetic ketoacidosis and lower limb amputation
C2.9 Access to community health services by people from BME groups
C2.10 Access to psychological therapy services by people from BME groups
C2.11 Recovery following talking therapies for people of all ages

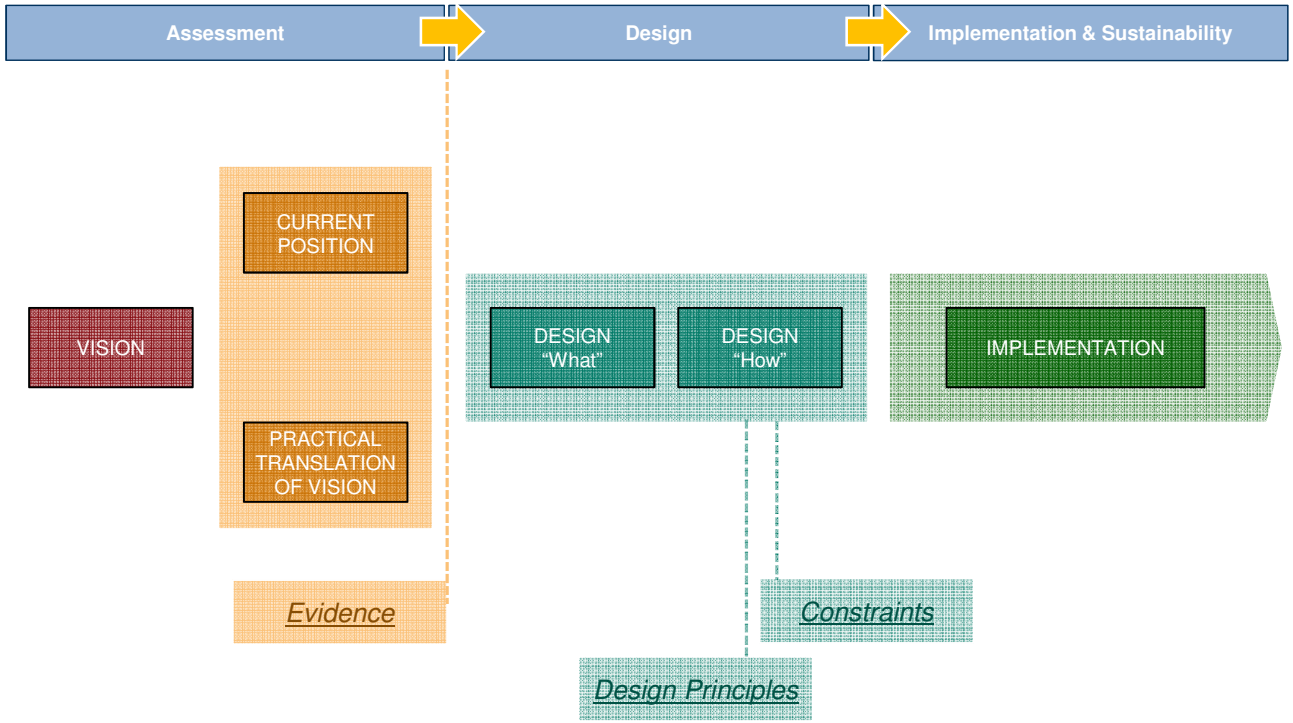
Measure
C2.12 Recovery following talking therapies for people older than 65
C2.13 Estimated diagnosis rate for people with dementia
C2.14 People with dementia prescribed anti-psychotic medication
C2.15 Health related quality of life for carers
C2.16 Health related quality of life for people with a long term mental health condition
C3.2 Emergency readmissions within 30 days of discharge from hospital
C3.3 Total health gain as assessed by patients; for elective procedures a) hip replacement b) knee replacement c) groin hernia d) varicose veins
C3.4 Emergency admissions for children with lower respiratory tract infections (LRTIs)
C3.5 People who have had a stroke who are admitted to an acute stroke unit within four hours of arrival to hospital
C3.6 People who have had a stroke who receive thrombolysis following an acute stroke
C3.7 People who have had a stroke who are discharged from hospital with a joint health and social care plan
C3.8 People who have had a stroke who receive a follow up assessment between 4-8 months after initial admission
C3.9 Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit
C3.10 Proportion of patients recovering to their previous levels of mobility or walking ability
C3.11 Hip fracture: formal hip fracture programme
C3.12 Hip fracture: timely surgery
C3.13 Hip fracture: multifactorial risk assessment
C3.14 Alcohol: admissions
C3.15 Alcohol: readmissions
C3.16 Readmissions to Mental Health within 30 days of discharge
C3.17 Proportion of adults in contact with secondary mental health services in paid employment
C4.1 Patient experience of GP out of hours services
C4.2 Patient experience of hospital care
C4.3 Friends and Family Test
C4.4 Patient experience of outpatient services
C4.5 Responsiveness to in-patients' personal needs
C4.6 Patient experience of accident and emergency (A&E) services
C4.7 Women's experience of maternity services
C4.8 Patient experience of community mental health services
C4.9 Bereaved carers views on the quality of care in the last 3 months of life
C5.1 Patient safety incidents reported.
C5.3 Incidence of healthcare associated infection (HCAI) MRSA
C5.4 Incidence of healthcare associated infection (HCAI) Clostridium Difficile (C difficile)

Adult Social Care Transformation

Thanet Health and Wellbeing Board
11th June 2015

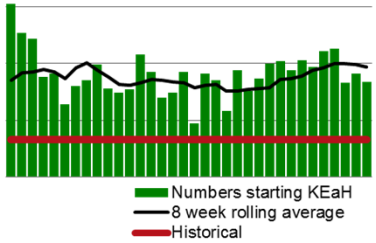
Mark Lobban
Director of Commissioning
Social Care, Health and Wellbeing

Transformation Approach

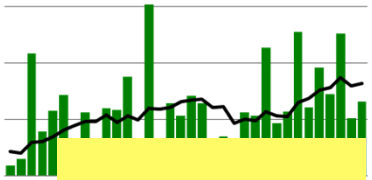


Phase one – better outcomes less cost

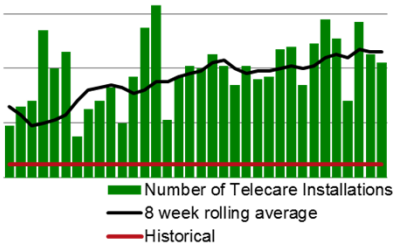
KEaH
Support and guidance allowing longer independent living after a change in circumstances
1910 Additional people using KEaH since project roll-out



PIRs
Reviews focusing on providing necessary care without reducing independence and making best use of local voluntary services
1820 People have received a review with this focus & methodology

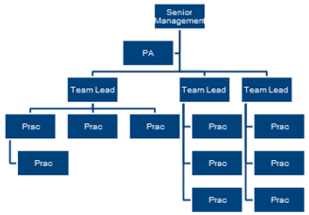


Telecare
Specialist equipment providing remote support for service users and increased independence
1034 Additional People have received Telecare Equipment since project roll-out

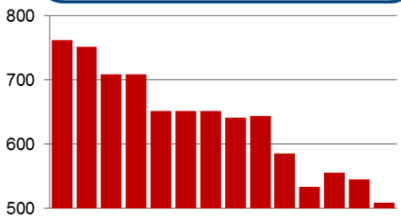


c£30M savings

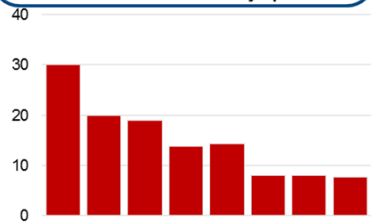
Optimisation – Org Structure
Improvements made to service delivery have allowed vacancy freezes and staff numbers have gotten closer to agreed establishment levels through natural attrition. A small number of compulsory redundancies may need to be made. **23% Reduction in staff**



Imp… rec… …d by practitioners i.e. the number of service users who are awaiting a visit and/or review of care provision.
Overdue reviews have reduced by 60%



Lead Time – Contact to Assessment
Using a scheduling system, appointments can be booked directly into calendars and assigned to the correct skill set. This significantly reduces service user anxiety.
Lead Times have reduced by up to 70%



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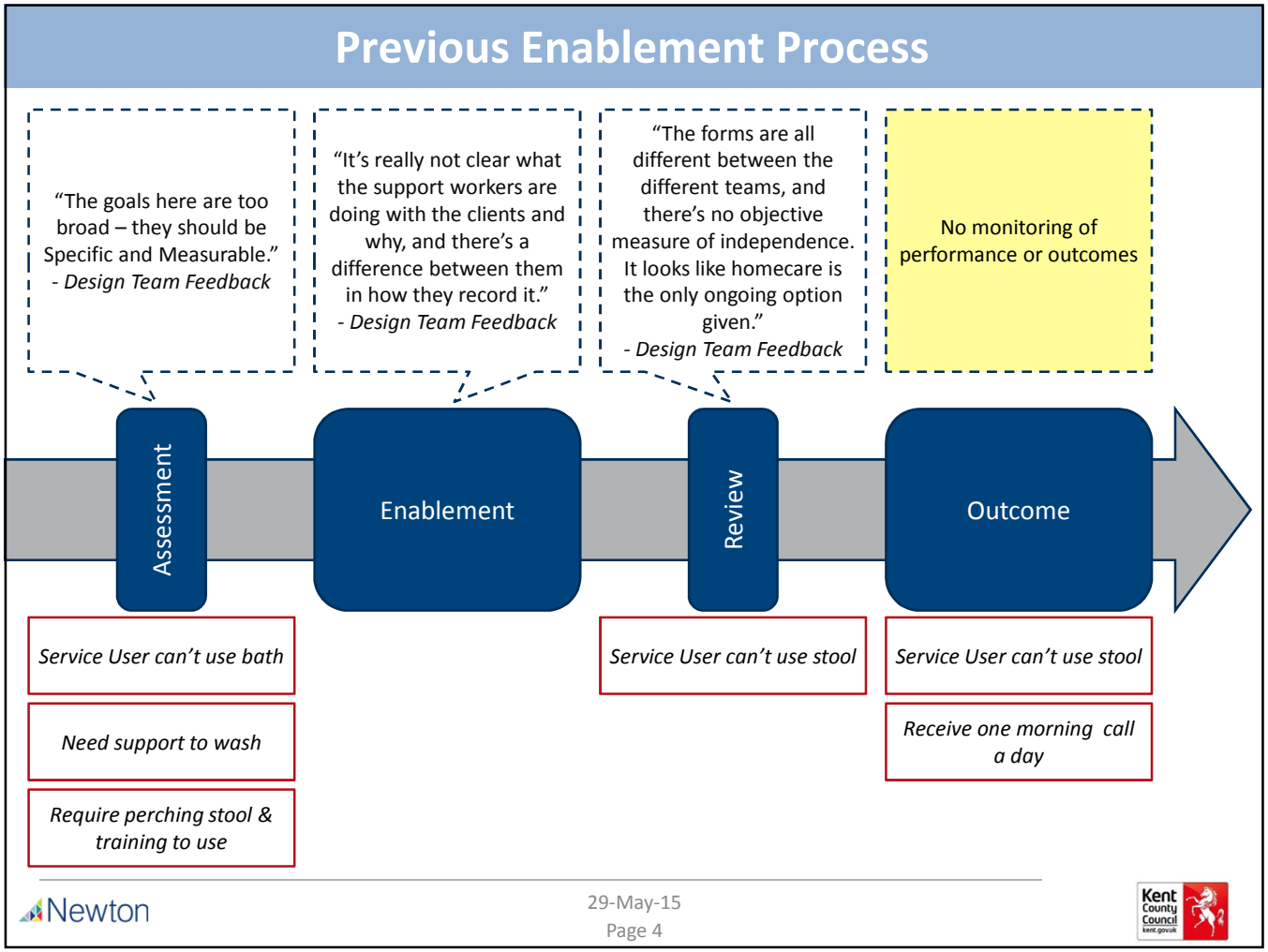
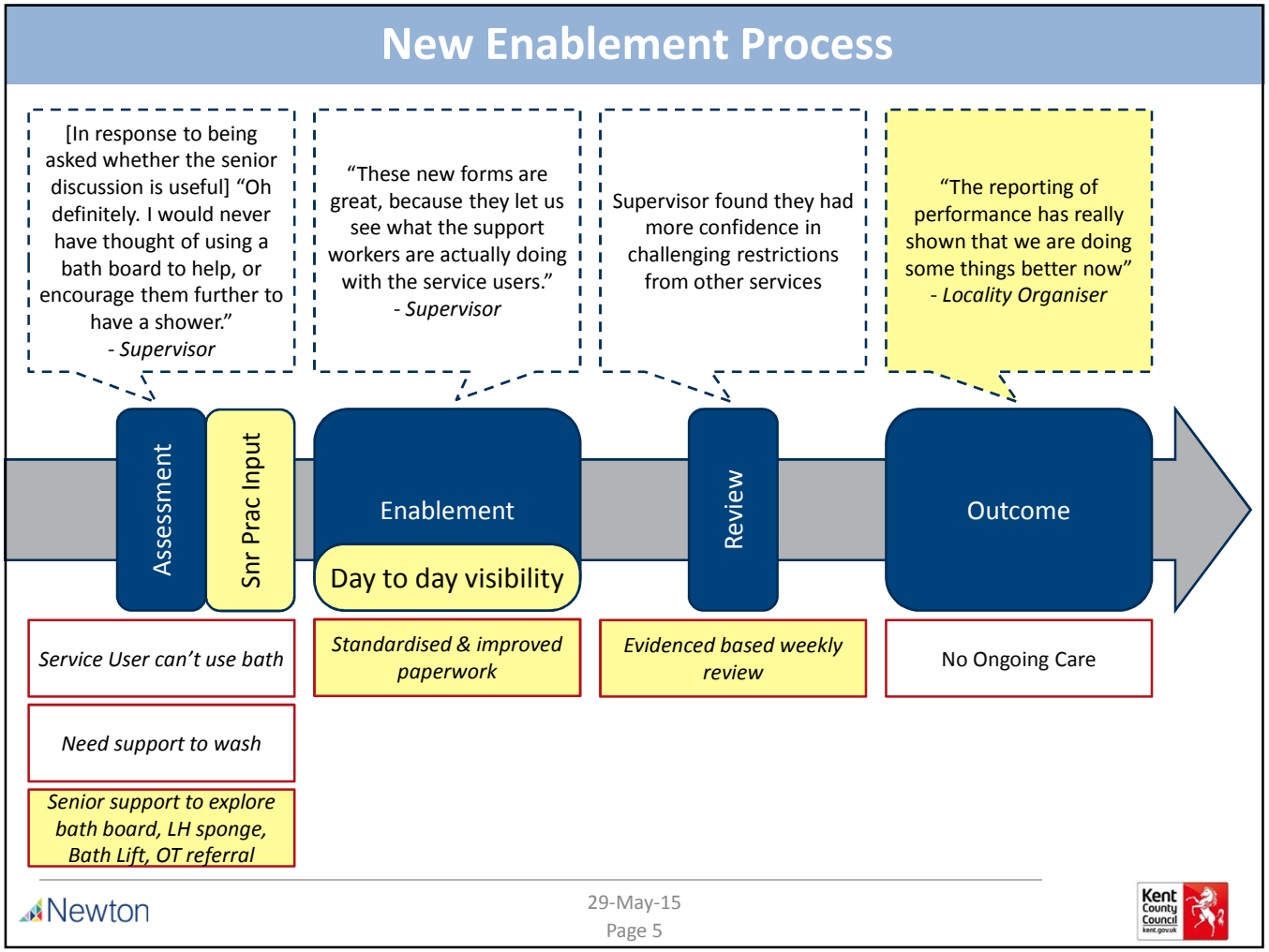
Previous Enablement Process



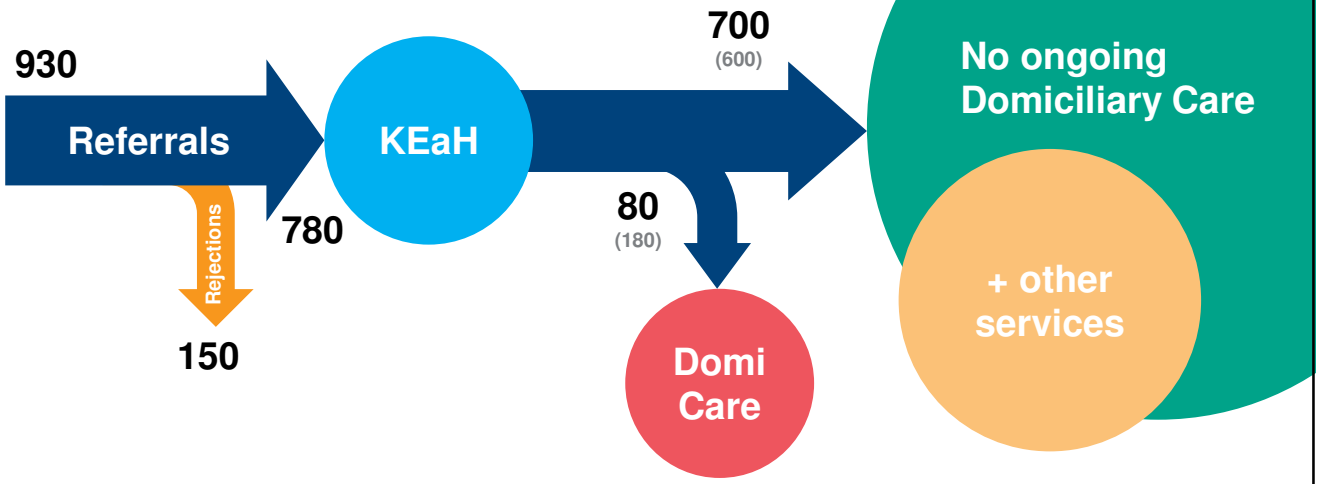
New Enablement Process



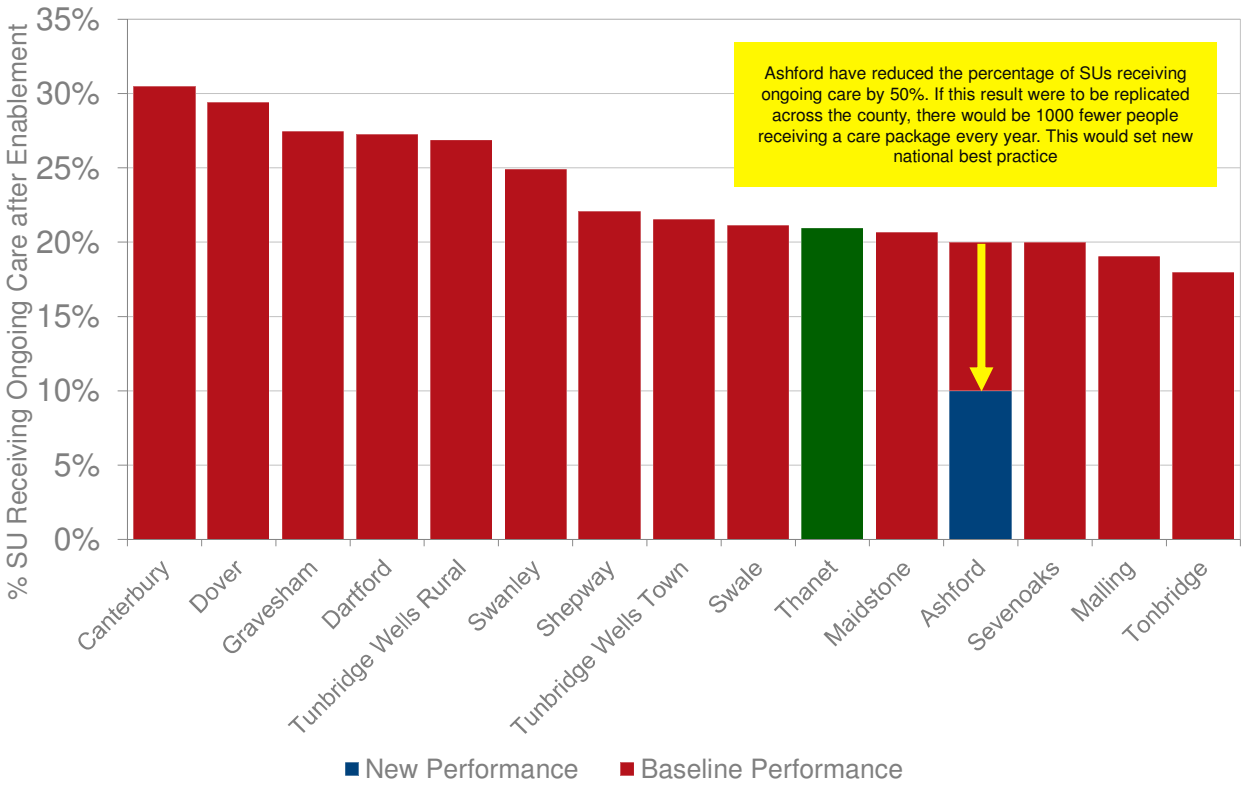
What is the impact of the change in practice?

Figures describe the total number of people on each pathway if performance (as of April 2015) were sustained for one year

The results of the Sandbox means 100 fewer service users per year will receive an ongoing care package on leaving the service in Ashford



What does that mean Countywide ?



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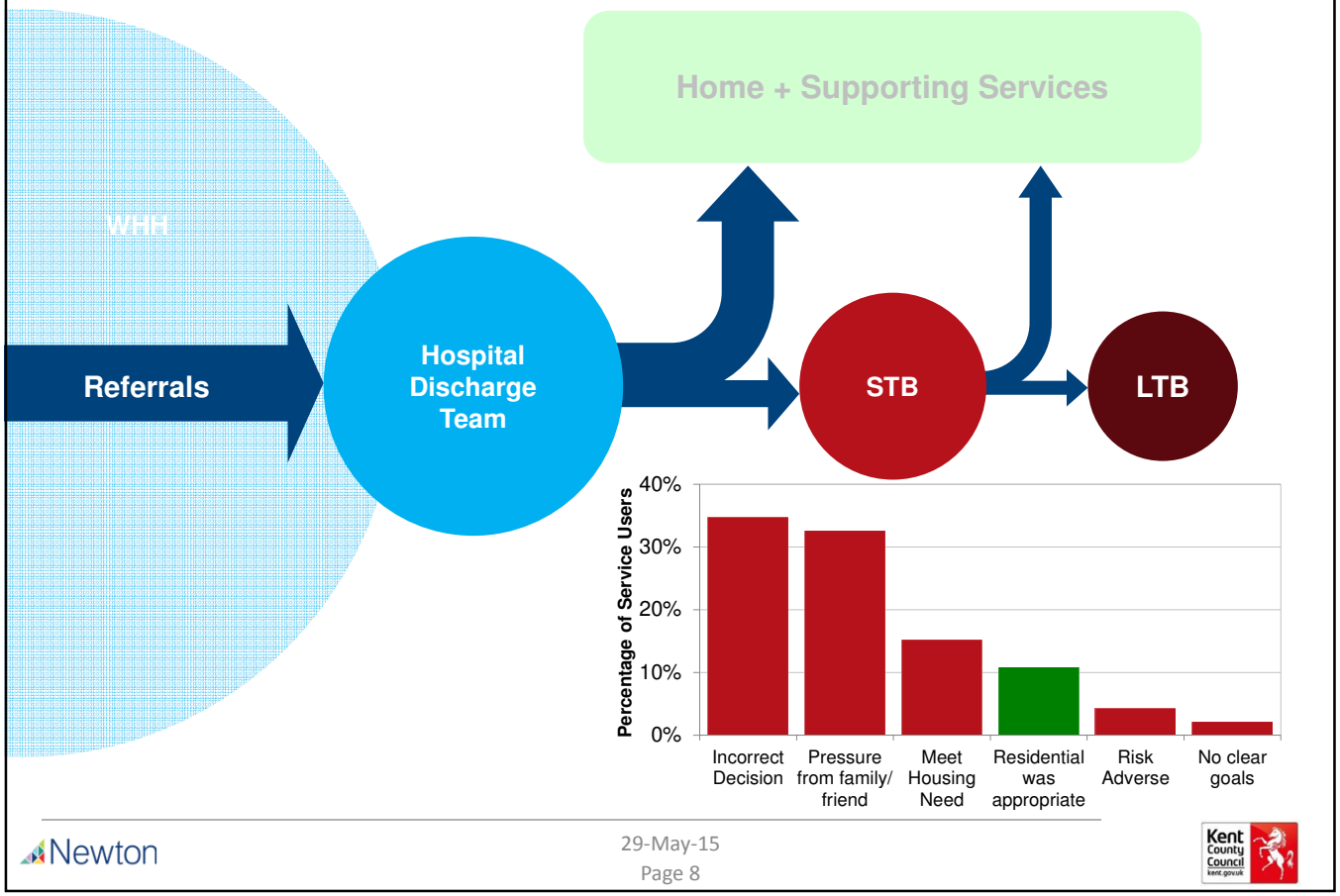
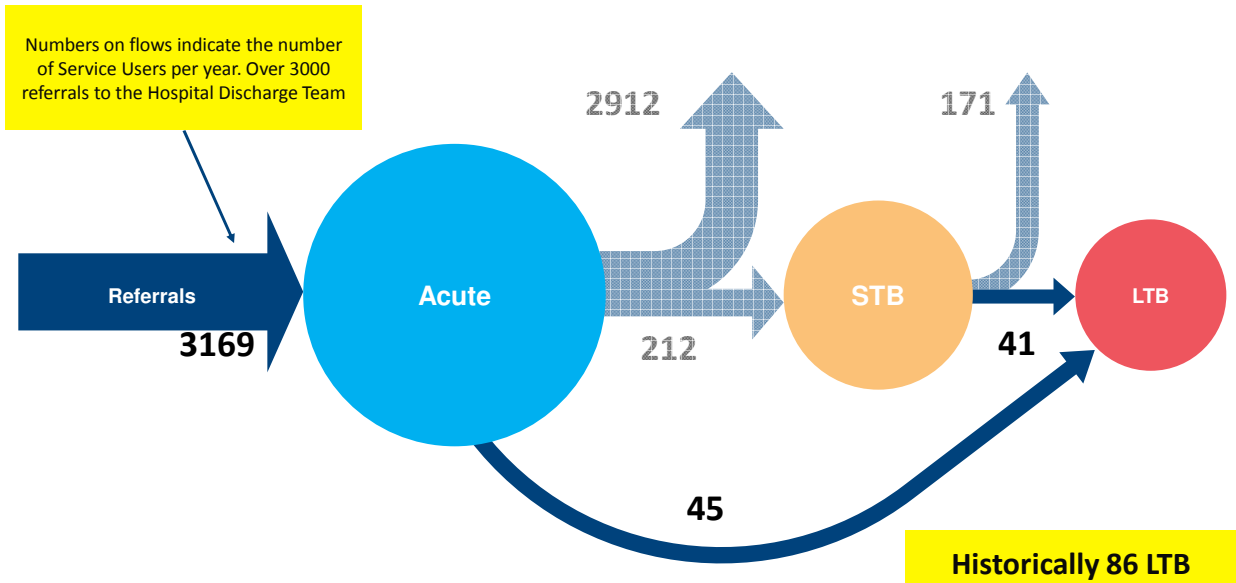
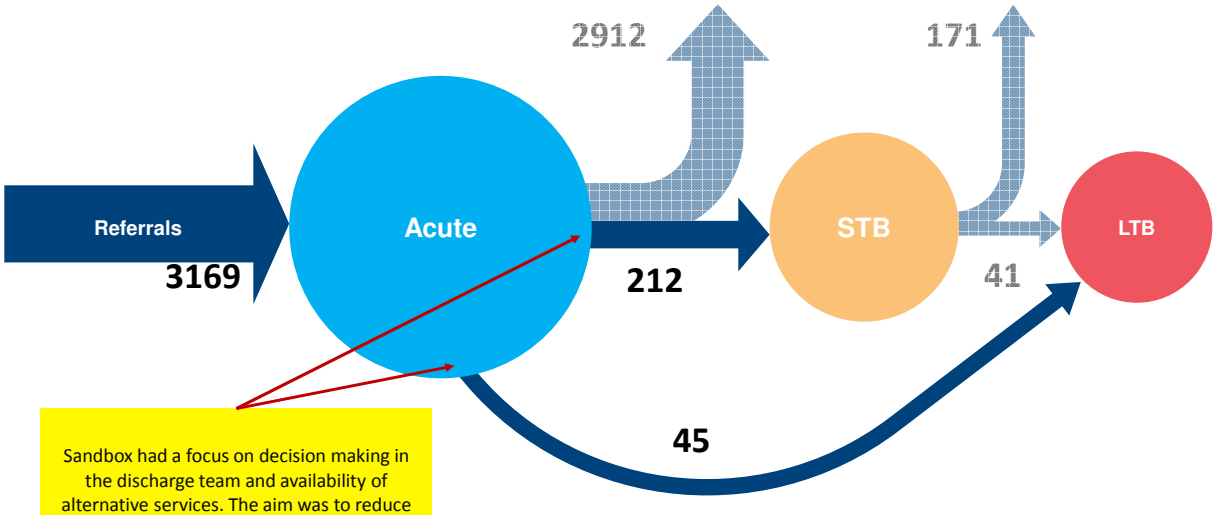
William Harvey Acute Pathway



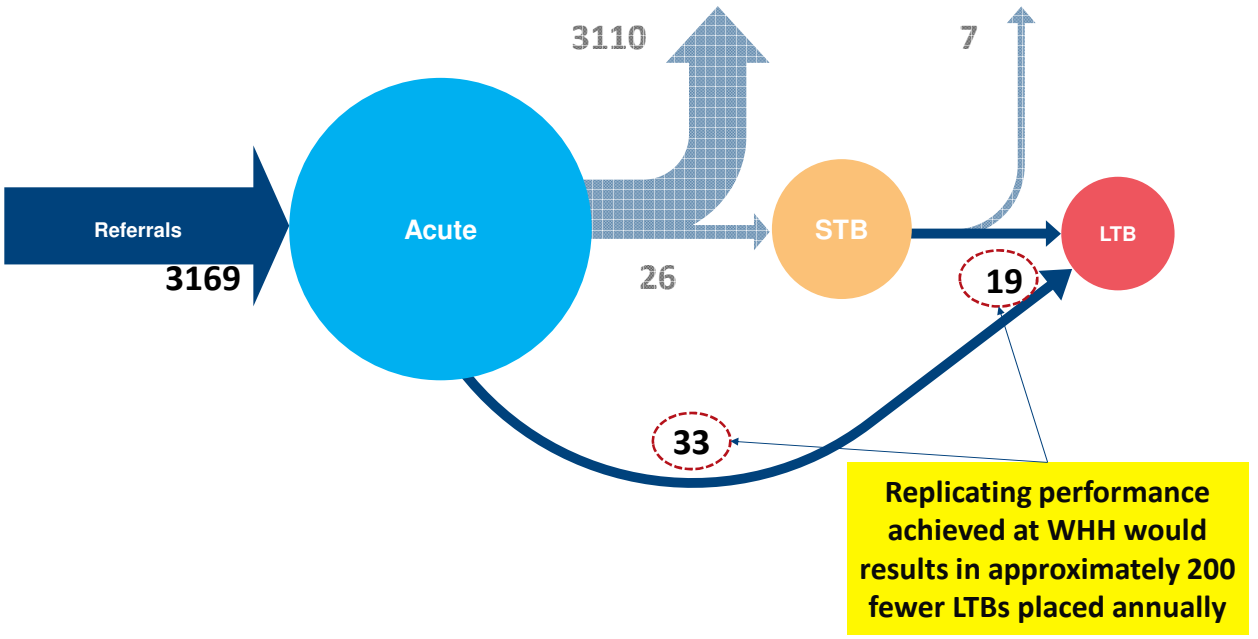
William Harvey Acute Pathway – 2014 Past Performance



William Harvey Acute Pathway – 2014 Past Performance



William Harvey Acute Pathway – Sandbox Results



Adult Social Care Future Vision

	Prevention	Promoting Independence	KCC	Complex / Specialist	Accommodation
Summary sentence / strapline	• First contact capability to enable self management and ensure people receive the right level of response "not getting sucked in unnecessarily"	• Outcome based support with a "relentless focus on maximising people's independence"	• In-house function tasked with commissioning & overseeing all aspects of KCC's care model	• Outcome based support to cater for more complex requirements	• High quality accommodation options for target client groups
Objectives Why?	• Secure a lower level of ongoing referrals • Promote self management, health & wellbeing	• Identify and provide the best long term outcome for clients • Promote & maximise people's independence	• Improve overall efficiency & effectiveness of KCC's social care	• Provide all clients with highest possible levels of wellbeing, self sufficiency & dignity	• Provide an increased choice to clients at the right time • Reduce overall numbers of people in long term care • Improve £ for quality

Advice info and guidance, self care, building community capacity (community agents)

Integrated Commissioning, Performance, Programme Management

Developing capacity and how we work with care homes

Redesigning enablement, homecare, intermediate care, teletechnology and equipment

End of life, dementia

A new joint workforce in the right place at the right time (career pathways etc.)

HEALTH INEQUALITIES IN THANET

To: **Thanet Health and Wellbeing Board – 11 June 2015**

By: **Colin Thompson, Consultant in Public Health**

Subject: **Health inequalities**

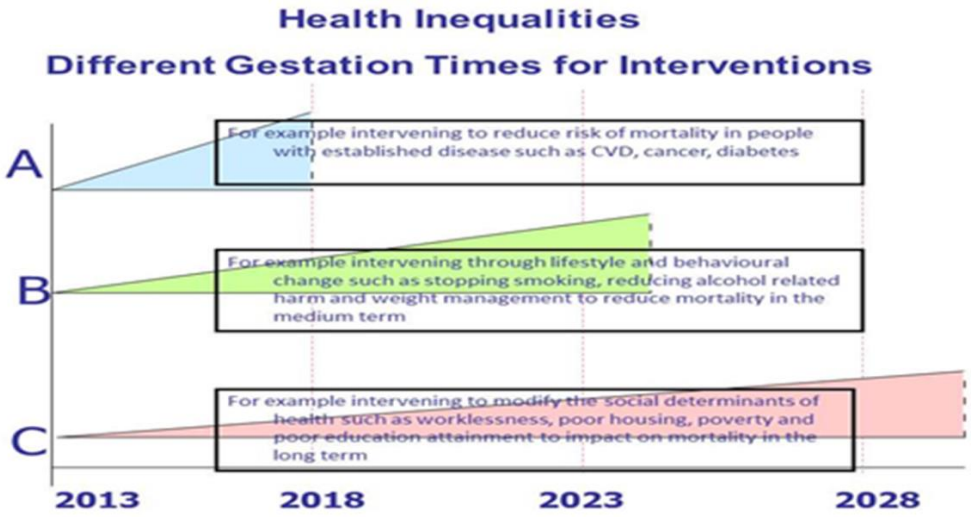
Classification: **Unrestricted**

Summary: Health inequalities are avoidable variations in health. Thanet has the widest gap in health inequalities out of the districts in Kent. The gap in life expectancy at birth between the highest and lowest ward is 16.77 years. Tackling health inequalities requires a systematic approach utilising a range of interventions. A localised action plan should be developed that is owned by the Thanet Health and Wellbeing Board.

1.0 Introduction and Background

1.1 Health inequalities are avoidable variations in health status of groups and individuals and are a complex issue. There is evidence that populations in areas with high deprivation experience higher morbidity and mortality than those areas with low deprivation (Marmot strategic review, 2010), however some less deprived areas may contain pockets of high mortality.

1.2 Tackling health inequalities is a complex. The diagram below highlights the potential gestation times for different types of interventions. The interventions that can potentially have an effect in the short-term are those that reduce the risk of mortality in people with established disease (i.e. ensuring those with heart disease are diagnosed and treated so that their blood pressure/cholesterol is under control). Longer term solutions include those that tackle worklessness, poor educational attainment and poverty.



1.3 In 2012, Kent County Council launched Mind the Gap. Mind the Gap is Kent's Health Inequalities Action Plan which aims to improve health and wellbeing for everyone in

Kent by narrowing the gap in health status between our richest and poorest communities. It provides a framework and tools to identify, analyse and evaluate actions that contribute to reducing health inequalities.

1.4 Thanet has the widest gap in health inequalities out of all of the districts in Kent. There is a need to ensure that there is a clear strategic action plan specific to Thanet that is owned by the Health and Wellbeing Board that tackles short, medium and long-term interventions.

2.0 The Current Situation

2.1 There are a range of indicators to demonstrate that there are considerable health inequalities across Thanet. Life expectancy at birth between different wards in Thanet is 16.77 years. Life expectancy at birth is 73.57 years in Margate Central and 90.34 years in Kingsgate. Between 2010-2012, the teenage conception rate was 113 per 1,000 women aged between 15-17 in Cliftonville West and zero in Kingsgate, Viking and Bradstowe. The Age Standardised Mortality Rate per 100,000 population for under 75 Circulatory deaths between 2009-2013 was 252.67 per 100,000 population in Margate Central and 35.06 in Birchington North. Mental health contact rates between December 2012 and November 2013 were 71.73 per 1,000 people aged 18-64 in Margate Central and 17.87 in Kingsgate.

2.2 There are also variations in wider determinants that have an effect on health inequalities. For example in 2013, 30.89% of children in Cliftonville West achieved five GCSEs at grade C or above, whereas in Viking it was 76.47%.

2.3 There are also inequalities in relation to undiagnosed disease and a recent report by Kent County Council Public Health department highlighted that generally there is a greater proportion of undiagnosed disease prevalence in practices serving the most deprived populations within the district.

3.0 Recommendations

3.1 Thanet Health and Wellbeing Board should ensure that tackling health inequalities is one of its key priorities.

3.2 A health inequalities action plan should be developed. This work should be led by Kent County Council Public Health, in partnership with all stakeholders. The action plan will be brought to the next Health and Wellbeing Board.

3.3 All Stakeholders to identify a lead individual who will take the responsibility of reducing health inequalities.

3.4 Establishing a Thanet Health Action Group as a sub-group of the Health and Wellbeing Board. This group can deal with more detailed actions relating to localised health issues such as implementation of the local alcohol action plan.

4.0 Background Papers

4.1 None

5.0 Contact details

Report Author

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Colin.thompson@kent.gov.uk

Relevant Director

Andrew Scott-Clark: Director of Public Health, Kent County Council
Andrew.scott-clark@kent.gov.uk

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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** ……

DISCRETIONARY 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.