

Public Document Pack



Date: 7 September 2015
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THANET HEALTH AND WELLBEING BOARD

17 SEPTEMBER 2015

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 17 September 2015** in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Membership:

Dr Tony Martin (Chairman); Hazel Carpenter, Esme Chilton, Councillor L Fairbrass, Councillor Gibbens, Madeline Homer, Mark Lobban, Emma Hanson, Colin Thompson, Clive Hart and Councillor Wells.

A G E N D A

Item No

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 THE PREVIOUS MEETING** (Pages 1 - 4)
To approve the minutes of the meeting held on 11 June 2015, copy attached.
4. **LEADING INTEGRATED HEALTH AND SOCIAL CARE COMMISSIONING IN THANET**
(Pages 5 - 12)
5. **THANET CCG LOCALITY PROFILES**
6. **LOCAL ALCOHOL PROFILES** (Pages 13 - 36)
7. **PUBLIC HEALTH TRANSFORMATION WORK** (Pages 37 - 44)
8. **DEMENTIA UPDATE** (Pages 45 - 54)

Declaration of Interests Form

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Public Document Pack Agenda Item 3

THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 11 June 2015 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Hazel Carpenter (Thanet Clinical Commissioning Group), Councillor L Fairbrass (Thanet District Council), Councillor Gibbens (Kent County Council), Mark Lobban (Kent County Council), Colin Thompson (Kent County Council), Councillor Wells (Thanet District Council), Clive Hart (Thanet Clinical Commissioning Group) and Larissa Reed (Thanet District Council)

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

Councillor Gibbens proposed, Councillor Wells seconded and Members agreed that Dr Martin be appointed as Chairman of the Thanet Health and Wellbeing Board for the ensuing year.

Dr Martin proposed, Councillor Wells seconded and Members agreed that Councillor Fairbrass be appointed Vice-Chairman of the Thanet Health and Wellbeing Board for the ensuing year.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 12 February 2015 were agreed.

3. DEVELOPMENT OF THE THANET HEALTH AND WELLBEING BOARD

Alisa Ogilvie, Chief Operating Officer, Thanet CCG, presented her report noting that there would be an executive group set up which would report to the Thanet Health and Wellbeing Board (THWB). She added that there had been a THWB development workshop held on 3rd June during which it was agreed that there should be a shift of responsibilities from the CCG to THWB and that the purpose of this item was to seek ratification from those present to move in that direction.

In response to comments and questions it was noted that:

- Members highlighted that they felt the development session had been a useful exercise. Advice from TDC and KCC policy officers would now be required in order to progress the proposed developments;
- delivery was what mattered to the public, therefore it was important to demonstrate least one successful and meaningful outcome quickly.
- this development of THWB should take place over the next 12 months to coincide with a retendering exercise that KCC would be undertaking.

It was agreed that the executive group would provide an update on the development of the THWB at the next meeting.

4. DEMENTIA BRIEFING

Colin Thompson, Consultant in Public Health, KCC presented the report which gave a background to the condition and gave an update on work carried out both within Thanet and nationally.

In response to comments and questions it was noted that:

- there is still a degree of stigma attached to dementia, this could adversely impact early identification and treatment;
- some councils have offered dementia awareness training;
- an assessment would be required to establish the level of support and facilities (both medical and non-medical) available to those with dementia within Thanet;
- E-Kids, Age UK Thanet, and dementia friendly café's provide some support to dementia sufferers. Links to these organisations would be made available on the TDC's website.

Members agreed that the executive group would appoint a lead officer to establish the level of dementia service available in a medical setting and within the community.

5. AGE UK SUPPORT

Diane Aslett and Nicola Parish from Age UK gave a presentation on the work of Age UK with a particular focus on the Support at Home Service.

It was noted that there was a focus on the early identification of problems before issues could develop in more serious conditions.

It was recognised that the Support at Home Service prevented repeated hospital visits by enabling those discharged from hospital to get back on their feet and regain independence.

6. QUALITY PREMIUM 2015/16

Adrian Halse, Senior Business Analyst, Thanet CCG introduced the report which gave some background to the principles of the quality premium and detailed specific indicators chosen by the Thanet CCG.

In response to comments and questions it was noted that the Thanet CCG had been required to submit its proposals to NHS England in May, however it wished for the Thanet Health and Wellbeing Board to ratify the indicators. These indicators were largely derived from blanket indicators issued across the country.

Members agreed to ratify the list of indicators as set out in paragraph 4.2 of the report, namely:

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

7. EKHUFT POSITION STATEMENT

The Chairman introduced the item, and noted the following:

- there would need to be a shift of increased care provision with in the community rather than in hospitals.

- the health service had seen a trend of medical specialisation, however there would be an increasing demand for consultants with more generalised expertise, this knowledge would take time to develop.
- that acute health care could not continue in its current form when faced with changing budgets and demographic, Buckland Hospital could be an example of what future health provision might look like.

In response to comments it was noted that effective communication would be vitally important, and co-ordination would be required with elected Members at TDC and KCC.

8. ADULT SOCIAL CARE TRANSFORMATION

Mark Lobban, Director of Commissioning Social Care, KCC presented the item. He noted that this was to update Members regarding phase two of the transformation. Mr Lobban advised that the modelling was based upon success demonstrated in Ashford where improvements to the Ashford enablement team had resulted in 90% of people having no on-going care needs after a period of enablement.

In response to questions and comments it was noted that:

- the Thanet Health and Wellbeing Board would have a role in assessing the success of the integrated support proposal;
- the transformation would require a larger domiciliary workforce with care providers becoming more specialist;
- there are currently some perverse incentives in domiciliary care that encourage dependency on the service rather than independence;
- more needed to be done to get young people interested in domiciliary work, there was recognition that current pay and conditions were not an incentive to young people to embark on a career as care workers;
- secondary schools received an invitation to the East Kent Social Care and Health Careers Event which would take place in October 2015.

It was agreed that the executive board would look further into the transformation programme at its next meeting.

9. HEALTH INEQUALITIES IN THANET

Colin Thompson, Consultant in Public Health, KCC presented the report noting that compared with the other districts in Kent, Thanet had the widest gap in health inequalities between its areas.

Members agreed the recommendations as set in the report, namely:

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

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.

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

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.”

10. THANET HEALTH PROFILE

Colin Thompson, Consultant in Public Health, KCC presented the document, noting that the profile is produced by Public Health England each year. He added that it was evident that a number of indicators showed Thanet as significantly worse than the England average.

It was noted that these issues of inequality were persistent and on-going, they had been highlighted in 2004 and remained a problem. More resource was required into areas where inequality was most prevalent.

Members agreed that the executive group would look into inequalities as a priority order to drive the issue forward.

11. REPORT ON THE CHILDREN'S BOARD

Members noted the report.

12. AGENDA TOPICS FOR THE NEXT MEETING

A number of items were referred to the executive board for investigation and development, an update on these items would be provided at the following meeting of the THWB.

Meeting concluded: 12.00 pm

Leading Integrated Health and Social Care Commissioning in Thanet

Thanet Health and Wellbeing Board
10 September 2015

Context

- HWBBs established 2012 to drive the integration agenda
- 2013 Kent selected one of 14 integration Pioneers
- Better Care Fund programme underway

- Variable delivery by HWBBs across the UK
 - positive relationships established
 - Some new models of health improvement emerging
 - Differing pace and tendency to be 'talking shop'

Context

- February 2015 THWBB agrees commitment and ambition to become vehicle for change
- June 2015 Development Workshop & Board
 - shaped vision for future direction
 - future direction agreed by THWBB
- June 2015 'Making it better together' published
 - LGA & NHS Clinical Commissioners - a call to action on the future of health and wellbeing boards
- Timely to pick up pace to deliver in Thanet

Leading Integrated Health and Social Care Commissioning in Thanet

- June Board -Principles underpinning Thanet model agreed
 - strategic place-based approach
 - political leadership with commitment to subsidiarity
 - shared leadership
 - shared risk and collective security
 - collaboration and engagement
 - THWBB as an institution, not a meeting
- In line with national ‘call to action’ by LGA & NHS Clinical Commissioners

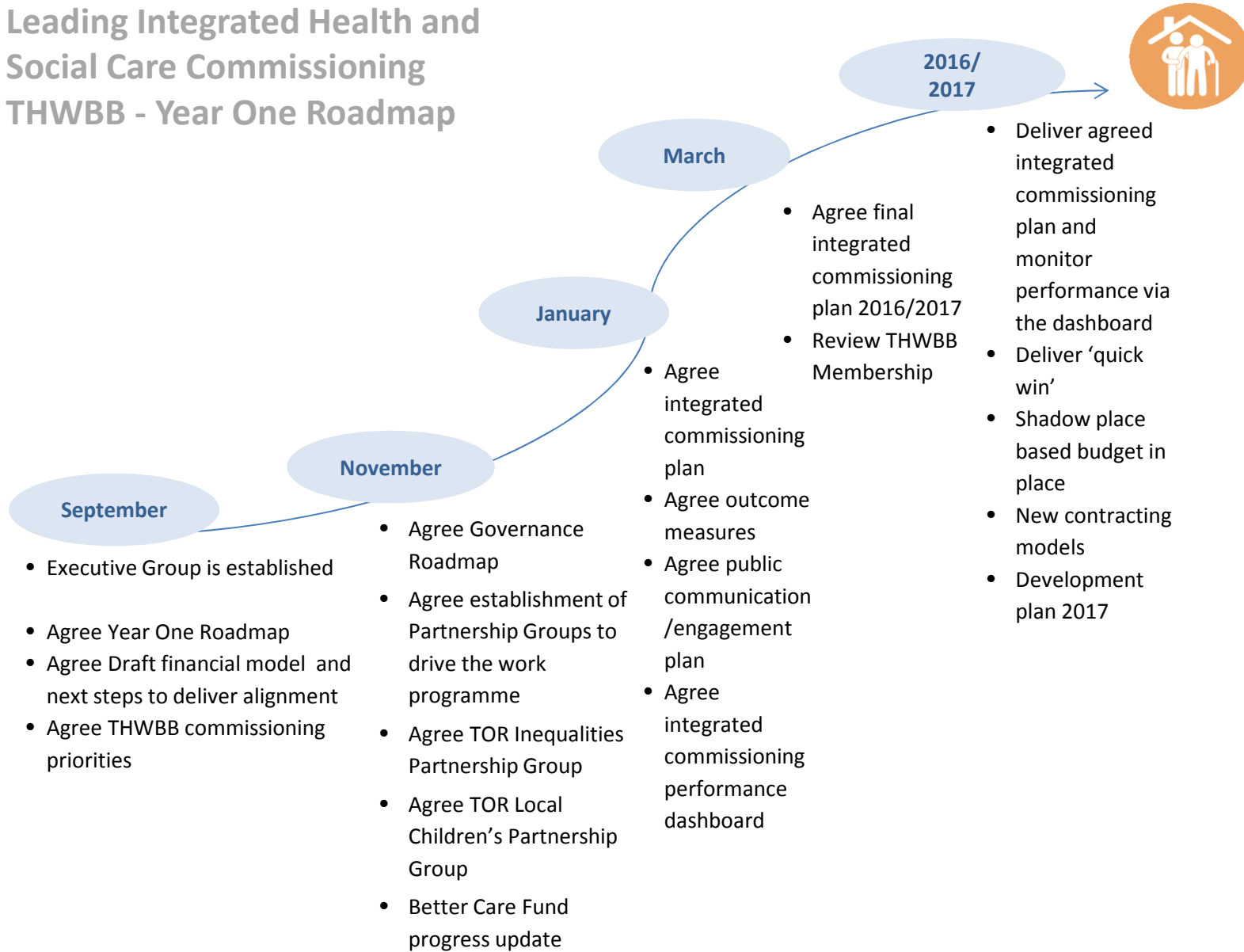
Leading Integrated Health and Social Care Commissioning in Thanet

- June Board – Key development proposals agreed
 - Establish an Executive Group to support Board development and direction
 - Agree a work programme with focus on outcomes
 - Membership kept under review, but unchanged in the short term
 - Wider involvement including by providers via task and finish groups/for specific agenda items
 - Board underpinned by working groups to drive the work programme
 - Alignment of resources

Leading Integrated Health and Social Care Commissioning in Thanet

- June Board – Year one goals agreed
 - Takes decisions that influence action
 - Plan prioritised by politicians and officers
 - Has taken on some of the CCG function
 - Has successfully aligned expenditure
 - Contribution by wider public services
 - Has had at least one successful and meaningful outcome, a quick win

Leading Integrated Health and Social Care Commissioning THWBB - Year One Roadmap



Questions

- Roadmap
 - Is there anything missing?
 - Are the timelines right?
 - Potential blocks to HWBB development
 - Does the roadmap form the basis of future agenda
 - Is current meeting frequency adequate?



Thanet

This profile was produced on 2 June 2015

Local Alcohol Profile 2015

Introduction

Alcohol use has health and social consequences borne by individuals, their families, and the wider community. The aim of these profiles is to provide information for local government, health organisations, commissioners and other agencies to monitor the impact of alcohol on local communities, and to monitor the services and initiatives that have been put in place to prevent and reduce the harmful impact of alcohol.

Reducing harmful drinking is one of seven priority areas that Public Health England is focusing efforts on securing improvement. The indicators contained within the web-tool were selected following consultation with stakeholders and a review of the availability of routine data. The Local Alcohol Profiles for England (LAPE) are part of a series of products by Public Health England that provide local data alongside national comparisons to support local health improvement.

For further information about each indicator please view the definitions tab within the tool at <http://fingertips.phe.org.uk/profile/local-alcohol-profiles>. For further information on alcohol and health please visit <http://www.lape.org.uk>.

Spine Charts

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Tartan Rugs

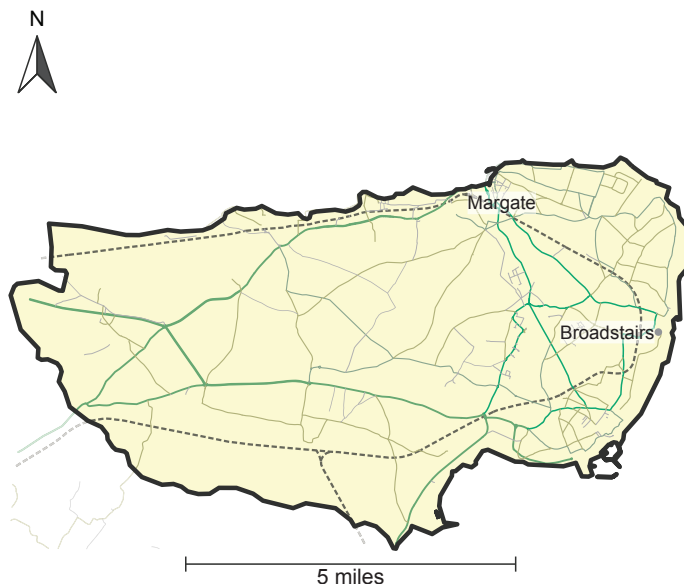
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Bar Charts

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Trends

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Produced by Public Health England.

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For enquiries please contact KITNorthWest@phe.gov.uk or call us on 0151 231 4535.

Spine Charts

Mortality

	Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
1	1.01 - Months of life lost due to alcohol (Male)	2011 - 13	14.4	12.0	6.1	28.0
2	1.01 - Months of life lost due to alcohol (Female)	2011 - 13	6.4	5.6	13.5	2.8
3	2.01 - Alcohol-specific mortality (Persons)	2011 - 13	14.6	11.9	31.2	3.4
4	2.01 - Alcohol-specific mortality (Male)	2011 - 13	21.6	16.6	44.5	3.6
5	2.01 - Alcohol-specific mortality (Female)	2011 - 13	8.3	7.5	29.9	1.6
6	3.01 - Mortality from chronic liver disease (Persons)	2011 - 13	16.7	11.7	31.7	3.3
7	3.01 - Mortality from chronic liver disease (Male)	2011 - 13	20.5	15.5	44.8	2.4
8	3.01 - Mortality from chronic liver disease (Female)	2011 - 13	12.9	8.2	23.7	0.0
9	4.01 - Alcohol-related mortality (Persons)	2013	53.3	45.3	83.6	27.9
10	4.01 - Alcohol-related mortality (Male)	2013	74.8	65.4	117.3	38.5
11	4.01 - Alcohol-related mortality (Female)	2013	35.1	28.4	68.7	14.8

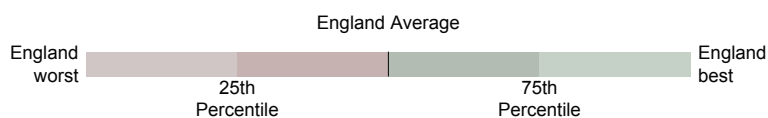
Hospital Admissions

	Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
12	5.01 - Alcohol-specific hospital admission - under 18s	2011/12 - 13/14	46.5	40.1	105.8	11.2
13	6.01 - Alcohol-specific hospital admission (Persons)	2013/14	412	374	1074	131
14	6.01 - Alcohol-specific hospital admission (Male)	2013/14	557	515	1494	170
15	6.01 - Alcohol-specific hospital admission (Female)	2013/14	281	241	658	77
16	7.01 - Alcohol-related hospital admission (Broad) (Persons)	2013/14	1253	1253	2070	731
17	7.01 - Alcohol-related hospital admission (Broad) (Male)	2013/14	1733	1715	2820	1011
18	7.01 - Alcohol-related hospital admission (Broad) (Female)	2013/14	856	859	1386	498
19	8.01 - Alcohol-related hospital admission (Narrow) (Persons)	2013/14	521	444	808	264
20	8.01 - Alcohol-related hospital admission (Narrow) (Male)	2013/14	679	594	1049	338
21	8.01 - Alcohol-related hospital admission (Narrow) (Female)	2013/14	387	310	583	190
22	9.01 - Admission episodes for alcohol-related conditions (Broad) (Persons)	2013/14	1892	2111	3493	1115
23	9.01 - Admission episodes for alcohol-related conditions (Broad) (Male)	2013/14	2674	2917	4848	1582
24	9.01 - Admission episodes for alcohol-related conditions (Broad) (Female)	2013/14	1250	1426	2392	727
25	10.01 - Admission episodes for alcohol-related conditions (Narrow) (Persons)	2013/14	653	645	1231	366

Key

Significance compared to England average:

- Significantly worse
- Significance not tested
- Not significantly different
- ◆ Regional average
- Significantly better



Hospital Admissions continued		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
26	10.01 - Admission episodes for alcohol-related conditions (Narrow) (Male)	2013/14	843	835	1538		474
27	10.01 - Admission episodes for alcohol-related conditions (Narrow) (Female)	2013/14	492	475	940		262

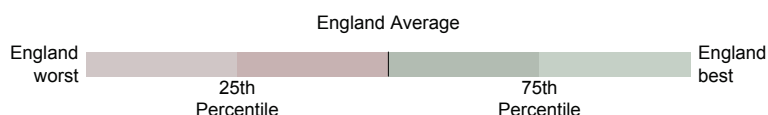
Hospital Admissions - Cause groups

	Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
28	9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Persons)	2013/14	109.5	175.8	368.2	71.4
29	9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Male)	2013/14	124.9	177.0	438.9	63.7
30	9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Female)	2013/14	97.2	176.5	380.5	58.8
31	9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Persons)	2013/14	859	1049	1706	550
32	9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Male)	2013/14	1309	1524	2575	842
33	9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Female)	2013/14	508	673	1129	307
34	9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Persons)	2013/14	376	394	1296	111
35	9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Male)	2013/14	577	579	1894	161
36	9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Female)	2013/14	194	218	706	63
37	9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Persons)	2013/14	90.1	105.3	245.6	18.7
38	9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Male)	2013/14	123.1	147.1	351.8	27.1
39	9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Female)	2013/14	59.6	65.8	272.9	16.9
40	10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Persons)	2013/14	75.8	150.7	359.9	49.8
41	10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Male)	2013/14	91.6	154.7	404.7	47.8
42	10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Female)	2013/14	63.2	149.3	352.3	39.3
43	10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Persons)	2013/14	147.0	141.8	223.9	96.6
44	10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Male)	2013/14	229.0	215.2	351.3	142.5
45	10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Female)	2013/14	75.4	74.2	107.5	49.9
46	10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Persons)	2013/14	96	87	222	17
47	10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Male)	2013/14	138	124	310	21

Key

Significance compared to England average:

- Significantly worse
- Significance not tested
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- ◆ Regional average
- Significantly better



Thanet

Hospital Admissions - Cause groups continued		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
48	10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Female)	2013/14	57	52	152		10
49	10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Persons)	2013/14	102.3	58.6	254.1		11.1
50	10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Male)	2013/14	66.5	52.0	269.1		7.1
51	10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Female)	2013/14	135.6	65.4	239.1		10.1

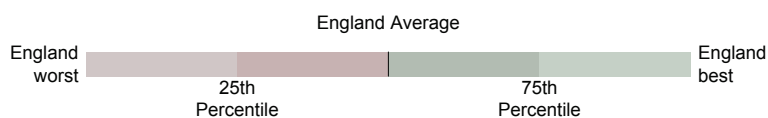
Other Impacts

	Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
52	11.01 - Claimants of benefits due to alcoholism	2014	180.7	131.0	528.3	15.7

Key

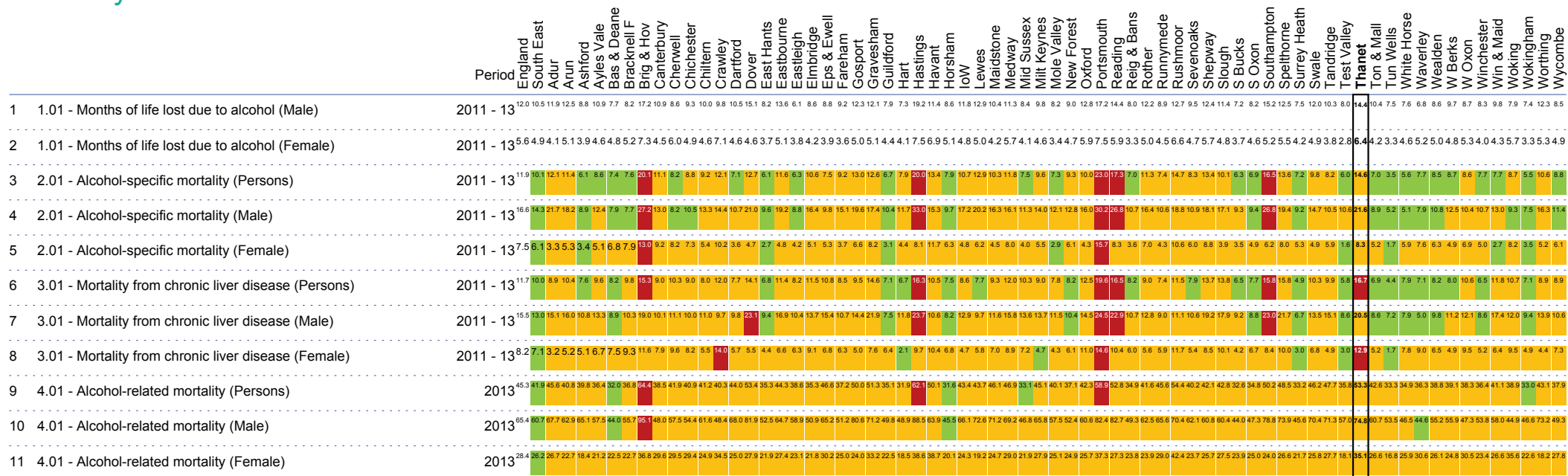
Significance compared to England average:

- Significantly worse
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Tartan Rugs

Mortality



Hospital Admissions

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Comparison with respect to England value

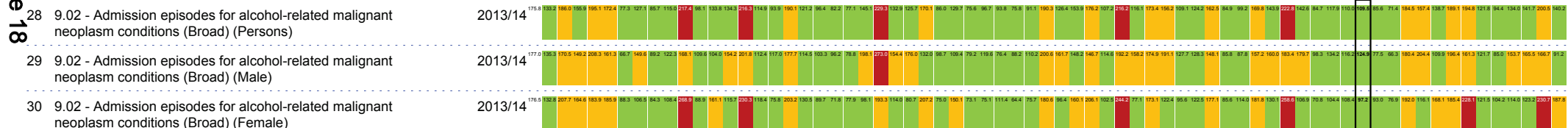


Thanet

Hospital Admissions continued



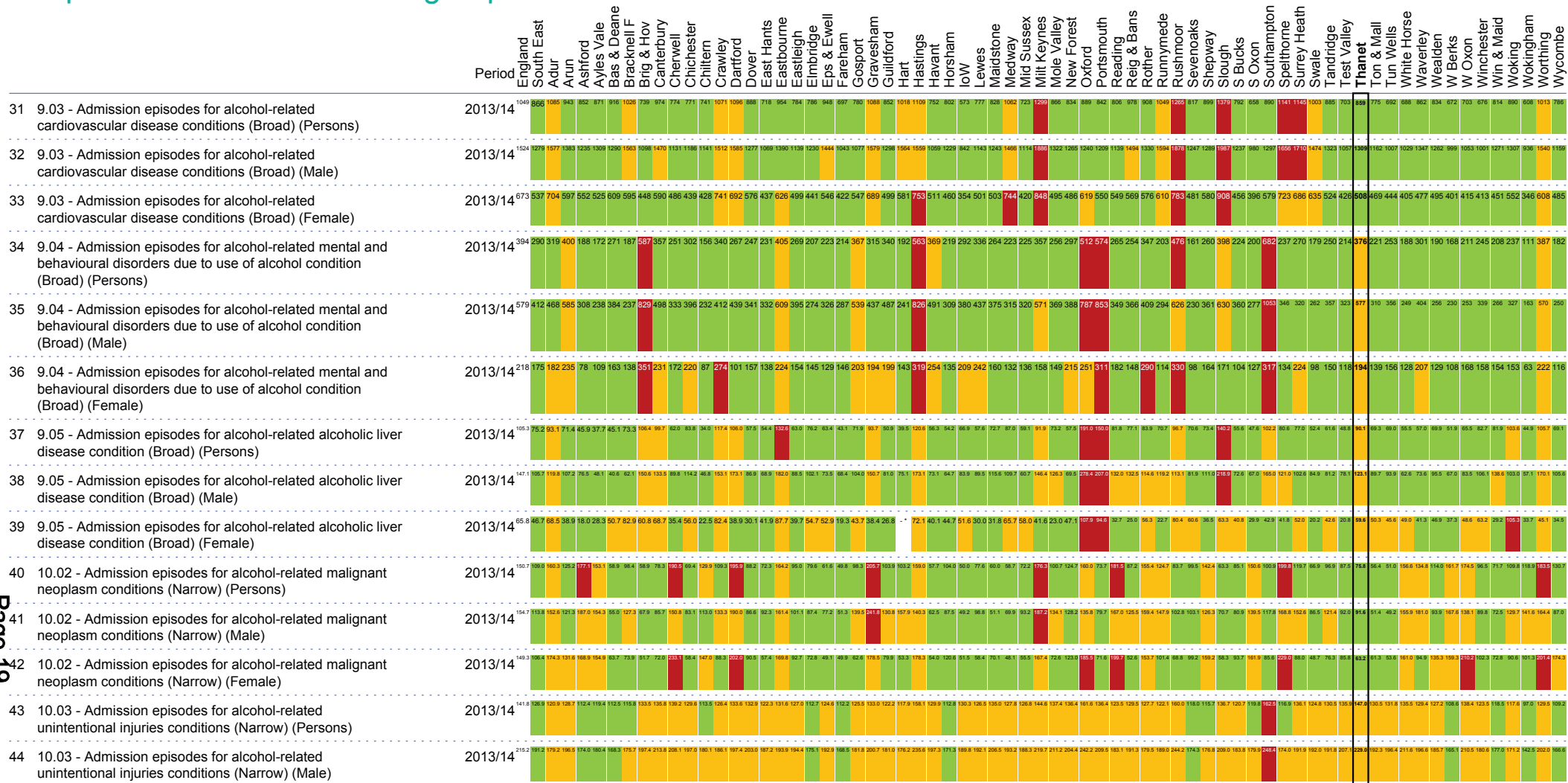
Hospital Admissions - Cause groups



Comparison with respect to England value



Hospital Admissions - Cause groups continued

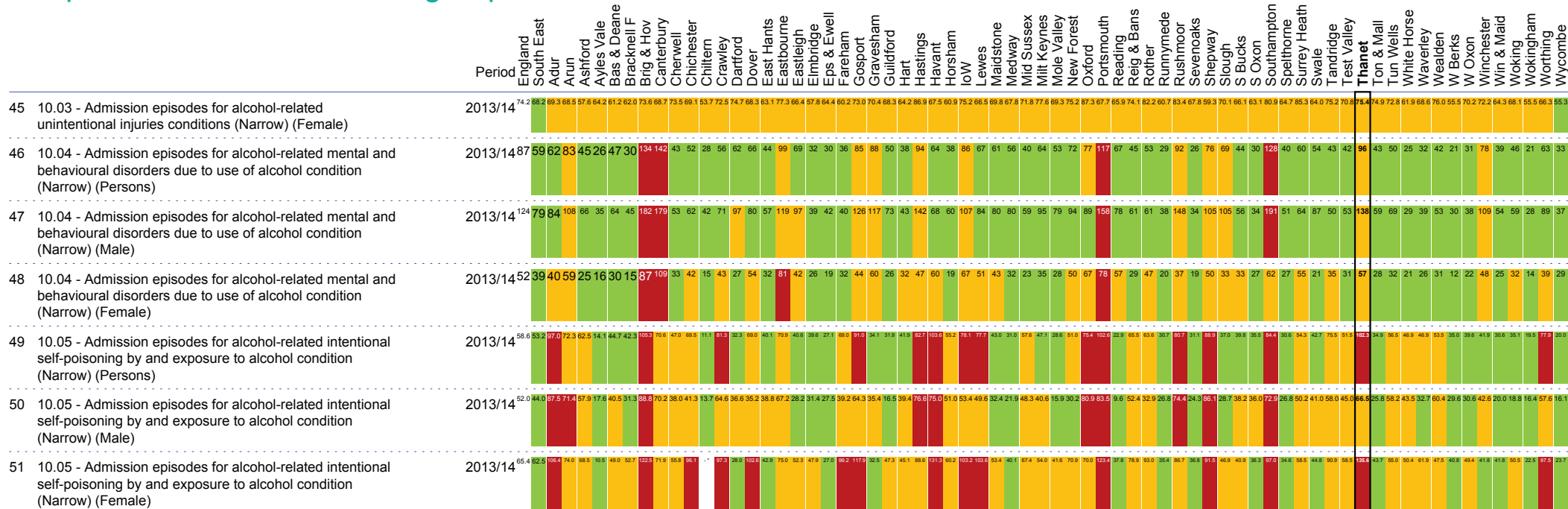


Comparison with respect to England value Better Similar Worse Not compared

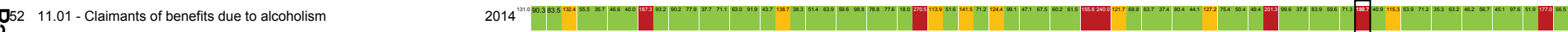
Note: * - Disclosure control applied

Thanet

Hospital Admissions - Cause groups continued



Other Impacts



Comparison with respect to England value

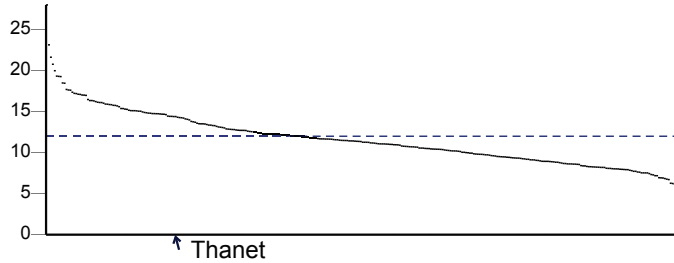


Note: * - Disclosure control applied

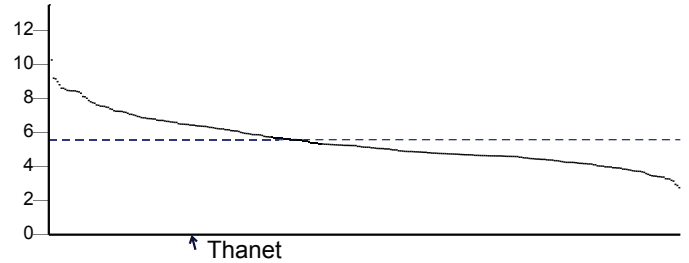
Bar Charts

Mortality

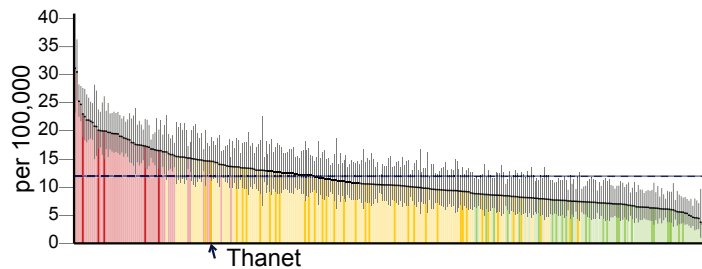
1.01 - Months of life lost due to alcohol (Male)



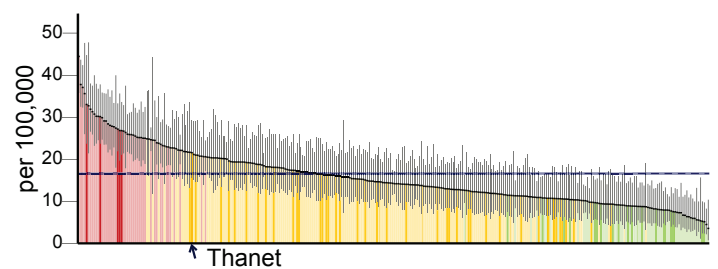
1.01 - Months of life lost due to alcohol (Female)



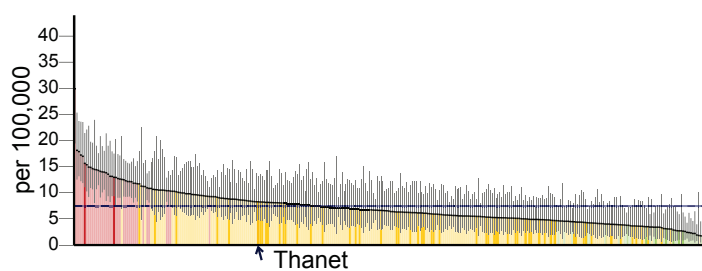
2.01 - Alcohol-specific mortality (Persons)



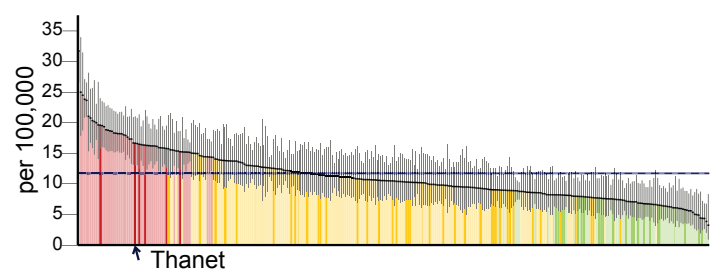
2.01 - Alcohol-specific mortality (Male)



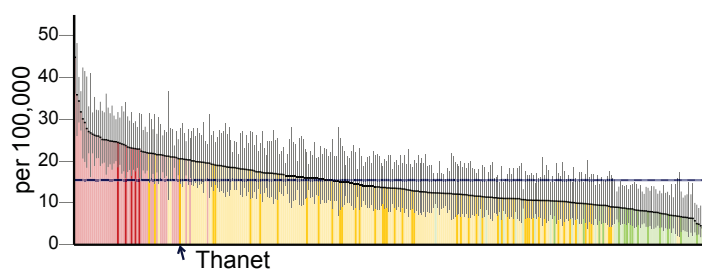
2.01 - Alcohol-specific mortality (Female)



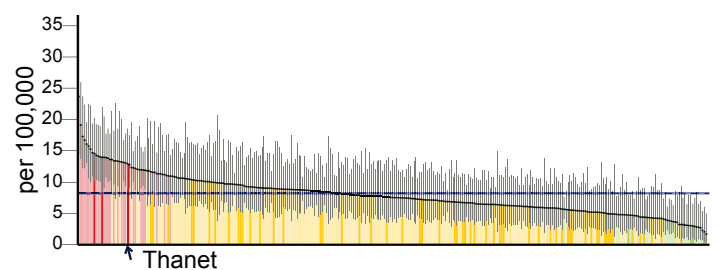
3.01 - Mortality from chronic liver disease (Persons)



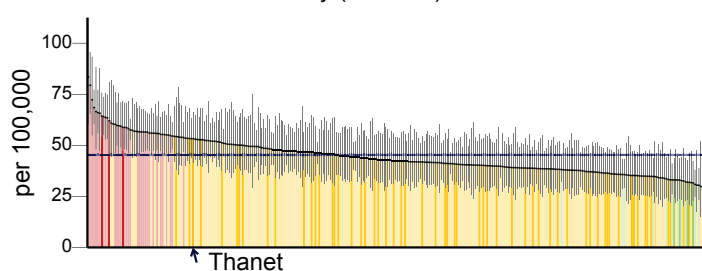
3.01 - Mortality from chronic liver disease (Male)



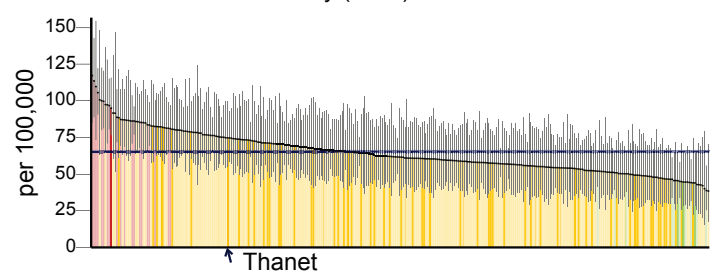
3.01 - Mortality from chronic liver disease (Female)



4.01 - Alcohol-related mortality (Persons)



4.01 - Alcohol-related mortality (Male)

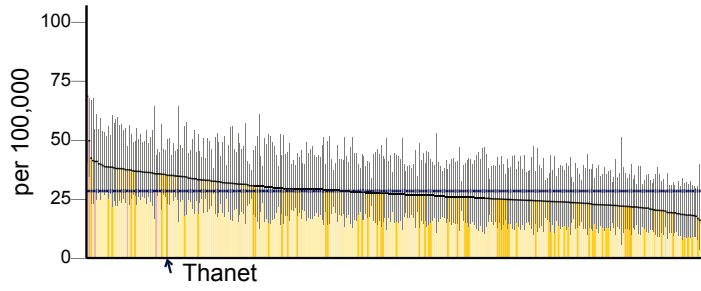


Key South East LAs: ■ Better ■ Similar ■ Worse ■ England value and confidence interval
 Other LAs: ■ Better ■ Similar ■ Worse

Thanet

Mortality continued

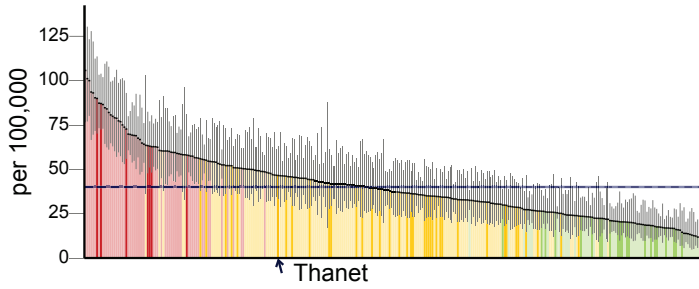
4.01 - Alcohol-related mortality (Female)



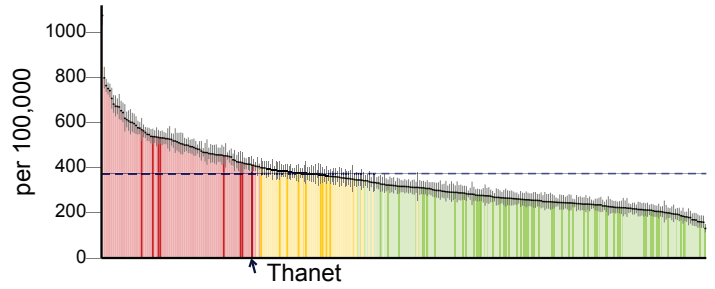
Key South East LAs: ■ Better ■ Similar ■ Worse ■ England value and confidence interval
Other LAs: ■ Better ■ Similar ■ Worse

Hospital Admissions

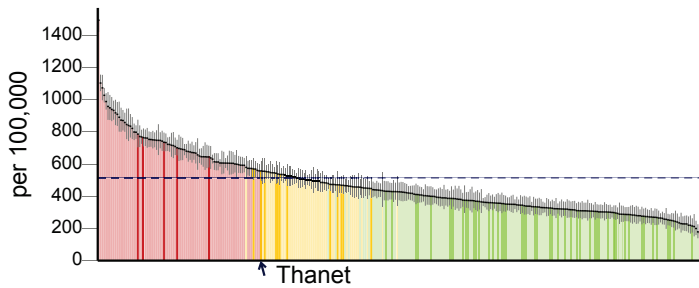
5.01 - Alcohol-specific hospital admission - under 18s



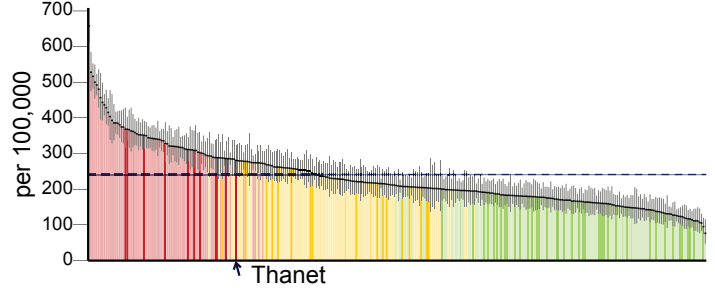
6.01 - Alcohol-specific hospital admission (Persons)



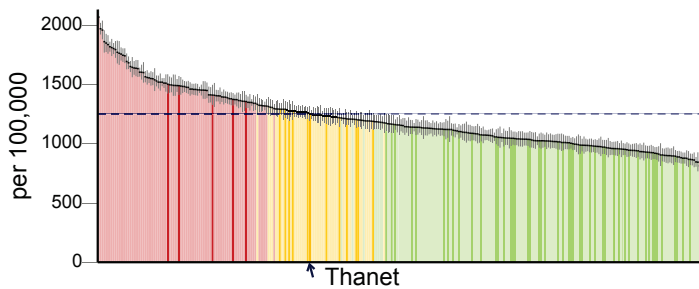
6.01 - Alcohol-specific hospital admission (Male)



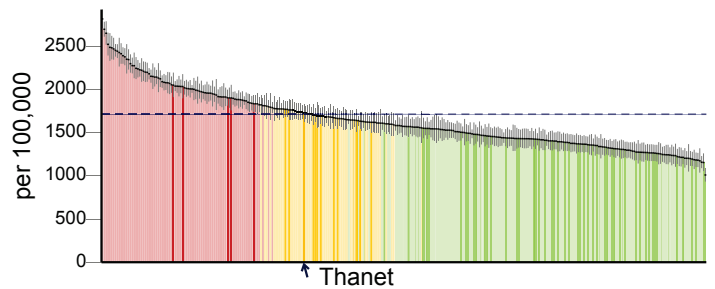
6.01 - Alcohol-specific hospital admission (Female)



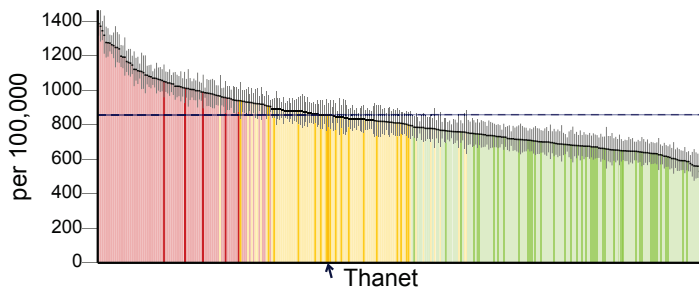
7.01 - Alcohol-related hospital admission (Broad) (Persons)



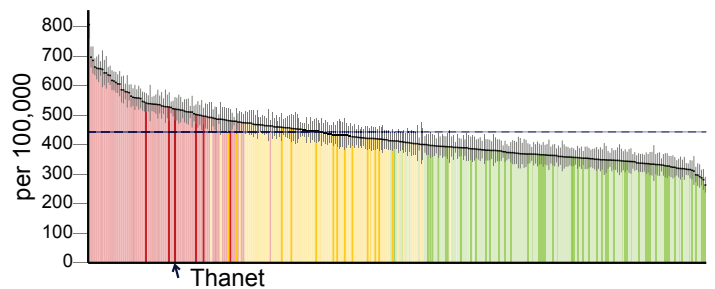
7.01 - Alcohol-related hospital admission (Broad) (Male)



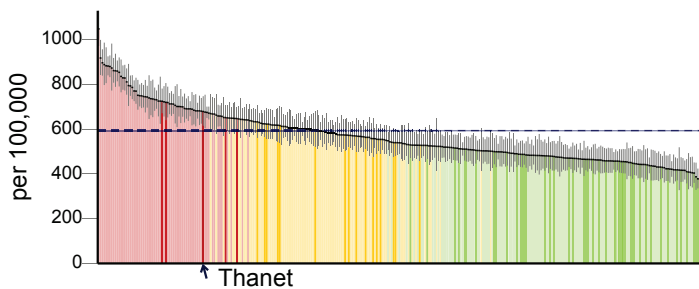
7.01 - Alcohol-related hospital admission (Broad) (Female)



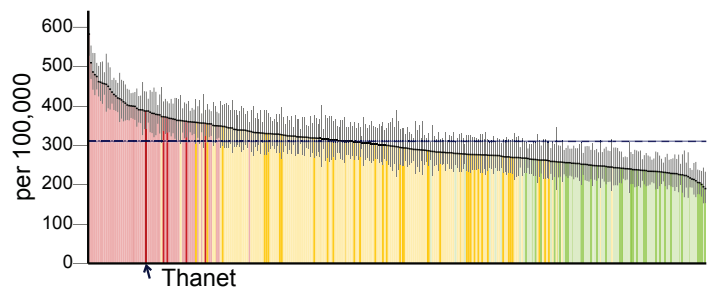
8.01 - Alcohol-related hospital admission (Narrow) (Persons)



8.01 - Alcohol-related hospital admission (Narrow) (Male)



8.01 - Alcohol-related hospital admission (Narrow) (Female)

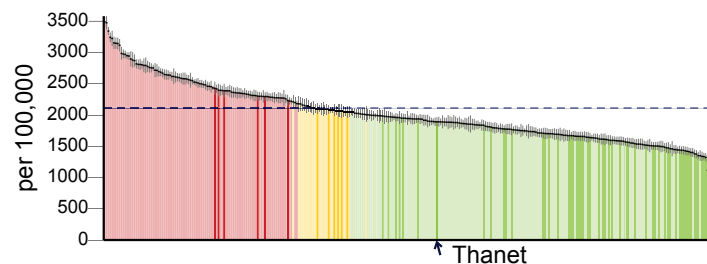


Key South East LAs: ■ Better ■ Similar ■ Worse ■ England value and confidence interval
 Other LAs: ■ Better ■ Similar ■ Worse

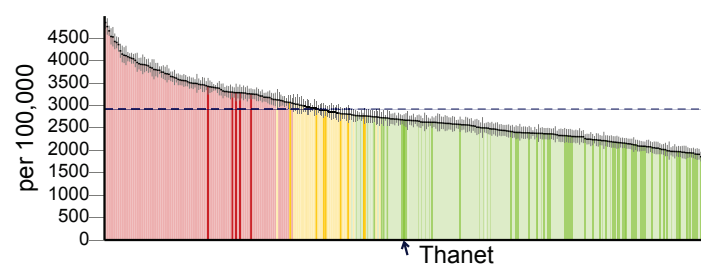
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Hospital Admissions continued

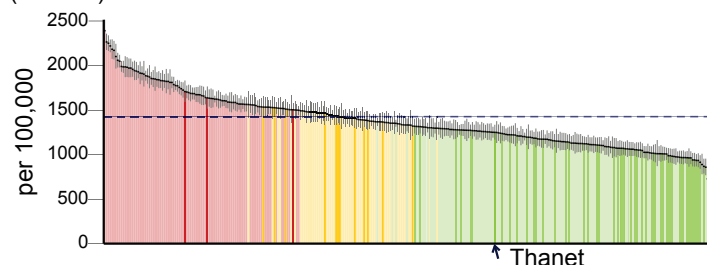
9.01 - Admission episodes for alcohol-related conditions (Broad) (Persons)



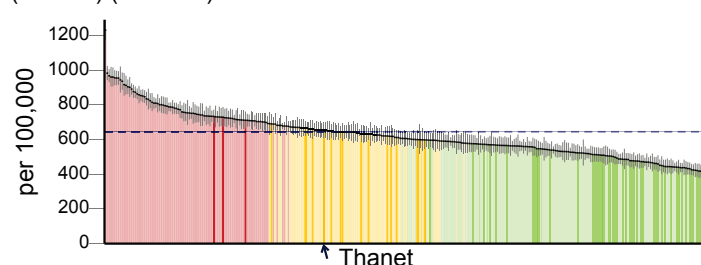
9.01 - Admission episodes for alcohol-related conditions (Broad) (Male)



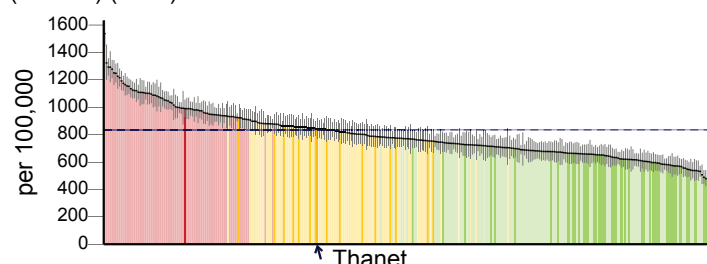
9.01 - Admission episodes for alcohol-related conditions (Broad) (Female)



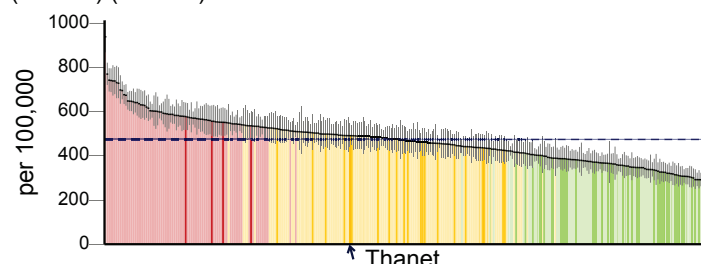
10.01 - Admission episodes for alcohol-related conditions (Narrow) (Persons)



10.01 - Admission episodes for alcohol-related conditions (Narrow) (Male)



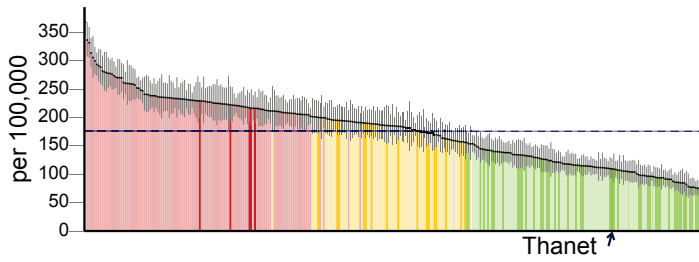
10.01 - Admission episodes for alcohol-related conditions (Narrow) (Female)



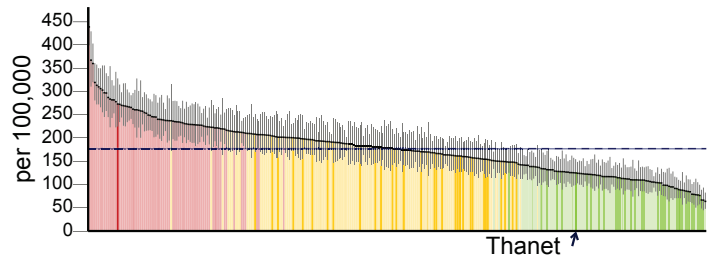
Key South East LAs: ■ Better ■ Similar ■ Worse ■ England value and confidence interval
 Other LAs: ■ Better ■ Similar ■ Worse

Hospital Admissions - Cause groups

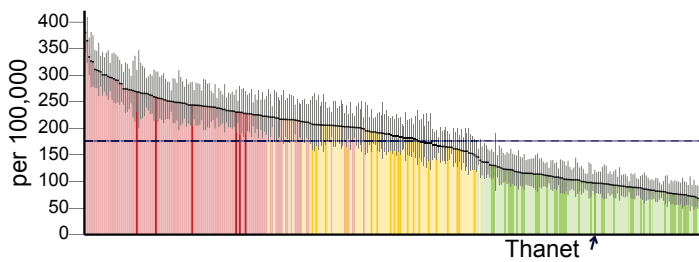
9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Persons)



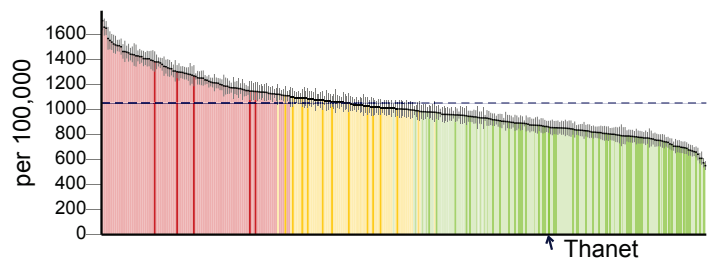
9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Male)



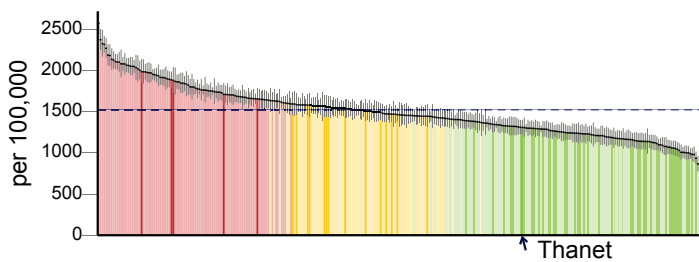
9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Female)



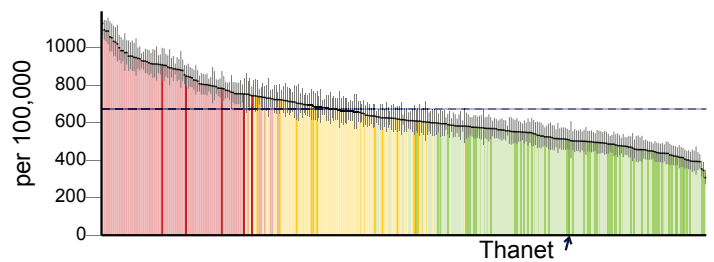
9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Persons)



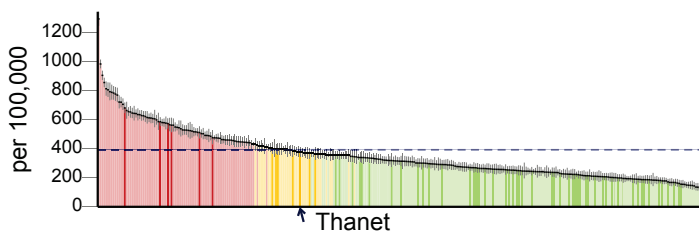
9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Male)



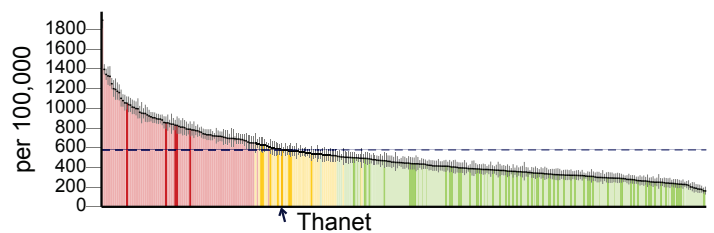
9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Female)



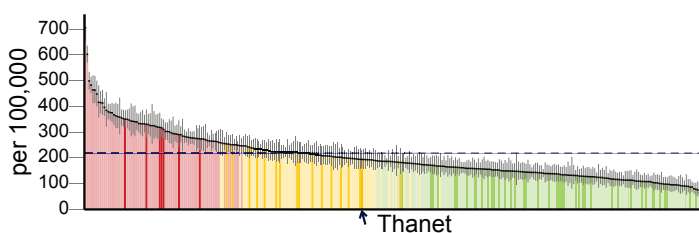
9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Persons)



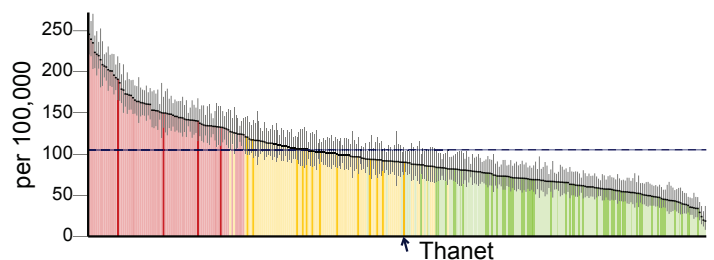
9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Male)



9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Female)



9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Persons)

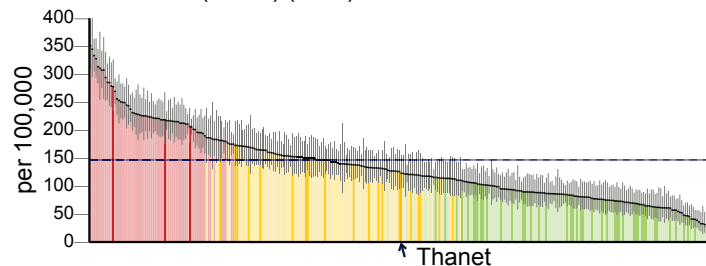


Key South East LAs: ■ Better ■ Similar ■ Worse ■ England value and confidence interval
 Other LAs: ■ Better ■ Similar ■ Worse

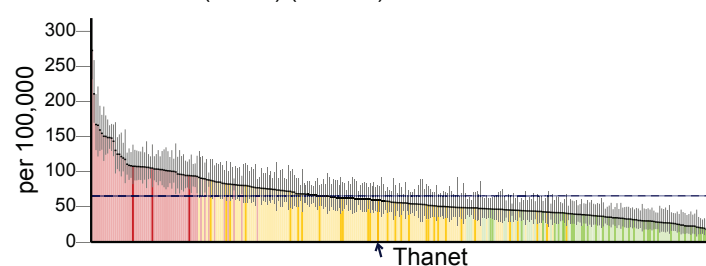
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Hospital Admissions - Cause groups continued

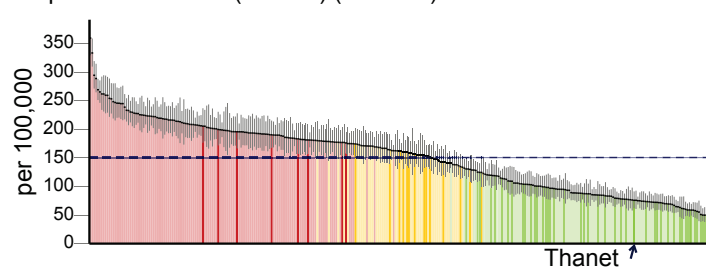
9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Male)



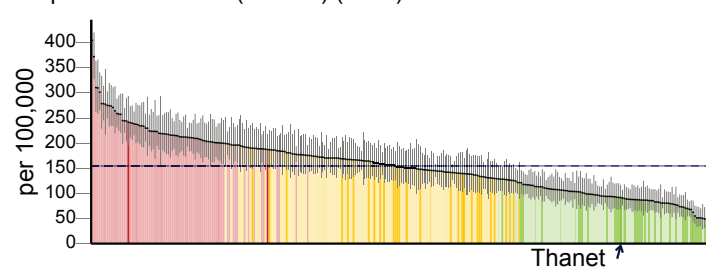
9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Female)



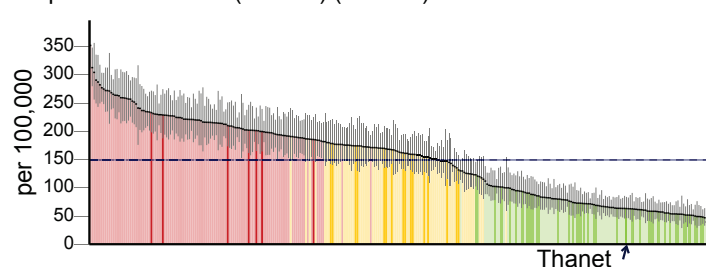
10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Persons)



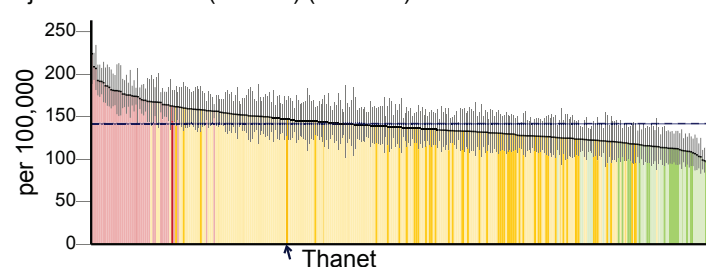
10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Male)



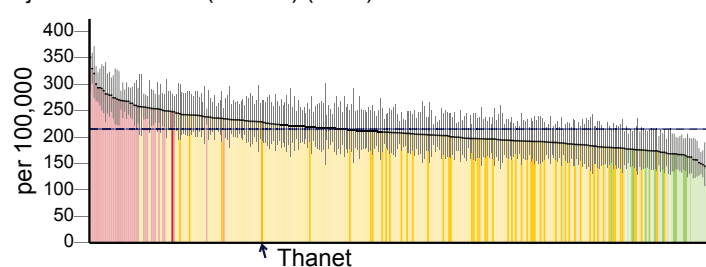
10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Female)



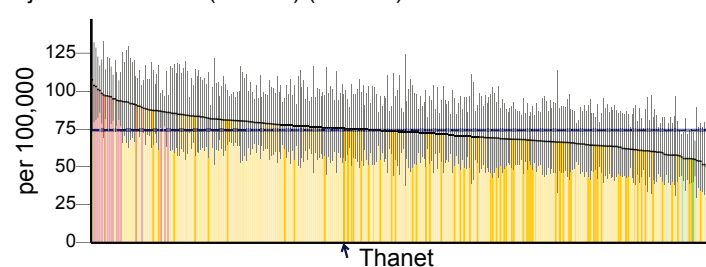
10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Persons)



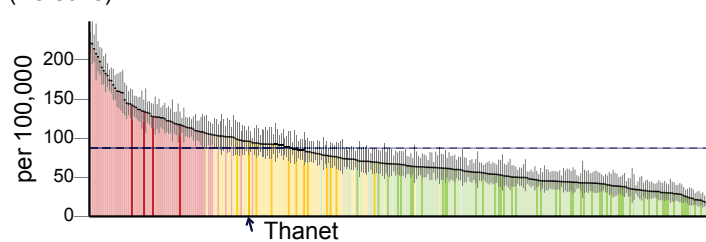
10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Male)



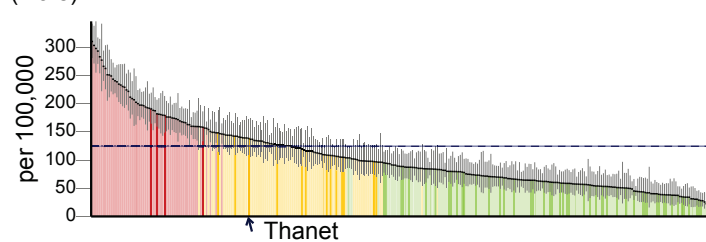
10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Female)



10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Persons)



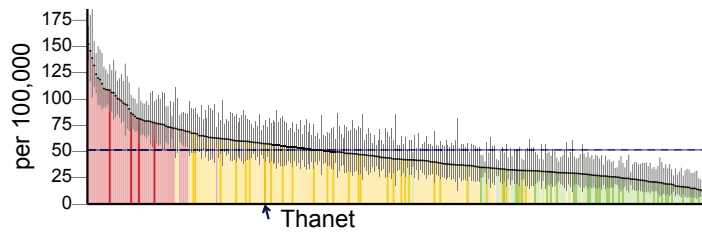
10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Male)



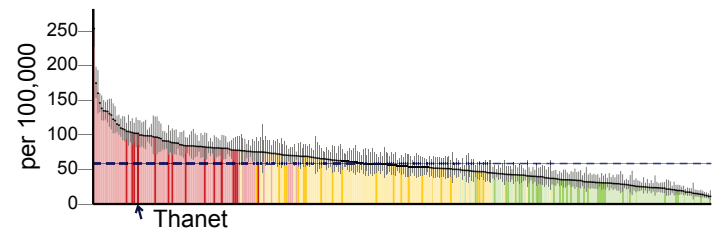
Key South East LAs: ■ Better ■ Similar ■ Worse ■ England value and confidence interval
 Other LAs: ■ Better ■ Similar ■ Worse

Hospital Admissions - Cause groups continued

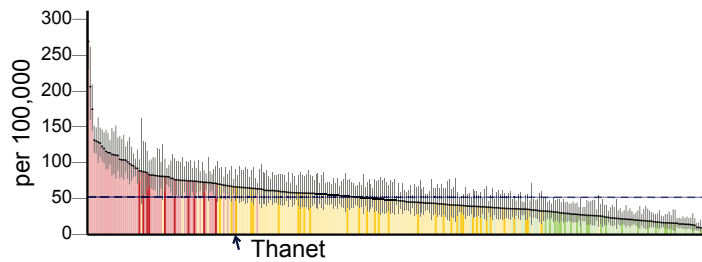
10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Female)



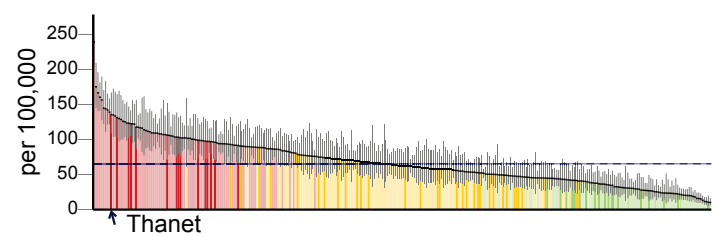
10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Persons)



10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Male)



10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Female)

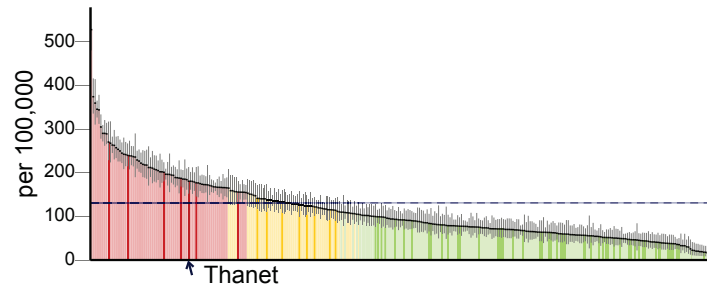


Key South East LAs: ■ Better ■ Similar ■ Worse ■ England value and confidence interval
 Other LAs: ■ Better ■ Similar ■ Worse

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Other Impacts

11.01 - Claimants of benefits due to alcoholism

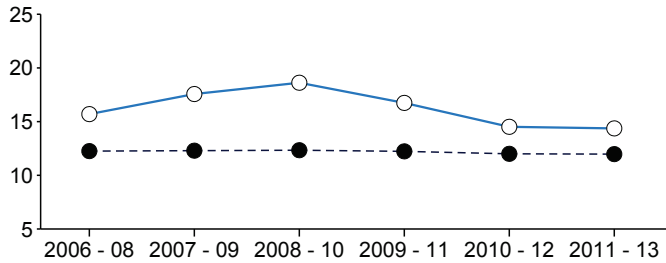


Key South East LAs: ■ Better ■ Similar ■ Worse ■ England value and confidence interval
Other LAs: ■ Better ■ Similar ■ Worse

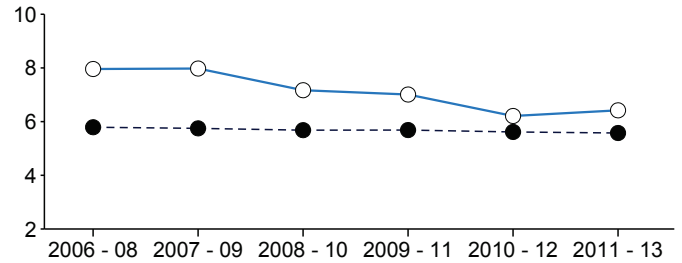
Trends

Mortality

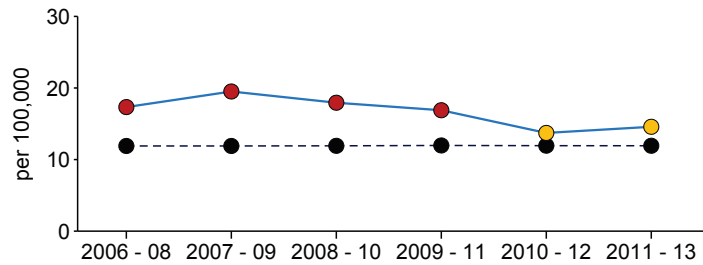
1.01 - Months of life lost due to alcohol (Male)



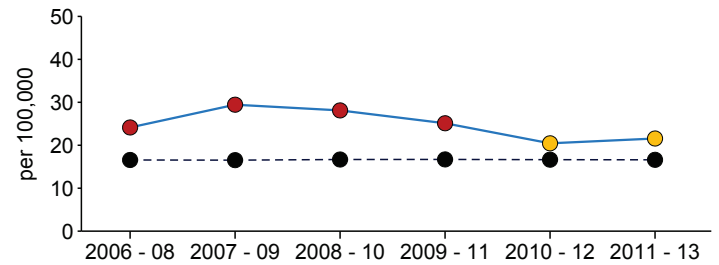
1.01 - Months of life lost due to alcohol (Female)



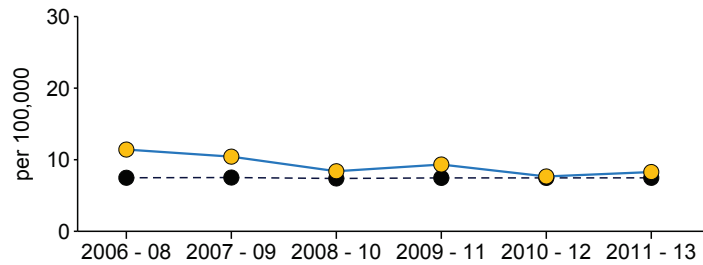
2.01 - Alcohol-specific mortality (Persons)



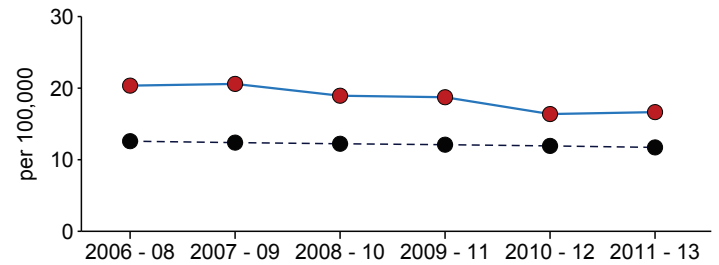
2.01 - Alcohol-specific mortality (Male)



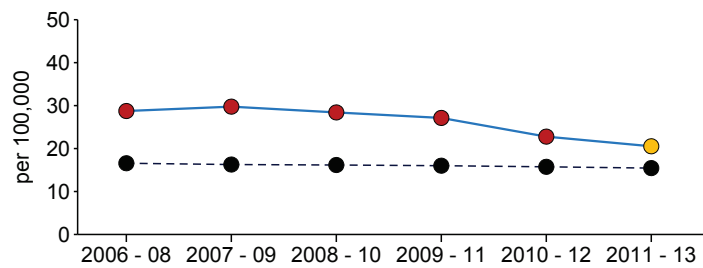
2.01 - Alcohol-specific mortality (Female)



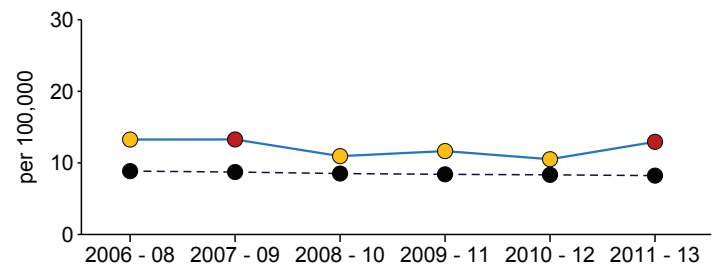
3.01 - Mortality from chronic liver disease (Persons)



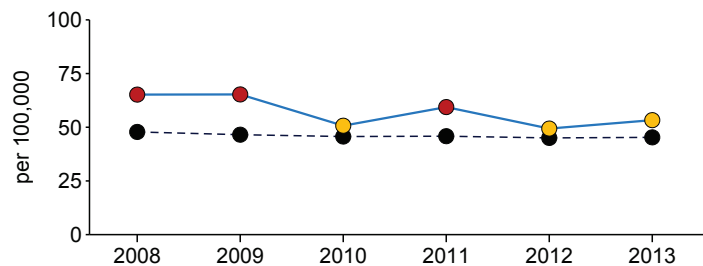
3.01 - Mortality from chronic liver disease (Male)



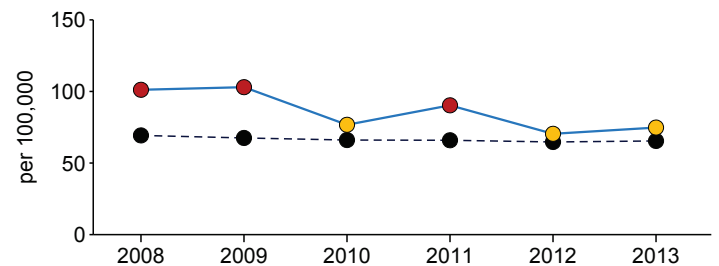
3.01 - Mortality from chronic liver disease (Female)



4.01 - Alcohol-related mortality (Persons)



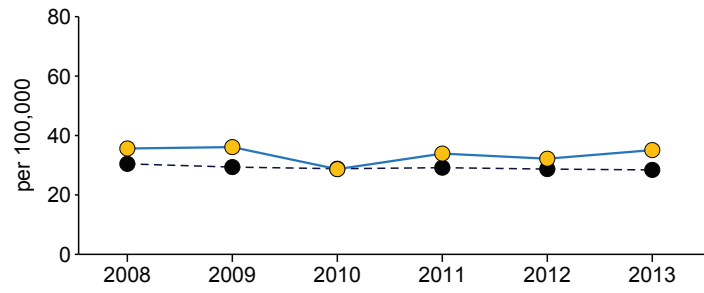
4.01 - Alcohol-related mortality (Male)



Key ●... England ● Significantly worse ● Not significantly different ● Significantly better ○ Significance not tested

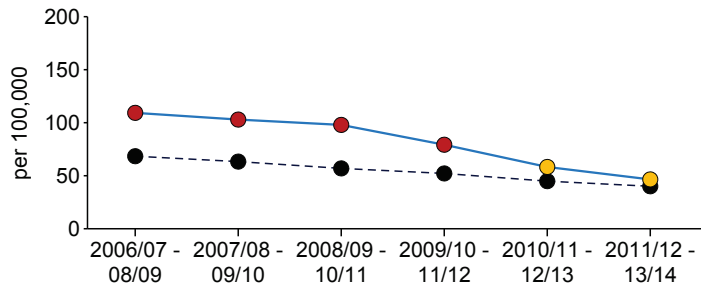
Mortality continued

4.01 - Alcohol-related mortality (Female)

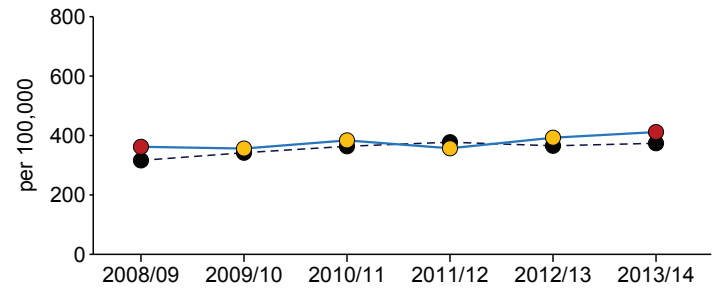


Hospital Admissions

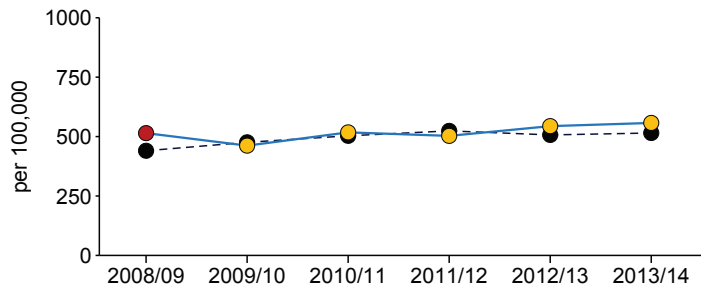
5.01 - Alcohol-specific hospital admission - under 18s



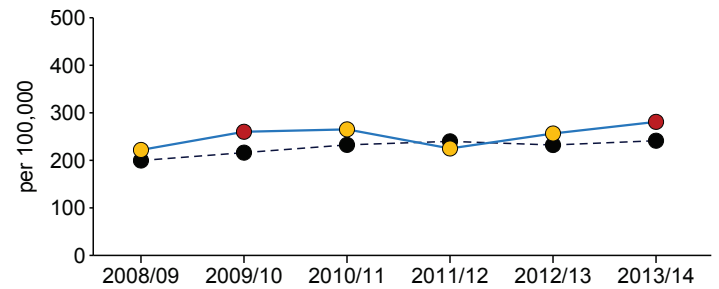
6.01 - Alcohol-specific hospital admission (Persons)



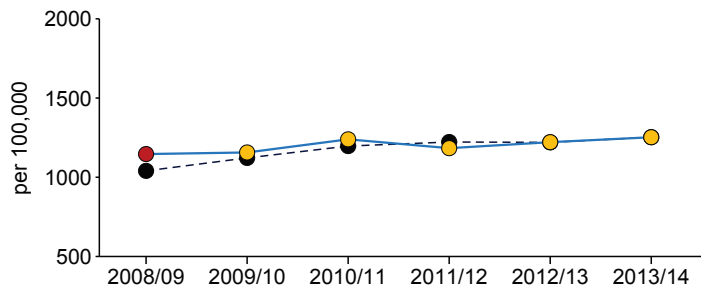
6.01 - Alcohol-specific hospital admission (Male)



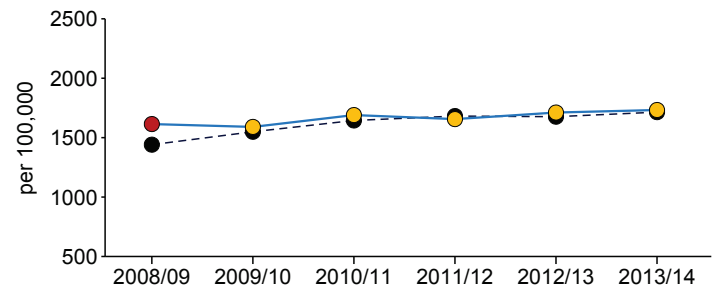
6.01 - Alcohol-specific hospital admission (Female)



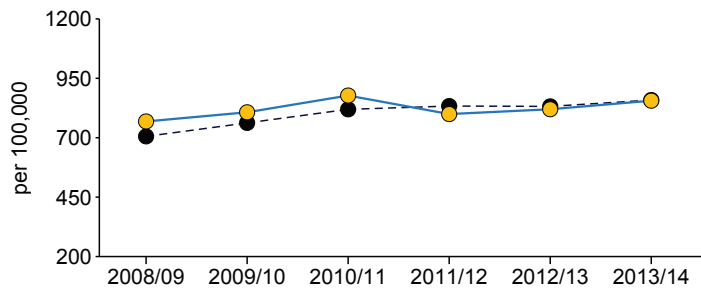
7.01 - Alcohol-related hospital admission (Broad) (Persons)



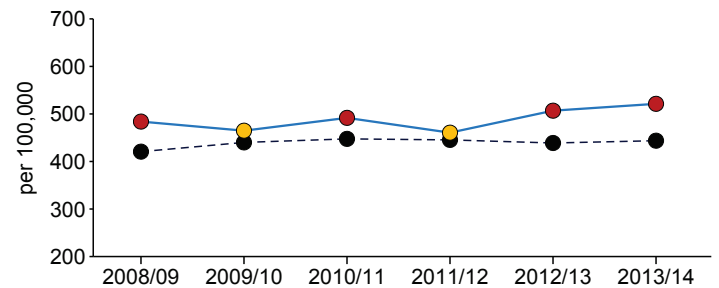
7.01 - Alcohol-related hospital admission (Broad) (Male)



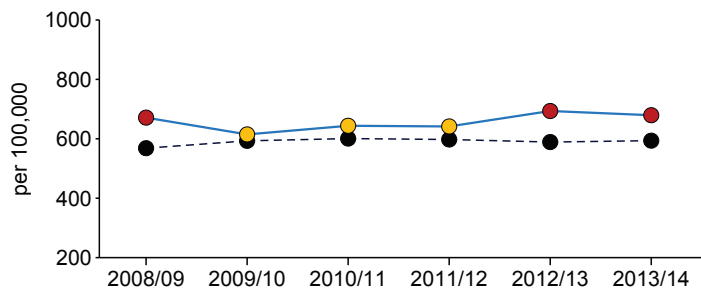
7.01 - Alcohol-related hospital admission (Broad) (Female)



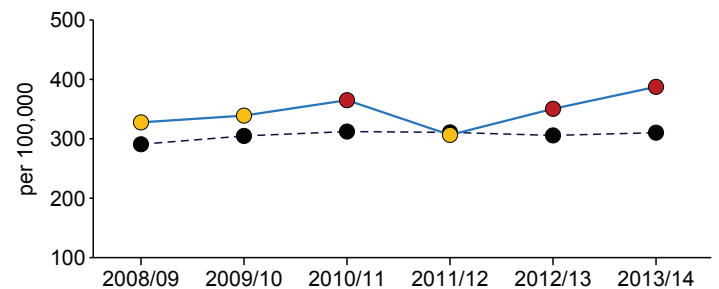
8.01 - Alcohol-related hospital admission (Narrow) (Persons)



8.01 - Alcohol-related hospital admission (Narrow) (Male)



8.01 - Alcohol-related hospital admission (Narrow) (Female)

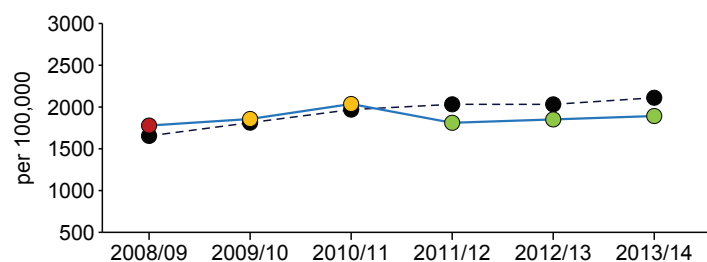


Key ●●● England ● Significantly worse ● Not significantly different ● Significantly better ○ Significance not tested

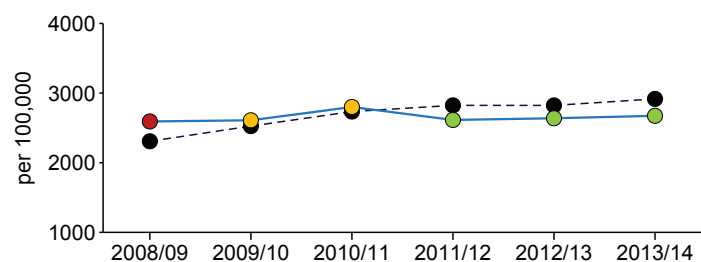
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Hospital Admissions continued

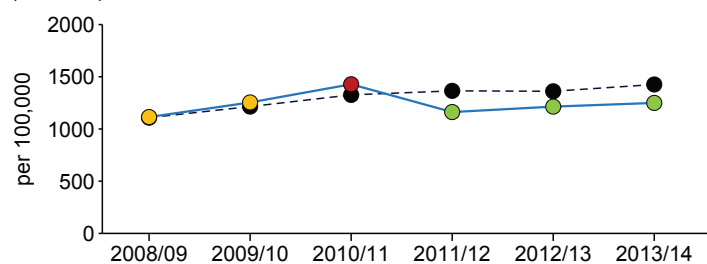
9.01 - Admission episodes for alcohol-related conditions (Broad) (Persons)



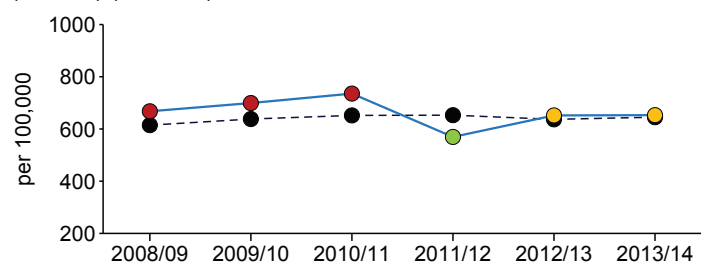
9.01 - Admission episodes for alcohol-related conditions (Broad) (Male)



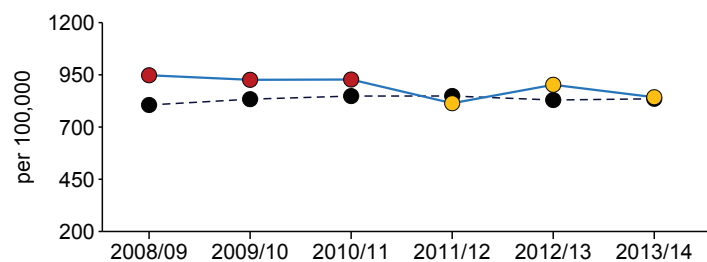
9.01 - Admission episodes for alcohol-related conditions (Broad) (Female)



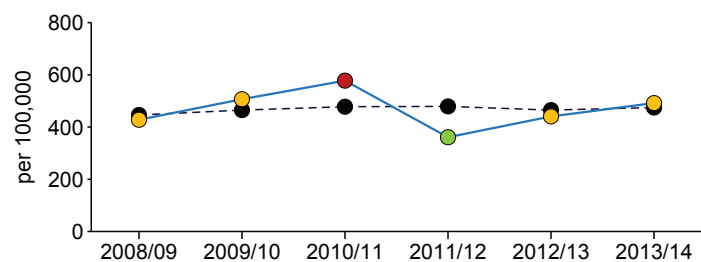
10.01 - Admission episodes for alcohol-related conditions (Narrow) (Persons)



10.01 - Admission episodes for alcohol-related conditions (Narrow) (Male)

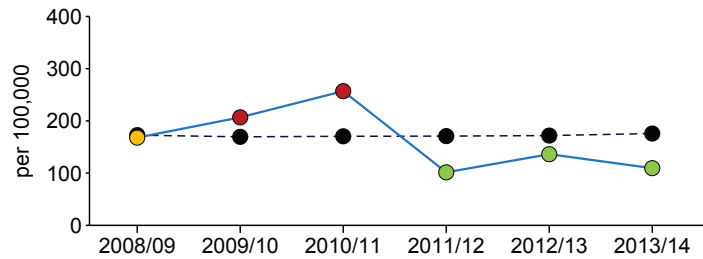


10.01 - Admission episodes for alcohol-related conditions (Narrow) (Female)

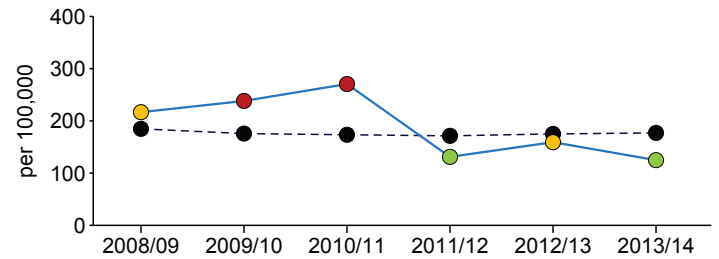


Hospital Admissions - Cause groups

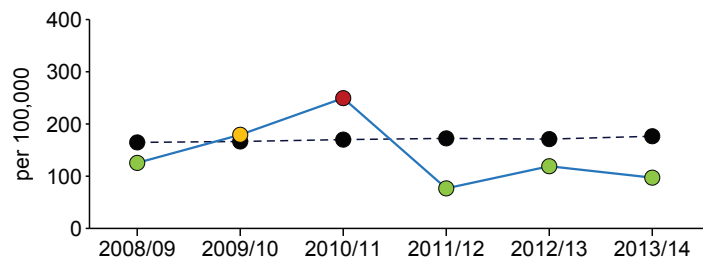
9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Persons)



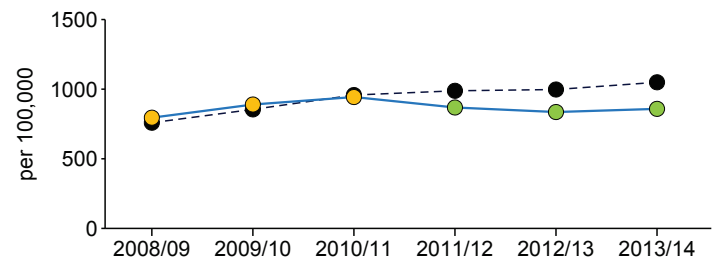
9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Male)



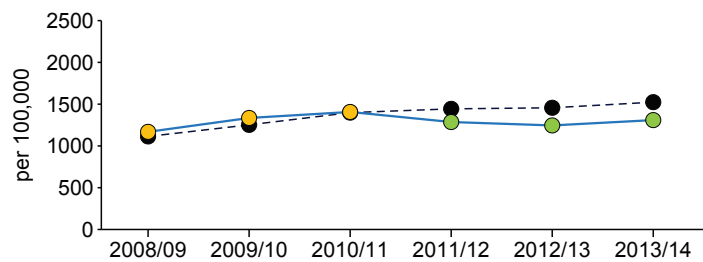
9.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Broad) (Female)



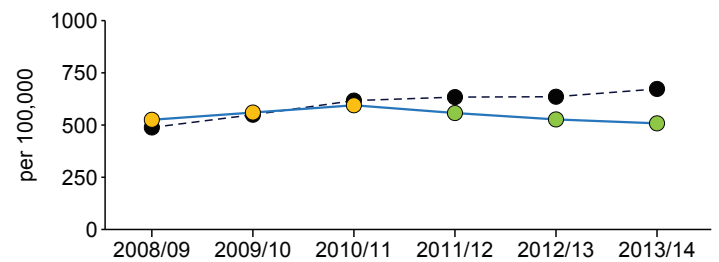
9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Persons)



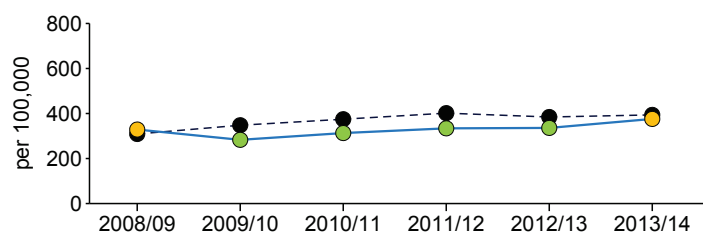
9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Male)



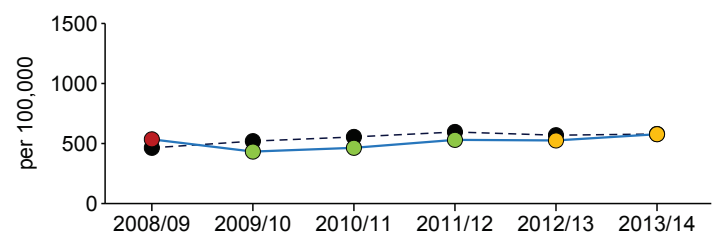
9.03 - Admission episodes for alcohol-related cardiovascular disease conditions (Broad) (Female)



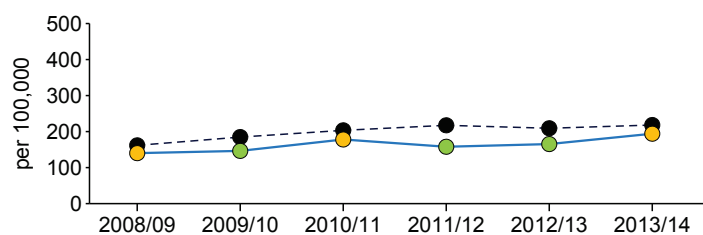
9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Persons)



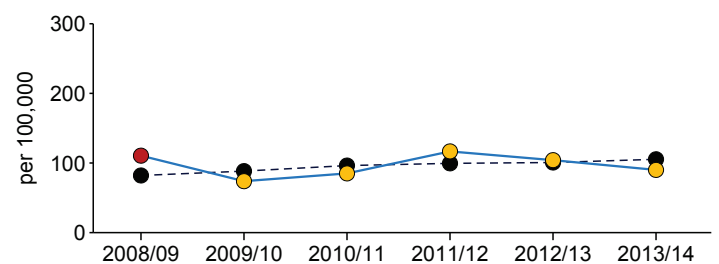
9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Male)



9.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Broad) (Female)



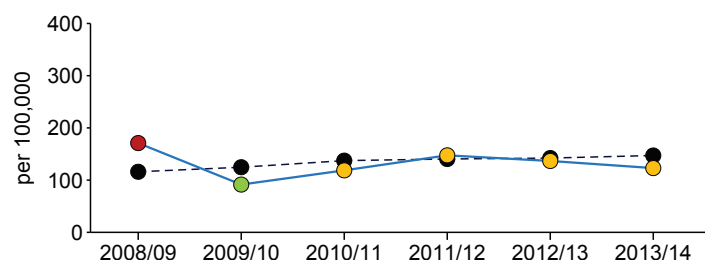
9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Persons)



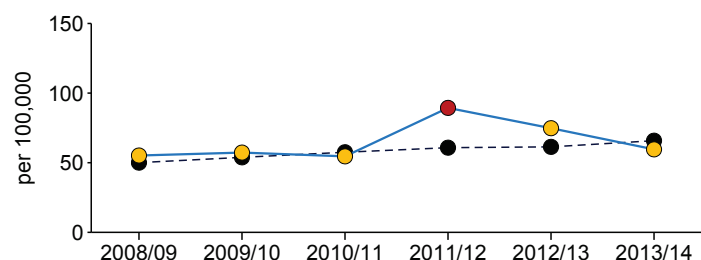
Key ●●● England ● Significantly worse ● Not significantly different ● Significantly better ○ Significance not tested

Hospital Admissions - Cause groups continued

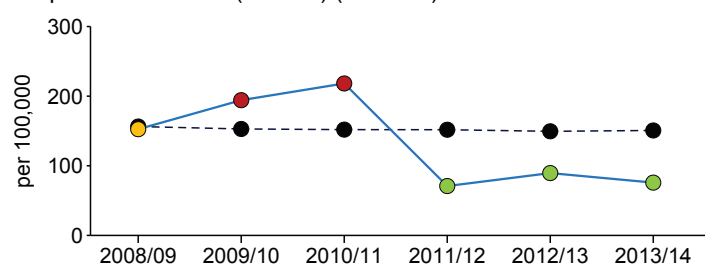
9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Male)



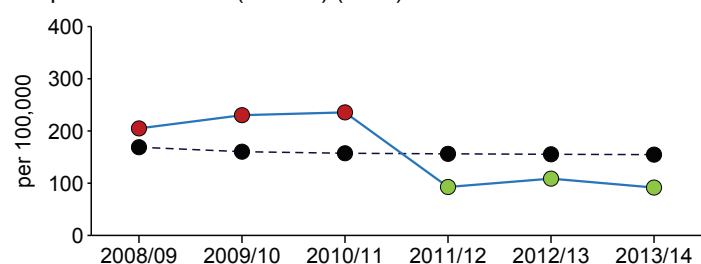
9.05 - Admission episodes for alcohol-related alcoholic liver disease condition (Broad) (Female)



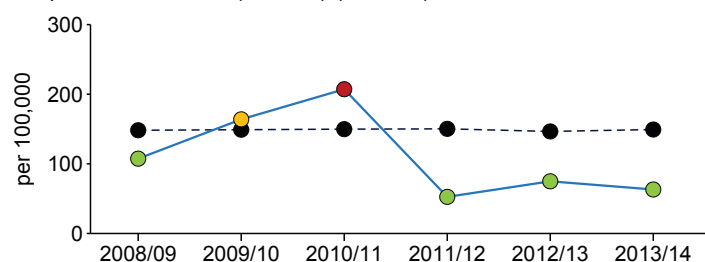
10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Persons)



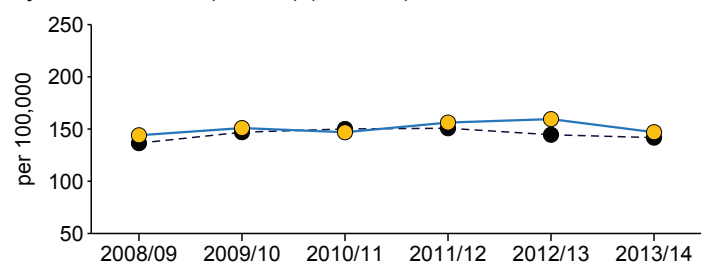
10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Male)



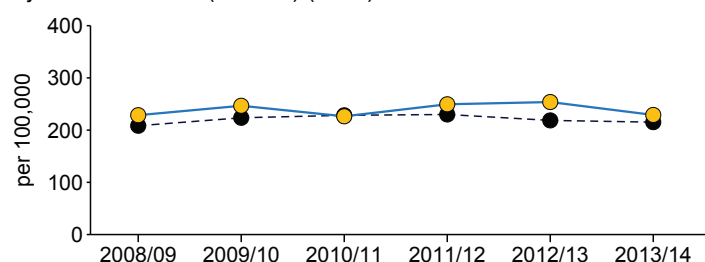
10.02 - Admission episodes for alcohol-related malignant neoplasm conditions (Narrow) (Female)



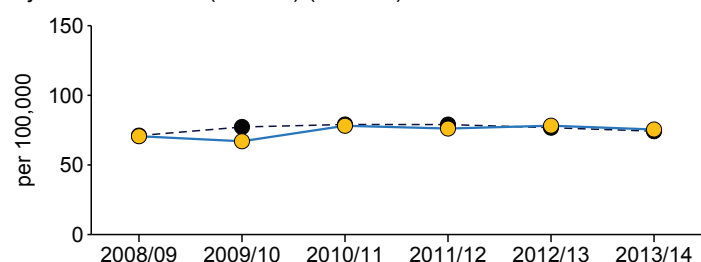
10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Persons)



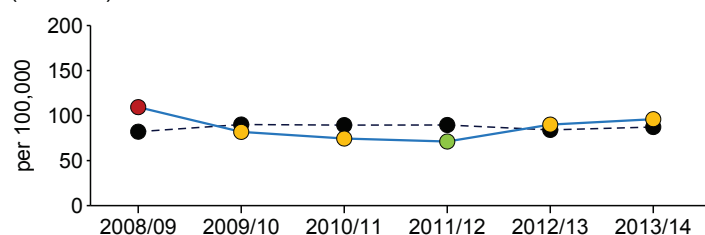
10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Male)



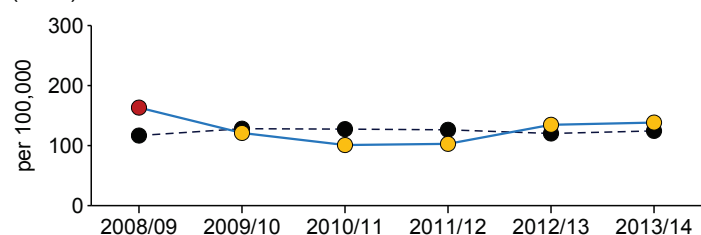
10.03 - Admission episodes for alcohol-related unintentional injuries conditions (Narrow) (Female)



10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Persons)



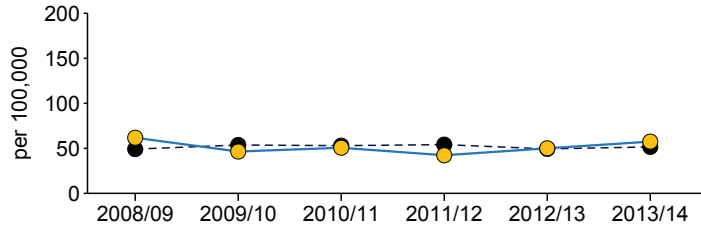
10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Male)



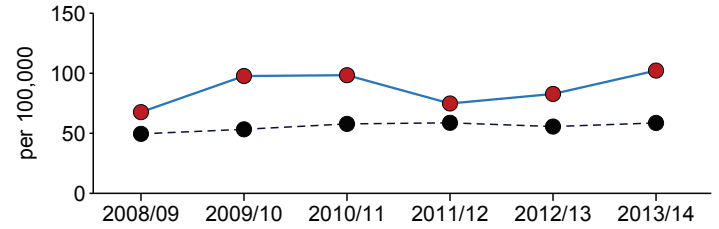
Key ●●● England ● Significantly worse ● Not significantly different ● Significantly better ○ Significance not tested

Hospital Admissions - Cause groups continued

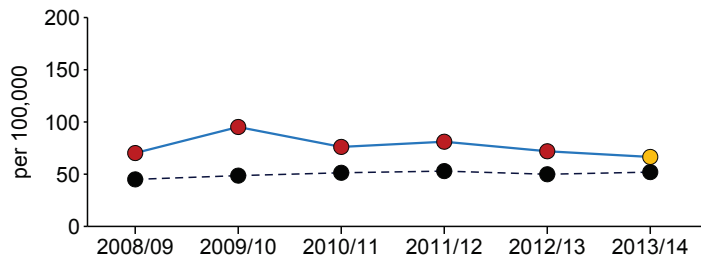
10.04 - Admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition (Narrow) (Female)



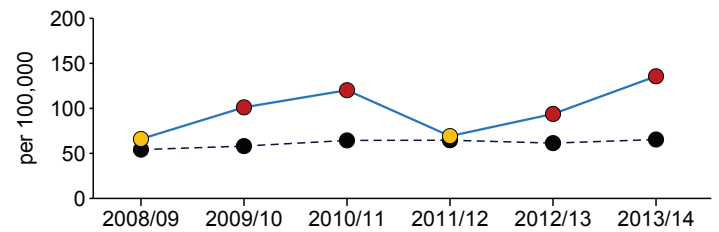
10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Persons)



10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Male)



10.05 - Admission episodes for alcohol-related intentional self-poisoning by and exposure to alcohol condition (Narrow) (Female)



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To: Thanet Health and Wellbeing Board

From: Colin Thompson Consultant Public Health
Karen Sharp Head of Commissioning Public health

Date: 17th September 2015

Subject: Public Health Services Transformation and Commissioning Plans

Summary

Public Health programmes are delivered by many partners in the Health and Wellbeing Board and play a key role in delivering the outcomes of the Health and Wellbeing Strategy.

During 2015 the KCC Public Health team have reviewed the programmes commissioned from the public health grant, and are seeking the views of partners on transforming the approach. The aim is to embed an approach which is more locally focussed to promote health and wellbeing, and is focused on tackling health inequalities.

This paper outlines some of the work to date and the changes that are being considered.

The Board are asked to:

1. Comment on the work to date.
2. Comment on how local priorities should shape local delivery.
3. Promote the public consultation on public health programmes

1. Introduction

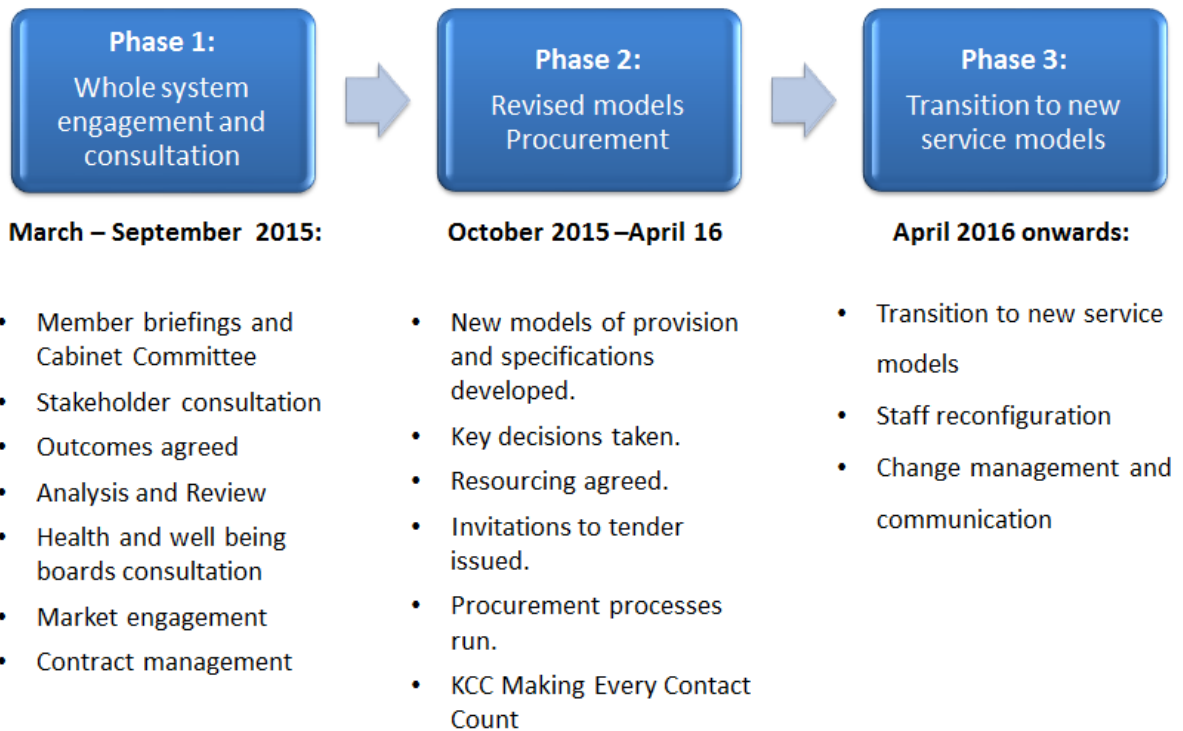
- 1.1. This paper is to update the Thanet Health and Wellbeing Board on KCC Public Health transformation work that is currently underway and to seek the Board's views.

2. Background

- 2.1. In April 2015 KCC decided to begin a review the use of the public health grant, and the programmes commissioned through the grant. National drivers for this review included The NHS Five Year Forward View which identifies the need to **radically increase** the role of prevention, and The Care Act which describes new responsibilities that clearly show that effective prevention is key. It is also clear that in many parts of the country Local Authorities are examining the approach to public health, in particular the adult health improvement services.
- 2.2. During this time the Public Health team have been conducting a review and analysis of the programmes commissioned through the Public Health grant. This review is providing a more thorough understanding of the potential and the limitations of the current services and there are clear opportunities for a new and more integrated approach.

2.3. Reports such as The King’s Fund Report – *Clustering of Unhealthy Behaviours Over Time* (2012) set out the need to review services and focus on a holistic approach to health improvement and the wider health system. Other parts of the country are also proposing changes in line with these drivers, with the aim to integrate and realign these services. Please see appendix B for further details on these changes.

3. The timeline for this programme of work is as follows.



4. Progress to date

4.1. In June 2015 KCC Adult Social Care and Public Health Cabinet Committee agreed to extend as needed and align all of the current adult health improvement contract dates so that a new model of provision could include within scope the range of services currently commissioned as standalone services.

4.2. Using the drivers for change outlined above a vision and outcomes framework has been developed. The vision is: “to improve and protect the health of the people across Kent, enabling them to lead healthy lives, with a focus on the differences in outcomes within and between communities”.

4.3. The analysis has been structured locally and also into a Life Course approach as outlined in Sir Michael Marmots review. This life course review structures the understanding of our approach into the following

- Starting Well
- Living Well
- Ageing Well

DRAFT v1

4.4. We have mapped health outcomes and priorities with each stage of the Life Course Approach. The priority areas are:

- Smoking
- Healthy eating, physical activity and obesity
- Alcohol and substance abuse
- Wellbeing (including Mental Health and Social Isolation)
- Sexual Health & Communicable Disease
- Wider Determinants of health

A review has taken place of the mandated provision that the Local Authority must ensure how the public health grant is prioritised and the performance of services.

The table below summarises this work.

Starting Well – Thanet			
	Agreed Outcomes	Current Health Performance <i>Source: PHOF unless stated</i>	PH Activity
Smoking	Reduce smoking prevalence at age 15	Smoking prevalence at age 15 (2009-12) – <i>reg smokers only</i> : Thanet: 10.9%	Stop Smoking Service Tobacco control programmes
	Reduce smoking prevalence at time of delivery	Smoking prevalence at time of delivery (Q2 14/15) Thanet CCG: 18.8%	
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight in children	% children classified as overweight or obese (2013/14) 4-5 yr olds (YR): 22% 10-11 yr olds (Y6): 34%	Early Help Workforce funding Ready Steady Go Change4Life
	Increase levels of breastfeeding	% all mothers who breastfeed their baby in first 48hrs after delivery (breastfeeding initiation) (2013/14): Kent: 71.3%	Community Infant Feeding Service
	Increase physical activity in young people	<i>No data available</i>	Sky Ride
	Reduce levels of tooth decay	% children with one or more decayed, missing or filled teeth (aged 5 years) (2012): Kent 19.8%	Dental Health Programmes
Alcohol & Substance Misuse	Reduce under 18 hospital admissions due to alcohol	Alcohol specific admission rate per 10,000 population aged <25 (2011/12 to 2013/14) – source: SUS, ONS Thanet: 15.6	Young People’s Substance Misuse Service
	Reduce levels of drug taking and use of legal highs	Drug specific hospital admissions: rate per 10,000 population aged <25 (2011/12 to 2013/14) – Source: SUS, ONS Thanet: 13.3	
Wellbeing	Increasing emotional resilience in families and young people	Admissions for mental health, rate per 1,000 population, ages 0-17 (2011/12 to 2013/14) – Source: SUS, ONS Thanet: 1.1	Domestic Abuse Projects Mental Health First Aid Youth Mental Health Matters Helpline Positive Relationships Social Integration Activities Project Young Healthy Minds
	Ensure levels of social and emotional development		
	Reducing levels of self-harm and suicide rates	Deliberate self harm admission rate per 10,000 population aged 0-17 (2011/12 - 2013/14) – Source: SUS, ONS Thanet: 15.2	
Sexual Health, Communicable Disease	Reduce rates of Chlamydia	chlamydia positivity screening rate/ 100,000 15-24yrs (Q2 14/15) Thanet: 2,127	Condom Programme Integrated Sexual Health Service National Chlamydia Screening Programme Pharmacy Sexual Health Programme
	Reduce rates of STIs	all new STI diagnoses (exc. Chlamydia <25 yrs) 15-64yrs/100,000 (2013) Thanet: 718	
	Reduce levels of teenage pregnancy	<18 conception rate /1,000 (2013) Thanet: 35.6	
All Priority 5	As above	As above	Children Centres Health Visiting & FNP Aspirations Healthy Living Centre School Nursing

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Living Well – Thanet			
	Agreed Outcomes	Current Health Performance <i>Source: PHOF unless stated</i>	PH Activity
Smoking	Reduce smoking prevalence in general population	Smoking prevalence in general population 18+ (2013) Thanet: 24.8%	Smoking Cessation Service Tobacco Control
	Reduce smoking prevalence in routine and manual workers	Smoking prevalence in routine and manual workers (2013) Thanet: 32.8%	
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight	% excess weight in adults (2012) Thanet: 68.4%	Ready Steady Go Change 4 Life Fresh Start Tier 3 Weight Management
	Increase levels of physical activity	% physically inactive adults (2013) Thanet: 35.5%	Health Walks Exercise Referral Scheme
Alcohol & Substance Misuse	Reduction in number of people drinking at problem levels	Alcohol specific admission rate /10,000 population aged 25 - 64 (2011/12 - 2013/14) – Source: SUS, ONS Thanet: 79.6	Adult Substance Misuse Service
	Reduction in hospital admissions due to alcohol		
	Reduction in drug misuse		
Wellbeing	Improve wellbeing of population	Mental Health Contact rate per 1,000 people, aged 25-64 (2014) – Source: KMPT, ONS Thanet: 38.9	Domestic Abuse Projects Kent Sheds Mental Health Community Services Mental Health First Aid Mental Health Matters Helpline Mental Wellbeing Programmes Primary Care Link Workers
	Reduction in suicide rates	age-standardised mortality rate from suicide and injury of undetermined intent/100,000 population (2011-13) Thanet: 9.9	
	Reduction in domestic abuse	rate of domestic abuse incidents (recorded by the Police) /1,000 (2013/14) Kent: 18.1	
Sexual Health, Communicable Disease	Increase early diagnosis of HIV	Late diagnosis of HIV % newly diagnosed with a CD4 count less than 350 cells per mm ² (2011-2013) Thanet: 52.6%	Integrated Sexual Health Service Pharmacy Sexual Health Programme Psychosexual Counselling
	Reduce rates of STIs	all new STI diagnoses (exc. Chlamydia <25 yrs) 15-64 yrs /100,000 (2013) Thanet: 718	
	Reduce excess under 75 mortality rates	Mortality rate from diseases considered preventable (persons) /100,000 (2011-2013) Thanet: 216	NHS Health Checks Programme
All Priorities	As above	As above	Children's Centres Health Trainers Aspirations Healthy Living Centre Healthy Living Pharmacies Learning Disability Health Improvement Programme NHS Health Checks Programme

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Ageing Well – Thanet			
	Agreed Outcomes	Current Health Performance <i>Source: PHOF unless stated</i>	PH Activity
Smoking	Reduce smoking prevalence	Smoking prevalence in general population 18+ (2013) Canterbury: 19.0%	Smoking Cessation Service Tobacco Control
Healthy Eating, Physical Activity and Obesity	Reduce levels of excess weight	% excess weight in adults (2012) Thanet: 68.4%	Fresh Start Tier 3 Weight Management Health Walks Exercise Referral Scheme
Alcohol & Substance Misuse	Reduction in number of people drinking at problem levels	Alcohol specific admission rate /10,000 population aged 65+ (2011/12 - 2013/14) -Source: SUS, ONS Thanet: 47.9	Adult Substance Misuse Service
	Reduction in hospital admissions due to alcohol		
Wellbeing (inc Mental Health & Social Isolation)	Improve wellbeing	Mental Health Contact rate per 1,000 people, aged 65+ (2014) – Source: KMPT, ONS Thanet: 27.1	Kent Sheds Mental Health Community Services Mental Health First Aid Mental Health Matters Helpline Mental Wellbeing Programmes Primary Care Link Workers
	Reduce social isolation	% all households occupied by single person aged 65+ (2011) Kent: 5.52%	
	People with mental ill health are supported to live well	Mental Health Contact rate per 1,000 people, aged 65+ (2014) – Source: KMPT, ONS Thanet: 27.1	
Sexual Health	Reduce rates of STIs	<i>No data available for 65+</i>	Integrated Sexual Health Service
All Priorities	As all above	As all above	Health Trainers Healthy Living Pharmacies Learning Disability Health Improvement Programme NHS Health Checks Programme

5. Wider engagement

5.1. Public Health have conducted a series of market engagement events which indicated a strong willingness by many providers to engage in the transformation work. The exercise involved representatives from more than 80 service provider organisations from the public, private and voluntary sector. Feedback included the below points :

- A strong appetite to engage in the programme.
- Different models emerging nationwide: many providers come with knowledge wider than Kent and & keen to share what has and hasn't worked elsewhere.
- Keenness to collaborate between public private and voluntary sector providers.
- Providers keen to explore new contract opportunities, in many cases beyond services that they are already providing - many providers are keen to diversify the service offer
- Suggestions that go beyond traditional 'service-based' approaches e.g. using behavioural science and marketing approaches to generate motivation.
- Many providers are thinking about their strategies and in some cases re-focusing their service offer in order to respond to the potential market for health improvement
- A number of different providers suggested commissioning a generic 'behaviour change service'
- Pharmacies keen to be more engaged

5.2. Customer insight work is also in progress. A focussed piece of work into women who smoke during pregnancy has been completed. Insight focus groups will take place in October and November with aim of gaining further insight into why people engage in multiple unhealthy behaviours and what will motivate them to access a health improvement service. A full public consultation on the proposed model will then be undertaken in November and December and will include an on-line survey to gather the general public's views and opinions on the model, and secondly focus groups will be held and targeted at those with greater need so that we gather in depth feedback from the populations that we want to access the new service.

5.2.1. Whilst we are still in consultation there have been no decisions taken about future models. However a number of themes have come out of the work to date. This includes some core principles for the approach moving forwards,

5.3. Health promotion across the population

5.3.1. One of the strongest pieces of feedback has been that the approach to public health messaging could be hugely strengthened and coordinated much more with partners. There has been feedback that the approach to date in public health has tended to be to invest in services, relying on people to feel motivated to use those services. There is a need for than a highly proactive approach to increase the use of campaigns, social marketing and communication channels across partners to produce high profile, high impact messages.

5.4. A focus on health inequalities

5.4.1. A key theme for both children and adult services has been to further identify the opportunity to enhance public health into partner programmes of work already in place in communities where there are high health inequalities. It is also clear that better use of data and intelligence that is available can be used to target communities with high health inequalities

5.5. Locally flexible services

5.5.1. The current approach has been based on a one size fits all across Kent. Future procurement should include local representation to ensure a model which varies according to local priorities. The service models in development must enable better alignment with local need. Local representatives are welcomed in further developing this model.

5.6. Adult health improvement services

5.6.1. A core theme has been to move from the standalone provision which currently exists in health improvement services to a much more integrated service, strengthening the approach currently taken in the health trainer service.

5.7. Children and Young People's services

5.7.1. A review of Children and Young People's services, including the School Public Health services and Substance Misuse services for young people, has been completed. From October 2015 KCC will inherit the commissioning responsibility for the Health Visiting Service from NHS England and prior to transfer we have worked closely with CCG's, General Practice and KCC to develop a new specification for the service based on the national framework.

5.7.2. Key themes from the review have included much better visibility of core services including the health visiting and school nursing service, shared records and a much more closely aligned approach with KCC Early help services particularly in relation to emotional wellbeing and drug and alcohol services.

6. Conclusion

6.1. Since May, Public Health has been undertaking a review and analysis of the services commissioned through the public health grant and which it welcomes engagement and feedback on the proposed changes to service.

7. Recommendation

7.1. The Board are asked to:

- | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none">1. Comment on the work to date.2. Comment on how local priorities should shape local delivery.3. Promote the public consultation on public health programmes. |
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Thanet Clinical Commissioning Group

Services and Support for People with Dementia and their Families in Thanet



Linda Caldwell
Commissioning Support Manager,
Thanet CCG

Dementia Pathway

- Identification.
- Assessment and Diagnosis.
- Early Intervention and Treatment.
- Living Well With Dementia.
 - Community Support.
 - Intensive Support.
- End of Life Care.

Identification

- Reducing Stigma.
- National and Local Campaigns.
- Training Programmes.
- Dementia Friends Training.
- Development of Dementia Friendly Communities.

Assessment and Diagnosis

Primary Care

- History taking.
- Cognitive assessment.
- Baseline tests to exclude other causes.
- Diagnosis, dependent on presentation and knowledge of GP.

Kent and Medway Partnership Trust – Memory Assessment Service

- Further assessment.
- Diagnosis.
- Sub typing of dementia.

Early Intervention and Treatment

Kent and Medway Partnership Trust – Memory Assessment Service

- Initiation of anti dementia drugs, if appropriate.
- Post diagnostic support.
 - Prognosis and future planning.
 - Cognitive stimulation therapy.
 - Carers support.
 - Signposting to other services.
- Addition to QOF register.

Living Well with Dementia - Community Support (1)

Service	Provider	Commissioned By	
		CCG	KCC
Carers Information and Support	Carers Support	√	√
Carers Short Breaks	Crossroads Care	√	√
Carers Respite for Health Appointments	Crossroads Care	X	√
RSAS 'Learning Curve' for Carers	RSAS	X	X
Admiral Nurse	KMPT	√	X
24 Hour Helpline	ADSS	X	√
COGGS Clubs	Various	X	X
Day Service	Age UK	X	√

Living Well with Dementia - Community Support (2)

Service	Provider	Commissioned By	
		CCG	KCC
Day Service	Westbrook House	X	√
Intergenerational Project	Age UK	X	X
Peer Support Groups	Trinity Resource Centre	X	√
Dementia Cafes	EKIDs	X	√
Dementia Outreach Service	Crossroads Care	X	√
Domiciliary Care Services	Various	√	X

Living Well with Dementia - Intensive Support

Service	Provider	Commissioned By	
		CCG	KCC
Community Teams	KMPT	√	X
24/7 Dementia Crisis Service	Crossroads Care	√	X
Care Homes	Various	X	√
Care Homes Nursing	Various	√	√
Inpatient Beds	KMPT	√	X
Hospital Discharge Service	Crossroads Care	√	X

End of Life Care

- There are no specific services for people with dementia who are at the end of their life.

Service Gaps

- End of life care which takes into account the specific needs of people with dementia.
- Insufficient suitable care homes (nursing).
- Intermediate care services for people with dementia.
- Improved interface between primary care and secondary mental health services.

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.