AGENDA

WEST KENT CCG HEALTH AND WELLBEING BOARD MEETING

Date: Tuesday 15 July 2014
Time: 4.15 p.m.
Venue: Swale Room One, County Hall, Maidstone

Membership:

Gail Arnold, William Benson, Councillor Annabelle Blackmore, Dr Bob Bowes (Chairman), Lesley Bowles, Alison Broom, Councillor Alison Cook, County Councillor Roger Gough, Jane Heeley, Fran Holgate, Dr Caroline Jessel, Dr Tony Jones, James Lampert, Mark Lemon, Reg Middleton, Councillor Mark Rhodes, Dr Sanjay Singh, Penny Southern, Malti Varshney and Councillor Lynne Weatherly

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Issued on 7 July 2014

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact MARK LEMON** on 01622 696252

Kent County Council, Policy and Strategic Relationships, Room 2.65, Sessions House, Maidstone, Kent ME14 1XQ

7.	Children's Operational Group Update and Next Steps - Michael Thomas-Sam and James Harman	
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WEST KENT CCG HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON TUESDAY 15 APRIL 2014

Present: **Dr Bob Bowes (Chairman) and Gail Arnold, Hayley Brooks, Alison Broom, Councillor Richard Davison, Tristan Godfrey, County Councillor Roger Gough, Jane Heeley, Steve Inett, Dr Caroline Jessel, Dr Tony Jones, Councillor Brian Lukker, Jonathan MacDonald, Mairead MacNeil, Dr Sanjay Singh, Malti Varshney and Tracy Veasey**

In Attendance: **Julie Beilby, Alexandra Dave, Katie Latchford and Martine McCahon**

1. APOLOGIES FOR ABSENCE

It was noted that apologies for absence had been received from William Benson, Lesley Bowles, Councillor John Cunningham, Dave Holman, James Lampert, Mark Lemon and Dr Meriel Wynter.

2. DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS

There were none.

3. MINUTES OF THE MEETING HELD ON 18 MARCH 2014

RESOLVED: That the Minutes of the meeting held on 18 March 2014 be approved as a correct record.

4. MATTERS ARISING FROM THE MINUTES OF THE MEETING HELD ON 18 MARCH 2014

Minute 9 – Children's Operational Groups

In response to a question, the Chairman said that he had written to Kent County Council seeking clarification regarding the role of the new Children's Operational Groups (COGs) and their governance arrangements, and a reply was awaited. The decision to establish the Children's Operational Groups as sub-groups of the local Health and Wellbeing Boards, accountable to them for the effective delivery of their programmes, brought new responsibilities which would need to be discharged.

Julie Beilby advised the Board that the establishment of the new COGs had been discussed by the Kent Chief Executives who had expressed concern, particularly about the loss of a District perspective. She would refer the need for further clarification back to the Kent Chief Executives with a view to them raising the matter with the County Council.

5. OVERVIEW OF TASK AND FINISH GROUPS

Malti Varshney presented an overview of the Task and Finish Groups which had been established to review how collaborative working and the co-ordinated provision of services could better address specific causes of ill health and tackle health inequalities. Reference was made in the presentation to (a) the topics covered by the Task and Finish Groups and their common objectives and findings and (b) the lessons learned, the recommended way forward and the key challenges which had been identified.

In response to a question as to whether any interventions had been identified which might address all cases, Malti explained that every contact should count and issues relating to system connectivity needed to be addressed to enable people to be directed to the right place. Partner organisations should be identifying individuals/teams that could be trained to deliver quick, brief advice to high risk groups, targeting in particular unhealthy lifestyle choices such as alcohol and tobacco.

RESOLVED: That the presentation be noted with interest.

6. CHILDHOOD OBESITY TASK AND FINISH GROUP

Katie Latchford presented the findings and recommendations of the Childhood Obesity Task and Finish Group.

Members of the Board commented that:

- Consideration should be given to the provision of comprehensive joined-up services for women with a high BMI during pregnancy.

- There was reluctance on the part of professionals at all levels to talk about weight to children, young people and their families, and this meant that potential weight management referrals were slipping through the net.

- There were nationally mandated activities in relation to childhood obesity. In Kent there was also the Workplace Health Programme. No work had been undertaken locally to engage with the food industry.

- There was a need to work with schools on initiatives to tackle obesity in children and young people, promote healthy lifestyles and increase physical activity. As an example, schools could be encouraged to remove vending machines that offer unhealthy foods from their buildings.

- There was a need for a simple strategy with a comprehensive, integrated approach to screening, prevention, early intervention and commissioning aimed particularly at children aged 0-5 years and adolescents.

- There was a need to promote local leadership at all levels with strategic leadership through the Health and Wellbeing Board. Consideration could be given to the appointment of a person to champion the cause and move things forward.

- The possibility of promoting healthy eating in association with local food producers should be explored.

- Children's centres were well placed to engage with families and children at an early stage and to offer interventions to start to build healthy eating habits.

- There was a real opportunity to promote the commissioning of services to tackle obesity in children and young people in a different, comprehensive joined-up way. For example, adhoc programmes were currently being commissioned by District Councils whereas a systematic commissioned approach was required. Council departments such as planning and leisure should be fully involved to ensure a joined-up approach.

RESOLVED:

1. That the report of the Childhood Obesity Task and Finish Group be noted.

2. That the Group be requested to give further consideration to the points raised in the discussion; in particular, the possible use of Children's Centres as providers and the need to (a) raise the profile of obesity in children and young people and (b) to promote prevention through education.

7. CHILDREN AND YOUNG PEOPLE TASK AND FINISH GROUP

Malti Varshney presented the findings and recommendations of the Children and Young People Task and Finish Group. Malti explained that the Group had identified that the current governance framework for achieving outcomes in services for children and young people needed to be strengthened. There were opportunities for integrated commissioning, provision or person centred approaches, but these could only be progressed if representation, reporting and lines of accountability between the Board and decision making bodies at different geographies could be established. Progress was being made against priorities, but clarity of leadership, purpose and expectation was required. Schools and colleges were key partners in the delivery of health and wellbeing outcomes for children and young people, but were largely absent from West Kent Health and Wellbeing Board discussions and decision making.

Members commented that:

- There was a need to engage education providers in the Board's discussions and decision making regarding the health and wellbeing of children and young people.

- In terms of the proposed establishment of a Sub-Group of the Board to progress the health and wellbeing of children and young people, clarification was required as to the role of the new Children's Operational Group (COG) to avoid duplication.

- Given the current uncertainty regarding the role of the COG, it could be argued, if it was considered that there was potential for improvement, that there was a case for the establishment of a Children's/Young People's Sub-Group of the Board which would build upon common themes whilst having regard to different District needs.

RESOLVED: That further consideration be given to the establishment of a Children's/Young People's Sub-Group of the Board to address the conclusions and recommendations of the Task and Finish Group at the proposed Board development event, taking into account the implications of the decision to establish the COGs on Health and Wellbeing Board boundaries.

8. TOBACCO CONTROL AND SMOKING CESSATION TASK AND FINISH GROUP

Jane Heeley presented the conclusions and recommendations of the Tobacco Control and Smoking Cessation Task and Finish Group. Jane explained that the whole agenda in relation to smoking cessation was more advanced as smoking remained the main cause of preventative death. The Task and Finish Group had developed a multi-agency action plan that focused on supporting and developing capacity in tobacco control to take forward tobacco control initiatives.

Members of the Board commented that:

- Districts could engage with employers through the Work Place Wellbeing Charter on initiatives relating to tobacco control and smoking cessation.

- National advertising in relation to the health risks associated with smoking was blatant. It was the issue of denial that needed to be addressed.

- Training was needed to overcome the perception on behalf of health practitioners of having to deliver a difficult message in relation to smoking.

- In terms of "Making Every Contact Count", stakeholder organisations should be identifying key staff and services well placed to deliver "very brief advice" and generate referrals. The provision of "very brief advice" should be incorporated into service specifications and contracts.

- The skills of frontline staff should be developed to enable them to encourage and support patients to adopt healthier lifestyles and to signpost them to appropriate preventive services.

RESOLVED: That the recommendations of the Task and Finish Group be endorsed.

9. MENTAL HEALTH AND WELLBEING TASK AND FINISH GROUP

RESOLVED: That consideration of the report of the Mental Health and Wellbeing Task and Finish Group be postponed until the next meeting of the Board.

10. PROGRESS TO DATE ON DEMENTIA TASK AND FINISH GROUP

Martine McCahon updated the Board on the progress made to date by the Dementia Task and Finish Group. It was noted that all parts of the health and care system would need to work in collaboration to achieve good health outcomes for people with dementia and their carers. A service audit was being undertaken to identify gaps in service provision/utilisation. The findings from the audit would inform service redesign/future integrated commissioning intentions.

Members of the Board commented that:

- There was a need to ensure that people with dementia are proactively supported to improve their physical, emotional and social wellbeing and to raise public and professional awareness of dementia by, for example, developing dementia friendly communities in West Kent.

- The vision for dementia care was moving from a medically based model of health care to a social model.

RESOLVED: That the progress made to date by the Task and Finish Group be noted, and that the recommendations of the Group be endorsed.

11. BOARD DEVELOPMENT PROGRAMME

The Board gave further consideration to its role, responsibilities and ambitions.

Members of the Board commented that:

- Consideration should be given to the development of the democratic element in the work of the Board and the costs/benefits of building health and wellbeing into the culture of all public service providers.

- The Kent Health and Wellbeing Board provided an overview of the health system in Kent and strategic direction, but the West Kent Health and Wellbeing Board could lead and advise on the

development of CCG level integrated commissioning strategies and plans and monitor outcomes. There was potential to influence commissioning and provision across the NHS, social care, public health and district councils etc. to ensure that resources were directed where required.

- The opportunity should be taken to promote the role and responsibilities of the Board and its relationship with providers.

- Education was the common denominator and resources were required to provide leadership on the commissioning and provision of services.

- A whole system approach was required to the effective commissioning of plans and services.

- It was disappointing that there were no elected Members on the Board of the CCG.

RESOLVED: That the points raised in the discussion be taken into account at the forthcoming Board development event.

12. DATE OF NEXT MEETING

RESOLVED: That the next meeting of the Board be arranged to take place on Tuesday 17 June 2014 at a venue within the West Kent area to be finalised. The meeting should commence early in the afternoon and take the form of a development session with the discussion led by a facilitator.

13. DURATION OF MEETING

4.00 p.m. to 6.05 p.m.

By: Ivan Rudd, Public Health Specialist for Mental Health and Wellbeing

To: West Kent CCG Health and Wellbeing Board

Subject: Mental Health and Wellbeing Task and Finish Group: Updated July 2014

Classification: Unrestricted

Summary
The Mental Health Task and finish Group was tasked by the HWBB to review key issues and make recommendations to the HWBB on how it could support wellbeing and the prevention of mental ill health.

1. Introduction

The Task and Finish Group for Mental Health was formed subsequent to a presentation made to West Kent Health and Wellbeing Board.
The membership of the T&F Group membership varied and included:

Ivan Rudd, Public Health Specialist KCC (Chair - Hayley Brooks Manager Sevenoaks District Council unable to attend meetings)
Anton Tavernier-Gustav, Sevenoaks Council
Katie Latchford, Maidstone BC
Heidi Ward, Tonbridge and Malling BC
Sara Watkins, Tunbridge Wells BC
David Chesover , Deputy Chair NHS West Kent CCG
Ivan Rudd, Public Health Specialist KCC
Dave Holman NHS West Kent CCG
Sue Scamell, KCC
Jill Roberts, CEO Sevenoaks Mind
James de Pury NHS West Kent CCG

The aim of the Group was to understand four issues:

1. **Mental health improvement opportunities funded by Section 256,**
2. **Opportunities for supporting employers and schools in prevention**

3. **The need for a communications strategy to make sure that everyone who might need the service finds it easy to access.**
4. **How can we build community resilience? What would districts/ boroughs, the various sectors of the NHS need to do to enhance this?**

1. Mental health improvement opportunities funded by Section 256

Section 256 Services. Section 256 provides funding for the Local Authority to support voluntary sector providers to provide the Services for people with severe mental health needs to enable them to live independently. The services are also designed to meet the needs of people diagnosed with common mental illness and people can self-refer enabling a 'universal' approach. The core vision being developed is to grow the 'wraparound' holistic support offered that helps people into employment, meaningful activity, care navigation and building resilience and coping skills. This year's Section 256 agreements have been signed off and future plans will be shared with all HHWBB partners as they are developed this financial year; the Programme Oversight Group (POG) chaired by West Kent CCG is the current forum for exploring the development Section 256 services.

2 a) Opportunities for supporting employers and schools in prevention
Schools

Mental health prevention has two strands - keeping well, and preventing people with mental health issues from further ill health through promoting recovery. There are many initiatives within schools to maintain health and improve emotional wellbeing but it is difficult to map them or to have a strategic sense of their quality in West Kent. For schools governing bodies are responsible for ensuring that wellbeing and pupil support structures that seem most appropriate are in place. It is not clear how good targeted and universal provision is in primary and secondary schools, and how it complies with NICE Guidance on school emotional Health and Wellbeing. Two recent developments may help understand opportunities for supporting schools better, these are the development of the COG in West Kent and the work surrounding the Lottery's HeadStart work programme which is developing interventions and these will be shared with the Board.

> **Note on parenting support provision**. Parenting is most important determinant of mental health and resilience across the life course. It influences a child's ability to benefit from primary education and builds the confidence and skills that contribute to a successful secondary education. The infant's

emotional and social brain is very plastic and it is the relationship with parents and carers that shapes it. This dictates risk and resilience for mental illness and psychological distress throughout life. The current universal support for parenting picture is unclear.

Question – does the Board wish this T&F Group to continue to explore the emotional health and wellbeing support available in schools or should this be a priority for the COG to consider? Should the COG also consider including a review of access and barriers to universal parenting opportunities in West Kent?

2 b) Workplaces

Workforce mental health and wellbeing. The workplace is a key environment to promote good mental health and there is a range of guidance on how to maintain and improve health and wellbeing in the workforce. Sevenoaks Mind is leading a major 'Chatter Matters' campaign based on improving health in the workplace amongst other objectives and it will link into the wider communications strategy. Public Health at KCC have a significant workplace programme and are funding training for GPs in Mental Health First Aid to contribute to the Kent Suicide Prevention Strategy and Action Plan.
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Action The Board is asked to note the growing interest in workplace wellbeing and to consider receiving a presentation from KCC PH Workplace Leads on current progress and what more can be achieved in West Kent.

3 The need for a communications strategy to make sure that everyone who might need the service finds it easy to access

There is a wealth of mental health and wellbeing support services in West Kent and the T&F Group recognised the benefits of closer working to develop a communication plan to enable the public to understand what free NHS services are available.

The T&F group identified that more can be done to make the public aware of the MH support that is available to them and those they care for. We looked at the communication resources that existed such as the Live it well website – www.liveitwell.org.uk which was a key product of the Live It Well strategy.

Communicating services example: Access to Improving Access to Psychological Therapies services. The T&F Group noted the low numbers accessing Improving Access to Psychological Therapies (IAPT) services, and West

Kent CCG has led a partnership to develop a strategy and action plan that seeks to close the gap in the population's understanding of Improving Access to Psychological Therapies services available. It will facilitate the development of a wider communications approach. **The Board is asked to note that as part of the IAPT communication strategy there is an IAPT publicity event at the Hop Farm in the evening of 17th July.**

Recommendation. The T&F group recognised the Live it Well strategy should be revisited and recommends that the revision process should form part of a wider communication strategy with an action plan to ensure greater understanding in West Kent of services available throughout the life course.

4 How can we build community resilience? What would districts/ boroughs, the various sectors of the NHS need to do to enhance this?

A World Health Organisation report for the European region [1] has made the case for both individual and wider societal public health solutions to increase resilience and improve mental health and well-being which is described as a community or individuals 'ordinary magic' which allows them to achieve good outcomes in spite of serious threats to adaptation or development." [2]

How is resilience grown in communities? The literature suggests we focus on growing those key assets that make a difference. Assets can be individuals, community groups, associations, buildings and spaces. KCC PH is has funded some pilot research in Kent to understand further how community wellbeing - are utilised using mapping and resident 'deep dive' interviews and workshops

This asset pilot should help the T&F Group start to understand the individual experience and value of different community assets as a step towards making recommendations to enhance community resilience.

Question: Does the Board wish the T&F Group to continue to further develop this resilience work in West Kent?

Ivan Rudd

July 2014

[1] Friedli L (2009) *Mental health, resilience and inequalities*. Copenhagen: World Health Organisation Regional Office for Europe

[2] Masten, A. S. (2001). "Ordinary magic: Resilience processes in development." *American Psychologist **56(3): 227-238*** Resilience is common and it typically arises from the operation of normal rather than extraordinary human capabilities, relationships, and resources. In other words, resilience emerges from *ordinary magic.*

Report Subject: West Kent Health and Wellbeing Board – Assurance Framework

Date: 15 July 2014

Summary:

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

Recommendations:

The West Kent Health and Wellbeing Board is asked to:

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

1. Introduction

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

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

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

2. Background to the report

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

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

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

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

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

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

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

Key to KPI Ratings used

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

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

Report Prepared by

Malti Varshney, Consultant in Public Health
Malti.varshney@kent.gov.uk

Mark Gilbert, Commissioning and Performance Manager, Public Health
Mark.gilbert@kent.gov.uk

Susannah Adams, Programme Officer, Public Health
Susannah.adams@kent.gov.uk

3. Strategy Indicators

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

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

Outcome 1: Every child has the best start in life

Indicator	Kent Status	West Kent Status	DoT	Time Period
1.1 Increasing breastfeeding initiation rates (PHOF)	72.1%	not currently available	-	2012/13
1.2 Increasing breastfeeding continuation 6-8 weeks (PHOF)	40.8%	not currently available	-	2012/13
1.3 Improve MMR vaccination update - two doses 5 years old, (PHOF)	92.2%	not currently available	-	2012/13
1.4 Reduction in the number of pregnant women with a smoking status at the time of delivery (KMPHO)	13.1%	9.4%	-	2013/14
1.5 Unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 10,000, KMPHO)	14.6	12.3	⇧	2013/14
1.6 Unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 10,000, KMPHO)	7.3	5.5	⇩	2013/14
1.7 Unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 10,000, KMPHO)	8.8	6.5	⇧	2013/14
1.8 Reduction in conception rates for young women aged under 18 years old (rate per 1,000, PHOF)	25.9	16.6 Sevenoaks	⇧	2012
		26.1 T & M	⇩	
		13.5 T Wells	⇧	
		19.2 Maidstone	⇧	
1.9 Decrease the proportion of 4-5 year olds with excess weight (PHOF)	21.7%	19.2% Sevenoaks	⇔	2012/13
		20.9% T & M	⇩	

Indicator	Kent Status	West Kent Status	DoT	Time Period
		21.5% T Wells	⇧	
		24.4% Maidstone	⇧	
1.10 Decrease the proportion of 10-11 year olds with excess weight (PHOF)	32.7%	30.2% Sevenoaks	⇧	2012/13
		31.3% T & M	⇧	
		30.3% T Wells	⇩	
		30.1% Maidstone	⇧	

Exception items:

- The rate of unplanned hospitalisation for diabetes (primary diagnosis) for people aged under 19 years old in West Kent increased from 4.82 per 10,000 in 2012/13 to 5.5 in 2013/14. Although this is more likely to be related to Type 1 diabetes, further local analysis may need to be undertaken to understand what proportion are due to Type 1 and Type 2 diabetes, and if it is increasing over time. This analysis will assist in service improvement action planning at a local level.

- Tonbridge & Malling experienced an increase in the under 18 conception rate for 2011 at 21.8 per 1,000 to 26.1 per 1,000 in 2012; Dartford was the only other district to have increased during this time period.

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

Indicator	Kent Status	West Kent Status	DoT	Time Period
2.1 Reduction in the under-75 mortality rate from cancer (rate per 100,000, KMPHO)	135.5	145.2	⇧	2012
2.2 Reduction in the under-75 mortality rate from respiratory disease (ASR per 100,000, KMPHO)	30.7	30.0	⇧	2012
2.3 Increase in the proportion of people receiving NHS Health Checks of the target number to be invited (where GP Practice can be linked, Public Health)	36.1%	27.8%	-	2013/14

Indicator	Kent Status	West Kent Status	DoT	Time Period
2.4 Increase in the number of people quitting smoking via smoking cessation services (Public Health)	5254	965	-	2013/14
2.5 Reduction in the number of hip fractures for people aged 65 and over (ASR per 100,000, KMPHO)	480.5	397.7	⇩	2012/13
2.6 Reduction in the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000, KMPHO)	295.5	299.2	⇧	2010-12
2.7 Decrease the proportion of adults with excess weight (PHOF)	64.6%	65.3% Sevenoaks	-	2012
		65.2% T & M	-	
		59.4% T Wells	-	
		66.2% Maidstone	-	
2.8 Increase the Percentage of physically active clients (PHOF)	57.2%	64.3% Sevenoaks	-	2012
		61.1% T & M	-	
		64.8% T Wells	-	
		60.9% Maidstone	-	

Exception items:

- Although West Kent remains above Kent on the mortality rate for cancer, it has been reducing year on year from 2009. West Kent has the 2nd highest rate behind South Kent Coast.
- The rate of smoking attributable deaths in West Kent is similar to Kent overall although there has been a decrease between 2009-11 and 2010-12 from 310.4 to 299.2.
- Adults with excess weight is a new indicator and only one year is currently available, no direction of travel can be presented; district-level data is available and shows Sevenoaks, Tonbridge & Malling and Maidstone to have higher proportions than Kent.

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

Indicator	Kent Status	West Kent status	DoT	Time Period
3.1 Clients with community based services who receive a personal budget and/or direct budget	67%	not currently available	-	February 2014
3.2 Increase in the number of people using telecare and telehealth technology	2,992	not currently available	-	February 2014

Exception items:

- There has been a further drop in the proportion of people receiving a personal budget and/or direct budget, this is due to more people receiving a short term service such as enablement or telecare and would not therefore be eligible for a personal budget or direct payment.
- There have been further increases in the number of people using telecare and telehealth technology and to February there were 2,992 clients, this far exceeds the target of 2,125.
- Local health and wellbeing board area figures on both metrics will be available for the next report.

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

Indicator	Kent Status	West Kent Status	DoT	Time Period
4.1 Reduction in the number of suicides (ASR per 100,000, KMPHO)	5.31	4.83	⇧	2011-13
4.2 Increased employment rate among people with mental illness/those in contact with secondary mental health services (ASCOF)	7.4%	not currently available	-	2012/13
4.3 Increased crisis response of A&E liaison within 2 hours – Urgent (KMCS)	73.5%	81.0%	⇔	Q3 2013/14
4.4 Increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours (KMCS)		100%	⇔	Q3 2013/14

Indicator	Kent Status	West Kent Status	DoT	Time Period
	100%			
4.5 Number of adults receiving treatment for drug misuse (primary substance) number (KDAAT)	to be presented in next report			
4.6 Number of adults receiving treatment for alcohol misuse (primary substance) number (KDAAT)	to be presented in next report			
4.7 Increase in the successful completion and non-representation of opiate drug users leaving community substance misuse treatment (PHOF)	10.9%	not currently available		2012
4.8 Decrease the number of people entering prison with substance dependence issues who are previously not known to community treatment (PHOF)	Awaiting indicator development and reporting from PHE			

Exception items:

- There was little variance between Q2 and Q3 2013/14 on A&E liaison for West Kent and remains seeing a higher proportion within 2 hours than Kent for Q1, Q2 and Q3.
- Further work is needed on the substance misuse metrics (4.5, 4.6, 4.7 and 4.8) with the aim to provide figures for the next report.

Outcome 5: People with dementia are assessed and treated earlier

Indicator	Kent Status	West Kent Status	DoT	Time Period
5.1 Increase in the reported number of dementia patients on GP registers as a percentage of estimated prevalence (KMCS)	41.5%	42.6%	⇧	2012/13
5.2 Rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000, KMCS)	25.1	24.1	⇩	2013/14
5.3 Rate of admissions to hospital for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000, KMCS)	50.5	48.5	⇩	2013/14
5.4 Total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	225.7	231.4	⇧	2013/14

Indicator	Kent Status	West Kent Status	DoT	Time Period
5.5 Total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	452.5	467.7	⇧	2013/14

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

Exception items:

- The reported number of dementia patients on GP registers as a proportion of estimated prevalence has increased in West Kent from 2012/13 to 2013/14 at 40.1% to 42.6% and continues to be higher than Kent; however Ashford, Canterbury, DGS and Swale all had higher proportions than West Kent, Swale was the highest at 44.8%.

- The two metrics on bed-days for West Kent had rates above Kent in 2013/14, however both are decreasing and heading in the right direction.

4. Stress Indicators

Children's Services

Indicator	Kent Status	West Kent status	DoT	Time Period
6.1 Decrease the number waiting for routine treatment after assessment – CAMHS (KMCS)	565	95	⇧	April 2014
6.2 CAMHS Caseload, for patients open at any point during the month (excluding Medway and Out of Area, KMCS)	8,523	2,033	-	April 2014
6.3 Increase proportion of SEN assessments within 26 weeks (MIU KCC)	94.5%	95.5% Sevenoaks	⇩	March 2014
		100% T & M	⇔	
		100% T Wells	⇔	
		100% Maidstone	⇧	
6.4 SEN Kent children placed in independent or out of county schools (number, MIU KCC)	583	62 Sevenoaks	⇩	March 2014
		43 T & M	⇧	
		42 T Wells	⇔	
		48 Maidstone	⇩	

Exception items:

- The districts within West Kent continue to show high proportions of SEN assessments within 26 weeks, and remain above Kent levels. Although Sevenoaks and Maidstone show an increase in the number of SEN Kent children placed in independent or out of county schools, the increases are either by one or two children,

Public Health

Indicator	Kent Status	West Kent Status	DoT	Time Period
6.5 Population vaccination coverage – Flu (aged 65+, PHOF) Target: 75%	71.4%	not currently available	-	2012/13
6.6 Population vaccination coverage – Flu (at risk individuals, PHOF) Target: 75%	48.7%	not currently available	-	2012/13

Exception items:

- Currently metrics on Flu vaccinations in not available at CCG level, however alternatives are being investigated.

Acute/Urgent and Primary Care

Indicator	D&G NHS Trust	EKHUFT	MTW	MFT	Time Period
6.7 Bed Occupancy Rates (overnight)	96.7%	92.3%	93.6%	94.3%	Q4 2013/14
6.8 A&E Attendances within 4 hours (all) from arrival to admission, transfer or discharge	97.9%	93.5%	96.9%	83.2%	Week ending 25/05/2014
6.9 Number of emergency admissions	To be further discussed and developed with NHS England				
6.10 GP Attendances	Awaiting information from NHS England and indicator development				
6.11 Out of Hours activity	Awaiting information from KMCS and indicator development				
6.12 111 NHS Service	Work ongoing with KMCS to shape and define				

Exception items:

- Overnight bed occupancy rates for Q4 2013/14 vary between 92.3% at EKHUFT to 96.7% at DGS NHS Trust.

- A&E attendances within 4 hours from arrival also varies from 83.2% in Medway NHS Foundation Trust to 97.9% in DGS NHS Trust. These figures relate to the week ending 25/05/2014.

- Work is ongoing to either define or find suitable current metrics for those listed above; monthly data meetings are held that include KMCS and NHS colleagues where discussions are ongoing.

Social care / Community care

Indicator	Kent Status	West Kent Status	DoT	Time Period
6.13 The proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services **BCF**	Under review by Adult Social Care			
6.14 Number of delayed days, acute and non-acute for Kent **BCF**	2170 days	Not currently available	-	April 2014
6.15 Infection control rates	Work ongoing with NHS England to shape and define			
6.16 Percentage of people with short term intervention that had no further service	Under further development with Adult Social Care			
6.17 Admissions to permanent residential care for older people (number). **BCF**	100	not currently available	-	April 2014

Exception items:

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

Appendix A: Local area indicators

Outcome 1: Every child has the best start in life									
Indicator	Time Period	Kent	Ashford	Canterbury	DGS	SKC	Swale	Thanet	West Kent
1.4 Reduction in the number of pregnant women with a smoking status at the time of delivery	2013/14	13.1%	10.9%	12.8%	12.9%	16.5%	20.6%	17.0%	9.4%
1.5 Unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	14.6	16.6	11.5	16.5	18.0	16.3	14.8	12.3
1.6 Unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	7.3	4.7	7.9	6.2	9.6	10.2	11.9	5.5
1.7 Unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	8.8	8.1	8.2	9.9	6.4	13.6	15.7	6.5

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing									
Indicator	Time Period	Kent	Ashford	Canterbury	DGS	SKC	Swale	Thanet	West Kent
2.1 Reduction in the under 75 mortality rate from cancer (rate per 100,000)	2012	135.5	111.4	121.0	128.5	147.9	133.8	140.0	145.2
2.2 Reduction in the under 75 mortality rate from respiratory disease (rate per 100,000)	2012	30.7	28.1	26.8	30.1	34.8	23.6	40.2	30.0
2.3 Increase in the proportion of people receiving NHS Health Checks of the target number to be invited	2013/14	36.1%	38.7%	40.1%	15.9%	33.6%	28.3%	29.2%	27.8%
2.4 Increase in the number of people quitting smoking via smoking cessation services	2013/14	5254	420	630	834	957	518	930	965
2.5 Reduction in the number of hip fractures for people aged 65 and over (rate per 10,000)	2013/14	480.5	459.7	562.5	554.9	431.5	559.6	540.9	397.7
2.6 Reduction in the rates of the deaths attributable to smoking persons aged 35+ (rate per 100,000)	2010-12	295.5	245.3	270.4	287.7	301.7	334.8	333.9	299.2

Outcome 4: People with mental health issues are supported to 'live well'									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
4.3 Increased crisis response of A&E liaison within 2 hours – Urgent	Q3 2013/14	73.5%	**65.4%**	**67.6%**	**90.8%**	**57.5%**	**86.0%**	**80.9%**	**81.0%**
4.4 Increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours	Q3 2013/14	100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Outcome 5: People with dementia are assessed and treated earlier									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
5.1 Increase in the reported number of dementia patients on GP registers as a percentage of estimated prevalence	2012/13	**41.5**	**43.0**	**43.2**	**44.2**	**38.7**	**44.8**	**34.6**	**42.6**
5.2 Rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	2013/14	**25.1**	**20.5**	**28.8**	**27.0**	**25.1**	**21.3**	**26.1**	**24.1**
5.3 Rate of admissions to hospital for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	2013/14	**50.5**	**43.3**	**56.6**	**53.3**	**50.3**	**48.7**	**50.2**	**48.5**
5.4 Total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	2013/14	**225.7**	**187.6**	**168.1**	**342.8**	**183.0**	**257.4**	**193.0**	**231.4**
5.5 Total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	2013/14	**452.5**	**382.4**	**327.1**	**673.0**	**363.9**	**573.1**	**383.1**	**467.7**
Trust Level Data									
	Time Period	**D&G NHS Trust**		**EKHUFT**		**MTW**		**Medway**	
5.6 The proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been:									
(a) identified as potentially having dementia	Q4 2013/14	**92%**		**100%**		**99%**		**78%**	
(b) who are appropriately assessed		**100%**		**94%**		**99%**		**88%**	
(c) and, where appropriate, referred on to specialist services in England		**100%**		**100%**		**100%**		**91%**	

Stress Indicators									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
Children's Services									
Decrease the number waiting for routine treatment after assessment – CAMHS	April 2014	**565**	**16**	**0**	**216**	**120**	**69**	**49**	**95**
CAMHS Caseload, for patients open at any point during the month (excluding Medway and Out of Area)	April 2014	**8523**	**724**	**1206**	**1432**	**1347**	**531**	**1250**	**2033**

NHS
West Kent
Clinical Commissioning Group

PRIVATE AND CONFIDENTIAL

NHS West Kent Clinical Commissioning Group
Wharf House
Medway Wharf
Kent
TN9 1RE
Tel: 01732 375200
Email: westkent.ccg@nhs.net

Dr Bob Bowes
Chair of West Kent Local Health and Wellbeing Board

18th June 2014

Dear Colleague,

Re: CQC Safeguarding Review

The Care Quality Commission today publishes the report of its recent review of health services for looked after children and safeguarding arrangements within health for all children in the West Kent, Dartford, Gravesham and Swanley, and Swale areas.

The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

CQC inspectors looked at:

- the role of healthcare providers and commissioners.
- the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
- the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

They also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

The report cites many examples of good practice, with midwives, A&E staff, health visitors, school nurses and others working effectively to protect vulnerable children and young people, supported by a good understanding of the systems and processes to use if they have concerns.

“Overall, we have seen numerous examples of committed and diligent practitioners across services working hard to protect children across the range of health services that we visited,” the report says.

Examples of good practice include:

- information sharing between midwifery services and other health and social care professionals, particularly at initial stages of pregnancy and booking, is good
- very good care and practice for vulnerable women who were pregnant, including one exemplary case of peri-natal care and birth planning at Medway Maritime hospital for a woman with mental health problems in the Swale area
- diligent follow-up of mothers and children in a number of cases where parents failed to attend appointments, including escalation through to safeguarding in persistent cases
- effective and highly valued specialist Kent Community Health NHS Trust outreach contraception and sexual health teams supporting vulnerable young people
- effective electronic flagging systems across the four hospital emergency departments to help staff identify risk factors indicating that children are vulnerable, including multiple hospital attendances.
- examples at Darent Valley hospital of extremely good practice in identifying the need for early help, including the paediatric liaison worker identifying the need for continence training for a young child, and an ambulance worker flagging concerns about possible neglect.
- separate and distinct paediatric emergency treatment cards, incorporating a safeguarding risk assessment, at Maidstone and Tunbridge Wells hospitals.

The report also made some recommendations for improvement, including that:

- The three clinical commissioning groups for West Kent, Dartford, Gravesham and Swanley, and Swale, and the mental health trust Kent and Medway NHS and Social Care Partnership Trust (KMPT) work together to ensure prompt access to appropriate mental health support for new and expectant mothers
- The CCGs, NHS England Kent and Medway, and Sussex Partnership NHS Foundation Trust ensure that young people with mental health needs have access to facilities which are right for their age and needs when they are admitted to hospital
- Maidstone and Tunbridge Wells NHS Trust, Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust, and Kent Community Health NHS Trust ensure that practitioner referrals to children's social care clearly articulate the risks to the child or young person
- NHS England Kent and Medway and the CCGs put in place arrangements for a sexual assault response service for children and young people, including out of hours, in line with national guidance
- The CCGs, Kent Community Health NHS Trust and Kent County Council ensure that children and young people who are looked after benefit from quality, timely and comprehensive initial and review health assessments by suitably qualified and experienced health professionals, subject to effective quality assurance and robust performance management and reporting arrangements, including young people placed out of area and unaccompanied asylum seeking children.

As you are aware, the CCG is committed to working with our partners to ensure every child in our area has the best start in life. While the Care Quality Commission acknowledges that much of what it found was already known to and being acted on by commissioners and providers, this thorough and comprehensive review helps to give a clear focus to our work to further improve services.

We are pulling together a joint action plan with partners to implement all the recommendations made by this review.

Kind regards,

Dr Steve Beaumont
Chief Nurse