AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 21st March, 2018, at 6.30 pm Ask for: **Ann Hunter**

Darent Room, Sessions House, County Hall, Maidstone Telephone **03000 416287**

Refreshments will be available 15 minutes before the start of the meeting

Membership

Mr P J Oakford (Chairman), Dr B Bowes (Vice-Chairman), Cllr S Aldridge, Dr F Armstrong, Mr I Ayres, Ms H Smith, Mr P B Carter, CBE, Dr S Chaudhuri, Ms F Cox, Ms P Davies, Mr M Dunkley, Dr S Dunn, Mr G K Gibbens, Cllr F Gooch, Mr R W Gough, Mr S Inett, Dr N Kumta, Dr S MacDermott, Dr T Martin, Mr S Perks, Mr A Scott-Clark, Ms A Singh, Dr R Stewart and Vacancy - District Council Representative

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1 Chairman's Welcome

2 Apologies and Substitutes

3 Declarations of Interest by Members in items on the agenda for this meeting

4 Minutes of the Meeting held on 22 November 2017 (Pages 5 - 10)

5 Establishment of a new Kent and Medway JOINT Health and Wellbeing Board (Pages 11 - 20)

6 KSCB Update on Ofsted Recommendations from the Review of the Local Safeguarding Children Board (LSCB), March 2017 (Pages 21 - 34)

7 Joint Strategic Needs Assessment - Exceptions Report 2017-18 (Pages 35 - 58)

8 Kent Pharmaceutical Needs Assessment 2018 - 2021 (Pages 59 - 98)

9 Kent & Medway Safeguarding Adults Board Annual Report - April 2016 - March 2017 (Pages 99 - 160)

10 0-25 Health and Wellbeing Board (Pages 161 - 170)

11 Minutes of the Local Health and Wellbeing Boards (Pages 171 - 214)

To note the minutes of local health and wellbeing boards as follows:

Ashford – 17 January 2018
Canterbury and Coastal – 11 January 2018
Dartford, Gravesham & Swanley – 21 February 2018
South Kent Coast – 7 November 2017
Thanet – 9 November 2017 and 11 January 2018
West Kent – 20 February 2018

12 Date of Next Meeting (tbc)

The meeting will be held during the normal working day and it will be the first meeting of the Kent and Medway Joint Health and Wellbeing Board. The date and venue have yet to be confirmed

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Benjamin Watts
General Counsel
03000 416814

Tuesday, 13 March 2018

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KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 22 November 2017.

PRESENT: Mr P J Oakford (Chairman), Dr B Bowes (Vice-Chairman), Cllr S Aldridge, Dr F Armstrong, Mr I Ayres, Mr P B Carter, CBE, Dr S Chaudhuri, Ms P Davies, Mr I Duffy, Dr A Duggal (Substitute for Mr A Scott-Clark), Dr S Dunn, Mr G K Gibbens, Mr R W Gough, Mr S Inett, Dr N Kumta, Mr S Perks, Ms A Singh, Ms H Smith and Dr R Stewart

ALSO PRESENT: Cllr Alan Jarrett and Mr Neil Davies

IN ATTENDANCE: Mrs L Whitaker (Democratic Services Manager (Executive))

UNRESTRICTED ITEMS

309. Chairman's Welcome
(Item 1)

(1) The Chairman welcomed Cllr Alan Jarrett and Mr Neil Davies from Medway Council and Glen Douglas (Chief Executive of the Sustainable Transformation Partnership) to the meeting.

(2) He invited Cllr Jarrett and Mr Davies to comment on the proposal to develop joint health and wellbeing arrangements. Mr Jarrett said he supported the proposals in principle. He referred to the proposed membership, as set out in paragraph 3.2 of the report, and said he strongly supported the inclusion of representatives from district councils with a minimum of observer status. He also said the Medway Health and Wellbeing Board would continue to operate, the terms of reference of the joint board were key to its success and should be written in a way that ensured any joint board did not acquire executive functions.

(3) Mr Davies said a joint board would facilitate working with the STP.

310. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Cllr F Gooch, Dr S MacDermott, Dr T Martin and Mr A Scott-Clark. Alison Duggal attended as substitute for Mr Scott-Clark.

311. Declarations of Interest by Members in items on the agenda for this meeting
(Item 3)

There were no declarations of interest.

312. Minutes of the Meeting held on 20 September 2017
(Item 4)

Resolved that the minutes of the meeting held on 20 September 2017 are correctly recorded and that they be signed by the Chairman.

313. Update on the STP and its links with the HWB - Presentation by Glenn Douglas - Chief Executive of Kent and Medway STP
(Item 5)

(1) Mr Douglas gave a presentation which is available on-line at Appendix 1 to these minutes.

(2) Comments were made about the need to consider patient involvement and engagement in the new arrangements; the role of the HWB in having a strategic overview of the arrangements for and the delivery of local care; the reduction in investment in primary care as a proportion of the total NHS spent; the tension between central control and local autonomy particularly in relation to local care; and the relationship between the Case for Change and the Joint Strategic Needs Assessment.

(3) Concerns were also raised that social care funding might be used to support the acute sector and that Better Care Funding might be withdrawn.

(4) Dr Stewart said the Kent and Medway Integration Pioneer was a working group of the Health and Wellbeing Board and had developed into the Design and Learning Centre for Clinical and Social Innovation (DLC). The DLC was now recognised as the Service Improvement and Innovation facility for the Kent and Medway STP in collaboration with Medway and Swale Centre of Organisational Excellence and the Academic Health Science Network.

(5) Resolved that the presentation be noted.

314. Discussion paper: Health and Wellbeing Board - proposal to move to a joint board with Medway Council
(Item 6)

(1) David Whittle (Director of Strategy, Policy, Relationships and Corporate Assurance) introduced the report which provided the foundation for further discussion to support the Board in coming to an in-principle agreement to develop a joint arrangement. He referred to Cllr Jarrett's comments at the beginning of the meeting in support of such an arrangement and said that if it was the wish of the Board, terms of reference and other technical matters could be developed by officers.

(2) Comments were made about the relationship of a joint board with local care providers and integrated commissioning as well as the opportunity to learn from Medway's experiences in local care commissioning.

(3) In response to questions and comments, Mr Whittle confirmed that the intention was to have representatives from the Strategic Commissioner function and a representative from each Accountable Care Partnership (ACP).

(4) Comments were also made about the importance of arrangements for children and the 0-25 Health and Wellbeing Board in any new arrangements.

(5) Resolved that:

(a) It be agreed to recommend to County Council the creation of a Joint Board with Medway Council dependent on agreement from Medway Council, and further discussions with STP Leadership;

b) The joint Board would focus on the Kent and Medway STP;

c) Membership might include future representation from the strategic commissioner function and ACPs as new structures developed;

d) Responsibility for agreeing Terms of Reference for the joint Board with Medway Council and STP Leadership be delegated to the Chairman.

315. Kent and Medway Growth and Infrastructure Framework - 2017 Update
(Item 7)

(1) Katie Stewart (Director of Environment., Planning and Enforcement) introduced the report which provided an overview of the emerging Kent and Medway Growth and Infrastructure Framework (GIF) and asked the Board to make recommendations on the emerging headline messages and infrastructure costings for the update of the GIF.

(2) Sarah Platts (Strategic Planning Infrastructure Manager) outlined the approach taken to developing the GIF including engagement with the STP, the emerging narrative and costings. The analysis showed a significant gap between the funding required and the anticipated contributions from central government, developer contributions and other sources.

(3) Comments were made about the need to use the same language as being used in the STP; to avoid any implication that primary care practices might be forced into larger buildings; and to move away from the idea that the proposed hubs were physical buildings when it might be the way that services would beaggregated virtually to deliver services to populations of 40,000-50,000.

(4) Comments were also made about the desirability of following other authorities who were considering radical ways of raising funds for infrastructure delivery; and the need to lobby government for adequate funding to meet current and future growth forecasts.

(5) Resolved that the report be noted.

316. NHS Preparations for and Response to Winter in Kent 2017/18
(Item 8)

(1) The Chairman welcomed Mr Duffy to the meeting. Mr Duffy said that planning for winter 2017/18 had started towards the end of last winter. Two debriefs had been held which had led to further work in relation to demand and

capacity. Local A&E Delivery Board (LAEDB) plans for winter across Kent and Medway, had been assured as "Amber", however the plans continued to be developed, refined and tested with support from NHSE/NHSI. NHSE were also working with LAEDBs to produce a Kent and Medway Surge Plan in order to strengthen mutual aid agreements. He also said that each LAEDB would conduct a Surge Capacity Exercise ahead of winter.

(2) Mr Duffy also said that all LAEDBs were promoting the nationally led "Stay Well this Winter Campaign" which was aimed at asking the public to protect themselves from the cold and included encouragement to be vaccinated against the flu.

(3) Mr Duffy thanked the Health and Wellbeing Board for its continued support and said the Health and Wellbeing Board needed to retain good oversight of funds and to continue to work to deliver the required reductions in the delayed transfers of care which were key to providing capacity in the acute sector. He concluded by saying robust plans were in place to manage this year's winter pressures, a strong national communications plan was being supported and delivered locally, and LAEDBs had well-rehearsed plans to manage the impact of emergencies.

(4) Comments were made about the plans in place in East Kent to respond to winter, the opportunity to further exploit information systems to help with the escalation process, the capacity of primary care to assist in extreme emergencies, the role of the out-of-hours GP service. Further comments were made about the fact that during times of pressure, it tended to be across the whole system including both primary and acute care, as more people were sick, they also tended to be sicker and to stay in hospital for longer; and there was a limited number of staff with the appropriate skills who could be called upon to respond to increased demand.

(5) Resolved that the report be noted.

317. Kent Safeguarding Children Board Annual Report
(Item 9)

(1) Members of the Board expressed surprise that a representative of the Kent Safeguarding Children Board was not in attendance to present the report. Mr Ireland suggested a report providing an update on the recommendations made by Ofsted be received at a future meeting of the Health and Wellbeing Board. He also outlined some of the potential changes to arrangements for safeguarding children arising from the Health and Social Care Act.

(2) Resolved that the Chairman of the Kent Safeguarding Children Board be asked to attend the meeting of the Health and Wellbeing Board in January 2018 to present an update on actions since the Ofsted inspection and potential changes to arrangements for safeguarding children arising from the Health and Social Care Act.

318. 0-25 Health and Wellbeing Board
(Item 10)

Resolved that the minutes of the meeting held on 19 July 2017 be noted.

319. Minutes of the Local Health and Wellbeing Boards
(Item 11)

Resolved that the minutes of the local health and wellbeing boards be noted as follows:

Ashford - 18 October 2017
Canterbury and Coastal – 5 October 2017
Dartford, Gravesham and Swanley – 25 October 2017
South Kent Coast – 16 May 2017
Thanet – 7 September 2017
West Kent – 15 August 2017 and 17 October 2017

320. Date of Next Meeting 24 January 2018
(Item 12)

(1) Mr Oakford said that this was Andrew Ireland's last meeting and thanked him for his contribution to the organisation and for his personal support and patience. He also wished him well for the future.

(2) Resolved that from April 2018 the meetings of the Health and Wellbeing Board be held during the working day.

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From: Peter Oakford, Deputy Leader, Cabinet Member for Strategic Commissioning & Public Health and Chairman of the Kent Health and Wellbeing Board

David Whittle, Director Strategy, Policy, Relationships and Corporate Assurance

To: Kent Health and Wellbeing Board – 21 March 2018

Subject: Establishment of a new Kent and Medway JOINT Health and Wellbeing Board

Classification: Unrestricted

Summary:

This report seeks approval for the establishment of a Kent and Medway Joint Health and Wellbeing Board from 1 April 2018. This will be for an initial period of two years to secure a collaborative approach between the Kent and Medway Health and Wellbeing Boards as they contribute to the development of the Sustainability and Transformation Partnership Plans. It is proposed to constitute the Joint Health and Wellbeing Board as an Advisory Sub Committee of both Boards as provided for in the Health and Social Care Act 2012.

1. Introduction

1.1 Following approval from the Kent Health and Wellbeing Board on 22 November 2017 further work has taken place with Medway Council to develop the proposal to create a Joint Health and Wellbeing Board (HWB).

1.2 Section 198 of the Health and Social Care Act 2012 allows two or more Health and Wellbeing Boards to establish a Joint Sub Committee of the Boards to advise them on any matter related to the exercise of their functions.

1.3 The proposal to establish a Kent and Medway Joint HWB constituted as an Advisory Sub Committee together with the determination of its size, membership, terms of reference and rules of procedure must be formally agreed by each Board.

1.4 A similar paper was presented to Medway's Health and Wellbeing Board on 20 February 2018 where the proposal was agreed.

2. Establishment of a new Kent and Medway Joint Health and Wellbeing Board (KAMJHWB)

2.1 Given the complexity of the Sustainability and Transformation Partnership (STP), the Leader and Cabinet in Kent and the Leader and Cabinet in Medway will play an important role in overseeing local authority engagement

with the STP and will be the decision-makers in the event of any proposals for reconfiguration of the way social care and public health services are commissioned and delivered.

2.2 Separately, but in parallel, both the KCC and Medway HWBs will continue to be under a duty to discharge their statutory functions during this period of change. It is considered there would be significant merit in both Councils working together through the vehicle of their HWBs to provide a strong democratic voice in the STP discussions as the future design and delivery of health and social care services moves forward. In particular it is considered there should be a joint focus on the STP local care and prevention work streams given the responsibilities of both local authorities in social care and public health. The STP would benefit from Kent County Council and Medway Council working jointly to actively shape and develop the proposal for a system wide Strategic Commissioner and the relative roles, responsibilities and accountabilities for the emerging Integrated Care Systems.

2.3 The Health and Social Care Act provides for the HWBs of two or more local authorities to work jointly on several levels; either by exercising their functions jointly (for example by having one Kent and Medway HWB and one JSNA/HWB Strategy for the whole area) or by arranging for a Joint Sub Committee to exercise any of their functions or by setting up a Joint Sub Committee to advise them on any matter related to the exercise of their functions.

2.4 Following discussion between the Leaders and HWB Chairmen of both Kent County Council and Medway Council it is proposed that Kent and Medway should each continue to discharge their HWB functions separately and that a Joint Advisory Sub Committee of both HWBs would be the most appropriate vehicle for a collaborative approach on the issues emerging from the STP plans for both local authorities. This would be called the Kent and Medway Joint Health and Wellbeing Board and would operate principally to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and for the purpose of advising on the development of the STP plans for Kent and Medway.

2.5 Draft governance arrangements for the Joint Board are set out at Appendix 1 to this report including proposed terms of reference, a proposal for the membership (voting and non-voting) and suggested rules of procedure. Each Council will support the Board for one year following which there would be a review of the arrangements to determine if they should continue.

2.6 It is proposed, subject to further discussion, that Health will be represented by the Managing Director of East Kent, the Managing Director of Medway, North and West Kent and the Chief Executive of the STP. This will support the Joint Board with its focus on STP related matters.

3. Financial, legal and risk management implications

3.1 There will be a cost associated with establishing a Joint Advisory Sub Committee of the Kent and Medway HWBs in terms of support for the Board and meeting arrangements. This cost will be shared, with each local authority supporting the Board for one year in turn within existing resources. The Board itself will not have a budget. Any executive decisions or the determination of any matter relating to the discharge of the statutory functions of the Kent and Medway HWBs will remain a matter for each Council.

3.2 The scope for two or more Health and Wellbeing Boards to establish arrangements to work jointly is provided in section 198 of the Health and Social Care Act 2012. Section 198 allows for the joint exercise of functions by a Joint HWB or by a Joint Sub Committee or for the establishment of a Joint Sub Committee to advise the participating HWB's on any matter related to the exercise of their functions

3.3 There are no risks arising from the proposal to set up joint arrangements between the Kent and Medway Health and Wellbeing Boards.

4. Recommendations

4.1 The Health and Wellbeing Board is asked to agree:

i. The establishment of a new Kent and Medway Joint Health and Wellbeing Board constituted as an Advisory Sub Committee, with Terms of Reference and procedure rules as set out in Appendix 1 to this report;

ii. That the membership of the Sub Committee should be as set out in paragraph 5 of Appendix 1 to this report.

iii. That the role and continuation of the KAMJHWB should be reviewed after two years

REPORT AUTHOR:

Karen Cook
Policy and Relationships Adviser (Health)
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Appendix 1:

Draft Governance Arrangements for the Kent and Medway Joint Health and Wellbeing Board

1. The Medway Health and Wellbeing Board and the Kent Health and Wellbeing Board are each separately responsible for discharging the following statutory powers and duties for their own areas:

(a) Preparation and publication of a Joint Strategic Needs Assessment (JSNA) – Section 196 of the Health and Social Care Act 2012.

(b) Preparation and publication of a Joint Health and Wellbeing Strategy to meet the needs identified in the JSNA – Section 196 of the Health and Social Care Act 2012

(c) Assessment of need, preparation and publication of a Pharmaceutical Needs Assessment – Section 128A of the National Health Service Act 2006

(d) For the purpose of advancing the health and wellbeing of the people in either Kent or Medway, to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner – Section 195 of the Health and Social Care Act 2012

(e) Encouragement to persons who arrange for the provision of any health-related services in Kent and Medway to work closely with the Board – Section 195 of the Health and Social Care Act 2012

(f) Encouragement to persons who arrange for the provision of any health or social care services in Kent and Medway and to persons who arrange for the provision of any health-related services in the area to work closely together – Section 195 of the Health and Social Care Act 2012

(g) Provision of such advice, assistance or other support as thought appropriate by the respective HWBs for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services – Section 195 of the Health and Social Care Act 2012

(h) Involvement in preparation or revision of CCG Commissioning Plans – Section 26 of the Health and Social Care Act 2012

(i) Review of draft CCG Commissioning Plans before the beginning of each financial year (and any in - year revisions to plans) and provision of an opinion to the CCG as to whether or not the draft, or any revisions, take proper account of the Joint HWB Strategy (with an option to provide an opinion to NHS England) -Section 26 of the Health and Social Care Act 2012

(j) Provision of advice to the local authority that established the HWB of its views on whether the local authority is discharging its duty to have regard to the JSNA and Joint Health and Wellbeing Strategy – Section 196 of the Health and Social Care Act 2012

(k) Provision of a view to NHS England when the annual performance assessment of CCGs is conducted, on the contribution of the CCG to the delivery of the Joint HWB Strategy – Section 26 of the Health and Social Care Act 2012

2. Establishment of an advisory joint sub-committee to be known as the Kent and Medway Joint Health and Wellbeing Board

(a) In exercise of their powers under Section 198 of the Health and Social Care Act 2012 which permits two or more Health and Wellbeing Boards to make arrangements for any of their functions to be exercised jointly, Kent County Council and Medway Council have agreed to establish an advisory joint sub-committee to be called the Kent and Medway Joint Health and Wellbeing Board KAMJHWB) for a time limited period of two years to start from 1st April 2018.

3. Operating principles

(a) The KAMJHWB is an advisory sub-committee which operates to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and for the purpose of advising on the development of the Sustainability and Transformation Partnership (STP) Plans for Kent and Medway.

(b) It will seek to:

i. Ensure collective leadership to improve health and well-being outcomes across both local authority areas, to enable shared discussion and consensus about the STP across the Kent and Medway footprint in an open and transparent way;

ii. Help to ensure the STP has democratic legitimacy and accountability, to seek assurance that health care services paid for by public monies are provided in a cost-effective manner.

iii. Consider the work of the STP and encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner

iv. Take account of and advise on the wider statutory duties of Health and Social Care Partners

4. Key Functions

(a) To consider and influence the work of the STP focussing on prevention, Local Care and wellbeing across Kent and Medway.

(b) To consider and shape the development of Local Care within the STP which will impact on adult social care delivery in both authorities, advising the Kent and Medway Health and Wellbeing Boards accordingly.

(c) To give advice to the STP in developing clear plans and business cases to assist commissioners in making best use of their combined resources to improve local health and well-being outcomes, particularly relating to the Local Care and Prevention work streams, making recommendations to the Kent and Medway Health and Wellbeing Boards on support that could be provided.

(d) To keep NHS commissioning plans under review, insofar as they relate to STP Plans to ensure they are taking into account the Kent and Medway JSNAs and local HWB Strategies, referring back to the STP Programme Board and respective Kent and Medway Health and Wellbeing Boards where they do not.

(e) To champion integration in local care delivery, including working with the STP to establish a Kent and Medway Local Care Board

(f) To support the development of the Clinical Strategy

(g) To ensure alignment of the Kent and Medway JSNAs with population health needs to inform the STP Case for Change and the associated Clinical Strategy

(h) To consider and advise on the development of the STP Preventative work-stream given it is heavily focussed on Public Health functions within both upper-tier authorities

(i) To consider and advise on the development of options for the local authorities' role in a Strategic Commissioner arrangement with Health – the engagement in which remains a matter for each of the local authorities.

(j) To consider options for the Local Authority role in the development of Integrated Care Systems (previously known as Accountable Care Partnerships), the engagement in which remains a matter for each of the local authorities.

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5. Membership

(a) The Chairman of the KAMJHWB will be appointed at the first meeting of the Board and thereafter at the first meeting of the Board after the annual meetings of Kent County Council and Medway Council. It is expected that the position of Chairman will be rotated between the chairmen of the constituent authorities' Health and Wellbeing Boards on an annual basis.

(b) The Vice-Chairman of the Joint Board will also be appointed at the first meeting of the Board and thereafter at the first meeting of the Joint Board after each Kent and Medway Annual Council meetings. It is expected that the position of vice-chairman will also be rotated on an annual basis and will be the chairman of the authority's Health and Wellbeing Board who is not the chairman of the KAMJHWB.

(c) Voting members of the KAMJHWB are as follows:

- The Leader of each Council and up to three other members of each council nominated by the respective leaders (or their substitutes)
- The Director of Adult Social Services for Kent and the Assistant Director Adult Care Services for Medway
- The Director of Children's Services for Kent and the Director of Children and Adults for Medway
- The Director of Public Health for each local authority
- Representatives of the Local Healthwatch organisations for Kent and Medway who must not be a Member of a Health Overview and Scrutiny Committee for either authority and who may each have a named substitute
- A representative of each Clinical Commissioning Group (noting that section 197 (7) of the Health and Social Care Act 2012 provides for one person to represent more than one CCG on a HWB subject to the agreement of the Board). Each CCG representative may have a named substitute.

(d) Non-Voting Members of the KAMJHWB are as follows:

- The Police and Crime Commissioner
- A representative of the Kent and Medway Local Medical Committee (who may also have a named substitute)

(e) The KAMJHWB may appoint other persons to be non-voting members as it considers appropriate. If at any time after the establishment of the Joint Board either of the authorities' Health and Wellbeing Boards wish to appoint additional non-voting members of the Board this may only be done after consultation with the KAMJHWB. In addition, there should be observer representatives from two District Councils in Kent (aligned with the footprint of the Integrated Care Systems)

(f) With the agreement of the Joint Board, voting or non-voting members from new structures that are emerging in Health may also be included.

6. Procedure Rules

(a) **Conduct**. Members of the KAMJHWB must comply with the relevant Council's Code of Conduct.

(b) **Registration and Declaration of Interests**. Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by

a single member) applies to the KAMJHWB. A register of interests is held by Kent County Council and Medway Council. Members of the KAMJHWB must register interests as required by the relevant Council's code of conduct. A Member of the Board or any substitute may not participate in a discussion of or vote on any matter in which he or she has a DPI or other significant interest (both those already registered and those disclosed at the meeting) and must withdraw from the room during such discussion.

(c) **Frequency of Meetings**. The KAMJHWB will usually meet quarterly. The date, time and venue of meetings are fixed in advance by the JKAMHWB. At the end of the time limited period the Board may agree to continue its arrangements with approval through the relevant Council governance for each authority.

(d) **Meeting Administration**. Administration for the KAMJHWB will be rotated annually between Kent County Council and Medway Council.

- The Joint Board will give at least five clear working days' notice in writing to each member of every ordinary meeting of the KAMJHWB, to include any agenda of the business to be transacted at the meeting.
- Papers for each KAMJHWB meeting are published at least five clear working days in advance.
- Late papers may be added to the agenda at less than five days' notice only where the Chairman is satisfied that the business is urgent by way of special circumstances which must be specified in the minutes.
- Meetings will take place in public with provision for exclusion of the press and public where confidential or exempt information is likely to be disclosed as defined in the Local Government Act 1972.

(e) **Special Meetings**. The Chairman or Vice-Chairman may convene special meetings of the KAMJHWB in addition to scheduled meetings as considered necessary

(f) **Minutes.** Minutes of all of KAMJHWB meetings are prepared recording:

- the names of members of the KAMJHWB (and any substitutes) who are present at a meeting and any apologies for absence
- details of all proceedings and resolutions of the meeting
- Minutes are normally published and circulated before the next meeting of the KAMJHWB, when they are submitted for approval by the KAMJHWB and are signed by the Chairman.

(g) **Agenda.** The agenda for each meeting normally includes:

- Apologies for absence
- Declarations of interest
- Minutes of the previous meeting for approval and signing
- Reports to the KAMJHWB

- Any item which a member of KAMJHWB wishes included on the agenda provided it is relevant to the Terms of Reference of the Board must be notified to the Chairman and relevant Democratic Services Officer at least one calendar month before the meeting however any decision to include an item on any agenda rests with the Chairman and Vice-Chairman following advice from the relevant officers.

(h) **Absence of Members and of the Chairman**. If a member is unable to attend a meeting, they may provide an appropriate substitute to attend in his/her place (noting that CCG, LMC and Healthwatch representatives must have named substitutes). The Democratic Services Officer for the meeting should be notified of any absence and/or substitution prior to the meeting. Any substitute member must register his/her interests, in accordance with either the Medway or Kent Councillor Code of Conduct and these must be published before participation as a formal member of the Joint Board is permitted.

(i) The Chairman presides at KAMJHWB meetings if he/she is present. In their absence the Vice-Chairman presides. If both are absent, the KAMJHWB appoints from amongst its members an Acting Chairman for the meeting in question.

(j) All matters coming before the KAMJHWB shall be decided by a majority of the members of the Board present and voting thereon at the meeting. In the case of an equality of votes the person presiding at the meeting shall have a second or casting vote.

(k) **Quorum.** A third of the total number of voting members of the Board, and at least one representative from each of the two councils, form a quorum for the KAMJHWB meetings. No business shall be transacted at any meeting of the KAMJHWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman must either suspend business until a quorum is re-established or declares the meeting at an end.

(l) **Adjournments**. By the decision of the Chairman, or by the decision of a majority of those members present, meetings of the KAMJHWB may be adjourned at any time to be reconvened at any other day, hour and place, as the KAMJHWB decides.

(m) **Order at Meetings**. At all meetings of the KAMJHWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. The Chairman decides all questions of order that may arise.

(n) **Overview and scrutiny**. Overview and scrutiny (within the meaning of the Local Government Act 2000 and The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) will be the responsibility of each constituent Authority and the appropriate scrutiny arrangements of each Authority will apply. No member of a Health Overview and Scrutiny Committee from either Kent County Council or Medway Council may also be a member (or substitute member) of the KAMJHWB.

From: **Gill Rigg, Independent Chair of the Kent Safeguarding Children Board (KSCB)**

To: **Kent Health and Wellbeing Board (HWB)**

Subject: **KSCB Update on Ofsted Recommendations from the Review of the Local Safeguarding Children Board (LSCB), March 2017**

This paper is submitted for the information of the HWB

Classification: **Unrestricted**

Summary.
In March 2017, Ofsted undertook a review of Kent Safeguarding Children Board, as part of its Inspection of Kent's Services for children in need of help and protection, children looked after and care leavers. Following this review, Ofsted made some recommendations as to areas where they felt that the Board needed to improve its working.

These recommendations, which were areas already being worked on, have been incorporated in to the Board's Business Plan (2017-20). The Board's sub groups undertake actions from the Board's Business Plan and the Ofsted recommendations and report updates to the Board's Business Group. (The LSCB structure is appended.) These are then reported in to the Board where they are reviewed and signed off.

This paper relates to the current status of the LSCB's response to the Ofsted recommendations that was presented to the LSCB on the 15th February 2018.

Recommendation(s):

For information only

Body of the report:

Following the Ofsted review, the following recommendations were made to the LSCB:

1. Ensure that a comprehensive multi-agency dataset is in place to enable the Board to scrutinise local safeguarding performance.

2. Ensure that the Board has systems in place to monitor risks that have the potential to have an impact on the ability of agencies to safeguard and protect children.

3. Further develop a comprehensive programme of single and multi-agency audits to improve the scrutiny of safeguarding practice across partner agencies.

4. Develop the annual report to ensure that it provides rigorous and transparent assessment and scrutiny of frontline practice, the effectiveness of safeguarding services and the work of the independent reviewing service, as well as learning from serious case reviews and child deaths.

5. In partnership with the local authority, launch the multi-agency neglect strategy and ensure that local professionals working with families, at all levels of need, are equipped to identify, assess and address neglect within families.

6. Put in place a system for the Board to receive assurance regarding safeguarding practice within early years settings, schools and colleges.

As can be seen by the attached Action Plan, significant progress has been made by the Board, its Sub Group and partners in addressing each of the recommendations.

However, there is one area where progress has been challenging. This is the recommendation 6. Ofsted were looking at the Board receiving safeguarding re-assurance from every school and early year settings in Kent. It was felt by KCC Education Senior Managers, and thus then by the Board at the time of the review and is still now, that this is not a realistic aim. It is recognised that this piece of work needs to be evidenced, so it is proposed that the first stage in this re-assurance programme is to focus on the 8% of schools and 3% of early years settings that have currently been rated as below Good by Ofsted.

This piece of work is being undertaken by the Board's Education and Early Help and Quality and Effectiveness Sub Groups, with support from the Education People's Education Safeguarding Unit. Subsequent activity will be driven and overseen by the Board.

The Board's Business Group, made up of the Chairs of the Board's Sub Groups, provides oversight and challenge to the progress of the activities against both the Ofsted recommendations and the Board's Business Plan. These are standing agenda items at their meetings and they then report to the full Board. This approach to providing the Board with the re-assurance it needs, will continue.

This paper is submitted for the information of the Health and Wellbeing Board.

Contact details

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KSCB Ofsted Recommendations - Update Feb 2018 (HWB)

Ofsted Recommendation 1						
Ensure that a comprehensive multi-agency dataset is in place to enable the Board to scrutinise local safeguarding performance.						
Ref	**Action**	**Owner**	**Timescales**	**Activity**	**Comments/Progress**	**RAG**
OR 1.1	Produce a comprehensive multi-agency dataset	Quality and Effectiveness Group	Feb-18	Produce a meaningful and comprehensive multi-agency dataset	Stuart Collins, as Chair of the QE Group is personally leading on this and has presented regular updates to the Board with progress. The latest version is to be presented in Feb 2018. Agreed by QE and the KSCB - it will be a changing document and needs more partner agency information included. Looking to streamline EHPS and SCS data as CRU/Triage combine.	
		Quality and Effectiveness Group		Introduce a new multi-agency data set. This will be an evolutionary process, data will rationalise as processes evolve, such as the new front door. New data will be requested from partners.	**November 2017 -** Proposed data set to QE November 2017. **January 2018 -** Agreed by QE and the KSCB - it will be a changing document and needs more partner agency information included. Looking to streamline EHPS and SCS data as CRU/Triage combine.	

		Quality and Effectiveness Group		Ensure it goes to the board on a regular basis.	**November 2017 -** Requires QE approval, will then go to the Business group, then the full Board. Once approved it will be regularly presented to both. **January 2018 -** Agreed and on the QE agenda as a standing item	
		Quality and Effectiveness Group		Include QE analysis on the performance within data set. Partners will be required, and asked, to supply analysis of their data.	**November 2017 -** Some is received at present, more to be requested. **January 2018 -** This has been agreed to be undertaken within QE meetings, January meeting will be the first where this happens. This will develop as more agency data is included.	
OR 1.2	Use the dataset to oversee, scrutinise and challenge local safeguarding performance	Quality and Effectiveness Group	Ongoing	QE to present the outcomes report to the Board with a meaningful commentary, including identified key areas of performance, e.g. Central Referral Unit, UASC, OLA placed children, Children who go missing.	QE agreed discussions will occur within meetings and the regular QE report to the Business Group and Board will update Board.	
		Board members	Ongoing	Board members to scrutinise and challenge local multi-agency safeguarding performance		
OR 1.3	Provide evidence of the impact of the Board's scrutiny and challenge role	Board members	Jul-18	Board members are to provide evidence of the impact of their greater scrutiny and challenge of partner agencies' safeguarding performance.		

Ofsted Recommendation 2						
Ensure that the Board has systems in place to monitor risks that have the potential to have an impact on the ability of agencies to safeguard and protect children.						
Ref	**Action**	**Owner**	**Timescales**	**Activity**	**Comments/Progress**	**RAG**
OR 2.1	Bring to the Board any agency risk that has the potential to have an impact on the ability of agencies to safeguard and protect children.	Board members	Apr-18	Board members are to bring to the Board any agency risk that has the potential to have an impact on the ability of agencies to safeguard and protect children. Board agenda standing item.	Any agency risk identified will be brought to the Board.	
OR 2.2	Identify and record those risks that the Board agrees have the potential to have an impact on the abilities of agencies to safeguard and protect children.	Board members KSCB Business Unit	Apr-18	The Board is to record those risks that it agrees have the potential to have an impact on the abilities of agencies to safeguard and protect children. Board agenda standing item.	Identified risks will be adder to the Board's Risk Register	
OR 2.3	Provide updates as to the actions taken to mitigate or address their agency's identified risks	Board members	Apr-18	Board members are to provide updates as to the actions taken to mitigate or address their agency's identified risks. Board agenda standing item.	The agency owning the risk will provide evidence and reassurance to the Board as to the actions taken to address the identified risk.	
OR 2.4	Updated the Board's Risk Register following each Board meeting	Business Unit	Ongoing	Updated the Board's Risk Register following each Board meeting	Risk Register last updated, January 2018	

Ofsted Recommendation 3						
Further develop a comprehensive programme of single and multi-agency audits to improve the scrutiny of safeguarding practice across partner agencies.						
Ref	**Action**	**Owner**	**Timescales**	**Activity**	**Comments/Progress**	**RAG**
OR 3.1	The Board to continue its comprehensive multi-agency audit programme	Quality and Effectiveness Group	Feb-18	The yearly multi-agency audit programme will be produced following QE discussions around Board priorities, emerging concerning themes and recommendations from Serious Case Reviews	Proposed Audit process being taken to January QE for approval. It follows the EHPS premise of ongoing auditing in area with the addition of a multi-agency meeting to discuss a proportion of the cases. SCR and audit topics discussed in QE meetings, smaller practitioners sessions on a regular basis.	
OR 3.2	A follow up reporting programme is required to evidence how the outcomes of the audits have been used to improve practice	Quality and Effectiveness Group	Feb-18	The yearly multi-agency audit programme will be produced following the Feb Board meeting.	The Feb Board meeting has been postponed to Summer 18, QE will agree the schedule and topics are determined by QE meeting discussions, single and multi agency audit findings, case reviews and ongoing performance data.	
OR 3.3	Reports on single agency safeguarding audits are to be presented to the QE Group, with analysis of strengths and areas for development	Partner agency representatives on the Quality and Effectiveness Group	Quarterly	Outcomes, findings and learning from single agency audits are to be presented to the QE as part of the single agency reporting process	Report summaries are being presented and findings and outcomes are being mapped across to other single and multi-agency audit themes	

OR 3.4	Follow up reports from agencies as to how the outcomes of the audits have been used to improve practice	Partner agency representatives on the Quality and Effectiveness Group	Quarterly	Evidence is to be provided by agencies as to how the outcomes of audits have led to improvements in service.	A focus group session was held in December 2017 where the issue of record keeping was explored in detail with front line practitioners. The report is to be presented to the QE Group meeting in January 2018.	

Ofsted Recommendation 4

Develop the Annual Report to ensure that it provides rigorous and transparent assessment and scrutiny of frontline practice, the effectiveness of safeguarding services and the work of the independent reviewing service, as well as learning from serious case reviews and child deaths.

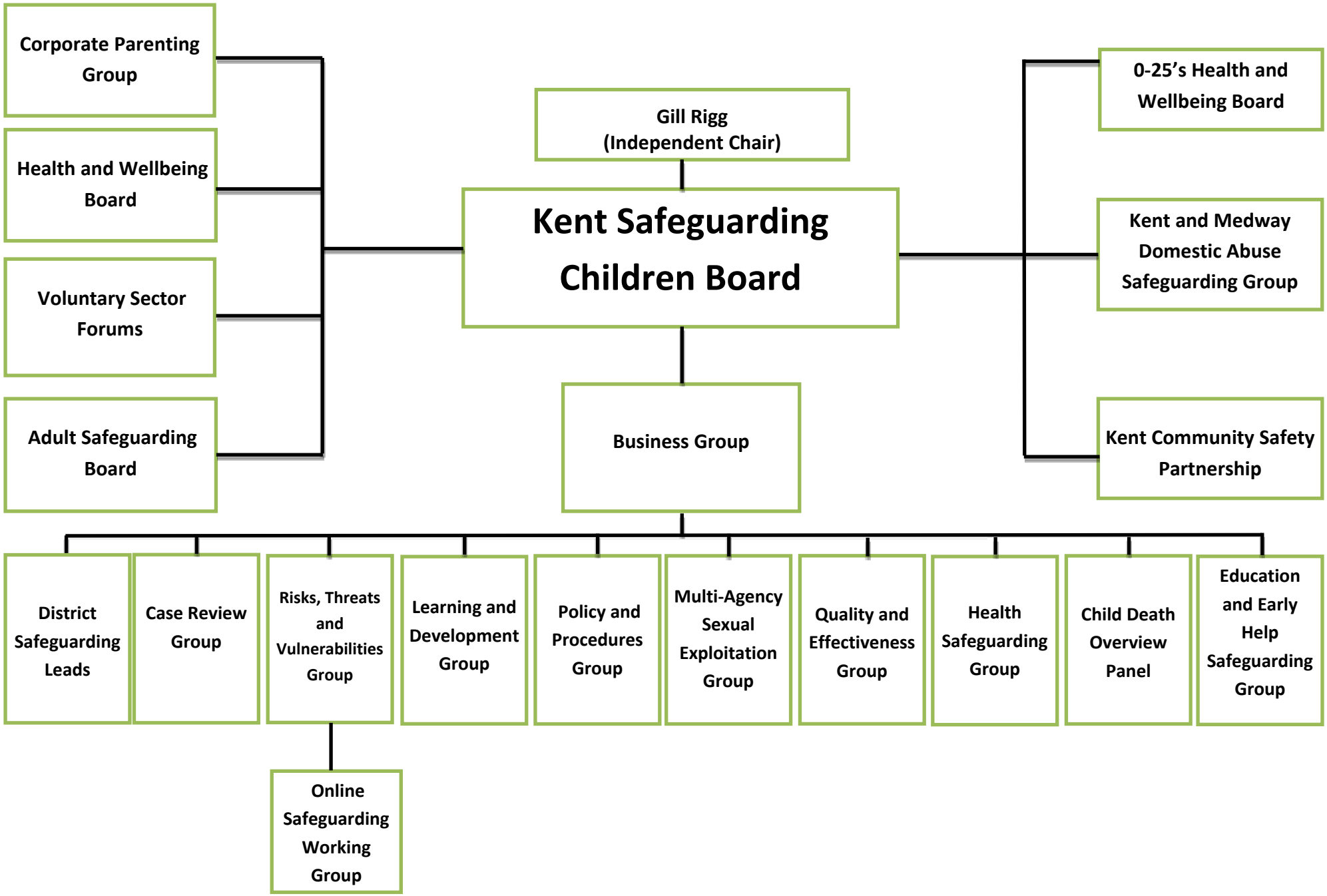
Ref	Action	Owner	Timescales	Activity	Comments/Progress	RAG
OR 4.1	To provide the Sub Groups' contributions to the Annual Report, evidencing rigorous and transparent assessment and scrutiny of frontline practice and the effectiveness of safeguarding services	Sub Group Chairs	Jun-17	Sub Group Chairs to provide their Group's yearly report to the Programme and Performance Manager for inclusion in the Annual Report	Reports submitted and included in the final Report	

OR 4.2	To provide personal and agency contributions to the Annual Report, evidencing rigorous and transparent assessment and scrutiny of frontline practice and the effectiveness of safeguarding services	Board members	Aug-17	Board members and Sub Group Chairs to provide personal comments and sub group reports for the Annual Report	Limited response from Board members for a personal contribution, however, selected quotes were taken from the write ups of the Board members' one to ones with the Independent Chair	
OR 4.3	Produce a final report that addresses all issues identified in this recommendation	Programme and Performance Manager	Oct-17	To produce an Annual Report that addresses all the issues identified in the Ofsted Review Report.	Report completed	
OR 4.4	Oversee and sign off the Annual Report, ensuring that it addresses all issues identified in this recommendation	Independent Chair	Oct-17	Board members and Independent Chair to agree and sign off the Annual Report	Report circulated to Board members on the 27th September. The Report was signed off by the Board on the 4th October It was presented to Full KCC on the 19th October	

Ofsted Recommendation 5						
In partnership with the local authority, launch the multi-agency neglect strategy and ensure that local professionals working with families, at all levels of need, are equipped to identify, assess and address neglect within families.						
Ref	**Action**	**Owner**	**Timescales**	**Activity**	**Comments/Progress**	**RAG**
OR 5.1	Produce the multi-agency Neglect Strategy	Policies and Procedures Group	Jul-17	P and P sub group to produce the multi-agency Neglect Strategy	Strategy produced	
OR 5.2	Agree and sign off the multi-agency Neglect Strategy	Board members	Aug-17	Strategy presented to the Board on the 2nd August where it was signed off	Strategy signed off	
OR 5.3	Launch the Neglect Strategy	KSCB Business Unit	Nov-17	Publish the Strategy on the KSCB Website	The strategy has been published.	
OR 5.4	Continue to develop the Neglect Training programme and ensure that partner agencies are made aware of training	Learning and Development Group	Apr-18	Multi-agency training programme to be designed and implemented	Neglect conference to be held in the Spring of 2018, (L and D, CDOP and Case Review Groups to lead).	
OR 5.5	Report training take up to the Board	Learning and Development Group	Apr-18	Present the multi-agency training figures for attendance on Neglect training sessions, including an agency breakdown.		

OR 5.6	Undertake a post training evaluation to evidence the impact of Neglect training on frontline practice	Learning and Development Group	Apr-18	An evaluation programme to be established to evidence the impact of the training on frontline practice		

Ofsted Recommendation 6						
Put in place a system for the Board to receive assurance regarding safeguarding practice within early years settings, schools and colleges.						
Ref	**Action**	**Owner**	**Timescales**	**Activity**	**Comments/Progress**	**RAG**
OR 6.1	Establish a system for the Board to receive assurance regarding safeguarding practices within early years settings, schools and colleges.	Education and Early Help Safeguarding Group	Sep-18	Establish a system for the Board to receive assurance regarding safeguarding practices within early years settings, schools and colleges.	This will require discussions with the Educating People Company as to how this is going to be undertaken and how results will be reported in to the Board.	
OR 6.2	Provide reports to the Board	Education and Early Help Safeguarding Group	Yearly	Responses from Education establishments are to be presented to the Board to provide the required assurance		


Corporate Parenting Group
Health and Wellbeing Board
Voluntary Sector Forums
Adult Safeguarding Board
Gill Rigg (Independent Chair)
Kent Safeguarding Children Board
Business Group
0-25's Health and Wellbeing Board
Kent and Medway Domestic Abuse Safeguarding Group
Kent Community Safety Partnership
District Safeguarding Leads
Case Review Group
Risks, Threats and Vulnerabilities Group
Learning and Development Group
Policy and Procedures Group
Multi-Agency Sexual Exploitation Group
Quality and Effectiveness Group
Health Safeguarding Group
Child Death Overview Panel
Education and Early Help Safeguarding Group
Online Safeguarding Working Group

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From: Peter Oakford Cabinet Member for Strategic Commissioning and Public Health

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

Date: March 2018

Subject: Kent Joint Strategic Needs Assessment Exceptions Report 2017/18

Classification: Unrestricted

Summary:
This report describes changes made to the JSNA development process and provides a summary of new priorities emerging from key population highlights from reports, audits, briefings, chapter summaries and needs assessments as well as case studies from the Kent whole population cohort model.

The Kent Health and Wellbeing Board is asked to **comment and endorse** the following recommendations:

- To adopt a broader consistent structure for outlining priorities for population health improvement, encompassing: primary prevention (lifestyle modification) for the whole population; secondary prevention (early diagnosis and treatment) for those at risk of LTCs e.g Cancer and Mental Health; and tertiary prevention (recovery, rehabilitation and reablement of patient with complex needs), ensuring better quality of care.

- Greater investment from the STP delivery board and KCC is required on primary prevention services such as smoking cessation and weight management integrated directly into local care and acute care models of the Kent & Medway STP.

- Emphasis should be placed on *Making Every Contact Count* for workforce planning and understand more in detail how frontline NHS and social care staff can incorporate key principles such as better identification of risky behaviour, brief advice and onward referrals for lifestyle modification.

- Industrialise social prescribing from primary care and onward referral to district and other public-sector services such as Fire and Rescue safe and well visits, Warm Home interventions to tackle fuel poverty and other home improvements to reduce unintentional injuries such as slips trips and falls.

- Industrialise the use of risk profiling tools in primary care to identify

patients at high risk of rehospitalization who may benefit from social prescribing. Improve existing tools by incorporating more information on social determinants of health, such as information on housing insulation and enable better governance arrangements to allow district officers and NHS clinicians to work together to access such tools.

1 Introduction

1.1 The Kent JSNA development process is undergoing significant changes in light of changing organisation and system priorities, particularly Kent & Medway STP. Several papers to the Kent Health & Wellbeing Board in the last few years have highlighted gaps and challenges to the current process and the need to incorporate more complex analytics and locally linked datasets for robust forward planning, not just examination of historical trend analyses on population need and health inequalities.

1.2 At the same time, capacity for the JSNA development has been trimmed down in light of current organisation restructures. Some of the regular JSNA outputs such as the three yearly JSNA overview report, the annual JSNA chapter summaries and the Health and Social Care maps will either be discontinued or reduced significantly.

1.3 A small JSNA programme management team based within Public Health has been tasked to prioritise and complete a limited number of JSNA related reports and analyses. For example, a set of infographics shown in Appendix A lists keys indicators and information of health and wellbeing data in a simple format, easily accessible for the general public, structured around the three main areas - Starting well, Living well & Ageing well. Further changes and improvements are expected for the next JSNA refresh in 18/19.

1.4 As part of the vision for developing a 'JSNA plus' to support forward planning and commissioning, a Kent whole population cohort model is being tested and co-designed with local stakeholders to determine how it can help towards future scenario planning.

1.5 As discussed at the March 2017 Kent HWBB, use of local datasets such as Kent Integrated Dataset (KID) has helped considerably towards such as advanced analytics and has given new insight on data quality improvement back to local providers. Examples include population segmentation analyses to identify cohorts with high spend and high needs, variation in health and social care provision, estimating average and total health and care costs and complex care evaluation of local services (such as Kent Fire & Rescue Safe and Well Visits) have already been carried out, stimulating local discussion and service planning priorities.

2 Notable analyses carried out / commissioned by Kent County Council Public Health

2.1 The following analyses and reports have been completed or commissioned by the Public Health team in the last year:

- Maternity needs assessment
- Obesity in reception year – short briefing
- Obesity in year 6 – short briefing
- Inequalities in Obesity & Excess Weight in Childhood, NCMP: Kent 2016/17 update

- Baseline data for Healthy Child Programme (years 0-4)
- Hospital admissions for substance misuse in 15-24year olds
- Starting Well: Summary of demography and health statistics in children 0-19 years in Kent districts
- Adult Lifestyle Weight Management
- Health Checks Equity Audit
- Pharmaceutical Needs assessment
- Excess Winter Deaths
- Smoking and Tobacco Control
- Prevention and healthy behaviour change in families- Stakeholder Voice Report by Activmob
- The impact of socioeconomic deprivation on per capita health and social care costs in Kent
- Mental Health Needs assessment: Analytical report
- Emotional and Mental Health Needs Assessment for Children and Young People in Kent

2.2 System modelling projects done in Kent:

- Weight management model – a summary of work to model the impact of changes in demand for tier 3 and 4 weight management services (2016).
- Estimating health and care capacity for older people in NHS West Kent CCG (October 2016) – full report
- Modelling the development of adult health improvement services in Kent (October 2016) – project report and model user guide
- Kent & Medway Adult Mental Health Services capacity modeling (July 2016) – project report
- West Kent Adult Mental Health Services and the impact of New Primary Care (2017) – project report
- Encompass Anticipatory Care (Nov 2017) – model report and user guide
- Warm Homes (Feb 2018) – 'using a simulation and modelling approach to inform local strategies for addressing fuel poverty' report as part of an Open Data Institute funded project

2.2 Key highlights of these outputs are summarised in later sections of this report together with excerpts from the Kent & Medway Case for Change refresh in December 2017. Data described represent indicators changes in the last year unless stated otherwise.

3 Emerging Issues

3.1 Planned housing developments are expected to increase migration to Kent considerably. The greatest increases in housing are predicted in Dartford and Maidstone, a large proportion will be to the new town in Ebbsfleet. This growth will place pressure on health and social care services, particularly maternity and children's services. Latest population projections using housing-led forecasts estimate Kent's population to grow by 99,600 (6.3% increase) from 2018 to 2023. This projection is an increase compared to previous year.

3.2 Older people are the fastest growing group of people; from 2018 to 2023 Kent's population aged 65 years and over is estimated to grow at a faster rate (11.4%) compared to those aged less than 65 years (5.0%), which represents an increase from last year's projection. This is an age group with a high rate of limiting long-term illness and high service utilisation compared to other age groups, particularly hospital admissions and use of community services.

3.3 In 2016 the biggest causes of death to Kent residents were from long-term conditions, many of which are preventable: cancer (28.4%), circulatory (24.8%) and respiratory (14.1%). Combined, they equated to 67.3% of all Kent resident deaths. There are an estimated 163,500 (12.9%) people across Kent and Medway aged over 16 who have a treatable common mental illness (depression and/or anxiety). People living in the most deprived areas are disproportionately affected. Suicide rates in Kent are significantly higher than the national average 2014-16 (11.6 vs 9.9/100 000).

3.4 Alcohol and/or substance misuse commonly occurs together. In Kent there are more people in contact with mental health services when they access services for drug or alcohol misuse than on average in England. An analysis of Kent primary care data suggest that is most commonly younger adults (<35 years) in the most deprived communities that are reported by their GP as excess drinker and having a serious mental illness.

3.5 Perinatal mental illness affects up to 20% of women and rates of maternal deaths from psychiatric causes have been increasing for several years. The population of women of child bearing age in Kent has been rising and is estimated to increase further; however, currently there are insufficient data collection systems in place to capture local data on perinatal mental health.

3.6 National estimates derived from surveys conducted in 2014 indicate that around 10% of children aged 5-16 years in Kent are believed to have a diagnosable emotional or behavioural mental health condition, a percentage which is estimated to have increased since. There also appears to be a short fall in access to and utilisation of services for mild to moderate mental health needs in Kent. The number of deaths by suicide amongst children and young people under 18 is significantly lower than that of adults and has remained stable from 2006-2016. In 2017 however, there was a stepped increase in deaths by suicide.

3.7 In Kent 13.8% of women respectively smoked during pregnancy 2016/17, and increase from 13.0% in 2015/16 and significantly higher than the national average of 10.7%. Over half of all expecting mothers in Kent are overweight or obese, which can complicate pregnancy, labour and delivery. In addition, 38% of pregnant women (38%) have at least one long term conditions, 21% have mental health conditions and 15% respiratory conditions. Studies have shown that such mothers are also more likely to have overweight or obese adolescent offspring.

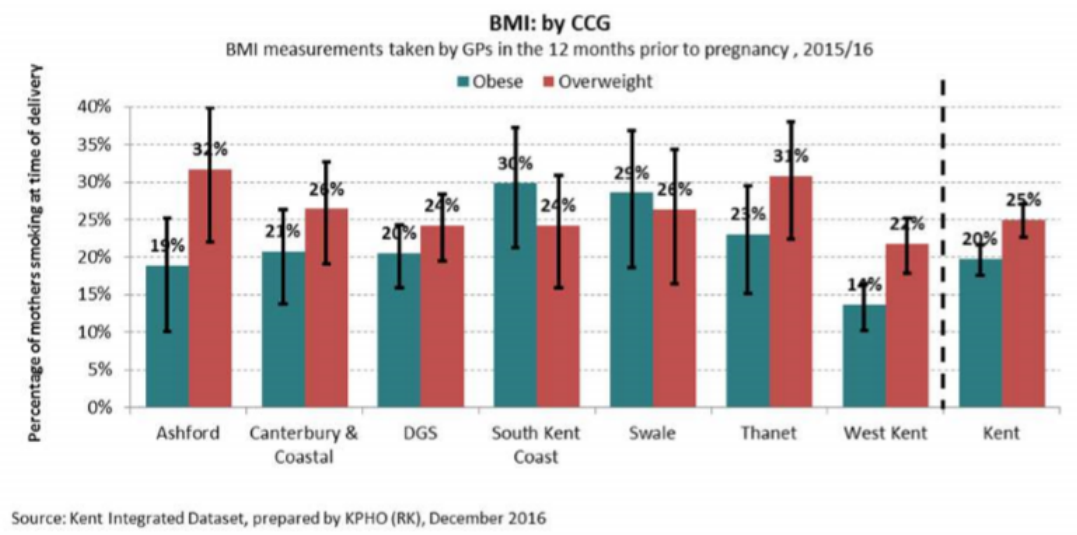
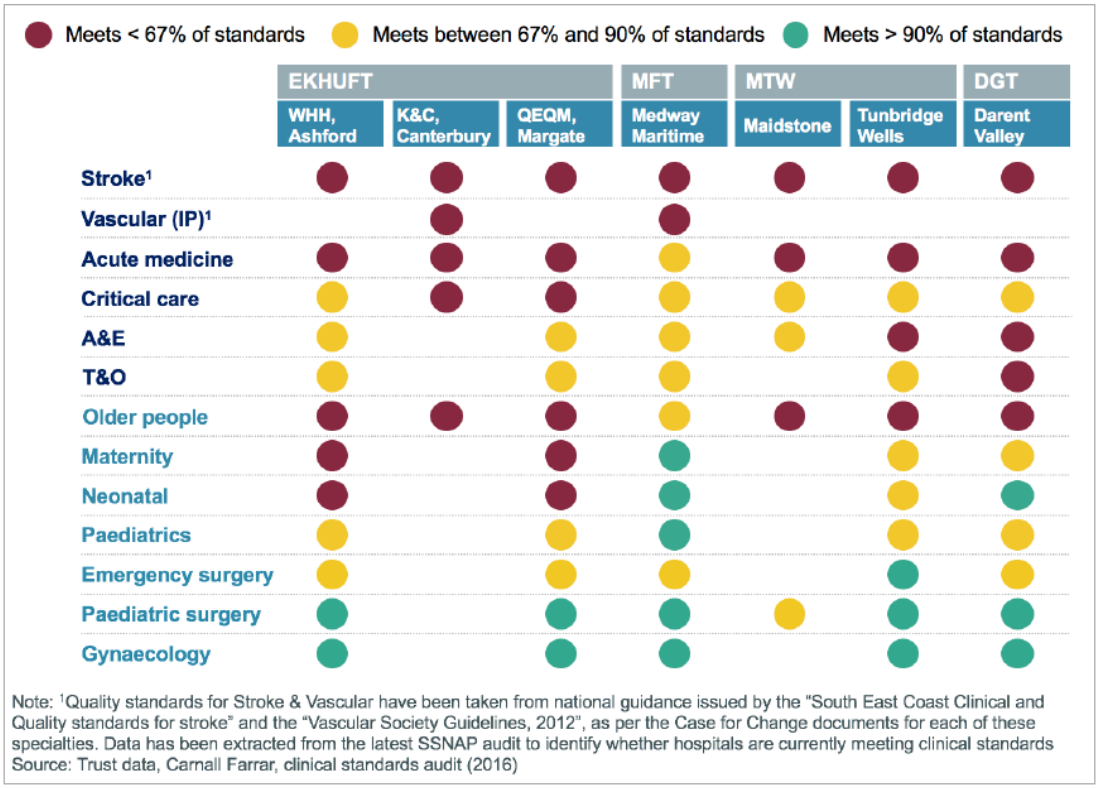


Figure 1 shows the percentage of obese or overweight women, measured 12 months prior to pregnancy

3.8 In many areas of Kent significantly more children are overweight or obese compared with England overall and in almost half of all districts the number of children living in poverty is higher than the national average. Also of concern is that the number of hospital admissions substance misuse in 15-24-year olds is 13% higher in Kent than the national benchmark.

3.9 There are challenges in maintaining and recruiting workforce to general practice; half of the CCGs in Kent have low numbers of GPs and practice nurses compared to the national average, with particularly low levels of GPs and practice nurses in Thanet and Swale, a shortage which results in long waiting times, later identification of disease and inadequate monitoring of chronic conditions. These lead to low patient satisfaction and increased hospital admissions.

3.10 In hospital trusts across Kent and Medway many specialities fail to meet 90% of national standards (see Figure 2). Stroke services fail to meet 67% of standards across every trust in Kent and Medway. Cancer services are also facing issues; the percentage of cancers detected at an early stage is generally lower in Kent and Medway resulting in 1-year survival rates significantly lower than the national average in Medway, Swale and Thanet.



Note: [1]Quality standards for Stroke & Vascular have been taken from national guidance issued by the "South East Coast Clinical and Quality standards for stroke" and the "Vascular Society Guidelines, 2012", as per the Case for Change documents for each of these specialties. Data has been extracted from the latest SSNAP audit to identify whether hospitals are currently meeting clinical standards
Source: Trust data, Carnall Farrar, clinical standards audit (2016)

Figure 2 Source 'Kent and Medway Case for Change'

3.11 Over 3,000 people are treated in Kent and Medway for a stroke every year at six acute hospitals, however these are not operated by specialist staff 24 hrs a day, seven days a week as evidence for best practice suggests. Therefore, plans for an addition of three hyper acute stroke units' to existing 'acute' stroke units in Kent and Medway have been developed. Across Kent the overall prevalence of stroke is higher as are recorded prevalence of risk factors for stroke- atrial fibrillation and hypertension- in comparison to England in 2015 to 2016, indicating the need for further investment and integrating services for prevention. The vast majority of stroke patients in Kent have another underlying LTC such as obesity and diabetes (Figure 3). The extent and impact multi-morbidity on stroke management needs to be considered when redesigning services.

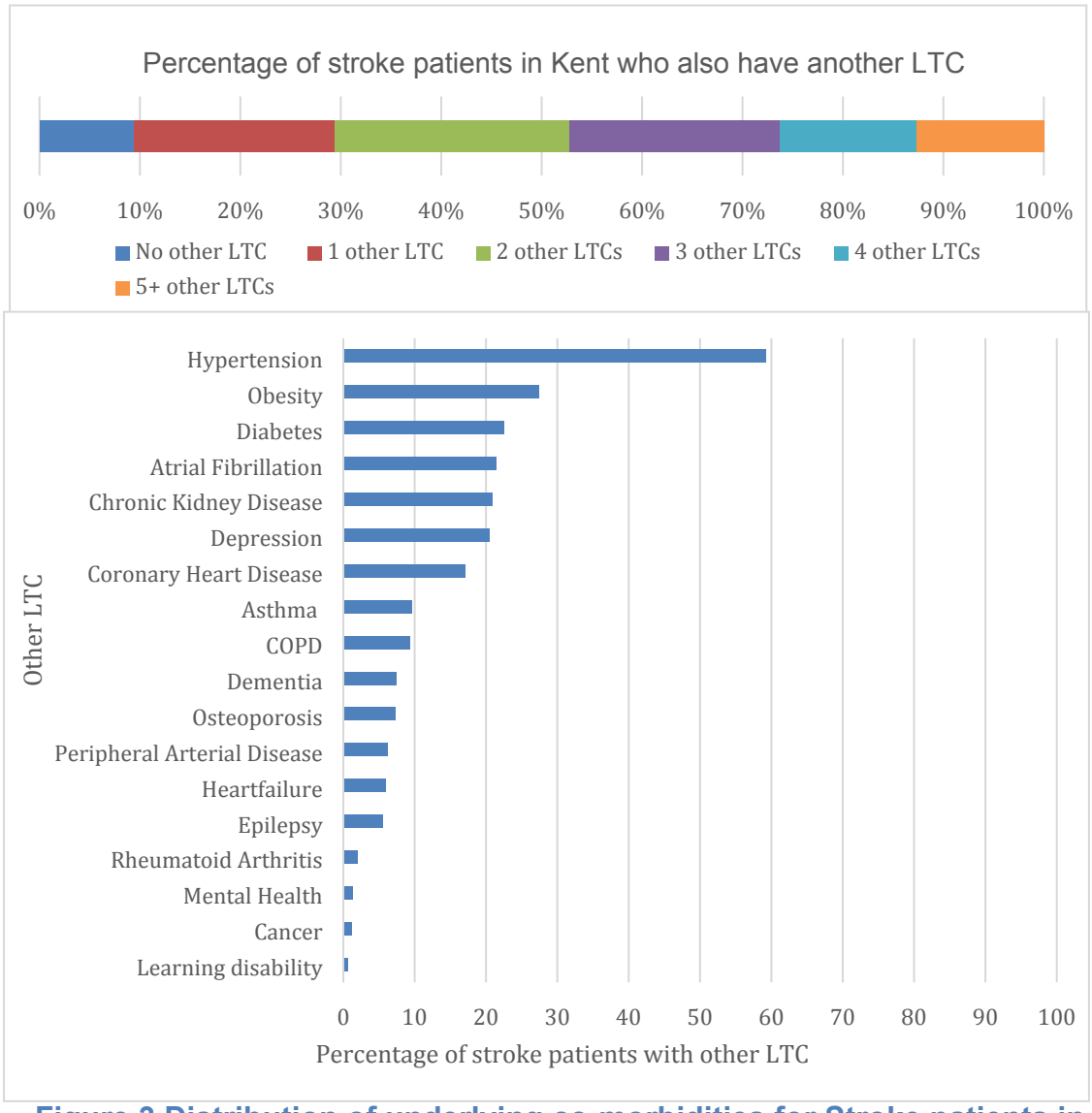


Figure 3 Distribution of underlying co-morbidities for Stroke patients in Kent (n=14,523) Data from Kent Public Health Observatory, LTC= Long-term condition

3.12 There are key equity issues associated with access to the NHS Health Checks Programme in Kent. Several population groups are less likely to complete a Health Check including males, mixed/multiple ethnic groups and less affluent groups. Access issues to the Health Checks programme might be improved for people who have the most to benefit from cardiovascular preventive action.

3.13 A study was conducted to establish the impact of deprivation on per capita health and care service utilisation costs using KID. It showed that in over 50-year olds, after adjusting for age and gender, those living in the most deprived quintile areas in Kent had annual per capita healthcare costs that were £437 higher than those in the least deprived quintile areas, (95% CI: £399 - £474). The difference is mostly due to the increased morbidity in deprived populations, and could be mitigated through action to prevent the onset of ill-health in these groups. These findings suggest that reducing health inequalities would substantially reduce costs on the NHS and social care.

4 Stakeholder Insight

4.1 Activmobs was commissioned by KCC Public Health to carry out an in-depth study on lay public views to understand factors influencing lifestyle behaviours.

4.2 Interviews with families were carried out in areas with high levels of deprivation and / or health inequalities (Thanet, Maidstone and DGS CCG areas). Forty-nine families (131 respondents) shared their experiences and views on the health and wellbeing of their family and what impacts on adopting positive lifestyles and stopping negative ones, their perception of what is healthy, how they could improve their overall health, wellbeing and happiness, their priorities and what changes they and their family might like to make in the future.

4.3 Key themes emerging to date included perceptions on life style behaviours impacting on health including smoking, drinking, diet and exercise and views on the support provided by the wider system (health and local government) (See Appendix B). These emerging themes indicate the strong need for a ‘whole system thinking’ approach to change the environment around families to empower them to adopt a healthy life style. Engagement with families across the system needs to be consistently supportive and constructive. Recommendations to improve interactions and ensure effective frontline staff engagement with patients and clients, particularly addressing sensitive issues confidently and identification of missed opportunities for positive intervention and support.

5 JSNA population cohort model

5.1 The JSNA Cohort Model uses ‘Systems Dynamics’ a well-established research methodology that uses a ‘Stock Flow’ approach to model impact of key policy and service capacity changes. Two linked prototype

cohort models (Adult and Children & Young People (CYP)) have been developed to predict future heath and care needs for the Kent population, and to test the potential impact of 'what if' scenarios focusing on additional investment on prevention. It seeks to integrate and synthesise best estimates from a variety of sources to reliably estimate the extent to which a range of factors, acting in combination, explain or predict certain health outcomes. Key model outputs include projected incidence, prevalence of long term conditions as well as population cohorts relevant for the Kent & Medway STP. It uses epidemiological information to estimate the impacts of changes in population-level risk factors and changes in the uptake of prevention interventions on the level of transition between cohorts. The outputs from the model include cohort incidence, prevalence, mortality and resource use. The model is split into two sections, children and young people (under 18 years, or under 25 years for selected conditions) and adults (18 years and over). Several case examples are shown in Appendix C Within the CYP model, 'Adverse Child Experience' (ACE), which describes vulnerable children by including significant social factors has been incorporated into a dynamic approach to population segmentation

5.2 The above work has resulted in the setting up of a 'Community of Practice' or peer support group, funded by the Health Foundation, to develop local skills and competencies among senior analysts and commissioners around the use of modelling and simulation methods for capacity planning and service demand modelling. The project is expected to last for 18 months or longer and will engage local organisations among the Kent & Medway STP. A number of modelling projects are expected to be initiated to support and influence STP priorities and decision making as well as contribute to the JSNA development process in general.

6 Recommendations

6.1 The Kent Health and Wellbeing Board is asked to **comment and endorse** the following recommendations:

6.2 To adopt a broader consistent structure for outlining priorities for population health improvement, encompassing: primary prevention (lifestyle modification) for the whole population; secondary prevention (early diagnosis and treatment) for those at risk of LTCs eg: Cancer and Mental Health; and tertiary prevention (recovery, rehabilitation and reablement of patient with complex needs), ensuring better quality of care.

6.3 Greater investment is required on prevention services such as smoking cessation and weight management integrated directly into local care and acute care model of the Kent & Medway STP.

6.4 Emphasis should be placed on *Making Every Contact Count* for workforce planning and understand more in detail how frontline NHS and social care staff can incorporate key principles such as better

identification of risky behaviour, brief advice and onward referrals for lifestyle modification.

6.5 Industrialise social prescribing from primary care and onward referral to district and other public-sector services Fire and Rescue safe and well visits, Warm Home interventions to tackle fuel poverty and other home improvements to reduce unintentional injuries such as slips trips and falls.

6.6 Industrialise the use of risk profiling tools in primary care to identify patients at high risk of rehospitalization who may benefit from social prescribing. Improve existing tools by incorporating more information on social determinants of health, such as information on housing insulation and enable better governance arrangements to allow district officers and NHS clinicians to work together to access such tools.

7 Contact Details

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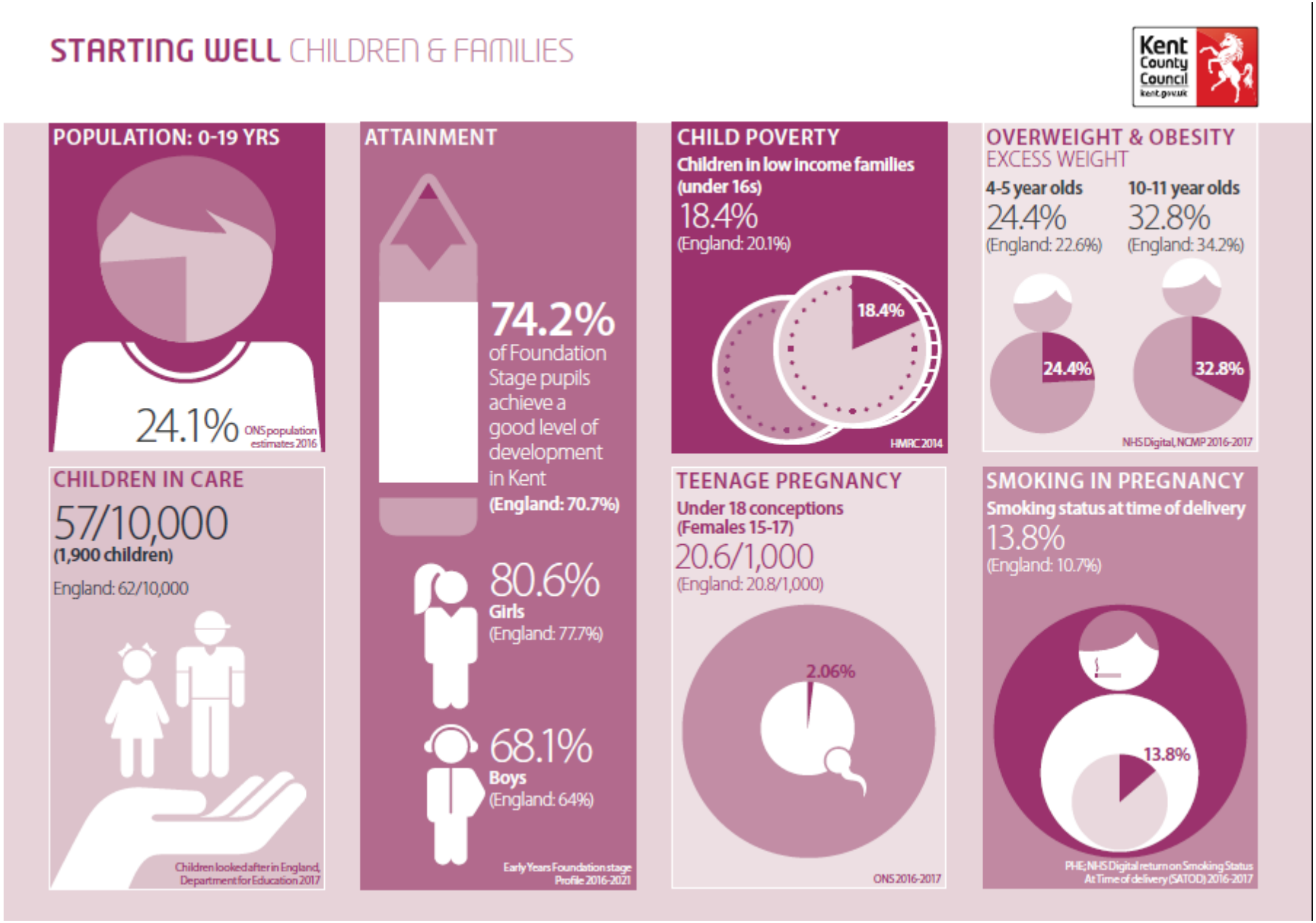
APPENDICES

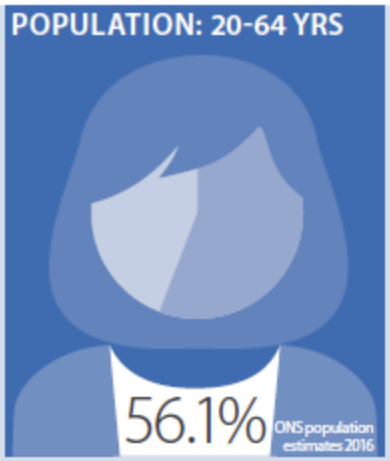
Appendix A: Infographics



LIVING WELL WORKING AGE

Kent County Council kent.gov.uk

POPULATION: 20-64 YRS



ONS population estimates 2016

PHYSICAL ACTIVITY

Physically active adults (aged 18+)
64.7%
(England: 64.9%)

Physically inactive adults (aged 18+)
22.0%
(England: 22.3%)

PHE Fingertips - 2015/2016

SEXUAL HEALTH

New HIV diagnosis rate (aged 15+)
4.8/100,000
(England: 10.3/100,000)

New STI diagnoses (exc. chlamydia, aged <25)
536/100,000
(England: 795/100,000)

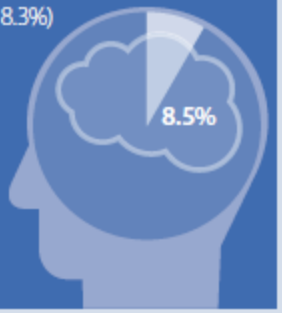
Chlamydia detection rate (aged 15-24)
1,212/100,000
(England: 1,882/100,000)

Total prescribed LARC excluding injections rate
47.8/1,000
(England: 46.4/1,000)

PHE Fingertips - 2016

MENTAL HEALTH

Depression: Recorded prevalence (aged 18+)
8.5%
(England: 8.3%)



QOF 2015

SMOKING

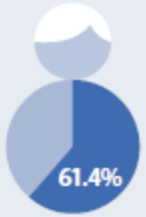
Smoking prevalence in adults – current smokers (aged 18+)
15.2%
(England: 15.5%)

Annual Population Survey (APS) 2016

OVERWEIGHT & OBESITY

EXCESS WEIGHT

Adults (aged 18+) classified as overweight or obese
61.4%
(England: 61.3%)

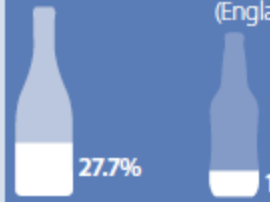


Public Health England (based on Active Lives survey, Sport England) 2015-2016

ALCOHOL

Adults drinking over 14 units a week
27.7%
(England: 25.7%)

Adults binge drinking on heaviest drinking day
15%
(England: 16.5%)



Local Alcohol Profiles for England 2014

LONG-TERM CONDITIONS

Diabetes: QOF prevalence (17+)
6.4%
(England: 6.5%)

Hypertension: QOF prevalence (all ages)
14.7%
(England: 13.8%)

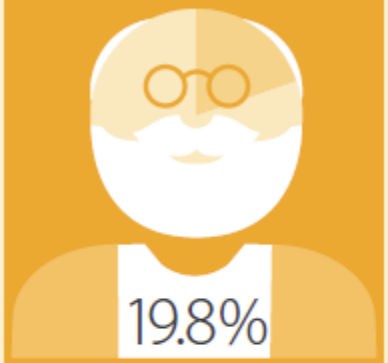
Coronary Heart Disease: QOF prevalence (all ages)
3.1%
(England: 3.2%)

The Quality and Outcomes Framework (the QOF) is the system through which GP practices are rewarded for undertaking specified clinical activities and achieving specific treatment standards

QOF 2015/2016

AGEING WELL OLDER PEOPLE

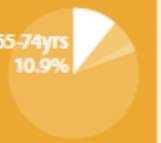
POPULATION: 65+ YRS



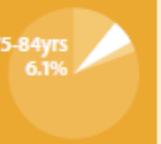
Projected growth by 2021

↑14.0%

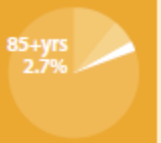
Percentage of population between 65 and 74 years of age: 10.9% (169,200)



Percentage of population between 75 and 84 years of age: 6.1% (95,000)



Percentage of population over 85 years of age: 2.7% (41,700)



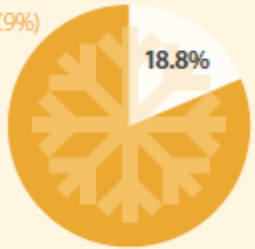
ONS population estimates 2016

EXCESS WINTER DEATHS

Percentage of deaths above the mortality rate if it was stable throughout the year

18.8%

(England: 17.9%)



PHE Finger Tips 2013-2016

FALLS AND FRACTURES

Hip fractures

1,761 patients

over 65 years of age were admitted to hospital as emergency admissions with hip fractures

Number of hospital admissions due to falls

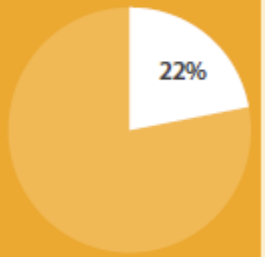
6,337

PHE Finger Tips 2015-2016

MULTI-MORBIDITY

1 in 5

of those aged 70 and above have 2 or more QOF long term conditions



Kent Integrated Dataset, 2018

HEART DISEASE / STROKE

People under 75 suffer an early death due to heart disease and stroke

64.6/100,000

(England: 73.5/100,000)

PHE Finger Tips 2014-2016

DEMENTIA

Dementia: Recorded prevalence (aged 65+)

4.1%

(England: 4.3%)

PHE Finger Tips 2017

END OF LIFE CARE

Cause of death

- Cancer: 28%
- Coronary heart disease: 7%
- Respiratory disease: 15%
- Stroke: 7%
- Other circulatory diseases: 12%

Place of death

- Hospital deaths: 42% (England: 47%)
- Home deaths: 21% (England: 23%)
- Care home deaths: 25% (England: 23%)
- Hospice deaths: 9% (England: 6%)
- Other: 3% (England: 2%)

PHE Finger Tips 2017

CARERS

10.4% (England: 10.2%)

Number of carers

151,777

Census 2011

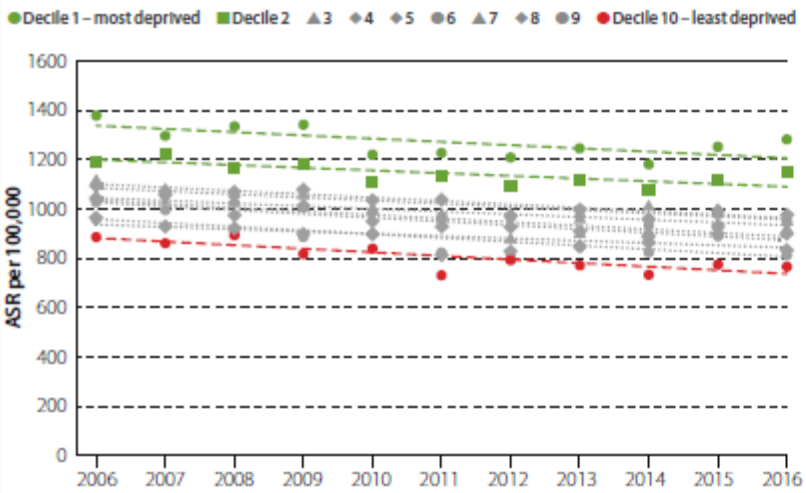
INEQUALITY

– Our health as individuals is shaped by the conditions in which we are born, grow, live, work and age. We measure health inequalities, the differences in health outcomes within and between communities, through health statistics such as life expectancy or rates of death.

– The Index of Multiple Deprivation (IMD) is the official measure of deprivation for small areas in England. The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area). The IMD combines information from 7 areas: income, employment, education, health and disability, crime, barriers to housing and services, living environment.

All Age All Cause Mortality: By Deprivation

Age-Standardised All Age All Cause Mortality Rate (per 100,000), Kent IMD 2015

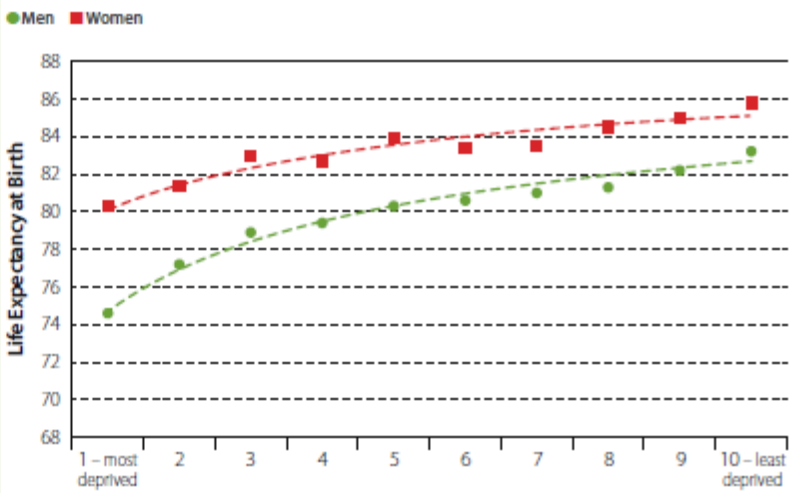


Source: PCMD, Prepared by KPHO (RK), Nov 2015

Mortality rates in Kent have been falling, but the 'gap' between the most deprived and least deprived remains the same.

Life Expectancy: By Deprivation

Kent, 2012-2014, IMD 2015



Source: PCMD, Prepared by KPHO (RK), Nov 2015

The most deprived populations have worse life expectancy than the least deprived.

NOTES AND WEBLINKS

RATIONALE FOR CONTENT

This report provides a simple infographic summary of some of the key health and wellbeing issues in Kent. It is designed to be helpful for partner organisations of the County Council, as well as the wider public.

The health measures we have presented are indicative of the issues raised in the Kent Joint Strategic Needs Assessment, and are reported under three important life stages (Starting Well, Living Well and Ageing Well). Data for Kent has been compared to averages for the whole country wherever possible.

DATA INCLUDED

This report was produced in February 2018 and the data used was the most up to date at the time of publication. All the measures presented have sources and dates. High level links have been provided below, from which you will be able to find further detailed information. A link to the full Joint Strategic Needs Assessment is also provided.

DEVELOPMENT OF THE JSNA

This version of the report is published in our online JSNA as a useful document to share with partner organisations of the County Council, and the wider public. We are, however, currently reviewing the way we develop and create our JSNA with the objective of providing a product that better meets with the expectations of our partners and others engaged with the JSNA process.

WEBLINKS

Key sources of data for this report include:

Kent JSNA
https://www.kpho.org.uk/joint-strategic-needs-assessment/jsna-overview-and-exception-reports#tab1

Kent Facts and Figures
https://www.kent.gov.uk/about-the-council/information-and-data/Facts-and-figures-about-Kent

Public Health England Fingertips Tool
https://fingertips.phe.org.uk/

NHS Digital
http://content.digital.nhs.uk/home

Office for National Statistics
https://www.ons.gov.uk/

Government statistics
https://www.gov.uk/government/statistics

Appendix B: Key emerging themes from stake holder interviews

- Alcohol the new ‘crutch’ for dealing with stress but not discussed openly
- Smoking the behaviour to stop with clear understanding of why
- Exercise/ healthy eating and weight are behaviours families feel they need to do something about but struggle with low commitment and lack of awareness of what to do ‘what is enough’
- Wellbeing (including relationships, children having friends and being happy) top priority for families ‘at all costs’.
- Families said the ‘system’ is bad at engaging with families on their health and wellbeing: Experiences include feeling judged, many missed opportunities, feeling let down and fearful.

Appendix C: JSNA Cohort model -case studies

Kent County Council JSNA – cohort model insight[1]

Case study 1: Stroke

The question

The development of effective and efficient stroke services for the population of Kent is the subject of current consultation and business case development across Kent. We have therefore used the JSNA cohort model to ask the following question:

What levels of need is likely for stroke services over the medium to long term (10-20yrs) for the Kent population?

The cohort model includes the following information, derived from the KID, with respect to the prevalence of the population who will have experienced a stroke in any one year:

- It has a separate cohort for stroke incidence for people who have no other health or care needs, as defined in the cohort model segmentation approach, which in 2017 is estimated at 8,800;
- There are a further 13,250 people who have a stroke alongside another long-term condition and 3,600 who are also frail, making a total of 25,600;
- Expected stroke prevalence in 2017 using QoF is 27,400.

The needs of these three different groups within the overall stroke cohort will differ significantly. This initial report focusses on the former as an illustration of the potential to use the cohort model to inform future plans for Stroke services.

The outputs from the model

The model has been used to develop three scenarios for the prevalence of stroke as a single condition cohort (i.e. a sub-set of the whole stroke prevalence). The number of attendances to A&E from this cohort (for all reasons) has also been derived from the model, which in this case is informed by KID analysis for the cohort in question and their risk of attending A&E in any one year. The single condition stroke prevalence over the period 2017 to 2037 has been modelled for:

- Demographic change only, applying risk factors for incidence and use of A&E as at 2017;
- Demographic change plus trends in underlying risk factors, in this case the fact that changes in levels of smoking, physical inactivity, blood pressure, cholesterol and BMI within the population are all changing;
- An additional reduction in the percentage of untreated hypertension (currently estimated at 50%) by 30% between 2018 and 2024.

We have not made any assumptions about changes in the rate of access to services by the cohort in question, only the factors that change the size of the cohort. Changes in access to

[1] The cohort model was commissioned by the Kent Health & Wellbeing Board to complement existing JSNA reporting through the development of a single 'whole-population', prospective perspective on understanding and addressing the health and care needs of the local population. It has been informed by the Kent Integrated Dataset (KID) and other national studies of incidence, prevalence and mortality and has been build using System Dynamics software. The model can be accessed from the KCC JSNA home page (link).

services would represent a change in the service model, which would be modelled over a shorter term with more detail reflecting service pathways. The result is shown in Figure 1.

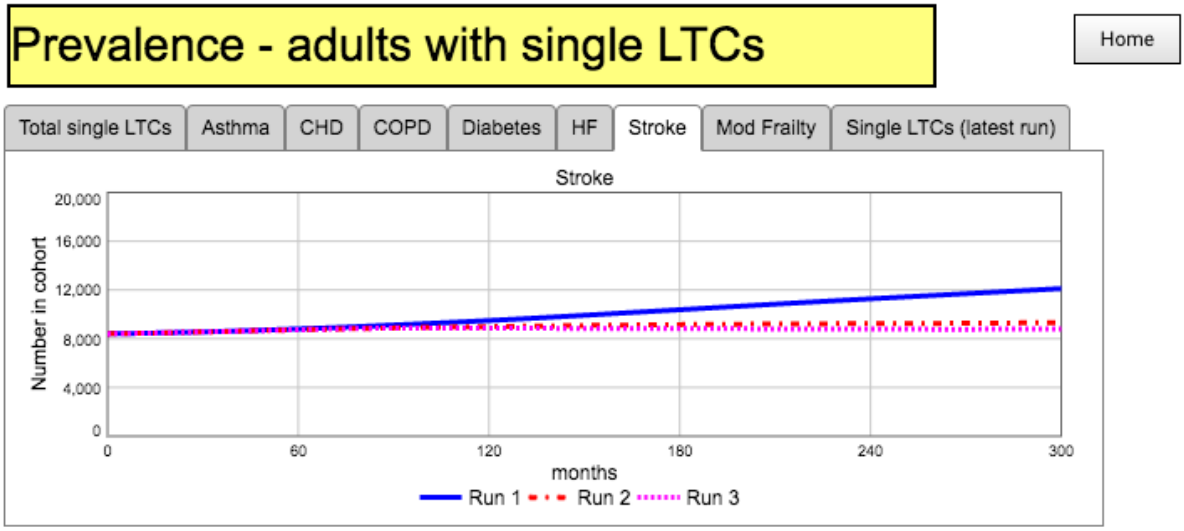


Figure 1 The prevalence of the single condition stroke cohort under the scenarios described above

Exporting the data for cohort size, and for one example of service access, i.e. A&E attendances, shows the scale of the impact of changes in underlying risk factors, as shown in Figure 2. The difference, over 20 years, between a 38% and an 8% increase for the single condition stroke cohort is striking, and is reflected in changes in rates of A&E attendance.

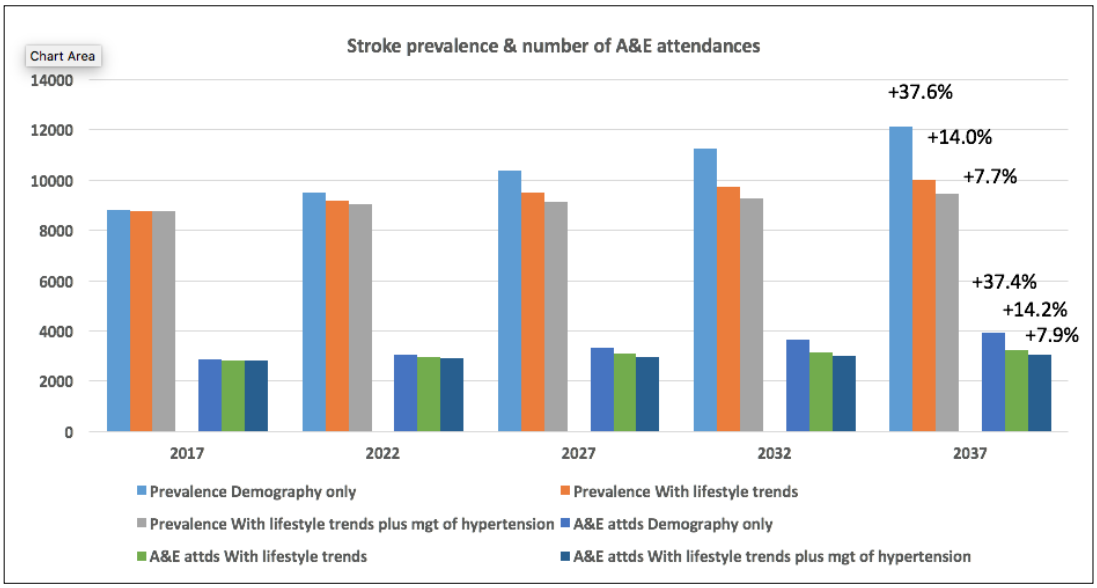


Figure 2 Changes in cohort size and attendances at A&E

A further scenario, this time based on levels of unscheduled admissions for the single condition stroke cohort, identifies changes over the period 2017 to 2037 of 36%, 13% and -1% respectively, with the latter figure reflecting improvements in all the five underlying risk factors.

Insights & further considerations

The cohort model clearly demonstrates the potential variation in needs for the single condition stroke cohort, and its sensitivity toward underlying risk factors in the population. It therefore has the potential to inform decisions about both risk reduction strategies and future capacity planning for the health sector. A similar application to the other stroke cohorts can be developed to consider the overall future needs for the cohort of people who have

experienced a stroke, taking account of the different levels of risk due to comorbidities. To inform the future capacity requirements relating specifically to stroke then further analysis would be required to derive stroke-specific activity from the KID.

Case Study 2: Smoking (and smoking cessation)

The question

The development of effective and efficient smoking cessation services for the population of Kent is the subject of the approval of the STP clinical and professional boards We have therefore used the JSNA cohort model to ask the following question:

What is the impact of smoking reduction and smoking cessation over the medium to long term (10-20yrs) for the Kent population?

The cohort model includes the following information, derived from the KID and other sources with respect to the prevalence of smoking and conditions related to smoking as a risk factor in any one year:

- It has a baseline prevalence of smoking set to 20%, which reduces at a rate of 0.4% per year without any intervention.
- It has a scenario where smoking cessation reduces smoking prevalence by a further percentage decided by the user, in this case 5%.
- It has a separate and combined incidence and prevalence of long term conditions such as CHD, Stroke and COPD;
- It measures the incidence of cancers, focussing in this case on the impact upon lung cancers.

This initial report focusses on the potential to use the cohort model to inform plans and impacts for smoking cessation services.

The outputs from the model

The model has been used to develop three scenarios for the impact of underlying smoking prevalence changes and smoking cessation services. The number of A&E attendances from smoking related cohorts has also been derived from the model, which in this case is informed by KID analysis for the cohort in question and their risk of unscheduled admissions in any one year. The smoking related cohorts (single conditions) prevalence over the period 2017 to 2037 has been modelled for:

- Demographic and risk factor (minus smoking prevalence changes) change only, applying risk factors for incidence and use of A&E as at 2017;
- Demographic change plus trends in underlying risk factors, in this case changes in levels of smoking, within the population are all changing;
- An additional reduction in the prevalence of 5% from smoking cessation interventions between 2018 and 2030.

We have not made any assumptions about changes in the rate of access to services by the cohort in question, only the factors that change the size of the cohort. Changes in access to services would represent a change in the service model, which would be modelled over a shorter term with more detail reflecting service pathways. The result is shown in Figure 1.

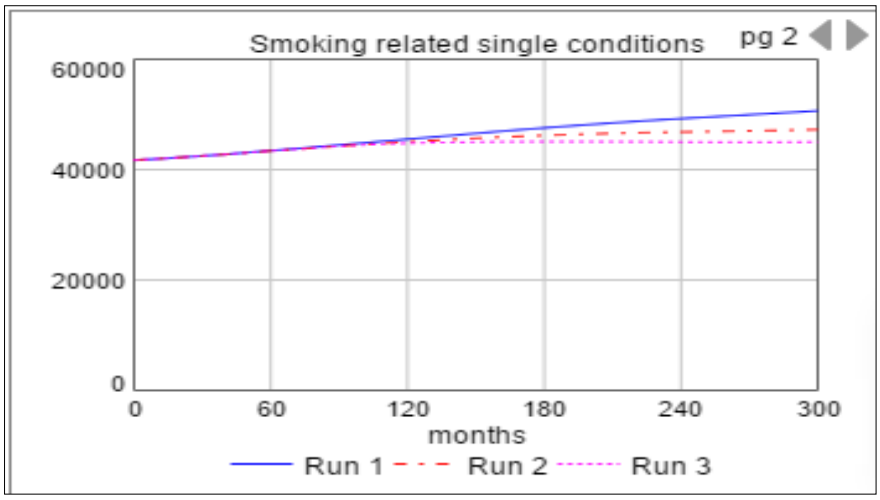


Figure 3 The prevalence of the smoking related single conditions[i] (combined) under the scenarios described above

Exporting the data for cohort size, and for one example of service access, i.e. A&E attendances, shows the scale of the impact of changes in smoking, as shown in Figure 2. The difference, over 20 years, between a 17% and 4% increase for the single condition cohorts is striking and is reflected in changes in rates of A&E attendance.

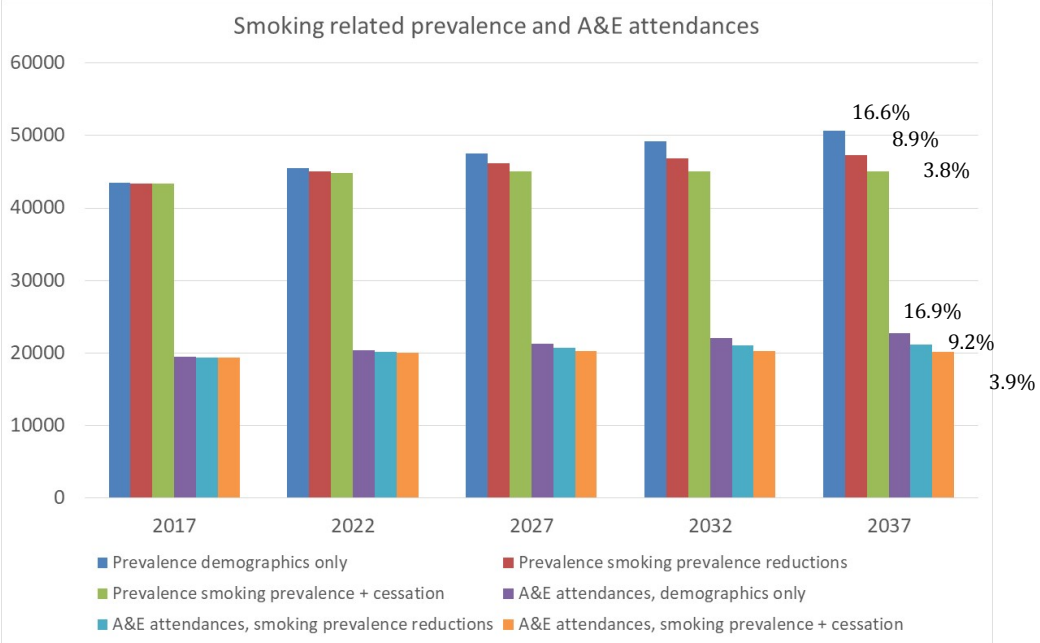


Figure 4 Changes in cohort size and attendances at A&E

A further scenario, this time based on levels of unscheduled admissions for the single condition smoking related cohort, identifies changes over the period 2017 to 2037 of 16.9%, 9.2% and -3.6% respectively, with the latter figure reflecting improvements in smoking prevalence and smoking cessation. This is an £8million saving[ii] over 20-year from smoking cessation.

Insights & further considerations

The cohort model clearly demonstrates the potential variation in impacts of smoking reductions and smoking cessation interventions. It therefore has the potential to inform decisions about both risk reduction strategies and future capacity planning for the health

sector. A similar application to the other health and care service contacts can be developed to consider the overall future impacts of smoking

[i] Single conditions = CHD, COPD and Stroke

[ii] Average cost of admission = £1500.

Case study 3: Fuel Poverty

The question

The impact of fuel poverty upon health outcomes and health and care activity rates is of interest across Kent. We have therefore used the JSNA cohort model to ask the following question:

What are the health impacts of reversing fuel poverty upon the health of children and older people and their utilisation of hospital services (e.g. emergency admissions) over the medium to long term (10-20yrs) for the Kent population?

The cohort model includes the following information, derived from the KID and other sources, with respect to the prevalence of the population who will have experienced a health problem relative to fuel poverty in any one year:

- It has a baseline prevalence of fuel poverty[ii] of 17% for children under 17 years and 14% for people aged 65 years and over, which is above the Kent average of households which stands at c.10%;
- It includes a scenario where fuel poverty is reduced by 50% for both children and older people;
- The incidence and prevalence of conditions relative to fuel poverty and the impact of reversing the effects of fuel poverty on the progression of these conditions;
- The impacts upon health and care contacts for cause specific admissions, particularly respiratory related emergency admissions;
- Seasonal variations in mortality for the Kent population.

This initial report focusses on illustrating of the potential to use the cohort model to inform policies to ameliorate fuel poverty in Kent.

The outputs from the model

The model has been used to develop three scenarios for the impact of fuel poverty for children and adults. The number of unscheduled admissions for respiratory conditions (for all reasons) has also been derived from the model, which in this case is informed by KID analysis for each cohort and the risk of unscheduled admissions relative to fuel poverty in any one year. The impact of fuel poverty over the period 2017 to 2037 has been modelled for:

- Demographic change plus trends in underlying risk factors, in this case the fact that levels of smoking, physical inactivity, blood pressure, cholesterol and BMI within the population are all changing;
- An additional reduction in the percentage fuel poverty for children (currently estimated at 17%) by 50% between 2018 and 2024;
- An additional reduction in the percentage fuel poverty for older people (currently estimated at 14%) by 50% between 2018 and 2024.

We have not made any assumptions about changes in the rate of access to services by the cohort in question, only the factors that change the size of the cohort. Changes in access to services would represent a change in the service model, which would be modelled over a shorter term with more detail reflecting service pathways. The result is shown in Figure 1.

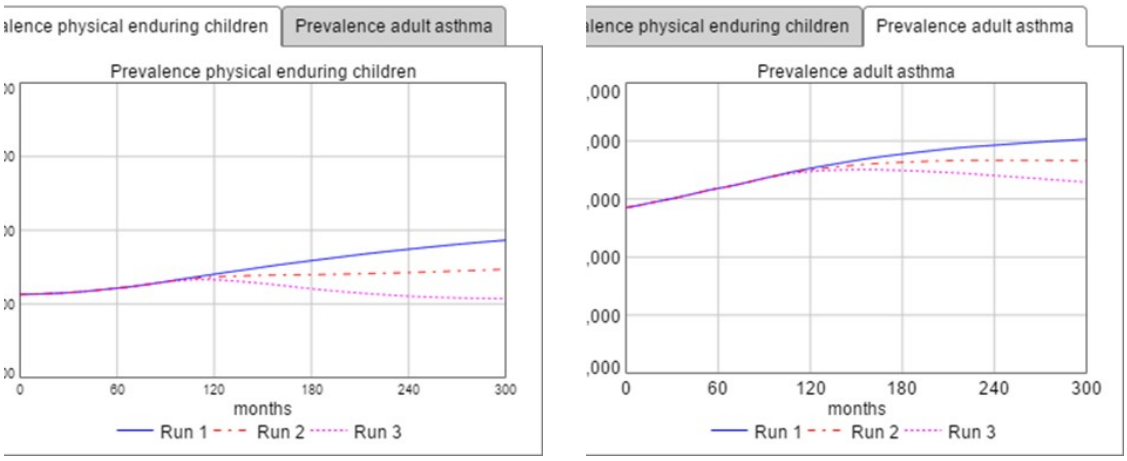


Figure 5 The prevalence of asthma

Reductions in fuel poverty for Kent residents is reflected by reductions in the prevalence of asthma for children and adults over the medium to long term:

- For children there is the potential to reverse the increasing trend and;
- For adults there is the potential for asthma prevalence to plateau.

Exporting the data for cohort size, and for one example of service access, i.e. unscheduled admissions for respiratory conditions, shows the scale of the impact of changes in fuel poverty, as shown in Table 1. The table illustrates the cumulative (5-year periods) number of unscheduled admissions for respiratory conditions in Kent. The difference, over 20 years, is about 1,600 and 2,400 for a 50% and 75% reduction in fuel poverty for older people respectively.

	2012-2017	2018-2022	2023-2027	2028-2032	2033-2037
Run 1: demographic and risk factor change only	22494	24150	25937	27691	29483
Run 2: Reduce fuel poverty by 50%	22494	24081	25517	27145	28893
Difference Run 2 - Run 1	0	-69	-420	-546	-590
Run 3: Reduce fuel poverty by 75%	22494	24047	25307	26872	28598
Difference Run 3 - Run 1	0	-103	-630	-819	-885

Table 1 Changes in unscheduled admissions for respiratory conditions

Additionally, the model illustrates the potential impact that fuel poverty can have upon excess winter deaths. For a 50% reduction in fuel poverty the model suggests that about 100 deaths can be prevented annually.

Insights & further considerations

The cohort model clearly demonstrates the potential impacts that fuel poverty can have upon the health of the Kent population, and is sensitive toward underlying risk factors

in the population. It therefore has the potential to inform decisions about both risk reduction strategies and future capacity planning for the health sector. A similar application to include further fuel poverty impacts can be developed to consider the overall future impact of fuel and other poverty measures. Similarly, further model outputs can help illustrate which cohorts should be targeted for fuel poverty interventions.

From: Peter Oakford, Cabinet Member for Strategic Commissioning and Public Health

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

Date: 21 March 2018

Subject: Kent Pharmaceutical Needs Assessment 2018-2021

Classification: Unrestricted

1. Introduction

1.1 The Health and Social Care Act 2012 transferred responsibility for the Pharmaceutical Needs Assessment from Primary Care Trusts to Health and Wellbeing Boards on the 1st April 2013.

1.2 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-servicesregulations/

1.3 Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up-to-date a statement of the need for pharmaceutical services in its area, otherwise referred to as a Pharmaceutical Needs Assessment (PNA). Each HWB was required to publish its own revised PNA for its area by 1st April 2015 and to renew this every three years.

1.4 The main aim of the Kent Pharmaceutical Needs Assessment is to describe the pharmaceutical services in Kent and systematically identify any gaps/unmet needs, consulting with stakeholders and making recommendations on assessed gaps and future developments.

1.5 The Pharmaceutical Needs Assessment is a key document used by NHS England and the local area Pharmaceutical Services Regulations Committee (PSRC) to make decisions on new applications for pharmacies and change of services or relocations by current pharmacies. It is also used by commissioners reviewing the health needs for services within their particular area, to identify if any of their services can be commissioned through pharmacies.

1.6 The Kent Pharmaceutical Needs Assessment consists of an overarching document explaining the details about pharmaceutical services and how needs are assessed, accompanied by a separate PNA document for

each Clinical Commissioning Group area making recommendations for that area.

2 PNA Development

2.1 In September 2017, a paper was taken to the Health and Wellbeing Board seeking agreement to set up a Steering Group to oversee the production, consultation and publication of the Pharmaceutical Needs Assessment. This was approved. Approval was sought to formally consult on the draft PNA and the Health and Wellbeing Board approved this.

2.2 The steering group is made up representatives of key stakeholders as well as representatives of each of the Clinical Commissioning Groups.

3 Consultation

3.1 The County Council consulted with key stakeholders as defined in the regulation and as per KCC guidelines from the 15th November 2017 until 22 January 2018. Consultation was conducted through HealthWatch Kent, via the Kent County Council website and via CCG Patient Participation groups and local networks.

3.2 The PNA has been revised to reflect the consultation results where appropriate and recommendations for each individual area have been discussed in detail by the steering group and are documented in the CCG level PNAs.

3.3 Publication of the PNA will include results of the consultation and relevant comments.

4 Recommendations

4.1 Note the key strategic findings of recommendations of the PNA which are as follows:

- Overall there is good pharmaceutical service provision in the majority of Kent.
- Where the area is rural, there are enough dispensing practices to provide basic dispensing pharmaceutical services to the rural population.
- There are proposed major housing developments across Kent, the main ones being Chilmington Green near Ashford and Ebbsfleet Garden City. This will mean that these areas will need to be reviewed on a regular basis to identify any increases in pharmaceutical need.
- The current provision of “standard 40 hour” pharmacies should be maintained.
- The current provision of “100 hour” pharmacies should be maintained.

4.2 The Health and Wellbeing Board has the responsibility of publishing supplementary statements when the pharmaceutical need and services to an area change significantly. It is proposed that these are issued every 6 months by NHS England (a member of the Board) as they hold all the relevant data. They will be published on the Council website alongside the PNA.

4. Recommendations

5.1 The Health and Wellbeing Board is asked to approve the process and timeframe.

5.2 The Health and Wellbeing Board is asked to approve the final PNA ready for publication subject to final checking with NHS England on any pharmaceutical service application grants made following the consultation and any final changes through proofing and editing.

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Kent Pharmaceutical Needs Assessment 2018
General Public Consultation responses

Responses via online consultation	58
Responses via email	2
Responses via Post	3
Total number of responses	**63**

Q1 Please tell us which borough/district you live in		
Ashford	4	6%
Canterbury	5	8%
Dartford	1	2%
Dover	10	16%
Gravesham	3	5%
Maidstone	7	11%
Sevenoaks	6	10%
Shepway	4	6%
Swale	7	11%
Thanet	4	6%
Tonbridge and Malling	4	6%
Tunbridge Wells	8	13%
	63	100%

Q2. Postcodes

Received but not published

Q3. Do you have your medicines dispensed at a pharmacy?		
Yes	60	95%
No	3	5%
Not answered	0	0%
	63	100%

Q4. Do you have your medicines dispensed at a dispensing doctor's practice?		
Yes	4	6%
No	58	92%
Not answered	1	2%
	63	100%

Two responders said Yes to Question 3 and 4

One responder said No to Questions 3 and 4

Q5. If you use a pharmacy, how often do you use one?		
Once a week	3	5%
Once every couple of weeks	17	27%
Once a month	29	46%
Once every couple of months	9	14%
Less often	4	6%
Don't Know	0	0%
Not answered	1	2%
	63	

Q6. Do you have a regular pharmacy that you use?		
Yes	61	97%
No	2	3%
Don't Know	0	0%
	63	100%

Q7. In terms of location, what is the main reason you use this pharmacy regularly?		
Near to home	32	51%
Near to my doctors	15	24%
In town/Shopping area	9	14%
In the supermarket	1	2%
Near to my work	1	2%
Other	3	5%
Not answered	2	3%
	63	100%

Q8. If your regular pharmacy was not open, would you…		
Wait for them to open	36	57%
Find another pharmacy	23	37%
Don't Know	2	3%
Not answered	2	3%
	63	100%

Q9 . If your regular pharmacy didn't have the things you need, would you...		
Wait for them to order the items	48	76%
Find another pharmacy	12	19%
Don't Know	1	2%
Not answered	2	3%
	63	100%

Q10. How do you usually travel to your regular pharmacy?		
Walk	27	43%
Car (driver)	23	37%
Car (passenger)	5	8%
Bus	3	5%
Bicycle	0	0%
Taxi	0	0%
Other*	3	5%
Not answered	2	3%
	63	100%

Q11. Which of the following PNA consultations have you read?	
Countywide document	18
The document that covers the area in which you live	48
All 7 area documents	4
None	6
Don't know	3

Q 12. Please tell us if you have any comments on the PNA documents

See comments sheet

Q13. If you have any other comments specifically about any of the following, please provide them in the box below:

• accessing either a pharmacy or dispensing doctor's surgery to obtain your prescribed medicines
• the advice given by the pharmacy or dispensing doctor's surgery around the safe and effective use of these medicines
• any general health advice offered to help you keep yourself well

Q14. We have completed an Equality Impact Assessment (EqIA) to see whether the Pharmaceutical Needs Assessment could affect anyone unfairly. We welcome your views on the assumptions we have made and the conclusions we have drawn.
See comments sheet

Q15. Are you....?

Male	31	49%
Female	31	49%
I prefer not to say	0	0%
Not answered	1	1.59%
	63	100%

Q16. Is your Gender the same as your birth?

Yes	61	97%
No	0	0%
I prefer not to say	1	2%
Not answered	1	2%
	63	100%

Q17. Which of these age groups applies to you?

under 18	0	0%
18-24	0	0%
25-34	0	0%
35-49	6	10%
50-59	10	16%
60 - 64	6	10%
65-74	31	49%
75-84	7	11%
85+	2	3%
Not answered	1	2%
I prefer not to say	0	0%
	63	100%

Q18. Do you regard yourself as belonging to a particular religion or holding a belief?

Yes	34	54%
No	24	38%
I prefer not to say	4	6%
Not answered	1	2%
	63	100%

Q18a. Which of the following applies to you?		
Christian	29	46%
Buddhist	0	0%
Hindu	1	2%
Jewish	0	0%
Muslim	0	0%
Sikh	0	0%
Other*	3	5%
Not answered	30	48%
	63	

* Pagan, Spiritualist, Atheist

Q19. Do you consider yourself to be disabled as set out in the Equality Act 2010?		
Yes	18	29%
No	42	67%
I prefer not to say	1	2%
Not answered	2	3%
	63	100%

Q19a. Please tell us which type of impairment applies to you.		
Physical Impairment	11	17%
Sensory Impairment (hearing, sight or both)	6	10%
Long standing illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes	13	21%
Mental Health condition	1	2%
Learning disability	0	0%
I prefer not to say	1	2%
Other*	1	2%
Not answered	30	48%
	63	100%

* neuroleptic condition

Q20. Are you a Carer?		
Yes	14	22%
No	48	76%
I prefer not to say	1	2%
Not answered	0	0%
	63	100%

Q21. To which of these ethnic groups do you feel you belong?

White: English	57	90%
White: Irish	0	0%
White Scottish	0	0%
White Welsh	1	2%
White Northern Irish	0	0%
White: Gypsy / Roma	0	0%
White: Irish Traveller	0	0%
White: Other*	3	5%
Mixed: White and Black Caribbean	0	0%
Mixed: White and Black African	0	0%
Mixed: White and Black Asian	0	0%
Mixed: Other**	0	0%
Mixed: Arab	0	0%
Asian or Asian British: Indian	1	2%
Asian or Asian British: Pakistani	0	0%
Asian or Asian British: Bangladeshi	0	0%
Asian or Asian British: Other*	0	0%
Asian or Asian British: Chinese	0	0%
Black or Black British: Caribbean	0	0%
Black or Black British: African	0	0%
Black or Black British: Other**	0	0%
I prefer not to say	0	0%
Other: not specified above	1	2%
Not answered	0	0%
	63	

* White British

Q22. Are you...?

Heterosexual/Straight	57	90%
Bi/Bisexual	1	2%
Gay man	1	2%
Gay woman/lesbian	0	0%
Other*	3	5%
I prefer not to say	0	0%
Not answered	1	2%
	63	

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Results of the Kent Pharmaceutical Needs Consultation 2018

Each Health and Wellbeing Board has a duty to consult with key stakeholders as defined in Regulation 8 of the above regulations. These include

(a) any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(b) any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(c) any persons on the pharmaceutical lists and any dispensing doctors list for its area;

(d) any LPS chemist in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services;

(e) any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB has an interest in the provision of pharmaceutical services in its area; and

(f) any NHS trust or NHS foundation trust in its area;

(g) the NHSCB (now known as NHS England); and

(h) any neighbouring HWB.

The consultation ran from 15 November 2017 to 22 January 2018 inclusive. All consultation information was held on the consultation directory on kent.gov.uk with its own weblink: www.kent.gov.uk/pharmaceuticalneeds.

Each stakeholder organisation was sent a personal invitation to take part in the consultation from the Deputy Director of Public Health (Chair of the Pharmaceutical Needs Assessment (PNA) Steering Group). The general public were informed of the consultation through:

- The website
- Healthwatch and local community groups
- KCC social media posts
- The CCGs were asked to consult through their patient participation groups
- 5500 email invites sent to registered users of KCC's consultation directory based on their selected interests ('general interest' and 'healthcare and public health')
- Press release: this wasn't picked up by the media but was stored on the Media Hub section of KCC's website.

Participants were asked to complete a questionnaire either using the online form or a paper copy. Access to alternative formats was promoted.

Conversations were held with organisations in localities where it was perceived that there may be a concern regarding provision. This was to ensure they were encouraged to provide their views as part of the consultation

Responses from the general public

There were 63 responses from the general public. **The actual breakdown of responses received can be found listed in Appendix C.**

Q1 recorded which district/ borough the responder lived in

Q2 recorded the responder's postcode

Q3. 95% used a pharmacy to access medicines

Q4. 6% used a dispensing doctor's practice to access medicines.

2 responders used both and 1 said they did not use either.

Q5. Over 46% visited the pharmacy at least once a month with over 14% visiting every couple of months, 6% less often than every couple of months, over 27% every couple of weeks and just 5% every week. 1 responder did not fill this in.

Q6. Nearly 97% said they used the same pharmacy regularly.

Q7. 51% used the pharmacy near home, 24% used the pharmacy/dispensary near the doctors' practice, just over 2% near work, 16% whilst shopping either in the supermarket or in town and the rest had it delivered, picked up by a relative or went elsewhere because they liked the service received.

1 responder commented "*I tried others nearer home but this was the best for service, advice and helpfulness.*"

Q8. When asked what they would do if the pharmacy were closed, 57% said that they would wait.

Q9. When asked what they would do if the pharmacy did not have the things needed, 76% said they would wait for them to be ordered.

Q10. 45% of responders drove to the pharmacy, with 43% walking, 5% used the bus and the rest either had their medicine delivered or did not use a regular pharmacy.

Q11. When asked which of the PNA consultation documents they had read, eighteen responders said that they had read the countywide document with 14 of them also reading the document for the area in which they lived (this was the way it was suggested that the documents should be read) One responder read all 7 area documents. Thirty four responders only looked at the document for their area without reading the overarching information, six had not read any of the documents and three did not answer.

Q12. Responders were asked if they had any comments about the PNA documents. 29 responded to this question.

Twelve responders gave positive feedback on the PNA. Two responders felt the documentation was too long winded and excessive.

Two responders commented on the performance and quality of pharmaceutical services provided. Monitoring quality and performance is provided by NHS England as they manage the contracts and is not judged as part of the PNA. These comments will be passed onto NHS England.

Two responders promoted the use of internet pharmacy and one felt that the pressure from internet providers to gain business was inappropriate.

One responder was concerned that the results of the PNA may result in the closure of providers of pharmaceutical services. The PNA does not give an opinion as to whether there are too many providers although it does state if a provider is essential for that area.

Two responders felt that the provision of pharmaceutical services should be included in all planning applications along with GP services.

Five responders queried some of the information provided in PNA. These queries will all be looked at individually and responded to accordingly.

One person commented on the problems accessing both doctors, surgeries, pharmacies and A&E in certain rural parts of the county.

Q13 Responders were also asked if they had any other comments specifically about any of the following,

- accessing either a pharmacy or dispensing doctor's surgery to obtain your prescribed medicines
- the advice given by the pharmacy or dispensing doctor's surgery around the safe and effective use of these medicines
- any general health advice offered to help you keep yourself well

Forty two responded to this question.

Access - Fifteen responders mentioned access as an issue. These comments ranged from issues with parking to a lack of public bus services especially in rural areas. One person mentioned that their dispensing surgery was essential because of where they live and two people felt that the delivery service currently offered was essential.

Access to pharmacies out of hours was mentioned by four responders, one praising the service and the rest stating that out of hours services were difficult to access if you did not have a car.

One person felt there were too many pharmacies in close proximity.

Two responders had either no specific comments or problems

Performance and quality Twenty six responders had comments about performance and quality. Fifteen of these were positive about the service they receive. The remaining responders either had concerns about the efficiency of the pharmacies they used or issues with the systems used to order and receive their medications. These were sent to NHS England to review as they manage the performance of both pharmacies and GP surgeries, or the relevant CCG about ordering systems etc. One person expressed concerns about current medicine shortages. This is a national problem and is currently being reviewed by the Department of Health and Social Care.

Five responders had ideas for commissioning new or different services from pharmacies. These will be passed onto the relevant commissioners.

Demographics.

The ages of the respondents ranged from 35 to over 85 with just over 41% over 65.

95% of respondents were White British and there was an even number of males responding as females.

22% of the responders acted as a carer to another person and 29% of the responders considered themselves as disabled, predominantly with a long standing health condition (21%) or a physical/sensory disablement (27%)

EqIA

Eighteen responders added comments about the EqIA. Of these eight agreed with the EqIA. 3 had queries which will be answered in the final document. 2 had not actually read the document and the rest had comments which were not related to the EqIA but will be addressed elsewhere.

Overall

The main purpose of the PNA is to identify whether patients can access pharmaceutical services. Any comments about access were identified and the PNA amended where necessary to reflect these comments.

Assessing performance and quality, although important, is carried out by NHS England as part of contract monitoring and is not within the remit of the PNA. All comments about performance and quality were forwarded to NHS England.

Comments about health related services which were not pharmaceutical services either current or proposed were forwarded to the relevant commissioner.

Comments re planning and the provision of services that were not health related were forwarded to the relevant council.

Various comments re the wording of the PNA were take into account and the PNA changed where appropriate

Adjustments to the EqIA were made were appropriate

Please see Appendix E for a breakdown of comments received

Responses from key professional stakeholders

There were thirteen responses from key stakeholders.

Five responded via the online consultation, eight responded by email

Q1 There ten responses on behalf of an organisation. Three responded as individuals.

Q1a Three were from Clinical Commissioning Groups, two within Kent and one on the borders

Four were from a local dispensing doctor's practice

One was from a neighbouring Health & Wellbeing Board

One was from a Community Pharmacy independent with more than one branch.

Two were from local Borough Councils.

Two was from an independent health professionals

Q2 Districts that responders worked in

- Ashford 1
- Canterbury 1
- Dartford 0
- Dover 0
- Gravesham 1
- Maidstone 5
- Sevenoaks 1
- Shepway 0
- Swale 1
- Thanet 2
- Tonbridge & Malling 1
- Tunbridge Wells 1
- Outside of Kent 4 Bexley, National but lives in county, East Sussex, Weald

One responder worked over 5 different areas.

Q3 When asked which of the PNA consultation documents they had read, five responders said that they had read the countywide document with two of them also reading the document for the area in which they lived (this was the way it was suggested that the documents should be read). Two responders read all 7 area documents. Seven responders only looked at the document for their area without reading the overarching information.

Q4 When asked to *what extent do you agree or disagree that the information in the draft documents is a good reflection of the current pharmaceutical service provision within the district(s) in which you work?*

Five responders strongly agreed and four tended to agree. Three responders neither agreed nor disagreed and one did not answer

Q4a Eight responders left comments

Q5 When asked *to what extent do you agree or disagree that the information in the draft documents is a good reflection of the needs of the population in the district(s) in which you work?*

Four responders strongly agreed and eight tended to agree. One person did not answer.

Q5a Seven responders left comments

Q6 Nine responders had other comments that they wanted to make about the draft PNA.

Q7. EqIA

Four responders added comments about the EqIA. Three of these expressed concerns about what would happen if dispensing doctors closed and the fourth asked about services for gypsies, travellers and people who spoke a foreign language.

Overall

The main purpose of the PNA is to identify whether patients can access pharmaceutical services. Professionals were consulted to identify whether they considered that the draft PNA reflected both the current provision of pharmaceutical services and also the pharmaceutical needs of the population.

The majority of responders agreed that the draft PNA reflected both the current provision and the needs of the population. Nobody disagreed with these statements although a couple did not answer the question at all.

The majority of comments were about the importance of dispensing services provided by rural GP surgeries being maintained. Whether a rural GP can dispense and who they can dispense to, is defined by regulation and the PNA can only recommend whether pharmaceutical services are adequate in that area and has no role in differentiating between the providers.

One representative of a local borough council asked that his particular area, which has been subject to increased housing development, be reassessed as to whether the area could have a local pharmacy. This area, which is currently controlled and therefore designated rural, is currently undergoing a rurality review.

Another borough council emphasised the need for more health services including pharmacies to be commissioned in areas which are currently being developed for housing. This had already been identified in the PNA.

Adjustments to the EqIA were made were appropriate

Please see Appendix F for a breakdown of comments received

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Comments received from the general public during the consultation for the Kent Pharmaceutical Needs Assessment 2018

Comments have been cut and pasted directly from the responses as written without amending for spelling or grammar. Names and addresses have been removed to anonomise the information for general publication.

***see note at end**

Q12	Comments on the PNA documents	Type of response	Response from PNA steering group	
Shepway	You say transport links are good. They might be between large cengtres and larger villages, but not between small rural villages and either Doctors surgery or pharmacy - very limited rural bus services and very poor rural roads. Access to walk in centres or A&E sites are extremely restricted.	Access issues	Transport issues	Referred to KCC
Maidstone	Please don't close our Pharmacy. I use it to get my medication and my husbands, he has dementia and has had heart attacks so he has medication regularly. I don't know of another near and would have to go into town. A bus ride away.	Access issues	The PNA does not look at closing pharmacies. However it does identify when a pharmacy is esssential	
Sevenoaks	Categorisation of DG&SCCG areas as Gravesham or Swanley is rather random wth New Ash Green linked to Swanley and West Kingsdown to Gravesham. The opposite would be more logical.	Change to PNA	Amend PNA if appropriate	
Ashford	It is difficult to see from the area maps whether residents who live near the boundary of a map can in fact access pharmacies from a neighbouring map area. eg do residents of Appledore where the pharmacy has closed have access to a pharmacy in South Kent & Coastal area?	Change to PNA	KPHO are going to produce a map	Added to PNA
Swale	The map of population density in the countywide document had no legend.	Change to PNA	Already amended	
Canterbury	The overall feeling is that there will be areas in the future without adequate provision. Has there been any thought of providing a delivery service from a central location triggered by online prescriptions from the appropriate surgery?	Change to PNA	EPS is available in all pharmacies in Kent. Internet pharmacies are available for those that just want a delivery service without the face to face contact. Delivery is not part of the NHS contract so there may be a charge involved.	
Dover	To be honest, i am none the wiser. You have to legally review the document every 3 years, it is not due till next year 2019. (page 4)	Change to PNA	Thank you for the feedback. The PNA will be amended if appropriate	
Tonbridge and Malling	Surprised by some of the findings for over 60s.	Change to PNA	Thank you for the feedback	

Sevenoaks	I have been contacted by 'junk mail' of an organisation based in Leeds, said to be supported by the NHS, which has offered to supply my medication by post. I have ignored this as I wish to patronise my local pharmacy and cannot trust the mail to deliver my essential medication on time. The PNA does not seem to have mentioned the service they provide for dispensing the Flu Vaccine. The PNA does not seem to have noted the access provided by chemists which they provide to some members of the population with addiction problems who need a regulated/overseen supply of a controlled drug. Some community hospitals with no pharmaceutical resource sometimes need to obtain a drug for new or discharging patients potentially at 'unsocial times' and I feel access to a service of this kind needs to be borne in mind to prevent 'bed blocking'	Multiple comments	1. The contact by the internet pharmacy mentioned is currently being investigated nationally. 2. The provision of NHS Flu vaccinations is mentioned under Advanced services see pg 13 of Kent overarching document. 3.Provision to addicts is a PH service commissioned service and therefore not listed under PNA see pg 14 of Kent document. However such services are mentioned in the Local services appendix . 4. Pharmacies within Hospitals are not part of the PNA as they only supply patients within the hospital. These are also provided by the local hospital trust and have a 24 hr 7 day a week support.	
Maidstone	Very long document - as norm.	Negative feedback	Thank you for your feedback	
Thanet	long winded and excessive	Negative feedback	Thank you for your feedback	
Maidstone	The pharmacy in the supermarket works well for me I can do my weekly shop and collect any medicine that I require. However there is a pharmacy within walking distance which I use in an emergency. Generally I am not impressed with the competence of the staff at my regular pharmacy. It was good when run by the supermarket but since it has been transferred to a well know pharmacy company it is not as good.	Performance & quality*	Thank you for the feedback. Please see note at end.	Referred to NHS England & LPC
Dover	No account seems to be taken of how busy or efficient pharmacies are. Many pharmacy customers have mobility problems or are immunosuppressed making them vulnerable to common infections and it is not uncommon to have to queue up in a small shop for 15 minutes or so putting them at risk and tiring themselves out. It also seems quite ridiculous to me that when a pharmacy receives an electronic prescription from a surgery then it can take many days before that prescription is ready to collect even when all items are in stock or it is a repeat prescription.. Talking to pharmacist for advice in private is also a bit of a joke . Some seem to have a curtained area others a small cupboard with absolutely no soundproofing. Also on ad hoc visits the pharmacist is usually busy so may have to wait a considerable time before they are available.	Performance & quality*	Thank you for the feedback. Please see note at end.	Referred to NHS England & LPC
Dover	With the additional homes being built at Whitfield, provision for a pharmacy should have been included before building started.	Planning	Identified in PNA	
Canterbury	I feel there's a need for more pharmacies to be planned due to increased housing.	Planning	Identified in PNA	
Sevenoaks	The documents are very well written and cover all of the factors I consider to be important in the review of required services.The challenge is providing adequate services to rural communities.	Positive feedback	Thank you for the feedback	

Tunbridge Wells	They seem well balanced with good coverage of the subject matter.	Positive feedback	Thank you for the feedback	
Gravesham	Very informative and easy to read Need more 100 hour pharmacies and their addresses more publicly known	Positive feedback	Current 100 hour pharmacies are marked on maps with postcodes. Also in NHS Choices. New 100 pharmacies are no longer an exemption option in the regulations	
Sevenoaks	Looks well produced	Positive feedback	Thank you for the feedback	
Dover	No comment other than I am pleased to see that see that the issue of pharmacies is being considered.	Positive feedback	Thank you for the feedback	
Ashford	The plans for new development and the need for new services has been recognised. I wasn't clear whether there is a certain level of growth to force a new chemist facility. These need to be in same area as either a supermarket or dr surgery to allow ease of access. Regular chemist users are often in pain or in need and don't want to walk far.	Positive feedback	Thank you for the feedback. There is not a defined criteria for need for a new pharmacy . It it dependent on geography, demographics and the increase in population in a defined area. With the increase of use of EPS, pharmacies do not need to be close to surgeries and are more effective sited with shopping or leisure areas which people access regularly.	
Tunbridge Wells	They are clearly written and easy to understand	Positive feedback	Thank you for the feedback	
Tunbridge Wells	Easy to read & comprehensive	Positive feedback	Thank you for your feedback	
Sevenoaks	It all seems clear and appropriate, both in its planning expectations and the logical conclusions therefrom.	Positive feedback	Thank you for your feedback	
Swale	Appears thorough	Positive feedback	Thank you for your feedback	
Swale	Very comprehensive and thorough	Positive feedback	Thank you for your feedback	
Shepway	I am pleased to see that my local pharmacy (****) provides a number of services, most of those reported in the documents	Positive feedback	Thank you for your feedback	
Dover	Consideration should be given to the use of mail order pharmacies for repeat prescriptions, as when the system is working, it works well and medication is received within a few days. (see further comments ref EPS system in Q 13)	System issue	EPS is available in all pharmacies in Kent. Internet pharmacies are available for those that just want a delivery service without the face to face contact. Delivery is not part of the NHS contract so there may be a charge involved.	
Swale	They all mention public transport. We already know that KCC is looking at curtailing bus services. What hasn't been mentioned is the effect of Universal Credit, and benefit sanctions which will affect people's ability to pay for public transport. Also many disabled people are losing their Motability vehicles but cannot use public transport. People on zero hours contracts, and those with small earnings on self-employment will both have fluctuating incomes and may also find accessing pharmaceutical help difficult.	Transport issues	Thank you for your feedback	Referred to KCC

Q13	Comments about access and services	Type of response	Response from PNA steering group	
Sevenoaks	Access to 100 hours pharmacies from New Ash Green is very poor for people with no personal transport.	Access	Nearest 100 hour pharmacies are in Dartford, Gravesend and Swanley.	Forward to KCC
Tunbridge Wells	1. Lack of out of hours pharmacies in our area. 2. No prescribing pharmacies in our area, nearest Medway.	Access	There is one 100 hour pharmacy in middle of Tun Wells and one in nearby Tonbridge. Pharmacy in Medway which prescribes for its patients is a private service not NHS.	
Tonbridge and Malling	I find the availability of the dispensing pharmacy a major boon, this has been the case for the past 30+ years - from being a mother of young children to a pensioner and grandparent.	Access	Positive feedback	
Swale	Although I usually walk to the pharmacy, I do take the car if the visit is part of a longer outing. For that purpose, the presence of the small car park nearby is very useful. Parking on the A2 is a hazard to all.	Access	Parking is common issue	Pharmacies list their car parking facilities on NHS Choices
Ashford	Offering extra services at the pharmacies is useful. Being able to get in and move around (from a disabled point of view) is clearly important. Having somewhere to sit whilst waiting is also advantageous. Parking needs to be close by so that people can nip in.	Access	Parking is common issue. All pharmacies should have disabled access and private areas	Pharmacies list all their facilities on NHS Choices
Dover	****** do a delivery service so this may well be a better solution to providing a new pharmacy in Whitfield, or, perhaps convince *** Pharmacies to locate a place in Whitfield.	Access	Delivery services are not part of the NHS contract and are provided at the discretion of the pharmacy. With the recent reduction of overall funding to community pharmacy, many now have to charge for this service. Whitfield area is identified in PNA	
Dover	re TRansport: In the documents this is considered to be GOOD. However this does NOT take account of the recent withdrawal of some local bus services, in particular that serving Staple Village	Access	Rural area	Forward to KCC
Dover	Too many pharmacies in close proximity to each other .	Access	The PNA looks at access.	
Shepway	Apart from public transport and rural roads, access to dispensing doctos surgery is good - is open when doctors surgery is open.	Access	Rural area	
Dover	The pharmacy in our local minor injuries clinic and emergency out of hours doctors, Buckland (Laughably called a hospital), was recently closed. This has meant that anyone accessing Buckland out of hours, or by public transport or on foot (which is many as the Dover has 50% of households with only one car), has to travel from Buckland with their prescription to the nearest pharmacy. If it is out of hours, the nearest pharmacy open is at Whitfield which is not accessible easily without a car.	Access	The dispensing service at Buckland Hospital was provided by the Hospitals Trust and was only for patients being treated by the hospital. There is a 100 hour long opening pharmacy in Folkestone Road Dover which is close to the station.	
Maidstone	I don't know of another near and would have to go into town. A bus ride away.	Access	Maps showing all pharmacies in a locality are available alongside the PNA and are also available on NHS Choices. The PNA recommends that where pharmaceutical services are essential that they are maintained.	

Thanet	All pharmacists lie. YES lie. I require a particular brand of drug , when I cannot get it I am told by every pharmacist that all brands are exactly the same. WRONG. The active drug ingredient has to be the same but there are not any strict controls on the make up of capsules or pill coatings and some will dissolve quicker and some slower and in some cases patients can react to the material in the capsule or pills. In my own case the Ramipril capsule actually has an ingredient that causes cancer. Unfortunately we know that drug companies control the whole system. The medical professions state that they want to find out what causes dementia etc well it is mercury and aluminium all which can be found in vaccines and drugs. There is also ketamine, the horse tranquilliser, which is banned in the sensible countries but used on infants in dental sedation clinics in the UK. I could go on but I know that who ever reads this will deny my claims even though the CCG in Thanet did admit that I was right 3 years ago.	Performance & quality*	Negative feedback.	Referred to NHS England & LPC
Ashford	I choose to use a pharmacy which is not the closest in terms of travel time because the pharmacist takes the time and trouble to get to know his customers. This is important when seeking his advice (thereby avoiding the need for a GP appointment).	Performance & quality*	Positive feedback	Referred to NHS England & LPC
Gravesham	Being able to use the same pharmacy close to my doctor's surgery means I can request specific brands of usual medications and I can trust the health advice offered by the pharmacist, in private if necessary.	Performance & quality*	Positive feedback	Referred to NHS England & LPC
Sevenoaks	My doctor's surgery has made it very straightforward to obtain prescribed medicines, both on-line (including self ordering) and by phone (repeat/batch prescriptions). My local pharmacy is superb in being able to offer advice on the medicines I am prescribed and potential interactions with other medicines I may need to treat e.g. minor ailments (cough's etc). The pharmacists on duty provide more general health advice in a highly professional manner such that I am confident they know what they are talking about. This is very important given the modern trend of 'Googling it'.and clearly	Performance & quality*	Positive feedback	Referred to NHS England & LPC
Tunbridge Wells	I use ***** because they are able to give additional help when I have a minor problem, especially as they are able to look at my record of what they prescribe for me and check there will not be a clash with medication.	Performance & quality*	Positive feedback. All pharmacies are able to provide this service	Referred to NHS England & LPC
Gravesham	The pharmacy I use is very overworked and sometimes it involves a long wait to get the medication. This means that the pharmacist does not have enough time to offer advice and recalls to discuss taking the correct medication and explain what it is for have been discontinued.	Performance & quality*	Negative feedback	Referred to NHS England & LPC
Tunbridge Wells	It would be useful if all pharmacies would offer blood pressure testing	Performance & quality*	Blood pressure testing is not an NHS service . However many pharmacies offer it as a private service or as part of healthchecks	Referred to NHS England & LPC
Canterbury	Currently I enjoy an excellent service in Herne Bay	Performance & quality*	Positive feedback	Referred to NHS England & LPC

Tunbridge Wells	I use a local pharmacy other than *****. This is because the local ***** pharmacy is inefficient. They do not seem to have a regular pharmacist and they always seem to be under pressure. The queues in there are bad. I use a local pharmacy where I may have to wait a short time, but where they have what I am prescribed and will make an effort to put things right if there is a problem. They may be a bit old fashioned, and their systems may not be state of the art, but I trust them. Glitzy TV advertising does necessary equate to a worthwhile service.	Performance & quality*	Negative and Positive feedback	Referred to NHS England & LPC
Thanet	We have the use of an excellent pharmacy at *****	Performance & quality*	Positive feedback	Referred to NHS England & LPC
Tunbridge Wells	I have no access to a dispensing doctor's surgery. If the Pharmacist is not too busy or have no idea or even better, talks to you on the shop floor in front of everyone, literally what general advice?/ see above. My doctor forgets my name, literally.The pharmacists shrugs her shoulders on waste medicines, the other pharmacy is like a cattle auction market, the other one is too elitist and the other one.....MUR checks are done at my preferred pharmacy by the locum, never the pharmacist	Performance & quality*	Negative feedback	Referred to NHS England & LPC
Tonbridge and Malling	I mostly use my doctor but the pharmacy I use has been really helpful when I didn't want to have an appointment but needed something that would help me without causing me problems. As I keep my repeat prescriptions with **** in Tonbridge, I can phone for a repeat and if they don't have the script they will request it for me from the doctor's. They've been very helpful with this and also when I needed something for muscular pain taking into account that I cannot take Ibuprofen. They also check with me that I know how to take prescriptions that they can see from my records are not my regular items. Sometimes they conduct their own surveys on their services. I do order some items from my doctors online and I find being able to access my records at ****** group very helpful.	Performance & quality*	Positive feedback. All pharmacies can provide advice on long term conditions and with the patients' consent access their Summary Care Record to check for allergies and current drugs prescribed.	Referred to NHS England & LPC
Tunbridge Wells	**** is an excellent pharmacy , always very helpful on the phone or in person. The help with information about medication and all aspects of my health.	Performance & quality*	Positive feedback	Referred to NHS England & LPC
Tunbridge Wells	Pharmasist excellent at providing information & advice. Reviews undertaken to check if happy with medication.	Performance & quality*	Positive feedback	Referred to NHS England & LPC
Sevenoaks	Very impressive advice from ***** Sevenoaks about pain-killers recently; most considerate and thoughtful response to my question. Always well received, efficiently served and supported in the **** pharmacy. An outstanding service!	Performance & quality*	Positive feedback	Referred to NHS England & LPC
Swale	When I was prescribed new medication, the pharmacist took me to a separate room and explained how it worked and what to do if any problems. Didn't expect it but was pleased that he was so pro-active.	Performance & quality*	Positive feedback	Referred to NHS England & LPC

Maidstone	I am very disturbed that in Maidstone we appear to be putting all our eggs into the **** basket. My experience of this pharmacy chain (in particular the **** branch) is dire. On a number of occasions they have made mistakes in my husband's prescription and do not appear to be particularly interested or concerned. For five years my husband's medication has been processed by the **** Pharmacy in **** , who are excellent. For some reason I am being told that "whoever" will not pay the**** Pharmacy to dispense my husband's Nomad packs, despite my GP agreeing. I have had to very reluctantly return to ***** this time. **** do not appear to have enough staff and in **** there are very long queues to be served (45 minutes). The **** Pharmacy provide an excellent service and have never made a mistake with my husband's prescription. I feel **** have a monopoly with the NHS and give a very poor service. Your comments on situation with the ***** doing Nomad packs would really be appreciated as I am the person in the middle who is being told conflicting stories about Nomad service. Thank you.	Performance & quality*	Positive & Negative feedback. Provision of medication in Nomad/dossette boxes is not an NHS service and although it has been commissioned by CCGs in some areas, this is not the case in West Kent. Therefore pharmacies either fund the service themselves or have to ask the patients to contribute. With the recent large reducton in overall funding to community pharmacies, many are no longer able to provide this service free of charge. This patients details (supplied) have been passed onto NHS England to reply to her concerns.	Referred to NHS England & LPC
Sevenoaks	Most usefully most of my prescription are handled electronically between surgery and pharmacy. The advicxe is vert useful that the pharmacist gives including reviews of prescribed medicines. Mt=y pharm,acy offers a number of useful tests - e.g. Cholesterol, blood pressure, mini health assessmnets which take [ressure off the surgery.	Performance & quality*	Positive feedback. The electronic prescription service is available at all pharmacies.	Referred to NHS England & LPC
Swale	Sometimes Pharmacy is very busy and I worry that mistakes could be made	Performance & quality*	Negative feedback	Referred to NHS England & LPC
Shepway	I very much appreciate the services available at the pharmacy. Some, automatic repeat prescriptions, medication review, new medicatio were all offered by the pharmacist, without my having to ask. She is very helpful with other queries, either general or specific. On occasions when she does not immnediately know the answers, she will take time to find out. When new regulations concerning certain controlled drugs and driving were introduced, she was extremely helpful in making sure that I had exactly the information needed	Performance & quality*	Positive feedback	Referred to NHS England & LPC

Thanet	There was an occasion where I had to complain to the surgery about over-dispensing, ie producing all the items on my list though not requested. The surgery said that they had not prescribed them and that it was a ruse by the surgery to increase sales, that they did not suffer as a surgery but the CCG did.	Performance & quality*	Negative feedback	Referred to NHS England
Gravesham	I use **** pharmacy near to me and I also use**** pharmacy when I visit Kings college hospital. My local one always seems to be understaffed and slow to complete prescriptions . However it is nowhere near as bad as the Kings one which can mean literally waiting hours for prescriptions. It has recently been moved out of the hospital corridor into a separate potacabin type building and must have been designed by a committee! No thought has gone into the waiting areas dispensing areas it is awful.	Performance & quality* - Out of area	Negative feedback	Referred to NHS England & LPC
Canterbury	Parking can be difficult but it is outweighed by the professional service given	Performance & quality*/Access	Parking is a common issue	Pharmacies list their car parking facilities on NHS Choices
Tonbridge and Malling	The***** pharmacy attached to *****s operates very well and is particularly useful because it covers many 'out of hours' periods in the week and weekends. There have been some problems with parking (which I do not use) though observation suggests that these have been overcome. Difficulty in supplying particular medicines can be a problem but possibly no more than with other pharmacies.	Performance & quality*/Access	Parking is a common problem. Medicine shortages is a national issue for all pharmacies at the moment which is being addressed by the Dept of Health and Social Care.	Pharmacies list their car parking facilities on NHS Choices
Maidstone	It is very important for me to be able to order my husband's 18 medications online and have them delivered regularly. He is severely disabled and I am therefore housebound as his carer.	Performance & quality*/Access	Delivery is a private service	Referred to NHS England & LPC
Swale	It's very difficult for people on the Isle of Sheppey in remote villages to access pharmacies, also those anywhere on a low income who have to pay to use public transport. The advice offered by pharmacies is excellent PROVIDING they know what medication the enquirer uses. I've been referred back to my GP on occasion even when I've given details of my medication. I haven't asked for health advice, only about medication (both prescribed and off prescription).Pharmacies are often under great pressure from people trying to collect their prescriptions, and some seem permanently short staffed, so you can't go in and immediately expect advice. I've spoken to several people who are involved in health issues. Most of them were unaware of this consultation. I also had comments that people had lost faith in KCC consultations because they felt it was a paper exercise that didn't impact on decision making.	Performance & quality*/Access	Negative and Positive feedback. Transport issues	Referred to NHS England & LPC. Comments about consultation and transport issues referred to KCC
Thanet	i do think the rule of only have a month;s supply of regularly, taken till death medicines is a bit restrictive especially if ony 1-2 tablets are taken per week. means an excessive use of plastic bottles(have to have mine dispensed in bottles due to lack of strength in hands) i understand with acute illness treatment it is reasonable and more controllable but if like me i have 7 chronic illnesses, remembering which one of 20+ medications is going to run out when is tedious and having 4 weeks supply whereas 3 months would at least cut down on the traffic and excessive visits and on bags, bottles and time	Systems issue - Repeat prescribing services	Issue with repeat prescription service	Referred to CCG

Dover	Point #1: There is no way you can check to see whether the prescription is ready, before you journey to the pharmacy (wherever it is.) Before all prescriptions had to be made through the surgery (implemented mid 2016) the pharmacies (****, **** and no doubt some of the local chemists) ran a repeat prescription service, on the behalf of (and agreed with) the patient). This was extremely useful as the pharmacy would ensure the repeat prescription was received from the Surgery, and all items dispensed prior to sending a confirmatory text for collection to the patient. However, Since the change, and although you can order electronically through the doctor, it seems to be in the lap of the gods as to where the prescription goes. Many wasted journeys to date, as either the prescription has not been received, or sent to the wrong pharmacy. **** have also indicated to wait over a week to ensure dispensing is complete (which seems ridiculous in this day and age). Also, time wasting for GP's/surgery as prescriptions have had to be requested again, or GP visit has had to be made for urgent prescriptions (ie likely to run out of medication). Point #2: **** Dover does a periodic medication review, which does not seem to be referenced in the document.	Systems issue - Repeat prescribing services	1-Issues with repeat prescription service which was implemented by the CCG. 2- Reviews mentioned are called MURs. All pharmacies can provide this service - see documentation and maps	Referred to CCG

Q14	Comments on EqIA	Type of response	Response from PNA steering group	
Thanet	If GP`s get paid to prescribe more some patients will try the quick fix and will not do the sensible thing in selecting a proper diet and exercise. We all know that diabetes can be controlled without drugs by diet and exercise. I would like to see less movement of services to the private sector where the only real governing factor is profit.	Query	Check and amend EqIA if appropriate	
Shepway	have same conclusion	Positive	Thank you for your feedback	
Sevenoaks	A well constructed document	Positive	Thank you for your feedback	
Tunbridge Wells	Apart from 'poor rural' areas most places are well covered.	Positive	Thank you for your feedback	
Swale	Seems OK to me.	Positive	Thank you for your feedback	
Canterbury	It's a hard area in which you try and make pharmacies accessible to everyone. But hopefully home delivery helps	Positive	Thank you for your feedback	
Canterbury	It appears not to affect anyone unfairly	Positive	Thank you for your feedback	
Dover	Does the EQiA take in the age of the population centres of Wards?	Query	Check and amend EqIA if appropriate	
Dover	No additional comments	Positive	Thank you for your feedback	
Tunbridge Wells	Saying all the right things, now let's see how well it implemented	Positive	Thank you for your feedback	
Tonbridge and Malling	No comments	Positive	Thank you for your feedback	
Sevenoaks	Sorry, not read this part.	Not read	Thank you for your feedback	
Swale	There is little point in the Government/NHS nationally paying for Media adverts saying in effect, don't bother your GP, talk to your local pharmacist, if you are going to start shutting our local pharmacists. You can't have it both ways.	Query	Check and amend EqIA if appropriate	
Thanet	not read it but see notes to above, chronic illness patients do not want to keep going to doc for repeats and pharmacy's every few weeks	Not read	Thank you for your feedback	
Swale	NO views		Thank you for your feedback	
Swale	Increase in House Building on Sheppey could have as negative effect on pharmacy efficiency	Not EqIA	Thank you for your feedback	
Shepway	I have read the EqIA and agree with its content. In my view, all necessary areas have been cover entirely satisfactory	Positive	Thank you for your feedback	
Swale	You don't seem to have taken into account those disabled people who live at home, have lost their Motability vehicle and can't use public transport. There is also an issue that KCC, seeing Councillors are predominantly Tory, ought to have more concern for the poorest people this Government is pushing into poverty and destitution. The Welfare State and the NHS are being destroyed and the motto seems to be 'Greed before Need'	Query	Check and amend EqIA if appropriate	

Comments received from professionals during the consultation for the Kent Pharmaceutical Needs Assessment 2018

Comments have been cut and pasted directly from the responses as written without amending for spelling or grammar. Names and addresses have been removed to anonomise the information for general publication.

Q4a current provision of services	Comments by responders	Type of comment	Response by PNA steering group
Health care professional	All provisions are adequate or good, which is great to read.It's a shame that all services provided are not recorded in the PNA as it would be good to see which Pharmacies are providing which services to the public so we could see what service is needed.	Services	Local pharmaceutical services are not part of the PNA. However we are planning to list them alongside the PNA for completeness.
A neighbouring Health and Wellbeing Board	There is a clear summary of overall provision. There is a very good explanation of controlled localities and rural deprivation. The document acknowledges that the maps need updating. The document recognises the importance of 100 hour pharmacy provision n.b. the 100 hour pharmacies appear in the legend but do not appear on the Kent wide map.	Positive	Lack of completeness of legend had already been noted and changed
A local dispensing doctor's practice	The current pharmacy provision for the population in our local practice area is meeting local need. The 3 practices in the *****area provide efficient and effective dispensing services as identified in CQC reports and patient feedback.	Positive	Thank you for your feedback
A local Clinical Commissioning Group	From analysis is adequate pharmaceutical provision in Dartford Gravesham and Swanley area, which neighbours NHS Bexley CCG	Positive	Thank you for your feedback

A local Clinical Commissioning Group	The comment: “Therefore pharmaceutical services are mainly good across the area from Mondays to Fridays and we do not need any more providers in the area except 1) There will be a need for pharmaceutical services in the Leybourne Chase development and in the Peters Village development, within the life of this PNA. 2) Services are poor within the smaller villages on Saturdays and all villages on Sundays. 3) Much of the current and proposed development in the area will result in the landscape changing from rural to urban. This may have an effect on current provision in these areas. 4) Future developments in Paddock Wood and Fort Halstead need to be reviewed regularly” I tend to agree with the statement made above. With respect to point 3, we have to be particularly mindful of the current medical and pharmaceutical service provided by the local practices and the impact on their financial viability in the introduction of a new community pharmacy. This would leave patients in a vulnerable position trying to register with a practice which could be a fair distance from their home. Some patients will be housebound hence making them more vulnerable and possibly leaving them without a GP.	Access	Affect on current providers already stated in PNA. The PNA is not directed to assess the viability of any pharmaceutical services. There is no mention of closure of any pharmaceutical services within the PNA.
A local dispensing doctor's practice	I have read the document and looked at the information regarding the area in which I practice, and believe it to be accurate.	Positive	Thank you for your feedback
A local dispensing doctor's practice	In the covering document it highlights that there is a good level of pharmaceutical services in our area with a high proportion of dispensing doctors and community pharmacies. Page 12 in the PNA for Kent document lists Essential Services provided by community pharmacies. However, these are also all provided by ******: Dispensing of medicines and appliances Repeat dispensing Waste management Public health campaigns Signposting Support for self-care Clinical governance Delivery services We annually participate in the DSQS and undertake Medicines Reviews for at least 10% of our dispensing patients. Most of the local community pharmacies will also, upon request, deliver to our patients	Quality & performance	The PNA does not assess either the quality or the performance of any pharmaceutical providers and is not directed to take this into account when assessing ACCESS to services. This is the responsibility of the relevant organisation which manages/oversees these contracts.
A local district or borough council	Whilst the reflection of current provision seems to be accurate from my current knowledge, I do not have detailed enough knowledge of the finer details of provision to be able to respond with authority.	Positive	
Q 5a Current needs of patients	**Comments by responders**	**Type of comment**	**Response by PNA steering group**
Health care professional	It confirms it is adequate and good in comparison of how the population are.	Positive	Thank you for your feedback
A neighbouring Health and Wellbeing Board	As commented by the Members there needs to be further information from the consultation about how the needs of hard to each groups will be met. How will a representative sample of the population be obtained by the consultation?	Query	Check and amend in the EqIA
A local Clinical Commissioning Group	Your analysis seems to reflect the needs of your population and the new developments in the area	Positive	Thank you for your feedback
A local Clinical Commissioning Group	As Q4a	Access	As Q4a

A local dispensing doctor's practice	Whilst I agree that providing pharmaceutical services for the rapidly increasing population south of Maidstone along the Sutton Road corridor needs to be born in mind, the development of any new pharmacy within the practice areas of ******would have grave implications for the viability of both practices. Dispensing income in both cases provides the vast majority of profit, and neither practice would be viable without this. Regrettably our only possible response if this were to happen would be to close our practice or hand in our notice to the CCG, potentially leaving 6000 patients without a GP, at a time when GP recruitment is known to be difficult or impossible. This sounds drastic but is a matter of fact. I hope that this can be born in mind when considering the local population needs. Indeed the whole purpose of the Doctors Dispensing Scheme is to allow rural practices to be viable, and this must be born in mind when any future changes in pharmacy provision are made.	Viability	Changes to rural areas are assessed by rurality review not PNA. The PNA is not directed to assess the viability of any pharmaceutical services. There is no mention of closure of any pharmaceutical services within the PNA.
A local dispensing doctor's practice	There are sufficient pharmaceutical services available from Monday to Friday, provided by both dispensing doctors and community pharmacies in our area. This practice has never received a patient complaint regarding lack of provision or at weekends. However, we understand that needs do change. We regularly audit the service we provide and we are currently looking at extended hours and external collection points for those patients who commute or who cannot visit the practice during the week (Pharmaself 24). From previous audits, we identified that, due to the rural locality of some of our patients, some would benefit from a delivery service. This has been in place for over 3 years and has been very successful, having received 100% satisfaction in our latest patient survey. This service includes the use of an appliance contractor to deliver dressings and appliances to non-dispensing patients. This has significantly reduced the number of wasted visits by our district nurses. In addition, we make prescribing savings by only supplying the number of dressings that are required, and by monitoring requests. We robustly believe that the pharmaceutical services in our locality are at least adequate and there is no rationale to identify need for additional pharmaceutical services.	Quality & performance	The PNA does not assess either the quality or the performance of any pharmaceutical providers and is not directed to take this into account when assessing ACCESS to services. This is the responsibility of the relevant organisation which manages/oversees these contracts.
A local district or borough council	The population growth reflects the current areas of growth in the borough, most notably Finberry (Weald East) and Tenterden (Tenterden South) and Repton (Godinton) wards.	Positive	Data came from this council.
Q6 any other comments	**Comments by responders**	**Type of comment**	**Response by PNA steering group**
A local Clinical Commissioning Group	CCG commissioned services listed separately	Services	Local CCG services are not part of the PNA. However we are planning to list them alongside the PNA so will amend where necessary.

A neighbouring Health and Wellbeing Board	The comment on P.9 para 3 about care homes may need rewording. This is a very general statement. Whilst care homes will receive deliveries from contractors, they do need regular medicines management advice from local pharmacies. They also are in receipt of interim prescriptions on a regular basis.	Access	Most of the Care Homes in Kent have a contract with a multiple national provider. All advice is part of this contract.
A local dispensing doctor's practice	These comments are put forward by **** at ****.The *** is a dispensing practice in a rural area and we have 3550 patients registered with us , dispensing to 1800 patients. We are members of The Dispensing Doctors Association and achieve the targets necessary for the Dispensing Services Quality Scheme for NHS West Kent CCG. We strive to maintain high quality dispensing services with standard operating procedures to ensure safe and responsive practice.The practice has robust procedures to monitor any dispensing errors or failures in service and respond to these as an organisation to improve procedures and patient safety. This was recognised by the CQC inspection undertaken at the practice in December 2017 and mentioned in the CQC report. The rating for all parameters in the CQC report was good.Quote from CQC report: named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). Dispensing stock checks were conducted every three months ".Close professional relationships are maintained with our neighbouring practices, ******* . Regular meetings are held between these practices to share best practice and learning from significant events, including dispensing subjects. In total these 3 practices provide services for around 9,500 patients. I agree with my colleagues who have commented that any threat to dispensing services provided by these practices would have grave consequences for the viability and sustainability of their business models and thus could threaten both the pharmaceutical services and also the general practice services to this population. We strongly believe that there is no unmet pharmaceutical need in our area currently and that future need can be met using current pharmaceutical services and services from the dispensing practices.	Quality & performance	The PNA is not directed to assess the viability of any pharmaceutical services. There is no mention of closure of any pharmaceutical services within the PNA. The PNA does not assess either the quality or the performance of any pharmaceutical providers and is not directed to take this into account when assessing ACCESS to services. This is the responsibility of the relevant organisation which manages/oversees these contracts.

A local Clinical Commissioning Group	We feel the current provision of pharmaceutical services is good and covers the pharmaceutical needs of the population in West Kent. The provision of '100 hour' pharmacies needs to be maintained and may need to expanded in some areas in West Kent i.e. opening on Sundays and evenings . The dispensing practices in rural/ controlled need to be preserved as the introduction of a news community pharmacy in the rural area particular the Weald area is likely to destabilise the medical services / practices in the area. Any application must demonstrate that it can improve on the availability of services across the specific area without destabilising the current providers.	Access	The PNA is not directed to assess the viability of any pharmaceutical services. There is no mention of closure of any pharmaceutical services within the PNA
A local dispensing doctor's practice	This document has been completed by*****senior GP at *****. We are a dispensing medical practice and have a practice population of 3600 patients. We are classed as a rural general practice and have highly satisfactory quality of outcomes from CQC (Care Quality Commission) as well as patient survey and results. We are members of The Dispensing Doctors Association and also take part in Dispensing Services Quality Scheme for NHS West Kent CCG. We strongly believe that upon completion of this questionnaire we agree that there is no existing unmet need for pharmaceutical services in the area or any future unmet need over and above the dispensing services we offer from our local practice. We would also like to underpin this statement by supporting the two other local dispensing practices in our local area of *****and ******who both dispense to local patients. The total number of patients registered at the three practices is between 9-10,000 patients. For purposes of clarity and demonstration of intent, we have listed and documented objective evidence to support our dispensing services. We would like to confidently state that dispensing services at our practice are of the highest quality and we pride ourselves on excellent customer services, safe prescribing and dispensing and quality assurance. We would also like to extend this belief to the two local practices stated previously as the senior GP completing the questionnaire document has worked extensively in both environments and in a position to report confidently. We have discussed in detail the consultation and pharmaceutical needs assessment both with the Local Medical Council as well as the Dispensing Doctors Association Board. We do believe that any threat to dispensing accreditation and abilities at our practice, as well as those of our neighbouring practices, would define grave consequences for viability and sustainability of the business models. Thus this would directly threaten the ability to service and provide primary care services and medical cover for 3600 local patients as well as globally up to 10,000 patients in the locality. This undoubtedly signals as significant concern for general practice services in the area should dispensing abilities become compromised. In august 2017 we undertook our first CQC inspection at the practice. We achieved a standard of 'Outstanding' across the domains due to practice quality. The inspection team comprised of a chief	Quality & performance	The PNA is not directed to assess the viability of any pharmaceutical services. There is no mention of closure of any pharmaceutical services within the PNA. The PNA does not assess either the quality or the performance of any pharmaceutical providers and is not directed to take this into account when assessing ACCESS to services. This is the responsibility of the relevant organisation which manages/oversees these contracts.

A local dispensing doctor's practice	We have a robust Repeat Prescribing Protocol to monitor patients' medication and use regularly. This protocol has been highlighted by the West Kent Clinical Commissioning Group as being a model standard. This has been adapted and implemented by other practices. Our latest Care Quality Commission report rated this practice as Good in all areas and highlighted some areas of excellence. In particular, our management and monitoring of significant events was praised. We have a very low rate of dispensing errors, due to highly trained, qualified and effective team and individuals. We regularly review our staffing levels with workload and patient list size to ensure that we have sufficient staff to maintain a safe and efficient service. Dispensary regularly monitors elderly and vulnerable patients in conjunction with our volunteer delivery drivers, e.g. living conditions, general health and well-being, and any concerns are reported to our GPs, District Nurses and/or Health & Social Care Co-ordinator.	Quality & performance	The PNA does not assess either the quality or the performance of any pharmaceutical providers and is not directed to take this into account when assessing ACCESS to services. This is the responsibility of the relevant organisation which manages/oversees these contracts.
A local district or borough council	Good morning There is great concern about the number of new build with the lack of services for medicines dispensing in and around leybourne west malling and wider area as the local chemist cannot process or dispense in a reasonable time due to excess demand or lack of stock requiring multiple visits. When an application and consequent appeal we were told there was enough capacity this is not the case and some review is necessary. I do hope this is helpful	Access	This area is currently rural. Rurality review already ongoing

A local district or borough council	The Council welcomes the focus on future housing developments to project future need. These developments are highlighted within the emerging Local Plan and those developments which are either already underway or have outline planning permission. Chilmington Green is the largest housing development in the borough with 5,750 homes expected to be completed over a period of about 20 years. House building will start on site in 2018 with first occupations in 2019. The council is working with the lead developer, Hodson Developments to set up a community management organisation which will adopt and own all community assets (excluding schools and highways). This portfolio of assets includes a community hub to be built and open by the occupation of 1800 homes which will include an eight GP practice (or equivalent). The council is working with many partners (through a working group) to bring forward this facility which will be located at the heart of the district centre. The Group includes, the Ashford CCG and KCC (including Public Health). Clearly, given the Hub will not be open for five-eight years, there is a need for early services on site to provide for the community and/or signposting to existing facilities which have the capacity to support new residents. Early provision is also being discussed and could consider early pharmacy provision too. Given the central location of the community hub and the opportunities this provides to deliver a range of services and facilities from one central location, the council and its partners would welcome a discussion to look at possible sites for a a pharmacy within the district centre and agree the best location given the uniqueness and high quality approach which is being applied to Chilmington Green. A discussion about the type of pharmacy which could be provided at Chilmington and its associated opening hours would be helpful. The opportunity to have other service provisions from a pharmacy in Chilmington Green (potentially in partnership with the GP surgery) such as public health services, non NHS and private services and the chance to create a Healthy Living Pharmacy would be welcome. The council would welcome further information on the provision of a pharmacy at Repton, given there is land set aside for health service provision.	Access	Already identified in PNA. PNA will be amended if appropriate

Lay member of PHE HLP task Group. Personal response as this is my home county	1.) There is scant reference to the need for Pharmacy to engage with Parish Councils in respect of their Neighbourhood Plan which after local referendum becomes part of the LA plan. The Pharmacy is an infrastructure on register of asset like the Post Office, School, Library etc The adoption of a neighbourhood plan delineates the area for future house building.etc. 2.) Some of the documents refer to a five year projection while others take a longer term view. This is complementary to the Neighbourhood Plan. 3.) In view of the proposals to take some items out of the prescription list in favour of OTC advice and recommended purchase, .these should be the same in all CCG's (there may be areas where discretion to provide additional items could be argued for) The recognition (it is shameful that 75 since Beverage we are still discussing one of his "Five Giants" that poor Health and deprivation go hand in hand will not be helped for instance for someone on benefits. Removal of a "Free" medication is a direct loss to their available income for rent, heating diet etc. The Cabinet Papers | 1940's Origins of the Welfare State 4.)The progress to HLP accreditation is slowed by multiple commissioners excluding or having different service provision. Policy is to accelerate this with provision of all Framework Services. Minor Ailment P& GSL medication. 5.) I either missed or there is little mention of proactive patient /practice engagement – the main plank of HLP Level 2,- This could be done through PPG awareness meetings or presentation to local voluntary sector organisations, or Newsletter. How is "One You" to be implemented? 6.) One of the biggest difficulties in achieving HLP Accreditation I see is the lack of floor space in many Rural Pharmacies and the difficulty of maintaining a viable business as foot fall decreases I see no proposals to help such businesses. 7.) There are paragraphs that are repeated in each CCG statement with more or less the same meaning..Care Homes for instance sure it is only necessary to show a variation from the overarching document. 8.) I did not find any reference to Gypsies and Travellers or foreign language services for ethnic communities.9.) There are recommendations in each CCG statement. I feel there should be priorities set for the next PNA period and a statement on those set in the previous PNA10.) I hear there are proposals to withdraw on line repeats due to over ordering	Multiple comments	Many of the comments made by this responder are important and relevant but are separate from the purpose of the PNA where the remit is "Can patients actually access in Kent, the pharmacetical services defined in the regulations. The Steering Group thanks the responder for their very detailed feedback which they will consider individually, discuss with the responder if necessary and refer onto the relevant organisation. Changes to PNA will be made where appropriate

Q7 EqIA	Comments by responders	Type of comment	Response by PNA steering group
A neighbouring Health and Wellbeing Board	As commented by the Members there needs to be further information from the consultation about how the needs of hard to each groups will be met. How will a representative sample of the population be obtained by the consultation?	Query	Check and amend in the EqIA
A local dispensing doctor's practice	Please see comments listed in question 6 reply with reference to impact on patients and staff with any threat to dispensing at the surgery	Re dispensing services	The PNA is not directed to assess the viability of any pharmaceutical services. There is no mention of closure of any pharmaceutical services within the PNA
A local dispensing doctor's practice	Only what I have said in Q5a, qualified further by the fact that our patients are extremely satisfied with the service that hey are getting at present, with both ***** scoring repeatedly amongst the highest in the country in the National GP Survey. Dispensing contributes significantly to the high levels of satisfaction.	Performance & Quality	The PNA does not assess either the quality or the performance of any pharmaceutical providers and is not directed to take this into account when assessing ACCESS to services. This is the responsibility of the relevant organisation which manages/oversees these contracts.
Lay member of PHE HLP task Group. Personal response as this is my home county	I did not find any reference to Gypsies and Travellers or foreign language services for ethnic communities.	EqIA	Check and amend in the EqIA

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By: Graham Gibbens – Cabinet Member for Adult Social Care

Deborah Stuart-Angus – Independent Chair, Kent and Medway Safeguarding Adults Board

To: Health and Wellbeing Board – 21 March 2018

Subject: Kent and Medway Safeguarding Adults Board Annual Report April 2016 – March 2017

Classification: Unrestricted

Summary: This report introduces the Kent and Medway Safeguarding Adults Annual Report April 2016–March 2017, which details the work of the multi-agency partnership and how it managed safeguarding adults issues in 2016-2017. The report provides safeguarding activity information and also contains key statements from partner organisations regarding how they dealt with safeguarding issues in their respective agencies and outlines key priorities for the year ahead.

Recommendations: The Health and Wellbeing Board is asked to note the progress and improvements made during 2016-17, as detailed in the Annual Report from the Kent and Medway Safeguarding Adults Board and note the 2016-17 Annual Report attached.

1. Introduction

1.1 This report presents the 2016-2017 Annual Report produced by Deborah Stuart-Angus, the Independent Chair of the Kent and Medway Safeguarding Adults Board (KMSAB) and endorsed by members of that Board.

1.2 Following the Care Act 2014 Safeguarding Adults is now a statutory responsibility for all Agencies, with Local Authorities taking the lead. Safeguarding continues to be the major priority of the Adult Social Care and Health Directorate. In meeting this responsibility, it is essential that the Directorate plays a key role in the workings of the Kent and Medway Safeguarding Adults Board.

1.3 The Kent and Medway Safeguarding Adults Board works to make sure that all agencies are working together to help keep Kent and Medway's adults safe from harm and to protect the rights of citizens, in line with the Care Act 2014 and the Mental Capacity Act 2005.

1.4 The enactment and implementation of the Care Act 2014, placed Safeguarding Adults Boards on a statutory basis from April 2015. The Care Act (14.116) states that the following organisations **must** be represented on the Safeguarding Adults Board:

- Local Authority
- Clinical Commissioning Groups in the Local Authority's area
- Police

1.5 The Care Act (14.10) also requires that each Local Authority **must**:

- make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect , and if so, by whom
- set up a Safeguarding Adults Board
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them
- co-operate with each of its relevant partners (as set out in Section 6 of the Care Act) in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

1.6 In line with the Care Act 2014, the Kent and Medway Safeguarding Adults Board is required to publish an Annual Report each financial year.

1.7 The following agencies are currently represented on the Kent and Medway Safeguarding Adults Board: Medway Council, Kent County Council, Kent Police, Acute Trusts, Clinical Commissioning Groups, Community Health Trusts, Kent and Medway NHS and Social Care Partnership Trust, NHS England, Kent Surrey and Sussex Community Rehabilitation Company, National Probation Service, Kent Fire & Rescue Service, Prison Service, both Kent and Medway Community Safety Partnerships, Healthwatch, District Councils, Advocacy Services, Housing providers, elected Members from both Kent County Council and Medway Council and representatives from independent provider organisations.

1.8 The Care Act 2014 states that once the Annual Report is published, it should be submitted to the Chief Executive (where one is in situ) and Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

2. Increasing Opportunities, Improving Outcomes

2.1 The work of the Kent and Medway Safeguarding Adults Board, which is detailed within the Annual Report, plays a key role in supporting KCC's Strategic Statement 2015-2020 'Increasing Opportunities, Improving Outcomes':

"Older and vulnerable residents are safe and supported with choices to live independently".

3. The 2016–2017 Annual Report

3.1 The report contains a wealth of information from each of the key agencies engaged in the Kent and Medway Safeguarding Adults Board.

3.2 Section 3 of the report details how the Board delivered against its priorities for 2016 – 2017. Some of the key achievements during the reporting period include:

- Board members arranged and delivered a safeguarding adults awareness raising campaign from 3– 7 October 2016, it was centred on the theme "Abuse: See It, Report It, Stop It". The campaign provided general information on how to identify and report abuse, and the support and services available for those at risk or experiencing abuse. The campaign received positive feedback and there has been an increase in referrals.

- The Learning and Development Working Group led on a significant project to review the course structure and content for the Board's multi-agency training programme. The group designed a new training specification and drew up the commissioning and tender strategy for the new training offer. The tender process was successful a new provider was commissioned to deliver the training.

- In response to an increase in the number of commissioned SARs, the Board established a Safeguarding Adults Review Working Group to strengthen quality assurance processes and to oversee the progress of SAR action plans and related learning.

- A 'Multi Agency Case Audit' process has been established to create further scope for delivering learning from case analysis, enabling practice improvement and to deliver learning from the analysis of complex safeguarding cases.

3.3 Section 3 also provides an update on Safeguarding Adult Review activity. Five new SAR referrals were received in 2016-17 of these; two were commissioned as SARs, one was commissioned as a Domestic Homicide Review and the other two referrals did not meet the criteria and were managed through other processes.

3.4 One SAR, 'Mrs D', was completed during this reporting period, the executive summary, detailing the findings was published in June 2017 and is available at http://www.kent.gov.uk/social-care-and-health/information-for-professionals/adult-protection/safeguarding-adult-reviews. The lessons from all Kent and Medway SARs and from other National SARs continue to influence the focus of KMSAB's multi-agency learning and development strategy and training programme.

3.5 Section 7 outlines the activity data for adult safeguarding in Kent and Medway. This includes referral data, the background data in regard to victims and the current trends in relation to adult safeguarding in Kent and Medway.

3.6 There has been a significant increase in safeguarding enquiries, especially in Kent. In 2015–2016 there were 3,906 safeguarding enquiries in Kent compared to 5,715 safeguarding enquiries in 2016-2017. This is a 46.3% increase. In Medway there was a 14.9% increase, from 268 safeguarding enquiries in 2015-2016 to 308 safeguarding enquiries in 2016–2017.

3.7 Section 8 identifies the key priorities for the Kent and Medway Safeguarding Adults Board for 2017-2018:

- To engage with residents of Kent and Medway, empowering and enabling them to contribute to safeguarding and the work of the Board.
- To ensure that lessons are learnt from the outcomes of Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs) and Children's Serious Case Reviews (SCRs) and Multi Agency Case Audits and these directly influence practice improvements.
- To ensure that structure and governance arrangements enable the KMSAB to meet its statutory duties effectively and efficiently.
- To ensure that Policy, Procedures and Guidance documents are compliant, easy to use and reviewed and updated regularly.
- To provide a high quality multi-agency training offer.

3.8 The KMSAB Constitution was signed off by the Board at their June 2016 meeting. This constitution details how the Board will operate, outlines roles, responsibilities and governance arrangements. Work to develop the Board's strategic plan for 2018-2021 has commenced. The outcome of this will determine the future structure of the Board and related working groups. A Business Group will be established to manage the implementation of the strategic plan, monitoring and signing off the outcomes delivered by the working groups. This allows the Board to focus on strategic priorities and Safeguarding Adult Reviews outcomes.

4. Conclusion

4.1 During 2016-17, KMSAB and our partner agencies have built on the good work from the previous year. The Board has continued with its

scrutiny and challenge role through stricter governance and lines of accountability, implementing a more robust governance structure to reflect clear Board deliverables.

5. Recommendations

5.1 The Health and Wellbeing Board is asked to note the progress and improvements made during 2016-17, as detailed in the Annual Report from the Kent and Medway Safeguarding Adults Board and note the 2016-17 Annual Report attached.

6. Background Documents

Kent and Medway Safeguarding Adults Board - Annual Report 2016-2017

7. Contact Details

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Kent and Medway Safeguarding Adults Board

Annual Report

April 2016 – March 2017

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Foreword from Deborah Stuart-Angus, Independent Chair, Kent and Medway Safeguarding Adults Board

It gives me great pleasure to share with you Kent and Medway's Safeguarding Adults Board Annual Report. It details the vast range of activity that our partnership has delivered to help keep our population safe, so that our citizens can live free from harm, abuse and neglect. This has been an exceptionally busy and exacting year, where we have focused our strategic direction on strengthening safeguarding activity, in the wake of a 40% increase in safeguarding referrals.

Our Board set its safeguarding priorities to prevent harm in our communities and am proud to say that the partners of Kent and Medway have delivered. I offer my personal thanks for their continuous efforts, set within challenging times, and their proactive, mutual collaboration. Recognition for this contribution and the dedicated effort that continues to be made to keep our residents safe has to be acknowledged.

In the wake of a vast increase in safeguarding activity, Kent and Medway are probably experiencing the full impact of the changes brought about by the Care Act 2014. This has made us more determined to raise awareness; continuously improve our multi-agency safeguarding adult policy and procedures; measure our impact and quality outputs and challenge our partners to gain assurance that safeguarding arrangements are effective.

We have undertaken an increased number of Safeguarding Adult Reviews (SARs) and ensured that the SAR Multi Agency Decision Making Panel is supported by a standing Working Group, enabling the ongoing development of a rigorous quality assurance processes and implementation planning to embed lessons learned, where agencies could have worked better together.

We have also developed a high level Multi Agency Case Audit process to create further scope for delivering learning from case analysis, enabling practice improvement and have delivered and reviewed a comprehensive, competence based multi-agency training programme to support the '6 Safeguarding Principles', promoting choice and control for adults who may be or are, at risk.

The work to better engage with adults at risk, carers and the public is now lead by a Citizen's Panel task and finish group and last October, we saw the delivery of a further successful Safeguarding Adults Awareness Raising Campaign, with the strap line: "Abuse: See It, Report It, Stop It". The campaign was positioned in shopping centres, supermarkets and hospitals, promoting scam awareness, community engagement and domestic abuse one stop shops, attracting social media and press coverage. This one event alone positively impacted on the reporting of Domestic Abuse.

We have signed off the KMSAB Constitution and members have opted to re-structure the Board for 2017-18. This will improve expeditious decision making and produce a defined focus on strategic priorities and the delivery of SAR outcomes. A Business Group will implement the future designated 2018-2021 Strategic Plan.

There has been a very successful collaborative and innovative approach to strengthening safeguarding delivery, oversight and governance for Medway's residents, with the setting up of the Medway Safeguarding Adults Executive Group (MSAEG). The Group are able to clearly

focus on the safeguarding needs of Medway's adult's at risk population and have been able to create a 'golden thread' to connect KMSAB's strategic vision to achieving outcomes for adults with care and support needs. MSAEG are also delivering on the outcomes from a constructive Peer Review for adult safeguarding.

We wanted to work more closely with Kent Safeguarding Children's Board and Medway's Safeguarding Children's Board. Following successful negotiation, we are now represented on the Joint Risk, Threats and Vulnerabilities Working Group, pooling our efforts to reduce gang violence, prevent child sexual exploitation and taking a strong view on PREVENT and Chanel anti-terrorism duties, working closely with both the Community Safety Partnership and partner Boards across Kent and Medway.

The achievements of our partners are too numerous to mention here and I would urge you to read on, to gain a measure of the magnitude of what has been realised this year. To mention but a few, there has been the noted success of the Kent Learning Disability Advocacy Project and Speaking up Groups for People with high functioning Autism; the deployment of 'Keeping Safe' training for adults with learning disabilities; raising awareness and understanding of Making Safeguarding Personal in Adult Social Care; increased activity from proactive Community Wardens; Mental Capacity Act audits across KMPT; the focus on the 'vulnerability strategy' by Kent Police, establishing the innovative New Horizons policing model; attaining safeguarding training compliance improvement in Maidstone and Tunbridge Wells NHS Trust, Medway NHS Foundation Trust, SECAMB and Kent Fire and Rescue Services. There has been a wide ranging review of safeguarding training requirements for providers by the NHS Clinical Commissioning Groups; delivery on the 'Think Family' approach by Medway Community Healthcare and safer custody implementation across the Prison Service.

As a Board, of course we face our challenges, but we have decided that we will pre-empt what we can and endorse building on our priorities by jointly setting out a three-year Safeguarding Strategy for Kent and Medway and an associated Business Plan. We will work to ensure that our structure reflects the best delivery model to keep our residents safe; we will develop a systematic implementation plan for lessons learned to be delivered across the partnership and continuously improve and learn from the outcomes measured by our Quality Assurance Framework.

Our shared responsibility to safeguard adults at risk in Kent and Medway can only be achieved by collaboration, by working together and understanding the challenges our partners face. However, it is their success in delivering on their achievements, versus challenge, that contributes to inspire me to lead this Board with pride. As Chair, I remain humble and cognisant to the ever increasing demands made on the members of this Board and will continue to offer a potent contribution, so that we can together, continue to be strident in the face of preventing abuse and neglect, so that people live safer lives.

Thank you for taking the time to read this, I hope it inspires you to read on.

Deborah Stuart-Angus
Independent Chair of the Kent and Medway Safeguarding Adults Board

Section 1. Introduction

What is safeguarding?

Adult Safeguarding is the process of ensuring that adults at risk are not abused, neglected or exploited. The Care Act 2014 defines safeguarding as:

> "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action." Care Act (2014)

The Care Act states that safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect.

Care and support is the combination of practical, financial and emotional support for adults, who need extra help to manage their lives and be independent. Care and support can mean different things for different people, for example it can include:

- help to get out of bed, dressed or washed
- help with eating or cooking
- help seeing friends and family
- help caring for others.

Abuse or neglect can take many forms. The Care Act lists the following types of abuse and neglect:

- Physical abuse
- Domestic violence
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect.

For a full definition of each category of abuse and neglect please see Appendix 2.

These are reflected Board's Multi-Agency Safeguarding Adults Policies, Protocols and Guidance for Kent and Medway.

How do I report abuse or neglect?

If you think someone is in immediate risk or danger call 999 for the emergency service

If you think you or another person is at risk of harm, neglect or abuse, please contact:

If you live in Medway:
01634 334466
(Next Generation Text Service - 18001 01634 334466)

If you live in any other part of Kent:
03000 41 61 61
(Next Generation Text Service - 18001 03000 416161)

.
For further information go to: www.medway.gov.uk/abuse
www.kent.gov.uk/adultprotection

What is the role of the Kent and Medway Safeguarding Adults Board?

Local Authorities are required by law to have a Safeguarding Adults Board. The Board is not involved in operational practice. The purpose of the Board is to:

- help protect the people of Kent and Medway's right to live free from harm, abuse and neglect.
- provide strategic oversight of safeguarding activity in Kent and Medway
- fulfil the statutory requirements outlined in the Care Act 2014 and related guidance.

Kent and Medway Safeguarding Adults Board (KMSAB) achieves this by bringing together partner agencies that have a responsibility for safeguarding, such as police, local authorities and health. These agencies work collaboratively, and with local communities. The KMSAB meets four times a year and is supported by working groups, see appendix 3 for the structure chart.

The key responsibilities of the KMSAB include:

- Providing strategic direction for the adults at risk agenda
- Developing and reviewing multi-agency policy, procedures and guidance for safeguarding adults at risk
- Monitoring and reviewing the implementation and impact of policy
- Promoting and deploying multi-agency training
- Undertaking Safeguarding Adult Reviews (replacing Serious Case Reviews)
- Holding partners to account and gaining assurance of the effectiveness of safeguarding arrangements

The KMSAB supports adults at risk to have choice and control over their lives by following and endorsing the six safeguarding principles outlined in the Care and Support Guidance:

- Empowerment - individuals will be asked what they want the outcomes from the safeguarding process to be and these outcomes will directly inform what happens wherever possible

- Prevention - individuals will get help and support to report abuse and neglect and get help to take part in the safeguarding process

- Proportionality - individuals will be confident that professionals will work for their best interests and that professionals will only get involved as much as needed

- Protection - individuals will receive clear information about what abuse and neglect is, how to recognise the signs and what they can do to seek help and support

- Partnership - individuals will be confident that professionals will work together to get the best outcomes for them. They will also be confident that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary

- Accountability - individuals will receive timely help they need from the person or agency best placed to provide it

The KMSAB used these principles to inform the Strategic Plan.

Section 2. National Context

Key documents which have influenced the safeguarding agenda include:

The Care Act 2014

The Care Act 2014 came into force on 1 April 2015, replacing and consolidating a number of previous laws and statutory guidance, to create a single, consistent approach to establishing entitlement to adult social care in England. It sets out duties for local authorities and partner agencies and introduces the right to an assessment for anyone, including carers, in need of support. The Act promotes a preventative approach and aims to put individuals in control of their care and support.

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Care Act Statutory Guidance 2016 Update

The updated Care Act 2014 statutory guidance was published on 10 March 2016. The update reflects; regulatory changes, feedback from stakeholders and the care sector; and other relevant developments. Chapter 14 specifically relates to safeguarding.

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#contents

Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards (DoLS) came into force in England and Wales in April 2009, under an amendment to the Mental Capacity Act 2005. These safeguards are intended to protect individuals, who lack the capacity to consent to care or treatment, from being deprived of their liberty unless there is no other, less restrictive alternative, and a deprivation of liberty is assessed to be in their best interests to protect them from harm, or to provide treatment.

The definition of what constitutes a deprivation of liberty was amended following a Supreme Court Judgement in 2014, P v Cheshire West and Chester Council (2014), which created an 'acid test' for what constitutes a deprivation of liberty. The 'acid test' is fulfilled, and an individual is considered to be deprived of their liberty, if they:

- lack the capacity to consent to their care/treatment arrangements **and**
- are under continuous supervision and control **and**
- are not free to leave

The following are not relevant to the application of the test:

- the person's compliance or lack of objection
- the relative normality of the placement and the reason
- the purpose for the placement having been made

Statistics by the NHS Digital (formerly Health and Social Care Information Centre) illustrate a continued increase in the number of DoLs applications received. "195,840 DoLS applications were reported as having been received by councils during 2015-16. This is the most since the

DoLS were introduced in 2009 and represents 454 DoLS applications received per 100,000 adults in England"[1]. It is expected that the figures for 2016-17 will be published in October 2017.

In March 2017, The Law Commission issued its report following review of the DoLS legislation. The Government will determine how the recommendations will be taken forward.
The main highlights are:

- DoLS will be replaced by the 'Liberty Protection Safeguards'
- This will apply to individuals over the age of 16 years
- It will apply in any setting
- The Supervisory Body will be replaced by the 'Responsible Body'
- Responsible Bodies will include NHS and Local Authorities
- Additional scrutiny of restrictions by an Approved Mental Capacity Professional for those Relevant Persons who are objecting

The full report is available at:
http://www.lawcom.gov.uk/wp-content/uploads/2017/03/lc372_mental_capacity.pdf

Modern Slavery Act 2015

Trafficked adults are at increased risk of significant harm because they are largely invisible to the professionals and volunteers who would be in a position to assist them. The adults who traffic them take trouble to ensure trafficked adults do not come to the attention of the authorities, and either have no contact or disappear from contact with statutory services soon after arrival in the United Kingdom (UK), or in a new area within the UK.

The Modern Slavery Act 2015 consolidates slavery and trafficking offences.

The Modern Slavery Act 2015 Section 52 places a duty on a range of public authorities to notify the Home Office about suspected victims of slavery or human trafficking.

The Counter Terrorism and Security Act

The Counter Terrorism and Security Act 2015 aims to disrupt the ability to travel abroad to engage in terrorist activity and then return to the UK. It also places a duty on a range of organisations to prevent people from being drawn into terrorism. It places Channel, the Government's programme for people vulnerable to being drawn into terrorism, on a statutory footing.

Female Genital Mutilation (FGM) Act 2003 as amended by the Serious Crime Act 2015

The Female Genital Mutilation Act (2003) was amended by section 73 of the Serious Crime Act 2015 to include FGM Protection Orders. A FGM Protection Order is a civil measure which can be applied for through a family court. The FGM Protection Order offers the means of protecting actual or potential victims from FGM under the civil law. Breach of an FGM Protection Order is a criminal offence carrying a sentence of up to five years in prison. As an alternative to criminal

[1] Health and Social Care Information Centre (Now NHS Digital) (2016) Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England), Annual Report 2015-16. Published 28 September 2016 http://content.digital.nhs.uk/catalogue/PUB21814

prosecution, a breach could be dealt with in the family court as a contempt of court, carrying a maximum of two years' imprisonment. (NSPCC).

Controlling or Coercive Behaviour in an Intimate or Family Relationship

This legislation allows the Crown Prosecution Service to prosecute specific offences of Domestic Abuse if there is evidence of repeated, or continuous, controlling or coercive behaviour. This type of abuse in an intimate or family relationship can include a pattern of threats, humiliation and intimidation, or behaviour such as stopping a partner socialising, controlling their social media accounts, surveillance through apps and dictating what they wear. The legislation states that to be defined as controlling or coercive, the behaviour must have had a 'serious effect' on the victim, meaning that it has caused the victim to fear violence will be used against them on 'at least two occasions', or it has had a 'substantial adverse effect on the victims' day to day activities.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

When a person dies as the result of domestic violence, the law requires that professionals involved in the case review what happened so they can identify what needs to be changed and reduce the risk of it happening again in the future. In 2016 the Home Office updated the Statutory Guidance which details the requirements on how to conduct a review.

A summary of the changes can be found on the link below
http://aafda.org.uk/resource/aafda-detailed-analysis-key-changes-new-home-office-domestic-homicide-review-guidance-published-december-2016/

Section 3. Local Context

This section includes key areas of work for the Board and details how we delivered against our priorities for 2016 – 2017

Engagement with Service Users and Carers

The KMSAB is continuously pursuing ways to engage with service users, carers and the public. The ambition is to provide a forum for them to influence the work of the Board and empower and enable them to contribute to safeguarding in Kent and Medway. A citizen's panel task and finish group, made up of multiagency partners, has been established to lead this work. They are required to provide a progress update at each Board meeting.

Having considered different models, it was agreed that rather than ask representatives to attend a formal meeting, engagement would be mostly 'virtual'. Utilising existing service user and carer groups and forums to share updates and seek views on the work of the KMSAB. The task and finish group has compiled a list of service user and carer groups already established in Kent and Medway. As expected, due to the size of the local area, they found that there are a very large number of such groups and forums already in place.

A pilot questionnaire was circulated to a sample of user and carer groups. 618 people were contacted to ascertain how best to involve them in matters relating to safeguarding adults in Kent and Medway. Even with the provision of self-addressed envelopes, only 16 responses were received. Despite some initial challenges the group remain committed to finding the most effective ways to encourage participation. This work remains a priority for the 2017-18 work programme.

Increasing Awareness

As well as being good practice, Safeguarding Adults Boards have a duty under the Care Act to prevent harm and "raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect"[2]. Research has found that successful awareness raising campaigns can make a significant contribution to the identification and prevention of abuse.

Board members arranged and held a safeguarding adults awareness raising campaign from 3–7 October 2016, it was centred on the theme "Abuse: See It, Report It, Stop It". The campaign provided general information on how to identify and report abuse, and the support and services available for those at risk or experiencing abuse. Each agency focused their activities on the themes most relevant to them. When preparing the events, agencies consulted with service users and carers, where possible. Events included:

- A conference for providers
- Information stalls at places such as; community hubs, shopping centres, markets, supermarkets and hospitals
- Scam awareness and safety presentations
- Domestic abuse one stop shops
- A staff conference for hospital staff in Medway
- Engagement day with community groups
- Awareness raising through social media and press coverage

[2] [2] Care and Support Statutory Guidance Issued Under the Care Act 2014

Feedback regarding the events included:
"*the number of domestic abuse cases being reported and consulted about has risen dramatically"*

"The public were very engaged and appreciated having someone to talk to about their issues"

"Supermarket management were very supportive of the community warden stands, taking leaflets for their staff room and inviting them back to host regular events"

"this was a well-planned out campaign and we welcome being part of it again in the future"

To support safeguarding awareness week, and awareness raising work more generally, the Policy, Protocols and Practice Working Group reviewed the flyers and leaflets produced by the Board, ensuring that they were up to date, relevant and fit for purpose. The 'Report It' information leaflet for the public was redesigned to provide more details on the types of abuse and to make it more eye catching. The flyer design and "Abuse: See It, Report It, Stop It" strapline was used to develop:

- a web and social media banner
- a signature banner for emails
- a contact card
- a poster
- information "pop-up" stands

These continue to be used to raise awareness of the Board.

Signature banner for emails:

Progress Safeguarding Adults Reviews, ensuring lessons learnt lead to practice improvements

Kent and Medway Safeguarding Adults Board has a duty to carry out a Safeguarding Adults Review (SAR) when an adult at risk in Kent or Medway dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. KMSAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. KMSAB can also arrange for a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice.

The KMSAB continues to review and strengthen the SAR process. In 2016/17 the following improvements were made:

SAR decision making panel - To ensure a more robust and consistent process for determining whether a case referred for a safeguarding adults review meets the criteria, a decision making panel has been established, it is chaired by a Detective Superintendent. This multiagency panel is convened when a new referral is received. Each agency brings a summary of their involvement, these are considered to assess if the referral meets the criteria for a SAR or whether any other review or action is required.

SAR Working Group – In response to the increasing number of SAR referrals, a SAR working group was established. The group is responsible for tracking and progressing SARs in progress and related action plans. The group also review the SAR process and quality assurance mechanisms, making recommendations for improvement as appropriate.

Development of Case Audit Process – The Policy, Protocols and Practice Working Group developed a multiagency audit process which can be used to review a case that does not meet the SAR criteria, but where it is agreed that a multiagency audit would be beneficial, to scope areas of improvement and to determine if there are lessons to be learnt. This process was piloted on a case in September 2016. Multiagency partners met to discuss the case and review practice, they developed 10 recommendations for agencies to progress.

SAR Activity

2016-17 saw an increase in the number of SAR referrals. In addition to the two SARs which were in progress (Mrs D[3] and Mrs H) a further five referrals were received. Of these; two were commissioned as SARs (Mrs C and one other) and one was commissioned as a Domestic Homicide Review. The other two referrals did not meet the criteria.

The executive summary, detailing the findings of the Mrs D case was published in June 2017. http://www.kent.gov.uk/social-care-and-health/information-for-professionals/adult-protection/safeguarding-adult-reviews
The learning from this review has been disseminated to partner agencies. An action plan is being developed and lessons learnt workshops are being arranged. These will combine learning from three safeguarding adults reviews and are expected to take place in November 2017.

Some KMSAB agencies have also been involved in two SARs which are being led by other Safeguarding Adults Boards. The findings of these reviews will be shared and lessons learnt workshops are being planned to support practice improvement.

In September 2014, the Board commissioned a Safeguarding Adults Review (SAR) in respect of Mary Smith,[4] chaired by Paul Pearce. The overview report and recommendations were presented to the Board in June 2015. Agencies have now completed the action plan which addressed the recommendations.

Review of the Kent and Medway multi-agency training programme and commission training providers

The Learning and Development Working Group led on a significant project to review the course structure and content for the Board's multi-agency training programme. The group designed a new training specification, taking into account each agency's requirements, competency and capability frameworks and statutory requirements.

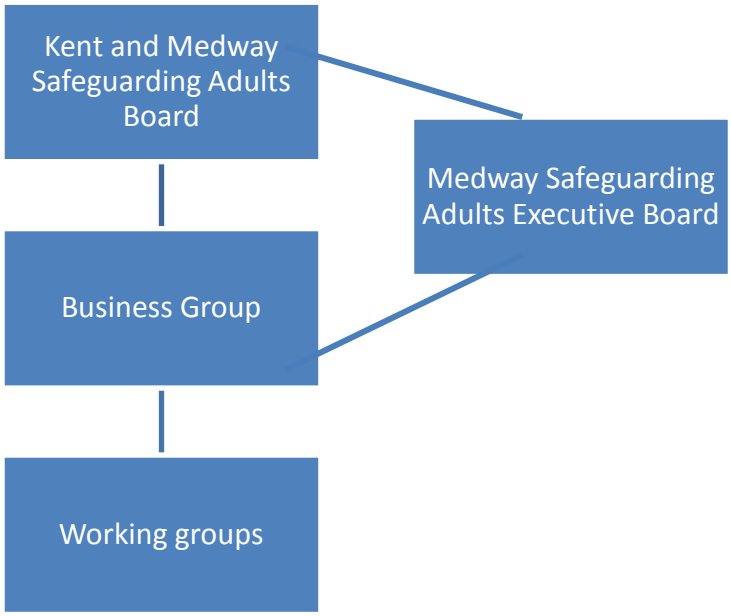
[3] To protect the identity of the individuals initials are not the person's real initial
[4] To protect the identity of the individual this is a fictitious name

On behalf of the Board, the group also drew up the commissioning and tender strategy for the new training offer with multi-agency partners supporting the process. The tender process was a success and a contract was awarded. Details of the new training programme can be found here.

Board Structure, Constitution and Strategic Plan

The KMSAB Constitution was signed off by the Board at their June 2016 meeting. This constitution details how the board will operate, outlines roles, responsibilities and governance arrangements. As there was no clear agreement on the preferred structure of the Board, KMSAB members attended a development day on 2 December 2016 to consider different options and decide on a final structure.

At the meeting members agreed that the current structure was no longer sustainable, with increasing membership and too many items on the agenda. Members proposed a new model, with the addition of a business group, as shown in the structure chart below:



The intention is that the Business Group will manage the implementation of the strategic plan, monitoring and signing off the outcomes delivered by the working groups. This allows the Board to focus on strategic priorities and SAR outcomes.

Following the development day there has been a process of consultation and refinement. Work to develop the strategic plan for 2018-2021 has commenced. The outcome of this will determine the working group structure. It is anticipated that the new Board structure will commence 1 January 2018.

During this period of change, the Board has continued to operate as usual, collaborating and working closely with partners to ensure a variety of safeguarding contribution. As an example of this, the KMSAB is now represented on the Joint Risk, Threats and Vulnerabilities working group with Kent Safeguarding Children's Board and Medway Safeguarding Children's Board.

Medway Safeguarding Adults Executive Group

Medway Safeguarding Adults Executive Group (MSAEG) brings together senior representatives from the key agencies responsible for the effective delivery of Adult Safeguarding in Medway.

The MSAEG works collaboratively to deliver the strategic priorities of the Kent and Medway Safeguarding Adults Board, strengthening delivery, oversight and governance. A peer review of was carried out in Medway Council in December 2016. The theme for the review was; "Is there evidence to demonstrate a robust and effective golden thread, originating from the strategic vision of the Kent and Medway Safeguarding Adults Board, across partner agencies, through to the achievement of individual outcomes for adults with care and support needs in Medway?" The report was positive but suggested some areas for development. An action plan has been developed in response to these and a follow up visit from ADASS will take place later in the year.

Deprivation of Liberty Safeguards

The national context is reflected in both Kent and Medway. Given the high number of referrals, both local authorities have robust triage processes in place, as recommended by ADASS, to prioritise applications. The current DoLS process puts significant pressure on the health and social care system. Since the Supreme Court Judgement in 2014, there continues to be a significant increase in the number of applications locally. There is a proactive approach in mitigating risk to applications that are deemed as Non Priority and re-prioritisation takes place where appropriate.

Prevent and Channel

The Kent Multi-Agency Prevent Duty Delivery Board (PDDB) has continued to oversee the delivery of the Prevent Duty across Kent and Medway. The Board receives feedback from Channel, shares information regarding Prevent awareness raising and training activity within individual agencies and drives the Kent-wide action plan. The PDDB also connects to the KMSAB, Kent Safeguarding Children's Board, Kent Community Safety Partnership and Health and Wellbeing Board.

Channel is a voluntary early intervention mechanism used before a person engages or becomes involved in criminal terrorist activity. It is focused on safeguarding individuals. All agencies and members of the community can refer individuals to Channel by emailing the Kent Police Channel inbox (prevent.referrals@kent.pnn.police.uk). A county wide Kent Channel Panel meets monthly to consider the cases of those who have been identified at risk of being drawn into terrorism and if necessary plans tailored support for them.

Kent County Council also has its own internal Prevent group that ensures the Prevent duty is mainstreamed throughout the organisation.

Medway has a Channel Panel separate to Kent's. This Panel meets as required and referrals are made using the Kent-wide referral form. Medway Council also has its own internal Prevent Board as well as a multi-agency Prevent Board to meet the guidance laid down in the Counter Terrorism and Security Act 2015.

Sub-group Activity

The Practice, Policy and Procedures Working Group (PPPWG)

Key achievements in 2016-2017:

- **The PPPWG reviewed and updated the following documents:**
    - **KMSAB Multi-agency Safeguarding Adults Policy, Protocols and Guidance Document.** The updated document can be found here.
    - **Additional Guidance for Health and Care Service Providers In Kent and Medway, When Adult(s) with Care and Support Needs or Care or Support Needs alone Abuse Each Other** The updated document can be found here.
    - **Procedure for Safeguarding Adult Reviews.** The updated procedure can be found here
    - **Kent and Medway Multiagency - Resolving Practitioner Differences; Escalation Policy for Adult** The updated document is available online.
- **Multi-Agency Case Audit Process**
  The PPPWG developed a multiagency Case Audit process.
- **Review of KMSAB literature.** The PPPWG reviewed the flyers and leaflets produced by the Board, ensuring that they were up to date, relevant and fit for purpose.

The Quality Assurance Working Group (QAWG)

Key achievements in 2016-2017:

- **Self Assessment Framework**
  The KMSAB requires agencies to complete a self- assessment framework, developed by the QAWG, to measure their progress against key quality standards. The returns are then peer reviewed by another agency and findings are presented to the Board. Any actions rated red or amber require regular update reports to the QAWG and Board to ensure the required standards are achieved.
- **Annual Plan 2017-18**
  The QAWG developed, and will monitor, the Board's annual plan for 2017-18. The plan details how the Board will deliver the priorities set out in the Strategic plan.
- **Development of Strategic Plan**
  The QAWG is leading on work to revise and update the strategic plan for 2018-2021. As part of this work the group are revising the quality assurance framework.
- **Safeguarding Adults Reviews**.
  Until the SAR working group was established the quality assurance working group was responsible for monitoring progress against Safeguarding Adults Reviews. The group ensure that action plans address the recommendations made in the review and that these are subsequently progressed. During 2016/17 the action plan in relation to Mary Smith[5] was completed.

The Learning and Development Working Group (LDWG)

Key achievements in 2016-2017:

- **Delivery of Multi-agency Training Programme**

The Learning and Development Working Group maintains oversight of the delivery of multi-agency safeguarding training, monitoring demand and uptake of training. More details are provided in the next section of the plan.

- **Evaluation of Training and Recommissioning Strategy**

As detailed here the LDWG undertook a comprehensive review of the course structure and content for the multi-agency training offer and commissioned a new provider.

- **KMSAB Competence Framework**

An update of the KMSAB Competence Framework document, 2014, was also undertaken. Since its introduction, the Framework has been a positive step towards establishing more efficient and consistent safeguarding practice across Kent and Medway, providing employees and employers with a benchmark for the minimum standard of competence required of those who work to safeguard adults across a range of sectors.

Each statutory partner agency is responsible for ensuring their staff are trained at the appropriate level for their role, and, since the Care Act 2014, which put safeguarding adults on a firm statutory footing, key agencies have also developed their own Competency / Capability Frameworks to ensure that their staff meet the expectations of the Care Act and the supporting Statutory Guidance and the requirements of their own organisation / professional bodies.

Section 4. Kent and Medway Multi-Agency Training

The Kent and Medway Safeguarding Adults Board has continued to commission multi-agency safeguarding adults training specifically for staff from the statutory sector, covering the roles and responsibilities of statutory partners in relation to Safeguarding Adults Section 42 Enquiries.

The existing course materials had been reviewed and aligned to fit with the new Safeguarding Adults Capability Framework which was introduced in April 2016, at the same time as meeting the multi-agency partners' required competencies.

The Kent and Medway multi-agency training is structured to ensure that staff can build on their existing knowledge and skills by adopting a sequential learning approach, and is designed to reflect core and complimentary knowledge and skills, within the multi-agency context of safeguarding work. This year's offer included:

- Level A / Level 1 and Level 2– Adult Safeguarding Awareness and Application of Law and Policy
- Level B – Guide to Undertaking Safeguarding Enquiries
- Level C – Decision Making and Accountability in Safeguarding
- Level D – Post Abuse Responsibilities

All agencies take responsibility for the delivery of Levels 1 and 2 training to their staff, using the training standards tool to record the quality of the content and delivery methods and evaluation of the training in line with the KMSAB Competence Framework. Kent County Council has continued to offer Level A (Levels 1 and 2) training for staff in the private, voluntary and independent sectors.

Levels B, C and D of the multi-agency training programme are provided by external training consultants, funded by the KMSAB.

The table below outlines the level of multi-agency course provision and attendance during April 2016-March 2017.

		Attendance by Agency				
Course	**Total No of Persons Attending**	**KCC**	**Medway Council**	**KMPT** (incl staff seconded from KCC)	**Health - other**	**Other Agencies**
Level B (18 courses)	307	162	31	101	11	2
Level C (6 courses)	83	44	21	11	5	2
Level D (1 course)	22	17	1	3	1	0
Total trained	**412**	**223**	**53**	**115**	**17**	**4**

In addition to the training detailed above, agencies may supplement this with their own training programmes.

Section 5. Funding Arrangements

The Kent and Medway Safeguarding Adults Board is funded by five partner agencies including Kent County Council, Medway Council, Kent Police, Kent Fire & Rescue Service, Clinical Commissioning Groups and commissioned Health provider organisations. Each of these agencies made the following percentage contributions in 2016-17:

- KCC, Social Care Health and Wellbeing – 40.4%
- Medway Council – 8.2%
- Kent Police – 14%
- NHS Kent and Medway – 35.8%
- Kent Fire & Rescue Service – 1.7%

The multi-agency budget covers the salaries for the Independent Chair, Safeguarding Adults Board Co-ordinator and Administration Officer posts. It also covers the administration costs for the various multi-agency group meetings, Safeguarding Adult Reviews and the provision of multi-agency training.

The table below sets out the budget contributions for the past three years

	2014-2015 Agreed contribution (£000's)	2015-2016 Agreed contribution (£000's)	2016-2017 Agreed contribution (£000's)
KCC	61	72.8	80.8
Medway Council	12.6	14.8	16.5
Local Health Commissioners and Providers	54.8	64.5	71.5
The Office of the Police and Crime Commissioner	21.9	25.3*	28.1*
Kent Fire & Rescue Service	2.6	3	3.3
Shortfall	15.2	1.9	10.0
Total	168.1	182.3	210.2

*21 received

A decision was made by the Board to use reserves in order to reduce the contributions of partners, given the savings agencies needed to make in the financial year.

Section 6. Partner Highlights

Advocacy for All

Overview of 2016‑2017

- All staff undertake safeguarding e learning as part of induction
- Safeguarding regularly discussed during team meetings, supervision and appraisals
- Service-user led Safeguarding training for people with a learning disability and staff from service providers
- Support self advocacy group members and others with a learning disability and/or Autism with 1:1 advocacy support via our Kent Learning Disability Advocacy Project and Speaking up Groups for People with high functioning Autism.
- Current IMCA and Care Act provider – safeguarding support for those who lack capacity or who have difficulty understanding information.

Key Achievements

- Provision of 'Keeping Safe' training to adults with learning disabilities by our 'A Team', a group of people with learning disabilities who are trained as trainers for other disabled young people and adults to ensure they are aware of, and can recognise abuse.
- Provision of advocacy through IMCA and Care Act advocacy to ensure the voice of the client is heard at safeguarding meetings.
- Safeguarding training provided to all staff during our organisation training day.

Key Challenges

- Ensuring an advocate is involved at the start of all relevant safeguarding processes.
- Access to advocacy for people who live in Kent but funded by another local authority when they are not covered by a statutory service
- Being able to enable support for vulnerable people at risk, where their situation is not seen as safeguarding.

Future Plans 2017-2018

- To provide further opportunities for 'Keeping Safe' to people with a learning disability, so they can recognise abuse and how to report it.
- To update and renew our Safeguarding training for all our staff
- To work with partners to ensure advocacy is available to all those who have a statutory or non statutory right to advocacy during a safeguarding process

Dartford and Gravesham NHS Trust

Overview of 2016‑2017

During 2016-2017 the Trust has seen some challenging times. There has been an increasing number of people attending the Emergency Department who require hospital admission. Additional support has been given to the Emergency Department by the Safeguarding Lead in order to raise awareness regarding safeguarding adults, especially during difficult periods. There has been increased presence by the Safeguarding Lead throughout the Trust, with the aim to promote and enhance awareness regarding the safeguarding process and mental capacity. As a result during the past year there have been 104 safeguarding referrals made, which include 15 raised against the Trust, which have been investigated as part of the safeguarding process. The previous year the Trust made 37 referrals.

The Safeguarding Lead continues to support staff throughout the Trust in all matters relating to safeguarding. The Trust has reviewed the levels of training that it provides in relation to safeguarding adults, MCA and DoLS. The Safeguarding Adults Lead continues to produce a quarterly Safeguarding Adults newsletter which is made available Trust wide via the Trust Intranet. It highlights current safeguarding points, training dates and changes in services (i.e. IMCA services) and lessons learnt. The Safeguarding Lead continues to report to the Clinical Commissioning Group, Trusts Quality and Safety Committee and attend the various sub-groups as required by the Kent and Medway Safeguarding Adults Board.

Key Achievements

- The Trust has played an active role in the Frequent Attenders Steering Group. This has involved looking at its top 20 frequent attenders of 2016 so as to reduce attendance in the Emergency Department in a positive way. This involves care planning with other agencies involved in their care including primary health services and the Local Authority.
- Successful collaborative working with the Emergency Department to increase their awareness of safeguarding and MCA. A diary is used by the department and SECAmb to raise additional concerns. This is reviewed on a daily basis.
- Safeguarding Adults training has been reviewed and now includes training to a higher level.

Key Challenges

- Investigation of historical safeguarding alerts with the Local Authority, some of which dated back to 2014.
- The balance between the increase numbers of people attending the Emergency Department whose medical needs take priority and completion of paperwork i.e.: KASAF and DOLS. The department remains very busy; staff require additional support during these times to complete safeguarding paperwork.
- The increase in patients requiring prolonged hospital admission due to changes in their needs/MCA following admission to hospital. This results in delayed discharges and possible safeguarding concerns.

Future Plans 2017-2018

The Trust will continue to promote the importance of safeguarding adults via education, training and newsletter updates. The importance of regularly assessing MCA will continue to be highlighted, so that all clinical staff feel confident.
The Trust will continue to work collaboratively with external organisations in order to improve the patients experience in relation to Safeguarding MCA and DoLS.

East Kent Hospitals University NHS Foundation Trust

Overview of 2016 – 2017

The Trust and The People at Risk Team (PART) have experienced significant change with in the last year. EKHUFT is no longer in CQC Special Measures. Despite significant financial pressures, PART have been supported by the Trust in replacing staff members as they have moved on. Two new members are in post and a third for Learning Disability awaits recruitment. Between October and January the team operated with reduced capacity, impacting on its ability to support services.

Key Achievements

- Successful campaign in raising Domestic Abuse awareness amongst staff and the public.
- Continued greater levels of involvement with medical teams, to support complex discharges for patients who lack mental capacity.
- Ability to report training compliance restored and improved compliance

Key Challenges

- Achieving 85% compliance with Level 2 training equivalent of training 3,500 staff.
- There is an on-going issue with vulnerable patients being admitted to the Trust with immediate, but short term, acute health problems who then remain on the wards for months after their acute illness is resolved. Many of these patients lack mental capacity, exhibit challenging behaviour and are difficult to manage.
- Changing practice in record keeping to evidence adherence to the Mental Capacity Act.

Future Plans 2017-2018

- Improve level 2 training compliance in Midwifery and Women's health to meet a target of 85%.
- Highlight the importance of robust communication about patient care at point of discharge with staff
- Continue to embed identification of high risk patients with in the acute setting and thus improve discharge planning.
- Develop the Trust's responses to cases of Domestic Abuse, Modern slavery and Trafficking.

Kent Advocacy – Information provided by seAp

Overview of 2016-2017

Kent Advocacy was launched on 1 April 2016. It is a partnership of 9 providers - ADSS, Advocacy for All, Assert, CiLK, CROP, RAD, Rethink, seAp and Support for Sight - led by seAp.

Previously there had been around 17 providers delivering advocacy so the idea behind Kent Advocacy was to streamline provision and make referral pathways easier. This is achieved by having one central referral point for professionals and self-referrers. seAp, as the lead partner, allocates the case to the most appropriate provider depending on the needs, type of advocacy and location of the client.

During this year our referrals include the following which are particularly relevant to the KMSAB:

- Safeguarding under the Care Act: 231
- Safeguarding under the MCA: 48
- DoLS 39a: 287
- relevant person's representative: 420

Key Achievements

- A wide range of professionals and individuals know how to refer to Kent Advocacy
- The partnership has started to continue the co-production work which was so important in the production of the service specification
- Clients are receiving good quality advocacy from a range of specialist organisations

Key Challenges

- Working on a spot purchase contract where we can only charge for client work recorded on our database
- seAp had a new database on 1 April 2016, for staff and partners
- Ensuring professionals and individuals know about and how to access Kent Advocacy

Future Plans 2017-2018

- To undertake significantly more awareness raising across the county to potential clients and professionals
- To continue co-production work with clients
- Develop working relationships with less formal partners, enabling them to become involved in the continued development and promotion of the service.

Kent Community Health NHS Foundation Trust (KCHFT)

Overview of 2016-2017

During 2016/17, a total of 250 adult protection referrals were received by the Trust's safeguarding (SG) service, 201 were raised by KCHFT implicating others, compared to 225 raised within the same time period for 2015/16. 49 were raised implicating KCHFT (of which 33 were raised by KCHFT staff against KCHFT and 16 by other organisations against KCHFT), compared to 61 raised within the same time period for 2015/16. The highest area of abuse raised is Neglect. The Trust had 8 cases in which abuse has been substantiated, or partially substantiated, by KCC.

The Trust's Safeguarding Service provides a daily duty rota for provision of safeguarding advice to staff who may have a safeguarding concern. Audit actions and audits for 2016/17 have been completed and have provided assurance and evidence of good practice and identified areas for further development.

Key Achievements

- Although neglect remains the largest area of abuse within the Trust, there were 20 cases less reported compared to 2015/16.
- The Trust's SG service developed closer working relationships with its Community Hospitals and operational services, to raise awareness of practice that could constitute potential abuse and encourage staff to identify and raise safeguarding concerns resulting in less adult protection referrals being raised during 2016/17 compared to 2015/16
- The Trust's SG service provided staff with support and SG supervision (reflective and restorative) following any referrals received implicating the Trust

Key Challenges

- To reduce the Trust's number of cases of avoidable harm affecting patients across the Trust
- To ensure services work collaboratively with internal and external partners to reduce patient harms
- To encourage services to "Think Family" and consider the family as a whole when delivering care to individual clients

.**Future plans 2017-2018**

- SG service to continue to work with internal and external partners to strengthen collaborative and co-ordinated working that will further reduce avoidable patient harms
- Continue to develop existing electronic systems, to collate, enhance and evidence reporting of safeguarding activity and performance data
- Continue to support services within the Trust, including supporting KCHFT services based outside of, or extended beyond the geographical boundaries of Kent.

Kent County Council, Social Care, Health and Wellbeing

Overview of 2016 – 2017

Adult safeguarding is managed at operational levels in the divisions of Older People and Physical Disability (OPPD), and Disabled Children and Adults Learning Disability and Mental Health (DCALD/MH), including the Kent and Medway Mental Health and Social Care Partnership Trust (KMPT). These divisions are supported by Adult Safeguarding Co-ordinators**.** The Adult Safeguarding Unit maintains a strategic role, focussing on quality assurance through arranging practice audits, reporting on performance and developing relevant policy and guidance in partnership with other agencies. The Deprivation of Liberty Safeguards (DOLS) function sits within this Unit.

Key Achievements

- **Older Persons and Physical Disabilities**
  In October 2016 the operational management of the adults safeguarding response in the Central Referral Unit (CRU) was transferred to the Older Persons and Physical Disabilities Division. The transition was managed with no interruption to service for either the public or partner agencies. This cross division service responds to approximately half of the adult safeguarding activity in the county and work is underway to ensure that resources can be matched to needs. Additional resources will support improvements in collaborative working with partner agencies and respond to the work demands arising from changes in partner agency
- **Learning Disabled Services**
  During the last year our 5 Safeguarding coordinators within Learning Disabled Services have been working very closely with many of our external providers to raise their awareness of Safeguarding and Making Safeguarding Personal. This has resulted in many of the providers now having an initial consultation with us, enabling our LD teams to signpost the concern more effectively via Safeguarding, Quality and Care and/or complex casework. With an improved understanding of Making Safeguarding Personal, we are now seeing that clients remain central in a greater number of safeguarding discussions. We have developed good communication links, resulting in improved joint working and ultimately better outcomes for our clients.
- **Mental Health**
  The Mental Health Adult Safeguarding Team have been undertaking the Local Authority Designated Senior Officer role since April 2016 for Secondary Care Mental Health and the Mental Health Primary Care Social Work Service. There has been a significant increase in safeguarding enquiries. The team are working closely with partners at local community levels in responding to these concerns, improving practice through targeted workshops and continuing to work alongside practitioners within MH and in partnership with KMPT (secondary care). A scoping exercise in September 2016 identified domestic abuse in over a 1/3 of the safeguarding cases. This has resulted in the Directorate commissioning specific training for Mental Health staff on the impact of Domestic Abuse, Substance Misuse and Mental Health, one Safeguarding Coordinator attending Train the Trainer provided by Ripfa on Coercion and Control and closer working with Commissioning. A refresh of the scoping exercise will be completed in May 2017.
- **Public Protection**

- A joint Kent and Medway Domestic Homicide Review (DHR) Steering Group (established in 2011) ensures that the requirements of the DHR legislation and the Home Office guidance are followed. The Kent & Medway Adult Safeguarding Board receives feedback from the DHR Steering Group on the reviews, and shares information around the learning and recommendations resulting from completed cases. The Home Office published revised Domestic Homicide Review (DHR) Guidance in December 2016. An

estimated 15,000 visits to vulnerable people were undertaken by the Kent Community Warden Service in 2016/17. Stop the Scammers is a KCC Public Protection project involving Trading Standards and the Kent Community Warden Service. In 2016/17: over 500 scam victims were visited by Community Wardens and given sustainable support; 110 scam friends and scam champions were trained; and 25 call blocker units were installed for vulnerable residents, resulting in 99% of nuisance calls blocked.

- **Prevent** In order to raise awareness of Prevent, mandatory e-learning training was undertaken by all KCC staff. To ensure that everyone is aware of how to make a referral to Channel, relevant information was added to the multi-agency Kent and Medway Adult Safeguarding Policy, Protocols and Guidance document and to our Kent.gov website. We continue to work closely with the Police, Central Government and other multi-agency partners to ensure robust processes and measures are in place and communicated to all colleagues.

Key Challenges

- The volume of DOLS applications continues to be a significant challenge.
- Safeguarding concerns continue to rise. In the specific areas of domestic abuse and self-neglect, it is identified that staff training and policies must be reviewed and updated in order to ensure clear guidance is provided.

KCC Adult Social Care and Health Directorate is currently undergoing a 'design' process, which will result in recommendations later in 2017

Future Plans 2017-2018

To continue to work with staff, providers and multi-agency partners to ensure that lessons learned from Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs) are shared to inform practice.
To continue to support the Kent and Medway Safeguarding Adults Board in future developments.
To work closely with colleagues in Commissioning and providers to ensure that the Quality in Care agenda is embedded in order to implement preventative strategies in adult safeguarding work.

Kent Fire and Rescue Services

Overview of 2016-2017

Working with partners, specific safeguarding audits have been used to develop the direction of travel for our safeguarding work. We have updated our policy, training and how we manage safeguarding concerns. This will ensure we are better able to safeguard children and vulnerable adults.

Key Achievements

- We have published a renewed policy on safeguarding and how we deal with allegations, which have been approved by the Kent and Medway Fire and Rescue Authority. This includes clearer responsibility for safeguarding at a strategic level within the Corporate Management Board.
- We have developed a new safeguarding module within our Customer Relations Management database to ensure that our safeguarding actions are managed and recorded effectively.
- We have trained an additional sixteen operational managers as On-call Safeguarding Officers to DSO level, ensuring we have resilience when dealing with out of hours safeguarding issues

Key Challenges

- Identification and delivery of training is a key challenge for KFRS, ensuring that we have the correct level of training to meet the needs of all roles.
- Embedding safeguarding within the Service to ensure that all staff are aware of their responsibilities.
- Keeping all our staff up to date with relevant legislation and also changes in new types of safeguarding issues.

Future plans 2017-2018

- To work with the local safeguarding boards to identify best practice and translate that into training and awareness for staff.
- To have a full training package available for all staff and volunteers applicable to their specific role, this will include the Corporate Management Board and Members of the Fire and Rescue Authority. This training will also include CPD events to ensure continual learning.
- We will improve the quality assurance for all our safeguarding work through peer review before a safeguarding case is closed. Monthly audits will be completed and reported to the strategic lead on a quarterly basis.

Kent and Medway NHS and Social Care Partnership Trust (KMPT)

Overview of 2016-2017

The year has seen KMPT work hard to embed best practice around the application of the Mental Capacity Act and Deprivation of liberty Safeguards across the organisation. Alongside mandatory training several bespoke sessions have been delivered to practitioners on these key statutory areas. Improvement has been seen in practice and noted by the Care Quality Commission during their inspection of the organisation in January 2017.

Audits have continued within KMPT to gain further assurance around the application of the Mental Capacity Act and adherence to policies and protocols in place. Audits were also completed by the Trust internal auditors to ensure systems and processes around the Mental Capacity Act are being followed. There is an action plan in place to address some minor gaps in process.

There has been continuous review of referrals for safeguarding to ensure quality and timeliness as well as the adherence to the 'Making Safeguarding Personal' principles. This is an ongoing piece of work by the safeguarding team. KMPT has participated in both Domestic Homicide Reviews and Serious Adult Reviews with partner agencies.

Training has been reviewed to ensure it meets the training requirements laid down in the *Adult Intercollegiate Document* alongside updating of all training packages both face to face and e-learning**.**

Key Achievements

- An overall assessment by the CQC of 'Good' across KMPT and 'Outstanding for caring services.
- Good partnership working with the Safeguarding Co-ordinators across mental health and adult services.
- Very successful Safeguarding Adult week campaign across KMPT featuring Domestic Abuse, Scams & Fraud and Radicalisation.

Key Challenges

- The historical safeguarding adult cases that were previously the delegated responsibility of KMPT remain a challenge to close. Progress is slow but steady.
- The numbers of breached Deprivation of Liberty applications have started to show an increase which is an ongoing concern.
- Consistency is needed in the 'Making Safeguarding Personal' elements of raising a concern and subsequent follow through once the process is over to ascertain whether the victim felt their outcomes were met.

Future plans 2017-2018

- Continue to aim for total closure of all historical cases formerly held by KMPT.
- Focussed work on Making Safeguarding Personal and encouragement and assistance to victims to complete the feedback in to the care and delivery of the safeguarding process they underwent.
- Review how KMPT can become more involved in the Prevent Channel Panels across Kent and Medway.

Kent Police

Overview of 2016- 2017

In line with the Government and College of Policing recommendations Kent Police have set their Force Control Strategy to focus on vulnerability. This strategy also delivers against the strategic policing requirement for policing. The Safeguarding of vulnerable adults or adults at risk is also addressed in these objectives.
Kent Police has undertaken specific activities in the past year to improve safeguarding as set out below:
The Kent Police Control Strategy has been significantly updated and includes key areas of public protection including adult abuse, child abuse and exploitation, domestic abuse, serious violence and sexual violence, human trafficking and gangs. The control strategy is the mechanism by which Kent Police prioritise its activities and coordinate its resources. This emphasis on vulnerability is a move away from the traditional target based policing priorities and a focus on protecting those most vulnerable in our community, preoccupied for many years with acquisitive crime, and violence (particularly in relation to night time economy).

A comprehensive review of policing across Kent has been completed and agreement has been made that a new force wide Vulnerability framework will be introduced. The Chief Constable has conducted roadshows across the county to engage and consult with staff on how these changes will be delivered. The Vulnerability Policing model has appropriately been called New Horizons and the changes within Kent Police will be completed in phases; phase 1 will see changes in the Central Referral Unit (CRU) planned for Spring 2017, phase 2 will be the changes within Districts and Investigation teams taking place in the Autumn of 2017.

As part of the change programme the New Horizons team held 60+ focus groups, workshops and events, engaging with over 1000 police officers & police staff. They held engagement events with vulnerable communities attended by over 200 people as well as engaging across Kent and Medway with partners at strategic and practitioner level.

Kent Police remain committed to engaging with multi agency partners. We have representation across all the Strategic as well as operational Boards. As well as being proactive in supporting last year's adult awareness week, we have hosted two multiagency exploitation and vulnerability conferences and a conference on FGM/FM/HBA within the last year to raise awareness on these subjects. We have also put on development days for officers and staff regarding interviewing vulnerable suspects and Domestic Abuse. We have created a vulnerability events planner for this year and are actively engaging with partner agencies to ensure learning and best practise is shared across agencies.

Domestic abuse (DA) has been a significant focus for Kent Police this year, recognising the long term impact on victims and children if we do not work effectively and quickly in partnership to provide appropriate support and safety. The recent HMIC PEEL inspection found the force response to DA to be very effective across all elements under Op Unity. The number of calls in the Force Control Room for domestic abuse that were pending attendance had reduced significantly and there were clear processes for assessing risk and managing DA incidents. Vulnerable and repeat incident flags had been re-introduced allowing Kent Police to understand the volumes of callers relevant to this assessment.

HMIC noted the increases that had been made in the DA arrest rate but were also impressed that officers and staff fully understood the reasons for making these arrests. The result is that the rate at which Kent Police charge people with offences relating to domestic abuse has also

increased. It was noted that consistency across Kent Police in responding to domestic abuse is achieved through DA Leads and Advisors.

The HMIC found the Force's processes for dealing with vulnerable adults was good, and Kent Police were considered to be in a good position regarding its use of Domestic Violence Protection Notices (DVPNs) and Domestic Abuse Notifications Scheme (DANS)

Key Achievements

- Vulnerability being recognised as central to the control strategy of Kent Police.
- The creation of the Vulnerable Adult Intervention Officer (PCSO) role and the Missing Adult Liaison Officer.
- The improved response in relation to missing episodes for adults at risk, specifically in relation to Dementia and the use of the 'At risk of going missing' process.
- An increase of police staff investigators across all areas of vulnerability.

Key Challenges

- Maintaining and improving safeguarding services for victims of crime during the force restructure.
- Developing a multi-agency approach to persistent & repeat business from adults at risk of harm (incorporating lessons learnt from recent SAR's)
- Ensuring that all Police Officers and Frontline Police staff receive Protecting Vulnerable People training as well as Vulnerability conversion courses where required.

Future plans 2017-2018

- Improving awareness around MARAC for the partner agencies within Adult safeguarding.
- Improve services to Adults at risk of fraud – Operation Signature.
- Delivering training for police staff investigators within vulnerability teams to provide a better service to victims and support to partner agencies.
- Introduction of Forensic Investigatively Trained officers to achieve best evidence from adults with learning disabilities/difficulties and autism

Adult Abuse Data Financial Year 2016/17

	Total Recorded Crimes	Total Secondary Incidents	Total
Kent	550	649	1199
Medway	81	200	281
Force Total	**631**	**849**	**1480**
2015-16	525	703	1228
2014-15	676	1058	1734

Crime Type Breakdown
Notifiable

	Violence Against the Person	Sexual	Theft	Robbery	Other Crime	Total Notifiable Offences
Kent	386	93	59	2	10	**550**
Medway	58	14	8	1	0	**81**
Total	**444**	**107**	**67**	**3**	10	**631**
2015-16	**358**	**67**	**67**	**5**	**28**	**525**

Definitions:

Notifiable – A Notifiable Offence is any offence under United Kingdom law where the police must inform the Home Office.

Secondary Incidents – This term is used when recording non crime incidents – for example a verbal altercation or an adult protection concern that would not constitute a crime, for example: an elderly person found wandering the street would lead to a referral being made.

Kent Prison Service

Overview of 2016-2017

The Kent Prison Service has had a challenging year, our inability to recruit staff in sufficient numbers to offer full regimes within our establishments, has led to most of the prisons running restricted regimes. During the year, the main establishments received additional funding, to improve safety, this resulted in increased stability, and offered more predictability within the core day. Towards the end of the reporting year, establishments reported, a more stable, environment, for prisoners and staff.

Key Achievements

- Increased Stability
- Safer, Decent and Secure Prisons
- Recruitment of new staff, coming through

Key Challenges

- Keeping Prisons Safe
- Staff Shortfalls
- Predictable Regimes

Future Plans 2017-2018

The Kent Prison Service will be undergo significantly changes in its structure. HMP Rochester will be re-developed and as a result will close at the end of 2017, it will re-open as a Category C male establishment. The new prison is expected to re-open by May 2020. Although remaining in Kent HMP Swaleside will become part of the Long Term Prisoner Estate, and HMP Maidstone will become part of the Foreign National Estate. The Group Director of Custody for Kent & Essex will be responsible for, Elmley, Standford Hill, Chelmsford and Rochester.

Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)

Overview of 2016-2017

The main aim of KSS CRC is to reduce reoffending and thereby protect the public. Recognising that safeguarding of children and adults is an important aspect to public protection KSS CRC has revised its policies so that it now brings together all the key documents that fall within the safeguarding of children and adults under one set of overarching principles. In addition, to support clarity and best practice we have added, extremism, modern slavery, sex working, gangs, child sexual exploitation and trafficking (CSE) and female genital mutilation (FGM) as key strands to the policy.

Key Achievements

- Our plans for a new IT platform were successfully implemented. Our moves to new premises, where the layout and physical environment provides for and reflects our collaborative approach to rehabilitation, has been welcomed by staff, service users and our partners.
- KSS CRC implemented a Quality Assurance Audit and Performance Strategy which outlines the purpose, principles, strategies and key deliverables for quality assurance.
- During November 2016 the CRC completed a safeguarding week to increase staff knowledge of safeguarding issues and impact positively on behaviours and attitudes . This included articles in staff and partnership magazines, daily safeguarding 'top tips' posted in the intranet, posters around offices and a subsequent on line staff quiz. The safeguarding section of the intranet has been fully revised to store all safeguarding documents and other relevant reports in a manner that facilitates staff access.

Key Challenges

- Embedding new IT system.
- Embedding the Quality Assurance Audit and Performance Strategy whilst maintaining front line delivery and performance against contract.
- Consolidation of Estates Strategy and maintaining service delivery during office moves.

Future Plans 2017-2018

- KSS CRC plan to replace the national case management system we currently use – NDelius – with a new case management system (MySIS).
- We are currently re-aligning the assessment and rehabilitation functions into one function. This is to ensure a better continuity for the service user and the responsible officer as the responsible officer will be involved in both the assessment and case management.
- Launch of Women's Strategy and KSS CRC is currently in the process of completing a new Risk of Harm Strategy.

Maidstone and Tunbridge Wells NHS Trust

Overview of 2016-2017

The Executive Lead for Safeguarding Adults is the Chief Nurse, this agenda is supported by the Deputy Chief Nurse and Matron for Safeguarding Adults. The Trust has a mature multi-agency Safeguarding Adults Committee, chaired by the Deputy Chief Nurse, with Local Authority and Clinical Commissioning Group representation.

The Trusts Safeguarding Adults at Risk of Harm Policy has again been reviewed this year. The Domestic Abuse policy for patients and staff will be jointly reviewed by the Safeguarding Adult's and Children's leads in the forthcoming year.

Level 1 and 2 Safeguarding Adults training compliance is now above the Trusts target of 85% compliance overall. The Trust eagerly awaits the final publication of the NHS England Intercollegiate Document in order to finalise our Training Needs Analysis. All safeguarding Adults training delivery has either been reviewed or is under review so as to include PREVENT basic awareness. A programme of PREVENT Wrap training has been developed for the year with the expectation that 1000+ staff will receive this training.

There have been 58 hospital alerts raised about hospital practice or by hospital staff, of which: 14 have been upheld or partially upheld, 20 discounted, 3 insufficient evidence, 4 closed at CRU and 15 awaiting an investigation report. The remaining two were relatives or visitors who were alleged responsible. Trust staff continue to follow the new Care Act definitions and raise safeguarding alerts appropriately.

Key Achievements

- Development of PREVENT training programme, delivering in excess of 29 WRAP training sessions this year.
- Trust staff showing an understanding of the difference between the definitions of a 'vulnerable adult' and an 'adult at risk of harm' and completing KASAF's in accordance with this change in threshold.
- Continued 'buy in' from all Trust staff to adhere to the Care Act and to continue to raise safeguarding concerns about patients, visitors and staff.

Key Challenges

- Inconsistent application of the 'adult at risk of harm' definition from external partners.
- Competing demands on resources leaving us unable to employ a Learning Disability Hospital Liaison Nurse.
- DoLS applications that the Supervisory Body have not been able to apply the safeguards to, due to volume of referrals.

Future Plans 2017-2018

- To employ the services of a Hospital Learning Disability Liaison Nurse.
- To work with the Medical Director and Clinical Directors to ensure that the Mental Capacity Act is embedded in all medical practitioners practice.
- To develop Level 3 Safeguarding Adults training without reliance upon external, or costed speakers.

Medway Community Healthcare

Overview of 2016-2017

Work continued within MCH during 2016-17 to empower and improve our workforces understanding and confidence in their safeguarding practice. We undertook a review of the safeguarding team and underwent a restructure with the aim of embedding a “Think Family” approach in practice. This has enabled the safeguarding adults and children’s teams to merge as one safeguarding team, increasing resource and access across operational services to safeguarding practice support. We built on earlier successes in providing training that encompassed safeguarding the family across all ages and also reviewed training packages in light of the draft intercollegiate guidance for Safeguarding Adults. The organisation was also subject to a CQC inspection towards the end of the year, we await our report.

Key Achievements

- Introduction of a half day safeguarding training session for all new starters including safeguarding adults and children, domestic abuse and Prevent
- Restructure of the safeguarding teams to enable the embedding of a “Think Family” approach
- Review and implementation of Safeguarding Adults training packages in line with the NHS England Intercollegiate Document (draft)

Key Challenges

- Improving confidence in safeguarding practice in the workforce
- Preparation for our CQC inspection in conjunction with our colleagues
- Communication route clarification regarding quality in care concerns regarding other providers with commissioners

Future Plans 2017-2018

- To initiate the new Think Family approach across all training and supervision packages
- To initiate the Strengthening Families model currently used in Safeguarding Children supervision across Safeguarding Adults supervision
- To work with colleagues in the local authority to review means of communication and multiagency partnership in regards to quality in care concerns.

Medway Council

Overview of 2016-2017

The number of Safeguarding Adult concerns opened by Medway Council were 998 in 2016/17. In 2015/16 there were 965 concerns opened therefore there has been a 3.4% increase in the past year. The Adult Social Care Teams (the Over 25 Disability Team, the Mental Health Social Work team, the 0-25 Disability team, the Older People East team and the Older People West team) retain responsibility for screening and progressing safeguarding adult concerns received by Medway Council. The Deprivation of Liberty Safeguards Service manages and processes all DoLS applications and authorisations.
Medway ASC took part in a safeguarding peer review in December 2016. The report was largely positive but did highlight areas for improvement. An action plan has been developed and a follow up visit from ADASS will take place later in the year

Key Achievements

- The annual customer satisfaction survey was completed and all responses relating to individuals' safety were followed up by staff.
- Medway Council has an established working relationship with the safeguarding team at Medway Foundation Trust. Operations Managers attend scrutiny meetings and the MFT Quality Assurance Group. As a result of this we are now working to achieve consistent practice across the Trust and the Council.
- The DoLS team also have a good working relationship with the MFT safeguarding team, ensuring oversight of cases referred. The DoLS team work with the Quality Assurance team in the Council to highlight issues within care homes which require improvement and to ensure good working relationships for the benefit of residents.

Key Challenges

- DOLS applications continue to be a challenge for the Council. Applications continue to increase although this slowed slightly in the year 2016/17 compared to the rise from 2014/15 to 2015/16. Cases are prioritised according to ADASS tool however, there is a steady increase in objections requiring application under s21A to the Court of Protection. The DOLS risk assessment has been updated.
- Adult Social Care is in the process of being restructured. It is planned that the new arrangements will be in place in July 2017.
- Domestic Abuse governance arrangements have been discussed at CMT to ensure oversight from Adult Social Care.
- Implementing Making Safeguarding Personal across all our partners.
- Assessment and authorisation of DoLS applications in a timely manner

Future Plans 2017-2018

- Development of a Performance and Quality Framework
- Devise an action plan to improve practice across the service to ensure that Medway Council is Making Safeguarding Personal compliant.
- A human trafficking and modern day slavery action plan is being developed within the Council with colleagues from Medway Children's' Safeguarding Board and the Community Safety Partnership.
- Developing arrangements for community volunteers to promote MSP locally

Medway NHS Foundation Trust

Overview of 2016-2017

In April 2016 a new safeguarding team was recruited at Medway Foundation Trust. The focus of work was to achieve the CQC actions and meet the remedial action plan set by the CCG for safeguarding.

Training was reviewed and implemented. Governance strengthened and the safeguarding profile was raised throughout the organisation.
In February 2017 the remedial action plan was closed down and in March 2017 the CQC report was published with the recommendation the Trust be taken out of special measures.

Key Achievements

- Raising the awareness of safeguarding adults, MCA & DOLS across the organisation. This included reviewing all levels of training and the staff roles linked to each level.
- Initiating the PREVENT training and process into the Trust, achieving 48% of those requiring level 1 and 49% of those requiring WRAP 3.
- Developing governance structures and up to date policies and procedural documents to inform practice.

Key Challenges

- Embedding MCA / DOLS knowledge and process into practice.
- Getting clinical engagement from all disciplines in the safeguarding investigation process when carrying out section 42 investigations.
- Managing the external expectations and intense scrutiny in addition to carrying out an increasing workload of safeguarding activity on a day to day basis.

Future Plans 2017-2018

- Audit safeguarding responses and outcomes.
- Develop new substantive team and embed processes for sustainability
- Work closely with partner agencies to ensure that patients are safeguarded appropriately and in a timely manner.

National Probation Service (NPS)

The National Probation Service (NPS) South East and Eastern (SEE) Kent Local Delivery Unit (LDU) has a designated lead for Safeguarding Children and Adults; the Senior Operational Support Manager (SOSM).

The SOSM attends the Safeguarding Adults Board (SAB), the Quality Assurance Working Group (QAWG) and is a virtual member of the Learning & Development Group.

During the past year, aside from commitment to the Board itself, the SOSM engaged in the SAB Development Day (December 2016) and works closely with the NPS Kent LDU Safeguarding Officer/Probation Officer located at the Central Referral Unit, Kroner House, Ashford who is responsible for raising adult safeguarding issues amongst frontline practitioners in the NPS Kent LDU including recent involvement in the Safeguarding Adults Awareness Campaign 2017.

NHS Clinical Commissioning Groups across Kent and Medway

Overview of 2016-2017

Clinical Commissioning Groups (CCGs) are established under the Health and Social Care Act 2012 and are clinically-led membership organisations. They are statutory bodies which have the function of commissioning services for the purposes of the health services in England.
CCGs work with closely with NHS England, which has three roles in relation to CCGs. The first is assurance: NHS England has a responsibility to assure themselves that CCGs are fit for purpose, and are improving health outcomes. Secondly, NHS England must help support the development of CCGs. Finally, NHS England are also direct commissioners, responsible for highly specialised services and in some cases primary care, though a number of CCGs have now taken on either full or joint responsibility alongside NHS England for this. As co-commissioners, CCGs work with NHS England's Regional Teams to ensure joined-up care.
NHS England has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG and it does this through the assurance process.
Safeguarding Adults continue to be a high priority for the CCGs and has been embedded across all commissioning intentions.

Key Achievements

- Safeguarding training requirements for providers has been reviewed in line with the NHS England Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document. (draft); provider contractual safeguarding metrics have been revised to reflect these.
- A safeguarding training matrix has been developed by the Designated Nurses that will be circulated to Primary Care
- As part of our commissioning arrangements the expanding agenda for safeguarding is included as part of all providers contracts; this includes all independent health providers and primary care. It is important to note that currently each CCG is at a different stage along the co-commissioning pathway but there is recognition of the need to address safeguarding in all contracts
- Developing a more robust system to measure how primary and secondary care services learn lessons from Safeguarding Adults Reviews and Domestic Homicide Reviews is a

gap that we have not been able to fully address within the current year pan-Kent and will be a key objective for next year. This will be assisted through the new governance structure developed by the SAB.

Key Challenges

- Trying to take practice forward whilst awaiting publication of key documents that impact on learning such as NHS England Safeguarding Intercollegiate document, National Training packages and Prevent competencies.
- Dissemination of co-commissioning responsibilities from NHS England and each CCG taking up co-commissioning at different times.
- Lack of medical advisor resource within CCG's specifically for adult safeguarding has impacted on the CCG's ability to support the Serious Adult Review and Domestic Homicide Review processes and gain engagement with primary care.

Future Plans 2017-2018

- Identify statutory role for the Designated Nurse for Safeguarding within the Sustainability and Transformation Plan (STP)
- Developing a more robust system to measure how primary and secondary care services learn lessons from Safeguarding Adults Reviews, Domestic Homicide Reviews and Learning Disabilities Mortality Review (LeDeR) process.
- Taking the lead from the NHS England Prevent agenda (one of their 5 key priority areas), raise awareness and promote the PREVENT agenda within Primary Care.

Report collated by Designated Nurses for Adult Safeguarding from:

- Ashford and Canterbury and Coastal CCGs
- North Kent CCG's (incorporating NHS Swale, NHS Dartford, Gravesham and Swanley and NHS Medway Clinical Commissioning Groups)
- South Coast Kent and Thanet CCGs
- West Kent CCG

South East Coast Ambulance Service NHS Foundation Trust

Overview of 2016-2017

During 2016/17 the Safeguarding team has worked hard to raise the profile of safeguarding, and the team, throughout the year, including articles in the Trust's weekly bulletin and the development of a quick reference guide (pocket-book insert) for safeguarding incorporating both adult and child safeguarding arrangements. Referral rates have been maintained across the whole Trust for the first year, which for Kent, translates to 2527 concerns being shared with Kent Adult services from April 2016 to March 2017 (an increase of 147) and equates to 29% of all adult referrals.

Key Achievements

- Maintaining rates of safeguarding training (level 2 for all frontline staff) to over 90% across the Trust and delivering face to face PREVENT training to 82% of Trust frontline staff.
- Re-starting the Trust Safeguarding Sub-Group to increase Trust-wide accountability and Governance arrangements, this group has overseen the review of all Trust-wide safeguarding related policy and procedures in year.
- Development and implementation of Mental Capacity Act assessment documentation following Trust learning in response to two Safeguarding Adult Reviews.

Key Challenges

- Capacity within the safeguarding team has continued to be a challenge throughout the year.
- Publication of the Care Quality Commission (CQC) report which identified some areas requiring improvement within safeguarding, particularly regarding the training levels for safeguarding children.
- Frequent changes within the Trust leadership team has meant the Safeguarding Department has had three separate executive leads over the past year.

Future plans 2017/18

- The Level 3 training, piloted during 2016/17 is being rolled out to frontline practitioners, of all grades, across the whole Trust. This includes clinical staff at the 111 centre.

- The Trust has reviewed the capacity and the function of the Safeguarding Team, utilising the expertise of the Designated Nurse consultants within the Trust. A key priority will be to ensure that the agreed team structure is finalised and all positions are recruited to

Section 7. Safeguarding Activity

Background to data

The data for this report was extracted from the Kent County Council social care system (SWIFT) and the Medway Council Adult Social Care database Frameworki.

Data included in this report is consistent with the Department of Health (DH) statutory returns: Abuse of Vulnerable Adults (AVA) for 2012-13, the Safeguarding Adults Return (SAR) for 2013-14 and 2014-15, and the Safeguarding Adults Collection (SAC) for 2015-16 and 2016-17.

Following the implementation of the Care Act 2014, terminology now used within safeguarding refers to safeguarding concerns and safeguarding enquiries. This terminology has been used within this report.

The first part of the report looks at new adults safeguarding concerns, which is a sign of suspected abuse or neglect that is reported to the local authority or identified by the local authority, and new safeguarding enquiries. Safeguarding enquiries are defined as the action taken, or instigated, by the local authority in response to a concern that abuse or neglect may be taking place.

The second part of the report summarises the outcome of safeguarding enquiries in Kent and Medway.

New safeguarding concerns and enquiries

Number of safeguarding concerns

This section is new to this report this year and presents the number of safeguarding concerns that have been reported to each local authority. Figures are presented for 2016-17 only as this information now forms statutory reported information.

Anyone may report concerns regarding actual, alleged or suspected abuse or neglect. Reports can be made by phone, e-mail or in writing. Safeguarding concerns can include all types of risk, including cases of domestic abuse, sexual exploitation, modern slavery and self-neglect.

Area	2016-17
Kent	9668
Medway	998
Total	**10666**

Table 7.1 Number of safeguarding concerns received in Kent and Medway, 2016-17

The number of concerns received represents significant activity in both Kent and Medway, with a total of 10,666 safeguarding concerns received in the 2016-17 period. Each local authority will need to engage with referrers to determine whether the concerns raised constitute the need to undertake a safeguarding enquiry.

Number of safeguarding enquiries and rate of change

In the period of April 2016 to March 2017, 6023 new safeguarding enquiries were started, which reflects a 44.3% increase. Both Kent and Medway demonstrated increases in enquiry activity, with Kent reflecting the greatest proportion (46.3% increase) and Medway reflecting an increase of 14.9%.

Intelligence suggests that the significant increases seen in enquiry activity in Kent and Medway are associated with greater awareness of safeguarding, with increased awareness through more publications relating to safeguarding and events such as 'Safeguarding Awareness Week' providing a basis for increased recognition of safeguarding issues.

Area	2013-14	2014-15	2015-16	2016-17	% change between 15-16 and 16-17	% of Total in 2016-17
Kent	3176	3273	3906	5715	46.3%	94.9%
Medway	315	244	268	308	14.9%	5.1%
Total	**3491**	**3517**	**4174**	**6023**	**44.3%**	**100.0%**

Table 7.2 Number of enquiries year on year and rate of change 2013-14 to 2016-17

Age of alleged victims

The majority of all safeguarding enquiries, 38.1%, related to the 18-64 age group, followed by the 85+ age group where 27.9% of all enquiries related to this age group. Of the 18-64 age group, the highest proportion of enquiries in this age band relate to the 45-54 age group (9.1%) followed by the 55-64 age group (8.6%).

In the 2016-17 year there has been an increased proportion in the age groups of 65-74 where a 1.0% increase has been observed and the 75-84 age group, where a 0.8% increase is reflected. The percentage of enquiries where the age of the alleged victim is unknown has decreased between the four reporting periods.

	2013-14		2014-15		2015-16		2016-17	
Age group	Number	%	Number	%	Number	%	Number	%
18-64	**1372**	**39.3%**	**1454**	**41.3%**	**1726**	**41.4%**	**2294**	**38.1%**
18-24	-	-	-	-	-	-	369	6.1%
25-34	-	-	-	-	-	-	470	7.8%
35-44	-	-	-	-	-	-	375	6.2%
45-54	-	-	-	-	-	-	554	9.2%
55-64	-	-	-	-	-	-	526	8.7%
65-74	**416**	**11.9%**	**391**	**11.1%**	**483**	**11.6%**	**761**	**12.6%**
75-84	**707**	**20.3%**	**690**	**19.6%**	**855**	**20.5%**	**1284**	**21.3%**
85+	**974**	**27.9%**	**976**	**27.8%**	**1100**	**26.4%**	**1678**	**27.9%**
Unknown	**22**	**0.6%**	**6**	**0.2%**	**10**	**0.2%**	**6**	**0.1%**
Total	**3491**	**100%**	**3517**	**100%**	**4174**	**100%**	**6023**	**100%**

Table 7.3 Age breakdown of alleged victims for the periods 2013-14 to 2016-17

***Note:** Caution should be taken if comparing the 18-24 age group, as this age group represents a smaller age band than all other age bands.*

For comparison purposes, based on the 2016 mid-year population estimates, the following table presents the total adult population, by gender and age range, for Kent and Medway.

	Kent		Medway		Kent & Medway combined	
Gender	Number	%	Number	%	Number	%
Male 18-64	446,611	36.9%	85,858	40.0%	532,469	37.4%
Female 18-64	456,313	37.7%	85,750	39.9%	542,063	38.1%
Total Persons 18-64	902,924	74.7%	171,608	79.9%	1,074,523	75.5%
Male 65+	139,105	11.5%	19,755	9.2%	158,860	11.2%
Female 65+	166,819	13.8%	23,482	10.9%	190,301	13.4%
Total Persons 65+	**305,924**	**25.3%**	**43,237**	**20.1%**	**349,161**	**24.5%**
Total Persons 18+	**1,208,848**	**100%**	**214,845**	**100%**	**1,423,693**	**100%**

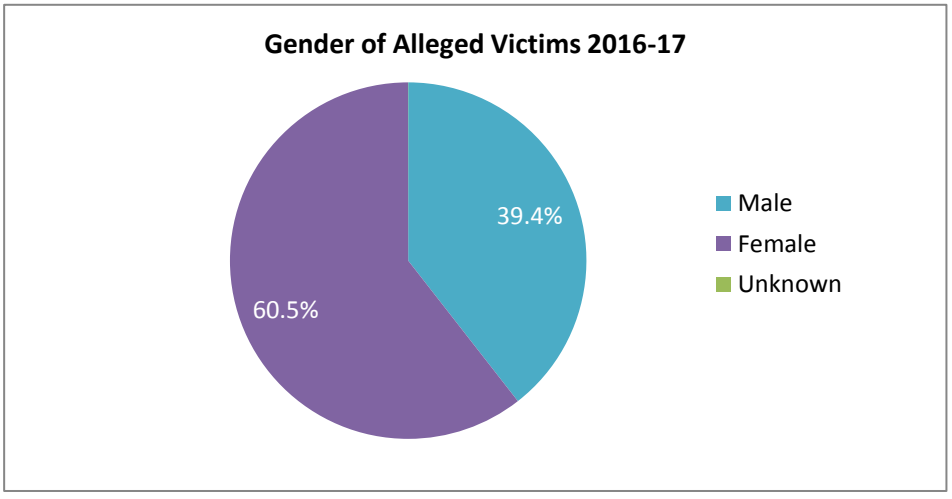
Table 7.3a: Population estimates by Gender and Age Range
Source: Population Estimates Unit, ONS (Crown Copyright).
Data released on 22 June 2017 by the Office for National Statistics.

Gender of alleged victims

In 2016-17 the highest proportion of alleged victims was Female at 60.5%, which reflects a marginal increase compared with the 2015-16 percentage. Overall, the proportions remain consistent over the reporting periods.

	2013-14		2014-15		2015-16		2016-17	
Gender	Number	%	Number	%	Number	%	Number	%
Male	1375	39.4%	1366	38.8%	1680	40.2%	2376	39.4%
Female	2116	60.6%	2151	61.2%	2494	59.8%	3646	60.5%
Unknown	0	0.0%	0	0.0%	0	0.0%	5 or less	0.0%
Total	**3491**	**100%**	**3517**	**100%**	**4174**	**100%**	**6023**	**100%**

Table 7.4 Gender of alleged victims over the periods 2013-14 to 2016-17



For comparison purposes, based on the 2016 mid-year population estimates, the following table presents the total population, by gender, for Kent and Medway.

Gender	Kent		Medway		Kent & Medway combined	
	Number	%	Number	%	Number	%
Male	756,568	49.1%	138,262	49.6%	894,830	49.1%
Female	785,325	50.9%	140,280	50.4%	925,605	50.9%
Total Persons	**1,541,893**	**100%**	**278,542**	**100%**	**1,820,435**	**100%**

Table 7.4a: Population estimates by Gender
Source: Population Estimates Unit, ONS (Crown Copyright).
Data released on 22 June 2017 by the Office for National Statistics.

Ethnicity of alleged victims

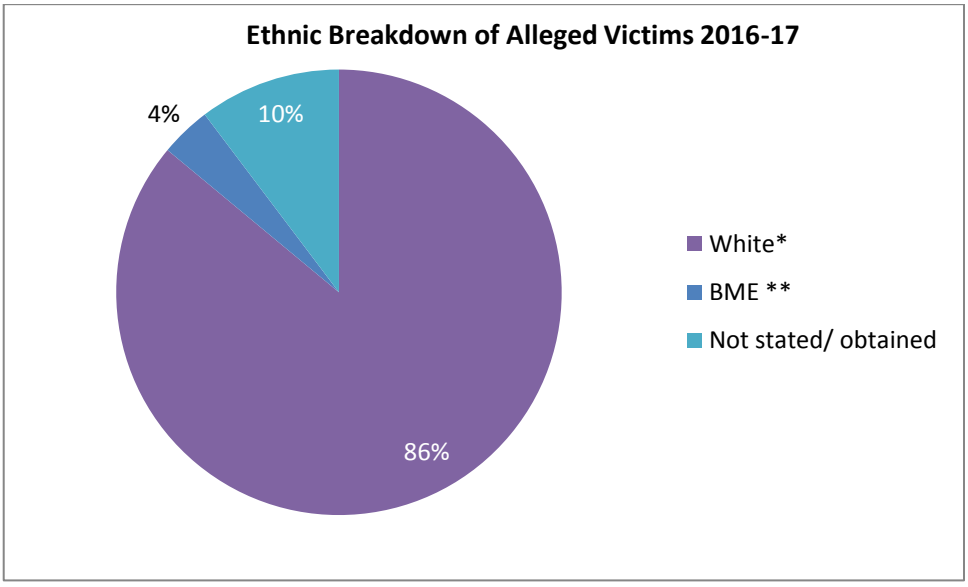
Between the periods of 2015-16 and 2016-17, the percentage of enquiries relating to alleged victims from a white background increased from 84.9% to 86.0%. The percentage of alleged victims from a black or ethnic minority background has increased by 0.4%, from 3.3% to 3.7%.

In contrast, enquiries where the ethnic origin was not stated or obtained, has reduced by 1.5%.

Ethnic Group	2013-14		2014-15		2015-16		2016-17	
	Number	%	Number	%	Number	%	Number	%
White*	3077	88.1%	3062	87.1%	3544	84.9%	5181	86.0%
BME **	106	3.0%	118	3.4%	136	3.3%	222	3.7%
Not stated/ obtained	308	8.8%	337	9.6%	494	11.8%	620	10.3%
Total	**3491**	**100%**	**3517**	**100%**	**4174**	**100%**	**6023**	**100.0%**

Table 7.5: Breakdown of Ethnic Group for the periods 2013-14 to 2016-17

** White' contains the DoH ethnic groups of White British, White Irish, Traveller of Irish Heritage, Gypsy/Roma, Other White Background*
*** 'BME' includes all Asian or Asian British, Black or Black British, Mixed and Other groups*



For comparison purposes, based on the 2011 census, the following table presents the total population, by ethnic group, for Kent and Medway.

Ethnic Group	Kent		Medway		Kent & Medway combined	
	Number	%	Number	%	Number	%
White	1,371,102	93.7%	236,579	89.6%	1,607,681	93.1%
BME	92,638	6.3%	27,346	10.4%	119,984	6.9%
All usual residents	1,463,740	100%	263,925	100%	1,727,665	100%

Table 7.5a: Kent Population by Ethnic Group
Source: 2011 Census: Key Statistics Table 201, Office for National Statistics (ONS) © Crown Copyright

Primary Support Reason of alleged victims

The table below shows the number of individuals according to the Primary Support Reason of alleged victims.

As in previous Annual Reports, in both Kent and Medway, the most prevalent support reason remains Physical Support. This is then followed by no support reason at the time of the alleged incident, with Kent and Medway reflecting 21.7% and 22.4% of cases respectively having no support reason. The percentage of cases with no Support Reason are in-line with those previously reported and is to be expected, as individuals subject to a safeguarding referral will not always be receiving support from the local authority.

Primary Support Reason	Kent	Medway
Physical Support	36.9%	56.5%
Sensory Support	2.2%	0.3%
Support with Memory & Cognition	11.4%	3.6%
Learning Disability Support	12.5%	8.4%
Mental Health Support	14.1%	5.2%
Social Support	1.0%	3.6%
No Support Reason	21.7%	22.4%
Total	**100%**	**100%**

Table 7.6 Breakdown of Primary Support Reason (PSR) for the period 2016-17

Location of alleged abuse

Following changes within statutory reporting requirements, the table below has been updated to reflect new codes. These include breaking down the care home location to residential and nursing settings and reporting hospital settings broken down by acute, mental health hospital and community hospital locations. The location of public place has also now been recoded under the setting of 'in the community (excluding community services)'.

In 2016-17 the most prominent location for incidents of alleged abuse was within the alleged victim's own home. This location represents 41.1% of all incident locations and has seen a 6.4 percentage point increase over since the previous year, 2015-16. This is a significant increase and the highest percentage seen across the four reporting years for this location.

Previously the care home setting was the main setting of alleged incidences of abuse but this location has seen a 6.3 percentage point drop, to 35.7% in 2016-17.

Please note, from 2015-16 the method of calculating the location of alleged abuse is based on closed enquiries in the reporting year. Therefore, the total number of enquiries will not correlate with earlier sections of the report which detail number of enquiries received within the reporting period.

	2013-14		2014-15		2015-16		2016-17	
Location of Alleged Abuse	Number	%	Number	%	Number	%	Number	%
Own Home	**1215**	**34.8%**	**1209**	**34.4%**	**1262**	**34.7%**	**2223**	**41.1%**
In the community (exc. community services)	**71**	**2.0%**	**70**	**2.0%**	**-**	**-**	**190**	**3.5%**
In a community service	**109**	**3.1%**	**116**	**3.3%**	**111**	**3.1%**	**199**	**3.7%**
Care Home*	**1415**	**40.5%**	**1359**	**38.6%**	**1528**	**42.0%**	**1932**	**35.7%**
Care Home - Nursing	-	-	-	-	-	-	420	7.8%
Care Home - Residential	-	-	-	-	-	-	1512	27.9%
Hospital**	**191**	**5.5%**	**262**	**7.5%**	**171**	**4.7%**	**420**	**7.8%**
Hospital - Acute	-	-	-	-	-	-	181	3.3%
Hospital - Mental Health	-	-	-	-	-	-	148	2.7%
Hospital - Community	-	-	-	-	-	-	91	1.7%
Other***	**130**	**3.7%**	**156**	**4.4%**	**563**	**15.5%**	**451**	**8.3%**
Not Known	**360**	**10.3%**	**345**	**9.8%**	**-**	**-**	**-**	**-**

Table 7.7: Location of alleged abuse for the periods 2013-14 to 2016-17

** All care home settings, including nursing care, permanent and temporary*
*** Acute, community hospitals and other health settings*
**** Includes any other setting that does not fit into one of the above categories including Not Known.*

Types of alleged abuse

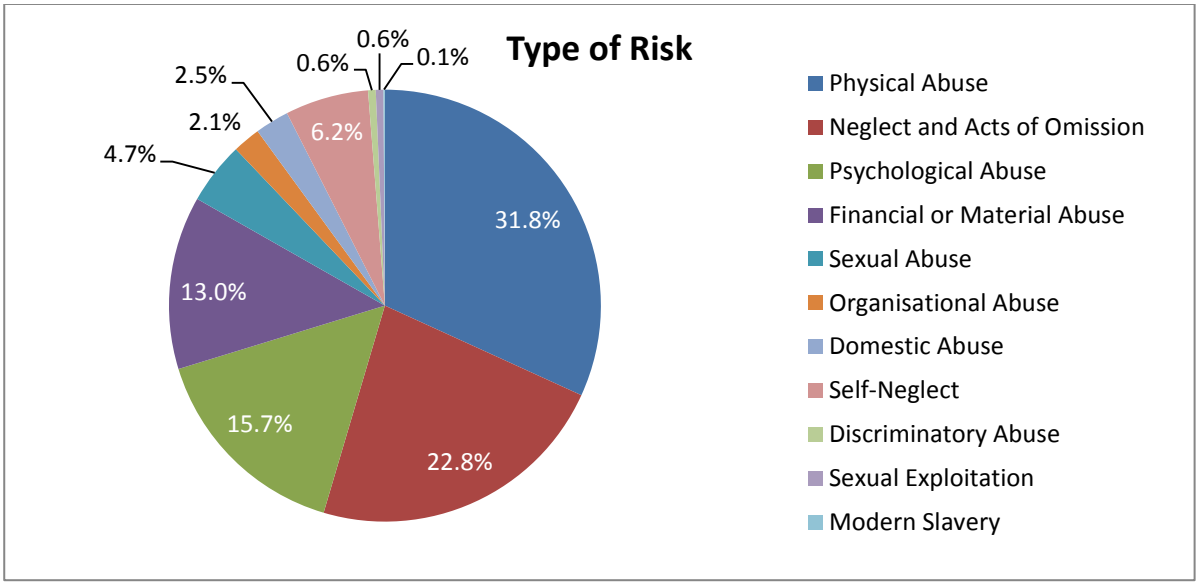
Physical abuse has remained to be the most predominant type of risk over the four reporting years as shown in table 7.8. However, the percentage of types of risk relating to Physical abuse has reduced 4.2 percentage points since 2014-15, decreasing to 31.8% in the 2016-17 period.

Neglect and Acts of Omission has remained the second most prevalent type of risk but this type of risk has also reflected a reduction in the 2016-17 period, reducing by 2.5 percentage points to 22.8% in the latest reporting period.

Incidents relating to risk types of Domestic Abuse or Self-Neglect have both reflected percentage increases in the 2016-17 period. Domestic Abuse has increased from 1.7% in 2015-16 to 2.5% in 2016-17, whilst Self-Neglect increased from 1.4% to 6.2% over the same periods.

Categories of alleged abuse	2013-14		2014-15		2015-16		2016-17	
	Number	%	Number	%	Number	%	Number	%
Physical Abuse	1407	33.6%	1100	36.0%	1482	34.5%	2063	31.8%
Neglect and Acts of Omission	1054	25.2%	750	23.5%	1090	25.3%	1477	22.8%
Psychological Abuse	691	16.5%	366	17.0%	656	15.3%	1017	15.7%
Financial or Material Abuse	688	16.4%	572	14.7%	600	14.0%	841	13.0%
Sexual Abuse	206	4.9%	146	5.8%	215	5.0%	302	4.7%
Organisational Abuse	98	2.3%	65	2.4%	91	2.1%	135	2.1%
Domestic Abuse	-	-	-	-	75	1.7%	165	2.5%
Self-Neglect	-	-	-	-	62	1.4%	405	6.2%
Discriminatory Abuse	39	0.9%	9	0.6%	24	0.6%	37	0.6%
Sexual Exploitation	-	-	-	-	5 or less	<1%	37	0.6%
Modern Slavery	-	-	-	-	5 or less	<1%	7	0.1%

Table 7.8: Type of Risk (an enquiry may have multiple types of risk recorded – the percentage figures relate to the proportion of all enquiries where each type of risk was apparent)



Source of safeguarding concern leading to safeguarding enquiry

Table 7.9 below shows the comparison of the sources of safeguarding concerns leading to safeguarding enquiries over the past four years. As reflected in previous annual reports, the majority of enquiries continue to initiate from social care staff - however; there has been a 0.6 percentage point decrease from 2015-16 to 2016-17. The second most prevalent source group is health staff, which has seen a 5.8% percentage point increase in the last period, rising to 32.2%.

The 'Other' category, which includes carers, voluntary agencies/independent sector, anonymous, legal, other LA, Benefits Agency, Probation Service and strangers, has reflected a 5.1% percentage point decrease between 2015-16 and 2016-17.

Both Kent and Medway have safeguarding websites and leaflets accessible by members of the public. Safeguarding Awareness Week is key to increasing safeguarding awareness amongst members of the public.

Source of safeguarding concern leading to enquiry	2013-14		2014-15		2015-16		2016-17		% point change 2015-16 to 2016-17
	No.	%	No.	%	No.	%	No.	%	
Social Care staff	1689	48.4%	1602	45.6%	1701	43.5%	2654	44.1%	0.6%
Health Staff	718	20.6%	827	23.5%	1032	26.4%	1937	32.2%	5.8%
Other	298	8.5%	386	11.0%	553	14.2%	546	9.1%	-5.1%
Police	152	4.4%	132	3.8%	158	4.0%	225	3.7%	-0.3%
Family member	271	7.8%	202	5.7%	135	3.5%	109	1.8%	-1.7%
Care Quality Commission	115	3.3%	132	3.8%	125	3.2%	162	2.7%	-0.5%
Self-Referral	129	3.7%	122	3.5%	105	2.7%	18	0.3%	-2.4%
Housing	45	1.3%	60	1.7%	66	1.7%	189	3.1%	1.4%
Friend/Neighbour	49	1.4%	25	0.7%	23	0.6%	17	0.3%	-0.3%
Education/Training/ Workplace	10	0.3%	22	0.6%	6	0.2%	23	0.4%	0.2%
Other Service User	8	0.2%	7	0.2%	5 or less	<1%	4	0.1%	-
Unknown	7	0.2%	0	0.0%	5 or less	<1%	139	2.3%	-
Total	**3491**	**100%**	**3517**	**100%**	**3906**	**100%**	**6023**	**100%**	**-**

Table 7.9 Source of safeguarding concerns for the periods 2013-14 to 2016-17

Note: The 2015-16 information does not include Medway data as this data was not collated.

Prior to the review of Medway Council's computer system in Spring 2016, the data relating to referral source was manually input into the computer system and was difficult to report on. Following review of the safeguarding adults computer system, this data can now be collected. Medway will run a report and analyse this data on a quarterly basis to determine high level of referrals and areas where referral numbers are low or non-existent. This will focus local awareness raising activity.

Closed referrals

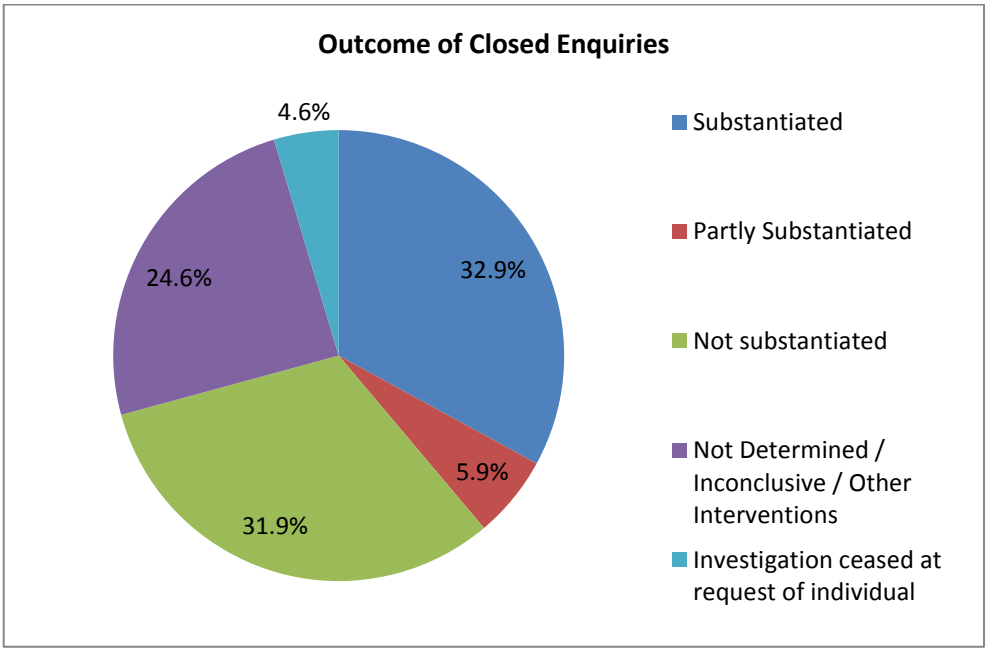
Outcome of closed enquiries

The greatest proportion of cases in Kent relate to substantiated cases (33.2%), which has seen a 7.9 percentage point drop from the 41.1% of cases substantiated in 2015-16. The biggest increase relates to the not determined/inconclusive/other interventions outcome, which has reflected an increase of 11% percentage points this year. Other interventions will include self neglect protocols and statutory intervention. In Kent, the total of cases that are not substantiated has fallen by 5.4% (to 31.9%).

In Medway, the highest proportions of cases are not substantiated at 32.1%, which has increased by 1.1 percentage points in 2016-17. Cases that are substantiated represent a slightly lower proportion in Medway (29.5%) when compared with Kent (33.2%). Partly substantiated cases for Medway represent 16.0%, and this remains consistent with the 15.1% seen in 2015-16.

	Substantiated		Partly Substantiated		Not Substantiated		Not determined/ inconclusive/ Other Interventions		Investigation ceased at request of individual	
Area	No.	%	No.	%	No.	%	No.	%	No.	%
Kent	1692	33.2%	270	5.3%	1628	31.9%	1283	25.1%	230	4.5%
Medway	92	29.5%	50	16.0%	100	32.1%	49	15.7%	21	6.7%
Total	**1784**	**32.9%**	**320**	**5.9%**	**1728**	**42.8%**	**1332**	**13.7%**	**251**	**4.6%**

Table 7.10 Outcome of closed enquiries in Kent and Medway 2016-17



Risk outcomes for closed enquiries

This section looks at where a risk was identified, what happened to the risk following action being taken. Action can include anything that has been done as a result of the safeguarding concern or enquiry. It can include examples such as disciplinary action for the source of risk or increased monitoring of the individual at risk.

	Risk Remained		Risk Reduced		Risk Removed	
Area	No.	%	No.	%	No.	%
Kent	101	3.9%	2096	80.3%	413	15.8%
Medway	19	13.4%	80	56.3%	43	30.3%
Total	**120**	**4.4%**	**2176**	**79.1%**	**456**	**16.6%**

Table 7.11: Risk Outcomes for closed safeguarding enquiries 2016-17
Note: Only presents information for cases where a risk was identified.

In Kent, there were 3.9% of cases where the circumstances causing the risk were unchanged and the same degree of risk remained. In Medway this risk outcome represents 13.4%. It should be acknowledged that there are valid reasons that a risk could remain, for example in the case of an individual wanting to maintain contact with a family member who was the source of the risk. In such an example action could still be taken to refer the individual at risk for counselling.

Table 7.11 demonstrates that in both Kent and Medway the greatest proportions relate to risk being reduced or removed. In 96.1% of cases where a risk was identified in Kent, the risk was either reduced or removed. In Medway a similar picture is presented, with 86.6% of cases where a risk was identified having the risk reduced or removed.

Section 8. Priorities for 2017-2018

The KMSAB Annual Plan for 2017–2018 details how we will meet the following priorities:

- We will engage with residents of Kent and Medway, empowering and enabling them to contribute to safeguarding and the work of the Board.
- We will ensure that we learn from the outcomes of Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs) and Children's Serious Case Reviews (SCRs) and these directly influence practice improvements
- We will ensure our structure and governance arrangements enable us to meet our statutory duties effectively and efficiently.
- We will ensure that our Policy, Procedures and Guidance documents are compliant, easy to use and reviewed and updated regularly
- We will provide a high quality multi-agency training offer

Appendices

Appendix 1 : Kent and Medway Safeguarding Adults Board Principles and Values

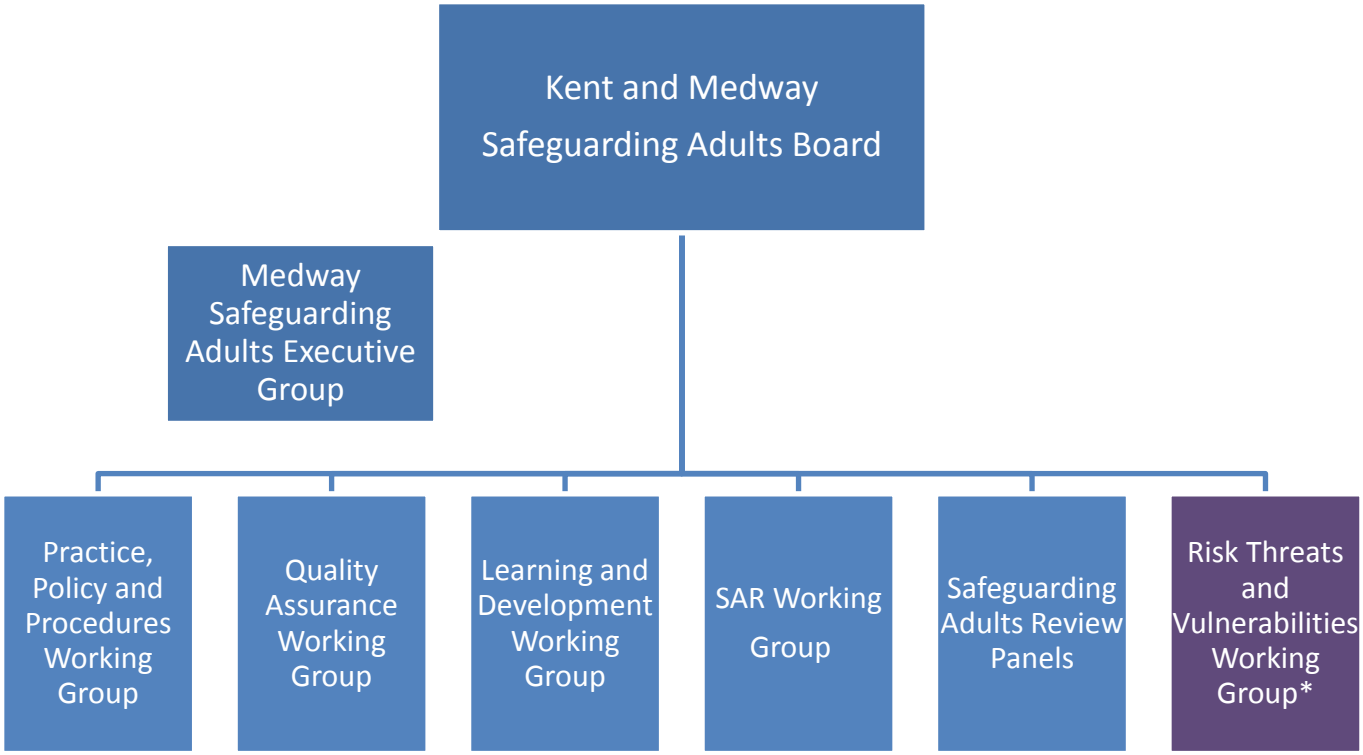
The Kent and Medway Safeguarding Adults Board is underpinned by the following principles and values:

- It is every adult's right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity
- All agencies and services should ensure that their own policies and procedures make it clear that they have a zero tolerance of abuse
- Priority will be given to the prevention of abuse, by raising the awareness of adult safeguarding issues and by fostering a culture of good practice through support and care provision, commissioning and contracting
- Adults who are susceptible or subjected to abuse or mistreatment will receive the highest priority for assessment and support services
- These principles are applicable to all adults whether living in a domestic setting, care home, social services or health setting, or any community setting
- Protection of adults experiencing, or at risk of, abuse or neglect, is a multi-agency responsibility and all agencies and services should actively work together to address the abuse of adults
- Interventions should be based on the concept of empowerment and participation of the individual at risk
- These principles should constitute an integral part of the philosophy and working practices of all agencies involved with adults experiencing, or at risk of, abuse or neglect, and should not be seen in isolation
- It is the responsibility of all agencies to take steps to ensure that adults experiencing, or at risk of, abuse or neglect, are discharged from their care to a safe and appropriate setting
- The need to provide support for carers must be taken into account when planning services for adults experiencing, or at risk of, abuse or neglect, and a carer's assessment should be offered
- These principles are based upon a commitment to equal opportunities and practice in respect of race, culture, religion, disability, gender, age or sexual orientation

Appendix 2 : Types of Abuse

- **Physical abuse** is when someone is physically harmed by another person, for example through assault, such as slapping, pushing, kicking or rough handling. It can also include the misuse of medication, or inappropriate sanctions or restraint.
- **Domestic Abuse** is when abuse occurs between partners, former partners or by a family member. It can include psychological, physical, sexual, financial or emotional abuse as well as 'honour' based violence, forced marriage and female genital mutilation.
- **Sexual abuse** relates to any sexual activity which the adult has not consented to, was not able to consent to or was pressured into consenting to. This can include rape, sexual assault or harassment, sexual photography, subjection to pornography or inappropriate touching.
- **Psychological abuse** includes emotional abuse, verbal assault, intimidation, bullying, cyber bullying, abandonment, threats of harm, humiliation or blaming. Any unjustified withdrawal of services or support networks is also a form of psychological abuse, as is not letting the person have choices or ignoring their wishes.
- **Financial or material abuse**, abuse relates to theft, fraud, internet fraud/scams, exploitation or pressure in connection with financial affairs or arrangements. It can also include the misuse or misappropriation of property, possessions or benefits.
- **Modern slavery** is when individuals are coerced, deceived or forced into a life of abuse, servitude and inhumane treatment. This can be through human trafficking, forced labour or domestic servitude
- **Discriminatory abuse** is when a person suffers ill-treatment or harassment because of their race, gender, cultural background, religion, physical and/or sensory impairment, sexual orientation or age. This can be referred to as hate crime.
- **Organisational abuse** is where an adult is placed at risk through poor professional practice and/or organisational failings. It can be a one-off incident or ongoing ill-treatment or neglect. This abuse can happen when care and support is provided at home or within an institution or care setting, such as a hospital or residential home.
- **Neglect and acts of omission** is when someone deliberately or unintentionally causes a person to suffer by failing to provide the required medical or physical care. This may include failing to provide access to appropriate health, social care or education. This can result in their essential day to day needs, such as: medication, food, drink and heating, being denied.
- **Self-neglect** is when a person's behaviour, such as neglecting to care for personal hygiene, health or surroundings, has a detrimental effect on their health and wellbeing. It can include behaviour such as hoarding.
- **Forced Marriage** is a marriage in which one or both of the parties is married without his or her consent or against his or her will
- **Honour Based Violence** is a term used to describe violence committed within the context of the extended family which is motivated by a perceived need to restore standing within the community, which is presumed to have been lost through the behaviour of the victim
- **Hate Crime** is any crime that is targeted at a person because of hostility or prejudice towards that person's: disability, race or ethnicity, religion or belief or sexual orientation
- **Mate Crime** is a form of crime in which a perpetrator befriends a vulnerable person with the intention of then exploiting the person financially, physically or sexually

Appendix 3 : Kent and Medway Safeguarding Adults Board Governance Structure (2016-17)



*KMSAB joined this working group in February 2017. It is a joint working group with Kent Safeguarding Children's Board and Medway Safeguarding Children's Board

If you think you or another person is at risk of harm or abuse, please contact:

KENT
Tel: 03000 41 61 61
NGT: 18001 03000 416161
Kent.gov.uk/adultprotection

MEDWAY
Tel: 01634 334466
NGT: 18001 01634 334 466
Medway.gov.uk/abuse

If someone is in immediate risk contact the emergency services on 999

Minutes of the 0-25 Health and Wellbeing Board Meeting
10 October 2017
14:00 – 15:45
Medway Room Sessions House

Present:			
Andrew Ireland	AI	-	Social Care Health & Wellbeing Corporate Director, KCC (Chair)
Peter Oakford	PO		Cabinet member – Strategic Commissioning and Public Health
Roger Gough	RG	-	Cabinet Member – Education & Health Reform, KCC
Penny Southern	PSo	-	Director, Disabled Children, Adults with a Learning Disability and Mental Health, KCC
Patrick Leeson	PL	-	Education and Young People's Services Corporate Director, KCC
Jess Mookherjee	JM	-	Assistant Director Public Health, KCC
Claire Hayward	CH	-	East Kent Clinical Commissioning Group
Dr Bryn Bird	BB	-	Children's Clinical Lead, West Kent CCG
Wendy Jefferies	WJ	-	Public Health Specialist, KCC
Matthew Scott	MS	-	Police and Crime Commissioner
Amanda Kenny	AK	-	Swale & DGS Clinical Commissioning Group Commissioner
Karen Sharp	KS	-	Head of Transformation and Commissioning, KCC
Jo Tonkin	JT	-	Public Health Specialist, KCC
Sue Mullin	SM	-	East Kent Clinical Commissioning Group
Mark Janaway	MJ	-	Programme & Performance Manager, KSCB (for Gill Rigg)
Stuart Collins	SC	-	Director Early Help and Preventative Services, KCC
Patricia Denney	PD	-	Assistant Director of Safeguarding and QA, CCC SCS (for Sarah Hammond)
Jo Hook	JH	-	District Manager, Gravesham, KCC EHPS
Natalie Manuel	NM	-	Maternity Commissioner, West Kent CCG
David Weiss	DW	-	Head of HeadStart Kent

Apologies	
Sue Mullin	Thanet Clinical Commissioning Group
Sarah Hammond	Interim Specialist Children's Services Director, KCC
Gill Rigg	Kent Children's Safeguarding Board Independent Chair
Sarah Robson	Kent Housing Group
David Holman	West Kent Clinical Commissioning Group, Children's Lead
Debbie Stock	Swale Clinical Commissioning Group

1. Welcome & Introductions

1.1 The Chair welcomed everyone to the meeting and introductions were made.

2. Minutes from meeting held on 28 March 2017

2.1 The minutes were agreed as an accurate account subject to the update to Action No. 3 as below. The Board were also advised that on Page 6, Item 7.3 it is Ken Pugh and Not Kent Pugh.

2.2 Update on Actions:

2.2a Action No 1: This action is closed. The written confirmation from KMPT that they do accept patient from overseas according to the DHS guidance was circulated with the meeting papers

2.2b Action No 3: Christine Jackson-Haywood, Transforming Care Children's Co-ordinator will present the paper.

2.2c Action No 4: Complete - the Human Trafficking Presentation will go to the next meeting of the KSCB.

2.2d Action No 5: This action related to the paper that came to the last meeting around progressing the Children's commissioning arrangements with partners. There were a series of actions in the paper that were to be picked up at the summit organised by East Kent CCG. The Board were advised that the Summit took place and went well. Hazel Carpenter will be taking forward the work that was in the paper with the commissioning leads and the STPs. Some of the specifics that came to the last Board included:

- establishing a plan and programme of integrated commissioning
- the establishment of an SRO within the STP
- CCGs in the East and West of the County to develop a report on integrated commissioning arrangements
- Development of an integrated plan and bringing that back to this Board in the Autumn

It was suggested and agreed that this be fed back to Hazel and that she be invited to give an update at the December meeting of the Board. **Action 1 – Hazel Carpenter**

The Chair advised that the key is how it is all pulled together and driven forward through the STP. A query was raised as to whether Hazel was taking this forward for the whole of the Kent's Children's agenda or is it for East to talk to North and West. It was felt it would be for the whole but clarity on this was to be sought.

North Kent were not represented at the meeting so there will need to be additional discussions.

3. Feedback from Kent Children and Young People Mental Health and Wellbeing Transformation Board

Item 3.1 – Sign off of Local Transformation Plan – Sue Mullin, Jo Tonkin

3.1 The Board noted the presentation

3.2 Commissioners and Public Health specialists have worked to pull together a transformation plan for 17/18. It is annual plan that has to be reviewed and is quality assured by NHS England.

3.3 Clarity was provided on the meaning of Emotional and Mental Health. Mental and Emotional Health includes externalising Mental Health Disorders which are sometimes referred to as behavioural and internalising mental health disorders which are often known as emotional. Children and young people often present with both but the interventions which address the symptoms are different and the role of Health Services and Local Authorities differ in relation to the different presenting issues.

3.4 In terms of Self-Harm, 22% of 15 year olds have and 32% of young women ever self harmed and there is an increasing trend of admissions to A&E.

3.5 The 17/18 Plan is a leap forward and the thinking, the governance process, communication within the system and identifying where investment is needed is

more robust than previously. It is an iterative live document about all children in Kent and all agencies in Kent.

3.6 The Plan comes with some money to CCG baselines. Some CCG areas have moved all the money into their specialist mental health provider. In Kent consideration is being given to what success would look like if investment could be moved from Tier 3 services to get the Tier 1 and 2 services right. The money will cease in 2021 and sustainability needs to be addressed.

3.7 The document is evaluated by NSPCC along with the National Audit Office and NSHE.

3.8 NSHE evaluated last year's document as the best in the SE Region whilst NSPCC advised that there was not enough in the document for vulnerable children.

3.9 Last year NSHE scored the document against 12 areas. This year it will be against 50/60 areas.

3.10 The Board were advised that in the last 12 months there have been 5 teenage suicides. Is it possible to reach these people as the suicides were quite unpredictable? The Health Needs Assessment that has been undertaken looks at the evidence (based on national work undertaken) of what works to prevent teenage suicide. There is a particular workstream in the plan that brings people together to write a suicide prevention strategy and this will take in the chronologies of these children. Increasing interventions around self-harm, earlier identification of emotional and mental health needs and increased access to mental health services are critical.

3.11 A query was raised as to how transition is captured going forward. It was felt a lead commitment from Social Care and the wider Health Economy is needed and PSo offered to be part of the conversation.

3.12 NSHE have advised that the sign off of the document is via the Health and Wellbeing Board although this Board might be a better forum because of the content and context. Formal agreement from this Board that they agree the iterations received at the meeting are suitable enough to be published as a point in time document was sought. Dave Holman will also ensure that it is tabled at the Health and Wellbeing Board. Following discussion it was agreed that:

- Any comments on the document should be sent to Sue Mullin by 20 October at the latest. **Action 2- All Members**
- AI to ensure the final version is published on Kent.gov.uk. **Action 3 – Andrew Ireland**
- DH to ensure the document is taken to the Health and Wellbeing Board in November for retrospective approval. **Action 4 – Dave Holman**

Item 3.2 – Update on Children & Young People's Mental Health Services

3.13 When it became evident that the procurement of the Children & Young People's Mental Health Services was necessary as the existing contracts were ending, the plans within the early work around transformation were aligned.

3.14 In the first iteration of the plan, the following were referenced:

- Single point of access
- Equity across the system
- Investing in targeted in mental health
- Vulnerable groups

3.15 The Health Needs Assessment of 2014 lead to the development of a specification for a future Children & Young People's Mental Health Service by Committee.

3.16 A service that stretched up as well as down, that has a single point of access, and would be a strategic improvement partner was requested. The procurement went

ahead and the contract was awarded to the North East London Foundation Trust as from 1 September 17 who set up a single point of access from day one.

3.17 The Trust has over 300 members of staff in Kent and caseloads of 8 – 9000 children and the transition must be safe and secure. There will not be a change in how the service is delivered for some months. They have just released the restructure document to their staff and it is understand that there is a real increase in band 6/7 posts and a reduction in the number of the highly expert posts. The new structure will in place by Jan 18 and by March it is expected that every aspect of the new contract will be implemented and up and running including a new ASC/ADHD assessment pathway, a new complex needs pathway which includes vulnerable groups and different ways of working.

3.18 The various steps and stages must to be communicated once the consultation is finished.

3.19 It was agreed that an update on Children & Young People's Mental Health services be received at the next meeting with particular reference to communication. **Action 5: Sue Mullin**

3.20 A bulletin has been developed and it was agreed that all Board members should be signed up and receive it as it is published. **Action 6: Sue Mullin**

Item 3.2 – Update on HeadStart

3.21 The Board noted the presentation.

3.22 The Board were invited to attend a HeadStart conference taking place on 17 October.

3.23 A query was raised as to whether any work has been done with disabled children? The Board were advised that in each school grouping includes a Special School and the 10,000 young people referenced includes young people from special schools and the information gathered and the evaluation of the survey will be shared. In addition Kent has recommended a specific focus in the research programme around how children with disabilities benefit from this.

4. Item 4: Local Maternity Strategy (LMS) – Claire Haywood, Natalie Manuel

4.1 The National Maternity Review was published in February 2016 and sets out the five year forward view for maternity services. It includes a section on national recommendations that have to be adopted in their entirety. In order to do this Kent and Medway had to come together as a local maternity system to look at how maternity services could be transformed across the footprint. In addition West Kent won the pilot with choice and personalisation so they are able to pilot some of the recommendations and the LMS will be able to learn from that.

4.2 The LMS intends to reduce variation across Kent and Medway, ensure women have unlimited choice and services are safe. There will be shared policies and protocols

4.3 The LMS is the maternity element of the STP. The current plan goes up to 2021 and is very high level and does not currently have any detail. It needs to be submitted to NHS England by 31 October.

4.4 The governance structure reports directly into the STP but 0 – 25 Health and Wellbeing Board, the CCGs and Trust have also been sited

4.5 Some funding has been received from NHS England for a Project Manager and a Clinician Chair and the work will progress once the posts are filled.

4.6 A question was raised as to whether the LMS is fully integrated into the Early Years Children Centre settings. The Board were advised that once the workstreams are up and running, Children's Centres will be allocated into them. It was agreed that there needs to be a seamless link through midwifery to health visiting and other services across into children's centres. There are also several public health related

issues including breast feeding that need to be fully integrated into this. In terms of child protection and safeguarding there are issues in terms of foetal alcohol and foetal drug syndromes and there needs to be a very clear process of identification of risk at the pre-birth stage.

4.7 Following discussion it was agreed that an update should come to the Board in 6 months' time once the workstreams have started. **Action 7: CH/NM**

5. Item 5 Ofsted Action Plan – Patricia Denney

5.1 The overall grading was good but with Help and Protection and KSCB areas of improvement.

5.2 10 recommendations were given and the LA produced an action plan in relation to these. The actions are completed or in the process of being completed with the exception of Action 3: Adolescent Risk Management and Child Sexual Exploitation (CSE) and Action 4: Adolescent Risk management and return home interviews.

5.3 There is a need to formulate a plan for how adolescent risk is recognised. ARM panels are complicated and there needs to be a more strategic meeting where those that attend are of the right grade and level and have an understanding of their community.

5.4 There is a challenge for KCC in that the Police have just been reorganised and clarity is needed on the MCET and CCET teams. The PCC agreed to take this up with Jon Sutton, Kent Police. **Action 8: MS**

5.5 Partner agencies need to be engaged in both understanding and formulising the management of adolescent risk and participating in the strategic management of adolescent risk.

5.6 A number of the issues are also being progressed through the Safeguarding Board.

5.7 Ofsted will test the action plan and in January 2018 a self-evaluation will need to be completed which will need to address the areas picked up in the Inspection.

5.8 It was agreed that an update should come to the Board in 6/9 months' time. **Action 9: SH**

Item 6.1: Special Educational Needs and Disability (SEND) Update – Patrick Leeson

6.1 An inspection is still anticipated and work is being undertaken to prepare for that. It will be a multi-agency inspection about the local area arrangements.

6.2 Work is being undertaken on putting together the multi-agency self-assessment. There are still gaps and Health partners still need to respond.

6.3 Part of the Inspection will be around lack of equal access to health provision in Kent. There are good examples of recommissioning – speech and language service, CAHMS, and there are helpful steps being taken in the recommissioning of Health Visiting to make sure that joint assessments at age 2 and 2½ will help with the early identification of SEN.

6.4 There are still on-going issues re assessing the need for and delivery of specialist service across special schools. This is a safeguarding issue as many children in special schools have life threatening medical conditions and staff need support, advice and training in order to feel confident and compliant with providing the support required.

6.5 Demand on resources to support SEN and disabilities continue to increase. Whilst most parents are satisfied with the process many complaints are received in relations to timeliness. The target for assessment and completion of plans is 20 weeks and the current rate within the 20 weeks is 74%. This will be an issue in the Inspection.

6.6 There is a 16% increase in requests for statutory assessments mostly from parents who are aware of their entitlements and rights. There is evidence that sometimes this is recommended to them by professionals and there is a need for clear messages to be communicated.

6.7 The high needs funding has been reviewed in terms of where the money is being spent and changes are being made as a result.

6.8 There is an aim to achieve more awareness raising, training and confidence in terms of supporting children with autism.

6.9 Parents continue to say that professionals are not joined up around the child and family when the child has ASD and this needs to be addressed.

6.10 The area where there is most pressure and challenge in terms of provision, especially in terms of education and training for young people with SEN, is post 16 and the opportunities for post 19. Several 100 young people are now post 19 and Kent has the responsibility to continue to support them but there is a challenge re bespoke provision for these individuals.

6.11 Siblings who do not get so much focus and how they are supported is something that needs to be considered although out of school support is important. There is also an offer from Early Help and Young Lives.

6.12 It was agreed that the most pressing issues is filling the gaps in the self-assessment and health partners were asked to chase to ensure the information is provided.
Action 10: Health Partners

Item 6.2: LCPG update – Jo Hook

6.13 The last LCPG Chairs meeting was held on 26 September and discussion included:

a. LCPG Early Help Grants – All partnership groups will be setting priorities for the Early Help Grants for 18/19. These will also include consideration to meeting the Troubled Families objectives as the two financial pots re coming together.

b. LCPG Chairs Meetings **–** Whilst work is being undertaken to improve the governance routes between the local Health and Wellbeing Boards and the LCPG, the LCPG will moving to a twice yearly ½ day meeting where the focus will be on Priorities and Impact. These will be chaired by the Director for Early Help who bring a more strategic overview. The meetings will be consist of two sessions, one for the chairs and one incorporating the co-ordinators.

c. Childhood Obesity **-** Public Health delivered a presentation to the Chairs highlighting the importance of the continued focus on childhood obesity (something that was picked up through many of the districts in their 17/18 priorities). There is a proposal for the governance of childhood obesity work streams to be taken on by the LCPGs and Val Miller from Public Health will work with the DPMs to see what structures there are locally to agree a direction of travel for local delivery of childhood obesity prevention and care. Where there are no existing structures Val will work with the LCPG to develop these.

d. Kent Transformation Plan – Jo Tonkin gave a presentation asking how the LCPGs want to be involved? Chairs/co-ordinators will contact their local CCG rep to ensure that this comes to the next round of meetings.

e. Dashboard – Dashboard discussions are still continuing and some potential improvements to the dashboard were presented including wider comparison with England data. Considerable discussions were prompted within the Group around the use of the dashboard, its usefulness or otherwise in setting priorities and different opinions were voiced. Common themes included the

need and importance of analysis and interpretation of data. This is lacking at the LCPGs and the resource to undertake this work is deemed unavailable.

6.14 The Chair suggested that it would be useful to have a lengthier discussion at the next meeting or the following and that one or two Chairs should be invited to attend for the discussion. The discussion should include exploration of the prioritisation and the work being undertaken on the Health and Wellbeing Board **Action 11: Helen Cook**

7 Drug & Alcohol Strategy Update – Jess Mookherjee

7.1 The Strategy is a combined Drug and Alcohol one as there is a desire to work much more closely with the Police Drug Strategy and capitalise on the successes of the Alcohol Strategy.

7.2 The Board were asked to comment and approve the Strategy. The Delivery plan will be available by the end of the month.

7.3 The pattern of drug use has changed and the landscape in terms of available drugs has also changed. For Adults there has been a concentration and complexity of both drug and alcohol abuses. In terms of young people there have been some notable improvements with young people responding to messages about alcohol use and more young people abstaining, although 1 in 4 deaths of 16-24 years olds are alcohol related, and there is a need to embed drug and alcohol issues in all of the strategies that relate to young people.

7.4 It was agreed that it was beneficial to join this up with the Police Alcohol Strategy. Some of the analysis around mental health shows that a growing proportion of people coming to police attention under S136 are intoxicated and the underlying issues of drugs, alcohol, mental health and police contact need to be considered.

7.5 The profile of drinking and drug use is changing across the Country with more young people not drinking at all but those who are still drinking are much more risky and vulnerable and the link between drugs and sexual behaviour is increasing.

7.6 Older people are also drinking more and so the issues of family need to be addressed.

7.7 A lot of young people turn to drink and drugs as a result of underlying insecurity and mental wellbeing problems.

7.8 Following discussion the Board approved the Strategy and agreed that the Delivery Plan, in particular the young people's element, should be presented at a future Board meeting. **Action 12: Jess Mookherjee**

8. Any Other Business

8.1 The Chair advised that this was his last meeting as Chair of the Board and he would be handing over to Matt Dunckley the incoming DCS

8.2 PL also advised that this was his last meeting.

Next meeting:

Monday 19 March 2018, 2.00pm – 5.00pm Medway Room Sessions House

Action List

Action No	Action Required and By Whom	By When
	Item 2 – Matters arising	
1	STP and the profile of children – Hazel Carpenter to give an update on the specifics that came to the July meeting of the Board at its December meeting	**12.12.17**
	Item 3.1 – Sign off of Local Transformation Plan (LTP)	
2	All Board members to send comments on the document to Sue Mullin by 20 October at the latest	**10.10.17**
3	Andrew Ireland to ensure the final version of the LTP is published on KNet	**a.s.a.p.**
4	Dave Holman to ensure the LTP is taken to the Health and Wellbeing Board in November for retrospective approval.	**22.11.17**
	Item 3.2 – Update on Children & Young People's Mental Health Services	
5	An update on this, with particular reference to communication, to be received at the December Board meeting – Sue Mullin	**12.12.17**
6	All members to be signed up to receive the Bulletin – Sue Mullin	**a.s.a.p.**
	Item 4 – Local Maternity Strategy (LMS)	
7	The Board to receive an update in 6 months' time once the workstreams have started – Claire Haywood/Natalie Manuel	**23.07.18**
	Item 5 – Ofsted Action Plan	
8	The PCC to raise the issue of clarity on MCET and CCET to be raised with Jon Sutton, Kent Police	**12.12.17**
9	An update on the self-assessment to come to the Board in 6-9 months' time – Sarah Hammond	**08.10.18**
	Item 6.1 – Special Educational Needs and Disability (SEND) Update	
10	Health partners to ensure the information for the self-assessment is provided to Julie Ely	**12.12.17**
	Item 6.2 – LCPG Update	
11	A lengthier discussion to take place at the December meeting of the Board including exploration of the prioritisation and the	**12.12.17**

	work being undertaken on the Health and Wellbeing Board. One or two LCPG Chairs to be invited to attend for the discussion – Helen Cook	
12	**Item 7 – Drug and Alcohol Strategy Update** The Delivery plan and in particular the young people's element, to be presented at a future meeting of the Board – Jess Mookherjee	**19.03.18**

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Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the
17th January 2018

Present:

Councillor Brad Bradford - Portfolio Holder for Highways, Wellbeing and Safety, ABC (Chairman)

Dr Navin Kumta – Clinical Lead and Chair, Ashford CCG (Vice-Chairman)
Councillor Jenny Webb, Deputy Portfolio Holder for Highways, Wellbeing and Safety, ABC
Sheila Davison – Head of Health, Parking and Community Safety, ABC
Karen Cook – Policy Advisor, KCC
John Bridle – HealthWatch
Chris Morley – Patient and Public Engagement (PPE) (Ashford CCG)
Roy Isworth – KALC
Deborah Smith – Public Health, KCC,
Lorraine Goodsell – Local Care Director, NHS Canterbury and Coastal CCG
Victoria Tatton – Ashford Vineyard
Chris Kimmance – Ashford Vineyard
Mark Wiltshire – KCC Early Help
Hannah Patton – HeadStart Kent
Sharon Williams – Head of Housing, ABC
Christina Fuller – Head of Culture, ABC
Belinda King – Management Assistant, ABC
Will Train – Corporate Scrutiny and Overview Officer, ABC
Keith Fearon – Member Services Manager, ABC

Apologies:

Tracey Kerly, Chief Executive, ABC, Simon Perks, Accountable Officer, CCG, Helen Anderson, Ashford Local Children's Partnership Group

1 Notes of the Meeting of the Board held on 18 October 2017

The Chairman referred to Minute No. 4(a)(v) and advised that he had still to action the letter to secondary schools about smoking cessation. **NB – Post Meeting Note – an email had been sent to CSP Head Teachers representative Sara Williamson.**

The Board agreed that the notes were a correct record.

2 Update on the Kent Health and Wellbeing Board Meeting – 22 November 2017

2.1 The Minutes of the Kent Health and Wellbeing Board meeting held on 22nd November 2017 could be accessed using the link provided under item 4 on the agenda. Navin Kumta summarised the items discussed at the

meeting, it being noted that there were no specific actions to be addressed by the Ashford Health and Wellbeing Board.

3 Update on Ashford Health and Wellbeing Board Priorities

(a) Stop Smoking Action Plan report 2017-2018: Quarter 3: October to December 2017

3.1 Debbie Smith introduced this item. She advised that there were an estimated 16,000 smokers in Ashford which was the 5th highest smoking prevalence in Kent. The One You Shop was proving very popular and now offered a clinic for pregnant women who smoked.

Resolved:

That the Board agreed that the report be received and noted.

(b) Healthy Weight Action Plan report 2017-18 Quarter 3: October to December 2017.

3.2 Debbie Smith drew attention to the progress report. The report advised that excess weight amongst children aged 4-5 and 10-11 year olds and overweight and obesity rates amongst adults were higher in Ashford than the national average.

Resolved:

That the Board agreed that the report be received and noted.

(c) Housing & Health

3.3 Please see the discussion under the presentation under item 5 below.

(d) Diabetes Update

3.4 The report presented an update on the current status of: - the proposed CCG pathway changes for diabetic care, using Tiers of Care approach; Ashford's progress against the Kent & Medway Structured Education Transformation Programme; and Ashford's progress in line with National Diabetes Prevention Programme: Healthier You.

Resolved:

That (i) the report be received and noted

(ii) a progress update be submitted in 6 months.

4 Presentation: Focus on Housing and Health

4.1 The report provided an overview of the progress in taking forward the new priority of Housing and Health. Sharon Williams also gave a presentation which had been published on the Council's web site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

4.2 Sharon Williams drew particular attention to the slide regarding Farrow Court and said that health professionals would be invited to view the facility and consider ways in which other health services could be provided from that site.

4.3 In response to a comment about the need for formal multi task meetings to take forward joined up health service provision, the Chairman explained that this was one of the functions of the Ashford Health and Wellbeing Board.

4.4 Sharon Williams also said that her team would be happy to feed into the current Sheltered Housing Consultation being conducted by KCC.

Resolved:

That the report and presentation be received and noted.

5 Presentation: Ashford Vineyard Church: Bringing life to Ashford

5.1 The report provided background to a presentation by Ashford Vineyard Church. Victoria Tatton and Chris Kimmance of Ashford Vineyard gave a presentation on their wellbeing activities. The report and presentation had been published on the Council's web site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

5.2 Chris Kimmance explained that the Church had been established about 10 years ago under the strapline 'bring life to Ashford'. Their work was based around two main arms of 'Gathering' and 'Compassion'. During the presentation 2 videos were also played regarding Ashford Sings and an example of help offered under their 'Mummy's Meals' scheme. In response to a question, it was explained that they did not charge for the meals and that they were provided to people who were in a potential crisis situation on a short term basis. They did not have the resource base to commit to this indefinitely as their funding came solely from donations to the church.

5.3 Victoria Tatton also explained that as part of Churches Together In Ashford, they had provided 200 beds from their building as part of the winter shelter scheme. This also included shower facilities and food and health care. Chris Kimmance then showed a final video titled '1000 Hours – A Kindness revolution' which showed that volunteers had given 5997 hours in Ashford in 2017.

5.4 The Chairman thanked the presenters for attending the meeting and said that he considered that they undertook excellent work. He said that ABC Officers would be happy to assist the Church in terms of access to any grant or funding applications they wished to make. Chris Kimmance distributed information packs which contained further information about the work of the church and relevant contact details.

Resolved:

The Board agreed that the presentation be received and noted.

6 Presentation: Annual Update from Local Children's Partnership Group and HeadStart Kent Phase 3

6.1 The report gave an overview of Local Children Partnership Groups (LCPGs) and the Ashford LCPG and sought to encourage further partnership commitment to achieving outcomes against identified local priorities for children and young people.

6.2 Hannah Patton of HeadStart gave a presentation on the work undertaken by HeadStart which had been published on the Council's Web Site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

6.3 The Chairman thanked Hannah Patton for her presentation.

Resolved:

That: (i) the local priorities as voted for by young people and as identified through the LCPG be used to provide direction for the Ashford Health and Wellbeing Board to inform partnership working on local priorities.

(ii) the integration of service delivery to families from both adult and children's services to be developed in Ashford be supported through the sharing of expertise and promotion of opportunities.

7 Ashford Estates Technology Transformation Fund (ETTF)

7.1 The report gave an update on the Ashford Estates Technology Transformation Fund (ETTF) premises scheme which had been successful in getting through the initial NHS England funding gateway in 2016. Lorraine Goodsell explained following publication of the report there had been discussions about the facts reported in paragraphs 8-13 and therefore this information would be reviewed and a revised report issued in due course.

7.2 Lorraine Goodsell explained the progress to date on the ETTF and said that in January 2017 NHS England had advised that £25,000 had been allocated as

pre-project costs to enable the appointment of professional advisers to support the project.

7.3 Following discussions with NHS England it had become clear that they were looking to the CCG to develop proposals that addressed the needs across the CCG area. A Business Case was also needed to be developed and work needed to be undertaken on population growth areas including activity to ensure full utilization of Section 106 resources. The process would involve working with ABC and the recruitment of a permanent officer at the CCG to undertake this work, was being pursued. In response to a question, Lorraine Goodsell said that the timescale for the submission of options appraisals was 31 March 2018. Sheila Davison considered that it was important for a person with the right skills to be recruited and Lorraine Goodsell said that she was happy for ABC to be involved in the recruitment process.

7.4 The Chairman expressed concern that despite funding of £1m being approved in January 2017 for health infrastructure projects, nothing definite had been agreed and no projects had actually been started. He believed that there was a deadline of 31 March 2018 to spend this money and he was very concerned that the funding would be lost to the Borough. The Chairman also was concerned that there appeared to be a lack of engagement by the CCG with ABC Officers. Lorraine Goodsell said she believed that the CCG had not effectively engaged with the Council or others and there was a need to develop a much stronger partnership with the Council and make it an absolute priority. Lorraine Goodsell advised that a new Ashford Estate Group has been formed and that this would provide the necessary direction on this vital issue. The Chairman suggested that the issue of improved partnership working be explored outside of the meeting.

Resolved:

That (i) the report be received and noted.

(ii) an Officer be nominated to join the Ashford Premises Group.

(iii) the CCG establish the position regarding the £1m grant and update the Chairman as soon as possible.

8 Sustainability and Transformation Plan

(a) Transforming Health & Care in East Kent

8.1 Lorraine Goodsell advised that unfortunately it had not been possible for a representative from the William Harvey Hospital to attend this meeting. She further advised that the presentation had been produced for her by Louise Dineley, East Kent STP Programme Director - email: louise.dineley@nhs.net The presentation had been published on the Council's web site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

8.2 The presentation explained the two potential options for the future provision of hospital services in East Kent and the next steps which would be to evaluate the options and then to undertake a consultation exercise. The presentation provided clarity on the assessment criteria for the hospital options. Loraine Goodsell said that a representative of East Kent Hospitals would be happy to attend a future meeting of the Board.

8.3 In response to a comment about the retention and attraction of staff, in particular consultants, Navin Kumta, said that this issue was being considered but it did not just relate to consultants and affected all staff. The principal aim was to reduce the number of people who needed to be seen by consultants. Sheila Davison highlighted the need to see the wider developments within Ashford and the fact that it was such an attractive area to live in (affordable housing, access to London, good transport links) This bigger picture would help attract the health workforce to the area and hospital for employment. She also advised that the interim Chief Executive of the Hospital Trust would be attending the next meeting in April.

(b) Implementation of Local Care – Ashford CCG

8.4 Navin Kumta gave a presentation on the key areas of Local Care Implementation. The presentation had been published on the Council's web site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

8.5 In response to a question, Navin Kumta explained that paramedic staff at the present time could not access patient records via the Cloud but they did have dedicated telephone access to the GP surgery which would enable the GP to give advice as to whether the patient should be taken to A&E or whether it was a pre-condition which could be treated by the surgery itself.

8.6 Roy Isworth referred to the Tenterden Day Centre and said that he believed that it would be helpful if there was a formal liaison process with the Day Centre Service in terms of managing recovering patients at home. He also referred to vacant space at West View hospital. Navin Kumta said that under the proposed arrangements engagement would take place with day centres but it was intended that there would be a move away from current practice and be based on either GP or hospital based support. John Bridle said that it was important in cases of patients with long term conditions to have access to practitioners who knew them.

8.7 In response to a comment, Navin Kumta explained that the NHS did have a workforce strategy in place which was used to enable upskilling of existing staff. He also said that prevention sat at the heart of local care and that work was continuing with Public Health. Lorraine Goodsell also explained that local care schemes in Canterbury had a close working relationship with the fire service and police who were able to provide a broader knowledge base and thus contribute to the prevention agenda.

8.8 Lorraine Goodsell advised that Matthew Capper would be the future representative from the CCG on the Ashford Health and Wellbeing Board.

Resolved:

That: (i) the presentations be received and noted

(ii) an update report on the Implementation of the Local Care agenda be submitted to the next meeting.

9 Partner Updates

(a) Clinical Commissioning Group

9.1 Update noted.

(b) Kent County Council (Public Health)

9.2 Update noted.

(c) Ashford Borough Council

9.3 Update noted.

(d) Voluntary Sector

9.4 Not provided as position currently vacant.

(e) HealthWatch

9.5 John Bridle said that if any members of the Board had any issues of concern he would be happy for them to be taken up by HealthWatch.

(f) Ashford Local Children's Partnership Group

9.6 Update noted.

10 Forward Plan

10.1 It was agreed that an item on the Ashford Clinical Providers would be on the agenda for the Board meeting on 18th April 2018.

11 Dates of Future Meetings

11.1 The next meeting would be held on 18th April 2018.

11.2 Subsequent dates:

18th July 2018
17th October 2018

CANTERBURY CITY COUNCIL

CANTERBURY AND COASTAL HEALTH AND WELLBEING BOARD

Minutes of a meeting held on Wednesday, 11th January, 2017 at 6.00 pm in the The Boardroom, Council Offices

Present Dr Sarah Phillips (Chairman)

Sam Bennett
Neil Fisher
Velia Coffey
Councillor S Chandler
Amber Christou
Mr Gibbens
Councillor Howes
Mark Lemon
Councillor Cllr Pugh
Jonathan Sexton
Sari Sirkia-Weaver

1 **APOLOGIES FOR ABSENCE**
Simon Perks
Wendy Jeffreys
Steve Inett

2 **MINUTES OF THE LAST MEETING AND ACTIONS**
The minutes were approved as an accurate record.

Matters Arising
Neil Fisher advised that the Annual Plan was submitted on 23 December 2016 and no feedback has been received so far from NHS England. The summary will be circulated.

Velia Coffey reported that she and Marie Royle met with Encompass (previously Vanguard) to discuss how community services can input into the new

Disabled Facilities Grant - Amber Cristou advised that Swale have spent their grants and would not be prepared to fund Kent County Council (KCC) Occupational Therapists (OTs).
It was noted that the assessment backlog in Canterbury district has now been resolved and now looking to work with Encompass to work smarter.
Action: Amber Cristou to liaise with Marie Royle.

Sustainability and Transformation Plan
Sarah Phillips advised that there is now a Kent and Medway Sustainability and Transformation plan (STP).

Sarah Phillips gave a presentation giving an update on the STP and advised that a further Case for Change document will be released covering the whole of Kent & Medway.

The following was highlighted:

- Hospital beds are being used by people unnecessarily as there is not the support available in their own home.
  Action: Sarah Phillips to circulate the hospital bed audit to Board members.
  Discussions have been ongoing for years around 'bed blocking' and facilitating people moving out of hospital in a timely way. Neil Fisher advised that delayed transfers are at their lowest level for a number of years and now the key is to prevent people being admitted in the first place and organisations need to work more closely to make this happen. The Health and Wellbeing Board and subgroups have helped facilitate organisations working together and it is felt that progress is being made.
- It is hoped that there will be a formal consultation in East Kent in Summer 2017.
- Engagement with the public is ongoing ahead of the formal consultation.

3 **HEALTH INEQUALITIES DISCUSSION AND WORKSHOP**

Sam Bennett gave a presentation with a focus on Canterbury data.

The following was highlighted:

- Smoking and drinking alcohol are higher in more deprived areas and have a big impact on mortality in deprived areas.
- In Canterbury the more deprived clusters are mainly people in social housing although it was noted that young people in private rented housing and also some rural areas also show some deprivation but do not reach a critical mass so risk being overlooked. It is easier to focus resources in obvious clusters such as social housing as this gives a focus.
- Canterbury has a high rate of alcohol admissions and work is being done to ascertain whether this is mainly students or residents in more deprived areas.
- Within education physical education is not a high enough priority as children from deprived areas are often behind academically and lose physical education time to more academic timetabling.
- Forces that put people into deprivation are very strong therefore targeting small groups of deprived people is not addresses the underlying causes. It was noted that the health inequalities do influence ongoing deprivation eg the ability to work, so small changes now may have future effects.
- Universal services and an offer to the whole population is of benefit to the whole population but those who are deprived tend to benefit more. Eg health trainers.
- Communities are not always cohesive therefore finding a community hub or centre can be difficult. Aylesham has had a lot of money invested into it and is has a good community but it is still showing as an area of deprivation, perhaps as opportunities are poor. It was noted that this could still be described as an area of deprivation even if the health of the residents had improved.
- Sam Bennett and Sari Sirkia Weaver are doing some work looking at inequalities in early years where the biggest changes can be made to achieve long term outcomes. The gap in attainment between children from more and less deprived areas is very high in Canterbury and is growing.
- Childrens' centres and other programmes such as Sure Start do lots of good work but resources are reducing so there is less focus on deprivation. The childrens' centre in Northgate is classed as outstanding therefore it could be used, with additional resources, to target some levels of deprivation. It was noted that outreach has been cut back and this has affected contacts with harder to reach families.

- It was agreed to support assets already in the community, such as childrens' centres and schools.

Action: The Board was asked to each think how they can support the childrens' centres in their areas, and what additional support would be needed to take things further.

4 **FOCUS OF THE BOARD IN 2017**

The Board discussed holding some of the meetings closed to the public with a more working group/workshop style meeting and hold a meeting in public perhaps twice a year to give meaningful public facing updates and sharing information that will be important to local people. This will encourage members of the public to attend.

It was agreed that openness is to be welcomed and the public meetings should be better publicised and more relevant to local people

It was agreed to alternate development and public facing meetings. that march meeting in MA room at 16.00.

Action: Neil Fisher to ensure that the public meetings are well publicised through the CCG.

5 **CQC REPORT FOR EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - FOR INFORMATION**

Noted.

6 **ANY OTHER BUSINESS**

Sarah Phillips advised that she will be chairing the next meeting in March but is taking up post as Medical Director for Kent Community Health NHS Foundation Trust from April 2017. The Board congratulated her on her appointment and thanked her for the work she had done with the HWB.

7 **DATE OF NEXT MEETING**

8 March 2017.

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DARTFORD BOROUGH COUNCIL

DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

MINUTES of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on Wednesday 21 February 2018.

PRESENT: Councillor Roger Gough (Chairman)
Councillor Mrs Ann D Allen MBE
Councillor Tony Searles
Councillor David Turner
Sheri Green
Sarah Kilkie
Melanie Norris
Nick Moor
Val Miller
Hayley Brooks
Dr Manpinder Sahota

ALSO PRESENT: Ian Gray, Premier
Rob Swain, Gravesham Community Leisure

34. APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Theresa Oliver, Alison Duggall, Graham Harris and Lesley Bowles.

Councillor Turner had submitted apologies for lateness due to another meeting commitment and subsequently joined the meeting.

35. DECLARATIONS OF INTEREST

There were no declarations of interest.

36. MINUTES - 25 OCTOBER 2017

The minutes of the meeting of the DGS Health and Wellbeing Board held on 25 October 2017 were agreed as an accurate record.

37. KENT COUNTY COUNCIL HEALTH AND WELLBEING BOARD

The minutes of the last meeting of the Kent County Council Health and Wellbeing Board on 22nd November 2017 were noted. The meeting in January had been cancelled.

The Chairman highlighted progress towards establishing a joint Health and Wellbeing Board between Kent and Medway following a change of heart by Medway who had not originally supported the idea. The new joint board would focus on the Kent and Medway STP and made more sense in the context of this footprint. The KCC Health and Wellbeing Board had also received an

update on the emerging Kent and Medway Growth and Infrastructure Framework to ensure that this worked across to the STP where the assumptions of growth were key.

The KCC Health and Wellbeing Board had also received a report on the NHS's preparations for the delivery of services during the Winter. This had been cursory in nature and the Board had asked for it to be revisited, particularly with regard to the preparedness of A&E and the scale of demand. As a result the Board had received a reasonable level of assurance which had been a significant improvement on the original report.

38. URGENT ITEMS

There were no urgent items.

39. PREMIER EDUCATION

The Board received a presentation entitled "Let's Educate and Activate the World" from Ian Gray, Area Director (North Kent & South Essex), Premier (formerly Premier Education).

Mr Gray explained that Premier was the UK's largest provider of sports coaching and physical activity in primary schools. They worked in 15% of all primary schools across the UK dealing with 250,000 primary school children per day and had 1,200 "activity providers." The company had been operating in Kent for the last 11 years and had a penetration rate of 20% of Kent primary schools, c.80 schools across the county and 40 activity providers.

There were 3 main strands of delivery:

- Premier Sport – provision of physical education and support
- Premier Arts – engaging young people through arts

Both of these strands were delivered by a combination of curricula teaching, after school clubs, holiday activities etc

The latest stream under development was :

- Premier Wellbeing – designed to improve health and wellbeing in primary schools. The delivery mechanisms for this differed from the first two services.

    - Play Trition- aimed at Reception children and 3-4 year olds, providing children with access to relevant and appropriate lifestyle messages that could be taken through into later life. This was often the first point of access to such messages and used tools including "character dolls".

- Fun Trition- aimed at 5-11 year olds. This took forward and reinforced similar messages but with more advanced tools engaging children across the curricula programme to give the right messages to make health lifestyle choices. The National Children Measurement Programme provided evidence that this period of development was vital for later life choices.
- Fit Trition – this was designed to be delivered by parents and teachers in the primary school environment and to provide children with healthy and engaged adult role models.

The delivery mechanisms were carefully designed to help schools to develop a whole life approach to wellbeing. Wellbeing was important because health metrics were startling; obesity levels were rising sharply in primary school age children, dental problems were the number one cause of hospital presentations by children in this age group, and there were also issues with diabetes and mental health.

There was clearly a need for a different approach to tackling these issues and this had been highlighted by initiatives over the last decade ranging from Jamie Oliver's campaigns for healthy food in schools, the readmission of cookery lessons to the curriculum, the universal free school meals programme, the improvement in School Food Standards and the introduction of Government targets on health and wellbeing and Ofsted targets. Premier had developed its programme around Ofsted reporting requirements.

The 4 fundamentals of Fit Trition were to:

- Eat well;
- Drink well;
- Move well;and
- Sleep well.

This offered a comprehensive solution to problems that had developed over a number of years.

The Board sought more information about the services delivered by Premier and how the programme was delivered in schools. Mr Gray explained that unlike other competitors who had developed programmes to be delivered by teaching staff, thereby detracting from teaching resources, Premier delivered its services directly through its own trained staff who had the advantage of being new to the children and providing fresh role models. The programmes were delivered by way of 2 six week modules targeted at each year group from Reception to Year 6. The cost involved for each module was £2,400 and whilst each school was required to find this funding it was affordable as each school received a Sports Level Premium of £18-19K and could also use funding from the sugar tax. Whilst the programme worked on re-enforcing messages across each year group it was also possible to deliver single modules.

The Chairman asked whether there was any evidence of the outcomes of the programmes and whether this and the level of take up was different between schools in more deprived areas, across all ranges of provision or in more affluent areas. Mr Gray emphasised the importance of engaging parents especially in areas of deprivation. In terms of working with schools across Kent currently only the Sports and Arts services were being delivered. The health and wellbeing services were being piloted at sites in Hertfordshire, the South west and North West with a view to rolling out more widely in September. Anecdotal evidence showed that these were working although it would take some time to build an empirical evidence base to support this in the way that data existed for the more established programmes. Evidence gained from surveying pupils at the start and end of the modules demonstrated the benefits of the programmes and outcomes could be measured to assess things like fitness levels. Outputs had been measured for some time and there was now more focus on looking at outcomes in terms of changes to behaviour and attitudes. In terms of sustaining the work once the programmes had been delivered Premier had developed CPD programmes for the established programmes and would be doing so for the health and wellbeing modules. In terms of increasing penetration into schools Premier welcomed any help possible in helping it to get the right messages across to schools and were happy to attend meetings with head teachers, trusts and Member bodies and to offer taster sessions.

Dr Sahota welcomed any programme to improve physical activity and the clear benefits that good nutrition and physical wellbeing had and how these translated into better educational results. He stressed the need to involve parents and the need for behavioural change to tackle issues such as obesity and for these to be sustainable. Mr Gray said that it was also important to look at the demographics of each school and that the modules delivered by Premier were sufficiently flexible to adapt to local needs.

It was agreed that Mr Gray would supply details of the schools already using Premier's services in Kent and that details of the opportunities available from Premier would be raised via DASco. It would be possible to map out this activity and to identify where access was being made into the most deprived areas and links into those schools using their sports premium funding. Mr Gray agreed to send details of the presentation to members of the Wellbeing Group.

40. A NEW VISION OF HEALTH MANAGEMENT IN LEISURE CENTRES - UPDATE

The Board received an update from Rob Swain, Managing Director of Gravesham Community Leisure, on the new vision for Health Management in

Leisure Centres in Gravesham. This developed themes from his presentation to the Board in August 2017.

This was based around moving away from the outputs traditionally used to measure success away from purely leisure management targets towards more health related outputs and reducing the incidence of lifestyle illnesses. This involved focussing on issues such assessments of current fitness, nutrition, exercise and activity levels and mindfulness for each individual. The ambition was to make Dartford, Gravesham and Swanley the healthiest area in the UK and a particular challenge was to help the estimated 6,000 type 2 diabetes sufferers in Gravesham. Activities to engage with sufferers had included a double page editorial in the Your Borough publication which, had resulted in 30 responses alone, and another article was planned. Posters had also been distributed to GP surgeries in the area, a facebook page had been developed and a google app. The success of a Bodytrack programme which allowed users to measure progress by employing technology was also described and the motivational aspects outlined. Gravesham Community Leisure also now had 84 members on medical memberships which was a good but small start. All of the measurable health indicators within the Bodytrack programme were moving in a positive direction. Ways of encouraging greater involvement were now being considered including a possible outreach programme.

Dr Sahota welcomed these initiatives and stressed that the best way to address these issues was through greater joined up working between all of the agencies and the co-location of services. He stressed the importance of proximity and location in getting people to take up and use services and the enormous benefits that could arise from this. He particularly noted the impact that this could have in reducing diabetes and the ineffectiveness of current NHS practices much of which could be treated by dietary measures and more active lifestyles.

It was suggested that this should be an issue for the County Council to take a stance and seek to pilot with statutory providers to provide a model for Kent.

It was agreed to look again at what is being done on industrialisation provision though the STP one aspect of which was the rationalisation of the health estate and how it is deployed and shared to see whether there were opportunities for co-locating complimentary services. Work was also being carried out to develop an Obesity Prevention Plan and the Board asked to receive an update on this at its next meeting.

41. CHILDHOOD OBESITY - UPDATE

Val Miller provided an update on work being carried out to deal with childhood obesity. Data from the National Childhood Obesity Programme had shown that the prevalence of obesity and excess weight had increased in Gravesham and that there were clear links to deprivation and ethnicity.

District Healthy Weight Partnerships had been established to bring together other partnerships dealing with aspects of childhood obesity to share information and opportunities for joint working as well as identifying gaps and areas for improvement. Each area had a work plan and examples of work were detailed in each plan. Some schools had proved to be resistant to change but it was felt that this down to the need for better communication and some Head Teachers were very supportive.

42. UPDATE FROM LOCAL CHILDREN'S PARTNERSHIP GROUPS

The Health and Wellbeing Board received a report which detailed the work of the Local Children's Partnership Groups in Sevenoaks, Gravesham and Dartford.

43. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS AND FORWARD WORK PLAN

The Forward Work Plan was discussed. It was noted that Catherine Read had gone on maternity leave but had prepared a report on the Headstart project for her maternity cover, Gwen Box, to deliver at the next meeting. Sarah Kilkie would establish her availability.

Alex Flint had confirmed his availability to attend the next meeting to give a presentation on the Cyclopark.

Alison Duggall would be invited to attend the next meeting in April to provide an update on the Falls Prevention Plan.

The item on School Nursing would be taken at the June meeting as Linda Starkie could not attend the next meeting.

An item on Health visitors should be added to the list of Items to be Scheduled.

44. PROPOSED MEETING DATES FOR 2018/2019

The proposed dates for the meetings of the DGS Health and Wellbeing Group were agreed for 2018/19 with the exception of the proposed date for August. It was agreed to seek an alternative date in late July.

45. INFORMATION EXCHANGE

No items were reported.

The meeting ended at 5.15pm.

DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

WEDNESDAY 21 FEBRUARY 2018

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Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 7 November 2017 at 3.00 pm.

Present:

Chairman: Dr J Chaudhuri

Councillors: Ms K Benbow
Councillor S S Chandler (as substitute for Councillor P M Beresford)
Councillor J Hollingsbee
Mr S Inett
Councillor M Lyons

Also Present: Ms S Jaswal (Centre for Health Service Studies, University of Kent)
Mr M Needham (Integrated Accountable Care Organisation)

Officers: Head of Leadership Support
Leadership Support Officer
Community Safety Manager (Shepway District Council)
Democratic Services Manager

65 ELECTION OF A CHAIRMAN

The Democratic Services Manager called for nominations for the position of Chairman following the resignation of Councillor P A Watkins.

It was moved by Councillor J Hollingsbee and duly seconded that Dr J Chaudhuri be elected as Chairman for the remainder of the municipal year 2017/18.

In the absence of other nominations it was

RESOLVED: That Dr J Chaudhuri be elected as Chairman of the South Kent Coast Health and Wellbeing Board for the remainder of the municipal year 2017/18.

66 APOLOGIES

Apologies for absence were received from Councillors P M Beresford (Dover District Council) and G Lymer (Kent County Council).

67 APPOINTMENT OF SUBSTITUTE MEMBERS

It was noted that, in accordance with the Terms of Reference, Councillor S S Chandler had been appointed as substitute for Councillor P M Beresford.

68 DECLARATIONS OF INTEREST

There were no declarations of interest made by members of the Board.

69 MINUTES

It was agreed that the Minutes of the Board meeting held on 16 May 2017 be approved as a correct record and signed by the Chairman.

70 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no matters raised on notice by members of the Board.

71 SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE

Karen Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group) presented the update on the Sustainability and Transformation Plan (STP).

The Board was advised that the four Clinical Commissioning Groups (CCGs) in East Kent and the East Kent Hospitals University Foundation Trust (EKHUFT) had signed a Memorandum of Understanding regarding a new system of local care relating to the provision and delivery of some cardiology, respiratory and rheumatology services. This would result in more planned care taking place in a community setting rather than at hospitals which would free up hospital beds across East Kent for more urgent and emergency cases.

Expressions of Interest were being sought for providers of tier 2 rheumatology services based on the model piloted in Deal and provided elsewhere in the UK. Members of the Board were advised that the competitive procurement process could take up to 12 months to complete.

The Stroke Programme Board was leading a review of acute stroke services for the Kent and Medway STP and would be consulting on the list of options in early 2018. It was anticipated that the shortlist would include several options involving three specialist hyper acute stroke centres at the existing acute hospitals.

An update was also provided on the challenges in building a sustainable workforce for the future in Kent and Medway. A multi-disciplinary workshop had been held in October which aimed to recognise the current workforce risks for all partners; identify current and future workforce needs; and quantify the gaps between new care models.

In respect of GP vacancies, it was stated that some areas within Dover and Shepway were able to recruit but others were struggling to fill vacancies.

Members of the Board expressed support for proposals for a new medical school to be built in Kent and cited the success of Canterbury Christ Church University in recruiting nursing students.

RESOLVED: That the update be noted.

72 INTEGRATED CARE ORGANISATION RESEARCH AND EVALUATION PROJECT

The Board received a presentation from Sabrina Jaswal (Centre for Health Services Studies, University of Kent) in respect of the Integrated Care Organisation Research and Evaluation Project.

The Centre for Health Services Studies (CHSS) had been working with the South Kent Coast Clinical Commissioning Group (CCG) to develop evidence based Key Performance Indicators and monitoring frameworks for specific integrated care initiatives that would enable the CCG to evaluate outcomes internally. The specific integrated care initiatives selected were End of Life Care (EOLC), Deal Multidisciplinary Team (MDT) and Integrated Intermediate Care (IIC).

The outcome from the work would be to identify for the CCG what was working and what wasn't in the three areas evaluated.

RESOLVED: (a) That the presentation be noted.

(b) That a further update be provided in six months.

73 SOUTH KENT COAST HEALTH AND WELLBEING BOARD: NEXT STEPS

The Board received a report from Michelle Farrow (Head of Leadership of Support, Dover District Council) on the future role of the South Kent Coast Health and Wellbeing Board (SKCHWBB).

The SKCHWBB had been formed in 2011 with aspirations relating to integrated service commissioning. The introduction of the Sustainability and Transformation Plans (STP) and local Integrated Accountable Care Structures meant that many of these aspirations were being met and it was considered appropriate to review the future role of the SKCHWBB.

It was proposed that should the members of the Board wish to continue with the SKCHWBB that it reduce the number of meetings from the current six per year and focus its activities on:

(a) Reducing health inequalities;
(b) Creating a high quality health and care system; and
(c) Having a financially sustainable health and care system

The role of the Board would be:

(a) To enable and facilitate collaborative working across the South Kent Coast
(b) To identify, and seek to address, any challenges/obstacles that might hinder delivery of added value, improvements in reducing health inequalities or improvements in health and wellbeing outcomes locally.
(c) To review the delivery of local outcomes and priorities contained within the Kent and Medway Sustainability and Transformation Plan, Integrated Accountable Care Organisations, Clinical Commissioning Groups and Local Authorities and to provide support where applicable.

Members discussed the achievements of the SKCHWBB to date and agreed that it should continue. The consensus of opinion was that six meetings per year were too many and that four meetings per year would be more appropriate.

The issue of CCGs working closer together at an East Kent level was raised and it was suggested that there would be merit in joint working between Boards on matters of commonality.

RESOLVED: That an updated set of Terms of Reference be brought to the 9 January 2018 meeting of the Board.

74 INTEGRATED ACCOUNTABLE CARE ORGANISATION UPDATE

Mark Needham (Chief Officer, Integrated Accountable Care Organisation) presented an update.

The Local Care Hubs would provide access to primary care services 7 days a week between 8am to 8pm with practices working as hubs serving 35,000 – 65,000 patients. The successful delivery of Local Care Hubs would reduce the number of hospital admissions and release funding for increased investment in prevention.

The service specification had identified the complex range of services that needed to be provided through the Local Care Hubs. The home visiting service had gone live in August 2017 and had 300 contacts during September. The minor injury hubs were expected to go live in early 2018.

There was some duplication of services between organisations that needed to be converted into integration and mental health and health and wellbeing still needed to be integrated into the hubs. There would need to be 20-30 care navigators (approximately 1 per practice).

The Board was advised that there were currently 3.75 funded care navigator posts and that the South Kent Coast Clinical Commissioning Group was unable to fund the remaining balance of needed care navigator posts. The care navigator posts were non-medical roles and it was suggested that Dover and Shepway District Councils could provide the needed care navigators. The Board was advised that the care navigator posts would need to be filled by 1 April 2018.

The Head of Leadership Support (Dover District Council) advised that there needed to be more information provided on the care navigator role so that its implications could be better understood and that specific examples of where this model had been adopted elsewhere would be of assistance.

RESOLVED: That the update be noted.

75 URGENT BUSINESS ITEMS

There were no items of urgent business.

The meeting ended at 4.45 pm.

THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 9 November 2017 at 10.00 am in the Austen Room, Council Offices, Cecil Street, Margate, Kent.

Present: Ms Button, Mr Hart, Dr Martin, Ms McLaughlin, Ms Ogilvie, Cllr Rev. Piper and Ms Sykes.

In Attendance: Ms Smith

1. APOLOGIES FOR ABSENCE

Apologies were received from Ms Carpenter, Councillor Wells and Ms Homer for whom Ms Button was present as a substitute.

2. DECLARATION OF INTEREST

There were no declarations of interest made at the meeting.

3. MINUTES OF THE PREVIOUS MEETING

The board agreed the minutes to be a correct record of the meeting that was held on 7 September 2017.

4. UPDATE ON THE LOCAL CH ILDR EN 'S PARTNERSHIP GROUP

Ms McLaughlin, Chair of the Local Children's Partnership Group (LCPG), provided a presentation on the work of the partnership.

During consideration of the item it was noted that:

- A core theme of the partnership was a recognition that every child was unique and that the needs of the child should be put at the heart of everything that was done.
- There was a wide range of representatives in LCPG and additional representatives were always welcome.
- Some of the indicators within the dashboard were not really fit for purpose; however it did provide a rough guide of the challenges faced within Thanet.
- Thanet featured in the bottom three districts for 13 of the 17 dashboard indicators across Kent.
- 22% of families with primary school aged children, and 15% of families with secondary school aged children lived in short term privately rented low cost accommodation.
- The LCPG had a number of priorities in 2017/18 that were grouped into two outcomes:
    - Outcome 1 – Safer Families and Communities: which promote and support the ability for Thanet's children to grow up in safe families and communities; free from neglect or domestic abuse, with safe and stimulating places to play, learn and socialise
    - Outcome 2 – Opportunities to Achieve: which improve the educational aspirations, outcomes and career prospects of young people in Thanet from pre-school age through to post 16, overcoming barriers to achievement and providing opportunities to develop core life skills.
- Last year 17 grant requests were received and six were granted. The objectives of the successful bids were in support of the LCPG's priorities, and a review would be conducted during November.

- The priorities for 2018-19 has been slightly amended from 2017/18 to the following:
    - Outcome 1 – Safer Families and Communities: Priority Areas of Concern for Thanet's Local Children's Partnership Group are children and young people; who go missing, who suffer neglect, and those who are at risk of exploitation. In addition, improve their awareness of risk taking behaviour including substance misuse, unprotected sex and group violence and to support them in building resilience
    - Outcome 2 – Opportunities to Achieve: Priority Areas of Concern for Thanet's Local Children's Partnership Group are key transition points but especially;
        - Supporting development in pre-birth and early years so that there are fewer barriers for their successful transition into Primary School; by developing a shared understanding of school readiness and to support families to help their children from pre-birth through the Early years to develop this.
        - To reduce those post 16 young people not in education, training or employment can be supported to identify, access appropriate education, employment or training opportunities to enable them to successfully realise their aspirations
- Representatives from TDC and Thanet CCG had met with Greenwich and Lewisham Council's to discuss out of area looked after children. Following this meeting actions were in place to improve communication between the councils.
- There was concern within the medical community that medical treatment for ADHD was being over used and relied upon as a quick fix to the detriment of the child. There was need to consider and address environmental or parenting issues in some case. Dr Martin highlighted a TED talk by Nadine Burke Harris on the issue which can be seen at the address below: https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime
- Problems with speech and language had been identified as a core contributing factor that was often found at the root of a wide range of issues that effect upon troubled children. In recognition of this a programme to up-skill health visitors to provide speach and language support would begin in November. This programme was being led by the Head of Health Visiting Services and Ms Smith would provide Ms Ogilvie with contact details.
- Ms McLaughlin would give the THWBB a further update regarding the LCPG in the early part of 2018.

5. EAST KENT PROGRAMME BOARD UPDATE

Ms Ogilvie provided the board with a summary of the headlines from the report and suggested that an updated on tears of care could be provided at a future meeting. This was agreed by the Board.

6. THANET LEADERSHIP GROUP - STATEMENT OF INTENT

Ms Button, Head of Safer Neighbourhoods, TDC, introduced the item, noting that the intention was to build upon the proven success that partnership working had achieved in the past. A key theme to move the group forward was the aspiration to have one view, one voice and one budget.

During consideration of the item it was noted that:

- The statement of intent was the first step for the group, the next stage would be to agree how exactly these intentions would be realised.
- Ms Sykes enquired what the relationship between the Thanet Leadership Group and the Thanet Health and Wellbeing Board would be in terms of governance and

decision making powers. Ms Button offered to make enquires and respond to her after the meeting.

Note regarding the Cancer Steering Group.

Ms Ogilve would advise Ms Sykes about details of the next meeting of the Cancer Steering Group. Responsibility for leadership of the group had recently been taken on by Dr Bonnett.

Meeting concludedog: 11.10 am

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 11 January 2018 at 10.00 am in the Business Suite - Council Offices.

Present: Dr Tony Martin (Chairman); Councillor Gibbens (Kent County Council), Clive Hart (Thanet Clinical Commissioning Group), Madeline Homer (Thanet District Council), Steve Inett (Healthwatch Kent), Sharon McLaughlin (Thanet Children's Committee), Ailsa Ogilvie (Thanet Clinical Commissioning Group) and Claudia Sykes (Voluntary Sector Adult Services)

In Attendance: Councillor Johnston and Ged Timson

7. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Wells.

8. DECLARATION OF INTEREST

There were no declarations of interest made at the meeting.

9. MINUTES OF THE PREVIOUS MEETING

The minutes were agreed as a correct record of the meeting that was held on 09 November 2017.

10. EAST KENT PROGRAMME BOARD UPDATE

Ms Ailsa Ogilvie presented some updates to the meeting and made the following points:

- Interviews for the Kent and Medway Accountable Officer post will be held on 16 January;
- Development of the STP was progressing well;
- The change process was at a critical stage;
- The focus is on making local improvements for the patients.

In response to the update, other Board members made the following comments:

- It is important that the role of the district councils be articulated clearly in this STP;
- Local Council CExs attended STP Partnership meetings and at the November 2017 meeting, it was agreed that district councils would be giving updates on what was happening at the district level;
- Involvement of district councils was a positive move forward, particularly for agreeing governance arrangements under the new STP;
- A view was shared that Thanet CCG was not yet ready to share an Accountable Officer at the moment;
- It was important to agree the modalities of how this shared arrangement would work;

- Initial plans were that Ashford will provide the main hub for Acute Care. However there was not much detail at the moment;
- Consultation on hospitals had not yet started and there appeared to be slippage on the timing of the consultation;
- Work on the other Stroke Care work stream seems to be progressing well;

- This was likely to be centralised at Ashford. A meeting was scheduled for 31 January to progress this issue further.
- There was a likelihood that the NHS England might intervene on health and safety grounds if the time slippage on making the changes continued;

The Board agreed that it was important to get the communication out to the public regarding the various stages of progress for making the changes to the patient care in the district.

The report was noted.

11. LOCAL CARE UPDATE

Ged Timson, ART and IACO Delivery Lead gave an update presentation and made the following points:

- Work on the Workforce Plan was progressing on well;
- The international recruitment of 55-155 GPS was underway and it would was noted that it would take some months for all the GPs to be in placement across Kent and Medway;
- GP workforce was particularly challenging in Thanet;
- 4 Primary Care Homes (PCH) had been reconfigured to 3;
- A lot of work was taking place that would lead to improved patients experience;

- Social prescribing training was underway and progressing on well;
- The Acute Response Teams (ARTs) were set up in November 2016 and had now been made a permanent service; that would help work with patients who would otherwise be routinely admitted to hospital;
- Planning for the future workforce for this new service was in progress;
- There have been discussions with clinicians on how best to integrate the work of the ARTs with the A&E for the benefit of the patients;
- The intention was to extend this approach to other services like Social Care;
- The GP Five Year Forward View - work was underway to improve patient access to GPs;

- Additional capacity procurement being considered as from April 2018;
- Other parts of the country had already started work on this pilot scheme and Thanet could learn some lessons from the pilot;
- Winter support for additional GP hours will continue to be provided through the Primary Care at QEQM Hospital up to March this year;
- Registration of frail patients will give the patients better care;
- The Acute Response Teams will ensure that acute patients are kept out of hospital through triaging of patients in the A&E to GPs;
- So far there has been a reduction of 196 cases of hospital admissions through the work of these teams;
- GPs have access of patients' records in real time that helps the work of ARTs.

Board members made the following observations in response to the presentation:

- Board members agreed the need to come up with a title for PCH that would offer better clarity on the service being offered to the public;
- The more there was integrated working the more common language there would be, making it easier for the patients to understand the new services;
- It was important for the 14 GP practices to understand the need to share practices;

- It was also important for the public to be advised of that will be fewer (than the current 14) but that they will not be three;
- There was a need to put out some good news story coming out of the change process for better health service delivery to the area;
- The Hub premises for to be built at Westwood Cross will be going to the Planning Committee in February/March 2018;
- A few of the surgeries were on the edge of delicate in terms of their capacity, hence the need for change;
- It should be noted that the CCG should be prepared to step in at short notice;

- Proposals for development at Westwood Cross had received very positive from both TDC and KCC;
- £700,000 had been set aside to look at the pre-building works;
- KCC were happy to be the project manager;
- 6 surgeries were also happy to move to the proposed premises at the Westwood Cross;
- More meetings for further discussion had been planned for this project;
- £10 million may be required to complete this project;
- It was important to put out key messages coming out of this change process, on the CCG website. The webpage would need to be updated regularly;

- The Clinical Network was looking at the non-acute services that included the outpatients, therapies and diagnostics;
- Steve Inett would attend one of the Clinical Network meetings to provide a view on what challenges to the patients come across;
- GPs have to be advised that they will be taking on more patients who would be referred from the A&E;

The Board agreed the following:

1. That more good news story be put out as part of the CCG communication of progress on the new STP;
2. That key messages regarding progress for implementing the new STP should be communicated by the CCG;
3. A timeline of key events/activities relating to the STP should be regularly put be made available on the website;
4. Updates on Local Care to be made a standing item on the Board agenda.

12. <u>THANET LEADERSHIP GROUP - STATEMENT OF INTENT</u>

Madeline Homer gave a verbal presentation to the Board and highlighted the following points:

- The Thanet Leadership Group supports the work of the Board;
- The Group was set up in October 2017 to focus on a place based approach for partnership working across public sector agencies working in Thanet;
- The purpose of the Group is to provide leadership for integrated working and provide better co-ordination of the work of public sector organisations;
- The remit is to re-align partnership agencies for improving education achievements, safeguarding children and vulnerable adults;
- It was also felt that the Group could contribute to the development of the local care model for Thanet;

- The Group could assist with work on the preventative approach;
- The view of the Group was that the strategic direction regarding the local care model could come from the centre, but the delivery could have a local focus and be locally controlled.

- Ms Ogilvie was assisting with putting together the proposal for such an approach and this will inform the creation of the hub for delivering such a service;
- A role for the Group on the integrated commissioning group would need to be clearly defined;
- Ms Ogilvie was exploring ideas with organisations that make up the Leadership Group on building the proposed local care model;
- This will lead to the first workshop for the preventative care model for Thanet;
- Ms Ogilvie was exploring availability with the Leadership group with the aim that the workshop is planned for February 2018.

Members raised the following points:

- It was important that Kent County Council and its leadership be involved in these discussions;
- It was also important to ensure that at the centre of these innovative approaches localism is retained.

The Chairman requested that further updates on this issue be brought to the next Board meeting.

AOB

LCPG Update

There were better applications made by families on speech and language improvement. There was significant interest from the Margate Task Force towards engaging families in increasing speech among the affected children. Ms Sharon McLaughlin will provide updates on Grants at the next meeting.

Meeting concluded: 11.10 am

Draft Minutes of West Kent Health and Wellbeing Board Meeting
20 December 2016
16.00 -18.00
Tonbridge & Malling Borough Council, Gibson Drive, Kings Hill, West Malling, Kent, ME19 4LZ

PRESENT:

Gail Arnold (GA)	Chief Operating Officer, NHS West Kent Clinical Commissioning Group
Alison Broom (AB)	Chief Executive, Maidstone Borough Council (MBC)
Pat Bosley (PB)	Councillor, Sevenoaks District Council (SDC)
Lesley Bowles (LB)	Chief Officer Communities & Business, SDC NHS England (NHS E)
Roger Gough (Cllr RG)	Councillor, Kent County Council (KCC) - Chair
Steve Humphrey (SH)	Director of Planning, Housing & Environmental Health, Tonbridge & Malling Borough Council (TMBC)
Mark Lemon (ML)	KCC
Gary Stevenson (GS)	Head of Street Scene, Tunbridge Wells Borough Council (TWBC)
Malti Varshney (MV)	Public Health Consultant, KCC, NHS WK CCG
Lynne Weatherly (Cllr LW)	Councillor, TWBC

IN ATTENDANCE:

Nazima Chauhan	NHS WK CCG
Kevin Driscoll (KD)	Public Health England Kent, Surrey & Sussex
Tristan Godfrey (TG)	STP Workforce Programme Manager , Kent and Medway Health Education England, Kent, Surrey and Sussex
Priscilla Kankam	NHS WK CCG
Kas Hardy (KH)	PH KCC
Jane Heeley (JH)	TMBC
Matt Roberts	MBC
Karen Sharp(KS)	KCC
Heidi Ward	TMBC
Sarah Ward (SW)	MBC
Helen Wolstenholme	TWBC
Yvonne Wilson (Minutes)	NHS WK CCG
Sarah	TWBC

1.	**Welcome and Introductions**	Action
1.2	Vice Chair, Cllr Roger Gough was acting in the position of chair as Bob Bowes was unable to attend. Cllr Gough welcomed all present to the meeting.	

1.3	Apologies were received from: Dr Bob Bowes, Dr Tony Jones, Penny Graham, Cllr Maria Heslop, Dr Caroline Jessel, Reg Middleton, Dr Andrew Roxburgh, Dr Sanjay Singh, Cllr Fran Wilson, Julie Beilby had advised a Substitute – Steve Humphrey to attend.	
1.4	Cllr Fran Wilson, Leader, Maidstone Borough Council will be attending the Board in the future as one of the Borough's representatives.	YW
2.	**Declaration of Disclosable Pecuniary Interests** There were none.	
3.	**Minutes of the Previous Meeting – 18 October 2016** The minutes of the previous meeting were agreed as a true record.	
4.	**Matters Arising**	
4.1	**Update: Implementing the Health and Wellbeing Board Annual Report Recommendations**	
4.1.1	It was reported that the date of the Board Development Event re-scheduled to the 17 January 2017 will need to re-arranged. A new date would be identified and invitations extended to Board members to participate.	Yvonne Wilson/Bob Bowes
4.2	Chief Executive Officer & Leader Meetings	
4.2.1	Cllr Gough relayed feedback from Dr Bob Bowes on themes which have emerged in the course of the meetings between the CCG Accountable Officer (Ian Ayres) the Chair, Bob Bowes and the Leaders and Chief Executives of the four district and borough councils: • Geography; the difference in size between the CCG area and the LAs' areas make it difficult to engage and commit when the CCG has to have one policy across all. This will be simplified for the LAs by clustering of LAs but more complex for the CCG. • Perception of the Boroughs/Districts are that although much Public Health data is received and debated by the board, the Board does not derive clear requests to commissioners from these conversations, in other words, progress seems stalled on delivery. The West Kent Health and Wellbeing Board (WK HWB) has not gained authority over commissioners, but also has not tried to do so. • WK HWB has not moved commissioners towards budgetary unification; shared risk taking or joined-up commissioning. For example, NHS WK CCG and local authorities (LAs)have a crucial agenda in 'one public estate' but different stages of strategy	

	development mean that CCG and LAs work on this has been limited so far, although good progress is being made in some areas. CCG Town Hall Event	
4.3 4.3.1	Representatives s from the 4 local councils took up an invitation to lead an all CCG Staff event in November to start the process of strengthening joint working/collaboration and generating better awareness of the role of local councils in promoting the health and wellbeing of local residents. The Town Hall event was led by senior council officers and covered the following key issues: • How Councils work • Decision making • Local authority finances • Day in the life of a Council: • District/borough council role in health • Tackling the wider determinants of Health • Health Improvement Initiatives • Case Studies (self-neglect; weight;) • Scenarios – 'doing things differently – working better together'	
4.3.2	Golden Nuggets/Future Action – Progressing Make Every Contact Count (MECC) training for a range of staff groups; use of the Primary Care information resource (DORIS) to better promote referrals into the healthy lifestyles programmes offered by local councils; Risk identification; Need to explore opportunities around the development of New Primary Care Models; Social Prescribing; Better use of Technology and others who can support/promote wellbeing e.g., Pharmacists and Care Navigators.	
4.4	**It was resolved:** to ensure that the issues highlighted in paras 4.2 and 4.3 inform the agenda for the planned Board Development event.	Yvonne Wilson/Bob Bowes
5.	**Assurance Framework**	
5.1	Ms Varshney and Mrs Wilson gave a brief introduction to the main findings of the report, drawing the Board's attention to the various appendices highlighting the specific outcomes and recommendations identified to address the issues in the report. The Board's attention was drawn to the fact that there were 7 recommendations, not eight as one was duplicated.	
5.2	Comments in discussion included: • Top level analysis unhelpful as it doesn't sufficiently express what the difference is that should be expected. Particular reference made in relation to childhood obesity – a whole family approach required and information contained in report does not help the Board to be assured.(AB) • Is there a strategy for measuring progress on Dementia issues? KHWB had asked all local HWBs to provide assurance. • It was acknowledged that a number of the issues highlighted will need to be addressed in the Task & Finish Groups (JH) and the specific obesity reference in the report was found to be helpful (JH).	

5.3	Ms Varshney and Mrs Wilson provided some further details to Board members about the actions required to ensure delivery against the outcomes, including childhood obesity.	
5.4	**It was resolved that:**	
5.4.1	The recommendations presented in the report are agreed and that a report to be prepared in time for the next Board meeting that sets out the details of *who* will be required to take *what* action to ensure the recommendations can be delivered by specific agencies/groups and *how* progress towards delivering meaningful outcomes will be effectively monitored.	Yvonne Wilson Malti Varshney
6.	**Commissioning Children's and Maternity Services – Proposals & Prospects**	
6.1	Karen Sharp, the Interim lead for Children's Commissioning shared a Powerpoint Presentation which adopted an approach that considered *universal, additional, intensive* and *specialist* support/services model. Ms Sharp outlined areas of activity within Children's Commissioning which included: • Health Visiting (subject to a 10% efficiency savings programme in 2016 -17 and 2017 - 2018) • School Nursing • Family Support (New Youth and Young Carers provision) • Intensive Support (Troubled Families, Drugs & Alcohol and Portage) • Integration • Commissioning against outcomes (contained in the Children & Young People Framework)	
6.2	Ms Sharp outlined the review programme which was underway. Ms Sharp explained that KCC's ambition was to re-design services (linked to the KCC Front Door Review); create a stronger focus on emotional well-being; strengthen the school nursing service offer within secondary schools settings; better align school nursing with child and adolescent mental health services and establish greater synergy between different elements of the children/family support offer.	
6.3	Ms Sharp emphasised current work towards integration in partnership between KCC and North Kent CCGs. The Plan included seeking opportunities for joint procurement, re-modelling; agreement on shared local priorities and better consistency of approach.	
6.4	Comments, Discussion & Questions • What linked work was being considered with districts, borough and Local Children's Partnership Groups(LCPGs) and between KCC Specialist Commissioning and CCGs	

	(needs of children with disabilities)? • Indicators within the Children and Young People Framework of interest – what endorsement had been secured from partners and had any work been carried out to assess overlaps with the Joint Health & Wellbeing Strategy and CCG Plans? • Perceived value in assessing the progress on the integration pilot in North Kent. • Broad endorsement of the 'direction of travel' outlined and keenness expressed in reviewing progress and prospects for adopting/embedding good practice elsewhere. • Note cross-Kent work to strengthen Children's Centre, Early Help and Health Visiting collaboration. • Interest in exploring the approach to risk assessment and early preventative support e.g., reviewing needs of families at risk of homelessness; vulnerable young people; young care leavers so as to anticipate needs and assemble early support/intervention.	
6.5	**It was resolved that:**	
6.5.1	The agencies represented on the WK HWB seek to formally endorse the Children & Young People Framework	Relevant WK HWB Member organisations
6.5.2	Officers requested to prepare a report that provides a detailed update on the progress made towards embedding the new operational arrangements for integrated/ joint working currently being piloted by North Kent CCGs and KCC be submitted to the Board in 6-9 months' time. The purpose will be to consider lessons learnt and to assess the prospects for implementing an integrated children's service model across health and KCC in the West Kent area.	Karen Sharp
7.	**Addressing Health Inequalities in West Kent**	
7.1	Ms Varshney and Ms Hardy introduced this item by presenting an overview of the key Public Health issues in relation to understanding relative deprivation across West Kent. Ms Hardy explained that mapping across Kent was evaluated at a West Kent level and paints the picture of little deprivation compared to Kent, with only 5 Lower Super Output Areas (LSOAs) being identified in the West Kent CCG area of having deprivation scores of 37.9 or above. However, this did not mean that West Kent does not have deprivation relative to its more affluent areas. Examples of the types of deprivation found in West Kent were shared.	
7.2	Maidstone Borough Council Sarah Ward, Maidstone's Health & Housing Manager reported on	

	how the Borough council had addressed the inequalities agenda. Ms Ward explained that the Maidstone Health and Wellbeing Board is the key mechanism for driving forward priorities identified for the area and owns the Inequalities Action Plan. Internal departments also held responsibility for contributing to delivery. A review of progress highlights that the following areas are significantly worse than the national average: • Statutory Homelessness Acceptances (per 1000 households) • Admission episodes for alcohol-related conditions (ASR per 100,000) • Excess winter deaths (single year, all ages/person) Four sub groups are established to lead delivery and in addition, a range of other stakeholders will contribute, such as KCC, CCGs and voluntary and community sector partners.	
7.3	Sevenoaks District Council Lesley Bowles, Chief Officer, Communities and Business updated the Board on the objectives, actions and priorities set out in the council's Inequalities Plan. Ms Bowles explained the arrangements for reviewing progress, identifying achievements and areas of challenge. Five main areas of concern have been highlighted: • An increase in numbers killed or seriously injured on our roads (45.1 to 51.8 per 100,000 population) • Increases in smoking related deaths (164 to 236.1 per 100,00 population), excess winter deaths (17.6 to 19.6 ratio) and hip fractures in 65s and over (451 to 616 per 100,000 population) • Increases in recorded diabetes (5.0% to 5.4%) and malignant melanoma (13.7 to 18.0 per 100,000 population) • An increase in drug use (2.0 to 2.2 per 1,000 population) • An increase in alcohol specific hospital stays for the under 18s (35.0 to 28.9 per 100,00 population) Ms Bowles reported that a new three year plan which includes six priorities for action had been approved for the period 2015 – 2018 and at the half year stage, just over 89% of actions were 'on target'.	
7.4	Tonbridge & Malling Borough Council Jane Heeley, the Chief Environmental Health Officer presented the update on work carried out at TMBC. Ms Heeley explained that a partnership body and a group representing key frontline services held responsibility for delivering a range of activities intended to address health inequalities. Ms Heeley explained how the Council's Inequalities Plan reflected the six Life-course objectives as categorised in the Marmot Review (2010). Ms Heeley reported on the plans for developing a new Health Inequalities Action Plan in 2017 to run until 2020 and made	

	reference to the current work on 'devolution' in partnership with Sevenoaks District Council and Tunbridge Wells Borough Council. Ms Heeley explained that the new devolution proposals were likely to positively impact on delivering health improvement across the three council areas. A detailed progress update schedule was attached to the report allowing closer examination of the objectives agreed and outcomes. Tunbridge Wells Borough Council	
7.5	Gary Stevenson, the Head of Environment & Street Scene outlined the local activity relating to health inequalities and updated the Health & Wellbeing Board on progress against the Tunbridge Wells Health Inequalities Action Plan. Mr Stevenson reported on the aims of the group which oversees the health inequalities agenda in Tunbridge Wells which includes supporting the wider workforce to understand the causes of Health Inequalities and how the work that is undertaken and decisions made have a positive or negative influence on Health Inequalities. Mr Stevenson highlighted the importance placed on joint work with partners to facilitate a reduction in Health Inequalities and shared information on the new model for consolidating the resources of the three councils participating in the 'West Kent Deal'(TWBC, SDC and TMBC). Mr Stevenson explained that the West Kent Deal aimed to offer a single referral point for the three Districts that feeds into a local arrangement for each district or borough that enables a holistic assessment of individual needs and considers the wider determinants of health such as debt, employment and housing conditions. NHS West Kent CCG	
7.6	Gail Arnold, Chief Operating Officer gave a detailed slide presentation to Board members which set out the CCG vision for primary care built on a strong bedrock of General Practice with the following characteristics: Sustainable In A Suitable Estate Supported By Technology Efficient Skilled Workforce Accessible Timely High Performing Patient Centred Holistic Population Based Healthcare Ms Arnold explained that the new primary care model is based on a	

	'hub and cluster' model, but working with the other local care providers to fully align and further develop to full 'Multi-specialty Community Provider' (MCP) status. Ms Arnold outlined the workstreams (and enablers) being developed to help transform care for patients moving towards a model which prevents ill health, intervenes earlier and delivers excellent, integrated care closer to home. Ms Arnold explained how in line with the model outlined in the "The Five Year Forward View", practices are getting together in clusters or network of practices to share knowledge, resources and teams. Ms Arnold reported on the ways in which inequalities would be addressed by intervening earlier; (more and timely preventative measures) and reducing the gap in health and wellbeing outcomes.	
7.7	The Chair Cllr Gough thanked all the officers who had presented the work being led by the six agencies across West Kent.	
7.8	Questions, Comments and Discussion: • That there were examples of shared approaches to addressing inequalities in local communities. (Cllr RG) • The majority of the most deprived LSOAs are in Maidstone and two are in Sevenoaks District. (AB, MV) • The Public Health presentation provides a useful starting point for considering the content, variation and outcomes of NHS Health Checks (GS, GA) • That the Asset Mapping approach adopted by KCC PH potentially offers a useful approach to targeted work in areas showing features of deprivation (GS, MV, AB) • Interest was expressed in the targeted approach to intervention undertaken by the KCC Children's Services Commissioning Unit (GA)	
7.9	**It was resolved:**	
7.9.1	To receive a report at the next meeting which identifies common areas of interest where partners can learn lessons that help provide assurance in relation to addressing inequalities. This would explicitly explore the correlation between delivery outcomes of NHS Health Checks and areas of Deprivation and assess the potential for creating bespoke elements to be added to the Health Check – to influence improved outcomes and greater confidence in the value of the programme.	Gail Arnold and Karen Sharp
7.9.2	A report to be presented to a future Board meeting on the outcomes identified in the Asset Mapping work completed in TWBC area with a view to exploring the potential for a 'consistency of approaches' towards asset mapping (to also relate to the Devolution Deal; focus on the formation of Local Care facilities and	Gary Stevenson/

	'spatial patterns' within the context of the development of New Models of Primary Care).	Helen Wolstenhulme
8.	**Delivering the Five Year Forward View** Workforce Development & Role of Make Every Contact Count (MECC)	
8.1	Tristan Godfrey, STP Workforce Programme Manager for Kent & Medway, (Health Education England, Kent, Surrey & Sussex, Policy Adviser for STP Workforce workstream) and Kevin Driscoll, Public Health England, Kent, Surrey & Sussex MECC Lead, gave a joint presentation to the Board. Mr Godfrey and Mr Driscoll highlighted that Workforce is a key enabler for the Kent and Medway STP and reported that £480k funding had been allocated through Medway Council, to deliver Making Every Contact Count (MECC) as an integral aspect of workforce development and the prevention agenda which is at the heart of the STP. It was explained that a portion of this funding was to be made available specifically for the benefit of the primary care workforce	
8.2	Mr Driscoll reported that six MECC Spearheads have been established across Kent, Surrey and Sussex. The current position was that longer term planning was required to ensure that MECC is aligned with local STP aims and objectives and to tackle three key issues which have emerged in delivering MECC across Kent and Medway: i. Harnessing targeted workforces e.g. 'housing sector'; ii. Industrializing preventative working across all sectors and scoping the training needed for this approach; iii. Working with new ICO/MCPs in embedding a new culture of pro-active health and social care.	
8.3 8.3.1	**It was resolved:** To note the report.	
8.3.2	To ask officers to continue local efforts to develop arrangements for delivering MECC training to key occupational groups across West Kent.	Agencies represented on WK HWB Malti Varshney
9.	**Kent Health and Wellbeing Board**	
9.1	Cllr Roger Gough provided feedback from the Kent Health and Wellbeing Board on issues of joint concern for the West Kent Board.	
9.2	**It was resolved:**	
9.2.1	That the West Kent HWB contribute to work around 'One Public	TBC

	Estate' initiative.	
9.2.2	That the WK HWB ensures that there is an integrated system for assurance in relation to Dementia (including work with care homes; and arrangements for 'end of life care)	Dave Holman/Yvonne Wilson
9.2.3	That once the H&WB Strategy Review is completed later in 2017 – WK HWB to ensure that it takes full account of it to ensure it establishes a plan of action that adds value to the STP ambitions	Chair, All Board Awayday
10.	**Update: Obesity Task & Finish Group**	
10.1	Jane Heeley reported progress of the Obesity Task & Finish Group including: • Chair and Member Champion attendance at the recent National Conference which focussed on national guidance and monitoring, through contributions from the authors of the Childhood Obesity Action Plan and NICE, as well as highlighting a number of interventions that have achieved some strong outcomes. • Engagement with KCC PH Campaigns officers who reported on the outcomes of the local booster campaign to support national Change4Life Sugar Smart initiative and shared options for continuing to strengthen the proposed follow up national campaign. In addition, members explored the issue of value for money of interventions in relation to outcomes – issues linked to the findings in relation to National Child Measurement Programme. • Discussions regarding the National Diabetes Screening Programme and links with Healthy Lifestyles Programmes; Audit of 'commissioned arrangements for Tier 2 services (to help avoid duplication and effective use of local resources) • Acknowledgement of the need for effective engagement with other agencies and partnerships around the Obesity agenda.	
10.2	**It was resolved:** That the Task & Finish Group Chair provide a report to the next Board meeting on its intentions for extending its influence to strengthen the delivery actions of a range of agencies across the system could be encouraged to undertake – given the issues highlighted under the Health Inequalities agenda item – where progress remains poor in addressing obesity.	Cllr Lynne Weatherly/Jane Heeley
11.	**Any Other Business – Future Agenda Items**	
11.1	It was resolved that: The items suggested on the meeting agenda were agreed to be brought forward onto the Work Programme for the Health and Wellbeing Board.	Chair/Yvonne Wilson

12. 12.1 12.2 12.3	**Date of Next Meeting** **21 February 2017 Cancelled** Next Meeting - 18 April 2017 – Sevenoaks District Council Board Development Event : 21 February 2017, 13.30 – 17.00, Mercure Hotel, 8 Tonbridge Road, Pembury, Tunbridge Wells, TN2 4QL	All
13.	**West Kent Health & Wellbeing Board Meetings:** Proposed Future Meeting Dates 2017 -2018 • **20 June 2017** • **15 August 2017** • **17 October 2017** • **19 December 2017 TBC** • **20 February 2018** • **17 April 2018**	All
	For any matters relating to the West Kent Health & Wellbeing Board, please contact: Yvonne Wilson, Health & Wellbeing Partnerships Officer NHS West Kent CCG Email: yvonne.wilson10@nhs.net Tel: 01732 375251	

Quorum 7: To be made up of at least one representative from each of the main partners (Kent County Council, District/Borough Councils and West Kent CCG)

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