AGENDA

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

This Board Is Hosted By Medway Council

Friday, 14th December, 2018, at 9.30 am	Ask for:	**Jade Milne Tel: 01634 332008 or jade.milne@medway.gov.uk**
St George's Centre, Pembroke Road, Chatham Maritime, Chatham ME4 4UH	Telephone	**Ann Hunter Tel: 03000 616287 or ann.hunter@kent.gov.uk**

Tea/Coffee will be available 15 minutes before the start of the meeting in the meeting room

Membership

Cllr S Aldridge, Mr I Ayres, Cllr David Brake, Mr P B Carter, CBE, Cllr Doe, Mr G Douglas, Mr M Dunkley CBE, C Foad, Mr G K Gibbens, Mr R W Gough, Mr S Inett, Cllr A Jarrett, Mr Chris McKenzie, Mr P J Oakford, Cllr M Potter, Mr M Scott, Mr A Scott-Clark, Cllr T Searles, Ms C Selkirk, Ms P Southern, Mr I Sutherland and Mr J Williams

UNRESTRICTED ITEMS

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

Agenda Pack for meeting on 14 December 2018 (Pages 3 - 218)

Minutes (Pages 219 - 234)

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)

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Kent and Medway Joint Health and Wellbeing Board

A meeting of the committee will be held on:

Date: Friday, 14 December 2018

Time: 9.30am

Venue: St George's Centre, Pembroke Road, Chatham Maritime, Chatham ME4 4UH

Membership: *non-voting Members		
	Councillor Sarah Aldridge*	Swale Borough Council, Cabinet Member for Health and Wellbeing
	Dr John Allingham*	Kent Local Medical Committee
	Ian Ayres	Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs
	Councillor David Brake (Chairman)	Medway Council, Portfolio Holder for Adults' Services
	Mr Paul Carter, CBE	Kent County Council, Leader and Cabinet Member for Health Reform
	Councillor Howard Doe	Medway Council, Deputy Leader and Portfolio Holder for Housing and Community Services
	Glenn Douglas	Accountable Officer for the eight CCGs in Kent and Medway
	Matt Dunkley, CBE	Kent County Council, Corporate Director Children, Young People and Education
	Catherine Foad	Chair, Healthwatch Medway
	Mr Graham Gibbens	Kent County Council, Cabinet Member for Adult Social Care and Public Health

Mr Roger Gough	Kent County Council, Cabinet Member for Children, Young People and Education
Penny Graham	Healthwatch Kent
Councillor Alan Jarrett	Medway Council, Leader
Chris McKenzie	Medway Council, Assistant Director Adult Social Care
Councillor Martin Potter	Medway Council, Portfolio Holder for Educational Attainment and Improvement
Mr Peter Oakford (Vice-Chairman)	Kent County Council, Deputy Leader and Cabinet Member for Finance and Traded Services
Matthew Scott*	Kent Police and Crime Commissioner
Andrew Scott-Clark	Kent County Council, Director of Public Health
Councillor Tony Searles*	Sevenoaks District Council
Caroline Selkirk	Managing Director of Ashford, Canterbury and Coastal, South Kent Coast, and Thanet CCGs
Penny Southern	Kent County Council, Corporate Director Adult Social Care and Health
Dr Robert Stewart*	Clinical Design Director for the Design and Learning Centre for Clinical and Social Innovation
Ian Sutherland	Medway Council, Director of People - Children and Adults
James Williams	Medway Council, Director of Public Health

Agenda

1 Apologies for absence

2 Record of Meeting **(Pages 7 - 18)**

To approve the record of the meeting held on 9 October 2018.

3 Declaration of Disclosable Pecuniary Interests and other interests

Members are invited to declare the existence and nature of any interests in relation to any agenda item in accordance with the relevant Council's Code of Conduct.

4 Urgent matters by reason of special circumstances

The Chairman will announce any late items which do not appear on the main agenda but which he/she has agreed should be considered by reason of special circumstances to be specified in the report.

5 Obesity Deep Dive **(Pages 19 - 54)**

This report presents a 'deep dive' into the current situation in relation to overweight and obesity across Kent and Medway. The report references national policy and initiatives and covers the prevalence data for Kent and Medway and the range of services and interventions.

6 NHS Health Check Deep Dive **(Pages 55 - 68)**

This report presents a 'deep dive' into the implementation and outcomes of the NHS Health Check Programme across Kent and Medway.

7 Sustainability and Transformation Partnership (STP) Local Care Update **(Pages 69 - 156)**

This report provides an update on: Local Care governance, in line with progress and alignment to Strategic Commissioning development; Local Care deep dives; progress on an Implementation and Local Care Delivery Framework; actions for winter pressures and details of how Local Care is supporting carers and care navigation.

8 Sustainability and Transformation Partnership (STP) Strategic Commissioner and System Transformation Update **(Pages 157 - 162)**

This report provides an update on the establishment of the Strategic Commissioner for Kent and Medway and what this means for the wider system and development of an Integrated Care System and Integrated Care Partnerships across Kent and Medway.

9 Briefing Paper: The Kent Joint Strategic Needs Assessment **(Pages 163 - 166)**

Following the STP collaboration in the delivery of the statutory duties of Kent County Council, Medway Council and the Clinical Commissioning Groups (CCGs) as underpinned by the Case for Change, this report outlines the rationale and approach to

undertaking the Joint Strategic Needs Assessment (JSNA) for Kent County Council.

10 Design and Learning Centre Update **(Pages 167 - 182)**

This report provides an update on the work of the Design and Learning Centre and how it is leading and supporting clinical and social innovation and providing support to the Sustainability and Transformation Partnership and the Joint Health and Wellbeing Board. Progress against the range of projects and programmes is detailed in the report including recent high-profile exposure on a national level.

11 Kent and Medway Hyper-Acute Stroke Units **(Pages 183 - 210)**

The NHS in Kent and Medway is establishing three Hyper-Acute Stroke Units (HASUs). This report sets out details of Medway Council concerns in relation to the matter. Medway Council believes that the sites that have been selected are not in the best interests of the health service in Kent and Medway. Furthermore, Medway Council believes that there were flaws in the way that the Joint Committee of Clinical Commissioning Groups was led to choose the selected sites.

12 Work Programme Report **(Pages 211 - 216)**

The report advises the Joint Board of the forward work programme for discussion in the light of latest priorities, issues and circumstances. It gives the Joint Board an opportunity to shape and direct the Joint Board's activities.

The report also advises the Joint Board of a request to appoint Dr Bob Bowes as a member of the Joint Board, in his capacity as Chairman of the Strategic Commissioner Steering Group.

For further information please contact Jade Milnes, Democratic Services Officer on Telephone: 01634 332008 or Email: jade.milnes@medway.gov.uk

Date: 6 December 2018

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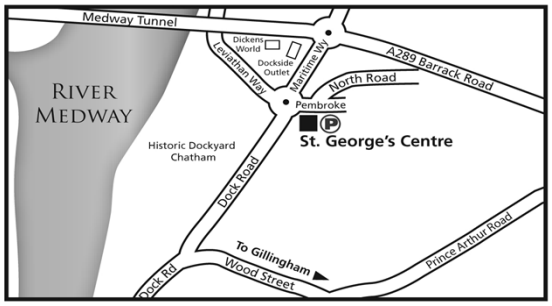

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Medway Council

Meeting of Kent and Medway Joint Health and Wellbeing Board

Tuesday, 9 October 2018

3.05pm to 5.10pm

Record of the meeting

Subject to approval as an accurate record at the next meeting of this committee

Present:

Councillor David Brake, Portfolio Holder for Adults' Services, Medway Council (Chairman)
Ian Ayres, Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs
Mr Paul Carter, CBE, Leader and Cabinet Member for Health Reform, Kent County Council
Councillor Howard Doe, Deputy Leader and Portfolio Holder for Housing and Community Services, Medway Council
Glenn Douglas, Accountable Officer for the eight CCGs in Kent and Medway and Chief Executive of the Kent and Medway STP
Mr Graham Gibbens, Cabinet Member for Adult Social Care and Public Health, Kent County Council
Mr Roger Gough, Cabinet Member for Children, Young People and Education, Kent County Council
Councillor Alan Jarrett, Leader of Medway Council
Mr Peter Oakford, Deputy Leader and Cabinet Member for Finance and Traded Services, Kent County Council (Vice-Chairman)
Councillor Martin Potter, Portfolio Holder for Educational Attainment and Improvement, Medway Council
Councillor Tony Searles, Sevenoaks District Council
Caroline Selkirk, Managing Director of Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCGs
Penny Southern, Corporate Director Adult Social Care and Health, Kent County Council
Ian Sutherland, Director of Children and Adults Services, Medway Council
James Williams, Director of Public Health, Medway Council

Substitutes:

Councillor Tina Booth, Swale Borough Council (Substitute for Councillor Sarah Aldridge)
Margaret Cane, Healthwatch Medway (Substitute for Cath Foad)
Dr Allison Duggal, Consultant in Public Health, Kent County Council (Substitute for Andrew Scott-Clark)
Penny Graham, Heathwatch Kent (Substitute for Steve Inett)
Dr Caroline Rickard, Medical Secretary, Kent Local Medical Committee (Substitute for Dr John Allingham)

In Attendance: Sharon Akuma, Legal Services, Medway Council
Cathy Bellman, Kent and Medway STP Local Care Lead
Karen Cook, Policy And Relationships Adviser (Health), Kent County Council
Julie Keith, Head of Democratic Services, Medway Council
Jade Milnes, Democratic Services Officer, Medway Council

402 Chairman's Announcement

The Chairman of the Joint Board advised Members of recent updates to the Membership of the Joint Board. It was explained that owing to Simon Perks' new position at the Kent and Medway Sustainability and Transformation Partnership (STP) as Director of System Transformation, the Joint Board Member, Ian Ayres, had nominated Stuart Jeffery to be his named substitute.

403 Apologies for absence

Apologies for absence were received from Councillor Aldridge, Dr John Allingham (Kent Local Medical Committee), Andrew Scott-Clark (Director of Public Health, Kent County Council), Matt Dunkley, CBE (Corporate Director for Children, Young People and Education, Kent County Council), Catherine Foad (Healthwatch Medway), Steve Innet (Healthwatch Kent), Chris McKenzie (Assistant Director of Adult Social Care, Medway Council), Matthew Scott (Kent Police and Crime Commissioner) and Dr Robert Stewart (Clinical Design Director for the Design and Learning Centre for Clinical and Social Innovation).

404 Record of Meeting

The record of the meeting held on 28 June 2018 was agreed and signed by the Chairman as correct.

405 Declaration of Disclosable Pecuniary Interests and other interests

Disclosable pecuniary interests

There were none.

Other interests

There were none.

406 Urgent matters by reason of special circumstances

There were none.

407 Briefing Paper: Care Quality Commission Review and Emerging National Context for Health and Wellbeing Boards

Discussion:

The Policy and Relationships Adviser (Health) at Kent County Council presented the Joint Board with the findings from a number of recent national reviews of progress made towards integration of Health and Social Care systems in England. As well as progress made, these reviews examined the challenges of integration, ways in which national and local bodies were managing these challenges and the consequential impacts on service users. The Joint Board's attention was drawn to the conclusions and recommendations from the following three key reports:

1. The Care Quality Commission (CQC) report 'Beyond Barriers: How Older People Move Between Health and Care in England';
2. The National Audit Office report 'The Health and Social Care Interface'; and
3. The report compiled by NHS Providers 'Key Questions for the Future of Sustainability and Transformation Partnerships (STP) and Integrated Care Systems (ICSs).

The Joint Board was advised that one of the conclusions drawn from these reviews was a need for system wide leadership, either through a Health and Wellbeing Board (HWB) or a Sustainability and Transformation Partnership (STP) Programme Board. The CQC report also noted that within the Health and Social Care systems it had reviewed, it was difficult to identify where system leadership came from and that, in general, Health and Wellbeing Boards were not fulfilling their potential and were underused where Sustainability and Transformation Partnership footprints did not align. However, these bodies could be effective in bringing together local leaders to plan and deliver services.

Across the Kent and Medway footprint it was explained that system leadership had developed and, in particular, the Kent and Medway STP Programme Board was strong and inclusive, with representation from both Local Authority areas and on each of the component workstreams. In addition, the Kent and Medway Joint Health and Wellbeing Board had been established and had a programme of work in place that broadly reflected the recommendations made by the CQC and set out within the report.

In relation to the vision expressed by the CQC, a Member commented that neither the Joint Board nor the STP Programme Board was empowered to make decisions on behalf of the health and social care system. He added that in this respect it made it very difficult for health and social care to come together in decision-making. In response, the Joint Board was advised that, in the context of the current national planning and regulatory frameworks, local systems have had to find workarounds. NHS Providers have expressed this concern in their report, particularly owing to the expected scale and pace of integration required. However, it was added that whilst it was not within the gift of the Local Authorities' Health and Wellbeing Boards, the Joint Board or the

STP Programme Board to make decisions on behalf of the system, Kent and Medway were in a strong position if there were any future changes in legislation or national guidance.

With reference to recent decision-making on a key decision for Medway by one part of the system, a Member expressed the view that it was appropriate that this joint Board and the STP Programme Board could not make decisions on behalf of the health and social care system in Kent and Medway. It was added that he was in favour of a consensus-based approach and that moving to a more formal decision-making structure should only occur when joint working had matured and confidence built.

A Member expressed support for the Joint Board undertaking the CQC recommendation set out at paragraph 5.2.1 of the report, a joint plan for older people. In response, the Joint Board was advised that a joint plan exists through the Case for Change supported by the work programme for the local care workstream. In Kent, the Adult Social Care Strategy was being refreshed and there would be merit in joint working to meet the requirements of the CQC. It was added that Medway's Adult Social Care Strategy was approved in 2016 and that one of six strategic themes within the Strategy was integration, and so Kent and Medway were well placed to enable joint working through the Local Care workstream.

Referring to the Canterbury, New Zealand Model, a Member commented that system leaders could learn a lot from this and other models of integrated working in health and social care. In response to a question regarding national examples of good practice, the Joint Board was advised that examples of good practice included Manchester and Frimley. With respect to Frimley, it was explained that their integrated care system was considered outstanding and that they had established a Memorandum of Understanding (MOU) between partners to achieve this. It was noted that the extent to which the Local Authority was involved in these areas differed and that full integration in these areas had not been achieved. It was also outlined that Manchester had recently submitted a report on the barriers to integrated working to the Public Accounts Committee. One of the primary barriers was the need to use intricate arrangements to work around current legislation.

Members acknowledged that a common factor in more advanced integrated health and social care systems was that partners had been working together in an integrated manner for long periods of time. Moreover, it was suggested that the preferred starting point in these successful models was to build relationships, trust and common agendas ahead of determining the structure of a model. A Member added that in some instances, such as in the Canterbury, New Zealand Model, adversity had forced a move to an integrated model.

The Joint Board was advised that representatives of Canterbury, New Zealand Model had visited Medway to share their experience and lessons learned. The Team considered that integrated working would have advanced more quickly, if the first steps taken were to embed a common information system and invest in falls prevention.

The Managing Director of the East Kent CCGs advised the Joint Board that there was a Frailty Group working across Kent and Medway, which had drawn lessons from the experience of Canterbury, New Zealand and New South Wales.

Referring to the outcome of the recent NHS Kent and Medway review of urgent stroke services in Kent and Medway, a Member emphasised the importance of information sharing and transparency.

A Member also stressed the importance of accountability in any health and social care system to ensure the quality of provision for service users and to maintain confidence in the system.

Decision:

The Joint Health and Wellbeing Board noted this report and the contribution that the Joint Board makes to system wide leadership across Kent and Medway Health and Social Care.

408 Prevention Dashboard Progress

Discussion

Medway Council's Director of Public Health presented the Joint Board with a subset of six high-level indicators which had informed and been drawn from the priority areas within the Kent and Medway STP Prevention Action Plan. The indicators, as set out in Appendix 1 of the report were:

- Smoking prevalence 18+ (%)
- Smoking at time of delivery (%)
- Physically active adults (%)
- Adults overweight or obese (%)
- Obesity in children aged 10-11 (%)
- NHS Health Checks invitations offered.

The Director of Public Health highlighted the financial impact of addressing these challenging areas, noting for example that the cost in Kent and Medway to treat adult obesity was £151 million per annum. He stressed the importance of prevention to reduce morbidity and mortality and the need to be efficient with available resources.

The Joint Board's attention was drawn to particular focus areas where the data indicated that further intervention was needed; one example given was the need to increase physical activity among adults in Gravesham (the rate of physically active adults in Gravesham in 2016/17 was 61.4% compared to a target rate of 70%). The Joint Board was advised that the actions to improve outcomes in these six focus areas were set out in section 3 of the report and it was explained that detailed work programmes accompanied each area.

With respect to the indicator 'NHS Heath Checks invitations offered', a Member requested that data be included on Learning Disability (LD) Health Checks. It was explained that this would give the Joint Board a fuller understanding of the position across the whole population of Kent and Medway. In response, the Joint Board was advised that other health partners, namely GPs, rather than Local Authority Public Health Teams tracked LD Health Checks and that it may be difficult to obtain this data. However, the Director of Public Health undertook to review whether data on LD Health Checks could be incorporated. Concerning the likelihood for individuals with LD to have more adverse health outcomes, the KCCs consultant in Public Health explained that this was currently under review and could be presented to the Joint Board at a future meeting.

In response to a question asking whether the comparative data provided for each indicator could reflect similar demographic areas at borough and district level rather than England, the Director of Public Health advised the Joint Board that other comparators could be incorporated and that this would be reviewed.

A view was expressed that more detailed data was required in respect of the indicators and should include, narrative on what the data showed, whether the required outcomes were being achieved, lessons learnt from interventions that had worked and those which had not and information on expenditure. With reference to an example in Manchester, where the careful consideration of data helped target interventions to improve outcomes for men in the most deprived areas, it was explained that the Joint Board should use this more comprehensive data to focus preventative interventions and target commissioning in the right areas and to set broad new targets which could be tracked by the Joint Board on an ongoing basis. Support was expressed by Members in relation to analysing data at a lower super output area level, with a view to focussing interventions where need was considered greatest and to learn from what had worked well elsewhere.

The Board was advised that the Public Health Team held comprehensive data at individual conurbation level and at Lower Super Output Areas (LSOA), in addition to detailed financial information on, for example, costs associated with treating individuals as a result of a specific health condition. It was explained that analysis of this suite of information had enabled the Team to highlight key areas of focus to the Joint Board, whose role was considered to be as an enabler. The Joint Board was reminded that the dashboard presented was a synopsis of data in the context of the Kent and Medway STP Action Plan rather than the Joint Strategic Needs Assessment (JSNA). However, it was suggested that more detail could be provided as part of the 'deep dives' into the priority areas.

In response to a question regarding measuring substance misuse and the impact substance misuse has had on prevention aims, the Joint Board was advised that in Medway a new drug and alcohol service had recently been commissioned which was based on a recovery model. As well as addressing the addiction, this model aimed to assist individuals with maintaining work and/ or education. In Kent, it was noted that a move towards a psychosocial model

had been made which looked at services around an individual as well addressing addiction. It was added that one of the Joint Board's future 'deep dive' topics would be reducing alcohol consumption.

With regards to a question concerning take up of Health Checks, the Joint Board was advised that Medway was one of the best areas in delivering Health Checks, with double the rate compared to the rest of the South East region. It was added that within Medway, the Public Health Team was working with NHS colleagues to target areas where take up of Health Checks was considered low. These tended to be areas of higher deprivation, such as Chatham. It was noted that specialist Health Advisers were based at the Smokefree Advice Centre in Chatham to offer easily accessible Health Checks to this demographic.

With regards to the position in Kent, the Joint Board was advised that there had been problems with the IT systems which had meant that some invitations had not been sent to individuals. However, it was explained that the Public Health Team in Kent were in constant contact with the Health Check provider and that specific areas had been targeted to improve rates.

Owing to the importance of Health Checks as the first step in the preventative agenda, Members requested that at the next meeting of the Joint Board a 'deep dive' into this topic be undertaken, taking account of the comments made at this meeting regarding the detail of information provided. It was noted that the Joint Board would need to consider two to three 'deep dives' per meeting so that within six months, the Joint Board would be in a position to draw conclusions on where these areas of work and outcomes should to be in 5 -10 years' time.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the progress on the included outcomes;
b) continued to support the prevention workstream to achieve the prevention plan priorities;
c) agreed that a 'deep dive' on Health Checks be scheduled for the next meeting of the Joint Board on 14 December 2018; and
d) requested that further detail be provided in future reports providing an analysis of data at a lower super output level, lessons learnt and information on expenditure.

409 Reducing Tobacco Usage

Discussion:

Kent County Council's Consultant in Public Health set out a detailed review of reducing tobacco usage in Kent and Medway, which was one of the priority areas within the Kent and Medway STP Prevention Action Plan. The Joint Board's attention was drawn to the data, set out at section 3 of the report and on page 29 and 30 of agenda item 6 (Prevention Dashboard Progress). It was noted that the priority areas were Canterbury, Gravesham and Thanet, as well as smoking prevalence amongst young people and routine and manual workers

across Kent and Medway. It was explained to the Joint Board that the actions to reduce smoking were set out in sections 6 and 7 of the report with a list of recommended further actions set out at Appendix 1 of the report.

It was clarified that bullet point number 3 at section 6 of the report should read, "Kent County has a Tobacco Control Alliance…"

With reference to examples, a Member commented that given the impact of smoking on the health of the population, not enough was being done to reduce smoking prevalence in Kent and Medway and insufficient detail was provided in the report concerning current and future actions. In particular, the Member expressed disappointment with respect to the rates of smoking at the time of delivery (SATOD). Noting that in quarter 1, the rate SATOD in Dartford and Gravesham was below the England average, a Member commented that lessons learned from what they had done well should be shared, if appropriate.

In response to a question regarding examples of good practice in Kent and Medway, the Joint Board was advised that Kent County Council had funded a pilot programme of specialist midwife posts to help with reducing SATOD. This pilot delivered very good results, as had the campaign 'What the Bump'. It was added that this campaign would be rolled out across Kent and that with respect to the pilot programme, Kent County Council's Director of Public Health and the Local Maternity System had requested the CCGs to scale up the programme to all maternity services in Kent and Medway. It was also noted that Medway's 'Grow My Brain' campaign had been submitted for an LGC award.

Medway's Director of Public Health reiterated the need for a whole system approach to scale up smoking cessation programmes. He noted that in Medway, smoking cessation activities had reduced smoking prevalence from 25% to 17% over a short period of time, which was a step in the right direction. He added that when people had accessed Quit Services, the quit rates were good, however some cohorts within the population did not want to access such services. It was considered that focus needed to be on encouraging this cohort of individuals to access quit services, addressing tobacco control and preventing smoking among young people.

Members also recognised the importance of the social and economic context when addressing smoking cessation. In response to a question concerning integrated partnership working to tackle deprivation, the Joint Board was advised that Medway's Draft Local Plan required prospective Health Impact Assessments to be undertaken for housing developments. Using the example of Kitchener Barracks, in a more deprived area of Medway, the Joint Board was advised that the Public Health Team was working with partners, including NHS Medway CCG and community groups, to ensure adequate healthcare provision in this area. In addition, Medway had established a Skills Board and a housing initiative which brought together education, housing and employment. In Kent, it was explained that a place based Public Health approach was taken, particularly within the Healthy New Town programme. In addition it was explained that work was ongoing with partners, including local NHS CCGs and the districts to address areas of most need, i.e. the 88 LSOAs. In addition,

across Kent and Medway the Public Health Teams had submitted an Interreg bid to deliver a social prescribing intervention across the Kent and Medway footprint.

With reference to the significant expenditure on smoking cessation services in Kent, in order to ensure that money was being spent intelligently to deliver the best outcomes for the population, a Member undertook to request that a further deep dive into smoking cessation be added to the Kent County Council's Public Health Cabinet Committee's work programme.

It was also suggested that once the data had been reviewed, the Joint Board should set out its vision for smoking cessation and measure performance within the Dashboard. In response, the Joint Board was advised that there was an existing national target as set out in the National Tobacco Control Plan 2017-2022 which performance could be measured against.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) supported the specific actions set out in Appendix 1 of the report focused on preventing and reducing to use of tobacco in Kent and Medway; and
b) noted the requirement for the NHS in Kent and Medway to identify resources for specific stop smoking interventions in the 'Health Care' settings that fall outside the remit of Local Authority stop smoking service provision.

410 Sustainability and Transformation Partnership (STP) Local Care Update

Discussion:

The STP Local Care Lead summarised the progress made implementing Local Care across Kent and Medway between June 2018 and September 2018. This included significant progress developing multidisciplinary team working, the impact of which had been demonstrated through Encompass Vanguard, the development of an Organisational Development (OD) toolkit and the development of a carers app to support anyone in a caring role by providing consistent training across the care sector.

It was also noted that the eight CCG localities had progressed their operational and financial plans in line with the Investment Case. However, these plans were all at different levels of maturity. As a result, the Local Care team was undertaking a series of 'deep dives' with each sub-system (east Kent, west Kent, Medway and north Kent) to establish an overarching outcomes framework, which would be presented to the Joint Board.

Members commended the direction of travel of the local care workstream. However, it was stressed that significant financial investment from the government into local care was needed, as well as a focus on outcomes. A Member expressed particular concern that hospitals countrywide, including in Kent and Medway, were planning for 30% less acute medical care patients,

owing to the predicted success of preventative local care, without additional investment into this workstream. It was noted that the Kent and Medway CCGs had agreed to invest in local care. However, further concern was expressed in regards to the certainty of this sum of money. It was explained to the Joint Board that these 'deep dives' would provide some assurance in regards to the financial position, namely the amount of money available and where it was being invested. It would also result in a series of business cases, which could be exploited quickly if additional government funding was released. A view was expressed by a Member that money from health partners and local authorities should be pooled.

Further assurances were given regarding concerns expressed over the expected reduction in acute medical care hospital beds. It was explained that all business cases that reduced the number of acute beds in any hospital would need to follow an assurance process which stated that any lost provision needed to be adequately resourced elsewhere before changes were made.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the progress of the Local care workstream;
b) supported the approach for investment in local care, as set out in paragraph 3.2 of the report, with a view to receiving an outcomes framework, progress of which would be presented to the December 2018 meeting of this Joint Board;
c) supported the Organisational Development (OD) approach, for the change in culture required to deliver local care; and
d) agreed to schedule a 'deep dive' of the following areas on the work programme:
    i) support for carers; and
    ii) support for growing the voluntary sector.

411 Strategic Commissioner Update

Discussion:

The Accountable Officer for the Kent and Medway CCGs and the Kent and Medway STP Chief Executive updated the Joint Board on the progress and next steps towards the development of a single Strategic Commissioner across all eight CCGs.

The Joint Board was advised that an agreement in principle had been reached between the clinical chairs of each CCG for how they would work together as a Strategic Commissioner across the Kent and Medway footprint.
It was noted that a significant amount of work had been undertaken to determine how the Strategic Commissioner function would be structured, its responsibilities and how it would be accountable to the individual CCGs. It was also explained that a common approach to cancer care would be undertaken and that this would one of the first work areas.

With regards to next steps, the Joint Board was advised that further consideration would be given to the division of responsibilities at Strategic Commissioner level and local level. In addition, a report would be compiled outlining the vision for how the Strategic Commissioner fits within an accountable care system environment in Kent and Medway. It was anticipated that this would be completed by November and could be presented to the Joint Board at its meeting in December.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the update provided on the Kent and Medway Strategic Commissioner function; and
b) agreed that a report outlining the vision for how the Strategic Commissioner fits within an accountable care system environment in Kent and Medway be presented at the next Joint Board Meeting on 14 December 2018.

412 Work Programme

Discussion:

The Democratic Services Officer at Medway Council introduced the work programme report and drew the Joint Board's attention to the recommended amendments to the work programme set out at paragraphs 2.4 to 2.7 of the report which had been reflected in the work programme set out at Appendix 1 of the report.

A view was expressed that the work programme should include items related to the outcomes for children and young people. It was recommended that specific proposals be discussed at the next agenda setting meeting on 8 November 2018.

The Chairman of the Joint Board referred to the outcome of the recent NHS review of urgent stroke services. Under the preferred option, Hyper Acute Stroke Units (HASUs) would be located alongside Acute Stroke Units at Darent Valley Hospital in Dartford, Maidstone Hospital and William Harvey Hospital in Ashford.

He explained that Medway Maritime Hospital had been excluded and yet had a critical role in the delivery of stroke treatment for over 500,000 people across Medway and Swale and this hospital currently cared for the largest number of stroke patients in Kent and Medway.

The Chairman also explained that whilst it was important to secure the best outcome for the whole population of Kent and Medway he was concerned and disappointed that Medway Maritime Hospital was not included in the preferred option, despite featuring in 3 of the 5 options initially presented for consultation and given the level of deprivation in the area.

He drew the Joint Board's attention to the motion he had submitted to Medway's Council meeting on Thursday 11 October 2018 which sought support for the matter to be discussed and debated within all appropriate forums, including the Joint Board.

The Chairman welcomed the opportunity to discuss the concerns Medway had at the next Joint Board meeting, in relation to the evaluation process and the underpinning methodology, which had led to the exclusion of Medway Maritime Hospital from the preferred option and undertook to discuss this further at the next agenda setting meeting for the Joint Board on 8 November 2018, following the debate on the motion at Medway's Council meeting.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) agreed the work programme attached at Appendix 1 to the report; and
b) agreed to give further consideration at the agenda planning meeting on 8 November 2018 to scheduling:
    i. a report on the outcome of the NHS review of urgent stroke services for the next meeting of the Joint Board on 14 December 2018; and
    ii. specific proposals relating to children and young people.

Chairman

Date:

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
14 DECEMBER 2018
OBESITY DEEP DIVE

Report from: Andrew Scott-Clark, Director of Public Health for Kent County Council

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Scott Elliott, Head of Health and Wellbeing Services, Medway Council

Summary

This report presents a 'deep dive' into the current situation in relation to overweight and obesity across Kent and Medway.

A BMI of between 25 and 29.9 is classified as overweight and a BMI of between 30 and 39.9 is classified as obese with a BMI 40 and over classified as morbidly obese. For children and young people aged 2 to 18, the BMI calculation takes into account age and gender as well as height and weight.

The report references national policy and initiatives and then covers the prevalence data for Kent and Medway and the range of services and interventions.

The report concludes by identifying a need for a particular focus on Tier 3 specialist weight management services.

1. Budget and Policy Framework

1.1 The Health and Social Care Act 2012 conferred the statutory duty of Public Health on local authorities. Local authorities are responsible for improving health in their local area and working with other organisations to meet national targets for key health indicators.

1.2 Being overweight or obese can have a serious impact on health. Obese individuals have an increased risk of premature death or disability associated with cardiovascular disease (mainly heart disease and stroke), type 2 diabetes, musculoskeletal disorders like osteoarthritis, and some cancers (endometrial, breast and colon). Supporting residents to achieve and to maintain a healthy weight is a key priority for Health and Wellbeing Boards. Obesity prevalence is also heavily influenced by the wider determinants of health. Prevalence is generally higher in disadvantaged communities so it is important that a 'place based' approach is applied, for example ensuring regeneration and development plans support the obesity agenda.

2. Background

2.1 There are number of national policy, initiatives and approaches which influence local authority work in relation to obesity. These include:

2.2 **Healthy Lives, Healthy People: A Call to Action on Obesity**[i] (October 2011). This paper urged each local authority to 'harness it's reach' with other local authority activities such as planning, sport and green spaces and to take advantage of the wide ranging influence a local authority can have on obesity.

2.3 **Public Health Outcomes Framework**[ii] (August 2016). This framework sets out the key national priorities for improving health and reducing inequalities. It contains a number of key measures to assess the state of local health and wellbeing at the national and local level. The key indicators relating to obesity are:

- Utilisation of outdoor space
- Breastfeeding initiation
- Breastfeeding prevalence at 6-8 weeks
- Excess weight in 4-5- and 10-11 year olds
- Daily fruit and vegetable consumption in adults and 15-year olds
- Proportion of adults classed as overweight or obese
- Proportion of adults classed as physically inactive.

2.4 **Making Obesity Everyone's Business – A Whole Systems Approach to Obesity**[iii] (2017)**.** This report highlighted the importance of local authorities adopting a Whole Systems Approach to tackling obesity. Referring to the Obesity Systems Map[iv], the report argues that the complexity of the obesity issue makes it a difficult problem to tackle one component at a time.

2.5 Kent County Council is currently working on the implementation of the new draft guidance on the use of a Whole Systems Approach to obesity with partners from PHE and Leeds Beckett University. This is at an early stage as it will be challenging to implement this approach in such a large geographical area and complicated health economy.

2.6 A Whole System Approach to reducing obesity is delivered in Medway through the Medway Healthy Weight Network. This is a collaboration of 28 partner organisations from the private, public, voluntary and academic sectors working together to take a multi-agency approach to reducing obesity across

the population. The partners are united by a single vision “Working together to support all Medway residents to adopt healthier lifestyles and achieve a healthy weight”. The network meets annually to discuss and agree ways the partners can work together to bring the vision to life. Throughout the year the partners deliver a wide range of obesity, physical and nutrition interventions. Medway Council performs a coordination and leadership role with this network, the Chair of the Medway Health and Wellbeing Board hosts the annual event.

2.7 **Making Every Contact Count (MECC)** is currently utilised by many of our partners and is in further development in Kent and Medway as part of the STP Prevention Plan. The programme enables the use of the everyday conversations people have, to encourage positive behaviour changes.

2.8 **Change 4 Life** is a national initiative that focuses on family health. It aims to reduce adult and childhood obesity simultaneously by making health a family issue. The Change4Life Sugar Smart campaign which launched in 2016 aimed to engage families to reduce the amount of sugar they consume.

2.9 Across Kent, there were nearly 1,800 registrations to the Sugar Smart campaigns in 2016, this is in the context of a target population of 111,200 families with the youngest child under 10 years of age. Equating to 1.6% for Kent, this was higher than the national figure for registrations as a percentage of target families (See Appendix 3, Table 1).

2.10 The Sugar Smart Medway campaign was launched in October 2018. Medway Council’s Public Health Team will be providing advice and support to residents to equip them with the tools they need to be Sugar Smart, including learning about healthier snacks and meals. The campaign aims to support 1,000 residents and 100 businesses to become Sugar Smart. In addition to a large social media presence to keep engagement in the year long project, the Team will be delivering 12 roadshows across Medway to raise awareness.

2.11 Medway Public Health Team work closely with Medway Planning Service. In 2014, a supplementary guidance note was introduced to restrict the volume and opening hours of Hot Food Takeaways within a 400m radius of schools. Since the success of this, the collaboration has been extended to include the Public Health Team providing input on a large number of planning applications and processes. This includes commenting on large developments, attending pre-application stage meetings with developers and providing significant input to the master planning of towns. The Public Health Team continue to input to the development of the new Local Plan, writing specific health policies, and ensuring health and wellbeing is a golden thread running through all policy chapters. This includes significant references to the obesogenic environment, physical activity, active travel, healthy eating and food growing agendas.

2.12 In Kent, the broader work on obesity and obesogenic environments has been worked through the Local Health and Wellbeing Board plus our work with our Growth, Economy and Transport Directorate, particularly on active travel and increasing physical activity. The One You Kent service is broadly delivered through partnerships with districts in Kent with obesity being a key priority.

3. Advice and analysis

Child overweight and obesity: national performance

3.1 Nationally, the prevalence of overweight and obesity among children (2-15), as measured by the Health Survey for England, has increased from 25.0% in 1995 to 33.4% in 2005 and the trend has been stable since.

Obesity in children aged 10 -11 Kent and Medway performance overview

3.2 The 'Obesity in children aged 10 -11' dashboard (Appendix 1) shows the rates of obesity for children of this age across Kent and Medway from 2006/07 to 2016/17. At 18.5%, Kent has a statistically lower level of obesity at this age than England (20%). The Kent rate is 3.5% above the target of 15%. This gap corresponds to 542 children. At 21%, obesity in children aged 10 -11 in Medway is at a similar level to England. The Medway level is 6% above the target, this gap representing 181 children.

3.3 From the Dashboard it can be seen that both Tunbridge Wells (12.5%) and Tonbridge and Malling (14.7%) have met their target and are achieving statistically lower levels of obesity in this age group than the England benchmark at 20%. Gravesham have statistically higher rates of obesity in children aged 10 -11 than the England benchmark and the dashboard shows they are 8.2% adrift of their target. This gap represents 101 children.

Child overweight and obesity: Kent performance

3.4 The National Child Measurement Programme (NCMP) in 2017/18 found 12.4% of reception aged children to be overweight and 8.3% to be obese. Overall in Kent, the percentage of reception year pupils classified as overweight or obese is lower than the national figure and ranks 4th amongst the 16 statistical neighbours (Appendix 3 Table 2).

3.5 In 2017/18, the percentage of year six pupils (aged 10 to 11) classified as overweight or obese based on the NCMP was 33.2% for Kent, which is lower than the national figure and ranks 15th amongst the 16 statistical neighbours (Appendix 3 Table 3).

3.6 Obesity was more common amongst year six pupils compared to reception year, affecting 18.8% of children measured. 14.4% were overweight across Kent as identified by the NCMP in 2017/18.

3.7 In 2017/18, the prevalence of obesity was higher in year six boys (20.6%) than girls (16.9%) as measured by the NCMP across Kent. However, among reception year the prevalence of obesity across boys and girls was similar (8.4%, 8.3% respectively). Nationally, obesity prevalence was higher for boys than girls in both age groups.

3.8 In 2017/18, the prevalence of obesity was generally highest amongst certain ethinic minority groups. These include Black pupils in reception (27.7%), as well as, amongst Black and Asian pupils in year six (44.5%, 42.0% respectively) as measured by the NCMP across Kent. The same pattern was

observed nationally for Black pupils in both age groups. Further work needs to be undertaken to understand how to better engage families in the offer.

3.9 Overweight and obesity prevalence is higher in pupils living within the most deprived areas than the least deprived areas, as measured by the NCMP across Kent and England. For year six pupils across Kent, the inequality gap in obesity prevalence between the most and least deciles has been increasing, equating to a difference of 6.8% in 2010/11 and increasing to 14.1% in 2017/18. Nationally, this difference has been increasing in both age groups between 2010/11 and 2017/18.

3.10 The prevalence of overweight and obesity in reception year pupils is higher in Dartford, Dover and Swale (See Appendix 3, Table 4). The prevalence of overweight and obesity in year six pupils was higher in Dartford, Gravesham and Thanet than the Kent figure in 2017/18 (See Appendix 3, Table 5).

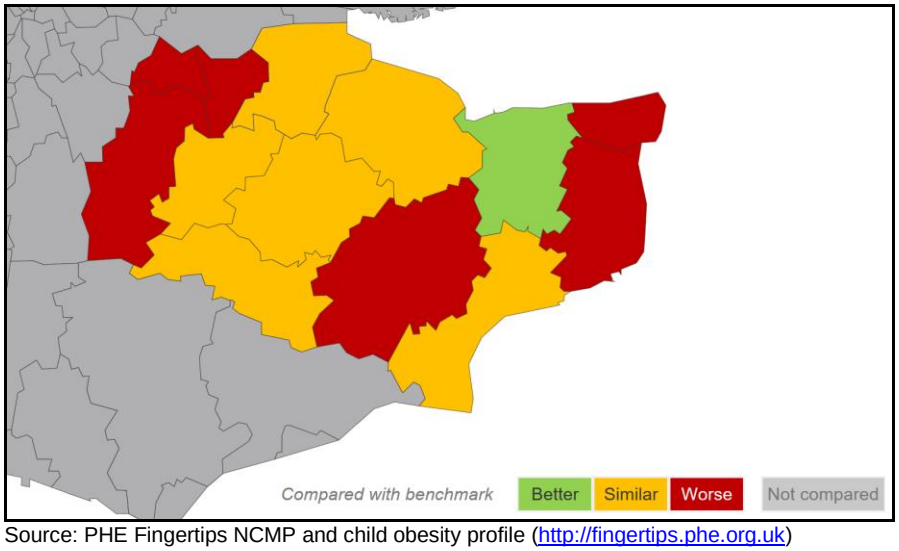
Child overweight and obesity: Medway performance

3.11 In reception year, the percentage of children categorised as being overweight or obese has increased slightly from 22.6% in 2016/17 to 23.4% in 2017/18, all of this increase occurring in the overweight category.

3.12 For year six pupils, the percentage of children categorised as being overweight or obese has decreased from 35.5% in 2016/17 to 34.0% in 2017/18. These changes are not statistically significant and Medway is in line with the national average. National data shows that the prevalence of overweight (including obesity) is strongly associated with deprivation.

3.13 Chart 1 shows the prevalence of overweight (including obese) across Kent and Medway for reception children 2016/17 compared with England as the benchmark.

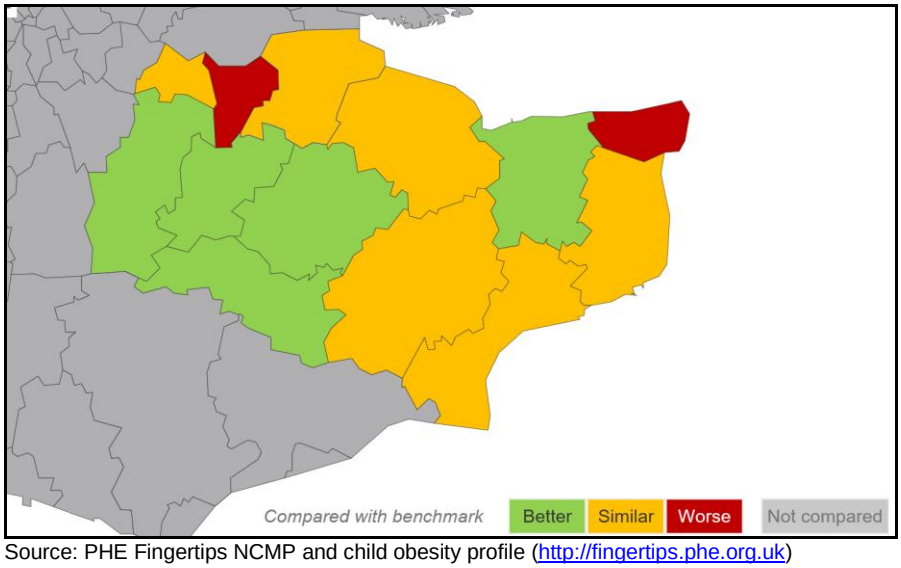
Chart 1: Prevalence of overweight (including obese across Kent and Medway for reception children 2016/17 benchmarked against England



Source: PHE Fingertips NCMP and child obesity profile (http://fingertips.phe.org.uk)

3.14 Chart 2 shows the prevalence of overweight (including obese) across Kent and Medway for year six pupils 2016/17 compared with England as the benchmark.

Chart 2: Prevalence of overweight (including obese) across Kent and Medway for year 6 pupils 2016/17 benchmarked against England



Source: PHE Fingertips NCMP and child obesity profile (http://fingertips.phe.org.uk)

3.15 There are also increasing levels of excess weight amongst females of reproductive age which is impacting on the reproductive and maternal health of individuals. Maternal obesity not only affects the outcomes of pregnancy, it also impacts on the health and well-being of the future child (See Appendix 4).

Adult Overweight and Obesity: National Performance

3.16 Nationally, the prevalence of overweight and obesity in adults (16+), as measured by the Health Survey for England, has increased from 52.9% in 1993 to 61.3% in 2009 and the trend has been stable since. Being overweight was more common with over a third of adults (16+) being overweight (35.2%) and over a quarter being obese (26.2%) nationally in 2016.

3.17 Nationally, among adults (16+) overweight was higher in men (39.9%) than women (30.5%), obesity levels were similar across men and women (25.7%, 26.6% respectively). However, morbid obesity levels (body mass index of 40 or more) were higher in women (3.8%) than men (1.9%) in 2016.

3.18 There is evidence that members of Black, Asian and Minority Ethnic groups are at an increased risk of chronic health conditions at a lower BMI that the white population and nationally among adults (16+), Black (84.9%) and Asian (72.6%) groups were more likely to have body mass index classifications at increased or high risk of diabetes in comparison to White (62.0%) groups as measured by the Health Survey for England 2014.

3.19 The prevalence of overweight and obesity among adults (16+) was greater within women living in the most deprived quintile (66.7%) in comparison to the

least deprived quintile (48.3%), as measured by the Health Survey for England in 2016. However, the same pattern was not seen in men.

Adult overweight and obesity: Kent and Medway performance overview

3.20 The 'Adults overweight or obese' dashboard (Appendix 2) shows that in Kent 63% of adults (18+) are overweight or obese and in Medway 64.6%. The percentage of adults who were overweight or obese in Kent increased from 2015/16 to 2016/17 and is now significantly higher than in England. The rate in Medway was significantly higher than England in 2015/16 and has fallen in 2016/17, it is now not significantly different to England. Note that the confidence intervals for Medway are wider than for Kent. The trends for districts in Kent and Medway can be seen in the Adult Overweight and Obese Dashboard in Appendix 2.

3.21 The dashboard shows two Kent districts where the number of adults overweight or obese is less than the rest of England, Canterbury at 54.5% and Tunbridge Wells at 50.0%, compared to England at 61.3%. Swale at 72.7% has the highest level of obesity compared to the England benchmark.

Adult overweight and obesity: Kent performance

3.22 In 2016/17, the percentage of adults (18+) classified as overweight or obese based on the Active Lives survey was 63.0% for Kent, which is higher than the national figure and ranks 11th amongst the 16 statistical neighbours.

3.23 The percentage of adults (18+) classified as overweight or obese based on the Active Lives survey is high across many of the Kent districts in 2016/17 (Appendix 3 Table 6). The prevalence of overweight and obesity in Maidstone and Swale were higher than the Kent figure in 2016/17. Prevalence of overweight and obesity in Canterbury and Tunbridge Wells were lower than the Kent figure in 2016/17 (See Appendix 3, Table 7).

Adult overweight and obese: Medway performance

3.24 The most recent data for Medway (2016/17) indicates that 64.6% of Medway adults are overweight or obese, which is slightly higher than the national average (England: 61.3%). This indicator is based on self-reported measures of height and weight, which may be less accurate than measured data. As with childhood obesity/overweight, prevalence is associated with deprivation and is generally higher among males and older people. Detailed information for Medway is set out at a locality level in the JSNA which is currently being refreshed.

Tier 4 Bariatric surgery

3.25 Nationally, admissions for bariatric surgery, as analysed from Hospital Episode Statistics, have decreased from 16.9 in 2011/12 to 12.2 per 100,000 resident population in 2016/17. The same has been observed across Kent decreasing from 17.6 in 2011/12 to 11.2 per 100,000 resident population in 2016/17. In Medway the rate has remained statistically stable moving from

19.3 in 2011/12 to 18.9 per 100,000 resident population in 2016/17 (See Appendix 5).

Services and Interventions: Kent

Child overweight and obesity interventions

3.26 Universal healthy weight interventions for 0-5s are provided by the Health Visiting Service. This offer is developing and includes health promotion messages given at the 5 mandated contacts, information and support on infant feeding including introduction to solids, portion size and at other opportunities where they arise.

3.27 There is a growing evidence base developing regarding programmes such as the Healthy Eating in the Really Young (HENRY) programme which is being being piloted in Kent. HENRY is a programme commissioned to support families to live healthy lifestyles in the early years. The programme focuses on a number of elements including parenting, family lifestyle habits, nutrition, activity and emotional wellbeing.

3.28 At primary school age, the School Health Service, supported by Children's Centres and Youth Hubs, offers support to schools to promote healthy school environments and increase children's knowledge about healthy lifestyles. The School Health Service also delivers a 1:1 package of care with families, using goal setting techniques to change behaviours. This is offered to children identified through the NCMP programme and through professional or self-referral. Despite an offer, the take up is very low.

Tier 2 Family Weight Management

3.29 Family weight management services are commissioned by Kent County Council to provide support to help children with families with a body mass index above the 91st UK National BMI centile for clinical assessment, typically for children aged 7 to 11 years. These are multi-component programmes, delivered across Kent; that address dietary intake, physical activity levels and behaviour change. The programmes deliver between 10-12 weekly or fortnightly group sessions over a period of at least 3 months.

3.30 In 2017/18, Tier 2 family lifestyle weight management services had 120 engagers. The percentage completing was 83.3%, achieving the target of 60%. In total, 75 child completers reduced or maintained their BMI z-score (See Appendix 3, Table 8).

3.31 A further analysis has been completed for a sample of referrals and initial assessments between 1 April 2016 and 31 December 2017. Generally, there was good equity of access. Children attending the family weight management services had similar outcomes regardless of age, sex and ethnic group. But, children resident in the most deprived decile were less likely to complete the full course of sessions. Overweight children were more likely to complete the full course and had better outcomes than children who were obese at the start.

3.32 Further information on Healthy Weight services for children and young people in Kent can be found in Appendix 6.

Tier 2 Adult Lifestyle Weight Management – One You

3.33 The adult lifestyle weight management services (Tier 2) are commissioned by Kent County Council to provide support to help adults to achieve long term weight loss and behavioural change. These are multi-component programmes, delivered across Kent; that address dietary intake, physical activity levels and behaviour change. The programmes deliver between 10-12 weekly or fortnightly group sessions over a period of at least 3 months.

3.34 One You makes connections between weight loss/maintenance and other lifestyle issues, such as money saving, to strengthen lifestyle change motivations. Service Users can learn about different healthy weight and exercise referral programmes available to them in their area. (Appendix 3, Table 9 shows outcomes from the One You social marketing campaign)

3.35 In 2017/18, Tier 2 adult lifestyle weight management services had 1,400 referrals. The percentage of engagers completing was 72.7%, achieving the target of 60%. In total, 650 completers lost weight, with 22.2% achieving a 5% weight loss (Appendix 3, Table 10).

3.36 A further analysis has been completed for a sample of referrals and initial assessments between 1 April 2015 and 30 September 2016. Access was consistent regardless of residence in areas of deprivation, suggesting services sufficiently target those with greater need. Men and the older age groups had lower access despite evidence for higher need. Outcomes suggested that younger groups and those resident in areas of deprivation were less likely to engage with services and complete the programme. There was also evidence for lower weight loss success despite good engagement within those aged 35-64 years and ethnic minority groups. Men did show higher weight loss success.

Services and interventions: Medway

3.37 Medway Council likewise provide a wide range of obesity prevention and treatment interventions. This includes front line services such as weight management services, physical activity and cookery sessions. There are also policy level interventions including, use of planning to create healthy environments and training of volunteers and professionals on obesity topics.

3.38 The Medway Joint Strategic Needs Assessment (JSNA) obesity chapter provides a wealth of data about obesity prevalence in Medway. The chapter is being updated and due to be published online early in December 2018. For Medway, the JSNA references the higher rates of childhood obesity found within more deprived wards, as measured by the NCMP.

3.39 The Medway JSNA concludes with recommendations for commissioners to explore commissioning more targeted weight management support interventions such as Tier 3 children and young people services. It also

recommends targeted support for women above a healthy weight at the perinatal period of their lives.

Child healthy weight services

3.40 Medway provide a wide range of family and childhood weight management services including the 'Tri For You' programme. This 12 week family-centred support package includes cookery skills, activity opportunities and home pack/self support.

3.41 In addition the Council offers a wide range of indoor and outdoor leisure and green space opportunities. Work between Public Health, planning and other Regeneration, Culture, Environment and Transformation (RCET) services is underway to create a healthier environment, that allows children to be more active and eat healthier food.

Adult health weight services

3.42 There is a range of services designed to meet different needs. Some are structured programmes over a number of weeks and months with strict eligibility criteria and others are volunteer-led such as Medway Health Walks and Active Medway cycling groups.

3.43 The structured programmes involve intensive support from trained practitioners to help people lose weight, be more active, understand risk and improve their wellbeing.

Medway Public Health services contacts

3.44 The number of people accessing related Public Health Services in 2016/17 is shown in Appendix 3, Table 11.

3.45 Medway conducted a large community consultation in 2016 to understand residents' views, about their priorities for the Medway Healthy Weight Network. The results were compared against those of the network members who also offered their opinions on priority areas.

3.46 As a result of a relatively low uptake of males participating in the survey in 2016, the survey was repeated in 2017 specifically targeting men. The survey was specifically taken into locations that were more commonly frequented by males. Some elements of the collective results of this consultation are set out in the bullet points below. Outcomes from the consultation demonstrated that these should form key priorities for action.

- People felt PE and sport in schools were most important for children
- People who were overweight should be provided with opportunities to be active as part of routine healthcare treatment
- A prevention strategy is best conducted through workplace health initiatives
- Teaching people how to cook healthy meals was the most common intervention for healthy eating category
- Weight management services are an integral part of the obesity system.

The challenge

3.47 National and local analysis demonstrates that there is a strong relationship between obesity and multimorbidity, independently of age, gender and residence in areas of deprivation. Multimorbidity is described as the co-occurrence of multiple long-term conditions and has been associated with impact on quality of life, higher mortality and higher unplanned care use. As an example, across Kent the age-standardised prevalence of multimorbidity in normal weight was 29.5% rising to 38.6% in overweight and 65.9% in obesity in 2017/18.

3.48 Nationally, hospital admissions where obesity is a factor have increased from 524.9 in 2011/12 to 1138.8 per 100,000 resident population in 2016/17. The same has been observed across Kent increasing from 267.3 in 2011/12 to 946.9 per 100,000 resident population in 2016/17. Medway has increased from 372.2 to 1599.6 per 100,000 resident population moving from position statistically better than England in 2011/12 to a position statistically worse than England in 2016/17. Although, Kent has seen a greater increase in the latest year, the overall pace of change is similar across Kent and England.(See Appendix 3, Table 12)

3.49 As has been demonstrated in this report there are a wide range of Tier 1 and Tier 2 services which are available and promoted to Kent and Medway residents. Whilst increased funding would enable the reach of these services to be broadened, the more pressing need is for a focus on Tier 3 services. There is a need for greater access to medical, multidisciplinary, multicomponent, weight management services for obese patients requiring specialised management.

3.50 For adults, 82% of adults receiving Tier 3 services are estimated to lose 5% of their body weight over a year and 24% to lose 10% of initial body weight, lowering their risk of diabetes and heart disease.

3.51 There are no services in place across Kent and Medway to support 5-19 year olds who are eligible for this service. Evaluations of Tier 3 services have demonstrated a significant reduction in weight (BMI z-score) that was sustained over the two years of follow up. Evidence suggests multi disciplinary teams with a psychosocial element are important elements of the service.

4. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Failure to reduce obesity levels	Failure to reduce obesity levels will result in increased morbidity and mortality in the Kent and Medway population. It will also result in increasing health inequalities and impact on life expectancy and healthy life expectancy. Treating and caring for obese people will have a major impact on NHS and social care systems in the short, medium and long term. High obesity prevalence has the potential for wider societal costs. These include work (productivity) and wider economy, as the evidence suggests that people above a healthy weight and/or suffering ill health have more sick days and days from work than average and suffer more mental ill health.	Range of interventions to tackle obesity from different perspectives.	C2
No reduction in excess maternal weight	Increased costs to health services across the stages: antenatal, delivery and postnatal. Excess maternal weight also affects the health and wellbeing of the future child and their propensity to obesity.	Maternal weight and height measurements planned to take place during the first 12 weeks of pregnancy. These are a vital component in the overall care and management of pregnant women and pregnancy outcomes.	C2
No change in the proportion of pregnant women with excess weight	Increase in prevalence of gestational diabetes and increased risk of subsequently developing type 2 diabetes with ongoing social care, health care and economic costs.	Range of interventions to support pregnant women to make choices which support a healthy lifestyle.	C2

Lack of Tier 3 provision	Increased morbidity and disease and costs associated with treating morbidity obese individuals (type 2 diabetes, cancer, musculoskeletal issues).		B2

5. Financial implications

5.1 There are no financial implications arising directly from this report.

6. Legal implications

6.1 The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012

6.2 The Joint Board 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. In accordance with the terms of reference of the Kent and Medway Joint Health and Wellbeing Board, the Joint Board may consider and seek to influence the work of the STP focusing on prevention, local care and wellbeing across Kent and Medway.

6.3 The Joint Board is advisory and may make recommendations to the Kent and Medway Health and Wellbeing Boards.

7. Recommendation

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to consider the report and consider how best to facilitate delivery of Tier 3 specialist weight management services.

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Appendices
Appendix 1: Obesity in children aged 10 -11 dashboard
Appendix 2: Adult overweight and obesity dashboard
Appendix 3 Tables

Appendix 4: Maternal weight and child obesity
Appendix 5: Tier 4 Bariatric surgery
Appendix 6: Health Weight Services for Children and Young People in Kent
Appendix 7: Tier 3 Specialist weight management

Background papers

Health Lives, Healthy People: A Call to Action on Obesity in England
https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england

Public Health Outcomes Framework
https://www.gov.uk/government/statistics/public-health-outcomes-framework-may-2018-data-update

Making obesity everybody's business: A whole systems approach to obesity
https://local.gov.uk/sites/default/files/documents/15.6%20Obesity-05.pdf

Foresight Tackling Obesities: Future Choices – Obesities System Atlas
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/295153/07-1177-obesity-system-atlas.pdf [Accessed 26 November 2018]

https://www.henry.org.uk/sites/www.henry.org.uk/files/2017-12/6.The_impact_of_HENRY_on_parenting_and_family_lifestyle-A_national_service_evaluation_%282016%29.pdf

PHE [2018] Health of women before and during pregnancy- demographic and risk factor investigation tool https://www.gov.uk/government/publications/preconception-care-making-the-case

https://www.nice.org.uk/guidance/ph11/chapter/4-Recommendations

https://www.gov.uk/government/case-studies/health-exercise-nutrition-for-the-really-young-henry

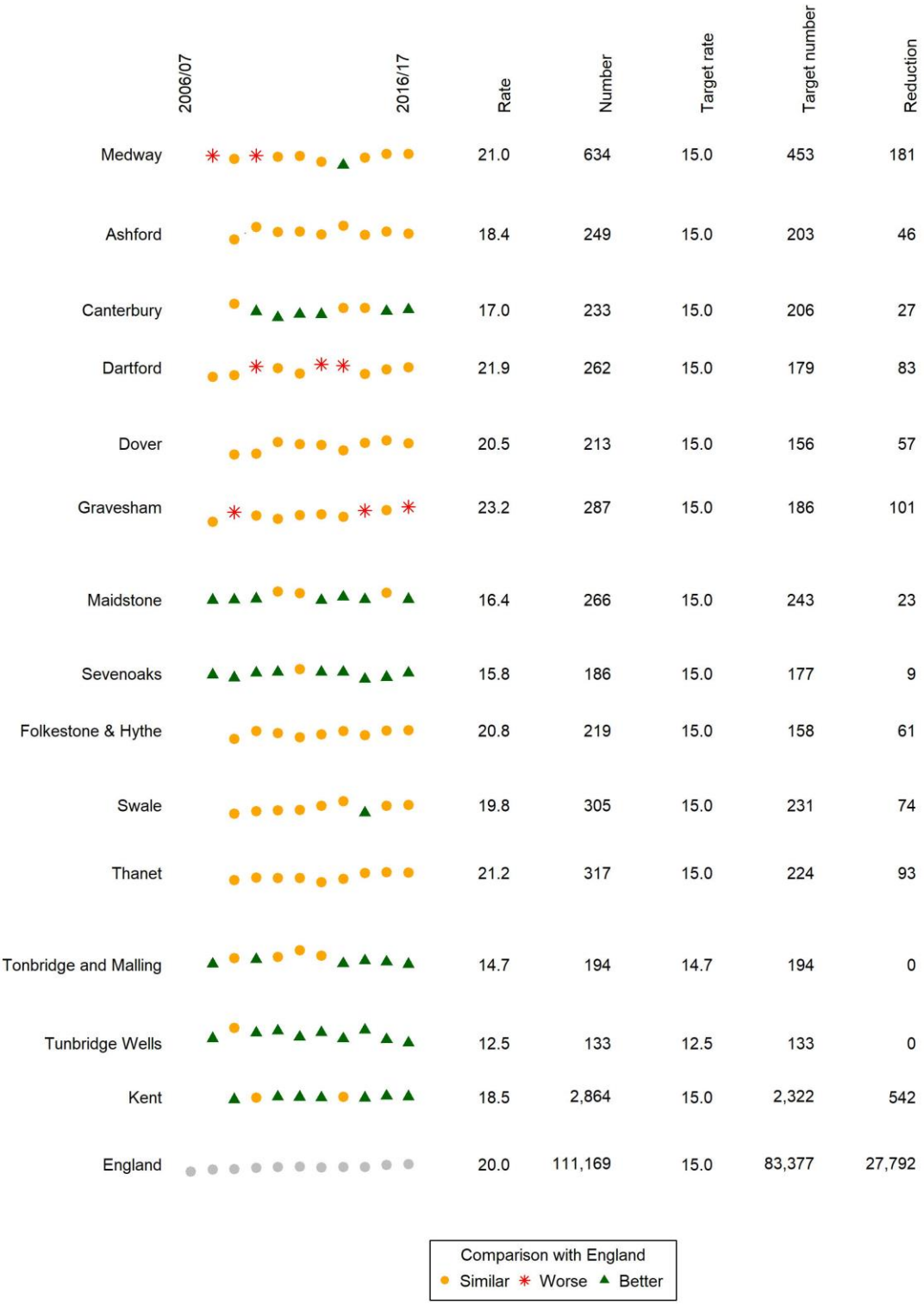
NICE (2013), *Weight management: lifestyle services for overweight or obese children and young people.* Available at https://www.nice.org.uk/guidance/ph47. Accessed 7 November 2018

Sutcliffe K, Burchett H, Rees R, Melendez-Torres GJ, Stansfield C, Thomas J (2016), *What are the critical features of successful Tier 2 lifestyle weight management programmes for children aged 0-11 years? A systematic review to identify the programme characteristics, and combinations of characteristics, that are associated with successful outcomes*. London: EPPI Centre, Social Science Research Unit, Institute of Education, University College London.

Appendices
Appendix 1 Obesity in Children aged 10 -11 (%)

Obesity in children aged 10-11 (%)

Prevalence of obesity (including severe obesity, BMI greater than or equal to the 95th centile of the UK90 growth reference) among children in Year 6 (age 10-11 years)



	Rate	Number	Target rate	Target number	Reduction
Medway	21.0	634	15.0	453	181
Ashford	18.4	249	15.0	203	46
Canterbury	17.0	233	15.0	206	27
Dartford	21.9	262	15.0	179	83
Dover	20.5	213	15.0	156	57
Gravesham	23.2	287	15.0	186	101
Maidstone	16.4	266	15.0	243	23
Sevenoaks	15.8	186	15.0	177	9
Folkestone & Hythe	20.8	219	15.0	158	61
Swale	19.8	305	15.0	231	74
Thanet	21.2	317	15.0	224	93
Tonbridge and Malling	14.7	194	14.7	194	0
Tunbridge Wells	12.5	133	12.5	133	0
Kent	18.5	2,864	15.0	2,322	542
England	20.0	111,169	15.0	83,377	27,792

Comparison with England
● Similar ✳ Worse ▲ Better

Produced by Medway Public Health Intelligence Team (2018-11-21)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

Appendix 2 Adults overweight or obese

Appendix 3: Tables

Key:

RAG Ratings

(g) GREEN	Higher
(a) AMBER	Similar
(r) RED	Lower

Trend significance

⇧	increasing
⇩	decreasing
⇔	remained the same

Table 1: Change4Life Sugar Smart 2016

Change4Life Sugar Smart 2016		
Key Indicator	**Kent**	**National**
No. total registrations	**1,800**	**58,000**
Registrations as a percentage of families with youngest child aged under 10	**1.6% (g)**	**1.4%**
No. total individuals sent at least one email	**4,200**	**138,900**
One email opened as a percentage of individuals	**3,600 84.3% (a)**	**117,800 84.8%**
Three emails opened as a percentage of individuals	**1,700 40.6% (a)**	**55,700 40.1%**
Percentage of individuals clicking on at least one content link	**1,000 23.1% (a)**	**31,200 22.4%**

Source: Public Health Obesity produced by KPHO (ZC) November 2018

Table 2: Percentage of reception year pupils classified as overweight or obese

	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Kent	**3,500 23.0 (a)**	**4,300 24.4 (r)**	**3,400 20.7 (g)**	**- 3.7**	⇔	**4th**
National	**22.6**	**22.6**	**22.4**	**- 0.2**	⇔	

Source: NHS Digital, NCMP produced by KPHO (ZC) November 2018

Table 3: Percentage of year six pupils classified as overweight or obese

	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Kent	**4,700 33.3 (a)**	**5,100 32.8 (g)**	**5,400 33.2 (g)**	**+ 0.4**	⇔	**15th**
National	**33.4**	**34.2**	**34.3**	**+ 0.1**	⇔	

Source: NHS Digital, NCMP produced by KPHO (ZC) November 2018

Table 4: Percentage of reception year pupils classified as overweight or obese

Percentage of reception year pupils classified as overweight or obese						
	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Ashford	270 21.1 (a)	400 25.7 (a)	310 21.0 (a)	- 4.7	⇔	7th
Canterbury	290 20.9 (a)	290 19.5 (g)	270 20.2 (a)	+ 0.7	⇔	3rd
Dartford	270 23.9 (a)	370 24.9 (a)	320 23.3 (r)	- 1.6	⇔	11th
Dover	230 23.2 (a)	300 25.6 (a)	270 23.5 (r)	- 2.1	⇔	6th
Folkestone & Hythe	230 22.2 (a)	280 24.8 (a)	250 22.9 (a)	- 1.9	⇔	8th
Gravesham	290 24.2 (a)	390 28.0 (r)	280 21.8 (a)	- 6.1	⇔	5th
Maidstone	350 22.7 (a)	470 23.9 (a)	330 17.5 (g)	- 6.4	⇔	2nd
Sevenoaks	240 20.5 (g)	340 25.5 (a)	230 19.0 (g)	- 6.4	⇔	10th
Swale	330 22.4 (a)	380 21.0 (g)	400 23.8 (r)	+ 2.9	⇔	7th
Thanet	330 23.0 (a)	430 26.7 (r)	330 22.2 (a)	- 4.5	⇔	2nd
Tonbridge & Malling	380 29.1 (r)	350 23.5 (a)	240 16.6 (g)	- 6.9	⇩	2nd
Tunbridge Wells	260 23.0 (a)	310 25.0 (a)	170 16.4 (g)	- 8.5	⇩	1st
Kent	23.0	24.4	20.7	- 3.7	⇔	

Source: NHS Digital, NCMP produced by KPHO (ZC) November 2018

Table 5: Percentage of year six pupils classified as overweight or obese

Percentage of year six pupils classified as overweight or obese						
	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Ashford	430 34.6 (a)	440 32.2 (a)	450 32.0 (a)	- 0.2	⇔	9th
Canterbury	330 28.1 (g)	430 31.4 (a)	440 32.2 (a)	+ 0.7	⇔	7th
Dartford	370 36.5 (r)	440 36.9 (r)	490 38.0 (r)	+ 1.1	⇔	16th
Dover	370 36.8 (r)	360 34.6 (a)	390 34.9 (a)	+ 0.3	⇔	10th

Percentage of year six pupils classified as overweight or obese						
	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Folkestone & Hythe	370 35.3 (a)	380 35.9 (r)	350 32.8 (a)	- 3.2	⇔	6th
Gravesham	370 33.5 (a)	470 38.3 (r)	490 37.5 (r)	- 0.9	⇧	15th
Maidstone	500 32.1 (a)	510 31.7 (a)	570 32.8 (a)	+ 1.2	⇔	14th
Sevenoaks	310 30.7 (a)	330 27.8 (g)	340 27.6 (g)	- 0.2	⇩	10th
Swale	450 31.5 (a)	500 32.6 (a)	570 35.2 (a)	+ 2.6	⇔	12th
Thanet	490 35.9 (a)	560 37.1 (r)	570 38.6 (r)	+ 1.5	⇧	16th
Tonbridge & Malling	400 33.1 (a)	390 29.1 (g)	420 29.1 (g)	0.0	⇩	9th
Tunbridge Wells	310 31.7 (a)	280 26.1 (g)	320 26.9 (g)	+ 0.9	⇩	5th
Kent	33.3	32.8	33.2	+ 0.4	⇔	

Source: NHS Digital, NCMP produced by KPHO (ZC) November 2018

Table 6: Percentage of adults (18+) classified as overweight or obese

	2015/16	2016/17	Difference from 2015/16*	Year change significance**	Nearest neighbour rank***
Kent	734,000 61.4 (a)	761,000 63.0 (r)	+ 1.6	⇔	11th
National	61.3	61.3	0.0	⇔	

Source: Public Health Obesity produced by KPHO (ZC) November 2018

Table 7: Percentage of adults (18+) classified as overweight or obese

Percentage of adults (18+) classified as overweight or obese					
	2015/16	2016/17	Difference from 2015/16*	Year change significance**	Nearest neighbour rank***
Ashford	64,000 67.1 (r)	58,000 59.8 (a)	- 7.3	⇩	3rd
Canterbury	72,000 55.0 (g)	73,000 54.5 (g)	- 0.5	⇔	1st
Dartford	53,000 67.0 (r)	53,000 66.1 (a)	- 1.0	⇔	15th
Dover	60,000 66.0 (a)	56,000 61.4 (a)	- 4.6	⇔	7th

Percentage of adults (18+) classified as overweight or obese					
	2015/16	2016/17	Difference from 2015/16*	Year change significance**	Nearest neighbour rank***
Folkestone & Hythe	61,000 68.4 (r)	57,000 63.1 (a)	- 5.3	⇔	9th
Gravesham	53,000 64.5 (a)	54,000 65.5 (a)	+ 1.0	⇔	10th
Maidstone	74,000 57.5 (a)	90,000 68.9 (r)	+ 11.4	⇧	16th
Sevenoaks	48,000 52.0 (g)	56,000 60.4 (a)	+ 8.4	⇧	13th
Swale	66,000 59.9 (a)	82,000 72.7 (r)	+ 12.8	⇧	14th
Thanet	74,000 67.5 (r)	73,000 66.1 (a)	- 1.4	⇔	9th
Tonbridge & Malling	56,000 58.4 (a)	61,000 61.9 (a)	+ 3.5	⇔	8th
Tunbridge Wells	50,000 55.6 (g)	45,000 50.0 (g)	- 5.6	⇔	1st
Kent	61.4	63.0	+ 1.6	⇔	

Source: Public Health Obesity produced by KPHO (ZC) November 2018

Table 8: Kent Family weight management service

Family weight management		
Key Indicator	2017/18	Target
No. of engagers (attending 2 sessions)	120	
No. of completers (attending 60% of sessions)	100	
Percentage of engagers completing	83.3% (g)	60%
Percentage of completers reducing or maintaining their BMI z-score at 10/12 weeks	75 75.0%	

Source: Public Health Obesity produced by KPHO (ZC) November 2018

Table 9: One You 2016 social marketing programme

One You 2016		
Key Indicator	**Kent**	**National**
No. total registrations	**18,700**	**629,900**
Registrations as a rate per 1,000 population aged 18 and over	**15.5 (g)**	**14.5**
No. emails sent	**270,100**	**9,389,500**
At least one email opened as a percentage of sent	**77,100 28.5% (g)**	**2,591,600 27.6%**
Percentage of emails opened clicked through to access content	**14,300 18.5% (a)**	**485,100 18.7%**
No. completing 2+ How are You? quizzes	**2,300**	**73,800**
Percentage of 2+ quizzes with better outcomes	**700 29.7% (a)**	**21,400 29.0%**

Source: Public Health Obesity produced by KPHO (ZC) November 2018

Table 10: Kent adult lifestyle weight management

Adult lifestyle weight management		
Key Indicator	**2017/18**	**Target**
No. referred into services	**1,400**	
No. of engagers (attending 2 sessions)	**990**	
No. of completers (attending 60% of sessions)	**720**	
Percentage of engagers completing	**72.7% (g)**	**60%**
No. of completers who have lost weight at 10/12 weeks	**650**	
Percentage of completers achieving 5% weight loss or greater at 10/12 weeks	**160 22.2%**	**30%**

Source: Public Health Obesity produced by KPHO (ZC) November 2018

Table 11: Medway Public Health services contacts 2016/17

Activity	2016/17 attendance	Activity	2016/17 attendance
Medway Health Walks	2,128	Medway Cooks courses and workshops	101
Exercise Referral	800	Little Chefs	159
Healthy Way: Diabetes Prevention Programme	786	Tri for You/MEND Programme	98
Medway Breastfeeding Network	413	FitFix Teenage Weight Management Programme	41
Tipping the Balance	380	Start4Life and Change4Life 1-1Clubs	26
Active Medway Cycling Groups	293	Nordic Walking	26
Little Food Explorers	270		

Table 12: Age standardised rate for obesity admissions per 100,000 resident population

	2011/12	2015/16	2016/17	Difference from 2015/16*	Trend since 2011/12 significance**
Kent	**3,800 267.3 (g)**	**10,500 707.7 (g)**	**14,300 946.9 (g)**	**+ 239.2**	⇧
Medway	**900 372.2 (g)**	**3,600 1401.6 (r)**	**4,200 1599.6 (r)**	**+ 198.0**	⇧
National	**524.9**	**980.1**	**1138.8**	**+ 158.7**	⇧

Source: NHS Digital, HES produced by KPHO (ZC) November 2018

Appendix 4

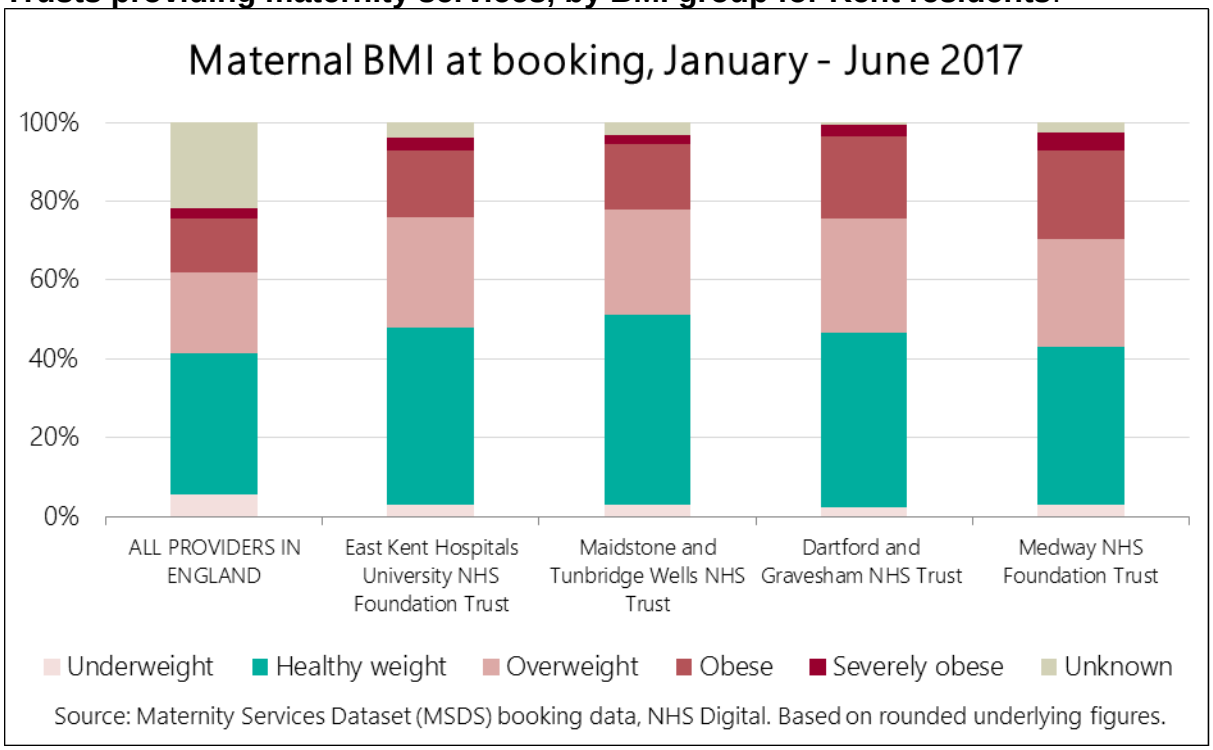
1. Maternal Weight and child obesity

- There are increasing levels of excess weight amongst females of reproductive age which is impacting on the reproductive and maternal health of individuals. Maternal obesity not only affects the outcomes of pregnancy, it also impacts on the health and well-being of the future child.'[v]The maternal weight and height measurements which should take place during the first 12 weeks of pregnancy and usually by the time of the booking appointment are therefore a vital component in the overall care and management of pregnant women and pregnancy outcomes. Approximately 1 in 12 pregnant women resident in Kent and 1 in 10 resident in Medway attended services after 12 weeks in the first 6 months of 2017 which will potentially impact upon the BMI calculated.

- Body mass often increases with age and therefore age is identified as a risk factor in terms of maternal weight. That said, the maternal age at booking shows Maidstone and Tunbridge Wells (MTW) NHS Trust have provided more services for older pregnant women, compared to England and other trusts in Kent and Medway but not corresponding expected excess weights.

- Graph 1 below, shows the maternal BMI recorded at booking January – June 2017 across the maternity service amongst Kent residents.

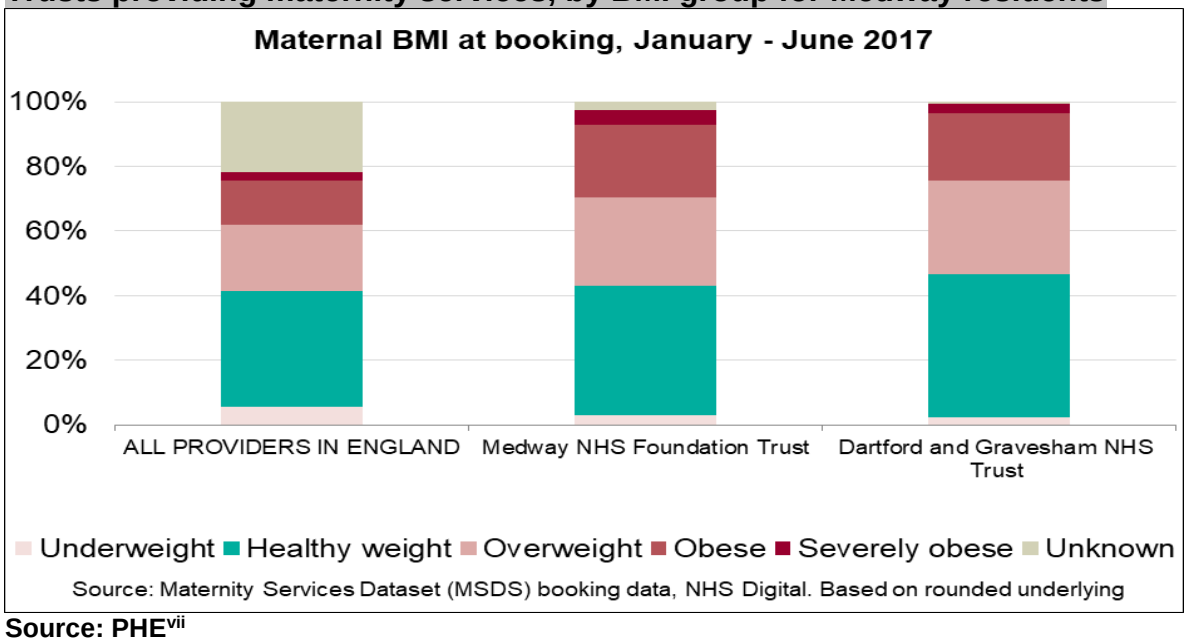
Graph 1: Proportion of persons at time of booking Kent and Medway NHS Trusts providing maternity services, by BMI group for Kent residents.



Source: PHE[vi]

- Graph 2 below, shows the maternal BMI recorded at booking January – June 2017 across the maternity service amongst Medway residents.

Graph 2: Proportion of persons at time of booking Kent and Medway NHS Trusts providing maternity services, by BMI group for Medway residents



Source: PHE[vii]

- One of the risk factors for gestational diabetes is excess weight. Glucose tolerance testing is undertaken to monitor this during pregnancy. Those detected with gestational diabetes are at subsequent risk of developing type 2 diabetes.

Appendix 5: Tier 4 Bariatric Surgery

- Nationally, admissions for bariatric surgery, as analysed from Hospital Episode Statistics, have decreased from 16.9 in 2011/12 to 12.2 per 100,000 resident population in 2016/17. The same has been observed across Kent decreasing from 17.6 in 2011/12 to 11.2 per 100,000 resident population in 2016/17.

- In 2016/17, the age standardised rate for admissions for bariatric surgery for Kent was like the national figure.

Age standardised rate for bariatric surgery per 100,000 resident population					
	2011/12	2015/16	2016/17	Difference from 2015/16*	Trend since 2011/12 significance**
Kent	**250** **17.6 (a)**	**190** **12.8 (a)**	**170** **11.2 (a)**	**- 1.6**	⇩
National	**16.9**	**11.8**	**12.2**	**+ 0.4**	⇩

- Admissions for bariatric surgery were higher in women (73.7%) than men (26.3%), the same pattern was observed nationally in 2016/17. It is important to note that the prevalence of morbid obesity is higher in women.

- Most admissions for bariatric surgery (74.3%) were for those aged between 35 and 64, the same pattern was observed nationally in 2016/17.

- For the period 2014/15-2016/17, the Kent age standardised rate for admissions for bariatric surgery was higher within those living in the most deprived decile (18.8 per 100,000 resident population) in comparison to the least deprived decile (5.5 per 100,000 resident population). The same pattern was observed nationally. It is important to note the known inequality gradient in the prevalence of obesity. There is national and local evidence to suggest that service delivery is below the level needed.

- The aged standardised rate for bariatric surgery per 100,000 resident population for Medway has shown no significant trend upward or downward since 2011/12. The rate in 2016/17 statistically significantly higher than the national rate.

Age standardised rate for bariatric surgery per 100,000 resident population					
	2011/12	2015/16	2016/17	Difference from 2015/16*	Trend since 2011/12 significance**
Medway	**50** **19.3 (a)**	**70** **25.9 (r)**	**50** **18.9 (r)**	**- 7.1**	⇔
National	**16.9**	**11.8**	**12.2**	**+ 0.4**	⇩

Appendix 6: Healthy Weight Services for Children and Young People in Kent

Age Group	Level of Support	Services
0-5s	Universal	The Health Visiting Service is the lead for delivering the healthy child programme, a programme of universal and targeted interventions of health promotion and prevention, to 0-5-year olds. The service provides 5 mandated contacts; antenatal, 10-14 days, 6-8 weeks, 10-12 months and 2-2 ½ years. Health visiting has six areas where it has been identified that they can have the highest impact, one of these areas is healthy weight. The key interventions they provide are: • Support for breastfeeding, the evidence tells us that being breastfed reduces the risk of a child becoming obese. This is delivered by the whole workforce, and where there are specific issues which requires support the infant feeding service hosted within the service. • Support for formula feeding. Under the UNICEF baby friendly initiative, the Health Visiting service provide advice on safe and responsive bottle feeding. • Support for introducing solid food. The health visiting service provide open access support for families, where they are able to access support about introducing solid foods. This is an important time to be given advice to ensure that healthy eating habits are instilled early and that there is an understanding of appropriate portion sizes. The service has recently delivered open access information sessions focused on the needs of parents of children aged 3-4 months. One of these sessions is introducing solid foods and where possible is delivered by health visitors in conjunction with children centres. These are new sessions and will be evaluated to assess their impact. Children's Centres provide a variety of support across the County to support healthy lifestyles in ages up to 8. This includes supporting the change for life campaigns and delivering associated events. All areas now have food champions trained by KCHFT who deliver healthy eating sessions across Kent. The service also supports the delivery of the introduction of solid food sessions. Children's Centres have policies in place to ensure they are health promoting environments.
	Targeted	Health Visitor Brief interventions. It is recommended that healthy babies are weighed at 6 key points in their first year[viii] and following that as part of their 2 2 ½ year review. When a baby is weighed, and it is appropriate, there is an opportunity to undertake a brief intervention with families if there baby is measuring as not being at a healthy weight. The service has developed a healthy weight discussion tool, which is a simple one-page prompt sheet to facilitate a conversation with families about why a child might be not at a healthy weight. Health visitors and nursery nurses have been trained in its use and have the prompts to use in open access clinics and mandated reviews. The family should then be offered a follow up discussion. Where the tool has been used, professionals have reported its benefits.

		Health Visitor Healthy Weight Package of Care. A healthy weight pathway was developed where families who wanted to engage and had a child at an unhealthy weight where lifestyle changes were not made after the above brief intervention were to be offered a 3-4 session intervention with an aim of increasing healthy lifestyles. HENRY – HENRY is a commissioned programme to support families to live healthy lifestyles in the early years. The programme focuses on a number of elements including parenting, family lifestyle habits, nutrition, activity and emotional wellbeing. The intervention can work at a number of levels including equipping whole early years workforces with the skills, knowledge and confidence to discuss with families about their lifestyle issues and/or provide more targeted support through group workshops for those families who need more intensive support. There is evidence that HENRY can be effective in changing lifestyle behaviours for families. The programme is commissioned in 35 local authority areas and a national service evaluation published in 2016[ix] found that following the targeted 8-week programme parents reported statistically significant increases in the healthiness of family lifestyle, parenting attributes, and emotional wellbeing. There were also reported increase in healthy eating patterns, behaviours, physical activity and screen time. It is inferred that these changes will have an impact on obesity in the longer term. These results seem positive, and where the HENRY approach at a workforce and targeted level has been implemented over 7 years in Leeds City as part of their city-wide obesity strategy, there has been a fall in obesity rates in reception compared to the static pattern across the country. The obesity rates between the least and most deprived has narrowed over the 5 years.[x] However, there has been no randomised controlled trial to truly test the effectiveness of the intervention and one is currently underway. HENRY has been provided on a smaller scale in two areas in Kent. It ran at Folkestone Early Years Children's Centre between January 2016 – April 2017 whilst the Centre was commissioned by an external provider. The local evaluation found that over the 4 programmes that were run 36 children aged 0-5 were reached. There was retention of 96% of the programme, with 100% of respondents feeling good or great about the programme. The numbers completing the evaluation were small, however, from this small sample 88% of programme respondents improved the overall healthiness of their family lifestyle. There was a positive change across the other outcomes measured.
5-11	Universal	The School Public Health service lead the delivery of the healthy child programme up to the age of 19. They support schools to develop whole school approaches to health and wellbeing and deliver targeted interventions through packages of care, including for healthy weight. This would include publicising the change for life resources and the PHSE curriculum resources to schools. The service carries out the national child measurement screening programme. The results are provided to each child who took part by letter. All children regardless of their result receive signposting to the change for life resources for support around adopting healthy lifestyles. Both Children's Centres and Youth Hubs have policies to ensure they are health promoting environments. Some Youth Hubs have implemented an energy drink ban on the premises to support specific action.

<table>
<tr><td></td><td></td><td>The Children's Centre offer for 5-8s is the same as 0-5s. For the 9-11 offer youth hubs also promote change for life resources</td></tr>
<tr><td></td><td>Targeted</td><td>The School Health Service provide a short-term 1:1 package of care for healthy lifestyles where a young person has been identified as being at an unhealthy weight. Families and professionals can refer into the school public health service. The package of care is comprised of 6 sessions, including goal setting and including information on healthy eating, physical activity, triggers and sleep. This offer is being evaluated, as although based on evidence-based principles it does not offer the full NICE recommended model for children who are at an unhealthy weight[xi] or the key elements (group sessions and practical work) that has been identified being associated with models that have achieved changes in behaviours.[xii] Following the NCMP, the School Public Health Team contact all parents of children in year R who have measured as very overweight and year 6 children measured as very overweight in target schools[xiii] Those undertaking the proactive phone call offer every parent a package of care and if this is not taken up, the families are signposted to change for life resources for healthy lifestyles. The table below presents the take up of the packages of care following the proactive phonecalls for the 2017/18 NCMP measurements.
<table>
<tr><th></th><th>Year R</th><th>Year 6</th></tr>
<tr><td>Proactive phone calls made</td><td>767</td><td>700</td></tr>
<tr><td>Families spoken to</td><td>179</td><td>299</td></tr>
<tr><td>Families signposted to support</td><td>122</td><td>251</td></tr>
<tr><td>No answer/wrong number</td><td>321</td><td>401</td></tr>
<tr><td>Packages of care accepted (Kent)</td><td>16</td><td>64</td></tr>
</table>
This shows that the uptake is proportionally low. The uptake amongst year 6 (9%) families was higher than year R (2%). The comments of parents are recorded following the phone call and although a very small minority are upset by the conversations as they do not believe their child to be overweight, the majority are positive, with responses ranging from families recognising they need to make a change but wish to do this in their own way or particularly for year R children parents believe that they will grow out of it. This highlights a gap in knowing how to effectively engage parents, to both recognise the child's unhealthy weight and engage them with efforts to change behaviours.

NICE guidance recommends the provision of Family Weight Management Services.[xiv] These services are provided to families where a child is</td></tr>
</table>

		already overweight. The key components of this system are: • Use behaviour change techniques to increase motivation and confidence • Support positive parenting • Emphasise the importance of all family members to eat healthily and to be physically active, regardless of their weight. • Information and help to master skills in, for example, how to interpret nutritional labelling and how to modify culturally appropriate recipes on a budget. • Help to identify opportunities to become less sedentary and to build physical activity into their daily life (for example, by walking to school and through active play) • Introduce a range of physical activities (such as games, dancing and aerobics) that the children or young people enjoy and that can help them gradually become more active Until recently family weight management services were provided across Kent. In West Kent, these were provided by the District Councils and in East Kent by Kent Community Health Foundation Trust. However, these are no longer provided consistently across Kent. The service is no longer provided in East Kent, as the family weight management service struggled to engage families and when the adult's healthy lifestyle service was recommissioned the funding was absorbed into the adult's service. In West Kent, Maidstone have recently commissioned a new provider to deliver a family weight management service to 5-16-year olds. Tunbridge Wells, Tonbridge and Malling and Sevenoaks provide a service on a 1:1 basis when they receive a referral. Only a handful of families are accessing the 1:1 service. Funding is still provided to the Districts for this but is held within the adults budget for healthy lifestyles. In Dartford and Gravesham, they continue to provide their family weight management service in conjunction with the school nurse offer. See below for details. A review of the outcomes for these services before the changes found: • 532 records for 21-month period analysed, 308 child referrals and initial assessments were of sufficient quality to analyse • Majority of referrals and initial assessments for ages 9 to 12 years, white ethnic groups, residents in the most deprived areas and those obese at initial assessment. • Generally good equity of access – but some evidence for higher prevalence and lower referrals/ initial assessments in those aged 13 to 16 years. • 72.4% of participants completed. Completion was not significantly associated with age, sex or ethnicity. Lower levels of completion within residents in the most deprived decile and within East Kent. Higher levels of completion from school referrals, those overweight at initial assessment, those resident within North Kent. • 86.4% of participants achieved body mass index z-score maintenance and 7.1% achieved a reduction. Body mass index z-score change was not significantly associated with age, sex, ethnicity or district of residence . Those referred by health and social care, resident in the least deprived areas or overweight at initial assessment were more likely to have reducing body mass index z-scores. Whereas, those who were obese were more likely to be maintaining their body mass index z-score.

		Nationally, many Local Authority areas are struggling to engage families into family weight management programmes and to achieve positive outcomes. In Dartford and Gravesham, areas with some of the highest levels of childhood obesity, a new approach is being trialled by a partnership of KCC, the District Councils, Kent Community Health Foundation Trust and the University of Kent. In four target schools in both Dartford and Gravesham a programme has been developed which will: • Develop healthy lifestyle partnership group in each school • Deliver an 8-session intervention using the 1:1 School Health Package of Care with the group District practical cooking and physical activity interventions. • Recruit participants through the NCMP proactive phonecalls, special assemblies at the school and engagement with the school. The programme will run 2 courses in each school between January 2019 and July 2019. This programme is being evaluated by the University of Kent, As comparator groups they will be evaluating the school health package of care in East Kent and using the reporting data from the commissioned service in Maidstone. The aim of the evaluation is to identify whether this hybrid model using existing resources can increase engagement in the programme and improve healthy lifestyle behaviours in the participating families.
11-19	Universal	School Health offer support about the whole school approach. Youth Hubs offer a range of healthy lifestyles activities across the County and implement policies to ensure the hubs as environments support healthy lifestyles.
	Targeted	There is currently no healthy weight package of care by the School Health Service developed for secondary school aged children. This is being explored with an emphasis on the emotional health angle of weight in adolescence and exploring digital options for intervention. If a referral is made to School Health for healthy weight issues support will be offered. The commissioned family weight management service in Maidstone will provide 1:1 sessions of support to secondary age pupils if referred into the service. There is no service for adolescents in the rest of Kent.
All Ages	Tier 3	Tier 3 weight management services are the responsibility of the CCGs. These provide more intensive interventions by multidisciplinary teams for those children who are obese or severely obese with complex needs. There are no tier 3 service provided in Kent.

Appendix 7: Tier 3 Specialist Weight Management

Prescribing for the treatment of obesity

- Nationally, prescribing for the treatment of obesity, as analysed from electronic Prescription Analysis and Cost data, has decreased from 9.1 in 2014/15 to 6.5 per 1,000 resident population in 2017/18. The same has been observed across Kent decreasing from 8.7 in 2014/15 to 6.5 per 1,000 resident population in 2017/18.

- In 2017/18, the crude rate for obesity prescription items for Kent was lower than the national figure.

Table 13 Crude rate for obesity prescription items per 1000 registered population

Crude rate for obesity prescription items per 1,000 registered population					
	2014/15	2016/17	2017/18	Difference from 2016/17*	Trend since 2014/15 significance**
Kent	**13,300 8.7 (r)**	**11,300 7.2 (r)**	**10,300 6.5 (r)**	**- 0.7**	⇩
National	**9.1**	**7.7**	**6.8**	**- 0.9**	⇩

Source: NHS Business Services Authority, ePACT produced by KPHO (ZC) November 2018

[i] Health Lives, Healthy People: A Call to Action on Obesity in England https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england

[ii] Public Health Outcomes Framework https://www.gov.uk/government/statistics/public-health-outcomes-framework-may-2018-data-update

[iii] Making obesity everybody's business: A whole systems approach to obesity https://local.gov.uk/sites/default/files/documents/15.6%20Obesity-05.pdf

[iv] Foresight Tackling Obesities: Future Choices – Obesities System Atlas https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/295153/07-1177-obesity-system-atlas.pdf [Accessed 26 November 2018]

[v] https://www.henry.org.uk/sites/www.henry.org.uk/files/2017-12/6.The_impact_of_HENRY_on_parenting_and_family_lifestyle-A_national_service_evaluation_%282016%29.pdf

[vi] PHE [2018] Health of women before and during pregnancy- demographic and risk factor investigation tool https://www.gov.uk/government/publications/preconception-care-making-the-case

[vii] PHE [2018] Health of women before and during pregnancy- demographic and risk factor investigation tool https://www.gov.uk/government/publications/preconception-care-making-the-case

[viii] https://www.nice.org.uk/guidance/ph11/chapter/4-Recommendations

[ix] https://www.henry.org.uk/sites/www.henry.org.uk/files/2017-12/6.The_impact_of_HENRY_on_parenting_and_family_lifestyle-A_national_service_evaluation_%282016%29.pdf

[x] https://www.gov.uk/government/case-studies/health-exercise-nutrition-for-the-really-young-henry

[xi] NICE (2013), *Weight management: lifestyle services for overweight or obese children and young people*. Available at https://www.nice.org.uk/guidance/ph47. Accessed 7 November 2018

[xii] Sutcliffe K, Burchett H, Rees R, Melendez-Torres GJ, Stansfield C, Thomas J (2016), *What are the critical features of successful Tier 2 lifestyle weight management programmes for children aged 0-11 years? A systematic review to identify the programme characteristics, and combinations of characteristics, that are associated with successful outcomes*. London: EPPI Centre, Social Science Research Unit, Institute of Education, University College London.

[xiii] These are schools in each district who have high enough prevalence and sufficient numbers of children who are overweight or very overweight where action from services is targeted.

[xiv] NICE (2013), *Weight management: lifestyle services for overweight or obese children and young people.* Available at https://www.nice.org.uk/guidance/ph47. Accessed 7 November 2018

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
14 DECEMBER 2018
NHS HEALTH CHECK DEEP DIVE

Report from:	James Williams, Director of Public Health for Medway Council
	Andrew Scott-Clark, Director of Public Health for Kent County Council
Author:	Katherine Bell, Public Health Programme Manager, Medway Council
	Louise Merchant – Senior Commissioner, Kent County Council

Summary

This report presents a deep dive into the implementation and outcomes of the NHS Health Check Programme across Kent and Medway.

Local authorities have a statutory responsibility to deliver the NHS Health Check (NHSHC) Programme which is a nationally mandated screening programme and contributes to the delivery of the prevention strand of the Kent and Medway Sustainability and Transformation Plan.

The NHS Health Check is a national cardiovascular screening programme for individuals aged between 40 and 74 who have previously not been diagnosed with stroke, kidney disease, heart disease, type 2 diabetes or dementia. Each eligible resident will be invited every five years for this free check.

The programme provides a systematic approach to identifying people with previously undiagnosed high-risk conditions with the intention of reducing early death, disability and health inequality.

1. Budget and Policy Framework

1.1 This matter falls within the Medway Council budget and policy framework and addresses the Council Plan for Medway by supporting Medway's people to realise their potential.

1.2 This matter also falls within the Kent County Council budget and policy framework. The NHS Health Check Programme contributes to Kent County Council's strategic aim to: "Improve lives by ensuring every pound spent in Kent is delivering better outcomes for Kent's residents, communities and businesses".

1.3 More specifically the Health Check programme supports:

- Outcome 2: *Kent Communities feel the benefits of being in work, healthy and enjoying a good quality of life*
- Outcome 3: *Older and vulnerable residents are safe and supported with choices to live independently*

1.4 Local Authorities (LAs) have a statutory obligation to offer an NHS Health Check to 100% of eligible people over a period of five years and to seek continuous improvement in the number of people having an NHS Health Check (NHSHC) each year. Public Health England (PHE) aspires to achieve a national take up rate in the region of 75% of the eligible population receiving a health check once every 5 years[1].

2. Background

2.1 As people get older, they are at higher risk of developing a number of conditions many of which are preventable with lifestyle changes or clinical intervention. The NHS Health Check plays an important role in the prevention and early detection of these conditions, especially cardiovascular disease (CVD) which is one of the main causes of death and disability in the UK.

2.2 The programme aims to prevent heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia, both across the population and within high risk and vulnerable groups. In April 2013, the NHS Health Check became a statutory Public Health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years.

2.3 An NHSHC is made up of three key components: risk assessment, risk awareness and risk management. During the risk assessment, standardised tests are used to measure key risk factors and establish the individual's risk of developing cardiovascular disease. The outcome of the assessment is then used to raise awareness of cardiovascular risk factors, as well as to inform a discussion on, and agreement of, the lifestyle and medical approaches best suited to managing the individual's health risk.

2.4 The NHSHC Programme is the largest Public Health programme in England, with nearly seven million people receiving an NHSHC since 2013.

2.5 Local authorities are required to:

- offer all eligible residents a free NHS Health Check once in every five years;
- ensure the results are communicated effectively to them;
- record the data from the check and notify the person's GP practice; and
- continuously improve the percentage of eligible individuals having an NHS Health Check[2].

3. Advice and analysis

Programme delivery in Medway

3.1 In Medway, the number of people dying prematurely from CVD is 53.5 per 100,000 of the population between 2014 and 2016. This is higher than regionally in the South East at 38.4 and nationally at 46.7 per 100,000[3]. Identifying those with CVD or at risk of CVD early, may prevent premature death and disability. It also contributes to reducing health inequalities in Medway; given the people more likely to be at greater risk of an adverse event related to CVD, live in the most disadvantaged areas.

3.2 The NHSHC Programme in Medway began in 2009/10 and originally GPs were commissioned to deliver the service. In April 2013 Medway Council commissioned a third party provider to deliver an outreach service targeting hard to reach groups. These groups included:

- eligible residents in the five most deprived wards in Medway
- all individuals aged between 40-55yrs with specific focus on men
- eligible residents from a number of ethnic groups.

3.3 The third party provider was decommissioned in March 2015 and GPs once again become the sole providers of the programme until November 2017. Following the decommissioning of this outreach service, performance for Health Checks was impacted, with 6.6% of the Total Eligible Population receiving a Health Check in 2015/16 compared to 9.1% the previous year.

3.4 In November 2017, Medway Council launched a small scale outreach NHSHC service from its Smokefree Advice Centre based in Chatham High Street. The aim of the service is to increase access to Medway residents that are eligible for a Health Check, but integrating the Health Check Programme into Smoking Cessation core delivery.

3.5 Currently, all 49 GP practices offer NHSHCs via a service level agreement. The Medway Council Health Check Team work with GP practices in deprived areas that have limited capacity to deliver the service. The Health Check Team also work with workplace health and various settings in the community. In 2017/18, 8.29% of the Total Eligible Population received an NHS Health Check.

3.6 The Medway Clinical Commissioning Group (MCCG) have purchased third party software, Informatica and its reporting function, Audit +. Audit + allows the CCG to extract data for analysing and as of November 2018, Informatica is installed in all 49 practices in Medway. The Public Health Team in Medway use Audit + to monitor health check activity in GP practices.

3.7 The data is used to ensure that statutory objectives are met for invites, uptake rate and completeness of checks; reporting to Public Health England (PHE) on a quarterly basis. This software helps inform the efficient management of the Medway NHS Health Check programme. It enables effective monitoring of GP practices' activity including payment. It also helps to determine how well the service is actually performing in terms of identifying those at risk of developing CVD and action taken to reduce clinical risk.

Programme delivery in Kent

3.8 The Health Reform and Public Health Cabinet Committee supported proposals to enter into a Partnership arrangement with Kent Community Health NHS Foundation Trust (KCHFT), who deliver the core NHS Health Check programme. KCHFT oversee delivery of the programme, managing arrangements across: 180 GP surgeries; 30 Pharmacies; KHCFT/Wellbeing Teams and District Councils. KCHFT provides support, training, quality assurance and project management across subcontractors. KCHFT monitors performance and issues payments, escalating issues to KCC as required.

3.9 The majority (85%) of Health Checks are conducted in GP surgeries and subcontracted through the core Health Check contract with KCHFT. Surgeries choose from four contract types to meet the resource capacity of local practices and ensure universal coverage.

3.10 Pharmacies and the KCHFT Community Health Check Team offer appointments for residents who would prefer not to visit their GP. KCHFT also work with Wellbeing People to take NHS Health Checks to busy town centre locations where there is a high footfall from target groups. This supports uptake for people who may not respond to their invitation for an NHS Health Check.

3.11 The programme is supported by an IT system that links with GP clinical systems to invite patients, capture and feedback results. From the 1 April 2018, KCC contracted with Health Diagnostics who offer an efficient end to end solution.

3.12 The NHS Health Check delivery is closely linked with KCC's lifestyle service (One You Kent[4]), with referrals routinely made as part of the NHS Health Check. This aims to support people to quit smoking, lose weight, be more active or address underlying issues preventing lifestyle change, such as debt or housing.

3.13 Significant inequalities still exist in Kent with up to a 10 years difference in life expectancy between men living in the most affluent and most deprived wards. The programme provides a significant opportunity to reduce early death, disability and health inequality by providing a systematic approach to identifying people with previously undiagnosed high-risk condition.

Service costs

3.14 The 2018/19 budget for the Medway NHS Health Check Programme is £240,439. This funds the Service Level Agreements (SLA) with GPs and Medway Council's outreach service. GPs receive £2.30 for inviting an eligible patient for a Health Check and a further £14.80 for a screen and subsequent advice. In 2017/18, the NHSHC programme in Medway cost £172,792 equating to £25.91 per check.

3.15 Medway Council launched a small scale NHSHC outreach service in November 2017, allocating additional funding for 2018/19 to the programme. Cost per check for 2018/19 is not yet known due to being halfway through the financial year.

3.16 In Kent, the total budget for 2018/19 is £1,982,638. The majority of this funding (£1,271,240) is an activity based budget which pays only for work carried out. This

includes a payment to GPs of 50p for inviting patients and payments of between £15.00 and £23.70 for carrying out an NHS Health Check. The remaining funding covers equipment, staff costs, training, project management, quality processes overheads, IT and a targeted outreach programme. In Kent this equates to an average cost of £47.66 per NHS Health Check carried out based on this year's activity, which is expected to be 41,600 checks. The total budget commitment for Health Checks in Kent also includes a commissioned outreach service to village communities where there is a higher previous history of disease. A 'Health MOT' is also offered to those who are not eligible for Health Checks.

3.17 KCC and KCHFT are continuing to work together to see how further efficiencies can be delivered, including the roll out of the new system. This took effect on the 1 April 2018 and includes a centralised invitation process reducing the administrative burden on primary care. It also offers the opportunity to pilot the use of text messaging.

Performance

3.18 At the end of 2017/18, the NHSHC programme had completed its first full five year cycle since responsibility for the programme moved over to LAs, with implementation and oversight from Public Health England (PHE). LAs are required to report their Total Eligible Population (TEP) to PHE each year. This is used to calculate the invite and uptake rate and is based on activity that is reported quarterly to PHE.

Kent and Medway benchmarked against England

3.19 Table 1 shows the percentage of people invited for an NHS Health Check in 2017/18 and the percentage of those invited, who took up an NHS Health Check in 2017/18. The data is benchmarked against England. Red denotes a rate statistically worse than England, amber shows statistical similarity and green a rate statistically better than England.

Table 1 NHS Health Check invitations made and uptake Kent and Medway 2017/18

Year 2017/18	**England**	**South East**	**Kent**	**Medway**
People invited for an NHS Health Check per year	17.3%	17.4%*	22%	21.5%
People taking up an NHS Health Check invite per year	47.9%	45.3%*	42%	38.5%

Source: Public Health England. (2018). Public Health Profiles NHS Health Check [Online].
*Figures aggregated from all known lower geography values

Medway comparison with the Chartered Institute of Public Finance and Accountancy (CIPFA) neighbours

3.20 Table 2 below shows the Medway NHS Health Check performance in comparison to its CIPFA neighbours when benchmarked against England. Using CIPFA comparators, enables a relative assessment of performance against areas with similar population and social and economic characteristics. This comparison highlights the strength of performance in Medway when compared to CIPFA neighbours on the number of invites. There are, however, areas for improvement and

learning from CIPFA neighbours. For example one area achieved an uptake rate of 98.7%, another 76%.

Table 2 Medway NHS Health Check performance in 2017/18 compared to England and CIPFA neighbours

2017/18	England	Medway	Calderdale	Bury	Kirklees	Derby	Swindon	Bolton	Telford and Wrekin	Plymouth	Wigan	Stockton-on-Tees	Tameside	Dudley	Stockport	Rochdale	Bradford
People invited for an NHS Health check per year	17.3	21.5	19.1	21.0	13.3	15.4	19.4	50.3	8.8	18.1	34.2	19.3	13.0	21.9	21.9	33.8	18.3
People taking up an NHS Health check per year	47.9	38.5	46.2	76.0	51.2	48.5	44.1	29.4	51.4	42.3	26.1	53.7	50.1	98.7	35.5	40.5	49.9

Source: Public Health England. (2018). Public Health Profiles NHS Health Check [Online].

Kent comparison with CIPFA neighbours

3.21 Table 3 shows the Kent performance in comparison to its CIPFA neighbours when benchmarked against England. Similarly to Table 2, this comparison shows strength against CIPFA neighbours on the number of invites, but an area for improvement in the number of people taking up those invites against some of its neighbours.

Table 3 Kent NHS Health Check performance in 2017/18 compared to England and CIPFA Neighbours

2017/18	England	Kent	Essex	Lancashire	Hampshire	Northamptonshire	Gloucestershire	Worcestershire	Warwichshire	West Sussex	East Sussex	Suffolk	Nottinghamshire	Staffordshire	Devon	Herfrodshire	Norfolk
People invited for an NHS Health check per year	17.3	22.0	20.2	28.0	20.3	14.1	10.5	23.2	18.0	13.7	20.6	20.1	10.4	11.8	3.4	19.1	16.9
People taking up an NHS Healthcheck per year	47.9	42.0	52.5	53.1	49.8	50.7	59.8	38.9	30.4	33.8	49.0	56.9	66.8	45.4	56.8	43.7	48.5

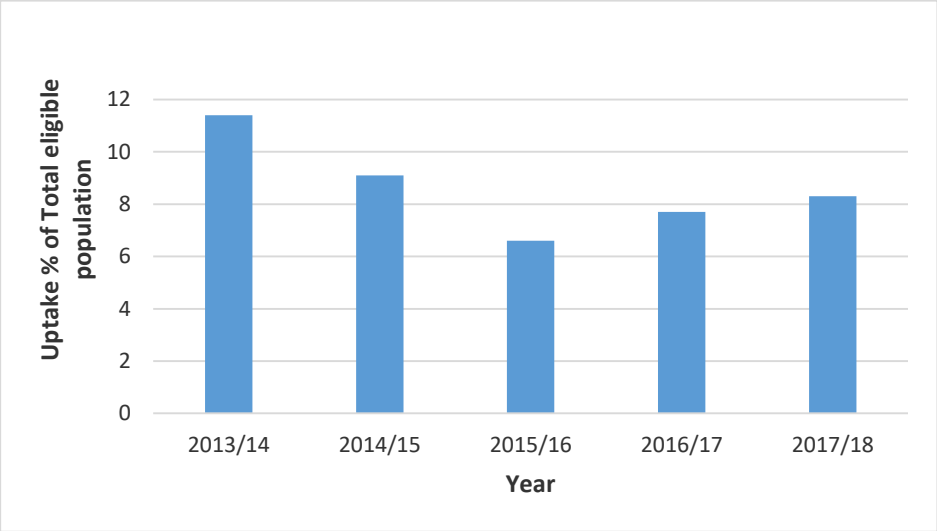
Source: Public Health England. (2018). Public Health Profiles NHS Health Check [Online].

Performance: Medway

3.22 The statutory obligation for 100% of the Total Eligible Population (TEP) to receive an invite to attend an NHSHC over the five year period has been met in Medway, with 100.6% of the residents receiving an invite cumulatively 2013 – 2018. This compares favourably to the invite rate in the South East where 86.1% of the TEP received an invite and 90.9% nationally. (*At 100.6% the percentage invited is greater than the TEP, this is possible as a result of population movement during the period)*

3.23 The uptake of NHSHCs has varied over the first five years in Medway after a slight downward trend in 2014/16 (partly attributable to the de-commissioning of the third party provider who delivered the outreach programme in March 2015 and changes to the TEP). This trend is set out in Chart 1. Cumulatively over the five year period 42.9% attended an NHSHC in Medway compared to 39.2% in the South East and 44.3% in England.

Chart 1 NHS Health Check Coverage in Medway 2013-2018



Source: Public Health England. (2018). Public Health Profiles NHS Health Check [Online].

3.24 The drop in uptake rate was exacerbated as there was an increase in TEP in 2014/15. In this year Medway moved from basing its eligible population on persons resident in Medway to those who were registered with Medway GP Practice. This resulted in an increase of the TEP from 75,491 in 2013/14 to 84,700 in 2014/15. In 2017, Public Health England consulted on a proposal to change the way in which the NHSHC TEP was calculated. The new proposal will mean all areas will now be required to use the GP registered populations as opposed to resident populations. The implications of this are that programmes that have not been using GP registered populations, may experience a decline in performance and increase in service costs. This is because registered populations are generally higher and programmes will not have budgeted for this increase. There will be no impact on Medway performance or costs as this change was enacted in 2014/15.

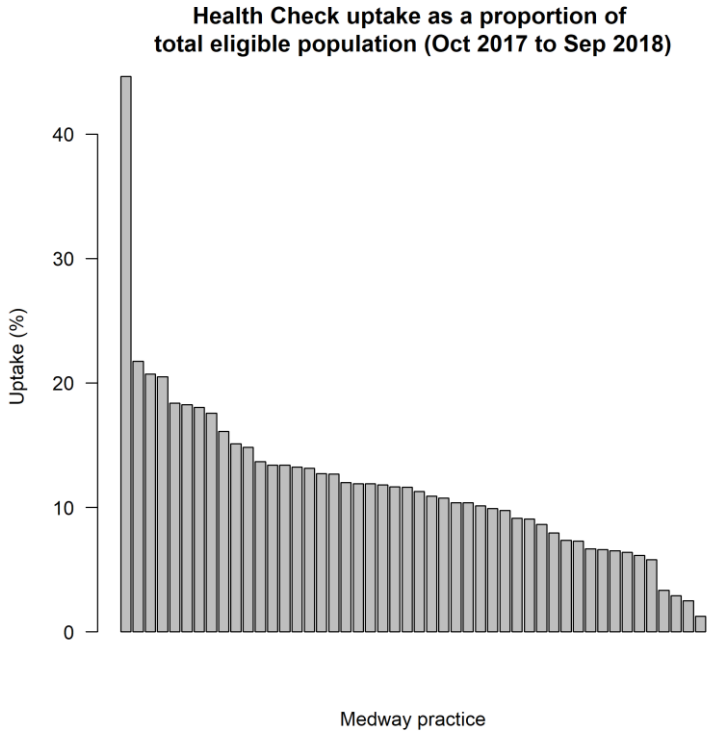
3.25 Medway Public Health have designed a number of audits to monitor Health Check activity. This allows analysis of performance and outcomes based on a number of factors including deprivation, with deprivation based on GP postcode. Data extracted for outcomes includes risk factors identified such as CVD risk score and smoking

status. This data works on a 12 month rolling period. It should be noted that this data has its limitations.

3.26 Using the postcode of the GP as opposed to the patient's postcodes means the data may not accurately reflect the level of deprivation for the individual's address. The data does not extract ethnicity, gender or age at time of the Health Check.

3.27 Chart 2 shows the variation of Health Check uptake across GP practices in Medway for the period October 2017 to September 2018. The data shown is for uptake as a proportion of the Total Eligible Population. The GP practice showing >40% uptake is an exception, as due to its small size it is able to contact patients individually and personally to invite them.

Chart 2: Health Check uptake as a proportion of total eligible population (October 2017 to September 2018)



Source: Medway Health Check Evaluation Audit, Medway Public Health Team

3.28 Table 4 below sets out the data extracted by Medway Public Health covering the period October 2017 to September 2018.

Table 4 Medway NHS Health Check activity October 2017-Sept 2018

Medway NHS Health Check Activity Oct 2017 - Sep 2018									
Quintile	No. Practices	% Attendances of TEP	% with CVD risk 10-19%	% with CVD risk >20%	% with BP >= 140/90	% Total Chol >= 7.5	% Obese	% Inactive	% Current smokers
Most deprived 1	10	8	22.7	5.6	19	3.6	29.5	23.5	19.5
2	9	10	22.1	6.6	24.8	1.3	27.1	28.2	18.8
3	9	12.9	19.2	5.6	21.4	0.8	27.4	17	16
4	9	11.8	23.6	6.1	24	0.6	27.9	24.1	15
Least deprived 5	10	12.2	22.9	3.9	24.7	0.6	23.5	19.6	9.5

3.29 As expected, uptake is lowest in the two least affluent quintiles. Quintile 1 has the lowest uptake, with only 8% of the TEP receiving a Health Check. This presents challenges as to how to better engage with individuals. A range of initiatives are in place, including the use of targeted outreach and social marketing to engage with these harder to reach communities. Medway did however meet the overall NHS Health Check performance targets for 2017/18. 2101 Health Checks were carried out in Q1 2018/19 and 2214 in Q2. Medway has exceeded the number of Health Checks expected for the first two quarters of 2018/19.

Performance: Kent

3.30 Table 5 shows the statistics for Health Check invites and take up for the year 2017/18. Table 6 shows the statistics for Health Check invites and take cumulatively for the 5 year period 2013 -2018.

3.31 Cumulatively, the percentage of the Total Eligible Population invited for a Health Check between 2013 and 2018 is 108% and from those invited, the number of Health Checks delivered is 40.8%.

Table 5 Kent 2017/18 Health Check Activity statistics*

Kent 2017/18 NHSHC statistics*	
Total Eligible Population 2017/18	452138
Number of people who were offered a NHS Health Check	99331(21.97%)
Number of people that received a NHS Health Check	41677 (9.22%)
Percentage of people that received an NHS Health Check of those offered	41.96%

*Source: https://www.healthcheck.nhs.uk/commissioners_and_providers/data/south_of_england/south_east/

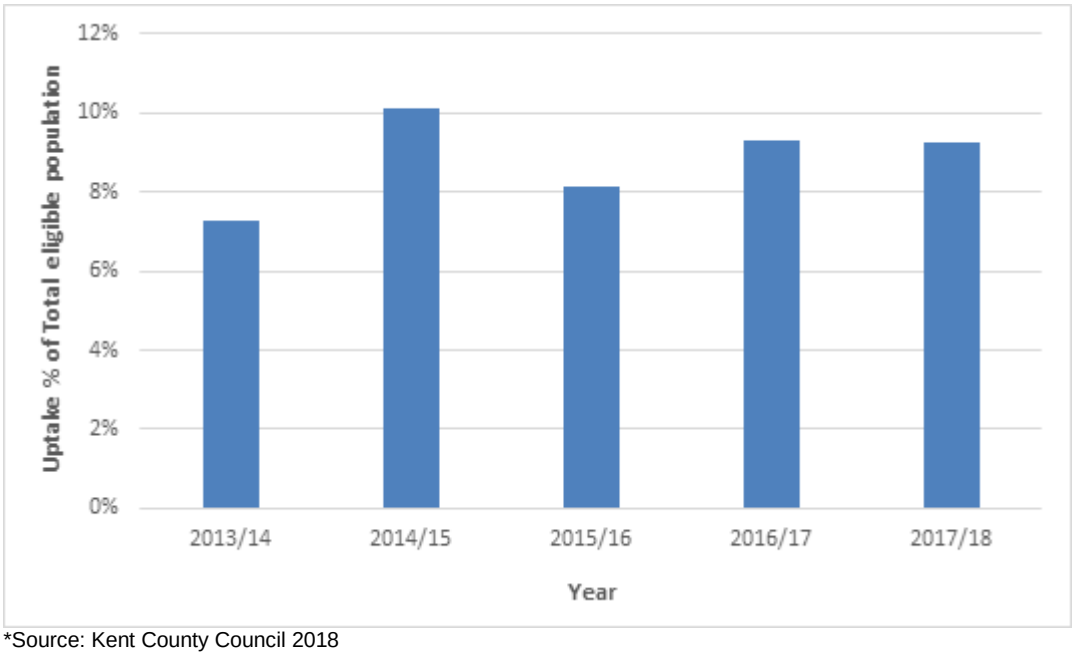
Table 6 Kent cumulative performance 2013 to 2018

Kent 2013-2018 cumulative statistics*	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
5-year estimated eligible population (2017/18)					452,000
Cumulative number of first invites sent	95,004	202,034	288,359	387,760	487,091
Cumulative number of Health Checks delivered	32,924	78,547	115,232	157,303	198,980

*Source: Kent County Council 2018

3.32 Chart 3 shows the NHS Health Check coverage in Kent 2013 -2018

Chart 3 NHS Health Check Coverage in Kent 2013-2018



*Source: Kent County Council 2018

3.33 More recent data for the Health Check Programme to the end of the quarter 1 2018/19 shows that the number of NHS Health Checks delivered in the 12 months to June 2018 did not achieve target. This followed a focus on ensuring an effective roll-out of a new IT system across Kent.

3.34 In addition to the roll out of the new IT system, an NHS Health Check App has been launched, allowing residents to view their results on their mobile phone and see how lifestyle changes affect their heart age score. There is also an e-learning module for practitioners to improve service quality and patient experience.

3.35 Although the actual number of Health Checks delivered decreased in Q1 2018/19, the take-up rate of invite to check was 27% compared to 22% in the same period last year. There were over 20,000 invites sent in Q1 and the programme is on track to invite 100% of the eligible population.

Delivering an equitable programme

3.36 In 2017, the Public Health Observatory published a report exploring equity differences in the uptake of NHS Health Checks for Kent County Council[5]. Findings for Kent showed that:

- The ratio of males completing a Health Check compared to females is 1 to 1.4. In other words, for every one male completing a Health Check, 1.4 (95% CI 1.32 - 1.44) females completed a Health Check. This represents a 40% equity deficit with respect to males.
- The ratio of male to female inequity increases with age, with males becoming increasingly less likely to attend as they get older. For example in the 65-69 age group, when female completion rates are compared with male completion rates, the equity deficit for males rises to over 50%.

- Using the ACORN segmentation tool at house hold level to explore the odds of completing a Health Check, patients in the 'Affluent Achievers' and 'Comfortable Communities' categories, were significantly more likely to complete their Health Check when compared with patients categorised as 'Financially Stretched' or 'Urban Adversity'.
- Equity comparisons using the ACORN Wellbeing types showed that patients categorised as 'Anxious Adversity', 'Poorly Pensioners', Hardship Heartland', 'Perilous Futures' and 'Struggling Smokers' were significantly less likely to complete their Health Check when compared to higher wellbeing types.

3.37 This analysis has been used to formulate an action plan in Kent and supports ongoing investment in the outreach programme which delivers 50% of NHS Health Checks to residents living in the most deprived quintiles of the population.

3.38 There is a requirement to follow up the findings from the audit in order to better understand 'lost to follow-up' issues relating to person identified through the health checks process as having previous undetected cardiovascular risk. This will involve long term follow-up of symptomatic health check cohorts to determine the extent to which factors such as age, gender, social status, complication and co-morbidities play out with regard to long term opportunities for cardiovascular risk reduction. It was anticipated the Kent Public Health Observatory would conduct this work using the Kent Integrated Dataset in conjunction with advice and support from Public Health England.

3.39 At the Prevention Workstream meeting, on 26 October 2018, it was agreed that a Task and Finish Group would be set up to explore how the uptake of Health Checks for residents with Learning Disabilities (LD) could be increased across Kent and Medway. Outcomes of this work will enable both Kent and Medway to understand how to better meet the needs of this group more closely. It should be noted that delivery of these checks is the responsibility of NHS England and Clinical Commissioning Groups and outside of the LA remit/commissioned services. Kent and Medway Councils along with the other LD Alliance Providers have a responsibility to enable their clients to access the HC with their GP, but not to deliver them themselves.

3.40 It is also proposed that a report on Learning Disabilities Health Checks and the outcomes of the work of the task and finish group set out at paragraph 3.39 of this report be added to the work programme for the June 2019 meeting of the Joint Board.

4. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Funding to continue outreach work	Outreach work forms an important part of the programme, without the budget to fund this there is a risk that vulnerable patients may not receive their Health Check or follow up.	Continued work to monitor delivery of equitable process to provide strong case for funding.	C2
Collaboration between GPs/delivery partners and LAs	It is imperative that a strong collaborative working relationship is maintained between LAs and GP practices/delivery partners to ensure the Health Check Programme is implemented comprehensively.	Close working relationship between LAs and GP practices/delivery partners is maintained and developed to ensure the programme is working in the most efficient and effective way.	D2
Ensuring effective delivery	Ensuring effective delivery by all partners is essential, without this there is a risk not realising the full potential of the benefits.	Delivery data is collated and monitored regularly	D2

5. Financial implications

5.1 There are no financial implications arising directly from this report.

6. Legal implications

6.1 The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012

6.2 The Joint Board 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. In accordance with the terms of reference of the Kent and Medway Joint Health and Wellbeing Board, the Joint Board may consider and seek to influence the work of the STP focusing on prevention, local care and wellbeing across Kent and Medway.

6.3 The Joint Board is advisory and may make recommendations to the Kent and Medway Health and Wellbeing Boards.

7. Recommendations

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to:

7.1.1 Consider and note the difference in uptake between the most affluent areas of Kent and Medway and the most disadvantaged.

7.1.2 Work with the NHS to increase the uptake of Health Checks across the eligible population.

7.1.4 Agree that a report on Learning Disabilities Health Checks and the outcomes of the review set out at paragraph 3.39 of the report be added to the work programme for the June meeting of the Joint Board.

Lead officer contact

Louise Merchant, Senior Commissioner, 03000 416476, louise.merchant@kent.gov.uk

Katherine Bell, Public Health Programme Manager, 01634 333136, katherine.bell@medway.gov.uk

Appendices

None

Background papers

NHS Health Check Best practice guidance. Department of Health. December 2017. https://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/

NHS Health Check Programme: Health Equity Audit Guidance, Public Health England, December 2016 https://www.kent.gov.uk/social-care-and-health/health/one-you-kent

Public Health England. (2018). Public Health Profiles NHS Health Check [Online]. Available at: https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data#page/0/gid/1938132770/pat/6/par/E12000008/ati/102/are/E06000035/nn/nn-1-E06000035

https://www.kent.gov.uk/social-care-and-health/health/one-you-kent

Health Checks Equity Audit, Kent Public Health Observatory, June 2017, https://www.kpho.org.uk/__data/assets/pdf_file/0007/71638/Kent-Health-Checks-Equity-Audit_Final-Report-2017.pdf

[1] NHS Health Check Best practice guidance. Department of Health. December 2017.
[2] NHS Health Check Programme: Health Equity Audit Guidance, Public Health England, December 2016
[3] Public Health England. (2018). Public Health Profiles NHS Health Check [Online]. Available at: https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data#page/0/gid/1938132770/pat/6/par/E12000008/ati/102/are/E06000035/nn/nn-1-E06000035 [Accessed: 30 October 2018].
[4] https://www.kent.gov.uk/social-care-and-health/health/one-you-kent
[5] Health Checks Equity Audit, Kent Public Health Observatory, June 2017, https://www.kpho.org.uk/__data/assets/pdf_file/0007/71638/Kent-Health-Checks-Equity-Audit_Final-Report-2017.pdf

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KENT AND MEDWAY

JOINT HEALTH AND WELLBEING BOARD

14 DECEMBER 2018

SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) LOCAL CARE UPDATE

Report from: Caroline Selkirk, STP Local Care Senior Responsible Officer

Author: Cathy Bellman, STP Local Care Lead

Summary

This report will provide the Joint Board with an update on: Local Care governance, in line with progress and alignment to Strategic Commissioning development; Local Care Deep Dives; progress on an Implementation and Local Care Delivery Framework; actions for winter pressures and how Local Care is supporting carers and care navigation.

1. Budget and Policy Framework

1.1 The Kent and Medway Sustainability and Transformation Plan outlines the intention of the Kent and Medway health and care system to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting.

1.2 Additionally, the Kent and Medway Case for Change identified the priority to develop more and better local care services. There are a number of workstreams within the Sustainability and Transformation Partnership, one of which is a dedicated Local Care workstream to deliver the Plan.

2. Update on Local Care Governance

2.1 As communicated to this Joint Board, on the 9 October 2018, the governance for Local Care has been reviewed as part of a wider review of the Kent and Medway STP governance. The aim being to ensure that there is no duplication with other forums and that there is clear accountability for Local Care.

2.2 There are two changes, as follows:

I. A new Local Care Board at a Kent and Medway level has been established, comprising senior leadership across the health and social

care system, representing the key organisations involved in the commissioning and delivery of local care services.

The rationale for this is to have a smaller Board, overseeing the monitoring of Local Care implementation, and development and operationalisation of strategic solutions to support Local Care delivery at pace and scale.

The current Local Care Implementation Board (LCIB), as mentioned, has a large membership which makes it difficult to efficiently and effectively exercise the responsibility to monitor implementation. Additionally, a new smaller, senior Board would interact more directly with those responsible on the ground for the delivery of Local Care.

Appendix A to this report sets out details of the changes to Local Care Governance and how this would work in practice. The diagram shows that, across Kent and Medway, there are now emerging governance forums for Local Care at a Clinical Commissioning Group (CCG) footprint level, and it will be important that the new smaller Kent and Medway Local Care Board interacts with these footprint level forums.

As the Kent and Medway Integrated Care System (ICS) develops, it needs to be recognised that not all governance can be conducted centrally and there is need to strike the right balance between Kent and Medway governance and local level governance, with clear lines of sight between the two. The newly formed Board will:

- Revisit the shared ambitions and priorities for Local Care
- Monitor implementation and hold footprint Local Care Boards to account
- Speak to footprint Local Care Boards with ‘one voice’ as leaders regarding expectations
- Provide leadership to Local Care Boards and create the conditions for delivery of Local Care - by addressing strategic/systemic barriers to implementation (this may involve making requests of/ putting recommendations to other forums/Boards)
- Set the work programme for the STP Local Care Team and monitor delivery against agreed plan
- Start to manage the complexity of large providers being part of multiple partnerships/arrangements at different levels of the ICS.

II. The second change is to the current LCIB; with the establishment of a small senior team responsible for overseeing Local Care implementation, it is proposed that the focus of the existing LCIB is changed. It is not anticipated that the group be disbanded, as there is real value in the wide range of organisations and individuals continuing to come together. This forum has been successful in engaging partners from across the Kent and Medway system, therefore making it an excellent vehicle to keep and use as a Local Care Knowledge Share Forum, with the focus on sharing practical information to help support the delivery of Local Care. The proposal is that this group meets 4-6 monthly, in a conference type forum, to share:

- Progress across Kent and Medway

- Learning from other areas, nationally and internationally
- Ideas and examples of innovation.

All members of the existing LCIB have been sent a letter, explaining the above, from Glenn Douglas, STP Chief Executive, and Mr Paul Carter, Chair of the Local Care Implementation Board. It is proposed that the newly formed Local Care Board will meet in early February 2019.

3. Local Care and Primary Care Alignment

3.1 The Local Care workstream is working to align the newly formed Primary Care Board with the delivery of Local Care. When the Local Care Workstream was established, primary care networks were a relatively new concept, so delivery has been driven by the CCGs. Across Kent and Medway, Primary Care Networks (PCNs) are now emerging, largely through coming together in federations. It therefore seems sensible and practical for the focus for development, moving forward, to sit with the PCNs supported by the Local Care and Primary Care workstreams. This would:

- Provide support for implementation
- Help with consistency of practice
- Help sharing learning and building on best practice

4. Local Care Deep Dives

4.1 The 9 October 2018 report to this Joint Board articulated that CCG colleagues have been working with their partners for some months on plans for the investment and implementation of Local Care in 2018/19. The planning exercise was initiated in late 2017 with first output in March 2018, and a refreshed output in June 2018. This was presented to the Local Care Implementation Board on 8 June 2018. At that meeting a greater level of detail was requested on the plans at CCG footprint levels. As it was not be possible to give the necessary time at the Board meetings for each sub-system to describe their individual plans in detail, a series of Deep Dives, chaired by Mr Paul Carter in his capacity as Chair of the existing LCIB, were arranged to enable a more in depth understanding of:

- the status of implementation (services in place, patient volumes, trajectories etc.);
- planned investment in Local Care; and
- the development of a framework to monitor Local Care delivery going forward.

4.2 Due to the number of personnel involved in these Deep Dives, diarising became a challenge; originally planned for October and November 2018, these sessions were rebooked to ensure comprehensive attendance:

- East Kent (EK), 23 November 2018
- Medway, North and West Kent (MN&WK), 11 December 2018.

A verbal update will be presented to the 14 December 2018 meeting of this Joint Board**.**

5. Progress on a Local Care Delivery Framework

5.1 It is important that across Local Care there is a consistent way of monitoring progress and agreeing a Local Care Delivery Framework. Part of the process in development of this is dependent on the discussions, challenges and outputs from the abovementioned deep dives. It is proposed that following these deep dives an update is brought to the next meeting of this Joint Board, on 19 March 2018.

6. Update on actions for Winter Pressures

6.1 As winter approaches, the Local Care workstream has been working with the Urgent and Emergency Care Workstream to understand the approach to winter pressures and plans to mitigate the impact this may have on the system.

6.2 The following appendices to the report set out more detailed information:
Appendix B – STP Winter Approach Presentation;
Appendix C – STP Winter Plan Update 15 November 2018.

6.3 The announcement of £240m to support winter pressures was made in October 2018. The letter announcing funding allocations is set out at Appendix D of the report. Kent will receive an additional £6.16m in 2018-19. This additional funding is intended to enable further reductions in the number of patients that are medically ready to leave hospital but are delayed because they are waiting for adult social care services. The Government is clear that this money should be additional to current budgeted expenditure on adult social care. In Kent we are working with our health partners to support this work building on some of our existing High Impact Change projects which will see Winter Pressures Funding supplement and increase capacity in these schemes. We are also working with our providers to increase capacity or flex existing contracts or through new commissioning activity. We will work with partners in the NHS to monitor improvements in these measures through local jointly agreed monitoring, comparing improvements in each of these areas of impact.

Kent Winter Pressures Investment Summary - £6.1 m

Promoting Wellbeing	Promoting Independence	Supporting Independence
£300k	£3.5m	£2.3m

*Your Life, Your Wellbeing is the Adult Social Care Vision and Strategy for 2016-2021. The three key themes are Promoting Wellbeing, Promoting Independence and Supporting Independence to help people to improve or maintain their well-being and to live as independently as possible.

6.4 Medway Council has worked closely with system partners to develop a range of plans to support the NHS over winter, and this work is managed locally through our Local A&E Delivery Board (LAEDB). The Council has planned a range of initiatives to ensure that we maintain our already low DTOC rates

over this winter, including the commissioning of additional bridging homecare packages to mitigate against the risk of delays in sourcing ongoing packages of care. Medway has received £997,871 of funding to support the NHS to cope with the effect of winter pressures and this funding will be used to meet the cost of services that support hospital discharges, and the impact will be monitored locally through the LAEDB.

7. How Local care is supporting carers and care navigation

7.1 NHS England and its partners have developed a toolkit to help health and social care organisations work together in identifying, assessing and supporting the wellbeing of carers and their families (Appendix F of this report).

7.2 Appendix F of this report, has a link to an easy read document explaining how health services, social care services and carer support organisations can work together and help local carers and their families. By finding out when someone is caring or looking after someone else we can make sure they receive the right help at the right time and that they are able to enjoy life outside of their caring role.

7.3 In the October 2018 report to this Joint Board there were examples of how Local Care is supporting Cares with initiatives such as the Carer's App development, social prescribing, care navigation and growing the voluntary sector.

7.4 At the last meeting of the Joint Board, 9 October 2018, the Joint Board agreed to schedule a 'deep dive' on support for carers and support for growing the voluntary sector. It is recommended that these be provisionally scheduled for September 2019 to provide sufficient time to evaluate the new KCC contract commencing April 2019, feedback on the progress the Carers App development and support offer for carers.

7.5 The proposed scope for the deep dive on support of carers is as follows:

- explore in more depth how organisations are working together across Kent and Medway to support carers
- understand how Local Care is helping to identify carers and or those requiring help and support
- give specific updates on initiatives set out in paragraphs 6.1 to 6.2 of the report
- show how these initiatives are being co-produced with carers
- give examples of the outcomes and impact, with individual case studies.

7.6 The proposed scope for the deep dive on growing the voluntary sector is as follows:

- Update from Medway on their Social Prescribing revised model and progress on embedding social prescribing in care navigation and Voluntary Care Sector contracts, with special reference to tackling social isolation in older people.
- Update on the Kent County Council provision of a Community Navigation service across Kent, and relationship with existing commissioning arrangements for similar services.

8. Risk management

8.1 The Local Care Implementation Board has regularly reviewed the overarching Local Care risk register. Going forward the risk register will be reviewed on an ongoing basis by the Local Care Board. As system level plans are developed the risk register will be updated.

9. Financial implications

9.1 As set out in previous reports to this Joint Board, the investment has been identified for Local Care in 2018/19, with clear timelines for identifying the key deliverables in 2019/20 and beyond. There are no financial implications arising directly from this report i.e. notwithstanding the discussions happening elsewhere, this is an update report and there are no requests for resources.

10. Legal implications

10.1 The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012.

10.2 The Joint Board 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. In accordance with the terms of reference of the Kent and Medway Joint Health and Wellbeing Board, the Joint Board may consider and seek to influence the work of the STP focusing on prevention, local care and wellbeing across Kent and Medway.

10.3 The Joint Board is advisory and may make recommendations to the Kent and Medway Health and Wellbeing Boards.

11. Summary

11.1 Local Care is undergoing a period of transition, responding to local and national drivers and emerging partnerships; to this end there are changes to governance in an attempt to streamline processes, provide the leadership and direction for Local Care and avoid duplication across the system.

11.2 The Local Care deep dives, which form part of the overall governance, and are part of the process to help shape the overall Delivery Framework have been delayed. It is proposed that a detailed summary be presented to the next meeting of this joint Board.

12. Recommendations

12.1 The Kent and Medway Joint Health and Wellbeing Board is asked to:

12.1.1 note the content of this joint report, including verbal updates on the Local Care deep dives;

12.1.2 agree that at the next meeting of the Joint Board, on 19 March 2018, the Joint Board be presented with a report which sets out greater detail on the Local Care deep Dives and progress on the outcomes framework; and

12.1.3 consider the scope of the deep dives on support for carers and support for growing the voluntary sector as set out in paragraph 7.5 and 7.6 of the report respectively and agree that these be scheduled on the work programme for September 2019.

Lead officer contact

Caroline Selkirk, Local Care Senior Responsible Officer,
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Emma Lloyd
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Tel: 03000 424091

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Appendices

Appendix A – Proposed changes to Local Care Governance
Appendix B – STP Winter Approach Presentation
Appendix C – STP Winter Plan Update 15 November 2018
Appendix D – Winter funding letter, Department of Health and Social Care
Appendix E – NHS England and Partners Carers toolkit
Also found at: https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf
Appendix F – Easy Read document for Carers support
Also found at: https://www.england.nhs.uk/publication/working-together-to-support-carers-easy-read-document/

Background papers

Agenda and minutes of Kent and Medway Joint Board Meeting – 9 October 2018
https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=510&MId=4247

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Transforming health and social care in Kent and Medway

Appendix A

Proposed changes to Local Care Governance

Nov 2018

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Proposal – create a small senior group for Local Care with two functions 1) Holding Local Care Boards to account 2) helping to create conditions for success

K&M Local Care Board

Function 1) - Oversight

An accountability relationship would exist between the K&M Local Care Board and CCG footprint level Local Care Boards

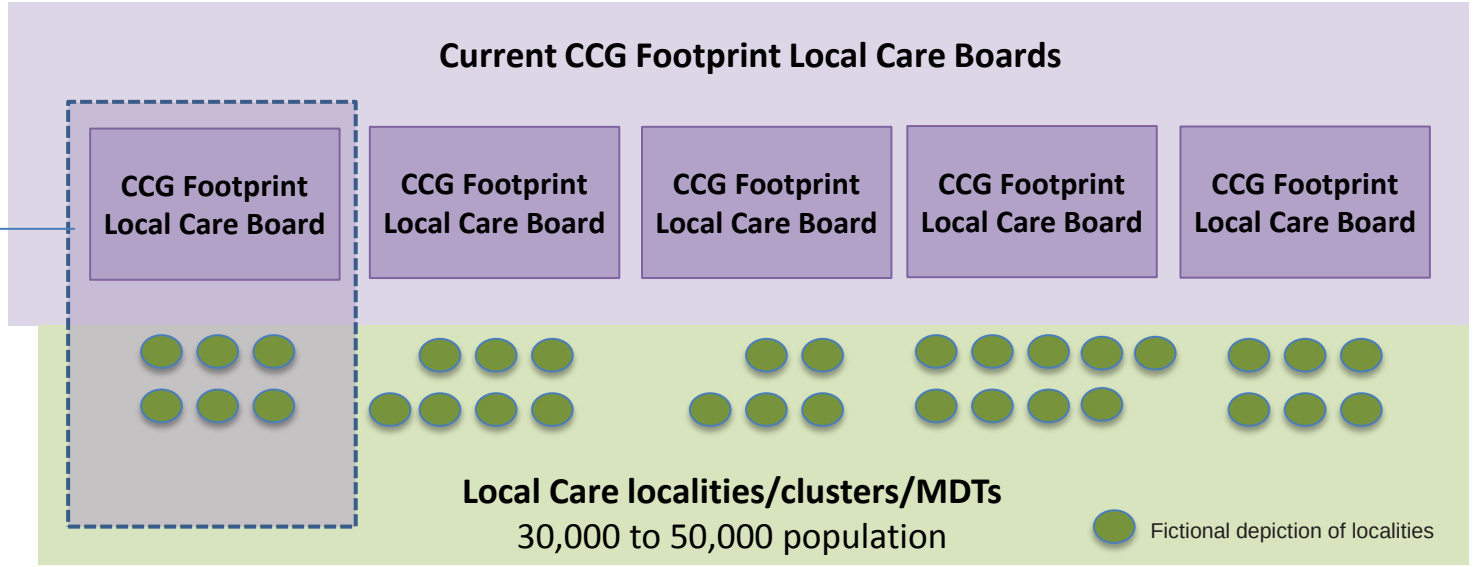
- Members of CCG footprint Local Care Boards would attend the K&M Local Care Board for 'performance review' discussion (for example, this might be the GP chair of the Local Care Board, a Local Care Operational Lead and a finance representative and could vary depending on the theme to be reviewed)

An accountability relationship would also exist between the K&M Local Care Board an the STP Local Care Team including:

- K&M Local Care Board would also monitor delivery of agreed STP deliverables by STP Local Care team and would influence the future work programme

Function 2) – Leadership

- The K&M Local Care Board would receive risks/issues escalated by both the STP Local Care Team and individual CCG footprint Local Care Boards and carry out 'system solutioning' – possibly resulting in actions for individual leaders as well as requests to other groups/forums, for example, the STP Programme Board, a K&M Strategic Commissioner, individual CCG Governing Bodies or individual provider organisation Boards (depending on the nature of the risk and the solution). In this way, the Local Care Board would help to create the conditions for implementation at pace and scale



NB:

Boards currently exist for WK, Medway,DGS and Swale.

EK are currently reviewing Local Care governance arrangements as part of the wider transformation and PCBC

How a K&M Local Care Board would interact with other forums

K&M STP Programme Board
K&M Strategic Commissioner

Programme Board and Strat Comm receives 'summary report' from the K&M Local Care Board

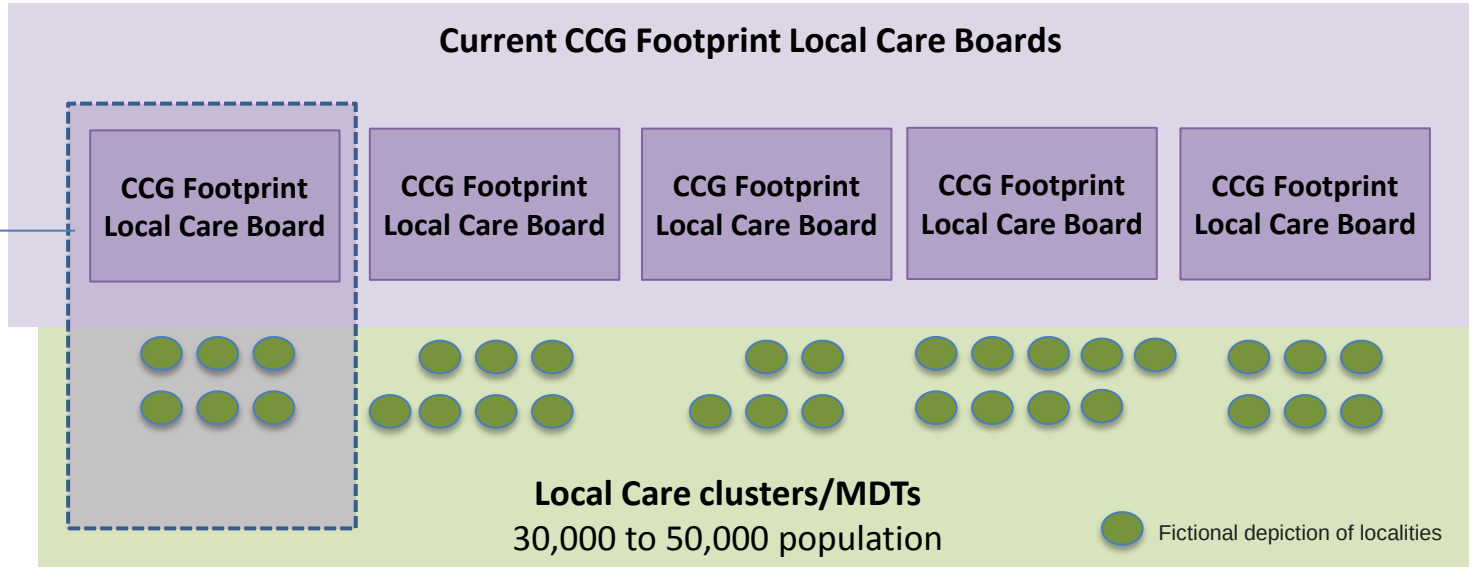
Local Care Knowledge Share Forum
(for existing members of Local Care Implementation Board – optional attendance and not part of the governance structure)

CCG Footprint Local Care Boards report to K&M Local Care Board

K&M Local Care Board

K&M Local Care Board makes requests of/ puts recommendations to other forums in order to create conditions for successful delivery of Local Care

- **Other STP/system groups such as Finance Group**
- **CCG Governing Bodies**
- **Individual provider org Boards**



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Transforming health and social care in Kent and Medway

Kent and Medway STP Winter Approach

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Principles

82

- The STP will support the four Kent and Medway systems to:
  - Develop a proactive approach to preventing capacity challenges through capacity planning, weekend planning, MADE events and early reactive approaches to increasing demand
  - Maintain a consistent single ‘version of the truth’ using SHREWD and national reporting systems to allow pre-emptive upwards briefing and information sharing with a view to limiting adhoc requests for information from systems by regional and national teams
  - Develop and maintain consistent and comparable reporting metrics in order that systems can compare their performance and are aligned to national priorities
  - Align to the winter weekly schedule through proactive information sharing whilst minimising the need for large system-wide calls

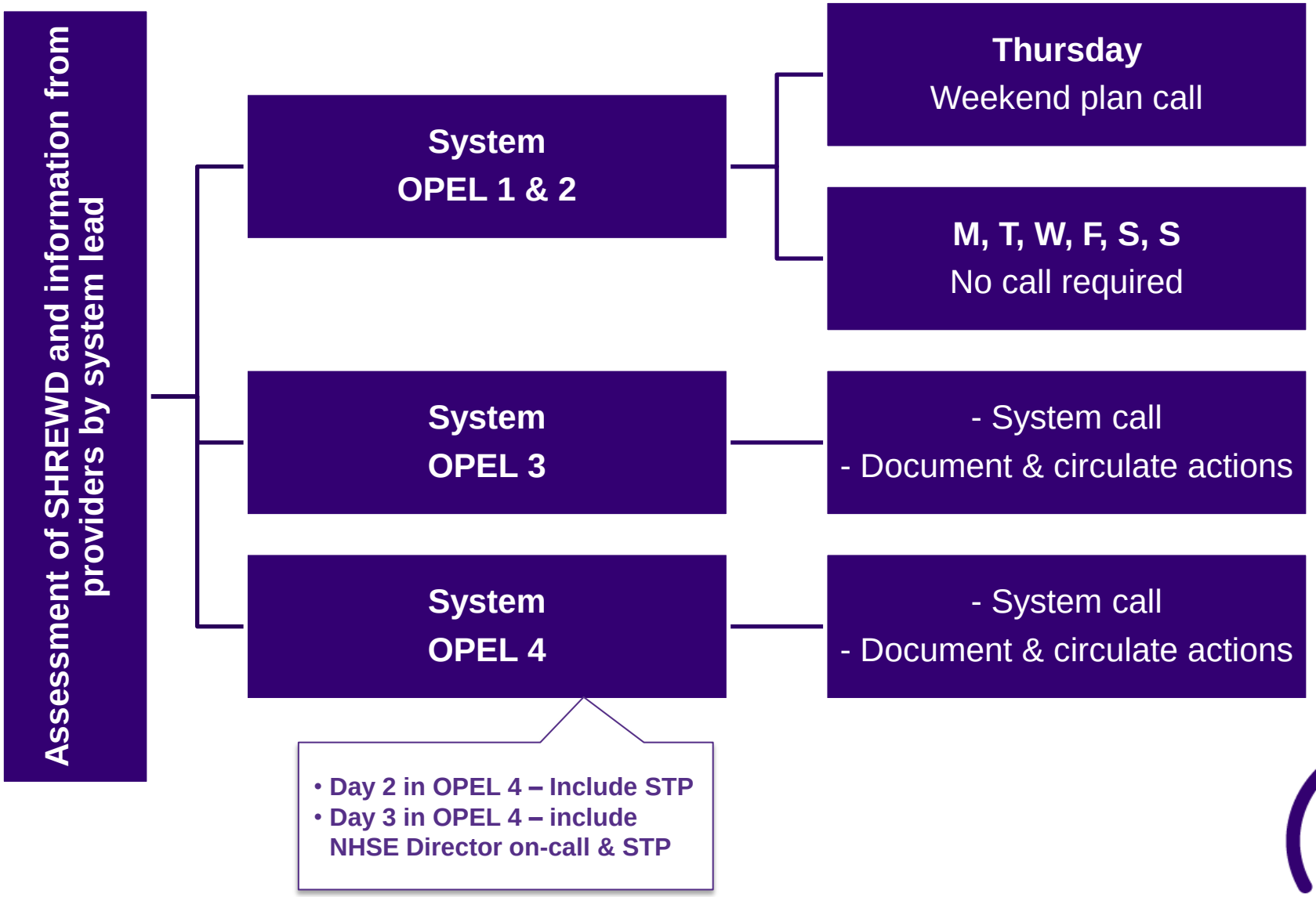
Winter Weekly Schedule

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
08:00							
	NHSE/I SECAmb Call	NHSE/I SECAmb Call	NHSE/I SECAmb Call	NHSE/I SECAmb Call	NHSE/I SECAmb Call	NHSE/I SECAmb Call	NHSE/I SECAmb Call
09:00							
10:00							
	System Escalation Calls	System Escalation Calls	System Escalation Calls	System Weekend Look Ahead Calls	System Escalation Calls		
11:00							
	Systems Update SHREWD with System OPEL Status, System Call Notes and Actions						
12:00				Upload Weekend Plans to SHREWD			
13:00		K&M UEC Leads to Provide Update to STP		K&M UEC Leads Weekend Plan Call			
						National Winter Call	National Winter Call
14:00				WOLF Meeting			
	National Winter Call	National Winter Call	National Winter Call	Challenged Trusts National Call*	National Winter Call		
15:00	System Escalation Calls	System Escalation Calls	System Escalation Calls	System Escalation Calls	System Escalation Calls		
16:00	K&M Exec Call	K&M Exec Call	K&M Exec Call	K&M Exec Call	K&M Exec Call		
17:00							
18:00	NHSE/I PMO Close Down and Handover to on-call						

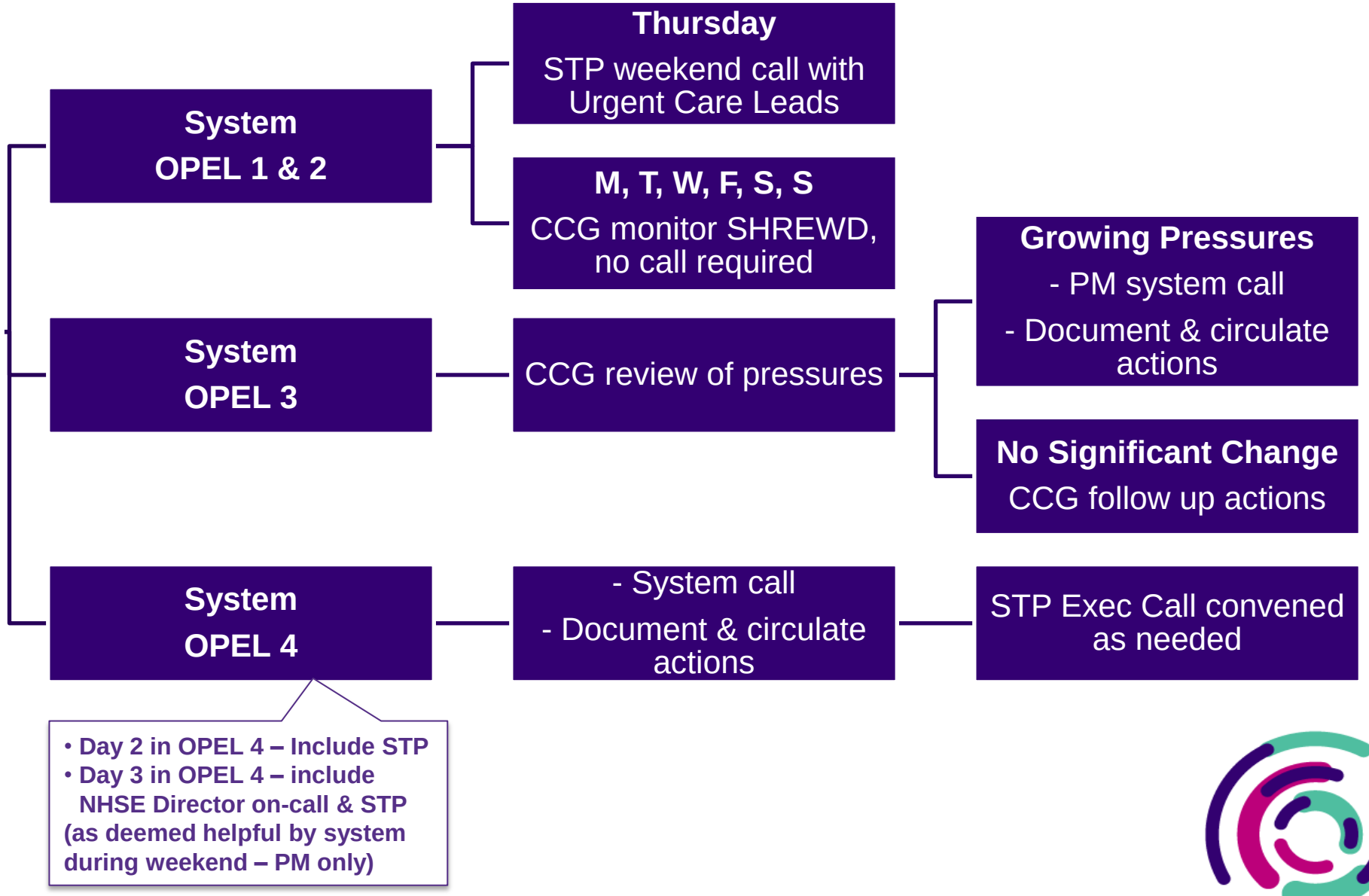
K&M Escalation | K&M Planned | Regional/National

* East Kent, Medway, DVH – discussed once a fortnight

Escalation Actions – Morning



Escalation Actions – Afternoon



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Transforming health and social care in Kent and Medway

1. Purpose of the paper

Following the KCC HOSC meeting on the 21st September a further update was requested from the STP once Winter Plans for Kent and Medway had been tested and finalised. This paper provides an update.

2. Update

All four health systems in Kent and Medway (West Kent, Dartford, East Kent and Medway & Swale) have completed testing of their winter plans through a series test conference calls and face to face table top exercises. Key lessons have focussed on improving information sharing, early escalation of issues to prevent delays for patients and improved communication within and between systems.

Following a review of draft plans for the four systems by a joint NHS England, NHS Improvement and STP team additional support was provided to the Medway & Swale and East Kent systems through a series of workshops funded by NHS Improvement and facilitated by 20:20 in order to provide an independent perspective. These workshops have helped systems to unlock a number of outstanding issues and to build resilience and relationships across system senior teams.

Final plans for each system building in learning from test events, feedback from regulators and shared learning across Kent and Medway have, this week, been submitted to regulators and are now in place for use.

Each system has undertaken demand and capacity modelling as part of their planning and this has been used to informal local investment of NHS and social care winter funding. In addition to investment of revenue funding across health and social care capital funding has been secured to support East Kent hospitals in increase capacity and to move elective orthopaedic care to Canterbury supporting patient flow and capacity at the Ashford and Margate sites.

As a broader STP system we have in place a joint communications plans across STP partners for both staff and the public which provides an overarching framework for provider plans and is supported by STP funding to support systems to provide consistent messaging. The STP will also host proactive calls each week with systems to support early identification of pressure and proactive approaches to preventing escalation. A joint approach by the STP, NHS England and NHS Improvement is being used with a view to reducing the reporting burden for systems.

All systems will be using consistent SHREWD dashboard to report and monitor key demand, capacity and flow metrics across key pathways and providers. This is available to local, county and regional teams to aid reporting and will provide early alerting of potential pinch points and challenges.

A further update will provided to the KCC HOSC following completion of winter debrief events in 2019.

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Department of Health & Social Care

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

To: Council Leaders
17 October 2018

Dear Leader,

Winter funding

On 2 October 2018, I announced £240m of additional funding for councils to spend on adult social care services to help councils alleviate winter pressures on the NHS, getting patients home quicker and freeing up hospital beds across England. Supporting the NHS to deliver high quality services for patients this winter is a critical priority for the Government and we already know that councils can add real value to this endeavour. We recognise the significant progress that councils have already made in tackling delayed transfers of care (DTOC), achieving a 39% reduction in DTOC attributable to adult social care since February 2017, and the good relations between colleagues across the health and care system which mean that local systems are working together towards common aims.

This additional funding is intended to enable further reductions in the number of patients that are medically ready to leave hospital but are delayed because they are waiting for adult social care services. We expect the spending to be focussed on reducing DTOC, helping to reduce extended lengths of stay, improving weekend discharge arrangements so that patients are assessed and discharged earlier and speeding up the process of assessing and agreeing what social care is needed for patients in hospitals. We will expect health providers and local authorities to monitor improvements in these measures through local jointly agreed monitoring, comparing improvements in each of these areas of impact.

Allocations will be based on the Relative Needs Formula for adult social care and individual council allocations can be found at annex A. The Government is clear that this money should be additional to current budgeted expenditure on adult social care. We will be closely monitoring delivery of additionality throughout winter.

It is important that the maximum impact for your local health and social system is achieved from this additional funding. Building on the relations already established with local NHS partners to deliver Better Care Fund projects and tackle delays, you will want to continue local discussions with health partners including local acute trusts as you work up your plans to spend the funding to reduce NHS pressures. This level of cooperation is best delivered by joint development and discussion between the local authority's CEO/DASS, and their relevant trust CEO(s). We will be asking trusts to confirm they have had satisfactory engagement with you.

A formal grant determination letter will follow, and your authority will be asked to send us certain information. Given the importance that this funding makes an impact during winter, your return should confirm:

1. that the totality of the grant will be spent on providing adult social care services, in addition to funding already planned; and that you have discussed this with local NHS partners, including local acute hospital trusts.

2. that councils include alongside their certifications what additional volumes of care and support the additional funding will purchase by returning a central template.

I am copying this letter to trust Chief Executives and CCG Chief Executives.

Yours ever,

MATT HANCOCK

Annex A

Table of £240m ASC winter funding, by local authority

Funding has been distributed using the Adult Social Care Relative Needs Formula. The Formula is described at:
http://webarchive.nationalarchives.gov.uk/20140505104701/http://www.local.communities.gov.uk/finance/1314/settle.htm

Local Authority name	£240m Winter 2018-19 funding
Barking and Dagenham	£913,061
Barnet	£1,447,489
Barnsley	£1,238,401
Bath and North East Somerset	£729,753
Bedford	£620,812
Bexley	£928,375
Birmingham	£5,600,295
Blackburn with Darwen	£764,416
Blackpool	£903,685
Bolton	£1,390,102
Bournemouth	£883,914
Bracknell Forest	£361,836
Bradford	£2,297,209
Brent	£1,343,037
Brighton and Hove	£1,228,660
Bristol, City of	£2,028,366
Bromley	£1,190,455
Buckinghamshire	£1,671,318
Bury	£816,711
Calderdale	£920,617
Cambridgeshire	£2,324,056
Camden	£1,285,762
Central Bedfordshire	£865,972
Cheshire East	£1,450,638
Cheshire West and Chester	£1,467,219
City of London	£48,791
Cornwall	£2,793,384
County Durham	£2,822,376
Coventry	£1,551,062
Croydon	£1,401,339
Cumbria	£2,507,222
Darlington	£501,172

Local Authority name	£240m Winter 2018-19 funding
Derby	£1,148,569
Derbyshire	£3,627,306
Devon	£3,575,532
Doncaster	£1,509,880
Dorset	£1,935,188
Dudley	£1,561,621
Ealing	£1,417,568
East Riding of Yorkshire	£1,445,968
East Sussex	£2,585,651
Enfield	£1,298,636
Essex	£5,919,494
Gateshead	£1,133,285
Gloucestershire	£2,529,984
Greenwich	£1,330,277
Hackney	£1,405,003
Halton	£639,132
Hammersmith and Fulham	£918,381
Hampshire	£4,754,497
Haringey	£1,148,202
Harrow	£969,828
Hartlepool	£501,123
Havering	£1,005,683
Herefordshire, County of	£880,614
Hertfordshire	£4,134,415
Hillingdon	£1,041,108
Hounslow	£999,342
Isle of Wight	£766,415
Isles of Scilly	£12,662
Islington	£1,285,889
Kensington and Chelsea	£866,806
Kent	£6,164,434
Kingston upon Hull, City of	£1,452,943
Kingston upon Thames	£573,179
Kirklees	£1,859,881
Knowsley	£977,056
Lambeth	£1,508,916
Lancashire	£5,518,152
Leeds	£3,310,729
Leicester	£1,573,738
Leicestershire	£2,414,247
Lewisham	£1,367,882

Local Authority name	£240m Winter 2018-19 funding
Lincolnshire	£3,367,950
Liverpool	£2,957,108
Luton	£788,125
Manchester	£2,666,050
Medway	£997,871
Merton	£747,910
Middlesbrough	£757,937
Milton Keynes	£908,078
Newcastle upon Tyne	£1,500,831
Newham	£1,468,413
Norfolk	£4,178,678
North East Lincolnshire	£779,710
North Lincolnshire	£760,919
North Somerset	£923,945
North Tyneside	£1,031,077
North Yorkshire	£2,423,601
Northamptonshire	£2,717,108
Northumberland	£1,521,452
Nottingham	£1,550,028
Nottinghamshire	£3,527,070
Oldham	£1,122,354
Oxfordshire	£2,291,555
Peterborough	£793,661
Plymouth	£1,284,105
Poole	£637,547
Portsmouth	£890,417
Reading	£569,502
Redbridge	£1,115,976
Redcar and Cleveland	£720,225
Richmond upon Thames	£660,842
Rochdale	£1,108,358
Rotherham	£1,345,287
Rutland	£135,720
Salford	£1,317,668
Sandwell	£1,847,928
Sefton	£1,524,885
Sheffield	£2,705,263
Shropshire	£1,393,823
Slough	£515,453
Solihull	£870,356
Somerset	£2,497,567

Local Authority name	£240m Winter 2018-19 funding
South Gloucestershire	£935,046
South Tyneside	£915,260
Southampton	£1,109,386
Southend-on-Sea	£824,000
Southwark	£1,570,648
St. Helens	£962,856
Staffordshire	£3,541,964
Stockport	£1,283,215
Stockton-on-Tees	£845,239
Stoke-on-Trent	£1,331,896
Suffolk	£3,261,399
Sunderland	£1,567,778
Surrey	£3,994,637
Sutton	£737,282
Swindon	£769,255
Tameside	£1,154,036
Telford and Wrekin	£774,291
Thurrock	£654,204
Torbay	£828,580
Tower Hamlets	£1,464,965
Trafford	£945,705
Wakefield	£1,648,875
Walsall	£1,431,825
Waltham Forest	£1,088,692
Wandsworth	£1,297,456
Warrington	£823,737
Warwickshire	£2,234,584
West Berkshire	£500,898
West Sussex	£3,303,452
Westminster	£1,323,159
Wigan	£1,592,223
Wiltshire	£1,823,064
Windsor and Maidenhead	£476,457
Wirral	£1,800,370
Wokingham	£401,589
Wolverhampton	£1,376,477
Worcestershire	£2,384,625
York	£731,801
Total	**£240,000,000**

Appendix E

An integrated approach to identifying and assessing Carer health and wellbeing

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance	Specialised Commissioning	

Publications Gateway Reference:	**05231**
Document Purpose	Tools
Document Name	An integrated approach to identifying and assessing Carer health and wellbeing
Author	NHS England/Patient Experience Team
Publication Date	May 2016
Target Audience	CCG Accountable Officers, Directors of Adult SSs, CCG PPI Lay Members
Additional Circulation List	Health and Wellbeing Board Chairs, local Carer Support Organisations
Description	
Cross Reference	NHS England Commitment to Carers, NHS England/RCGP Commissioning for Carers: Principles and resources to support effective commissioning for adult and young carers'
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	
Contact Details for further information	Dave Ross Patient Experience Team Room 5W33 Quarry House, Leeds LS2 7UE 0113 825 5579 https://www.england.nhs.uk/ourwork/pe/commitment-to-carers/

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Prepared by: Dave Ross

Classification: OFFICIAL

Contents

1 Introduction

1.1 The purpose of this paper

This paper builds on the work started by the NHS England *Commitment to Carers* that was published in May 2014, and which sought to give the five and a half million Carers in England the recognition and support they need to provide invaluable care for loved ones.

In December 2014, NHS England and the Royal College of General Practitioners published '*Commissioning for Carers: Principles and resources to support effective commissioning for adult and young carers'*, to help Clinical Commissioning Groups (CCGs) better identify and help Carers to stay well and to deliver the best outcomes for Carers.

Copies of the *Commitment to Carers* and *Commissioning for Carers* can be accessed at https://www.england.nhs.uk/ourwork/pe/commitment-to-carers/ .

This paper addresses changes to the way in which Carer health and wellbeing need is identified, assessed, and supported, as a result of changes introduced by the Care Act 2014 and the Children and Families Act 2014. It is, essentially, a resource to help promote working together between Adult social care services, NHS commissioners and providers, and third sector organisations that support Carers, of all ages, with a specific focus on developing an integrated approach to the identification, assessment and support of Carers and their families across health and social care. To support this joint working, a template Memorandum of Understanding, to be discussed and agreed locally, is included at Appendix One.

A secondary purpose of this paper is to provide clarity and ensure consistency around the language of care and caring. We understand that, in some cases, different sectors of care are not clear about their duties under the relevant legislation, that the duties of co-operation between agencies are not clearly understood, and that there are variations in understanding of some of the terms used.

An additional purpose of this paper is to identify positive practice in supporting Carers, with a particular focus on Carers from vulnerable communities or at key transition points, in order to reduce health inequalities.

The Better Care Fund (BCF) was launched in 2014 and aims to transform local health and social care services so that they work together to provide better joined up care and support, through CCGs and local authorities agreeing joint plans and agreeing to pool elements of their budgets.

Local Health and Wellbeing Boards are responsible for overseeing agreement of the joint plan and for ensuring that funds are used in accordance with the agreed plan. There is a requirement that plans outline the support that would be made available to Carers, reflecting the retention of £130m to fund Carers breaks in 2016/17.

Given the above responsibilities, it is suggested that all partners on the local Health and Wellbeing Board sign the Memorandum of Understanding at Appendix One in order to demonstrate commitment to the duties of co-operation and promotion of wellbeing, as well as the wider commitment to identifying, recognising, assessing and supporting Carers.

It is recognised that the template Memorandum of Understanding may need to be varied to reflect local circumstances and policies. The important thing, here, is that any such local variation should be discussed and agreed to by all parties on the Health and Wellbeing Board.

Nothing in this paper seeks to amend or replace statutory guidance or accepted best practice. Statutory guidance, *Care and Support Statutory Guidance (DH, 2014)*, on implementation of the Care Act 2014 can be accessed at:

https://www.gov.uk/guidance/care-and-support-statutory-guidance

A template Memorandum of Understanding for supporting Young Carers and their families can be accessed at:

http://adcs.org.uk/early-help/article/no-wrong-doors-working-together-to-support-young-carers-and-their-families

Established best practice and examples of positive practice are included in Appendix Two to this document.

1.2 Acknowledgements

The development of this paper was informed by the invaluable contributions of members of ADASS (the Association of Directors of Adult Social Services) and its regional Carers Policy Network meetings, the support and advice of the Department of Health and NHS England, the Standing Commission on Carers, NHS England regional nursing staff, members of individual clinical commissioning groups, and the many national and local carer support organisations we have met with and spoken to.

We also wish to acknowledge the individual and collective contributions made by Young Carers and Carers from vulnerable communities.

2 The new framework for Carer health and wellbeing

2.1 Understanding the duty of co-operation

The Care Act 2014 introduces a number of reforms to the way that care and support for adults with care needs are met. It requires local authorities to adopt a whole system, whole council, whole-family approach, co-ordinating services and support around the person and their family and considering the impact of the care needs of an adult on their family, including children.

In several places, the Act makes provision for all Carers, including Young Carers and Older Carers. This "whole system" approach bestows a duty of co-operation on local authorities and all agencies involved in public care.

What is the duty of co-operation?

The Care Act 2014 now makes integration, co-operation and partnership a legal requirement on local authorities and on all agencies involved in public care, including the NHS, independent or private sector organisations, some housing functions, and the Care Quality Commission (CQC).

Section 6 of the Act provides for a general duty to co-operate. Section 7 of the Act provides for co-operation in specific cases and includes caveats for specific cases when co-operation is not possible.

Further, Section 15.22 of the statutory guidance provides for "the local authority…consider what degree of co-operation is required and what mechanisms it may have in place to ensure mutual co-operation (for example, via contractual means)".

Who has the duty to co-operate?

Relevant partners of a local authority include any other local authority with which they agree it would be appropriate to co-operate and the following agencies or bodies who operate within the local authority's area, including:

- NHS England
- Clinical Commissioning Groups
- NHS trusts and NHS Foundation Trusts
- Any NHS-funded service
- Job centres

- Justice - the Police, prisons and probation services
- Housing – officers who exercise the local authority functions in relation to housing for adults with needs of care and support, or local authorituy functions in respect of Carers and, in some cases, private registered providers of social housing
- Education services

Source: *Care and Support Statutory Guidance*, Chapter 15

The 2015/16 Planning Guidance for the NHS, *Five Year Forward View into Action*, set out how the NHS will seek to implement its duties under the above acts, including a clear expectation that, “CCGs alongside local authorities…draw up plans to identify and support carers and, in particular, working with voluntary sector organisations and GP practices, to identify young carers and carers who themselves are over 85, and provide better support”.

Further, “In developing plans, CCGs should be mindful of the significant changes to local authority powers and duties from April 2015 under the Care Act 2013 [*sic*]. Plans should focus on supporting young carers and working carers through the provision of accessible services, and services for carers from vulnerable groups”.

Copies of the 2015/16 Planning Guidance for the NHS can be accessed at:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/forward-view/

2. 2 Understanding the duty to promote wellbeing

The general duty of a local authority towards individuals, under Section 1 of the Care Act 2014 is “to promote that individual’s well-being”. Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person, and that person should be enabled to participate as fully as possible in decisions at every stage in their care.

What is “wellbeing”?

Wellbeing is a broad concept and it is described as relating to the following areas in particular:

- personal dignity, including treatment of the individual with respect
- physical and mental health and emotional wellbeing
- protection from abuse and neglect

- control by the individual over day-to-day life (including control over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society

Source: *Care and Support Statutory Guidance*, Chapter 1

There is no hierarchy to these areas, and all should be considered of equal importance when considering "wellbeing" in the round, for the individual concerned.

Further, wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs from developing and escalating, and on supporting people to live as independently as possible for as long as possible.

It is recognised that social care and voluntary sector care practitioners may not always be qualified to clinically assess a carer's physical or mental health. Where a health need is identified as part of the assessment, the carer should be referred back to their GP so that this health need may be addressed.

2. 3 Understanding the duties to address the needs of Young Carers, Parent Carers and to adopt a "whole family approach"

Both the Care Act 2014 and the Children and Families Act 2014 address the needs of Young Carers clearly and directly. The Children and Families Act 2014 builds on the Children Act 1989 to amplify the rights to improve how Young Carers and their families are identified and supported, and extends the right to an assessment of their support needs to all Young Carers under the age of 18 regardless of who they care for, what type of care they provide or how often they provide it. Thus, the principle of the whole family approach applies across all age groups and across all categories of care.

This change also introduces a requirement to make an assessment on the appearance of need. The new provision works alongside measures in the Care Act 2014 (Sections 60-64) to enable a "whole-family approach" to assessment and support, for example in addressing the inter-related needs of Young Carers and their families.

We have heard that many Young Carers take on their role because of multiple care needs in the family and that many Young Carers find themselves with a long-term career in care within their family. Equally, it is now becoming increasingly common to find multiple caring in families, with major implications for some family members.

The intention of the whole family approach is for local authorities and their partner agencies to take a holistic view of the person's needs, in the context of their wider support network. The approach must consider both how the individual Carer or their support network or the wider community can contribute towards meeting the outcomes they want to achieve (see above), and whether or how the needs for care and support impact on family members or others in their support network.

There is a particular need for NHS bodies and the local authority to work closely when planning to support the discharge of patients from hospital and this is covered by Schedule 3 of the Care Act 2014.

2. 4 Delegation of authority for carers' needs assessments

Section 79 of the Care Act 2014 provides for local authorities to delegate some, but not all, of their care and support functions to other parties. This power to delegate is intended to allow flexibility for local approaches to be developed in delivering care and support, and to allow local authorities to work more efficiently and innovatively, and provide better quality care and support to local populations.

However, as with all care and support, individual wellbeing should be central to any decision to delegate a function.

Delegation does not absolve the local authority of its legal responsibilities. When a local authority delegates any of its functions, it retains ultimate responsibility for how the function is carried out.

The Care Act 2014 is clear that anything done (or not done) by the third party in carrying out the function, is to be treated as if it has been done (or not done) by the local authority itself. This is a core principle of allowing delegation of care and support functions.

Where a local authority delegates its responsibility for Carers' needs assessments, it needs to assure itself that these assessments are compliant with the Care Act 2014.

3 An integrated approach to the identification, assessment and support of Carer health and wellbeing needs

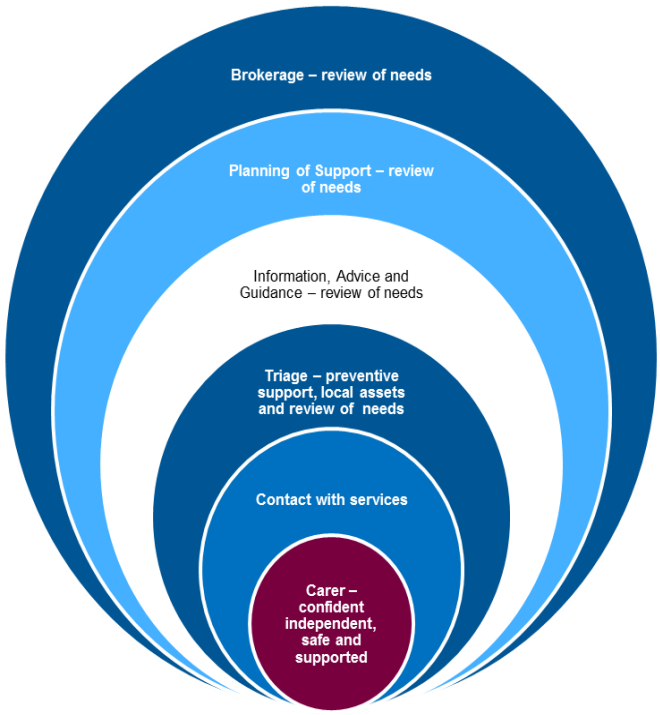
3. 1 The aim of the approach

The aim of this work was to develop an integrated approach to the identification, assessment and support of Carers' health and wellbeing needs across health and social care to:

a. maintain the independence, physical health and emotional wellbeing of Carers and their families
b. empower and support Carers to manage their caring roles and have a life outside of caring
c. ensure Carers receive the right support, at the right time, in the right place
d. respect the Carer's decision about how much care they will provide and respect the Carer's decision about not providing care at all

The integrated approach sits on a number of supporting principles which are discussed more fully below and which will be used to support and promote the implementation of a combined process across health and social care.

The proposed integrated approach for identifying and assessing carers' and wellbeing needs



3.2 The approach explained

The central aim is to keep the Carer at the centre, or core, of the “onion”. This preserves the Carer’s independence, their family and social network relationships, and their ability to undertake their caring role. The Carer’s primary care team has a crucial role in initiating the discussion about the Carer’s support needs and in supporting and maintaining Carer health and wellbeing. The primary care team also has a crucial role in identifying Carers.

The integrated approach recognises that, under the Care Act 2014, Carers have the right to request a formal Carer’s assessment of their own needs at any time.

When a registered Carer has any contact with the NHS they are to be asked the core questions to identify whether or not they feel they are in need of additional support, either in order to continue their caring role or to continue contributing to their family and social networks.

Suggested core and supplementary questions are included below. It is recognised that some care settings will need to ask different questions, or phrase questions differently, according to the communication and information needs of the individual carer presenting to that setting.

The inclusion of these questions in this document is to encourage local debate about the range of questions that could be used to initiate a discussion with the Carer of their changing support needs.

Suggested core questions

Throughout our engagement process, it was suggested that the following could provide the basis for a key question to initiate a discussion about a Carer’s changing needs:

- Do you look after someone who couldn’t manage without your help and support?

This should then be followed by one or more supplementary questions, for example:

- As a result of you being here having (medical) treatment would you be able to continue that care?
- Will you need any extra support because of your own health needs/medical treatment which we are discussing today? (if the answer to this question is “yes” the Carer should be asked what support they need)
- Are you willing/able to continue your caring role?

There may also be an opportunity for services to identify Child/Young Carers by asking along the following lines:

- Are there any children in the household?
- Will any of these children be involved in caring?

Where the Carer identifies they are in need of support, or may need support in the future, the healthcare practitioner should seek to establish what needs the Carer may have as it may be possible to meet these needs during the consultation. Where this is not possible, the Carer should be asked if they are aware of the local Carer support organisation and, if not, referred to the local Carers support organisation. If social care or carer support practitioners are identifying a health need as part of their Carers assessment they should have the ability to refer the Carer back to their GP for health support.

In some areas, NHS primary care services employ care navigators, or other Carer link/support workers, to offer carers advice and information about accessing local support, and, in some cases, to arrange this support on behalf of the Carer. In these cases, it would be useful to ensure primary care and local Carer support work closely to provide the Carer with a seamless service and avoid unnecessary duplication.

The Carers support organisation will then discuss the Carer's situation, including their ability to provide the patient with the required level of care, the wellbeing needs of the family, to assess the level of need and work with the Carer to meet these. This could include referral to other local support, carer support training, preventive services, or referral into the formal needs assessment process. The focus is on meeting needs as quickly as possible to prevent them from escalating and becoming more complex.

For older Carers, many of whom have their own health problems, this discussion could include continuing healthcare arrangements, how this may impact on the Carer's capacity to care, and planning to mitigate against possible failure of the continuing healthcare provider, to ensure that a vulnerable couple is not left without support. It may be useful to complete an initial assessment of support needs and a risk assessment within this discussion.

Where a Carer is offered, or requests, a formal needs assessment, the primary care team may wish to consider what further information, advice and guidance (including advocacy) the Carer requires, at this stage, in order to ensure that the Carer is fully informed about the needs assessment process and how they can prepare for this. In some cases, this may require arranging for an advocate to assist the carer.

In other cases, local Carer support organisations have received delegated authority from the local authority to provide a seamless service for Carers and work closely with the primary care team.

Where a Carer has evidence of support needs and meets the eligibility criteria as set out in the Care Act 2014, this will be picked up during support planning, at which point a more thorough discussion will take place about the ability of the local care support market to meet the identified needs of the Carer, and where additional services may have to be bought in or commissioned. This provides an opportunity for Carers to identify previously unmet need in an area.

A Carer's financial situation may be financially assessed in relation to services provided directly to the carer if a local authority has decided to charge carers. Where a local authority arranges care and support to meet a person's needs, it may charge the adult, except where the local authority is required to arrange care and support free of charge.

The new framework is intended to make charging fairer and more clearly understood by everyone. The overarching principle is that people should only be required to pay what they can afford. People will be entitled to financial support based on a means-test and some will be entitled to free care.

The principles are that the approach to charging for care and support needs should:

- ensure that people are not charged more than it is reasonably practicable for them to pay
- be comprehensive, to reduce variation in the way people are assessed and charged
- be clear and transparent, so people know what they will be charged
- promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control
- support carers to look after their own health and wellbeing, and to care effectively and safely
- be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs
- apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings
- encourage and enable those who wish to stay in or take up employment,

education or training or plan for the future costs of meeting their needs to do so, and

- be sustainable for local authorities in the long-term.

Source: *Care and Support Statutory Guidance*, Chapter 1

In practice, the expectation is that local authorities should apply a 'light-touch' to assessing whether or not to charge for carer support services, "a local authority should ensure that any charges do not negatively impact on a carer's ability to look after their own health and wellbeing and to care effectively and safely… excessive charges are likely to lead to carers refusing support, which in turn will lead to carer breakdown and local authorities having to meet more eligible needs of people currently cared for voluntarily." (*Care and Support Statutory Guidance*, sections 8.50 and 8.51).

The needs of the Carer and their family will be reviewed at regular stated intervals, or when a key transition point is reached, to see what new or emerging needs have developed and to identify additional support may be required. This will be particularly important at key transition points (see below) or when the Carer is approaching the end of their caring role.

3. 3 Supporting Principles

The integrated approach to identifying and assessing Carer health and wellbeing needs rests on a number of supporting principles. These principles are also included in the template Memorandum of Understanding at Appendix One to this document.

Each of these principles covers a number of practical points and each of these practical points features examples of positive practice, in order to encourage and enthuse other practitioners and commissioners to replicate or build on success. These examples of positive practice are summarised in Appendix Two.

In developing a local Memorandum of Understanding, it may prove necessary to develop local supporting principles. Again, this should be based on local discussion and agreement.

3.3. 1 Principle 1 – We will support the identification, recognition and registration of Carers in primary care

The role of the primary care team as the one to which all Carers have access is recognised as being paramount in supporting Carers and maintaining the capacity of Carer to care, if they so choose.

There is a need to improve the registration and assessment of Carers, including Young Carers, in primary care so that their needs can be identified more quickly and before their health and wellbeing deteriorates.

3.3. 2 Principle 2 - Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health.

Carers have a dual role as both providers of care for the cared for and as clients of services as a result of the caregiving role which affects their own health and wellbeing. Thus, primary care has a unique opportunity to make a telling contribution to improving the lives of Carers.

Primary care teams are already seeking to support carers in a number of practical ways, including offering Carers flexible appointment times, longer appointments, offering Carers appointments on Sundays, and referrals to a range of local services through Carer/social prescribing schemes.

There is also a need for local agencies to work together in developing integrated support to meet the identified and emerging needs of Carers.

3.3.3 Principle 3 - Carers will be empowered to make choices about their caring role and access appropriate services and support for them and for the person they look after

Carers need to be aware of their entitlement to request to an assessment of their needs in their own right, independent from any assessment of the person for whom they care.

Carers' main support needs may be support with their own health or with information and education to help them provide skilled caregiving and support for the cared for, either of which may be best addressed directly by healthcare practitioners at the time.

Many areas produce directories of Carer support services and some of these are comprehensive. Depending on identified need, referral to the local Carer support organisation may be the best way to ensure that carers receive the support they

need when they need it. Carers will be supported to exercise choice and make well-informed decisions about the support options available to them.

It is acknowledged that Carers are free to choose not to care, or to decide on the amount of care they will provide. Whatever decision a Carer makes should be respected by the staff with whom they come into contact.

The wellbeing needs of the Carer's family will be taken into account when identifying suitable support. The Carer will be supported to plan for life beyond caring, including where the Carer wishes to reduce the amount of care they provide, or where they are no longer able, or no longer wish, to continue their caring role.

3.3. 4 Principle 4 - The staff of partners to this agreement will be aware of the needs of Carers and of their value to our communities

NHS staff would benefit from Carer awareness training. Provision of Carer awareness training in health and social care induction and ongoing professional development programmes is desirable. This training should be offered by integrated health and social care teams to ensure consistency of approach.

Care staff will recognise signs of distress and diminished capacity that may affect the ability or willingness of Carers to continue caring, so that they can ask the Carer if they are in need of support. Care staff will also be aware of local Carer support organisations so that the Carer can be sign-posted. In some cases, care staff may be able to make the referral on behalf of the carer.

Where social care practitioners are identifying a health need as part of their Carers assessment they should have the ability to refer the carer back to their GP for health support.

The aim of this principle is for care staff to work holistically with the Carer and cared for and be aware of Carers' needs from diagnosis, discharge planning and reviews. Staff could provide the carer with information and/or refer early to support to try to avoid a crisis situation or a breakdown in the Carer's health.

3.3. 5 Principle 5 - Carers will be supported by information sharing between health, social care, Carer support organisations and other partners to this agreement.

We understand that the biggest risk to Carers is the failure to share information sensibly. We will work to remove burden of Carers having to repeat information and will reduce the barriers to effective sharing of information.

The registration of Carers in General Practice is key to this as being identified as a Carer will generate a READ code on the Carer's personal medical record and this will accompany that Carer whenever and wherever they use the NHS in England (by being shown on the Summary Care Record). Within integrated services, social care staff will have access to the Summary Care Record.

Service specifications for many Carer support services, including those that have been delegated to undertake needs assessments on behalf of the local authority, provide for data-sharing and processing arrangements that comply with information governance and data protection requirements. Examples of these are included in Appendix Two.

Improved sharing of information will help to identify vulnerable Carers earlier, improve the identification of Carers and the assessment of their support needs, and could improve the responsiveness of support to the changing needs of Carers. However, it is important to check that the Carer consents to this information being shared and has the capacity to give informed consent.

3.3. 6 Principle 6 - Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision-making and reviewing services.

Carers will be actively involved in the planning of care for the cared for. Carers will have their views taken into account when planning care in advance. Carers will be fully engaged in the planning, redesign and shaping of services.

It is acknowledged that whilst Carers will be expert in the preferences, context and disease history of the patient, they will often not be expert in the disease(s), its course and management and how to deal with emerging caregiving challenges. Carers may, therefore, still need support from healthcare practitioners to empower them to fully fulfil their role as expert partners.

Services will be continuously monitored and reviewed, with Carer inputs, in order to demonstrate where desired health outcomes are being achieved and to identify those areas in need of improvement.

3.3. 7 Principle 7 - The support needs of Carers who are more vulnerable or at key transition points are identified early.

The use of risk stratification tools will allow for predicative modelling through which to develop the necessary preventive and other support resources to meet the needs of vulnerable Carers or those Carers approaching key transition points, including:

- Young Carers as they leave primary school and approach secondary school

and, again, as they leave secondary school to go on to further education
- Young Carers as they move from adolescence to adulthood
- Parents as Carers, particularly parents of children with physical or learning disabilities as they leave the family home or as they become eligible for adult services
- Carers of people with substance misuse problems
- Carers aged over 75
- LGBT Carers
- Carers from BAME (Black, Asian and Minority Ethnic) communities
- Carers with multiple caring roles (e.g., Carers of partners and additional older or other relatives requiring care and support)
- Recognition of additional support needs of bereaved Carers.

3. 4 Benefits of the integrated approach

There are a number of important benefits, and possible benefits, to this approach:

- the focus is on supporting the independence of Carer and the wellbeing of the Carer and their families
- the needs of Carer and their families are identified as, or before, they arise
- the Carer can be fast-tracked to preventive and low-level support, including wellbeing checks
- safeguarding issues can be highlighted more quickly
- there is likely to be a reduction in Carer/family crisis and breakdown
- the Carer's right to opt for a formal Carer's assessment, where the eligibility Criteria are met, is clearly identified
- the approach avoids unnecessary referral to more complex services and will reduce unnecessary demand on these more complex (and more costly!) services
- the identification, assessment and provision of support for Carers from vulnerable groups will help to reduce health inequalities
- the approach will encourage social cohesion through identification and use of other local assets available to support the Carer
- the support needs of the Carer are continually reviewed
- the Carer is supported at key transition points, including any escalation or change in needs, in particular as they approach the end of their caring role.

3. 5 Thinking Carer across the local health and social care system

In order to ensure that Carers receive the right support at the right time and in the right place, Carers demonstrating eligible needs should be referred to the local Carer support organisation to have their immediate wellbeing needs addressed.

Where a Carer indicates they have a physical or mental health need during an interaction with the NHS, this health need should be addressed as soon as possible, after which the healthcare practitioner should initiate a discussion about the Carer's wider support needs and refer to the local Carer support organisation.

Partnership working and co-operation is key to providing a joined up seamless services. This will include joint working between the local authority, the NHS, voluntary organisations, education, public health, housing and local communities to support Carers.

Central to this joint working will be the development of local data and information sharing processes between agencies, so that information follows the Carer across their own care and support pathway without them constantly having to re-tell their story. Practical examples of how this can be achieved are included in Appendix Two.

The needs of Carers should also be recognised by commissioners and planned for. Work through the local Health and Wellbeing Board and the Joint Strategic Needs Assessment will include identification of the needs of Carers, including young Carers and young adult Carers in the local area; this identification will be crucial in avoiding crisis breakdowns.

The local Joint Health and Wellbeing Strategy will include shared strategies for meeting these identified needs, setting out arrangements for working together and the actions that each partner will take individually and collectively.

Local partners should set out their arrangements for periodic audit and the provision of assurance to the Council, Health and Wellbeing Board, Clinical Commissioning Group, and the public, on how the memorandum of understanding is being implemented. Feedback from Carers, their representatives and the cared for should be an essential element of these audits.

There is an opportunity to include Carers and service users as "experts by experience" in these audits - if Carers are to be genuine partners in strategic development, they have to understand how, why and when things can go wrong in order to achieve the ambition of co-designing the future.

Examples of where local partners have adopted an integrated approach to supporting Carers across a district can be found at:

http://www.coastalwestsussexccg.nhs.uk/our-commitment-to-carers

http://www.hertsdirect.org/docs/pdf/c/carstrat2015.pdf

www.surreynhscarersprescription.org.uk

http://www.wandsworthccg.nhs.uk/localservices/Pages/Carers-Support.aspx

4. Moving forward with our Commitment to Carers

NHS England will continue to work with its partners in CCGs, NHS providers, local Authorities, and the third sector, in order to deliver on the Commitment to Carers.

In 2016/17 we are proposing further work to demonstrate how an integrated approach to the identification and assessment of Carer health and wellbeing need is making a difference to their lives of Carers and their families.

This will include the development of an outcomes framework to identify where an integrated approach is making a difference a difference, work to develop positive practice to help Primary Care identify and support Carers, work to include Carer support within new models of care, and targeted work with vulnerable groups to identify challenges they may face in accessing Carer support.

Appendix One: Template Memorandum of Understanding

Memorandum of Understanding between

[insert partner organisations on the local Health and wellbeing Board]

OR

[insert name of Director of Adult Social Care] and [insert name of Commissioning Lead for local Clinical commissioning group] - :

Supporting an integrated approach to the identification and assessment of Carers' health and wellbeing needs

1. Introduction

This Memorandum of Understanding (MOU) sets out the agreed approach to supporting the implementation of an integrated approach to the identification and assessment of Carers' health and wellbeing needs across [insert name of district].

a. The local authorities [insert name of local authority/authorities]; and
b. The following commissioners and providers of NHS-funded care:
- [Insert name of CCG(s)]
- [List all acute NHS Trusts and FT's in area, including tertiary & specialist]
- [insert name of Director of Public Health]
- [Insert name of ambulance trust(s)]
- [Insert name of independent sector providers]
- [Insert name of mental health trusts – if applicable]
- [Insert name of community providers – if applicable]
- [Insert name of voluntary sector care providers – if applicable]

c. The local Carer support organisation(s) [insert name(s)]
d. Other local partners:
- [insert names of relevant local partner organisations]

2. Our vision for Carers

[insert name of district/borough] is a place where Carers are recognised, supported and valued, both in their caring role, and as individuals.

3. Working together to support Carers

Partners agree to co-operate with each other, to promote the wellbeing of individual Carers, and to adopt a whole family approach in their work to support local Carers of all ages, in order to:

a. maintain the independence and physical and mental health of Carers and their families

b. empower and support Carers to manage their caring roles and have a life outside of caring

c. ensure that Carers receive the right support, at the right time, in the right place

d. respect Carers' decisions about how much care they will provide and respect Carers' decisions about not providing care at all

4. Key principles

The integrated approach to identifying, assessing and supporting Carers' health and wellbeing needs rests on a number of supporting principles. Each of these principles covers a number of practical points and each of these practical points features examples of positive practice, in order to encourage other practitioners and commissioners to replicate or build on success.

These examples of positive practice are summarised in Appendix Two.

Partners to the Memorandum of Understanding agree that:

4.1 Principle 1 – We will support the identification, recognition and registration of Carers in primary care.

4.2 Principle 2 - Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health.

4.3 Principle 3 - Carers will be empowered to make choices about their caring role and access appropriate services and support for them and the person they look after.

4.4 Principle 4 – The staff of partners to this agreement will be aware of the needs of Carers and of their value to our communities.

4.5 Principle 5 - Carers will be supported by information sharing between health, social care, Carer support organisations and other partners to this agreement.

4.6 Principle 6 - Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision-making and reviewing services.

4.7 Principle 7 - The support needs of Carers who are more vulnerable or at key transition points will be identified early.

5. Moving forwards

Actions arising from this agreement will form part of our commissioning plan for Carers and of a more detailed action plan.

We will put in place arrangements for periodic audit and the provision of reasonable assurance to the Council, Health and Wellbeing Board, Clinical Commissioning Group, and the public, on how this memorandum of understanding is being implemented and how our work is making a difference to carers. Feedback from Carers, their representatives, and the cared for, will be an essential element of these audits.

We will involve Carers, in recognition that they are ‘experts by experience’, in monitoring and reviewing services, and when seeking to redesign, commission or procure Carer support services.

We will put programmes for learning and development in place to raise the awareness and understanding of the needs of Carers and their families, and of local Carer support services.

We will design training and support for those undertaking Carers needs assessments to have the necessary knowledge and skills. This will include ensuring that practitioners in the local authority and partner agencies are aware of the specific requirements concerning Carers of the Care Act 2014 and amendments to the Children and Families Act 2014 and accompanying Guidance and Regulations.

6. Thinking Carer across the system

By supporting carers we are also supporting the cared for. No one should have to care alone.

In order to ensure that carers receive the right support, at the right time, and in the right place, a Carer who indicates that they require additional support or that their capacity or willingness to continue caring is diminished, should be referred to the local Carer support organisation to have their immediate needs addressed.

Where a Carer indicates they have a health need during an interaction with the NHS, this health need should be addressed as soon as possible, after which the healthcare practitioner should initiate a discussion about the Carer's wider support needs and refer to the local Carer support organisation.

Partnership working and co-operation is key to providing a joined up, seamless service. This will include joint working between the local authority, the NHS, voluntary organisations, education, public health, housing and local communities to support Carers.

Central to this joint working will be the development of local data and information sharing processes between agencies, so that information follows the Carer across their own care and support pathway without them constantly having to re-tell their story. Practical examples of how this can be achieved are included in Appendix Two.

The needs of Carers should also be recognised by commissioners and planned for. Work through the local Health and Wellbeing Board, the Better Care Fund Board, and the Joint Strategic Needs Assessment, will include identification of the needs of Carers, including Young Carers and Young Adult Carers in the local area; this identification will be crucial in avoiding crisis breakdowns.

The local Joint Health and Wellbeing Strategy will include shared strategies for meeting these identified needs, setting out arrangements for working together and the actions that each partner will take individually and collectively.

This memorandum of understanding will be subjected to an annual review.

7. Signatories

Name and title	Organisation	Signature

Appendix Two: Resources to support core principles

Principle 1 - We will support the identification, recognition and registration of Carers in primary care. The role of the primary care team as the one to which all Carers have access is recognised as being paramount in supporting Carers and maintaining the capacity of Carer to care, if they so choose. There is a need to improve the registration and assessment of Carers, including Young Carers, in primary care so that their needs can be identified more quickly and before their health and wellbeing deteriorates.	
Some CCGs run Carer accreditation schemes for practices, to promote innovation and recognise good practice in supporting Carers	http://carersinwiltshire.co.uk/our-services/gp-support/
Some Carer support services work closely with GPs in identifying and registering Carers	http://www.carersleeds.org.uk/
The Carers Trust provides useful advice for primary care staff on practical ways in which carers can be identified in primary care	http://www.carerssupportcentre.org.uk/professionals-2/resources-for-gp-practices/how-to-identify-carers/
Derbyshire Carers Association has developed a carers pledge which promotes the identification of Carers within primary care	http://www.derbyshirecarers.co.uk/carers-pledge
Carers Support Centre Bristol and South Gloucestershire has a dedicated team which supports practices across the district to identify, inform and support all Carers	http://www.carerssupportcentre.org.uk/professionals-2/gp-practices/practice-managers-carer-leads/

Principle 2 – Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health. Carers have a dual role as both providers of care for the cared for and as clients of services as a result of the caregiving role which affects their own health and wellbeing. Thus, primary care has a unique opportunity to make a telling contribution to improving the lives of Carers. Primary care teams are already seeking to support carers in a number of practical ways, including offering Carers flexible appointment times, longer appointments, and referrals to a range of local services through Carer/social prescribing schemes. There is also a need for local agencies to work together in developing integrated support to meet the identified and emerging needs of Carers.	
There is an opportunity to build on best practice and use annual Carer health checks as an opportunity to identify Carer needs at a key entry point to the needs assessment pathway. This service also provides an online booking service for carers	http://www.healthpromotiondevon.nhs.uk/projects/carers-wellbeing http://www.devoncarers.org.uk/devon-carers
In some areas, GP surgeries have designated Carers Leads and run dedicated Carers clinics, to identify and check the needs of carers	http://carersinwiltshire.co.uk/our-services/gp-support/
In other areas, and where the Carer agrees, the provision of an online assessment/self-assessment form allows for primary care to link more easily with the rest of the needs assessment process	https://mycitizenportal.oxfordshire.gov.uk/web/portal/pages/help/other http://mychoicemycare.org.uk/i-need-help-with/being-a-carer/carers-assessments.aspx

In some areas, GPs are offering Carers-only appointments on Sundays	https://www.manchestercommunitycentral.org/news/carers-accessing-sunday-gp-appointments
It is also possible to recognise, support and value Carers through the use of Carers passports. In some cases these can offer Carer discounts on a range of services	http://www.carersinherts.org.uk/how-we-can-help/carer-services/carers-discount-passport
Some GPs are prescribing Carer breaks, as part of a wider Carer prescription scheme. Guidance for GPs can also be accessed by clicking on this link	http://www.actionforcarers.org.uk/professionals/general-practitioners/surrey-gp-carers-prescription/
In some areas, practice staff can access a wide range of resources to help them support Carers	http://www.carersinherts.org.uk/help-us-help-carers/carers-health-information-for-gps/downloads
All Carers should be given information, appropriate to their needs, about local Carer support services and the rights of Carers to an assessment, including right to request an advocate. In Hackney, the local authority has worked with partner agencies to ensure that local Carers receive advice, information and guidance that meets their individual needs and circumstances	www.hackney.gov.uk/Assets/Documents/carers-information-pack.pdf
Some Carer support organisations have been commissioned to work specifically within general practice, in order to provide integrated support for Carers. In other areas, primary care teams and Carers organisations work in partnership to support carers	http://www.supportforcarers.org/what-we-offer/gp-or-professional http://www.leedsnorthccg.nhs.uk/our-priorities/supporting-carers/

North Somerset CCG, Avon and Wiltshire Mental Health Partnership NHS Trust and charity Second Step are working in partnership, “Positive Step in North Somerset”, to provide psychological therapies for people with a range of issues including anxiety or panic, trauma, obsessions and depression. Carers receive tailored help thanks to a thriving talking therapies programme aimed at helping them find the strength to carry on. The psychological therapies (IAPT) service for Positive Step in North Somerset has helped more than 500 carers with therapy and support since launching three years ago	https://www.england.nhs.uk/mentalhealth/case-studies/positive-step/

Principle 3 - Carers are empowered to make choices about their caring role and access appropriate services and support for them and the person they look after.

Carers need to be aware of their entitlement to request to an assessment of their needs in their own right, independent from any assessment of the person for whom they care. Carers' main support needs may be support with their own health or with information and education to help them provide skilled caregiving and support for the cared for, either of which may be best addressed directly by healthcare practitioners at the time. Many areas produce directories of Carer support services and some of these are comprehensive. Depending on identified need, referral to the local Carer support organisation may be the best way to ensure that carers receive the support they need when they need it. Carers will be supported to exercise choice and make well-informed decisions about the support options available to them.

It is acknowledged that Carers are free to choose not to care, or to decide on the amount of care they will provide. Whatever decision a Carer makes should be respected by the staff with whom they come into contact.

The wellbeing needs of the Carer's family will be taken into account when identifying suitable support. The Carer will be supported to plan for life beyond caring, including where the Carer wishes to reduce the amount of care they provide, or where they are no longer able, or no longer wish, to continue their caring role.

Some Carer support organisations provide comprehensive information about Carers' rights	https://www.carersuk.org/help-and-advice/get-resources/carers-rights-guide
Some Carer support organisations also provide training on the choice and safe use of equipment to help support the cared for or on safe manual handling of the cared for	https://www.sutton.gov.uk/info/200335/at_home/1076/staying_in_your_own_home/4 http://www.birminghamcarershub.org.uk/free-safe-moving-handling-training/

Carers have told us they would also welcome more information and training on the safe prescribing of medication, and for clearer information about the patient's condition(s), its development and the prognosis	http://www.sja.org.uk/sja/what-we-do/community-projects/carers-support-programme.aspx
Carers have asked for clear information on how to access support out of hours and in emergencies There are a variety of carers emergency contact schemes in operation, some run by Carer support organisations, others run in partnership with the local authority	http://www.doncastercarersservice.org.uk/carers_emergency_contact_scheme/ http://www.kentcarersemergencycard.org.uk/ http://www.carerssupportcentre.org.uk/free-message-in-a-bottle-service/ http://www.yorkcarerscentre.co.uk/adult-carers/carers-emergency-card/
Some Carer support organisations run courses to help carers care with confidence, addressing themes ranging from handling emotions, looking after the Carer's own health, and dealing effectively with professionals and service providers	http://www.sunderlandcarers.co.uk/caringwithconfidenceprogramme.html http://www.yorkcarerscentre.co.uk/
Some organisations provide advice and support to carers who wish to return to work after their caring role has ended	https://www.carers.org/help-directory/after-caring

Principle 4 - All health and social care staff will be aware of the needs of carers and of their value to our communities. Care staff would benefit from Carer awareness training. Provision of Carer awareness training in health and social care induction and ongoing professional development programmes is desirable. Care staff will recognise signs of distress and diminished capacity that may affect the ability or willingness of Carers to continue caring, so that they can ask the Carer if they are in need of support. Care staff will also be aware of local Carer support organisations so that the Carer can be sign-posted. In some cases, care staff may be able to make the referral on behalf of the carer. Where social care practitioners are identifying a health need as part of their Carers assessment they should have the ability to refer the carer back to their GP for health support. The aim of this principle is for care staff to work holistically with the Carer and cared for and be aware of Carers' needs from diagnosis, discharge planning and reviews. Staff could provide the carer with information and/or refer early to support to try to avoid a crisis situation or a breakdown in the Carer's health.	
Some NHS organisations recognise Carers within their corporate induction programmes	http://www.gloshospitals.nhs.uk/en/Wards-and-Departments/Other-Departments/Education-Learning-and-Development/Induction/?id=6151 http://southtees.nhs.uk/patients-visitors/carers-supporting-your-needs-and-rights/
Some Carer support organisations employ hospital liaison workers to raise awareness of issues affecting Carers across local hospitals and other health services	http://www.carerssupportcentre.com/north-lincolnshire/information-for-healthcare-pro

Some Carer support organisations run Carer awareness training for professional health and social care staff, with a number segmenting this training to address the particular needs of Adult Carers, Young Adult Carers and Young Carers Some organisations provide this training online	https://www.carersuk.org/for-professionals/training/e-learning http://www.carerssupportcentre.org.uk/professionals-2/carers-awareness-training/ http://www.ycctraining.co.uk/
Some Carers organisations provide information on the signs of Carer stress	https://www.carers.org/help-directory/managing-stress
Some Carer support organisations have produced DVDs and video clips as a more flexible approach to raising awareness with health and social care agencies of the issues affecting Carer health and wellbeing	http://www.sunderlandcarers.co.uk/dvd.html

Principle 5 - Carers will be supported by information sharing between health, social care and Carer support organisations. We understand that the biggest risk to Carers is the failure to share information sensibly. We will work to remove burden of Carers having to repeat information and will reduce the barriers to effective sharing of information. Improved sharing of information will help to identify vulnerable Carers earlier, improve the identification of Carers and the assessment of their support needs, and could improve the responsiveness of support to the changing needs of Carers. The registration of Carers in General Practice is key to this as being identified as a Carer will generate a READ code on the Carer's personal medical record and this will accompany that Carer whenever and wherever they use the NHS (by being shown on the Summary Care Record). Within integrated services, social care staff will have access to the Summary Care Record. Service specifications for many Carer support services, including those that have been delegated to undertake needs assessments on behalf of the local authority, provide for data-sharing and processing arrangements that comply with information governance and data protection requirements.	
In some cases, data exchange and sharing between agencies is covered as part of the contract or SLA	https://democracy.wandsworth.gov.uk/documents/s34738/14-565%20Integrated%20Carer%20Support%20Services%20-%20Appendix%20A.pdf
In other cases, data processing contracts have been agreed to share information about Carers, and their support needs, between agencies	Available on request from Jane Weller, Commissioning and Contract Manager, Liverpool City Council jane.weller@liverpool.gov.uk
A Shared Care Record has been developed in Salford, under the Integrated Care Programme to support personalised care planning between health, mental health and social care	http://www.salfordtogether.com/wp-content/uploads/2016/04/Salford-Shared-Care-Record-Screenshots.pdf

Principle 6 - Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision-making and reviewing services. Carers will be actively involved in the planning of care for the cared for. Carers will have their views taken into account when planning care in advance. Carers will be fully engaged in the planning, redesign and shaping of services. It is acknowledged that whilst Carers will be expert in the preferences, context and disease history of the patient, they will often not be expert in the disease(s), its course and management and how to deal with emerging caregiving challenges. Carers may, therefore, still need support from healthcare practitioners to empower them to fully fulfil their role as expert partners. Services will be continuously monitored and reviewed, with Carer inputs, in order to demonstrate where desired health outcomes are being achieved and to identify those areas in need of improvement.	
Involving Carers in the planning of care can have significant benefits for the cared for	http://www.sabp.nhs.uk/advice/care-planning
The contribution of Carers in advance care planning is cited as good practice	http://www.ncpc.org.uk/freedownloads http://www.gloucestershireccg.nhs.uk/your-services/eolc/advanced-care-planning/
The involvement of Carers in personal care planning is also recognised as being beneficial	https://professionals.carers.org/involving-carers-planning
Carers are also involved in advance care planning and shared decision-making. The provision of patient decision aids (or PDAs) may support the involvement of Carers in this process	https://www.england.nhs.uk/ourwork/pe/sdm/tools-sdm/pda/ http://www.harrogateandruraldistrictccg.nhs.uk/reports-and-publications/shared-decision-making/

Carers will be fully engaged in the planning of services. Some areas have reviewed their care market around the needs of carers, in order to promote individual choice and control, and the personalisation/ tailoring of services to meet individual Carer circumstances and preferences	www.hertsdirect.org/hertsmpe
Many NHS trusts have their own strategies for involving Carers in the planning, delivery and evaluation of its mental health services	http://www.5boroughspartnership.nhs.uk/basepage.aspx?ID=5697 http://www.nsft.nhs.uk/Get-involved/Pages/Service-user-and-carer-involvement.aspx http://www.sssft.nhs.uk/service-users-carers/our-service-user-and-carer-charter

Principle 7 - The support needs of Carers who are more vulnerable or at key transition points are identified early. The use of risk stratification and carer recognition tools will allow for predicative modelling through which to develop the necessary preventive and other support resources to meet the needs of Carers approaching key transition points. The aim of this principles of to protect and support vulnerable Carers and to reduce health inequalities. It is important that commissioners ensure that this data is collected, handled and managed through arrangements that comply with information governance and data protection requirements. Carers within the following groups face the same challenges and difficulties as all Carers, but often face additional problems in accessing or using support.	
NHS Salford CCG and Salford Council use a risk stratification tool to help identify Carers who may need a bit of extra help to live their lives Action for Carers Surrey has worked closely with local CCGs in developing a Carers recognition tool to determine the level of stress on Carers and can be used to prioritise need and support plans for the Carer. It has been designed to help to support and inform clinical decisions around the role of the Carer	www.salfordccg.nhs.uk/vulnerable-standards http://www.actionforcarers.org.uk/professionals/general-practitioners/forms-information-and-other-downloads-gps/
Carers aged over 75 – NHS England, Age UK, Public Health England, and other partners, have produced a healthy ageing guide, and a sister publication, “a practical guide to Healthy Caring”	https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/healthy-ageing/ https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/healthy-caring/

Young Carers as they leave primary school and approach secondary school, as they leave secondary school to go on to further education, and as they move from adolescence to adulthood	http://www.scie.org.uk/care-act-2014/transition-from-childhood-to-adulthood/young-carer-transition-in-practice/transition-in-care-act-children-and-families-act.asp
The National Carer Family Network promotes the rights and views of those caring for a person with a learning disability	http://www.familycarers.org.uk/
Connexions Dudley provides a transition guide for parents/Carers of teenagers with learning difficulties and/or disabilities	http://www.connexionsdudley.org/about-2/resources-publications/
The Children's Society Young Carers in Focus programme and Carers Trust run the Young Carers in Schools scheme to improve the identification and support of young carers in schools	http://www.youngcarer.com/resources/young-carers-schools
Parents as Carers, particularly parents of children with physical or learning disabilities as they leave the family home or as they become eligible for adult services. A directory of local parent carer groups can be accessed at this link	http://www.cafamily.org.uk/what-we-do/parent-carer-participation/what-is-a-parent-carer-forum/
The National Network of Parent Carer Forums exists to develop good practice and effective participation for parent Carers	http://www.nnpcf.org.uk/

Leicestershire County Council runs a 'take a break' scheme for parent carers of disabled children	http://llrchildcare.proceduresonline.com/chapters/p_take_break.html
Lesbian, Gay, Bisexual and Trans (LGBT) Carers Age UK has produced a number of guides for older Carers who identify themselves as being Lesbian, Gay, Bisexual or Trans A number of LGBT Carer support groups exist to inform and advise LGBT Carers about the support available to them and to work with commissioners in representing the views and interests of LGBT Carers	http://www.ageuk.org.uk/health-wellbeing/relationships-and-family/lgbt-information-and-advice/lesbian-gay-bisexual-or-transgender-in-later-life/ http://www.ourgateshead.org/news/lgbt-carer-support-group http://www.thecarerscentre.org/our-services/adult-carers/reachingout/ http://lgbt.foundation/information-advice/Carers/
Carers from Gypsy, Roma and Traveller communities Carers Support West Sussex and the Sussex Traveller Advisory Group are working in partnership to identify and support the needs of Carers from these communities Carers Federation in Nottingham provide training, clinics, help and advice in the community for Gypsy, Roma Travellers	http://www.carerssupport.org.uk/all-carers/travellers/grt-health-and-caring http://www.sussextag.org.uk/ https://www.carersfederation.co.uk/services/the-clinic/gypsy-roma-traveller-health/

Military Carers and Military Young Carers - spouses and children in military families may be caring for a parent/sibling who has returned from combat injured, both physically and/or emotionally, or they may be caring for a parent who has health problems while their other parent is away with the military Carers Trust provides a national voice for the needs of Military Carers and Young Military Carers In Wiltshire, local partners have been running a pilot online support service to carers of people suffering from severe mental illness (SMI) in the Armed Forces Community over a one-year period. This pilot is currently being evaluated The Sussex Armed Forces Network works to improve the lives of armed forces communities. This links closely with local Carer support organisations, provides Carer awareness training and employs a Carers and Families Liaison worker	https://www.carers.org/community/blog/who-are-military-young-carers-and-why-do-we-need-raise-their-profile http://www.fim-trust.org/news/the-forces-in-mind-trust-awards-a-grant-to-wiltshire-mind-to-provide-a-pilot-project-offering-online-support-to-carers-in-the-armed-forces-community/ http://www.sussexarmedforcesnetwork.nhs.uk/about/
Carers of people with substance misuse problems - since 1997, Derbyshire County Council has funded Spoda to provide services to address the wide range of complex issues facing Carers of people with substance misuse problems. It was recognised that the shame and stigma associated with substance use meant that Carers do not fit well within generic carer services	www.spoda.org.uk

Carers from BAME (Black, Asian and Minority Ethnic) communities Bristol Black Carers supports carers and those whom they care for to access mainstream care and health related public services Carers First Nottingham City Carers team has African Caribbean, South Asian and Ethnic Minority Carer Support Workers who can offer culturally appropriate information including, language support for South Asian carers Gateshead Carers Association has published an evaluation of its work to support “hidden” carers	 http://www.bristolblackcarers.org.uk/ https://www.carersfederation.co.uk/services/adult-carer-support/adult-carers-nottingham-city/carers-federation-support-workers/ http://www.nemhdu.org.uk/news/2016/1/4/gateshead-carers-association-reaching-hidden-carers-project-evaluation-report
Carers and bereavement The death of the person being cared for can often lead to a double bereavement – the loss of a loved one and the loss of the caring role. Many health-related charities and carer support organisations offer bereavement support, with many areas running support groups for bereaved carers Young Carers and bereavement - a number of national and local groups support bereaved children, young people and their families.	 http://www.carersinherts.org.uk/how-we-can-help/carer-services/carers-bereavement-group http://carers-network.co.uk/bereaved-carers-support-group/ http://www.griefencounter.org.uk/ http://www.mosaicfamilysupport.org.uk/parents-and-carers4.asp

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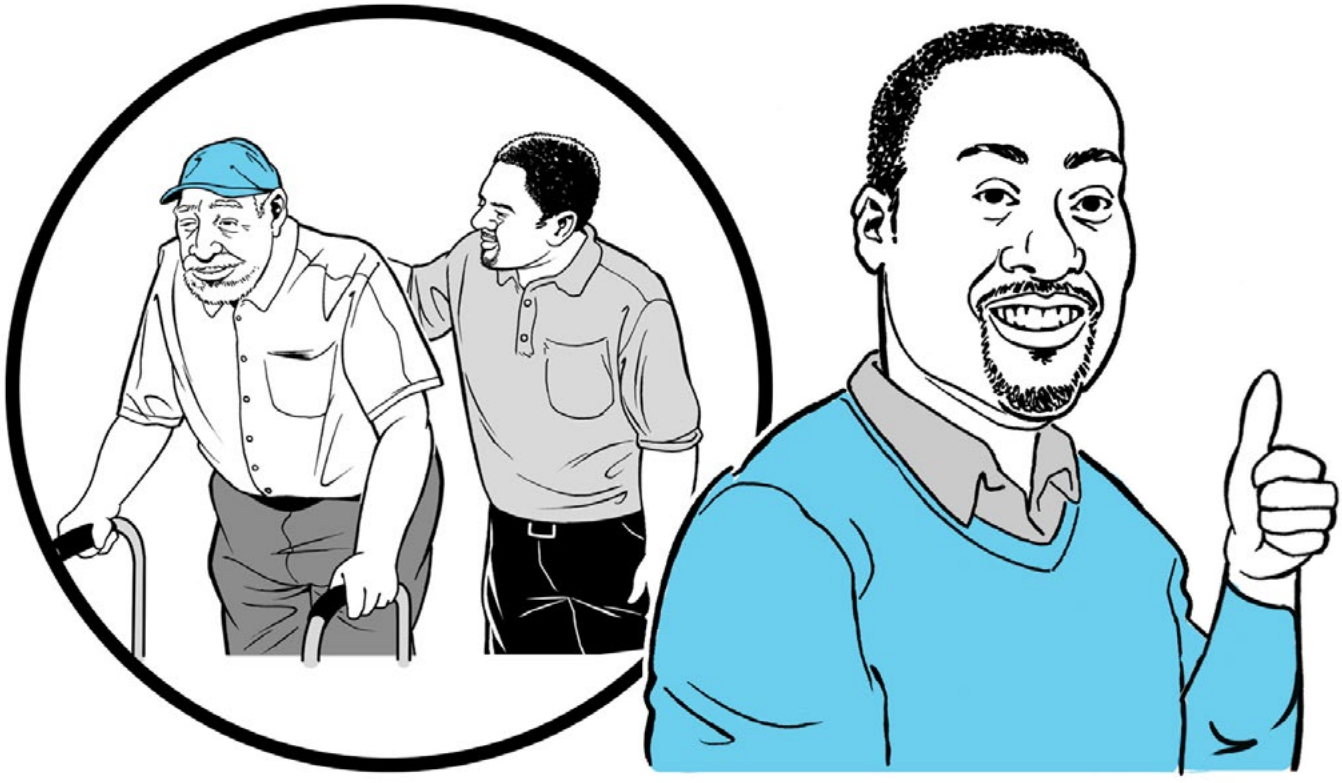
Easy Read

NHS England

Appendix F

Working together to support carers

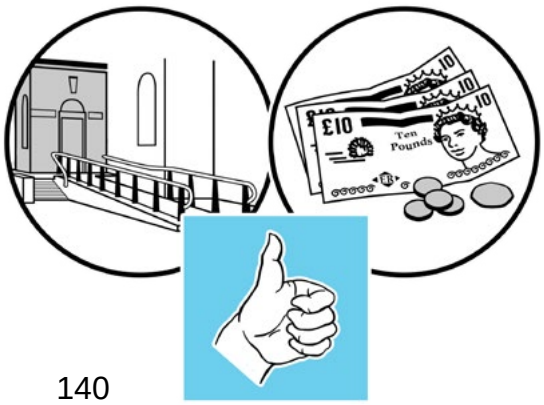


carersUK making life better for carers

carerstrust action · help · advice

The Children's Society

directors of adass adult social services



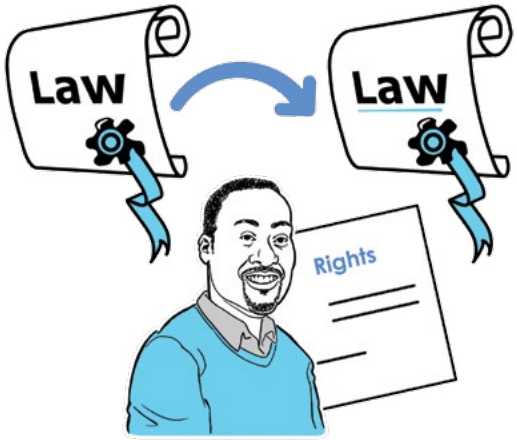
Working together to support carers

This document talks about how **health services**, **social care services** and **local carer support organisations** can work together to help carers and their families.

If these services work together, they can:

- Find out when someone cares for someone else
- Find out what support carers and their family need
- Make sure there is support for carers and their families

- Help carers to have a life outside of being a carer



The rights of carers

The law has recently changed about the rights of carers.

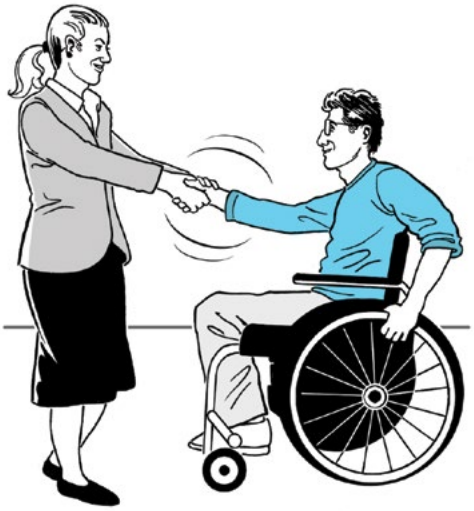
The law has been changed for all carers of any age.

You can find out more about Local Carer support by going to: **www.carersuk.org/help-and-advice/get-support/local-support**

The new law says that all services that provide care have to:

- Work together with other services

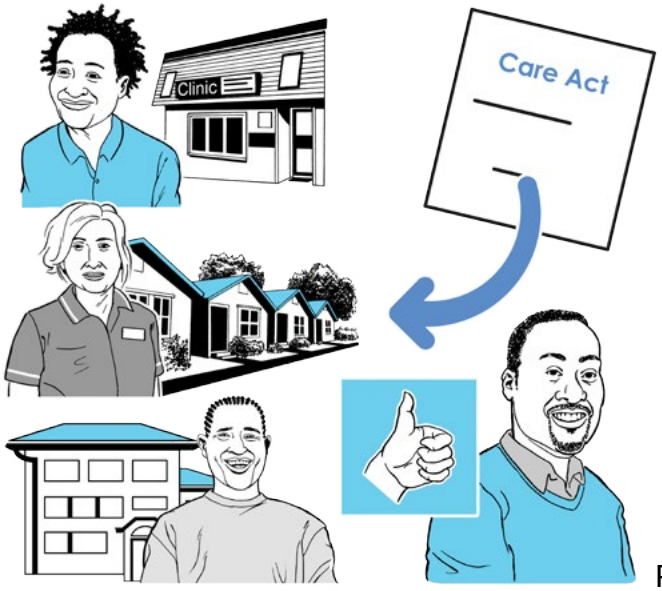
- Think about what support carers and their family need



- Make sure that carers and their families are safe and are treated with respect

You can find out more about this on the NHS website. The link is:
www.england.nhs.uk/ourwork/pe/commitment-to-carers/carers-toolkit/

What has changed?



The **Care Act 2014** says that any **health service**, **social care service** or **local carer support organisation** need to work together to support carers.

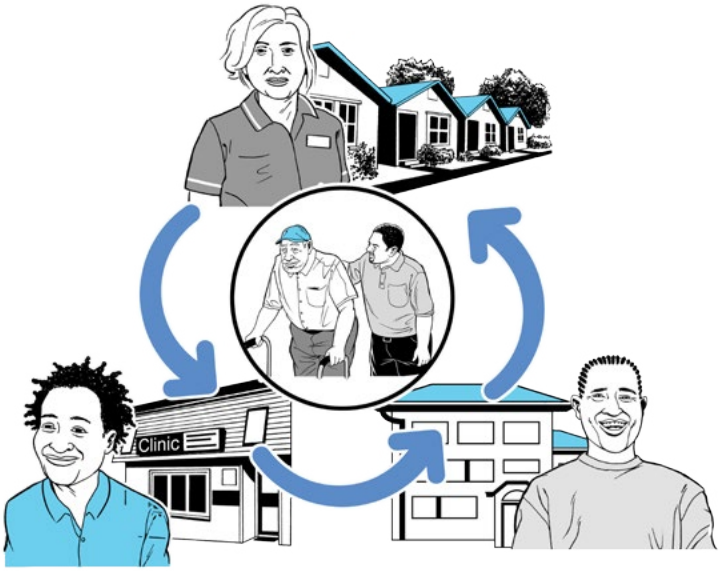
Some examples of these are:

- The NHS (This includes doctors, hospitals and health service managers)
- Social services
- Job centres
- The police, prisons and probation services

- Housing services

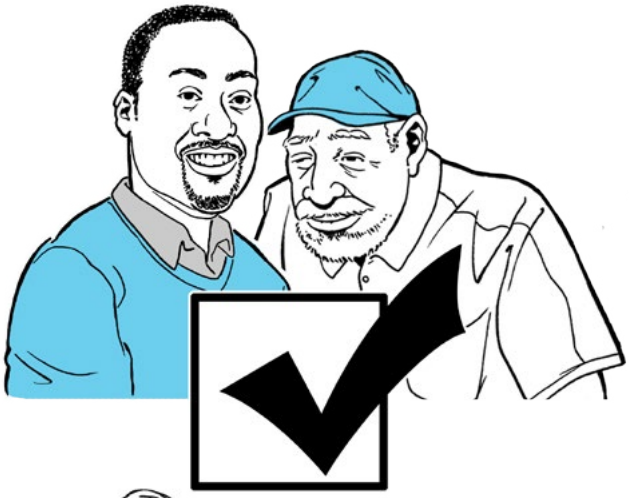
- Education services

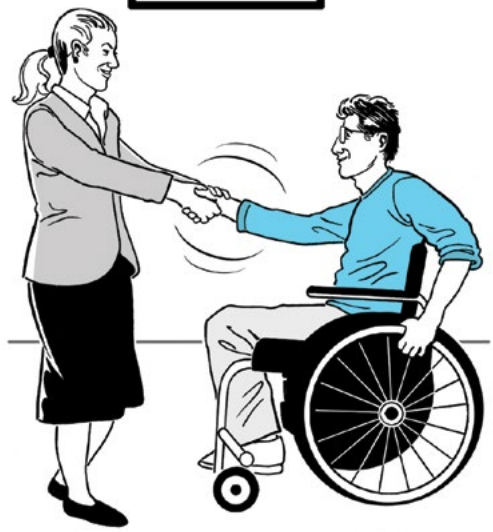
Making sure carers are safe

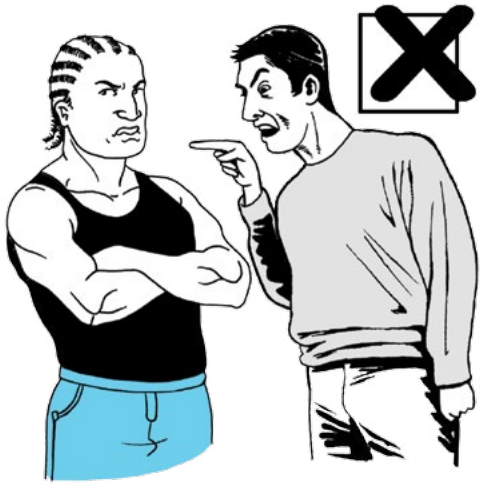


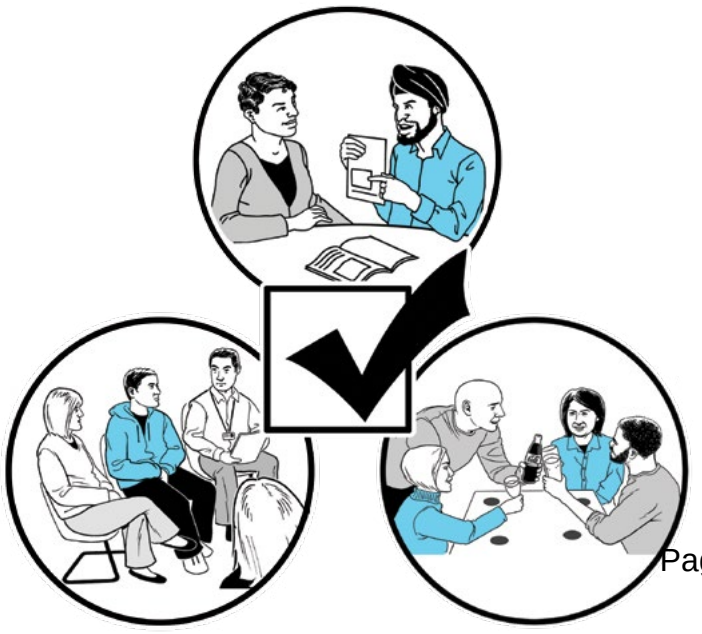
Health services, **social care services** and **local carer support organisations** must work together to make sure that carers are safe.

They must also make sure that carers are involved with decisions that are made about them and the person that they care for.









This means that carers and their families will have a better **wellbeing**.

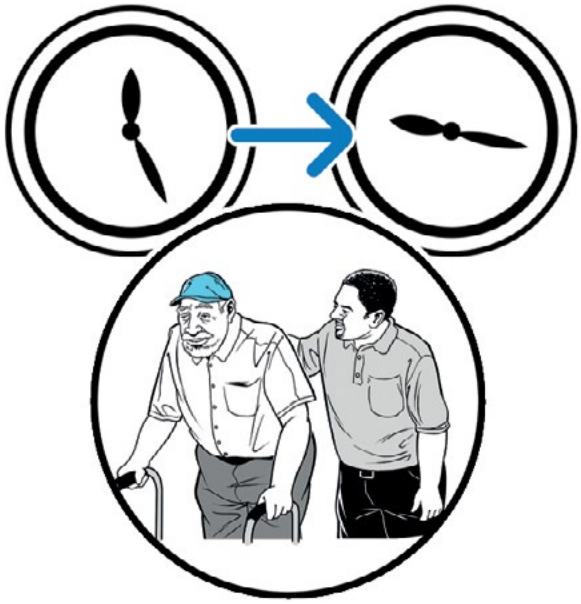
Wellbeing means that a carer and their family:

- are treated with respect
- are protected from abuse and neglect
- are able to join in with work, education, training and have a life outside of work.

- have good relationships with family, friends and partners

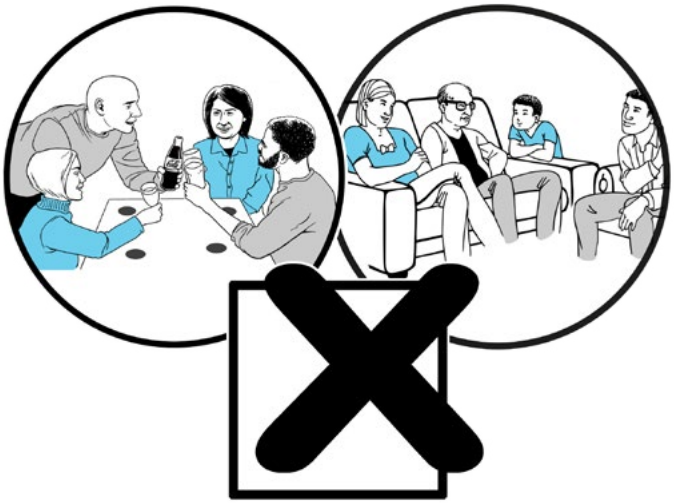
- live somewhere which meets their needs.

- are able to be a part of their community and the rest of society



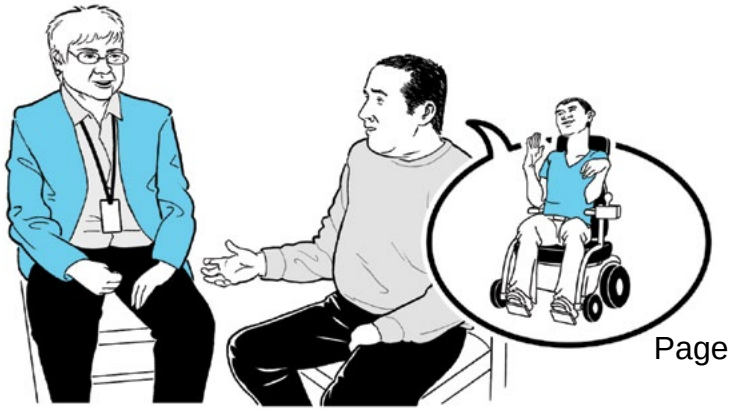
Carers and family members

A lot of carers spend a lot of time looking after the person they are caring for.

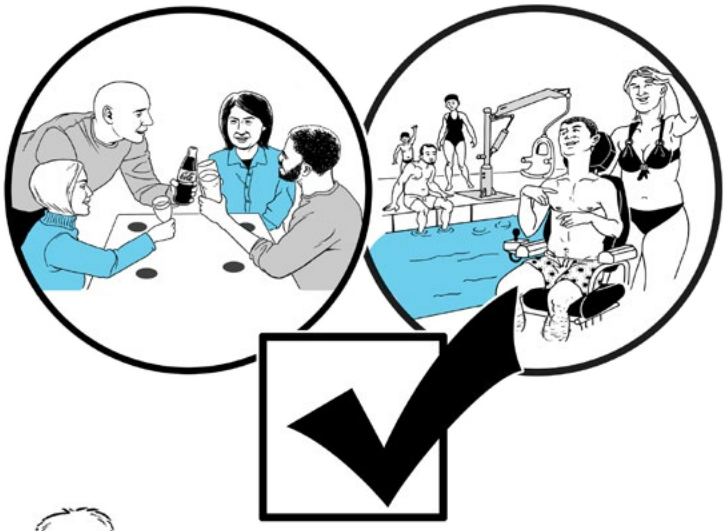


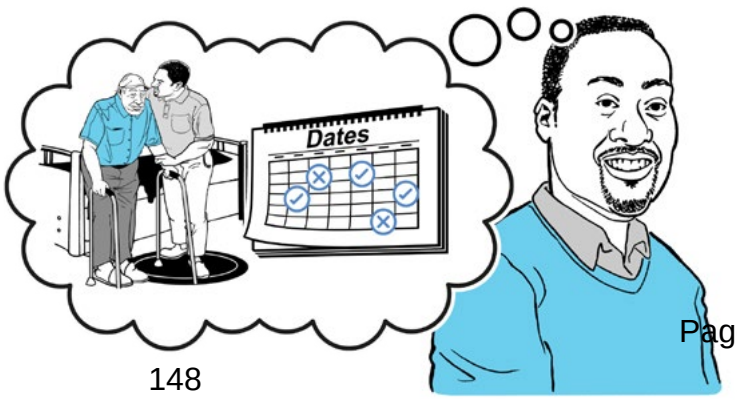
This means they might find it hard to have a normal family life or do things outside of their family life.

This means that **Health services**, **social care services** and **local carer support organisations** need to think about what it is like to be in a family with a carer.



They also need to think about what it is like to be a person that is asked for help by a carer.

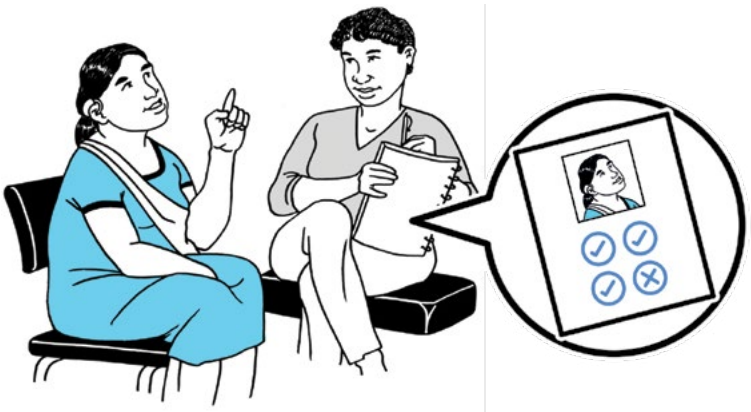




What will happen?

If services work together well, they can:

- make sure that carers are able manage all the care they give
- make sure carers and their families have a life outside of caring
- make sure carers get the support they need when they need it
- respect a carer's decision about how much care they give



Carers have the right to ask for a Carer's assessment at any time. A carer's assessment helps to find out if a carer's needs are being met.

If a person is a carer, it can be put on their medical record.

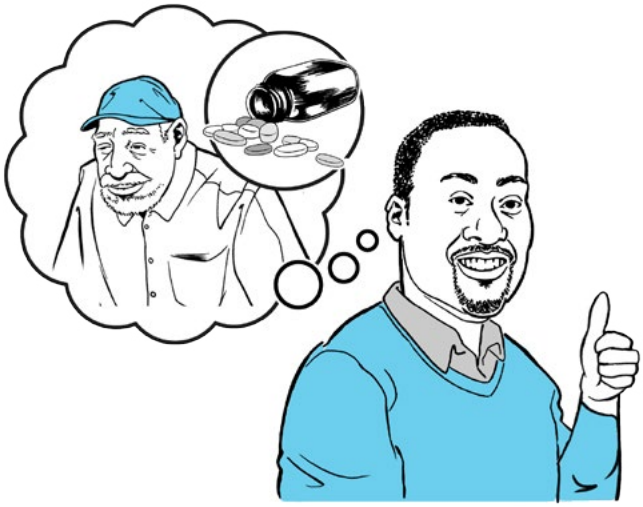
This means that NHS staff can find out if someone is a carer.

This means that NHS staff can ask a carer if they need more support.

If a carer asks for more support, NHS staff can talk to them about their local **carer support organisation.**

The **carer support organisation** can talk to a carer about support for them and their family.

The **carer support organisation** tries to help carers as soon as they need it, this is to stop any problems from getting worse.



How will it happen?

For this to work, local services will need to:

1

Find out whether someone is a carer when they visit a doctors surgery. This can then be written on their medical record for other NHS staff.

2

Find out what the support needs of a carer are. Local services can then work together to give that support.

3

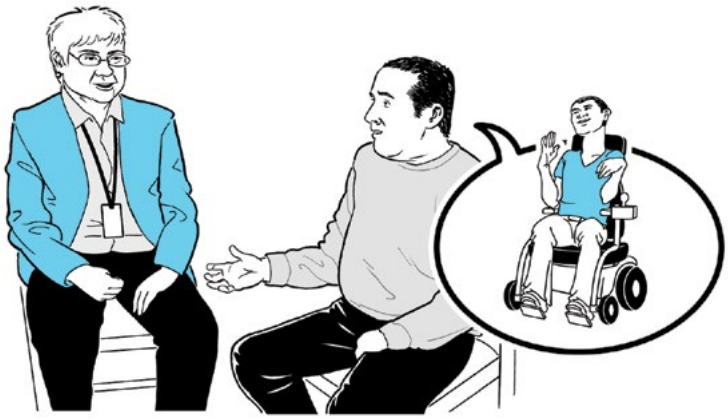
Give carers support so they can make choices about the care they give and help them with the care they give.

4

Make sure care staff know what the needs of carers are and how important they are to their communities.

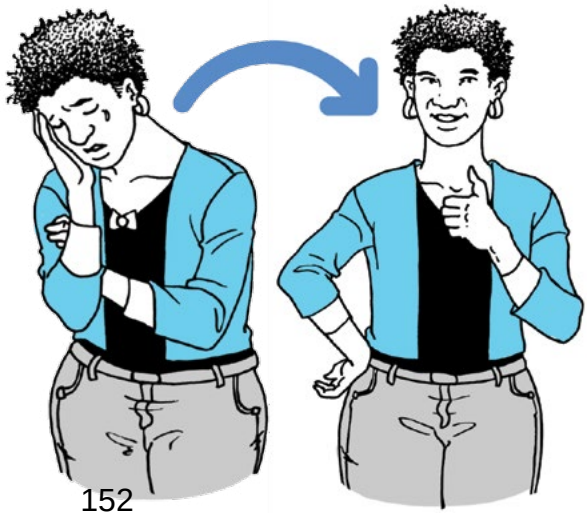
5

Share information better which will help carers.



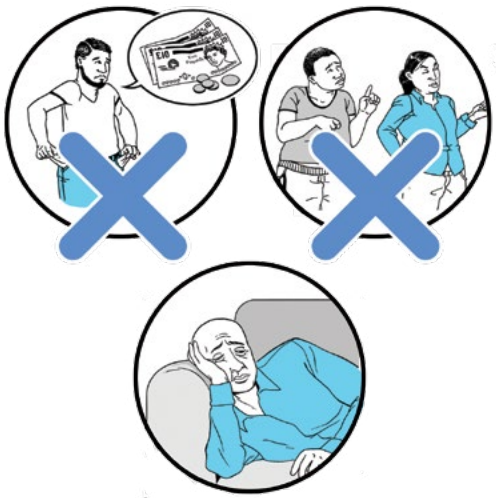
6

Listen to carers as they are experts and are a part of services being reviewed.



7

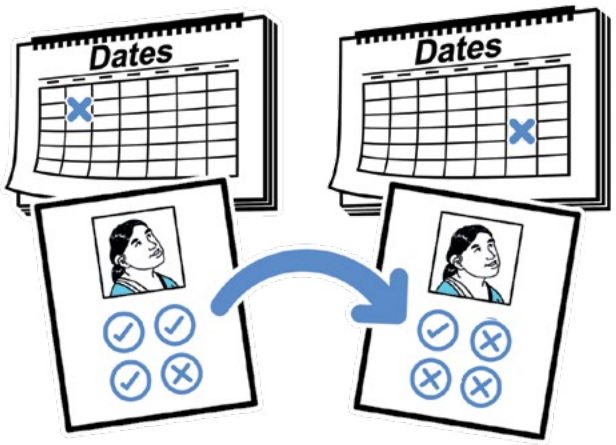
Find out whether carers are vulnerable and meet their support needs.



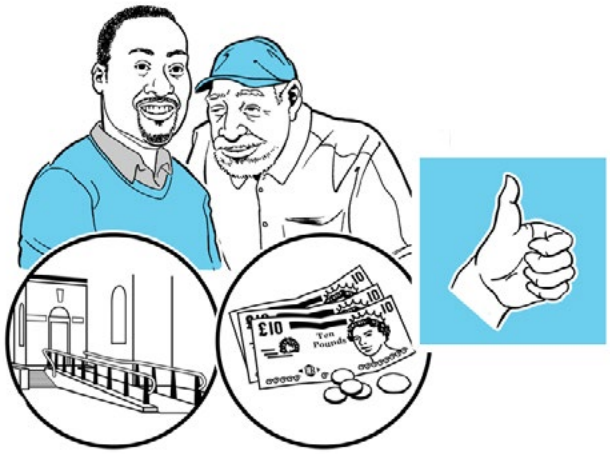
How will this help carers?

Doing all these things will help because:

- it will make sure carers and families get the right support
- it will also make sure the needs of carers and their families are met before any problems happen
- carers will get low-level support quicker
- the amount of problems that a carer family might have will go down



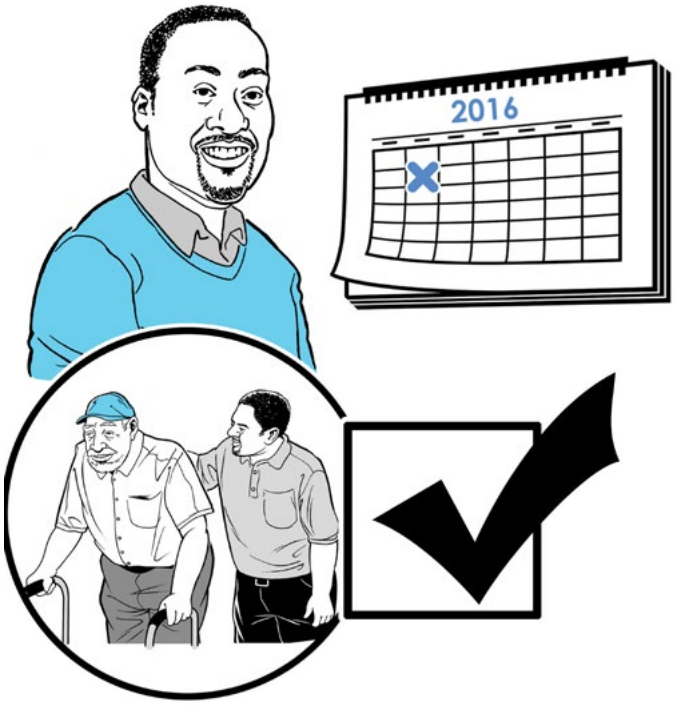
- a carer's support needs will keep being reviewed



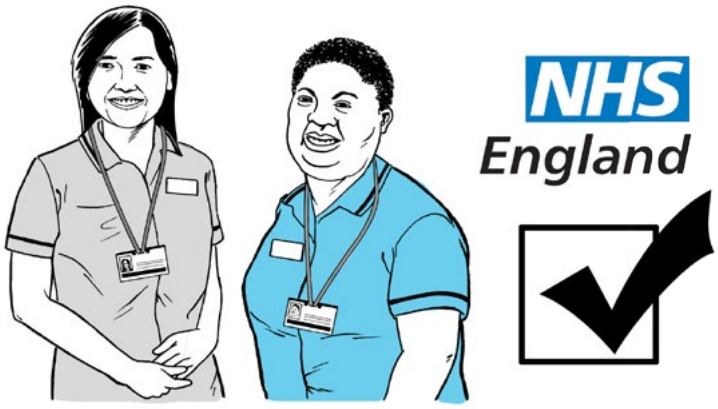
- Carers will still get the support they need even if something changes

Moving forward

This document has been written by NHS England and some of its partners. This is a part of the "Commitment to Carers" work.



This year, we will show how this joined up way of working will help carers and their families.



We will also be looking at ways to help primary care support carers and why some carers find out and use support more than others.

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KENT AND MEDWAY

JOINT HEALTH AND WELLBEING BOARD

14 DECEMBER 2018

SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) STRATEGIC COMMISSIONER AND SYSTEM TRANSFORMATION UPDATE

Report from: Glenn Douglas, Chief Executive Kent and Medway STP / Kent and Medway Clinical Commissioning Groups Accountable Officer

Author: Simon Perks, Director of System Transformation, Kent and Medway

Summary

This report will provide the Joint Board with an update on the establishment of the Strategic Commissioner for Kent and Medway and what this means for the wider system and development of an Integrated Care System and Integrated Care Partnerships across Kent and Medway.

1. Budget and Policy Framework

1.1 Over the last two years, the Kent and Medway Sustainability and Transformation Plan has outlined the intention of the Kent and Medway health and care system to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting.

1.2 In the last 12 months, national policy and guidance has promoted the role and expectations from “integration” of care, functions and organisational arrangements through the development of the Strategic Commissioner function and the design and introduction of Integrated Care Systems and Partnerships. National vanguards have already showcased examples of strong innovation as well as the potential for integrated service models and the benefits that they offer in meeting the needs of their local population through a shared and common purpose, a commitment responding to changing local need as well as strengthening of the prevention agenda in order to fully meet the health and well-being of local people. For providers this has resulted in increased collaborative working and the breaking down of organisational boundaries in joined up care (health and social care).

1.3 This paper provides an update on the progress and working principles underpinning the development of the Kent and Medway Integrated Care System and Strategic Commissioner.

2. Establishing a Strategic Commissioner and Integrated Care System

2.1 There is a strong drive nationally to progress at pace the move to the establishment of the Strategic Commissioner function and Integrated Care System. The Kent and Medway system and in particular the eight clinical commissioning groups committed to and started the journey towards this change in early 2018. Over the last 10 months, the commissioners of health and social care services have been working together in developing an understanding of what a Strategic Commissioner would mean for current arrangements, the opportunities that may exist such as changes to the scale and scope of commissioning, different models of commissioning as well as what a future end state may look like. This work has also benefitted from the shared experiences from the twelve vanguard Integrated Care Systems and the emerging national learning. This learning has helped to provide a degree of clarity around the expected future form and function of the Strategic Commissioner and characteristics of an integrated system.

3. Working Principles and Agreed Governance

3.1 In February 2018, the Strategic Commissioner Steering Group was established. This group chaired by Dr Bob Bowes, Clinical Chair West Kent CCG and consisting of health and social care commissioning representatives has provided leadership and oversight to the strategic development and thinking around the Strategic Commissioner function. The meeting in October represented a significant point in the planning process with the discussion and working agreement of a future option of what the commissioning and provider landscape may look like. This is described in more detail in section 4.

3.2 To date there are a number of “working” principles, these include:

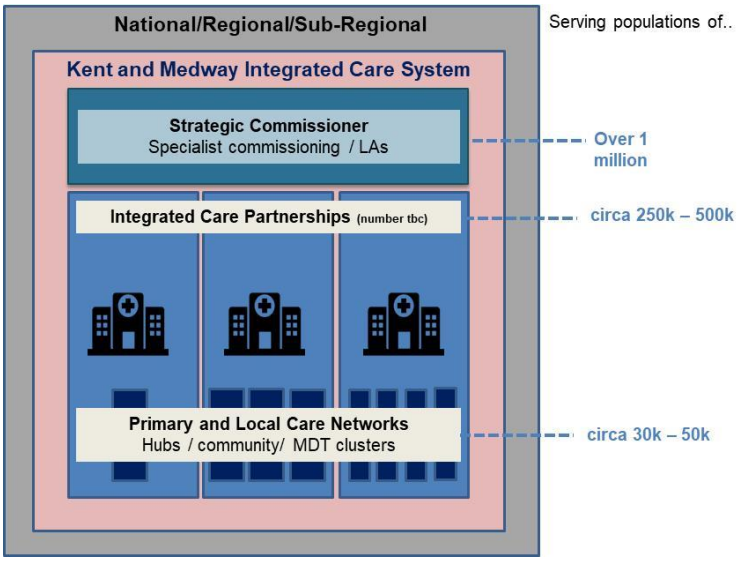
- A single Strategic Commissioner operating across Kent and Medway
- Transition to the Strategic Commissioner form and functions in 2019/20 with the end state realised from 1 April 2020
- Transitional management structures. To note these are already in operation at an executive level across the eight CCGs with leadership provided through the two Managing Directors
- The Integrated Care System would operate across Kent and Medway and be supported locally by Integrated Care Partnerships
- The geography and demographics of Kent and Medway could support potentially 3 or 4 Integrated Care Partnerships or equivalent models

4. Translating the national picture to Kent and Medway

4.1 Figure 1 outlines an emerging picture and possible arrangements for a Kent and Medway Strategic Commissioner and Integrated Care System. Engagement on this continues. The detail of core functions and operational

implementation will need to be explored and developed further and arrangements are expected to evolve based on engagement and feedback.

Figure 1: Emerging arrangements across Kent and Medway



4.2 National guidance and the strategic direction from NHS England suggests a number of characteristics such as geography and demography that can be used to shape how an integrated system may be formed and operate.

4.3 Applying these principles to Kent and Medway would create the following:

4.3.1 A **Strategic Commissioner** that operates at the level of Kent and Medway, facilitating more frequent commissioning at scale of core and services common across the county. This ability to commission once on behalf of the existing eight Clinical Commissioning Groups would help to support parity across the population of Kent and Medway in terms of the quality and access to services. In addition to the commissioning of health services the establishment of a Kent and Medway Strategic Commissioner also presents an opportunity to explore the potential for closer alignment or integration of health and social care commissioning in the future.

4.3.2 An **Integrated Care System** to operate at the level of Kent and Medway. The ability to work as a whole system, both commissioning and provision would strategically strengthen the planning in response to population needs as well as the management of resources and its deployment. NHS England has recently signalled that there is an expectation that “systems” will be capable of reporting a single system financial control total by 2022. In simple terms this equates to the ability to balance commissioning budgets and how much it costs to deliver services. It is expected that the Integrated Care System will also hold a number of assurance and oversight functions. The detail of these functions is closely aligned to the current consultation on NHS England and Improvement’s future management structures and responsibilities. In addition to assurance, the oversight function has the potential to support improvement and innovation across the system through the development of quality improvement techniques, skills and capacity as well as shared learning.

4.3.3 **Integrated Care Partnerships** represent provider led collaborative, operating most effectively across a population of 250,000 to 500,000. The logic behind this is the achievement of sufficient scale to collectively look at how services are provided and the benefits, in particular around collectively working together to offer existing and new models of care that are more effective in responding to people's needs. This use of new and alternative models, including ways of working can also support the achievement of improved outcomes, greater efficiency in terms of the use and deployment of resources (eg workforce, estate, adoption of new technology) and potentially greater cost effectiveness and output that aligns to a single system control total. The working proposal for Kent and Medway based on population size, is for 3 or 4 Integrated Care partnerships.

The ability to demonstrate the benefits of integrated working across a geographical area offers an additional option to the Integrated Care Partnership. The North Kent system (Dartford, Gravesham and Swanley CCG and Dartford and Gravesham NHS Trust) has joined forces and committed to an integrated Primary and Acute Care Services (PACS) model. The PACS will be a joint venture between the Trust, CCG, GP Federation and Community Services. It will be provider led and patient centric and continue to foster and deliver the type of multi organisational and multi-disciplinary teams that are developing around the local care hubs.

4.3.4 **Primary Care Networks** have been an emerging form over the last 12 months as part of the development of primary and more broadly local care provision. The planned Primary Care Networks across Kent and Medway will act as the local vehicles for integration of health and social care services, crossing organisational boundaries in the public, private and voluntary sectors based on local population and individual needs.

4.4 The outline above, pending further development, discussion and agreement, signals a change to the way in which health and potentially social care services have been commissioned to date. Future commissioning and delivery will be seeking to take advantage of models that:

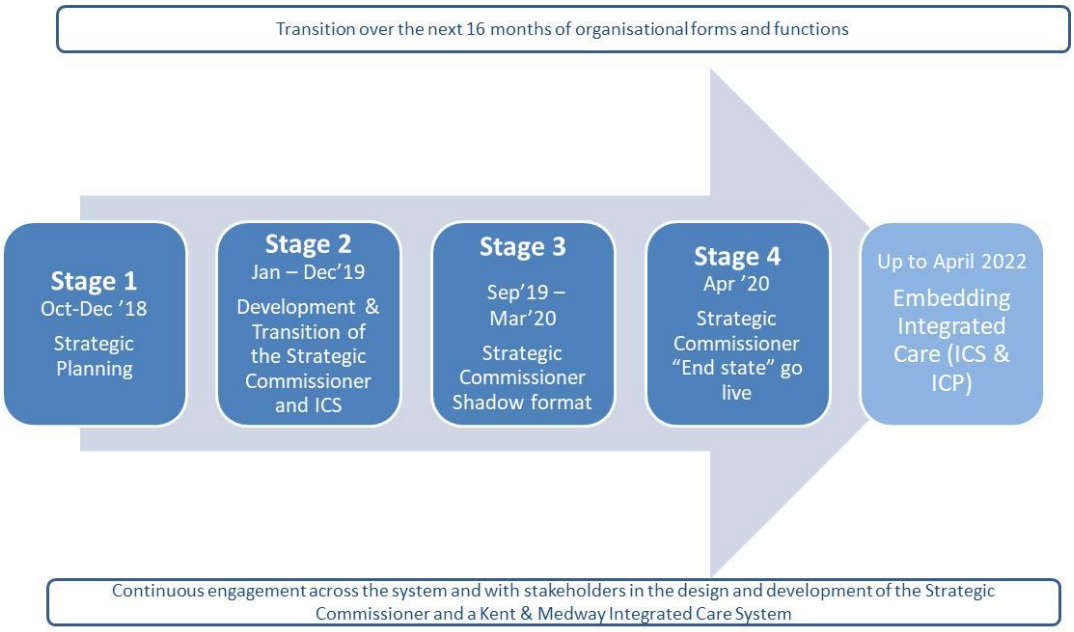
- Focus on and are responsive to the needs of the population of Kent and Medway
- Seek to be sustainable in their delivery considering key factors such as workforce, standards of care, co-ordination of health and social care needs and financial affordability
- Forward looking and seek to innovate and make improvement to the operational challenges facing current provision
- Champion integration and focus on the patient experience and improved outcomes across health, social care and general well being.

5. High Level Timeline for Delivery

5.1 As previously mentioned, the intent and vision for a Strategic Commissioner and move to an integrated system was signaled earlier this year. Figure 2 of the report sets out a high level timeline that would see a Strategic Commissioner (end state) fully operational by April 2020. It is anticipated that capability to carry out functions such as commissioning at scale will be in place from April 2019 with 2019/20 used as a transition year for the development and embedding of arrangements. Based on the scale and

complexity of the change, the current thinking is that the integrated care system will need a longer period to mature and be ready to operate at its full capacity and capability. Current planning proposes a further 2 years embedding period for Integrated Care Partnerships to be fully functional. This timeline aligns with proposed system reporting (eg control totals) by 2022.

Figure 2: High level timeline to Strategic Commissioner and Integrated System "end state"



6. Next steps

6.1 A key part of the transition to a Strategic Commissioner and the development of integrated care system is the engagement and feedback from stakeholders in the design of future functions. A critical part of this engagement is a system wide event on 12 December 2018. It is anticipated that the output from this will help to refine and develop the detail around delivering an integrated model, the functions that would sit with the Strategic Commissioner and at the different parts of the Kent and Medway system.

7. Risk management

7.1 A standing agenda item for the Strategic Commissioner Steering Group is the review of the risk and issues register. The risk register is subject to a monthly review or more frequently in the event of a change in circumstances or an escalated risk.

8. Financial implications

8.1 The financial implications of the Strategic Commissioner and wider system transformation programme are currently being worked through. As the transition to the "end state" is developed there are a number of working principles that are being incorporated within the programme including where possible the use of existing resources within the CCG to lead transition arrangement; the potential delivery of efficiencies through the scaling up or

consolidation of services as well as better targeting of resources through aligned planning across the system.

9. Legal implications

9.1 The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012.

9.2 The Joint Board 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. In accordance with the terms of reference of the Kent and Medway Joint Health and Wellbeing Board, the Joint Board may also consider and advise on the development of options for the Local Authorities' role in a Strategic Commissioner arrangement with Health.

9.3 The Joint Board is advisory and may make recommendations to the Kent and Medway Health and Wellbeing Boards.

9.4 The legal implications of the proposed changes with the establishment of the Strategic Commissioner and an Integrated Care System for Kent and Medway will need to be reviewed and agreed by governing bodies and membership of the existing eight CCGs as their constitutions.

10. Summary

10.1 The Strategic Commissioner programme has progressed at pace in the last two months. The programme is showing an early and emerging form of the Strategic Commissioner, the associated Integrated Care System and significant amount of work to do to achieve the end state of a Kent and Medway Strategic Commissioner by April 2020. Over the next two months and in particular with the planned system wide engagement to shape the design and development of the future state, the programme will develop in detail with early stages of the transition becoming increasingly visible.

11. Recommendation

11.1 The Kent and Medway Joint Health and Wellbeing Board is asked to note the update on establishing the Strategic Commissioner and the development of the Integrated Care System in Kent and Medway.

Lead officer contact
Simon Perks, Director of System Transformation
Email: simon.perks@nhs.net

Appendices
None

Background Papers
None

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD

14 DECEMBER 2018

BRIEFING PAPER: THE KENT JOINT STRATEGIC NEEDS ASSESSMENT

Report from:	Andrew Scott-Clark, Director of Public Health, Kent County Council
	James Williams, Director of Public Health, Medway Council
Author:	Remi Omotoye, JSNA Programme Lead (Interim), Kent County Council

Summary

Following the STP collaboration in the delivery of the statutory duties of the Kent County Council, Medway Council and the Clinical Commissioning Groups (CCGs) as underpinned by the Case for Change[1], this paper outlines the rationale and approach to undertaking the Joint Strategic Needs Assessment (JSNA) for Kent County Council.

1. Budget and Policy Framework

1.1 The Joint Health and Wellbeing Board is an advisory sub-committee to the respective Health and Wellbeing Boards (HWBB) of the Kent County Council and Medway Council[2]. Each HWBB still retains responsibility for their own statutory functions, which includes the production of individual JSNAs.

1.2 The Joint Health and Wellbeing Board works across the wider partnership to influence the future design and alignment of public health and social care services with health and care services at Sustainability and Transformation Partnership (STP) level, with the aim to ensure high standards of care and best outcomes for residents.

2. Background

2.1 Councils and Clinical Commissioning Groups (CCGs) have a statutory obligation[3] to produce a JSNA, the aim of which is to provide the evidence to

[1] https://kentandmedway.nhs.uk/wp-content/uploads/2018/07/KM_STP_case_for_change__March_2018_vF2.pdf
[2] https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=510&MId=4218&Ver=4
[3] http://www.legislation.gov.uk/ukpga/2012/7/section/192

support the development of health and wellbeing strategies and commissioning decisions for the local population.

2.2 The JSNA is a continuous process of strategic assessment of relevant need and planning, with the statutory guidance[4] outlining the following for consideration in its delivery:

2.2.1 Where required, collaboration between two or more local Health and Wellbeing Boards in a joint-production.

2.2.2 The use of any datasets, tools and information that can provide quantitative and qualitative evidence.

2.2.3 The independence to undertake JSNAs in ways best suited to local circumstances.

2.2.4 The undertaking of a more detailed needs assessment[5] in the following areas:

- specific disease groups and/or specific geographical footprints, especially those at risk of relatively poor outcomes,
- the wider issues that impact on health and well-being (e.g. employment, digital access, housing, planning, air quality, community safety, transport),
- the evaluation of services and outcomes, including that from service users,
- the use of analytical tools (e.g. simulation modelling) as an additional product, to predict and inform on future needs of population cohorts, and their demands on health and care services.

2.2.5 Any or all of these contribute to the broader delivery of a JSNA.

2.3 With the potential for overlap in the system between Case for Change and JSNA, this paper seeks to make a case for STPs to build on work associated with statutory duties discharged by Local Authorities and CCGs, on behalf of Health and Wellbeing Boards, some of which include an obligation to undertake JSNAs.

3. Proposal

3.1 The scope of work and statutory activities in the Case for Change is consistent with the outputs for a JSNA; it is therefore conceivable, by potentially avoiding duplication in strategic work, to adopt the Kent and Medway STP Case for Change as the JSNA for Kent and Medway.

3.2 This does not preclude more detailed needs assessment, and for each upper tier Local Authority maintaining the datasets and JSNAs for local areas. For example, Medway Council intends to maintain its own JSNA development and publication process, as does Kent.

[4] JSNAs and JHWS statutory guidance - GOV.UK
[5] https://www.kpho.org.uk/joint-strategic-needs-assessment

3.3 The 10-year NHS Plan, due to be published shortly, sets the direction of travel for the local and health care system.

3.4 The Plan will set out a national context, and this needs to be locally reiterated to present a Kent and Medway picture on the priorities for delivering the 10-year Plan.

4. Risk Management

4.1 Continued improvements in the transparency and processes of Kent JSNA delivery includes the governance structure, which mitigates against the risk of criticism, if subjected to independent review.

5. Financial Implications

5.1 There are no financial implications arising from the report.

6. Legal Implications

6.1 Section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Social Care Act 2012, requires that an assessment of relevant need (that is, a JSNA) must be prepared in relation to the area of each responsible local authority. The Medway Council and Kent County Council are each the responsible local authority respectively.

6.2 It is for each Council and each of its partner clinical commissioning groups to prepare the assessment of relevant needs and for each Council to publish each assessment of relevant needs. County Councils must also involve each relevant district council. Section 196 of the Health and Social Care Act 2012 confers the responsibility for exercising the functions set out on section 116 of the Local Government and Public Involvement in Health Act 2007 to the Health and Wellbeing Board established by each local authority.

6.3 The Statutory Guidance explains that Health and Wellbeing Boards may discuss and agree their own arrangements for signing off the process and outputs and further that two or more Health and Wellbeing Boards could choose to work together to produce JSNAs, covering their combined geographical area. 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 Health and Wellbeing Board's on any matter related to the exercise of their functions. In this instance the Health and Wellbeing Boards of Kent and Medway have not agreed to formally exercise this function jointly and as set out in paragraph 3.2 both Kent County Council and Medway Council intend to maintain their own JSNA development and publication process.

7. Recommendations

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to:

7.1.1 consider and comment on the paper;

7.1.2 note that Kent County Council's and Medway Council's JSNA development and publication process will continue to be maintained by each authority separately; and

7.1.3 recommend further discussion by the Health and Wellbeing Boards of Kent County Council and Medway Council on the proposal that the Case for Change for the STP could be developed to incorporate the JSNA's for Kent and Medway in the longer term.

Lead officer contacts

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Appendices

None

Background papers

1. Health and Social Care Act 2012 - http://www.legislation.gov.uk/ukpga/2012/7/section/192

2. JSNA Guidance - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277012/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

3. Case for Change - https://kentandmedway.nhs.uk/wp-content/uploads/2018/07/KM_STP_case_for_change__March_2018_vF2.pdf

4. NHS Five Year Forward review - https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf.

5. NHS 10 Year Plan - still in publication (expected in November 2018).

6. The Kent JSNA - https://www.kpho.org.uk/joint-strategic-needs-assessment

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
14 DECEMBER 2018
DESIGN AND LEARNING CENTRE UPDATE

Report from: Penny Southern, Corporate Director Adult Social Care and Health

Author: Dr Robert Stewart, Clinical Design Director, Design and Learning Centre

Summary

This report contains an update on the work of the Design and Learning Centre and how it is leading and supporting clinical and social innovation and providing support to the Sustainability and Transformation Partnership and the Joint Health and Wellbeing Board. Progress against the range of projects and programmes is detailed in the report including recent high-profile exposure on a national level.

1. Budget and Policy Framework

1.1 This update is within the council's policy and budget framework including the Council Plan.

2. Background

2.1 This report forms part of a series of progress updates to the Board, as the Design and Learning Centre (DLC) establishes itself as a support mechanism and enabler to the Sustainability and Transformation Partnership (STP).

2.2 The purpose of the DLC is to provide a dynamic organisation with a local, national and global reputation for designing better, safer, cheaper, different care. The DLC aims to take risks in order to succeed, with a methodology that is embedded within the health and care system.

2.3 The objective is to have a track record of co-implementation for a significant number of innovations at individual, community and system level. The aim of the DLC is to be a sustainable and highly effective entrepreneurial organisation, with a skilled team delivering an established methodology with a clear theoretical basis and share learning to act as a catalyst to develop the workforce of the future.

3. Key priorities :

The DLC has 4 key priority areas of work:

1) **Innovation:** to provide an innovation facility to health and care and provide information on developments that may be of interest and support the priorities of the STP including social care.

2) **Learning and Development:**

- Leading the work with the wider care sector and Workforce Boards in health and social care to support recruitment, retention and career opportunities for the care sector.
- Working with the Kent and Medway Medical School (KMMS) to develop their wider and person centred curriculum.

3) **External and International funding:** the DLC is supporting innovation initiatives by applying for external funding in order to pilot and evaluate the new initiatives.

4) **Engagement, Research, Analytics and Co-implementation:**

- the DLC is running Innovation forums with stakeholder for some of the key STP priorities such as: Local Care, End of Life care, Carers App, Being Digital Strategy and many others.
- Organising the wider Innovation, Research and Analytical network for the Clinical and Professional Board and other stakeholders.

4. Progress Update

4.1 **Kent and Medway Medical School** – the DLC is working with the new Kent and Medway Medical School to support the development of their wider access and person centred curriculum. As the DLC is the STP hub for training, research and development which includes Medway and Swale Centre for Organisational Excellence, University of Kent, and Canterbury Christchurch University it is ideally placed to link with and support the Medical School as it establishes itself

4.2 **Collaboration** - In order to progress and streamline the support and enabling offer to the STP the DLC has developed a collaborative approach with the Academic Health Science Network (AHSN). Recognising that having a range of support organisations offering similar but slightly different facilities is confusing, inefficient and potentially divisive. This partnership work known as 'the Collaborative' has an agreed Memorandum of Understanding, Terms of Reference and has now received its first challenge from the STP Clinical and Professional Board to innovate and use technology to transform Local Care in:

- Diabetes
- Asthma
- Chronic Obstructive Pulmonary Disease

4.3 The Collaborative operates with a core group of DLC and AHSN Directors and subject experts and a wider network of allied organisations and stakeholders including within Medway health and social care.

4.4 **Public Health initiatives**: The DLC is working with Public Health on the following initiatives:

- Antibiotic Reduction Challenge with aim to safely reduce antibiotic prescribing by up to 50% (CRP testing sites in Swale, West Kent and SKC CCGs).
- Increasing bystander response through the Push Project - Giving 10 minutes of life (Cardiac compression project in schools in Medway).

Other areas of progress of the DLC include:

4.5 **ESTHER Care Philosophy** – Roll out of ESTHER training continues at introductory, Ambassador and Coach levels, with an ESTHER training the trainer programme being planned for 2019, to significantly increase the numbers of staff trained in the care philosophy.

4.6 In conjunction with the Dartford, Gravesham and Swale (DGS) Multi-Disciplinary Team (MDT) Working Group, the DLC is supporting DGS Local MDT co-implementation of the ESTHER care philosophy. The next ESTHER Inspiration day on 21 March 2019 will take place in Dartford, in conjunction with the progress in DGS, as well as update on developments across Kent.

4.7 The work of the DLC on the ESTHER care philosophy was presented at the National Children and Adult Services Conference on 15 November 2018 under the title of 'What matters to me', alongside the Hilton 'Home to Decide' Model, further details are available via the link http://ncasc.info/presentations2018/

4.8 The ESTHER care philosophy will be presented at The Kings Fund Outstanding Care conference on 4 December 2018 featuring how this genuinely innovative project from Sweden was the catalyst for continuous quality improvement in Kent, by focusing on what matters to citizens and by redirecting communal resources. The presentation is one of the workshops addressing a conference theme of 'deal with demand and change the system'. Further details are available via the link https://www.kingsfund.org.uk/events/outstanding-social-care

4.9 On 14 November 2018 the ESTHER care philosophy was featured in The Guardian Social Care supplement. In the article the ESTHER care philosophy was promoted as 'a singular care model for multiple needs' and featured the work of the DLC team and coaches within the wider ESTHER network. The article is attached as Appendix 1.

4.10 The Care Quality Commission has acknowledged the ESTHER care philosophy and the work taking place in Kent as making a significant difference where staff are trained as Ambassadors and Coaches. Work is also underway for ESTHER training programmes to be endorsed by Skills for Care.

4.11 **Buurtzorg** – The Neighbourhood Care model originally designed in the Netherlands is being piloted in Kent and Medway funded by the Interreg 2 seas programme Transforming Care in the Community. The first pilots are now live in Edenbridge and Medway with further pilots planned in 2019, providing high-quality care delivered by integrated, self-managed teams featuring:

- teams made up of nurses, health and social care workers, homecare organisations, mental health practitioners and others
- targets for increased staff productivity, recruitment, retention and staff and patient satisfaction, decreased costs, emergency admissions and staff sickness
- delayed need for residential or end-of-life care.

4.12 **Digital Strategy** – The Adult Social Care and Health Being Digital Strategy 2018-2021 was approved by the Wider Leadership Team on 5 September 2018 and will be presented to Kent County Council's Adult Social Care Cabinet Committee on 22 January 2019.. The Strategy and Implementation Plan acknowledge that having effective digital capabilities which complement traditional care and support services, is fundamental to delivering the ambitions set out in our Corporate and Adult Social Care and Health strategic plans. The DLC has project managed the strategy and provides Innovation sessions for stakeholders in order to co-design the outcomes.

4.13 **Medication Project** – Multi-disciplinary team work is continuing a more joined up approach to medicines management in the community. The project has worked on an overview of all medication issues effecting social care providers and is working to provide effective solutions. A pilot is being planned to standardise Medication Administration Record (MAR) charts, to reduce errors and increase staff confidence when supporting patients with medication. The pilot will utilise the pharmacy network to provide a standard 'Kent MAR Chart' to people who have been discharged from hospital and are requiring support from a service after their discharge. The pilot is due to go live during the first quarter of 2019.

4.14 **Workforce** – The DLC is providing the STP Workforce Action Board and KCC's Organisational Development Group with a Learning and Development Hub to improve and support the wider social care workforce. An action plan is in place and progressing, containing a range of measures to improve recruitment , retention and skills development . The DLC hosted two highly successful conferences for care providers during 2018, providing cost effective opportunities for approximately 250 delegates per event to learn, share good practice and network. The conferences are supported by the Care Quality Commission , Kent Integrated Care Alliance and Skills for Care and featured a market place for maximum provision of information and engagement.

4.15 A series of workshops, innovation events, engagement and surveys have been provided throughout the year to focus on specific issues such as:

- apprenticeship levy and use of KCC levy to support non-levy payers within the care sector
- places for social care on the Nursing Associate apprenticeship programme, to upskill within the care sector
- decrease in college-based provision for health and social care qualification and learning programmes and the barriers creating this
- lack of work experience placements and solutions to change this.

5. Advice and analysis

5.1 For the long-term future of the DLC it will be important to develop an enterprising business model, enabling the DLC to be sustainable and independent. The aim is for the DLC to build on its existing reputation and be recognised locally and nationally and to continue to build local, national and international partnerships with a large supporting network.

6. Risk management, financial and legal implications

6.1 The current funding for the DLC is from KCC, Kent and Medway STP and successful bids to support project activity e.g. European funding and from the STP Local Workforce Action Board, NHS England and Health Education England. Going forward the aim of the DLC is to be a sustainable and highly effective entrepreneurial organisation, the funding arrangements will develop as part of the financial modelling to support this.

6.2 The DLC has a risk register in place and is monitoring and mitigating the risks identified.

6.3 There are no legal implications arising from this report.

7. Recommendations

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to:

i) Note the work of the Design and Learning Centre, how it is leading and supporting clinical and social innovation and providing support to the Sustainability and Transformation Partnership and Adult Social Care and Health.
ii) Note the Collaborative arrangements in place with the AHSN to streamline the support and enabling offer to the Sustainability and Transformation Partnership and the work commencing on the first challenge issued by the Clinical and Professional Board to the Collaborative.
iii) Note the work the DLC is doing with Public Health on antibiotic reduction and the PUSH project.
iv) Support the Design and Learning Centre in working with the Sustainability and Transformation Partnership to develop an offer to the new Kent and Medway Medical School.
v) Note the work of the DLC in establishing the Learning and Development Hub for the wider Care workforce aiming to improve recruitment, retention and career progression and supporting new delivery models for care providers
vi) Note the Digital developments the DLC is leading for Adult Social Care and Health and the STP and the Innovation methodology used.
vii) Note the ability by the DLC to access external and international funding.

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Appendices
Appendix 1 - Article in The Guardian Social Care supplement 14 November 2018

Background papers
None

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Wednesday 14/11/18
theguardian.com/society/social-care

Stick or twist? Experts debate the best future for the sector
pages 2-3

Why children's services remain an essential investment
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Support for older people: new tech and new models take the lead
pages 8-9

Social Care

'There are many mini awakenings'

Intergenerational care *pages 4-5*

The Guardian

Facing the future

How to approach the funding shortfall?

Too often beholden to capricious governments, can social care take control of its own destiny?

David Brindle

Still the wait goes on. Social care leaders gather this week in Manchester for their annual conference none the wiser about what the government has in mind to resolve the fundamental and long-ducked question of how England, and by example the rest of the UK, should care for its ageing population, and how it should pay for it.

It's a can that's been kicked down the road for almost 20 years, since the then Labour administration shelved the report of the royal commission on long-term care for the elderly. The can was booted heftily ahead in 2015 when a planned cap on individual liability for care costs was deferred first to 2020, then indefinitely. Most recently, ministers promised a green paper with fresh ideas before the parliamentary recess this summer, then revised that to autumn, and then to the end of the year.

While we continue to wait, the care system continues to crumble. One recent snapshot: just 42% of UK councils now offer any form of meals-on-wheels service, with as few as 13% in the north-west doing so. Even though older people are encouraged to stay living independently as long as possible, and loneliness is at last recognised as a priority public health issue, this crucial tool for enabling the former and countering the latter is at risk of vanishing.

Some more money is being pumped into the system, but it barely touches the sides. The "almost £1bn for social care" that was widely trailed ahead of last month's budget turned out to be £55m extra for home adaptations this winter and £240m exclusively for adult care in 2019-20, plus £410m to be shared with children's services, leaving local councils struggling on both fronts to make judgments of Solomon. All those allocations, for England alone, will be one-offs.

Glen Garrod, president of the Association of Directors of Adult Social Services, says councils will face "individious" choices over the £410m. His opposite number at the Association of Directors of Children's Services, Stuart Gallimore, comments: "We need five times this amount just to plug the funding gap expected in children's services by 2020." And Niall Dickson, chief executive of the NHS Confederation, representing health providers and commissioners, says the further "sticking plaster" leaves adult social care the Achilles heel of the whole health and care system - "consistently underfunded, neglected and unloved by politicians over many years".

With the government committed to boosting the NHS budget in England by £20.5bn by 2023, whether social care remains the Achilles heel in the medium term will depend not primarily on the promised green paper - any reforms emerging from which will take years to implement - but on the government's three-year spending review, to be conducted in 2019 for the period 2020-23.

Whatever the outcome, it is clear that much greater emphasis must be placed on preventing demand for social care, among both adults and children, to stop costs spiralling and needs going unmet. This supplement focuses on proven interventions and emerging ideas for prevention, including working with young people excluded from school, and simply listening to and learning from the experiences of people who have ended up in hospital unnecessarily. We also look at the vogue for intergenerational work that brings young and old together: does it deliver anything more tangible than warm feelings and television ratings?

We start, though, by turning the spotlight on a debate about tactics and priorities in adult social care. For this week sees not only the three-day National Children and Adult Services (NCAS) conference, but, for the first time alongside it, a parallel two-day fringe event organised by a grassroots group called Social Care Future. This promises a platform for new and radical thinking on what care and support might look like in years to come, developed in collaboration with people who have support needs.

Julie Stansfield, one of the organisers of the alternative event, sets out why she thinks it represents a necessary counterbalance to what critics see as NCAS's over-focus on the problems of funding existing patterns of services that are largely parcelled out to independent providers. In response, Garrod defends the record of the mainstream care sector in the face of unprecedented pressures and calls for unity to continue making a case to government.

Towards the end of the alternative event, a delegation will be admitted to the main conference to report on the fringe sessions and ideas for reinvigorating the sector's profile and message. It's a positive sign for forging a joint front in future discussions.

Too little, too rare

£2.6bn

The estimated combined funding gap for adult and children's social care in 2019-20, England

£650m

The one-off boost for adult and children's services in England, 2019-20

◀ *Changes afoot? The social care sector will decide how best to move forward at this week's events*
PHOTOGRAPHY: GETTY

Inside

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Comment
Julie Stansfield

We need to discuss an alternative future for social care

Perhaps now more than ever, during this time of terrible cuts, we need to reimagine and start to build a better future for social care. This year, for the first time, the National Children and Adult Services (NCAS) conference will run in parallel with a major fringe event, independently organised by voluntary network #socialcarefuture.

The network has for the past year been gathering and publishing a series of "visions and glimpses" of a positive future from a diverse range of voices. What unifies them is a willingness of public services to partner with citizens and communities, and to use all local resources to build health, wellbeing, inclusion and prosperity. They show how better support can be secured via human-sized and shaped approaches, led by organisations embedded in the community.

Even in the current, incredibly hard environment, we see exciting innovations that hold real promise. As sci-fi writer William Gibson said: "The future is already here - it's just not evenly distributed." For us, many experiencing the sharp end of cuts, despair is not an option - and neither is trying to sustain a system that isn't fit for the future.

'Social care is discussed and thought about as a costly problem, not as an opportunity ripe for investment. It needs to tell a better story'

These glimpses of the future are the basis of our coalition of the willing: local places where statutory organisations and communities move beyond traditional commissioning to build serious partnerships and start to see real results; where better ways of offering support are coming in from the margins; where, through reductions in bureaucracy, user-led organisations and self-managed teams enable people to take as much control as they want to over their support.

There are glimpses of support providers becoming real assets in their communities, beyond simply delivering contracts; of community business and micro-enterprises supporting full use of local assets; of people too often at risk of institutionalisation leading full lives in their own homes.

At least 300 contributors are coming together at two fringe venues in Manchester this week. Our gathering will connect people using social care, and their families, with workers and professionals, support providers, commissioners and politicians. What we have in common is our determination to turn frustration with social care that does not properly respond to our modern needs and aspirations into positive collective action for change. We are bringing people together who are not just going to share good examples and debate them; we will plan action to make practical change happen, and commit to these actions as people, groups and organisations.

We recognise that as well as working on what social care does, and how it does it, we must tell a compelling story of change that attracts support from the public and politicians, rather than one that repels people.

Research by the Frameworks Institute into public thinking on social care, and by Lancaster University into how the media talks about social care, found that it is overwhelmingly discussed and thought about as a costly problem, not an opportunity ripe for investment.

Yet it is the sector itself that has generated this narrative. It now has the opportunity and influence to tell a better story - and we believe we can do it.

By bringing more voices into the debate, and by sharing positive developments around the country that can be built upon, we believe we can turn crisis into opportunity. We need to make the future together.

Julie Stansfield is chief executive of In Control

▲ *Unity and community: key social care figures agree on the need for more care to take place outside of homes*
PHOTOGRAPHY: GETTY

Comment
Glen Garrod

We are dedicated to making an impact with ever-fewer resources

As we gather for the annual NCAS conference and gear up for a critical year ahead for social care, the need for unity has never been clearer. We all know the backdrop against which we are operating: massive challenges confront us, whether that's the sector's significant funding restrictions, fragile care markets, the sustainability of our under-recognised and under-rewarded workforce, or the societal and health impacts of an ever older and more disabled population. With wealth and health inequalities widening, we face these challenges with seemingly ever-fewer resources.

Yet against this backdrop, there have been significant successes. Overall, delays in transfers of care from hospital in England have fallen, with the number of delays attributable to social care consistently half those attributable to the NHS.

That focus, however, has come at a cost, and we at the Association of Directors of Adult Social Services (Adass) are looking at whether making funding contingent exclusively on reducing delays is the right thing to do when we need to be encouraging people's independence and interdependence. Without support to help people in their communities, more people will end up in hospital and pressures will only increase.

We've seen unique and innovative approaches to person-centred care across adult services - whether that's the use of digital technology, appointing "flu champions" to reduce winter pressures on adult care, or adopting whole-system approaches that provide wraparound support across and between generations within a family. We've also seen how personalised health budgets have begun to mirror the success we've achieved with personal budgets in social care.

These approaches show that social care has the dedication and determination among its workforce to make the biggest impact it can with the resources available to it. In short, when we are presented with issues, we get stuck in, work together, and fix them.

'Users of social care want us to advocate strongly for their needs, and for it to be put on a sustainable footing. It's the least they deserve'

That is why it is essential we adopt a unified approach. This week, the NCAS conference will play host to people from an array of divergent disciplines, with services from fostering to care homes represented. Our day jobs may vary wildly, but the challenges we face are startlingly similar. Both children's and adult social care face significant funding shortfalls, affecting their ability to deliver genuine care that takes the individual as its start and end point.

Together, we know that we can secure real, lasting and meaningful change. For my colleagues in adult social care, with a green paper and the NHS long-term plan around the corner, it is essential that we shift towards ensuring people are treated effectively in the homes and communities where they live - whether that's safeguarding vulnerable young people or ensuring older people are supported.

As this year's president of Adass, I've had two things reaffirmed for me: the passion that those who need social care have for it; and the desire that it be the best it can possibly be, because high-quality services can make a huge difference to people's lives.

Those people do not want us to meekly acquiesce to government policy, but to advocate strongly for their needs, and for social care to be put on a sustainable footing. That is the least that the people we care for need, deserve, and expect.

Glen Garrod is executive director of Adult Care and Community Wellbeing at Lincolnshire Council

Intergenerational care

‘Children make them feel more human’

The more time young and old people spend together, the more both parties benefit

Andrew Cole

We live in a society where age segregation is on the rise. Research by the Intergenerational Foundation has found that only 5% of older people in England and Wales now live near someone under 18, whereas 15% did so 25 years ago. So the idea of intergenerational care – where children and older people come together to sing, play or just chat – seems to have much to recommend it.

Studies claim this type of interaction can decrease older people’s loneliness, delay mental decline, lower blood pressure and even reduce the risk of disease or death. But, at heart, the benefit of almost any interaction between young and old is self-evident, according to Lesley Carter, clinical lead at charity Age UK.

“I have seen it so often, when a child touches the hand of somebody who is perhaps very withdrawn, and not really speaking, and all of a sudden that person is alive,” says Carter. “It’s really humbling.”

However, evidence for successful outcomes remains largely anecdotal and, partly because their growth has been driven mainly from the bottom up, funding for these programmes is often short-term and uncertain.

Prof Sarah Harper, an Oxford University gerontologist, points out that these initiatives are very small-scale and barely scratch the surface of the problem of social isolation: “We can learn a lot from them, but I don’t think this is going to be the solution.”

Intergenerational care started in Japan in the 1970s and was soon enthusiastically adopted in many other countries, including the US and Australia. The UK was slower off the mark, but there has been a rapid expansion in the past two years, inspired in part by the hit Channel 4 show, Old People’s Home for 4 Year Olds, which has just completed a second series.

United for All Ages, a thinktank that focuses on intergenerational work, says between 30 and 40 projects are now up and running around the country, most of which involve care homes linking up with nurseries or primary schools. Many more are in the pipeline, and director Stephen Burke predicts there will be more than 500 within five years.

▲ *Top to bottom: intergenerational care at the Albany nursing home, east London; children also benefit from the schemes; Marilyn O’Connor, activities co-ordinator at Albany nursing home*

PHOTOGRAPHY: ELENA HEATHERWICK

The model of engagement can range from occasional, informal visits to settings where two organisations share premises, enabling children and residents to interact every day.

The best-known example in the UK is the Apples and Honey nursery in Wandsworth, south London, which was purpose-built within the grounds of the 200-bed Nightingale House care home. Children (and care workers) take part with residents in daily activities such as singing, storytelling and playing games.

The project has been running for a year and, says co-founder Ali Somers, the results have been eye-opening. “There’s something about having children on site which makes residents feel more human and gives them permission to care about others. It boosts their confidence and feeling of self-worth.”

Many people with dementia seem to thrive in this environment. Somers recalls one very withdrawn resident who “became much more communicative with the baby and toddler group and, after coming to a singalong, took the song over and began to lead. There are many of these mini-awakenings.”

Other schemes include regular get-togethers between school pupils and older people with dementia and depression in east London; weekly visits by pre-school groups to care homes in Torbay; and a link-up between Augusta Court care home in Chichester – part of the Anchor group – and a neighbouring nursery, run by national organisation Busy Bees. Discussions are already under way about replicating this model elsewhere in the country.

Lorraine George, childcare development worker with Torbay council, who spent a month last year looking at intergenerational schemes in the US, came across many success stories: “Each one of these anecdotes describes real change to one person’s life, but, for some reason, we don’t value that as much as data and statistics,” she says.

The benefits are not only felt by the older people – George noted how children’s confidence also improved in these settings, as did their vocabulary and socialisation. “All the parents I spoke to felt their children had learned so much from the elderly residents,” she says. “We’re so time-poor as a society, so to be surrounded by people who have an unlimited amount of time to read with you and answer all your questions and offer unconditional love provides an incredible opportunity to learn.”

Other benefits included greater job satisfaction among staff, improved recruitment and retention, happier relatives, and stronger links with the surrounding community.

In most US cases the care home and kindergarten or school were located together, often developing from economic or logistical necessity, since local schools were expanding and care homes had space on their hands. The UK is beginning to face similar issues. “In Torbay we have care homes that are not full and nurseries that are overflowing,” says George. “It makes sense to team up and share some of the back-office costs.”

Another abiding problem is funding. One scheme, the Together Project, which has had success in north-east London (see right), needed crowdfunding to get going, and, even then, one of its flagship projects ground to a halt after a year because the home closed down. Age UK’s analysis of international schemes suggests they often founder if there is an imbalance in numbers between young and old or if one group feels at a disadvantage to the other.

Some observers also express concern about safeguarding, including the potential risk posed to young children by care home residents with dementia – the majority in most homes these days. Organisers say they take this issue extremely seriously, and follow rigorous safeguarding measures laid down by regulatory bodies.

Somers says Apples and Honey conducted detailed risk assessments before launching its scheme, and that residents are screened by staff before sessions and will never be left unsupervised with a child. School field-trip rules apply every time children leave the nursery.

While accepting the importance of risk assessment, however, George feels it can be used as an excuse for inaction. “Sometimes I feel we can risk-assess things so much we actually stop doing anything.”

Somers’s advice to anyone thinking about an intergenerational project is to go ahead, no matter how small the idea, because all interactions have an impact. As George puts it: “This is not rocket science and it’s not hard to do. And when you see it in action you think: ‘Why on Earth wouldn’t you do this?’”

Experience

‘When I tell her the babies are coming her face lights up and she’s animated’

An intergenerational initiative in London is transforming how care residents behave

Andrew Cole

When Louise Goulden brought her one-year-old son to see his great-great-aunt in her care home, the experience was “like a light had been switched on” for both the aunt and other residents. “Residents who were dozing or not particularly engaged suddenly lit up,” she recalls.

That was also a lightbulb moment for Goulden, and the result was Songs and Smiles, an intergenerational initiative that organises regular visits by local baby and toddler groups to five local care homes in north-east London.

The visits – part of the Together Project, also run by Goulden, which seeks to tackle ageism and social isolation – take place each week and last around an hour. They always start with music, taking in singing, playing instruments and movement. After a break for refreshments, parents and toddlers are then invited to stay and interact more informally.

The music acts as a focus and an ice-breaker, says Goulden. “It’s designed to work for the youngest and oldest and for a range of abilities and capacities. Some residents have quite advanced dementia, but we try to make it as inclusive and enjoyable as possible.”

Up to a dozen residents will usually attend the sessions, along with a similar number of children, plus parents, volunteers and care home staff. So it can often be quite a busy environment, but the pleasure both residents and children derive from the experience is clear.

Goulden says she and the care home staff have noticed quite significant changes in residents since Songs and Smiles launched last year. One care home manager described the transformation as miraculous. “She noticed that people who she wouldn’t have thought had the capability to use a musical instrument started to use them more and people with quite advanced dementia started to try to communicate more.”

Marilyn O’Connor, activities co-ordinator at Albany nursing home in Leyton, mentions one resident who rarely understands what people are saying to her, “but when I tell her the babies are coming her face lights up and she’s animated for the whole session”.

This impact is felt well beyond the sessions. “Residents look forward to them every week. It does wonders for them overall – it’s a bit like an anchor point in their week.”

It has also had an effect on the children. “Part of our aim has been to make older people and the ageing process an accepted part of their lives,” says Goulden. “Older people are people they sing with, play games with and have fun with – that makes a big difference.”

Getting to this point has not been easy. Finding suitable care homes, working out the logistics of the visits and recruiting and training volunteers to support residents and parents have all taken time and energy.

But, predictably, the biggest challenge has been funding. Goulden receives a payment from the care homes for each session, while parents pay £1 to attend. But the Together Project relied on crowdfunding to get off the ground in the first place, and future funding remains an issue. She nevertheless hopes to expand Songs and Smiles to other parts of London as well as, in time, further afield.

> ***‘It was like a light was switched on. People who were not particularly engaged suddenly lit up’***
>
> **Louise Goulden**
> *Songs and Smiles*

▶ *Louise Goulden has plans to expand Songs and Smiles, but must overcome funding challenges*

PHOTOGRAPHY: ELENA HEATHERWICK

Comment
David Williams

We are all capable of creating magical things in later life. Too often this is lost to society

Since it officially opened in April, St Monica Trust’s newest retirement village, The Chocolate Quarter, in Keynsham, near Bristol, has attracted national interest because it was designed by the people using its services and the local community. The core concept is about breaking down the walls that stop older people being valued, and promoting mutually beneficial relationships with the wider community.

The first series of Old People’s Home for 4 Year Olds, which was filmed at our Cote Lane retirement village, was a fantastic example of the benefits of developing these kinds of relationships. It had a hugely positive effect on both the young and old volunteers who took part and proved a showcase for the skills and experience that older people still have to offer.

> *‘Plan activities people are passionate about and try to meet somewhere that is comfortable for both young and old’*

Older people rightly feel aggrieved that at the age of 70 they are suddenly considered to have nothing to offer their communities. Many of the volunteers who applied to take part in the show either had teaching backgrounds, like Michael Hardwick, or worked in children’s services, like Pat Ison and Mary Evans. Hamish Hall had had a career in the insurance sector. Who would ever have thought that in his third stage of life he would become a television star, share a breakfast show sofa with Eamonn Holmes and be nominated for a Bafta award?

Their examples represent a real testament that we don’t stop developing after 60, and prove that we are all capable of creating magical things in later life. The potential of this asset base is more usually lost to society. It’s vitally important that we open up opportunities for older people to use their knowledge and expertise and enable them to deliver important outcomes for the wider community, as well as giving a sense of value and wellbeing to those involved.

However, if as housing and care providers we are to invest in new environments and services, we need to provide a clear evidence base in terms of what’s effective about bringing generations together. To that end, my trust has created a Guide to Intergenerational Activity, based upon the latest research, to act as a framework for those wishing to create their own projects.

Simple ways to ensure success for your initiative include helping friendships to develop by providing plenty of opportunities for one-to-one interactions; planning activities that people are passionate about; and trying to meet somewhere that is comfortable for both young and old. Good planning and preparation is a must – try to avoid reinforcing negative stereotypes and remember that not everyone wants to be involved, so make sure people have a choice.

Traditionally, care home environments have been very protective, because of the higher perceived vulnerability of their residents. However, as with retirement villages, the best outcomes come from breaking those walls down. Care homes shouldn’t be off limits and, as we have seen at our dementia care homes, visits by a mums’ and babies’ group and by local primary school children have led to some hugely exciting bonds developing. We have every intention of forging many more such bonds.

David Williams is chief executive of the St Monica Trust. The trust’s Guide to Intergenerational Activity can be downloaded at stmonicatrust.org.uk/guide

Children's services

Spend now, reap the benefits later

Investing in vulnerable young children and their families is a smart move for cash-strapped local services

Mark Ivory

Headteacher Ian Read recalls when children ran riot in the corridors of his primary school and told anyone reckless enough to intervene where to go. But Watercliffe Meadow, Read's school in the deprived north Sheffield community of Shirecliffe, has fought its way up the performance rankings, by engaging with families so that new arrivals are better equipped to learn.

"If you came here now you wouldn't think it was the same school, because they're just nice kids who want to learn and who value what we do for them," Read says. "Clearly, having more positive experiences at home is having an impact on their behaviour when they come here."

Much of this success has come from projects such as Families and Schools Together (Fast), a partnership with Save the Children that helps local parents support their child's learning and development at home and deepens parental relationships with the school. Now the partnership plans to start even earlier, when the child is just two, if the standard health visitor check finds the family in difficulty.

"Some children arrive at school and they can't hold a pencil, or they can't speak or they're still in nappies," says Read, adding that the social cost of failing to intervene early is enormous. Far too much money is spent on picking up the pieces later on, he says.

In her Vulnerability Report, published in July, England's children's commissioner, Anne Longfield, estimated the cost of late intervention to acute and statutory services alone at £17bn a year, while pointing out that the wider social and economic costs were far greater. Yet public spending on early intervention and youth services had fallen by 60% since 2010 and 1.6 million "potentially highly vulnerable" children had no professional support.

As the number of children in care reaches record levels, councils face unprecedented pressure to divert their dwindling budgets into statutory services. "You can't lose almost 50% of funding for children's services nationally without making cuts," says Alison Michalska, director for children and adults at Nottingham council, pointing to the closure of 600 youth services and 1,200 children's centres across England. A recent Guardian exclusive on the use of computer algorithms to identify families at risk of child abuse is just one example of the methods some councils are adopting to target scarce resources.

Michalska has begun to turn the tide by investing in prevention to keep children out of the care system. Largely through intensive therapeutic work with families whose children would otherwise go into care, and with teenagers vulnerable to knife crime or sexual exploitation, Nottingham's in-care population has fallen by 6%. It is an invest-to-save approach

> **'There will be a £2bn funding gap by 2020 unless we start investing in the future of our children'**
>
> **Alison Michalska**
> *Nottingham council*

predicated on what she describes as Nottingham council's "strong commercial outlook".

"By making these changes we're delivering £10m in savings every year, and we've reinvested a lot of that into more prevention services that push down on our costs," she says. "But I suspect that we're coming to the end of invest-to-save, unless the government starts to listen to those of us who are telling them there will be a £2bn funding gap by 2020. I just hope that, somewhere, a lightbulb switches on about investing in the future of our children."

Critics claim that councils struggling to balance budgets are too narrowly focused on quick wins, and need to take a longer-term view that looks beyond the balance sheet to determine success or failure. "The benefits of investing in prevention are wide-ranging, accrue to multiple public services and agencies, and often emerge some years down the line," says Donna Molloy, director of policy and practice at the Early Intervention Foundation (EIF), an independent charity and part of the government's What Works Network. "It is important we are clear about why these savings may not materialise; otherwise, early intervention will be seen as having failed to deliver."

Teaching children social and emotional skills before and during their school years is a case in point, and is one of more than 80 well-evidenced and targeted interventions that the EIF believes should be routine to access. Instead, schools trimmed away more than 32% of the time spent on these skills from 2012 to 2016, according to a study by the Sutton Trust foundation, which promotes social mobility.

"If you track the long-term results, these skills correlate with how well you do at school, better mental health and less involvement in violent crime," Molloy says. "That's why the Sutton Trust findings are so depressing. If you want to set children up for life and close the socioeconomic gap between disadvantaged and better-off children, social and emotional skills are core and fundamental."

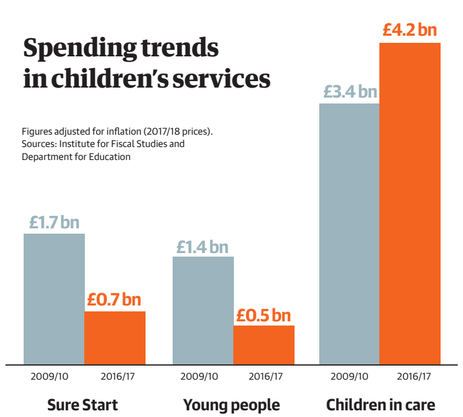
In the absence of better financial incentives for more public services to get involved, independent initiatives from the Big Lottery Fund and the voluntary sector are staking a claim. Save the Children devotes £8m a year to local partnerships like the one in Shirecliffe, while the Big Lottery's A Better Start programme is worth £215m over 10 years.

Based in five areas in England, A Better Start draws on the science of early childhood development and harnesses the contribution of parents who help with its outreach programme in poorer communities. Its south London project, the Lambeth Early Action Partnership, encourages parents to talk, sing and play with their babies to create strong attachments and give their children more confidence to express themselves, manage difficult feelings and form future relationships.

Laura McFarlane, the partnership's director, has four family engagement workers and 21 "parent champion" volunteers who often share the background of hard-to-reach families and can overcome cultural, linguistic and other barriers.

"Children's centres are reaching about 60% of their target population, but what about the 40% who aren't coming?" McFarlane asks. "It's about making sure parents are equipped and well-informed about attachment, reading to their child from when they are a baby, or knowing where they can get support for breastfeeding. Everything starts from there - better relationships for their child, better outcomes in early learning and a better foundation for their social and emotional life."

▲ *Children at the Fast graduation at Watercliffe Meadow Community primary school, near Sheffield*
PHOTOGRAPHY: BETHANY CLARKE/ SAVE THE CHILDREN



Intervention: turning young lives around

A new series of initiatives aims to get the growing number of excluded children back into education and realising their full potential

Linda Jackson

Leaders of children's services are growing increasingly concerned at the plight of vulnerable young people being "bounced" between public agencies after exclusion from school. A damning cross-party report by the Education Committee of MPs found that rising numbers of pupils are being needlessly excluded by schools and "abandoned" to alternative provision (AP).

Researchers at the Institute for Public Policy Research found that these youngsters are "twice as likely as others to be in care, four times as likely to have grown up in poverty and seven times as likely to have a special educational need". Alienated by their experience, many fail to thrive or end up in the prison system.

Local authority attention is now being focused on how early intervention in AP can make a real difference in these cases, and ultimately ease the burden on children's services. From Cornwall to east London, a more holistic approach is reaping rewards for youngsters, who are getting help with anger management, as well as other specialist support, during their education.

Recent official statistics reveal that 41 children face permanent exclusion in England every day. Others face fixed-term exclusions and are in and out of mainstream school. Many exclusions trigger a spiral of decline, leading to costly intervention by social workers and other children's services professionals.

"The situation is very worrying," says Stuart Gallimore, president of the Association of Directors of Children's Services. "Local authorities have seen their funding cut by 50% since 2010. Schools can no longer afford support staff, and money that would have been spent on early-years help services, such as children's centres, is being spent on safeguarding or looked-after children," he adds.

Against this backdrop, it is unsurprising that examples of good practice among AP or specialist education providers are attracting growing interest. In Cornwall, which has some of the poorest neighbourhoods in the UK, family support staff from the Wave multi-academy trust work alongside teachers to help children overcome their difficulties and reintegrate with mainstream education. Therapy dogs and mindfulness training are also used by staff at Wave, which is one of the top-performing AP providers inspected by Ofsted.

As a result, some youngsters who have been excluded from mainstream schools are now still able to go on to study at university or to gain apprenticeships after taking their GCSEs.

"Many of these children have spikey profiles in terms of behaviour and literacy," says Wave chief executive Rob Gasson. "There is a common thread - most of them don't like crowds and work better in small groups. It is really important that children have a fair shot at academic progress, while we support them emotionally and socially."

The trust, which comprises six academies and a hospital and community education service, aims to reintegrate children into mainstream education, or get them into further education or the world of work. It currently has 450 youngsters on its roll.

Academy staff use the natural environment, relying on forest schools, surfing and sailing, at different times, to re-engage the children. Over the next few months, however, they will also be creating stronger ties with parents and carers, having been selected for a pilot project by the Anna Freud National Centre for Children and Families. Restormel AP, in St Austell, is one of three units chosen nationally to take part in the project, which aims to get parents involved in their children's education and behavioural support programmes. It is hoped later to extend this work across Wave, which plans to expand into Devon.

Youngsters at Wave may be victims of domestic violence, drug abuse or sexual grooming, or may suffer mental health problems. The aim throughout is to integrate them back into mainstream society. This can mean extending support beyond year 11 (age 16), as they embark on further education or apprenticeships.

Similar support is offered in the capital, where staff at London East AP go the extra mile for 200 pupils across key stages 3 and 4 (ages 11-16). On-site vocational training, ranging from hairdressing to vehicle maintenance, and building and construction, is offered alongside a range of GCSEs. Its range of enrichment programmes, run on Fridays, includes activities such as boxing, songwriting, animal care, and photography.

▶ *Alternative provision can help get students back on track - emotionally and academically*
PHOTOGRAPHY: GETTY

> **'Children must have a fair shot at academic progress, while we support them emotionally'**
>
> **Rob Gasson**
> *Wave*

Fortnightly meetings with local schools ensure pupils are not lost in the system. As at Wave, the intention is to reintegrate young people into mainstream education. And, in a special move, London East extends year 11 into year 12 for pupils who fail to get English and maths GCSEs at 16.

"Our aim at London East AP is to find increasingly better ways of supporting, motivating and inspiring our students to be as successful as possible in the future," says headteacher John Bradshaw. "Students come to us at various points during their secondary schooling - usually as a result of their previous school placement having broken down, whether through ill-health, behaviour issues or other difficulties - frequently feeling less than positive about themselves and their life chances.

"Our job is to help get them back on track, either through a return to regular schooling or by completing year 11 with us, so that they emerge prepared to make a positive contribution wherever they go next. One kid left last year saying: 'You saved my life.'"

Ellie Owen, London East's top performer this year, has just left with five good GCSEs and plans to do a BTec business diploma. It is a far cry from when she arrived, at the end of year 10, having been excluded from mainstream schools for fighting.

"Here, teachers at the school know your name and how things are at home, and make you comfortable and ready to learn," says Owen.

"At my old school, I found it difficult to concentrate in large groups and my friends dragged me down. Here, I have been put around the right people and I have been supported all the way through," she adds.

Experience
From problem child to star pupil

Excluded from school as a teenager, Chelsea Stanyard was lucky to be supported by Cornwall's Wave multi-academy trust - now she's on the verge of doing her PhD

Interview by Linda Jackson

It is a remarkable story of academic success against the odds. While the rest of Britain spent the summer basking in glorious sunshine, Chelsea Stanyard was cooped up writing her dissertation for her master's degree in criminology at the University of Leicester. In a few months, she hopes to start a PhD.

Not too long ago, life was very different for the Cornish 23-year old, who has dyslexia. At 14, disillusioned and disengaged from school, she was almost out of control. After throwing a chair at a teacher, she was excluded for the fifth time. She changed schools and soon after ended up in alternative provision (AP).

With support from her teachers at the Wave multi-academy trust, and lessons in anger management, she turned her life around. "The teachers all really wanted to make a difference and I felt as if I had unconditional support," she says.

Having studied health and social care at Truro College, Stanyard got a job working in an amusement arcade. "The thought of university never occurred to me. But then I was laid off, so I started looking at my options, and applied to university to study criminology. It was a bit of a last-minute decision.

"Now, I am in love with studying, particularly social issues - I feel there should be more focus on the prevention of crime.

"I really want to make a difference and would like to look at positive approaches to alternative provision for my PhD."

> **'Now, I am in love with studying. I want to look at positive approaches to AP for my PhD'**

◀ *Chelsea Stanyard went from excluded pupil to master's graduate*

Adult care

How new tech is getting older people back on their feet

Smart speakers and fitness trackers are keeping people in their own homes for longer

Kim Thomas

Shropshire resident Ann Maltby, 72, lives with the bone disease osteomyelitis. “I tend to fall over for no reason at all,” she says. “One second I’m standing up and the next second I’m down on the floor.” Because she lives alone, there is no one to help her if she has a dangerous fall.

But, since July, support has come in the form of a fitness tracker she wears on her wrist, and an Amazon Echo, both provided by Shropshire council. The fitness tracker keeps track of her heart rate, how many steps she takes and how many flights of stairs she’s climbed. If she has been inactive for 50 minutes, it tells her to take a walk, and if she falls over, the fitness tracker will detect it.

The Alexa virtual assistant talks to her via the Echo, recommending recipes, providing the weather forecast and offering to book a seat on the local charitable bus service if she hasn’t been out for a few days. “It’s like having a friend in the house,” she says.

Maltby is one of a small group of older residents trying out consumer devices that might reduce the risk of injury and illness – and therefore enable people to stay out of residential care for longer. Already, Maltby says she couldn’t manage without her fitness tracker. But the plan, says Jamie Burns, Shropshire council’s housing services manager, is for it to do much more.

In future, the data it collects will automatically be sent to a GP, and a fall or abnormal heart reading will trigger an alert to send help. If data collected about the user’s gait shows someone is struggling to walk, it will be possible to “step in and stop them having the fall in the first place”, he says. Alexa, meanwhile, could be programmed to ask users how they’re feeling and offer to call the GP or a relative.

The introduction of consumer technology is part of a bigger plan to tackle the problem of providing expensive social care for an ageing population. It’s an issue felt particularly keenly in Shropshire, a county described by Andy Begley, director of adult social care and housing, as “a net importer of older adults and an exporter of younger, economically active adults”. Shropshire’s 65-plus population is predicted to grow from 74,300 in 2016 to 114,600 in 2041, while the population of people aged 85 and over is growing even more rapidly.

At 3,487 square kilometres, Shropshire is also one of England’s larger counties, which makes delivering services particularly challenging; and a diverse provider market means that the council is “contracting between 90 and 100 domiciliary care agencies in any one day”, says Begley.

Rather than succumb to despair at the scale of the challenge, Begley is asking commissioners to think about the economic opportunities social care can bring to the region. He has shifted resource away from residential care and into helping people stay in their own homes, introducing drop-in sessions, for example, at which residents can ask health professionals and voluntary sector workers for advice about local services.

Sceptical about the “big grey boxes with the red buttons” currently on offer to monitor older people in their own homes, Begley wants to embrace sophisticated – yet comparatively cheap – consumer technology such as fitness trackers, and is talking to technology companies, big and small, about what they can offer.

Pete Jackson, a programme manager at Improvement and Efficiency West Midlands, which helps councils to improve efficiency, believes this represents a great opportunity for the technology sector: “a guaranteed cohort of people constantly coming through who are going to have complex needs as they grow older”.

Jackson believes successful projects in Shropshire could be copied elsewhere; Dorset has already joined the county in a collaboration with a small tech company to develop an app that links small handyman-type tasks to willing volunteers.

Shropshire challenges

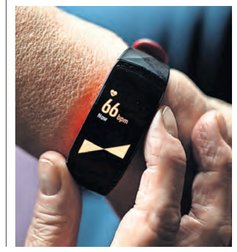
114,600

The predicted 65+ population in 2041 – up from 74,300 in 2016

90–100

The number of domiciliary care agencies contracted by Shropshire county council on any one day

◀ *Ann Maltby, who has been given a fitness tracker and an Amazon echo, describes the latter as ‘like having a friend in the house’* PHOTOGRAPHY: FABIO DE PAOLO



▶ *Fitness trackers could raise an alarm in the event of abnormal readings*

Fighting fire with data

One key strand of Shropshire’s drive to harness data to improve prevention in social care relies on combining the council’s own rich datasets, such as housing, with those of other agencies, to identify the people most at risk.

A new collaboration with Shropshire Fire and Rescue Service (SFRS) demonstrates what’s possible. For five years, it has been using a Public Health England dataset, Open Exeter – from which it can identify people aged 85 and over and registered with a GP – and the Strengthening Families dataset, which identifies families with multiple problems. Both groups are at higher risk of house fires, and are targeted for the 5,000 “safe and well” visits the SFRS makes each year.

By combining those datasets with the council’s housing dataset, it is possible to identify a group of interest to both the council and the fire service: residents aged 80 and over who live alone in thermally inefficient properties. Such properties are often a fire risk, especially when residents live in one room with a single fire that they use to dry laundry.

Guy Williams, head of transformation and collaboration at SFRS, says that as well as fitting smoke alarms and giving advice about fire prevention, the fire officer carries out other basic checks, such as asking elderly residents about “slips, trips and falls”.

The same householders are also often at risk of poor health, tending to stay in the one warm room and not drink water, so they don’t need to use the cold toilet. A lack of movement, together with a lack of hydration, can lead to urinary tract infections, which, says Andy Begley, Shropshire’s director of adult social care and housing, can “knock them off their feet completely”. If the visiting fire service officer reports that the resident is living this way, the council can offer to insulate the house for free, or suggest ways for the resident to become more socially active.

Although there could be many more opportunities for collaboration, data-sharing poses a challenge: while residents’ permission to share data has been sought and granted, the stringent provisions of GDPR have delayed implementation of data-reliant projects. If that hurdle can be overcome, the effect of sharing and analysing data between services could be transformational.

A singular care model for multiple needs

People’s needs don’t always fall into one neat category; the Esther model ensures care is tailored to the individual

Rachel Williams

It took time for Mandy Mitchell to find out why her client was unhappy with his care package – an hour and a half, to be precise. “A lot of people don’t want to ask the carers for anything, because they feel like they’re a burden,” she says. “They’re not used to being helped, because they’ve been through world wars, you know?”

It turned out the man in question simply wanted them to offer to wash his hair. “I think the breakthrough was when I asked: ‘What is important to you?’” recalls Mitchell, a case officer in the adult social services’ supporting independence team in Thanet, Kent. “He said: ‘My appearance – and I don’t want greasy, smelly hair.’”

Mitchell tells the story as an example of how her practice has changed since training last year under the Esther model – a Swedish scheme adopted in Kent in 2016 that’s designed to improve people’s experiences and quality of care by putting them at the heart of it, and encouraging health and social care providers to collaborate. Developed more than 20 years ago, it was inspired by a patient who, over 10 hours between falling ill with heart problems and being admitted to hospital, had to tell her story to professionals 32 times. Diagnosis, treatment and care planning were delayed as a consequence, prolonging her suffering.

The name Esther was picked to represent patients like her, who need attention from more than one health and care provider. Esthers tend to be admitted to hospital frequently because their needs are not recognised.

In the Höglandet region of Sweden, where the Esther model was developed, hospital admissions fell from 9,300 in 1998 to 6,500 in 2013, and readmissions within 30 days for patients aged 65 and over dropped from 17.4% in 2012 to 15.9% 2014.

In Kent, where the philosophy has so far been rolled out in east Kent, with work now beginning to implement it in north Kent, the mantra is simple. Rather than asking “What is the matter with Esther?” professionals should be asking “What matters to Esther?” A key feature of the model is “Esther cafe” sessions, during which Esthers recount their recent experiences of health and social care services to listening professionals from multi-disciplinary teams, who use those stories to identify what could have been done better, as well as what good practice can be spread.

“It’s not about how bad it has been in the past, but about what we can put in place to improve it in the future,” says Dr Robert Stewart, clinical design director of Kent’s Design and Learning Centre for Clinical and Social Innovation, set up to redesign and test new models of care and ways of working.

“When you’re listening to the story you shouldn’t be defending what your organisation did,” Stewart says. At the end of the cafe, professionals agree five things they think would make a difference, and ask the Esther if they are good ideas.

The scheme was born from a recognition that person-centred care needed to be improved. “We recognised that [with] a lot of those services, we think they’re joined up but actually they’re not,” Stewart says. A mark of success would be Esthers feeling safe to be in their own homes, not that hospital was the default place of safety. “They would feel empowered to look after their own health and wellbeing, and we’d reduce admissions to hospital and also reduce length of stay,” he adds.

Twelve Esther cafes have been held so far, and it’s hoped that will be scaled up as the work spreads. But it’s not always easy to recruit Esthers, admits Anna Carlbom, a former coordinator of the Swedish scheme who has been in Kent for two years, first employed by a private care home that piloted the approach, but now working full-time with the Design and Learning Centre.

“[Just] as we might be a bit scared of washing our dirty laundry in public, Esthers might be scared of putting forward what could be seen as complaints in public,” says Carlbom. “We’re trying to build confidence in the Esthers, and that’s why it’s so important the cafes have a very relaxed, informal atmosphere. It should be a no-blame culture.”

At the Esther event addressed by Stewart, attendees are given the chance to participate in a “mini Esther cafe”. In fact, Alison [not her real name], a 75-year-old who shattered bones in her arm, wrist and hand when she tripped up a kerb, has nothing but praise for how she was looked after – especially the care package that has meant she can stay at home, rather than going to a care home for rehabilitation. But the professionals in the room still identify room for improvement, including better pre-surgery communication, which would have given Alison a better idea of what to expect of her procedure.

Kent has already trained more than 600 Esther ambassadors, who promote the scheme within their organisations, and that number will rise to around 800 by the end of the year. There will also be 70 coaches, who have more intensive training and coach their teams to make improvements for Esthers.

Mitchell, an Esther coach, says the experience made her look at things completely differently, despite some initial misgivings. “When we first started doing the training, I thought: ‘We already do this, you’re teaching us to suck eggs.’ Then, by the third session I was just like: ‘No, we need to be more focused.’ We don’t need to go and change the world. Something very small can make such a big difference to a person.”

Hearing from clients informally at an Esther cafe is lovely, Mitchell says – and instructive. “Normally when I go out to see someone I’m there to review them, so I’m going over their care needs, whereas doing a cafe – it can be fun. They can tell us things that actually they might not want to tell us on a one-to-one basis.”

‘These Esther cafes can be fun. People tell us things they might not want to reveal one to one’

Mandy Mitchell
Esther scheme coach

▶ *The Kent scheme revolves around patients who require attention from more than one care provider* PHOTOGRAPHY: GETTY

Career changers

'They bring life experience and have an empathy'

Unfulfilled or plateauing in your current job? The social care sector offers a new challenge for those wanting to help others

Debbie Andalo

People who change careers are often attracted to the social care sector because of its potential to transform other people's lives. Success, whether supporting an older person to live more independently or helping a family in crisis, tends to be palpable.

Such recruits account for up to 40% of entrants to social work postgraduate training programmes and come from a variety of backgrounds - this autumn, according to course leaders, an undertaker and a singer and dancer are among those who have chosen to embark on a new career. In the past, many redundant miners retrained as adult support workers.

"A lot of career changers are looking for something more fulfilling, and when you look at social care, at its heart it's about relationships and what makes a good life for people," says Sharon Allen, chief executive at Skills for Care, the sector skills agency. "Social care is also probably the only career where there will always be a job for you."

Local councils continue to struggle to fill vacancies for child and family social workers: the national vacancy rate for England is 17%, but in some parts of London it rockets to 27%. In such a recruitment climate, career changers are pushing at an open door.

Mark Jenkins, recruitment manager for care group Anchor, which is campaigning to attract career changers, especially men, says: "We offer them the opportunity to develop their transferable skills in a different way - professional development in this sector goes as far as you want it to go. For us, they bring their life experience with them, which they can use in different roles, and they have an empathy with the people they support."

Postgraduate programmes for social workers traditionally attract career changers, especially teachers and other public sector workers. Frontline, which trains child and family social workers, says 40% of its 2018 cohort have switched careers. Around 30% of recruits to Step up to Social Work, the original fast-track postgraduate training scheme, are aged 35-plus, but it does not keep official career-changer figures. Think Ahead, the newest postgraduate programme, designed specifically for mental health services, says 30% of recruits are coming from other careers, including law and teaching.

Ivan Wise, Think Ahead's recruitment director, says: "Most of our recruits are in their late 20s and early 30s, but some are also in their 40s. People coming in after maybe 10 years in a different job are coming in after a longer level of reflection; they may have been thinking it through for a number of years. Some are attracted to Think Ahead because they have gone as far as they can in their career, or their career hasn't given them professional satisfaction."

With all the added value that career changers bring, does that make them better support workers or social workers than those who join straight from school or university?

> *'Having experience from another career helps people in what can be quite scary circumstances'*
>
> **Rosanna Ware**
> *Open University*

"There is a certain roundness to somebody who has been in a different career and has more life experience than other students, who need a bit more time to get there," says Rosanna Ware, education manager for the Open University's social worker undergraduate programme in Scotland - which includes students who are sponsored by their employer to complete the social worker degree, as well as others who self-fund. "Having that experience is really valuable in social work as a profession - it helps people's confidence in what can be quite scary circumstances."

Rachael Wardell is chair of the Association of Directors of Children's Services workforce committee and director of children, schools and families in Merton, south London. She believes that what makes a good social worker comes down to the individual being a good fit for the role. "I don't think a career changer will necessarily be a better social worker," she says. "It's true that life experience can bring benefits, and that you learn more by living, but the key issue is how people deploy that experience - if it brings wisdom into the workplace, or if it brings inflexibility."

Always in demand

110,000
The number of vacancies in adult social care at any one time in England

950,000
The predicted number of extra social care positions required to look after the ageing population by 2035

SOURCE: SKILLS FOR CARE

Experience

'Care isn't seen as a job for men. I wanted to explore that'

Simon Wells explains why he left his 'shallow' job as a librarian to become a care assistant in a residential home

Debbie Andalo

Simon Wells gave up his job as a librarian after 20 years to become a care assistant in a residential home for older people. He was looking for a new career that offered fresh challenges and in which he felt he was making a difference.

"The worst thing that can happen if you are a librarian is that somebody loses a book, or somebody has a paddy because they can't find the information that they want. I thought: 'There must be more to life than this,'" says Wells.

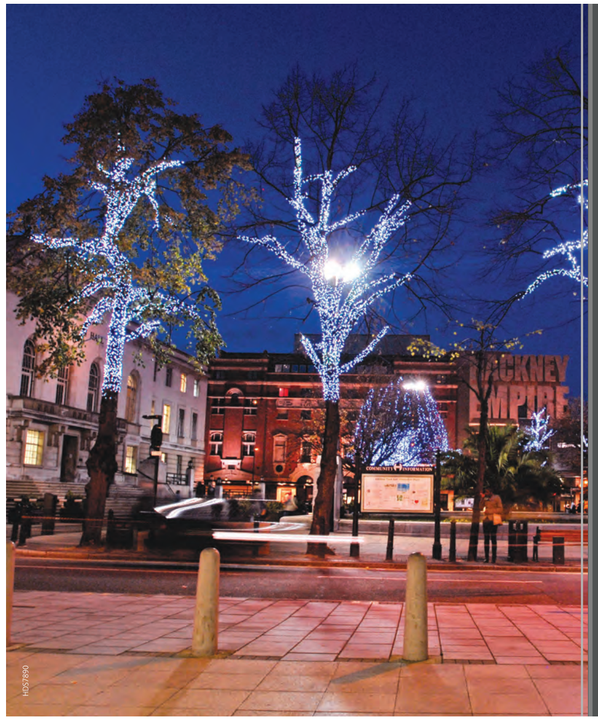
He was attracted to adult social care as he had always admired older people and felt they sometimes got a raw deal. "Older people have a wisdom and a sense of peace, and I'd always thought they were badly represented; I had an empathy with them and thought that I could bring something. The other thing that appealed was that care isn't seen as something that men want to do. I've always been a bit of an outsider, so I wanted to explore that."

▲ *Simon Wells on looking after older people: 'They have a wisdom and a sense of peace'*
PHOTOGRAPHY: HANNAH MAULIE FINCH

Today, 56-year-old Wells is a support worker at a home for 64 residents with differing needs, some with dementia, run by Anchor in Surrey. Every day is different: "There's a perception that care is a grotty job, that I must spend my time getting people ready for bed or changing them. But personal care is only a very small part of my day. I spend time socialising and entertaining residents. You aren't there to get things going all the time - it's about creating a homely atmosphere and sometimes it's just about sitting down and listening."

Wells, who completed a level 2 qualification in health and social care alongside continuing in-house training, thinks the rewards are "immense". He says: "Working in a reference library in Kensington and Chelsea was pretty shallow - I think the same can be said for a lot of intellectually based careers. But now I feel like I am making a difference - that I am part of a team that is committed to bringing quality of care and creating an atmosphere where people are happy."

And what added value does Wells think he brings as a career changer? "My experience of life."



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Cyngor Caerdydd Gwasanaeth Cymdeithasol
Cardiff Council Social Services

Mae Gwasanaethau Plant Caerdydd yn recriwtio Gweithwyr Cymdeithasol cymwys ar hyn o bryd

Mae Caerdydd yn lle gwych i fyw ynddo – dinas fywiog ac amrywiol. Mae'r Cyngor, drwy ei raglen Uchelgais Prifddinas, yn ymrwymedig i fynd i'r afael â gwraidd y rhesymau dros amddifadedd ac anghydraddoldeb drwy nifer o fentrau cyffrous gyda'r nod o leihau'r angen am wasanaethau cymdeithasol statudol.

Mae Caerdydd hefyd wrthi'n dechrau datblygu Gwasanaeth Cymorth Cynnar amlasiantaeth ar gyfer plant, pobl ifanc a theuluoedd er mwyn sicrhau bod pobl yn cael yr help iawn ar yr amser iawn cyn i bethau gyrraedd pwynt argyfyngus.

Ein dull yw cefnogi ein gweithwyr cymdeithasol wrth iddynt ddatblygu ymarfer rhagorol fel y gallant gynnig y canlyniadau gorau posibl i blant. Rydym yn cynnig amgylchedd gwaith cefnogol ynghyd â'r hyblygrwydd o weithio ystwyth.

Gwyddom y bydd angen i chi fod ar eich gorau felly byddwn ni yno i'ch cefnogi ar bob cam o'r ffordd. Gallwch ddisgwyl llwythi achos wedi eu diogelu a goruchwyliaeth reolaidd a byddwch yn gwerthfawrogi'r agwedd tîm yr ydym yn ei defnyddio i gefnogi plant a'u teuluoedd. Byddwch yn manteisio ar raglen hyfforddi eang yn ogystal â thîm rheoli gofalgar a fydd yn cymryd yr amser i wneud yn siŵr eich bod yn datblygu.

Rydym eisiau sicrhau bod gan Weithwyr Cymdeithasol yr amser a'r lle sydd eu hangen arnynt i wneud pob plentyn yn flaenoriaeth drwy roi pob unigolyn wrth galon ein gwaith. Mae'r tîm yn gweithio gan ddefnyddio dull seiliedig ar gryfderau (Arwyddion Diogelwch) i ddiwallu anghenion plant a'u teuluoedd.

Os ydych chi'n barod i dreulio amser yn gwrando ar yr hyn sydd gan blant i'w ddweud, yn datblygu perthnasoedd, a bod wrth ochr plentyn a'i deulu i'w helpu i gyflawni eu nodau a gwneud y newidiadau angenrheidiol, efallai mai hon yw'r swydd i chi.

Fel chithau, rydym yn gwybod bod angen ychydig o help ar deuluoedd pan fydd angen ymgysylltu â Gweithiwr Cymdeithasol – nid yw'r arferol yn ddigon da. Felly, os ydych chi'n Weithiwr Cymdeithasol creadigol a brwdfrydig, ar unrhyw gam o'ch gyrfa, sy'n credu bod gan blant yr hawl i fyw heb ofn a cham-drin a, lle y bo'n bosibl, gyda theulu sy'n eu caru ac sy'n gallu bodloni eu hanghenion, byddem wrth ein boddau'n clywed gennych.

I gael rhagor o wybodaeth am ein swyddi gwag presennol, ewch i **https://www.cardiff.gov.uk/CYM/preswylydd/Swyddi-a-hyfforddiant/Pages/default.aspx**

Os hoffech gael sgwrs anffurfiol am weithio yng Ngwasanaethau Plant yng Nghaerdydd neu os oes gennych unrhyw gwestiynau penodol, cysylltwch â Rachael Jones ar **02920 873847** neu e-bostiwch **RecriwtiorGwasanaethauCymdeithasol@caerdydd.gov.uk**

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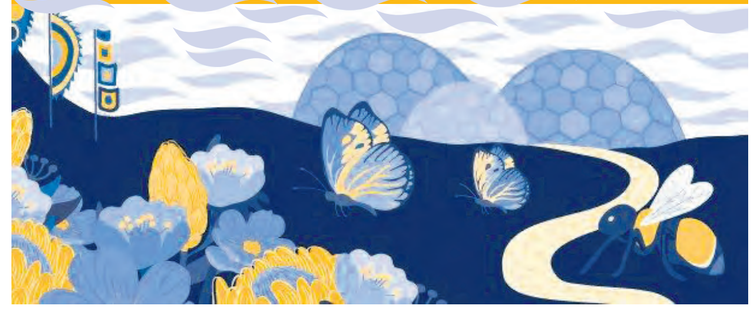

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
14 DECEMBER 2018
KENT AND MEDWAY HYPER-ACUTE STROKE UNITS

Report from: James Williams, Director of Public Health, Medway Council

Author: Dr David Whiting, Consultant in Public Health, Medway Council

Summary

The NHS in Kent and Medway is establishing three Hyper-Acute Stroke Units (HASUs). Medway Council believes that the sites that have been selected are not in the best interests of the health service in Kent and Medway. Furthermore, Medway Council believes that there were flaws in the way that the Joint Committee of Clinical Commissioning Groups was led to choose the selected sites.

Medway Council is asking the Joint Health and Wellbeing Board to consider the questions raised by Medway and to comment on the likelihood that Option D (which would locate HASUs at Medway Maritime, Tunbridge Wells and William Harvey Hospitals), would have emerged as the preferred option had questionable changes to the methodology and selection criteria not been introduced at a late stage in the process.

1. Budget and Policy Framework

1.1 Medway's vision for Adult Social Care is 'We will support the people of Medway to live full, active lives, to live independently for as long as possible, and to play a full part in their local communities'.

1.2 Our vision for Adult Social Care supports the delivery of Council Plan priorities, in particular 'Supporting Medway's people to realise their potential'; 'Older and disabled people living independently'; and 'Healthy and active communities'.

1.3 The proposed changes will have an impact on the delivery of stroke services for the residents of Kent and Medway. The Joint Board brings together system leaders across Kent and Medway to improve health and wellbeing outcomes across both Local Authority areas.

2. Background

2.1 The NHS in Kent and Medway wishes to establish three new specialist Hyper-Acute Stroke Units (HASUs) to "reorganise services so that specialist stroke staff can more consistently deliver high quality care around the clock, and in

so doing reduce deaths and long-term disability from stroke *for local people*."[1]

2.2 On 17 September 2018, the NHS in Kent and Medway published its preferred option for the three new units, with units in William Harvey Hospital (Ashford), Maidstone Hospital and Darent Valley Hospital.

3. Advice and analysis

3.1 Medway Council is concerned that the decision is not in the best interests of the health service in Kent and Medway and about how the Joint Committee of Clinical Commissioning Groups (JCCCGs) were led to make the decision. These concerns have been described in letters to the NHS (see Appendix 1) and the South East Clinical Senate (see Appendix 2).

3.2 Briefly, the concerns raised by Medway about the decision are that it fails to recognise that Medway is the largest and fastest growing urban area outside of London and that a larger proportion of stroke admissions in Medway are under the age of 75 than in Kent. The location of the HASUs outside of Medway will increase health inequalities. Nationally, there is clear evidence of inequalities in stroke incidence and outcomes, with higher rates in more deprived areas.

3.3 Secondly, Medway has raised concerns about capacity. It is understood that ambulance crews take patients to the nearest hospital, and it will not be possible to limit the number of patients that may come from outside of Kent and Medway to Darent Valley Hospital. Assurance is yet to be provided that there will be sufficient capacity for Kent and Medway patients in this scenario.

3.4 The independent review panel highlighted concerns about clinical leadership at two of the selected hospitals, and praised the clinical leadership at Medway hospital.

3.5 Medway has also raised a number of concerns about the process that led to this decision. These are described in detail in Appendices 1 and 2 and relate to changes in the way the selection criteria were evaluated and the process by which this change came about. In response to an FOI enquiry from Medway, see Appendix 3, it has been clarified that the decision makers were provided with inadequate time (less than 24 hours in a succession of meetings) to carefully consider the impact of fundamental changes to selection sub-criteria and decision-making methodology.

3.6 The changes appear to have been made to provide assistance to areas outside of Kent and Medway, in particular the Princess Royal University Hospital (PRUH), even though the NHS in Kent and Medway has said that the HASUs are being established to improve quality of care "*for local people"* (see 2.1 above).

3.7 The PRUH was included in some options but not others, after the public consultation, and then failed to deliver an implementation plan. This meant that any option that included the PRUH was penalised severely. As the PRUH had no intention of providing an implementation plan it should have been

[1] https://kentandmedway.nhs.uk/latest-news/identification-of-preferred-option-is-a-step-closer-to-improving-stroke-outcomes-in-kent-and-medway/

excluded from the evaluation of these options; the Kent and Medway patients that would have been affected by this could then have been reallocated to one of at least two other hospitals in Kent and Medway that are well within the desired travel-window.

3.8 Medway Council has submitted the letter in Appendix 1 to the regulator, NHS England, and have been told that the letter has been forwarded for response to the Chief Executive Officer of the Kent and Medway STP. Medway Council is yet to receive a response to the questions that have been posed in this letter.

4. Risk management

4.1 In 2016 the South East Clinical Senate published a review of the potential clinical implications for local hospitals not designated a HASU in any stroke reconfiguration. The evidence from this review highlighted a number of specific risks to the population of Medway as a result of the decision not to award HASU status to Medway Maritime Hospital.

4.2 Key risks include:

4.2.1 **Diagnosis and Treatment** - All specialist stroke physicians and nurses will be transferred from Medway Maritime Hospital to a HASU. This could impact on the initial treatment and care patients receive. Good practice in managing stroke requires all patients with symptoms of an acute stroke, to be urgently assessed and then discussed with the HASU. This initial triage requires maintenance of the appropriate clinical skills amongst the medical and nursing staff in the receiving specialties of the local hospital (mainly in A&E, acute medicine and elderly care). Failure to establish clear pathways between Medway Maritime Hospital and the designated HASU's could lead to disruption to the continuity of care, potentially causing slower recovery, greater clinical risk, and a longer length of inpatient stay.

4.2.2 **Early supported discharge (ESD)** - The aim of a HASU is to ensure appropriate treatment and care is provided in the acute phase of a stroke. Once patients are stabilised and deemed fit for discharge, they need to be transferred either home or to a suitable community setting for recovery. Medway social care teams will need to establish a mechanism to facilitate ESD for Medway residents at all 3 HASUs. This may impact on social care capacity to facilitate ESD within Medway Maritime and other Hospitals, for non-stroke patients.

4.2.3 **Rehabilitation** - The South East Clinical Senate review recommended that the provision of high quality, fully staffed and skilled specialist stroke rehabilitation services, is essential for good stroke care and patient outcomes. The new configuration of HASU's and movement of stroke care away from Medway Maritime Hospital, is likely to have an impact on Medway Council social care pathways for long term recovery (care home placement and supported living).

4.2.4 **Workforce** - Removing specialist stroke services, may impact on Medway Maritime Hospital ability to recruit clinical and therapy staff. This is in turn could destabilise remaining services (e.g. elderly care and therapies). This

would have a negative impact on council social care services and performance, for example Delayed Transfer of Care (DToC) targets.

4.2.5 **Family and carers** - It is anticipated there will be increased travel requirements for Medway families visiting relatives in a HASU. Additional travel costs will have a disproportionate impact on people from the most disadvantaged communities who may not be a position to pay fuel, taxi, public transport costs.

5. Financial implications

5.1 There are no direct financial implications for Medway Council resulting from this report.

6. Legal implications

6.1 A Joint Health Overview and Scrutiny Committee of Kent County Council, Medway Council, East Sussex County Council and Bexley Council (Joint HOSC) has been established to meet the requirements of health scrutiny legislation in relation to consultation by the NHS with these local authorities on proposed changes to Hyper Acute and Acute Stroke Services in Kent and Medway and it will be this Joint HOSC that will comment on the final decision making business case ahead of the Joint Committee of CCGs reaching a decision on the future configuration of Hyper Acute Stroke Services for Kent and Medway on 10 January 2019. (Regulations 23 and 30, Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013).

6.2 The four Councils involved in the Joint HOSC each have the ability to contest the proposed reconfiguration by referral of the matter to the to the Secretary of State for Health either because the Authority is not satisfied that consultation with Overview and Scrutiny on the proposal has been adequate in relation to content or time allowed or the Authority considers the proposal would not be in the interests of the health service in its area.

6.3 Once a final decision is made by the Joint Committee of Clinical Commissioning Groups (CCGs), which has delegated authority from each CCG, challenge is also possible by each Local Authority through the High Court exercising a review jurisdiction in judicial review. Any such challenge should be made within 12 weeks of the decision. The Court will exercise a review jurisdiction in circumstances where the decision has been made ultra vires (outside the powers of the decision maker), is “Wednesbury unreasonable” (no reasonable decision maker could have made the decision) or results in a breach of natural justice.

7. Recommendations

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to consider the questions raised by Medway and to comment on the likelihood that Option D (which would locate HASUs at Medway Maritime, Tunbridge Wells and William Harvey Hospitals), would have emerged as the preferred option had questionable changes to the methodology and selection criteria not been introduced at a late stage in the process.

Lead officer contact
Dr David Whiting, Consultant in Public Health, Medway Council. 01634 332636.
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Appendices
Appendix 1: Letter from the Leader of Medway Council to NHS England and the reply
Appendix 2: Letter from the Leader of Medway Council to the South East Clinical Senate and the reply
Appendix 3: Freedom of Information request to NHS after September 2018 meeting at which Option B was selected and responses from the NHS. (Excluding pack of papers and scores/summary scores referenced in questions 1 and 2 of FOI request)

Background papers
None

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Please contact:
Your ref:
Our ref: RC/RDM
Date: 08 November 2018

Medway Council
Serving You

Mr Ivor Duffy
Director of Assurance & Delivery
NHS England (KSS)
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Councillor Alan Jarrett
Leader
Medway Council
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Chatham
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Telephone: 01634 332514
Alan.jarrett@medway.gov.uk

Dear Mr Duffy

I am writing to you to express my deep concern about the decision to select Darent Valley, Maidstone and William Harvey Hospitals as the locations of the three HASUs in Kent and Medway.

My fellow councillors and I have concerns about the recommendation that the Joint Committee of CCGs made and the process by which they were led to the recommendation. I have enclosed my letter to the South East Clinical Senate (SECS) and the reply that we received from the SECS. In this letter I will not repeat the concerns expressed previously, but will provide additional justification for our concerns.

As you will be aware, the NHS consulted on five options, each consisting of three hospitals.

This Council believes that the decision to select Darent Valley, Maidstone and William Harvey Hospitals (Option B) is not in the interest of the health service in Medway, nor indeed, more widely the health service across Kent.

Our first concern is regarding capacity. We understand that ambulance services take patients to the hospital that has the shortest travel time and for many patients outside of Kent and Medway this will be Darent Valley Hospital. As there appears to be no way to limit the number of patients being brought from out-of-Kent and Medway we need to see evidence that this will not lead to patients from South East London over-whelming Darent Valley Hospital, should it become a HASU, resulting in insufficient beds for patients from Kent and Medway.

As well as capacity we are concerned by the observations of the independent assessment panel, and the way these were scored. The panel felt that Maidstone Hospital was "slightly insular looking" and "did not consider the whole of Kent and Medway or how they would work with other trusts." They also noted that there was "reliance on past progress and current performance as a marker of future success rather than a robust plan to deliver the new model of care", and yet Maidstone Hospital received the highest score of all the hospitals. Darent Valley "didn't tackle key

workforce and quality issues" and the panel had "concerns about the current level of clinical leadership in the Trust for the stroke programme". Nevertheless Darent Valley received a neutral score.

For Medway Maritime Hospital the panel noted the "impressive clinical leadership, experienced in this change." Whilst we acknowledge that they noted that a stronger plan was needed, this was also true of Maidstone Hospital; MMH received a negative score as a result, while Maidstone received a plus. It is hard to understand why Medway Maritime Hospital was scored so negatively given that it has the kind of clinical leadership and experience that is needed to create a successful HASU.

The observations of the independent panel lead us to believe that Maidstone and Darent Valley hospitals lack the leadership and attitude to deliver a HASU service for the population of Medway (and for the population of Kent).

Our concern regarding the process is that it appears that the decision was made to include Darent Valley Hospital (DVH) to assist the struggling Princess Royal University Hospital (PRUH) and the way the options were evaluated was modified to ensure that the Joint Committee of CCGs would be led to choosing an option that included DVH. The consultation was based on five criteria, each with sub-criteria:

1. Quality of care
2. Accessibility
3. Workforce
4. Feasibility
5. Finance

which were scored[1] through a series of engagement exercises resulting in a consensus score for each criterion. After the consultation period had ended the criteria remained the same, however, the mechanism for scoring the criteria was changed.

The NHS has claimed that this was necessary to help discriminate between the five options and argued that this is not a change in the process; however, it has substantially changed the assessment of the criteria. It is like saying that age is the criterion used to determine when someone can legally drink alcohol, and then changing the threshold at which this is permitted - (e.g. a "+" for over 18 becomes a "-"). The criterion has remained the same, but the way of using the criterion has changed.

The five criteria were ranked in order of importance in the consultation document[2] and the new approach to scoring the criteria meant that the first two, the two most important criteria, were neutralised, with all options having the same score whereas previously these criteria helped to discriminate between the options. This is the exact opposite of the rationale given for changing the way the criteria were scored. The new approach was signed-off by the Clinical Reference Group (CRG), however, the CRG was only given part of the information about the new approach to scoring the criteria one day before the meeting and further information at the meeting. During this meeting

[1] As ++, +, / , -, --

[2] Page 38, paragraph 2.

concerns were raised that this new approach neutralises the first two criteria, however with little time to properly consider the impact of this the group agreed to the approach. The CRG also did not see the impact of the approach on the remaining criteria.

I am puzzled by the lack of evidence behind the JCCG's assertion that William Harvey and Darent Valley can demonstrate better workforce mitigation compared to Medway Maritime Hospital. They share a workforce with on call consultant rotas and the shortages of relevant specialists affect all equally, a point made many times during the consultation and before.

With the first two criteria neutralised the recommendation was driven by criteria 4 and 5: feasibility and finance. In the public consultation reference was made to the PRUH however it was not explicitly included as part of any of the options. After the consultation period the PRUH was included in two options: C and D; the options that did not include DVH.

This meant that along with hospitals included in the options in the consultation, the PRUH was also required to submit a plan to demonstrate how it would expand to allow for patients from Kent and Medway for whom the PRUH would be the nearest HASU. The PRUH declined to do so, which substantially adversely affected the feasibility scores for options C and D.

It is now unclear to this Council whether the PRUH was or was not a part of Option D. If the PRUH is not willing to expand to accommodate Kent and Medway patients, then it should have been excluded from options C and D because ambulance crews would not be able to take patients to the PRUH. A fundamental aspect of the consultation was that patients should not travel more than one hour to get to a HASU; this is the justification for residents of Broadstairs, for example, being served by a HASU at William Harvey Hospital, approximately one hour away. Kent patients on the border would be within 45 minutes travel of Tunbridge Wells Hospital and Medway Maritime Hospital, two hospitals in Option D, and could therefore be taken safely to either of these hospitals. Therefore it seems irrefutable that Option D should only have included Medway, Tunbridge Wells and William Harvey hospitals.

The feasibility of option D was also adversely affected by the duration of implementation for Tunbridge Wells Hospital. This was noted as being excessively long by the independent review panel and could have been reduced. It is worth noting that during the consultation period a representative of Maidstone and Tunbridge Wells Trust (MTW) had stated that the Trust preferred the HASU to be at the Maidstone site rather than the Tunbridge Wells site.

The final criterion was finance. Option D increased substantially in costs from those in the consultation document, primarily due to a large increase in the costs to build a new education centre and car park at the Tunbridge Wells site. Option D also included increased costs for the PRUH, which as shown above, should have been excluded from Options C and D as the PRUH had no intention of taking additional Kent and Medway patients. With respect to Tunbridge Wells Hospital, the independent review panel "felt that all options hadn't been explored fully in the estates solution...meaning other plans should have been considered" and it is possible that other plans for Tunbridge Wells and the removal of the costs at the PRUH would have brought Option

D below the financial threshold, as well as being implemented in a reasonable timeframe.

Further support to our belief that the recommendation had been made to select Option B as the preferred option before the meeting of the Joint Committee of CCCGs was provided in a meeting between the NHS and councillors and council officers on 25 October 2018. When explaining why little had changed as a result of the consultation, as evidenced by the consultation report, yet the way the criteria were evaluated had changed considerably, including the inclusion of the PRUH, the NHS team stated that they "had further instruction from NHS England about the PRUH" after the consultation.

I would therefore ask NHS England to respond to the following questions:

1. Can NHS England explain why the scoring of the criteria was changed in a way that reduced the ability to distinguish between the options for the most important criteria when the objective was to provide greater distinction between the options?
2. Why was the Clinical Reference Group given so little time and information to review the changed approach to scoring the criteria?
3. Can NHS England please clarify whether or not the PRUH was part of Option D?
4. Why was the PRUH included in Options C and D in the final evaluation but not formally included in these options in the consultation documents?
5. Why was the PRUH included in Options C and D in the final evaluation when it has refused to submit an implementation plan? (It should have been excluded and patients from Kent on the border could have been diverted to Tunbridge Wells and Medway hospitals).
6. Why were the capital costs for the PRUH included in Options C and D when there was no plan for implementation?
7. Why were the comments from the independent panel about Tunbridge Wells needing to consider other implementation plans ignored?
8. Why were the comments from the independent panel about the quality of clinical leadership not considered appropriately and ignored in the final evaluation?
9. What "further instruction" did NHS England give to the Kent and Medway Stroke review team regarding the inclusion of the PRUH?

This Council is convinced that the process by which the CCGs were led to choosing Option B was flawed and that this option is not in the best interests of the health service in Medway and Kent more widely. We will also be pursuing our concerns through the statutory Joint Health Overview and Scrutiny Committee which may ultimately involve a referral to the Secretary of Health.

A timely response to this letter would be appreciated to enable us to prepare for the Joint HOSC discussions. Certainly we do not believe a final decision on the configuration of hyper acute and acute stroke services in Kent and Medway can be taken until these flaws in process have been addressed and a proper decision-making process put in place.

Medway Council reserves the right to seek further redress in this matter as it thinks necessary.

Yours sincerely

COUNCILLOR ALAN JARRETT
Leader
Medway Council

Encls.

cc: Reh Chishti MP, Gillingham and Rainham
Kelly Tolhurst MP, Rochester and Strood
Gordon Henderson MP, Sittingbourne and Sheppey

Appendix 1 - Reply from NHS England

By Email

Councillor Alan Jarrett
Leader
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Tel: 0113 8248575

21 November 2018

Dear Councillor Jarrett

Stroke Services Consultation – Kent and Medway

Thank you for your letter with regard to the Stroke Services consultation in Kent and Medway. Apologies for the delay in responding but I only received an electronic copy of the letter this morning.

I have reviewed the letter and the questions you pose are within the responsibility of the Clinical Commissioning Groups (CCGs) not NHS England. I have forwarded your letter to Glenn Douglas, Accountable Officer for the CCGs in Kent and Medway, to provide a response.

NHS England's role in service reconfiguration and transformation is that of assurance. It is the CCGs' role to consult on any proposed changes and to consider in their decision making the outcomes from the consultation. It is also their role to draw together the options and any shortlisting criteria. It is not NHS England's role to step in and influence a consultation and subsequent decision making process and it would be inappropriate for us to do so.

Kind regards.

Yours sincerely

Ivor Duffy
Director of Assurance and Delivery
NHS England South (Kent, Surrey & Sussex)

Copy To:

Rehman Chishti MP, Gillingham and Rainham
Kelly Tolhurst MP, Rochester and Strood
Gordon Henderson MP, Sittingbourne and Sheppey
Felicity Cox, Director Commissioning Operations, NHS England (Kent, Surrey, Sussex)
Glenn Douglas, Accountable Officer, Kent and Medway CCGs

Please contact: Julie Keith (01634 332760)
Your ref:
Our ref: JK/Stroke Review
Date: 12 October 2018

Mr Lawrence Goldberg,
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Councillor Alan Jarrett
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Dear Mr Goldberg,

Review of hospital-based urgent stroke services for people in Kent and Medway

I am writing to you on behalf of Medway Council, ahead of the South East Clinical Senate meeting on 18 October where you will be reviewing the decision making business case for the preferred option for reconfiguration of hyper acute stroke services across Kent and Medway. As you know the preferred option (B), published by the NHS in Kent and Medway on 17 September 2018, is to have hyper acute stroke units, alongside acute stroke units at Darent Valley Hospital in Dartford, Maidstone Hospital and William Harvey Hospital in Ashford.

At a meeting of Medway Council on 11 October 2018 the Councillors present resolved unanimously to ask me to make representations to you seeking a robust review by the Clinical Senate, of the methodology and evaluation process used to inform the selection of the preferred option for HASUs in Kent and Medway (taking into account the Council's concerns).

You will appreciate our very grave disappointment and concern that Medway Maritime Hospital does not feature in the preferred option despite being included in three of the five options under consideration and given the outcome of two pre-consultation impact analysis exercises completed by Mott MacDonald Group Ltd and by the Medway Public Health Intelligence Team which indicated that Option D (Tunbridge Wells Hospital, Medway Maritime Hospital and William Harvey Hospital) would have the greatest positive impacts and the least negative impacts for equality and travel and access. The NHS consultation material also clearly indicated the strength of Option D.

The Council's Health and Adult Social Care Overview and Scrutiny Committee met on 3 October with senior NHS Kent and Medway representatives present to explore how the methodology used had delivered a preferred option excluding Medway Maritime Hospital.

Very regrettably our request to NHS Kent and Medway on 18 September for access to the un-amended selection workshop documentation had been refused, forcing us to submit a request under Freedom of Information legislation, which had not been

responded to in time for our Overview and Scrutiny Committee meeting. This impeded the ability of Overview and Scrutiny Councillors to fully scrutinise the process and to formulate key lines of enquiry ahead of the meeting to test how an outcome has emerged which we believe will have a detrimental impact on health inequalities and outcomes for the population of Medway. We are concerned at this lack of transparency in relation to a process affecting a population in Medway of 280 000 people (with expected growth to 330 000 people by 2035) and a wider population of 500 000 people if you factor in the impact across Medway and wider North Kent. These concerns have also been expressed by Members of Parliament for Rochester and Strood, Gillingham and Rainham and Sittingbourne and Sheppey.

At the Overview and Scrutiny Committee meeting on 3 October the Members were advised of the rationale for the changes made to the evaluation sub-criteria ahead of the workshop on 13 September where the preferred option was chosen and the further work underway on mitigations relating to deprivation, journey times and rehabilitation.

However, Members of that Committee did not feel they received the assurances they were looking for in relation to the evaluation process and underpinning methodology. In particular, Members were concerned this process has failed to take into account the specific impact of disadvantage in Medway. Given Medway has higher rates of hospital admissions for stroke and TIA, in residents aged under 75, this is of concern.

An offer of a fuller in depth briefing has been made by the NHS but this could not be arranged before the Clinical Senate deadline for submission of the decision making business case, which has prompted us to ask for your support in testing the methodology underpinning the preferred option evaluation process.

Our Overview and Scrutiny Members will also be taking our concerns forward to the Joint Health Overview and Scrutiny Committee when it meets and potentially to the Secretary of State for Health under the power we have to contest and refer substantial health service changes.

There is a strong sense that after a review exercise taking 4 years the final stage of the process is being rushed resulting in an outcome that is not in the interests of the health service in Medway. For example, at the Joint HOSC meeting on 5 September Medway Councillors pointed out that the figures in the paperwork relating to the percentage of patients who would be able to access a hospital providing stroke services within a 30 or 45 minutes travel time, varied significantly for Option E compared to the percentages published during the consultation period. The effect of this was to move Option D from its position of offering the best travel times overall. This was of particular concern in view of the fact that the percentages for the other options had not changed significantly. Neither NHS colleagues, nor Carnall Farrar representatives were able to explain the discrepancies and after the meeting reported back that there had been a typographical error and that corrections needed to be made. We are now also being told that the final decision may be taken by the JCCG in December which provides little time for the full decision making business case to be scrutinised by the Joint HOSC in contravention of the legal obligation to allow adequate time for this.

All this together with last minute changes to the preferred option evaluation sub criteria and the refusal to provide us with timely access to the un-amended evaluation workshop documentation has undermined our confidence in the rigour, the fairness and frankly the bona fides of the process.

It is incomprehensible to Medway Council how methodology has been developed which has resulted in Medway Hospital being excluded as a site for a HASU given that it is serving the largest urban area in the South East outside London, with a population at greater risk of stroke due to the large number of elderly residents, high levels of deprivation and higher than average numbers of smokers. Medway Maritime Hospital is the only one of the seven hospitals in Kent and Medway that regularly treats over 500 stroke patients a year. Our hospital already has a wide range of supporting services needed to support stroke services making it ideally placed to become a hyper acute stroke service. On that basis it is not clear to Medway Council how any reasonable decision-maker could choose an option that does not include Medway Maritime Hospital as one of the HASUs. We understand, the Trust is itself is seeking feedback on how it has failed to be selected.

The particular questions we would ask the South East Clinical Senate to review when it meets on 18 October are as follows:

1. The time allowed for each of the Groups involved in the development of the evaluation criteria to assess and properly consider the last minute changes to sub criteria (ie the Evaluation Criteria working Group, Stroke Programme Board, Stroke Clinical reference Group and the JCCCG).
2. The rationale for changes made to the sub criteria and the impact these changes had on the capacity of the process to generate Option D as a preferred outcome – given Option D had been independently assessed as having the greatest positive impacts and the least negative impacts for equality and travel and access.
3. Why the preferred option selection process was allowed to proceed without an implementation plan from PRUH. It was argued previously that PRUH would experience a large flow of Kent and Medway patients if Options C or D were selected and an assurance was provided to the Joint HOSC on 5 September that PRUH would be required to present a plan to the Deliverability Panel.
4. How the estimated capital costs for Option D escalated from £36million (as published in the consultation documentation) to £49.7million at the workshop evaluation stage taking Option D to a place outside of the financial envelope of £38 million. This was an increase of nearly 38%. Option B also moved from being the fourth most expensive option at consultation stage to the least expensive in capital investment terms (reducing by £7.7 million). It is also mystifying how the NPV for Option B has increased by 208% since the consultation was launched but for Option D we see an improvement of only 17%. These massive shifts and discrepancies bring into the question the efficacy of the original options and also brings into question a selection methodology which has delivered an outcome which conveniently represents the least expensive in capital investment terms and most beneficial in terms of NPV (noting that at consultation stage Option B ranked fourth and fifth respectively for those factors).
5. The likely impact on the health service in Medway, and the wider population of North Kent, of an option being implemented which does not include Medway Maritime Hospital as one of the sites for a HASU in the context of deprivation. NHS Kent and Medway have stated they are working to mitigate risk arising from deprivation but are also publicly saying there is no evidence linking deprivation to prevalence of stroke. This latter statement flies in the face of the strong evidence that links socio-economic variation to stroke and poorer outcomes for disadvantaged populations in England[i] .

NHS Kent and Medway colleagues have acknowledged that the evaluation process is an art not a science and that there will be a degree of subjectivity. Medway Council would ask the South East Clinical Senate to rigorously review this process and to take into account the concerns we have for health equalities and outcomes for our population.

Please can this letter be provided to all members of the Senate before the meeting on 18 October and formally placed on record.

I look forward to hearing from you further.

Yours sincerely

COUNCILLOR ALAN JARRETT
Leader
Medway Council

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[i] Bray D, Paley L, et al (2018). Socioeconomic disparities in first stroke incidence, quality of care, and survival: a nationwide registry-based cohort study of 44 million adults in England. The Lancet Volume 3, ISSUE 4, Page 185-193, April 01, 2018. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30030-6/fulltext.
Accessed 2nd October 2018.https://doi.org/10.1016/S2468-2667(18)30030-6

NHS

South East Clinical Senate

Kent Surrey and Sussex

15 October 2018

Councillor Alan Jarrett
Leader, Medway Council
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South East Clinical Senate
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england.clinicalsenatesec@nhs.net

Dear Councillor Jarrett

Re: Forthcoming South East Clinical Senate review of the Kent and Medway stroke service reconfiguration draft decision making business case on 18 October 2018

Thank you for your letter of October 12th regarding the South East Clinical Senate's (SECS) forthcoming independent clinical review of the decision making business case (DMBC) for future stroke services in Kent and Medway due on October 18th. In your letter you outline two broad concerns through five questions you have posed to us, which I might summarise as:

- The process followed by the Kent and Medway stroke programme board in reaching the preferred option that does not include Medway NHS Trust as one of the three HASU/ASUs (relating to your questions numbered 1-4).
- Your concerns about the impact on the changes on the health service in Medway and the wider population of North Kent in the context of deprivation if Medway NHS Trust is not one of the three HASU/ASUs (your question 5).

In answering you, it is important for me to clarify the role of the clinical senate here, as against NHS England and its formal assurance role in service change (and as set out in NHS England's guidance document 'Planning, Assuring and Delivering Service Change for Patients', March 2018)[1]. Clinical senates exist to provide independent clinical advice and recommendations to healthcare commissioners and health systems. The clinical senate (composed of senior clinicians providing their clinical experience and expertise on a voluntary basis) is not constituted, skilled or tasked to review questions of process, nor of finance. When their input is invited, they can provide an independent, clinically focussed review of proposals for service change taking a population based approach that considers the health impacts of any planned change, with a focus on the coherence of clinical and patient pathways, the planned improvements in quality and outcomes, and the evidence base (where evidence exists).

[1] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

For this specific clinical senate review of the draft DMBC for the preferred option for future hyper-acute stroke units (HASUs) alongside acute stroke units (ASUs) in Kent and Medway, we agreed terms of reference with the requesting body, which was the STP's Clinical Board. The agreed aim was for 'the SECS to provide its advice on the final preferred option for stroke services configuration as part of the draft DMBC'. The review was 'to be of the draft DMBC, before the final DMBC is submitted for NHS England and NHS Improvement assurance', and the SECS 'will focus on the clinical elements of the DMBC'. On this basis, the SECS will be reviewing the various clinical aspects of the preferred option as described in the draft DMBC, not the process by which the preferred option was arrived at. It would be for NHS England to consider these as part of their formal assurance role.

In getting to this point in Kent and Medway's planning for stroke services, the SECS has provided input in the past through:

a) Review of the Case for Change for Stroke Services in Kent and Medway (June 2015)[2]

b) A review of the STP's draft proposals for future acute stroke services in Kent and Medway (Jan 2018). This was an independent clinical review of the draft pre-consultation business case

(PCBC), in which our recommendations were considered by the programme board before the PCBC was finalised and then went to public consultation. Our review of the draft PCBC was made available on line by the Kent and Medway team during the public consultation, and can be obtained from the K&M stroke programme team.

On the basis of our remit and role described above, your questions 1-4, that relate to process issues (Q1-3) or finance (Q4), are out with of the clinical senate's scope to answer or address. You may wish to consider referring these queries directly to NHS England- South East - Kent Surrey and Sussex.

In response to your fifth and important question, regarding the likely health impact on the population of Medway and North Kent in the context of the level of deprivation, if Medway NHS Trust does not provide a HASU/ASU service:

I can assure you that part of the forthcoming SECS review will include the consideration of access to high quality stroke services for the whole population of Kent and Medway, taking account of travel times and levels of deprivation their location. In that regard, thank you for sharing the recent Lancet Public Health article that shows the association of levels of deprivation with incidence of stroke and its risk factors[3]. The SECS has also previous provided an independent clinical review entitled 'Hospitals without Acute Stroke Units: a review of the clinical implications, and recommendations for stroke networks' (Jan 2016)[4], which although conducted for the Surrey clinical commissioners, it was a generic report relevant to any stroke reconfiguration, including that in Kent and Medway. I hope that will give you others confidence that we will be looking at the impact on hospitals and their local populations that do not have a HASU/ASU.

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[2] http://www.secsenate.nhs.uk/files/3914/4118/1216/SECS_Kent_and_Medway_Stroke_Services_Review_Report_June_2015.pdf

[3] Socioeconomic disparities in first stroke incidence, quality of care, and survival: a nationwide registry-based cohort study of 44 million adults in England. Bray B et al. Lancet Public Health 2018. https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(18)30030-6.pdf

[4] http://www.secsenate.nhs.uk/files/3814/5503/1676/Hospitals_without_acute_stroke_units__implications_and_recommendations._South_East_Clinical_Senate_Jan_Report.pdf

With kind regards

Yours sincerely

Dr Lawrence Goldberg MB ChB MD FRCP
Chair, South East Clinical Senate

Cc Ali Parsons, Associate Director, South East Clinical Senate

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Ref: FOI/GS/ID 4996 review

Please reply to:
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29 November 2018

Mr J Pitt
Jon.pitt@medway.gov.uk

Dear Mr Pitt

Freedom of Information Act 2000

I am writing in response to your request for a review of the information from Kent and Medway STP made under the Freedom of Information Act 2000 in relation to STTP Stroke JCCG workshop papers and associated information.

Original request	**Follow up 25/10**	**STP Response**
A full and un-amended copy of the documentation provided to those in attendance at the workshop and a copy of the power point presentation	This was not responded to appropriately as the Council would have expected this to have been formally provided to the person making the FOI request.	Thank you for your feedback. We have now sent a copy of these materials directly to Ms Keith.
The scores for each of the criteria and sub-criteria for each option and the summary scores that were generated from these;	Complete, however as per request 1, this was not sent to the person who made the request.	As above.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>Full details of the methodology used to derive summary scores for each option, including any summary sheets of combinations of options, e.g. the matrix;</td><td>Incomplete. The materials do not provide full details used to derive summary evaluations, e.g. how three pluses are summarised as a plus, and one plus with two neutral evaluations also equates to a plus. Please explain the rationale followed to derive the combined evaluations.</td><td>
Each of the five shortlisted options comprised three hospital sites. Individual sites were evaluated against each of the sub-criteria and assigned an evaluation ranging from double positive to double negative:
<table>
<tr><td>++</td><td>+</td><td>/</td><td>-</td><td>- -</td></tr>
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Individual site evaluations were then combined to give an overall ‘whole option’ evaluation.

At the PCBC stage, to identify the shortlist, this was done iteratively and in conversation during workshops attended by clinical and commissioning leaders from across Kent and Medway, as well as patient representatives and local councillors. However, this approach caused some confusion and there was concern that this might not always be consistent.

To ensure consistency at the post-consultation stage, a standard approach was developed. The Stroke Clinical Refence Group reviewed this standard approach and agreed it was a sound basis for combining individual site evaluations. They also specifically considered where this might be different to the evaluation in comparison for that done for the PCBC.

The approach agreed by the Clinical Reference Group was as follows:

If two or more of the sites within an option are assessed as double negative then the overall option is evaluated as a double negative
If one site within an option is assessed as a single negative then the overall option cannot be evaluated as double positive
If all sites are evaluated as single positives the overall evaluation cannot be double positive
A neutral evaluation cannot add or detract from the overall evaluation (i.e. two neutrals and one positive would equal a positive evaluation)

The impact of this standardised approach was that a double negative evaluation applied to a site within an option had more of an impact on the overall option evaluation than other evaluations. The rationale for this was to make explicitly clear in the overall evaluation matrix where options included a site with a double negative evaluation.

It is also important to note that for the overall option evaluations (as opposed to individual site evaluations) when two values were within 5% of each other, they were evaluated the same.

The table below shows where the standardised approach to evaluation, as opposed to any other factor such as refreshed data or new evaluation criteria, impacted the evaluation of an option.
<table>
<tr><th>Criteria</th><th>Option A

DVH, MMH, WHH</th><th>Option B,

DVH, MGH, WHH</th><th>Option C

MGH, MMH, WHH</th><th>Option D

TWH, MMH, WHH</th><th>Option E

DVH, TWH WHH</th></tr>
<tr><td colspan="6">Quality of care</td></tr>
</table>
</td></tr>
</table>

		Stroke co-adjacencies	No impact	No impact	No impact	Changed from ++ to +	No impact
		Co-adjacencies for mechanical thrombectomy	No impact	No impact	No impact	Changed from ++ to +	No impact
		Requirements for MEC	No impact	Changed from + to /	Changed from + to /	No impact	No impact
		Activity volumes	Not applicable – amended sub-criteria				
		Access to care					
		Blue light proxy	No impact	No impact	No impact	No impact	No impact
		Private car	No impact	No impact	No impact	No impact	No impact
		Workforce					
		Workforce gap	No impact	No impact	No impact	No impact	No impact
		Vacancy rates	Changed from / to -	No impact	No impact	Changed from - to - -	No impact
		Turnover rates	No impact	Changed from / to –	Changed from + to /	Changed from + to /	No impact
		Ability to deliver					
		Go live date	No impact	No impact	No impact	No impact	No impact
		Confidence in go live date	Not applicable: new sub-criteria				
		Quality of implementation plan	Not applicable: new sub-criteria				
		Value for money					
		Net present value	No impact	No impact	No impact	No impact	No impact
		Capital requirement	Not applicable: new sub-criteria				

The names of the groups that agreed this methodology and the amount of time they were given to review the methodology	Incomplete. To clarify this request, please advise how much time did participants in meetings that approved the standard approach	Please see below a table setting out the dates of each of the meetings referred to in the original email, the date papers for those meetings were circulated and the length of the meeting.

Meeting date	Papers circulated on	Meeting length
Clinical Reference Group		
27 July	26 July	2 hours
7 August	6 August	2 hours

before agreeing to it.	have to review the new approach to combining the individual site evaluations?	7 September	6 September	2.5 hours
		Stroke Programme Board		
		27 June	25 June	2 hours
		25 July	25 July	2 hours
		29 August	24 August	2 hours
		Stroke Joint Committee of CCGs		
		28 June	25 June	3 hours
		2 August	1 August	3 hours
		28 August	24 August	3 hours
		Evaluation workshop		
		15 September	N/A – papers were not circulated before the meeting	3 hours

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The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Yours sincerely

Gail Spinks
Head of Information Governance

FOI Applicant Feedback

Maidstone & Tunbridge Wells NHS Trust constantly reviews the services that we provide in order to ensure that we deliver the highest quality possible to our service users. In order to assist with this process we would ask you please to take a couple of minutes to provide us with some feedback with regard to the FOI service that you have been provided.

FOI Request reference Number	
Did you find it easy to make a request for information?	Yes / No
Did you receive an acknowledgement within a reasonable timeframe?	Yes / No
Are you satisfied that your request was dealt within a timely manner?	Yes / No
Did the response content address the requirement of your request?	Yes / No
What if anything do you feel the Trust could do differently to improve the FOI service for the benefit of our service users?	

Please send this completed form to:

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G Spinks
Head of Information Governance
Maidstone & Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
14 DECEMBER 2018
WORK PROGRAMME

Report from: Julie Keith, Head of Democratic Services

Author: Jade Milnes, Democratic Services Officer

Summary

The report advises the Joint Board of the forward work programme for discussion in the light of latest priorities, issues and circumstances. It gives the Joint Board an opportunity to shape and direct the Joint Board's activities.

The report also advises the Joint Board of a request to appoint Dr Bob Bowes as a member of the Joint Board, in his capacity as Chairman of the Strategic Commissioner Steering Group.

1. Budget and Policy Framework

1.1 On 20 February 2018 and 21 March 2018 respectively the Health and Wellbeing Boards of Medway Council and Kent County Council agreed to establish the Joint Board as an advisory sub-committee of the Kent and Medway Health and Wellbeing Boards as provided for in the Health and Social Care Act 2012.

1.2 The Joint Board has been established for a time limited period of two years commencing from 1 April 2018.

1.3 This Board facilitates a collaborative approach on the issues emerging from the Sustainability and Transformation Partnership (STP) for both Local Authorities. Given the responsibilities of both Local Authorities in social care and public health, there is a joint focus on the STP local care and prevention work streams.

1.4 With the agreement of the Joint Board, voting or non-voting Members from new structures that are emerging in Health may be included in the Membership.

2. Background

2.1 Appendix 1 to this report sets out the work programme. It should be noted that the work programme is likely to be subject to frequent changes and additions throughout the year and is for guidance only.

2.2 Members will be aware that agenda setting meetings are held on a regular basis. These give officers guidance on information that Members wish them to

provide on an issue. An agenda setting meeting took place on 8 November 2018.

2.3 At the meeting, the following was suggested:

2.3.1 To defer the Workforce: Kent and Medway Workforce Strategy from the December meeting to the meeting of the Joint Board on 19 March 2019. This would enable officers to align the Kent and Medway Workforce Strategy with the national Workforce Strategy expected to be published in December 2018, in line with the NHS 10 Year Plan.

2.3.2 To defer the report on Encompass Vanguard from the December meeting to the meeting of the Joint Board on 19 March 2019. This would facilitate the attendance of Dr John Ribchester, Clinical Lead and Chair Encompass MCP Vanguard.

2.3.3 That with respect to the standing agenda item concerning progress on the Prevention Strategy for Kent and Medway, that the deep dive on the final priority area, physical activity, be scheduled for June 2019.

2.3.4 That the Joint Board consider an item on Child and Adolescent Mental Health Services (CAMHS) in Kent and Medway. It is suggested that this item be scheduled on the work programme for September 2019.

2.4 At the agenda setting meeting, Members agreed to add a report setting out the details of the NHS 10 Year Plan to the agenda for 14 December 2018, if it had been published before the meeting. It is anticipated that the Plan will be published later in December and therefore it is suggested that this report be deferred to the meeting of Joint Board on 19 March 2019.

2.5 These amendments have been reflected in the work programme attached at Appendix A of the report for consideration by the Joint Board.

3. Dates for future meetings

3.1 Table 1 sets out the future meeting dates, including the provisional meeting dates for 2019/2020, and associated agenda despatch dates.

Meeting Date	Agenda Despatch
19 March 2019 4pm	11 March 2019
25 June 2019 2pm	17 June 2019
17 September 2019 2pm	9 September 2019
10 December 2019 2pm	2 December 2019
17 March 2020 2pm	9 March 2020

Table 1

3.2 Meetings within the 2019/20 municipal year (i.e. with effect from 25 June 2019) will be held at Kent County Council, Sessions House, County Hall, Maidstone, Kent ME14 1XQ.

4. Membership of the Kent and Medway Joint Health and Wellbeing Board

4.1 Appointment of an additional member

4.1.1 On 8 November 2018, at the agenda setting meeting for the Joint Board, it was reported that a request had been received to appoint Dr Bob Bowes to the Joint Board in his capacity as Chairman of the Strategic Commissioner Steering Group.

4.1.2 With the agreement of the Joint Board, voting or non-voting Members from new structures that are emerging in Health may be included in the Membership. The Strategic Commissioner Steering Group was established in February 2018 and provides leadership and oversight to the strategic development and thinking around the Strategic Commissioner function. On this basis it is recommended that Dr Bob Bowes be appointed as a member of the Joint Board in his capacity as Chairman of the Strategic Commissioner Steering Group to represent the views of Kent and Medway colleagues on this Steering Group.

5. Risk implications

5.1 There are no specific risk implications arising from this report.

6. Financial and legal implications

6.1 There are no specific financial or legal implications arising from this report.

7. Recommendations

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to:

7.1.1 agree the work programme attached at Appendix 1 to the report and to consider whether any changes need to be made;

7.1.2 consider and decide whether Dr Bob Bowes should be appointed as a member of the Kent and Medway Joint Health and Wellbeing Board in his capacity as Chairman of the Strategic Commissioner Steering Group and whether this should be a voting or non-voting position; and

7.1.3 note the provisional Joint Board meeting dates for 2019/2020 as set out at paragraph 3.1 of the report.

Lead officer contact
Jade Milnes, Democratic Services Officer
Telephone: 01634 332008, Email: jade.milnes@medway.gov.uk

Appendices
Appendix 1 – Work Programme

Background papers
None

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KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD WORK PROGRAMME

Please note, the following items are standing items on each agenda. By agreement of the Joint Board the focus of the item will be determined by the Joint Board and the Work Programme will be updated to reflect this.

a) Progress on Prevention Strategy for Kent and Medway

The Joint Board will explore the following priorities in more depth:

- Reducing Tobacco usage prevalence (19 October 2018)
- Reducing Obesity prevalence (14 December 2018)
- Reducing Alcohol Consumption (19 March 2019)
- Physical activity (25 June 2019*)

b) Progress on Local Care including Local Care Implementation Board

c) Workforce

d) Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities

Meeting Date (despatch date)	**Item**
19 March 2019 (11 March 2019)	Progress on Prevention Strategy for Kent and Medway, focus area: • Reducing alcohol consumption
	Progress on Local Care including Local Care Implementation Board
	Workforce: Kent and Medway Workforce Strategy
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities
	Encompass Vanguard
	NHS 10 Year Plan
25 June 2019* (17 June 2018)	Progress on Prevention Strategy for Kent and Medway, focus areas: • Physical activity
	Progress on Local Care including Local Care Implementation Board
	Workforce

	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities
17 September 2019* (9 September 2019)	Progress on Prevention Strategy for Kent and Medway
	Progress on Local Care including Local Care Implementation Board
	Workforce
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities
	Kent and Medway Child and Adolescent Mental Health Services (CAMHS)
10 December 2019* (2 December 2019)	Progress on Prevention Strategy for Kent and Medway
	Progress on Local Care including Local Care Implementation Board
	Workforce
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities
17 March 2020* (9 March 2020)	Progress on Prevention Strategy for Kent and Medway
	Progress on Local Care including Local Care Implementation Board
	Workforce
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities

* Please note, these meeting dates are provisional.

Medway Council

Meeting of Kent and Medway Joint Health and Wellbeing Board

Friday, 14 December 2018

9.35am to 12.00pm

Record of the meeting

Subject to approval as an accurate record at the next meeting of this committee

Present:

Councillor Sarah Aldridge, Swale Borough Council, Cabinet Member for Health and Wellbeing
Councillor David Brake, Portfolio Holder for Adults' Services, Medway Council (Chairman)
Councillor Howard Doe, Deputy Leader and Portfolio Holder for Housing and Community Services, Medway Council
Glenn Douglas, Accountable Officer for the eight CCGs in Kent and Medway and Chief Executive of the Kent and Medway STP
Cath Foad, Chair, Healthwatch Medway
Mr Graham Gibbens, Cabinet Member for Adult Social Care and Public Health, Kent County Council
Penny Graham, Heathwatch Kent
Chris McKenzie, Assistant Director - Adult Social Care, Medway Council
Mr Peter Oakford, Deputy Leader and Cabinet Member for Finance and Traded Services, Kent County Council (Vice-Chairman)
Councillor Martin Potter, Portfolio Holder for Educational Attainment and Improvement, Medway Council
Andrew Scott-Clark, Director of Public Health, Kent County Council
Councillor Tony Searles, Sevenoaks District Council
Caroline Selkirk, Managing Director of Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCGs
Dr Robert Stewart, Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation
Ian Sutherland, Director of People - Children and Adults Services, Medway Council
James Williams, Director of Public Health, Medway Council

Substitutes:

Councillor David Carr, Medway Council (Substitute for Councillor Alan Jarrett, Medway Council)
Anne Tidmarsh, Director Older People Physical Disabilities, Kent County Council (Substitute for Penny Southern, Kent County Council)

In Attendance:

Sharon Akuma, Legal Services, Medway Council
Cathy Bellman, Kent and Medway STP Local Care Lead
Karen Cook, Policy And Relationships Adviser (Health), Kent County Council
Rachel Jones, Senior Responsible Officer, Kent and Medway Stroke Review, Kent and Medway STP
Julie Keith, Head of Democratic Services, Medway Council
Jade Milnes, Democratic Services Officer, Medway Council

633 Chairman's Announcement

The Chairman of the Joint Board advised Members of recent updates to the Membership of the Joint Board. It was explained that Penny Graham had been nominated as the representative for Healthwatch Kent on the Joint Board and that owing her new position on Medway's Children and Young People Overview and Scrutiny Committee, Margaret Cane had resigned from her position as named substitute for Healthwatch Medway on the Joint Board.

634 Apologies for absence

Apologies for absence were received from Councillor Alan Jarrett (Leader, Medway Council), Mr Paul Carter, CBE (Leader Kent County Council and Cabinet Member for Health Reform) and Mr Roger Gough (Cabinet Member for Children, Young People and Education, Kent County Council), Dr John Allingham (Kent Local Medical Committee), Matt Dunkley, CBE (Corporate Director for Children, Young People and Education, Kent County Council), Matthew Scott (Kent Police and Crime Commissioner) and Penny Southern (Corporate Director Adult Social Care and Health, Kent County Council).

635 Record of Meeting

The record of the meeting held on 9 October 2018 was agreed and signed by the Chairman as correct.

636 Declaration of Disclosable Pecuniary Interests and other interests

Disclosable pecuniary interests

There were none.

Other interests

There were none.

637 Urgent matters by reason of special circumstances

There were none.

638 Obesity Deep Dive

Discussion:

The Director of Public Health for Medway Council presented the Joint Board with a detailed review of the prevalence of overweight and obesity in Kent and Medway. He noted that this was a significant problem caused by complex personal, social and environmental factors. He explained that a whole system approach to weight management was required, including different interventions targeted at different segments of the population.

The importance of considering factors such as making adaptations to the physical environment and facilitating other means of transport, like cycling, to encourage individuals to increase their physical activity levels was emphasised. He added that it was important to make a healthy choice the easy choice. An example of how the Local Authority could assist in this endeavour was by prohibiting fast food establishments from opening within 400m of a school.

He drew the Joint Board's attention to the data set out in section 3 of the report, which provided a review of the prevalence of overweight and obesity in children and adults in Kent and Medway, benchmarked against national performance. It was noted that prevalence was generally higher in disadvantaged communities. The Director of Public Health also highlighted trends in relation to bariatric surgery admissions in Kent and Medway. It was noted that nationally the rate of bariatric surgery admissions had decreased from 2011/12 to 2016/17. The same trend had been observed in Kent whilst in Medway, the rate had remained statistically stable.

The Joint Board was advised that weight management services were categorised into four tiers. Examples of Tier 1 and 2 services and interventions implemented in Kent and Medway were drawn to the attention of the Joint Board and were set out at paragraphs 3.26 to 3.46 of the report. Tier 4 services included bariatric surgery. It was recognised that there was a pressing need to focus on Tier 3 specialist weight management services.

Members raised a number of points and questions, including:

Workplace - A Member observed that there was a disconnect between leaving full time education and taking up employment. It was explained that at school there was an expectation that young people would engage with sports, but once individuals left school and entered the workplace, the opportunity for this was reduced. As such, there was an argument to persuade employers to help create active habits. In response, Medway's Director of Public Health explained that the impact of work on health was well recognised and employers were encouraged to support a healthy workplace. He added that Medway Council's Public Health Team ran a workplace health award scheme which encouraged employers to improve staff physical activity by, for example encouraging staff to change the way they travel to work and encouraging staff to use stairs. He noted that Kent County Council also employed workplace initiatives. It was recognised that more could be done.

Accessibility - In response to concerns expressed regarding accessibility to physical activity and leisure services for children and young people with Special Educational Needs (SEN), Medway's Director of Public Health recognised that children with SEN were more likely to be overweight or obese. Members were advised that further information would be presented to the Joint Board in the report on Learning Disabilities Health Checks and the outcome of the review set out at paragraph 3.39 of agenda item 6 (NHS Health Checks). It was noted that Medway Council's School Health Service would work with Leisure Services on practical solutions to improve accessibility.

Challenges - Kent County Council's Director of Public Health set out three key challenges in relation to tackling obesity. These were:

1. **Healthy diet** - he emphasised the importance of a healthy diet as well as physical activity. It was explained that in some instances people did not know how to cook, what was in their food or where it came from.
2. **Effective weight management services** - it was explained that being overweight or obese could bring physical, emotional and psychosocial health problems which could cost the Health Service a significant sum of money in the long term, owing to ongoing treatment costs. Acute and chronic mental health issues were particularly evident in individuals accessing Tier 3 weight management services. It was noted that there were no Tier 3 services in place across Kent and Medway to support eligible 5-19 year olds and a view was expressed that NHS partners needed to address this. He stated that it was important that Tier 1, 2 and 3 services were functioning effectively and that interventions were joined up and systematic.
3. **Targeting interventions** – using the example of the Kent One You Service, he advised Members that on reflection, whilst the marketing campaign was considered to be very good, aspects, such as the form which was required to be filled in to establish whether individuals meet the entry criteria, were too complex. He expressed a need to change the language of interventions to target different populations.

Interventions - A Member highlighted the importance of encouraging individuals to be active and make healthier choices and stressed the positive impact participation in sport can have on this. Kent County Council's Director of Public Health agreed with this position and explained to the Joint Board that if individuals are told what to do, they most likely would not listen. Referring to Sevenoaks District Council as an example, he explained that social marketing had been used effectively to convey simple messages and people had responded positively. Medway's Director of Public Health reiterated that a number of approaches were required to tackle obesity and he explained that interventions which worked well in one locality would need to be tweaked or shaped to ensure a good outcome in a different area.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the report; and

b) requested a detailed report which provides more information on programmes available to support weight management and effective ways to communicate this.

639 NHS Health Check Deep Dive

Discussion:

Kent County Council's Director of Public Health introduced the report which presented a detailed review of the implementation and outcomes of the NHS Health Check Programme in Kent and Medway. It was explained to the Joint Board that the Health Check was a national cardiovascular screening programme which sought to assess an individual's risk of developing cardiovascular disease and take appropriate action where required.

Local Authorities had a statutory obligation to offer an NHS Health Check to 100% of eligible people over a period of five years and seek continuous improvement in the number of people having an NHS Health Check each year. Public Health England (PHE) aspired to achieve a national take up rate in the region of 75% of the eligible population receiving a health check once every 5 years. The overall Kent and Medway performance was set out at paragraph 3.19 of the report.

It was emphasised that the NHS Health Check Programme was a critical element of the prevention workstream because it aimed to prevent diseases with a cardiovascular component such as heart disease, stroke, type 2 diabetes, as well as dementia and, in general, prevent people progressing to frailty. The programme also provided a significant opportunity to address health inequality and reduce early death.

The Joint Board was advised that Kent and Medway had invited the whole eligible cohort. He explained that the focus now needed to be on how individuals could be encouraged take up the offer of a Health Check and ensuring that GPs undertake the necessary diagnostic work, referring individuals to the appropriate lifestyle support to manage their health risk.

In response to a question regarding the services available for individuals aged 75 and over, above the upper threshold of eligibility, and a question asking how routine health testing could be normalised at earlier age, i.e. below the age of 40, the lower threshold for eligibility, the Joint Board was advised that the age range was nationally mandated. With respect to the query on the upper threshold, Kent County Council's Director of Public Health considered that at the age of 70 most individuals would already be on the GP register and therefore likely to be receiving adequate support. Referring to the prevalence of

cardiovascular disease in the poorest communities, he explained that with respect to the lower threshold, starting Health Checks at the age of 40 would provide two opportunities to provide health interventions (it was noted that in disadvantaged communities healthy life expectancy was as low as age 52). He expressed a view that for some populations where the cardiovascular risk was high, the age range should be lowered. However, he noted that the challenge in this respect would be affordability.

A Member commented that Health Checks had a positive impact on the health of an individual and were cost effective for the health service in the long term as ill health was prevented. As result, it was considered that this was a useful argument to lower the age threshold. With respect to the upper threshold, the Member commented that clarity was needed on support available to individuals aged over 75.

Kent County Council's Director of Public Health commented that whilst trained professionals were needed to undertake a Health Check, this did not need to be a GP and could be, for example a practice nurse. It was added that individuals outside the age criteria could be offered a Health MOT, which would measure weight and blood pressure and could help individuals familiarise themselves with the tests at an earlier age.

It was recognised that people respond well to data and Medway's Director of Public Health explained that tools were available to help individuals measure and monitor their own health, for example apps on a smartphone and smartwatches. He stressed the importance of encouraging individuals to take responsibility for their own health and the importance of self-care and self-management.

A Member commented that cardiovascular disease was not a disease of older people but rather young people and expressed that people may not appreciate the need for a Health Check. Another Member expressed support for lowering the age threshold and commented that introducing a focused test within the workplace at age 30 would be beneficial.

A Member suggested that officers review the age thresholds. In response, the Director of Public Health for Medway Council recognised that the suggestion to expand the age range for the eligibility criteria for Health Checks was positive, although the age range was prescribed nationally. He advised the Joint Board that a key priority area was increasing the current number of eligible people taking up an NHS Health Check invite per year, as only circa. 40% of the population at risk had accessed this service in 2017/18. It was particularly important to reach more challenged areas such as disadvantaged communities and support individuals who were not currently eligible to take more care of themselves and signpost them to existing support available. The Director of Public Health for Kent County Council expressed support for focusing on illness prevention and increasing uptake of Health Checks offered. He suggested that an analysis could be undertaken on the cohort of the eligible population that continued to be eligible over 70, it was considered that this cohort would be small. By way of a summary, the Chairman asked officers to take into account

the points raised during the discussion and report back to the Joint Board. It was noted that much of the discussion had centred on communication and the Director of Public Health for Kent County Council undertook to revert back to the Joint Board with a communications report.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the difference in uptake between the most affluent areas of Kent and Medway and the most disadvantaged;

b) agreed to work with the NHS to increase the uptake of Health Checks across the eligible population; and

c) agreed that the following reports be added to work programme for the June meeting of the Joint Board:

- Learning Disabilities Health Checks and the outcomes of the review set out at paragraph 3.39 of the report; and
- Health Check Communications Report.

640 Sustainability and Transformation Partnership (STP) Local Care Update

Discussion:

The STP Local Care Lead summarised amendments made to the governance arrangements for Local Care. This included the establishment of a new, smaller strategic Local Care Board which would be comprised of senior leaders from key organisations involved in the commissioning and delivery of Local Care services across the Kent and Medway health and social care system. She explained that the existing Local Care Implementation Board (LCIB) would not be disbanded, as this Board had been invaluable in bringing together a wide range of organisations. However, it was noted that the focus of LCIB would be amended. It was considered that this Board would be a “learn and share” Board, in which practical information to support the delivery of Local Care could be discussed. Owing to the emergence of Primary Care Networks (PCNs), the STP Local Care Lead also explained that the Local Care Workstream was working to align to the newly formed Primary Care Board with the delivery of Local Care.

The Joint Board was advised that the Local Care deep dives for East Kent and Medway, North and West Kent, set out at section 4 of the report, were held on 23 November 2018 and 11 December 2018 respectively. The STP Local Care Lead undertook to circulate a more detailed update from the deep dives to the Joint Board, but summarised the key themes which had emerged, this included:

- **Workforce challenges** - It was explained that attendees concluded that a holistic workforce plan across the Kent and Medway STP was required. They asked whether there were suitable and sufficient resources working in an integrated manner on pathways for

discharge/transfers of care and they established that there was a need to align resources to, and improve Multidisciplinary Team/s (MDTs) working. A need was also established to utilise the existing workforce better and to consider whether it could be made easier for staff to rotate across organisations, i.e. a staff "passport". It was considered that the latter could help with the recruitment and retention of staff.

- **Primary Care** – It was explained that attendees expressed support for the development of PCNs and the Local Care workstream working in collaboration with PCNs. It was added that the optimum conditions for PCN development needed to be defined and the importance of GP continuity was stressed.
- **Investment and Implementation** – It was explained that whilst £32M was actively being invested in Local Care, attendees considered that there was a need to secure a sustainable investment for Local Care going forward. A need was also expressed to increase the scale and pace of implementation. Enquiries were also made into how organisations could work towards a shared finance and risk framework.
- **Estates** – It was explained that attendees considered the possibility of a one public sector estate and working with local authorities to solve some of the estates funding challenges for the NHS. Further considerations included how best use could be made of non-acute beds, including extra care housing and what was the Kent and Medway step up and step down bed strategy.
- **System Governance** - It was explained that attendees expressed a need to: harmonise plans as each sub-system had their own; use consistent language; have shared metrics and comparators and an agreed framework for measurement across Kent and Medway; and a single point of entry/access across Health and Social Care. Further considerations included how partnerships could be leveraged for the benefit of Kent and Medway e.g. joint commissioning.
- **Outcomes** – It was explained that an outcomes framework would be developed from the information obtained from the deep dives. This would be presented to Local Care Board in February 2019.

Lastly, the STP Local Care Lead drew the Joint Board's attention to an update on actions for winter pressures, set out at section 6 of the report, and information on how Local Care was supporting carers and care navigation, as set out at section 7 of the report.

A Member expressed support for having a strong focus on Local Care. A Member also considered that it was important to embed prevention into Local Care and asked that consideration be given on how this could be achieved. It was also considered that it was important for the work of the Design and Learning Centre to fit with Local Care.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the content of this joint report, including the verbal update on the Local Care deep dives;

b) agreed that at its next meeting, on 19 March 2018, the Joint Board be presented with a report which sets out greater detail on the Local Care deep Dives and progress on the outcomes framework; and

c) considered the scope of the deep dives in relation to support for carers and support for growing the voluntary sector as set out in paragraph 7.5 and 7.6 of the report respectively and agreed that these be scheduled on the work programme for September 2019.

641 Sustainability and Transformation Partnership (STP) Strategic Commissioner and System Transformation Update

Discussion:

The Accountable Officer for the Kent and Medway CCGs and the Kent and Medway STP Chief Executive provided an update on the establishment of a Strategic Commissioner for Kent and Medway and provided details on the expected implications for the wider system and the development of an Integrated Care System and Integrated Care Partnerships across Kent and Medway.

It was explained that there was an expectation that within the next iteration of the NHS 5 Year Plan, Sustainability and Transformation Partnerships (STPs) would transform into Integrated Care Systems (ICSs). In most cases it was expected that these ICSs would follow the existing boundaries of their STPs, however, not in all cases, for example Frimley. Nationally, there had been a debate on how ICSs could incorporate provision and regulatory functions and the thoughts were further developing.

The Joint Board was advised that the Strategic Commissioner would operate at a Kent and Medway level, facilitating commissioning at scale of core services. It was explained that at present discussions were ongoing regarding how to achieve cooperation for commissioning across Kent and Medway and what functions would be retained at a local level or transferred to the strategic Kent and Medway level. It was noted that it had been agreed that one of the first remits of the Strategic Commissioner function would be cancer care. It was added that in the longer term the Strategic Commissioner may also have regulatory functions as well as commissioning functions, as the NHS landscape changes. It was noted that the Strategic Commissioner would commission outcomes.

These outcome based procurements would be commissioned from Integrated Care Partnerships (ICPs), a group of providers who respond to a required

outcome as specified by the Commissioner. It was noted that across Kent and Medway these partnerships had already started to emerge through the utilisation of aligned incentive contracts. West Kent was considered the most advanced. The Joint Board was advised that East Kent had not yet utilised these types of contract but the CCG and providers were working together and it was considered that the next steps would be enter into some form of aligned incentive contract. With respect to Medway and Swale, the Joint Board was advised that providers in both areas were working together and that the current assumption was that these two areas were likely to form a partnership, although there was some further thought to be given to this, as there was some merit for Swale joining with West Kent.

The last tier in the emerging arrangements would be Primary and Local Care Networks, which were set out in further detail at paragraph 4.3.4 of the report.

With respect to Local Authority engagement, the Accountable Officer for the Kent and Medway CCGs and the Kent and Medway STP Chief Executive expressed a view that Upper Tier Local Authorities should be engaged at all levels of the new arrangements. It was noted that lessons could be learnt from Local Authority commissioning.

It was added that the Kent and Medway Joint Health and Wellbeing Board was well placed to be fully integrated into the governance of the arrangements.

A Member welcomed the opportunity to connect NHS and Local Authority commissioning. However, he expressed concern in relation to emergency planning and sought assurances that the NHS had plans in place to manage emergencies, such as a no deal Brexit. In response, the Joint Board was advised that a new member of staff was transferring to Kent who was well placed to take this forward and the Joint Board was asked to consider whether emergency planning should be added to the Board's work programme.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the update on establishing the Strategic Commissioner and the development of the Integrated Care System in Kent and Medway; and

b) agreed that emergency planning be added to the Joint Board's work programme within the standing agenda item 'Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities'.

642 Briefing Paper: The Kent Joint Strategic Needs Assessment

Discussion:

Kent County Council's Director of Public Health introduced the report which sought support for a proposal to develop the Kent and Medway Case for

Change to incorporate Kent and Medway's Joint Strategic Needs Assessment (JSNA) and thereby better reflect the needs of the Kent and Medway population. It was explained that that following the publication of the NHS 10 year plan, the Case for Change would need to be revisited and as the Case Change would drive NHS commissioned services, a strategic JSNA would provide greater clarity on the needs of the Kent and Medway population.

It was reiterated that Kent County Council's and Medway Council's JSNA development and publication process will continue to be maintained by each Local Authority separately.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the paper;

b) noted that Kent County Council's and Medway Council's JSNA development and publication process will continue to be maintained by each authority separately; and

c) recommended further discussion by the Health and Wellbeing Boards of Kent County Council and Medway Council on the proposal that the Case for Change for the STP could be developed to incorporate the JSNA's for Kent and Medway in the longer term.

643 Design and Learning Centre Update

Discussion:

The Clinical Design Director, the Design and Learning Centre for Clinical and Social Innovation provided a presentation on the work of the Design and Learning Centre (DLC). He explained in detail four key work pillars, these were:

1. **Innovation** - The Clinical Design Director set out the innovation priorities which included:
    - working with the Kent and Medway Joint Health and Wellbeing Board and the Sustainability and Transformation Partnership (STP) across the priority area, Local Care;
    - working in collaboration with the Academic and Health Science Network (AHSN) to find innovative solutions to challenges set by the STP Clinical and Professional Board and social care; and
    - Using an agreed methodology to test the innovations and to roll out at scale / co-implementation if the evaluation proves positive.

2. **Learning and Development** - The Clinical Design Director explained that the DLC was established as the Kent and Medway STP Learning Hub and he set out the learning and development priorities which included:
    - rolling out the Carers App;

- developing an STP "offer" to the new Kent and Medway Medical School; and
- working directly with the wider care sector and supporting recruitment, retention and new career opportunities for this sector as well as clinical staff including portfolio careers.

3. **External and International Funding** - The Clinical Design Director set out the external and international funding priorities which included:
    - supporting innovation initiatives;
    - applying for further funding to pilot and evaluate new initiatives. It was noted that a series of funding bids had already been submitted including a bid of £10M for the Ebbsfleet Intergenerational Housing and Technology Project; and
    - the EU Buuertzorg Neighbourhood Care Model which had received £4.5M funding to enable health and social care teams to determine how best to meet the needs of their caseload across Kent and Medway.

4. **Engagement, Research, Analytics and Co-implementation** - The Clinical Design Director set out the engagement, research, analytics and co-implementation priorities which included:
    - running innovation workshops and forums for key STP priorities including, Local Care, End of life, Carers App and Being Digital;
    - facilitating the wider academic, analytical and research network including the Medway and Swale Centre of Organisational Excellence (MaSCOE) for the Clinical and Professional Board and other stakeholders; and
    - co-implementing successfully evaluated solutions, reducing the need for more local pilots.

The Joint Board was advised that the DLC had a new collaborative arrangement, focussing on technologies and solutions to meet the challenges set by the Clinical and Professional Board. The first three challenges were across the Primary/ Local Care topic areas of diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD).

The Clinical Design Director drew the Joint Board's attention to the DLC's current successes, this included the ESTHER Care Philosophy. Detailed information on this initiative was set out at paragraphs 4.5 to 4.10 of the report and it was explained that it had been featured in the Guardian Social Care Supplement set at out at Appendix 1 to the report. Other successful projects included: the Being Digital Strategy, the aforementioned Buuertzorg Neighbourhood Care Model and the Medication Compliance Project.

Lastly, it was explained that the DLC was working with Public Health on the following initiatives:

- Increasing bystander response through the Push Project - Giving 10 minutes of life (Cardiac compression project in schools in Medway).

- Antibiotic Reduction Challenge which aimed to reduce antibiotic prescribing by up to 50% (trials of blood testing had been completed at sites in Swale CCG area, and were underway in West Kent and the South Kent Coast CCG areas).

Decision:

The Chairman of the Joint Board thanked the Clinical Design Director for his comprehensive presentation and the Kent and Medway Joint Health and Wellbeing Board:

a) noted the work of the Design and Learning Centre (DLC), how it is leading and supporting clinical and social innovation and providing support to the Sustainability and Transformation Partnership and Adult Social Care and Health;

b) noted the collaborative arrangements in place with the Academic and Health Science Network (AHSN) to streamline the support and enabling offer to the Sustainability and Transformation Partnership and the work commencing on the first challenge issued by the Clinical and Professional Board to the Collaborative;

c) noted the work the DLC is doing with Public Health on antibiotic reduction and the PUSH project;

d) supported the Design and Learning Centre in working with the Sustainability and Transformation Partnership (STP) to develop an offer to the new Kent and Medway Medical School;

e) noted the work of the DLC in establishing the Learning and Development Hub for the wider Care workforce aiming to improve recruitment, retention and career progression and supporting new delivery models for care providers;

f) noted the Digital developments the DLC is leading for Adult Social Care and Health and the STP and the Innovation methodology used; and

g) noted the ability by the DLC to access external and international funding.

644 Kent and Medway Hyper-Acute Stroke Units

Discussion:

The Chairman welcomed Rachel Jones, Senior Responsible Officer (SRO) for the Kent and Medway Stroke Review, who was present at the meeting to answer questions from Members in relation to the review of urgent stroke services in Kent and Medway. He thanked her for attending.

The Director of Public Health for Medway Council explained to the Joint Board that whilst Medway Council welcomed the creation of Hyper Acute Stroke Units

(HASUs) there were some concerns in relation to the preferred option which had been selected by the Joint Committee of CCGs, option B. He drew the Joint Board's attention to the concerns set out in section 3 of the report, in particular he questioned whether option B took proper account of population growth and disadvantage levels in Medway and other localities across Kent, namely Swale and the South Kent Coast.

He also highlighted the clinical implications for local hospitals who would not be designated a HASU under stroke reconfiguration plans, set out at section 4 of the report, as summarised from the 2016 review published by the South East Clinical Senate. In particular, he drew the Joint Board's attention to issues around workforce, the potential impact on social care services and the implications for families and carers following removal of specialist stroke services from Medway. It was recognised that mitigation was proposed in the Decision Making Business Case (DMBC), however it was considered that these areas were particularly challenging to address.

Members raised a number of points and questions, including:

Methodology - with reference to the response from the NHS on Medway Council's Freedom of Information (FOI) request, set out at Appendix 3 to the report, a Member expressed concern regarding a lack of transparency and explanation in relation to the decision. He noted that the methodology was amended 24 hours ahead of decision making and he considered that changes to the methodology had disproportionately impacted option D. In response, the SRO for the Kent and Medway Stroke Review explained that the final decision had not been made and she confirmed that the final decision on the location of the HASUs would not be taken until January 2019. She also advised that with respect to the amendments made to the selection criteria, refinement of the criteria from the Pre-Consultation Business Case (PCBC) was considered an accepted part of the process to reach a preferred option from the five original shortlisted options. She assured the Joint Board that a clear rationale and evidence base was needed to make a recommendation or levy for any change. She stated that amendments to the criteria had been presented to several forums ahead of the evaluation workshop, including the Joint Health Overview and Scrutiny Committee.

Population growth and deprivation - A Member reiterated concerns that the selection of the preferred option did not take proper consideration of the level of: deprivation in Medway, the largest conurbation in the south east, outside of London; population growth, particularly in light of government housing targets; or transport and access to services located further afield. He expressed the view that the preferred option would deprive people of an essential service and amounted to switching a service off for a large number of residents. In response, the SRO for the Kent and Medway Stroke Review explained that the reconfiguration of Stroke Services represented a "switch on" of services for the whole population of Kent and Medway, with better services and better outcomes which would save lives. She recognised concerns in relation to travel times for ambulances, as well as families and carers and explained that this would be a critical part of any implementation plan. In referring to section 4 of

the report, the SRO recognised that there were a series of risks and mitigations which needed to be considered. She gave the Joint Board an assurance that necessary mitigations would be considered for the whole of Kent and Medway, including more rural and deprived areas to ensure travel and access are not negatively impacted.

The Chairman of the Joint Board concluded that Medway Council believed that the proposed sites that had been selected for the provision of HASUs were not in the best interests of the health service and residents in Kent and Medway. He added that Medway Council considered that option D, which included Medway Maritime Hospital, would provide a more sustainable solution for the population of Kent and Medway going forward. He advised the Joint Board that Medway Council's Health and Wellbeing Board and Full Council had considered the review of urgent stroke services and he thanked the Joint Board for considering the concerns of Medway Council.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the questions raised by Medway and commented on the likelihood that option D (which would locate HASUs at Medway Maritime, Tunbridge Wells and William Harvey Hospitals), would have emerged as the preferred option had questionable changes to the methodology and selection criteria not been introduced at a late stage in the process; and

b) requested that the concerns raised be taken into account by the Joint Committee of CCGs before a decision is made.

645 Work Programme Report

Discussion:

The Democratic Services Officer at Medway Council introduced the work programme report and drew the Joint Board's attention to the recommended amendments to the work programme set out at paragraphs 2.3 to 2.4 of the report which had been reflected in the work programme set out at Appendix 1 of the report. She also noted that provisional meeting dates for the 2019/2020 municipal year were set out at Table 1 of the report.

It was explained that that a request had been received to appoint Dr Bob Bowes to the Joint Board in his capacity as Chairman of the Strategic Commissioner Steering Group. The Strategic Commissioner Steering Group was established in February 2018 and provides leadership and oversight to the strategic development and thinking around the Strategic Commissioner function. On this basis it was recommended that Dr Bob Bowes be appointed as a member of the Joint Board in his capacity as Chairman of the Strategic Commissioner Steering Group to represent the views of Kent and Medway colleagues on this Steering Group.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) agreed the work programme attached at Appendix 1 to the report;

b) agreed to appoint Dr Bob Bowes as a voting member of the Kent and Medway Joint Health and Wellbeing Board in his capacity as Chairman of the Strategic Commissioner Steering Group; and

c) noted the provisional Joint Board meeting dates for 2019/2020 as set out at paragraph 3.1 of the report.

Chairman

Date:

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