KENT HEALTH AND WELLBEING BOARD

Wednesday, 6th December, 2023

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

KENT HEALTH AND WELLBEING BOARD

Wednesday, 6 December 2023 at 2.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Matt Dentten**
Telephone: **03000 418381**

Membership

Dr B Bowes (Vice-Chairman), Mr V Badu, Mr P Bentley, Cllr M Blakemore, Mrs S Chandler, Dr A Ghosh, Mr R Goatham, Mr R W Gough, Mrs S Hammond, Cllr Mrs A Harrison, Cllr J Howes, Mr R Smith and Mr D Watkins

UNRESTRICTED ITEMS

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

Item No	
1	Introduction/Webcast announcement
2	Membership To note that Mike Blakemore (Folkestone and Hythe District Council), Joe Howes (Canterbury City Council) and Dan Watkins (Kent County Council) have joined the Board.
3	Election of Chair
4	Apologies and Substitutes
5	Declarations of Interest
6	Minutes of the meeting held on 25 April 2023 (Pages 1 - 6)
7	Director of Public Health Verbal Update
8	Joint Strategic Needs Assessment Exception Report (Pages 7 - 28)
9	Update on Integrated Care Strategy development - To follow
10	Update on Inequalities, Prevention and Population Health Management Sub Committees (Pages 29 - 38)
11	Kent and Medway Safeguarding Adults Board Annual Report - To follow

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

Tuesday, 28 November 2023

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KENT COUNTY COUNCIL

KENT HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Kent Health and Wellbeing Board held in the Council Chamber, Sessions House, County Hall, Maidstone on Tuesday, 25 April 2023.

PRESENT: Mrs C Bell (Chairman), Dr B Bowes (Vice-Chairman), Dr A Ghosh, Mr R W Gough, Cllr Mrs A Harrison and Mrs R Hewett

IN ATTENDANCE: Mr M Dentten (Democratic Services Officer)

UNRESTRICTED ITEMS

16. Appointment of Co-opted Member

(Item 2)

RESOLVED to approve the re-appointment of Dr Bob Bowes as a co-opted member of the Kent Health and Wellbeing Board.

17. Election of Chair

(Item 3)

1. Cllr Harrison proposed and Mr Gough seconded that Mrs Bell be elected as Chairman of the Kent Health and Wellbeing Board. No other nominations were received.

RESOLVED that Mrs Clair Bell be elected as Chairman of the Kent Health and Wellbeing Board.

18. Election of Vice-Chair

(Item 4)

1. Mrs Bell proposed and Mr Gough seconded that Dr Bowes be elected as Vice Chairman of the Kent Health and Wellbeing Board. No other nominations were received.

RESOLVED that Dr Bob Bowes be elected as Vice Chairman of the Kent Health and Wellbeing Board.

19. Apologies and Substitutes

(Item 5)

Apologies for absence were received from Mrs Chandler, Penny Graham, Sarah Hammond, Cllr Hollingsbee and Vincent Badu who was substituted by Rachel Hewett.

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

(Item 6)

There were no declarations of interest.

21. Minutes of the Meeting held on 23 September 2022

(Item 7)

RESOLVED that the minutes of the meetings held on 23 September 2022 were an accurate record and that they be signed by the Chairman.

22. Director of Public Health Verbal Update

(Item 8)

1. Dr Ghosh (Director of Public Health, KCC) gave a verbal update. The contents of his update included: Covid-19; Integrated Care Partnership (ICP) sub-committees; and Public Health operational developments.
    a. Concerning Covid-19, he confirmed that the case rate in Kent stood at 20 per 100,000, its lowest level in recent months, and was on a downward trajectory, a reduction in the burden of disease and testing were cited as key factors. He explained that Kraken, a subvariant of Omicron, was the most common Covid-19 variant in Kent. Regarding global Covid-19 developments he noted that the Arcturus had spread rapidly in India, being responsible for two thirds of cases, though with a low severity. He cautioned the Board that the overall picture could change rapidly if a more severe variant developed.

    b. In relation to ICP governance, he explained that four sub-committees of its Inequalities, Prevention and Population Health Committee had been established each covering: Prevention; Health Inequalities; Population Health Management; and NHS Sustainability and the Green Agenda. He explained that the sub-committees would coordinate the work of partners on each issue.

    c. Regarding recent KCC Public Health developments, he updated the Board on commissioning activity as well as collaboration with other departments of the Council and district councils to improve wider determinants of health. He added that they had worked with Kent Housing Group, including supporting their develop of a health implementation plan for housing, and district councils on major town developments, embedding planning for health places. He reassured the Board that there had been constant activity in relation to the statutory health protection responsibility, encompassing the assessment, preparation for and handling of health threats, which included extensive multi-agency work and collaboration through the Kent Resilience Forum. He noted that Public Health had worked with the Growth, Environment and Transport directorate to develop a small grants programme on the theme of hope in relation to suicide prevention, eleven projects receiving £1,000 and three receiving £5,000, with a showcase of the projects taking place at the Turner Contemporary on 18 July. It was also explained that a lived experience programme and

advocacy programme for people with addictions was in development, to combat rising deaths from substance misuse. He concluded by explaining that Public Health were working closely with the Children's, Young People and Education directorate, in relation to the Family Hubs programme, especially on perinatal mental health, parent infant relationships, infant feeding and start of life from conception until the age of two.

2. In relation to health inequalities, Dr Bowes commented that many residents identifying hypertension were not registered with a GP or engaged with the health system. He asked whether Primary Care Networks (PCNs) could be provided with data on the overall picture for Kent.

3. Members discussed the importance of data sharing between partners, noting both the complexity of the issue and benefits improvements would have on services. Consideration of the issue by the Integrated Care Partnership was suggested by Mr Gough.

RESOLVED to note the verbal update.

23. Update on Kent and Medway Interim Integrated Care Strategy
(Item 9)

1. Dr Ghosh introduced the report which updated the Board on the development of the Integrated Care Strategy. He noted that the interim strategy represented a statement of intent from partners to tackle health inequalities, the wider determinants of health and prevention. He explained that the next version of the strategy was anticipated for late autumn. He explained that the final Integrated Care Strategy, once approved, would be the de facto Joint Local Health and Wellbeing Strategy for Kent. He noted that work was underway with Health and Care Partnership (HCPs) to develop plans and with district councils on public health plans. It was confirmed that Kent Police as well as district and parish councils were consulted as part of the strategy development process. He added that definitive plans on how the strategy would be monitored were to be completed in July. The Board were reminded that the ICP provided oversight of the strategy and that operational implementation would be monitored by sub-committees.

2. Mr Gough asked which body would own the work addressing wider determinants of health at a local level and whether it would be appropriate for that to be an HCP responsibility. Dr Ghosh emphasised the importance of local system ownership at the HCP level with the broader involvement of local partners including PCNs. Partnership arrangements in east and west Kent were explained.

3. Concerning the interim Strategy's pledge and shared outcomes, Mr Gough commented that it was important that partners fully understood the link between health and wider socio-economic outcomes.

4. Cllr Harrison commented that the economic impact of delays in treatment, including the years of economic activity lost, should be investigated as part of the strategy development process and to address the Strategy's pledge.

5. Dr Bowes commented that HCPs were the ideal footprint for local accountability and strategy setting. He asked that PCNs be effectively utilised for delivery and emphasised the importance of empowering local partners.

RESOLVED to consider and comment on the contents of the report.

POST MEETING NOTE: NHS Kent and Medway confirmed that the online platform for feedback on the Kent and Medway Integrated Care Strategy could be accessed at: https://www.haveyoursayinkentandmedway.co.uk/hub-page/kent-and-medway-integrated-care-strategy-hub

24. NHS Kent and Medway Draft Joint Forward Plan
(Item 10)

1. Mrs Hewett (Director of System Strategy, NHS Kent and Medway) introduced the report which contained NHS Kent and Medway's draft Joint Forward Plan and set out the requirement for the Board to consider whether the Plan took full account of the interim Integrated Care Strategy, as Kent's interim Joint Local Health and Wellbeing Strategy. She explained that the Plan would be refreshed annually and that the Board would be provided with the refreshed plans for its consideration. She clarified that the Plan was joint amongst NHS Kent and Medway and local Trusts rather than the wider Integrated Care System. The challenges of consulting with the public and stakeholders within the time available was noted, with it explained that the Plan had incorporated Strategy community engagement responses to avoid duplication. The Plan's incorporation of the Strategy's six shared outcomes was explained.

2. Following a question from the Chair, Mrs Hewett gave assurance that there would be further opportunities to receive public feedback on the Plan.

3. Cllr Harrison suggested the Isle of Sheppey as a pilot area for future communication and engagement activities.

4. Mr Gough asked for an explanation of the interplay between NHS population health management and KCC Public Health in relation to inequalities and preventing ill health, as well as the Joint Forward Plan's linkage to other statutory partners within the ICS. Mrs Hewett confirmed that the population management roadmap would be refreshed and that it along with many other NHS strategies interlinked and would be further developed. It was noted that following the interim Integrated Care Strategy refresh and development of delivery plans, metrics and measurements the linkage to other statutory partners would become clearer.

RESOLVED to endorse the NHS Kent and Medway Joint Forward Plan as a plan that takes proper account of the Interim Integrated Care Strategy.

25. Kent and Medway Safeguarding Adults Board Annual Report 2021-2022
(Item 11)

Andrew Rabey (Chair, Kent and Medway Safeguarding Adults Board) was in virtual attendance for this item.

1. Mr Rabey introduced the report. He confirmed that the Safeguarding Adults Board had published its Strategic Plan for 2022-2025 and that twelve safeguarding adults reviews (SARs) had been published since the previous annual report. The recommendations arising from the reviews were addressed and included making safeguarding personal, safe discharge from hospitals and improving working with individuals who were dependent on alcohol or substances. An overview of the workshops and training delivered by the Safeguarding Adults Board was provided. He reminded members that Safeguarding Adults Week had taken place in November 2022, raised awareness and shared material in multiple languages. It was also explained that a monthly newsletter was circulated to 290 local organisations.

RESOLVED to endorse the Kent and Medway Safeguarding Adults Board Annual Report, 2021-2022.

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From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Kent Health and Wellbeing Board, 6 December 2023

Subject: 2023 Kent Joint Strategic Needs Assessment (JSNA) Exception Report

Classification: Unrestricted

Summary:
The JSNA exception report summarises key population health highlights arising from various health needs assessments and other reports and analyses completed this year. This report enables the Kent Health and Wellbeing Board and the Kent and Medway Integrated Care Partnership to be aware of the relevant issues and trends which need to be addressed and reflected in the key priorities and outcomes of the Integrated Care Strategy and district local plans.

Recommendations:
The Kent Health and Wellbeing Board are asked to COMMENT and ENDORSE the following recommendations:

- Address health inequity in all the commissioned health improvement services, for example a more targeted approach to stop smoking service delivery.
- Identify and apply for funding opportunities to invest in large-scale training for Making Every Contact Count (MECC) for the wider public as well as selected frontline health professional groups.
- Maximise the potential of social prescribing schemes linked to an up-to-date directory of local services and other provisions.
- Refresh Health Needs Assessments (HNAs) for other inclusion health groups, where needed, and develop local research capacity to identify solutions for improvement and tackle health inequalities. Undertake further health needs assessment of adults experiencing severe and multiple disadvantages (SMD) particularly homelessness, substance misuse, and criminal justice systems in Kent.

Recommendations continued:

- Advocate for mandatory cultural competence and intersectionality as part of Diversity, Equity and Inclusion (DEI) training for healthcare providers, including those within the NHS Integrated Care Board (ICB) and Health Care Partnerships (HCP), to improve equitable care delivery to diverse patients.
- Complete Area-based Needs Assessments for the remaining HCP areas.
- Kent and Medway Substance Misuse Services, Mental Health providers and Adult Social Care staff and managers to adopt the operational protocol to provide person centred, timely, joined up care and recovery support for all people.
- Develop the JSNA cohort model to include and simulate the effect of wider health determinants which will support better health policy analysis and decision making for investing in population health improvement.
- KCC to actively participate in population health management programmes with the NHS, this includes action on council data sharing integration with the ICB and NHS partners for analytics including research. For example, integration in the risk stratification work by *Xantura* with similar risk stratification activities by the NHS.
- KCC Public Health to utilise emerging links with districts and key partners to support and facilitate the delivery of the Violence Reduction Unit's priorities.
- Promote vaccinations and tackle vaccine hesitancy particularly among marginalised communities and inclusion health groups.
- Focus on ensuring mental health crisis and recovery services are joined up between community, primary and urgent care – particularly prioritising East Kent (Thanet in particular) and Maidstone.

1. Background

1.1 The JSNA exception report is a regular annual report presented to the Kent and Medway Integrated Care Partnership Board and the Kent Health and Wellbeing Board. The format of the report contains:

- An overview of key population highlights taken from various reports and a review of population health intelligence tools.
- Summary of health needs assessments, analyses and insight work conducted in the past year.
- Recent changes to the Kent JSNA process and other notable wider improvements in data and intelligence across the health system.

1.2 The previous report was presented to and approved by the Kent Health and Wellbeing Board in September 2022. Upon consultation with the ICB senior leadership this year, the Kent JSNA exception report will be presented to the Kent and Medway Integrated Care Partnership Board for comments, before approval at the next available Kent Health and Wellbeing Board.

1.3 The following needs assessments, insight work and analyses have been completed over the last year by the KCC Public Health team and other partner

organisations. Where available, final reports have been published on the Kent Public Health Observatory (KPHO) website after approval from the Director of Public Health:

- Adult Mental Health
- Tobacco control
- Health and Care Partnership profiles
- Emergency hospital admissions for COPD
- National Child Measurement Programme 2023
- Serious Violence for Kent and Medway Strategic Needs Assessment
- Immunisation Flu
- Childhood Immunisation Coverage
- West Kent HCP Needs Assessment 2023
- Gypsy Roma and Traveller Needs Assessment 2023
- District Health inequalities summaries
- Integrated Care Strategy Engagement Workshops

1.4 Governance

1.4.1 After a number of years of absence, efforts were made to reinstate shared governance arrangements between health and local government over the JSNA development process. The Kent JSNA Steering Group was formed in January 2023 to provide oversight for this process. A key objective of the Steering Group is to ensure that the Kent JSNA is embedded in the Integrated Care Partnership (as per the Guidance on the preparation of Integrated Care Strategies) and establish the Kent JSNA as the first port of call for health needs assessments and other public health intelligence requirements, for commissioners, bidders, planners and system leaders and clinicians.

1.5 Context and Overarching Priorities

1.5.1. A 5-year Interim Integrated Care Strategy was approved in November 2022. The strategy fulfils the function of the Kent Joint Health and Wellbeing Strategy. Public Health has worked collaboratively with Kent and Medway system partners to gather insight and ensure the updated strategy reflects needs and priorities of the system. Further work was undertaken with partners to refresh the strategy in 2023, this process will be completed by January 2024.

1.5.2 The Public Health Transformation Programme commenced in 2023 with an ambition to undertake a comprehensive review and stock-take of Public Health commissioned services such as health visiting, sexual health, healthy lifestyle services, and wellbeing. The programme aims to improve services for local communities, maximise investment and impact, ensure services are safe, effective, aligned to best practice and are fit for the future.

2. Key population highlights

2.1 Demographic changes

2.1.1 The 2021 mid-year population estimates show that Kent remains the most populous county council area in the South East with a population of 1,578,500 people. Kent remains the largest non-metropolitan local authority area in England. Kent's population grew by 7.6% (112,100 people) between 2011 and 2021. This is higher than population growth in England (6.46%) and the Southeast (7.41%).

2.1.2 Kent has a population density of 4.5 persons per hectare. This is slightly higher than England (4.3) but lower than the South-East (4.9). Maidstone has the largest population of the local authorities in Kent with 176,700 people, which is equivalent to 11.2% of Kent's total population. Dartford is Kent's most densely populated local authority district with 16 people per hectare. Ashford is the least densely populated with 2.3 people per hectare.

2.2 Emerging health concerns between 2022 and 2023

2.2.1 The Health and Care Partnership (HCP) profiles are produced by the Medway Public Health Intelligence Team on behalf of all four HCPs across the Kent & Medway Integrated Care System. The profiles have been developed annually since 2019 and describe key health indicators, across the life course, in terms of trend and comparison across HCPs and Primary Care Networks (PCNs) They are updated every year, where data is available. Some of the key highlights from the latest profile updates are:

2.2.2 Dartford Gravesham & Swanley HCP

- Smoking prevalence has improved to 11% but physical activity has decreased among adults. It is estimated a quarter are physically inactive. These results should be interpreted with caution as they are both based on surveys which has yielded volatile estimates for Dartford Borough Council in the last two years.
- The overall rate of antibiotic prescribing has reduced.
- Breast screening rates have improved to 64% but bowel screening is now lower than England average despite improving since the previous year.
- The rate of attendance at A&E among those aged under 5 is highest in DGS HCP and has increased above pre-pandemic levels.
- There has been a small increase in Diabetes prevalence among those aged 17 years and over to 7.5%.
- The overall suicide rate has decreased, particularly among men.

2.2.4 East Kent HCP

- Life expectancy at birth has worsened among men, dropping by 0.8 years to 79.0. Smoking prevalence among those aged 18+ has

increased in Ashford and Canterbury. Overall, the prevalence is 18% which is highest among the four HCPs in Kent & Medway.

- The prevalence of overweight or obese among adults has increased to 68%, again the highest within Kent & Medway.
- The overall rate of antibiotic prescribing has reduced.
- The rate of attendance at A&E among those aged under 5 has increased above pre-pandemic levels. There has been an increase in hospital admissions for mental health conditions among those aged under 18 which is now 25% higher than the average across Kent & Medway.
- Emergency admissions for ambulatory care sensitive conditions has increased particularly in Margate and Dover, but the overall HCP figure remains lower than the England average.

2.2.6 West Kent HCP

- There has been an increase in the prevalence of overweight or obese among adults in Tonbridge & Malling and Maidstone districts which are now 63% and 67% respectively.
- Antibiotic prescribing rates have reduced.
- Breast screening rates have improved in Tonbridge and Tunbridge Wells, and the overall HCP figure is 66%.
- The rate of attendance at A&E among those aged under 5 has increased above pre-pandemic levels.
- Self-harm hospital admissions in those aged 10 to 24 years have increased overall, particularly in Maidstone PCN and Tunbridge Wells PCNs.
- Overall, all PCNs in West Kent are above the England average but this could be a result of different recording practices within local acute Trusts.

2.2.8 Medway and Swale HCP

- Sittingbourne PCN
    - The overall rate of antibiotic prescribing has reduced.
    - A&E attendances for under 5s increased above pre-pandemic levels.
    - Hospital admissions for self-harm among 10-to 24-year-olds has increased and GP recorded depression among adults has increased by nearly 1% to 15.1%.
- Sheppey PCN
    - Antibiotic prescribing remains high.
    - Breast cancer screening has reduced to 63% which is similar to the national average.
    - A&E attendances for under 5s increased above pre-pandemic levels.

- Hospital admissions for self-harm among 10- to 24-year-olds has increased and GP recorded depression among adults has increased by 1% to 16.0%.

2.3 Tobacco Control

2.3.1 The proportion of adults who smoke in Kent has continued to fall, from 16.3% in 2017 to 11.6% in 2022 (Figure 1). This is in line with the national trend where the prevalence has declined from 14.9% to 12.7% in the same period.

Estimated Smoking Prevalence

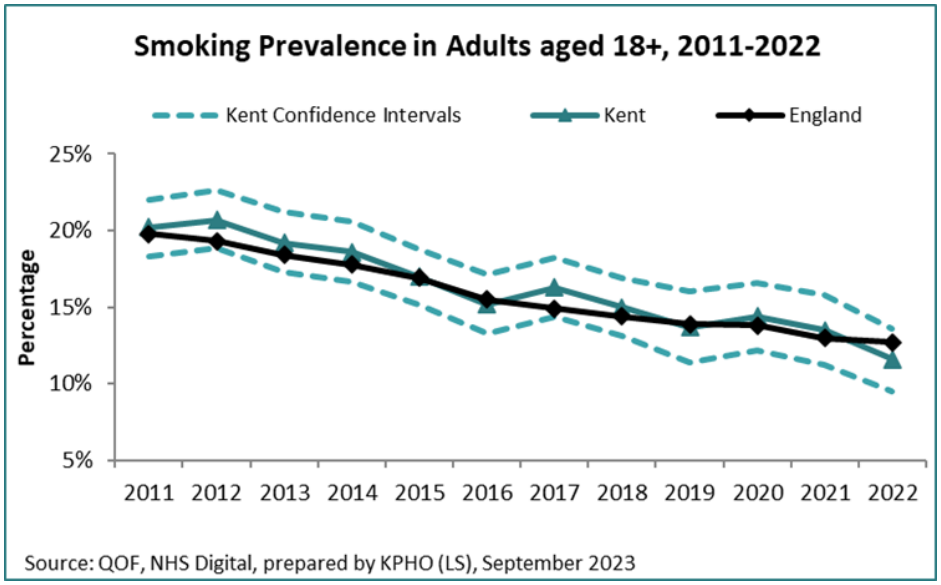

Figure 1: Estimated smoking prevalence in Kent and England from 2011 – 2022. Source: QOF, NHS Digital, prepared by KPHO

2.3.2 Despite the decline, smoking remains the largest risk factor for premature mortality and health inequalities, causing approximately 6,000 deaths in Kent each year. The highly addictive nature of nicotine present in cigarettes makes it difficult for many smokers to quit.

2.3.3 Smoking prevalence is particularly high among groups of people, such as routine and manual workers, LGBTQ communities, people with mental health illness, and across some ethnic groups. The ASH cost calculator estimates an annual cost around £499.4m each year to the Kent health economy alone. Motivation to quit can be particularly challenging for these risk groups. Furthermore, the cost of smoking can very often exacerbate their financial problems.

2.3.4 There has been a decline in the number of people using stop smoking services to quit, representing only 6.5% of smokers.

2.3.5 Vapes are considered an effective quit aid for smokers but should not be used by anyone under the age of 18 or by non-smokers. It is yet unclear whether vaping is likely to be a gateway into smoking and clear information and guidance is needed. It is also likely that services will be required to treat nicotine dependency in the future. It is also apparent that there is a need to improve regulations for vape products and their packaging, and to address

underage sales, all of which generates further work for Trading Standards services.

2.4 Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) in May 2023

2.4.1 There is marked variation between admission rates across Kent and Medway. Notably, there are much higher rates in Swale and Thanet where smoking rates are higher (Figure 2). The age-standardised admission rate in Medway and Swale HCP is approximately 60% higher than West Kent HCP. Overall, across the county admission rates nearly halved in 2020/21 financial year. They started to increase again in 2021/22, but they have not reached pre-pandemic levels.

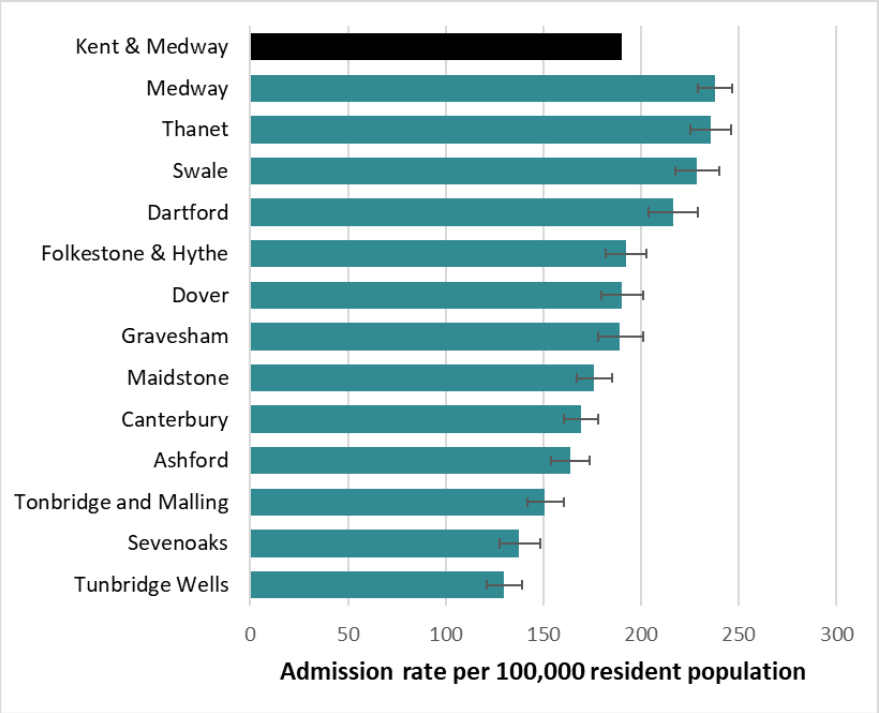

Figure 2. Emergency Admissions for COPD, 2017/18 – 2021/22. Age standardised rate per 100,000 in Kent districts & Medway with 95% confidence intervals shown. Source: HES.

2.4.2 Variation in COPD admission rates is strongly correlated with deprivation both locally and nationally (Figure 3). Between 2017-2022, the age-standardised admission rates are 4.1 times higher in those living in the most deprived quintile than the least in Kent and Medway. Significant variation also exists with length of stay.

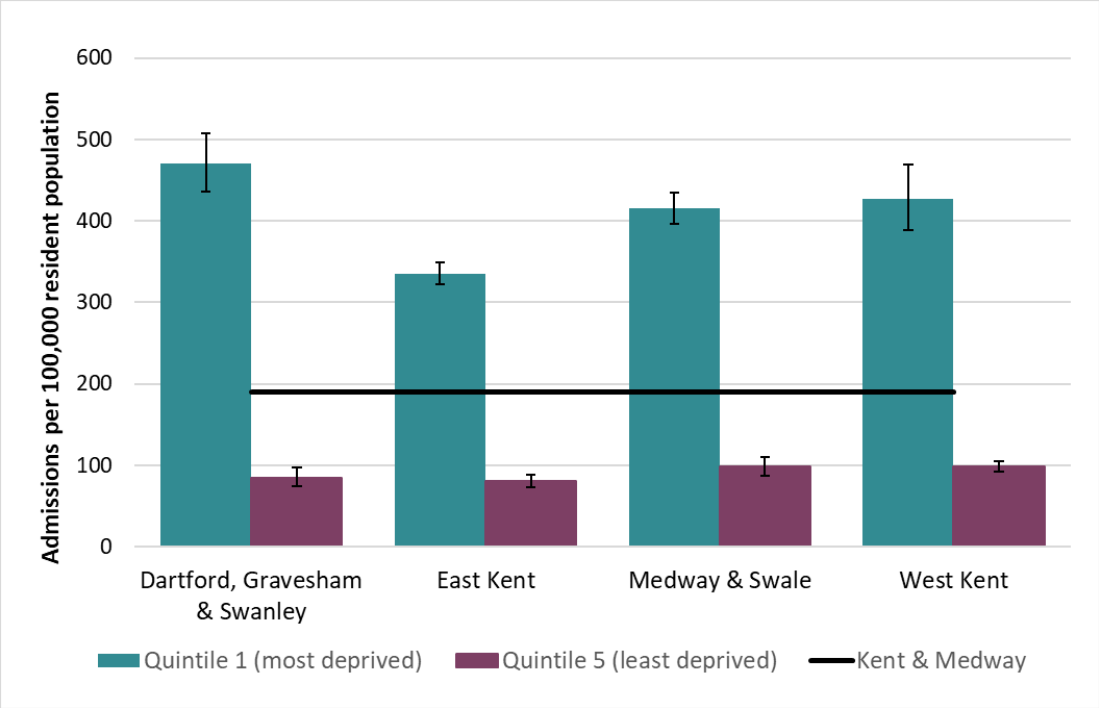

Figure 3. Emergency Admissions for COPD, 2017/18 – 2021/22 by deprivation quintile. Age standardised rate per 100,000 in Kent and Medway HCPs, with 95% confidence intervals. Source: HES.

2.5 National Child Measurement Programme

2.5.1 Excess weight in children continues to be a concern in Kent. The National Child Measurement Programme in 2021/22 found that 21.3% of reception children and 35.8% of year 6 children have excess weight.

2.5.2 There is variation in excess weight by Kent Districts. The prevalence in reception year was lowest in Sevenoaks (17.7%) and highest in Thanet (24.2%). For year 6, the prevalence was lowest in Tunbridge Wells (27.9%) and highest in Gravesham (41.7%).

2.5.3 Also, there is a difference in the prevalence of excess weight by deprivation. Reception year children living in the most deprived areas in Kent were twice as likely to be living with obesity than children in the least deprived areas.

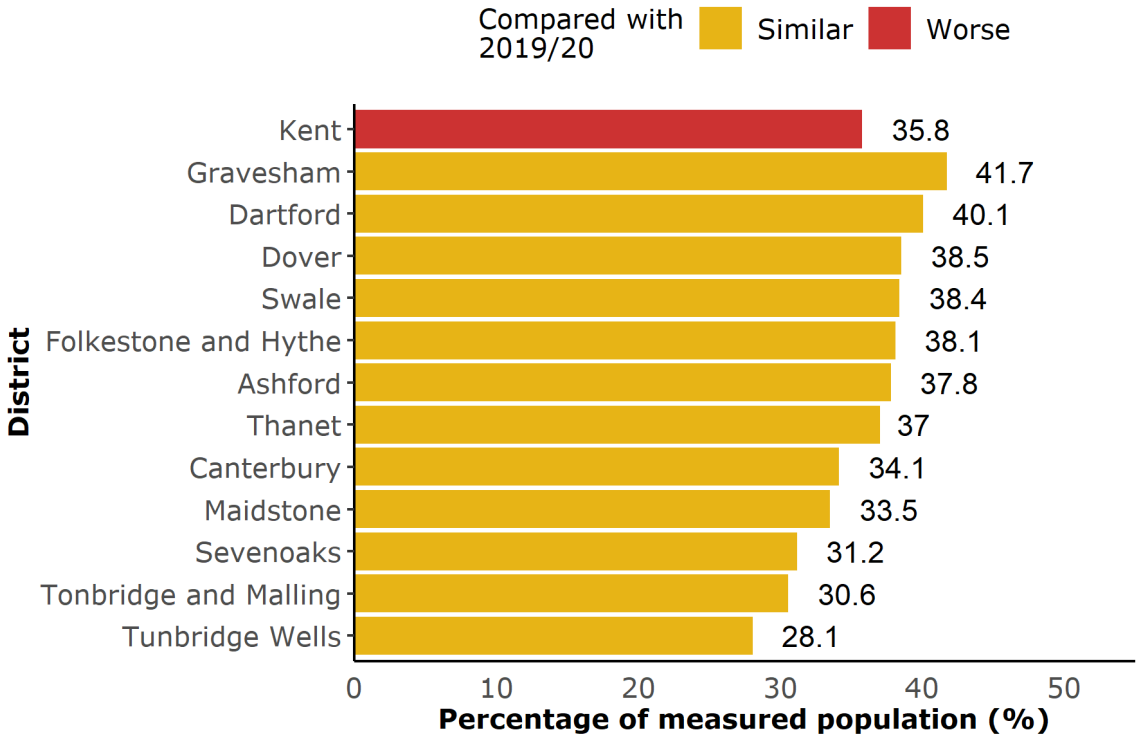

Figure 4: Year 6, prevalence of excess weight by district in Kent, 2021/22 compared with 2019/20. Source: NCMP, prepared by KPHO (SR) February 2023

2.5.4 The prevalence of excess weight in Kent Year 6 children increased in 2021/22 compared to 2019/20 (35.8% compared to 34.6%). Due to statistical uncertainty at district level, the changes aren't significant between years but when combined they add up to a significant difference at Kent level as shown in Figure 4.

2.5.5 In reception the prevalence of obesity, excess weight and severe obesity decreased in Kent in the latest year. In 2021/22, 21.3% of reception children had excess weight compared to 26.5% in the previous year. 9.4% of reception children were living with obesity compared to 13.4% in the previous year.

2.5.6 These figures are slightly lower than the England average and the differences are statistically significant. In England in 2021/22, 22.3% had excess weight, 10.1% were living with obesity and 2.9% were severely obese.

2.6 Flu vaccination 2022/2023

2.6.1 Rates have fallen below the expected rates (51%) for children aged between 2 and 3, the uptake was 46% meaning 2268 children haven't received their vaccination. Parents and guardians of 2 and 3-year-olds were surveyed, and valuable insights were incorporated into the flu action plan.

2.6.2 Similarly, lower than expected rates (82%) were also seen for over 65s and other vulnerable groups. For over 65s, the uptake rate was 79.7%, which meant 9905 patients had not received their vaccination.

2.7 Childhood Immunisation Coverage

2.7.1 The immunisation coverage for Measles, Mumps and Rubella (MMR2) vaccine varies across HCPs (2021/22). Sheppey PCN MMR2 immunisation

coverage was significantly lower when compared with Kent and Medway and other PCN's within the Medway and Swale HCP.

2.7.2 Vaccine coverage in East Kent HCP varied widely, with Margate and Canterbury North having significantly lower coverage. Within West Kent HCP, Maidstone South PCN appeared to have lower immunisation coverage when compared to both Kent and Medway as a whole and other PCNs within the HCP.

2.8 Adult Mental Health

2.8.1 As of December 2022, there were 194,698 people with depression in Kent, of which almost 30,000 people were from the most deprived areas. In contrast, nearly 15,000 people with depression lived in the least deprived areas. There is a greater rate of depression amongst women (64%). (See appendix 1 which shows an illustration for the population segmentation analyses).

2.8.2 There is a high burden (and variation) of mental health need across Kent, this is highlighted in hospital admission rates calculated for each district in Kent for 2021/22 (Figure 5).

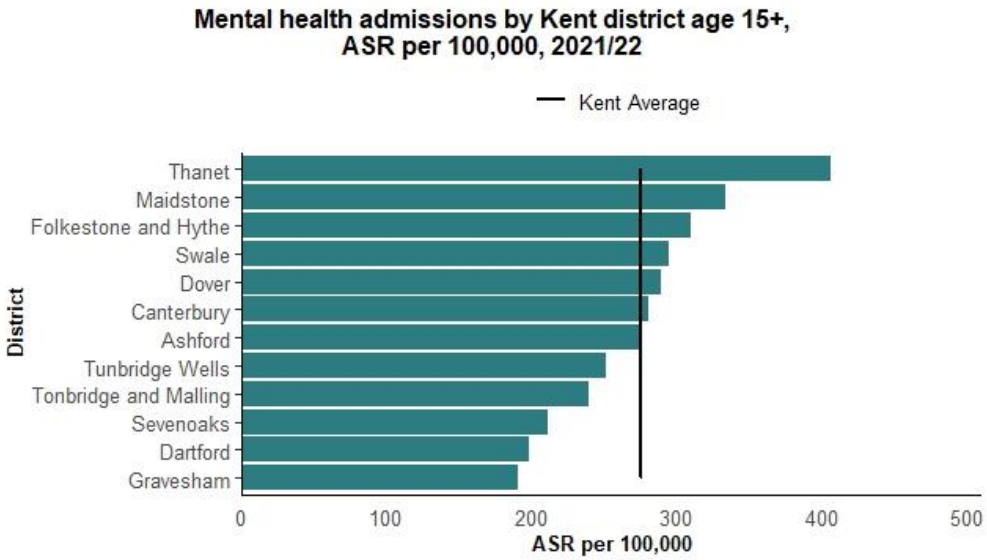

Figure 5. Mental health admissions by Kent district age 15+, ASR per 100,000, 2021/22. Source: HES, prepared by KPHO (SR), June 2023

2.8.3 There has been a small increase in the Kent suicide rate (3 year rolling average, 11.7 per 100,000), which remained above the national rate of 10.4 per 100,000 in 2019-2021. The graph below shows that mental health distress has increased as well as demand for services over recent years (Figure 6).

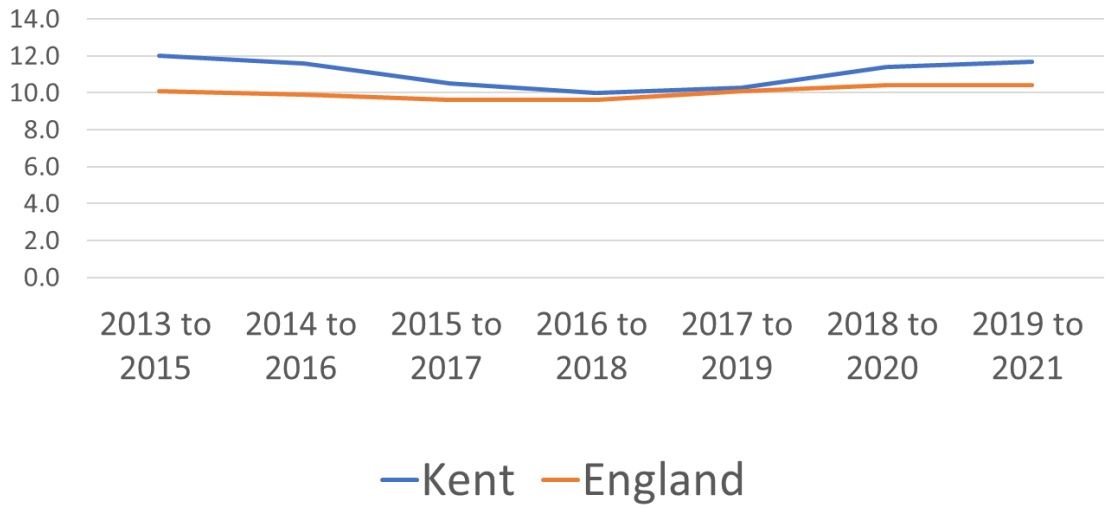

Figure 6. Kent Suicide Rate compared to England suicide rate (rate per 100,000, all people, 3 year rolling averages) Source: ONS

2.8.4 Based on data over the last 3 years, 30% of all suicides in Kent were associated with domestic abuse. This finding was based on enhanced local surveillance, known as the Real Time Suicide Surveillance (RTSS) system jointly set up by KCC and Kent police.

2.8.5 A health equity audit on NHS psychological therapies (IAPT) in Kent & Medway conducted in 2022, found that males had a lower access rates compared to females, and the highest access rates were amongst those aged 18 to 25 years old, reducing as age increased. Difference in rates by ethnicity were also present. Individuals from Asian groups had lower access rates compared to other ethnic groups and those reporting a disability had much lower access rates compared to those who did not have a disability. Half of IAPT service users did not have a record of whether they had a registered disability.

2.8.6 Research shows that poverty and mental ill-health are intrinsically linked to adults involved in the homelessness, substance misuse and criminal justice systems in England, known as severe and multiple disadvantage (SMD). A detailed needs assessment is being planned to explore this further.

2.9 Housing and homelessness

2.91 The number of households in emergency housing in Kent has increased and the proportion of households with children in temporary accommodation were the highest at the end of 2022 compared to the previous 2 years.

2.9.2 The average number of children living in temporary accommodation in Kent at the end of each quarter between April-June 2020 to January-March 2022 was 1,552. Housing insecurity is a key risk factor for mental distress.

2.9.3 A national one day survey on rough sleeping was undertaken in Autumn 2022, giving an estimate of 3,069, up by 626 or 25.6% increase from the 2021 estimate.

2.9.4 In Kent, the estimated number of rough sleepers over the same period was 80. This is up by 10 or 14.3% from the autumn 2021 figure of 70 but numbers will vary by district across the county. Use of 'snapshot' data is not the definitive number of people who are rough sleeping. This reinforces the importance for better data collection and collation to assess locality needs.

2.9.5 In Kent, it is estimated that of those sleeping rough, 86.3% are males, 75% are UK nationals and 85% are over the age of 26. The rate of rough sleeping per 10,000 households stands at 0.2 for London and 0.1 for the rest of England and Kent.

2.10 Gambling

2.10.1 According to GamCare data, 215 individuals in Kent & Medway contacted the gambling Helpline between 2022-2023. Across both areas, 60-66% of callers were male and the age groups most represented in the data were 26-35 years old and 36-45 years old.

2.10.2 The most common form of gambling cited by those seeking help were online casinos and online sports betting. The five most common impacts from gambling were: Anxiety / Stress, Financial Difficulties, Depression / Low Mood, Relationship Difficulties, Isolation / Loneliness. In Kent, the number of callers experiencing gambling who had ever experienced suicidal thoughts and ideation rose from 9% in 2021-2022 to 18% in 2022-2023.

2.11 Serious Violence

2.11.1 The levels of serious violence remain below those seen pre-pandemic (2019 – 20) but there has been an increase in the reporting period. This is partly due to the comparison with a time period that includes lockdown. The main crime types which cause the highest harm are violence with injury, robbery and weapons related offences. Violence linked to drug supply is also a concern. There has been a disproportionate increase in the last 12 months of those aged under 18 involved in violence with injury and weapon offences.

2.11.2 Thanet and Canterbury districts experience the highest levels of serious violence, followed by Swale, Gravesham and Maidstone. Deep dive analyses suggest correlation with deprivation, especially poor housing and school suspensions as shown in Figure 7.

Figure 7: Number of secondary school age pupils that received 3+ suspensions during academic year 2021/22 by school (source: VRU Strategic Needs Assessment)

2.11.3 Serious violence is most frequent after school (3-4pm), early evening (5 – 7pm) and in the nighttime economy. County Lines have reduced, but professionals suggest that the model is changing, and the assessment of drug supply may also need to change. There have been thirteen Young Street Groups (YSGs) mapped and two Gangs scored in the reporting period.

2.11.4 Professional assessments of those in the criminal justice system confirm known risk factors relating to: Special Educational Needs, and also how thinking skills impact on the ability to manage conflict without the use of violence, access to education, training or employment, poor or problematic relationships.

2.11.5 Alcohol is not identified as a significant factor in the link with serious violence by the Probation service whereas drug use is of more concern. However, alcohol is more likely to be a significant factor when considering all types of violence in the nighttime economy.

2.11.6 Young people report that there is a need to feel safe in schools and in community settings. They have identified transport hubs such as train stations as being of particular concern. They have also identified feeling unsafe around groups of males, with girls in particular feeling unsafe in this regard. British Transport Police report increases in violence with injury, and reductions in robbery and weapons offences. The stations where violence has increased in the last 12 months are Gillingham, Sittingbourne, Herne Bay and Ramsgate.

2.12 Carers

2.12.1 Findings from the Census data showed that 136,000 (9.1%) Kent residents aged 5 or over, provided some form of regular unpaid care and around 57,000 people (3.8%) provided 35 or more hours of unpaid care per week.

2.12.2 There is a similar proportion seen regionally and nationally. In Kent, women provide a higher proportion of unpaid care between ages 0 to 64 years old. domestic abuse and sexual exploitation also impact women more disproportionately than men and can also lead to poorer mental health and recovery.

2.13. Area Based Needs Assessment

2.13.1 West Kent HCP Needs Assessment

- The elderly population is set to increase substantially over the next 20 years implying the need for a broader consistent integrated approach towards primary prevention, secondary prevention and tertiary prevention.
- West districts perform worse than the England average for the following indicators: intentional self-harm diagnosis rates for dementia, diabetes and smoking at time of pregnancy.
- Obesity and severe obesity have increased in Tonbridge and Malling and Sevenoaks districts since the previous year alongside similar levels of physical activity in these areas.
- Most mental ill health indicators such as prevalence depression psychosis serious mental illness and suicide rates have increased across West Kent learning disabilities LD such as autism spectrum condition and attention deficit hyperactive disorder diagnostic and prescribing services continue to face significant capacity issues due to large waiting lists and a surge in demand.
- West Kent is an outlier for emergency hospital admissions due to folds in persons aged 65 and over. West Kent performs worse on A&E attendances for 0-4 years.

2.13.2 Area based needs assessment are being considered for the other HCPs.

2.14 Inclusion health needs assessments

2.14.1 Gypsy, Roma and Traveller Needs Assessment

2.14.2 Kent has a higher percentage of Gypsy and Traveller people than the England average and many Roma communities too. There are stark health inequalities faced by the Gypsy Roma Traveller communities. These communities have the poorest health outcomes of any ethnic groups, not only in the UK, but internationally. An ONS analysis of the 2011 Census (conducted in 2014) found that 14% of the Gypsy and Traveller community described their health as ‘bad’ or ‘very bad’ more than twice as high as the White British group.

2.14.3 Life expectancy is 10 to 12 years less than that of the non-Traveller population. Previous research has shown poor birth outcomes and maternal health, with an excess prevalence of miscarriages, stillbirths, neonatal deaths, and infant mortality in these communities (Figure 8). One in five Gypsy and

Traveller mothers will experience the loss of a child, compared to one in a hundred in the non-Traveller community. Childhood immunisation uptake is considerably lower in the Gypsy and Traveller community in comparison to the general population.

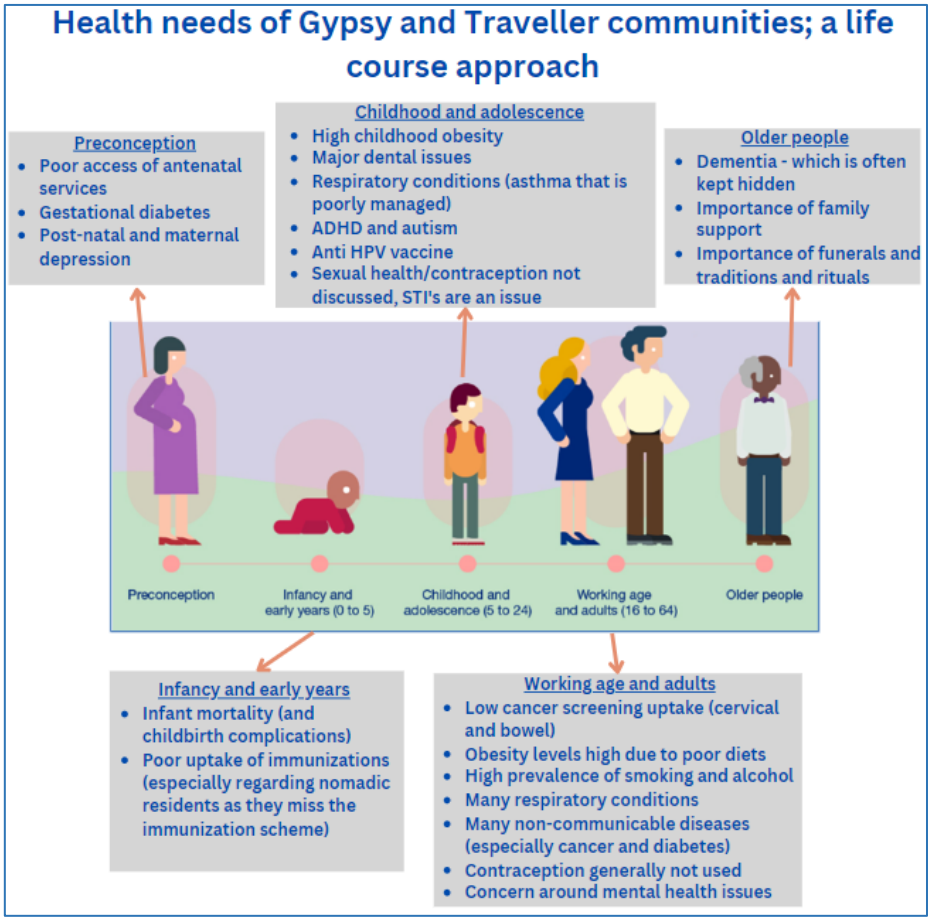

Figure 8: Health needs of Gypsy and Traveller communities.

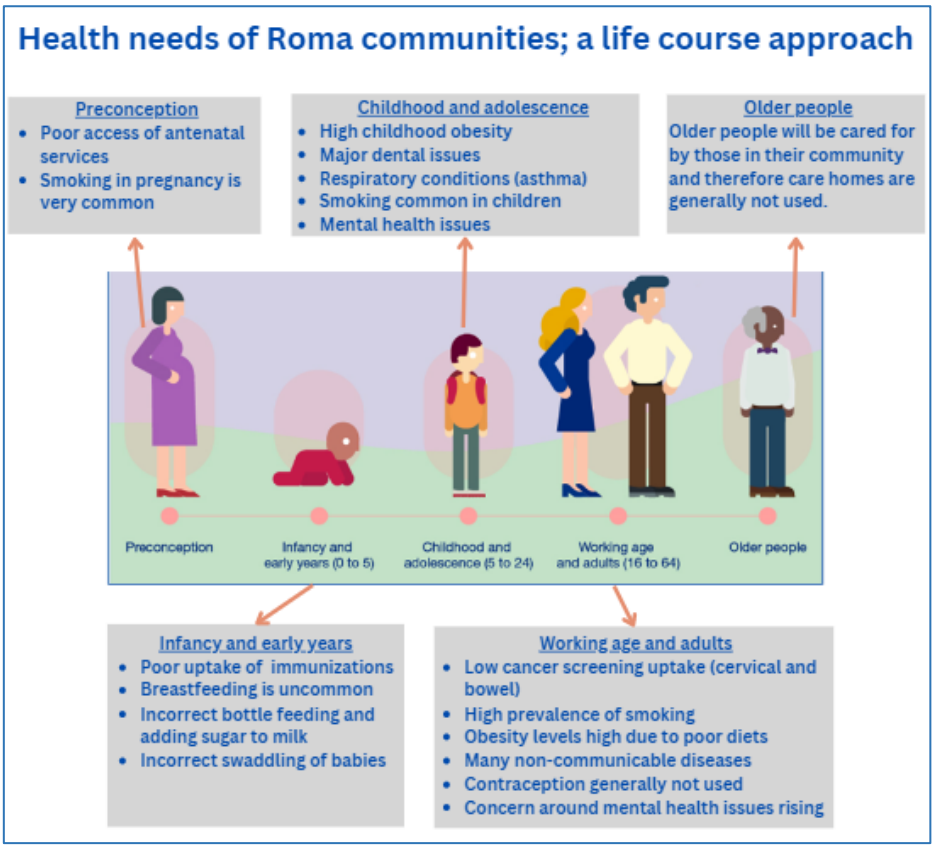

Figure 9: Health needs of Roma communities

2.14.4 Established research evidence demonstrates that Roma (Figure 9) have poorer health experiences and outcomes than non-Roma communities. Some findings from previous studies show that Roma men were five times as likely to suffer from two or more physical health conditions than white British men, higher figures than for any other ethnicity. High reported rates of anxiety and depression noted.

2.15. Veterans and serving armed forces.

2.15.1 A health needs assessment is currently in progress and is expected to be completed by the end of the year. This has been instigated by the NHS, based on recent national guidance and policy recommending ICBs to undertake detailed analyses and better data collection on current numbers and extent of burden of ill health.

2.15.2 There are over 52,000 veterans living in the County of Kent having served for more than one day in any of the armed forces representing 4.1% of the Kent population. Further conclusions from the HNA will be included in next year's JSNA Exception report.

2.6 Insight and engagement activity

2.16.1 A series of workshops and listening events to consult and discuss the Kent and Medway Integrated Care Strategy, were held with District Councils and their local partners including representation from the Voluntary, Community and Social Enterprise (VCSE).

2.16.2 Events were also held with Kent Association of Local Councils (KALC), Kent County Council Members' Briefing, Police and Crime Commission officers, Kent Housing Group, and internal KCC teams.

2.16.3 Health inequality summaries, particularly indicators on the wider health determinants, were created to present the local picture within each district such as life expectancy, unemployment, and housing. KCC Public Health senior team facilitated each event.

2.16.4 The insight from these workshops were valuable and various actions were identified. There were key concerns/opportunities raised across several districts which are highlighted below:

- Funding to the VCSE is often short term and therefore inhibits long term and sustained change.
- There is a lack of capacity within the health system to meet the need for crisis provision, which has meant that the VCSE frequently fill in the gaps to provide support, particularly for mental health.
- Many agencies recognised that Covid provided the conditions for collaborative working, however, a common barrier to continue this is the competitive nature of funding processes even after the COVID 19 pandemic.
- In several districts, there was a need for a single information platform for an up-to-date directory of services for residents (and referrers) to find out about local health and wellbeing services and groups.
- Social prescribing and Making Every Contact Count were thought to be valuable, if rolled out at pace and scale.
- Anchor institutions were considered key to facilitating more employment and training opportunities for local residents.
- Optimise the use of available community assets and spaces for public good.
- Constraints on data sharing (for direct care as well as analytics) between statutory organisations and voluntary sector partners limits collaborative working practices.
- More action is needed to help people increase physical activity and achieve a healthier weight.

2.16.5 Safer Communities Alliance, (DEI lead for Kent voluntary sector) conducted a consultation involving twenty participants from marginalised, diverse communities, and low-income backgrounds. Key findings included: for example, a desire for community-based health check hubs, easier access to healthcare providers, free fitness classes, dental care for low-income families, recognition of NHS limitations, improved education, and awareness in schools, understanding of rare diseases, localised services, simplified access to healthcare services, and easier inpatient meal access.

2.16.6 The consultation findings also revealed other key priorities, including the need for free fitness classes, dental care for children, improved cultural competence, mental health awareness, accessible GP services, support for social networks, and assistance with employment. Additionally, personalised care plans, addressing social phobias, free educational classes, collaboration among healthcare disciplines, mental health stigma reduction, and support for community groups were highlighted as important areas for improvement.

2.17 Core20PLUS5

2.17.1 A data pack was completed by Medway Public Health Intelligence to create a baseline of health indicators describing the key areas of the core20plus5 framework. Key indicators have been identified across the life course for children (Asthma, Diabetes, epilepsy, oral health and mental health) and for adults (Maternity, Hypertension, Cancer, COPD and Serious Mental Illness).

Outcome Measure	Commentary
Asthma Emergency hospital admissions for asthma (< 19 yrs)	Emergency admission rates are significantly lower than the England average for Kent and Medway as a whole and in West Kent HCP and similar to the England average for DGS, East Kent and Medway & Swale HCPs. Although emergency admission rates have been decreasing in East Kent and Medway & Swale over recent years, at PCN level, **Margate** in East Kent and **Sheppey**, **Gillingham South** and **Medway Practice Alliance** (MPA) are significantly higher that the England average.
Diabetes Emergency hospital admissions for diabetes (< 19 yrs)	Emergency admission rates are significantly above the England average for Kent and Medway as a whole, and across **DGS** and **Medway & Swale** HCPs, where there has been an uptick in rates in recent years. At sub-HCP level, admission rates in **Thanet**, **Gravesham**, **Medway** and **Swale** areas are significantly higher than the England average
Epilepsy Emergency hospital admissions for epilepsy (< 19 yrs)	Emergency admission rates across Kent and Medway as a whole are similar to the England average, as are rates for DGS HCP and West Kent HCP, which has the lowest rates. Admission rates for **Thanet** and **Dover** (in East Kent) are higher that the England average. Admission rates are significantly higher across **Medway** and **Swale**, and the highest of all HCPs and districts.
Oral health Percentage of 5-year-olds with experience of visually obvious dentinal decay	Across Kent and Medway as a whole and all HCPs and districts, the percentage five-year-old with obvious dentinal decay are similar or less than the England average, with the exception of **Dover** (East Kent), which is significantly higher than the England average.
Mental health Hospital admissions for mental health conditions (0-17 years)	Admissions for mental health conditions are higher than the England average across **East Kent** and within **Tunbridge Wells** (West Kent), which has the highest rates of admissions.

Figure 10: Health indicators for children

Outcome Measures	Commentary
Maternity Infant mortality rate Neonatal mortality rate Stillbirth rate	Infant mortality rates across Kent and Medway and in all HCPs and districts are similar or lower than the England average, although East Kent, Medway & Swale and DGS are significantly worse than West Kent. Neonatal mortality rates and stillbirth rates across Kent and Medway are similar to the England average. The MBRRACE-UK reports examining maternal and perinatal mortality show disparities still exist in outcomes for people from **Black, Asian and minority ethnic groups** and those living in the **most deprived areas**.
Hypertension Deaths from circulatory disease, under 75 years	Premature death rates from circulatory diseases are similar or significantly lower than the England average across Kent and Medway and all HCPs but are higher than the national average for specific PCNs, including **Medway Central**, **Sheppey**, **Margate**, **Ramsgate**, **Total Health Excellence West** and **Gravesend Central**, which has the highest premature death rate.
Cancer Deaths from all cancer, under 75 years	East Kent and Medway & Swale HCPs have premature death rates that are higher than the England average. **Margate**, **Ramsgate**, **Total Health Excellent West**, **Medway Central**, **Gillingham South** and **Sheppey** PCNs all have premature death rates higher than the national average. The highest rates can be found in **Strood** PCN (Medway & Swale).
Chronic obstructive pulmonary disease (COPD) Under 75 mortality rate from respiratory disease	The premature mortality rate for respiratory disease across Kent and Medway and across most districts are similar to the England average, with the exception of Sevenoaks, which is significantly lower and **Thanet**, which is higher than the national average. (NB. COPD is one of the major respiratory diseases.)
Serious mental illness Excess under 75 mortality rate in adults with serious mental illness (SMI)	Excess mortality rates for adults with SMI are similar to the national average within Kent and significantly lower than the England average in Medway.

Figure 11: Health indicators for adults

3. Other JSNA Products, new information and intelligence

3.1 Use of the JSNA Cohort Model

3.1.1 The JSNA Cohort model refresh is currently underway, awareness raising sessions have been delivered to select boards and groups such as PH consultants and specialists, the IPPH prevention and population sub-committees, and ICB finance working group, where the use of system modelling approaches such as actuarial modelling has been promoted by the national population health management guidance and policy.

3.1.2 The purpose of the sessions was to introduce a local approach to systems modelling, developed some years by KCC Public Health, for planning and decision making and, more importantly, and measure the population and system impact of new prevention programmes on the Kent health economy.

3.1.3 Specific training is being delivered to the Public Health team to learn how to use the tool and to develop their knowledge and skills, known as systems dynamics.

3.1.4 The tool has already started to be used internally. For example, in the public health transformation review process, work is ongoing to model the impact of the NHS Health Checks programme in terms of reduction in prevalence and burden of cardiovascular disease.

3.1.4 With respect to the segmentation aspect of the model, considerable effort has been made to align with the ongoing population segmentation work by the

ICB, developed by Outcomes Based Healthcare (OBH) mentioned further below.

3.1.5 A working group has been set up to look at how to model the effect of wider heath determinants such as education, employment, crime, housing, income and living environment on population health. Insights from the work will be tested and incorporated into the JSNA cohort model for future scenario generation and health needs assessment work.

3.1.6 A report on the original cohort model was recently published in a peer-reviewed journal. The report describes in detail the rigorous methodology used and process of model development and design. To our knowledge, Kent is one of the first if not, the only Local Authority in country to use such a tool for JSNA development.

3.2 Health and social care maps

3.2.1 The Health and Social Care Map function on the KPHO website presents information about the health and wellbeing of people in Kent with a particular focus on health inequalities, at sub-Kent geography such as by district and HCP. It will be continually updated and improved. Users can visualise the data as a trend, geographically and by benchmarking with other areas. Currently, comparisons can be made by deprivation, and gender and ethnicity in future updates.

3.3 Research, Innovation and Improvement (RII)

3.3.1 Going forward, it is expected that key insights on population needs will be generated through local research activity. This will be managed through the new and emerging RII team based at KCC Public Health. The significant growth of the RII team which has increased to 5 members (4 of them on fixed term appointments and externally funded). Over an 11-month period since its inception, approximately 95 project ideas were considered for funding and / or further research.

3.3.2 Since the team's inception in late 2022, a range of research activities have been initiated spanning different programme areas such health inequalities amongst Gypsy Roma Travelling communities, access to healthcare by migrant communities, substance misuse, association of healthy nutrition with net zero agenda, housing led interventions for homeless people, suicide prevention and many others. Through effective working relationships with university and NHS partners, the team have established new training placements with research (PhD) and medical students.

3.4 Population Segmentation

3.4.1 The ICB has implemented a population segmentation data visualisation tool which is based on the Bridges to Health life course model. Individuals are allocated to a segment such as generally healthy, or long-term condition and to subsegments which are disease registers.

3.4.2 A Power Business Intelligence (BI) dashboard has been created, which gives us the capability to look at different population risk groups based on levels of multimorbidity and association with key factors such as age deprivation and geography and the impact on healthcare demand.

3.4.3 The KPHO team have used this dashboard to compile a number of population health profiles to contribute to needs assessments and analyses including Mental health profiles, asthma cohort in adults, emergency admissions, multi-morbidity health profiles. Several examples of this dashboard are included in appendix 1.

3.5 New datasets

3.5.1 Approval from NHS England has been recently obtained to allow for the use of Kent and Medway Care Record (KMCR) to be used for research. Access arrangements for the use of KMCR by KCC PH is currently in progress.

3.5.2 KMCR is one of several linked datasets available locally. Going forward, planning is underway to mobilise the KERNEL in the next few years which will become the primary linked dataset for analytics including research, and then feed into national data repositories such as the NHSE federated data platform and the secure data environment, which will be exclusively for academic research.

4. Recommendations

4.1 The Kent Health and Wellbeing Board are asked to COMMENT and ENDORSE the following recommendations:

- Address health inequity in all the commissioned health improvement services, for example a more targeted approach to stop smoking service delivery.
- Identify and apply for funding opportunities to invest in large scale training for Making Every Contact Count (MECC) for the wider public as well as selected frontline health professional groups.
- Maximise the potential of social prescribing schemes linked to an up-to-date directory of local services and other provisions.
- Refresh Health Needs Assessments (HNAs) for other inclusion health groups, where needed, and develop local research capacity to identify solutions for improvement and tackle health inequalities. Further analysis is needed to understand the scope and needs of adults experiencing Severe and Multiple Disadvantages (SMD) who are disproportionately involved in homelessness, substance misuse, and criminal justice systems in England.

- Advocate for mandatory cultural competence and intersectionality DEI training for healthcare providers, including those within the NHS ICB and HCPs, to improve equitable care delivery to diverse patients.
- Complete Area-based Needs Assessments for the remaining HCP areas.
- Kent and Medway Substance Misuse Services, Mental Health providers and Adult Social Care staff and managers to adopt the operational protocol to provide person centred, timely, joined up care and recovery support for all people.
- Develop the JSNA cohort model to include and simulate the effect of wider health determinants which will support better health policy analysis and decision making for investing in population health improvement.
- KCC to actively participate in population health management programmes with the NHS, this includes action on council data sharing integration with the ICB and NHS partners for analytics including research. For example, integration in the risk stratification work by Xantura with similar risk stratification activities by the NHS.
- KCC Public Health to utilise emerging links with districts and key partners to support and facilitate the delivery of the Violence Reduction Unit's priorities.
- Promote vaccinations and tackle vaccine hesitancy particularly among marginalised communities and inclusion health groups.
- Focus on ensuring mental health crisis and recovery services are joined up between community, primary and urgent care – particularly prioritising East Kent (Thanet in particular) and Maidstone.

5. Background Documents

- Health and Care Partnership profiles
- National Child Measurement Programme 2023
- West Kent HCP Needs Assessment 2023
- Gypsy Roma and Traveller Needs Assessment 2023
- Health and social care maps

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Dr Anjan Ghosh, Director of Public Health

To: Kent Health and Wellbeing Board – 6 December 2023

Subject: Update on Inequalities, Prevention and Population Health Management Sub Committees

Classification: Unrestricted

Summary:
This report provides an overview of the Inequalities, Prevention and Population Health Committee (the Committee) and its three Sub Committees of the Inequalities, Prevention and Population Health Committee (IPPH) of the Kent and Medway ICB. Although the Committee reports into the ICB, due to its nature it is also responsible to the Integrated Care Partnership (ICP) which is a core component of the Kent and Medway Integrated Care System.

The report sets out how these Sub Committees are located within the governance structure of the Kent and Medway Integrated Care System (ICS). It also demonstrates how the Sub Committees relate to the 4 core purposes of the ICS, their connection with the key structural components of the ICS and the Integrated Care Strategy.

The next sections then outline the role of each Sub Committee along with some exemplification and updates on their work for the Health and Wellbeing Board to consider and note.

Recommendation:

The Kent Health and Wellbeing Board is asked to CONSIDER and NOTE the report.

1 Introduction

1.1 This report sets out the strategic fit, governance and delivery across the Kent and Medway ICS relating to health inequalities, prevention and population health management (PHM).

1.2 Included in the four core purposes of ICSs are the following:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access

1.3 The Kent and Medway ICS covers the areas served by Kent County Council (KCC) and Medway Council. The structure includes the NHS service based Integrated Care Board (ICB) and the Integrated Care Partnership (ICP).

1.4 The ICP is a core component of the Integrated Care System and is a broader coalition of partners which aims to join up planning and delivery to improve health and social care across Kent and Medway.

1.5 The Integrated Care Strategy is the mechanism by which the ICP, working closely with communities can deliver system level, evidence-based priorities to improve the health and wellbeing of people and communities throughout the ICP footprint.

1.6 The IPPH Committee of the ICB is the delivery vehicle for one of the strategic outcomes of the Integrated Care Strategy, which is focused on health inequalities, the wider determinants of health and embedding PHM approaches.

1.7 Three Sub Committees of the IPPH Committee drive forward the three specific areas of work related to Inequalities, Prevention and PHM. Each Sub Committee is chaired by a senior system leader and comprises a broad range of partners including the VCSE sector and the four Health and Care Partnerships (HCP) each representing one of the four 'places' across the Kent and Medway ICS.

1.8 The purpose of this report is to provide an overview of the role and work of each of the three Sub Committees, namely the IPPH Inequalities Sub Committee, the IPPH Prevention Sub Committee and the IPPH Population Health Management Sub Committee.

2 IPPH Sub Committees

Each of the IPPH Sub Committees works to their specific element of the IPPH Committee high level delivery plan. Coherence across the work of the three Sub Committees is maintained by regular communication between the senior leaders who chair the Sub Committees and the ICB Chief Medical Officer.

2.1 The following three sections outline the work and role of each of the IPPH Sub Committees.

3 IPPH Inequalities Sub Committee

3.1 The role of the IPPH Inequalities Sub Committee includes:

- Working together to influence improvement in the wider determinants of health and broader social and economic development, in areas such as housing, climate, transport, sport and leisure etc. improving mental health and well-being and reducing social isolation.
- Overseeing the ICS Core20PLUS5[1] development plan for adults and children and young people. The Sub Committee oversees the implementation of this plan at a local and system level.
- Developing and agreeing plans for the NHS England (NHSE) allocated ICB health inequality funding, ensuring it is appropriately spent and providing assurance on its impact.

3.2 The IPPH Inequalities Sub Committee oversees the ICB allocation of recurrent NHSE funding to address health inequalities in outcomes, experience and access. The funding provides for a range of programmes at HCP level and ICS wide. The IPPH Inequalities Sub Committee reviews highlight reporting to assure the progress and impact of these programmes.

[1] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

3.3 A small set of examples of programmes currently funded via the NHSE allocated ICB Health Inequalities funding include:

- Hypertension Heroes: An ICS system wide programme supporting blood pressure management within targeted communities, in this case Black, Asian and minority ethnic groups. Working with community partners, the project is focused personalisation for patients. The model works to address health inequalities around self-management of hypertension using an asset-based approach.
- West Kent: Designing and developing a Health and Housing intervention to address the links between poor housing and health, particularly relating to damp and mould.
- East Kent: Continuing the roll out of integrated care diabetes clinics and additional multidisciplinary teams across East Kent. Working with the voluntary sector and enhancing community support groups available to carers.
- Dartford, Gravesham & Swanley: targeted community development comprising, initially, scoping and engagement with underserved populations in identified areas of significant inequality (i.e. obesity, diabetes, cancer screening, and respiratory). A Health Creation approach is being taken with the voluntary and community sector with evidenced based feedback informing a programme of targeted interventions.
- Medway and Swale: Improving outcomes for children with asthma in deprived populations, providing a focused paediatric asthma review service for patients in the most deprived localities where fuel poverty is high, and patients may not have access to secondary care.

3.4 A key current role of the IPPH Inequalities Sub Committee is to define the approach across the Kent and Medway ICS to supporting PLUS groups within the Core20PLUS 5 programme.

3.5 Core20PLUS5[2] is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies five clinical areas for improvement:

- Core20: the most deprived 20% of the national population as identified by the index of multiple deprivation (IMD).
- PLUS: Within the Core20PLUS5 approach to reducing healthcare inequalities, PLUS refers to 'population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach'[3].
- 5: Five clinical areas of focus for adults are, maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension case-finding and optimal management, and lipid optimal management. The five clinical areas for children and young people are: asthma, diabetes, epilepsy, oral health and mental health.

[2] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/
[3] CORE20PLUS5 infographic - https://www.england.nhs.uk/publication/core20plus5-infographic/

3.6 The IPPH Inequalities Sub Committee have identified a range of groups which the Kent and Medway ICS should consider as PLUS groups within the Kent and Medway ICS. The IPPH Inequalities Sub Committee agreed that the overarching impetus should be for a cultural shift to incorporating ways of working and a health inclusion approach to facilitating the best outcomes for these groups. This approach is based on the Inclusion Health Framework recently published by NHSE and which is shown in Figure 1.

Figure 1 NHSE Inclusion Health Framework[4]

3.7 There is ongoing work to develop metrics for Core20PLUS5 being undertaken by the IPPH Inequalities subgroup to highlight the challenges and opportunities. The work of Kent and Medway analysts will be further informed by the NHSE publication when it is available; it is understood that Core20PLUS improvement metrics from NHSE are due to be released by the end of the 2023 calendar year.

3.8 Kent and Medway ICS were successful in bidding for Wave 2 of the Core20PLUS5 Community Connectors Programme[5]. This programme provided funding for recruitment and mobilisation of community connectors, individuals who are influential in their own communities. The community connector role is a dynamic one which both engages local people with health services but one which is also well placed to inform and shape services. Kent and Medway ICS has two programmes, the first focuses on bowel screening in Thanet and the South Kent Coast for people between the ages of 60-75, particularly those from Black, Asian and minority ethnic backgrounds, men, and those with a physical disability. The second engages with Black, Asian and minority ethnic women, contributes to wider work on the LMNS Maternity Equity Strategy and is centred around the work of a lead practitioner in Dartford and Gravesham. The

[4] https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/
[5] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-community-connectors/

proposal builds on work relating to perinatal outcomes for Black, Asian and minority ethnic women.

3.9 The IPPH Inequalities Sub Committee are reviewing analyses which examine the equity of provision of health services by age, gender, ethnicity and deprivation to determine if there are inequities in service delivery. Early analyses will include cancer, A&E data and referral to treatment (RTT), and these are planned for review at the IPPH Inequalities Sub Committee.

4 Prevention

4.1 The role of the IPPH Prevention Sub Committee includes:

- Working to deliver prevention at scale, maximising the use of resources to deliver better outcomes for the population and efficiencies for the system. Putting co-production at the heart of our efforts, ensuring the participation and engagement of our communities in all our work. The lived experience of residents will be central to this.
- Tackling inequalities and preventing ill health, targeting those most in need.
- Supporting the population to adopt positive health behaviours.
- Increase detection and optimise the management of hypertension, atrial fibrillation, high cholesterol, and 10-year cardiovascular disease risk.
- Protect the public from infectious diseases, chemical, biological, radiological, and nuclear incidents and other health threats.

4.2 The IPPH Prevention Sub Committee has identified 6 priority areas on which to focus; obesity, tobacco and smoking, alcohol and substance misuse, mental health, hypertension and screening and immunisations.

4.3 Action plans are being developed for each priority area by identified leads. The action plans focus on two short term actions (<12 months) and two longer term actions (1-2 years). A sample of actions identified include:

- Improving the outcomes of the most vulnerable people with mental health conditions.
- Ensuring clear and equitable weight management pathways for children and adults across all tiers.
- Increasing the number of smokers from high prevalence groups referred into stop smoking services.
- Delivering a multiagency hypertension campaign for ‘Know Your Numbers’ week.
- Increasing the numbers of people into structured treatment for substance misuse.
- Improving the uptake of flu vaccination amongst 2 and 3 year olds.

4.4 A Prevention Framework has been adopted by the IPPH Prevention Sub Committee to act as a guide to sense check and frame prevention plans and interventions. An infographic of the Prevention Framework can be seen in Figure 2. The Framework is underpinned by the following criteria:

- Support by the right authorising environment in terms of local, regional and national policies, strategies and plans
- Tackling wider determinants
- The levels of prevention that are included

- The principles which are represented
- The critical enablers that are in place.

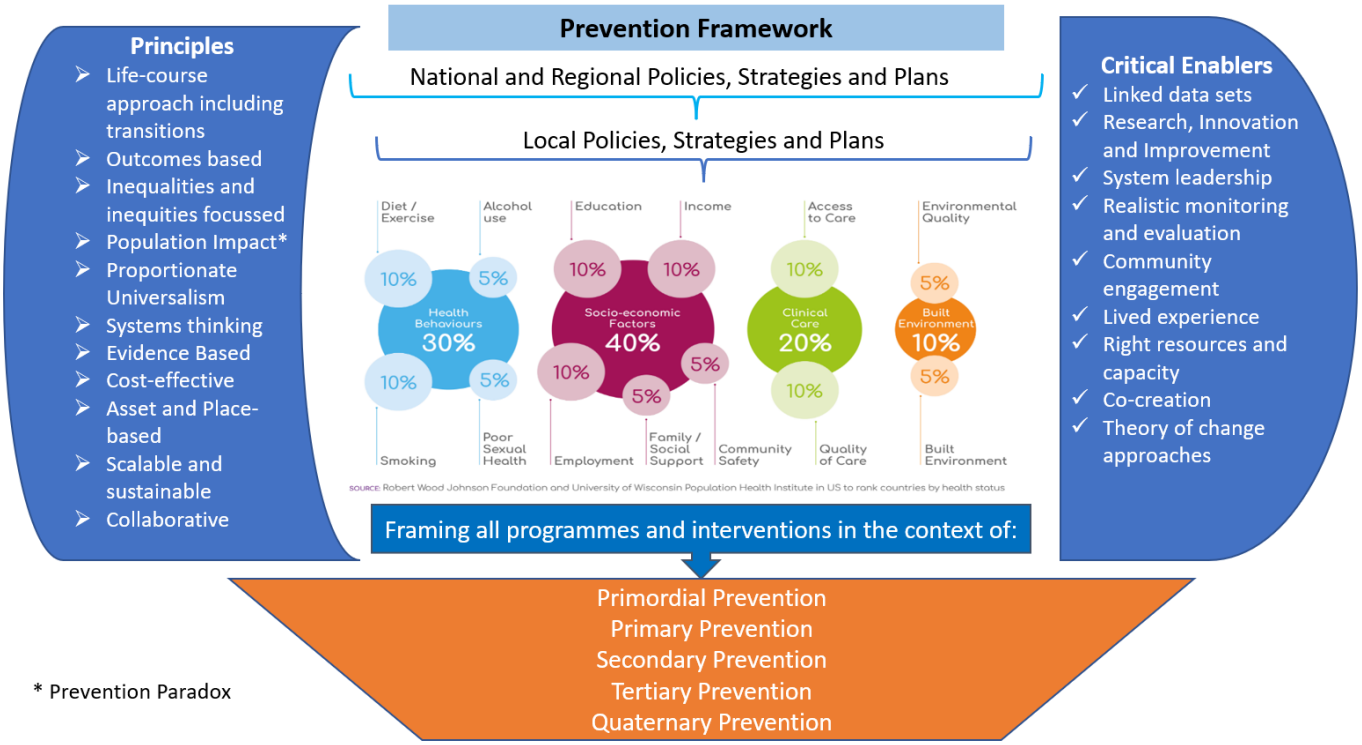

Figure 2 The Prevention Framework adopted by the IPPH Prevention Sub Committee

4.5 The Long Term Plan[6] committed to supporting people in contact with NHS services to quit smoking:

- By 2023/24 all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- The model will be adapted for expectant mothers and their partners with a new smokefree pathway.

Trusts, partners and stakeholders are collaborating across Kent and Medway ICS to implement this programme. All maternity services across Kent and Medway have now started delivery of this programme, which also builds on the work of the Smoking in Pregnancy midwives who have been established in each acute Trust since 2019.

4.6 A whole system approach to obesity programme[7] is being implemented across each of KCC and Medway Council, with a Whole Systems Approach to Obesity officer aligned to each HCP area. These programmes take a whole systems approach working with stakeholders and partners across each HCP place in an approach which makes full consideration of the wider determinants of health, such as environment, transport, food outlets, advertising etc.

[6] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[7] https://www.gov.uk/government/publications/whole-systems-approach-to-obesity

4.7 The Hypertension Support Package is a package of resources for Primary Care Networks and GP practices with a focus on the identification and treatment of hypertension. A robust approach to hypertension has been taken across Kent and Medway ICS which includes the Hypertension Heroes Programme (paragraph 3.3). There is much work to do, but from data from June 2022 to June 2023, Kent and Medway is one of the seven most improved systems nationally.

5 Population Health Management

5.1 The role of the IPPH Population Health Management Sub Committee includes:

- Developing, implementing and monitoring the spread and sustain programme for PHM including the development of key enablers e.g. linked data sets.
- Ensuring a consistent and coherent system wide approach across Kent and Medway which focusses on using a targeted and data driven approach to PHM to improve outcomes.
- Ensure that plans are built bottom-up using PHM data and local assessments of need (including local authority Joint Strategic Needs Assessments) to drive improvement with a specific focus on reducing inequalities, improving population health and in particular, considering communities that may have specific and or unique characteristics.
- Developing and delivering a strategic framework for PHM in Kent and Medway with the engagement of partners, to advance PHM capabilities across four core areas: infrastructure, intelligence, interventions, and incentives.
- Overseeing the development of a segmentation model to be used in conjunction with other tools and based on a linked data set. This will enable the ICS to use identify populations with common care needs and implement the most effective approaches to improve health and wellbeing outcomes in the population.

5.2 The purpose of the PHM Programme is to embed a population health management approach across the system, developing the knowledge, skills and understanding of people so that they can deliver health improvement and reduce inequalities, agreeing actions that are informed by data and intelligence.

5.3 A structured programme approach, based on an action learning methodology, was in place for Phase 1 (July 21 to March 22) and Phase 2 (July 22 to March 23) of the programme. This was delivered through System, HCP, Neighbourhood, and Analytics action learning sets over a defined period of time. Using a hands-on approach HCPs and Neighbourhoods reviewed their data, and shared knowledge and insights for their local area to identify a priority cohort. They used a logic model to agree the intended outcomes and develop interventions to meet those outcomes.

5.4 The Population Health Management Programme is now entering Phase 3. The IPPH Population Health Management Sub Committee has recently reviewed Phase 2 of the programme which concluded in March 2023 where key learning, insights and challenges along with key next steps were highlighted. A separate piece of work has also highlighted the importance of undertaking evaluation of projects which are part of the PHM Programme and other projects more widely. Along with an evaluation of the PHM action learning set from a Primary Care

Networks perspective, the learning from these three pieces of work has informed the design of Phase 3 of the programme.

5.5 Phase 3 of the programme transitions from the structured style of Phase 1 and Phase 2 where the programme is driven by HCPs to embed the approach across places and neighbourhoods, with some key aspects led at ICS level. HCPs are developing plans for embedding PHM locally, setting out their approach, priority areas, how they are using data to drive action, progress and challenges. In this phase the ICS will look at implementing an agreed Insights to Action framework.

5.6 This approach will provide a structure for teams, organisations and systems to gather insights and develop actions to deliver the best outcomes for patients, the population and staff. It covers multiple domains, including clinical, operational and staff well-being, and is based on five stages: gather data, analyse, make decisions, implement those decisions, and close the loop by monitoring effectiveness of the changes implemented. For instance, focus on developing insights to support action in care homes. During this Phase 3 there will be a focus on working with a small number of clinical transformation services to address inequalities in specific areas.

5.7 The six principles of the approach for Phase 3 of the PHM programme are:

- Strategic direction from System with HCPs driving delivery at Place.
- Transition from a programme approach to embedding operationally and led by HCPs.
- Develop a blueprint of PHM tools to provide a consistent approach.
- Develop a consistent approach to data and analytics, to consolidate the analytical tools, resource and shared data available to support HCPs and Neighbourhoods.
- Develop a system wide PHM education, training and development package to support HCPs to embed across Place and Neighbourhood.
- Much bigger focus on evaluation to ensure success can be scaled.

6 Financial Implications

6.1 There are no direct financial costs associated with this paper. It is important however that ICS resources in the future be prioritised as appropriate to tackle the agreed priorities.

7 Equalities implications

7.1 An Equality Impact Assessment (EqIA) has not been carried out directly in relation to this paper. However, an EqIA has been led by the ICB in relation to the development of the Integrated Care Strategy from which the IPPH Committee and IPPH Sub Committees take the guide for their work.

8 Conclusions

8.1 This report has provided an overview of the three Sub Committees of the Inequalities, Prevention and Population Health Committee (IPPH) of the Kent and Medway ICB. These are the IPPH Inequalities, Sub Committee, IPPH Prevention Sub Committee and the IPPH Population Health Management Sub Committee.

8.2 The report has set out how the Sub Committees are located within the structure of the Kent and Medway ICS and provided an overview of their role and exemplars of their work for the Health and Wellbeing Board to consider and note.

9 Recommendation(s):

9.1 The Kent Health and Wellbeing Board is asked to CONSIDER and NOTE the report.

10 Background Documents

None

11 Contact details:

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