Appendix A

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Medway Health and Wellbeing Board

Health and Wellbeing Board(s)

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Medway Council; NHS Kent and Medway Integrated Care Board (ICB), DFG Services, VCS Sector

We have established a Steering Group to support regular and ongoing engagement with key stakeholders and internal and external partners around BCF Planning and commissioning activity for the Better Care Fund. This group supports our work across Health and Social Care services and supports co-production of BCF plans and wider commissioning activity for our Partnership Commissioning Team. We have also engaged with our Health and Wellbeing Board, to input into the BCF Plan for 2022-23.

How have you gone about involving these stakeholders?

In responding to the pandemic, the health and social care partners adopted a more collaborative approach to working. We intend to continue this level of collaboration through adaptable contracted services, meeting the current need and reflecting this approach in new commissioning activity.

Priorities for the BCF in 2022/23 are:

1. Improved discharge pathways from hospital to realise the best health outcomes for our residents
2. Prevention to reduce hospital admissions and support maximising care capacity
3. Addressing the pandemic's 'hidden' impacts on citizens and services:
    - Improving health/including mental health outcomes
    - Reducing health inequities in service delivery
    - Challenging inequalities (Ethnic Minority Communities, social deprivation, social isolation)
    - The impact on climate change, ensuring that Medway can address the priorities identified for through Medway's Joint Health and Wellbeing strategy and JCMG's core principles.
4. Any unforeseen circumstances such as the cost of living crisis which is a developing risk for most areas.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Governance of the BCF in Medway

Our Joint Commissioning Management Group (JCMG) was established to lead on all elements of joint commissioning, including BCF, and has allowed learning to be shared for informing local plans across the system, providing the flexibility to adapt to changes in need, performance, or circumstance. Commissioning activity ensures there is a focus on defined and measurable outcomes and consistent contract management.

Meeting every six weeks, JCMG has ensured the separate NHSKM and Council governance processes are fully informed such as the Health and Wellbeing Board, NHS KM ICB's Governing Body, the Council's Health and Adult Social Care Overview and Scrutiny Committee, and Cabinet.

The M&S HCP provides whole place based system oversight and leadership to drive improvement in Emergency Departments performance and ensure high quality Urgent Care Pathways for patients in the context of the ICB priorities. Every system partner attends the Local A&E Delivery Board (LAEDB) and has executive level

representatives with the authority to commit to decisions on behalf of their organisation.

Through Population Health Management we have developed a 'Local Memorandum of Understanding' - a written understanding between the Statutory, Voluntary and Community Sectors and other partners within the Medway and Swale locality about how we will support each other, this recognises the contribution Voluntary and Community groups make.

We have also established a Partnership Commissioning Steering Group to support engagement around our development of our BCF plan and our commissioning activity. This group are developing their terms of reference and to date have met several times to support the programmes of commissioning including Wellbeing Navigation, Voluntary and Community Sector, Carers Support Services, Supported Living and Intermediate Care and Reablement. We work closely with our local Healthwatch Service to design and produce engagement materials to support our commissioning activity, ensuring the patient voice is captured and that we consider accessibility and equalities.

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- *Joint priorities for 2022-23*
- *Approaches to joint/collaborative commissioning*
- *How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.*

The Medway Better Care Fund Plan 2022-2023 has been created with reference to our local strategies for Social Care, NHS, Public Health, Disabled Facilities Grant and wider.

In Medway, shared leadership is demonstrated through the development of the M&S HCP for delivering integrated care and wellbeing, with a focus on population health management. There has been significant system-wide engagement with social care and health providers, Councillors, GPs and the Acute Trust, to develop the partnership, which puts the needs of our residents before organisational need.

The health and social care system in Medway has been redesigned to reduce the number of trips to hospital made by people and increase the level of access to the support they require from more specialist clinics provided in local surgeries. These changes simplify and connect the often-confusing access to health across the Emergency Department, GP out of hours, minor injuries and illness services,

ambulance services and 111 so that Medway residents know where they can get urgent help easily and effectively, seven days a week.

We work diligently to understand the variation in health and social care outcomes across a wide range of indicators. Demographic profiles for the M&S HCP have been developed by Public Health to ensure the work undertaken is data driven. Through a population health management approach, the Medway and Swale system has created a data repository which identifies all statutory organisational data sets across our locality. It will include qualitative and quantitative data from the voluntary and community sector to create a richer source of local place-based intelligence. The data sets will be continuously analysed through the population health management steering group in order to identify the highest inequalities with an aim to build community resilience within neighbourhoods. All partners including wide agreement and contribution from the voluntary sector are included in the discussions and design.

The Health and Social Care Act 2022 seeks to publish data sharing legislation which will support the health and care system in Medway to develop effective policies, plan and commission services and target care and resources where it is most needed.

Priorities for the BCF in 2022/23 are:

1 Improved discharge pathways from hospital to realise the best health outcomes for our residents

2 Prevention to reduce hospital admissions and support maximising care capacity

3 Addressing the pandemic's 'hidden' impacts on citizens and services:

- Improving health/including mental health outcomes
- Reducing health inequities in service delivery
- Challenging inequalities (Ethnic Minority Communities, social deprivation, social isolation)
- The impact on climate change, ensuring that Medway can address the priorities identified for through Medway's Joint Health and Wellbeing strategy and JCMG's core principles.
- Any unforeseen circumstances

As noted earlier, the Local Memorandum of Understanding between the Statutory, Voluntary and Community Sectors and other partners within the Medway and Swale locality sets out how we will co-operate.

It is crucial to the governance and wellbeing of communities in Medway and Swale that we work collaboratively through engagement of volunteers, promotion of active residence, promotion of debate, questioning and new ideas, and providing services. If the Memorandum of Understanding is effective, it will support the development of Voluntary and Community sector capacity, to increase and improve the impact of the

sector and benefit Medway and Swale residences. It is our intention that community health resilience will be developed through this approach.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- *Enable people to stay well, safe and independent at home for longer*
- *Provide the right care in the right place at the right time*

Please use this section to outline, for each objective:

- *The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care*
- *How BCF funded services will support delivery of the objective*

Plans for supporting people to remain independent at home for longer should reference

- *steps to personalise care and deliver asset-based approaches*
- *implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches*
- *multidisciplinary teams at place or neighbourhood level.*

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- *Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.*
- *Carry out collaborative commissioning of discharge services to support this.*

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Medway leaders are prioritising effective hospital discharge planning. Guidance published to date has set the direction Medway by all system partners. The introduction of the 'discharge to access' (D2A) pathway has seen a significant change in the number of people who experience a delayed discharge. The change in Government funding supporting discharge arrangements during Covid means we

have reframed our D2A pathways and we are working now with colleagues in NHS Kent and Medway, Medway Foundation Trust and Medway Community Health, to finalise those arrangements.

Hospital discharge in Medway remains a complex and challenging process for healthcare professionals, patients, and their carers. Particularly where the global pandemic has impacted so heavily on services and staff. The BCF facilitated several schemes highlighted below, which have helped to expediate an early response to the COVID-19 pandemic and support the earliest discharge and assessment at home possible. Our system undertook a review of the High Impact Change Model in August 2021 and this highlighted our strengths and challenges and there will be a review of progress against the action plan in 2022.

We are working with our providers to ensure we are able to support patients needing ongoing care at home. The provider market is fluctuating greatly due to changes in demand for services and also the Government furlough scheme, which has impacted on the market considerably, particularly for domiciliary care. We are anticipating changes in demand for residential care as a result of Covid, which is reflected in our metrics, residential care demand is also impacted by the establishment of our discharge to assess pathway and our strategic approach to delivering more care and reablement in people's own homes where possible.

The Rapid and Urgent response teams comprise of nurses and therapists providing specialist care in the community, responding within two hours of a call to support admission avoidance, re-admissions and discharge to assess. The teams are supported by MedOCC GPs providing prescribing advice and guidance.

Partnership Commissioning have been supporting care homes with managing falls through the purchase of Camel lifting chairs via the Medway Integrated Equipment Service. We work closely with our providers to develop new strategies and approaches to support people to remain at their normal place of residence.

The SMART Team at Medway Hospital supports patients in their home on discharge, where they need to remain under close care of a hospital clinician during their recovery.

Patients discharging from an acute episode of care can be referred in to the Multi Disciplinary Team where required. Members of the Integrated Discharge Team are attending these meetings to support discussions for those patients at risk of readmission. The Multi-Disciplinary Team also includes Adult Social Care and community providers such as the Voluntary Sector, the Wellbeing (Care) Navigation Service and community nurses and therapists.

The key to managing demand and reducing pressure on the system is to prevent people from becoming ill, ensuring that the system supports individuals to better manage their long-term conditions. The aim is to support people to live independently and well, for longer. Medway has a number of initiatives that are not funded by the BCF, which provide preventative services such as the 'Better Medway Services' and the Medway Better Mental Health and Wellbeing.

Support for patients requiring ongoing care at home is ensured through working with providers, particularly those in domiciliary care. The care sector is facing significant challenges partly due to an increase in demand. This is multi factored and wide ranging and on a national level, which has impacted particularly for domiciliary care.

The following BCF funded services support our system to effectively support safe and timely discharge from hospital.

Discharge to Assess

Regular Multi Agency Discharge Events (MADE) take place in Medway. Both planned and ad-hoc events take place to support effective discharge planning and performance and deliver continued learning and improvements.

As noted above, discharge arrangements are in the process of being reframed following the end of the discharge funding related to Covid. It is anticipated that there will need to be significantly greater spend on this area, from the BCF to ensure continued performance.

Home from Hospital Pilot Service

The pilot service commenced on 1 November 2020 and due to its success was extended to 31 March 2022. There is currently service provision from a national scheme provided by Royal Voluntary Service. We will monitor this and ensure there is appropriate provision to support hospital discharge. We also support Hospital Discharge throughout Wellbeing Navigation Service which has a presence at Medway Hospital and can help patients and families navigate local services to find appropriate support.

Intermediate Care and Reablement Service and Home First

Medway has an established service to deliver assessment and reablement at home. Home First is a multiagency response service that supports hospital discharge for people who are medically stable and have reablement potential. The significant difference with this model is that the assessment and reablement is delivered in the service user's home setting and not, as has traditionally been done, in a hospital ward or community bed.

Medway's Home First service has been highlighted at regional and national BCF network events and by the Emergency Care Improvement Pathway (ECIP), which supported its development as good practice.

Our Intermediate Care and Reablement Service (IC&RS), which was developed from the learning of the original Home First trial, commenced on 1 October 2016 with Home First as an embedded part of the contract and has been extend to the 30 September 2023, and varied to accommodate the new health pathways. The recommissioning process follows our established collaborative process with key partners.

Patient voice

An example of patient experience is summed up in the following quote “I was in a sorry state when I first got home, barely able to do more than sit up in bed (and that only with assistance!), but from the very start getting a Home Visit from [worker] advising me on what assistance and aids were available to me – from daily care/enabler visits to get me washed and dressed, to providing equipment ranging from a perching stool to a humble urine bottle, to a visit from a physiotherapist – was an absolute lifesaver…

… All my dealings with all my helpers – carers/enablers/managers etc – were positive, and it was clear that everyone, absolutely everyone, was fully committed to doing their very best for me, and I really appreciated it.”

Healthwatch are working with our commissioners to ensure we include the independent voice of patient experience for all commissioning initiatives.

Medway Integrated Community Equipment Service (MICES)

MICES was introduced during 2016 to bring together disparate equipment services into one integrated service. MICES has been vital in supporting the COVID-19 pandemic response supporting care homes with equipment, as well as hospital discharge and people remaining at home with maintained independence for as long as possible. The new MICES contract commenced on 1 September 2020 and supports the increased demand of Pathway 1 (discharge to assess) discharges.

The digitalisation and stock management system of the new contract ensures that all activity deliveries, collections, and repairs are now monitored in a much more robust way. This ensure KPI’s are measured, and equipment collection and recycling are maximised to its full potential. There are now 3 recycling drop off points across Medway for service users to use to return equipment and panels take place weekly for Adults and paediatric equipment.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

We have developed a Joint Carers Strategy for Medway which has been co-produced with a range of partners and stakeholders including statutory, community and voluntary sector organisations and in consultation with adult and young carers.

Medway’s BCF supports Carers through funding for carers breaks and through our high quality commissioned advice and support service which is delivered by Carers First.

Carers FIRST support carers at any stage of their caring journey; from a recent diagnosis, through to end of life. The support continues if the cared-for person dies or until the carer no longer requires help. This is through the following:

• Information, advice, and guidance
• Support for carers so that they know their rights and the help available to them
• Community support networks and group activities
• Support in workplaces, hospitals and GP practices to help staff understand the issues facing carers and how to signpost carers to services
• Work with Medway Wellbeing Navigator Service and community link workers to identify carers, make sure they are registered on GP systems and signposted to services or help
• A carers' coordinator placed in Medway Maritime Hospital to help carers when the cared for person is admitted or discharged from hospital
• A carers support payment or support is provided as an urgent response to carers who are not receiving financial support through the local authority.

Carers FIRST makes sure young carers are helped through a young carer's assessment. They work closely with health and social care to make sure that the person the young carer is caring for has proper support in place, not relying on the young person. They help young carers to access community and school-based activities that help to reduce the long-term impact on young carers' development.

In 2021 (January to December):

- 95% of carers felt an improvement in their health and wellbeing because of using the service, the same as in 2020
- 96% of carers felt better able to access support from health, social care, and welfare benefits system because of contacting the service, and increase of 4% compared to 2020
- 100% of young carers felt that the service helped them to reach their educational goals, the same as 2020, however, it should be noted that that response to the survey was low
- 88% of carers felt that the service enabled them to have a meaningful break from their caring role, of which 2% were young carers. Although meeting the 80% target, there was an 8% decline compared to 2020, and can be attributed: The impact of the pandemic on carers shielding the 'cared for' or themselves, issues recruiting staff in the sector and being unable to find a carer to look after the person they 'care for' for respite
- 94% of young and adult carers who use the Carers service, feel that they are supported, and a Crisis is avoided, a decline of 4% compared from 2020, again impacted by pandemic during the year
- 97% of carers felt they were better supported to develop contingency plans and plan for the future
- 94% of young and adult carers felt that their emotional wellbeing has improved due to using the Carers Service

Other groups
NHS KM are working with the Council and system partners to develop a Dementia Strategy to inform a needs assessment for dementia care.

Work with providers will continue to build changes into the local market, which will deliver savings and improvements in service delivery.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Medway Council understands how important support is to make sure vulnerable people can stay in their own home or find better accommodation to help them stay active and living independently. This may mean providing housing with support staff on site (supported housing) or having support staff visiting people in their home. Medway Council is currently reviewing whether there is the right type and right amount of housing related support and other help for people to stay in their homes for longer. The Housing Strategy 2018-2022 aligns with the Homelessness Prevention Strategy and links to a range of council plans and strategies.

It is predicted that there will be 22% more people living in Medway by 2037. There will be more households in all age ranges but especially those aged 65 and older. Medway Council will need to account for this in our future plans. An example of this is our current program of extra care schemes with future developments being planned in collaboration with our partners in Adult Social Care. Medway also recognises the changing needs of residents and aims to ensure that all new affordable housing developments include units which are accessible for people who use wheelchairs or have other mobility issues.

The Care Act 2014 shifted the focus to earlier intervention that offers a more preventative approach to supporting people. The principle of the DFG service for residents across Medway is to '*help me live in my own home, easily and with dignity with the right adaptation when I need it'.*

An established person-centred approach in place supports the needs of the person. The individual need is met through the DFG team or the MICES team dependent on that need.

In Medway, the MICES and DFG teams collaborate to meet the complex health and social care needs of residents.

The DFG team supports MICES and hospital discharge by providing community equipment to those with a temporary or permanent health need, or disability on a temporary or permanent loan basis.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- *Changes from previous BCF plan*
- *How these inequalities are being addressed through the BCF plan and BCF funded services*
- *Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered*
- *Any actions moving forward that can contribute to reducing these differences in outcomes*

The M&S HCP footprint has some of the highest levels of deprivation in the UK, with some wards being in the 10 percent most deprived areas in the country. Although Medway currently has a younger age profile than the England average, the number of people living in Kent and Medway is predicted to rise by almost a quarter by 2031. This population growth will have implications for health and care services.

The pandemic has had an on-going effect on the way services are delivered in Medway. In addition to the changes required to inform discharge and funding of operations, there are signs of a trend in reduced demand for residential services and a shift towards supporting more people in their own homes. To be responsive to the pandemic and the demands on services, the Council is working with all health partners to understand and alleviate the pressures around hospital discharge and acute and community care.

In Medway, 23% more people have an unplanned admission for a chronic condition that could be managed out of hospital, compared to the national average.

Medway Joint Strategic Needs Assessment March 2021 states that deprivation has a major impact on shaping the physical and mental health and wellbeing. Life expectancy in Medway has been consistently below the England average, and in recent years:

- has increased for females however, females are more likely to spend a greater proportion of life in poor health than males
- just below the England averages by 0.7 years for males, and 0.8 years for females.

The most deprived areas are more likely to have a lower life expectancy of up to ten years for a male and eight years for a female compared to the more affluent areas of Medway.

24% of children aged 4 to 5 years and 36% of 10- to 11-year-olds are classified as overweight or obese across Medway, with higher rates recorded in areas of deprivation. Nearly 70% of adults in Medway are classified as overweight or obese, which is significantly higher compared to England at 62%.

The number of people aged over 18 who smoke, is 4% higher than the national average. Smoking and obesity are known as the two key risk factors that contribute to morbidity and mortality across a range of conditions in adulthood. While smoking rates have fallen in Medway over the last decade, the prevalence remains high for manual occupations, and nearly half of adults with serious mental health illness smoke.

People with severe mental illness die on average fifteen to twenty years earlier than the general population, with smoking rates thought to be the largest contributor. In Medway, there is a higher rate of suicide, particularly in men, compared to the England average rate and a 2% higher prevalence of depression.
People with learning disabilities have shorter lives compared to the general population.

The one-year cancer survival rates are 5% lower in Medway than the national average. Cancer contributes to a greater extent in females (54.7%) than males (32.7%). Several areas in Medway have higher rates of death from cancer of approximately between 20% and 40% higher than the national average for England.

Addressing Health Inequalities in Medway

The Levelling Up White Paper will set out a complete 'system change' of how government works that will be implemented to level up the UK via cross-government, cross-society efforts. This is the first time a government has placed narrowing spatial economic disparities at the heart of its agenda.

Medway's BCF Plan will ensure the initiatives which the fund finances will focus on addressing the needs of those most vulnerable in the community. The aim is to proactively help people access the services, advice and care they need to maintain their physical and mental wellbeing.

Activities that look to address health inequalities are linked to the population health management programme (PHM). M&S HaCP are the lead HaCP for the national programme. All levels of prevention are included: primary, secondary, and tertiary. A M&S HaCP health inequalities interactive map is being created and will include service provision and disease prevalence to calculate level of need and ensure equitable access.

The Medway Joint Health and Wellbeing Strategy links into several health and social care strategies and provides a high-level framework to improve the health wellbeing and health inequalities of the Medway residents. The focus is on five key outcomes:

- Giving every child a good start
- Enabling our older population to live independently and well
- Preventing early death and increasing years of healthy life
- Improving mental and physical health and well-being
- Reducing health inequalities

The Joint Local Care Steering Group identified transitions as a priority area and recommended a proposal to JCMG to secure BCF funding for additional capacity to map health pathways, thresholds, and services for transition across a wider remit for the. HaCP

A Preparing for Adulthood Project Board has been established to improve the outcomes for service users transitioning from Children's Social Care to Adults' Social Care. This is to support people aged 16 and over with disabilities such as learning disabilities, autism, or physical disabilities. The objective is to develop a seamless process of transition to adulthood with clear signposting and information (such as education and providers) to young people, their families, and relevant stakeholders regardless of Care Act eligibility. This supports the life chances of children and young people with SEND by working with them and their parents and carers to effectively plan for and support their transition to adulthood.

As mentioned above, the 'Better Medway Services', the Medway Better Mental Health and Wellbeing and the Medway Health Champions also provide preventative services and also tackle health inequalities.

The Wellbeing Navigation Service, which we are in the process of recommissioning, aims to target areas of deprivation according to population health need as well as frequent attendees at GP surgeries. The service will work within and alongside, the PCNs, ASC and Housing and Benefits Teams within the Council.

The BCF Plan facilitates the Psychotherapy for Tier 3 Children Service psychotherapy support programme, which commenced in 2021. The service is a weight management with psychotherapy to support and engage with children and young people who are above a healthy weight and higher than the 98th percentile. Over 2years the service aims to:

- increase understanding of a healthy lifestyle
- increase wellbeing and physical activity
- reduce the levels of overweight and obese within the cohort
- reduce the prevalence of long-term obesity related conditions
- reduce the use (and cost) of statutory services due to obesity related conditions
- improve family awareness and understanding of the impact of obesity

Other areas where the BCF Plan provides support to ensure equity of service and addressing the health inequalities are:

- Carers play an essential role in supporting the independence of those being cared for by remaining in their own home. As the population increases, increasing the resilience of carers will also be a priority.
- Voluntary services have provided vital support to carers and health and social since the COVID-19 pandemic. Carers First provide carers information advice and guidance, a young carers and carers support payment service, and have actively supported carers throughout the pandemic by offering wellbeing calls, shopping and picking up medications for vulnerable carers. They also helped

GPs to identify carers for the COVID-19 vaccination programme, and provided young carers with emergency continency planning and virtual support throughout the COVID-19 pandemic.

Partnership Commissioning sits within the wider directorate of Public Health which enables our BCF funded team to consider the latest research and guidance in relation to health and health inequalities and produce strategies and plans to address these. Our Market Position Statements will be reviewed in 2022/23 and will address the changes in the market and in needs locally. Fair Cost of Care reviews are being undertaken.

We work closely with Healthwatch Medway to ensure our residents' voices are heard. Healthwatch informs strategic decision making, commissioning and design of services and evaluation of services.

The Kent and Medway Integrated Care System has developed a Turning the Tide Board, chaired by James Williams, Director of Public Health for Medway. The Turning the Tide Transformation Oversight Board is to drive implementation of a strategy which will help the system to address the impact Covid-19 is having on people from ethnic minority backgrounds and workforce and to support the Kent and Medway System in developing a sustainable response. This board has sub-groups focusing on: • Data and information • Social marketing, communication and behavioural insight • Clinical management and risk management • Health and social care workforce

An Overview of the Ethnic Minority Population in Kent and Medway:

- The outbreak of COVID-19 pandemic in March 2020 has highlighted the existing inequalities impacting on people from ethnic minority backgrounds across England, and the need to investigate them and understand them better. A recent report published by Public Health England has shown that mortality rates from COVID-19 in some ethnic minorities are nearly double than those in the White British population.

- During the 2011 Census the majority of the ethnic minority population in England, and also in Kent and Medway, was on average young, ageing between 20 and 39 years old. When compared with the SE region, the distribution of ethnic minorities by broad age group in Kent and Medway was very similar. However, Medway on its own had a slightly higher percentage of people from ethnic minority backgrounds aged 65-84 and 85+ years old, than the SE region and also Kent.

- The ethnic minorities with the highest number of social service users were Asian (690) and Mixed (492). Although the majority of service users were White British, Dartford, Gravesham, Maidstone, Shepway, and Thanet had a higher number of social service users from an ethnic minority group.

- The largest ethnic group in nursing and care home residents was Asian. Thanet (29%) and Gravesham (29%) had the highest percentage of people

from ethnic minority backgrounds resident in nursing and care home in Kent and Medway.

- The highest hospital activity rates for people from ethnic minority backgrounds in Kent and Medway were in Other ethnic group, which was higher than in White British. Hospital activity rates in Black and Other White population has been increasing over time and are currently higher than in White British population. It is very interesting how the rate of A&E attendances in Other White increased from 935 in 2018/19 to 1656 per 1,000 in 2019/20 which is very likely attributable to the outbreak of COVID-19.