Medway and Swale HaCP Population Health Management Programme

1. Fair Share Allocation

Fair share allocation in the health service is crucial to Population Health Management and reducing inequalities in health because it ensures that financial resources are distributed equitably based on population need rather population head count. The fair share allocation approach helps to address disparities in healthcare access and outcomes, promotes social justice, and maximizes the efficiency and effectiveness of healthcare delivery. Additionally, fair allocation fosters public trust in the healthcare system and enhances overall population health.

Demographic data tells us that deprivation in Medway and Swale is among some of the highest across the whole of the UK, with some areas being within the top 10%. It is known that people within areas of high deprivation require more funding for several reasons:

1. Greater Health Needs: Areas with high deprivation typically have higher rates of chronic illnesses, infectious diseases, mental health issues, and other health challenges, which can be seen through the Joint Strategic Needs Assessment (JSNA) for Medway and Swale. Addressing these needs requires more resources, including healthcare facilities, workforce and specialized services.

2. Reduced Access to Healthcare: People in deprived areas may face barriers to accessing healthcare services due to factors like limited transportation.

3. Wider Determinants of Health: Deprivation is often associated with factors such as poor housing conditions, unemployment, inadequate education, and limited access to healthy food. Within Medway and Swale, we are fortunate to have partners committed to addressing the Wider determinants of Health, however increased investment would accelerate alleviating health disparities and improve overall well-being.

4. Health Inequalities: Areas of high deprivation are known to experience significant health inequalities compared to more affluent areas. Additional funding can help bridge these gaps by providing targeted support and resources to address the specific needs of disadvantaged communities.

Fair Share Allocation in Medway and Swale would promote fairness, equality, and justice in resource distribution, ensuring that everyone has access to essential services and opportunities to achieve optimal health outcomes.

Historically funding has been not been on a fair share allocation basis, and has been based on other factors outside of this, including for example population head count. This widens the inequalities gap in Medway and Swale, as it means that deprivation is not factored into allocations, and it is widely known that areas of high deprivation require more funding, which has been seen in recent years in National programmes such as the Levelling Up Fund.

It is known that a full analysis has been undertaken across Kent and Medway on Fair Share Allocation, detailing the proportions of which would be applicable to each HaCP. This analysis has not been shared wider at this time.

1.1 Health Inequalities Allocation

The Kent and Medway Integrated Care Board (ICB) received Health Inequalities funding in 23/24 from NHS England totalling £5.95 Million, of which Medway and Swale HaCP were delegated £1.1 Million to fund local initiatives to reduce Health Inequalities. The agreement in principle at which time was that the programmes funded would be for a minimum of three years to ensure time to have a demonstratable impact on Health Inequalities.
Population Health data was used alongside local insights to decide upon the programmes that would be funded, that would support the strategic aims of the HaCP. Six programmes were agreed to fund through 23/24 (of which, two programmes were already mobilised through 22/23 allocation). The funded programmes are; Community Health Catalyst, Making Every Adult Matter, Childhood Asthma, Clinical Variation, Tier 3 Children's Weight Management and Social Prescribing. Further details of these programmes can be found in section 2.1.

In January 2024, the HaCP received a letter which detailed how the programmes would be funded in 24/25, which sees the six programmes split into three categories:

- Category one programmes are to be funded until September 2024, at which time outcomes must be provided
- Category two programmes are clinical programmes that could possibly be part of a system wide scheme, and are agreed funding until September 2024
- Category three programmes are to receive funding to September 2024, but no further funding from this point

Medway and Swale HaCP have had the Social Prescribing programme put into Category Three and therefore at this time is not guaranteed funding beyond September 2024. Tier 3 Children's Weight Management is yet to be placed into a category.

The allocations for 24/25 represent the challenges that the HaCP face in relation to funding and securing long term funding to begin to address Health Inequalities. With no security around funding, it becomes increasingly difficult to engage and build relationships and rapport with system partners, including the Voluntary Community Social Enterprise and Faith Sector (VCSEF) but also our communities.

2. Medway and Swale Population Health Management Programme

2.1 Health Inequalities Allocation 23/24 Programme Successes

The below indicates the success of the Health Inequalities Programmes that were funded through the Medway and Swale health Inequalities allocation for 23/24. Two of these programmes, Community Health Catalyst (2.1.1) and Clinical Variation (2.1.6) were funded in 22/23, and begun in September 2022.
Unless specified otherwise, the data shown is at December 2023.

2.1.1 Community Health Catalyst

The Community Health Catalyst Programme seeks to engage and listen to people in the most deprived areas of Medway and Swale, who fall into health inclusion groups that have been historically seldom heard. The project aims to understand Health Inequalities of these groups, and works on providing groups with signposting support, some social prescribing funding and community grants for projects born from the outcomes of the listening events.

The Community Health Catalyst Programme has been shortlisted for a 2024 Healthwatch Award in the category of 'recognising excellence in consultations and engagement'.

Project figures from the beginning of the programme to the end of December 2023 are as below:

Activation & Listening

	Engagement			Listening		
	Medway	Swale		Medway	Swale	
Mental Health	101	123		17	10	
Drug & Alcohol Dependent	80	24		11	10	
BAME	86	31		22	0	
Multi Morbidities	33	60		11	22	
Gypsy, Roma, Traveller	17	6		10	0	
Ex-Offenders	89	4		14	0	
Homelessness	90	40		16	10	
Learning Disabilities	27	46		17	19	
Vulnerable Migrants	47	17		11	12	
LGBTQIA+	30	40		8	9	
Sex Workers	0	0		0	0	
Victims of modern Slavery	0	1		0	0	
Coastal Communities		137			17	
Total	**600**	**529**	**1,129**	**137**	**109**	**246**

Action

- Medway - through the course of the project, 114 people have been signposted to services, groups and activities.

- Swale - through the course of the project, 80 people have been signposted to services, groups and activities.

- Local asset & signposting reports have been developed for those participating in the listening events. There is also a small pot of funding that can support social prescriptions where required, data for this is expected in Q4.

- Kent Community Foundation are being used for the brokerage of the Community Chest Fund which was opened in September 2023. As at March 2024, seven applications have been received.

- Outcomes from the health catalyst have resulted in a paper being presented at the HaCP Quality and Safety board, to highlight issues that partners can begin to address within service delivery.

2.1.2 Childhood Asthma

Outcomes for Children and Young People (CYP) with Asthma are worse than the England average, with significant inequalities being seen in the areas of highest deprivation. The HaCP CYP Asthma programmes seeks to apply a holistic approach to Asthma care, incorporating clinical intervention and importance of yearly reviews and Personalised Asthma Action Plans, but

also addressing the wider determinants of health and incorporating Asthma Friendly Schools, housing support and VCSEF support for improving outcomes.

The interventions and outcomes are as below:

- Asthma Friendly Schools – signed off at HaCP board with 3 secondary schools, 6 primary schools and one Special Educational Needs School signed up. This has been adapted for other educational settings which has enabled MidKent College to sign up, as well as a Children's Centre in Sheppey. This programme is being rolled out and conversations are being held to establish Kent & Medway wide roll out.
- Asthma Friendly Sports Clubs is being mobilised with Kent Football Association and Medway Rugby Club signed up to pilot the programme.
- 7 Training sessions have been held for non-clinicians, with 174 individuals attending. These sessions are predominantly around wider organisations including the VCSEF
- 4 Education sessions have been held with parents with 21 parents in attendance
- Through community-based events the clinical lead has had contact with 69 patients and supplied advice, guidance and signposting for CYP
- Professionals training – training developed and 5 professionals from GP Practice have attended training, with further training planned
- EMIS searches for highest risk CYP – created and 13 GP surgeries have been contacted to conduct the searches
- Early mapping of digital support for the programme

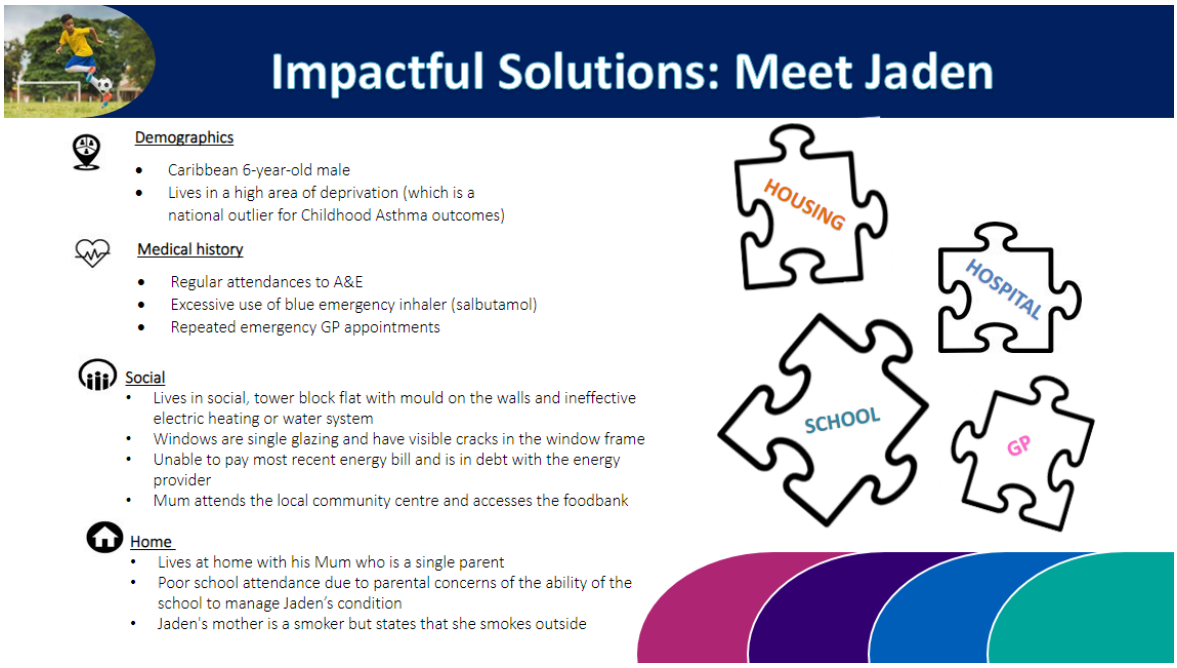
The Childhood Asthma programme has been shortlisted for a 2024 Healthwatch Award in the category of 'Involving people in commissioning and delivery of services'.

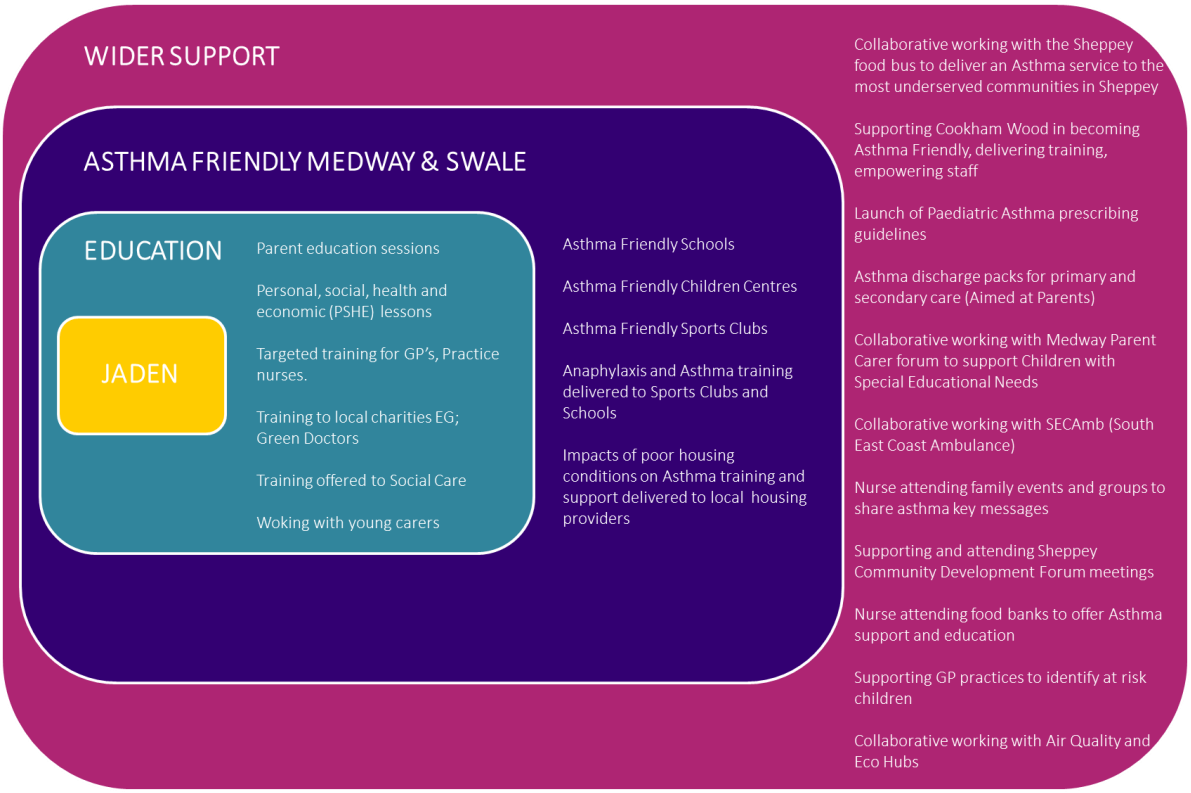
The clinical leads within the programme has been shortlisted for the South East Nursing and Midwifery Green Week Awards under the category 'Low carbon treatment and care settings'.

The expected impact of the programme is:

- Reduced numbers of Emergency Department (ED) attendance
- Improve diagnosis of CYP asthma – predicted increase in numbers on GP registers
- Increase % of children with a management plan
- Increase % of children with an annual review
- Asthma Friendly Schools & other education settings
- Increased numbers of PCNs having undertaken training on Asthma management
- Community reviews of highest risk children and those who are unable to access services
- Improve patient experience of Asthma
- Increase awareness across the community of the importance of Asthma

Case Study Example:





2.1.3 Making Every Adult Matter (MEAM

MEAM is a trauma informed, strengths-based approach to working with people experiencing multiple disadvantage. The programme prioritises people at highest risk of premature death for whom the system is not working.
Progress and other highlights so far include:

- A Medway Multiple Disadvantage Network (MMDN) Strategic Group has been established to oversee the development of partnership working of services including those funded through Health Inequalities, Rough Sleeping Drug and Alcohol Treatment Grant and Rough Sleeper Initiative as well as commissioned and non-commissioned partner services, such as probation and prison services, VCSEF and health services. Working in partnership is already bearing fruit in terms of coordination of care and support for clients with multiple needs. The first meeting of the MMDN Strategic Group is 1st Feb 2024.
- Inform is being developed as a Client Relationship Management system to support the MMDN partnership working, supported by an appropriate Data Sharing Agreement (this is currently being revised to reflect how the Inform system works to enable information sharing. MMDN operational teams have undergone training on the system and it is expected to go live early 2024.
- One of the principles of MEAM is co-production and we are continuing to actively engage with partners and other stakeholders through 1:1 meetings, attendance at Multi-Agency Meetings and a MEAM survey. Evaluation of the survey has produced a draft system map and identified key stakeholders to participate in MEAM either strategically, operationally, as part of co-production work or by providing case studies.
- The 2 MEAM Coordinators have been appointed and are actively working with an initial caseload of 4 of the most complex clients on the MEAM priority list. This has resulted in some successes and some challenges – learning from these cases is being written up to share with the Strategic Group to support system change. The coordinators are now picking up a second group of 5 clients whilst continuing to work with the in initial 4.
- Prior to the MEAM coordinators joining the team, we have supported joining up care across health and social care for some individuals through Multi-Agency Meetings (MAMs), with success in moving forward a couple of complex clients.

The MEAM programme has been shortlisted for a 2024 Healthwatch Award in the category ‘excellence in enabling local people to monitor standards and be involved in improving them.’

Specific examples from some of the individual cases included:

- Client 1
    - Rough sleeping for **circa 15 years**, exhausted housing options, crack and heroin, “non-engagement”, prison,
    - Previous brain tumour, not accessing care and medicines, multiple ED/victim of assaults, repeat head injury.
    - MEAM (with support from Network) – GP appointments, prescriptions, bloods, hospital referrals, accommodation (although evicted), Forward Trust – ECG, methadone script, counselling.
    - Moving forward - Looking at options to flex regarding housing, looking to get neuropsychology assessment to start Clinical Formulation, support to attend elective appointments.
- Client 2
    - **30 years** in and out of Prison (30+ sentences since age 18), LD with autistic traits, query personality disorder, self-harm, substances – alcohol, cocaine etc, brought up in care.
    - MEAM coordinators led MAMs prior to prison release that included multiple MMDN services plus care agency
    - Moving forward looking to access appropriate service to provide Clinical Formulation to develop long term plan.

2.1.4 Tier 3 Children's Weight Management Service

This programme aims to support children in the 98th percentile or above and their families to lose weight, eat healthily and move regularly. The intervention also aims to have a positive impact on anxiety, wellbeing levels, school attendance and family relationships.
It is not yet known whether this project will be funded from September 2024, due to a decision not being made around the categorisation of the programme.

Referrals have been made into the service via Medway Council from the waiting list held within Medway Council Tipping the Balance programme. As at the March 2024, 38 referrals had been received for Medway. The Swale pathway is complete, with the first referrals expected to come via the National Child Measurement Programme (NCMP) early in Q4.

The impact of this service to date is being collected and is expected to show:

- Reduction in weight for participants
- Improvement in healthy eating and physical activity levels
- Improvement in mental wellbeing including reduced anxiety
- Improvement in school attendance
- Improvement in family relationships

Longer term outcomes are expected in reduction in long term conditions for participants, and reduction in access to care services and medication costs for participants.

2.1.5 Social Prescribing

Social Prescribing has been identified as a key component of personalised care, connecting people to help and support in their community, based on what matters to them and their individual strengths and needs. The Social Prescribing programmes seeks to support the VCSEF through capacity building, by funding the social prescription together with a seed funding element.
The Social Prescribing programme has been identified by the ICB to not receive any further funding from September 2024. This cut in funding poses a great risk not only to the HaCP, but the wider Integrated Care System. The HaCP have worked on relationship building with the VCSEF over the course of many years, and this cut could result in irreparable damage to those relationships.

Progress to date on Social Prescribing is as follows:

- A Medway and Swale Social Prescribing Strategy Group is established and meets regularly.
- Sub-groups such as the Social Prescribers Forum and Social Prescribing Leaders Group are also in place to support development of social prescribing locally.
- A web-based app Joy has been identified to support delivery of social prescription fund and capture key metrics. The app is being further developed to support administration of funding flows for social prescriptions and this functionality will be completed in March 2024. While this is being developed a manual workaround allowed a soft launch the system in December 2023.
- Medway Voluntary Action (MVA) project manager, appointed in the last period, is working with Primary Care Networks, Social Prescribing Link Worker (SPLW) providers and VCSEF organisations to populate the Joy app with information on services that will accept social prescriptions and to give SPLWs accounts to use the app to make prescriptions.
- So far 45 organisations across Medway and Swale are live on Joy (up from 30) offering 315 activities (up from 71) with a further 5 organisations working to add activities to Joy. Work is continuing to increase both the number of organisations and activities on the system.

- 32 SPLWs have completed training to use the system with a further 12 booked. Further engagement to encourage all Medway and Swale SPLWs to attend training and an alternative recorded webinar session being developed to support more flexible and sustainable training offer.
- An evaluation partner has been appointed. Currently this is in mobilisation stage but will include an evaluation of wellbeing impact. Evaluation expected to run from Feb 24 to July 24. This is a slight delay to the original plan to allow more VCSEF organisations and SPLWs to on board.
- Given the delay in funding from the ICB and the time it will take to implement the app we are reviewing the plan to consider increasing seed funding element and introducing group booking of social prescribing activities. A seed funding application form and process is in late stages of development.

2.1.6 Clinical Variation

The Clinical Variation (CV) programme has been working with 20 practices across Medway & Swale (15 in Medway and 5 in Swale) to improve Clinical Coding, run the risk stratification searches to identify high priority patients to be reviewed, and prevention work by identifying patients at risk of developing Diabetes and Cardiovascular Disease (CVD) and inviting them onto the healthy way's programmes.

No of patients identified for coding and review (Hypertension and Diabetes)

Clinical Coding	No of patients identified to be reviewed & coded
All QoF areas	13,204
Diabetes	1,429
Hypertension	2,981

GP Practices are using these searches to ensure high risk patients are reviewed according to Risk. This approach will help practices to prioritise patient care to those who are at highest risk to help minimise exacerbations leading to secondary care intervention. These searches have identified the following number of patients at the highest priority to be reviewed:

Risk Stratification	Priority Group 1			Priority Group 2			Priority Group 3		
	No of Pts	No reviewed	% reviewed	No of Pts	No reviewed	% reviewed	No of Pts	No reviewed	% reviewed
Asthma	1807	1452	80.35%	1308	914	69.88%	2621	1818	69.36%
COPD	993	724	72.91%	1112	744	66.91%	79	2	2.53%
Diabetes	788	262	33.25%	1033	385	37.27%	877	299	34.09%
Hypertension	239	97	40.59%	1612	702	43.55%	4143	2132	51.46%

The Clinical Variation team have used new methods to identify patients with Hypertension and Diabetes linked to ethnicity and deprivation. The CV team can now identify where the need is and undertake targeted work for these groups of people.

<u>Potential Risk's</u>

- Capacity at the various healthy ways/preventative programmes – mitigating actions in place
- Engagement from GP surgeries, this includes timeliness of access to their clinical system to run reports and identification of patients in need of an intervention.

2.2 Population Health Management Analytics

The PHM programme has held an analytics function since its inception, which seeks to apply a data-driven methodology to PHM. The Analytics function sits at the centre of the PHM programme and brings together colleagues across statutory, VCSEF, education and other businesses to allow cross analysis of data sets and ensures all programmes of work are data driven.

2.2.1 Clinical Priority Areas

In January 2024, key representatives from the Analytics group came together to discuss and recommend clinical priority areas for the HaCP for 24/25.
Public Health conducted a comparison review with the previous set of priorities (as informed by the Medway and Swale profile v2.1 (2021) with the latest Medway and Swale profile v4.1 (2023) to indicate priorities for the Health and Care Partnership going forward, examining what has changed and comparing with national averages.

Table 1: RAG rating compared to England in 2023 vs. in 2021

- More indicators have got a worse RAG rating in 2023 relative to England (bottom centre and middle left squares) than better (top centre and middle right squares) compared to 2021.

	Worse than England 2023	Similar to England 2023	Better than England 2023
Worse than England 2021	Children excess weight Epilepsy admissions <19 Bowel cancer screening Hypertension prevalence Diabetes admissions <19 Cancer mortality <75 Hip fracture admissions >65 Depression prevalence ACSC admissions Under 18 conceptions Life expectancy (female)	Adults excess weight Physical inactivity adults	
Similar to England 2021	AE attendances (0-4) Diabetes admissions <19 Breast cancer screening Life expectancy (male) **Circulatory mortality <75**	Asthma admissions <19 Prescribed antibiotics Low birth weight Smoking prevalence Infant mortality Mental health admissions (0-17)	
Better than England 2021	Self-harm admissions (10-24)	Osteoporosis prevalence Substance misuse admissions (15-24) Suicide rate (persons) Suicide rate (male)	Cervical cancer screening CHD prevalence (all ages) CKD prevalence (18+) Stroke prevalence Falls admissions >65 SMI prevalence
Not shown: Dementia diagnosis rate, smoking status at time of delivery, air pollution: fine particulate matter, stillbirth rate, dental decay in five year olds, cancer diagnosed at an early stage, admission episodes for alcohol-specific conditions. More detail available in Table 2.			

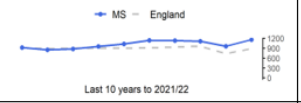
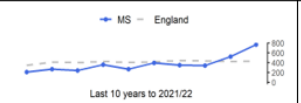
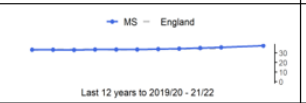
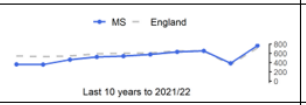
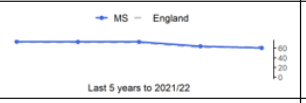
A weighted exercise was carried out, below is an extract and only represents first 7 to provide example. See appendix for full report. Indicators are listed in order of priority according to the criteria of.

1) comparison to England, trend 2023,

2) change in indicator value since 2021,

3) comparison with England trend.

Latest value compared to England carries triple weight to reflect the importance of this criterion and the fact that these comparisons are confirmed statistically.

Indicator	Latest time period	RAG rating 2021	RAG rating 2023	Latest value compared to value in 2021*	Comparison of trend since 2021*	Longer-term trend	Score
* = NOT CONFIRMED USING STATISTICAL TESTS – reflected in dull colouring SCORE: red = 1, orange = 0, green = -1, comparison to England 2023 weighted triple							
Emergency hospital admissions for diabetes (< 19 yrs)	2019/20 - 21/22	Similar	Worse	Worse	M&S worse England similar		5
Unplanned hospitalisation for chronic ACSC	2021/22	Worse	Worse	Worse	M&S worse England better		5
Hospital admissions as a result of self-harm (10-24 years)	2021/22	Better	Worse	Worse	M&S worse England better		5
Children with excess weight Year 6, three year average	2019/20 - 21/22	Worse	Worse	Worse	M&S worse England worse		4
AE attendances (0-4 years)	2021/22	Similar	Worse	Worse	M&S worse England worse		4
Breast cancer screening coverage (females aged 50-70)	2021/22.	Similar	Worse	Worse	M&S worse England worse		4
Emergency hospital admissions for hip fracture (persons aged 65 and over)	2016/17 - 20/21	Similar	Worse	Worse	Indirectly-standardised rate –	Trend data not available	4

Finally, a side-by-side review of each individual indicator was use to allow the group to see lower-level PCN data and where available health inequalities indicators. This enhanced the review to further discuss the severity of change, possible causes and determine whether it was a deemed a priority to put forward to the board.

The recommendation of priority areas for 24/25 has since been signed off at the HaCP Board, and are as below:

- ACSC (CVD, COPD & Heart Failure)
- Diabetes
- Cancer, early diagnosis
- Self-harm 10-24 years
- Frailty

Existing programmes for 23/24 priority areas will continue throughout 24/25 as business as usual and are not being replaced by the above clinical priority. The priorities identified above are in addition to current programmes.

2.2.2 Policy in Practice

A research project linking health and welfare data in tackling inequality and the determinants of ill health. Necessary welfare data has been provided, and health data is being provided to allow

Policy in Practice to begin to clean the data and begin to match the datasets. An update on the project is expected in April 2024.

2.3 VCSEF Framework Mobilisation

The Framework, agreed in 2022 set out our commitment as a system to work differently with our VCSEF partners and, to allow us to radically rethink how we support our community's health and wellbeing through an authentic commitment to working together. Through the process we are committing to build capacity and resilience in our communities matched by mechanisms that ensure the effective delivery of the principles set out in the framework.
A **Social Value Plan** is in place and outlines how the HaCP will become a greener, fairer and more prosperous community. Community engagement will be used to understand these local priorities and then co-design measures to enable benchmarking of progress against this 5-year plan.

A proposal is currently being worked upon to scope how the Better Together Consortium are suggesting they deliver this social value to ensure it aligns to strategic direction of the HaCP's identified needs of the population, and that the social value pledges to ensure activities support the wider social regeneration agenda.

Evaluation

The HaCP is committed to using this consumer intelligence at the core of its thinking and decision making to compliment the quantitative information that already flows through the PHM approach and widen its understanding of the challenges and needs of people living within Medway and Swale, beyond their clinical/medical needs.

Following the online survey that was sent out to organisations across Medway and Swale a Gathering Insights Network has been formed a pilot to identify and address health inequalities, the network has been asked to provide feedback on their views of place, feedback from this will directly inform the social regeneration conference, bringing community insights into the heart of the day.

To support Medway and Swale HaCP work at Place and to identify and address health inequalities a pilot is being undertaken with those that have identified a willingness to be part of an Insight sharing network.

2.4 Wider Determinants of Health

2.4.1 Volunteering

The HaCP and VCSEF sector have been working on the modelling of a Volunteer Passport since early 2023. A volunteer passport would see individual volunteers undertaking a set of essential training, which they could then use when volunteering at other organisations to reduce duplication. Insights are being gathered from a small number of VCSEF organisations to look to map where organisations require the same training e.g. Safeguarding, to begin to map how this could work.

The HaCP have applied for funding through a national Volunteering for Health Programme, which if successful, would see the Volunteer Passport progress accelerated, and would entwine with Health organisations and enable cross organisational volunteering opportunities.

2.4.2 Nursing Cadet Programme

In 2023 the Nursing Cadet Programme in MidKent College saw a cohort of Health and Social Care students undertake 40 hours of study, and 20 hours of placements. Placements were delivered through Medway Foundation Trust and HCRG Care Group.

MidKent college were successful in gaining funding for another cohort for 2024 which begun in February 2024. Placements are being sought through the same providers.

2.4.3 Estates

The Health and Care Partnership have drafted an estates strategy to utilise the resource that the partnership have and to understand opportunities to support the VCSEF where possible. Once the HaCP Estates Strategy has been agreed and signed off it will then be presented to the ICB who will include it in their overall strategy.

Medway Neurological Network have been using the Walter Brice Centre on a monthly basis since September 2023 where they have a stand to promote their offer, and support individuals with neurological conditions. The success of this will support longer term ambitions for VCSEF organisations utilising estates.

Further estates mapping is continuing to understand the type and location of estates that are available across Medway & Swale and how they can be better utilised to help support the VCSEF and bring services to the population rather than having the population travel to the services.

2.5 Implementing Core20PLUS5 to reduce Health Inequalities

The Health Inequalities funded programmes do overlap with the Core20PLUS5 programmes of work, which are detailed in section 2.5. The below summaries the remaining work under the Core20PLUS5 approach to tackling health inequalities outside of health inequalities funding, including the two committees that are in place to oversee the programme.

Core20PLUS5 Adults Committee

Following on from the Medway & Swale inaugural Committee held in June 2023, the committee had taken the action to collate all programmes that are in progress that relate to the key areas under Core20PLUS5 across the Health and Care Partnership organisations, which will in turn give an indication of any gaps. There has been a gap in meetings being held due to system pressures. The next meeting is expected to be restarted following the Health Inequalities Board in February 2024.

Cancer Inequalities

The Bowel Screening project that was bid for in 2023 is now being mobilised with the Memorandum of Understanding between the HaCP and the Kent and Medway Cancer Alliance being signed in January, and providers having contracts in place to deliver the project from March 2024. The project aims to increase bowel screening rates through community-based events to increase awareness and encourage uptake.

Cancer Non-specific Symptoms (NSS)

- Outcomes against target for our region are being collected and future planning in relation to the pilot is being progressed through Cancer Alliance Board.

qFIT

- Secondary care pathway/spec for K&M has been approved through the K&M Tumour Site Specific Group (TSSG). There are additional governance routes being progressed and following this mobilisation and comms are to be established.
- The HaCP are working with the Cancer Alliance on increasing uptake in Primary Care of low-risk pathway qFIT testing.

Respiratory workstreams

Spirometry - The HaCP continue to highlight specific issues for patients needing Spirometry to primary care and ensure the team are linked into progress with coverage across Medway & Swale. This includes awareness of the remote monitoring, progress with clearing current backlogs and Community Diagnostic Centres (CDCs) pathway development workstream.

Risks: Limited uptake on the service amongst practices in a PCN, and no hub within that PCN could lead to a backlog up in patients waiting lists and result in poor patient experience and patients not being diagnosed.

Home Oxygen - The Home Oxygen Service Assessment and Review (HOSAR) service in Medway & Swale is now mobilised from December 2023. Pathway mapping has been completed and signed off by key stakeholders Service specifications and CVs are in the process of being completed with providers.

Core20PLUS5 Children's Committee

Medway and Swale have had a Children's board running for over a year now. This board has now reformed to focus on the Core20Plus5 for children's framework. The Committee meet bimonthly and is attended by organisations across Medway and Swale, including parent forums and the VCSEF.

2.6 Engagement

The HaCP have dedicated Programme Management support for all the workstreams that provide meaningful engagement, to allow a mechanism to feed engagement and feedback into the system, as well as supporting the ICB held contracts for engagement.

There are various groups under the Engagement programme, including the People & Communities group, the Patient Participation Groups, and a Gathering Insights Network that has been formed with VCSEF representatives and a work plan has been developed.

Programmes such as the Health Catalyst and MEAM revolve predominantly around engagement, and feedback from such engagement gets fed into the groups as above. In October 2023, the feedback from the listening events through the Health Catalyst programme was compiled and themed to report to the HaCP Quality and Safety Board for action. The insights included some issues that sit within Health and Social Care but drew particular attention to the impact of the Wider Determinants of Health, including a sense of belonging and safety in the community.

Additional programmes around engagement include the Involving Medway and Swale programme, and Healthwatch insights which are regularly fed into the HaCP.

3 Social Regeneration at Place

The plans for social regeneration, stem from two years of extensive engagement with the most vulnerable communities when questions were posed as to what measures would support better

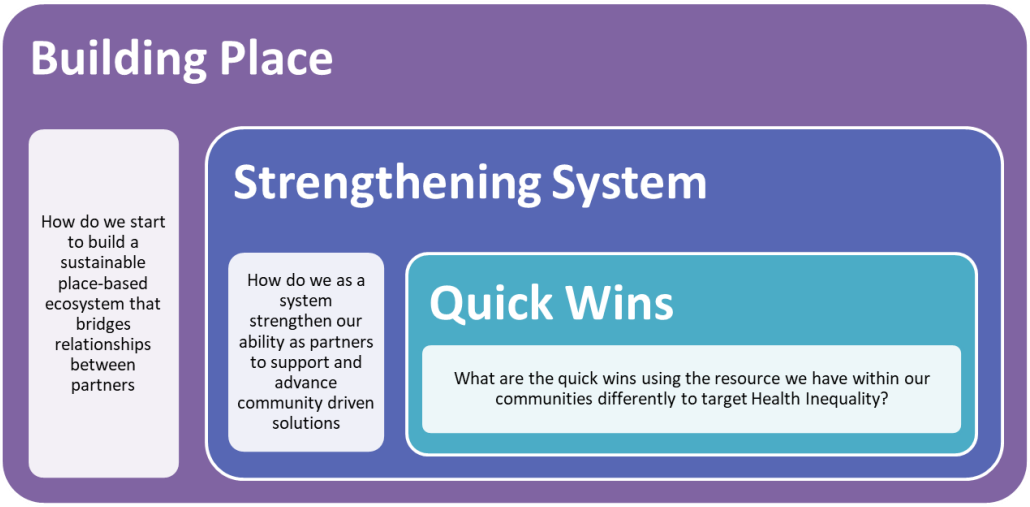
health and care outcomes, not one individual stated a clinical intervention, instead referencing elements that sat in the wider determinants of health such as housing, employment, education and overwhelming the need for a sense of belonging to the community.
The Medway and Swale HaCP has made a commitment to work collaboratively with system partners at Place to offer innovative solutions to complex issues that impact the health and wellbeing of the population we serve.

As systems, there is a need to radically rethink how we support our community's health and wellbeing through an authentic commitment to working together to build capacity and resilience in our communities matched by mechanisms that ensure the effective delivery and a process by which success can be measured and organisations held to account. "We need to think differently, act differently, alter our language and as a system sign up to a social regeneration plan that is meaningful and has its own energy to drive and influence changes that support our communities to thrive. Health is everyone's problem; Prevention is everyone's responsibility".

A Wider Determinants of Health workshop held on 11 October 2023 was a collaboration with MHS Homes. The workshop builds on the HaCP Population Health Management Programme and intended to explore "the art of the possible" by looking at our opportunities to collaborate as a system and improve the health of our communities.

The focus of the workshop was to enable discussion between the system and local teams to understand the wider picture, and to look for the best solutions to people's needs, not just medically but also socially, with a focus on the wider determinants of people's health.

The event brought together key system partners and was attended by representatives from the following sectors: Social Housing, Education, Voluntary, Community, Social Enterprise and Faith Groups Sector (VCSEF), Local Authority Public Health and Housing, NHS Mental Health Services, Kent Police, University and National Institute of Health Research, ICB Communications and Medway and Swale Health and Care Partnership.



The feedback from group discussions have been collated and analysed to generate an action plan of deliverables and themes. The actionable quick wins are being taken forward with representatives from the workshop to begin to unlock the opportunity that exists through existing infrastructure. The themes are the guiding principles and foundations needed to take forward a place-based approach to social regeneration and reducing health inequalities.

- Relationships
- Trust

- Commitment
- Communication
- Engagement
- Connections
- Utilising current infrastructure
- Education
- Adapting policy at local level
- Creating a legacy

This initial workshop provided valuable insight and highlighted the need for a wider event covering Medway and Swale. This will take forward the actions identified to build on the plan and achieve social regeneration.

On the 19 March 2024, the Medway and Swale Social Regeneration Launch Event was held. Social regeneration goes beyond being just an abstract idea or a concept; it is a call to action, a commitment to rebuild and revitalise the very fabric of our society.

It recognizes that our communities face complex challenges - from economic disparity and social injustice to ecological decline and cultural erosion. But it also acknowledges the inherent resilience and potential within each of us to effect meaningful change. The conference saw presentations from speakers across Medway and Swale, but also from National Organisations.

The conference was a success with lots of enthusiasm and energy for innovating and collaborating to create social solutions for the communities of Medway and Swale across organisations. All actions as a result of the conference are being followed up and the vision is to now be bought to life.

The Medway and Swale social regeneration strategy is a 10-year ambition to reimagine our systems, structures, policies and processes to better serve the needs of individuals and communities within Medway and Swale. It requires health and care services to come together with education, employment, housing, local business and our voluntary sector to work differently and find solutions for collective challenges. It's about the art of the possible.

4 Integration with the Wider System

The HaCP is committed to working with the wider system priorities and strategies to achieve synergy and cohesion. The below identifies two key strategic priorities which the HaCP are committed to supporting, and details how the priorities align with specific work streams.

4.1 Marmot City

Following the publication of The Marmot Review: Fair Society, Healthy Lives, in 2010, six key areas were recommended to focus on to reduce Health Inequalities. The HaCP are working alongside Medway Public Health colleagues to support existing actions against the recommendations, and the below table comprises of how HaCP initiatives work to support each action.

Recommendation	Medway and Swale HaCP integration with recommendation
Give every child the best start in life	• Prioritising CYP and seeking to harness the voice of CYP as part of the Social Regeneration strategy • Working with housing providers and ways in which housing can impact the health and wellbeing of CYP. • CYP Asthma programme established and working with CYP and creating a holistic approach to care
Enable all children, young people and adults to maximise their capabilities and have control over their lives	• Creating and adopting a bottom up approach to ensure that patients are empowered to take control of their own health and care. • Working with people and communities from Health Inclusion groups that historically the system has not engaged with, to create a safe and inclusive system that supports needs across communities and to understand health inequalities. • Working with organisations in the wider determinants of health through the social regeneration programme, for example education
Create fair employment and good work for all	• Looking to increase opportunities for CYP, supporting conversations around careers and supporting work experience and placements in health and care. • Bid for Volunteering for Health has been submitted, which could see some opportunities for volunteer to career pathways. • Through Social Regeneration, looking at adapting ways of working to support more people into employment and paid work.
Ensure healthy standard of living for all	• Through the VCSEF Framework, working with local organisations who provide essential support for people across the community, for example food banks, children's centres. • Working with housing and social housing providers on creating an approach to support healthy standards of living • Working with communities from Health Inclusion groups to ensure service user voice is harnessed throughout the HaCP
Create and develop healthy and sustainable places and communities	• The VCSEF Framework supports an integrated approach to health and care and beyond this into the wider locality which supports development of healthy and sustainable communities • Health Inequalities funding has been invested in community-based projects, which look to support the building of the community resilience and creating capacity in the VCSEF
Strengthen the role and impact of ill-health prevention	• Prioritisation of prevention across work programmes

	• Supporting local work on physical activity and looking at ways to increase physical activity in CYP and adults • Programme of work on Childhood Obesity and understanding how choices in Childhood affect health in adult life • Clinical Variation programme is looking at referring people who have been classified as high risk to Public Health programmes to prevent ill health • CYP Asthma programme is working to prevent ill health in Asthma and to prevent hospital admission by creating holistic care for CYP • Supporting and working on programmes of work that help to identify signs and symptoms of Cancer early to prevent late stage diagnosis

4.2 Integrated Care System (ICS) Strategy

As one of the four HaCP's across Kent and Medway, the HaCP are committed to supporting the ICS strategy. The alignment of HaCP workstreams and integration with the ICS shared outcomes are shown below.

Shared outcome	**Medway and Swale HaCP integration**
Give children the best start in life and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination	• Prioritising CYP through Social Regeneration • Programmes of work on CYP, including co-design of PSHE sessions for CYP • The Health Catalyst programme seeking to understand engage with people from disadvantaged backgrounds, allowing flow of information of systemic issues to subsequently drive improvements
Help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place	• The Health catalyst seeks to understand the issues surrounding people experiencing the worst Health inequalities, and supports the empowerment of people and communities in improving physical and mental health • The HaCP VCSEF framework demonstrates the system wide commitment to working in a different way which focuses on the wider determinants of health • Social Regeneration seeks to further the work with wider determinants and create a place-based system that works for the community
Help people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years	• Proactively engaging with people and communities and taking a bottom up approach to the health and care system • Encouraging people and communities to become empowered and take ownership of their health and wellbeing through the Health Catalyst programme • Supporting positive health behaviours through working with Public Health, as well as through the Clinical Variation programme

	• Working with system partners on ageing well
Support people with multiple health conditions to be part of a team with health and care professionals working compassionately to improve their health and wellbeing	• Working alongside partners in Primary Care and beyond to encourage personalised care. For example, supporting Primary Care with Asthma training to allow a more robust Personalised Asthma Action Plan for CYP • Supporting use of Multi-Disciplinary Teams for those with complex care needs
Ensure that when people need hospital service, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improve quality, safety and sustainability	• Working in partnership with partners across the system to focus on hospital discharge pathways. • Working on admission avoidance for patients, through PHM programme which emphasis healthier lifestyles and prevention • CDCs in Rochester and Sheppey to allow diagnostics closer to home, improving patient care and faster diagnosis and therefore treatment for conditions
Make Kent and Medway a great place for our colleagues to live, work and learn	• Social Regeneration which will support the local students and workforce of Medway and Swale through place-based ownership of issues and solutions. • The HaCP were actively involved in an ICS wide bid was submitted for a WorkWell programme which would support people back into work following long term sickness, the outcome of which is to be confirmed