# AGENDA

# COMMUNITIES, HOUSING AND ENVIRONMENT COMMITTEE MEETING

Date: Tuesday 18 October 2016
Time: 6.30 pm
Venue: Town Hall, High Street, Maidstone

Membership:

Councillors Barned, M Burton, Joy, D Mortimer (Vice-Chairman), Perry, Mrs Ring (Chairman), Mrs Robertson, Webb and Webster

Page No.

1. Apologies for Absence
2. Notification of Substitute Members
3. Urgent Items
4. Notification of Visiting Members

**Continued Over/:**

**Issued on Monday 10 October 2016**

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact Caroline Matthews on 01622 602743**. To find out more about the work of the Committee, please visit www.maidstone.gov.uk

Alison Broom

**Alison Broom, Chief Executive, Maidstone Borough Council, Maidstone House, King Street, Maidstone Kent ME15 6JQ**

5. Disclosures by Members and Officers

6. Disclosures of Lobbying

7. To consider whether any items should be taken in private because of the possible disclosure of exempt information.

8. Minutes of the Meeting Held on 20 September 2016 — 1 - 9

9. Presentation of Petitions (if any)

10. Questions and answer session for members of the public (if any)

11. Committee Work Programme — 10 - 11

12. Report of the Head of Environment and Public Realm - Community Toilet Scheme — 12 - 16

13. Report of the Head of Housing and Community Services - Homelessness Performance Quarter 2 — 17 - 20

14. Report of the Head of Housing and Community Services - Adoption of Byelaws for Cosmetic Piercing and Semi-Permanent Skin Colouring — 21 - 34

15. Report of the Head of Housing and Community Services - Maidstone Health Inequalities Action Plan 2016 — 35 - 89

16. Report of the Head of Housing and Community Services - KCC Adult Social Care Consultation — 90 - 129

17. Report of the Head of Housing and Community Services - MBC Safeguarding Policy for Children and Vulnerable Adults — 130 - 159

**PART II**

**To move that the public be excluded for the items set out in Part II of the Agenda because of the likely disclosure of exempt information for the reasons specified having applied the Public Interest Test.**

| | | **Head of Schedule 12 A and Brief Description** | |
|---|---|---|---|
| 18. | Report of the Head of Housing and Community Services - Brunswick Street and 180-188 Union Street Redevelopment | Para 3 – Information re financial/business affairs | 160 - 169 |

**PUBLIC SPEAKING**

In order to book a slot to speak at this meeting of the Communities, Housing and Environment Committee, please contact Caroline Matthews on 01622 602743 or by email on carolinematthews@maidstone.gov.uk by 5 pm one clear working day before the meeting. If asking a question, you will need to provide the full text in writing. If making a statement, you will need to tell us which agenda item you wish to speak on. Please note that slots will be allocated on a first come, first served basis.

# MAIDSTONE BOROUGH COUNCIL

## Communities, Housing and Environment Committee

## MINUTES OF THE MEETING HELD ON TUESDAY 20 SEPTEMBER 2016

**Present:** **Councillor Mrs Ring (Chairman), and Councillors M Burton, Joy, D Mortimer, Perry, Mrs Robertson, Webb and Webster**

**Also Present:** **Councillor Cuming**

47. APOLOGIES FOR ABSENCE

There were no apologies.

48. NOTIFICATION OF SUBSTITUTE MEMBERS

There were no Substitute Members.

49. URGENT ITEMS

There were no urgent items.

The Chairman agreed to take a revised appendix II to item 17 – Public Spaces Protection Order – Town Centre as this had not printed correctly.

50. NOTIFICATION OF VISITING MEMBERS

Councillor Cuming was in attendance as an observer but reserved his right to speak on item 17 – Public Spaces Protection Order – Town Centre.

51. DISCLOSURES BY MEMBERS AND OFFICERS

There were no disclosures by Members or Officers.

52. DISCLOSURES OF LOBBYING

There were no disclosures of lobbying.

53. TO CONSIDER WHETHER ANY ITEMS SHOULD BE TAKEN IN PRIVATE BECAUSE OF THE POSSIBLE DISCLOSURE OF EXEMPT INFORMATION.

It was moved that item 21 - Minutes of the meeting held on 19 July 2016 be taken in public, but the information contained therein should remain private.

**RESOLVED**: That the exempt items on the agenda be taken in private as proposed.

54. MINUTES (PART I) OF THE MEETING HELD ON 19 JULY 2016

**RESOLVED**: That the minutes (part I) of the meeting held on 19 July 2016 be approved as a correct record and signed.

55. PRESENTATION OF PETITIONS (IF ANY)

There were no petitions.

56. QUESTIONS AND STATEMENTS FROM MEMBERS OF THE PUBLIC (IF ANY)

Joan Langrick asked the following question:

Could this now lack of certainty regarding how effective antibiotics may be in treating patients with various infections, such as sepsis, pneumonia, tuberculosis and others, be taken into consideration when deciding how low the temperature has to fall before the homeless are accepted into a night shelter during bitterly cold winter months.

The Chairman responded to advise that the Council worked with partners and directly with those affected to tackle the issue of homelessness. An outreach programme offered screening for diseases to the street population.

The Head of Housing and Community Services explained that the Winter Shelter had been running for four years, and operated throughout the cold season regardless of the temperature. A pilot scheme to identify and treat tuberculosis infection among the street homeless had been successful and had subsequently been rolled out across Kent.

57. CHANGE TO THE ORDER OF BUSINESS

**RESOLVED**: That item 17 – Public Spaces Protection Order – Town Centre be taken in advance of item 11 due to a Visiting Member having reserved their right to speak on the item.

58. REPORT OF THE HEAD OF HOUSING AND COMMUNITY SERVICES - PUBLIC SPACES PROTECTION ORDER - TOWN CENTRE

The Community Partnerships and Resilience Manager introduced the report which provided results of the public consultation on Public Space Protection Orders (PSPOs), and recommended the implementation of an Order with prohibitions against drinking in a public space and begging.

The consultation was open for eight weeks, and it was summarised that:

- 86.4% of respondents felt safe in the town centre during the day and evening.
- 61.6% of respondents were in favour of the implementation of a PSPO to tackle drinking in a public place.

- There was little support among respondents for a PSPO to address rough sleeping.

The original proposal to committee in November 2015 had included rough sleeping and use of legal highs within the PSPO. The revised proposal omitted these for the following reasons:

- A small percentage of those who were classed as homeless were street sleeping. Of those, approximately ten people were believed to be street sleeping and involved in anti-social behaviour.
- Legislation against legal highs had been introduced nationally. In Maidstone the number of premises selling legal highs had significantly reduced.

The committee was advised that a PSPO prohibiting public drinking would feature two directions in the order. The first direction would allow an officer to request a person to surrender their alcohol if it was believed that there was a risk of anti-social behaviour. The second direction would require a person who had surrendered alcohol not to drink at that place for a period of 24 hours.

It was explained that there was already legislation in place to address begging, and so the proposed PSPO would specifically tackle the use of objects or animals when begging. Enforcement would be implemented through fixed penalty charges, civil injunctions or criminal behaviour orders.

During discussion it was confirmed that:

- A number of PSPOs have been implemented nationally. Where these have been used to prohibit rough sleeping, this has acted to displace street homeless to other areas outside the PSPO jurisdiction.
- With regard to a prohibition against the use of an object or animal for begging, the parameters of a breach would be accounted for in the drafting of the Order.
- A PSPO was enacted over a three year duration. The effectiveness of the Order would be monitored during that time. At the end of that term Members could decide to continue with or change the Order. Firm evidence would be required to extend the PSPO area to a wider area.
- The Order would primarily be enforced by the Police and Council Officers with delegated responsibilities.

A Member put forward that, as MBC was already involved in a successful publicity campaign which addressed the problems that can arise from donating to those who are begging, there was less reason to include begging within a PSPO. The money that would be spent on the PSPO could instead be diverted towards further financing the campaign.

It was moved that begging be removed from the PSPO. This was not seconded.

It was moved, seconded and:

**RESOLVED**:

1. That a PSPO be enacted in the town centre area defined by Appendix IV to the report of the Head of Housing and Community Services, including prohibitions for Drinking in a public place and Begging as set out in Section 5.4 of the report.

   For – 7 Against – 0 Abstain - 1

2. That authority be delegated to the Head of Housing and Community Services, in consultation with the Chairman and Vice-Chairman of Communities, Housing and Environment Committee, to make any minor amendments or corrections to the Order before it is enacted.

   For – 8 Against – 0 Abstain – 0

59. COMMUNITIES, HOUSING AND ENVIRONMENT COMMITTEE WORK PROGRAMME 2016-17

The Chairman raised the matter of the Health workshop, and the Head of Housing and Community Services advised that dates would be circulated.

Members were in agreement that the next Crime and Disorder Overview and Scrutiny Committee in November should be held on a separate date to the Communities, Housing and Environment Committee due to the amount of business to be considered.

**RESOLVED**: That the Communities, Housing and Environment Work Programme 2016-17 be noted.

60. REFERENCE FROM THE PLANNING COMMITTEE - AIR QUALITY MITIGATION

The Committee considered the reference from Planning Committee recommending that consideration be given to how the Sutton Road/Loose Road area can be built into any action plan (or similar programme should one be formulated) for air quality mitigation having regard to the housing developments coming forward.

It was noted that an item proposing the establishment of an Air Quality Working Group was included further on in the agenda, and that the details of this be reported back to the Planning Committee.

**RESOLVED**: That the reference be noted.

61. REPORT OF THE HEAD OF POLICY AND COMMUNICATIONS - STRATEGIC PLAN PERFORMANCE UPDATE Q1 FOR CHE

The Head of Policy and Communications introduced the report detailing the performance of the service areas within the remit of the committee.

It was explained that:

- Recycling rates had missed the target by 1%, but were expected to meet the target within the second quarter;
- Occurrences of fly-tipping had fallen by one third;
- Once the Safeguarding Policy had been agreed training would be delivered to practitioners;
- The target for the delivery of affordable homes had exceeded its target;
- The number of people using leisure facilities fell within the remit of the committee as it correlated with health and wellbeing.

Members requested a more detailed breakdown of the 16% increase in crime reports, attributed to an increase in reporting of domestic violence. The Head of Housing and Community Services confirmed that the Safer Maidstone Partnership was looking into the issue, and more information would be provided to the Crime and Disorder Overview and Scrutiny Committee.

**RESOLVED**:

1. That the summary of performance for Quarter 1 2016/17 for Key Performance Indicators (KPIs) and corporate strategies and plans be noted.

2. That it be noted where complete data was not currently available.

62. REPORT OF THE DIRECTOR OF FINANCE AND BUSINESS IMPROVEMENT - FIRST QUARTER BUDGET MONITORING 2016/17

The Chief Accountant presented the report which outlined the financial position of the service areas under the committee's jurisdiction at the end of the first quarter.

In response to a question it was clarified that a variance of more than £30,000 within a cost centre would be reported to the committee.

**RESOLVED**: That the report be noted.

63. REPORT OF THE HEAD OF ENVIRONMENT AND PUBLIC REALM - KENT COUNTY COUNCIL WASTE STRATEGY CONSULTATION

The Head of Environment and public Realm introduced the report setting out a draft response to Kent County Council's (KCC) Waste Disposal Strategy.

It was explained that the priorities outlined in the Waste Disposal Strategy, attached at appendix A to the report, closely aligned with those

of MBC. There was a good relationship between the two authorities, as evidenced by the Mid Kent Waste Partnership.

During discussion it was put forward that there was a need for an additional household waste recycling facility in Maidstone. KCC had stated that the current household waste recycling centre based at Tovil would be at capacity within five years, however feedback from residents and other users of the site suggested that capacity had already been reached.

**RESOLVED**: That the draft consultation response attached at appendix B to the report of the Head of Environment and Public Realm be agreed and submitted as the Council's response.

For – 8 Against – 0 Abstain – 0

64. REPORT OF THE HEAD OF ENVIRONMENT AND PUBLIC REALM - FLY-TIPPING PERFORMANCE

The Head of Environment and Public Realm presented the report which provided details of fly-tipping reporting, the new facilities within the mobile working system, and proposed a workshop to demonstrate the mobile solution.

With regard to the mobile working system it was advised that:

- The new system had been in operation for a year and allowed residents to pin point and report fly-tipping online. The location of the fly-tipping was then sent to an operative to remove;
- Benefits included the ability to collect data on fly-tipping behaviour. One downside was that the map only showed the areas that MBC was responsible for collecting fly-tipping from, and for other areas users were prompted to contact Environmental Enforcement. It was felt that the prompt needed to be clearer and more seamless;
- The data is collected had so far revealed that over 50% of fly-tipping was household waste, and that fly-tips were more prevalent in urban areas;
- Some councils used an app called Littergram to allow residents to report fly-tipping, however this was not currently compatible with MBC's system. A message had been placed on Littergram to advise residents to use the council's website;
- The closure of the refuse freighter service had not made any significant change to fly-tipping figures.

**RESOLVED**:

1. That the report of the Head of Environment and Public Realm be noted.

2. That a Member workshop to demonstrate the mobile solution used to report and manage fly tipping and other responsive services be held.

For – 8 Against – 0 Abstain – 0

65. REPORT OF THE HEAD OF HOUSING AND COMMUNITY SERVICES - ENVIRONMENTAL HEALTH SERVICE UPDATE

The Mid Kent Environmental Health Manager introduced the report providing an update on the delivery of the council's environmental health functions during the year 2015/16.

Councillor M Burton left the room at 8.22 p.m. and re-entered at 8.23 p.m.

During discussion it was clarified that Environmental Health did not comment on planning applications as a matter of course, and only provided a response where one had been requested due to noise or contaminated land queries. A Planning Officer could identify when an environmental health response was required by using the mapping software.

**RESOLVED**: That the service delivery made by Mid Kent Environmental Health in Maidstone Borough during 2015/16 be noted.

66. REPORT OF THE HEAD OF HOUSING AND COMMUNITY SERVICES - AIR QUALITY WORKING GROUP

The Head of Housing and Community Services presented the report asking Members to consider the establishment of a working group to explore themes arising from the Low Emissions Strategy workshop held in July 2016.

Three nominations to the working group were requested, and were received as follows: Councillors M Burton, D Mortimer and Robertson.

**RESOLVED**:

1. That a Member working group of five members be established.

2. That the three representatives of Communities, Housing and Environment Committee be appointed as follows:

   Councillors M Burton, Mortimer and Robertson.

3. That a reference be made to Strategic Planning, Sustainability and Transportation Committee to request the nomination of two Members to represent that committee on the working group.

4. That the terms of reference of the working group be agreed at the first meeting of the group.

For – 8 Against – 0 Abstain – 0

67. PART II

**RESOLVED:** That the public be excluded for the items set out in Part II of the Agenda because of the likely disclosure of exempt information for the reasons specified having applied the Public Interest Test.

| | **Head of Schedule 12 A and Brief Description** | |
|---|---|---|
| Minutes (Part II) of the meeting held on 19 July 2016 | Para 3 – info re: financial / business affairs;<br>Para 7 – info re: crime prevention, investigation or prosecution. | 148 - 149 |
| Exempt Report of the Head of Housing and Community Services - Property Acquisition | Para 3 – info re: financial / business affairs. | 150 - 158 |

68. MINUTES (PART II) OF THE MEETING HELD ON 19 JULY 2016

**RESOLVED**: That the Minutes (Part II) of the meeting held on 19 July 2016 be approved as a correct record and signed.

69. EXEMPT REPORT OF THE HEAD OF HOUSING AND COMMUNITY SERVICES - PROPERTY ACQUISITION

The Housing and Enabling Manager presented the exempt report on a proposed property acquisition.

It was explained that the property could be used to provide accommodation for six individuals.

In response to a question it was clarified that during financial calculations it was assumed that one room would always be empty so that all income scenarios could be accounted for.

**RESOLVED**:

1. That the purchase of the property named in the exempt report of the Head of Housing and Community Services for use as accommodation for homeless households be approved, subject to contract and survey.

2. That the acquisition and cost of works associated with the property be funded from available resources within the Housing investments Capital Programme.

3. That the Director of Finance and Business Improvement be authorised to conclude negotiations with the owner, and the Head of Mid Kent Legal Services be authorised to complete the purchase on the agreed terms.

For – 8 Against – 0 Abstain – 0

70. DURATION OF MEETING

6.31 p.m. to 8.43 p.m.

## Communities, Housing and Environment Committee - Work Programme Schedule

| Theme | Communities, Housing and Environment Committee |
|---|---|
| **Housing** | |
| Homelessness Performance Quarter Two (inc. number registered this quarter) | 18 October 2016 |
| Homelessness Performance Quarter Three (inc. number registered this quarter) | 17 January 2017 |
| Homelessness Performance Quarter Four (inc. number registered this quarter) | 18 April 2017 |
| **Town Centre Regeneration** | |
| Community Toilet Scheme | 18 October 2016 |
| Brunswick Street Redevelopment | 18 October 2016 |
| Union Street Redevelopment | 18 October 2016 |
| **Medium Term Financial Plan** | |
| MTFS - Fees and Charges | 13 December 2016 |
| Medium Term Financial Strategy and Budget Proposals 2017/18 | 17 January 2017 |
| **Monitoring Reports** | |
| Second Quarter Budget Monitoring | 15 November 2016 |
| Strategic Plan Performance Update Quarter 2 | 15 November 2016 |
| Crime and Disorder – Safer Maidstone Partnership – Mid-Year Update | 15 November 2016 |
| Strategic Plan 2015-2020 refresh | 13 December 2016 |
| CCTV Partnership | 17 January 2017 |
| Strategic Plan Performance Update Quarter 3 | 14 February 2017 |
| Third Quarter Budget Monitoring | 14 February 2017 |
| Crime and Disorder – Safer Maidstone Partnership – Update | 21 March 2017 |
| Fourth Quarter Budget Monitoring | TBA |
| Review of Waste Strategy 2014-19 | 18 April 2017 |
| Environmental Health Enforcement Policy Update | As and when |
| Strategic Plan Performance Update Quarter 4 | TBA |
| Maidstone Housing Strategy 2016-2020 Update | TBC |
| Licensing Partnership Update | TBC |
| **New/Updates to Strategic and Plans** | |
| Health and Wellbeing action plan refresh | 18 October 2016 |
| Maidstone Health Inequalities Action Plan 2016 | 18 October 2016 |
| Unauthorised Encampment Policy | 18 October 2016 |
| Taxi Rank Policy | 18 October 2016 |
| Adoption of byelaws for cosmetic piercing and semi-permanent skin colouring | 18 October 2016 |
| Low Emissions Strategy | 13 December 2016 |
| Air Quality Management Areas | 13 December 2016 |
| Disabled Facilities Grant Review | 17 January 2017 |
| Strategic Plan 2015-20 Refresh | 17 January 2017 |

| | |
|---|---|
| **Other** | |
| **Single Employing Authority for Mid Kent Environmental Health** | **18 October 2016 / 9 November 2016** |
| **Property Acquisitions – Temporary Accommodation** | **15 November 2016** |
| **Service Level Agreement Review** | **15 November 2016** |
| **Income Generation** | |
| **Commercial Waste Feasibility Report** | **January 2017** |

| **Communities, Housing and Environment Committee** | **Tuesday 18 October 2016** |
|---|---|
| Is the final decision on the recommendations in this report to be made at this meeting? | **Yes** |

# Community Toilet Scheme

| | |
|---|---|
| **Final Decision-Maker** | Communities, Housing and Environment Committee |
| **Lead Head of Service** | Head of Environment and Public Realm |
| **Lead Officer and Report Author** | Street Scene Operations Manager |
| **Classification** | Public |
| **Wards affected** | High Street |

**This report makes the following recommendations to this Committee:**

1. That the Committee notes the work which has been carried out to refresh the Community Toilet Scheme; and
2. Notes the 10 community toilets to replace those previously part of the scheme.

**This report relates to the following corporate priorities:**

- Keeping Maidstone Borough an attractive place for all – continuing to provide access to a number of toilets within the Town Centre for local residents and visitors
- Securing a successful economy for Maidstone Borough – ensuring Maidstone is an attractive town to visit and therefore for business to prosper

| **Timetable** | |
|---|---|
| ***Meeting*** | ***Date*** |
| Communities, Housing and Environment Committee | Tuesday 18 October 2016 |

# Community Toilet Scheme

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 A full review of the Public Conveniences in Maidstone was carried out in 2015/16, including the need for additional toilets, the existing Community Toilet Scheme and the future of the Butterfly Urinal which was no longer functional.

1.2 In March 2016, it was agreed by the Communities, Housing and Environment Committee for the Community Toilet Scheme to be reviewed and refreshed.

1.3 This report updates the Committee on the work carried out and which toilets should be included in the scheme.

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## 2. INTRODUCTION AND BACKGROUND

2.1 Maidstone launched the Community Toilet Scheme in 2008 following the review and closure of a number of the Council's public conveniences.

2.2 The scheme included 14 businesses, 13 of which were paid £300 per year and one paid £600 due to being available until the early morning.

2.3 In March 2016, a report was taken to the Committee to review the toilet provision in Maidstone and it was agreed that the Community Toilet Scheme needed to be reviewed and refreshed to take into account new businesses within the Town and ensure the toilets offered were good quality.

2.4 Following this, officers have been working with One Maidstone to identify the businesses within the Town Centre which have good quality toilets and would be willing to be part in the scheme.

2.5 One Maidstone kindly agreed to speak with businesses on a business to business level to gain support for the scheme.

2.6 Ten toilets have been identified as being suitable, both in terms of quality, provision and location within the Town Centre. A map of these toilets is provided in Appendix A (to follow).

2.7 The toilets are:

- Muggleton Inn, High Street
- McDonalds, Barker Road,
- Royal Albion, St Faiths Street
- McDonalds, Week Street
- Maidstone Museum, St Faiths Street
- Society Rooms, Week Street
- Fremlins Walk
- Royal Star Arcade

- The Mall, King Street
- Maidstone Market

2.8 A further two business, Starbucks and Creams have yet to confirm whether they will be part of the scheme as the decision has been referred to their head offices.

2.9 Five toilets have been removed from the scheme and a further business declined to be part of the scheme due to their entry policy.

2.10 The businesses providing the toilets will be required to sign an annual agreement with the Council and will be paid £600 per year to support the provision of appropriate supplies and cleaning of their toilets to facilitate public use.

2.11 The toilets will be monitored by the Council quarterly and following receipt of any complaint from a member of the public to ensure that they continue to meet the required standard.

2.12 The agreement with the businesses will require them to achieve an acceptable level of cleanliness and should this not be achieved, there will be a mechanism for them to be withdrawn from the scheme and for the payment to cease.

2.13 A new communications campaign has also been prepared to ensure that visitors are aware of the scheme, can identify toilets which are included and locate them easily.

2.14 Once agreements have been signed a number of national apps will be updated with the new details to help promote the toilets and enable visitors to find their nearest facility.

2.15 The Council's website, which is mobile friendly, will also be used to help visitors find their local toilet.

2.16 Once the scheme has been finalised, a publicity campaign will also be carried out with press releases and advertising to raise awareness of the scheme.

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## 3. AVAILABLE OPTIONS

3.1 The Committee could note the 10 new community toilets to replace those previously part of the scheme.

3.2 Alternatively the Committee could decide that alternative toilets need to be considered as part of the scheme or reject specific toilets as not being suitable.

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## 4. PREFERRED OPTION AND REASONS FOR RECOMMENDATIONS

4.1 It is recommended that the 10 toilets proposed for the new scheme are agreed as they offer good quality facilities for visitors to Maidstone.

4.2 These toilets also comply with legislation relating to discrimination, particularly around disabled access and gender.

4.3 The toilets proposed also provide good coverage of the Town Centre as shown on the map included in Appendix A (to follow).

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## 5. CONSULTATION RESULTS AND PREVIOUS COMMITTEE FEEDBACK

5.1 Previously the Committee agreed that the Community Toilet Scheme should be reviewed and refreshed to take into account new businesses within the Town Centre.

5.2 It was agreed that the Head of Environment and Public Realm would be given delegated authority in conjunction with the Head of Commercial and Economic Development to agree the community toilets to be included in the scheme.

5.3 It has since been requested that an update is provided to the Committee.

5.4 Discussions with the new businesses within the Town Centre have been positive, with the majority approached agreeing to be part of the refreshed scheme.

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## 6. NEXT STEPS: COMMUNICATION AND IMPLEMENTATION OF THE DECISION

6.1 Agreements will be signed with the businesses involved in the Scheme and it is anticipated that the new scheme will be launched in by the end of the year.

6.2 Businesses no longer being included in the scheme will be formally contacted to advise them that they will no longer receive the payment and the previous agreements will be terminated.

6.3 The new communications campaign will be launched, with public toilet apps updated and new maps installed.

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## 7. CROSS-CUTTING ISSUES AND IMPLICATIONS

| Issue | Implications | Sign-off |
|---|---|---|
| **Impact on Corporate Priorities** | Keeping Maidstone Borough an attractive place for all – continuing to provide access to a number of toilets within the | Street Scene Operations Manager |

| | | |
|---|---|---|
| | Town Centre for local residents and visitors<br>Securing a successful economy for Maidstone Borough – ensuring Maidstone is an attractive town to visit and therefore for business to prosper | |
| **Risk Management** | | |
| **Financial** | The refreshed scheme will be funded from within the existing budget of £4,500. | |
| **Staffing** | | |
| **Legal** | | |
| **Equality Impact Needs Assessment** | | |
| **Environmental/Sustainable Development** | | |
| **Community Safety** | | |
| **Human Rights Act** | | |
| **Procurement** | | |
| **Asset Management** | | |

## 8. REPORT APPENDICES

The following documents are to be published with this report and form part of the report:

- Appendix A (to follow) – Community Toilet Map

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## 9. BACKGROUND PAPERS

Communities, Housing and Environment Committee Review of Public Conveniences Decision – 15 March 2016

| **Communities, Housing and Environment Committee** | **18th October 2016** |
|---|---|
| Is the final decision on the recommendations in this report to be made at this meeting? | **Yes** |

# Homelessness Performance Quarter Two 2016/17

| | |
|---|---|
| **Final Decision-Maker** | Communities, Housing and Environment |
| **Lead Head of Service** | John Littlemore |
| **Lead Officer and Report Author** | Ellie Kershaw |
| **Classification** | Public |
| **Wards affected** | All |

**This report makes the following recommendations to this Committee:**

1. That the Committee notes the performance for quarter two 2016/17

**This report relates to the following corporate priorities:**

- Keeping Maidstone Borough an attractive place for all
- Securing a successful economy for Maidstone Borough

| **Timetable** | |
|---|---|
| ***Meeting*** | ***Date*** |
| Communities, Housing and Environment | 18th October 2016 |

# Homelessness Performance Quarter Two

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The council has a statutory duty to provide housing advice and assistance, the scale of which will depend on each household's individual circumstances. Homelessness has been rising over the past few years, both locally and nationally. This has naturally led to an increase in work and expenditure for the council. It is therefore important that the Committee is kept apprised of up to date information.

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## 2. INTRODUCTION AND BACKGROUND

2.1 Over the past five years, Maidstone has seen a year on year increase in homelessness applications, from 84 in 2010/11 to 630 in 2015/16. The Committee therefore requested that quarterly information be provided concerning homelessness and the work that the council is undertaking.

2.2 Between April and June of 2016, 212 households have met the threshold to make a homelessness application. 208 decisions were made. In the same quarter in 2015/16 there were 178 decisions made. There have been 357 decisions made this year so far compared to 313 at the same period last year. It is reasonable to assume at this stage that there will be a significant annual increase, with 630 decisions having been made in the whole of the last financial year.

2.3 The Homelessness code of guidance suggests that where possible decisions should be made within 33 days. In quarter one 57% were made within this timeframe. This increased to 66% in quarter two, which, when taking into account the volume of decisions made represents a great deal of hard work on the part of the Housing Advisers. They have also managed to reduce their caseloads to 20-30 per adviser. Whilst this is still higher than is preferable, it is a significant improvement on the 30-40 each was holding at the end of last quarter.

2.4 The high number of homelessness applications continues to impact on the amount spent on temporary accommodation. In July and August £221,308 was spent on temporary accommodation (gross) against profiled budget of £128,082 resulting in an adverse variance of £93,226. In the whole of quarter two last year this was £224,581 against a profiled budget of £143,450 resulting in an adverse variance of £81,131. However, work which has been carried out between the Housing and Revenues and Benefits Teams means that the amount that can be recovered through a reasonable charge to clients has increased quite significantly from September of this year.

2.5 Across the quarter, the % of charges that have been recovered for rent in that quarter stands at 87%. This is a decrease on last quarter. However, a large proportion of the shortfall is due to housing benefit claims awaiting

assessment and monthly payers, whose contributions do not show at the date of writing this report.

2.6 There are currently 101 households in nightly paid temporary accommodation with a further 12 in long term temporary accommodation. 59 of these households are owed the main housing duty, meaning that the council will continue to accommodate them until a suitable tenancy can be identified for them. The remainder will be accommodated until such time as their enquiries are complete, leading to either them also being owed the main duty or in their accommodation being ended after a reasonable period of notice. There are no households with children residing in bed and breakfast accommodation.

2.7 102 preventions were recorded in this quarter. A prevention is where someone threatened with homelessness does not become homeless and the authority has had some part in the reason why. For example, this could be liaison with friends, parents or a landlord, assisting the household to make an application for a discretionary housing payment or helping with a bond to secure a new property. This high number is due in part to some high figures from the Single Homeless Support Officer, but also to all open preventions on the system having been assessed in the past few weeks. A number were identified where prevention work had been undertaken, but the system had not been updated to reflect this. However, annually this means the figure now stands at 129 against a target of 150, which, when taken in conjunction with the increase in homelessness decisions is an excellent result.

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## 3. CROSS-CUTTING ISSUES AND IMPLICATIONS

Report is for information only.

| Issue | Implications | Sign-off |
|---|---|---|
| **Impact on Corporate Priorities** | | [Head of Service or Manager] |
| **Risk Management** | | [Head of Service or Manager] |
| **Financial** | | [Section 151 Officer & Finance Team] |
| **Staffing** | | [Head of Service] |
| **Legal** | The Council has a statutory Duty with regards to homelessness. This | Interim Deputy Head of Legal |

| | | |
|---|---|---|
| | monitoring process enables the committee to remain aware of the current performance. | Partnership |
| **Equality Impact Needs Assessment** | | [Policy & Information Manager] |
| **Environmental/Sustainable Development** | | [Head of Service or Manager] |
| **Community Safety** | | [Head of Service or Manager] |
| **Human Rights Act** | | [Head of Service or Manager] |
| **Procurement** | | [Head of Service & Section 151 Officer] |
| **Asset Management** | | [Head of Service & Manager] |

| **Community, Housing and Environment Committee** | **18 October 2016** |
|---|---|
| Is the final decision on the recommendations in this report to be made at this meeting? | **No** |

# Adoption Of Byelaws for Cosmetic Piercing and Semi-Permanent Skin Colouring

| | |
|---|---|
| **Final Decision-Maker** | Full Council |
| **Lead Head of Service** | John Littlemore Head of Housing and Community Services |
| **Lead Officer and Report Author** | Peter Lincoln Food and Safety Team Leader |
| **Classification** | Public |
| **Wards affected** | All |

**This report makes the following recommendations to this Committee:**

To recommend to Council that Maidstone Borough Council adopts byelaws for registering businesses involved in the cosmetic piercing and semi-permanent skin colouring by implementing Section 120 and schedule six of the Local Government Act 2003

**This report relates to the following corporate priorities:**

Securing a successful economy for Maidstone Borough –

The adoption of the byelaws supports the Council's corporate priorities in maintaining a thriving and diverse local economy, by virtue that all registered businesses will need to meet the same standards.

| **Timetable** | |
|---|---|
| ***Meeting*** | ***Date*** |
| Committee (Community, Housing and Environment) | 18.10.16 |
| Full Council | 7.12.16 |

# Adoption of Byelaws for Cosmetic Piercing and Semi-Permanent Skin Colouring

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Council has adopted powers *set out in the Local Government* (Miscellaneous Provisions) Act 1982 which require the registration of businesses providing tattooing, electrolysis, ear piercing and acupuncture. The purpose behind this requirement is to prevent the tr*ansmission of blood* borne virus infections, such as Hepatitis *B, Hepatitis C and HIV and other* infections between persons through these invasive treatments. The Local Government Act 2003 extended the range of activities, which are required to be registered with the Council to include, cosmetic piercing and skin colouring, treatments that also have the potential to transmit communicable diseases.

1.2 This report seeks approval to adopt additional byelaws to give the Council similar powers to protect public health to correspond with existing byelaws for other treatments. The intention of byelaws is to ensure that hygienic and safe skin piercing practices are carried out by operators, to protect the health and safety of those being pierced and those carrying out the piercing activities.

1.3 The new byelaws will be based on models provided by the Department of Health [see Appendix 1], and cover cosmetic piercing and semi-permanent skin colouring. The adoption of the additional byelaws requires approval by Full Council and then confirmation by the Secretary of State for Health.

1.4 There are no financial implications. Fees are charged for registration. Ensuring compliance with the byelaws is part of our normal public health function.

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## 2. INTRODUCTION AND BACKGROUND

2.1 The Council has adopted powers set out in the Local Government (Miscellaneous Provisions) Act 1982 which require the registration of businesses providing tattooing, electrolysis, ear piercing and acupuncture. The purpose behind this requirement is to prevent the transmission of blood borne virus infections, such as Hepatitis B, Hepatitis C and HIV and other infections between persons through these invasive treatments.

2.2 The Local Government Act 2003 extended the range of activities, which are required to be registered with the Council to include, cosmetic piercing and skin colouring, treatments that also have the potential to transmit communicable diseases.

2.3 Over the last 13 years these activities have grown in popularity and include micro pigmentation (semi permanent tattooing of eyebrows, nipples etc) and body-piercing covering all areas of the body except female genitalia.

2.4 These activities are not covered by the existing byelaws in Maidstone and consequently officers are unable to implement the protection against infections that the new byelaws would give. Powers are limited to those under health and safety legislation for matters of evident concern.

2.5 The Local Government Act 2003 brought the additional treatments into the registration scheme. This means that any business carrying out these treatments must be registered but there are no byelaws in Maidstone that businesses must comply with, resulting in less protection for operators and members of the public having the treatments.

2.6 The Department of Health has made model byelaws. These have been adopted by Swale and Tunbridge Wells Councils. Adopting the byelaws in Maidstone would enable best practice, bring consistency in the registration regime and offer the same level of public health protection.

2.7 Adoption of the byelaws would also provide a level playing field for businesses in this sector by ensuring that all processes operated by businesses work to the same standards.

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## 3. AVAILABLE OPTIONS

3.1 Option One – Do Nothing

Maidstone Council would continue to have a registration regime where only some of the special treatments are covered by bye-laws. This effectively reduces the Council's ability to enforce proper provisions of hygiene to protect public health.

3.2 Option Two – Adopt byelaws covering cosmetic piercing and semi-permanent skin colouring to ensure that public health controls are implemented in businesses registered for the treatments..

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## 4. PREFERRED OPTION AND REASONS FOR RECOMMENDATIONS

4.1 Option Two – Adopt byelaws covering cosmetic piercing and semi-permanent skin colouring for the reasons given above.

This option involves adopting byelaws, based on model byelaws provided by the Department of Health, as in the Appendix and regularise the registration process in providing for byelaws covering all special treatments under The Local Government (Miscellaneous Provisions) Act 1982.

If this option is approved it will have to be agreed at Full Council before being submitted to the Secretary of State for Health for confirmation.

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## 5. CONSULTATION RESULTS AND PREVIOUS COMMITTEE FEEDBACK

5.1 Nil

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## 6. NEXT STEPS: COMMUNICATION AND IMPLEMENTATION OF THE DECISION

6.1 If option two is agreed the next step is to obtain the agreement at Full Council. The Council must pass a resolution authorising the affixing of the common seal to the byelaws and authorising the necessary procedure to apply to the Secretary of State for confirmation.

6.2 At least one calendar month before applying to the Secretary of State for confirmation notice of the Council's intention to apply for confirmation must be given in one or more local newspapers circulating in the area to which the byelaws will apply.

6.3 A copy of the byelaws must then be open to the public for inspection at the Council offices, without charge, at all reasonable times during that month.

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## 7. CROSS-CUTTING ISSUES AND IMPLICATIONS

| Issue | Implications | Sign-off |
|---|---|---|
| **Impact on Corporate Priorities** | The adoption of the byelaws supports the Council's corporate priorities in maintaining a thriving and diverse local economy, by virtue that all registered businesses will need to meet the same standards. | [Head of Service or Manager] |
| **Risk Management** | The extended byelaws will assist in protecting the health and safety of all people associated with non-medical semi -permanent skin colouring and cosmetic piercing. The proposed byelaws are very close to the model byelaws provided by the Department of Health which should ensure that the Secretary of State for Health confirms them. | [Head of Service or Manager] |
| **Financial** | None. Officer time is already spent on inspection of registered premises following an application to give health | [Section 151 Officer & Finance Team] |

| | | |
|---|---|---|
| | and safety advice and guidance. Adopting the byelaws would give specific hygiene criteria for businesses to meet | |
| **Staffing** | None | [Head of Service] |
| **Legal** | The existing registration requirement and byelaws for tattooing, electrolysis, ear piercing and acupuncture have proved to be effective controls at protecting public health. Adoption of the Local Government Act 2003 is the step to ensure that newer cosmetic treatments are provided with the same level of protection. If these provisions are not adopted the Council will continue to have little control over cosmetic piercing and semi - permanent skin colouring within the Borough, which will pose a concern for the health of people using these services and those working in this sector. | [Legal Team] |
| **Equality Impact Needs Assessment** | Adoption of the recommendations will ensure that all businesses offering any type of non-medical skin piercing will have to comply with the byelaws.<br>No detrimental impact on the protected characteristics of individuals identified. | [Insight and Information officer] |
| **Environmental/Sustainable Development** | None | [Head of Service or Manager] |
| **Community Safety** | The existing registration requirement and byelaws for tattooing, electrolysis, ear piercing and acupuncture have proved to be effective controls at protecting public health. Adoption of the Local Government Act 2003 is the step to ensure that newer | [Head of Service or Manager] |

| | | |
|---|---|---|
| | cosmetic treatments are provided with the same level of protection. If these provisions are not adopted the Council will continue to have little control over cosmetic piercing and semi -permanent skin colouring within the Borough, which will pose a concern for the health of people using these services and those working in this sector. | |
| **Human Rights Act** | None | [Head of Service or Manager] |
| **Procurement** | None | [Head of Service & Section 151 Officer] |
| **Asset Management** | None | [Head of Service & Manager] |

## 8. REPORT APPENDICES

The following documents are to be published with this report and form part of the report:

- Appendix I: Proposed byelaws for cosmetic piercing and proposed byelaws for semi-permanent skin colouring

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## 9. BACKGROUND PAPERS: None

# COSMETIC PIERCING BYELAWS

Byelaws for the purposes of securing the cleanliness of premises registered under section 15 of the Local Government (Miscellaneous Provisions) Act 1982 and fittings in those premises and of registered persons and persons assisting them and the cleansing and, so far as appropriate, sterilization of instruments, materials and equipment used in connection with the business of cosmetic piercing made by Maidstone Borough Council in pursuance of section 15(7) of the Act.

## Interpretation

**1.**—(1) In these byelaws, unless the context otherwise requires—

"The Act" means the Local Government (Miscellaneous Provisions) Act 1982;

"Client" means any person undergoing treatment;

"Operator" means any person giving treatment;

"Premises" means any premises registered under Part VIII of the Act;

"Proprietor" means any person registered under Part VIII of the Act;

"Treatment" means any operation in effecting cosmetic piercing;

"The treatment area" means any part of premises where treatment is given to clients.

(2) The Interpretation Act 1978 shall apply for the interpretation of these byelaws as it applies for the interpretation of an Act of Parliament.

**2.**—(1) For the purpose of securing the cleanliness of premises and fittings in such premises a proprietor shall ensure that—

(a) all internal walls, doors, windows, partitions, floors, floor coverings and ceilings are kept clean and in such good repair as to enable them to be cleaned effectively;

(b) all waste material, and other litter arising from treatment should be handled and disposed of as clinical waste in accordance with relevant legislation and guidance as advised by the local authority;

(c) all needles used in treatment are single-use and disposable, as far as is practicable; and are stored and disposed of as clinical waste in accordance with the relevant legislation and guidance as advised by the local authority;

(d) all furniture and fittings in the premises are kept clean and in such good repair as to enable them to be cleaned effectively;

(e) all tables couches and seats used by clients in the treatment area, and any surface on which the items specified in 3b below are placed immediately prior to treatment, have a smooth impervious surface which is disinfected immediately after use and at the end of each working day.

(f) where tables and couches are used they are covered by a disposable paper sheet which is changed for each client;

(g) no eating, drinking, or smoking is permitted in the treatment area and a notice or notices reading "No Smoking", and "No Eating or Drinking" is prominently displayed there.

**3.**—(1) For the purpose of securing the cleansing and so far as is appropriate, the sterilization of needles, instruments, jewellery, materials and equipment used in connection with the treatment—

(a) an operator shall ensure that, before use in connection with treatment—

any gown, wrap or other protective clothing, paper or other covering, towel, cloth or other such article used in the treatment—

i. is clean and in good repair and, so far as is appropriate, sterile;

ii. has not previously been used in connection with any other client unless it consists of a material which can be and has been adequately cleaned and, so far as is appropriate, sterilized.

(b) An operator shall ensure that any needle, metal instrument, or other item of equipment used in treatment or for handling instruments and needles used in the treatment is in a sterile condition and kept sterile until it is used;

(c) a proprietor shall provide—

(i) adequate facilities and equipment for the purpose of sterilization, [unless pre-sterilized items are used] and of cleansing, as required in pursuance of these byelaws;

(ii) sufficient and safe gas points and/or electrical socket outlets to enable compliance with these byelaws;

(iii) an adequate constant supply of clean hot and cold water readily available at all times on the premises;

(iv) adequate storage for all items mentioned in byelaw 3a and b above, so that those items are properly stored in a clean and suitable place so as to avoid, as far as possible, the risk of contamination.

**4.**—(1) For the purpose of securing the cleanliness of operators, a proprietor shall ensure that —

(i) Any operator keeps his hands and nails clean and his nails short;

(ii) Any operator wears disposable surgical gloves that have not previously been used with any other client;

(iii) Any operator of the premises wears a gown, wrap or protective clothing that is clean and washable, or alternatively a disposable covering that has not previously been used in connection with any other client;

(iv) Any operator keeps any open boil, sore, cut or open wound on an exposed part of the body effectively covered by an impermeable dressing;

(v) Any operator does not smoke or consume food or drink in the treatment area.

(b) A proprietor shall provide—

(i) suitable and sufficient washing facilities for the sole use of operators, including hot and cold water and sanitising soap or detergent;

(ii) suitable and sufficient sanitary accommodation for operators.

COUNCIL'S SIGNATURE COUNCIL'S SEAL

The foregoing byelaws are hereby confirmed by the Secretary of State for Health

on and shall come into operation on

[Printed name]

Member of the Senior Civil Service

Department of Health

**NOTE – THE FOLLOWING DOES NOT FORM PART OF THE BYELAWS**

Proprietors must take all reasonable steps to ensure compliance with these byelaws by persons working on premises. Section 16(9) of the Act provides that a registered person shall cause to be prominently displayed on the premises a copy of these byelaws and a copy of any certificate of registration issued to him under Part VIII of the Act.

Section 16 of the Local Government (Miscellaneous Provisions) Act 1982 provides that any person who contravenes these byelaws shall be guilty of an offence and liable on summary conviction to a fine not exceeding level 3 on the standard scale. If a person registered under Part VIII of the Act is found guilty of contravening these byelaws the Court may, instead of or in addition to imposing a fine, order the suspension or cancellation of his registration and of the registration of the premises in which the offence was committed if such premises are occupied by the person found guilty of the offence. It shall be a defence for the person charged under sub-sections (1), (2), (8), or (10) of section 16 to prove that he took all reasonable precautions and exercised all due diligence to avoid commission of the offence.

Nothing in these byelaws extends to the practice of cosmetic piercing by or under the supervision of a person who is registered as a medical practitioner, or to premises in which the practice of cosmetic piercing is carried out by or under the supervision of such a person.

Appendix 2

## SEMI-PERMANENT SKIN-COLOURING BYELAWS

Byelaws for the purposes of securing the cleanliness of premises registered under section 15 of the Local Government (Miscellaneous Provisions) Act 1982 and fittings in such premises and registered persons and persons assisting them and the cleansing and, so far as appropriate, sterilization of instruments, materials and equipment used in connection with the business of semi-permanent skin-colouring made by Maidstone Borough Council in pursuance of section 15(7) of the Act.

### Interpretation

**1.**—(1) In these byelaws, unless the context otherwise requires—

"The Act" means the Local Government (Miscellaneous Provisions) Act 1982;

"Client" means any person undergoing treatment;

"Operator" means any person giving treatment, including a proprietor;

"Premises" means any premises registered under Part VIII of the Act;

"Proprietor" means any person registered under Part VIII of the Act;

"Treatment" means any operation in effecting semi-permanent skin-colouring;

"The treatment area" means any part of premises where treatment is given to clients.

(2) The Interpretation Act 1978 shall apply for the interpretation of these byelaws as it applies for the interpretation of an Act of Parliament.

**2.**—(1) For the purpose of securing the cleanliness of premises and fittings in such premises a proprietor shall ensure that—

(a) all internal walls, doors, windows, partitions, floors, floor coverings and ceilings are kept clean and in such good repair as to enable them to be cleaned effectively;

(b) the treatment area is used solely for giving treatment;

(c) the floor of the treatment area is provided with a smooth impervious surface;

(d) all waste material, and other litter arising from treatment should be handled and disposed of as clinical waste in accordance with relevant legislation and guidance as advised by the local authority;

(e) all needles used in treatment are single-use and disposable, as far as is practicable, and are stored and disposed of as clinical waste in accordance with relevant legislation and guidance as advised by the local authority;

(f) all furniture and fittings in the premises are kept clean and in such good repair as to enable them to be cleaned effectively;

(g) all tables couches and seats used by clients in the treatment area, and any surface on which the items specified in 3b below are

placed immediately prior to treatment, have a smooth impervious surface which is disinfected immediately after use and at the end of each working day;

(h) where tables and couches are used they are covered by a disposable paper sheet which is changed for each client;

(i) no eating, drinking, or smoking is permitted in the treatment area and a notice or notices reading "No Smoking", and "No Eating or Drinking" is prominently displayed there.

**3.**—(1) For the purpose of securing the cleansing and so far as is appropriate, the sterilization of instruments, materials and equipment used in connection with the treatment—

(a) An operator shall ensure that, before use in connection with treatment—

any gown, wrap or other protective clothing, paper or other covering, towel, cloth or other such article used in the treatment—

i. is clean and in good repair and, so far as is appropriate, sterile;

ii. has not previously been used in connection with any other client unless it consists of a material which can be and has been adequately cleaned and, so far as is appropriate, sterilized.

(b) An operator shall ensure that-

i any needle, metal instrument, or other item of equipment used in treatment or for handling instruments and needles used in treatment is in a sterile condition and kept sterile until it is used;

ii all dyes used for semi-permanent skin-colouring are sterile and inert;

iii the containers used to hold the dyes for each customer are either disposed of at the end of each session of treatment, or are cleaned and sterilized before re-use;

(c) a proprietor shall provide—

(i) adequate facilities and equipment for the purpose of sterilization, [unless pre-sterilized items are used] and of cleansing, as required in pursuance of these byelaws;

(ii) sufficient and safe gas points and/or electrical socket outlets to enable compliance with these byelaws;

(iii) an adequate constant supply of clean hot and cold water readily available at all times on the premises;

(iv) adequate storage for items mentioned in byelaw 3a and b above, so that those items are properly stored in a clean and suitable place so as to avoid, as far as possible, the risk of contamination.

**4.**—(1) For the purpose of securing the cleanliness of operators-

a. a proprietor shall ensure that —

(i) any operator keeps his hands and nails clean and his nails short;

(ii) any operator wears disposable surgical gloves that have not previously been used with any other client;

(iii) any operator of the premises wears a gown, wrap or protective clothing that is clean and washable, or alternatively a disposable covering that has not previously been used in connection with any other client;

(iv) any operator keeps any open boil, sore, cut or open wound on an exposed part of the body effectively covered by an impermeable dressing;

(v) any operator does not smoke or consume food or drink in the treatment area.

(b) A proprietor shall provide—

(i) suitable and sufficient washing facilities for the sole use of operators, including hot and cold water, sanitising soap or detergent;

(ii) suitable and sufficient sanitary accommodation for operators.

COUNCIL'S SIGNATURE COUNCIL'S SEAL

The foregoing byelaws are hereby confirmed by the Secretary of State for Health

on and shall come into operation on

[Printed name]

Member of the Senior Civil Service

Department of Health

**NOTE – THE FOLLOWING DOES NOT FORM PART OF THE BYELAWS**

Proprietors shall take all reasonable steps to ensure compliance with these byelaws by persons working on premises. Section 16(9) of the Act provides that a registered person shall cause to be prominently displayed on the premises a copy of these byelaws and a copy of any certificate of registration issued to him under Part VIII of the Act.

Section 16 of the Local Government (Miscellaneous Provisions) Act 1982 provides that any person who contravenes any of these byelaws shall be guilty of an offence and liable on summary conviction to a fine not exceeding level 3 on the standard scale. If a person registered under Part VIII of the Act is found guilty of contravening these byelaws the Court may, instead of or in addition to imposing a fine, order the suspension or cancellation of his registration and of the registration of the premises in which the offence was committed if such premises are occupied by the person found guilty of the offence. It shall be a defence for the person charged under sub-sections (1), (2), (8), or (10) of section 16 to prove that he took all reasonable precautions and exercised all due diligence to avoid commission of the offence.

Nothing in these byelaws extends to the practice of cosmetic piercing by or under the supervision of a person who is registered as a medical practitioner, or to premises in which the practice of cosmetic piercing is carried out by or under the supervision of such a person.

| **Communities, Housing & Environment** | **18 October 2016** |
|---|---|
| Is the final decision on the recommendations in this report to be made at this meeting? | **Yes** |

# Maidstone Health Inequalities Action Plan – Progress Report

| | |
|---|---|
| **Final Decision-Maker** | Communities, Housing & Environment Committee |
| **Lead Director or Head of Service** | Head of Housing and Community Services |
| **Lead Officer and Report Author** | Sarah Ward, Housing and Health Officer<br>Ellie Kershaw, Housing Inclusion Manager |
| **Classification** | Non-exempt |
| **Wards affected** | Borough |

**This report makes the following recommendations to the final decision-maker:**

1. The Committee notes the progress of the Maidstone Health Inequalities Action Plan to date.
2. The Committee agrees the future priorities for the Maidstone Health Inequalities Action Plan.
3. The Committee adopts the refreshed action plan.

**This report relates to the following corporate priorities:**

- Keeping the Borough an attractive place for all, by:
  - Providing a clean and safe environment
  - Encouraging good health and wellbeing and;
  - Respecting the character of our borough
- Securing a successful economy across the borough, by:
  - Improving the transport infrastructure
  - Promoting a range of employment opportunities and skills and;
  - Planning for sufficient homes

| **Timetable** | |
|---|---|
| ***Meeting*** | ***Date*** |
| Communities, Housing and Environment Committee | 18 October 2016 |

# Maidstone Health Inequalities Action Plan – Progress Report

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of the report is to update the Committee on the progress of the Maidstone Health Inequalities Action Plan and confirm the Council's commitment going forward in tackling the borough's health inequality.

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## 2. INTRODUCTION AND BACKGROUND

2.1 Health Inequalities are differences in health outcomes between people or groups due to social, geographical, biological and other factors. These differences have a huge impact, because they result in the people who are in or closest to poverty experiencing poorer health and shorter lives.

2.2 The national vision is to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest which is measured through two key targets in the Public Health Outcomes Framework.

Outcome 1: Increased healthy life expectancy
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities.

At the local level responsibility for the public health function has been given to local government, in particular unitary and upper tier authorities. In Maidstone, this is Kent County Council. Responsibility for public health transferred from the former Primary Care Trusts to local authorities on 1 April 2013.

2.3 In 2012, Kent County Council adopted the Kent Health Inequalities Action Plan titled 'Mind the Gap Building Bridges to better health for all' (2012-2015). Mind The Gap was built upon the six key policy objectives derived from the work of Sir Michael Marmot entitled "Fair Society, Healthy Lives" published in 2010.

The policy objectives are as follows:

- Give every child the best start in life
- Enable all children, young people and adult to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

These policy objectives are still as relevant today as they were when published in 2010. However, just using these policy objectives without providing a greater geographical focus on the communities suffering the worst

health and lowest life expectancy, and planning over an unrealistic time period will not in themselves reduce health inequalities significantly.

2.4 Kent County Council, Health Inequalities Strategy, 'Mind the Gap 2016' continues to follow the policy objectives by Sir Michael Marmot. Kent County Council's approach to tackling health inequalities is Community Transformation. This is a means of empowering individuals and communities for better health and wellbeing. Kent County Council aim to radically improve health and wellbeing of identified communities, through coordinated actions across KCC, district councils, CCG's, service providers and community partners. In taking this approach, KCC will be concentrating on Shepway South, Park Wood and Postley Road.

2.5 District Councils have a major role to play in public health. The functions we deliver such as planning, housing, economic development, environmental health, leisure and community safety have key impact on the health of communities. In continuing to deliver core public health services from existing revenues, the Council must seek new, pioneering ways of delivery to achieve more and produce better outcomes with fewer resources. Taking a strategic approach to public health across all services will help the Council to better align and target resources in line with health and wellbeing priorities.

2.6 The Council also needs to support the commissioning process (at County Level) as an identifier of local needs and use our expertise in a multitude of public health areas to be potential provider, partner and sub-commissioner of public health interventions. Maidstone Borough Council is closer to our communities and therefore better placed to understand what is likely to be most effective in a given location.

2.7 In 2014, Maidstone Borough Council adopted its own Health Inequalities Action Plan demonstrating how the County wide objectives can be delivered locally. In the absence of localised data at the time, the Council adopted Sir Michael Marmot's policy objectives for consistency with the Kent County Council action plan to assist with delivery and reporting. The key to Marmot's approach is to create the conditions for people to take control of their own lives. The priorities recognise that disadvantage starts before birth and accumulates throughout life.

2.8 The Council recognises that reducing health inequalities cannot be done in isolation; we depend on developing and sustaining partnerships with organisation in the borough to help us achieve the goals for our residents. The Maidstone Health and Wellbeing Board have the responsibility to oversee the delivery of the action plan and report progress back to the Kent Health and Wellbeing Board. The Group own the action plan, but are not the sole owners of the actions contained within it.

2.9 The Maidstone Health Inequalities Action Plan runs until 2020; however as data has developed, knowledge has matured and local authorities face an ever-changing financial climate, there is a need to review progress to ensure priorities are still relevant and the Council is working to meet the needs of its communities.

## 3. AVAILABLE OPTIONS

3.1 To note the progress of the Maidstone Health Inequalities Action Plan as set out in Appendix A and continue with the current plan until it expires in 2020.

3.2 The Committee reviews the implementation and impact of the current Health Inequalities Action Plan (2014-2020) and examines the strategic direction for future delivery as highlighted in Appendix B – Refresh 2016 of the Maidstone Health Inequalities Action Plan.

The Committee considers the key objectives and priorities in the refreshed plan to determine the skills, capabilities and resources needed to successfully contribute to reducing health inequalities in the borough.

3.3 The Committee can choose not to act at all as Kent County Council has the statutory responsibility for Public Health. However, this would mean the Council foregoing the opportunity to influence the delivery of services that could reduce health inequalities in the borough.

## 4. PREFERRED OPTION AND REASONS FOR RECOMMENDATIONS

4.1 The preferred option is contained in paragraph 3.2, as this proposal will enable for progress to be reviewed and tracked and place Maidstone Borough Council at the forefront of tackling the wider determinants of health within its borough. This will ensure better outcomes for our residents and in the long-term reduce the financial burden on services.

4.2 Refreshing the action plan will enable Maidstone Borough Council to take a leap forward in improving resident health due to the development of data and maturity of knowledge. Some of the current work streams contained within the Maidstone Health Inequalities Action Plan 2014-2020 (e.g. Delivery actions contained in the Maidstone Teenage Pregnancy Action Plan) are no longer relevant so will be removed from the plan.

## 5. CONSULTATION RESULTS AND PREVIOUS COMMITTEE FEEDBACK

5.1 A draft of the 2015/16 progress report was presented at the Maidstone Health and Wellbeing Board on Monday 4th July 2016 and feedback from Board Members helped inform this report.

5.2 Additional consultations have taken place to demonstrate the importance of district council's involvement in public health on the following dates:

- Wider Leadership Team Workshop: Tuesday 13th September 2016. Following this session, Heads of Service were requested to nominate a

health champion for their area so consultation and delivery can continue internally for the duration of the action plan.

- Maidstone Health and Wellbeing Board: Tuesday 20th September 2016

5.3 A member's workshop has been scheduled for Monday 17th October 2016.

## 6. NEXT STEPS: COMMUNICATION AND IMPLEMENTATION OF THE DECISION

6.1 Following the decision of the Committee, should the plan be adopted, the Maidstone Health and Wellbeing Board will endorse the action plan and instruct the sub-groups for delivery. In addition, work will continue internally with Maidstone Borough Council Health Champions to ensure health and wellbeing is considered with planning and delivering across internal departments.

6.2 The refreshed Maidstone Health Inequalities Action Plan will be published on the Council's website.

6.3 The Maidstone Health and Wellbeing Board will provide annual reports to this committee to note progress to date, share achievements and note areas for concern.

## 7. CROSS-CUTTING ISSUES AND IMPLICATIONS

| Issue | Implications | Sign-off |
|---|---|---|
| **Impact on Corporate Priorities** | The Maidstone Heath Inequalities Action Plan contributes to the delivery of the Strategic Plan priorities: Keeping Maidstone an attractive place for all and Securing a successful economy for the Maidstone Borough. | Head of Housing and Community Services |
| **Risk Management** | Not being involved in the health agenda would carry the risk that the Council is unable to influence matters relating to the health and wellbeing of its communities. | Head of Housing and Community Services |
| **Financial** | Maidstone Borough Council receives approximately £146,000 from Kent Public Health for the delivery of health improvement programmes focusing on obesity and mental health and wellbeing.<br>Kent County Council is currently reviewing commissioning for adult health improvement service with the proposal to start the procurement process in autumn 2016. | Financial reviewers |

| | | |
|---|---|---|
| | Therefore, funding for 2016/17 cannot be guaranteed.<br><br>The actions listed within the Health Inequalities Action Plans covers a wide range of services provided by the Council and partner agencies and cannot be dependent on funding pilots / projects but be embedded as part of core council duties. | |
| **Staffing** | The priorities contacted within the Health Inequalities Action Plan cut across internal departments and external agencies. Delivery against priorities will be through the use of existing staff resources and where appropriate seek external grant funding. | Head of HR Shared Service |
| **Legal** | There are no legal implications relating to this report.<br>However, any commissioned projects (subject to future funding) will be subject to the standard terms and conditions. | Legal Services |
| **Equality Impact Needs Assessment** | The needs of different groups are considered through the development of the Maidstone Health Inequalities Action Plan. | Policy & Information Manager |
| **Environmental/Sustainable Development** | None. | |
| **Community Safety** | None. | |
| **Human Rights Act** | None. | |
| **Procurement** | Any commissioned services received through the Kent Public Health Funding will be subject to the procurement process. | |
| **Asset Management** | The sub-groups of the Maidstone Health and Wellbeing Board will be responsible for asset mapping existing provision, capabilities and needs assess a particular area before delivery work is undertaken. | Head of Housing and Community Services |

## 8. REPORT APPENDICES

The following documents are to be published with this report and form part of the report:

- Appendix A: Maidstone Health Inequalities 2015/16 Progress Report
- Appendix B: Refresh of the Maidstone Health Inequalities Action Plan

Background papers

- Maidstone Health Inequalities Action Plan 2014 – 2020 (adopted July 2014)

# Appendix A: Maidstone Health Inequalities 2015/16 Progress Report

*Information prepared by Maidstone Borough Council and supported by Kent County Council, Kent Public Health*

## Introduction

In 2012, Kent County Council launched Mind the Gap. Mind the Gap is Kent's Health Inequalities Action Plan which aims to improve health and wellbeing for everyone in Kent by narrowing the gap in health status between the most and least deprived communities. It provides a framework and tools to identify, analyse and evaluate actions that contribute to reducing health inequalities.

The Maidstone Health Inequalities Action Plan was developed following the transfer of public health responsibility to local authorities from the NHS. Tackling inequalities is a task that will require the efforts of all; across multiple organisations and within communities themselves. District Councils have a key role to play in keeping us healthy. We have a distinct, local role in service provision, economic development, planning, and helping to shape and support our communities – all key areas that are increasingly recognised as vital components of a true population health system.

There are 6 policy objectives embedded into the action plan based on the principles of the 'Fair Society, Healthy Lives' written by Professor Sir Michael Marmot.

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Health is impacted by wider determinants of health such as education, employment, housing, physical environment, relationships/networks; and these need to be addressed in order to improve health and wellbeing. Health services are not always the solution.

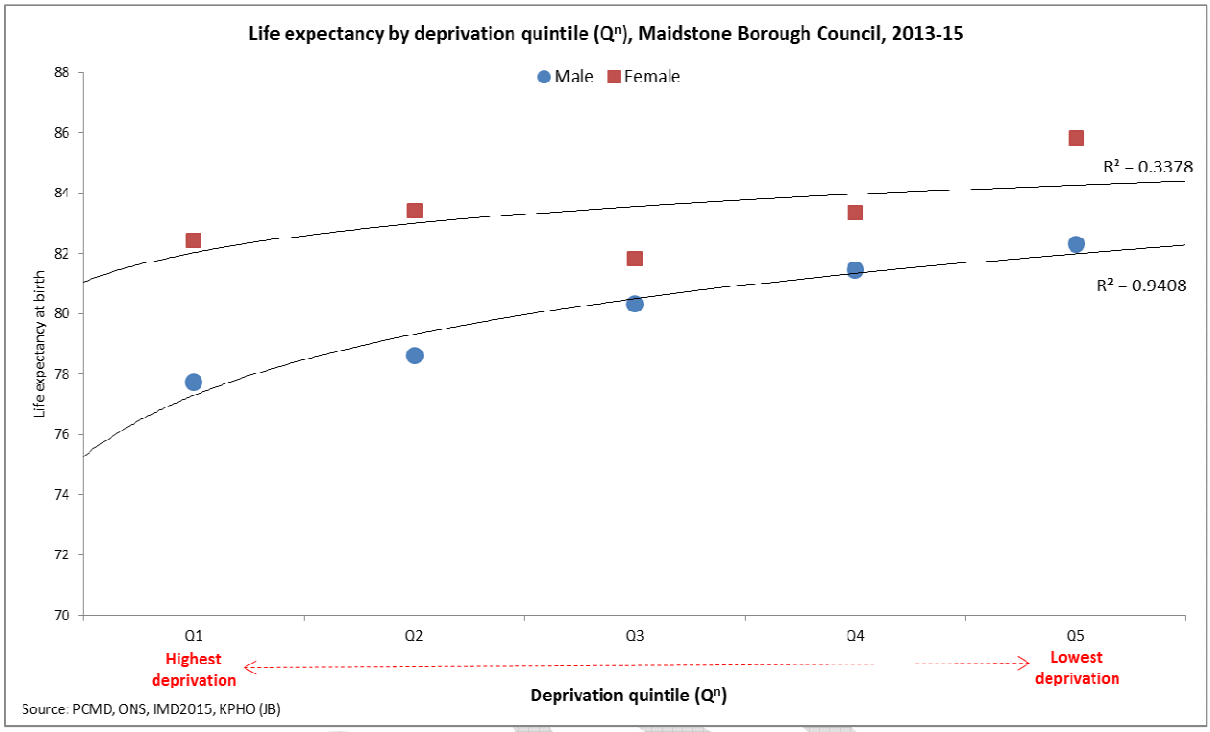
Now we are nearly two years in, it is an opportunity to review progress against actions and move forward in closing the gap in health inequalities.

## Measuring Health Inequalities

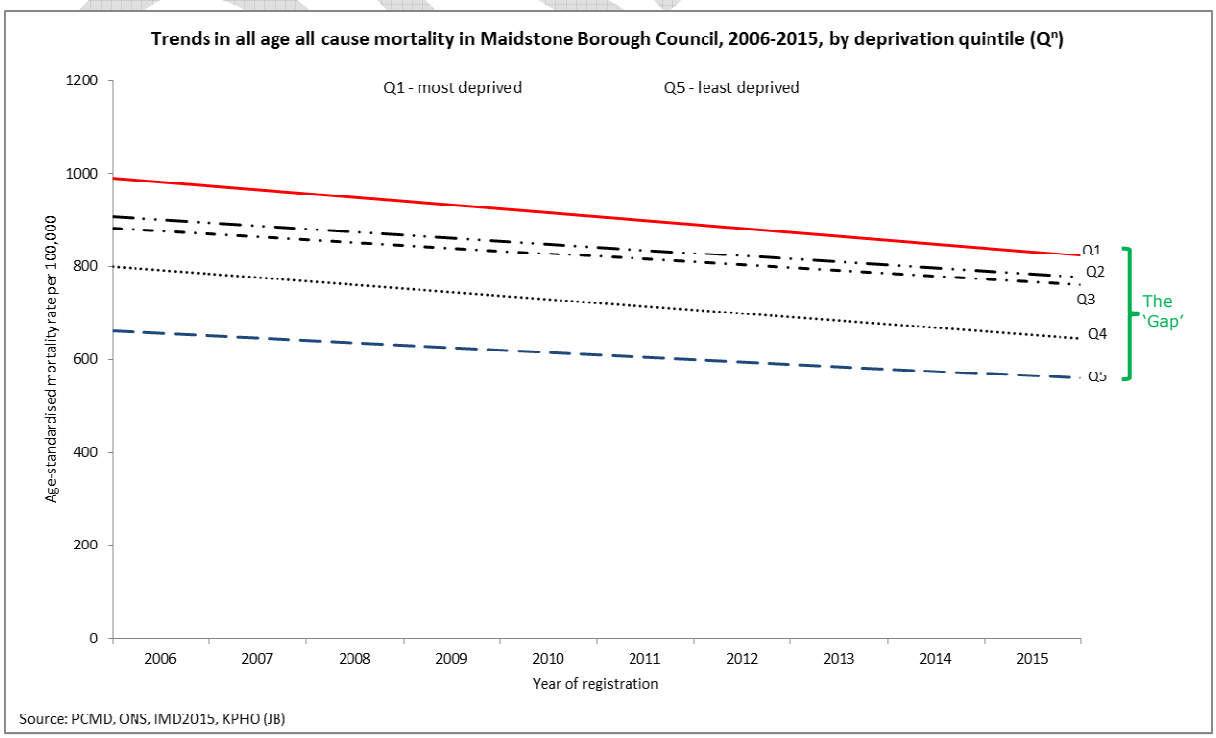
Overall indicator of progress in tackling health inequalities is to look at how mortality rates have changed over time for the most deprived compared to our least deprived.

It can be seen that although people's life expectancy is increasing, the gap in mortality rates between the most and least deprived remains largely unchanged.

The graph below looks at life expectancy by deprivation of those living in the bottom quintile and top quintile within the Maidstone Borough from 2013-2015. It shows that those living in the most deprived areas have a lower life expectancy than those living in the least deprived areas.



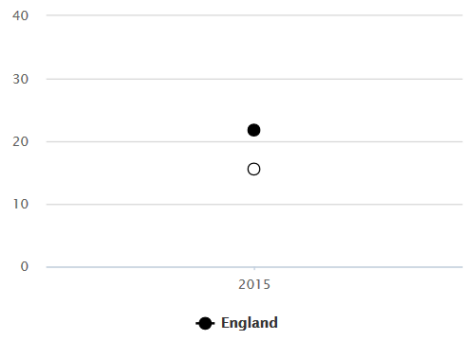

Although mortality rates have been falling over the past decade, the 'gap' in mortality rates between the most and least deprived persists (all lines are decreasing). The red line shows the most deprived population and the bottom line shows the least deprived population.



This persistent gap in health outcomes is not a phenomenon that is unique to Maidstone or Kent; the Office of National Statistics recently reported that there has been a persistent fixed gap in the life expectancy across England as a whole.[1]

In 2015, the deprivation score for Maidstone is 15.6 which is significantly lower than the deprivation score for England (21.8). This disguises pockets of deprivation at ward level and lower super output areas (LSOA)

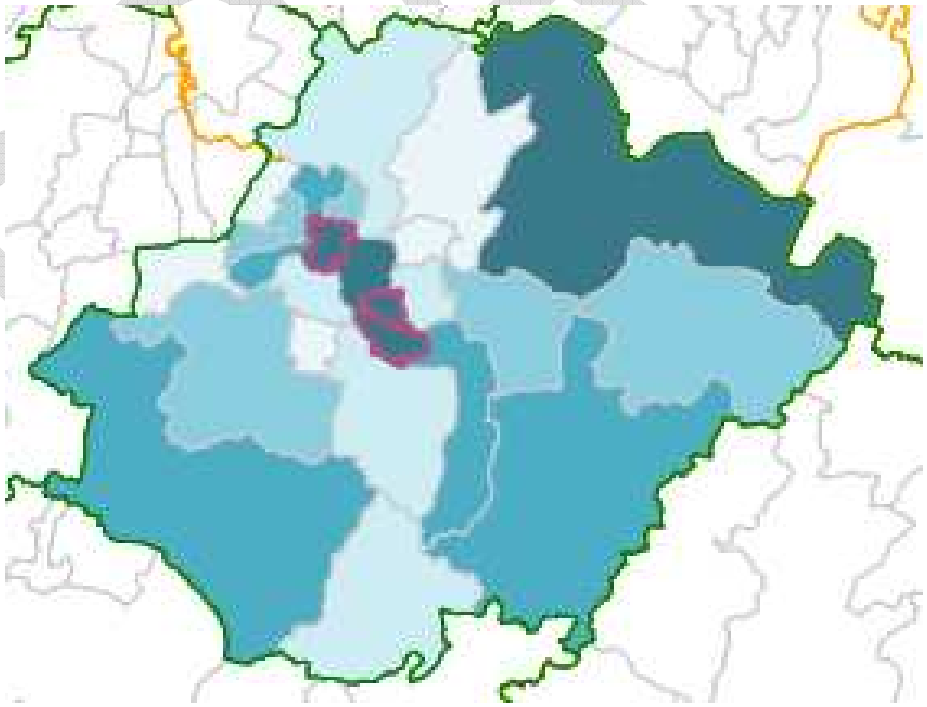
**Deprivation score (IMD 2015)** Maidstone




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2015 | ○ | - | 15.6 | - | - | - | 21.8 |

*Source: Department of Communities and Local Government (DCLG)*

Within the Maidstone borough, Park Wood; Shepway South and High Street are identified as areas of deprivation. It is important to remember that other pockets of deprivation do exist across the borough.



[1] Office for National Statistics. Statistical Bulletin Health Expectancies at birth by Middle Layer Super Output Areas, England, Inequality in Health and Life Expectancies within Upper Tier Local Authorities: 2009 to 2013. 2015:1-22.

*Indices of multiple deprivation 2015*

| Name | Ward values<br>Index of mulitple deprivation (2015) |
|---|---|
| Allington | 4.61 |
| Barming | 4.27 |
| Bearsted | 3.91 |
| Boughton Monchelsea and Chart Sutton | 10.25 |
| Boxley | 8.76 |
| Bridge | 10.51 |
| Coxheath and Hunton | 12.31 |
| Detling and Thurnham | 8.51 |
| Downswood and Otham | 9.96 |
| East | 13.17 |
| Fant | 17.88 |
| Harrietsham and Lenham | 12.74 |
| Headcorn | 14.7 |
| Heath | 13.03 |
| High Street | 27.83 |
| Leeds | 11.59 |
| Loose | 6.73 |
| Marden and Yalding | 18.33 |
| North | 17.18 |
| North Downs | 21.96 |
| Leeds | 11.59 |
| Loose | 6.73 |
| Marden and Yalding | 18.33 |
| North | 17.18 |
| North Downs | 21.96 |
| Park Wood | 33.3 |
| Shepway North | 23.99 |
| Shepway South | 34.54 |
| South | 9.98 |
| Staplehurst | 9.43 |
| Sutton Valence and Langley | 13.42 |

## Progress to date

Actions listed within the Maidstone Health Inequalities Action Plan were time-bound to 2015 and 2020 to assist with monitoring. However, it is hard to develop trends over a short period of time and to see statistically significant difference, particularly when there is a change of data collection so no comparisons can be drawn.

Progress has been noted against each priority and provided as an overview of each action. It is important to note that information cannot necessary be drawn from the data alone.

## Priority 1: Give every child the best start in life

A child's early years lay down the foundation for the rest of their life, and the first three years are most crucial. This is a crucial period of physical, intellectual and emotional development.

Inequalities are introduced before birth, as the health of a child is greatly affected by the health of their mother during pregnancy. Maternal stress, diet, smoking, drug and alcohol use all influences a baby's development in the womb.

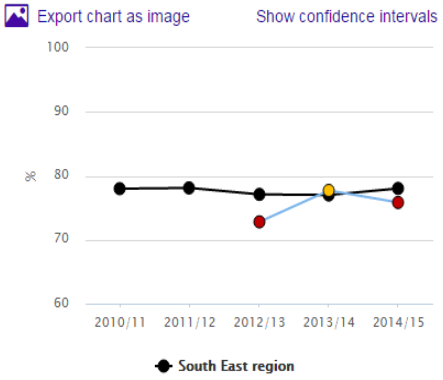
### Breastfeeding

Breastfeeding contributes significantly to the long term health of both infants and mothers and increases maternal bonding.

Breastfeeding initiation in Maidstone is better than national and Kent figures but has been less significantly worse than the South East. The breastfeeding initiation rate in Maidstone for those mothers who breastfeed their babies in the first 45 hours after delivery has increased slightly from 74.6% to 75.8%.

Data is insufficient to report on the prevalence of breastfeeding at 6-8 weeks.

**Breastfeeding initiation** Maidstone Proportion - %



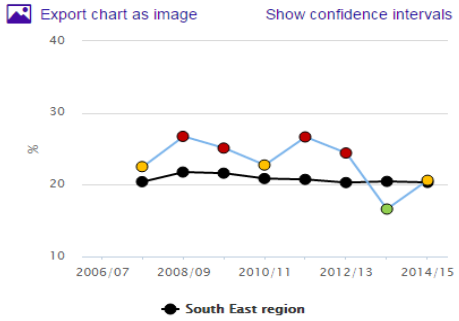

| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2010/11 | | - | - | - | - | 78.0 | 73.7 |
| 2011/12 | | - | - | - | - | 78.1 | 74.0 |
| 2012/13 | | 1,339 | 72.8 | 70.7 | 74.8 | 77.1 | 73.9 |
| 2013/14 | | 1,366 | 77.7 | 75.7 | 79.6 | 77.0 | 74.0 |
| 2014/15 | | 1,433 | 75.8 | 73.8 | 77.7 | 78.0 | 74.3 |

*Source: LA, Regional and England data are calculated by NHS England. Public Health England Knowledge and Intelligence Team (East) has calculated Shires and additional geographies.*

### Excess Weight in Children

Although the prevalence rates in Maidstone for overweight children at Year R and Year 6 are similar to England and South East rates, childhood obesity remains a priority for Kent and for the West Kent Health and Wellbeing Board.

**Reception: Prevalence of overweight (including obese)** Maidstone Proportion - %




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2006/07 | | - | * | - | - | - | 22.9 |
| 2007/08 | | 299 | 22.5 | 20.3 | 24.8 | 20.4 | 22.6 |
| 2008/09 | | 383 | 26.7 | 24.5 | 29.1 | 21.8 | 22.8 |
| 2009/10 | | 380 | 25.1 | 23.0 | 27.3 | 21.6 | 23.1 |
| 2010/11 | | 352 | 22.7 | 20.7 | 24.9 | 20.9 | 22.6 |
| 2011/12 | | 432 | 26.7 | 24.6 | 28.9 | 20.7 | 22.6 |
| 2012/13 | | 396 | 24.4 | 22.4 | 26.6 | 20.3 | 22.2 |
| 2013/14 | | 276 | 16.6 | 14.9 | 18.5 | 20.5 | 22.5 |
| 2014/15 | | 365 | 20.6 | 18.8 | 22.6 | 20.3 | 21.9 |

*Source: Health and Social Care Information Centre, National Child Measurement Programme*

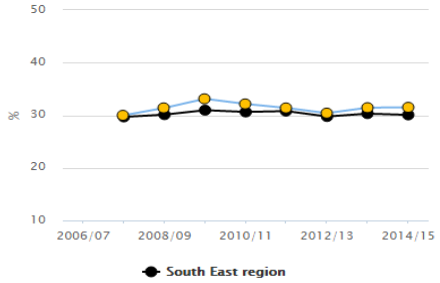
*Compared with benchmark:* Better Similar Worse

* a note is attached to the value, hover over to see more details

Trends for: Maidstone
All in South East region

**Year 6: Prevalence of overweight (including obese)** Maidstone Proportion - %

Export chart as image Show confidence intervals




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2006/07 | | - | * | - | - | - | 31.7 |
| 2007/08 | | 394 | 30.0 | 27.6 | 32.5 | 29.7 | 32.6 |
| 2008/09 | | 464 | 31.4 | 29.1 | 33.8 | 30.1 | 32.6 |
| 2009/10 | | 516 | 33.1 | 30.8 | 35.5 | 31.0 | 33.4 |
| 2010/11 | | 495 | 32.1 | 29.9 | 34.5 | 30.6 | 33.4 |
| 2011/12 | | 472 | 31.4 | 29.1 | 33.8 | 30.8 | 33.9 |
| 2012/13 | | 449 | 30.4 | 28.1 | 32.8 | 29.8 | 33.3 |
| 2013/14 | | 486 | 31.4 | 29.2 | 33.8 | 30.3 | 33.5 |
| 2014/15 | | 483 | 31.5 | 29.2 | 33.9 | 30.1 | 33.2 |

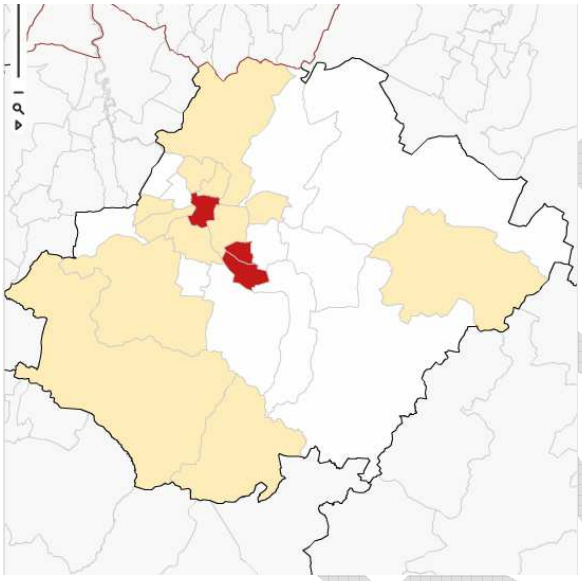
*Source: Health and Social Care Information Centre, National Child Measurement Programme*

Data from the National Child Measurement Programme shows a reduction in the number of obese children in reception year (10.7% down to 8.2%) and year 6 (20.0% down to 14.9%). However it is important to note that new cohorts of children are measured each year. Experiences in childhood affect behaviours and habits into adulthood.

## Priority 2: Enable all children, young people and adults to maximise their capabilities and have control over their lives

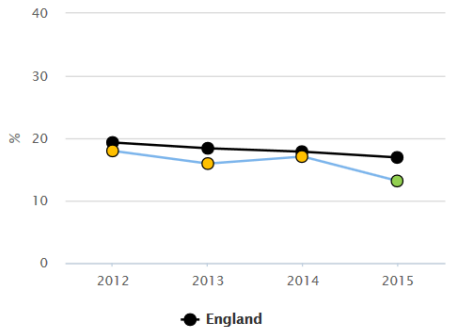
As children develop into young adults, they go through physical, emotional and psychological changes as they establish their own identities, independent from their families and carers. This is a time when services can offer children and young people opportunities to improve and shape their lives for the better, with impacts which last long into adult life.

**Teenage Conceptions**
The Under 18 conception rate in Maidstone is similar to the rate in England the South East and is declining. However, this disguises higher rates in Park Wood, Shepway South and High Street.



**Smoking**
In 2015, Maidstone has seen an improvement from the South East and National average with only 13.2% of the population smoking.

**Smoking Prevalence in adults** Maidstone — Proportion - %




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2012 | | - | 18.0 | 13.5 | 22.5 | 17.9 | 19.3 |
| 2013 | | - | 15.9 | 11.6 | 20.3 | 17.2 | 18.4 |
| 2014 | | - | 17.1 | 12.6 | 21.6 | 16.5 | 17.8 |
| 2015 | | - | 13.2 | 9.4 | 16.9 | 15.9 | 16.9 |

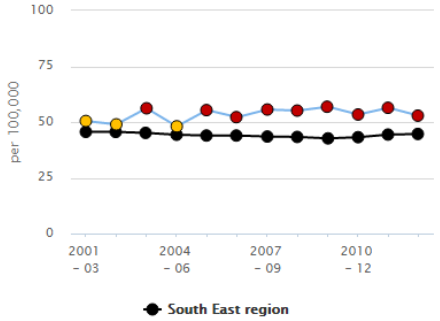
*Source: Annual Population Survey (APS)*

However, smoking attributable mortality in Maidstone is similar to the England and the South East region; deaths from Chronic Obstructive Pulmonary Disease

(COPD) are significantly higher. This is also reflected in a higher rate of Emergency admissions for COPD.

**Deaths from chronic obstructive pulmonary disease** Maidstone Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



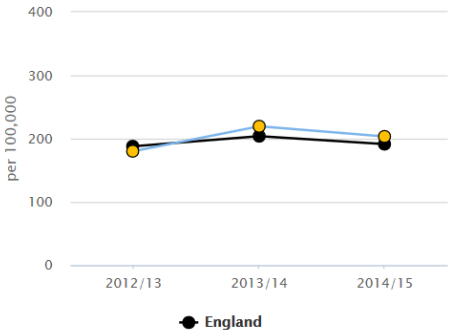

| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2001 - 03 | | 173 | 50.4 | 43.2 | 58.6 | 45.6 | 55.7 |
| 2002 - 04 | | 169 | 48.9 | 41.8 | 57.0 | 45.6 | 54.9 |
| 2003 - 05 | | 194 | 56.2 | 48.5 | 64.7 | 45.1 | 54.3 |
| 2004 - 06 | | 171 | 48.1 | 41.1 | 55.9 | 44.3 | 52.1 |
| 2005 - 07 | | 201 | 55.3 | 47.9 | 63.6 | 43.9 | 51.8 |
| 2006 - 08 | | 198 | 52.2 | 45.1 | 60.1 | 43.9 | 51.6 |
| 2007 - 09 | | 218 | 55.6 | 48.4 | 63.6 | 43.5 | 50.8 |
| 2008 - 10 | | 223 | 55.1 | 48.1 | 62.9 | 43.3 | 50.1 |
| 2009 - 11 | | 231 | 56.9 | 49.7 | 64.7 | 42.7 | 49.1 |
| 2010 - 12 | | 220 | 53.4 | 46.5 | 60.9 | 43.2 | 50.1 |
| 2011 - 13 | | 240 | 56.4 | 49.4 | 64.0 | 44.4 | 51.5 |
| 2012 - 14 | | 233 | 52.9 | 46.3 | 60.1 | 44.6 | 51.7 |

*Source: Public Health England (based on ONS source data)*

## Hospital Stays for Self-Harm

Maidstone is not significantly different to the England average for hospital stays for self-harm, however a slight reduction has been noted from 215.3/100,000 to 205.67/100,000 (2014/15 data)

**Hospital stays for self-harm** Maidstone Directly standardised rate - per 100,000




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2012/13 | | 283 | 180.2 | 159.8 | 202.5 | 183.0 | 188.0 |
| 2013/14 | | 344 | 219.6 | 196.8 | 244.3 | 205.6 | 204.0 |
| 2014/15 | | 324 | 203.4 | 181.8 | 226.9 | 193.1 | 191.4 |

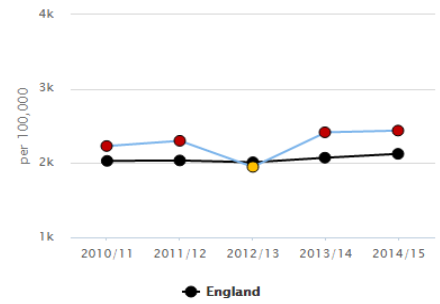
*Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.*

## Falls Prevention

The rate of injuries due to falls in the over 65s is higher in Maidstone than the England and South East. The rate of falls is significantly higher in over 85 year old men and women, although similar to those aged 65 to 74.

**2.24i - Injuries due to falls in people aged 65 and over (Persons)** Maidstone Directly standardised rate - per 100,000

Export chart as image Show confidence intervals




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2010/11 | | 615 | 2,230 | 2,048 | 2,422 | 1,994 | 2,030 |
| 2011/12 | | 656 | 2,300 | 2,118 | 2,493 | 1,982 | 2,035 |
| 2012/13 | | 573 | 1,949 | 1,785 | 2,123 | 1,962 | 2,011 |
| 2013/14 | | 713 | 2,415 | 2,231 | 2,609 | 2,056 | 2,072 |
| 2014/15 | | 741 | 2,438 | 2,257 | 2,629 | 2,086 | 2,125 |

*Source: Calculated by West Midlands Knowledge and Intelligence Team from data from the Information Centre for Health and Social Care - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates*

## Priority 3: Create fair employment and good work for all

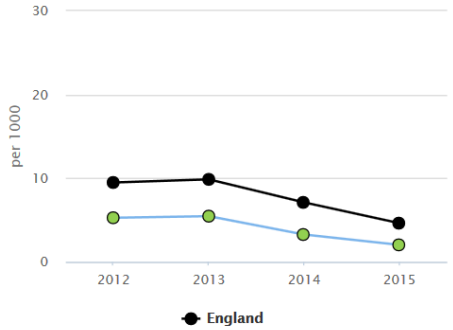
Patterns of employment both reflect and reinforce the social gradient, and being in good employment is protective of health. Unemployment leads to financial insecurity, psychologic stress, anxiety, depression and unhealthy behaviours such as smoking and alcohol consumption.

The quality of work is also important. Jobs that are insecure, low-paid and fail to protect employees from stress and physical danger lead to poorer health.

**Unemployment**

In Kent, the unemployment rate has been reducing over the last few years in all districts as the nation's economic recovery continues. The long-term unemployment rate in Maidstone is better than the England average.

**Long term unemployment** Maidstone — Crude rate - per 1000




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2012 | | 522 | 5.3 | 4.8 | 5.8 | 5.5 | 9.5 |
| 2013 | | 540 | 5.5 | 5.0 | 5.9 | 5.5 | 9.9 |
| 2014 | | 329 | 3.3 | 2.9 | 3.6 | 3.6 | 7.1 |
| 2015 | | 205 | 2.0 | 1.8 | 2.3 | 2.3 | 4.6 |

*Source: www.nomisweb.co.uk*

Businesses and workplaces have a key role to play in support good health and reducing health inequalities. Supervisor and peer support, stable rotas, safe conditions, an opportunity for training and promotion, and greater autonomy in the workplace are all factors that increase employees' wellbeing. In Maidstone, we work alongside Kent County Council to deliver the Kent Healthy Business Awards. The awards are self-assessed standard to help improve the health of the workforce. In 2014/15, 10 businesses had signed up to the awards in Maidstone, increasing to 31 businesses in 2015/16 with 5 achieving the awards.

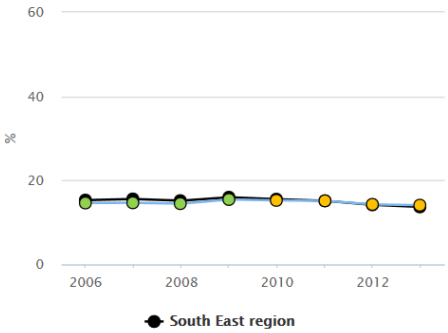
## Priority 4: Ensure a healthy standard of living for all

Income is a key determinant of health. Insufficient income is associated with worse outcomes in long term health and life expectancy. Income alone does not give a full picture of living standards.

### Children in low income families (under 16s)

Maidstone is not significantly different to the region average for the number of children living in low income families; 14.1% in Maidstone compared to 13.7% South East region.

**Children in low income families (under 16s)** Maidstone Proportion - %




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2006 | | 3,995 | 14.6 | 14.2 | 15.0 | 15.3 | 21.8 |
| 2007 | | 4,035 | 14.7 | 14.3 | 15.1 | 15.6 | 22.4 |
| 2008 | | 3,985 | 14.5 | 14.1 | 14.9 | 15.2 | 21.6 |
| 2009 | | 4,285 | 15.5 | 15.0 | 15.9 | 16.0 | 21.9 |
| 2010 | | 4,250 | 15.2 | 14.8 | 15.7 | 15.5 | 21.1 |
| 2011 | | 4,295 | 15.1 | 14.7 | 15.6 | 15.1 | 20.6 |
| 2012 | | 4,120 | 14.3 | 13.9 | 14.7 | 14.2 | 19.2 |
| 2013 | | 4,100 | 14.1 | 13.7 | 14.5 | 13.7 | 18.6 |

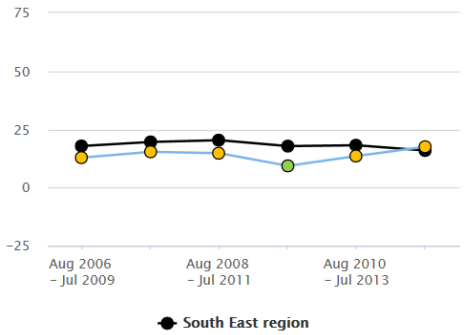
*Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)*

### Fuel Poverty

The people most likely to die or become ill during the cold weather are those least about to afford to heat their homes. Living in a cold home can lead to or worsen a large number of health problems including heart disease, stroke, respiratory illness, falls, asthma and mental health problems. The fuel poverty rate in Kent was 8.6% in 2013, less than the national rate of 10.4%. The number of excess winter deaths in Maidstone is not significantly different to the Kent average. Latest data available has Kent at 11.6% and Maidstone at 15.6%.

Please note the excess winter death trends seen below are only available to July 2013.

**Excess winter deaths** Maidstone Ratio

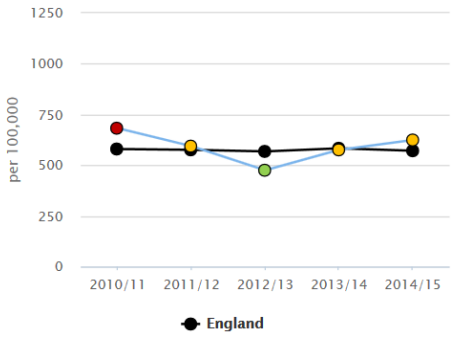



| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| Aug 2006 - Jul 2009 | | 161 | 12.8 | 5.7 | 20.4 | 17.8 | 18.1 |
| Aug 2007 - Jul 2010 | | 196 | 15.3 | 8.2 | 23.0 | 19.6 | 18.7 |
| Aug 2008 - Jul 2011 | | 191 | 14.7 | 7.6 | 22.3 | 20.3 | 19.0 |
| Aug 2009 - Jul 2012 | | 123 | 9.3 | 2.5 | 16.6 | 17.8 | 16.4 |
| Aug 2010 - Jul 2013 | | 177 | 13.5 | 6.5 | 21.0 | 18.2 | 17.4 |
| Aug 2011 - Jul 2014 | | 229 | 17.5 | 10.3 | 25.1 | 15.9 | 15.6 |

*Source: Office for National Statistics: Public Health England Annual Births and Mortality Extracts*

## Hip fractures in people aged 65 and over Maidstone

Directly standardised rate - per 100,000




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2010/11 | | 185 | 683 | 582 | 795 | 582 | 580 |
| 2011/12 | | 177 | 594 | 506 | 693 | 573 | 576 |
| 2012/13 | | 144 | 475 | 398 | 562 | 554 | 568 |
| 2013/14 | | 174 | 576 | 489 | 673 | 587 | 583 |
| 2014/15 | | 191 | 624 | 535 | 724 | 560 | 571 |

*Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2014, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England*

## Priority 5: Create and develop healthy and sustainable places and communities

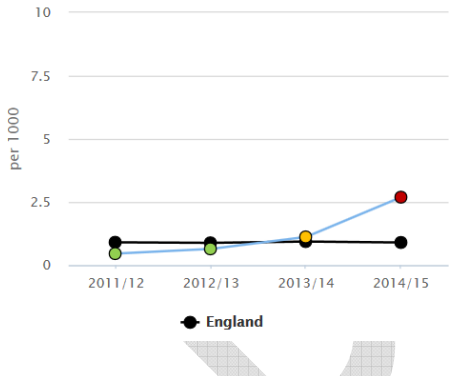
Creating a physical environment in which people can lead healthier lives is crucial to tackling health inequalities. Green spaces such as parks, woodland and other open spaces are associated with a number of health outcomes, relating to physical health, mental health and general wellbeing. There are many indirect benefits too, for example, providing space for social activity, sports and recreation and improving air quality.

Housing is a key aspect of inequalities; poor quality housing is a risk to health, and rates of overcrowded accommodation and shared dwellings are strongly associated with levels of deprivation.

**Statutory homelessness**

Homelessness can be more hidden in the form of temporary accommodation. This transient living can lead to poor continuity of care and service provision. In Maidstone, Statutory homelessness is persistently reported as red in Maidstone (significantly higher than the England average). The measure is the count of households who are eligible, unintentionally homeless and in priority need, for which the local authority accepts responsibility for securing accommodation under part VII of the Housing Act 1996 or part III of the Housing Active 1985. This comes from a return provided by housing authorities to the Department for Communities and Local Government (DCLG).

**Statutory homelessness** Maidstone — Crude rate - per 1000

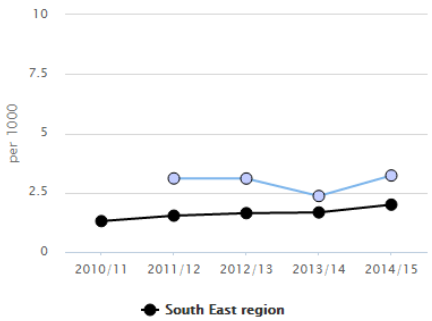



| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2011/12 | | 28 | 0.5 | 0.3 | 0.7 | 0.5 | 0.9 |
| 2012/13 | | 42 | 0.6 | 0.5 | 0.9 | 0.5 | 0.9 |
| 2013/14 | | 73 | 1.1 | 0.9 | 1.4 | 0.7 | 0.9 |
| 2014/15 | | 178 | 2.7 | 2.3 | 3.1 | 0.8 | 0.9 |

*Source: Department for Communities and Local Government*

**1.15i - Statutory homelessness - homelessness acceptances** Maidstone — Crude rate - per 1000

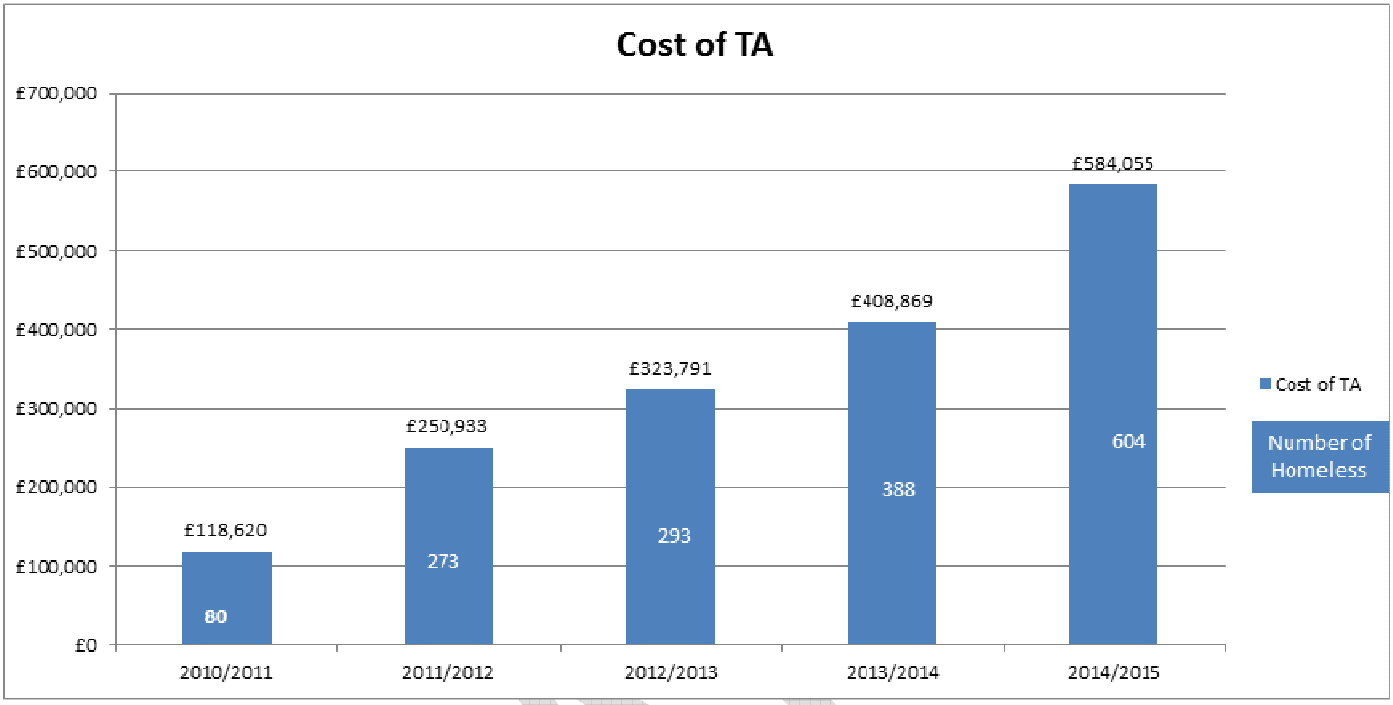
Export chart as image  Show confidence intervals




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2010/11 | | - | - | - | - | 1.3 | 2.0 |
| 2011/12 | | 189 | 3.1 | 2.7 | 3.6 | 1.5 | 2.3 |
| 2012/13 | | 198 | 3.1 | 2.7 | 3.6 | 1.6 | 2.4 |
| 2013/14 | | 155 | 2.4 | 2.0 | 2.8 | 1.7 | 2.3 |
| 2014/15 | | 213 | 3.2 | 2.8 | 3.7 | 2.0 | 2.4 |

*Source: Department for Communities and Local Government*

In Maidstone, between April and June of 2016, 176 households have met the threshold to make a homelessness application. 149 decisions were made. In the same quarter in 2015/16 there were 150 applications and 132 decisions made.




*(Approximately a 1/3 of those presenting as homeless are placed in temporary accommodation)*

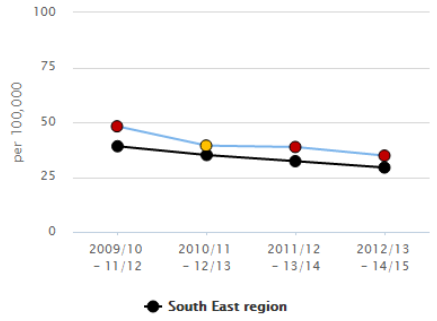
The length of stay in temporary accommodations has been reduced to 39.67 (2015/16); achieving the 2015 target of 42 days.

## Violent Crime

Maidstone has significantly higher rates of violent crime than the South East average, higher than the national rate but lower than the Kent figure. It has risen from 12/13 to 14/15. The rate for violent crimes per 1000 is also higher in Maidstone than the South East. The rate of sexual violence per 1000 is not.

**Misc: Violent crime (including sexual violence) - hospital admissions for violence** Maidstone Directly standardised rate - per 100,000

Export chart as image Show confidence intervals




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2009/10 - 11/12 | | 224 | 48.1 | 42.0 | 54.9 | 39.0 | 62.8 |
| 2010/11 - 12/13 | | 183 | 39.3 | 33.8 | 45.5 | 35.0 | 57.6 |
| 2011/12 - 13/14 | | 179 | 38.7 | 33.2 | 44.8 | 32.2 | 52.4 |
| 2012/13 - 14/15 | | 163 | 34.8 | 29.6 | 40.5 | 29.3 | 47.5 |

*Source: Data supplied by Hospital Episode Statistics, Health and Social Care Information Centre (HSCIC). Values calculated by KIT(NW).*

## Priority 6: Strengthen ill-health prevention

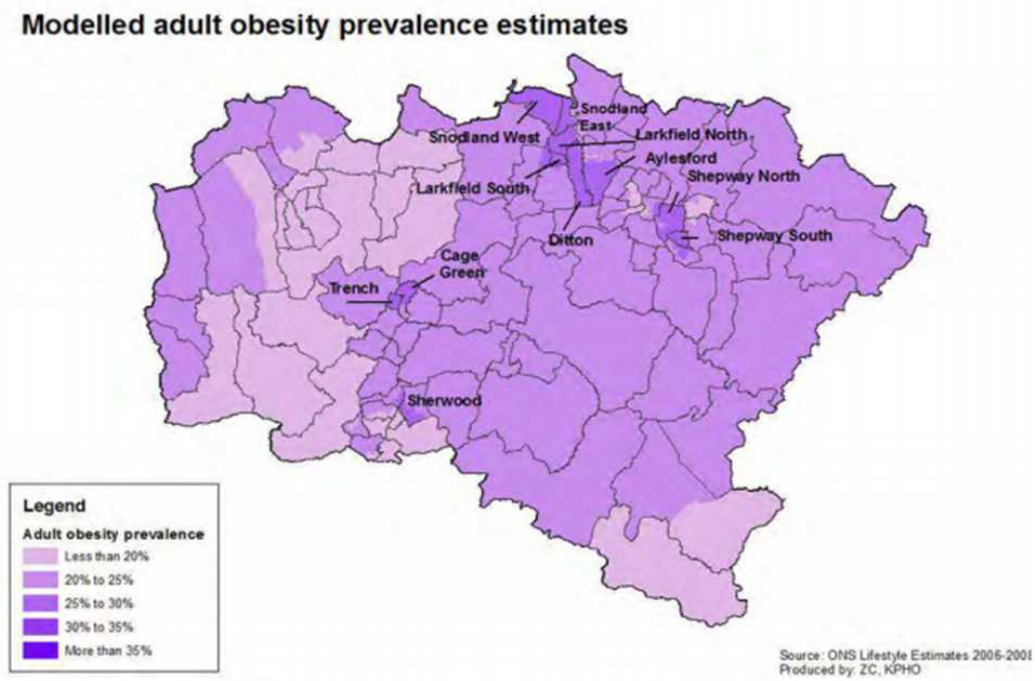
Strengthening ill-health prevention also required improve partnership working amongst the public, private and voluntary sector to find new ways to target and deliver services particularly with those who are hard to reach.

Maidstone Borough Council staff have been trained in Making Every Contact Count (MECC) as an approach to behaviour chance that utilises day-to-day interactions with our clients to support them in making positive changes to their physical and mental health and wellbeing.

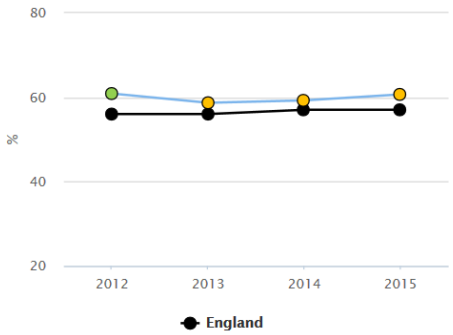
**Adult Obesity**

Obesity/excess weight in adults data has changed over time, from 2006-2013 it was a % modelled estimated derived from the Health Survey of England using 2006-2008 data. From 2014, excess weight in adults was measured using Active People Survey 2014. Latest data shows 65.5% of Maidstone residents (aged 16 and over) have a BMI greater than or equal to 25kg/m².

The modelled data goes down to ward level to provide an indication of the relative prevalence. Shepway North, Shepway South and Park Wood are estimated to have 25% more prevalence of adult obesity.



**Percentage of physically active adults** Maidstone — Proportion - %




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2012 | | - | 60.9 | 56.5 | 65.3 | 58.7 | 56.0 |
| 2013 | | - | 58.7 | 54.4 | 63.0 | 58.4 | 56.0 |
| 2014 | | - | 59.3 | 55.0 | 63.5 | 59.0 | 57.0 |
| 2015 | | - | 60.7 | 56.5 | 64.9 | 60.2 | 57.0 |

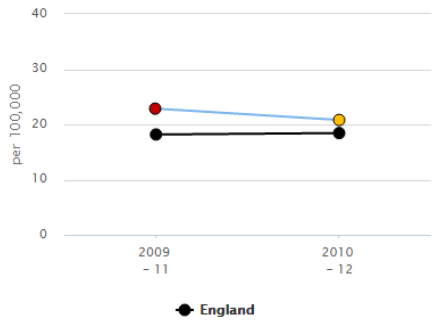
*Source: Active People Survey, Sport England*

## Malignant Melanoma

Malignant Melanoma is not significantly different to the England average. The risk factors associated with malignant melanoma including being white, the high number of sunlight hours and being over 65 years old. This in itself may be why the South East is generally higher than the England average.

**Incidence of malignant melanoma** Maidstone — Directly standardised rate - per 100,000

Export chart as image  Show confidence intervals




| Period | | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2009 - 11 | | 93 | 22.9 | 18.4 | 28.0 | 21.1 | 18.2 |
| 2010 - 12 | | 86 | 20.8 | 16.6 | 25.7 | 21.7 | 18.4 |

*Source: Health and Social Care Information Centre*

## NHS Health Checks

The NHS Health Check programme is a national cardiovascular screening programme for all individuals aged 40-74 who are not already treated for cardiovascular disease. Since cardiovascular disease will affect many people as they age getting five-yearly check of blood pressure, weight and cholesterol is a way of identifying risks and getting advice and support to change lifestyles for the better.

The number of NHS Health Checks carried out within the borough exceeded our target of 1,500 to 2,908 (93.86% above target)

## Indicators for Health Inequalities Action Plan

Actions identified within the Maidstone Health Inequalities Action Plan were time bound to 2015-2020. Kent Public Health Observatory has mapped Maidstone's progress to date, although this data cannot be used as standalone data due to inconsistency of data collected and reported.

Care needs to be taken in interpreting population health indicators and the changes that may have occurred in data may arrive as not statistically different.

The action plan is a partnership plan and not the sole responsibility of Maidstone Borough Council. Tackling health inequalities requires a co-ordinated approach.

# Indicators for Maidstone Health Inequalities Action Plan 2014-2020

| Priority | Target description | baseline | target | inc/ red | Review Date | Latest data available | Notes/Source |
|---|---|---|---|---|---|---|---|
| 1a. Give every child the best start in life (conception to 9 months) | Reduce number of low birth weight babies | 5.80% | 4.80% | -1% | 2015 | 6.10% (2012-14) | ONS via HSCIC |
| | Increase breast feeding initiation rates | 74.60% | 76.60% | +2% | 2015 | 75.8% (2014/15) | % who breastfeed their babies in the first 45hrs after delivery (PHOF) |
| | Increase rate of breast feeding at 6-8 weeks | 41.50% | 43.50% | +2% | 2015 | Not available | Value has not been published for data quality reasons (PHOF) |
| | Reduce infant mortality rate | 2.7/1,000 | <3.1/1,000 | n/a | | 2.0 | Rate of deaths in infants aged under 1 year per 1,000 live births (PHOF) |
| | Reduce number of pregnant women smoking during pregnancy | 12.20% | 6% | -50% | 2020 | 129 (Q3, 2015/16) | HSCIC. When Q3 maternities' are released this can be given as a percentage |
| 1b. Give every child the best start in life 9 months +) | Reduce the number of obese children: reception year | 10.70% | 9.70% | -1% | 2015 | 8.2% (2014/15) | National Child Measurement Programme |
| | Reduce the number of obese children: year 6 | 20.00% | 19.00% | -1% | 2015 | 14.9% (2014/15) | National Child Measurement Programme |
| | Increase % of children immunised before their 5 birthday | 91.40% | 95% | +3.6% | | MMR2 85.3%, DTaP/IPV Booster 81.4% (2015/16) | Averages have been taken for quarters 1 and 2 2015/16 |
| 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives | Reduce hospital admissions for self harm | 215.3/ 100,000 | 207.9 | -3% | 2020 | 205.67/100,000 (2014/15) | Admissions using 'X600' and X849' or 'Y100' and 'Y349' ICD 10 coding (SUS) |
| | Reduce number of teenage conceptions | 34.3 | <40/1,000 | reduce | 2020 | 18.0 (2014) | ONS |
| | Reduction in increasing and higher risk drinking | 23.9 | 22.30% | -2% | 2020 | 20.9% (IRD) and 6.8% (HRD) (2014) | This is no longer one indicator, this is split into 'increase risk drinking (IRD) (% of drinkers only) synthetic estimate' and 'higher risk drinking (HRD) (% of drinkers only) synthetic estimate' |
| | reduction in number hip fractures in over 65s | 468 | 457 | -2% | 2020 | | |
| | Reduction in excess winter deaths | 14.8 | monitor | reduce | 2020 | | |
| 3. Create fair employment and good work for all | Reduce the number of 16-18 year olds NEET | 6.00% | 5% | -1% | 2020 | | |
| | Reduce the number of 18-24 who are unemployed | 765 | monitor | reduce | 2015 | Kent 3,280 Maidstone makes up 2.4% - 787 | |
| | Reduce the percentage of people claiming job seekers allowance | 2.60% | 2.60% | reduce | | | |
| | Increase the number of healthy workplaces | 20 | baseline | increase | 2015 | 21 (2015 (to date)) | MBC |
| 4. Ensure a healthy standard of living for all | Reduce deprivation in key areas | 7.20% | monitor | reduce | 2020 | 7.5 (2015) | The % of people living in the 20% most deprived areas in England, 2015 (IMD 2015) |
| | Reduce the proportion of children living in poverty | 15.20% | monitor | reduce | 2020 | 0.15 (2015) | IDACI 2015 |
| | Reduce inequality in life expectancy in the borough (male) | 7 | monitor | reduce | 2020 | 11.7 (2011-15) | Figure given is the different between the highest life expectancy at ward level and the lowest life expectancy at ward level. Total life expectancy is 80.3 years (PCMD, ONS, SEPHO) |
| | Reduce inequality in life expectancy in the borough (female) | 4.4 | monitor | reduce | 2020 | 16.2 (2011-15) | Figure given is the different between the highest life expectancy at ward level and the lowest life expectancy at ward level. Total life expectancy is 83.6 years (PCMD, ONS, SEPHO) |
| | Reduce number of households living in fuel poverty (10% of income) | 12.70% | monitor | reduce | 2020 | | |
| | Increase number of households supported to improve their energy efficiency | baseline | monitor | increase | 2015 | | |
| 5. Create and develop healthy and sustainable places & communities | Increase number of homeless preventions | 592 | 450 | +24% | 2015 | | Not currently achievable due to the increase of households presenting as homeless |
| | Reduce number of households living in temporary accommodation | 29 | 15 | -1% | 2015 | | Number of households in temporary accommodation has increased - target is not achievable |
| | Reduce recorded crime per 1,000 population | 63.6 | 63.6 | maintain | 2015 | | |
| | Reduce levels of violent crime | 11.5 | monitor | reduce | 2015 | | |
| | Percentage CO2 reduction from local authority operations | 5481 | 5316 | -3% | | | |
| | Reduce length of stay in temporary accommodation to 42 days | 56 days | 42 days | -25% | 2015 | 39.67 | |
| 6. Strengthen the role and impact of ill health prevention | Increase the number of health checks delivered | 1500 | 1500 | maintain | 2015 | 2,908 (2015/16) | The number of health checks completed for 2015/16 (to date) by GP's; aggregated to district level (KCHFT) |
| | Reduce the number of obese children: reception year | 10.70% | 9.70% | -1% | 2015 | Repeat of target (part of 1b) | |
| | Reduce the number of obese children: year 6 | 20.00% | 19.00% | -1% | 2015 | Repeat of target (part of 1b) | |
| | Reduce adult obesity | 26.30% | 24.20% | -2% | 2020 | 18.9% (2012) | Active People Survey 2012, part of Health Profiles 2015 |
| | reduce the incidence of malignant melanoma | 19.40 | 14.5 | -5% | 2020 | 21.7 (2010-12) | PHE Health Profiles |
| | Reduce the number of hospital stays for self harm | 215.30 | 207.9 | -3% | 2020 | Repeat of target (part of 2) | |

## Health Inequality Indicators for Maidstone – June 2016

Taking into account our current Health Inequalities Action Plan and the need to understand what data is available; Public Health England have a list of indictors which have been considered and organised across the life course, consistent with the national strategy for tackling health inequalities. Indicators have been selected based on:

- Each indicator must relate to health inequalities (e.g. social determinants of health, health behaviours, health service uptake/use, health outcomes)
- Indicators collectively cover a wide breadth of issues, but minimising overlap
- Data for each indicators must be collected in a robust way, and consistent methodology, at least at County level, and ideally at District level (indicated where this is the case)
- Must be accessible on Public Health England (PHE) Fingertips website, for ease of access: fingertips.phe.org.uk/
- Data for each indicator must have been collected recently (post-2011) and must continue to be collected routinely and on a regular

The colour denotes whether the latest district value is better or worse than the national value or target value. This is currently only provided for Kent level data.

Looking at the latest district data from June 2016 the following areas are significantly better than the national average:

- Child Poverty (% of children under 16 in low income families)
- GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)
- Households that experience fuel poverty (%) (low income, high cost methodology)

These areas are significantly worse than the national average:

- Statutory Homelessness Acceptances (per 1000 households)
- Admission episodes for alcohol-related conditions (ASR per 100,000)
- Excess winter deaths (single year, all ages/person)

Whereas, these are not significantly different than the national average:

- Excess weight in adults
- Killed and seriously injured on roads, crude rate per 100,000
- Emergency readmissions within 30 days of discharge from hospital

# Health Inequalities Indicators for [District] 2016

The colour denotes whether the latest district value is better or worse than the national value or target value.
The trend line denotes the trend in the district over the recent history

| | |
|---|---|
| District significantly better than national rate = | Green |
| District significantly worse than national rate = | Red |
| District not significantly different from national = | Yellow |

| Lifecourse Stage | Indicator | Indicator Description | National (latest) | Kent (latest) | District (prior) | District (latest) | Performance Indicator | Latest Data Period |
|---|---|---|---|---|---|---|---|---|
| INFANCY | Infant Mortality | Infant mortality (rate per 1000 live births) | 4.0 | 2.9 | 2.1 | 1.5 | ↓ | 2012-2014 |
| | Smoking in Pregnancy | Smoking status at time of delivery (as % of maternities) | 11.4% | 12.60% | No data published | 9.41 | | 2014/15 |
| | Breast Feeding | Breast feeding initiation (as % of maternities) | 74.3% | 71.30% | 77.7% | 75.8% | ↓ | 2014/15 |
| | Teen pregnancy | Under 18 Conceptions (rate per 1,000 females aged 15-17) | 22.8 | 22.2 | 15.6 | 18 | ↑ | 2014 |
| | Childhood Obesity (YR) | Excess weight in 4-5 year olds (% of children overweight or obese) | 21.9% | 22.5% | 16.6% | 20.6% | ↑ | 2014/15 |
| CHILDHOOD | Childhood Obesity (Y6) | Excess weight in 10-11 year (% of children overweight or obese) | 33.2% | 32.8% | 31.4% | 31.5% | ↑ | 2014/15 |
| | Childhood Poverty | Childhood Poverty (% of children under 16 in low income families) | 18.6% | 17.3% | 14.0% | 13.3% | ↓ | 2013 |
| | Education (attendance) | Pupil Absence (% half days missed due to unauthorised/authorised absence 5-15yr olds) | 4.51% | 4.70% | 5.10% | 4.4% | ↓ | 2013/14 |
| | Education (attainment) | GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths) | 56.8% | 58.0% | 70.8% | 64.8% | ↓ | 2013/14 |
| | Childhood injuries | Hospital admission caused by injuries in children (aged 0-14 years) per 10,000 population | 109.6 | 103.0 | 92.6 | 88.5 | ↓ | 2013/14 |
| ADULTS | Unemployment | Longterm Unemployment (per 1000 of working age population) | 7.1 | 5.6 | 5.5 | 3.3% | ↓ | 2014 |
| | Homelessness | Statutory Homelessness Acceptances (per 1000 households) | 2.4 | 1.9 | 2.4 | 3.2 | ↑ | 2014/15 |
| | Violent Crime | Violent crime (violence offences, crude rate per 1000 population) | 13.5 | 15.6 | 14.2 | 15 | ↑ | 2014/15 |
| | Healthy Eating | Proportion of population meeting the recommended '5-a day' | 52.3% | 56.2% | 58.4% | 56.9% | ↓ | 2015 |
| | Healthy Weight | Excess weight: excess weight in adults | 64.6% | 65.1% | - | 65.5% | | 2012-2014 |
| | Physical Activity | Physical Inactivity (<30mins per week of moderate activity) | 27.7% | 28.4% | 25.2% | 25.4% | ↑ | 2014 |
| | Smoking | Smoking prevalence in adults (%) (from integrated household survey) | 18.0% | 19.1% | 14.5% | 17.3% | ↑ | 2014 |
| | Alcohol | Admission episodes for alcohol-related conditions (Broad) (ASR per 100,000) | 2120 | 1695 | 1589 | 1620 | ↑ | 2014/15 |
| | Road Injuries | Killed and seriously injured on roads, crude rate per 100,000 | 39.3 | 39.6 | 38.6 | 40.6 | ↑ | 2012-14 |
| ELDERLY | Fuel Poverty | Fuel Poverty - households that experience fuel poverty (%) (low income, high cost methodology) | 10.4% | 8.6% | 7.9% | 7.8% | ↓ | 2013 |
| | Winter Deaths | Excess winter deaths index (single year, all ages/persons) | 11.6 | 13.8 | 31.2% | 15.6% | ↓ | 2013/14 |
| | Falls | Injuries due to falls in people aged 65 and over (ASR per 100,000) | 2125 | 2201 | 2415 | 2438 | ↑ | 2014/15 |
| | Hip Fractures | Hip Fractures in people aged 65 and over (ASR per 100,000) | 571 | 598 | 576 | 624 | ↑ | 2014/15 |
| | Readmissions | Emergency readmissions within 30 days of discharge from hospital (Persons) | 11.8 | 11.9 | 10.9 | 11.5% | ↑ | 2011/12 |
| | Cancer Screening (Breast) | Cancer Screening Coverage - Breast Cancer - % of eligible women screened in prior 3 years | 75.4% | 77.0% | 79.6% | 79.6% | ↔ | 2015 |
| | Cancer Screening (Cervical) | Cancer Screening Coverage - Cervical Cancer - % of eligible women screened in prior 3.5 or 5.5 years | 73.5% | 77.1% | 78.6% | 78.2% | ↓ | 2015 |
| | Cancer Screening (Bowel) | Cancer screening coverage - bowel cancer - % of eligible people screened in previous 2.5 years | 57.1% | 58.1% | - | 62.7% | | 2015 |
| | Place of Death | Percentage of deaths that occur in hospital | 47.4% | 41.7% | 48.7% | 46.1% | ↓ | 2015 |
| | Place of Death | Percentage of deaths that occur in Usual Place of Residence | 44.7% | 46.2% | 45.9% | 48.2% | ↑ | 2015 |
| MORTALITY | Premature Mortality | Premature mortality from all causes, under 75, (ASR per 100,000) | 337.0 | 318.0 | 298 | 304 | ↑ | 2012-2014 |
| | Premature Mortality (cardio) | Under 75 mortality rate from cardiovascular disease considered preventable (ASR per 100,000) | 75.7 | 70.9 | 64.3 | 64.0 | ↓ | 2012-2014 |
| | Premature Mortality (resp) | Under 75 mortality rate from respiratory disease considered preventable (ASR per 100,000) | 32.6 | 30.9 | 31.1 | 30.3 | ↓ | 2012-2014 |
| | Premature Mortality (cancer) | Under 75 mortality rate from cancer considered preventable (ASR per 100,000) | 83 | 78.4 | 76.2 | 75.8 | ↓ | 2012-2014 |
| | Premature Mortality (liver) | Under 75 mortality rate from liver disease considered preventable (ASR per 100,000) | 15.7 | 13.7 | 10.7 | 14.2 | ↑ | 2012-2014 |
| | Air-pollution-related Mortality | Fraction of mortality attributable to air pollution (PM2.5) (% of all age all cause mortality) | 5.3% | 5.4% | 5.1% | 5.5% | ↑ | 2013 |
| | Communicable Disease Mortality | Mortality from communicable disease (ASR per 100,000) | 63.2 | 64.4 | 75.2 | 69.5% | ↓ | 2010-2012 |
| | Smoking-related Mortality | Smoking-related deaths (ASR pr 100,000) | 279.0 | 266.7 | - | 256.1 | | 2011-2013 |
| | Alcohol-related Mortality | Alcohol-related mortality (ASR per 100,000) | 45.5 | 42.4 | 46.0 | 41.9 | ↓ | 2014 |
| | Suicide | Suicide age-standardised rate per 100,000 (3 year average) | 8.9 | 10.2 | 8.7 | 10.1 | ↑ | 2012-14 |
| | Preventable Mortality | Mortality rate from causes considered preventable | 182.7 | 169.8 | 159.8 | 162.4 | ↑ | 2012-2014 |
| | Life Expectancy (male) | Life expectancy at birth - years (male) | 79.5 | 80.1 | 80.2 | 80.4 | ↑ | 2012-2014 |
| | Life Expectancy (female) | Life expectancy at birth - years (female) | 83.2 | 83.6 | 83.6 | 83.4 | ↓ | 2012-2014 |
| | Life Expectancy Gap (males) | Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (males) | 9.2 | 7.4 | 5.4 | 5.6 | ↑ | 2012-2014 |
| | Life Expectancy Gap (females) | Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (females) | 7.0 | 4.4 | 3.8 | 3.2 | ↓ | 2012-2014 |

## Kent Public Health approach to health inequalities

Kent County Council, Mind the Gap strategy came to an end in 2015. The County Council's new strategy 'Mind the Gap 2016' is currently in draft format. This strategy is not time-bound as changes to health inequalities are recognised over longer periods of time.

Kent County Council is concentrating on lower super output areas in each district with the aim of community transformation; empowering individuals and communities for better health and wellbeing. This will be achieved through community 'asset based' approach.

| **Needs based approach** | **Asset based approach** |
|---|---|
| Focus on deficiencies | Focus on strengths |
| Respond to problems | Identify opportunities |
| Provide services to users | See residents as co-producers |
| Short term solutions | Sustainable long-term change |
| Top down: residents have little say in local issues | Bottom up: empower residents to be part of the process |

It is a unified plan that recognises improving the health of an entire population does not necessarily address the health inequalities that exists between different parts of the society. Closing the 'health gap' will require a faster improvement in health in the most deprived areas.

Within Maidstone, Kent County Council has recognised Lower Super Output Areas (LSOA) of Park Wood, Shepway South and High Street as areas of deprivation. They have adopted Chris Bentley's Ten Point Plan of 'System and Scale into Community Empowerment' to tackle health inequalities within these areas.

1. Prioritisation of areas – most in need
2. Defining communities – should be self-defining where possible
3. Asset mapping – stocktake of positive resources in place
4. Behaviour of Partners – agreed ways of working and sharing resources
5. Community profiles - collating top-down and bottom-up
6. Neighbourhood Action Plans (NAPS) – linking aspirations and objectives
7. Community based research (CBR) – train residents to be involved
8. Outreach models – using community venues
9. Community Links Strategy – gathering intelligence from community infrastructures
10. Transfer of Service Ownership – appropriate segments

## Maidstone's approach to health inequalities

As a district council we are in a unique position to help Kent County Council Public Health deliver a health agenda particularly around the wider determinants of health.

A whole systems approach to public health can ensure our actions have a positive impact on public health, taking on more of an enabling role in the health of our residents and communities, ensuring actions are cost-effective and, where possible, offer a positive return on investment. Health Inequalities should be a major focus within this approach but should not be the 'sole' public health strategy but form part of a wider public health strategy as at county level.

Our health is primarily determined by factors other than health care. District councils are in a good position to influence many of these factors through their key functions and in their wider role supporting communities and influencing other bodies.

So how can Maidstone Borough Council achieve a whole systems approach to improving the health and wellbeing of our residents?

1. **Working in partnership and alignment**

We need to work in partnership with other agencies, ranging from Public Health England and other tiers of local government and directors of Public Health, to the local NHS, the voluntary and business sectors and communities themselves. This will enable us to share resources and achieve results.

**2. To demonstrate effectiveness and return on investment**

We should be more proactive in collating existing evidence on the health economics of our activities in order to guide decisions on our communities' health and wellbeing.

This could help us in attracting funds and other forms of support from other bodies, including health and higher tiers of local government.

**3. To lead innovation in services and their delivery**

Invest in health impact assessments (HIA) to move beyond innovative case studies to processes to show demonstrable improvements in health outcomes.

**4. To strength our enabling role in the health of our communities**

Actively engage with our communities involving them directly in decisions which affect their health and wellbeing.

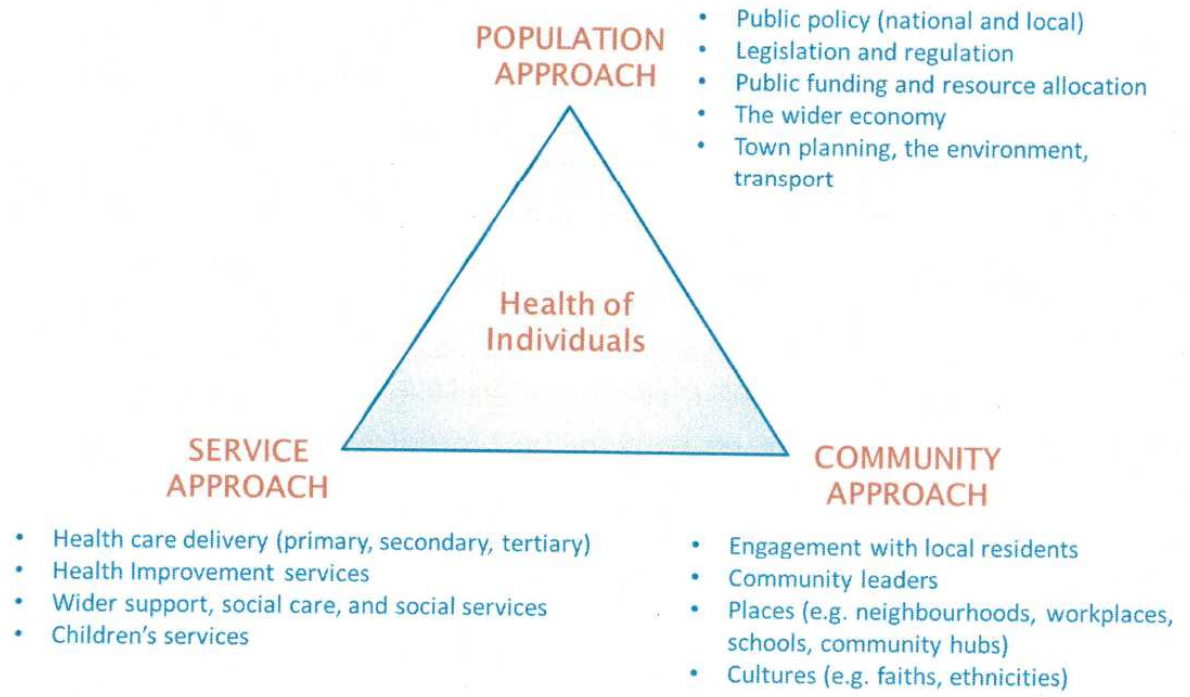
There is growing recognition that although disadvantage social groups and communities have a range of complex and inter-related needs, they also have assets at the social and community level that can help improve health, and strengthen resilience to health problems.

## Recommendations

1. To embed health within the culture of Maidstone Borough Council to deliver a whole systems approach producing a 'District Health Deal' with Kent County Council Public Health.

2. Produce and deliver a learning and development package to staff and councillors on the importance of health and how their role contributes and can contribute further to improving health and wellbeing of residents. This will include embedding this approach in the Council's Business Plan and appraisals.

3. Support the implementation and delivery of the Mind the Gap 2016 which focuses on a community asset based approach in lower super output (Parkwood, Shepway and High Street ward). We are close enough to our communities to understand how they work and how to best reach and support them.




*Model for impacting health at a population level (Chris Bentley 2012)*

4. Establish a good working relationship with the Kent Public Health Department so health data is readily available dependant on the needs and change of our population. Using their expertise to understand what is underneath the data and what the intelligence tells us which must include qualitative information. (Intelligence based approach)

5. Establish collaborative working agreements (internal) and partnership working agreements (external) for partners to work together on achieving shared outcomes in improving resident health and wellbeing.

6. Produce Health Impact Assessments on all future strategies produced by Maidstone Borough Council.

7. Review progress of health inequalities to date and implement a refreshed action plan examining strategic direction for future delivery.

8. To confirm key objectives and priorities for the refreshed health inequalities action plan, taking note of significant trends highlighted by data provided by the Public Health Stakeholders.

   Community Context:
   - Violent Crime
   - Statutory homelessness

   Children and Young People:
   - Breastfeeding initiation and maintenance at 6/8 weeks
   - Excess weight in children
   - Teenage Conceptions and Teenage Parents
   - Emotional Health and Wellbeing (linked to admissions for injuries)

   Adults:
   - Emotional and Mental Health including social isolation
   - Alcohol
   - Excess Weight
   - Smoking
   - Dementia Prevention – physical activity, smoking cessation

   With regards to populations of people: young parents; Black and Minority Ethnic (BME); older people and homeless individuals are recommended.

   The priorities above have been identified by: looking at public health outcomes; appraising data available; benchmarking against England, South East, Kent and other wards; looking at trends; and identifying actions and making links to strategic priorities for Kent.

## References

*Maidstone Health Inequalities Action Plan 2014-2020*

*Kent County Council, Mind the Gap: Kent's Health Inequalities Action Plan 2012-2015*

*Kent County Council, Mind the Gap 2016*

*The Marmot Review, 'Fair Society, Healthy Lives', 2010*

*The Kings Fund, The district council contribute to public health: a time of challenge and opportunity*

## Data Sources

*Kent and Medway Public Health Observatory*
*http://www.kpho.org.uk/*

*Public Health England*
*https://www.gov.uk/government/organisations/public-health-england*

*Public Health Profiles*
*http://fingertips.phe.org.uk/profile/health-profiles*

REFRESH 2016

# Maidstone Health Inequalities Action Plan

## 2014 - 2020

# Contents

# Foreword

In Maidstone we are committed to improving the health and wellbeing of our borough. We are also committed to reducing the health inequalities that exist across the area.

District Councils have a key role to play in keeping our population healthy. We have a distinct, local role in service provision, economic development, planning, and helping to shape and support our communities – all key areas that are increasingly recognised as vital components of a true population health system.

Health Inequalities are preventable and unjust differences in health status experienced by certain population groups. Everyone should have the same opportunity to lead a healthy life no matter where they live or who they are, which is why we must continue to narrow the gap in health inequalities. Organisation across the Maidstone borough must work together to address the health needs of their population and make a real difference in tackling health inequalities.

We want to ensure that, wherever possible, an individual's health and wellbeing is not determined by the area in which they were born, or in which they live.

The Maidstone Health Inequalities Action Plan which was adopted in 2014 provides the opportunity to review progress against actions and move forward in closing the gap in health inequalities. Since the development of the plan, data has developed, knowledge has matured and we face an ever-changing financial climate.

The Maidstone Health and Wellbeing Board will be the key mechanism to ensure that priorities for health and wellbeing in our area are identified and driven forward.

We are committed to ensuring that the Maidstone Health Inequalities Action Plan is implemented in a way which ensures that the benefits of health and wellbeing are available to all residents across the borough.

**Alison Broom**
**Chief Executive**

# Introduction

## What are Health Inequalities?

Health Inequalities are the differences in the health of different parts of the population. For example, people in more deprived areas have a shorter life expectancy than those who live in less deprived areas. Inequalities also exist in other aspects of people's health – for example, people in more deprived areas tend to smoke more, drink more alcohol, and are more likely to experience long-term illness. Inequalities also exist between groups accordingly to other factors such as gender, ethnic background, certain sorts of disability and sexual orientation.

## What leads to inequalities?

There are a number of factors which lead to Health Inequalities. Most experts tend to place these factors into a small number of groups – such as those listed below. It is important, however, to bear in mind that experts think of these as the factors which are likely to lead to poorer health. There is every reason to believe that people can live healthy lives even in the harshest circumstances.

Social Factors

These are issues which affect the population as a whole, but do not necessarily affect everybody equally. Examples include government policies, the availability of work, general levels of wages, taxation and how much things cost – particularly the prices of essentials such as fuel, transport, food and clothing.

Living and working conditions

These include the important issues such as education, training, employment, housing, public transport and amenities. It also includes basic facilities like reliable utility supplies (gas, water and electricity) and being able to get hold of essential goods like food and clothing.

Social and Community networks

A person's "network" includes his or her family, friends and social circles – and the way all of those people together support, influence, advise and guide the individual. A strong network of family and friends can help to ensure than an individual has a healthy lifestyle. Sometimes, individuals living alone may not have any "network" sometimes the "network" can have an unsupportive effect, such as encouraging the consumption of alcohol to excess.

Individual lifestyle factors

These are sometimes described as lifestyle choices, because they tend to refer to things that people can generally choose to do, or not do. This would include things such as smoking, alcohol consumption, and drug use, whether people eat healthily and whether they take regular physical exercise. These choices are

influenced by the environment in which the individual lives – how friends and family act, how products are advertised and so on.

Healthcare factors

There is evidence to suggest that sometimes the parts of the population in the greatest need are poorly understood. This can mean that services are constructed and commissioned to address the needs of the whole populations, but not in such a way that inequalities are addressed.

Additionally, low-cost healthcare is sometimes under-used in a population. When this happens, it tends to be the most deprived parts of the population who are worst affected, because illness and disease is most prevalent in those areas. This therefore leads to a widening of the gap between the most and least deprived areas of a population.

Personal factors

These include some of the basic definitions of who people are: age, sex, ethnicity and genetic factors. There is nothing that can be done to change these factors – but understanding more about the population can help us to develop strategies, policies and practices.

## National Context

The latest national strategy to tackling health inequalities, "Fair Society, Healthy Lives", was released in 2010 and is also known as the Marmot Review. Summarising the wealth of new research into health inequalities that had occurred since the previous national strategies into health inequalities; the Acheson Report (1998) and the Black Report (1980), the Marmot Review particularly stressed the action that would be required on the social determinants of health, such as education and employment. It also recognised that inequalities accumulates as we age, beginning even before birth. The six main policy objectives (below) take a 'life-course approach', from the early years through to ageing.

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

Delivering these policy objectives will require action by central and local government, the NHS, the voluntary and community sector and private sectors. National policies will not work without effective local delivery systems focused on health equity in all policies.

Kent County Council, Health Inequalities Strategy, Mind the Gap 2016 supports and follows the policy objectives suggested by Sir Michael Marmot. Kent County Council's approach to tackling health inequalities is Community Transformation. This is a means of empowering individuals and communities for better health and wellbeing. Kent County Council aim to radically improve health and wellbeing of identified communities, through coordinated actions across KCC, district councils, CCG's, service providers and community partners.

# Health Inequalities in Maidstone

Taking into account our current Health Inequalities Action Plan and the need to understand what data is available; Public Health England have a list of indictors which have been considered and organised across the life course, consistent with the national strategy for tackling health inequalities. Indicators have been selected based on:

- Each indicator must relate to health inequalities (e.g. social determinants of health, health behaviours, health service uptake/use, health outcomes)
- Indicators collectively cover a wide breadth of issues, but minimising overlap
- Data for each indicators must be collected in a robust way, and consistent methodology, at least at County level, and ideally at District level (indicated where this is the case)
- Must be accessible on Public Health England (PHE) Fingertips website, for ease of access: fingertips.phe.org.uk/
- Data for each indicator must have been collected recently (post-2011) and must continue to be collected routinely and on a regular basis

The colour denotes whether the latest district value is better or worse than the national value or target value. This is currently only provided for Kent level data.

Data from June 2016 shows, life expectancy is 5.4 years lower for men and 3.8 years lower for women in the most deprived areas of Maidstone than the least deprived areas. The neighbourhoods that make up the areas of higher deprivation lie particularly in the electoral Wards of: Park Wood; High Street; Shepway North; and Shepway South.

The following areas are significantly better than the national average:

- Child Poverty (% of children under 16 in low income families)
- GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths)
- Households that experience fuel poverty (%) (low income, high cost methodology)

These areas are significantly worse than the national average:

- Statutory Homelessness Acceptances (per 1000 households)
- Admission episodes for alcohol-related conditions (ASR per 100,000)
- Excess winter deaths (single year, all ages/person)

Whereas, these are not significantly different than the national average:

- Excess weight in adults
- Killed and seriously injured on roads, crude rate per 100,000
- Emergency readmissions within 30 days of discharge from hospital

# Health Inequalities Indicators for Maidstone 2016

The colour denotes whether the latest district value is better or worse than the national value or target value.
The trend line denotes the trend in the district over the recent history

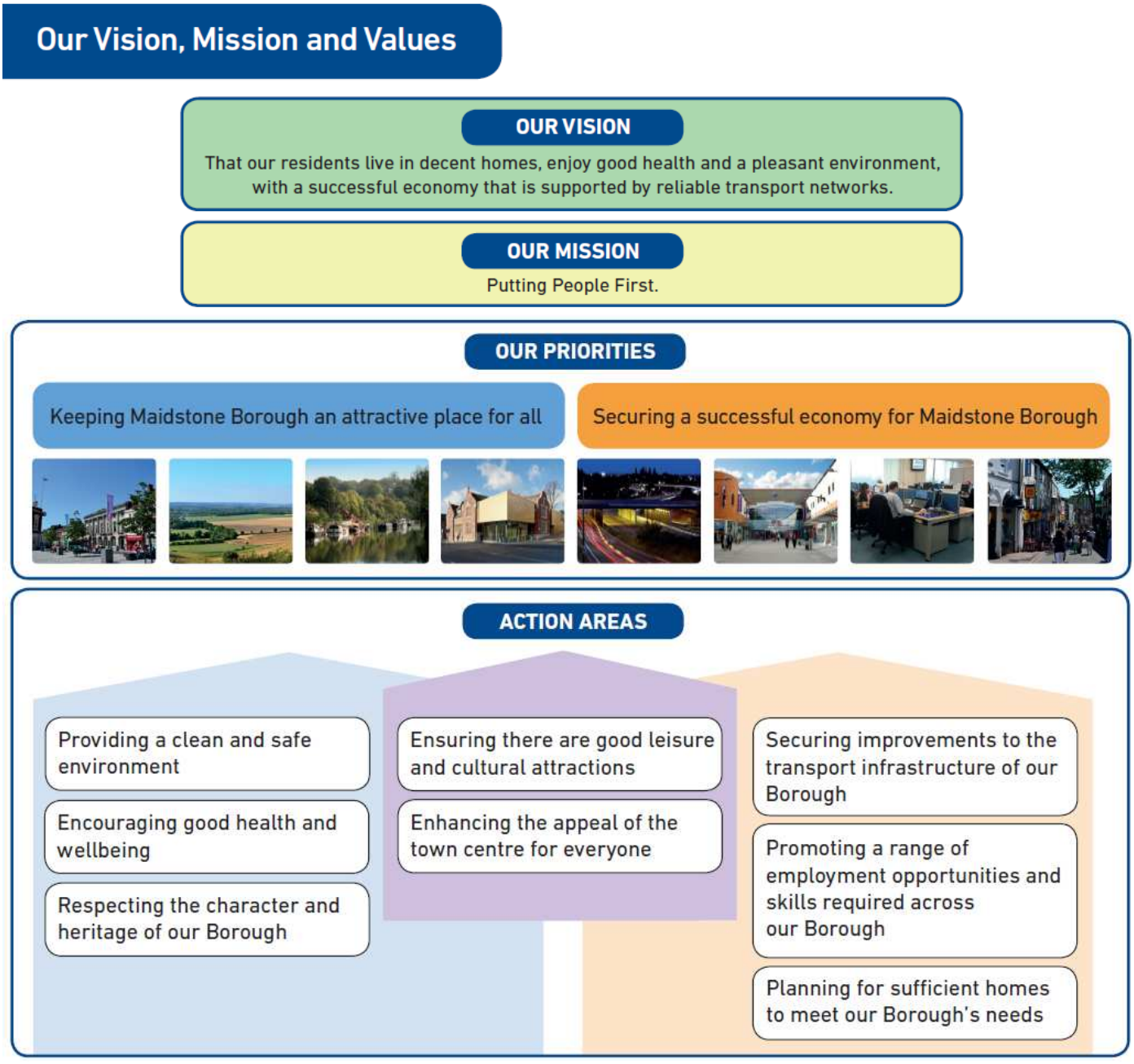
District significantly better than national rate = Green
District significantly worse than national rate = Red
District not significantly different from national = Yellow

| Lifecourse Stage | Indicator | Indicator Description | National (latest) | Kent (latest) | District (prior) | District (latest) | District (trend) | Latest Data Period |
|---|---|---|---|---|---|---|---|---|
| INFANCY | Infant Mortality | Infant mortality (rate per 1000 live births) | 4.0 | 2.9 | 2.1 | 1.5 | | 2012-2014 |
| | Smoking in Pregnancy | Smoking status at time of delivery (as % of maternities) | 11.4% | 12.60% | No data published | 9.41 | | 2014/15 |
| | Breast Feeding | Breast feeding initiation (as % of maternities) | 74.3% | 71.30% | 77.7% | 75.8% | | 2014/15 |
| | Teen pregnancy | Under 18 Conceptions (rate per 1,000 females aged 15-17) | 22.8 | 22.2 | 15.6 | 18 | | 2014 |
| | Childhood Obesity (YR) | Excess weight in 4-5 year olds (% of children overweight or obese) | 21.9% | 22.5% | 16.6% | 20.6% | | 2014/15 |
| CHILDHOOD | Childhood Obesity (Y6) | Excess weight in 10-11 year (% of children overweight or obese) | 33.2% | 32.8% | 31.4% | 31.5% | | 2014/15 |
| | Childhood Poverty | Childhood Poverty (% of children under 16 in low income families) | 18.6% | 17.3% | 14.0% | 13.3% | | 2013 |
| | Education (attendance) | Pupil Absence (% half days missed due to unauthorised/authorised absence 5-15yr olds) | 4.51% | 4.70% | 5.10% | 4.4% | | 2013/14 |
| | Education (attainment) | GCSE Attainment (% achieving 5 good GCSEs A*-C including English and Maths) | 56.8% | 58.0% | 70.8% | 64.8% | | 2013/14 |
| | Childhood injuries | Hospital admission caused by injuries in children (aged 0-14 years) per 10,000 population | 109.6 | 103.0 | 92.6 | 88.5 | | 2013/14 |
| ADULTS | Unemployment | Longterm Unemployment (per 1000 of working age population) | 7.1 | 5.6 | 5.5 | 3.3% | | 2014 |
| | Homelessness | Statutory Homelessness Acceptances (per 1000 households) | 2.4 | 1.9 | 2.4 | 3.2 | | 2014/15 |
| | Violent Crime | Violent crime (violence offences, crude rate per 1000 population) | 13.5 | 15.6 | 14.2 | 15 | | 2014/15 |
| | Healthy Eating | Proportion of population meeting the recommended '5-a day' | 52.3% | 56.2% | 58.4% | 56.9% | | 2015 |
| | Healthy Weight | Excess weight: excess weight in adults | 64.6% | 65.1% | - | 65.5% | | 2012-2014 |
| | Physical Activity | Physical Inactivity (<30mins per week of moderate activity) | 27.7% | 28.4% | 25.2% | 25.4% | | 2014 |
| | Smoking | Smoking prevalence in adults (%) (from integrated household survey) | 18.0% | 19.1% | 14.5% | 17.3% | | 2014 |
| | Alcohol | Admission episodes for alcohol-related conditions (Broad) (ASR per 100,000) | 2120 | 1695 | 1589 | 1620 | | 2014/15 |
| | Road Injuries | Killed and seriously injured on roads, crude rate per 100,000 | 39.3 | 39.6 | 38.6 | 40.6 | | 2012-14 |
| ELDERLY | Fuel Poverty | Fuel Poverty - households that experience fuel poverty (%) (low income, high cost methodology) | 10.4% | 8.6% | 7.9% | 7.8% | | 2013 |
| | Winter Deaths | Excess winter deaths index (single year, all ages/persons) | 11.6 | 13.8 | 31.2% | 15.6% | | 2013/14 |
| | Falls | Injuries due to falls in people aged 65 and over (ASR per 100,000) | 2125 | 2201 | 2415 | 2438 | | 2014/15 |
| | Hip Fractures | Hip Fractures in people aged 65 and over (ASR per 100,000) | 571 | 598 | 576 | 624 | | 2014/15 |
| | Readmissions | Emergency readmissions within 30 days of discharge from hospital (Persons) | 11.8 | 11.9 | 10.9 | 11.5% | | 2011/12 |
| | Cancer Screening (Breast) | Cancer Screening Coverage - Breast Cancer - % of eligible women screened in prior 3 years | 75.4% | 77.0% | 79.6% | 79.6% | | 2015 |
| | Cancer Screening (Cervical) | Cancer Screening Coverage - Cervical Cancer - % of eligible women screened in prior 3.5 or 5.5 years | 73.5% | 77.1% | 78.6% | 78.2% | | 2015 |
| | Cancer Screening (Bowel) | Cancer screning coverage - bowel cancer - % of eligible people screened in previous 2.5 years | 57.1% | 58.1% | - | 62.7% | | 2015 |
| | Place of Death | Percentage of deaths that occur in hospital | 47.4% | 41.7% | 48.7% | 46.1% | | 2015 |
| | Place of Death | Percentage of deaths that occur in Usual Place of Residence | 44.7% | 46.2% | 45.9% | 48.2% | | 2015 |
| MORTALITY | Premature Mortality | Premature mortality from all causes, under 75, (ASR per 100,000) | 337.0 | 318.0 | 298 | 304 | | 2012-2014 |
| | Premature Mortality (cardio) | Under 75 mortality rate from cardiovascular disease considered preventable (ASR per 100,000) | 75.7 | 70.9 | 64.3 | 64.0 | | 2012-2014 |
| | Premature Mortality (resp) | Under 75 mortality rate from respiratory disease considered preventable (ASR per 100,000) | 32.6 | 30.9 | 31.1 | 30.3 | | 2012-2014 |
| | Premature Mortality (cancer) | Under 75 mortality rate from cancer considered preventable (ASR per 100,000) | 83 | 78.4 | 76.2 | 75.8 | | 2012-2014 |
| | Premature Mortality (liver) | Under 75 mortality rate from liver disease considered preventable (ASR per 100,000) | 15.7 | 13.7 | 10.7 | 14.2 | | 2012-2014 |
| | Air-pollution-related Mortality | Fraction of mortality attributable to air pollution (PM2.5) (% of all age all cause mortality) | 5.3% | 5.4% | 5.1% | 5.5% | | 2013 |
| | Communicable Disease Mortality | Mortality from communicable disease (ASR per 100,000) | 63.2 | 64.4 | 75.2 | 69.5% | | 2010-2012 |
| | Smoking-related Mortality | Smoking-related deaths (ASR pr 100,000) | 279.0 | 266.7 | - | 256.1 | | 2011-2013 |
| | Alcohol-related Mortality | Alcohol-related mortality (ASR per 100,000) | 45.5 | 42.4 | 46.0 | 41.9 | | 2014 |
| | Suicide | Suicide age-standardised rate per 100,000 (3 year average) | 8.9 | 10.2 | 8.7 | 10.1 | | 2012-14 |
| | Preventable Mortality | Mortality rate from causes considered preventable | 182.7 | 169.8 | 159.8 | 162.4 | | 2012-2014 |
| | Life Expectancy (male) | Life expectancy at birth - years (male) | 79.5 | 80.1 | 80.2 | 80.4 | | 2012-2014 |
| | Life Expectancy (female) | Life expectancy at birth - years (female) | 83.2 | 83.6 | 83.6 | 83.4 | | 2012-2014 |
| | Life Expectancy Gap (males) | Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (male | 9.2 | 7.4 | 5.4 | 5.6 | | 2012-2014 |
| | Life Expectancy Gap (females) | Slope index of inequality in life expectancy at birth based on local deprivation deciles - years (fema | 7.0 | 4.4 | 3.8 | 3.2 | | 2012-2014 |

## Priorities

Local authorities are uniquely placed to tackle health inequalities, as many of the social and economic determinants of health, and the services or activities which can make a difference, fall within their remit. Services include: planning, housing, economic development, environmental health, leisure, licensing and community safety.
The challenge is to reduce the difference in mortality and morbidity rates between rich and poor and to increase the quality of life and sense of wellbeing of the whole local community.

Maidstone Borough Council's commitment to improve resident's health and wellbeing is set out in their Strategic Plan 2015 – 2020.




Public health is at the heart of local authorities roles with cross-cutting objectives in tackling health inequalities.

This action plan outlines our collective commitment and actions for improving the health of populations within the borough. Our approach will be targeted and proportionate, helping to close the gap between the least and most deprived. Sir Michael Marmot's life course approach is the foundation for this plan; based on 6 policy areas.

## Implementation

The Maidstone Health Inequalities Action Plan will be implemented by the Council and its partners through the detailed action plan set out below.

The Action Plan provides a framework and tools to identify, analyse partnership actions that will contribute to reducing health inequalities in the Maidstone Borough.

The Maidstone Health and Wellbeing Board will not be responsible for directly commissioning services but will provide oversight, strategic direction and coordination. The Group will own the action plan, but will not be the sole owner of the actions contained within it. The structure of the Maidstone Health and Wellbeing Board contains the following sub-groups:

- Ageing Well
- Homelessness and Health
- Local Children's Partnership
- Skills and Employability

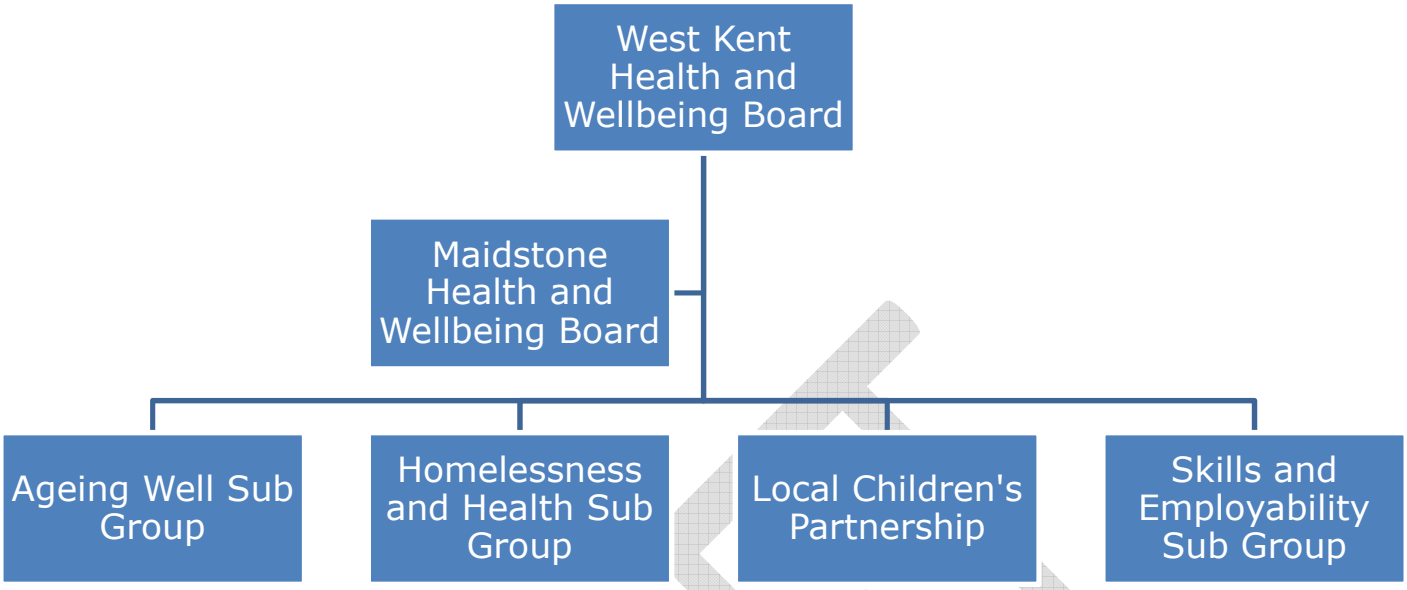
The sub-groups will co-opt members as appropriate to progress the work of the Health Inequalities Action Plan and requests from the Maidstone Health and Wellbeing Board.

Progress of the action plan will be reported to the West Kent Health and Wellbeing Board.

The Maidstone Health Inequalities Action Plan will be refreshed bi-annually to reflect progress and ensure that it remains current.

It is important to note that not all actions contained with the plan will be delivered by the Maidstone Health and Wellbeing Board. A number of key strategic partners and organisational strategies contribute to reduce health inequalities, such as: Kent County Council, Maidstone Borough Council, Clinical Commissioning Groups, and Voluntary and Community Sector.

## Structure




The purpose of each sub group is:

Ageing Well

- To work together as partners organisations and communities to improve local health outcomes for older people and build on the strengths of our diverse borough.
- To make prevention and early intervention the principles that guide how resources are deployed in Maidstone to achieve our priority outcomes.

Homelessness and Health

- To assess the impact of homelessness on the health of people in the borough
- To assess the initiatives currently in place to tackle homelessness and to address the health needs of homeless and vulnerable people in the borough
- To make effort to hear the views and opinions of some of the individuals concerned and make recommendations to the Council, the NHS and other relevant organisation to address the needs of rough sleepers and improve their health outcomes.

Local Children's Partnership

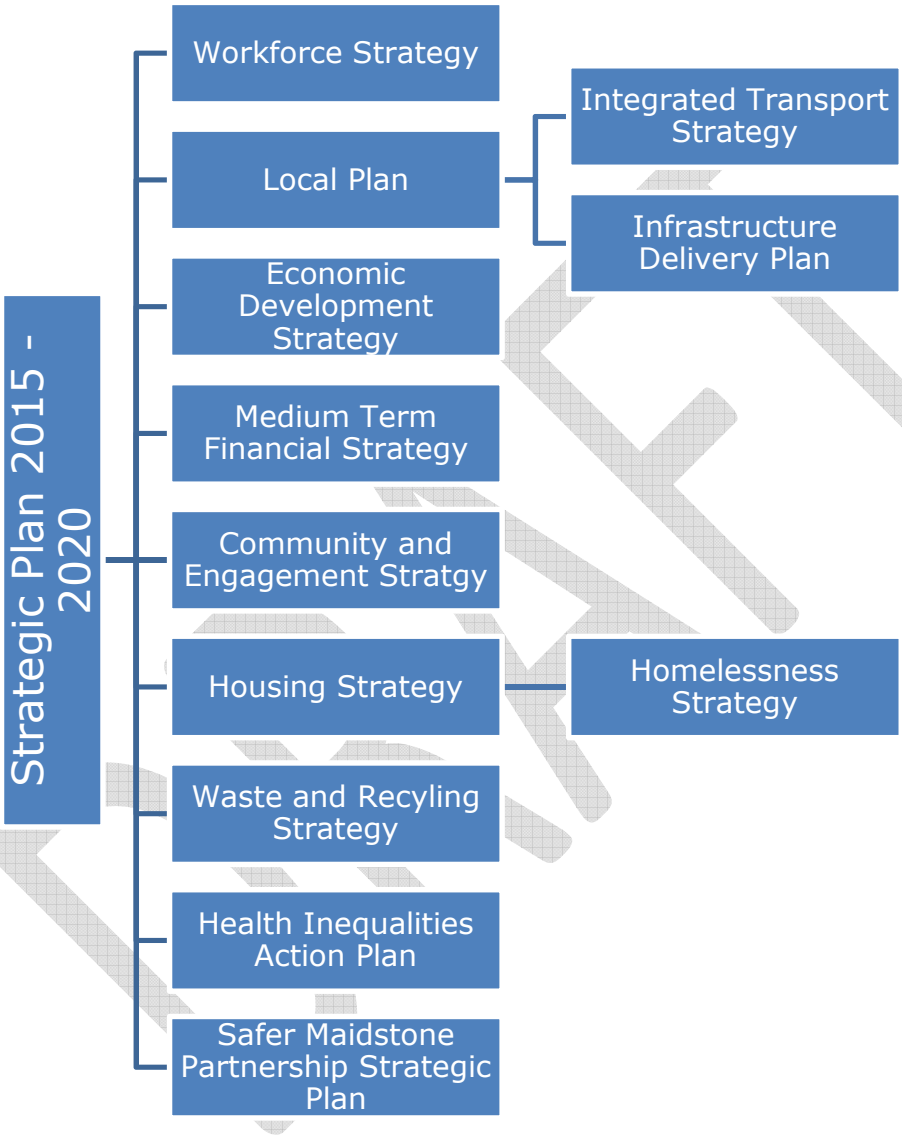
- Work in partnership at a district level and to drive improvement in specific outcomes for local children and young people.
- Sharing information to provide an understanding of local services and their thresholds.
- Providing a vehicle for identifying and addressing local needs and gaps in service provision.
- Facilitating and pooling resources to meet the needs of local children and families.

Skills and Employability

- To improve the employment prospects, education and skills of local people
- To support and promote growth in local economies and businesses to benefit local people.

The Marmot Priorities underpin the work of the subgroups by creating an enabling society that maximises individual and community potential; and to ensure social justice, health and sustainability.

The Health Inequalities Action Plan is not the only plan which tackles health inequalities among our residents. A number of other key plans and strategies contribute to improving the health and wellbeing and reducing the gap in inequality including:




The actions of the above strategies/plans have not been included within the Health Inequalities Action Plan and are being worked on outside of the Maidstone Health and Wellbeing Board.

# Action Plan

## Priority 1: Ageing Well

The work undertaken by the group feed in to the following Marmot priorities:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives (Priority 2)
- Ensure a healthy standard of living for all (Priority 4)
- Create and develop healthy and sustainable places and communities (Priority 5)
- Strengthen ill-health prevention (Priority 6)

Relevant standards against which to monitor progress on this priority could include: falls and injuries in the over 65s; Hip fractures in over 65s; excess winter deaths; hospital stays in 65s and over; number of health checks completed by GP's; excess weight in adults; number of referrals for a disabled facilities grant; number of completed disabled facilities grant; life expectancy;

| Theme | Commitment | Lead Sub-Group | Marmot Priorities |
|---|---|---|---|
| Support older people to live safe, independent and fulfilled lives | Improve social connectedness for older people<br><br>Improve levels of volunteering and participation<br><br>Promote independence and improve support for older people to stay in their own homes through provision of aids and equipment<br><br>Support people to maximise their incomes through good welfare benefits advice, education and training and support to stay or return to employment. | Ageing Well | Priority 2 & 4 |
| Ensure people experience services that support them to enjoy a good quality of life | Understand the local challenges facing older people accessing information and advice about local support services and opportunities<br><br>People are helped to live healthy lifestyles, make healthy choices and | Ageing Well | Priority 2, 5 & 6 |

| | | | |
|---|---|---|---|
| | reduce health inequalities<br><br>To ensure that future generations of older people are well equipped for later life by encouraging recognition of the changes and demands that may be faced and taking action early in preparation | | |
| Improve uptake of screening in most disadvantaged areas | Increase access to NHS health checks for 40 – 74 year olds | Ageing Well<br><br>Homelessness and Health | Priority 6 |

## Priority 2: Homelessness and Health

The work undertaken by the group feed in to the following Marmot priorities:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives (Priority 2)
- Ensure a healthy standard of living for all (Priority 4)
- Create and develop healthy and sustainable places and communities (Priority 5)
- Strengthen ill-health prevention (Priority 6)

Relevant standards against which to monitor progress on this priority could include: statutory homelessness acceptances (per 1000 households); number of homeless preventions; number of households living in temporary accommodation; average length of stay in temporary accommodation; number of households supported to improve energy efficiency; number of properties improved;

| Theme | Commitment | Lead Sub-Group | Marmot Priorities |
|---|---|---|---|
| Ensure Housing Policy is delivered in a way that prevents Housing contributing to Health Inequality | Reduce disrepair and health hazards to housing in the borough<br><br>Increase opportunities to provide information around affordable warmth and energy efficiency<br><br>Improve the quality of existing housing through a comprehensive programme of housing standards, advice, support, grants and enforcement (MBC's Housing Assistance Policy) | Homelessness and Health | Priority 2, 4 5 & 6 |
| Reduce and prevent homelessness | Implementation and delivery of the Maidstone Homelessness Strategy 2014-2019<br><br>Implement homelessness prevention and assessment services<br><br>Work in partnership to improve hospital discharge<br><br>Reduce the negative impacts of temporary accommodation on homeless families | Homelessness and Health | Priority 2, 4 & 5 |

| | | | |
|---|---|---|---|
| Promote opportunities to support people in poverty | Reduce barriers in registering and accessing services<br><br>Provide support, advice and information to residents about debt management and financial awareness<br><br>Promote support available to people in poverty e.g. Kent Saver's, food banks, Citizens Advice, KSAS | Homelessness and Health | Priority 4 & 5 |
| Provide information and advice to families to promote ongoing welfare reform support | Develop and deliver financial inclusion partnership and action plan<br><br>Implement communications strategy and continually review and update as more information is provided | Homelessness and Health | Priority 4 & 5 |
| Improve uptake of screening in most disadvantaged areas | Increase access to NHS health checks for 40 – 74 year olds | Ageing Well<br><br>Homelessness and Health | Priority 6 |

## Priority 3: Local Children's Partnership

The work undertaken by the group feed in to the following Marmot priorities:

- Give every child the best start in life (Priority 1)
- Enable all children, young people and adults to maximise their capabilities and have control over their lives (Priority 2)
- Create fair employment and good work for all (Priority 3)
- Create and develop healthy and sustainable places and communities (Priority 5)
- Strengthen ill-health prevention (Priority 6)

Relevant standards against which to monitor progress on this priority could include: rate of infant deaths (persons aged less than one year) per 1,000 live births; low birth weight of term babies; breastfeeding; smoking status at time of delivery; under 18 conception; excess weight at reception and year 6; engagement in Maidstone Families Matters programme; GCSE's (5+ A* - C including Maths and English; Young people not in education, employment or training;

| Theme | Commitment | Lead Sub-group | Marmot Priorities |
|---|---|---|---|
| Ensure good physical, mental and emotional health for all | Ensure mothers have good physical and emotional health in pregnancy and in the early months of life: focusing on increasing levels of breastfeeding and reducing smoking in pregnancy<br><br>Encourage and support healthy growth and weight of children through healthy eating and physical activity<br><br>Promote active travel to and from schools, children's centres and colleges<br><br>Work to promote Maidstone as a breastfeeding friendly town<br><br>Work with services who support families with complex needs e.g. Maidstone Families Matters | Local Children's Partnership | Priority 1, 2 & 5 |

| | | | |
|---|---|---|---|
| | Increase the awareness and importance of good health and wellbeing for all through media and signposting to services | | |
| Learn and have opportunities to achieve throughout their lives | To help young people and parents/carers to access the right pathways for learning and independence<br><br>Work in partnership to identify and support children and young people not in education, employment or training<br><br>Work alongside schools/colleges/universities to promote training appropriate for the skills needed in Maidstone | Local Children's Partnership<br><br>Skills and Employability | Priority 1, 2 & 3 |
| Make safe and positive decisions | Develop pathways for identifying children and young people 'at risk' of early sexual activity and teenage pregnancy and offer early intervention and support<br><br>Promote appropriate relationships and increase emotional resilience<br><br>Work collectively to increase access to services by providing information, advice and guidance on available services such as smoking, alcohol, domestic abuse | Local Children's Partnership | Priority 1 & 2 |

## Priority 4: Skills and Employability

The work undertaken by the group feed in to the following Marmot priorities:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives (Priority 2)
- Create fair employment and good work for all (Priority 3)

Relevant standards against which to monitor progress on this priority could include: number of healthy businesses in the borough; work related illness; long term unemployment (per 1000 of working age population); number of volunteers; unemployment; long term claimants of jobseekers allowance;

| Theme | Commitment | Lead Sub-group | Marmot Priorities |
|---|---|---|---|
| Increase the number of healthy workplaces in the borough | Promote awareness of health issues within the workplace<br><br>Work with employers to improve health and wellbeing in the workplace<br><br>Encourage and support employees to adopt healthier lifestyles | Skills and Employability | Priority 3 |
| Make employment accessible for all | Break the cycle of worklessness by undertaking positive action for vulnerable groups (low income families; unemployed adults; those who are NEET or at risk of becoming NEET)<br><br>Develop quality and multiple work experiences and volunteering opportunities for people as a route in to work | Skills and Employability<br><br>Local Children's Partnership | Priority 2 & 3 |
| Increase the number of volunteering opportunities | Work with third sector organisations to increase levels of community volunteering and skills levels | Skills and Employability | Priority 3 |
| Learn and have opportunities to achieve throughout their lives | To help young people and parents/carers to access the right pathways for learning and independence | Local Children's Partnership | Priority 1, 2 & 3 |

| | | | |
|---|---|---|---|
| | Work in partnership to identify and support children and young people not in education, employment or training<br><br>Work alongside schools/colleges/universities to promote training appropriate for the skills needed in Maidstone | Skills and Employability | |
| Increase the number of business start-ups | Encourage the establishment and growth of businesses (including self-employment) in the Borough to increase the choice of jobs<br><br>Continued promotion of the Maidstone Business Terrace<br><br>Support social enterprise growth including involvement of the third sector in service planning and delivery | Skills and Employability | Priority 3 |

## Overarching commitments

The following themes and commitments work across all four sub-groups of the Maidstone Health and Wellbeing Board and should be considered as part of their development and delivery plans.

Relevant standards against which to monitor progress on this priority could include: self-reported wellbeing; excess weight in adults; number of staff trained to deliver 'making every contact count' interventions; percentage of physically active adults;

| Theme | Commitment | Lead Agency | Marmot Priorities |
|---|---|---|---|
| Encourage self-care and access to health services for all | Build capacity to make sure people can take advantage of the opportunity to take control of their own health, and actively take part in improving the health and wellbeing of others<br><br>Support hard to reach and vulnerable people who do not traditionally engage with health services | | Priority 2 & 6 |
| Promote an environment and culture that makes healthy lifestyles easier to achieve | Recognise the importance of safe places to take part in physical activity, whether that be active travel, community centres or health facilities and improve accessibility in a physical and monetary sense to ensure available to the wider community | | Priority 2 & 5 |
| Provide brief interventions and referrals to effective preventative services, using the principles of 'Making Every Contact Count' | Train and support front line staff to confidently raise the issues of lifestyle and behaviours and provide confident brief interventions and sign posting | All agencies | Priority 2 |
| Create opportunities for individuals, groups and organisations to get together to discuss their circumstances, needs and aspirations, within and between communities and neighbourhoods | Support Kent Public Health in the delivery of their health inequalities action plan 'Mind the Gap'<br><br>Promote asset mapping and community development | Maidstone Health and Wellbeing Board | Priority 5 |

| | | | |
|---|---|---|---|
| Grow partnerships and find new works to target and deliver services | Work with the Health and Wellbeing Boards to support the delivery of key priorities set out in the health inequalities agenda | | Priority 6 |
| To implement strategies for promotion and prevention in mental health and wellbeing | Increase public knowledge and understanding about mental health and signpost to relevant services<br><br>Create and enable resilient communities<br><br>Promotion of Six Ways to Wellbeing<br><br>Encourage services/businesses to be 'mental health friendly' | | Priority 6 |
| Reduce obesity rates across the borough | Support the delivery of the West Kent Obesity Action Plan<br><br>Encourage healthy weight environments and discourage obesogenic environments | Maidstone Borough Council | Priority 6 |
| Reduce number of people living with preventable ill-health and people dying prematurely while reducing the gap between communities | Promotion of healthy lifestyles through behaviours/choices, and the environment and communities people live<br><br>Support national and local campaigns to highlight ongoing health issues (such as obesity, tobacco and substance misuse, dementia, social isolation) | All | Priority 2,4 & 6 |

# References

*Maidstone Health Inequalities Action Plan 2014-2020*

*Maidstone Health Inequalities 2015/16 Progress Report*

*Maidstone Borough Council's Communities, Housing and Environment Committee*

*Terms of Reference for Maidstone Health and Wellbeing Board and Sub-groups*

*Kent County Council, Mind the Gap: Kent's Health Inequalities Action Plan 2012-2015*

*Kent County Council, Mind the Gap 2016*

*The Marmot Review, 'Fair Society, Healthy Lives', 2010*

*The Kings Fund, The district council contribute to public health: a time of challenge and opportunity*

| **Community, Housing & Environment** | **18 October 2016** |
|---|---|
| Is the final decision on the recommendations in this report to be made at this meeting? | **Yes** |

# KCC Adult Social Care Strategy Consultation

| | |
|---|---|
| **Final Decision-Maker** | Community, Housing & Environment Committee |
| **Lead Director or Head of Service** | Head of Housing and Community Services |
| **Lead Officer and Report Author** | Sarah Ward, Housing and Health Officer |
| **Classification** | Non-exempt |
| **Wards affected** | Borough |

**This report makes the following recommendations to the final decision-maker:**

1. The Committee agrees the draft response to the KCC Adult Social Care Strategy consultation as set out in Appendix A to this report.

**This report relates to the following corporate priorities:**

- Keeping the Borough an attractive place for all
- Securing a successful economy across the borough

| **Timetable** | |
|---|---|
| ***Meeting*** | ***Date*** |
| Communities, Housing and Environment Committee | 18th October 2016 |

# KCC Adult Social Care Strategy Consultation

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Kent County Council is consulting on a new strategy for adult social care. The strategy explains KCC's vision for how they want adult social care delivered over the next five years.

1.2 Adult social care is there to support people who need help with daily living so they can live as independently as possible in the place of their choice. The care and support that adult social care commissions (arranges or provides) is based on needs assessment of adults (including carers and young people during transition) who are supported using public money or pay for their own service.

1.3 The following report includes Maidstone Borough Council's suggested response to KCC's Adult Social Care Strategy consultation. The consultation ends Friday 4 November 2016.

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## 2. INTRODUCTION AND BACKGROUND

2.1 It is well known that as a society we are living longer, and, as a result, an increasing number of people have several related needs which need the attention of the health and social care system. Expectations of adult social care are changing; people want a life, not a service. Adult social care in Kent needs to continue to respond to these challenges, in line with the economic climate and the new strategy sets out how Kent County Council plans to do this.

2.2 The five year strategy provides the basis for health and social care integration which is in progress and aims to deliver a more person-centred care and support, keep people safe, help people to have choice and control, make sure that there are enough care and support services available and organisations are working in partnership to make better use of resources.

2.3 Kent County Council's vision for adult social care is 'to help people to improve or maintain their well-being and to live as independently as possible'. The strategy breaks down their approach to adult social care into three themes that cover the whole range of services provided for people with social care and support needs and their carers:

- **Promoting well-being** – supporting and encouraging people to look after their health and well-being to avoid or delay them needing adult social care.
- **Promoting independence** – providing short-term support so that people are then able to carry on with their lives as independently as possible.

- **Supporting independence** – for people who need ongoing social care support, helping them to live the life they want to live, in their own homes where possible, and do as much for themselves as they can.

2.4 As this is a Kent wide strategy, it is not currently clear what services are currently commissioned within the district and how these may be affected as part of the consultation.

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## 3. AVAILABLE OPTIONS

3.1 The council can decide not to respond to the consultation on adult social care but to do so would miss the opportunity to represent our residents.

3.2 The council can provide a response on KCC's Adult Social Care Strategy providing feedback on the challenges, opportunities and recommendations for future delivery.

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## 4. PREFERRED OPTION AND REASONS FOR RECOMMENDATIONS

4.1 The preferred option is contained in paragraph 3.2; the committee should agree the draft consultation response set out in Appendix I ready for submission to Kent County Council.

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## 5. CONSULTATION RESULTS AND PREVIOUS COMMITTEE FEEDBACK

5.1 None.

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## 6. NEXT STEPS: COMMUNICATION AND IMPLEMENTATION OF THE DECISION

6.1 Once a decision has been reached as how to respond to the consultation it will then be submitted to Kent County Council prior to the deadline on Friday 4 November 2016.

## 7. CROSS-CUTTING ISSUES AND IMPLICATIONS

| Issue | Implications | Sign-off |
|---|---|---|
| **Impact on Corporate Priorities** | Keeping Maidstone Borough an attractive place for all<br>- encouraging good health and wellbeing | Head of Housing and Community Services |
| **Risk Management** | Not applicable. | |
| **Financial** | Not applicable. | |
| **Staffing** | Not applicable. | |
| **Legal** | Not applicable. | |

| | | |
|---|---|---|
| **Equality Impact Needs Assessment** | Not applicable. | |
| **Environmental/Sustainable Development** | Not applicable. | |
| **Community Safety** | Not applicable. | |
| **Human Rights Act** | Not applicable. | |
| **Procurement** | Not applicable. | |
| **Asset Management** | Not applicable. | |

## 8. REPORT APPENDICES

The following documents are to be published with this report and form part of the report:

- Appendix A: Maidstone Borough Council's Response to Consultation
- Appendix II: KCC draft Adult Social Care Strategy 2016-2021 'Your life, your well-being'

'YOUR LIFE, YOUR WELL-BEING'

# Vision and Strategy for Adult Social Care

## Maidstone Borough Council's Response

**Communities, Housing and Environment Committee**
**October 2016**

Maidstone Borough Council is encouraged by the release of the draft strategy for adult social care across Kent, 'Your life, your well-being' as we are expected to see a 45.4% increase of residents aged 60 – 85 by 2034 within the Maidstone Borough.

As the strategy and data demonstrates society is living longer and as a result will produce new challenges for our health and social care system. Therefore, we must act now to maintain wellbeing throughout life; improve the quality of life for older people and enable them to participate fully in society; and ensure everyone can access the tools and facilities to help them live a long and healthy life.

As a district council we have an important role to play in contributing to the strategy and assist Kent in delivering its vision 'to help people to improve or maintain their wellbeing and live as independently as possible' through our statutory functions such as:

- **Housing** – ensure residents are able to remain safe and live independently in their own homes through providing support to home owners, tenants and landlords; enforcement action; working with GP's to identify those 'at risk' and; the facilitation of disabled facilities grants.
- **Community safety** – enabling residents to feel safe within their home and community through safeguarding; and raising awareness of abuse and neglect.
- **Parks and leisure** – promoting wellbeing and supporting independence through providing access to green spaces and leisure opportunities within the borough.
- **Economic development** - promotion of volunteering, job opportunities, and social groups to aid social inclusion and promote independence.

Older people in our society deserve every opportunity to age well, in communities that value their experience. Local concerns need local solution.

The draft strategy has a clear focus on ensuring delivery of statutory responsibilities, whilst capturing all available opportunities to prevent, reduce or delay need for ongoing support.

Councils can take the lead in developing innovating ageing well approaches. Services provided should be based on evidence of what works, should be of high quality and accessible, irrespective of the level of need or who is delivering the service. Service users, including carers should have involvement in the development, commissioning and delivery stages.

<u>Challenges</u>

As the strategy highlights there are a number of key challenges in delivering adult social care over the coming years:

- Ageing population.
- People living for longer, some with lifelong conditions therefore requiring medication/care for a longer period.
- Reduction in resources and finances across organisations due to economic climate.

- How to engage the disengaged to be able to provide preventative services for those who need help most. Need to ensure the whole population is looked at including homeless individuals; service personnel and those being integrated back into community through relocation or release from prison.
- Lack of engagement from GP's to provide community hub due to lack of time, resources and high workload.
- Turnover of health and social care staff

These challenges are not going to go away; we therefore need to work in partnership to increase benefits through wider collaboration, additional funding, mutual advantage and resources only accessed through partnership working.

Opportunities

We are pleased to see the strategy recognises the benefits of working in partnership across a blend of statutory and voluntary sectors. We believe this will create a synergy for organisations to work together and move towards the shared goals and purposes. However; the strategy does not make clear how this will be executed, what will be done differently and the key roles for Kent County Council and the NHS.

Maidstone Borough Council operates a whole system approach by 'Making Every Contact Count'. This approach encourages conversations based on behavior change methodologies (ranging from brief advice, to more advanced behavior chance techniques), empowering healthier lifestyle choices and exploring the wider social determinants that influence all of our health.

This needs to be reflected within the strategy as Making Every Contact Count is a public health initiative that can contribute positively to the adult social care strategy, particularly signposting to the information and advice system (due to be developed by 2021).

This information can also be provided by the 'Doris' system to ensure GP's and health professionals have access to social prescribing.

As part of the development of the strategy, you have linked and referenced to other key local strategies. However, we feel an important strategy has been missed – Kent County Council's Mind the Gap 2016. Mind the Gap is Kent's Health Inequalities Action Plan which aims to improve health and wellbeing for everyone in Kent by narrowing the gap in health status between the most and deprived communities. The 2016 strategy takes on a community asset mapping and community development approach within lower super output areas; in Maidstone these are Park Wood, Shepway and High Street. The increase of ageing population may not be bound to these areas so a whole system approach is required.

Maidstone Borough Council is currently refreshing its own Health Inequalities Action Plan with a focus on 'ageing well'. This may provide excellent opportunities for partnership working through communication, sharing of resources, knowledge and commissioning.

Some questions have arisen through the development of the strategy which we seek further clarification on:

1) How is the Adult Social Care Strategy linked in with Kent Public Health commissioning intentions?

2) How much funding is associated with the strategy for commissioning of services? What services are currently commissioned / up for review?

3) Will the Community Hubs link in with the existing provision provided by NHS Health and Social Care Coordinators?

4) How will you ensure you '…make the best use of digital technology to share information between partners?' This is a struggle we face currently as although we endeavor to work together, we are told information cannot be shared due to data protection.

5) When you refer to safeguarding and protecting adults at risk of abuse or neglect; does this include self-neglect through lifestyle choice?

6) Through the models of care and support the strategy states 'ensure community development and increasing volunteering, befriending and good-neighbour schemes'. Will this be achieved through commissioning?

7) What is the link between the strategies for 16-18 year olds in transition to adult services and what protocols are in place to ensure they are not lost in transition?

<u>Recommendations for Maidstone Borough Council</u>
For Maidstone Borough Council to support the development and delivery of Kent's Adult Social Care Strategy through its statutory functions and the Maidstone Health and Wellbeing Board, Ageing Well Sub Group. The strategy demonstrates clear links between social care and the wider determinants of health.

To work collaboratively with organisations operating in Maidstone to identify those residents 'at risk' and provide extra support through partnership meetings; application for a disabled facilities grant; attendance/feedback with hospital discharge planning; and sharing of resources.

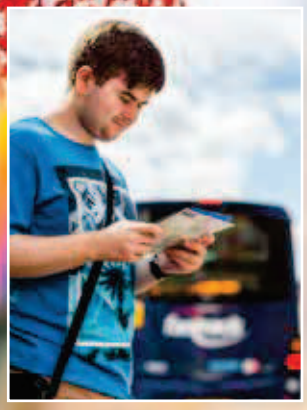
<u>Recommendations for Kent County Council</u>
To assist with the increase use of digital technology, purchase iPads for staff to complete appointments remotely via facetime or submit referrals whilst on home visits.

Raise awareness of the commissioned services to organisations and residents to ensure the knowledge is available to signpost.

Provide further detail in the strategy as to how the vision will be achieved.

# Your life, your well-being

## A vision and strategy for adult social care 2016 - 2021



Draft for consultation



Kent County Council
kent.gov.uk

# Contents



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Images Kent County Council, NHS photo library page 13,16,19,20,23,26.

# 1. Foreword

**By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health and Andrew Ireland, Corporate Director for Social Care, Health and Well-being.**

Graham Gibbens Andrew Ireland

It is well known that as a society we are living longer and, as a result, an increasing number of people have several related needs which need the attention of the health and social-care system. This is in the face of a dramatic reduction of resources since 2010 and all the available information shows that this is likely to continue for more years to come.

Our response to the changing environment is to set out a new vision for adult social care which this strategy is based on. It is a strategy that builds on our past successes but firmly points to the future in how we plan to work with the NHS to meet the challenges that we face. Our partners are people who use our services, carers, providers, the voluntary sector, health services, schools and colleges, district councils and other public services. This strategy sets out the overall direction that we aim to follow in the coming years, amidst the financial challenges and the ever-increasing demand for services that we know is the result of a growing population and the changing needs of people living in the area.

This new strategy is also based on the Care Act 2014, as opposed to the post-war legislation that it replaced. Under the 2014 legislation adult social care now has a broader responsibility to promote the well-being of adults when carrying out our legal obligations in relation to people living in the area.

This five-year strategy clearly explains our plans for the future. It provides the basis for health and social care integration which is in progress and aims to deliver more person-centred care and support, keep people safe, help people to have choice and control, make sure that there are enough care and support services available, work in partnership and, above all, make better use of our resources.

Our vision for adult social care is built on existing work with social-care professionals, doctors, carers, the public, and other partners in developing new models of care for the future. As a result, our vision is part of the broader process of joining up health and social care under the NHS Five Year Forward View work programme for transforming service provision at scale and pace in the coming years.

By improving integrated commissioning and provision people will receive their health and social care from one community place linked to their GP surgery.

People with more intense and complicated ongoing needs will have one professional who will lead on coordinating their care and build a team of support for the person. This support will include single assessment and enablement (helping people to become more independent by gaining the ability to move around and do everyday tasks).

We will make the best use of digital technology to share information between partners and as a tool for those receiving health and social care support.

We will also break down barriers between sectors and organisations where they get in the way of better care and support. Our vision, to put it simply, is to 'help people to improve or maintain their well-being and to live as independently as possible'. This document will interest members of the county council, our staff, the public and partner organisations who may want to know how the services we arrange or pay for would change during the lifetime of this strategy.

# 2. Strategy at a glance

| | |
|---|---|
| **Purpose** | Adult social care is there to support people (adults, young people and carers) who need help with daily living so they can live as independently as possible in the place of their choice. |
| **Context** | • Efficiency and finance<br>• Quality of care<br>• Outcomes and well-being. |
| **Strategic outcomes (Strategic Statement)** | Strategic outcome 3: Older and vulnerable residents are safe and supported with choices to live independently. |
| **Our vision for adult social care** | To help people to improve or maintain their well-being and live as independently as possible. |
| **Achieving our vision through three themes** | • Promoting well-being<br>• Promoting independence<br>• Supporting independence. |
| **What will make it happen?** | • Protection (Safeguarding)<br>• Workforce<br>• Commissioning<br>• Integration and partnerships. |
| **Our values and principles** | • Person-centred care and support<br>• Supporting people to be safe<br>• Promoting independence<br>• Prevention<br>• Quality of care<br>• Integration<br>• Answering for what we do<br>• Best use of resources. |

# 3. Introduction

Over the last 10 years we have been transforming adult social care in Kent, as can be seen from the timeline (on the following page).

This strategy replaces the previous 'Active Lives' strategy. The vision and aims set out in this document strongly link with and support 'Increasing Opportunities, Improving Outcomes: Kent County Council's Strategic Statement 2015-2020' and the principles described in the 'Commissioning Framework for Kent County Council'. It is important to understand that this strategy sits between the council-wide strategies and other specific social-care group strategies such as the Learning Disability Joint Commissioning Strategy, the Strategy for Adults with Autism in Kent and Live Well Kent Principles for Mental Health.

## What is the purpose of adult social care?

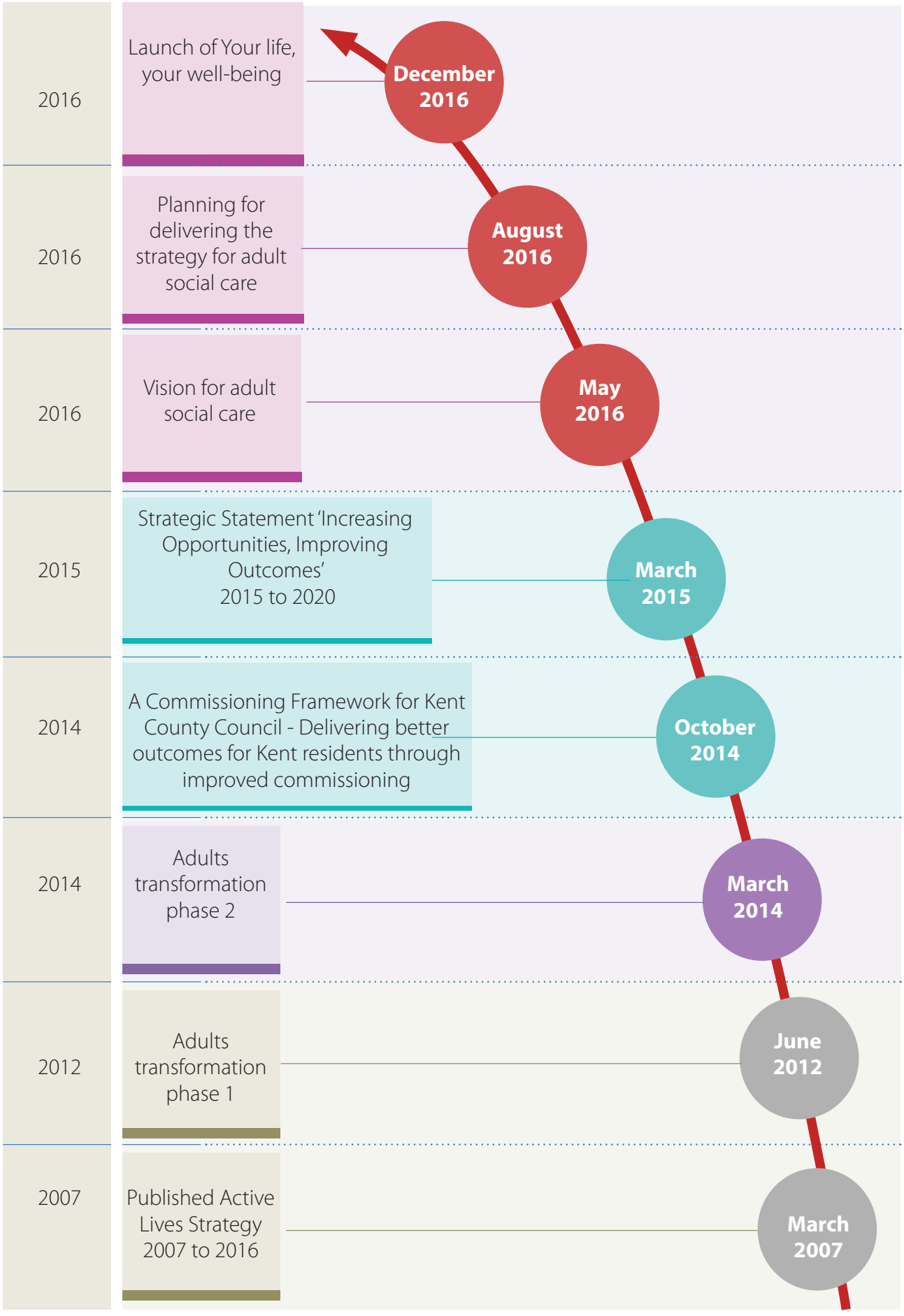
Adult social care is there to support people who need help with daily living so they can live as independently as possible in the place of their choice. The care and support that adult social care commissions (arranges or provides) is based on needs assessments of adults (including carers and young people during transition) who are supported using public money or pay for their own services. (By transition we mean the process where young people with health- or social-care needs move from children's services to adult services).

Keeping people safe is an important part of the legal obligations we must meet, and we take this very seriously.

The main responsibilities of adult social care are set out in three main pieces of legislation - the Care Act 2014, the Mental Health Act 1983 and the Mental Capacity Act 2005. As the overarching piece of legislation, the Care Act 2014 lays down new responsibilities and extends existing responsibilities, including:

- promoting well-being;
- protecting (safeguarding) adults at risk of abuse or neglect;
- preventing the need for care and support;
- promoting integration of care and support with health services;
- providing information and advice; and
- promoting diversity and quality in providing services.

# Timeline


2016
Launch of Your life, your well-being
December 2016
2016
Planning for delivering the strategy for adult social care
August 2016
2016
Vision for adult social care
May 2016
2015
Strategic Statement 'Increasing Opportunities, Improving Outcomes' 2015 to 2020
March 2015
2014
A Commissioning Framework for Kent County Council - Delivering better outcomes for Kent residents through improved commissioning
October 2014
2014
Adults transformation phase 2
March 2014
2012
Adults transformation phase 1
June 2012
2007
Published Active Lives Strategy 2007 to 2016
March 2007

# 4. Our vision and strategic approach to adult social care

While we are proud of our past successes, we believe that we must continue to do more to promote people's ability to improve and maintain their health and well-being, live independently, and cope well with deteriorating conditions. We will carry on putting the person at the centre of everything we do, offering a timely and integrated approach to care and support. In short, this is based on the central idea of focusing on 'a life not a service'. We have decided to use this approach based on consistent feedback that current models of support fit people into a narrow band of available services, whereas future support needs to be more personalised so people can achieve the outcomes that matter to them.

**Our vision is 'to help people to improve or maintain their well-being and to live as independently as possible'.**

This vision supports the delivery of some of our overall outcomes, set out in our Strategic Statement. In particular, it supports the following:

**Strategic outcome: Older and vulnerable residents are safe and supported with choices to live independently**

Supporting outcomes:

- Those with long-term conditions are supported to manage their conditions through access to good quality care and support
- People with mental health issues and dementia are assessed and treated earlier and are supported to live well
- More people receive quality care at home avoiding unnecessary admissions to hospital and care homes
- The health and social care system works together to deliver high quality community services
- Residents have greater choice and control over the health and social care services they receive

**Strategic outcome – Kent communities feel the benefits of economic growth by being in work, healthy and enjoying a good quality of life.**

Supporting outcome:

- Physical and mental health is improved by supporting people to take responsibility for their own health and well-being.

Our strategy for adult social care over the next five years breaks our approach down into three themes, supported by four building blocks, as shown in the image overleaf. The three themes cover the whole range of services provided for people with all kinds of social-care and support needs, and their carers, throughout their adult lives. Chapters 6, 7 and 8 explain our plans over the next five years for each of the themes, and Chapter 10 explains our plans for the building blocks, but we give a brief overview overleaf.


| | |
|---|---|
| Protection (safeguarding) | Workforce |
| Commissioning | Integration and partnerships |

## The vision explained

### Promoting well-being

This is delivered through services which aim to prevent, delay or avoid people from entering formal social-care or health systems, by helping people to manage their own health and well-being.

- We will promote and build on people's strengths to help them look after themselves, stay independent and live a full life within their community.
- People will be able to make the best use of available resources such as information and advice and local support.

### Promoting independence

This involves providing short-term support that aims to prevent or delay people's entry to the formal care system, and provide the best long-term outcome for people. They will have greater choice and control to lead healthier lives.

- We will promote independence by providing short-term support such as community equipment, enablement and other assisted living technology (products designed to help people live independently in their own homes).
- Our aim will always be to achieve the best long-term outcomes for the person.

### Supporting independence

This is delivered through services for people who need ongoing support and aims to maintain well-being and self-sufficiency. The aim is to keep people safe and help them to live in their own homes, stay connected to their communities and avoid unnecessary stays in hospitals or care homes.

- More people will receive care at home and stay connected in their community, avoiding unnecessary stays in hospital and care homes.
- We will change the way our services are commissioned and delivered to be more focused on achieving better outcomes for people.

## Four building blocks

Our approach to adult social care is supported by four building blocks that support the way we work and the changes we need to deliver.

- Making sure we provide effective management (with partners) to protect adults at risk of neglect or abuse and make sure staff are well trained and confident to carry out their duties.
- Developing a flexible workforce with the right skills to work across organisational boundaries, including having in place appropriate and smooth care pathways (see below) for people.
- Commissioning and providing a range of flexible care and support services based on a strong understanding about what people need and what matters to them, setting the outcomes that need to be delivered, and deciding which organisation is best placed to deliver them.
- Improving the way we work with the NHS through integrated commissioning and provision to promote the well-being of adults with care and support needs, including carers to deliver the ambition of effective and efficient co-commissioning.

**Care pathways**
By this we mean an agreed plan for caring for and supporting people with a particular health condition so they can move smoothly between services. It is based on evidence about what works to treat and manage particular conditions.

Through these models of care and support, our aim is to:

- improve people's experience and promote their health and well-being;
- end the current crisis-driven model of care; (a way of providing care based on a set of beliefs and principles about what is right and works best);
- create a value-driven and outcome-focused culture that nurtures creativity and find new ways to meet people's needs;
- support people to access good-quality advice and information that allows them to look after themselves;
- create the right conditions which allow people to find solutions that support their well-being outside of traditional medical- or service-driven models of care and support;
- encourage community development and increase volunteering, befriending and good-neighbour schemes;
- support carers in their vital role by providing advice and individually tailored support;
- provide flexible and responsive models of care and support, including long-term care, that can increase and reduce in size as needed;
- free professionals up from rules and bureaucracy so they can 'do the right thing' and provide person-centred support that promotes well-being; and
- bring services together to make sure there is better communication and effective use of resources which will create a comfortable experience for people.

## Prevention, support and managing the move for young people into adulthood

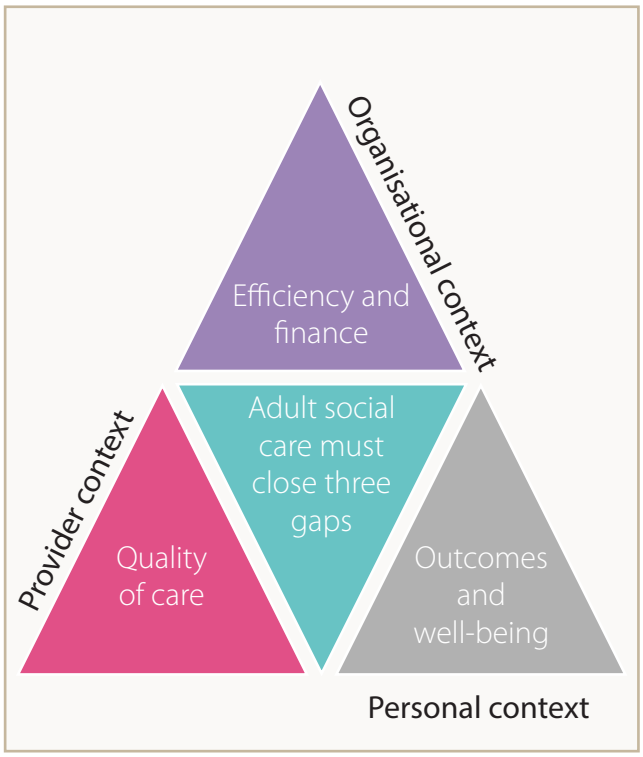
By prevention we mean any act that prevents or delays the need for people to receive care and support by keeping them well.

We recognise the importance of managing the move to adulthood for disabled young people receiving care and support. This can apply up to the age of 25. Our strategic outcome for children and young people is to make sure

that they get the best start in life. So, it is vital that we work with services for young people to make sure that they can have access to the appropriate preventative services as well as having the right links with health, education and housing. Getting this right should mean that we will be able to help young people to be with their families, until they can live independently (which will depend on their development needs). In making the changes described in this strategy, we will link with the 0-25 Portfolio Board's vision and priorities for transformation which is about supporting every child and young person in Kent to achieve their potential.

## Background

Like all councils, we are working within severe financial restrictions as well as seeing increased demand for services brought about in part by changes to the population. We know that this will continue for at least the next five years. We will measure our success by how well we manage to close three important gaps that are central to everything that we do. These are shown in the image below.




## Organisational background (efficiency and finance gap)

It is great news that people are now living longer than ever. Nationally the number of people aged over 60 is expected to pass the 20 million mark by 2030 and within Kent, by 2026, the number of people who are 65 or over is expected to increase by 43.4%. In addition improved medical care and higher survival rates following illnesses and accidents mean that we are seeing significant increases in the numbers of people with complex needs and the number of younger people with long-term support needs. All of these changes are putting huge pressure on the adult social-care system.

National funding has not kept up with these increases in demand, with significant reductions in spending across services. In the last five years (since 2010) we have delivered over £433million of savings, around £80 to £90million each year, and the percentage of our total budget which is going on adult social care is rising. Where possible, we have made savings by redesigning services and passing funding to front-line services (staff or services who have direct contact with people who need care and support).

So that we can keep providing the services that people need, with reduced funding and increasing demand, we are becoming a commissioning authority. This means examining and reviewing the way we deliver services in partnership with the NHS, private and voluntary sector, and looking at new ways of working to make sure that we develop the best services we can. This new approach involves working in a more joined-up way with our partners, including the NHS and providers of services. We will work with the people who use our services and their carers to produce changes in provision where possible. The health and social-care workforce will increasingly work in a flexible way across organisational boundaries to deliver smoother care and support.

## Provider background (quality of care gap)

Over 80% of our budget for adult social care is spent through the Kent care market, which is made up of around 500 providers of services in the public, private and voluntary sectors, employing over 40,000 people. We have significant buying power and this can help the economy in Kent to grow. The pressures on finances and demand are causing significant challenges for providers with many reporting that they are struggling to maintain their business, recruit staff with the right skills and maintain high-quality services.

As we move into delivering this strategy, we will need to look at our relationship with our main partners to see how together we can deliver what is needed in the most cost-effective way including using new models of care that are clearly based on outcomes. Like all local authorities, we have a duty under the Care Act to shape the local care market. As more people have control over their own care and support by being self-funders or through personal budgets, our role is increasingly focused on supporting providers to understand supply and meet demand.

Our relationship with the voluntary and community sector is changing, as reflected in our new Voluntary and Community Sector Policy. We will work with providers to help them become more sustainable, including by moving long-standing grants to contracts.

## Personal background (outcomes and well-being gap)

The Care Act makes very clear adult social care's responsibilities for promoting the well-being of people with care and support needs in the local area. This includes those who pay for their own care. Our commitment to promoting the well-being of people in Kent is reflected in our Strategic Statement and Commissioning Framework. At the moment we know that we do not always make the best use of information

about the benefits our services are bringing to all the people who use them so that we can shape how services could be improved.

Well-being is defined very broadly in the Act and includes personal dignity, physical, mental and emotional well-being, protection from abuse and neglect, control over day-to-day life, taking part in work, education, training or recreation, social and economic well-being, domestic, family and personal relationships, suitability of living accommodation and the person's contribution to society.

We will continue to put the well-being of the person at the centre of everything we do. This means that we will listen and respond to the views and issues that are important to the person when working with them and use information more intelligently, such as identifying people at most risk.

Outcomes for people are influenced by a number of factors including housing, education and lifestyle choices, some of which fall within our responsibilities in terms of public health.

This is an area where we believe more needs to be done working with our health partners, district councils and local communities, to reduce health inequalities (the differences in health between different population groups. For example, people from less well-off backgrounds tend to suffer from health problems more).

The carers of people with care and support needs (who might be family, friends or neighbours), play an essential role in the well-being of the people they care for and we recognise the important contribution that they make to society. We know that carers can experience significant negative effects on their finances, health (physical, mental and emotional) and employment prospects as a result of their caring role. As part of this strategy we will work with our partners to improve the lives of carers, as set out in Chapter 9.

## How the strategy will be put into practice

This strategy explains our vision for adult social care over the next five years. We will deliver it through the next phase of the transformation journey that adult social care is already on. The details of how we will deliver it will be set out in an implementation plan which we are developing for this strategy. In summary, this will include activity over the next 18 months around the following:

**Scoping** - in other words, defining the issues we are trying to tackle by identifying the span of the project, the resources and costs needed and producing a timeline

**Assessment** - this involves investigating the current delivery model and assessing against the proposed alternatives, supported by best practice. It means confirming the expected financial benefits and the changes needed to achieve the benefits . It also involves developing options to inform the next stage

**Design** - means testing changes in specific areas and refining the expected financial benefits and, after benefit change getting ready for putting into practice

**Implementation** - this means putting changes into practice across Kent and monitoring the benefits and making sure that performance is consistent

**Sustain** - this involves closing the project and making sure that the changes continue as part of day-to-day work in adult social care.

# 5. Our values and principles

These values and principles guide everything we do to provide care and support to adults and their carers.

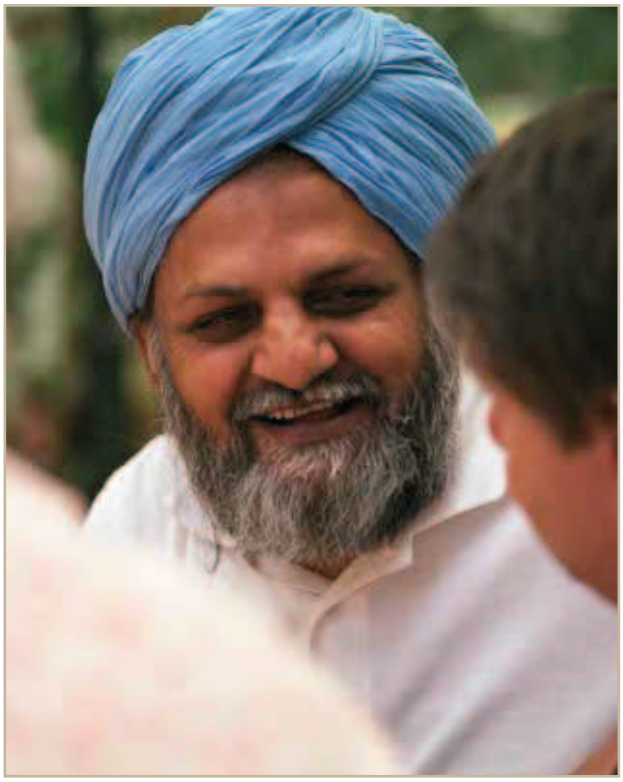
- **Person-centred care and support**
  We provide care and support that is tailored to the person so that they can achieve the things that matter most to them. This means putting the person at the centre of everything we do, supporting them to decide what care and support they want to receive so they can lead their lives in the way they choose.

- **Supporting people to be safe**
  Working with people to help them to manage risks of abuse or neglect is central in everything we do.

- **Promoting independence**
  Throughout the person's care journey we work with them and their carers to jointly design their care and support in a way that supports and encourages them to do as much for themselves as possible, including taking responsibility for their own health and well-being.

- **Prevention**
  We provide advice and support at the right time to prevent problems getting worse. We aim to prevent, delay or reduce people's need for social care by helping them to maintain or improve their well-being and independence, or to cope better with conditions which are gradually getting worse.

- **Quality of care**
  We maintain and improve the quality of the care and support that people receive, no matter which organisation provides it. We constantly look for opportunities to make improvements to the ways that people access our services and the ways we design and provide care and support, using information and feedback about people's experiences.



- **Integration**
  We aim to provide care that is 'joined-up' across organisations so that people do not experience duplication of services or delays in accessing support or fall between the gaps. We are open to new ways of doing things and we make the most of the strengths of all our partner organisations – from the public, private, voluntary and community sectors.

- **Answering for what we do**
  We answer to the people we provide care and support to, their carers and the whole community. We are clear about our roles and responsibilities and honest and open about our performance.

- **Best use of resources**
  We make the most of the resources (money and our staff) we have available to promote people's well-being by focusing on the outcomes they want to achieve, including by influencing other organisations and the community. We use information intelligently to plan services that achieve outcomes in the most cost-effective way.

# 6. Promoting well-being


**Providing the right response so people can manage their own need for care and support within their communities.**

Many older and vulnerable adults are able to manage their care and support needs themselves and continue to live in their own homes and communities. However, to do this, they may need information and advice about the help that is available. This could include information on benefits, facilities available in the community, aids they can buy to use at home and outside, and advice on how to maintain or achieve a healthy lifestyle (what we can call 'well-being' services).

This type of early intervention aims to prevent or delay people from entering the formal social-care and health system, by helping them to manage their own health and well-being. Well-being services are based in local communities and use local resources. They deal with the issues that lead to people entering formal care systems, such as social isolation, falls and where the person's carer is not able to cope. Access to good-quality information and advice will be the cornerstone of our well-being services, helping people to identify and access the support that they want so they can keep on living fulfilled lives in their own homes.

At the same time as helping people to take more responsibility for their own health and well-being, we need to strengthen communities to support the vulnerable adults living in them. We need to support communities so they can better use their own assets and help each other.

### How things are today

- Although there are various sources of support for people outside of the formal care system, it is not always easy to find out what is available locally and how to access it. Even GPs and other health and social-care professionals find it difficult keeping on top of all that is available in the community to support people's well-being.
- As a local authority we provide a range of useful information and advice in a number of places. But currently the system is broken up and it is not easy to access all of the information that a person may want or need. This is based on feedback from people stating that they have not always been told about support that exists in their communities.

### How we want things to be in the future

By 2021 we want to have developed, with our partners, a wide-ranging information and advice system so that people can access all the information they need from wherever they ask for support. We also want to have significantly developed the community and voluntary sector to make best use of community resources and improve the range of support offered.

We will continue to make information and advice an important part of the 'community hubs' we hope to have in all local areas. They could be developed around an existing GP practice, for example, or in other prominent locations where people can pop in for advice and support.

**Community hubs** – these are at the heart of our future vision. They will be based in GP surgeries and provide quick, co-ordinated access to a wide range of services and therapies close to or at home. They will contain the same main services:

- Integrated nursing and social-care services including home care, community nursing, occupational therapy, mental-health services, crisis care and palliative (end-of-life) care
- Services to prevent health problems and promote good health
- Access to voluntary and community services

We will develop these locally to reflect the needs in different areas of the county.

We will make sure information and advice can be accessed through a variety of channels and formats including, for example, advice lines, drop-in services, websites and care navigators or brokers (Care navigators or brokers are people whose job it is to give advice and information about what services are available in a person's area so that they can choose to arrange the care and support that best meet their needs).

We will make sure that when people ask for information or support services, all agencies either hold the information needed or know how to get hold of it.

We will greatly improve the information available to people who pay for their own care (self-funders) so that they are fully aware of all the options available to them and know which support is provided free of charge. This support includes assessment, enablement (helping people become more independent by gaining the ability to move around and do everyday tasks), some equipment and so on. It also includes information on what level of support people are likely to receive if it was arranged by us.

We will expand the use of 'care navigators', or other forms of community worker that we arrange using voluntary organisations. Their role is to help people manage their own health and well-being by accessing local community-based services, aids and equipment, benefits and other sources of support.

We will continue to expand the role of 'trusted assessor'. These are people who have been trained to assess whether a person could benefit from simple aids and equipment or adaptations and take full advantage of new technology, to support qualified occupational therapists. We recognise that getting the right aids, equipment and technology can make a huge difference to a person's ability to stay independent and safe.

We will be looking at how medical and social-care professionals can use social-prescribing models more widely. By social prescribing we mean, for example, GPs could prescribe a course of exercise classes rather than, or as well as, anti-depressants for someone with mild depression or anxiety.

Social isolation and loneliness can lead to ill health and we will be developing schemes which help people get together for mutual support, activity and fun. Keeping people connected helps to keep them well. We will work with the community and voluntary sector to make best use of our combined resources, encourage volunteering, befriending and good-neighbour schemes. Our focus will be on strengthening communities, making use of other social support networks where necessary to improve the range of support offered

Case Study


**George's story:**
**Promoting well-being in the future**

George is 75 and, since his wife died two years ago, has been living on his own in the house he had shared with her for the previous 40 years.

Over the last year he has started to put on weight as a result of not walking as much as he used to when his wife was alive. This has also been due to the arthritis in his hips which has been slowly getting worse (but is not yet bad enough to need a hip replacement).

George generally manages to look after himself, but getting in and out of the bath can sometimes be painful and he often feels lonely and isolated. He has a daughter and son but they both live over 100 miles away and so only visit occasionally. His daughter worries that her father is becoming depressed. He doesn't want to move from his home or the area as he knows it very well, it is within walking distance of several shops and he does have some friends in the area that he sees occasionally.

George belongs to his local Neighbourhood Watch as do most people in his area. Recently they have decided to add to what they do by looking out for their more vulnerable members, including older people, like George, who live alone.

The local council provided some training for them and other local groups in recognising signs of social isolation, dementia and other problems among older people and also where to go for information and advice to help with these things. As a result, one of George's neighbours invited him for tea and suggested that he goes to or phones the new community hub at his local GP surgery (recently expanded to try to provide a one-stop shop for information, advice and support for people who may need this due to loneliness, health problems, disabilities and so on).

A week later George saw someone at the community hub and, as a result, was given the information he needs to:

- join a befriending group organised by Age UK (this includes finding someone to go with him on regular walks);
- join his local University of the Third Age (a self-help organisation for retired and semi-retired people providing leisure, educational and creative activities) which holds all sorts of regular group activities (he is interested in the art appreciation one);
- arrange for a walk-in shower to be installed in his bathroom instead of his bath and to have grab rails put alongside the toilet; and
- signs up to a scheme whereby a volunteer driver will take him to see a friend who lives about five miles away (once a week).

He is also encouraged to see his GP who advises him to go on a diet to lose weight. He also talks to the GP about his feelings of isolation and it is agreed he will return to see him after two months of taking part in the above activities to see if he has improved. The GP is concerned that George may be becoming depressed but decides to wait to see how the various activities help before considering prescribing anti-depressants.

# 7. Promoting independence

**Providing the right short-term action when it is needed and the right environment so people can care for themselves.**

Not everyone who needs support needs it all the time. Some people only need help for a short period, either once or sometimes more often. This could be to help them get back on their feet after an illness or operation, to help them recover from a period of illness (physical or mental) or, if they have a carer, to give that person a break from caring.

Some people may need adaptations to help them manage without the need for formal support. This could include grab rails in the bathroom or the more sophisticated telecare services, for example to sense if someone has left the gas on or someone with dementia has gone missing from home.

People with long-term conditions (mental or physical) or disabilities may need training to help them be as independent as possible so they do not have to rely on formal care systems.

Our aim in promoting independence is to increase the availability of this type of support and to target it more effectively, at the right time, before a person's condition gets to the point that they need ongoing, long-term support.

### How things are today

- There are already services in place to provide some of the short-term support needed and to promote independence in the home. This includes enablement services (both for those who have physical needs and those with a mental-health problem), which we currently provide to some people. However, we need to significantly expand this type of support.


### Enablement

Enablement services are provided to respond intensively for a short period of time to help a person get back their independence or to make significant steps towards being as independent as possible. They can help with physical problems, such as after an accident or illness when a person might need help getting out of bed, washing, dressing and so on. They can also help people suffering from mental-health problems who need an intensive period of support to help them regain their confidence or ability to interact with people and continue with what matters most to them such as work, study or family life. Help could also include aids, equipment and telecare. These services are available for a specific period of time, which can vary from a few days to a number of weeks.

- For several years we have provided telecare services to people we believe could benefit from them. For most people this involves using personal alarms that are triggered when help is needed (for example, after a fall, the bath being overfilled or the gas being left on). Telecare is an area of continual innovation and we need to do more to make sure we are making best use of the new technology becoming available.
- We have also tried to improve our referral, assessment and review practice to increase opportunities to make the most of a person's independence at every stage that we have contact with them. Rather than expecting a person to go on needing the same level of support for the rest of their lives, we are encouraging our staff to consider ways to reduce people's reliance on formal care and support. However, there is much more that we want to do.

### How we want things to be in the future

By 2021 we want to have the systems and culture in place so that everyone we come into contact with is helped to be as independent as possible and this will be an ongoing process.

The starting point for all assessments will be to consider, with the person and any carers, what their specific goals are, what is important to them and what they would like to be doing that they cannot do at the moment. The above approach is supported by the Care Act which puts a person's well-being at the heart of the assessment. We will encourage people to make the best use of support from their own community, including voluntary organisations, as explained in the chapter on Promoting well-being.

Having considered what is important to someone, we will work with them to help them be as independent as possible and reduce, where possible, the need to rely on the formal care sector. Clearly there will be some people who do need ongoing support and we will provide this when needed (see the section on Supporting independence), but we will provide much more short-term support for people at the crucial points when this is needed.

Care and support, whether it is only short term or ongoing, will be co-ordinated from the 'community hub' (see box on page 15). The hubs will provide access to equipment and assistive technology. We will look to combine occupational therapy services we and the NHS provide to improve access and remove the risk of duplication and variation in assessments and services. We will continue to develop the use of more sophisticated telecare and other technology and will work with professional organisations to increase the range of equipment on offer.

We will work on the basis that 'your own bed is best', and that in most cases people are more comfortable in their own homes and so recover and get their independence back more quickly if they can receive good-quality therapeutic support at home. If we get this right, it will reduce unnecessary stays in hospital and allow people to leave hospital as soon as they are medically fit to do so.

We will not just try to increase independence when we are first in contact with a person. At every opportunity we will see if there is more that we can do. For example, we might provide a person with a learning disability a support worker to help them learn the route to work so they can get to work on their own. We will not assume that this support will be needed forever and will regularly review whether it is still needed.

While continuing to review the support we provide in this way, we will also be sensitive to the fact that people need some certainty about the help they will be given. Because of this, we will make it clear that, while the aim of any support is to encourage independence and that some support might be short-term, it can also be increased when needed.

Case Study

## Ben's story: Promoting independence in the future

Ben is 23 and lives with his parents who are in their 60s. He has always lived with them and not had any experience of living alone.

Ben has fragile x syndrome (a genetic disorder linked to the x chromosome – one of the most common forms of inherited learning disability). He also has epilepsy, which is fairly well controlled with medication. Fragile x syndrome affects Ben in several ways.

- Attention deficit disorder and hyperactivity have affected his ability to learn and retain information
- He can make himself understood but he gets very irritable quickly and this sometimes leads to aggressive and inappropriate behaviour
- He can travel on his own on some simple routes but easily gets lost if he doesn't know the route well.

Ben went to a special school until he was 19 and later a local college until age 21 where he was well-supported by the Additional Needs Unit in the college. He managed to get a certificate in basic computing and also gardening which is something he really enjoys.

He went to college for three days a week, and on the other two days he used some of his personal budget to pay for a support worker to go with him to a local garden centre where he carried out work experience. For the last six months of his college course he walked to the garden centre himself and stayed there on his own without his support worker. He was helped to do this by having a GPS locater on his wrist which would alert certain people if he got lost on the journey to and from the garden centre.

Towards the end of his time at college several meetings were held with Ben, his family and the main professionals involved. Ben got a part-time paid job at the garden centre. He used his personal budget for short-term support from a support worker, who also helped him when he had to learn new tasks and went with him to a local club for all abilities on Saturdays. He has made friends at work and now calls on his support worker less and less.

Ben has recently said he would like to live with friends in his own flat. He and his parents are also keen that he moves into his own place. Jane is finding it increasingly tiring supporting Ben and she doesn't like to leave him alone in the house for more than about an hour.

Ben and his family have started to look at options for independent living, including living in a shared house with other people with learning disabilities and on-site support if needed. He is spending short periods in one of these units to see how he gets on, which gives his parents a break. He has also gained new skills through support from the Kent Pathways Service.

As a result of the support being offered to Ben, his mum's situation as a carer has been helped. Jane has been given a personal budget and can use this for a monthly trip to a local spa which helps ease the stress of caring. She has also joined a local carers' support group.

# 8. Supporting independence

### Providing effective ongoing support

Supporting independence is the final part of our strategic approach to adult social care and is aimed at those who need ongoing care, whether at home or in a residential setting. It allows people to live in their own homes where possible, stay connected to their communities and avoid unnecessary stays in hospitals or care homes. Supporting independence is delivered though services that aim to maintain individual well-being and self-sufficiency, keep people safe and allow people to live and be treated with dignity.

### How things are today

We have a health and care system that is not responsive enough. This can unintentionally lead to people becoming dependent on services, which does not always lead to the best outcomes for them.

- The system is not always flexible enough to respond to changing needs, which can result in providing too much or not enough care.
- In spite of the progress on joining up health and social-care services across Kent, there are still areas where duplication of services could be avoided, more information could be shared and services could be better designed to provide more effective care.
- We need greater choice and availability of other accommodation options rather than long-term residential and nursing care. We need to work with partners to develop other options such as Extra Care housing and specialist accommodation for people who have dementia.

- Young people with disabilities and ongoing care needs can experience a jump between children's and adults' services as they grow up. We have started to manage this by bringing together our services for disabled children and adults, but there is more to do.


We are developing new models to provide more independent living options in the community, including **Your Life Your Home** which aims to move adults with learning disabilities out of residential care, and **Shared Lives** which provides support placements for adults with care and support needs within a family home. At the moment these new models are helping a small number of people with ongoing care needs.

- Currently we spend about £7million a year jointly with the NHS to provide support for carers whose health and well-being is affected by their caring responsibilities. The assessments and services provided are good quality but there are long waiting lists for some support such as sitting services to provide respite (a break from caring).

### How we want things to be in the future

By joining together health and social-care services in Kent, people who need ongoing care will receive personalised care and support that is focused on helping them achieve the outcomes that are important to them. More people will receive care in their communities or, wherever possible, in their own homes.

Only people who need the most intense and specialist care will be admitted to hospital or residential care, and the emphasis will be on moving people back to the community if they are able to. For those people who do need to live in residential accommodation (which includes group homes, care homes, Extra Care housing and other types of residential accommodation), ongoing care will be designed, paid for and delivered to keep them as independent as possible.

People will receive all of their health and social care from one 'community hub' linked to their GP surgery (see page 15). This means people will have quick, co-ordinated access to a wide range of services close to or at home. Working with the person and their carer, all the professionals who are involved in providing care to the person will assess their needs and share their records meaning there will be no duplication or gaps and the person's mental capacity will be taken into account (following the Mental Capacity Act). (Mental capacity deals with a person's ability to make decisions for themselves. The law says that a person may lose their right to make decisions if this is in their best interests.)

People with more intense and complicated ongoing needs will have one professional who will lead on coordinating their care and build a team of support for the person. They will be the first point of contact for them and their carers. Information, advice and guidance will be available at the right time for everyone to support people in making decisions about their care.

The services provided in the 'community hub' will be flexible enough to adapt to a person's changing needs immediately and step up or step down the intensity of care they are receiving. Services will also be able to work together to identify people who might be at risk of becoming more unwell and offer support before a problem happens. All the organisations involved in providing care and support will be spending their money with the aim of achieving the same outcomes, improving the care we are able to provide to people with ongoing needs.

Bringing health and social care together will mean that people will be able to access a joint health and social-care personal budget where appropriate, giving them choice and control over all of their care. People will be supported to get the best use from their personal budgets to meet their needs. There will be a wide range of quality care and support services for people to choose from.

For young people with ongoing care and support needs, services will be as smooth as possible as the person moves from being a child to an adult, so there will be no need for specific support over that period. For example, throughout their life, people with autism and attention deficit hyperactivity disorder (ADHD) will be cared for and supported along the right pathway that is understood and followed by all the services involved. This will bring together psychological, social and medical assessment and support so the person receives care that meets all of their needs and is consistent as they move from childhood to adulthood.

If people need care at home to help them with daily living, this will be focused around supporting the person to achieve the outcomes that are important to them, rather than being based on specific tasks. Over the next five years we will develop more home care that is nurse-led. This will bring together nurses from the NHS with the home-care providers we pay to provide services. This means that people will receive homecare that responds to their needs for social care and health care and can provide specialist care at home.

We will routinely use technology to help keep people safe and maintain their health and well-being at home. This includes telehealth, which allows medical professionals to remotely monitor a person's vital health signs including blood pressure and blood sugar, and telecare. We will continue to work with our providers to identify and, where helpful, put into place cutting-edge assistive technology. We will also make better use of technology to help people keep in touch with loved ones and stay connected with their community and the things that matter to them.

The aim is for fewer people to live in residential or nursing homes because there will be an improved choice of accommodation options that allows people with ongoing care needs to have their own homes. We will work with our partners, including district councils, to arrange accommodation in the right areas. There will be specially designed housing to meet the needs of people with ongoing care including people with mental-health problems, learning disabilities, physical disabilities and autism. Housing options will be available for young people to support them through the move into adult life and independence. We also hope to increase the amount of Extra Care housing available. Accommodation will have assistive technology built in, which uses telehealth and telecare. Options like Shared Lives will continue to be developed and will be available across the county where this best meets the needs of the person.

More people with ongoing care and support needs will stay in or enter education, training and employment. We will support people with disabilities and mental-health problems to find and maintain suitable and fulfilling education, training and employment. This is important to people's well-being and can help people keep or regain their independence and improve their health. The support we provide will be tailored according to the person's goals, strengths and situation. For people with ongoing mental-health problems, supported employment or education will be linked to their clinical treatment to support their recovery.

People with ongoing care needs will be able to access a range of activities in their local community to keep them active and doing things they enjoy. We will have a new model for day-care services that provides activities and opportunities that people with ongoing care needs want and that is of consistent quality across the county. We will work with providers, including in the voluntary and community sector, to build and maintain the market so people can access the day activities they want, when and where they want them.

For people who need to be in residential care, services from the community will go into care and nursing homes to provide specialist support to residents and to help staff develop skills and confidence. This will include enablement and rehabilitative care services and nurse-led home-care services coming into care homes and using assistive technology. The 'community hubs' will also aim to promote activity that involves care-home residents in their local communities.

### Extra care housing

Extra Care housing is designed for people who need care and support to help them live their daily lives. People who live in Extra Care housing have their own homes with their own front doors. Homes are usually provided as a block of flats or houses built together. Support such as personal care and help around the home is available from on-site staff. Extra Care housing usually includes facilities for people who live there, for example, a restaurant and health and fitness facilities.

Case Study

**Anita's story:**
**Supporting independence in the future**

Anita is 54 with a degree in French. She was born with cerebral palsy and uses a walking frame to get around. Later in life she has developed diabetes, and over the last year has had to stay in hospital frequently. Anita needs support with daily living, including her personal care, cooking and help around the house. Up until recently she has been able to manage living on her own in her own home with daily visits from a home-care worker. However, she has started to struggle being on her own in the house between homecare visits and is in need of some further adaptations to her house. She also now needs support a couple of times a day to help manage her medication and monitor her blood-sugar levels.

As Anita has complex ongoing conditions, she has been allocated a care co-ordinator (one person leading the planning, working with others) from the community hub that is responsible for Anita's care and support. Anita's care co-ordinator, James, meets with Anita to understand what is important to her, how she would like to live her life and the goals she would like to achieve. James has access to all of the assessments and records that the different health, mental-health and social-care professionals who have been involved in Anita's care and support have made. Based on this and what Anita has told him about what she wants, James brings together a team of health and social-care professionals with the right skills to support Anita including her GP, her community nurse with diabetes specialism, home-care worker and occupational therapist. Together they create a plan for Anita's care and support.

It is important to Anita that she has her own home with her own front door that she can stay in for the foreseeable future, but she also now needs a higher level of support. She is offered a home in a new Extra Care housing development that has just been built in her town. The on-site staff have caring and basic nursing skills and so can help Anita with her medication. Her new flat is completely accessible for her walking frame and a wheelchair. Telecare sensors are already installed that help to keep Anita safe while she is on her own in the flat, and she wears an alarm that she can press to call the on-site staff for help in an emergency. The flat also comes with telehealth technology, which Anita uses to monitor her blood sugar and send this information to her nurse and GP so they can help her manage her blood sugar levels and act quickly if there are any problems.

James and the team of professionals continue to monitor Anita and adapt her care and support plan as needed. If Anita needs some medical treatment, this is planned and all of the team know so they can arrange any extra support she might need afterwards. Anita now feels that she has regained her independence and feels confident that she has the support she needs to keep safe and well. Since moving to her new home and the start of her new care and support plan, Anita has only had to stay in hospital in an emergency once, which is a huge improvement.

## 9. Supporting carers

We recognise that the vast majority of care is provided by relatives and friends. Making sure those carers are supported in their role is a critically important part of this strategy as supporting carers is the most effective way of achieving our overall vision – so people can improve or maintain their well-being and live as independently as possible.

We will continue to work with carers' organisations in Kent to help identify and assess carers who could benefit from support.

Over the next five years we will work with carers to develop a new set of services and support for them. The new services will provide support for carers in all areas of their life that are affected by their caring responsibilities, helping them to achieve the things that are important to them. This should allow them to continue their caring role and also protect their own health and well-being, something which the Care Act puts at the very centre of care and support. This will also apply to carers who care for someone who is not receiving formal care and support.

We will continue to expand the use of personal budgets for carers of people with ongoing support needs. This will allow carers to choose and control the support they receive to best meet their needs and preferences.

We will also help carers by providing the right sort of support for the person or people they care for. Support for carers will be part of the community-hub model described earlier, meaning that they are fully joined up with all of the care and support that the person they care for is receiving. This will allow information to be shared and support managed together for the person with ongoing care needs and their carer, leading to better care for both.

The team of professionals involved in providing care will respect and value the skills, knowledge and commitment of carers of people who need ongoing care.

# 10. Building blocks

To deliver the vision and strategy there are important building blocks that must be in place. These are shown below.

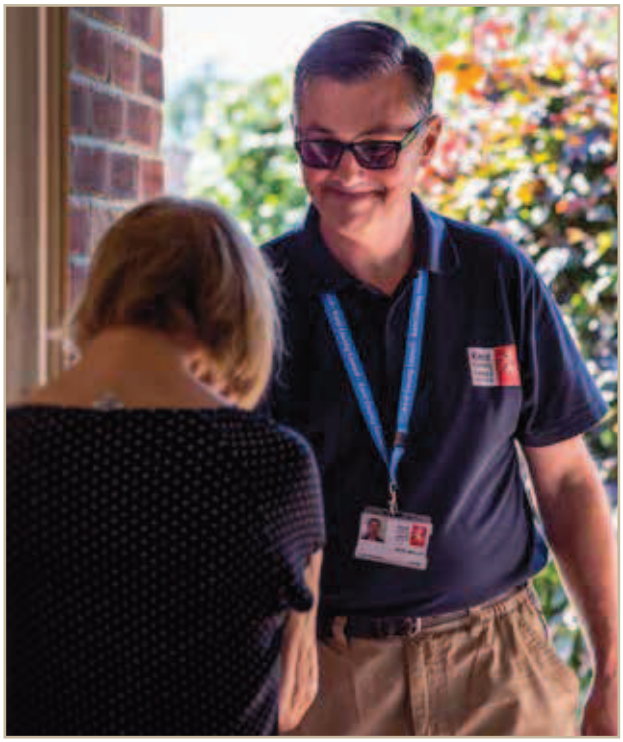
- Protection (safeguarding)
- Workforce
- Commissioning
- Integration and partnership

**Protection (Safeguarding)**
We have no greater duty than to help people exercise their right to live safely and we take our legal responsibilities in this area seriously. In carrying out our safeguarding duties, we aim to stop abuse or neglect wherever possible; prevent harm and reduce risk of it happening and allow adults at risk to have choice and control in how they live their lives. It is part of our main business to work with other partners to take necessary action to protect adults who may be at risk of abuse or neglect, whether they live in their own homes or in care homes. We consider our protection and mental capacity responsibilities as one of the building blocks or foundations which form the backbone of our vision and the strategy.

It is important that our protection work puts the outcomes a person wants at the centre of our action and, where possible, we take action before a vulnerable person is harmed. This approach is in line with the principles of the national guidance on 'making safeguarding personal'. We know that taking effective action works best where we work with communities in helping to prevent or report incidents of abuse or neglect.

As a member organisation of the Safeguarding Adults Board, we will continue to promote the principles that rightly govern how protection should be treated and carried out.

- It is every adult's right to live free from abuse in line with the principles of respect, dignity, autonomy (being able to control their own actions), privacy and equity (fairness).
- All agencies and services should make sure that their own policies and procedures make it clear that they have a zero tolerance of abuse. In other words, they will not put up with it at all.
- We will give priority to preventing abuse by raising the awareness of adult-protection issues and by fostering a culture of good practice by providing support and care, commissioning and contracting.
- Adults who are vulnerable or subjected to abuse or mistreatment will receive the highest priority for assessment and support services.



To continue to do this work well, we need to have competent and confident social-work staff who have the necessary skills and tools to do their jobs. Importantly, it will be expected that staff use an 'asset-based' approach, which is focused on what people can do, to identify the person's strengths and use meaningful community networks that can help them and their family in making difficult decisions and managing complicated situations.

We also recognise that we share these protection responsibilities with other partners – providers, the NHS, the police and the community in general. To this end we will work to make sure that the collective roles and

responsibilities are clear and continue to build on the already strong multi-agency framework in place for protecting vulnerable people. This means not only promoting strong multi-agency partnership working but also making sure we provide a supportive learning environment. By doing so we aim to break down cultures that are afraid of risk and clarify how we will tackle responses to protection concerns from poor-quality care or inadequacy of services and issues of safety of the person.

### Workforce

Without the right health and social-care workforce, we cannot deliver anything in this strategy. The Kent social-care market employs over 40,000 staff, most of whom are employed by private, voluntary and independent sector providers. The workforce needs to be appropriately skilled and competent to meet local needs, be sustainable and flexible. Staff will need to put outcomes for people first, and their performance will be assessed against this rather than a task-based approach.

Delivering tailored care that focuses on supporting people to achieve their outcomes will involve some changes to the skills, working practices and culture of the social-care workforce. We will make sure our staff and staff in partner organisations have the skills and knowledge needed so that people can have as much choice and control as possible. The emphasis will be on what works best to meet a person's outcomes, rather than what services are available that we can fit a person into. So we will encourage staff to be imaginative in the solutions they develop. People who provide care will take a new and creative approach in supporting people to maintain their independence. This will include the ability to design services alongside those receiving them and others involved in providing services. It also involves a sophisticated understanding of people's right to choose to take risks so they can lead the lives they want.

Currently, the social-care sector is experiencing many challenges – one in five social-care workers is aged 55 or over, each year there is a high turnover of staff in some roles and recruitment and retention can be difficult particularly in some areas of Kent. Given this pressure, levels of training, skills and status are falling compared with other professions. We need to give more attention to the kind of job roles available and how career pathways are designed to meet the changing needs of the service, and the people it will help and serve.

Social care and health will increasingly work together so staff will need to work across organisational boundaries, which will help reduce current duplication in assessments and other activities. We will need to support changes in culture so we can achieve this and support staff to make the best use of digital technology to share information between partners and as a tool for those receiving social care. If the team is to work as one, the planning and management of the workforce needs to take a whole-system approach. We are working with the NHS on developing our workforce to be ready for the future, and some of our agreed priorities include the following:

- Existing and emerging gaps – identifying where we currently have a shortfall in the workforce we need and where we are likely to have a shortfall in the future, including succession planning (finding and developing people with potential to move

into important roles in organisations)
- New models of care – making sure that, as new ways of delivering services are developed, the right workforce will be available to deliver them
- Recruitment and retention – making sure that Kent can recruit the people it needs and, once it has done so, keep hold of them.
- All this will need a shift towards focusing on the skills needed by a given workforce rather than how many of a particular staff group are needed. Care and health professionals will work as a team with colleagues from a range of other organisations and sectors as equals. Where appropriate they will take a co-ordinating role, managing the contributions of a range of professionals to meet a person's needs. We will develop specialist roles where needed and they will play an important part in the care and support team for people with complex ongoing needs.

To achieve this, we must treat the health and care workforce as one. We have already begun this process and examples include integrated discharge teams in all Kent and Medway hospitals to support roles that bring together health-and-social-care skills, joined-up working and a better career path. We have also introduced nurse-led outcome-based domiciliary care in a group of GP practices in Whitstable (Vanguard). These practices use new models of care which offer a more attractive career path for domiciliary care workers and blended roles with health-care assistants. This will also provide opportunities to train professionals who have traditionally worked in either social care or health so that they can meet all of the ongoing social-care and health needs of the people they care for in their own homes. This could include training home-care workers and carers to carry out medical procedures such as giving insulin injections to people who would otherwise also need a daily visit from a nurse.

We are using analysis of long-term hard-to-recruit professions to help us plan future care so that we move away from relying on locums or overstretching the current workforce. We are currently developing a strategic workforce action plan for health and social care together.

### Commissioning

Driving our strategy forward is a new approach to commissioning – in other words, deciding what kinds of services should be provided to local populations, who should provide them and how they should be paid for. Traditional commissioning often involved paying for certain activities to be carried out by a provider and this left little room for the specific needs of an individual to be taken into account. An outcome-based approach identifies what outcomes matter most, and payment to providers depends on achieving the outcomes and is not simply based on activities. Under this model, there is an incentive for different providers across health and social care to work together to achieve outcomes. Prevention activities are also given a clearer priority than is currently the case.

As we move towards becoming a commissioning authority, we will be in a good position to adopt this model, and will do so by working with the NHS. Clinical commissioning groups and NHS England are also shifting their approach to commissioning to an outcome-based approach. When this is done jointly, the entire assets of a community or neighbourhood can be considered and made best use of. Where a good community network or organisation exists and can contribute to achieving the outcomes of this vision, it will be able to play its part and benefit from this approach. This could be from the voluntary or community sector, or from a wider range of providers and public-sector organisations than currently delivers services for health and care. We recognise that making the shift from the current way of working to the future outcome-based commissioning approach will be a challenge for commissioners and all providers. It will also involve having appropriate IT systems in place, capturing and analysing information and tracking and monitoring quality.

In many cases, as direct payments and personal health budgets continue to develop, the person will be able to choose which services are provided.

Focusing on outcomes means that we, as commissioners, will have better information as to what does and doesn't work. This will mean that services improve steadily over time as further investment is directed to those services that work and away from those that do not contribute to the outcomes. Our role as commissioners will be to see how the market is delivering and decide how best to tackle any gaps in quality. This will support us in fulfilling our market-shaping responsibilities (market-sharing responsibilities are where we look at what care and support needs people have in the local area and consider what services are available – working out where there are any gaps and how they can be filled) under the Care Act.

The changes planned mean that we will need to develop new and effective ways of monitoring and managing contracts to achieve the best value for money from the resources we have available. The changes may include looking at new commissioning arrangements across both health and social care.

Increasingly our commissioning will be led by 'care pathways' for defined groups of users with similar characteristics and needs, for example young adults with long-term care needs or older people with dementia. We will be clear on our overall commissioning responsibilities and approaches, which consider the needs of the whole population, and which are different from place-based commissioning to meet local needs.

### Integration and partnerships

Kent has a good track record of health and care working together in partnership. It was one of the original 14 Integration Pioneers named in 2013 and this has continued through the Better Care Fund and the current Sustainability and Transformation Plans (STPs) which are to be the plans for delivering the NHS Five Year Forward View. The Five Year Forward View and the STPs give a name and framework to what Kent had already been moving towards. This involves approaching the health and care of the population as a whole system and breaking down barriers between sectors and organisations where they get in the way of better care and support.

This shift is necessary both to deliver the quality of care we want to see the people of Kent receive, but also making sure that the finances of health and social care are secure. In spite of this strong track record of partnership working, there are some barriers that we must work hard to overcome, such as a lack of common language and shared priorities, multiple IT systems, different performance frameworks and budget cycles. These all combine to make what we want to achieve more difficult at the current time.

Our vision for adult social care is built on existing work with social-care professionals, clinicians, carers, the public, and other partners in developing possible new models of care for the future. As a result, our visions is part of the broader process of joining up health and social care.

The new approach to commissioning is helping to develop a number of new models of care in Kent as set out in the Five Year Forward View. Particularly relevant to this vision for social care is the development of multi-specialty community providers (MCPs). These MCPs bring together GPs, nurses, other community-health staff, social-care, mental-health and acute hospital staff and services together to create fully integrated out-of-hospital care. At the heart of this are the 'community hubs' already discussed.

To deliver our ambition to work more with NHS services to provide smooth care and support will mean we need to overcome some substantial challenges including:

- finding the money to invest in the changes, including creating the 'community hubs';
- sharing information, which is vital for

high-quality, integrated care, but must be carefully managed in ways that keep to the Data Protection Act 1998 and various other laws;
- finding incentives and targets that work across health and social care, given the different audit systems and payment models which can result in conflicting interests, and problems in agreeing how evaluation will be measured; and
- differing workforce practices. These range from different employment terms and conditions through to different organisational cultures and attitudes.

We will work through these challenges with our NHS colleagues and we will work together on effectively planning for and managing our buildings (including through One Public Estate). For example, delivering services out of hospital that would have previously been delivered in hospital will need access to digital technology to support remote consultation, diagnostics and virtual multi-disciplinary teams (remote consultation is when professionals give advice about a person's care and treatment without the need for a face-to-face visit. A virtual multi-disciplinary team is a group of staff who are members of different professions work from different locations and who each provide specific services to the person.)

Private and voluntary-sector organisations that provide social care and support will need to work more flexibly in future, putting the needs and outcomes of the people they support at the centre of their services. To support this approach, our contracts with providers of care will be focused on outcomes. We will ask providers of services, including homecare, to show how they are helping to achieve outcomes for the people they care for (for example, to help a person regain their independence following an operation, or to reduce social isolation), and we will reward them as a result. This is in contrast to many current contracts that reward providers according to the time spent with a person and the tasks carried out. As a result, partners will

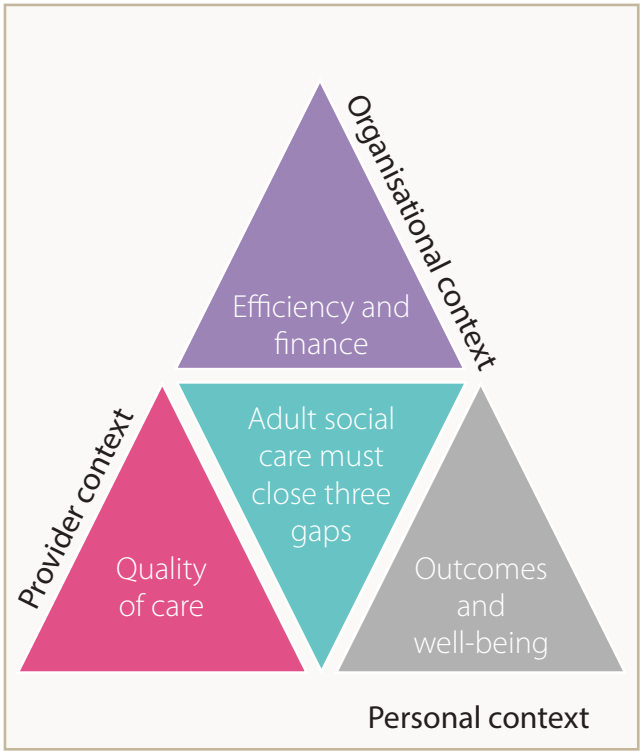
need to be flexible and responsive enough to meet the challenge of working with commissioners, and being commissioned on an outcomes-focused basis.

We will work with providers to increase and maintain the market in areas where we need greater choice and availability of services for people with ongoing care needs. This will include community activities and opportunities to help people keep active and involved in things they care about and enjoy. Working with providers, there will be an improved range of accommodation options to allow people to continue to live in the community including Extra Care and supported housing to meet specialist needs.

We will continue to work with the voluntary and community sector who will play an even more significant role in supporting people's independence. We will continue to support the sector so it can cope with the changing and increasing demands for care and support in the communities that it works with. We will encourage new enterprises (for example, befriending schemes) and work with existing organisations to help them work in new areas (for example, Neighbourhood Watch schemes, allotment societies and so on).

# 11. Monitoring our performance

As explained in the Introduction, this strategy explains our vision for adult social care over the next five years and we will set out the full details of how it will be delivered in an implementation plan which we are developing for this strategy. It is important that we understand the difference that we are making through delivering the vision and strategy. Our success will be measured by how well we manage to close the three important gaps that are central to everything that we do.




We will monitor performance by looking at outcomes. This will include existing methods for monitoring performance plus the experience of people who use our services, including using the following:

- Measures of success – a one-page activity, finance and performance information report used by adult social-care managers on a monthly basis to keep track of progress
- Progress on transformation programme – a report produced for the Adults Portfolio Board and our members to account for progress against the priorities in the transformation implementation plan already mentioned
- Local Account – an annual public report of how well adult social care is doing, produced with people who use our services and their carers, main partners and staff
- Corporate & Directorate performance management – a wide-ranging report for our members and senior management produced on a regular basis which the public have access to
- User surveys – surveys of people who use our services, and their carers, in their views on outcomes and experience of services
- Deep dives – an in-depth examination of the main service areas with the aim of improving service delivery
- CQC – service quality and other information put together by the Care Quality Commission, the independent regulator of health and social-care services
- KCC Strategic Statement Annual Report – an annual report on adult social care's contribution to achieving our strategic objectives which is produced with input from our partners
- Health and Well-being Board – a report on adult social care's contribution to the progress on outcomes in the Joint Kent Health and Well-being Strategy and this strategy.

Kent County Council
Social Care, Health and Well-being
Invicta House
County Hall
Maidstone
Kent
ME14 1XX

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Text relay: 18001 03000 421553 for details or email alternativeformats@kent.gov.uk



29/9/16 PJ

| **Communities, Housing & Environment Committee** | **18 October 2016** |
|---|---|
| Is the final decision on the recommendations in this report to be made at this meeting? | **Yes** |

# MBC Safeguarding Policy for Children & Vulnerable Adults

| | |
|---|---|
| **Final Decision-Maker** | Communities, Housing & Environment Committee |
| **Lead Head of Service** | John Littlemore, Head of Housing and Community Services |
| **Lead Officer and Report Author** | Matt Roberts, Community Partnerships & Resilience Manager |
| **Classification** | Non-exempt |
| **Wards affected** | All |

**This report makes the following recommendations to this Committee:**

1. That the Committee adopts the safeguarding policy to be used by the Council and gives delegated authority to the Head of Housing & Community Services to make any necessary operational amendments in consultation with the Chairman and Vice Chairman of the Communities, Housing and Environmental Committee.
2. That the Committee approve the formation of the MBC Safeguarding Forum which will oversee the implementation of the policy and be responsible for reviewing it on an annual basis to ensure that changes in legislation or working practices are included.
3. That the Committee requests that the Head of Housing & Community Services reports back to a future meeting on the training that should be undertaken by Councillors and takes this opportunity to refresh the training assessment for officers and report back on the appointment of Designated Officers within relevant teams.
4. That the Committee appoints a Member Safeguarding Champion.

**This report relates to the following corporate priorities:**

- Keeping Maidstone Borough an attractive place for all – By ensuring that all staff, contractors and elected Members understand the Council's Safeguarding obligations, children and vulnerable adults who are at risk harm can be referred to the appropriate agencies. Also has a positive impact on helping to reduce crime and anti-social behaviour.

| **Timetable** | |
|---|---|
| ***Meeting*** | ***Date*** |
| Communities, Housing and Environment Committee | 18 October 2016 |

# MBC Safeguarding Policy for Children & Vulnerable Adults

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Maidstone Borough Council has a statutory and moral responsibility to safeguard those at risk of harm. This policy has been written to give staff, contractors and elected Members guidance around relevant legislation, signs and types of abuse and what to do next to refer the concern to the most appropriate agency so that the subject of concern can receive suitable help.

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## 2. INTRODUCTION AND BACKGROUND

2.1 In October 2015 the Mid Kent Audit team undertook a review of MBC's safeguarding arrangements, whilst they found the Council is satisfying its statutory obligations and had no immediate concerns to report they gave the controls a 'weak' rating, stating that; 'further improvements are needed to provide greater resilience to these arrangements and to ensure safeguarding risks are being adequately managed'.

2.2 This policy will be made available to staff along with relevant training provided on the basis of the level of contact with members of the public or whether the member of staff will be acting as a 'Designated Officer' and will be supporting their teams in discharging their safeguarding duties.

2.3 Safeguarding training will be provided on three levels, the majority of training will be provided through online training provided to all staff.

2.4 Staff coming into regular contact with the children and vulnerable members of the public will receive a half day, classroom based training session. A second training session will be provided on Child Sexual Exploitation (CSE).

2.5 Designated Officers will receive a half day training session on how to act in an advisory capacity to help colleagues to assess and suitably refer any safeguarding concerns identified but will also be expected to take a further training session on thresholds for referrals, this training will be provided through the Kent Safeguarding Children's Board (KSCB).

2.6 It is proposed that a Safeguarding Forum be created to oversee Maidstone Borough Council's safeguarding policy and practice. This group will include managers from Kent County Council's Early Help & Preventative Services, Specialist Children's Services and Adult Social Care. The Forum will provide a platform to share best practice, learning and allow for discussion on new legislation and how all organisations can work to better safeguard children and vulnerable adults.

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## 3. AVAILABLE OPTIONS

3.1 Option one: Do nothing: this is not recommended as the current safeguarding policy is out of date and does not reflect changes in legislation and best practice.

3.2 Option two: Adopt this policy subject to amendments that may need to be made, such as inclusion of a list of Designated Officers and finalised terms of reference for the Safeguarding Forum once it has been agreed and approved by its members. Adopting this policy would also mean approving the delivery of training once an assessment of the levels of training required.

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## 4. PREFERRED OPTION AND REASONS FOR RECOMMENDATIONS

4.1 Option two is the preferred option. If the Council does not provide staff with a policy which captures legislative changes and current best practice then the organisation will not be able to adequately discharge its duties.

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## 5. NEXT STEPS: COMMUNICATION AND IMPLEMENTATION OF THE DECISION

5.1 An assessment of the level of training for every councillor to be combined with a refresh of the existing officer training programme. This was completed a year ago but within that time new members of staff have joined the organisation and some existing staff have changed job roles.

5.2 The Policy and further information on safeguarding should be made available via the Council's Intranet. Ideally this should include a referral system so that all concerns raised can be centrally logged and recorded.

5.3 Maidstone Borough Council's Safeguarding Forum will be set up, meetings to be arranged on a quarterly basis.

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## 6. CROSS-CUTTING ISSUES AND IMPLICATIONS

| Issue | Implications | Sign-off |
|---|---|---|
| **Impact on Corporate Priorities** | This policy will contribute to keeping Maidstone Borough an attractive place for all – By ensuring that all staff, contractors and elected Members understand the Council's Safeguarding obligations, children and vulnerable adults who are at risk harm can be referred to the appropriate agencies. | Head of Housing & Community Services |

| | | |
|---|---|---|
| **Risk Management** | The adopted policy will contribute to reducing the risk of the Council failing to achieve the standard of safeguarding required. | |
| **Financial** | There are no financial implications in this report. | |
| **Staffing** | Contained within the report. | |
| **Legal** | Assuming that the Council discharges its duties adequately there would not be any legal implications | |
| **Equality Impact Needs Assessment** | | |
| **Environmental/Sustainable Development** | | |
| **Community Safety** | The policy supports the key priority identified by the Safer Maidstone Partnership's Plan under Community Resilience. | |
| **Human Rights Act** | | |
| **Procurement** | | |
| **Asset Management** | | |

## 7. REPORT APPENDICES

The following documents are to be published with this report and form part of the report:

- Appendix A: MBC Safeguarding Policy for Children & Vulnerable Adults

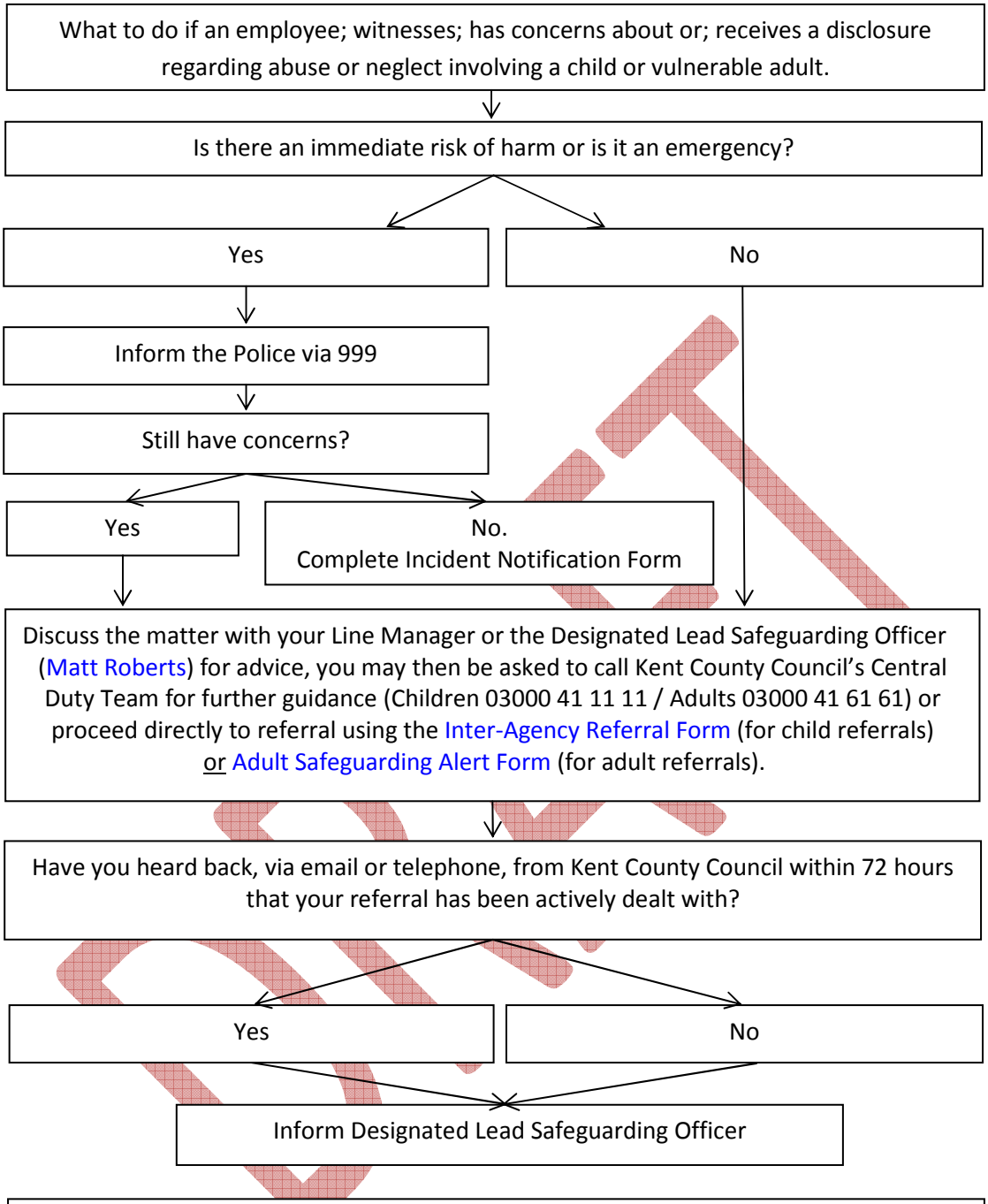
# Maidstone Borough Council

# Safeguarding Policy
# For Children and Vulnerable Adults'

| | |
|---|---|
| Document Purpose | Guidance |
| Document Name | Children and Vulnerable Adult' Safeguarding Policy |
| Author | Matt Roberts, Lead Designated Safeguarding Officer |
| Publication Date | TBC |
| Target Audience | All staff and Members |
| Additional Circulation List | Contractors & commissioned services |
| Description | This document sets out the requirements for Maidstone Borough Council to discharge its appropriate accountability for Safeguarding children, young people and vulnerable adults. |
| Cross Reference | This documents should be read alongside;<br>MBC Recruitment Guidance,<br>Whistleblowing Charter,<br>Disciplinary Procedures |
| Action Required | Read and embed Policy into normal practice |
| Contact Details | Matt Roberts |
| Version Control | Version 1.0 (October 2016) |

## Forward by Member Safeguarding Champion

# Quick View Referral Procedure




Chase via centraldutyteam@kent.gcsx.gov.uk (or the relevant Case Management Team if it is an adult referral and the adult is already known to services) via your own secure email until confirmation that Kent County Council has considered the referral has been received.

The onus is on you, as the referring officer, to ensure that Maidstone Borough Council fulfils its statutory obligation to receive confirmation from Kent County Council that they have actively considered your referral.

If you are concerned over Kent County Council's proposed course of action please refer to section 6.

## Contents

# 1. POLICY STATEMENT & FRAMEWORK

1.1 As a public body, Maidstone Borough Council expects high standards of conduct from all of its employees and councillors, in line with the key principles of the constitution. Maidstone Borough Council aspires to the highest standards of excellence and professionalism in the people it employs, the education, training and development they receive and in the leadership and management of the organisation.

1.2 This policy sets out Maidstone Borough Council's (MBC) commitment and intent towards its statutory and moral duties to safeguard children and vulnerable adults who come into contact with its services and activities.

1.3 It identifies how MBC staff, councillors and in our commissioned services must operate at both a strategic and operational level. It is important to understand that;

***'Safeguarding is everyone's responsibility'***

1.4 Which means that whether you are a permanent member of staff, on a temporary contract, are a casual or agency worker, volunteer, contractor or an elected Member, everyone carrying out the business of MBC has the same duty to report any witnessed or suspected concerns of abuse or neglect.

1.5 This policy sets out the procedures that must be followed to report a suspicion or allegation to Kent County Council (Specialist Children's Services / Adult Care and Support Service) and to meet Maidstone Borough Council's responsibility to ensure that such referrals are actively considered by Kent County Council.

1.6 Maidstone Borough Council also supports the Home Office Counter Terrorism strategy CONTEST, which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Throughout this document safeguarding children, young people and adults at risk includes those at risk of becoming radicalised.

## 1.7 The safeguarding children & young people

1.8 **The Children Act 1989** (as amended) states that every child has a right to protection from abuse, neglect and exploitation. Statutory guidance on making arrangements to safeguard and promote the welfare of children under the **Children Act 2004** was published in August 2005. The guidance came into force on 1 October 2005. Maidstone Borough Council's duties under the Act are:

1.9 **To co-operate to improve children's wellbeing:** Section 10 of the Act requires each local authority to make arrangements to promote co-operation between the authority, each of the authority's relevant partners and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority's area, which includes protection from harm or neglect.

1.10 **To safeguard and promote the welfare of children:** Section 11 requires a range of organisations (including district councils) to make arrangements for ensuring that their functions, and services provided on their behalf, are discharged with regard to the need to safeguard and promote the welfare of children.

1.11 Expectations on Maidstone Borough Council include:

- Corporate Leadership Team (CLT) commitment to the importance of safeguarding and the promotion of wellbeing.
- A clear statement of responsibility made available to employees and elected Members.
- Clear accountability for work on safeguarding and promoting wellbeing.
- Take the voice of children and young people into account to help shape services.
- Safe recruitment procedures for those coming into contact with children and young people.
- Appropriate training, learning and development for employees.
- Effective working relationships, both within the authority and with other agencies to safeguard and promote wellbeing, and to share information effectively and appropriately.

1.12 Other legislation and guidance relevant to safeguarding includes; The Public Disclosures Act 1998; Working together to safeguard children (2015); No Secrets (2000); The Crime and Disorder Act (1998); The Health and Social Care Act (2008); and the Care Act (2014).

## 1.13 Safeguarding vulnerable adults

1.14 The legal responsibilities for safeguarding adults at risk of abuse or neglect are set out in Part 1 of the Care Act 2014 with Care and Support Statutory Guidance issued in 2014 to support implementation.

1.15 Kent County Council is the lead agency, Maidstone Borough Council is a key partner and has a duty to co-operate in order to protect adults from abuse or neglect. In exercising their duties Kent County Council must:

- **Make Safeguarding Enquiries**: or request others to make them, if an adult is subject to or at risk of abuse or neglect.
- **Establish a Safeguarding Adults Board:** which develops, shares and implements a joint safeguarding strategy
- **Carry out Safeguarding Adult Reviews:** when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Or if an adult has not died, it is known or suspected that the adult has experienced serious abuse or neglect.
- **Arrange an independent advocate:** to represent and support an adult who is subject to a Safeguarding Enquiry or Adult Review
- **Co-operate with its relevant partners:** in order to protect adults experiencing or at risk of abuse or neglect.

1.16 All sectors, including district councils are expected to apply the following six key principles in its adult safeguarding role:

- **Empowerment:** people being supported and encouraged to make their own decisions and be able to give informed consent.
- **Prevention:** it is better and more cost effective to take action before harm occurs.
- **Proportionality:** provide the least intrusive response appropriate to the risk presented.
- **Protection:** support and representation for those in greatest need

- **Partnership:** local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse
- **Accountability:** accountability and transparency in delivering safeguarding

1.17 Safeguarding activity should be person-led and outcome-focused. It is about engaging the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

# 2. DEFINITIONS

## Safeguarding children

2.1 Safeguarding children is defined in the statutory guidance Working Together to Safeguard Children (March 2015) as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes.

2.2 A child is anyone under the age of 18 years. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection.

## Safeguarding vulnerable adults

2.3 Safeguarding adults is defined in Care and Support Statutory Guidance (October 2014) as protecting an adult's right to live in safety, free from abuse and neglect. Under section 42 of the Care Act 2014, safeguarding duties apply to adults who:

- Have needs for care and support (whether or not they are receiving any services); and
- Are experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect

2.4 An adult is anyone aged 18 or over. Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25.

2.5 Care and support needs is the mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent – including older people, people with a disability or long-term illness, people with mental health problems, and carers.

2.6 Care and support includes the assessment of people's needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations.

### Abuse and neglect

2.7 The No Secrets Guidance (March 2000) defines abuse as a violation of an individual's human and civil rights by any other person or persons. Abuse can happen to anyone, regardless of age, gender, class or ethnicity. Abuse may be a single act or repeated over a period of time and affect one person or more. It may take one form or a multiple of forms or follow a pattern of abuse. The lack of appropriate action can also be a form of abuse.

2.8 Neglect is a failure to care for someone with whom you have a responsibility to care for or represent, for example, by failing to provide adequate food, clothing, medical aid or accommodation. It can be a form of abuse if it is intentional, however, not all incidents of neglect are intentional and may be because a care giver is finding it hard to cope or is not receiving sufficient help.

2.9 Self-neglect covers a wide range of behaviour where a person neglects to care for one's own personal hygiene, health or surroundings, this can often have a negative effect on the wider community and sometimes exhibits as anti-social behaviour, while not exhaustive the list includes behaviours such as;

- Obsessive hoarding
- Living in very unclean, sometimes verminous circumstances
- Neglecting household maintenance, thereby creating hazards within and surrounding the property
- Erratic or eccentric behaviour/lifestyles
- Declining or refusing prescribed medication and / or other community healthcare support
- Repeated episodes of anti-social behaviour – either as a victim or perpetrator

2.10 Maidstone Borough Council's Self-Neglect & Hording Procedure was developed following the release of the Kent & Medway Policy in October 2014. To make a referral to the multi-agency self-neglect panel consult with a Designated Safeguarding and complete a SG1 notification form found in Appendix 3.

## 3. ROLES AND ACCOUNTABILITY

3.1 Whilst safeguarding is everyone's responsibility, there are a number of key roles that partner agencies and employees within Maidstone Borough Council hold.

3.2 **Kent County Council:** is the lead authority for safeguarding children and vulnerable adults. The Specialist Children's Services and Adult Care and Support Service are responsible for investigating allegations of abuse and neglect, determining whether it has or has not taken place and taking action to protect the child or vulnerable adult.

3.3 **Kent Safeguarding Children Board:** agrees how different partner agencies should co-operate to safeguard children and has a role in making sure that arrangements work effectively to bring about good outcomes for children.

3.4 **Kent and Medway Safeguarding Adults Board:** makes sure that all member agencies are working together to help keep adults safe from harm and protect their rights.

3.5 **Kent Police:** has a duty to investigate criminal offences and refer any suspicion, allegation or disclosure that a child or vulnerable adult is suffering and likely to suffer significant harm to Kent County Council.

3.6 **Maidstone Borough Council:** The Chief Executive Officer has ultimate accountability for safeguarding; this means ensuring that employees and elected Members comply with the principles contained in this policy and providing assurance that the Council complies with its statutory requirements. The CEO discharges these functions by appointing a Lead Designated Safeguarding Officer (LDSO) In Maidstone Council the LDSO is the Community Partnerships and Resilience Manager.

3.7 **MBC's Designated Lead Safeguarding Officer:** is a senior officer who leads on all safeguarding issues and acts as the child and adult protection professional on behalf of Maidstone Borough Council. Responsibilities include:

- Supports the CEO and Wider Leadership Team to provide strategic direction for the safeguarding agenda including the protection of child and vulnerable adults
- Championing the importance of safeguarding and promoting the welfare of children and vulnerable adults throughout Maidstone Borough Council
- Ensuring compliance with legislation including that contained within section 11 of the Children Act 2004, Part 1 of the Care Act 2014 and government guidance
- Ensuring that there is an up to date policy and procedure in place relating to Maidstone Borough Council's roles and responsibilities for the safeguarding and protection of children and vulnerable adults
- Ensuring that employee and Member training is undertaken and refreshed appropriately.

3.8 **MBC's Safeguarding Board:** monitors this policy and any safeguarding referrals which are made by Maidstone Borough Council. Chaired by the Safeguarding Lead, this group meets quarterly to discuss any reports of abuse or neglect raised through the reporting system, whilst ensuring that Maidstone Borough Council is taking its safeguarding responsibilities seriously and complying with legal requirements. Representative on this group include local managers for Kent County Council's

3.9 **Human Resources:** works to ensure that stringent recruitment procedures are in place for ensuring safe working practices and safe recruitment for job roles that involve working with children and vulnerable adults.

3.10 **Line Managers:** ensures that appropriate checks are made for all job roles that involve working with children and vulnerable adults. They also carry out the correct induction process for all new employees including booking the appropriate training and ensuring they are made aware of this policy and have the appropriate ongoing training.

3.11 **All employees, contractors, volunteers and Members**: ensures that the activities in which they are involved in during the course of their work are carried out in accordance with this policy and that they follow any guidance relating to it.

# 4. RECOGNISING ABUSE AND NEGLECT

## Child Neglect and Abuse

4.1 Abuse of children can take many forms but is usually divided into four main categories; physical, sexual, emotional and neglect. The Kent and Medway Inter-Agency Threshold Criteria for Children and Young People includes illustrative examples about how need may present itself for intervention. It can help to decide whether to refer a child and whether the child will meet either the 'child in need' or 'child protection' thresholds:

- **Child in need:** the child is unlikely to achieve or maintain a reasonable standard of health or development or development is likely to be significantly impaired (section 17 of the 1989 Children Act)
- **Child protection:** where a child has suffered or is likely to suffer significant harm, through neglect, physical, emotional or sexual abuse (section 47 of the 1989 Children Act)

4.3 The Inter-Agency Threshold document explains the signs and symptoms that may be consistent with abuse and illustrates good practice when working with children, before making a referral it is important that you discuss your concerns with a Designated Safeguarding Officer or contact the Lead Designated Safeguarding Officer.

4.4 The referral procedure in Section 6 of this policy should be followed if the thresholds are met and a child requires Specialist Children's Services intervention. If the concerns do not meet child in need or child protection thresholds, then consideration should be given to referring the case to the Early Help and Preventative Service, providing the family consent for the referral to be made.

4.5 **Early Help and Preventative Service:** the Kent Family Support Framework replaced the Common Assessment Framework process and delivers a streamlined preventative service, which can be accessed if concerns do not reach child in need or child protection thresholds.

4.6 The Early Help and Preventative Service aims to respond early to tackle issues emerging for children, young people and families, who are most at risk of developing problems and having poor outcomes. The service prevents or minimises the risk of problems arising; carries out early intervention work with those families and responds effectively to redress the situation, stop problems getting worse and improve outcomes.

4.7 To refer a case to the Early Help and Preventative Service, a Notification Form must be completed and consent given by the family, it is important that the young person's voice is captured. Consent can be given verbally but preferably be in writing. The Early Help team will then carry out a family assessment to the child's and family's needs and develop and agree a plan to work with the family to meet those needs. Contact details for this service can be found in Appendix 1.

## Child Sexual Exploitation (CSE)

4.8 Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.

4.9 The Kent and Medway Safeguarding Children Abused through Sexual Exploitation Procedures support employees to identify and respond appropriately to safeguard children who are or are at risk of experiencing CSE.

4.10 If there are concerns about a child or young person being sexually exploited, employees should first discuss their concerns with their Line Manager or a Designated Safeguarding Officer. The Lead Designated Safeguarding Officer should also be consulted to assist the Community Safety Unit in informing intelligence gathering. During the discussions, the Kent and Medway Child Sexual Exploitation Risk Assessment Toolkit should be used to make an assessment of risk of harm to the child.

4.11 Following completion of the risk assessment and if a decision is made to make a referral to Kent County Council under the procedure set out in Section 6, the risk assessment should be attached to the referral form.

4.12 Any intelligence on CSE can also be reported to Operation Willow's CSE Team using an Information Report Form, which can be located in Appendix 3, and sent via secure GCSX email or a password protected file to cse.intelligence@kent.pnn.police.uk. For help completing the form contact the CSE Champion or the Designated Lead Safeguarding Officer who should also be copied into the Information Report email.

4.13 The submission of an Information Report does not replace a safeguarding referral and should not be relied upon to safeguard an individual at risk. The existing safeguarding processes, as set out in this policy should therefore still be followed in tandem with any Information Reports.

## Vulnerable Adults

4.14 The Kent and Medway Safeguarding Adults Policy, Protocols and Guidance (pages 5 to 12), provides an illustrative guide to the various categories of abuse and details the indicators (pages 56 to 62). The main categories of abuse include:

- Physical
- Sexual
- Psychological
- Financial or material
- Slavery
- Discriminatory
- Exploitation
- Neglect and acts of omission
- Self-neglect and self-injurious behaviour

4.15 Maidstone Borough Council's Safeguarding Guidance document further explains the signs and symptoms that may be consistent with abuse and neglect. Staff can obtain this guidance on the Intranet.

4.16 The referral procedure in Section 6 of this policy should be followed if the vulnerable adult meets the following criteria:

- Has needs for care and support (whether or not they are receiving any services); and
- Is experiencing, or at risk of, abuse or neglect; and

- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

## Domestic abuse

4.17 Is any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial or emotional abuse.

4.18 Other forms of domestic abuse can include so called 'honour' based violence, female genital mutilation and forced marriage.

4.19 Maidstone Borough Council has trained employees who are able to complete the Risk Indicator toolkit (DASH) where it is identified that an adult at risk is in a domestic abuse situation. The Kent and Medway Multi-Agency Protocol for Dealing with Cases of Domestic Abuse to Safeguard Adults at Risk, provides guidelines on dealing with cases of domestic abuse where this affects adults with care and/or support needs. Referrals in these cases should be made in accordance with the procedure in section 6.

4.20 Self-neglect or self-injurious behaviour: covers a wide range of behaviour; neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. The Kent and Medway Multi-Agency Policy and Procedure to Support People who Self-Neglect, should be referred to for procedures on how to respond to cases of self-neglect. Under this, the identifying agency will need to co-ordinate a multi-agency meeting at which the lead agency will be identified and agreed. If the vulnerable adult is in need of care and/or support then Kent County Council is likely to be the lead agency.

## Modern slavery

4.21 Encompasses slavery, servitude, forced and compulsory labour and human trafficking. Traffickers and slave drivers coerce, deceive and force individuals against their will into a life of abuse, servitude and inhumane treatment.

4.22 From 1 November 2015, public authorities have a duty to notify the Secretary of State of any individual identified in England and Wales as a suspected victim of modern slavery. This duty includes district councils and applies to both children and adult victims. The information provided in a notification will be used to build a better picture of modern slavery in England and Wales, and to improve law enforcement response, by sharing the information with the National Crime Agency and other law enforcement agencies.

4.23 The Home Office Guidance: duty to notify the Home Office of potential victim of slavery, should be referred to and the MS1 Notification of Potential Victim of Modern Slavery Form, should be used to submit a notification via secure GCSX email to dutytonotify@homeoffice.gsi.gov.uk. The LDSO should be copied into the notification email.

4.24 This notification does not replace a safeguarding referral and should not be relied upon to safeguard an individual at risk. The existing safeguarding processes, as set out in this policy, should therefore still be followed in tandem with a notification.

### Extremism and radicalisation

4.25 The Counter Terrorism and Security Act 2015 places a duty on specified authorities to have due regard to the need to prevent people from being drawn into terrorism, referred to under the term '**Prevent**'. This statutory duty includes district councils and applies to both children and adults. Prevent forms part of Contest, the Governments plan for tackling terrorism; Prevent, Prepare, Protect, Pursue.

4.26 The Prevent duty is addressed through a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into committing acts of terrorism through a process known as 'Channel'. A 'Channel Panel' comprising of agencies who have a role in the Prevent process look at putting into place interventions and a tailored support package to safeguard those at risk based on an assessment of their vulnerabilities.

4.27 If a child or adult are identified as being at risk radicalisation, either by themselves, the actions of others, or drawn into committing act of terrorism, then employees should first discuss their concerns with their Line Manager or a Designated Safeguarding Officer. The LDSO should also be consulted to assist the Community Safety Unit with intelligence gathering.

4.28 A Channel Referral Form should be used to make a referral to the Kent Channel Panel, via secure GCSX email to channel@kent.pnn.police.uk. The LDSO should be copied into the referral email.

4.29 The submission of a referral to the Channel Panel should not replace a safeguarding referral and should not be relied upon to safeguard an individual at risk. The existing safeguarding processes, as set out in this policy, should therefore still be followed in tandem with a referral to the Channel Panel.

## 5. RESPONDING TO A DISCLOSURE OF ABUSE OR NEGLECT

5.1 If a child or vulnerable adult discloses abuse or neglect, stay calm and try not to show shock or disbelief. Listen carefully to what they are saying, be sympathetic ('I am sorry that this has happened to you') and be aware of the possibility that medical evidence might be needed.

5.2 Tell the person that:

- They did the right thing to tell you
- You are treating the information seriously
- The alleged abuse was not their fault
- You have to inform the appropriate person
- You/the service will take steps to protect and support them

5.3 Use open questions, such as 'can you tell me what happened / can you tell me what was said / can you describe that to me?' Write down what was said (as set out in 5.6) as soon as possible and report the abuse, following the procedure in section 6.

5.4 Do not:

- Press the person for more details; this will be done at a later date
- Stop someone who is freely recalling significant events, as they may not tell you again
- Ask leading questions that could be interpreted as putting words or suggestions to the person
- Promise to keep secrets. You cannot keep this kind of information confidential

- Make promises you cannot keep
- Contact or confront the alleged abuser
- Start an investigation on your own
- Be judgmental e.g. 'why didn't you run away?'

5.5 Pass on the information to anyone other than those with a legitimate need to know, such as your Line Manager or other appropriate person

## Records and information

5.6 Information passed to Kent County Council or the Police must be as comprehensive as possible, hence the necessity for making a detailed report at the time of the disclosure/concern. Information included in this report should include:

- The nature of the allegation
- A description of any visible bruising or other injuries
- The effect on the child or vulnerable adult
- The child or vulnerable adults' account, if it can be given, of what has happened and how any bruising or other injuries occurred
- Witnesses to the incident(s)
- Any times, dates or other relevant information
- A clear distinction between what is fact, opinion or hearsay

5.7 When recording the incident of abuse or neglect:

- Note what was said, using the exact words and phrases with ink that can be photocopied
- Describe the circumstances in which the disclosure came about
- Note the setting and anyone else who was there at the time
- Be aware that your report may be required later as part of a legal action or disciplinary procedure
- Make every effort to preserve any evidence which may be relevant to a Police investigation, however taking into account that the wellbeing of the child or vulnerable adult is your first priority

## Consent

5.8 **Child referrals**: If you are making a referral that meets the threshold for a 'Child in Need' then consent must be obtained from the parent or guardian. Should a parent or guardian refuse their agreement to a referral being made, consideration should be given to the impact this may have on the level of concern for the child's welfare, and the parent's or guardian's ability to meet the child's needs.

5.9 If you are making a 'Child Protection' referral, immediate advice should be sought from either a Designated Safeguarding Officer or the Lead Designated Safeguarding Officer on whether to advise the parent or carer about the referral. If you remain unsure you should consult Specialist Children's Services.

5.10 The safety of the child is of paramount importance and informing a parent or guardian may place the child at increased risk or may compromise Police evidence.

5.11 The outcome of any consultation around consent and any advice provided should be fully recorded.

5.12 **Adult referrals:** Every adult has the right to make their own decisions and it is assumed they have mental capacity unless it is proved otherwise by a speciallist. Mental capacity is the ability to understand the effect of their actions and retain the information in relation to a specific act, decision or transaction, to weigh up their consequences and to communicate the decision, at the time the decision needs to be made.

5.13 It is important to consider whether the vulnerable adult has the capacity to give consent to a referral. Where there is any doubt around capacity and/or their ability to consent, further advice should be sought from your Line Manager, a Designated Safeguarding Officer or the Lead Designated Safeguarding Officer or via consultation with Adult Social Services.

5.14 Where an adult who is deemed to have capacity has made a decision that they do not want action taken to address the alleged abuse or neglect, this should be respected unless failure to act will leave other adults or children at risk, there is anti-social behaviour or a crime has or will be committed.

# 6. REFERRAL PROCEDURE

6.1 The flow chart at the beginning of this policy outlines the referral procedure for reporting a safeguarding concern regarding children and/or vulnerable adults and contains links to the referral forms.

## Child referrals

6.2 All safeguarding referrals for children should be sent via secure GCSX email to centraldutyteam@kent.gcsx.gov.uk. Urgent referrals outside of office hours that cannot wait until the next working day should be referred to the **Out of Hours Team on 03000 41 91 91**. If an Early Help or other assessment has been completed (e.g. DASH or Child Sexual Exploitation Risk Assessment Toolkit), it should be attached to the referral form.

6.3 **Child Protection Referrals:** If there are concerns that a child may be suffering significant harm, the information must be telephoned directly through to the **Central Duty Team**, on **03000 41 11 11**. The referral form should then be completed and forwarded to the Central Duty Team as soon as possible.

6.4 **Child In Need:** Referrals of children with high levels of need should be forwarded to the Central Duty Team without prior telephone discussion with the Central Duty Team, unless a professional consultation is considered necessary or useful. If you feel that a consultation should take place, contact your Designated Safeguarding Officer or the LDSO prior to any consultation with the Central Duty Team.

## Adult referrals

6.5 If the adult is already known to Kent County Council, the referral will need to be sent directly to the relevant Case Management Team (either the Learning Disability, Mental Health or Older Persons and Physical Disability Team) using the contact details on the referral form. The **Central Duty Team** (Tel: **03000 41 61 61**) will be able to confirm whether the adult is already known to services. If the adult is not already known to services, the referral should be sent via secure GCSX

email to centraldutyteam@kent.gcsx.gov.uk. If any other assessment has been completed (e.g. DASH), it should be attached to the referral form.

6.6 Urgent referrals outside of office hours that cannot wait until the next working day should be referred to the **Out of Hours Team** on **03000 41 91 91**.

6.7 The Lead Designated Safeguarding Officer (LDSO) should be copied into the email for all safeguarding referrals via their secure GCSX email: MattRoberts@maidstone.gcsx.gov.uk

6.8 For employees without a secure email, they should try to send the referral as a password protected file. Or ask their department Designated Safeguarding Officer or the LDSO to forward the referral on their behalf.

6.9 Reporting the matter should not be delayed by an attempt to obtain more information. A summary of any consultation with, or referral to, the Central Duty Team will be issued to the referring officer. This ought to be retained on file in case any follow-up is needed and should be logged centrally with the Community Safety Unit. If a response is not received within 72 hours of making a referral, the referring officer should follow up with the Central Duty Team or the relevant case management team if it is an adult referral and the adult is already known to services, as outlined in Flowchart A. If a case has been referred to the Police due to an immediate risk of harm or emergency, the Police crime report number should be noted and placed on file.

### Escalating a referral

6.10 On rare occasions Maidstone Borough Council employees may feel that the course of action outlined by Kent County Council in their response to a referral does not represent, in their opinion, the best course of action in relation to the referred case. If so, then concerns should be raised with the Lead Designated Safeguarding Officer. Please note that sensitive matters should be sent to and from a secure GCSX email address if being sent outside of the organisation, or else discussed in person or over the phone.

6.11 The Lead Designated Safeguarding Officer will make the final decision as to whether a case will be referred back to Kent County Council, expressing Maidstone Borough Council's continuing concerns in relation to the welfare of the individual(s) concerned and may bring the case in question to the attention of the Safeguarding Forum members.

## 7. SUSPICIONS OF ABUSE INVOLVING STAFF

7.1 Any suspicion that an employee has abused a child or vulnerable adult should be reported to their Line Manager, Head of Service or the Lead Designated Safeguarding Officer immediately. Alternatively, suspicion may also be reported according to Maidstone Borough Council's Whistleblowing Policy.

7.2 The LDSO representative informed will take such steps as they feel appropriate to ensure the safety of the child or vulnerable adult and will report the incident to the relevant Director and Human Resources.

7.3 If a Line Manager or Designated Safeguarding Officer is the subject of the suspicion/allegation, the report must be made directly to a Director and Human Resources. Advice will be sought from the Local Authority Designated Officer (for children) or Adult Social Services Duty Team (for

adults), who may involve the Police. A disciplinary investigation team will be formed to oversee the internal investigation.

7.4 Any employee accused of abuse will, if necessary, be redeployed pending further Police, Kent County Council and/or the internal investigation.

7.5 The Police, Kent County Council or the regulatory authorities may be consulted at any time regarding suspected abuse.

7.6 Irrespective of the findings of the Kent County Council or of Police inquiries, Maidstone Borough Council will assess all individual cases under disciplinary procedures to decide whether an employee has breached Maidstone Borough Council policy and will reach a decision based on the available information and decide on a balance of probability whether an allegation is founded. The welfare of the child or vulnerable adult will always remain paramount.

## 8. COMPLAINTS

8.1 On occasions members of the public, partner agencies or Maidstone Borough Council employees may feel that safeguarding action has not been taken by Maidstone Borough Council in accordance with this policy.

8.2 **Members of the public and partner agencies:** should be encouraged to first raise their concerns directly with the staff member they have been dealing with or with Customer Services if they are unsure who they have been dealing with. If the matter is not resolved informally then they should be directed to Maidstone Borough Council's Corporate Complaints Procedure. The welfare of the child or vulnerable adult will always remain paramount.

8.3 **Maidstone Borough Council employees:** should report their concerns to their Line Manager or the Lead Designated Safeguarding Officer immediately for investigation. Alternatively, employees may also report this through Maidstone Borough Council's Whistleblowing Policy. If employees do not wish to raise their concerns internally they can report their concerns to the national Child Abuse Whistleblowing Helpline (0800 028 0285 or email help@nspcc.org.uk).

8.4 The investigation will ascertain whether the policy has been followed correctly and if any subsequent action is required to remedy the situation. The welfare of the child or vulnerable adult will always remain paramount.

## 9. INFORMATION SHARING AND DATA PROTECTION

9.1 Information sharing is vital to safeguarding and promoting the welfare of children and vulnerable adults. A key factor in many serious case reviews has been a failure to record information, to share it, to understand its significance and then take appropriate action.

9.2 **Government guidance, Safeguarding Practitioners:** Information Sharing Advice (March 2015), highlights seven golden rules for information sharing regarding children, young people, parents and carers. These rules are also helpful with regards to working with vulnerable adults:

9.3 Remember: that the Data Protection Act 1998 and human rights law **are not barriers to justified information sharing**, but provide a framework to ensure that personal information about living individuals is shared appropriately

9.4 Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so

9.5 Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the person where possible.

9.6 Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information.

9.7 You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared

9.8 Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions

9.9 **Justified, Authorised, Proportionate, Auditable, and Necessary (JAPAN):** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion.

9.10 Keep a record of your decision and the reasons for it whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

9.11 Maidstone Borough Council is a signatory to the Kent and Medway Information Sharing Protocol and is committed to close working with partners in matters relating to safeguarding and protecting children and vulnerable adults.

# 10. SAFE RECRUITMENT

10.1 All Maidstone Borough Council employees will be appointed in accordance with its Recruitment and Selection Policy and Procedures and its policy on Disclosures Barring Service checks on employees. These are designed to provide a rigorous and thorough selection process and to carry out all necessary checks, particularly on individuals seeking to work with children, young people and vulnerable adults.

## Disclosure Barring Service (DBS) Checks

10.2 There are three types of Disclosure Barring Service (DBS) checks: standard, enhanced and enhanced with a barred list check;

10.3 **Standard DBS checks:** are for people entering certain professions, such as members of the legal and accountancy professions. Standard checks contain the following: Convictions, cautions,

reprimands and warnings held in England and Wales on the Police National Computer (PNC), relevant convictions in Scotland and Northern Ireland may also be included. Standard checks no longer include a check of the old or new barred lists from 12 October 2009.

10.4 **Enhanced DBS Checks:** Also referred to as an enhanced disclosure. These are for posts that involve a far greater degree of contact with vulnerable groups including children. In general the type of work will involve regularly caring for, supervising, training or being in sole charge of such people. Examples include a Teacher, Scout or Guide leader. Enhanced checks are also issued for certain statutory purposes such as gaming and lottery licences.

10.5 This level of check involves an additional level of check to those carried out for the Standard DBS check - a check on local Police records. Where local Police records contain additional information that may be relevant to the post the applicant is being considered for, the Chief Officer of Police may release information for inclusion in an enhanced check.

10.6 **Enhanced DBS Check with barred list check – (child), (adult), (child and adult):** Enhanced checks with information from the DBS' children and adults barred list is only available for those individuals engaged in regulated activity with vulnerable groups including children and a small number of posts as listed in the Police Act regulations, for example prospective adoptive parents.

10.7 Source of information Guidance and Disclosure and Barring Service.

10.8 Maidstone Borough Council requires employees to have an enhanced DBS check if they have unsupervised contact with children, young people and vulnerable adults or fulfil a Safeguarding role such as a Designated Safeguarding Officer.

10.9 Line Managers are responsible for deciding which of their employees require a DBS check and for ensuring that DBS checks are kept up to date, through liaising with Human Resources.

10.10 For contractors and agency staff, Maidstone Borough Council has a policy of requiring all relevant contractors and agency staff who have access/contact with children, young people and vulnerable adults to undergo an enhanced DBS check. The contract must stipulate whether a current DBS disclosure is required.

## 11. TRAINING

11.1 Employees must accept and be able to recognise their responsibilities with regard to their own good practice and the reporting of signs of suspected abuse or neglect to either the Police or Kent County Council and understand Maidstone Borough Council's statutory obligation to ensure confirmation is received from Kent County Council that any referrals made are being actively dealt with. Everyone with access to children and vulnerable adults shall have regular training.

11.2 Training needs and opportunities relating to child and adult safeguarding and protection issues will be identified and addressed through Maidstone Borough Council's Induction and Appraisal Procedures, and in response to any changes in legislation. Training may include internal courses/workshops, externally accredited courses/seminars or workshops.

11.3 Staff acting as Designated Safeguarding Officers will be required to refresh their training every two years.

## 12. EQUAL OPPORTUNITIES

12.1 The Equality Act 2010 places a legal obligation on public authorities to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity; and to foster good relations, between persons with different protected characteristics. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Maidstone Borough Council will have full and proper regard to the Equality Act 2010 when making safeguarding referrals under this policy, so as to avoid any possible indirect discriminatory impact on particular groups.

## 13. REVIEW

13.1 All referrals made by Maidstone Borough Council and the responses that they receive from Kent County Council, are recorded centrally and will be reviewed regularly through the Safeguarding Steering Group.

13.2 **Reviewing this policy:** This policy will be reviewed in line with any changes in legislation and the periodical reviews of the Kent and Medway Safeguarding Policy, Protocols and Guidance.

## 14. LEGISLATION, GUIDANCE AND REFERENCE

14.1 This policy has been has been developed in line with the principles of the Children Act 1989, the Children Act 2004, the Care Act 2014 and the Kent Safeguarding Children Board and Kent and Medway Safeguarding Adults Board procedures. Further guidance and reference can be obtained from the following:

| **Safeguarding Children** | |
|---|---|
| Working Together to Safeguard Children | Department for Education (2015) |
| What to do if you're worried a child is being abused | Department for Education (2015) |
| Safeguarding Practitioners: Information Sharing Advice | HM Government (2015) |
| Tackling Child Sexual Exploitation: a resource pack for councils | Local Government Association (2014) |
| Child Sexual Exploitation: Warning Signs and Vulnerabilities Checklist | Children's Commissioner (2013) |
| Kent and Medway Safeguarding Children Procedures | Kent Safeguarding Children Board |
| Kent Inter-Agency Threshold Criteria for Children and Young People | Kent Safeguarding Children Board |
| Kent and Medway Safeguarding Children Abused through Sexual Exploitation Procedures | Kent Safeguarding Children Board |
| Kent and Medway Sexual Exploitation Risk Assessment | Kent Safeguarding Children Board |

| | |
|---|---|
| Toolkit | |
| **Safeguarding Vulnerable Adults** | |
| Care and Support Statutory Guidance | Department of Health (2014) |
| No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse | Department of Health (2000) (Note: this guidance has been superseded by Care and Support Statutory Guidance) |
| Making Safeguarding Personal | Local Government Association (2014) |
| Kent and Medway Safeguarding Adults Policies, Protocols and Guidance | Kent and Medway Safeguarding Adults Board |
| The Kent and Medway Multi-Agency Protocol for Dealing with Cases of Domestic Abuse to Safeguard Adults at Risk | Kent and Medway Safeguarding Adults Board |
| The Kent and Medway Multi-Agency Policy and Procedure to Support People who Self-Neglect | Kent and Medway Safeguarding Adults Board |
| **Other Guidance and Reference** | |
| Guidance: duty to notify the Home Office of potential victim of slavery | Home Office |
| MS1 Notification of Potential Victim of Modern Slavery Form | Home Office |
| Prevent – Kent Channel Panel Referral Form | Kent Channel Panel |
| Multi-Agency Statutory Guidance on Female Genital Mutilation | HM Government (2016) |

14.2 This policy and the accompanying guidance should also be read in conjunction with the following Maidstone Borough Council documents which can be found on the Intranet:

- Recruitment and Selection Policy and Procedures
- Induction Procedure
- DBS checks
- Comprehensive Equalities Policy
- Employee and Member Codes of Conduct
- Health, Safety and Welfare Policy
- Disciplinary Policy and Procedure
- Data Protection Policy

# Appendix 1 – CONTACT INFORMATION

## MAIDSTONE BOROUGH COUNCIL

CEO and Chair of Safeguarding Steering Group
Alison Broom
Maidstone Borough Council, Maidstone House, King Street, ME15 6JQ
Tel: 01622 60 2019
Email: AlisonBroom@maidstone.gov.uk

Hayley Bourner – PA to Alison Broom
Tel: 01622 60 2018
Email: HayleyBourner@maidstone.gov.uk

Matt Roberts – Lead Designated Safeguarding Officer (LDSO)
Community Partnerships & Resilience Manager, Housing, Communities & Environment
Tel: 01622 60 2404
Email: MattRoberts@maidstone.gov.uk

Jayne Bolas – Legal Advisor
Legal Services)
Tel: 01622 60 2181
Email: JayneBolas@Maidstone.gov.uk

**MAIDSTONE BOROUGH COUNCIL DESIGNATED SAFEGUARDING OFFICERS**

## KENT COUNTY COUNCIL

**SPECIALIST CHILDRENS SERVICES (SCS)**

**Specialist Children's Services Central Duty Team**
Tel: 03000 41 11 11
Fax: 03000 412 345 (only to be used if secure email or password protected files are not an option)
Out of hours: 03000 41 91 91
Email: centraldutyteam@kent.gcsx.gov.uk

Penny Ademuyiwa - Maidstone Integrated Family Support Service Manager
Tel: 03000 410 060
Email: Penny.Ademuyiwa@kent.gov.uk

**Early Help and Preventative Service**
Hema Birdi - District Manager Maidstone
Tel: 03000 411 407
Email: Hema.Birdi@kent.gov.uk
**Triage Team**
Tel: 03000 41 92 22
Email: earlyhelp@kent.gov.uk

**Local Authority Designated Officers (LADO)**
Kroner House, Eurogate Business Park, Ashford, TN24 8XU
Tel: 03000 41 08 88
Email: kentchildrenslado@kent.gov.uk

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**Kent Adult Social Services**

**Central Duty Team**
Tel: 03000 41 61 61
Fax: 03000 412 345 (only to be used if secure email or password protected files are not an option)
Out of hours: 03000 41 91 91

**Mental Health Team**
Tel: ????

**Learning Disability Team**
Tel: ????

**Older Persons and Physical Disability Team**
Tel: ????

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## KENT POLICE

**Operation Willow – Child Sexual Exploitation Team**

Email: cse.team.kent.and.medway@kent.pnn.police.uk
Tel: 01622 652 668
Staff can send a CSE intelligence report via secure email to; cse.intelligence@kent.pnn.police.uk

**Kent Channel Panel**
Staff can send Channel referrals via secure GCSX email to; channel@kent.pnn.police.uk

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## HOME OFFICE

**Modern Slavery – Duty to Notify**
Modern Slavery Helpline
Tel: 0800 0121 700
Email: dutytonotify@homeoffice.gsi.gov.uk

NSPCC Child Abuse Whistleblowing Helpline
Tel: 0800 028 0285
Email: help@nspcc.org.uk

# Appendix 2

## SAFEGUARDING STEERING GROUP
## TERMS OF REFERENCE

### Purpose

To lead on safeguarding children and vulnerable adults and to ensure that all employees recognise and understand their responsibility to report any signs of abuse and neglect.

### Responsibilities

To oversee and steer the development, promotion and review of the Council's Safeguarding Policy
To provide a platform for the discussion of all aspects of safeguarding issues and ensure liaison and where appropriate, joint working internally between Council Departments/Directorates and externally with Kent County Council's Specialist Children's Services and Adult Care and Support Services.

To review any reports made by employees of suspected abuse or neglect.

To oversee the Safeguarding Training Plan for employees, councillors, contractors and other stakeholders deemed appropriate by legislation or Steering Group decision.

To review and, if necessary, prioritise recommendations/action plans based on national guidance, local priorities etc.

To ensure that the Corporate Leadership Team is kept regularly informed of progress in developing and implementing the Council's safeguarding requirements.

To ensure that other key stakeholders (employees, councillors, contractors, customers, community groups etc) are kept informed of the activities of the Steering Group through annual reports and by communicating key messages/information as appropriate, through a variety of media/methods, including the Council's intranet and internet.

### Membership

Safeguarding Champion: Alison Broom, Chief Executive Officer
Lead Designated Safeguarding Officer: Matt Roberts, Community Partnerships & Resilience Manager
John Littlemore, Head of Housing, Communities & Environment
Policy Lead / Member Services: ???
Legal Advisor: Jayne Bolas
Safeguarding Children's Liaison: Penny Ademuyiwa, Kent County Council
Safeguarding Vulnerable Adults Liaison: TBC, Kent County Council
Other co-opted members as and when specialist input is required.

### Responsibilities

Feedback into their work areas and drive forward the Council's safeguarding agenda as part of their overall work programmes.
Report back to the Group on progress made in their work areas.
Report back to the Group on issues related to safeguarding, that arise through their work areas.

## Accountability

The Group is accountable to the Corporate Leadership Team (CLT)

## Frequency of meetings

Meetings will be held on a quarterly basis unless otherwise necessary.

## Minutes and reports

1. The Safeguarding Board will produce a set of minutes from each meeting.
2 Quarterly reports on actions and plans will be presented to the CLT / WLT.

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