# A Place for Prevention

## An action plan for improving the health and wellbeing of marginalised communities in Kent

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PLAYBOOK ACTION PLAN

BREAKING BARRIERS INNOVATIONS

# About Breaking Barriers Innovations

Breaking Barriers is an independent project with the principal aim of radically improving the delivery of public services across the UK for maximum social impact. We are Chaired by Professor, The Lord Patel of Bradford OBE and our Research Director is Dr Jon Bashford.

Breaking Barriers works to achieve this by creating an open space for debate in which public service professionals, innovative suppliers, experts and other stakeholders devise new public service models based on innovative place-based working.

Specifically, we act on a place-based agenda. Tackling the paradox of place where too many people talk about it, but not enough act on it.

We work with local authorities, NHS bodies, voluntary and community services, and private industry to deliver bespoke solutions to complex problems at a truly local level.

To do this, we focus on a series of key themes:

- **social determinants of health**
- **place-based solutions**
- **systems change**
- **innovation**
- **policy development**

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# 1 Introduction

Few would argue with the age-old axiom that prevention is better than cure, and yet it still remains the case that investment on prevention is significantly lower than that for treating illness. Work undertaken by The Charted Institute of Public Finance and Accountancy (CIPFA) and Public Health England (PHE) estimated that in 2014, £5.2bn was invested in prevention, representing 4.7% of total health spending (CIPFA and PHE, 2019).

The NHS Long Term Plan calls for a radical uplift in prevention, including a move towards population health management and using predictive prevention (linked to new opportunities for tailored screening, case finding and early diagnosis), to better support people to stay healthy and avoid illness complications (NHS England, 2019).

However, prevention can mean different things depending on the organisational and professional context. For example, primary prevention encompasses a range of programmes from vaccinations to smoking cessation and weight reduction programmes. Secondary prevention can include harm minimisation measures such as needle exchange schemes and brief interventions in alcohol use. Tertiary prevention concerns mitigation of factors that are likely to increase complexity or chronicity in existing health conditions such as psychological and pharmacological interventions in serous mental illness. There is even talk of quaternary prevention, which aims to protect patients from medical harm (Martinsa et al., 2018).

Prevention in healthcare is often focused on specific disease categories or conditions, whether at the level of individuals or population groups, for example, heart disease or diabetes. Interventions may be designed to prevent the disease from occurring in the first place or to avoid problems and complications from occurring later on. This involves a focus on risk factors, whether through lifestyle choices, genetics or environment. The latter has taken on increasing importance in recent years as the social determinants of health or the so called `causes of the causes' of ill-health have become the prime focus.

For example, in his recent ten year on review of health equity in England, Professor Marmot concludes that the health picture for England is getting worse, with life expectancy falling in many communities outside London (Marmot et al., 2020). This is a complete reversal of the major trends of the 21st century and clearly points to the toll taken by a decade of austerity in which child poverty has risen, employment has become more precarious, homelessness has increased, and more people have insufficient resources to lead a healthy life (Human Rights Watch, 2019).

These problems have not been felt equally as some population groups appear to have suffered more with greater declines in health and fewer years of life expectancy, especially amongst some Black, Asian and Minority Ethnic (BAME) groups, for people who are disabled and those with serious mental illness. The increasing risk factors and continuing disparities in health for some population groups has also been demonstrated by the experience of the Covid-19 pandemic and the differential impact this has had on some communities.

Arguably, those who are more marginalised and who were already experiencing health inequalities are also more vulnerable to the pandemic, and there is a clear case for ensuring that prevention efforts are appropriately and effectively targeted to these groups as part of the recovery plans for the pandemic.

The programme of work described in this report and the action plan that it sets out commenced before the pandemic, but the action plan for prevention amongst marginalised population groups has even greater urgency and relevance as we move towards recovery from the pandemic and restoring health and care services. As a result, we have attempted to draw on learning from the pandemic responses and reviewed recent evidence on population groups who have experienced differential impacts, especially those that are more marginalised.

As the report sets out, there is no single agency or sector that has all of the answers and the action plan seeks to combine resources, services, professional development plans and infrastructure on a fully collaborative basis. If there is anything positive to come from the pandemic then it is the knowledge and experience of what can be achieved when agencies from across the public, private and community, voluntary and social enterprise sectors work together with local people.

We have witnessed a rebirth of community activism and volunteering on an unprecedented scale and traditional professional and organisational silos have been challenged and, in many situations, removed to enable new and innovative ways of working. This is the essence of a place-based approach, where the needs of the local population take precedence over organisational and sector sovereignty, but the challenge ahead is how to ensure that is sustained.

We believe that the Playbook methods employed in this programme of work hold the key to a sustainable future, which puts the social determinants of health at the heart of planning and service provision. This requires recognition and consensus that the dominant strategy for prevention is one that puts marginalised communities at the forefront, as part of an approach that is defined by proportionate universalism.

The report sets out the context and evidence to support this, drawing on interviews with frontline practitioners, managers and commissioners alongside feedback from local residents and service users. These data are further explored by comparing the particular demographics and socioeconomic status of two contrasting areas: Northfleet in Gravesend and the Isle of Sheppey in Swale. This learning is applied to develop a series of actions that seek to operationalise a conceptual framework for prevention with marginalised population groups, including the need for ongoing community engagement and participation on the basis of co-design and co-production and workforce transformation in the short and longer term.

The action plan is not an end in itself but is designed to provide impetus to a new way of working and a new governance and delivery model. In some respects, this is only the beginning of this programme of work but with the right commitment and shared values there is a very real prospect of ensuring that the health and wellbeing of the whole community is improved and that no one is left behind.

# 2 The Breaking Barriers Innovations Playbook Programme

Breaking Barriers Innovations (BBI) and Health Education England (HEE) are leading a series of pilot projects on place and the social determinants of health across England. The pilots seek to provide a facilitated and comprehensive approach to place-based development and delivery of health and care services that can address the social determinants of health and wellbeing. Developed from a programme of work on housing and health with the NHS West Lancashire Clinical Commissioning Group (CCG), the programme uses a Playbook methodology based on four building blocks, which, performed concurrently, serve as the structure for a rapid process of appraisal and action planning:

1. **Strategic alignment**
2. **Workforce development**
3. **Resident, service user and community engagement and co-design**
4. **Action planning for service integration and innovation**

The building blocks are inter-dependent, and the Playbook is designed to be tailored to appropriate local variations in demographics, needs and strategic priorities. For example, while one area may view the highest level of need and priority as housing, another may view skills and employment as being more relevant. The Kent pilot is focused on prevention for marginalised population groups, including shifting service responses and improving skills and competencies amongst the generic health and care workforce in addressing prevention. The work has been focused in two contrasting localities: Northfleet (Gravesham) which is largely urban the more rural Isle of Sheppey (Swale).

The overall aim is to support workforce development and planning across health and social care and related staff groups who contribute to wellbeing such as those working in transport, housing and social infrastructure so that all frontline staff, managers, and commissioners are confident and skilled in understanding the relationship between the ability and capacity of people to effectively access services and the impact that marginalisation has on their health and wellbeing. There is a particular emphasis on prevention, whether that is helping people to avoid reaching crisis points where interventions may have to be more urgent with regards to time and resources or actually stopping people from becoming ill as a result of their particular living circumstances and environmental conditions.

A small steering group has overseen the programme from its inception. The group comprised representation from Kent County Council, the Design and Learning Centre, Public Health, Kent Association of Local Councils, Health Education England, and NHS West Kent CCG. This report sets out the findings from the inquiry part of the programme, including feedback from professional stakeholders and local residents, data analysis of the chosen areas in Kent, and desktop research of evidence and best practice. The report concludes with an action plan for improvement that also seeks to capture learning from the Covid-19 pandemic and how the positive achievements from this can be incorporated into a sustainable plan for the future.

# 3 The National Context for Prevention

The NHS Long Term Plan is predicated on a radical uplift in prevention work, which is characterised by greater use of predictive healthcare measures and tools, including population based screening and earlier case identification. The Plan sets out some specific actions that the NHS are expected to improve including:

- better support for patients, carers and volunteers to enhance 'supported self-management' particularly of long-term health conditions;
- ensuring health is hardwired into social and economic policy;
- considering whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and how best to commission these services in the future.

All of the above is expected to take place against a renewed NHS prevention programme focusing on smoking, poor diet, high blood pressure, obesity, alcohol and drug use alongside actions to improve air pollution and address lack of exercise. These priority areas are intended to have a clear focus within the shift towards greater local integration of services through Integrated Care Systems (ICS) as the NHS continues to move from reactive care towards a model embodying active population health management. Specific commitments on prevention activities include:

**Smoking**

- by 2023/24, all people admitted to hospital who smoke will be offered NHS funded tobacco treatment services;

- the model will be adapted for expectant mothers and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments;
- a new universal smoking cessation offer will be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.

**Obesity**

- provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+;
- funding a doubling of the NHS Diabetes Prevention Programme over the next five years, including a new digital option to widen patient choice and target inequality;
- test an NHS programme supporting very low-calorie diets for obese people with type 2 diabetes;
- continue to take action on healthy NHS premises and ensure nutrition has a greater place in professional education training.

### Mental Health

- enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people;
- ramp up support for people to manage their own health including the development of apps and online resources to support good mental health and enable recovery;
- expand the offer in mental health services, for people with a learning disability and people receiving social care support;
- more accurate assessment of need for community health and mental health services, as well as ensuring the allocations formulae are more responsive to the greatest health inequalities and unmet need.

### Alcohol

- hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish Alcohol Care Teams (ACTs), which are designed to significantly reduce accident and emergency (A&E) attendances, bed days, readmissions and ambulance callouts.

### Air pollution

- the NHS will work to reduce air pollution from all sources. Specifically, cutting business mileages and fleet air pollutant emissions by 20% by 2023/24.

### Antimicrobial resistance

- the health service will continue to support implementation and delivery of the government's five-year action plan on Antimicrobial Resistance.

## 3.1 Action on health inequalities and the social determinants of health

Aside from the above significant commitments on prevention, the NHS Long Term Plan also contains actions to address health inequalities, in recognition of the role that the social determinants of health play in the overall health and wellbeing of the population. The Plan seeks to take a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variations in care including:

- continuing to target a higher share of funding towards geographies with high health inequalities;
- supporting local planning and ensuring national programmes are focused on health inequality reduction;
- setting out specific, measurable goals for narrowing inequalities, including those relating to poverty;
- implementing an enhanced and targeted continuity of care model to help improve outcomes for the most vulnerable mothers and babies;
- further increasing the number of people receiving physical health checks to an additional 110,000 people per year;
- ensuring that all people with a learning disability, autism, or both can live happier, healthier, longer lives;
- investing up to £30 million extra on meeting the needs of rough sleepers, to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services;

In addition, the Plan sets out some specific actions for carers including:

- continuing to identify and support carers, particularly those from vulnerable communities;
- ensuring that more carers understand the out-of-hours options that are available to them and have appropriate back-up support in place for when they need it;
- rolling out 'top tips' for general practice, developed by Young Carers, which includes access to preventive health and social prescribing, and timely referral to local support services.

The ultimate aim of prevention, as envisaged in the Long Term Plan, is to moderate growth in demand for healthcare, on the assumption that action on prevention and health inequalities relieves pressure on other essential public services. This is also to be done within the context of continuing to commission, partner with and champion local charities, social enterprises and community interest companies, which provide services and support to vulnerable and at-risk groups.

## 3.2 Advancing our health: prevention in the 2020s

In 2019, the government held a consultation on advancing our health and prevention in the 2020s (DHSC, 2019). The consultation set out a vision for a decade of proactive, predictive, and personalised prevention, in which people are not passive recipients of care, but are co-creators of their own health through:

- targeted support;
- tailored lifestyle advice;
- personalised care; and
- greater protection against future threats.

The government set out its intention to:

- embed genomics in routine healthcare, making the UK the home of the genomic revolution;
- review the NHS Health Check and setting out a bold future vision for NHS screening;
- launch phase 1 of a Predictive Prevention work programme from Public Health England (PHE).

The consultation recognised the commitments in the NHS Long Term Plan, including targets for smoking cessation, obesity and mental health. The consultation also indicated that government will seek a stronger focus on prevention across all areas of government policy, which is not too far removed from Professor Marmot's call ten years ago for health in all polices.

At local levels, the government wants to see organisations working more closely together on putting prevention at the centre of decision making and moving from dealing with the consequences of poor health to promoting the conditions for good health.

# 4 The local context for prevention

Prevention is at the heart of Kent and Medway's Sustainability and Transformation Plan (Transforming health and social care in Kent and Medway, October 2017). The plan sets out the intention to deliver prevention interventions at scale in order to improve the health of the local population and reduce reliance on institutional care. In particular, it is envisaged that prevention will enable local system leaders to take forward the development of acute hospital care by reducing the number of patients who are supported in acute hospitals, including supporting these individuals in the community.

The plan also contains a commitment to transform care by enlisting public services, employers and the public to support health and wellbeing, with efforts to tackle the future burden of cardiovascular disease and diabetes. This is part of a plan to involve the whole Kent and Medway community in improving health and wellbeing through a prevention programme. This will be achieved by:

- delivering workplace health initiatives, aimed at improving the health of staff delivering services;
- industrialising clinical treatments related to lifestyle behaviours and treating these conditions as clinical diseases;
- treating both physical and mental health issues concurrently and effectively; and

- concentrating prevention activities in four key areas:
    - Obesity and Physical Activity
    - Smoking Cessation and Prevention
    - Workplace Health
    - Reduce Alcohol-Related Harms in the Population

The prevention workstream is being jointly led by both Directors of Public Health for Medway Unitary Authority and Kent County Council.

The case for change that underpins the Sustainability and Transformation Plan was published in 2017 and it sets out a number of significant challenges, including a deficit of £110m across local health and commissioning, which was projected to rise, without significant changes, to £486m by 2020/2021.

The case for change also highlights a shortfall in public health expenditure compared to the national average (2% locally in Kent and Medway compared to an average of 5% nationally). In addition:

- 1,600 local people are estimated to die every year from causes considered amenable to healthcare, with people in deprived areas and those with severe mental illness more likely to be affected;
- stark health inequalities exist across the area, for example, women in the most deprived areas of Thanet live on average 22 years less than those in the least deprived;
- 1,000 people (32%) are in hospital beds that do not need to be;
- Over 528,000 (almost one in three) local people live with one or more significant long-term health conditions;
- on average around one in five people smoke, but in some areas, it is as high as 30%;

- around 20% of primary school children are obese or overweight and around 10% of adults are obese. More than a quarter do not get enough physical activity;
- teenage pregnancy is above the national average.

There are also systemic shortages of staff, for example, GP access is difficult with 136 vacancies across Kent and Medway. If staffing in Kent and Medway were in line with the national average, there would be 245 more GPs and 37 more practice nurses.

This is an immensely challenging local context and one that clearly demonstrates the urgency of moving to a radically increased focus on prevention. It has been estimated that cost variations associated with health inequalities in the population older than 55 years in Kent are equivalent to health and social care costs of £111 million, or 15% of the estimated total expenditure in this age group (Jayatunga et al, 2019).

In fact, per capita health and social care costs are 35% higher in the most deprived areas of the county. Significantly, the social gradient costs per head are not distributed evenly and they increase with deprivation across each deprivation quintile:

- secondary care costs, as the largest component of per capita costs, increased by £141 between the least and most deprived quintiles, an increase of 27%;
- social care costs increased by £121 (47%);
- primary care costs increased by £74 (26%);
- mental health and community care are smaller components of overall per capita costs, but the cost increases (£44 and £37 respectively) represent steep social gradients (66% and 54%, respectively).

Appropriate interventions to reduce socioeconomic inequalities could reduce health inequalities and produce cost savings (Marmot et al, 2020). However, despite this evidence it is not clear how system leaders can best enable a coherent and collaborative response that encompasses all sectors, what the workforce transformation needs are and how to

better engage residents and service users in co-designing and delivering service changes to meet these challenges.

In order to consider these challenges and barriers in more depth the following section presents the feedback from a series of qualitative interviews with frontline practitioners, managers and commissioners and local residents and service users from across the system.

# 5 Workforce perspectives on key issues

The following analysis is taken from qualitative interviews with 19 key respondents from across health, social care, the community, voluntary and social enterprise sector and parish councils and local government. All interviews were conducted on a confidential basis and in order to protect this, quotations are only indicated as the sector from which the individual belongs.

Interviews were conducted by two researchers to ensure that an adequate transcript could be recorded. These transcripts have been analysed using constant comparative methods whereby the data is continually compared and contrasted with each respondent until a series of themes and key issues are identified.

A quotation is used where this represented a consensus of views across several respondents. If only one or two people commented on a particular issue this is included if the point is thought to have relevance to other data, for example, local and/or national literature but the text explains that it was a singular or minority view.

## 5.1 Comprehension of prevention

Prevention is understood in many ways. It is regarded in the sense of primary prevention, for example, preventing a problem arising in the first place, but more commonly it is understood as preventing further harm or complication of an existing condition. The impression from practitioners is that they are much more focused on secondary and tertiary prevention rather than primary. This is particularly relevant for community, voluntary and social enterprise sector (VCSE) agencies:

*"More often than not we are working on crisis, it gets harder and harder to reach people before they are in a situation where the problems have become much worse."*

(VCSE respondent)

Even amongst public sector agencies there is a concern that it is difficult to defend a prevention approach, because the benefits are not realised immediately:

*"Proving your worth is really difficult, how does prevention fit into that when the benefits of that approach are delayed or perhaps never seen?"*

(Public service respondent)

This view is particularly concerning as it suggests there are disincentives for staff to adopt stronger prevention approaches. Participants also link this to scale and the level at which prevention strategies and interventions are planned and focused. The problem is perceived to be three-fold:

- The county level focus on prevention is too high.
- At the district level there is too little focus, but this is where interventions need to be planned.

- The real value is perceived to be on local actions, for example, at the Parish or neighbourhood level with communities showing by example. That is where prevention becomes real and it is where community leaders need to engage who have the passion, but not yet, necessarily, the skills to make a difference.

There is a clear perspective from respondents that effective prevention is that which is local, involves residents and has meaning for the communities that is intended to benefit. The problem for some respondents is that there is insufficient appreciation of this because services often operate in silos, and the lack of effective prevention means that most interventions are crisis responses, which is viewed as putting sticking plasters over the problems:

*"My observation is that services are very much focused on their own criteria and what is in front of them. Prevention doesn't seem to be much of a live issue, it is more about putting sticking plasters on things."*

(Public service respondent)

This is strongly associated with a perception that there is a cohort of service users who continually move through various states of crisis and complications, which affects the level of service provision they are able to access:

*"There is a sense that some people are going through a roundabout system, in and out of crisis and different levels of provision."*

(VCSE respondent)

This matches the perspective of many community, voluntary and social enterprise sector respondents who perceive their role to be increasingly one that is involved with meeting gaps in statutory provision:

*"We are mainly dealing with people who have already developed problems and we are increasingly expected to plug gaps in statutory services, which can no longer work with people."*

(VCSE respondent)

In some respects, these perceptions are driven by presenting cases and referral patterns, but there is a perception that there is a gap in the way these issues are understood from a strategic perspective, in particular the social determinants of health and what keeps people engaged and connected:

*"No one is talking about prevention in core terms, for example, doing employment support as a means to keep poorly people well, rather than help prevent mental problems."*

(VCSE respondent)

*"There is not much sophisticated thought about social isolation, and what really keeps people engaged in social support and how to strengthen community involvement."*

(Public sector respondent)

In particular, there is a view that the social determinants of health are not sufficiently understood in the context of prevention:

*"I don't have a strong sense that people are working strategically on the prevention agenda – thinking is limited, for example, the main focus is on eating well, stopping smoking but not on the basis of the social determinants of health."*

(VCSE respondent)

What is clear from the respondents is that this is a very live agenda amongst VCSE respondents, but they struggle to demonstrate the value of prevention approaches:

*"It is getting harder and harder to demonstrate the value, some commissioners get it, but many don't fully appreciate the picture. That means that they don't know what is happening on the ground and they end up duplicating services through funding more and more with dwindling resources… instead of funding the existing services."*

(VCSE respondent)

The impression amongst community and voluntary respondents is that they are increasingly being asked to fill gaps in statutory provision, but without the resources and full recognition from commissioners that they are now fulfilling a fundamental role not only in prevention, but also in core service provision:

*"It feels like we're just fighting fires. We have had problems at a community level with demonstrating the return on investment for what we do; commissioners are looking for a very numerical, quick return, and community programmes don't always expose that quickly."*

(VCSE respondent)

This is a really important consideration because without consensus about the value of prevention, there cannot be a coherent approach to investment on the basis of the social determinants of health.

## 5.2 Health equity and marginalisation

A primary function of this programme of work was to identify what prevention meant for marginalised community groups. The term itself, 'marginalised group' was subject to some discussion. Are these hidden or somehow concealed population groups? Are they hard to reach, as so many service objectives seem to consider some communities? Or is it that services are hard to reach for some individuals and that there are population groups who, no matter how hard they try, cannot access the services they need, at the time they need them? And no matter how they are defined, what are the particular barriers and

challenges for prevention amongst these groups?

These are questions that not only concerned the key respondents, they are questions on which the literature is uncertain. To be marginalised commonly means to be at the edge of something, unable or unwilling to participate, not part of the mainstream narrative.

It is easy to think of marginalised individuals and groups as being hard to reach because they are in many ways unknown, their needs, aspirations, hopes and the conditions in which they live appear diffused, oblique, unobtainable to mainstream eyes. This was sometimes evident in historical approaches to population health, which viewed population groups as somehow homogenous, affected in the same ways by various health concerns and conditions. But more enlightened approaches know that this is not true. Populations are diverse, heterogenous and there are significant variations between and across different groups in terms of health, living conditions and culture and behaviours.

In fact, the need for greater inclusion and participation of communities in health received international prominence in the World Health Organisation's Alma Ata Declaration on primary health care in 1978, which called for social justice and equity in health service delivery:

*"The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries."*

(WHO, 1978).

***Table 1: Typology of impacts from marginalisation amongst adult populations***

| | Characteristics | Capacities | Access to resources |
|---|---|---|---|
| **Socially isolated** | Lonely; living alone; single (including single parents); unemployed; disabled; mobility restrictions; refugee and asylum seekers; intersection with age, ethnicity and sex; depression; LGBT | Limited social network; physical distance from family; long term health conditions; low support for personal needs; language and communication barriers; culture and identity; house bound | Poverty and low income; low literacy; Personal Independence Payment (PIP), universal credit; social renting; home ownership but cash poor – mainly over 55; reliant on public transport; digital exclusion; experience of discrimination |
| **Working poor** | Young families; single parents; young to mid-range adults; part time workers and those on zero hours contracts - gig economy workers; anxiety and stress | Reliance on close family and friends; limited travel capacity; food poverty; low self-esteem, aspirations not met | Limited access to leisure, holidays etc.; use of food banks; social renting or precarious home ownership; low educational attainment; reliant on public transport; digital exclusion |
| **Physical disabled** | Visual and auditory impairment; physical mobility restrictions; isolation, depression | Limited mobility; high communication needs; self-reliance – peer support; long term health conditions; under employment | Restricted or inappropriate service access; low income and reliance on benefits; restricted access to leisure and sport; experience of discrimination |
| **Mental illness** | Socially isolated; highly medicated; vulnerable to problematic alcohol and drug use; | Under employment; stress at work – intermittent or long-term sickness and absence; | High levels of primary and urgent care use; experience of stigma and discrimination; |
| **Socially vulnerable** | Frail elderly; victims of sexual assault and domestic violence; learning disabled; adult autism and Asperger's syndrome; carers; single adults; dementia; transient or travelling lifestyle; street homeless and sofa surfers; care leavers | Early childhood trauma manifesting in adult life; contact with the criminal justice system; family conflict, relationship problems; long term health conditions; low or impaired mobility – house bound; limited social networks; low educational attainment | Failure to meet service access thresholds; experience of stigma and discrimination; low or no mental capacity; residential care residents; little or no access to leisure and sport; poor literacy; unstable housing; over occupation; poverty and unemployment; transition from young people to adult services; digital exclusion; reliance on public transport |
| **BAME** | Diverse and heterogenous; marginalisation linked to racism and prejudice; generational divides | Faith and culture; close family and neighbourhood ties; language barriers; intersection between age and sex; long term health conditions; higher educational attainment not matched by employment | Acculturation; experience of racism and discrimination; unemployment; overcrowding; fear of mental health services; over contact with criminal justice system |

In 1986, the Ottawa Charter for Health Promotion suggested the incorporation of community capacity and empowerment as part of a broader conception of public health, which incorporated wellbeing, lifestyles and equal opportunities:

*"Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential."*

(WHO, 1986)

However, despite these clear statements on equity and capacities for wellbeing that encompass social justice and equality, there was little to define or operationalise participation for marginalised population groups (Montesanti et al, 2016).

Two conceptual barriers are identified in the literature:

1. The terms community and marginalisation are variously defined from ideas about community that stem from solidarity and sharing a common identity to geographical definitions and differing approaches to targeting of services, for example, whether it is about individuals or groups and how marginalisation can be experienced at different stages of the life course.

2. Frameworks and examples of participation and involvement have been variously used, but often without the required recognition that this is shaped by the lived experience and context of people's lives and is not a sequence of activities that can be done to people.

For respondents to this programme both barriers are relevant.

The conceptualisation of marginalised community groups encompasses:

- demographic characteristics;
- geography

- culture and identity
- physical and mental capacity; and
- socioeconomic disadvantage and access to resources.

Analysis of the interview transcripts has been used to develop a typology of marginalisation using characteristics, capacities and access to resources.

The presented typology (page 29) derives from the interviews with respondents and is not, as such a definitive list of all the factors that can impact on marginalisation. However, there are some common categories that are also supported by the literature, for example:

- Poverty and unemployment.
- Low educational attainment and poor literacy.
- Long term health conditions.
- Social isolation and restricted mobility.
- Stigma and discrimination.

The intersection between age, sex and ethnicity is a common feature and this is something that has been the focus of much concern about the differential impacts of Covid-19. The pandemic came about towards the end of this stage of the programme of work, but it is important to acknowledge learning about the impact of the pandemic on marginalisation and for prevention and management of risks for particular groups.

### 5.2.1 Covid-19 and the differential impacts by sex and ethnicity

The Covid-19 pandemic and the impact of social distancing and shielding has brought to light a number of concerns about the ways in which marginalisation can increase vulnerability. From the outset of the pandemic, the vulnerability of those who are older and have long term health conditions was known, but it is only more recently that the importance of age, sex and ethnicity have been recognised. For example:

- The highest age standardised diagnosis rates of Covid-19 per 100,000 population were in people of Black ethnic groups.
- After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity.
- People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10% and 50% higher risk of death when compared to White British.

There were also some important differences with respect to sex:

- Compared to previous years, all-cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males.
- Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females.

(PHE, 2020a)

In its subsequent report, Pubic Health England presented findings from both literature and feedback from over 4,000 people with a broad range of interests in BAME issues. These findings identified a number of factors that match the typology of marginalisation outlined above, for example:

- Covid-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups.
- Both ethnicity and income inequality are independently associated with Covid-19 mortality.
- Individuals from BAME groups are more likely to work in occupations with a higher risk of Covid-19 exposure.
- Individuals from BAME groups are more likely to use public transportation to travel to their essential work.

PHE found that historic racism and poorer experiences of healthcare or at work may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk (PHE, 2020b).

The context of historic racism and poorer experiences of public services have taken on additional resonance following the death of George Floyd in the USA and the global public reaction through the Black Lives Matter protests. This has become much more than a criminal justice issue, it goes to the heart of health equity, social justice and marginalisation.

There is more that needs to be understood with respect to Covid-19 and the intersection with sex and ethnicity, but what is clear is that there must be an explicit acknowledgement of the historical context of racism and discrimination and the lived experience of marginalisation.

## 5.3 Transport and infrastructure

One of the most commonly recurring themes amongst key respondents from workforce and residents and service users was transport:

"Transport is irregular and unreliable; it makes it difficult for the services to reach people – can't get them in." (VCSE respondent)

Cost and affordability for marginalised population groups are perceived to be significant barriers, but there are also perceived cultural barriers to using public transport:

"It's sometimes just a state of mind – a relatively short journey (10 miles) is considered another planet." (Public service respondent)

These cultural barriers are more commonly associated with more rural areas and those with deep local family ties where travelling outside of the immediate neighbourhood can be seen as unwelcoming and socially distant. This can remain a barrier even when a service provides transportation.

NHS hospital services in particular are seen to be inaccessible for some groups, once more partly due to frequency and cost, but also a perception that some services are inflexible in appointment times, or do not appreciate the impact that, for example, a 9.00 a.m. appointment can have with respect to public transport:

"Patients cannot get to out-patient services. Even if you can afford transport, the quality of transport is so poor. Service referrals aren't linking up either. Offering inappropriate time appointments i.e. 9.00 a.m. on the other side of the county." (Public service respondent)

Access to reliable and affordable public transportation has long been recognised as necessary in promoting inclusion and addressing marginalisation. Transportation is also increasingly recognised as integral to health and wellbeing, for example, improvements in air quality and reductions in carbon emissions from lower use of travel by planes and private cars can significantly improve pulmonary conditions.

The promotion of walking and cycling can reduce obesity with consequent benefits for related conditions such as heart disease and diabetes. Reducing the volume and frequency of private vehicle journeys and greater access to public transportation can yield a wide range of environmental and personal health benefits for individuals, local communities, wider society and the planet (Mindell, J S., 2017).

There have been marked improvements in air quality since the restrictions on movement and private transportation as a result of Covid-19, which in some instances may be improving mortality. However, these may be quickly reversed if a consequence of releasing restrictions is higher private car use and less use of public transportation.

Covid-19 has also brought to light fresh thinking about the importance of localities and proximity to essential infrastructure and amenities, including places of employment, schools, leisure facilities including parks and the local high street. A legacy of poor planning and urban design, neglect of rural and coastal community infrastructure and the impact of a decade of austerity have left many communities struggling to sustain their local identity and access to vital amenities and services.

Addressing this as we move towards recovery from Covid-19 will require political will, but also a radical shift in the approach to sustainable modes of transportation and increasing access for marginalised groups. This needs to go beyond transport planning and public health policy towards a wider shift in spatial planning that encompasses employment, education, access to health services and social activities within short distances of home.

A place-based approach to addressing marginalisation and preventing significant health harms needs to include a sustainable transportation system. Spatial planning that prioritises reliable and affordable public transport alongside incentives and infrastructure support to increase walking and cycling will result in greater inclusion, protect the environment, support the economy and improve health and wellbeing through prevention of significant health harms. This approach would also reduce road traffic injuries, increase social contact and improve air quality.

More cities and towns are adopting this kind of system, for example, in Scandinavia and in cities such as Copenhagen, Freiburg and Amsterdam. While some UK cities and towns have attempted to adopt similar approaches such as Bristol and Edinburgh, there is still much more that needs to be done to match the potential ambitions and benefits that such an approach can bring.

In order to ensure appropriate measures to inform policy makers, it may be necessary to develop mechanisms for a broader exploration of different modes of transportation and community choice. For example, how urban design attributes and transport mode choices including walking, cycling, public transport and private car use can contribute to or ameliorate marginalisation and improve health and wellbeing (Boulange et al., 2017).

## 5.4 Service access

For some services, particularly those in the community, voluntary and social enterprise sector, prevention and working with marginalised groups and communities is at the heart of service delivery. However, this is increasingly perceived to be from a perspective of secondary and tertiary prevention, for example, crisis intervention and providing mitigations to prevent worsening chronic health and care conditions. This is in part due to austerity and the subsequent uplift in access criteria and thresholds for a number of statutory services in mental health and adult social care. This is thought to have had two impacts:

1. For some individuals and groups there has been an increase in the experience of marginalisation resulting from exclusion from or limited access to services.

2. There has been a related rise in the complexity and needs of service users accessing VCSE services, which were not included in their original or historical commissioning and procurement arrangements.

5.4.1 Exclusion from and limited statutory service access

It is a common perception amongst workforce respondents and residents and service users that at a time when resources and budgets have been under tight fiscal constraints, the demand for services and the complexity of presenting needs has increased. An example of this can be seen in mental health services, whereby restrictions in funding for Community Mental Health Teams is perceived to have resulted in raised access thresholds that only include those with the most serious mental illness. Service users described how they felt marginalised as a result of not meeting the raised access criteria and feeling that they were excluded from the service:

"You can be left feeling cut off, people are only being seen by the mental health service if they are in crisis, just because you're not in crisis doesn't mean you don't need help." (Service user respondent)

Similar issues are reported with respect to a rise in thresholds for access to social care through the Care Act, in particular for older people. Another example from respondents related to exclusions due to age, for example the transition from children and young people's services to adults and from adult to elderly. Although the latter two are long standing issues and not necessarily related to the impact of austerity, they are perceived as exclusionary because of the wider context of service limitations and restrictions.

Professional respondents and service users and residents thought that prevention was compromised by restricted service access, as people were increasingly left to fall back on their own resources without adequate support. This inevitably led to an increase in people reaching crisis points and being at risk of developing more acute and chronic health conditions.

### 5.4.2 Increased demand and complexity in VCSE services

The perceived impact of the withdrawal of many statutory services from supporting people with less acute needs, is that there has been an uplift in presentations to the CVSE sector of people who have more complex and challenging needs and conditions:

*"There are increasing numbers of complex mental health needs that the service contract was never designed to support."*

(CVS respondent)

This shift is placing additional pressures on the CVSE sector as they were not designed or contracted to address these challenges. There are also increases in demand and complexity arising from Covid-19, for example in many cases the CVSE sector have become frontline services in addressing needs, alongside health and social care services. This includes, care homes and hospices, food banks, befriending services, mental health support and support for domestic violence. Any further weakening of the CVSE sector would inevitably result in further increases on demand on the statutory health and care services. But Covid-19 is threatening the sector:

- Charities stand to have lost out on an estimated £4bn in the 12 weeks since the start of this crisis.
- The financial measures announced for business are proving to be of limited benefit to charities, although they are eligible to apply for them.
- The Chancellor's £750m support package for charities is welcome, but it will not be enough to prevent good charities around the country from closing their doors. Even many that survive will look very different in a few months' time, with a severely reduced capacity to provide the support that people rely on.

(NCVO, 2020)

However, the future need not be entirely bleak. The CVSE sector has seen to be essential during the pandemic and many new ways of working in partnership with the statutory health and social care sectors have developed. A good example is how the Parish, Town and Community Councils have responded to Covid-19:

- co-ordination of a buddy helpers' scheme for those in isolation (Appledore Parish Council);
- 171 volunteers offering help with shopping, phone calls, prescription collection etc. (Benenden Parish Council);
- a community hotline and support network (Woodchurch Parish Council);
- providing transport, befriending and support to those in need (Swanley Town Council);
- establishing WhatsApp groups for people in need (Shorne Parish Council in collaboration with Gravesham Council);
- a volunteer service set up to help people in the Parish of Meopham who are self-isolating or shielding at home (Meopham Parish Council).

These are just a few examples of the many frontline services that have been delivered during the pandemic. There is an opportunity to learn from this and build on the strengths of these new ways of working.


Northfle

# 6 Marginalisation in place – comparison of data across Isle of Sheppey and Northfleet

Respondents identified the demography and characteristics of marginalised community groups, but it was also considered important to explore the context of this from the perspective of place. It was decided that this would be done by comparing two areas: Northfleet in Gravesham and the Isle of Sheppey in Swale. This not only provides two contrasting examples of place, but the highly localised nature of the enquiry enables a more nuanced approach to the dynamics between infrastructure, service planning and delivery and community participation.

The Breaking Barriers Playbook is a place-based change model and there is learning already from other localities in the programme about the significance of place and how this interacts with the social determinants of health. Thus far, four aspects of this wider learning have emerged:

1. How people experience place is very localised, it operates at the level of the street and neighbourhood in which people live, the local shops, parks and amenities that are within easy reach. This is also a factor that has taken on even greater significance due to the social distancing restrictions and travel limitations imposed by Covid-19.

2. Sustainability and Transformation Plans and Integrated Care Systems are useful for planning at scale, but they are systems not places and do not easily lend themselves to considering the needs of place-based population groups.

3. Workforce transformation plans are characterised by organisational and professional silos rather than place with the subsequent risk that duplication and opportunities for innovation and new roles and competencies can be lost.

4. Communities are often poorly engaged in decision making about place-based service developments and infrastructure needs. This includes the need for stronger models for partnership working with local VCSE agencies.

These aspects are discussed further in the context of Kent in the following section, but before doing this the salient points of contrast are explored for the two target localities.

## 6.1 Northfleet

Northfleet is a town in the borough of Gravesham, North West Kent, immediately to the west of Gravesend and on the border with the borough of Dartford. It has two wards: Northfleet North and Northfleet South. Both areas are urban and marked by relative deprivation, but Northfleet North scores higher on the Index of Multiple Deprivation (32 compared to 22.7 for Northfleet South).

There are some key variations in the characteristics of residents with Northfleet North having more people who are transient renters - single people privately renting low cost homes (21.2% compared to 14.7% in Northfleet South). However, both areas score higher for transient renters than the county average (6%). Other key variations include:

- Northfleet North has significantly more people who are characterised as municipally challenged - urban renters of social housing facing an array of challenges (18.9% compared to 2.3% in Northfleet South and a county average of 1.4%).
- Northfleet South has more residents who are Aspiring Homemakers – younger households settling down (28.1% compared to 14.2% in Northfleet North and a country average of 12.4%).
- Northfleet North has more settled residents with a strong sense of identity (18.5% compared to 13.1% in Northfleet South and a county average of 1.5%).

- Northfleet South has more people characterised as Senior security – elderly people with assets (5.8% compared to 0.9% in Northfleet North, but both areas are below the county average of 10.7%).
- Northfleet South has more families with limited resources who have to budget (16.1% compared to 13.3% in Northfleet North and a county average of 8.8%).
- Northfleet South has fewer Rental hubs - educated young people privately renting (4.3% compared to 7.7% in Northfleet North and a county average of 6.9%).6.1.1 Economic disadvantage: Northfleet

## Table 2: Resident comparisons Northfleet North and Northfleet South

| Population group | Northfleet North | Northfleet South | Gravesham | Kent County |
|---|---|---|---|---|
| A: County living – well off owners in rural locations | 0.0% | 0.0% | 3.0% | 8.5% |
| B: Prestige positions – established families in large homes | 0.0% | 0.0% | 7.0% | 8.9% |
| C: City prosperity – high status city dwellers living in central locations | 0.0% | 0.0% | 0.1% | 0.4% |
| D: Domestic success – thriving families | 0.0% | 0.4% | 6.2% | 9.8% |
| E: Suburban Stability – mature suburban owners | 0.9% | 8.0% | 10.4% | 7.4% |
| F: Senior Security – elderly people with assets | 0.9% | 5.8% | 10.6% | 10.7% |
| G: Rural Reality – households living in inexpensive homes in village communities | 0.0% | 0.0% | 1.9% | 7.3% |
| H: Aspiring Homemakers – younger households settling down | 14.2% | 28.1% | 12.6% | 12.4% |
| I: Urban Cohesion – residents of settled urban communities with a strong sense of identity | 18.5% | 13.1% | 8.6% | 1.5% |
| J: Rental Hubs – educated young people privately renting | 7.7% | 4.3% | 6.3% | 6.9% |
| K: Modest Traditions – mature homeowners of valued homes | 1.5% | 5.4% | 5.6% | 3.8% |
| L: Transient Renters – single people privately renting low cost homes | 21.2% | 14.7% | 7.5% | 6.0% |
| M: Family Basics – families with limited resources who have to budget | 13.3% | 16.1% | 11.8% | 8.8% |
| N: Vintage Value – elderly people reliant on support to meet financial needs | 3.0% | 1.8% | 5.1% | 5.2% |
| O: Municipal Challenge – urban renters of social housing facing an array of challenges | 18.9% | 2.3% | 3.1% | 1.4% |

Source: Experion Ltd 2014 - taken from Kent County Council Strategic Commissioning Analytics, version date November 4th 2019.

Within North Northfleet North, there are four Lower Layer Super Output Areas (LSOAs), which are geospatial statistical units used in England and Wales to facilitate the reporting of small area statistics. They are part of the Office for National Statistics (ONS) coding system and have a minimum population of 1,000 with a mean size of 1,500. The following table compares the Index of Multiple Deprivation (IMD) for the four LSOAs. The IMD is an overall relative measure of deprivation constructed by combining seven domains of deprivation according to their respective weights, as described below:

- The **Income Deprivation Domain** measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).
- The **Employment Deprivation Domain** measures the proportion of the working-age population in an area involuntarily excluded from the labour market. This includes people who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities.
- The **Education, Skills and Training Deprivation Domain** measures the lack of attainment and skills in the local population. The indicators fall into two sub-domains: one relating to children and young people and one relating to adult skills.
- The **Health Deprivation and Disability Domain** measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation.
- The **Crime Domain** measures the risk of personal and material victimisation at local level.

- The **Barriers to Housing and Services Domain** measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: 'geographical barriers', which relate to the physical proximity of local services, and 'wider barriers' which includes issues relating to access to housing such as affordability.
- The **Living Environment Deprivation Domain** measures the quality of the local environment. The indicators fall into two sub-domains. The 'indoors' living environment measures the quality of housing; while the 'outdoors' living environment contains measures of air quality and road traffic accidents.

In addition to the Index of Multiple Deprivation and the seven domain indices, there are two supplementary indices: the Income Deprivation Affecting Children Index and the Income Deprivation Affecting Older People Index.  The following table sets out their degree of deprivation against a series of metrics. It asked the question whether the LSOA is within the top 20% most deprived in England for each metric.6.1.2 Ethnicity: Northfleet

## Table 3: Northfleet North SLOA comparisons of IMD rankings for top 20% most deprived areas (2015)

| LSOA | IMD Rank 2015 | Income Rank | Employment Rank | Health Deprivation & Disability Rank | Education Skills and Training Rank | Barriers to Housing & Services Rank | Crime Rank | Living Environment Rank | Income Deprivation Affecting Children Index | Income Deprivation Affecting Older People |
|---|---|---|---|---|---|---|---|---|---|---|
| **Gravesham 001A** | No | No | No | No | No | No | No | No | No | No |
| **Gravesham 001B** | **Yes** | **Yes** | **Yes** | No | **Yes** | No | No | No | **Yes** | No |
| **Gravesham 001C** | **Yes** | **Yes** | **Yes** | **Yes** | **Yes** | **Yes** | **Yes** | No | **Yes** | **Yes** |
| **Gravesham 001D** | No | No | No | No | **Yes** | No | **Yes** | No | **Yes** | No |

Source: Kent County Council - Council Strategic Commissioning Analytics, version date July 18th 2015.

The two LSOAs (001B and 001C) have the greatest deprivation scores across multiple categories. More recent data from the IMD for 2019 enables comparison across each LSOA for the top 10% IMD ranking of most deprived areas.

## Table 4: Northfleet North SLOA comparisons of IMD rankings for top 10% most deprived areas (2019)

| LSOA | IMD Rank 2015 | Income Rank | Employment Rank | Health Deprivation & Disability Rank | Education, Skills and Training Rank | Barriers to Housing & Services Rank | Crime Rank | Living Environment Rank | Income Deprivation Affecting Children Index | Income Deprivation Affecting Older People |
|---|---|---|---|---|---|---|---|---|---|---|
| Gravesham 001A | No | No | No | No | No | No | No | No | No | No |
| Gravesham 001B | No | No | No | No | No | No | Yes | No | No | No |
| Gravesham 001C | **Yes** | **Yes** | No | No | **Yes** | **No** | **Yes** | No | Yes | No |
| Gravesham 001D | No | No | No | No | No | No | No | No | No | No |

Source: Kent County Council Strategic Commissioning Analytics, version date November 4th 2019.

The above data demonstrates the importance of viewing marginalisation in the context of place, in particular, place as a very local, neighbourhood area. The overall IMD ranking for Northfleet North remains unchanged from 2015 to 2019, but there has been an increase in the crime rating for Gravesham 001B from not being in the top 20% most deprived deciles, to being in the top 10%. It should be noted that overall Gravesham has experienced the largest decrease in deprivation relative to other areas in Kent (Kent County Council, 2020).

Within Northfleet South, there are five LSOAs and these are marked by fewer deprivation rankings in the top 20% in 2015:

## Table 5: Northfleet South SLOA comparisons of IMD rankings for top 20% most deprived areas (2015)

| LSOA | IMD Rank 2015 | Income Rank | Employment Rank | Health Deprivation & Disability Rank | Education, Skills and Training Rank | Barriers to Housing & Services Rank | Crime Rank | Living Environment Rank | Income Deprivation Affecting Children Index | Income Deprivation Affecting Older People |
|---|---|---|---|---|---|---|---|---|---|---|
| Gravesham 004C | No | No | No | No | No | No | **Yes** | No | No | No |
| Gravesham 004D | No | No | No | No | No | No | **Yes** | No | No | No |
| Gravesham 004E | No | No | No | No | No | No | **Yes** | **Yes** | No | No |
| Gravesham 006A | No | No | No | No | No | No | No | No | No | No |
| Gravesham 006B | No | No | No | No | **Yes** | No | **Yes** | No | No | **Yes** |

Source: Kent County Council - Council Strategic Commissioning Analytics, version date July 18th 2015.

The significant difference is that five of the SLOAs in Northfleet South ranked in the top 20% for crime. In 2019, two of the SLOAs rank in the top 10% for crime:

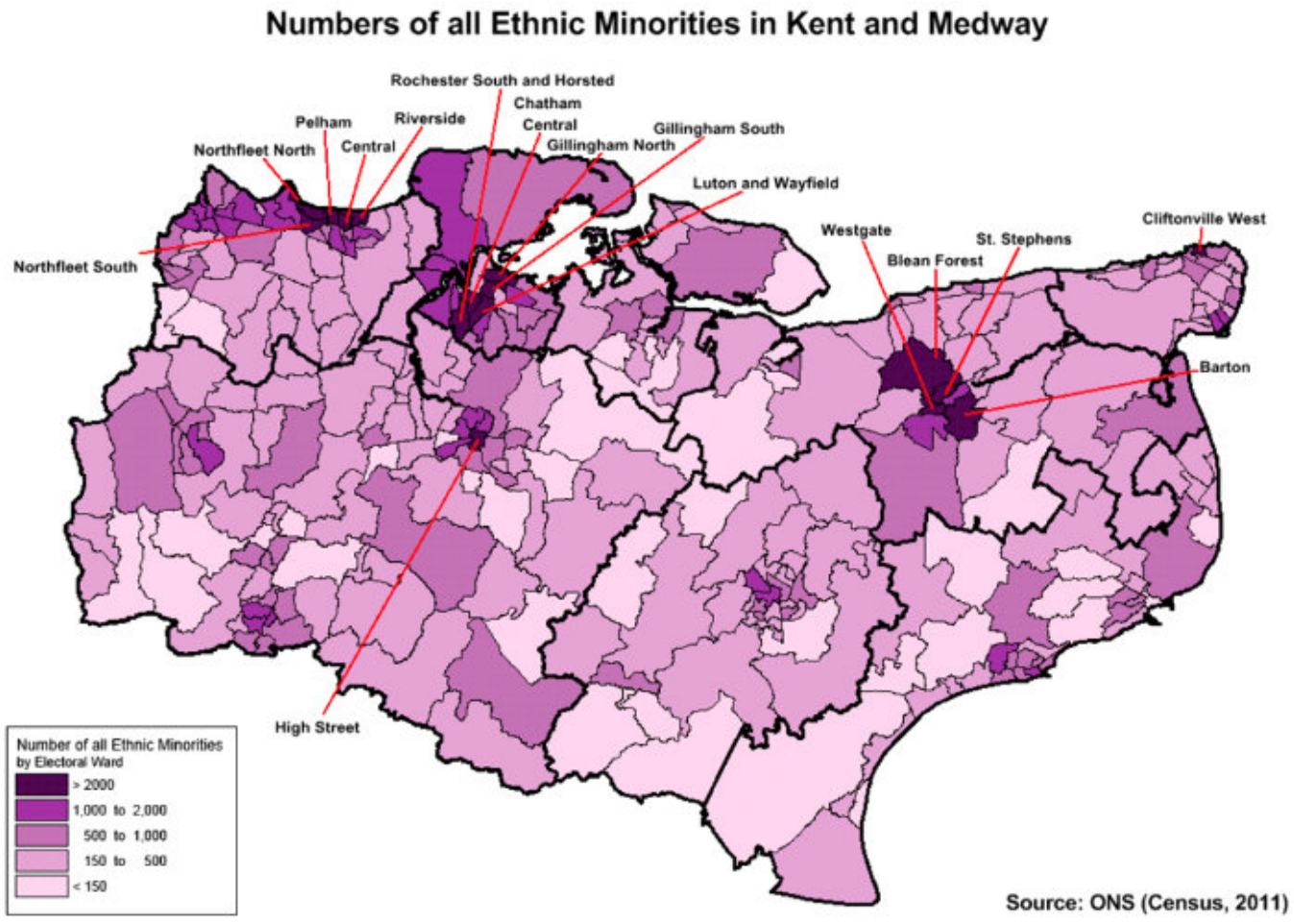
## Table 6: Northfleet South SLOA comparisons of IMD rankings for top 10% most deprived areas (2019)

| LSOA | IMD Rank 2015 | Income Rank | Employment Rank | Health Deprivation & Disability Rank | Education, Skills and Training Rank | Barriers to Housing & Services Rank | Crime Rank | Living Environment Rank | Income Deprivation Affecting Children Index | Income Deprivation Affecting Older People |
|---|---|---|---|---|---|---|---|---|---|---|
| Gravesham 004C | No | No | No | No | No | No | **Yes** | No | No | No |
| Gravesham 004D | No | No | No | No | No | No | No | No | No | No |
| Gravesham 004E | No | No | No | No | No | No | No | **Yes** | No | No |
| Gravesham 006A | No | No | No | No | No | No | No | No | No | No |
| Gravesham 006B | No | No | No | No | **Yes** | No | **Yes** | No | No | No |

Source: Kent County Council Strategic Commissioning Analytics, version date November 4th 2019.

## Ethnicity: Northfleet

There are some important variations in the ethnic breakdown of Gravesham and Northfleet compared to other areas in Kent. The Black, Asian and Minority Ethnic (BAME) population of Kent and Medway is approximately 198,453, which equates to 11.4% of the entire population. This has increased from the 2001 Census when the ethnic population was 6.2% (97,672 persons). Northfleet North is one of the areas that has much higher density of BAME population groups:



Dartford, Gravesham and Swanley CCG has the highest percentage of BAME population groups (17.4%):

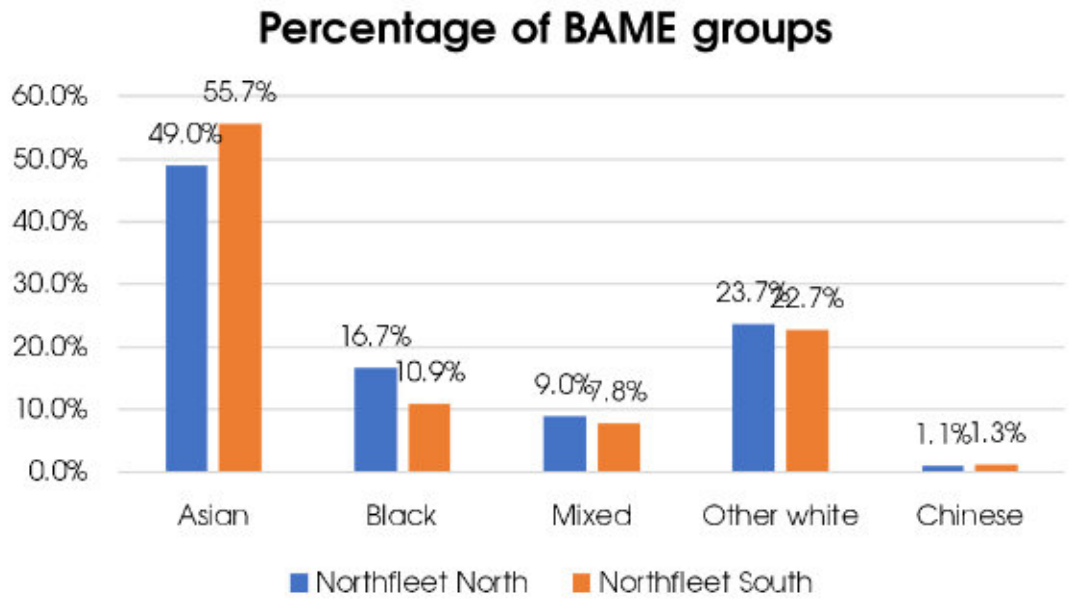
**Table 7: Ethnic minority groups by CCG**

**Percentage of Ethnic Minority Groups by CCG**

| Clinical Commissioning Group | All Ethnic Minorities | Asian | Black | Mixed | Eastern European | Other White | Chinese |
|---|---|---|---|---|---|---|---|
| NHS Ashford CCG | 10.5% | 3.3% | 1.2% | 1.4% | 0.2% | 4.2% | 0.4% |
| NHS Canterbury and Coastal CCG | 10.9% | 2.8% | 1.0% | 1.5% | 0.4% | 5.1% | 0.8% |
| NHS Dartford, Gravesham and Swanley CCG | 17.4% | 6.8% | 2.7% | 1.9% | 0.6% | 4.8% | 0.5% |
| NHS Medway CCG | 14.1% | 5.0% | 2.4% | 1.9% | 0.4% | 4.1% | 0.4% |
| NHS South Kent Coast CCG | 8.3% | 2.8% | 0.4% | 1.1% | 0.5% | 3.8% | 0.3% |
| NHS Swale CCG | 7.4% | 1.2% | 1.3% | 1.2% | 0.1% | 3.6% | 0.2% |
| NHS Thanet CCG | 9.6% | 1.9% | 0.7% | 1.6% | 0.9% | 5.1% | 0.3% |
| NHS West Kent CCG | 9.7% | 2.4% | 0.6% | 1.5% | 0.3% | 4.8% | 0.4% |
| **Kent and Medway** | **11.5%** | **3.5%** | **1.3%** | **1.6%** | **0.4%** | **4.5%** | **0.4%** |

The percentage in Northfleet North is thought to be as high as 30%.

The main BAME groups are Asian (approximately 50% of the BAME population) followed by White other (23%):




Source Kent County Council: Ethnicity in Kent and Medway

### 6.1.3 Health, disability and long-term conditions: Northfleet

Residents in Northfleet South have relatively good health compared to Gravesham as a **whole and the county:**

**Table 7: Comparisons of self-reported health in Northfleet South**

| 2011 | Northfleet South | | Gravesham | | KCC Area | |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| ALL PEOPLE - Total | 7,638 | 100% | 101,720 | 100% | 1,463,740 | 100% |
| Day-to-day activities limited a lot | 507 | 6.6% | 7,796 | 7.7% | 116,407 | 8.0% |
| Day-to-day activities limited a little | 644 | 8.4% | 9,546 | 9.4% | 140,631 | 9.6% |
| Day-to-day activities not limited | 6,487 | 84.9% | 84,378 | 83.0% | 1,206,702 | 82.4% |
| **2011** | **Northfleet South** | **Gravesham** | **KCC Area** | | | |
| **General Health - all people** | **7,638** | **100%** | **101,720** | **100%** | **1,463,740** | **100%** |
| Very good health | 3,587 | 47.0% | 47,298 | 46.5% | 683,205 | 46.7% |
| Good health | 2,732 | 35.8% | 35,572 | 35.0% | 510,399 | 34.9% |
| Fair health | 963 | 12.6% | 13,629 | 13.4% | 194,931 | 13.3% |
| Bad health | 277 | 3.6% | 4,104 | 4.0% | 58,536 | 4.0% |
| Very bad health | 79 | 1.0% | 1,117 | 1.1% | 16,669 | 1.1% |

Source: Kent County Council Strategic Commissioning Analytics, version date November 4th 2019.

The picture for Northfleet North is not dissimilar but there are marginally more people reporting bad or very bad health compared to Northfleet South, Gravesham and the County as a whole:

**Table 8: Comparisons of self-reported health in Northfleet North**

| 2011 | Northfleet North | | Gravesham | | KCC Area | |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| ALL PEOPLE - Total | 7,803 | 100% | 101,720 | 100% | 1,463,740 | 100% |
| Day-to-day activities limited a lot | 590 | 7.6% | 7,796 | 7.7% | 116,407 | 8.0% |
| Day-to-day activities limited a little | 629 | 8.1% | 9,546 | 9.4% | 140,631 | 9.6% |
| Day-to-day activities not limited | 6,584 | 84.4% | 84,378 | 83.0% | 1,206,702 | 82.4% |
| **2011** | **Northfleet North** | **Gravesham** | **KCC Area** | | | |
| | **No.** | **%** | **No.** | **%** | **No.** | **%** |
| General Health - all people | 7,803 | 100% | 101,720 | 100% | 1,463,740 | 100% |
| Very good health | 3,648 | 46.8% | 47,298 | 46.5% | 683,205 | 46.7% |
| Good health | 2,738 | 35.1% | 35,572 | 35.0% | 510,399 | 34.9% |
| Fair health | 944 | 12.1% | 13,629 | 13.4% | 194,931 | 13.3% |
| Bad health | 343 | 4.4% | 4,104 | 4.0% | 58,536 | 4.0% |
| Very bad health | 130 | 1.7% | 1,117 | 1.1% | 16,669 | 1.1% |

Source: Kent County Council Strategic Commissioning Analytics, version date November 4th 2019.

This may seem counterfactual given that life expectancy is lower in Northfleet North (72 years for males compared to 79.6 for Gravesham and 79.9 for Kent; 77 years for females compared to 83.6 for Gravesham and 83.4 for Kent). Life expectancy is also lower in Northfleet South by similar percentages for males and females.

The ONS metric is a self-reported measure of health and wellbeing and while this has a good track record of reliability, it can mask certain differences amongst groups. For example, the data is not shown for ethnic groups, who may report poorer health and some groups are known to optimise their self-reports due to cultural and age factors that make people less willing to admit to poor health.

What the data does show is the limitation of solely focusing on health-related measures as this could give a more positive picture of issues that may be more related to marginalisation and deprivation factors. It is important to consider the profile of needs and demographics in the round.

## 6.2 The Isle of Sheppey

The Isle of Sheppey is a largely rural, island community in the borough of Swale, North West Kent. It has five wards: Sheerness, Minster Cliffs, Sheppey East, Sheppey Central and Queensborough and Halfway (for the purpose of the Playbook programme the focus is on the first four wards). The largest town on the island is Sheerness and whole north coast is dotted with caravan parks and holiday homes, which adds a distinct character to the population as many are not residents, but only stay temporarily.

There are some key variations in the characteristics of residents across the four wards with Sheerness having significantly more transient renters - single people privately renting low cost homes (31.7% compared to 7.4% in Swale and 6% across Kent). Other key variations include:

- Minster Cliffs has more residents characterised as Domestic success - thriving families (14.5% to 8.5% in Swale and a county average of 9.8%).
- Minster Cliffs and Sheppey central have more people characterised as Suburban stability – mature suburban owners (19.5% in Minster Cliffs and 15.2% in Sheppey central (compared to 9.2% in Swale and a country average of 7.4%).
- Minster Cliffs and Sheppey East has more residents characterised by Rural Reality – households living in inexpensive homes in village communities (21.4% in Minster Cliffs and 15.7% in Sheppey East (compared to 7.1% in Swlae and a county average of 7.3%).
- Sheppey Central has significantly more people characterised as Aspiring Homemakers – younger households settling down (35.1% compared to 16.7% in Swale and a county average of 12.4%).

- Sheerness has significantly more residents characterised as Family Basics – families with limited resources who have to budget (30.4% compared to 10.3% in Swale and a county average of 8.8%).
- Sheerness has more people characterised by Vintage Value – elderly people reliant on support to meet financial needs (8.6% compared to 1.8% for Swale and a county average of 1.4%).

**Table 9: Resident comparisons across the four wards on the Isle of Sheppey**

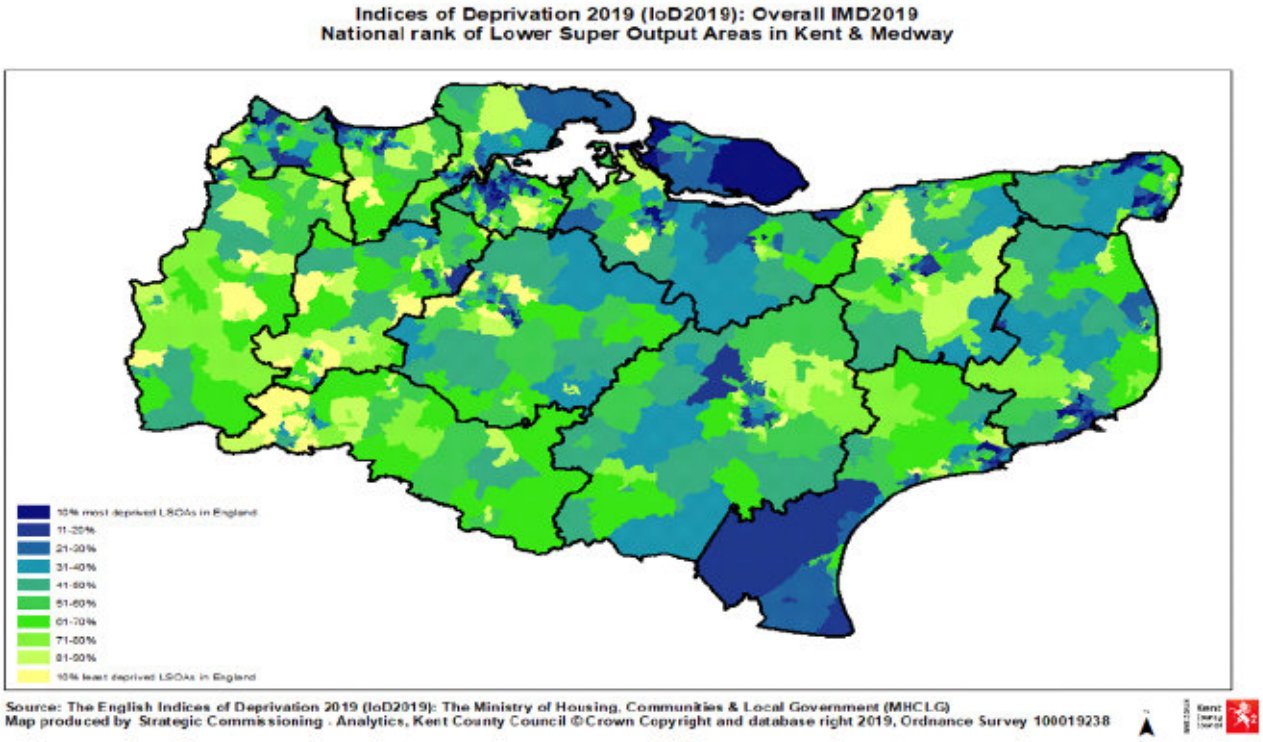
| Population group | Sheerness | Minster Cliffs | Sheppey East | Sheppey central | Swale | KCC |
|---|---|---|---|---|---|---|
| A: County living – well off owners in rural locations | 0.0% | 3.5% | 4.9% | 1.8% | 6.6% | 8.5% |
| B: Prestige positions – established families in large homes | 0.0% | 1.8% | 3.9% | 0.0% | 3.5% | 8.9% |
| C: City prosperity – high status city dwellers living in central locations | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.4% |
| D: Domestic success – thriving families | 0.0% | 14.5% | 0.0% | 8.5% | 8.5% | 9.8% |
| E: Suburban Stability – mature suburban owners | 1.2% | 19.5% | 0.0% | 15.2% | 9.2% | 7.4% |
| F: Senior Security – elderly people with assets | 0.1% | 15.1% | 1.2% | 10.6% | 8.9% | 10.7% |
| G: Rural Reality – households living in inexpensive homes in village communities | 0.0% | 21.4% | 51.7% | 7.1% | 11% | 7.3% |
| H: Aspiring Homemakers – younger households settling down | 4.1% | 9.9% | 0.1% | 35.1% | 16.7% | 12.4% |
| I: Urban Cohesion – residents of settled urban communities with a strong sense of identity | 0.0% | 0.0% | 0.0% | 0.0% | 0.1% | 1.5% |
| J: Rental Hubs – educated young people privately renting | 0.7% | 0.0% | 0.0% | 0.4% | 1.7% | 6.9% |
| K: Modest Traditions – mature homeowners of valued homes | 9.5% | 3.6% | 0.0% | 4.6% | 7.0% | 3.8% |
| L: Transient Renters – single people privately renting low cost homes | 31.7% | 1.2% | 0.0% | 2.6% | 7.4% | 6% |
| M: Family Basics – families with limited resources who have to budget | 30.4% | 4.9% | 0.4% | 9.9% | 10.3% | 8.8% |
| N: Vintage Value – elderly people reliant on support to meet financial needs | 13.8% | 4.4% | 3.2% | 4.2% | 5.3% | 5.2% |
| O: Municipal Challenge – urban renters of social housing facing an array of challenges | 8.6% | 0.0% | 0.4% | 0.0% | 1.8% | 1.4% |

### 6.2.1 Economic disadvantage: Isle of Sheppey

It is not possible to match IMD data for Swale due to new ward boundaries coming into effect in some local authority districts, which includes Swale. However, it is worth noting that while the number of Kent LSOAs that are within the 10% most deprived LSOAs in England between the IMD2015 and the IMD2019 remains at 51, some areas such as Swale and other lesser deprived areas have witnessed a decline.

For example, four areas have experienced an increase in the number of LSOAs within the most deprived decile: Swale (+2); Ashford and Dover (both with +1) and Canterbury, which now has 2 LSOAs within the 10% most deprived LSOAs for IMD2019 when there were none in the IMD2015.

In fact, Swale has the second highest number of LSOAs to remain within the 10% most deprived LSOAs for the IMD2015 and the IMD2019 with 14. This accounts for 16% of all LSOAs in Swale (Kent, 2020):

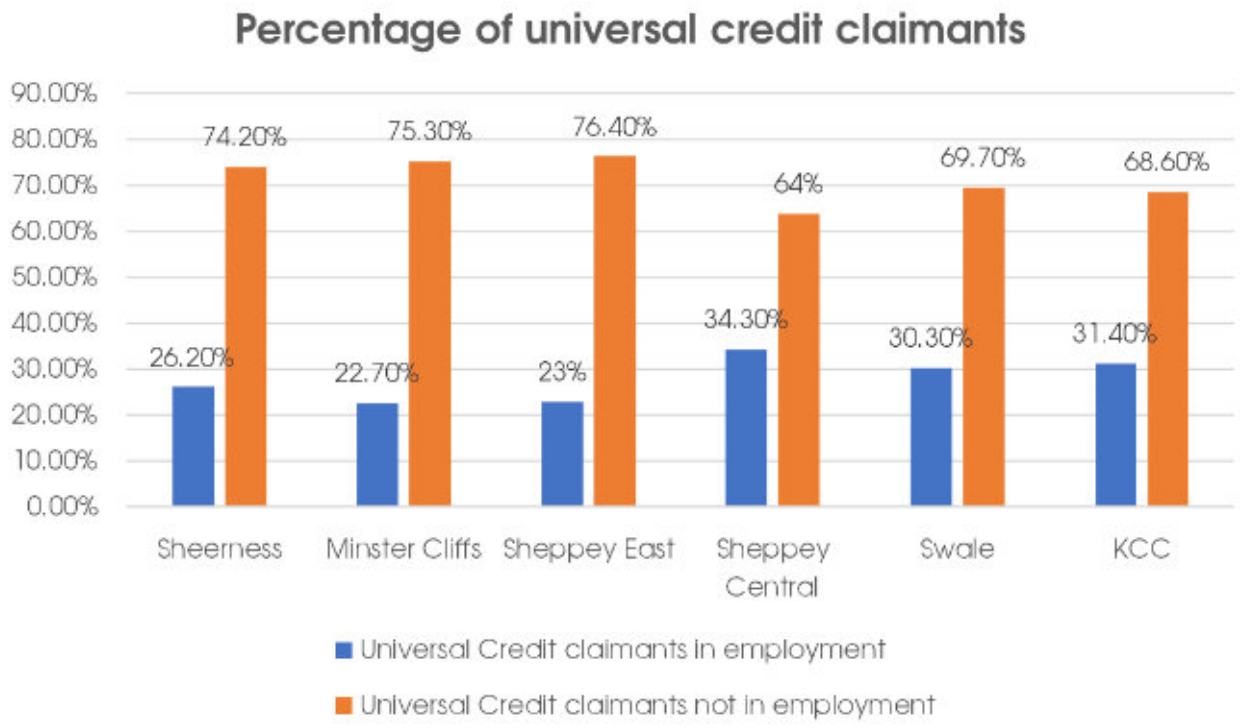


Out of the 14 LSOAs in Swale that are within the top 10% of deprivation rankings for both Kent and nationally, nine are with Sheerness (64%), two are in Sheppey East and one is Sheppey Central.

### 6.2.2 Related measures of income deprivation: Isle of Sheppey

The following shows benefit claimant data for each of the wards. The highest percentage universal credit claimant count for not in employment is in Sheppey East (76.4% compared to 69.7% for Swale and 68.6% for Kent).

The highest percentage universal credit claimant count for those in employment is in Sheppey central (34.3% compared to 30.3% for Swale and 31.4% for Kent):

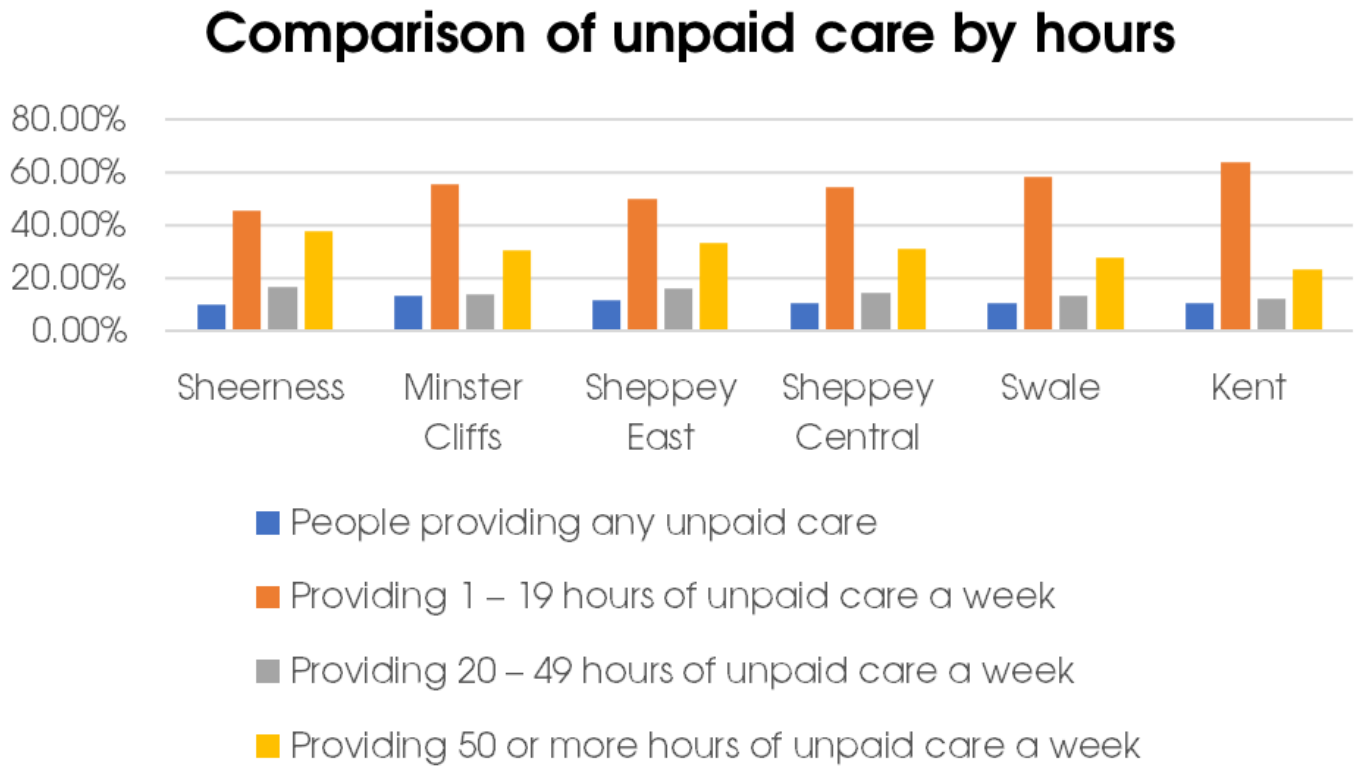



Source: Kent County Council Strategic Commissioning Analytics, version date November 4th 2019.

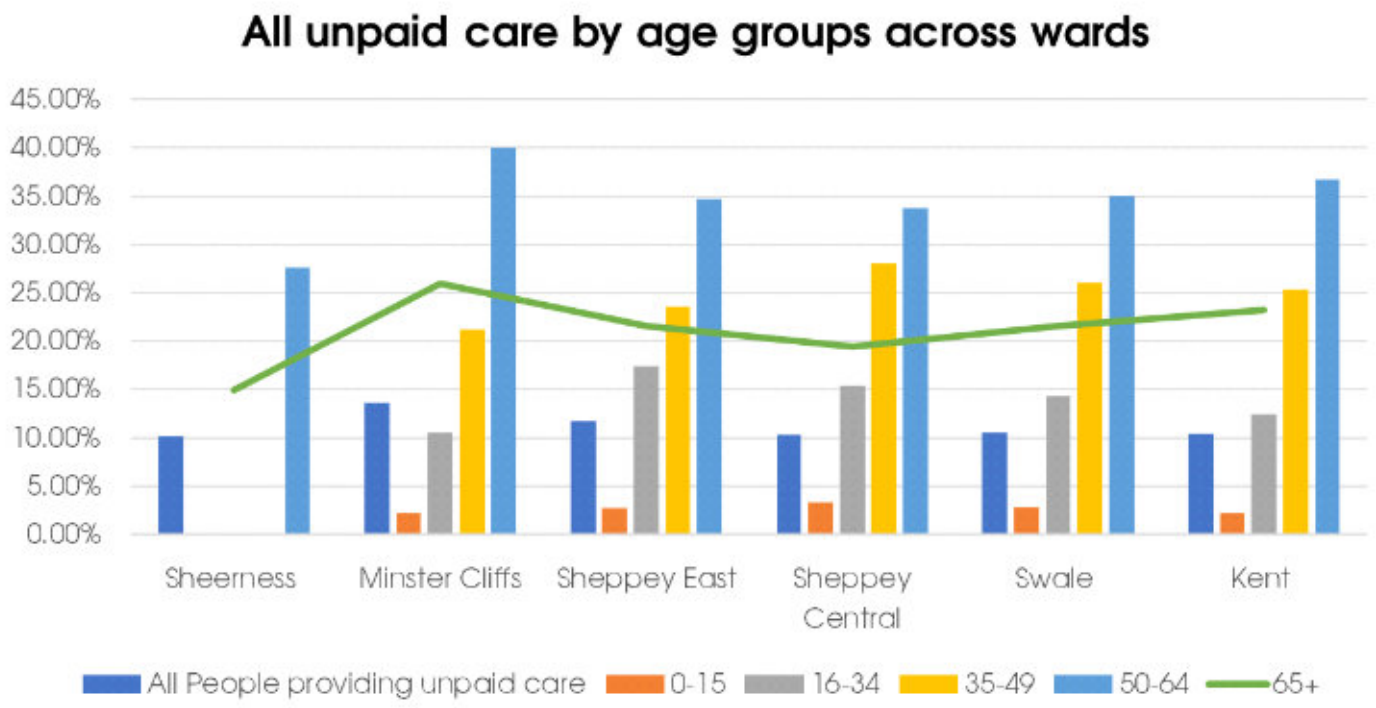
According to 2019 DWP Personal Independence Payment (PIP) data, 8.2% of all residents in Sheerness are claiming disability benefit of some kind. This is higher than the borough average (6.2%) and the Kent wider average (5.4%). The rate of PIP claimants in Sheerness (7.6%) is also significantly higher than the Kent county average (3.3%).

### 6.2.3 Caring: Isle of Sheppey

While the overall number of people providing unpaid care is similar in Sheerness, Swale, and Kent county, there are increasing disparities when the hours of unpaid care increases (37.8% of carers in Sheerness providing 50 hours or more of unpaid care compared to 28.1% in Swale and 23.6% in Kent);



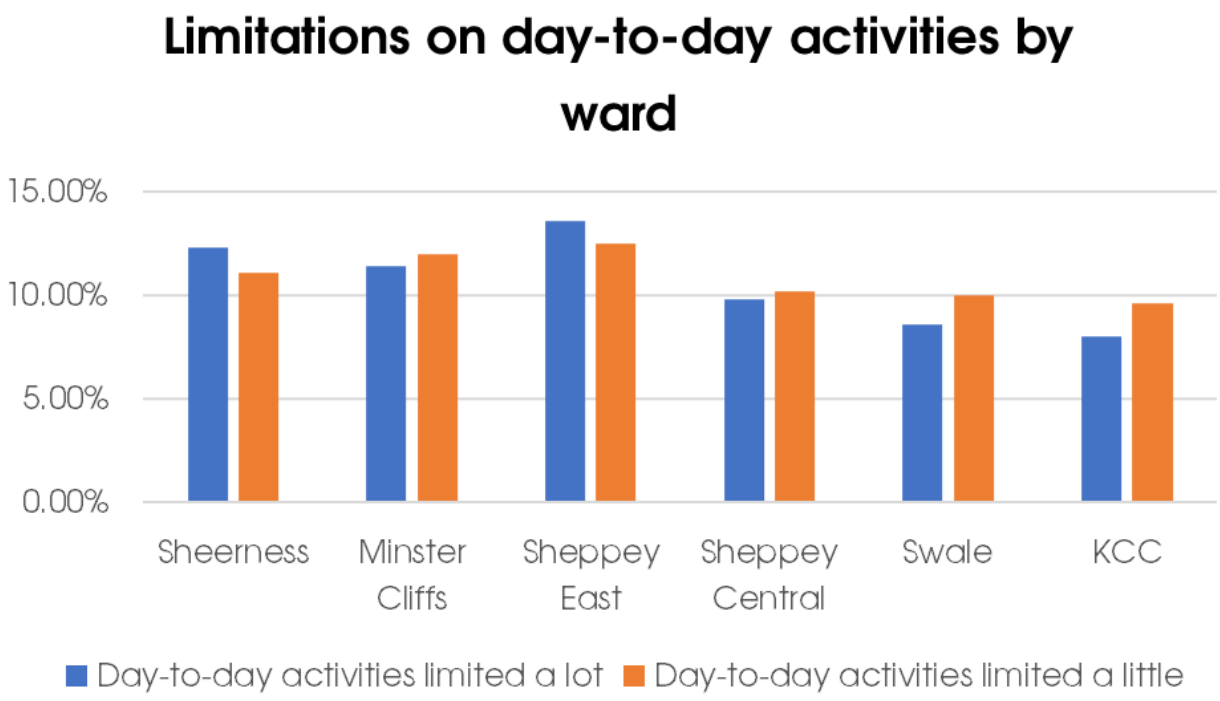
It is younger people of working age who appear to bear the brunt of this unpaid work. With the 16-34 year old bracket in Sheerness representing nearly double that of the Kent county average (24.3% compared to 14.3% in Swale and 12.4% in Kent):



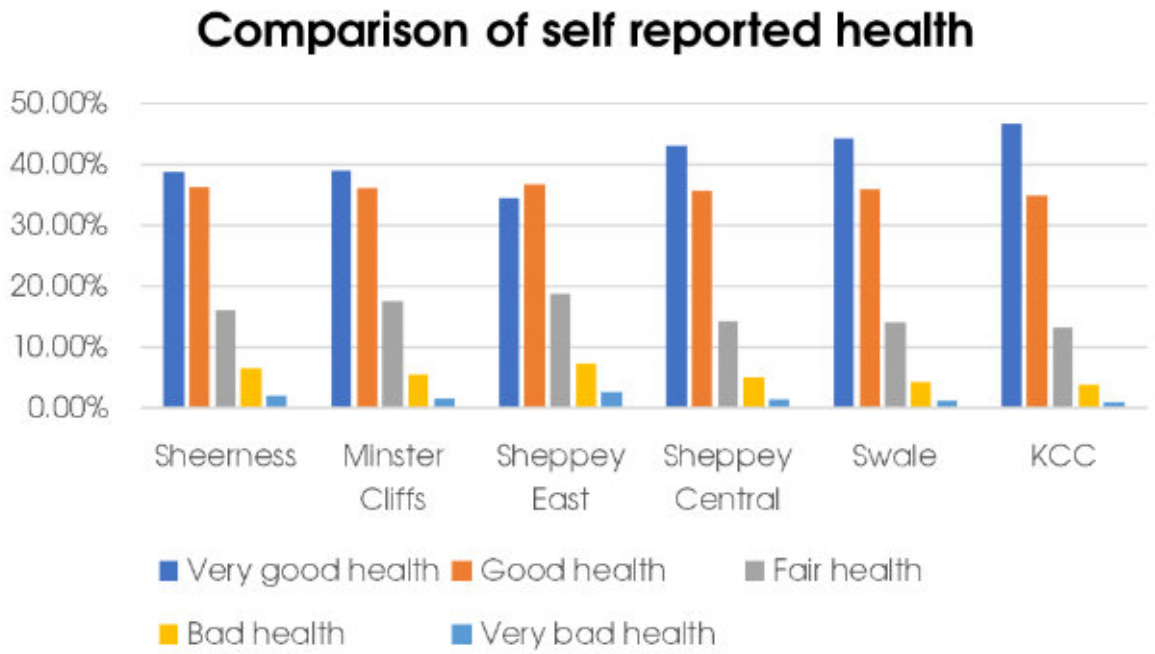

Young carers are particularly vulnerable to marginalisation as they often miss out on peer associations, schooling and leisure time as a result of their caring responsibilities.

### 6.2.4 Comparisons of self-reported health: Isle of Sheppey

Compared to Swale and the county average, the numbers of people whose day-to-day activities are limited a lot is slightly higher, with the highest numbers in Sheppey East (13.6% compared to 8.6% in Swale and 8% in Kent):

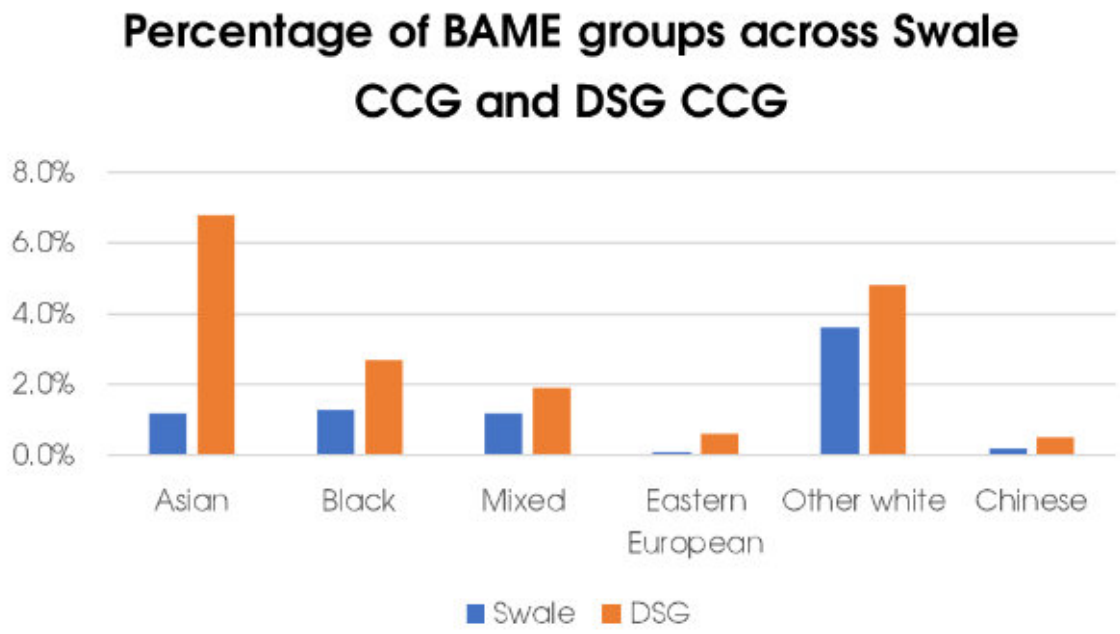



Comparison of self-reported health show fewer people saying that their health is very good and slightly more people reporting that their health is bad or very bad. Sheppey East has the worse ratings for self-reported health (9.9% reporting that their health is bad or very bad compared to 5.7% for Swale and 5.1% for Kent):

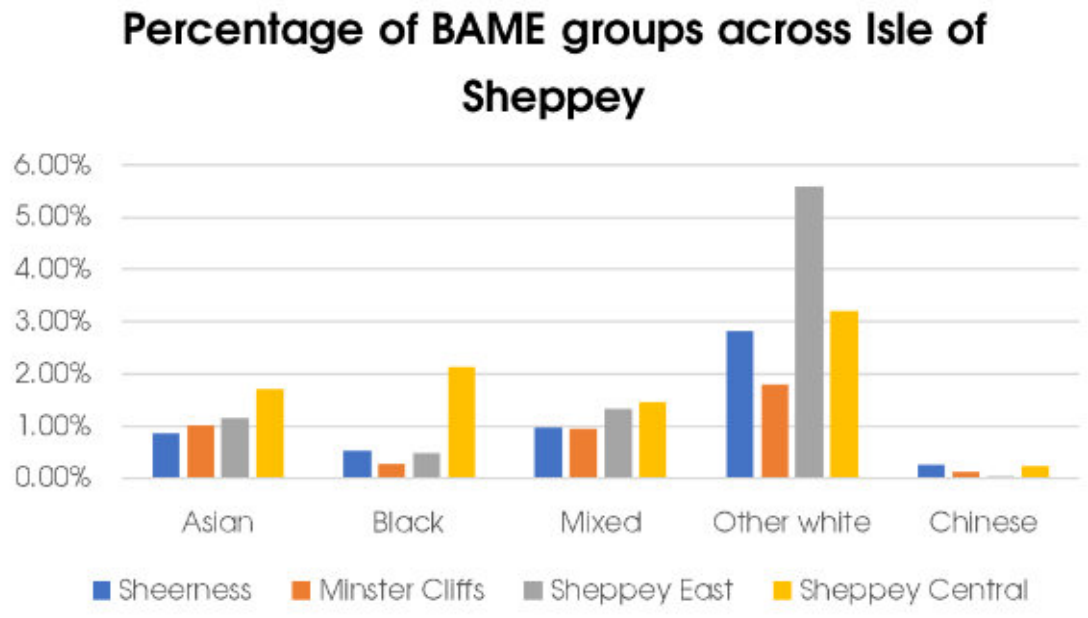



### 6.2.5 Ethnicity: Isle of Sheppey

The ethnic profile of Swale and the Isle of Sheppey is very different to that of Gravesham and Northfleet. The BAME population in Swale CCG in the 2001 Census was 5.11% (4,694 people) and this was estimated to have increased to 7.1% in 2011 (an additional 3,495 BAME individuals). While this was a significant increase, it is still much lower than other areas:




The closest comparison is with Other white groups and it is worth noting that this category includes Gypsy, Roma and Travellers, though specific data on these communities is not available. While the actual numbers are very small, the largest percentage of BAME individuals reside in Sheppey East.



# 7 Marginalisation in people – community and service user engagement and participation

The Playbook programme does not seek to replace or circumvent existing processes and statuary duties on community engagement, participation and involvement. Rather, it seeks to identify the flash points, gaps and strengths and deficits in community and service user engagement so that these can be better addressed in the action plan.

The previous section explored some of the structural aspects of marginalisation from the perspective of place, this section will consider some of the implications from this in terms of marginalisation for people. There are two principal ways in which marginalisation for people is classified and understood: formal and informal.

**Formal marginalisation** refers to the official categorisation of marginalised population groups whether through policy or legislation e.g. the definition of protected characteristics afforded by the Equality Act, safeguarding and legal protections for people with learning disabilities, lack of mental capacity or who are detained under the Mental Health Act.

**Informal marginalisation** relates to the lived experience of marginalisation and in particular how as a result of difference from normative behaviours and social grouping individuals and population groups can become marginalised e.g. transgender individuals, people with autism, offenders and conduct disorders in children.

For respondents and in much of the literature and research on marginalisation, formal definitions and categories are the dominant way in which groups are identified and perceived. Such an approach lends itself to easier access to resources and service planning as it meets specific legislative and policy objectives. However, the informal, lived experience of marginalisation can have much more profound implications for health and wellbeing and may be a more suitable and effective focus for prevention.

For example, the minority stress model (Brooks, 1981) originates in the premise that chronic stress arises from the experience of stigmatisation. The minority stress model distinguishes between the excess stress to which individuals from stigmatized or marginalised social categories are exposed as a result of their social, often a minority, position and other lifestyle and/or occupational stressors (Meyer, 2003). This can be explained through a two-fold process:

1. Subjective experience – the degree to which people internalise discrimination through negative perceptions about their minority status.

2. Objective experience – the actual experience of discriminatory or prejudicial behaviours and actions, for example, physical violence and assault or negative treatment as a result of unfair and discriminatory laws or policies.

Both processes can impact on an individual's health and affect the degree to which their experience of other stress related phenomena has significant and lasting impacts.

Self-directed stigma, which reflects the adoption of society's negative attitudes about some marginalised groups e.g. Lesbian, Gay, Bisexual and Transgender (LGBT), disabled, people with mental illness is applied to the self through perceived stigma and the expectation that one will be rejected and discriminated against.

From the interview transcripts with professional and service user and resident respondents the following informal factors, which are thought to be influencing marginalisation and lack of uptake of prevention services, have been identified:

- **Trust** – poor service experience especially if this relates to aspects of personal identity that are associated with marginalisation such as sexuality or disability, is perceived to be one of the main barriers to effective service use and engagement with prevention.

  *"Rough sleepers are a very stark example of how powerful distrust is – they will often refuse help because they don't trust people/services even though that service is necessary."*

(CVSE respondent)

- Age related transitions – whether young people having to leave Child and Adolescent Mental Health Services (CAMHS) and enter adults services as a result of their age (the cut off can be as young as 18) or older adults who are treated as elderly and only able to access to services for older people – many of whom may be significantly older – age can have a big impact on self-perceptions about marginalisation and experience of services.

  *"Work with anyone over the age of 18, younger males 18-30 is a difficult age bracket. Once someone gets to 18 it's a really difficult transition point because they're no longer on CAMHS and the mental health adult community teams don't always pick up on things, leaving them in a gap."*

(Public service respondent)

- Stigma, exclusion and discrimination – internalised stigma and discrimination can result in people being more withdrawn, socially isolated and less willing or able to engage with services.

  *"Travellers have a lot of stigma around mental health and they are especially hard to reach"*

(CVSE respondent)

- Disparities – Protected characteristics remain significant factors in marginalisation, in particular age, ethnicity and disability. Physical mobility, visual and hearing impairments and learning disabilities are factors where many respondents report ongoing restrictions and limitations in service access and support that would help reduce marginalisation and increase prevention.

  *"Being deaf doesn't just mean you can't hear. Other agencies and professionals need to understand the complexity of sensory loss."*

(Public service respondent)

- Poverty – one of the most debilitating factors that is thought to increase marginalisation and result in people feeling disempowered and unable to contribute to community life or access services is poverty.

*"People struggle to pay for their fuel and water. That's a preventative measure – safe and secure fuel and water prevents people from getting further illnesses."*

(Public service respondent).

While all of the above heighten the experience of marginalisation, they also have the potential to hinder engagement and participation. Programmes to address this need to encompass an effective approach for empowerment and capacity building, which in turn can increase and strengthen resilience. This forms the basis for the community engagement approach in the action plan.

# 8 Workforce transformation

There are 2.5 million people across England working in the health and social care sectors, but in recent years staff numbers have not kept up with rising demand, pay has been constrained and pressure on the system has grown. While the total FTEs working in the NHS in England in 2018/19 increased by the fastest rate this decade (2.8% – almost 30,000 extra staff), this mostly reflects the slow growth in the years preceding it. Workforce growth this decade has been just half that of the decade before, and growth has not been equal among different staff groups. The issues within the social care workforce are even greater than healthcare, with workforce shortages at around 122,000, with 1,100 people estimated to leave their job every day – an annual leaver rate of almost a third – and a quarter of staff on a zero-hours contracts.

Research by the Health Foundation, the King's Fund and the Nuffield Trust projected that, without major policy action, overall shortages of staff could exceed 250,000 by 2030 (Gershlick and Charlesworth, 2019).

A joint report by the Nuffield Trust and the Health Foundation identified a number of actions that are required to close the gap in recruitment and address retention and attrition of existing staff including:

- ensuring the funding and availability of clinical placements are not a bottleneck in the training pipeline, in particular for nursing;
- focusing on reducing attrition during training, for example additional support with living costs;
- having greater focus on supporting staff who are at the beginning and end of their NHS career;
- making better use of the Apprenticeship Levy including improvements in regional co-ordination between health and social care settings;
- increase understanding about the decisions that both prospective students and providers of training make when choosing particular professional courses, for example in mental health nursing and learning disability;
- further expand the multidisciplinary team drawing on the skills of other health care professionals;
- provide more support for staff to adapt and enhance their digital skills and use of technological advances and innovations;
- develop compassionate and inclusive leadership.

(Beech et al., 2019)

As stated in the NHS Interim People Plan more of the same will not be enough to deliver the promise of the NHS Long Term Plan:

*"We need different people in different professions working in different ways. We also need to address the cultural changes that are necessary to build a workforce that befits a world-class 21st century healthcare system."*

(NHS England and NHS Improvement, 2019)

The order of workforce transformation that is required presents some significant challenges, some of which are highlighted in the analysis of the current health and social care sector below.

## 8.1 The current health and social care sector

The health care sector is characterised by a workforce that is generally older than other occupations (45% are aged over 45 years old). It is also very strongly gendered (78% are female compared to 46% who are female in general employment). There are high numbers of people working part time (34% compared to 27% across the whole economy) and there are a wide range of careers (over 300) most of which are highly specialised (Wheeler and Yeomans, 2012). Some of the challenges faced by key roles include:

### Hospital medical staff

- Some hospitals are experiencing difficulties with medical staffing in a number of specialties and there are variations in this by region for example, approximately one in ten specialty postgraduate medical training posts go unfilled in some areas.

- Around two-in-five consultants (40%) and nearly two-thirds of senior trainee doctors (63%) said that there were daily or weekly gaps in hospital medical cover. Where gaps in rotas mean there are not sufficient senior medical staff to assure the quality and safety of training, junior doctors may be withdrawn from hospitals, reducing the staffing complement even further (Rolewicz and Palmer, 2019).

**Nurses**

- The growth in nurse numbers has not kept pace with demand and nursing vacancies (the gap between the number of staff and the need for them) increased to almost 44,000 in the first quarter of 2019/20 – 12% of the nursing workforce. This is despite continuing growth in health care activity.
- While 'output' (the number of operations, A&E attendances, etc) grew by almost a quarter between 2010/11 and 2016/17, the number of nurses grew by just 1% (Wheeler and Yeomans, 2012)

**GPs**

- The number of people working as fully qualified, permanently employed GPs is falling, with a 1.6% decline from 27,830 to 27,380 in 2018/19.
- Temporary staff and doctors in training are making up a greater proportion of the GP workforce, rising from 19% to 21% over the year.
- Due to falling numbers of GPs and the rising population, the number of patients that each qualified permanent GP is responsible for continues to grow, increasing from 2,120 to 2,180 over 2018/19. This is clearest in the most deprived areas: on average, a GP working in one of the most deprived areas (where health needs are greater) can expect to be responsible for 370 more patients than a GP working in one of the least deprived areas (Ibid).

### Mental health staff

- Around 200,000 people are employed by the NHS to care for people who need mental health services. The largest group of clinicians are registered mental health nurses, but their numbers are in decline (Ibid).
- There was a 12% drop in the number of nursing posts between November 2009 and July 2019. In 2015, the Migration Advisory Committee added core psychiatry training to the list of occupations experiencing a shortage of staff. The psychiatry fill rate was only 58% in 2017, but this was substantially improved to 86% in 2019.
- Psychologists have also been added to the list of occupation shortages. Their numbers would contribute to Health Education England's (HEE) mental health strategy to have an additional 4,200 allied health professionals working in mental health by 2021.

### The social care sector

- The estimated number of adult social care jobs in England, in 2018, was 1,620,000, of which 1,225,000 (76%) were direct care staff jobs and another 84,000 (5%) were regulated professionals, including 41,000 registered nurses.
- While the overall numbers of staff were up by 1.2% compared to 2017/18, nursing jobs in social care have decreased by 10,400 (20%) since 2012, and by 2% in 2018/19.
- If demand for the social care workforce grows proportionally to the projected number of people aged 65 and over, then the number of social care jobs will need to increase by 36% to around 2.2 million jobs by 2035 (Ibid).
- Staff turnover in social care, compared with the vast majority of other sectors, is very high. While the average annual turnover rate in England is 15%, many social care roles far exceed this, with 32% of registered nurses and 27% of care workers leaving their job each year (this compares with average turnover of 11% in the NHS).8.2 Education and qualifications of the health and social care workforce

## 8.2 Education and qualifications of the health and social care workforce

The health sector workforce is more highly qualified than the UK average. Almost 60% of the workforce are qualified to the equivalent of Level 4 or above compared to just over a third of workers across the whole economy. In addition, just 2% of the workforce has no qualification compared to an estimated 4% of workers across all sectors. This is most likely due to the fact that many occupations, including nursing are heavily regulated, which ensures minimum skill requirements across large sections of the healthcare workforce.

Personal service occupations are the second largest major occupational group in the sector, accounting for around one sixth of the workforce, but around one quarter of this group either have no qualifications or a qualification below Level 1.

Social care has greater concentrations of workers with no formal qualifications and those whose highest qualification is at Level 2 (equivalent to 5 GCSEs at grade C or above).

The National Employer Skills Survey found that 19% of health and social care employers reported having skills gaps. The main skills gaps that need to be tackled to ensure more people are equipped to work in social care included core functional and transferable skills such as basic employability skills (e.g. team work), language skills, record-keeping ability and a focus on core values such as dignity, respect, learning and reflection, and commitment to quality and person centred support.

There are also differences in the average qualification levels of the workforce in the independent sector compared to the public sector. Compared to the public health sector it has a slightly higher proportion of its workforce with Level 2 and 3 qualifications, but fewer with Level 4 and above (UK Commission for Employment and Skills, 2009).

## 8.3 Workforce priorities, gaps, challenges and opportunities in Kent and Medway

There are around 83,800 FTE workforce employed across Kent and Medway in over 350 careers across health and social care organisations. The workforce supply has decreased for most workforce groups and is behind the national average. The Kent and Medway Academy for Health and Social Care has been established to working collectively on:

- Promoting Kent and Medway as a great place to work.
- Maximising supply of health and social care workforce.
- Creating lifelong careers in health and social care.
- Developing system leaders and encouraging culture change.
- Improving workforce wellbeing, inclusion and workload to increase retention.

Some of the significant workforce challenges that are relevant to this action plan and developing the approach to prevention amongst marginalised groups includes:

- high volume of care worker vacancies;
- NHS and social care not the career of choice for many young people with only 6% of under 25 year–olds working in the NHS risking future workforce supply;
- need for system leaders to work differently together to address system challenges including addressing the health and wellbeing gap;
- NHS National Staff Survey results showed five out of the six NHS providers had a higher than average staff reporting discrimination at work (2017);
- shortages of key mental health professional workforce including, psychiatrists and nurses, and growth needed in wider mental health workforce (498 FTE);

- shortage of skilled social care workforce providing direct care and support in local communities, with over half of all vacancies in Kent and Medway within social care – estimated vacancy rate of 8.7%.

(Kent and Medway Sustainability and Transformation Partnership, 2019)

Addressing the workforce recruitment and retention challenges needs to be addressed as part of a wider approach to skills and education that encompasses working with prevention and in particular marginalised community groups. This needs to include:

| | |
|---|---|
| **Maximising workforce supply** | Post-16 skills for health and care; Experience into practice; Apprenticeship Levy |
| **Lifelong personalised careers** | Skills ladders; Competency based learning; Role rotation |
| **Developing system leaders and encouraging culture change** | Inclusion leadership programme; System change agents |
| **Promoting wellbeing, addressing workload and supporting retention** | Social isolation at work; Digital inclusion and MedTech |

# 9 The Logic Model for the Action Plan

The action plan is evidenced based in that it is drawn from the inquiry data and system learning that has been generated by the Playbook methods. The logic model that underpins the action plan is derived from Soft Systems Methodologies (SSM) and in particular an adapted approach to Checkland and Smyths' use of the CATWOE (Customers, Actors, Transformation process, World View, Owners and Environment) methods (Checkland, 1999; Smyth and Checkland, 1976).

SSM is a sense making tool for addressing complex problems that are not easily amenable to traditional project management methods. The type of situations suitable for SSM approaches are characterised by multiple change factors such as organisational culture, power, leadership and management, which is especially pertinent to marginalisation and prevention at a community level. There is also an assumption that people are a central part of the process and people are not always rational in their decisions and choices when moving from strategy to action.

The CATWOE methods were designed for identifying specific problem contexts and desired outcomes from a change process and the solutions that can influence the relevant system leaders. It seeks to define the foundations or the root of the problem context and set out the parameters for action based on multi-stakeholder perspectives. Checkland defined the CATWOE acronym as standing for:

- **Customers** - "…beneficiaries or victims affected by the systems activities"
- **Actors** - "…the agents who carry out or cause to be carried out the main activities of the system"
- **Transformation** - "The means by which defined inputs are transformed into defined outputs"
- **Worldview** - "…an outlook, framework or image that makes this particular root definition meaningful"
- **Ownership** - "…some agency having a prime concern for the system and the ultimate power to cause the system to cease to exist"
- **Environmental constraints** - "…features of the system's environments and/or wider systems which it has to take as 'given'"

(Checkland, 1999. pp224 – 225)

It is some time since Checkland and Smyth created the CATWOE methods and although it has been widely and successfully applied in a number of different organisational and system contexts, the focus and definitions have been adapted to better suit the purposes of this programme and the Playbook approach. These adaptations are explained with examples in the following table. The draft action plan provides a detailed description of how the logic model has been applied to the context of prevention for marginalised groups in Kent.

# 10 The Kent Action plan on prevention

## 10.1 Aim and Objectives

To demonstrate the value of taking a place-based approach to prevention of health and social harms for marginalised groups by developing and piloting a health inclusion and prevention framework in Northfleet and the Isle of Sheppey.

**Objectives:**

- To focus resources and investment for prevention based on place and the social determinants of health rather than individual health conditions.
- To develop an understanding that prevention goes beyond a clinical definitions and must include a focus on the social determinants of health.
- To engage local community members and service users to participate in co-design of solutions, including digital solutions, alongside commissioners and service providers.
- To make more intelligent use of population health data for the social determinants of health as a means of improving the evidence base for monitoring impact over time.
- To improve access to support and services through more flexible and targeted use of transportation options and to empirically evidence how flexible and targeted use of transportation options can tackle health inequalities and social harms for marginalised groups.
- To learn from, build upon and sustain the positive outcomes from grater use of

community assets and resilience that have developed through the Covid-19 pandemic.

- To widen the entry options into health and social care careers through pre-employment engagement, volunteering and apprenticeships with a specific emphasis on pathways and digital skills.
- To deliver a single, place-based approach whereby those in Growth and Community roles can better support those in health and social care roles, and vice versa.

**Anticipated outcomes:**

1. Individuals and communities show measurable improvements in resilience to significant health risks and are better able to manage the social conditions in which they live.
2. Increased participation of marginalised groups in service co-design.
3. An increase in entry to and progression along health and care career pathways from marginalised groups.

**The action plan is based on the following *building blocks:***

1. Targeted use of data and intelligence on the social determinants of health at a place-based level.
2. Lived experience and Community engagement, face to face or virtual
3. Transport development.
4. Volunteering, apprenticeships and skills development including digital skills, and pre-employment support.
5. Wider system adoption.

The building blocks are interdependent and reliant on the system wide adoption of a place-based approach to the social determinants of health, as the most effective way to improve prevention for marginalised groups.


Data and intelligence
Lived experience
Transport
Volunteering & apprenticeship
Wider system adoption

The interventions and actions will be developed in the two pilot areas of Gravesham, Northfleet and Swale, the Isle of Sheppey. Based on the evidence from staff perceptions about priorities and analysis of ward based demographic variations and inequalities, the primary focus in each area will be:

- Gravesham, Northfleet – Black, Asian and minority ethnic communities
- The Isle of Sheppey – Transport, mental health, and wellbeing

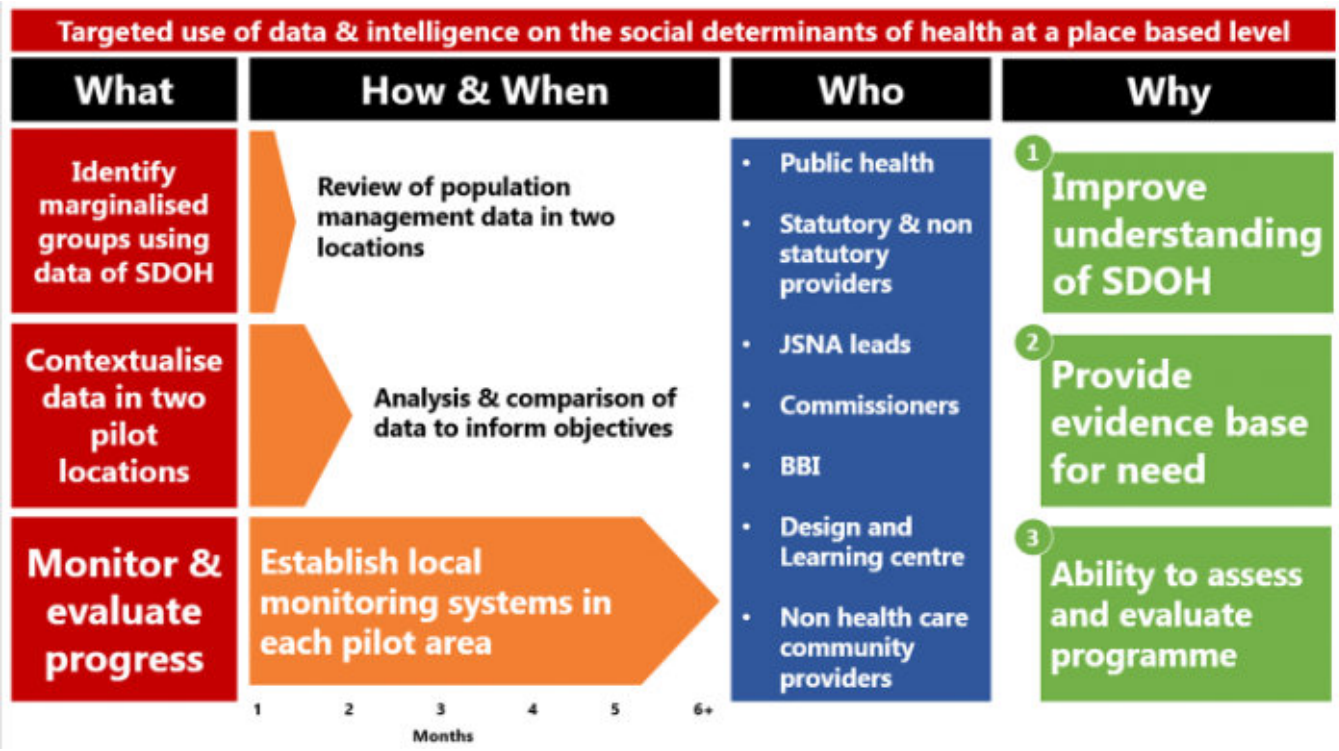
The building blocks are interdependent and reliant on the system wide adoption of a place-based approach to the social determinants of health, as the most effective way to improve prevention for marginalised groups.

While a number of the actions are focused on the local areas of Northfleet and the Isle of Sheppey, these are intended as pilot demonstrations, in order to gain wider system support across Kent for the adoption of the model and approach. This may also be used for attracting national agency and/or governmental support and resources for investment over the longer term.

## 10.2 Targeted use of data and intelligence


In order to achieve the behavioural change necessary to implement the Action Plan, a prerequisite is having a full and clear understanding of the available data and intelligence on the social determinants of health (SDOH) across the two pilot locations. KeRNEL[1] provides an excellent foundation for achieving this, but it is critically important that there is a data system that can utilise linked data from community and other public sector organisations, which will require further adaptation and development of KeRNEL.

1. KeRNEL – Kent Research Network for Education and Learning is the system for expanding the breadth and depth of linked data in the use of more clinical datasets and across more NHS and partner organisations.



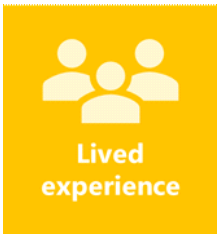

This should include moving from formal definitions of marginalisation, for example those that are narrowly defined by law such as protected characteristics towards more informal definitions that capture lived experience. This will involve a shift in the approach from one that is largely based on clinical data sets, to one which draws on the intelligence and data from a wider group of public sector organisations and the community, voluntary and social enterprise sector.

These new linked data sets will need to be contextualised in each of the two pilot areas in order to understand the specific place-based variations but also to be able to compare and contrast the evidence base.

While gathering, analysing, and presenting the data in an accessible way is a short-term activity which can be achieved with existing resources, equally as important is the ability to monitor and evaluate progress over time, particularly as the strategic objectives of Kent County Council and their partners change. This may require the establishment of a dedicated monitoring system in each pilot area and a workforce that is capable of monitoring the progress.

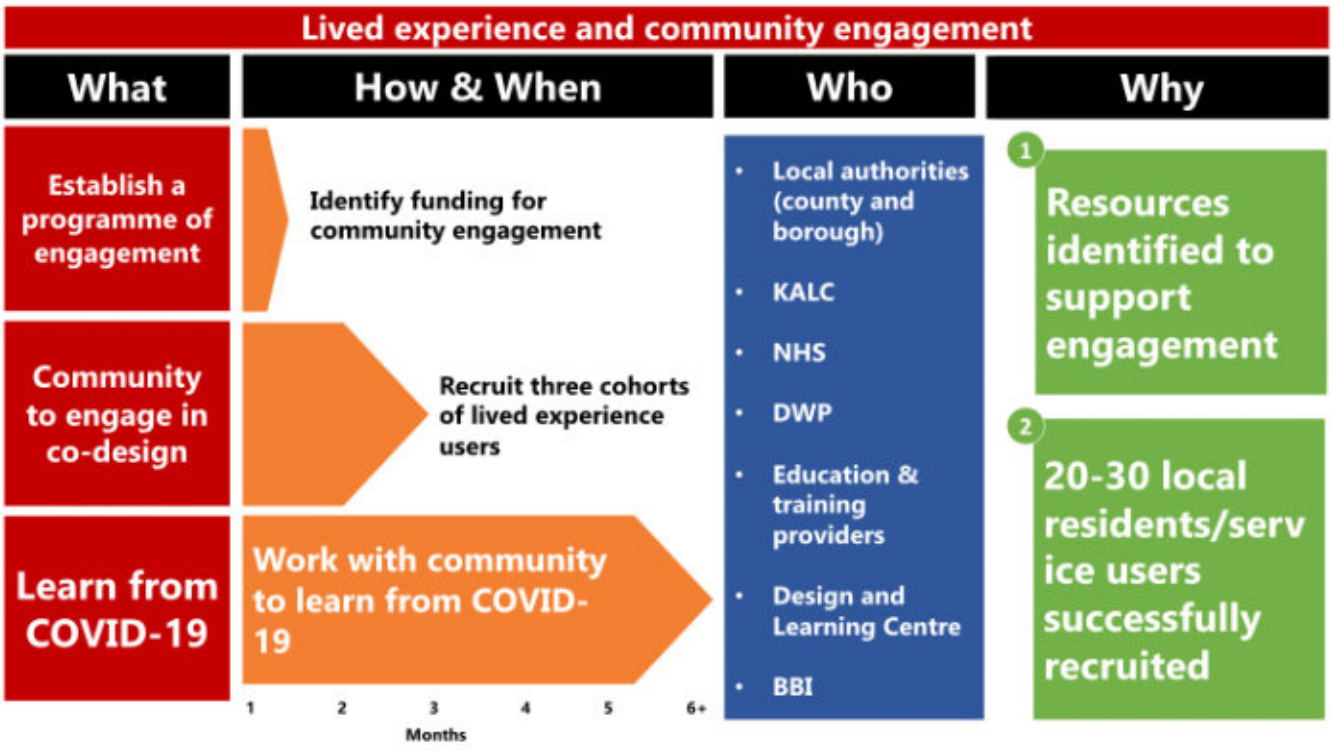
## 10.3 Lived experience and community engagement

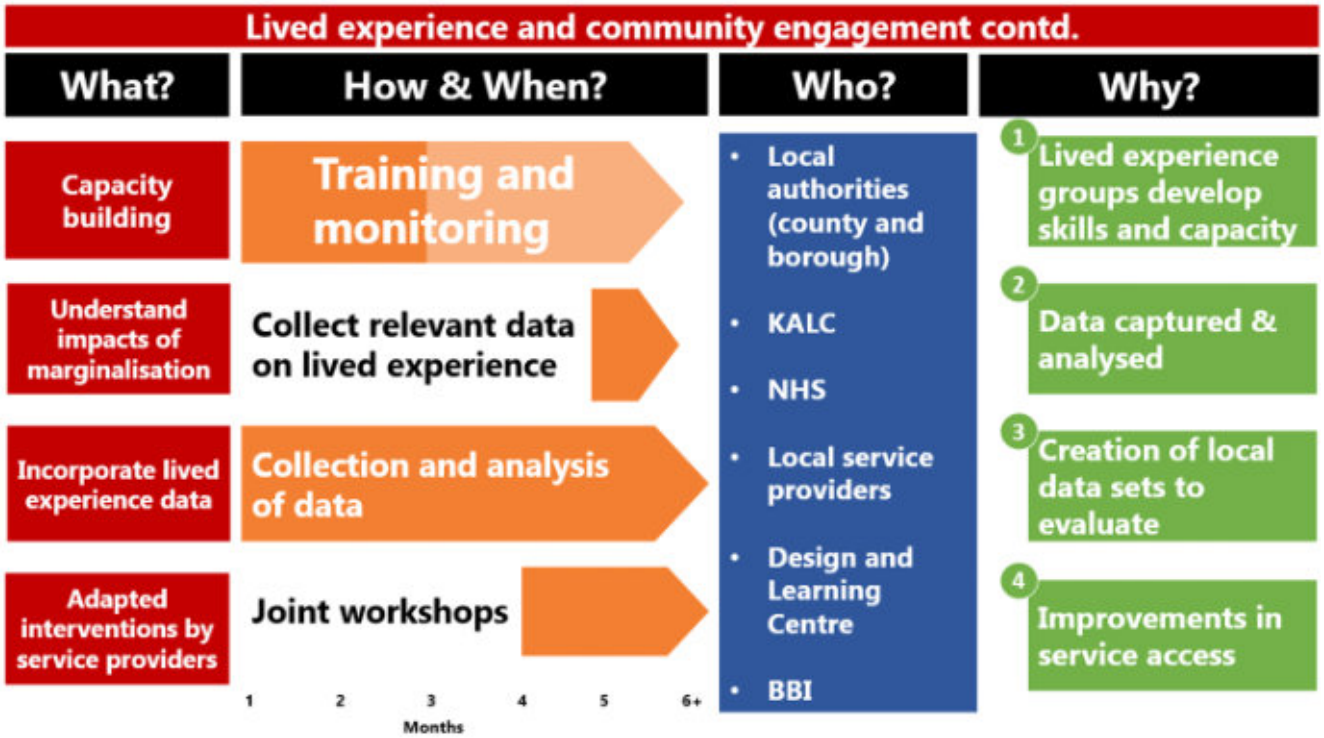
An effective and robust programme of community engagement and asset building based on lived experience is essential to provide further evidence of needs and support the co-design of interventions.




As the report demonstrates, prevention measures often fail more marginalised groups because they do not appropriately align with people's lived experience and the reality of marginalisation means that they are less well engaged. Addressing this can only be done through a dedicated programme that will require specific funding to be effective, which may be a combination of external grants e.g. Health Foundation, Kingsfund, Big Lottery alongside maximising and better aligning existing resources and budgets.

Once a suitable funding route is secured, it will be possible to recruit at least three cohorts of lived experience service users/residents for two target localities. While there can be different models for community engagement, the BBI team have a tested and evaluated approach that has been successful in a wide range of contexts, places, and community groups.


Lived experience and community engagement
What
How & When
Who
Why
Establish a programme of engagement
Identify funding for community engagement
Community to engage in co-design
Recruit three cohorts of lived experience users
Learn from COVID-19
Work with community to learn from COVID-19
1 2 3 4 5 6+
Months
Local authorities (county and borough)
KALC
NHS
DWP
Education & training providers
Design and Learning Centre
BBI
1 Resources identified to support engagement
2 20-30 local residents/service users successfully recruited


Lived experience and community engagement contd.
What?
How & When?
Who?
Why?
Capacity building
Training and monitoring
Understand impacts of marginalisation
Collect relevant data on lived experience
Incorporate lived experience data
Collection and analysis of data
Adapted interventions by service providers
Joint workshops
1 2 3 4 5 6+
Months
Local authorities (county and borough)
KALC
NHS
Local service providers
Design and Learning Centre
BBI
1 Lived experience groups develop skills and capacity
2 Data captured & analysed
3 Creation of local data sets to evaluate
4 Improvements in service access

The BBI model, which is based on the pioneering work of Professor, The Lord Patel of Bradford OBE uses community capacity building methods alongside institutional change to effect sustained benefits including: raised awareness, identification of previously unknown needs, increased trust and participation, development of skills and competencies and improved life chances for education and employment. Moreover, it also helps shift the understanding of prevention away from its strict adherence traditional public heath guidance which tends to focus on conditions, and instead encompasses a wider definition of prevention and community inclusion.

The approach ensures that there is a robust mechanism to ensure co-design of solutions that are based on the lived experience of the community and can be sustained over the longer term. Experience from the COVID-19 pandemic has demonstrated the vital importance of participation and involvement from local residents and community groups. While much data and intelligence on the benefits and value of this work has been gathered, there is a need to formally use these data and information to fully learn the lessons.

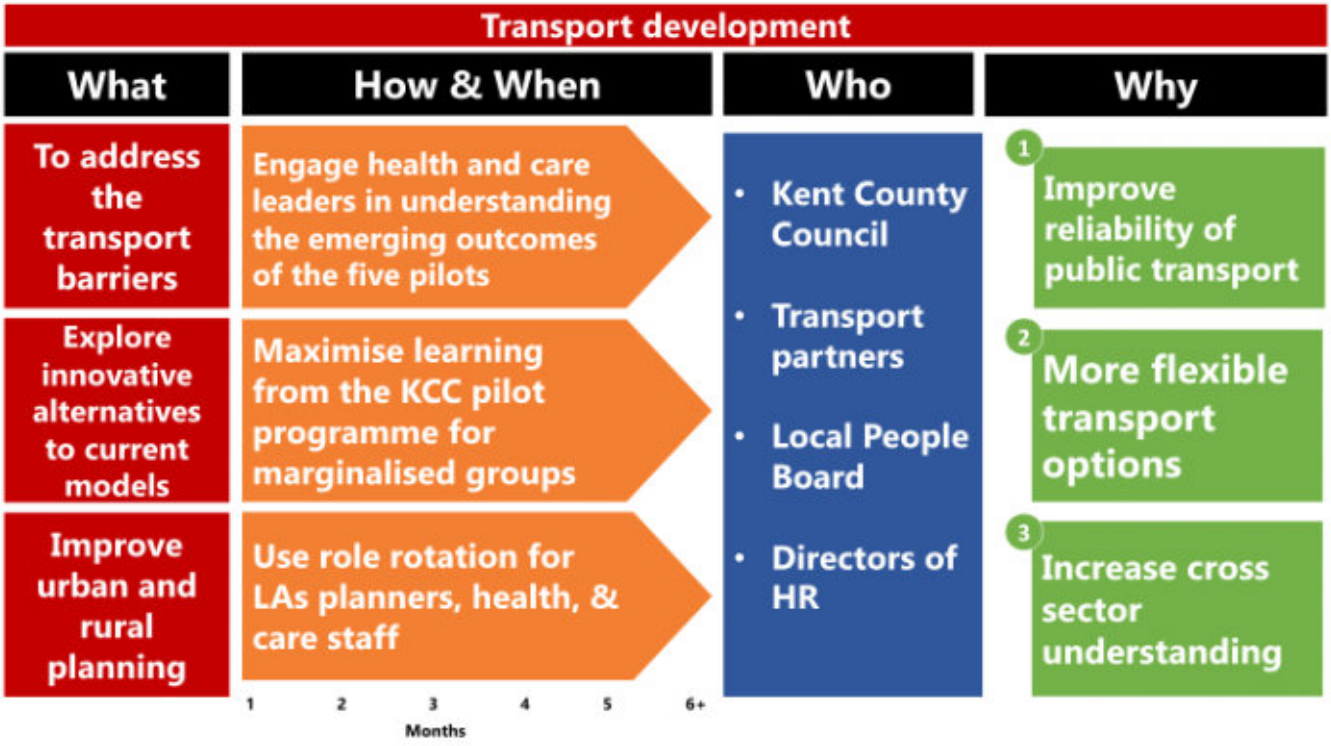
The community engagement programme provides a vehicle by which this can be done in a way that ensures it is focused on the lived experience of local people. The community engagement programme is not intended to be a discreet activity, but rather it is to be used in combination with the improved population health management data from KeRNEL as the basis for shared learning across stakeholders. One of the most powerful ways to create the desired behaviour change is to combine the factual evidence base with lived experience through joint workshops with the lead stakeholders in both areas. This will result in adapted and improved services.

## 10.4 Transport development


Since the inception of the programme of work in October 2019, transport has consistently been raised as an issue from both professional stakeholders and service users alike. Whilst there are a number of pilots underway, led by Kent County Council, aimed at better understanding the barriers to use of public transport for more marginalised groups, there is not as yet a funded solution.

A place-based approach to prevention for marginalised groups depends not only on locality-based population health management and community engagement to drive service delivery innovations, but it must also be part of wider infrastructure and planning for the environment, and housing, while starting with transport. While a number of service providers have found it necessary to provide their own transportation to ensure access for service users who might not otherwise be able to reach the service, there continues to be innovative pilots being run by Kent County Council where lessons will be able to be learnt.

Others, who used to have their own transport have been unable to sustain this following austerity and cuts to budgets. Age UK uses a volunteer mini-bus system to transport their clients to their home and to the shops and The Kent County Council pilots utilise a range of vehicle types and providers. The ambition exists to share this kind of resource across more agencies and client groups as part of a drive to maximise the local area assets and improve the cost effectiveness of investments. As one of the main factors behind marginalisation is poverty, many such affected groups cannot afford public or private transport and can become increasingly isolated and further marginalised from reduced capacity to reach services. Although many transport providers are directly engaged with communities, the challenge is that commercial routes are limited (and unaffordable, or in some way not accessible for some marginalised groups).




Engaging more effectively with community users is something both Kent County Council and their transport providers have attempted to do. However, two consistent challenges emerge. Firstly, how to raise awareness of problems amongst marginalised population groups with the commissioned provision, and secondly, how to fund such provisions in a way that suits all stakeholder interest.

In addition, there may be the need to invest new resources into a dedicated piece of community engagement to fully understand where the future solutions lie, especially as we begin to enter a post-COVID environment which will have had effects on the types of public transport people need and are willing to access. There is also scope to ensure that one of the community engagement projects is focused on transport, ideally in one of the less well served areas such as the Isle of Sheppey, but very much building on the five existing community transport pilots being delivered in Kent.

Wider engagement between health, social care and other public sector workforce such as transport, housing and urban planning can be supported through job rotation schemes to promote greater cross sector understanding. The concept of role rotation can be applied on a cross sector basis and introduced at an early age through pre-employment work experience or apprenticeships. Prioritising this approach will be crucial for the newly established People Board to understand, for example how short to medium term learning from this building block can be used to improve skills and competencies in cross sector approaches to health, transport, housing, and town planning. This will also involve expansion of learning placements to benefit people in training.

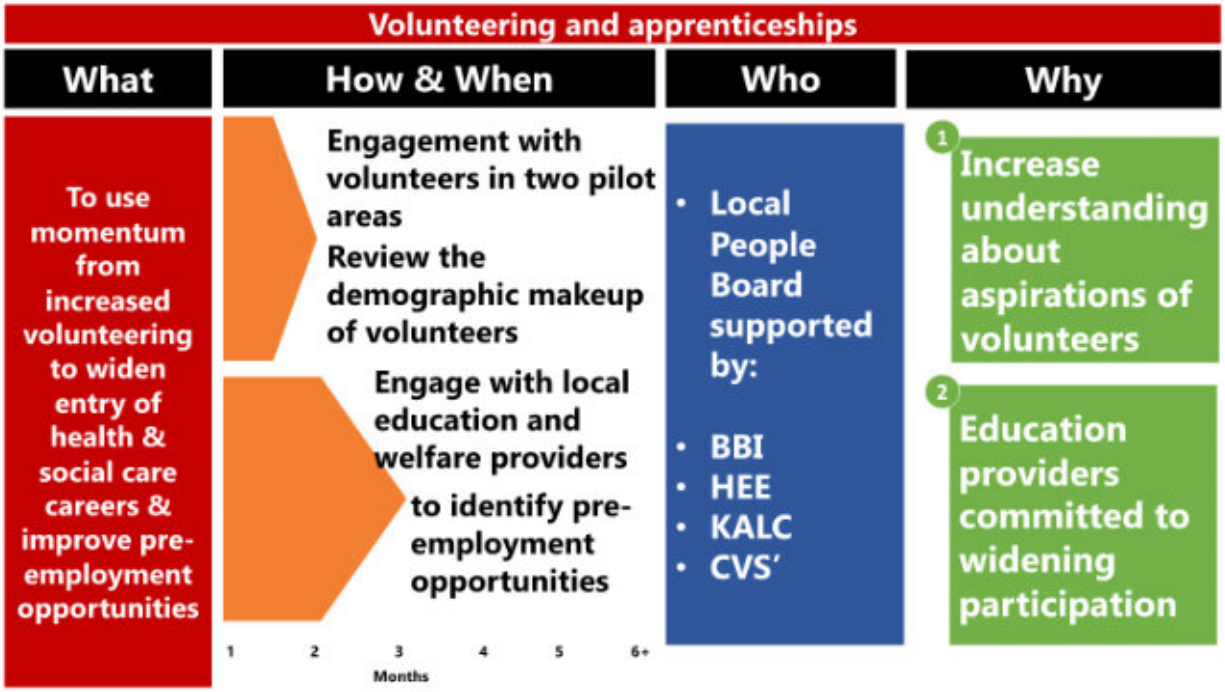
## 10.5 Volunteering and apprenticeships

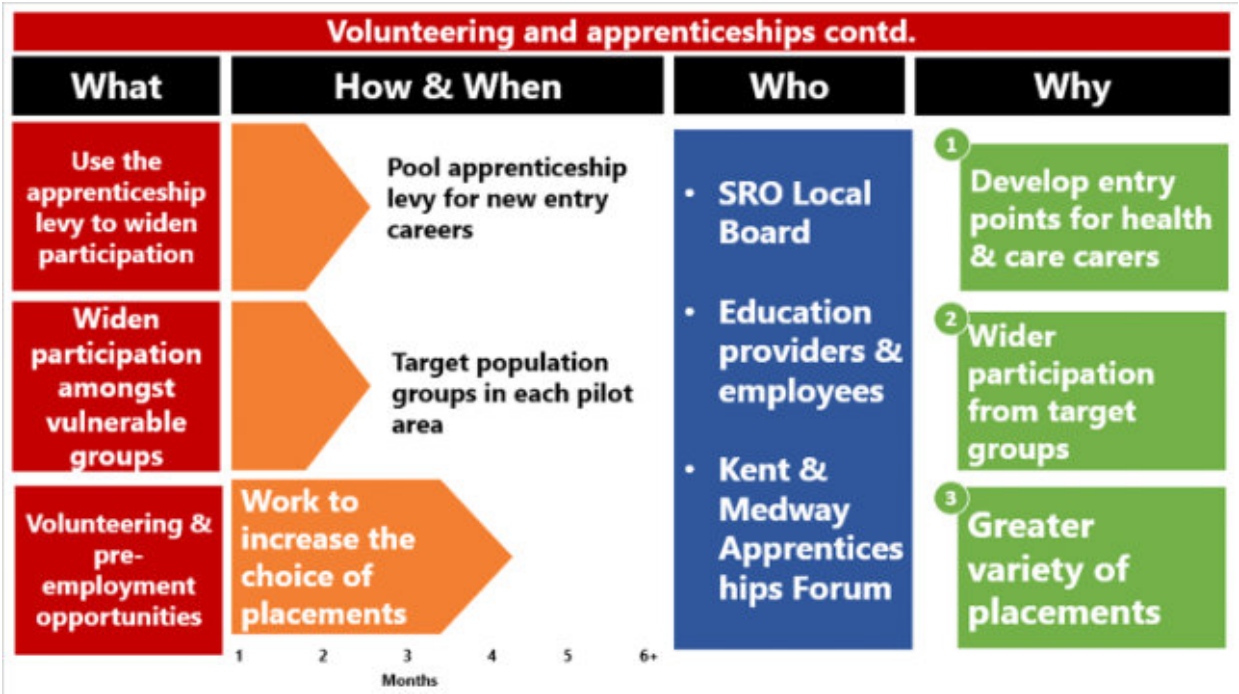

While there have been some clear and beneficial impacts from the increases in volunteering and community activism as a response to the COVID-19 pandemic, there is a fear that support networks that have been established by local groups and volunteers will quickly disappear and leave vulnerable people without the support they have come to rely on. In order to make sure this does not happen; it is important to engage with volunteers – to understand their aspirations and motivations – but also those who have benefitted from their work and how they view this. This can be done using the improved data and evidence base combined with the community engagement programme from the previous building blocks.

It may be possible, depending on the ambitions of volunteers, to harness the momentum from the increase in volunteering with the aim of widening the entry to health and social care careers.

For example, by engaging with education providers and employers it will be possible to make constructive and innovative use of the apprenticeship levy to provide more flexible and diverse entry points, which will have the added benefit of increasing the diversity of the workforce and those with lived experience of marginalisation.

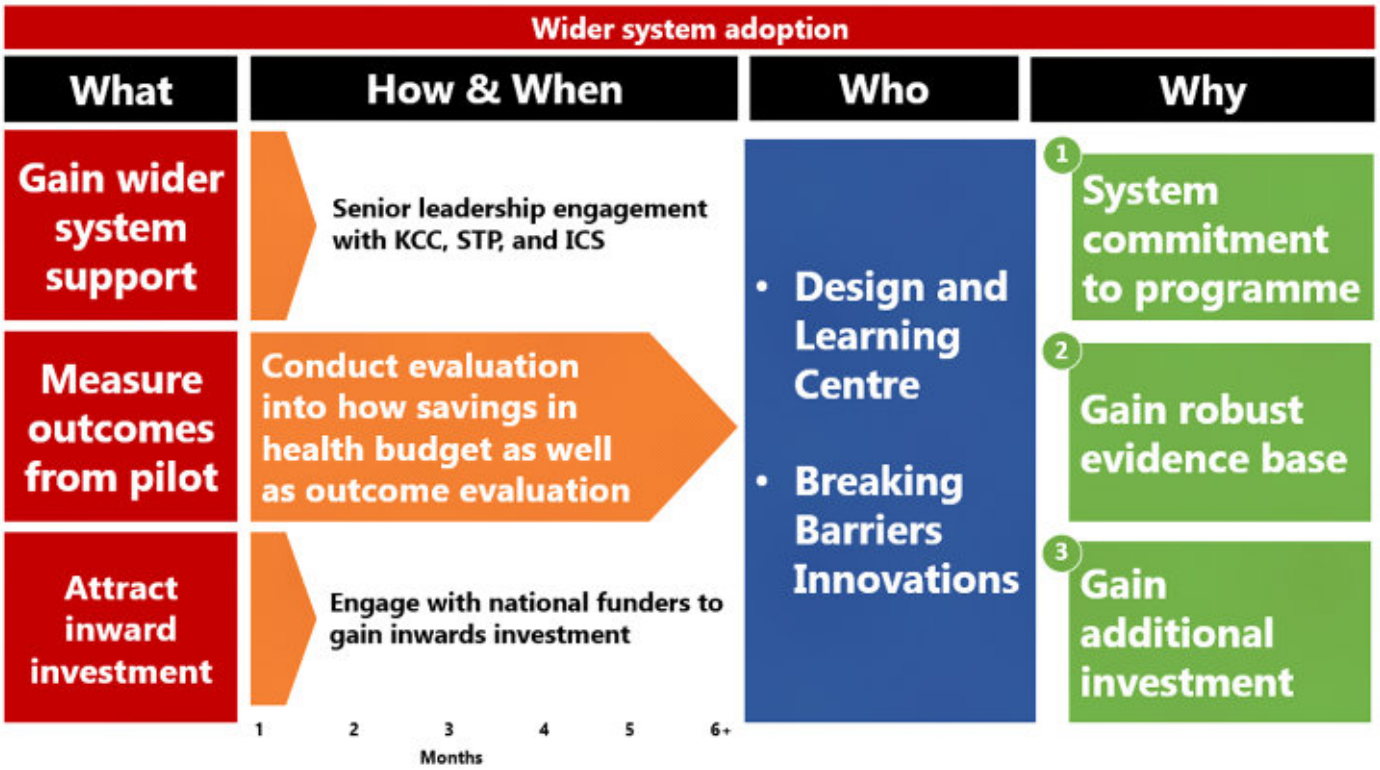
This could include the Black, Asian and minority ethnic community in Gravesham and those with poorer mental health on the Isle of Sheppey. Some of these objectives – such as engaging with education providers - can be done with few additional resources and in a short time producing quick and visible results, however, changing the approach to allocations and awards of the apprenticeship levy will be more challenging.



In order to succeed, this will need to be recognised as a priority programme area for the local People Board, but it also provides an opportunity to review the functions of the new board in contrast to its predecessor, the Local Workforce Action Board (LWABs). In particular, how to extend the participation of a wider range of healthcare providers and employers outside of traditional health services, for example introducing training on the social determinants of health to those in Growth and Community careers alongside training on place based delivery to those in health and care as a means of driving place based workforce development. In this way planning for workforce development on the basis of place rather than organisational and professional silos could be truly transformational. This can be done by using the pilot action plan to:

- Widen the sources of data that are used to inform workforce planning for the future by ensuring that social conditions are at the heart of this.
- Leverage the support of Health Education England in developing learning platforms, mentoring, digital skills alignment and competency-based learning frameworks.
- Apply the community engagement programme to ensure that the lived experience of service users and residents is being used to co-design workforce transformation plans.
- Provide evidence of the value of widening participation in health and care careers and supporting measures to raise the esteem of care careers in particular through demonstrations as part of current efforts to share learning and best practices from across the BBI Playbook programmes.




## 10.6 Wider system adoption


While the action plan is focused on two target areas of Northfleet and Isle of Sheppey, this will only be value in so far as it serves to demonstrate the value of the approach and learning to the wider systems across Kent. To ensure this, it is important to evaluate the pilot programmes thoroughly using the improved data management system established at the outset, the lived experience of service users and local residents and the testing out of innovative approaches to transport. Recent opportunities surrounding future funding from Kingsfund streams can help expand the model to other towns such as Margate and Dover.

By using an outcome focused approach to the evaluation of the programme, the wider system and budgetary benefits and opportunity costs will be clearly evidenced.

This will be key in translating a place-based health and care system from a "nice to do" to a "critical to do". The buy-in from other lead stakeholders is essential, this includes senior leadership with the local authorities at an officer and political level. There also needs to be buy-in from all other relevant stakeholders present throughout the programme at the steering group.

While this can be done with existing resources, in order to fully realise the system wider adoption, inward investment will be required. There is a broad range of national stakeholders that can be engaged with, with the support of BBI if necessary.

# 11 Conclusion

Throughout our engagement in this project, we have seen that a failure to address deprivation in a place based way through prioritising prevention will cost the system £111 million per year. The above sets out the case that genuine delivery of place-based health and all of the financial and outcome benefits that ensue, requires an effective and robust programme that encompasses:

- better use of data and intelligence on a cross sector and cross organisational basis to encompass the wider social determinants of health;
- engagement with local communities as part of an asset and capacity building programme that increases awareness, reduces marginalisation and enhances life opportunities through training and development;
- workforce skills and competency development and staff welfare that enables a truly cross-sector approach with shared learning platforms, role rotations and sustainable entry points through volunteering and apprenticeships that meet people's aspirations and ambitions;
- learning from robust outcomes focused evaluation of targeted pilots that can support wider system adoption across the county.

The action plan seeks to achieve all of the above with specific, measurable and attainable actions that have the support of local system leaders. Prevention and marginalisation are currently areas of national concern, partly as a result of learning about disparities of outcomes and impacts from Covid-19, but also due to the long standing issues on health inequalities and the need to find more effective ways to drive prevention from the perspective of the social determinants of health. While the ongoing impacts of the pandemic provides an important backdrop to the action plan and cannot be ignored, for example the way in which actions can help inform and drive progress as part of Recovery, Resilience and Reset across Kent, this is not the driving factor.

The specific aim and objectives of the action plan are to ensure that there is wider symbiotic benefit for the whole public service sector including healthcare in partnership with wider Growth and Community services and workforce. Without this, place-based delivery of health and care and breaking down service commissioning and delivery silos cannot be fully realised.

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