HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 24th January, 2018

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 24 January 2018 at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Theresa Grayell**
Telephone: **03000 416172**

Tea/Coffee will be available 15 minutes before the start of the meeting

Membership (13)

Conservative (10): Mr G Lymer (Chairman), Mrs P A V Stockell (Vice-Chairman), Mr A Cook, Miss E Dawson, Mrs L Game, Ms S Hamilton, Ms D Marsh, Mr K Pugh, Miss C Rankin and Mr I Thomas

Liberal Democrat (2): Mr D S Daley and Mr S J G Koowaree

Labour (1) Dr L Sullivan

Webcasting Notice

Please note: this meeting may be filmed for the live or subsequent broadcast via the Council's internet site or by any member of the public or press present. The Chairman will confirm if all or part of the meeting is to be filmed by the Council.

By entering into this room you are consenting to being filmed. If you do not wish to have your image captured please let the Clerk know immediately

UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in items on the Agenda

To receive any declarations of interest made by Members in relation to any matter on the agenda. Members are reminded to specify the agenda item number to which it refers and the nature of the interest being declared

4 Minutes of the meeting held on 1 December 2017 (Pages 7 - 14)

To consider and approve the minutes as a correct record.

5 Verbal updates by Cabinet Members and Directors (Pages 15 - 16)

To receive a verbal update from the Leader and Cabinet Member for Traded Services and Health Reform, the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health.

6 Prevention in the Kent and Medway Sustainability and Transformation Plan (Pages 17 - 22)

To receive a report from the Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, setting out the development of a Prevention Workstream and Strategy for the Sustainability and Transformation Plan for Kent and Medway Health and Social Care system. Members are asked to comment on the progress of the Workstream and the future planned work.

7 'One You Kent' campaign update (Pages 23 - 46)

To receive a report from the Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, setting out progress of the campaign. The committee is asked to comment on the progress and impact of the campaign and suggest local organisations which could support it.

8 Draft 2018-19 Budget and 2018-20 Medium Term Financial Plan (Pages 47 - 52)

To receive a report from the Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, to accompany the final draft 2018-19 Budget and 2018-20 MTFP published online on 12 January. The committee is asked to note the draft budget and MTFP and is invited to make suggestions to the Cabinet Member for Strategic Commissioning and Public Health on any other issues relating to Public Health which should be reflected in the draft budget and MTFP prior to Cabinet on the 5 February 2018 and County Council on the 20 February 2018.

9 Schedule of contract monitoring reviews (Pages 53 - 56)

To receive a report from the Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, setting out a proposed schedule of contract monitoring reviews for the next two years. The committee is asked to comment on and agree the schedule of contract monitoring reviews to be presented to the committee over the next two years.

10 Contract Monitoring Report - Sexual Health Services (Pages 57 - 88)

To receive a report from the Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, setting out an update on the performance, outcomes and value for money of the sexual health services commissioned by the County Council. The committee is asked to note the performance of the County Council-commissioned sexual health services the processes in place to manage the contract effectively.

11 Performance of Public Health commissioned services (Pages 89 - 96)

To receive a report from the Cabinet Member for Strategic Commissioning

and Public Health and the Director of Public Health, setting out an overview of key performance indicators (KPIs) for Public Health commissioned services in the latest quarter. The committee is asked to note and comment on the Q2 performance of Public Health commissioned services.

12 Work Programme 2018/19 (Pages 97 - 100)

To receive a report from the General Counsel on the committee's work programme.

MOTION TO EXCLUDE THE PRESS AND PUBLIC FOR EXEMPT BUSINESS

That, under Section 100A of the Local Government Act 1972, the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act.

EXEMPT ITEMS

(At the time of preparing the agenda there was an exempt appendix to item 10. During this and any such items which may arise the meeting is likely NOT to be open to the public)

Benjamin Watts
General Counsel
03000 416814

Tuesday, 16 January 2018

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Darent Room, Sessions House, County Hall, Maidstone on Friday, 1st December, 2017.

PRESENT: Mrs P A V Stockell (Vice-Chairman in the Chair), Mr R H Bird (Substitute for Mr S J G Koowaree), Mr A Cook, Mr D S Daley, Miss E Dawson, Mr D Farrell (Substitute for Dr L Sullivan), Ms S Hamilton, Ms D Marsh, Mr K Pugh, Miss C Rankin and Mr I Thomas

OTHER MEMBERS: Paul Carter, CBE and Peter Oakford

OFFICERS: Andrew Scott-Clark (Director of Public Health) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

27. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Mrs L Game, Mr S J G Koowaree, Mr G Lymer and Dr L Sullivan.

Mr R H Bird was present as a substitute for Mr Koowaree and Mr D Farrell as a substitute for Dr Sullivan.

As the Chairman, Mr G Lymer, was unable to attend due to illness, the meeting was presided over by the Vice-Chairman, Mrs P A V Stockell.

28. Declarations of Interest by Members in items on the Agenda.
(Item. 3)

Mr I Thomas declared a personal interest as a member of his family was funded by the County Council in a nursing home.

Mrs P A V Stockell made a similar declaration.

During the discussion which followed Mr Carter's verbal updates, Mr Thomas declared that he was a Canterbury City Councillor serving on the Planning Committee. He did not take any part in the discussion of the possibility of a new hospital site in Canterbury.

29. Minutes of the meeting held on 22 September 2017.
(Item. 4)

1. ***Minute 19, paragraph 3:*** The Director of Public Health made two corrections to the section of his verbal update dealing with foreign mosquitoes, as follows:

a) 'a mosquito larva and egg' not 'a colony' had been identified; and

b) The deletion of the final sentence of paragraph 4 b).

The Democratic Services Officer undertook to make these changes to the final minutes before they were signed by the Vice-Chairman.

2. It was RESOLVED that, subject to the amendments above being made, the minutes of the meeting held on 22 September 2017 are correctly recorded and they be signed by the Vice-Chairman.

30. Meeting Dates 2018/19.
(Item. 5)

It was RESOLVED that the dates reserved for meetings of the committee in 2018 and 2019 be noted, as follows, with all meetings commencing at 10.00am at Sessions House:-

Wednesday 24 January 2018
Tuesday 13 March 2018
Thursday 3 May 2018
Wednesday 27 June 2018
Friday 14 September 2018
Thursday 22 November 2018
Wednesday 9 January 2019
Wednesday 13 March 2019

31. Verbal updates by Cabinet Members and Directors.
(Item. 6)

1. The Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health, Mr P J Oakford, gave a verbal update on the following issues:

Infant Feeding – a group of Kent mothers had recently submitted a petition of 4,931 signatures about breastfeeding support services and had met the Leader to discuss this. In line with the County Council's petition scheme, the petition would be the subject of a debate at this committee's next meeting on 24 January 2018 and would form part of the public consultation on this subject.
Kent Health and Wellbeing Board – work was ongoing to establish a joint Kent and Medway Health and Wellbeing Board. The terms of reference of the new joint board were currently being finalised and would be ratified by both councils, and the new board would start work in April 2018. Glenn Douglas, Chairman of the Sustainability Transformation Partnership, had addressed the most recent meeting of the Kent Health and Wellbeing Board and the establishment of the new joint board had been welcomed. The present Kent Health and Wellbeing Board would continue to exist and would meet briefly once a year to undertake formal procedural tasks, with all other business being considered by the new joint board.

2. The Leader and Cabinet Member for Traded Services and Health Reform, Mr P B Carter, CBE, commented that, as it continued to establish its workload, the committee needed to include more health reform issues on its agenda. He then gave a verbal update on the following issues:

Sustainability Transformation Plan (STP) update – Mr Oakford and Mr Carter both served on the Sustainability Transformation Programme Board, which was

pursuing the priorities of hospital care, local care, prevention and public health issues, with the former taking up much STP time. Regarding ***hospital care***, Mr Carter said he had been surprised by the short notice given of a public consultation on a reconfiguration of East Kent hospitals' A&E services, which would start on 4 December. He suggested that population modelling, to identify service need in East Kent, should extend as far as Swale and Faversham. He outlined the response to the consultation which the County Council would make by the closing date of 8 December; the need for a new solution, with A&E services added to the Chaucer Hospital, QEQM retaining its current A&E services, but no new hospital being built at Canterbury. Regarding ***local care***, he said the County Council should seek new investment of £40m-70m to fund a full range of local care services to keep people out of hospital. It was well known that, for every additional £1 spent on local care, it was possible to save £3 - 4 on the provision of hospital care. There was a proposal that there be eight pilot local care schemes, but he expressed an opinion that it would be better instead to have four well-targeted pilots. He suggested that *an item on this area of work be added to the committee's January agenda to ask Anu Singh, Corporate Director of Adult Social Care and Health, to set out her vision of how social care and public health could best link to local care, and what an ideal model of local care would look like.*

3. Mr Carter then responded to comments and questions from the committee, including the following:-

a) good progress had been made in promoting and supporting training for medical staff in the Canterbury area, which was vitally important, and a bid for a medical school in Kent would further help this. The medical school was supported by Canterbury Christ Church University and the University of Kent at Canterbury and could possibly have a second campus in Medway. What was important was that good staff be recruited, properly deployed and retained; and

b) reference was made to the lessons which could be learned from past experience of new hospital building and service reconfiguration in Maidstone and Tunbridge Wells. Good links between hospital services and community services would address delayed transfers of care. One of the main challenges of implementing the STP was how to deliver new, local services on the ground. Mr Carter responded that his view was that enhancing service delivery at existing Canterbury hospitals was a better use of funding in the long term than the construction of a new hospital, and the County Council should make a good business case for this option.

4. During discussion of this item, Mr Thomas declared that he was a Canterbury City Councillor serving on the Planning committee. He did not take any part in the discussion of the possibility of a new hospital site in Canterbury.

5. The Director of Public Health, Mr A Scott-Clark, then gave a verbal update on the following issues:

Kent Medical School – to what had already been said about this, Mr Scott-Clark added that a Kent medical school could helpfully relate to a 'parent' medical school at Brighton and confirmed that his team would host medical trainees to give them a grounding in public health issues.

Sustainability Transformation Plan update: Public Health Input – Mr Scott-Clark had met with the Director of Public Health at Medway Council to discuss public health work and how best to work together and avoid duplication of work streams, particularly around prevention.
Public Health Observatory – work was underway with Carnall Farrar on a 'case for change', to seek to enhance mental health work and improve outcomes for cancer patients via a holistic approach, including early diagnosis and faster treatment.
Clinical Strategy for Kent and Medway - both Directors of Public Health served together on a clinical board and were working together to develop a clinical strategy for Kent and Medway, to seek the best outcomes for the population. Key areas of work included mental health, workplace stress and lifestyle changes, joining up digital work streams and tackling the challenges around local care and hospital care. In response to a comment, he emphasised the importance that mental health issues had among current work streams and the need to view mental and physical health as being of equal importance.

6. It was RESOLVED that the verbal updates be noted, with thanks.

32. 17/00098 - Infant Feeding Consultation Update.
(Item. 7)

Ms W Jeffreys, Locum Consultant in Public Health, was in attendance for this and the following item.

1. Mr Scott-Clark introduced the report and advised the committee that the public consultation would end on 3 December and that comments made by the committee would contribute to this. More than 316 responses had been received so far, and all responses received would be analysed following the end of the consultation period. Ms Jeffrey set out the key elements of the service which had been identified as needing improvement, including the initiation of breastfeeding by the maternity service in the first 10 days following birth and the move to the health visitor service beyond 10 days, and the need to avoid a gap between these two services. The proposed new model sought to improve both this and the rate of breastfeeding continuing at 6 – 8 weeks following birth. Mr Scott-Clark and Ms Jeffreys responded to comments and questions from Members, including the following:-

a) asked about the training given to health visitors in supporting mothers to attempt breastfeeding, and if they would take on this work in addition to other workloads, Ms Jeffreys explained that, while all health visitors were fully trained to support breastfeeding mothers, 36 of them were additionally trained to give specialist support and 4 of the 36 were trained as lactation consultants;

b) a view was expressed that some mothers would prefer to see and talk about breastfeeding with a health visitor that they already knew. Health visitors would know the family and be in a better position to advise them;

c) asked if the birthing unit at Maidstone Hospital had been among the consultees, Mr Scott-Clark confirmed that the consulting midwife there had indeed been a consultee;

d) concern was expressed that the health visitor service was being asked to deliver more with less resource, as the number of appointments available across the county was being reduced, Ms Jeffreys explained that the arrangement of clinics across the county would be different and, while there would be fewer clinics, there would be more opportunities to engage in a different way. Mr Carter added that, due to government involvement, the number of health visitors had doubled in the last few years and the health visitor service was confident that it had the capacity to deliver the proposed new breastfeeding support;

e) new mothers were often given a 'goody bag' of products for the first few days with a new baby, and this could include advice and guidance on services available to new mothers, including the health visitor service and support for breastfeeding;

f) the number of babies suffering from 'tongue-tie' had increased in recent years as this condition was now easier to diagnose. There were two types of tongue-tie, posterior and anterior, and the condition could be corrected by a small operation. Mr Scott-Clark added that the report on breastfeeding scheduled for the committee's January meeting would include information currently available on tongue-tie, including the prevalence of the condition;

g) expectant mothers needed to be given advice on breastfeeding before giving birth, as many stayed only a very brief time in hospital after giving birth. At this time a plan could be drawn up to cover the first few weeks and months after giving birth;

h) Mr Scott-Clark advised that Kent's statistics for breastfeeding initiation were below the national average and that rates across the county varied. It was important to find out the reason for this and identify areas of good practice and seek to spread this. A leading midwife was working with the County Council to look into this; and

i) the titling of the subject as 'infant feeding' rather than 'breastfeeding' was welcomed as some mothers did not wish to, or were not able to, breastfeed their babies, for a variety of reasons. The support needs of these mothers were also important and should be identified. It was important that those mothers not breastfeeding should not be made to feel they had 'failed';

2. It was RESOLVED that:-

a) the detailed findings of the consultation be noted and that Members' comments, set out above, be considered as a part of the consultation; and

b) the detailed findings of the consultation and subsequent proposal be presented to the committee for consideration at its meeting in January 2018, prior to a formal decision being taken by the Cabinet Member.

33. Adolescent Health.
(Item. 8)

1. Ms Jeffreys and Mr Scott-Clark introduced the report, which set out the new model of service delivery and had been prepared in response to a request for an update on adolescent health as part of the committee's ongoing contract monitoring role. Mr Carter added that reports such as this would help the committee to increase its understanding and develop its role and that, as part of monitoring service delivery, it would be important to identify what should be measured and what a good service should look like. Ms Jeffreys and Mr Scott-Clark responded to comments and questions from the committee, including the following:-

a) nationally-generated data on the need for adolescent health services should be treated with caution as this did not contain the level of detail that Kent would expect to see as a basis for service development;

b) young people's habitual use of personal electronic devices and screens meant they had become unused to making any sort of eye contact with others, and a modern culture of not being able to touch or comfort a young person meant that whole generations had grown up with very limited human interaction and an impaired ability to connect to others and form social relationships. This would not help them develop good mental health;

c) asked about services for young people up to the age of 19 or 25, as in other areas of children's and young people's services, Mr Scott-Clark explained that the service concerned in the report was school-based and so would not relate to school leavers. He clarified that services such as sexual health, drug and alcohol misuse and Child and Adolescent Mental Health Services (CAMHS) related to different age ranges and had different upper age limits A young person in receipt of services at the time they left school would be given a transition plan which would set out how they would access similar services in the future;

d) a request was made for a full schedule of services available and their status (statutory or discretionary), how and by whom these were provided and how their success could best be measured;

e) asked how the human papillomavirus (HPV) vaccine was delivered, Mr Scott-Clark explained that all vaccinations were delivered by NHS England and that the HPV vaccination was a key preventative strategy and would be monitored as part of the prevention work stream;

f) concern was expressed about the reliance on personal, social, health and economic education (PSHE) lessons to help deliver public health messages as this was not uniformly delivered across the county. A more useful link could be to young people via the Kent Youth County Council, higher education and the Youth Service instead of relying just on schools;

g) it would be helpful for Members to be given information about the patterns of drug and alcohol misuse and eating disorders in Kent;

h) PSHE covered a wide range of personal and cultural issues and the way in which these issues were approached in any particular school was important in shaping young people's own approach to them. Years ago, young people would have been shown photographs of alcohol-related and sexually transmitted conditions and this frank visual approach seemed to be effective in conveying the implications of risky behaviours. Another speaker questioned whether PSHE was even being taught in all schools and highlighted how important it was that this issue be addressed;

i) statistics were given for the number of young women under 16 giving birth but no statistics seemed to be offered for the number of young men becoming fathers at very early ages; and

j) the need for children and young people to have regular school trips and opportunities to attend out-of-school activities to develop skills such as team building was emphasised.

2. The Cabinet Member, Mr Oakford, said how useful it had been for the committee to debate this important issue and said this opportunity demonstrated the value of this new committee. He undertook to ensure that the issues raised were looked into.

3. It was RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks.

34. Revenue and Capital Budget Monitoring - August 2017-18.
(Item. 9)

Miss M Goldsmith, Finance Business Partner for Adult Social Care and Public Health, was in attendance for this item.

1. Mr Oakford introduced the report and said that the method of budget reporting used for other Cabinet Committees was less useful for this committee as the Public Health budget consisted entirely of grants and would always make full use of all grants available, leaving a zero balance. However, the committee would need to be able to see how the public health grant was allocated for the current and future financial years.

2. Miss Goldsmith advised that a breakdown of the planned budget allocations for public health services in 2017/18 had been set out in the budget book published early in 2017 and offered to prepare the same for 2018/19 and present this to the committee at its next meeting. This was welcomed as it would form the basis of the committee's performance and contract monitoring activity and allow it to identify good service delivery and value for money.

3. It was RESOLVED that-

a) the revenue and capital forecast variances for the 2017-18 budget in the remit of this Cabinet Committee, based on the August monitoring position presented to Cabinet on 30 October 2017, be noted; and

b) a breakdown of the planned budget allocations for public health services in 2018/19 be presented to the committee's January meeting.

35. Work Programme 2018/19.
(Item. 10)

1. The inclusion of a regular ***contract monitoring*** item on agendas was supported as an important part of the committee's role. Members who had attended recent contract monitoring training recommended it to others as a good grounding in the subject which had helped their understanding of the issues involved.

2. It was suggested that a timetable of contract monitoring activity be drawn up to cover the next 12 – 24 months, to offer a planned approach, and that contracts due to be renewed soonest be prioritised so the committee could consider performance so far and be able to make a timely contribution to future contracting decisions.

3. It was RESOLVED that, taking account of the points set out above, the committee's work programme for 2018/19 be agreed.

By:	Mr P B Carter, CBE, Leader and Cabinet Member for Traded Services and Health Reform Mr P J Oakford, Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health Mr A Scott-Clark, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee – 24 January 2018
Subject:	**Verbal updates by the Cabinet Members and Corporate Director**
Classification:	Unrestricted

The Committee is invited to note verbal updates on the following issues:-

Health Reform

Leader and Cabinet Member for Traded Services and Health Reform – Mr P B Carter, CBE:

Sustainability Transformation Plan update

Public Health

Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health – Mr P J Oakford:

1. update on the infant feeding consultation
2. update on the Kent Health and Wellbeing Board and progress towards forming a joint board with Medway.

Deputy Director of Public Health – Dr A Duggal

1. Influenza and 'flu jabs.
2. Dry January – media coverage
3. Public Health Funding update

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From:	Peter Oakford Cabinet Member, Strategic Commissioning and Public Health Andrew Scott-Clark, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee
Date:	24 January 2018
Subject:	**Prevention in the Kent and Medway Sustainability and Transformation Plan**
Classification:	Unrestricted
Past Pathway of Paper:	This is the first committee to consider this report
Future Pathway of Paper:	Cabinet Member Decision
Electoral Division:	All

Summary

Kent and Medway Public Health teams have collaborated with partners on the development of a Prevention Workstream and Strategy for the Sustainability and Transformation Plan for Kent and Medway Health and Social Care system.

Recommendations

Members of the Committee are asked to **COMMENT** on the progress of the Kent and Medway Sustainability and Transformation Plan Prevention Workstream and the future planned work.

1. Introduction

1.1. Kent Public Health, alongside colleagues from Medway Public Health and NHS Partners have been working to embed prevention into the work of the Sustainability and Transformation Plan (STP) for Kent and Medway.

1.2. Health Reform and Public Health Cabinet Committee asked for an update on the work of the Prevention Workstream of the Kent and Medway STP and this paper provides this update along with a description of some of the future work planned.

2. Background

2.1. Kent and Medway Health and Social Care partners have come together to develop a Sustainability and Transformation plan to improve the quality of care and improve access for all residents to health and social care within the financial constraints of taxpayer affordability over the next five years.

2.2. This is against a background of significantly increasing demand as Kent and Medway have not only aging populations, but also have significant areas of housing development. The population is expected to grow by 90,000 people (5%) over the

next five years; this will be in a number of areas such as Chilmington, Maidstone, Ashford and Canterbury. In addition to the growth in Dartford there are expected to be an additional 20,000 residents in Ebbsfleet Garden City and there are current plans for further Garden Cities/Towns elsewhere in Kent. Growth in the number of over 65s is expected to be 4 times greater than those under 65; and this aging population means increasing demand for health and social care.

2.3. There are health inequalities across Kent & Medway; in Thanet, one of the most deprived areas of the county, a woman living in the best ward for life expectancy can expect to live 7.1 years longer than a woman in the worst and for men, this figure is 10 years. The main causes of early death are often preventable.

2.4. Over 500,000 local people live with long-term health conditions, many with multiple long-term health conditions, dementia or mental ill health. A large proportion of these conditions are preventable.

2.5. The STP presents an exciting opportunity to change the way we deliver prevention to our population and Kent and Medway public health colleagues have been collaborating on many of the STP workstreams, in particular the STP prevention workstream where we are working to embed prevention as the first step in all patient health and social care pathways.

2.6. The Prevention workstream is part of the Care Transformation workstream and is currently led by Allison Duggal, Deputy Director Public Health Kent County Council and meets monthly. The Senior Responsible Officers are Andrew Scott-Clark, Director Public Health Kent County Council and James Williams, Director Public Health Medway Council. The workstream reports to the Clinical Board for the STP which in turn reports to the STP Programme Board.

2.7. The prevention workstream has taken a broad definition of prevention, including primary, secondary and tertiary prevention. Smoking and obesity have been prioritised to ensure that those areas that have the greatest effect on health outcomes are brought to the fore. Primary prevention aims to provide interventions aimed at individuals that have no current health or social care support needs and includes promoting healthy and active lifestyles and immunisation. Secondary prevention is the prevention of illness in those known to be susceptible e.g. screening to identify people at higher risk of cancer and interventions to then prevent the development of cancer and tertiary prevention refers to interventions aimed at minimising the impact of disability or further deterioration in people with existing an health condition or complex care and support needs.

3. Current Activities

3.1. The workstream aim is to make the prevention vision the responsibility of all health and social care services, employers and the public in Kent and Medway to allow delivery of prevention interventions at scale and realisation of improved population health outcomes. In particular the involvement of clinicians in secondary care for secondary and tertiary prevention is stressed as these compliment the population-level primary prevention initiatives of the STP. It is felt important that all health and social care pathways start with prevention and it is the aim of the workstream to ensure that this is reflected in all the work of the STP.

3.2. The current plans include:

- 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, i.e. treating the nicotine or tobacco addiction;

- Treating both physical and mental health issues concurrently and effectively;

- Concentrating prevention activities in four key areas which are described below:

4. Progress

4.1. The main areas for focus for prevention activities in Kent and Medway have been identified and are:

Obesity and Physical Activity:
Apply a whole systems approach including implementation of 'Let's Get Moving' physical activity pathway in primary care at scale across Kent and Medway. Increase capacity in Tier 2 Weight Management Programmes from 2,348 to 10,000 and Tier 3 services for children as these are not currently available.

Smoking Cessation and Prevention:
Support all Trusts to become smoke-free with trained advisors, tailored support for the young and youth workers, pregnant and maternal smokers and people with mental health conditions. This will include the ambition for mental health trusts and NHS community trusts to be completely smokefree by the end of 2018/19 and all acute trusts by the end of 2019/2020.

Workplace Health:
Working with employers on lifestyle interventions including; smoking cessation, alcohol misuse, providing training programmes for improved mental health and wellbeing in the workplace.

Reduce Alcohol-Related Harms in the Population:
'Identification and Brief Advice' (IBA) in hospitals ('Healthier Hospitals initiative') and screening in GPs. Alcohol health messaging to the general population.

4.2. Business cases have been submitted to the Programme Board for the obesity and smoking cessation and prevention workstreams. These business cases have been agreed in principle and have the full backing of the clinical board. Members should note that the funding required is over and above the funding available to local authority public health in Kent and Medway.

5. Future Activity

5.1. The workstream is currently developing a number of strands of work. A Prevention Action Plan is being developed for Kent and Medway STP with the aim to publish in spring 2018. This action plan will include full details of the four main areas of prevention for the STP; will detail the timing of the initiatives, data to be collected and performance indicators. It will also outline future considerations for the local

populations such as the links between housing and public health and how the workstream can collaborate with other teams in the local health and care economy.

5.2. An action plan is being developed for an initiative on workforce development for partners to enable wider dissemination of public health philosophies and concepts and empower partners to deliver health promotion messages in many areas of health, care and wider public services e.g. fire service. This will be based on the Making Every Contact Count programme.

5.3. The workstream has already developed links with many partners and other workstreams and there is representation at the workstream meetings e.g. from communications and finance workstreams. In addition, links have been made to other parts of the health and social care system such as the Local Maternity Service and Cancer Network. There are plans for 'deep dive' meetings to explore particular areas of health and care such as improved prevention in maternity service and cancer prevention, particularly where there are disease specific prevention strategies for example HPV Vaccination to prevent cervical cancer.

There will also be a major focus to address the impact of chronic long term health conditions. Improving the population's ability to manage issues such as high blood pressure, obesity, diabetes and respiratory disease, will reduce the need for care and support and help alleviate the pressure on existing care services.

5.4. The work of the STP continues at pace. The Prevention Workstream is developing to ensure that the work of the public health teams and partners is keeping pace with developments. A number of innovative proposals are currently being considered. The Kent and Medway public health teams are liaising with a range of stakeholders to establish more efficient and effective ways to improve the population's health. Partners include The Kent Design and Learning Centre, Medway and Swale Centre for Organisational Leadership and The Kent Surrey and Sussex Academic Health Science Network. This collaboration is focussed on how current and future challenges can be best addressed, through the use of research and digital technology.

6. Finance

6.1. The Five Year Forward View sought a radical upgrade in prevention as part of the overall plan to modernise the NHS. In Kent and Medway through the prevention work we've sought to increase the NHS funding for prevention and in particular for clinical interventions related to both smoking and obesity. It has been agreed by the STP senior leadership, that all future NHS business cases need to take into account their impact on the achievement of prevention priorities. The Kent and Medway Public Health Departments are working with NHS colleagues to embed this process within the STP business and planning processes.

7. Risks

7.1. The key risk for this workstream is the lack of financial input from the STP. The funding required for the prevention of lifestyle-related harm is substantial and it is not possible to fund this from the public health budgets of local authorities without detriment to the prescribed legal functions of local authority public health. The funding is required in order to deliver interventions at scale and pace.

7.2. An additional risk is the time it may take for frontline primary and secondary care staff to adapt to a preventative approach. There is support from senior clinical leadership across the STP and we need to ensure workforce development plans across the workstreams prioritise prevention.

8. Conclusion

8.1. KCC Public Health along with partners from Medway Public Health and the wider health economy continue to make progress with the local prevention workstream and to develop collaborations with other parts of the health economy and with partners in other workstreams of the STP.

8.2. Spring 2018 will see the publication of an action plan for prevention in Kent and Medway and the public health team will continue to work with partners in order to deliver.

9. Recommendations

Recommendation: Members of the Committee are asked to **COMMENT** on the progress of the Kent and Medway Sustainability and Transformation Plan Prevention Workstream and the future planned work.

Background Documents: none

Report Author:

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Relevant Director

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By: Peter Oakford, Cabinet Member for Strategic Commissioning and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

Date: 24 January 2018

Subject: **One You Kent Campaign Update**

Classification: Unrestricted

Past pathway: This is the first committee by which this issue will be considered**.**

Future pathway: N/A

Electoral Divisions: All

Summary

Marketing and communications is a key element in delivering successful public health interventions. This paper reports on progress of the One You Kent campaign.

Delivering effective campaigns and communication to the residents of Kent is a key priority agreed for improving population health. The core aim is to drive behaviour change particularly in communities with the highest need.

The One You Kent campaign has been developed based upon the findings from the behavioural insights research conducted as a part of the recommissioning of healthy lifestyle services.

The approach that has been developed is to promote healthy lifestyles by delivering messages to the whole population, with the support of our partners, but ensuring that the call to action from these messages form part of a simple customer journey, ensuring that people can find information, resources and eventually local services to help them if needed.

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to:

i) Comment on the progress and impact of the One You Kent campaign to date

ii) Suggest additional local organisations which could support the One You Kent campaign

1. Introduction

1.1 Marketing and Communications is a key element of the public health strategy to support Kent residents to improve both their physical and mental health.

1.2 Public Health Marketing and Communication has three key elements:

- Promoting healthier behaviours
- Giving information and advice
- Promoting local services

1.3 Two guiding principles direct the work in Kent:

- Marketing and communications should form a key part of the customer journey
- Where Public Health England have a relevant brand this will be extended into Kent to take advantage of the national investment into social marketing, tools and resources, and to ensure that residents are not confused by competing brands, or messages.

1.4 During the consultation period for the re-design of healthy lifestyle services in Kent the public commented that they were not aware of the services that were available, and were unsure of where to go if they wanted further support.

1.5 Whilst the re-design work was underway, Public Health England (PHE) launched the One You brand to promote healthier lifestyles with the intention to create a brand awareness as strong as that of Change 4 Life (over 90% brand recognition).

1.6 The One You brand is supported by a series of PHE apps to support people , including apps to support giving up smoking, to encourage physical activity, and healthy meal planners.

2 The One You Kent Campaign

2.1 As a part of a planned programme of campaign work, KCC commissioned two agencies to work on ensuring that the One You message is promoted across Kent, in line with the findings from the behavioural insights report (e.g social media adverts have referenced the trigger points for change – e.g. becoming a grandparent. These two agencies have specific remits:

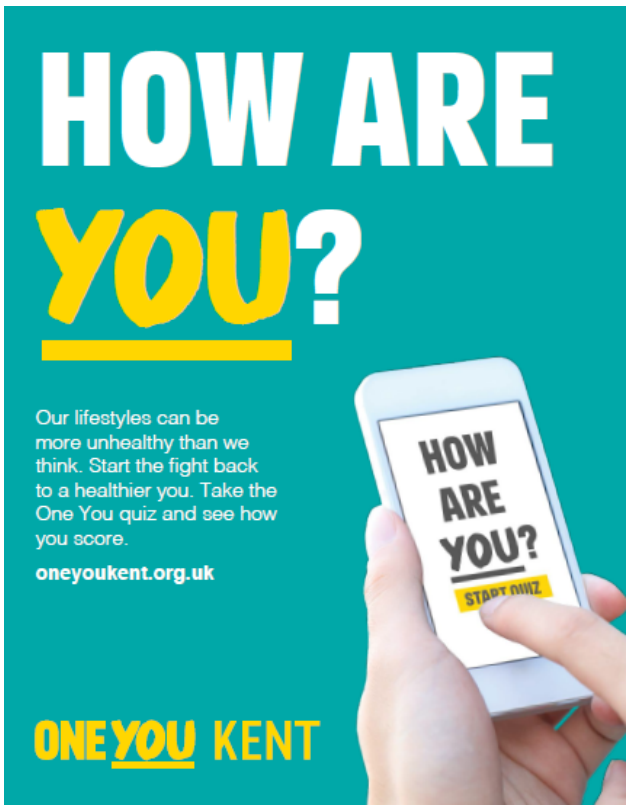
- Zest were engaged to deliver a programme of consumer led work

2.2 iFour have been engaged to work with partners, providers, stakeholders and channels across Kent to understand how the One You message can be effectively spread, and what materials could be developed to support each of these groups to promote healthier lifestyles in a consistent way (using standardised wording and messaging).

2.3 To complement all elements of the campaign, a hub has been created at www.oneyoukent.org.uk which can be used as the unique call to action in the marketing messages.

3 The One You Kent Consumer Campaign

3.1 The consumer marketing campaign elements launched with a burst during March and April. (with the intention of priming, and of creating a greater brand awareness of One You).



3.2 The initial burst of activity consists of:

- Out of home advertising (six sheet adshels, passenger bus panels, pharmacy bags)
- Radio – advertising on Heart/KMFM
- TV (Sky Adsmart/ITV on demand) – this element was phased to coordinate with national TV advertising
- Print – hospital magazines
- Social media (Facebook)
- Digital (Network, PPC, Kentonline)
- Experiential events in Dover, Margate and Maidstone
- Local District Council pubications such as Sevenoaks “In Touch”

3.3 The call to action of all of this advertising has been for people to either search One You Kent (radio/tv), to visit www.oneyoukent.org.uk or to click on the digital/social media ad to come through to the website.

3.4 In the first phase of the campaign over 85,000 Kent residents have visited the www.oneyoukent.org.uk site, with more than 25,000 people taking the How Are You (HAY) quiz.

3.5 The results from over 18,000 Kent people who have taken the quiz until September 2017, have recently been shared by PHE and are currently being analysed by the

Kent Public Health Observatory. These will help us to further target our campaigns based on the motivations, location and lifestyles of the people of Kent.

3.6 The contract with Zest ended in December, as a part of the evaluation, a survey was undertaken that established that 10% of the key target population (40-60 year olds) had made a change in behaviour as a result of the campaign.

4. One You Kent Stakeholder Promotion

4.1 The One You Kent campaign is designed to ensure that consistent messages are given to the people of Kent. To achieve this it was recognised that there are many organisations that have the opportunity to interact with the public at times when they are open to change.

4.2 Over the past year, work has been ongoing, supported by iFour the appointed agency, to develop a series of resources to help bring about the consistency of messaging.

4.3 A series of meetings were held with partners from across the health and public sector to understand how stakeholders could help promote the One You Kent messages, and what resources they would need to do so.

4.4 A set of resources have been developed, in line with the research, based around four segments of stakeholders:

- Providers of One You Kent services (such as Kent Community Health Foundation Trust - KCHFT - , District councils in West Kent, and Healthy Living Centres)
- GP Practices
- Partners, such as other District councils, Hospitals, Job Centre Plus
- Wider supporters of the campaign, e.g. community organisations

4.5 Resources include:

- brand guidelines for providers (including designs for uniforms, leaflets, posters etc)
- empty belly posters, business card holders and business cards for public facing areas
- staffroom posters, and conversation tip leaflets for frontline staff
- generic online adverts, and social media resources for people to use
- a GP “prescription pad” for GPs to prescribe a One You app or intervention

4.6 The intention is that wherever people might be triggered to make a change to their lifestyles, that they will be able to see, or meet with a frontline worker who knows about One You Kent. Key trigger points can include; starting a new job, moving home, becoming a parent so for example initial discussions have been help with Job Centre Plus, Housing groups, and Libraries and Registration about getting the message out through their locations and staff.

4.7 The healthy lifestyle services provided by KCHFT and District Councils in the West of Kent have all been rebranded as One You Kent, and will be relaunching under this new branding during January.

4.8 A stakeholder conference will be held on 14th March to brief stakeholders on the resources that are available, and how they can use One You Kent in their areas of work.

5. Next phase of promotion for One You Kent

5.1 The consumer promotion will continue, with a focus on social media, utilising the resources that were developed during the contract with Zest

5.2 An agency, Pillory Barn, have recently been appointed to promote One You Kent to employees, reaching them through their place of work. They have been tasked with reaching 150,000 employees, with a particularly focus on routine and manual workers, as poor health outcomes are higher in this group.

5.3 Work through the STP and the Prevention work stream to build on the NHS "Making every contact count" initiative to ensure consistent messages are being given by NHS staff to people they come into contact with.

6 Conclusion

6.1 The One You Kent campaign has the potential to deliver clear, consistent messages to the people of Kent about how they can improve their health. By using the behavioural insights research, and the wider public sector, there is an opportunity to deliver these messages to people at key points in their life, when they are open to change, and enable them to find the right level of support for them, whether that is information, advice, and app or a service.

7 Recommendation

7.1 The Health Reform and Public Health Cabinet Committee is asked to:

i) Comment on the progress and impact of the One You Kent campaign to date

ii) Suggest additional local organisations which could support the One You Kent campaign

Background Documents
None

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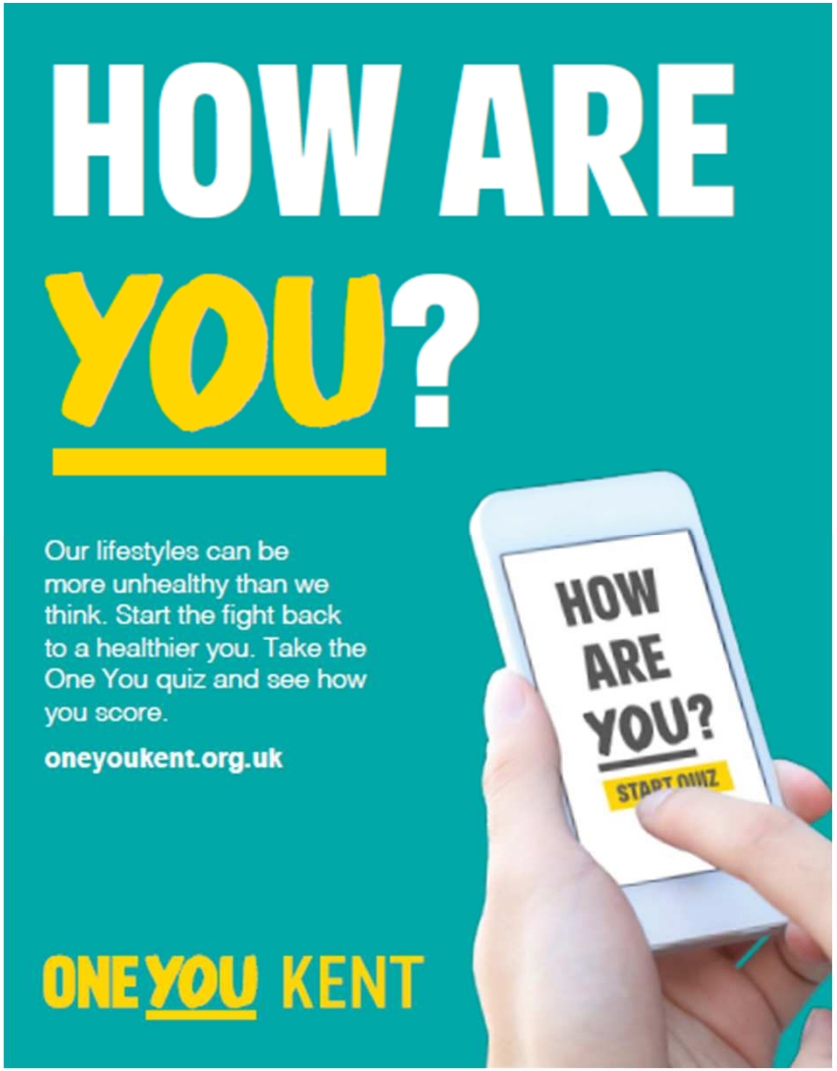

HOW ARE YOU?
Our lifestyles can be more unhealthy than we think. Start the fight back to a healthier you. Take the One You quiz and see how you score.
oneyoukent.org.uk
HOW ARE YOU?
ONEYOU KENT

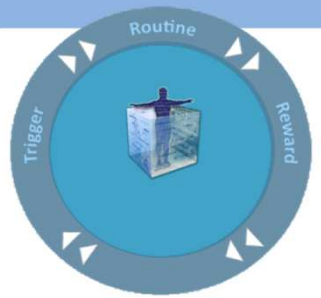
Behavioural Insights

- The study focused on developing our understanding of why people with the unhealthiest lifestyles are least likely to engage with our services.

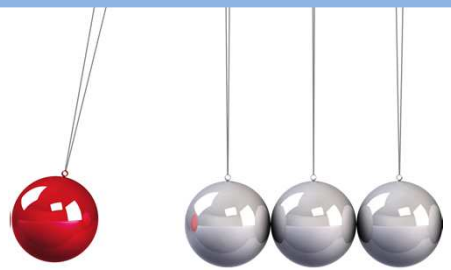
- In depth research, with twelve people over a course of two weeks, understanding their daily choices, and the influences on their behaviour.

The audience's multiple unhealthy behaviours cluster in two key ways

1. UNHEALTHY HABITS SUBSTITUTE FOR ONE ANOTHER



2. UNHEALTHY HABITS REINFORCE ONE ANOTHER



Segmenting the target audience

Ability and motivation for behaviour change is heavily influenced by people's mental state and emotional wellbeing at a given point in time. We see 3 key groups:

Surviving for Today	Open to change	Living for Today
Fatalistic: *"Bad things will happen anyway, why bother to change?"* Often facing more acute issues –mental/ physical health, domestic abuse, housing / debt Lack ***cognitive bandwidth*** for lifestyle change, esp. ability to plan Primary barriers are ***ability*** and ***motivation*** to change	Realistic: *"I need to change something(s) about my lifestyle"* Doubts around lifestyle behaviours creeping in with accumulation of relevant **personal primes –** motivation building but yet to be ignited Primary barrier to change is a ***trigger*** *(N.B. This was the largest group in the research)*	Optimistic: *"It won't happen to me"* Often experiencing strong social rewards from unhealthy behaviours that override any reasons or influences for changing – Younger life stage skew Primary barrier is ***motivation*** to change

Unhealthy habits substitute for one another

BOREDOM

LONELINESS

A range of contexts and times across the day

Unhealthy behaviours:

- ***Smoking***
- ***Drinking***
- ***Lack of exercise – hours spent in front of TV etc.***
- ***Unhealthy snacking / missing meals then over-eating***

*"I **smoke in the van**, it's **just boring driving on my own**. I **barely speak to anyone all day** except when I stop in a lay by to get a burger or butty… When I'm at home, my **mum makes it clear she doesn't want me around**, so I **come to the pub most days** to have a few pints and **talk with people**."*

Male, Younger, Family, Tunbridge Wells

*N.B. repeating these behaviours gradually builds up **automatic habit loops***

ENJOYMENT

EMPOWERMENT

BONDING

PSEUDO COMPANY

Removal of one unhealthy behaviour risks it being replaced by another – important to fill the void with positive alternatives

Behavioural insights study into multiple unhealthy behaviours gave us tools to talk to partners

Prime	Trigger	Get Ready	Make change(s)	Live with the change(s)	Sustain change(s)/ normalise
Accumulation of influences and building underlying motivations for making change	The specific factor which prompts and ignites motivation for change 	Preparation, building commitment and capability for change *N.B. Can be very fleeting and informal*	Begin to make change – moment and situation of getting started *N.B. Can be at the trigger point or some time afterwards*	Adjusting to the change, experiencing knock on effects: positive rewards and negative feedback / **void that is left** from removal of old behaviours	Develop habits that make new behaviour automatic and part of your identity. **Reliant on a sufficiently powerful REWARD.**
☹ ☺ 😐	😐	😐	😐	😐	😐
Primed but differing levels of motivation &/or ability for change	Sufficiently primed, motivated and able to progress along journey				

Example triggers that ignited motivations

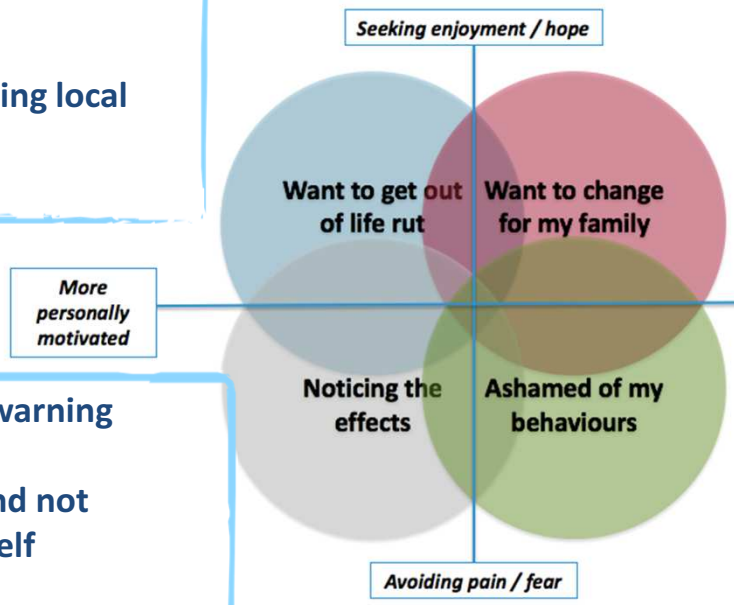
Invitation to go on walking holiday with Dad and other men

Moving home and joining local gym

Child joins school healthy cooking club at school & tells mum he wants to lose weight

Becoming a new Dad and needing to stay sober in evening for baby

New partner who does not share behaviours



Health scare/Drs warning

Seeing photos and not recognising self

Illness (e.g. flu) or particularly bad hangover

Upcoming holiday or wedding

New Job where colleagues don't smoke and don't want them to know I do

Peers making changes

Pregnancy / new baby prompts fear of judgment

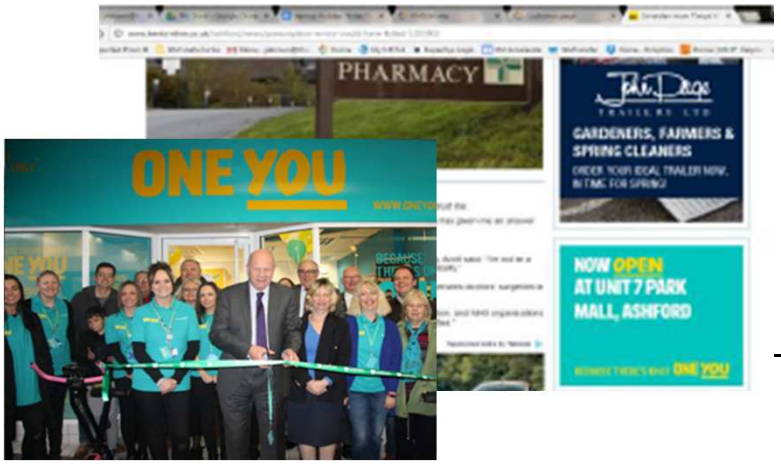
- Opportunity to **leverage touchpoints where people are triggered** (e.g. workplace, Health Visitor) to support Get Ready stage

ONE YOU KENT

- One You Kent is the localised campaign brand.
- Two agencies have been commissioned to work on the campaign, each has its own remit:
  - To plan and implement the consumer facing campaign.
  - To work with Kent providers, partners and supportive channels to develop resources that support each group to promote healthier lifestyles in a consistent manner.
    - To include brand guidelines for providers, and campaign guides for partners and supporters.

Consumer campaign activity

- Passenger bus panels and pharmacy bags
- Radio advertising on Heart/KMFM
- TV (Sky Adsmart/ITV on demand)
- Print in hospital magazines and the KM
- Social media (Facebook)
- Experiential events and leaflet door drops
- Digital (Network, PPC, Kentonline)



One You Kent TV advert

https://www.youtube.com/watch?v=UqoYwPJSH88

One You Kent – Consumer results to date

The 6 campaign activity generated:

- Over 85,000 sessions on oneyoukent.org.uk.
- Over 25,800 referrals to the PHE How Are You quiz.
- 90% of visitors on mobile or tablet
- Over 20,000,000 interactions across Kent media.
- Evaluation survey of people in the target audience - 29% had seen the One You Kent campaign.
- 66% of those who saw the campaign took small, positive steps towards changing their lifestyle.

Stakeholder engagement work

- We have worked with a number of key stakeholders and partners to develop tools to support the wider Kent workforce – including how they can help trigger a behaviour change

- Stakeholder engagement activities including a stakeholder workshop and online survey, have informed the production of resources.

Partner Resource Packs

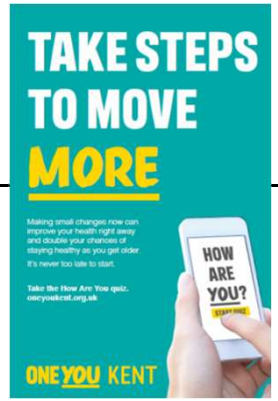
GP Surgery Kit	Partners Pack	Providers Pack	Supporters Pack

Stakeholder to customer

- Posters and flyer template
- Flag banner
- Pop up banner
- Bunting
- Signposting credit card

Partner Community

- What is ‘One You Kent?’ tent card
- ‘What is One You Kent?’ poster
- Partner guide
- E-newsletter
- Conversation tips for staff



Partner resources cont..

Supporting the Campaign

As part of the ONE YOU KENT network you can encourage people you meet to visit oneyoukent.org.uk and take the first step towards a healthier life.

Join us at:
kent.gov.uk/oneyouresources and find resources to help you support ONE YOU KENT .

BECAUSE THERE'S ONLY ONE YOU

ONE YOU KENT

TALKING ABOUT HEALTHY LIFESTYLES

Some tips to make it easier

UNDERSTANDING BEHAVIOURAL CHANGE CAN HELP YOU SUPPORT IT.

1. Focus on people who are **READY** to change

NOT READY	READY	NOT READY
Facing challenges like illness, debt, addiction or lack of time.	Realistic about the damage their habits cause, with good reasons for wanting to change.	Enjoying their lifestyle and feeling no ill effects.

2. Spot the **DRIVERS** and **TRIGGERS** behind **their change**

Driver	Trigger
I want to get out of a rut	'I've got another hangover.' 'I had four takeaways last week.'
I'm ashamed of behaviour	'My colleagues don't know I smoke.' 'I had to ask for a bigger uniform.'
I want to get healthier for loved ones	'My new boyfriend doesn't smoke.' 'I'm about to become a Grandma.'
I'm noticing the effects of my habits	'I didn't recognise myself in a photo.' 'My teeth are stained.'

3. Start a CONVERSATION

a. ASK

Questions like

'Why do you want to stop smoking?'

Help people think about their reasons for changing.

"Must be tough to do it by YOURSELF"

"Why do you want to STOP smoking / drinking?"

b. ADVISE

Encourage small steps.

"ONE YOU KENT provides free weight loss services"

"10 minutes walking a day can make a BIG difference"

c. ACT

Signpost and refer to ONE YOU KENT

"There's a great recipe app on ONE YOU KENT"

"Take a look at the ONE YOU KENT website"

DO

- Listen and show you understand
- Chat about shared experiences or relevant stories from the media

DON'T

- Judge, push, lecture, nag or frighten
- Worry about lapses - they're normal!

Watch the film about behaviour change and find more resources at kent.gov.uk/oneyouresources

Font

ONEYOU KENT

SIMPLE STEPS TO A HEALTHIER YOU

PATIENTS NAME ..... AGE ..... M / F ..... DATE .....

I RECOMMEND THAT TO BENEFIT YOUR HEALTH YOU SHOULD:

- ☐ **Do 10 - 30 minutes brisk walking each day**
  Search 'Active 10' for a free app to help track walking
  Find group walks in your area at oneyoukent.org.uk
- ☐ **Try preparing something new for dinner each day**
  Take a look at the 'Easy Meals' app for help and advice
- ☐ **Reduce the amount you drink through the week**
  The 'Drinks Tracker' app helps you take control each day
- ☐ **Stop smoking with daily support and motivation**
  The 'Smokefree' app can help you stop smoking
  Find stop smoking support in your area at oneyoukent.org.uk
- ☐ **Book your health check**
  If you're aged 40-74 book your NHS Health Check with us soon
- ☐ **Take the 'How Are You?' online health quiz**
  Do the 10 minute quiz for your FREE personalised health score

Medical condition specific advice:
(optional)

SIGNED* ..... DATE .....

*(GP or Health Professional)

Doctors notes:

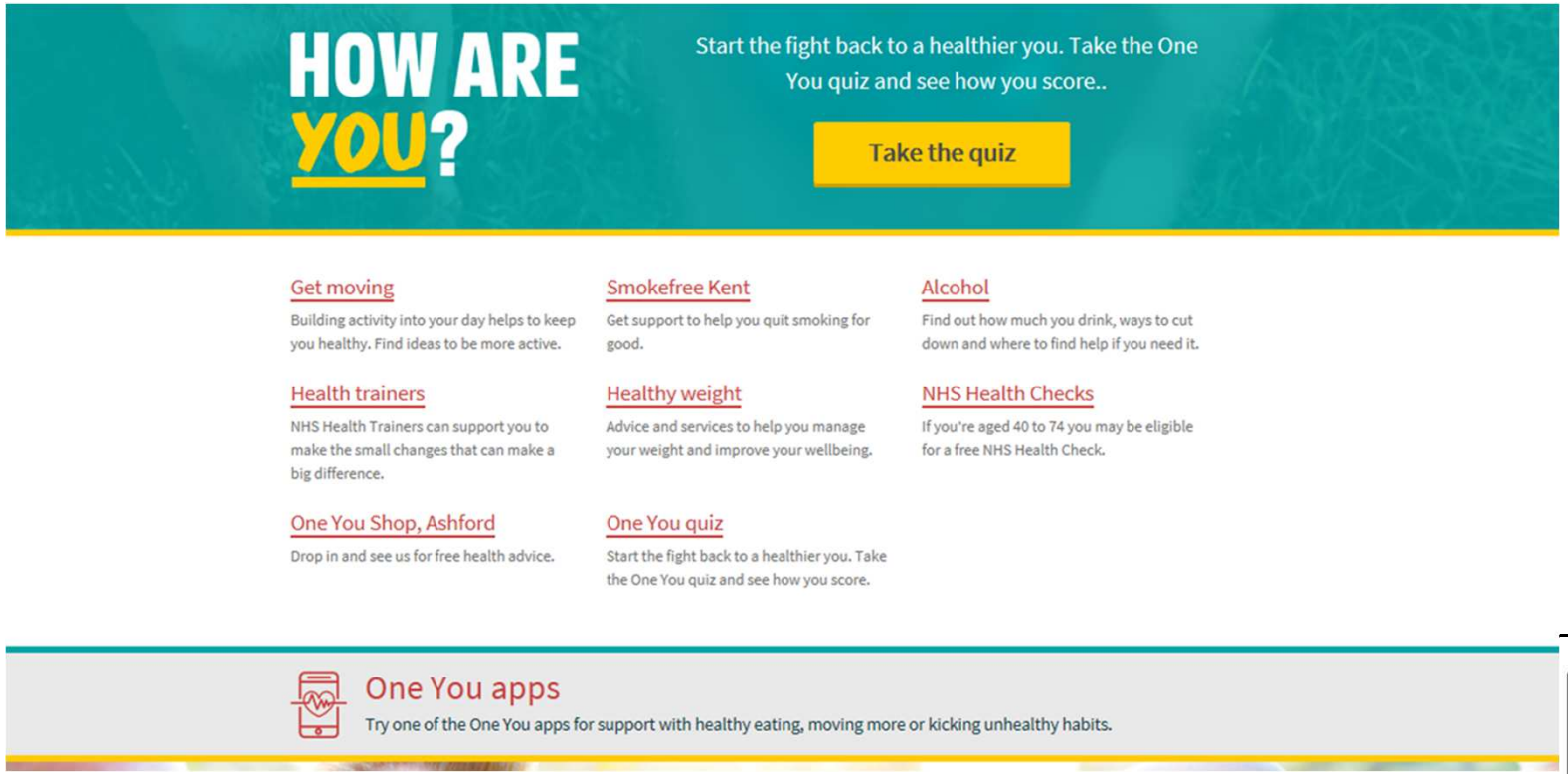
.....

.....

oneyoukent.org.uk - Free tips, apps and services to help YOU

ONE YOU KENT

- The One You Kent website has been created at www.oneyoukent.org.uk.
- The website contains content on the campaign, as well as being the hub for the adult health improvement services.



Engaging employees through their employers

- To reach 150,000 employees
- To pay particular attention to industries that are most likely to experience health inequalities, including routine and manual occupations
- Concentrating on priming and triggering

From: Peter Oakford, Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health

Andrew Scott Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee – 24 January 2018

Subject: **Draft 2018-19 Budget and 2018-20 Medium Term Financial Plan**

Classification: Unrestricted

Summary:

County Council debated the authority's Autumn Budget Statement on the 19 October 2017. The Autumn Budget Statement report set out an update to the Medium Term Financial Plan (MTFP) for 2018-19 and 2019-20 including progress on proposals to close the unidentified budget gap in the original plan. County Council reaffirmed the role of Cabinet Committees in scrutinising the budget. This report is designed to accompany the final draft 2018-19 Budget and 2018-20 MTFP published online on 12th January.

Recommendation(s):

The **Health Reform and Public Health Cabinet Committee** is asked to note the draft budget and MTFP and is invited to make suggestions to the Cabinet Member for Strategic Commissioning and Public Health on any other issues relating to Public Health which should be reflected in the draft budget and MTFP prior to Cabinet on the 5 February 2018 and County Council on the 20 February 2018.

1. Introduction

1.1 The draft Budget and MTFP publication, which we intend to publish on 12 January, sets out the overall national and local fiscal context, KCC's revenue and capital budget strategies, and KCC's treasury management and risk strategies. It also includes a number of appendices which set out the high level revenue budget plan, a more detailed one year plan by directorate, prudential and fiscal indicators, and an assessment of KCC's reserves. The financial plans in this publication take into account all of the significant changes from the current year including additional spending demands, changes to funding, and the consequential savings needed to balance the budget to the available funding.

2. Fiscal Environment and KCC Financial Strategy

2.1 Cabinet Committees need to have regard to the overall fiscal environment in which the Council has to operate, and the Council's overall budget strategy, when considering individual Directorate proposals. The revenue budget and Medium Term Financial Plan (MTFP) and the capital investment programme have been proposed based on the spending plans set out from central government in the 2015 Spending Review (SR2015) and subsequent annual Budget Statements and Local Government Finance Settlements. SR2015 represented an extension of the period of austerity on public spending from 2010 in response to the need reduce the national budget deficit and control the total public sector borrowing. SR2015 allowed individual authorities to

agree to a four year budget plan setting out intended medium term efficiencies in return for greater certainty of government grant allocations.

2.2 SR2015 represented a flat cash settlement for local government for the period 2016-17 to 2019-20. Effectively this means that the whole sector could expect to have the same amount in total to spend on local services in 2019-20 as it had in 2015-16, in cash terms. This flat cash settlement included phased reduction in the main Revenue Support Grant (RSG) and transitional grants to mitigate the impact in 2016-17 and 2017-18; the phased introduction of Improved Better Care Fund (iBCF) from 2017-18 onwards; and annual council tax increases to cover inflation/referendum limit, estimated increases in the tax base, and the introduction of an 8% social care precept over the four year period (2% per annum). In reality flat cash represents a significant reduction in real terms as it provides no additional funding to cover rising costs and demand for local government services, and requires all councils to find substantial spending reductions/income generation in order to set balanced budgets (a statutory requirement). The only viable alternative to budget savings/income generation is to seek agreement to higher council tax increases under the referendum arrangements introduced under the Localism Act 2011.

2.3 The settlement for 2017-18 was improved for social care allowing greater flexibility over the social care council tax precept (enabling up to 3% to be levied in any one year but no more than 6% over the period 2017-18 to 2019-20) and the introduction of a one-off social care support grant in 2017-18. These changes allowed councils to support additional spending in the short term but had no impact on the medium term flat cash settlement. The March 2017 Budget included additional monies in the iBCF in 2017-18 (with lesser increases for 2018-19 and 2019-20). This announcement enabled the council to address urgent issues around delayed transfers of care and market sustainability and marginally improved the flat cash equation over the four year settlement.

2.4 The provisional local government settlement 2018-19 did not include any substantial changes to the grant settlements from previous announcements i.e. substantial reductions in RSG, removal of transitional grants in 2018-19, and phased introduction of iBCF over three years. This when combined with council tax increases (base, referendum limit and social care precept) maintained the flat cash equation. The settlement allowed for an increase of 1% on the council tax referendum limit (3% for 2018-19 and 2019-20) and the announcement of 10 additional areas to pilot 100% business rate retention as a one-off for 2018-19.

3. Specific Issues for the Health Reform & Public Health Committee

3.1 Full details of the Directorates budget proposals are included with the draft 2018-19 Budget Book and 2018-20 Medium Term Financial Plan which was published on the 12 January. This document will set out the whole council budget and MTFP. Individual committees will need to refer to the individual directorate tables in the capital programme (section 9), revenue budget (sections 10 & 11), and appendix A(ii) to the MTFP.

3.2 However because the Health Budget is embedded within the Strategic & Corporate Services Directorate for the revenue budget and the MTFP, 2 further appendices are attached to this report showing just the detail for Public Health.

4. Recommendation(s)**:**

The **Health Reform and Public Health Cabinet Committee** is asked to note the draft budget and MTFP and is invited to make suggestions to the Cabinet Member for Strategic Commissioning and Public Health on any other issues which should be reflected in the draft budget and MTFP prior to Cabinet on the 5 February and County Council on the 20 February.

5. Background documents

5.1 Consultation materials published on KCC website and the outcome report.

Budget Consultation Materials - http://www.kent.gov.uk/about-the-council/have-your-say/our-budget

5.2 The Chancellor of the Exchequer's Spending Review and Autumn Statement on 22 November 2017 and OBR report on the financial and economic climate.

Autumn Budget Statement - https://www.gov.uk/government/publications/autumn-budget-2017-documents/autumn-budget-2017

OBR Forecasts http://budgetresponsibility.org.uk/download/economic-and-fiscal-outlook-november-2017/

5.3 The provisional Local Government Finance Settlement 2018-19 announced on 19 December 2017 - https://www.gov.uk/government/speeches/provisional-local-government-finance-settlement-2018-to-2019-statement

5.4 The 2018-19 Dedicated Schools Grant settlement – https://www.gov.uk/government/publications/dedicated-schools-grant-dsg-2018-to-2019

6. Contact details

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SECTION 11 - KEY SERVICES STATEMENT

WHAT IS THE MONEY SPENT ON?

Row Ref	2017-18 Base (Net Cost) £000s	Directorate & Key Service	2018-19 Proposed Budget						
			Staffing £000s	Non Staffing £000s	Gross Expenditure £000s	Income £000s	Grants £000s	Net Cost £000s	Description
Strategic & Corporate Services (S&CS) - Corporate Director: David Cockburn									
		Public Health - Director: Andrew Scott-Clark							
	0.0	Children's Programme	0.0	31,688.4	31,688.4	0.0	-31,688.4	0.0	Includes the provision of 0-5 year old Health Visiting Service, universal school nursing, other children's programmes aimed at children's emotional wellbeing, healthy weight and infant feeding
	0.0	Mental Health, Substance Misuse & Community Safety	184.1	15,921.1	16,105.2	-5,055.4	-11,049.8	0.0	Includes the provision of drug & alcohol services,and Mental Health early intervention
	0.0	Sexual Health	0.0	12,627.6	12,627.6	-1,000.0	-11,627.6	0.0	Commissioning of mandated contraception and sexually transmitted infection advice and treatment services.
	0.0	Healthy Lifestyles	0.0	8,945.0	8,945.0	0.0	-8,945.0	0.0	Improving health and lifestyles through provision of health checks to support the following outcomes: reduction in smoking, improved exercise & healthy eating to tackle obesity levels.
	0.0	Staffing & Other Programmes	2,711.6	2,080.1	4,791.7	-518.5	-4,273.2	0.0	Includes cost of management, commissioning, and operational staff to deliver statutory Public Health advice
	0.0	**Total - Public Health**	**2,895.7**	**71,262.2**	**74,157.9**	**-6,573.9**	**-67,584.0**	**0.0**	

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From: Peter Oakford, Cabinet Member for Strategic Commissioning and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

Date: 24 January 2018

Subject: **Schedule of contract monitoring reviews**

Classification: Unrestricted

Previous Pathway: This is the first committee to consider this report

Future Pathway: None

Electoral Division: All

Summary:
This report provides the Committee with a proposed schedule of contract monitoring reviews for the next two years following the request at the previous Committee meeting.

Recommendation:
The Committee is asked to COMMENT on and AGREE the schedule of contract monitoring reviews to be presented to the Committee over the next two years.

1. Introduction

1.1. The Health Reform and Public Health Cabinet Committee previously agreed to have an agenda item on contract monitoring. At its December 2017 meeting, the Committee requested a proposed schedule of Public Health contracts to be presented to the Committee over the next two years.

2. Proposed Schedule

2.1. The table at Appendix A provides this proposed schedule. The proposed schedule groups all Public Health contracts above £50,000 into the key public health programme topics.

2.2. The schedule also includes the details of the current work plan for the Committee. The first topic of sexual health was agreed at the December 2017 Committee meeting and is included on the agenda for the 24th January.

2.3. The purpose of the contract monitoring items will be:

- to provide the committee with assurance about the contract monitoring arrangements that are in place on the key public health contracts; and

- provide the committee with a more detailed breakdown of contract performance, outcomes, and value for money.

2.4. The regular contract monitoring item will complement the regular item on performance of Public Health commissioned services and other papers seeking the Committee's comments or endorsement on proposed commissioning plans and contract awards.

3. Conclusion

3.1. This paper seeks the Committee's approval for the proposed schedule for contract monitoring reviews at Appendix A. Once schedule has been agreed, the items will be incorporated into the Committee's work plan for 2018 and 2019.

Recommendation

The Committee is asked to COMMENT on and AGREE the schedule of contract monitoring reviews to be presented to the Committee over the next two years.

Background Documents:

None

4. Contact Details

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Appendix A – Proposed Schedule of Reviews

Meeting	Contract Monitoring Topic	Contracts	Cabinet Committee Programme
24th January 2018	Sexual Health Services	• KCHFT • MTW • Metro • GP s (LARC)	• **2018/19 Budget and Medium Term Financial Plan** • **Deep Dive on NHS health checks** *(added at 22 Sept agenda setting)* • **17/00098 – outcome on Consultation on Community Infant Feeding Service** • **'One You Kent' campaign update** • ***Verbal Updates – could include STP update*** • ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)* • ***Public Health Performance Dashboard – incl impact of STP*** • ***Work Programme 2018/19***
13th March 2018	NHS Health Checks	• KCHFT NHS Health Checks • Wellbeing People	• **Draft Directorate Business Plan** • **Risk Management report** (with RAG ratings) • **Tobacco Control in Kent** *(added at 22 Sept agenda setting)* • **Air quality in Kent** (incl pollution from roads, and petro-chemical plants in continental Europe and 'turn off your engine' campaigns by schools) *(added at 22 Sept agenda setting)* • **Report on Public Health outcomes** *(added at 22 Sept agenda setting)* • **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)* • ***Verbal Updates – could include STP update*** • ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)* • ***Work Programme 2018/19***
3rd May 2018	Primary School Public Health Services	• KCHFT	• ***Verbal Updates – could include STP update*** • ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)* • ***Public Health Performance Dashboard – incl impact of STP*** • ***Work Programme 2018/19***
27th June 2018	Postural Stability	• KCHFT • Involve	• **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)* • ***Verbal Updates – could include STP update*** • ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)* • ***Work Programme 2018/19***
14th September 2018	Adult Drug and Alcohol Services	• CGL (West Kent) • Forward Trust (East Kent & Prisons) • Addaction (YP)	• **Annual Report on Quality in Public Health, incl Annual Complaints Report** • **Annual Equality and Diversity Report** • ***Verbal Updates – could include STP update*** • ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)* • ***Public Health Performance Dashboard – incl impact of STP*** • ***Work Programme 2018/19***
22nd November 2018	0-5 Children and Young People's Services	• Health Visiting	• **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)* • ***Verbal Updates – could include STP update*** • ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)* • ***Work Programme 2019***
9th January 2019	Adult Health Improvement Services (including workplace health	• KCHFT • One You Campaigns	• ***Verbal Updates – could include STP update*** • ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)* • ***Public Health Performance Dashboard – incl impact of STP*** • ***Work Programme 2019***
13th March 2019	Adolescent Health Services	• KCHFT	• **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)* • ***Verbal Updates – could include STP update***

Meeting	Contract Monitoring Topic	Contracts	Cabinet Committee Programme
			• ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)* • ***Work Programme 2019***
May 2019	Domestic Abuse & Positive Relationships	• New contract (Provider TBC)	• To be agreed
July 2019	Mental Health	• Live Well Kent	• To be agreed
September 2019	Workforce Development	• Various	• To be agreed
November 2019	Young Persons Drug and Alcohol	• Addaction	• To be agreed

From: Peter Oakford, Cabinet Member for Strategic Commissioning and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

Date: 24 January 2018

Subject: **Contract Monitoring Report – Sexual Health Services**

Classification: Unrestricted

Previous Pathway: This is the first committee to consider this report

Future Pathway: None

Electoral Division: All

Summary:

This report provides the Committee with an update on the performance, outcomes and value for money of the sexual health services commissioned by KCC. The services have performed well since the contracts were competitively tendered and awarded in 2015. KCC has effective contract management arrangements in place to ensure that KCC secures best value for money and continuous improvement in service delivery and outcomes.

The sexual health needs of the population are continuing to change. The current sexual health contracts are due to expire in March 2019 but the Committee has previously agreed to incorporate the KCHFT sexual health services into its Public Health Services Partnership Agreement

Commissioners will bring draft commissioning plans to the Committee later in 2018 once an updated needs assessment has been completed and market options have been fully assessed.

Recommendation

The committee is asked to NOTE the performance of the KCC-commissioned sexual health services and the processes in place to manage the contract effectively.

1. Introduction

1.1. This report provides the Committee with an update on the performance, outcomes and value for money of the sexual health services commissioned by Kent County Council (KCC). The report aims to complement the Public Health Performance Report by providing a more detailed commentary on the contracts for sexual health services and the contract management arrangements that are in place.

2. Background

2.1. Since 2013, KCC has had statutory obligations, not only to take steps to improve the health of the people of Kent, but also to ensure provision of a range of open access

sexual health and community contraceptive services across the county[1]. KCC also has a statutory obligation under the Care Act to prevent the escalation of needs.

2.2. Commissioning responsibility for sexual health services is split across KCC, NHS England, and clinical commissioning groups (CCGs). KCC is responsible for testing and treatment of most sexually transmitted infections (STIs)[2] but not the treatment of all conditions that could be caused by untreated STIs. For this reason KCC has worked with other statutory bodies to try to ensure services are as joined up as possible for the user and the impact of any service change is fully considered.

2.3. An example of this is the seen in HIV treatment services, where KCC provides HIV treatment services on behalf of NHS England and receives funding for this activity and management. These services therefore support aspirations of the STP to create a more sustainable health system with a focus on prevention.

2.4. The Social Care and Public Health Cabinet Committee endorsed proposals in October 2013 to commission an integrated sexual health service in Kent to meet the needs of the population. Subsequent Cabinet Committees endorsed the proposed contract award following a tender process and contract extensions upon completion of the initial contract term.

2.5. The Health Reform and Public Health Cabinet Committee agreed in December 2017 to review the service provision and performance of sexual health services as part of its on-going programme of contract monitoring reports.

3. Population needs and service provision

3.1. The two key risks that sexual health services aim to address are:

- Risk of sexually transmitted infections
- Risk of unwanted pregnancy.

3.2. Poor sexual health creates a significant burden of disease through sexually transmitted infections, particularly repeat or undiagnosed infections. Good access to effective testing and treatment is essential to reduce this burden of disease and to prevent escalation of needs. Good access to planned and emergency contraception is also essential to help reduce unwanted pregnancy and improve sexual health and emotional wellbeing.

3.3. There are a range of risks to wellbeing and sexual health for different sectors of the population including; sexuality, sexual preference, gender identification, lifestyle and behaviours, age and ethnicity. In turn these vary depending upon individual self-

[1] Regulation 6, The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

[2] Known as covering genito-urinary medicine (GUM) services

esteem, resilience or self-confidence. More information about the population needs on sexual health can be found on the sexual health section of the Kent Public Health Observatory website[3].

3.4. To fulfil its statutory obligation on sexual health and to minimise the risks of sexually transmitted infections and unwanted pregnancy, KCC assigns a budget of approximately £11.7m p.a. (supplemented by a £1m contribution from NHS England[4]) to commission a range of sexual health services, including:

- Open access Integrated sexual health services providing:
  - testing and treatment of STIs
  - contraception and contraception advice
  - HIV outpatient services
  - Sexual health promotion and advice
- Sexual health outreach
- Online ordering of STI home-testing kits
- Provision of free condoms
- Psychosexual counselling
- Sexual health advice and treatment through community pharmacies

3.5. Most of these are clinical services which meet critical health needs of the Kent population. The services are commissioned through contracts with local NHS Trusts and voluntary sector providers. The table at Appendix A provides a breakdown of the providers and contract values for each of these services.

3.6. All of the sexual health service contracts have been competitively tendered since 2013 when KCC took on commissioning responsibility for Public Health. As part of the last round of retendering in 2015, KCC took on responsibility for leasing the main sexual health service premises. This arrangement has given KCC a greater degree of control over where the services are located to meet the population need. The leasing arrangements are managed through KCC's Property Commissioning team and GEN[2].

3.7. In addition to its commissioned services, KCC is responsible for paying the costs of STI testing and treatment (via GUM clinics) of Kent residents even when the service is provided outside Kent. This presents an additional demand pressure on the sexual health budget.

3.8. The sexual health needs of the Kent population have changed in recent years, as they have across the country:

[3] http://www.kpho.org.uk/health-intelligence/lifestyle/sexual-health#tab1

[4] NHS England contribution funds HIV outpatient services delivered through the KCC contracts

- Rates of syphilis and gonorrhoea are increasing. This has been particularly notable in the 45-64 age group.
- the populations where the burden of infections is greatest or increasing is changing
- rates of pelvic inflammatory disease (PID) have increased notably in some areas of the county
- teenage pregnancy rates have fallen
- impact of the influences of lifestyle and behaviour change
- demand for more responsive, easily accessible services.

3.9. Many young people are or will become sexually active and therefore access to high quality, safe sexual health services which improve and protect their health and wellbeing a key part of prevent unwanted pregnancies, under 18 conceptions and terminations of pregnancy.

3.10. There are apparent links between deprivation, risk taking behaviour and sexual exploitation, within coastal areas and specific population groups experiencing the poorest sexual health. Investment in these services is therefore designed to reduce the widening gap in health inequalities. An overview of the key public health outcomes associated with sexual health services is included at Appendix C.

3.11. Sexual health services support KCC to deliver on its strategic statement which aims to "Improve lives by ensuring every pound spent in Kent is delivering better outcomes for Kent's residents, communities and businesses. More specifically these services contribute towards achieving Outcome 2; "Kent Communities feel the benefits of being in work, healthy and enjoying a good quality of life.

4. Contract Management approach

4.1. KCC have an effective contract management process in place for all of its commissioned sexual health services. This includes:

- Regular contract monitoring meetings with service providers
- Financial reporting and forecasting
- Contract governance and oversight
- Risk Management and escalation procedures
- Quality monitoring and service user feedback.

4.2. The contracts specify the service outcomes and standards that need to be delivered to meet the population needs. The contract also includes a range of key performance indicators (KPIs) which are monitored by the Public Health team and discussed with providers at quarterly contract monitoring meetings. A summary of the contract KPIs are included at Appendix B.

4.3. Commissioners and providers also jointly review quality (including service user feedback) and contract finances at the quarterly meetings. Exception reports and action plans are scrutinised and providers are challenged on any performance, quality or contract compliance issues that are identified in the contract monitoring process.

4.4. To ensure value for money, each contract includes an element of variable payment. This is designed so that contract payments are adjusted to reflect the fixed and variable costs of the service and to ensure that:

- Providers have the financial incentives to respond to service demand and changing patterns of need
- KCC only pays that for the services that are actually delivered

4.5. This commercial strategy has delivered good value for money over recent years. A more detailed breakdown of the commercial terms of the agreements is included in the accompanying restricted paper.

5. Performance and Continuous Improvement

5.1. Performance data for the past two years show that the sexual health services have been performing well since the services were retendered in 2015. The services have maintained excellent levels of access for urgent GUM cases and have maintained the level of clinic and outreach capacity that is required in the contract. The increasing numbers of STI diagnoses and the high levels of service user satisfaction all indicate that the services are effective and compliant with contractual requirements.

5.2. As well as on-going monitoring of contract compliance and performance, a key part of contract management is striving for continuous improvement in service delivery and outcomes.

5.3. To ensure that local services meet current needs, KCC commissioned the sexual health services which could adapt and respond quickly to emerging trends or developments in the provider landscape. KCC has worked closely with service providers to find innovative ways to provide services in a cost effective way.

5.4. Changes made since commencement of the 2015 contracts include:

- Expanding clinic capacity in Canterbury to respond to increased demand
- Extending Saturday morning opening hours in Maidstone in response to service user feedback
- Commissioning a new service which allows Kent residents to order a wider range of STI home-testing kits online

- Expanding the access to free condoms from 19 years and under to those aged under 25 yrs and making these accessible online
- Piloting a new more streamlined approach for the resupply of oral contraception.

5.5. Sexual health services aim to offer choice and have continued to change in line with latest evidence, user feedback, and results of service audits or developments in technology. The new online home-testing service which offers residents the ability to test themselves for STIs confidentially in the comfort of their own home. Not only is this quicker for the user, provides a service that young people said they wanted it also offers a financial saving to KCC.

5.6. Service providers have worked well with KCC to respond to changing population needs and have adapted their service models accordingly. Contracts are due to expire in March 2019 and KCC is therefore in the process of reviewing the best approach to provide these services going forward.

5.7. KCC has already entered into a Public Health Services Partnership with Kent Community Health NHS Foundation Trust (KCHFT) following the Committee's endorsement of this proposal at its meeting in June 2017. This partnership arrangement allows KCC and KCHFT to co-operate in order to pursue common objectives in the public interest.

5.8. Sexual health services support the delivery of the common objectives of improving and protecting of the public's health, prevention of ill-health and successful delivery of the Kent and Medway Sustainability and Transformation Plan (STP). Detailed proposals for the future commissioning strategy for sexual health will be presented to the Committee later in 2018.

6. Risks

6.1. There are a number of risks associated with the commissioning and delivery of sexual health services which are managed through the commissioning cycle and contract monitoring process.

6.2. Sexual health services are mostly demand-led services that must respond to population needs. A key risk for sexual health services and commissioners is that they are not able to predict and respond to new trends in STIs or service needs. Services in Kent and elsewhere could be overwhelmed by demand from Kent residents would could place significant pressure on the public health budget.

6.3. These risks are managed by effective commissioning and contract monitoring, working collaboratively with providers to identify and examine emerging trends and to plan and monitoring service capacity and usage. The good performance over the past 2 years suggests that KCC and providers are managing this risk effectively.

6.4. As well as these pressures on service volumes, there is the risk that services will not continue to be effective, will not be able to keep up with the changing needs of the population or not maintain quality standards. There is also a risk of not being able to keep pace with changing evidence of clinical effectiveness. This could present financial and quality risks as new technologies are often more expensive.

6.5. These risks are managed by ensuring that the services have robust clinical governance processes in place and working with providers to audit and monitor clinical effectiveness and outcomes. Commissioners and providers are also working together to manage a number of financial risks which are discussed in the accompanying restricted paper.

7. Conclusion

7.1. The KCC-commissioned sexual health services have performed well since the contracts were competitively tendered and awarded in 2015. KCC has effective contract management arrangements in place to ensure that KCC secures best value for money and continuous improvement in service delivery and outcomes.

7.2. The sexual health needs of the population are continuing to change and it is crucial that the commissioned services adapt to new trends and emerging needs. KCC will need to continue to manage the risks to effective service delivery in order to ensure it complies with its statutory obligation to ensure provision of comprehensive open access sexual health services.

7.3. The current sexual health contracts are due to expire in March 2019. The Committee has previously agreed to incorporate the KCHFT-delivered sexual health services into the Partnership Agreement as effective service delivery is a common objective for KCC and KCHFT and is in the public interest.

7.4. However, commissioners will bring draft commissioning plans to the Committee later in 2018 once an updated needs assessment has been completed and market options have been fully assessed.

Recommendation

The committee is asked to NOTE the performance of the KCC-commissioned sexual health services and the processes in place to manage the contract effectively.

Background Documents:

The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013,
http://www.legislation.gov.uk/uksi/2013/351/regulation/6/made

Making it Work: A guide to whole system commissioning for sexual health, reproductive health and HIV, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf

Sexual Health JSNA Chapter Summary (needs assessment): http://www.kpho.org.uk/__data/assets/pdf_file/0008/71693/Sexual-Health.pdf

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Appendix A – Contract values

Contract Title	Supplier	Contract Start Date	Contract End Date	Estimated Total Contract Value (£)	Forecast 2017/18 spend (£)
East Kent Integrated Sexual Health Service	Kent Community Health NHS Foundation Trust	01/08/2015	31/03/2019	14,399,996	3,806,002
North & West Kent Integrated Sexual Health Service	Maidstone and Tunbridge Wells NHS Trust	01/04/2015	31/03/2019	18,434,479	4,439,359
Sexual Health Pharmacy Programme	Kent Community Health NHS Foundation Trust	01/04/2015	31/03/2019	1,533,510	384,374
Psychosexual Counselling Service	Kent Community Health NHS Foundation Trust	01/04/2015	31/03/2019	1,168,453	293,580
Condom programme	METRO	01/04/2015	31/03/2019	828,185	202,040
Online STI testing services	Maidstone and Tunbridge Wells NHS Trust	01/10/2017	31/03/2019	560,000	236,000
LARC GP Procedure charges	Individual GP Practice Contracts	01/04/2015	31/03/2018	950,000	950,000
HIV Online testing	PreventX	16/03/2016	31/03/2017	20,000	10,000
Chlamydia screening programme	*Kent Community Health NHS Foundation Trust*	*01/04/2015*	*30/09/2017*	*867,858*	*114,162*

Appendix B – Contract KPIs Dashboard

Service	Indicator	Reporting Period							DoT	Sparklines
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17		
Community Sexual Health Services	No. of clinic based sessions offered	6558	7736	7393	7765	8176	7803	8321	↑	
	No. of clinic based sessions attended	5607	6580	6258	6484	6681	6329	6514	↑	
	Clinic Utilisation	85.5%	85.1%	84.6%	83.5%	81.7%	81.1%	78.3%	↓	
	No. of Sexual Health Outreach sessions	631	713	707	508	234	482	601	↑	
	No. of Sexual Health Outreach sessions attended	231	202	151	164	138	182	211	↑	
	Sexual Health Outreach attendance rate	36.6%	28.3%	21.4%	32.3%	59.0%	37.8%	35.1%	↓	
	Presentation Rate - Asymptomatic	59.3%	57.1%	57.2%	59.4%	57.6%	57.5%	61.3%	↑	
	Presentation Rate - Symptomatic	40.7%	42.9%	42.8%	40.6%	42.4%	42.5%	38.7%	↓	
	No. of positive chlamydia diagnoses	228	221	229	219	240	234	225	↓	
	No. of HIV Tests Offered	2580	2935	2827	3077	3051	2925	2830	↓	
	No. of HIV Tests Completed	1679	1944	1921	2135	2120	2106	1989	↓	
	HIV Test Uptake	65.1%	66.2%	68.0%	69.4%	69.5%	72.0%	70.3%	↓	
	No. of new HIV positive diagnoses	3	7	3	4	5	2	3	↑	
	No. of late stage HIV infection presentations	1	1	1	2	3	0	3	↑	
	No. of HIV tests requested online	104	150	114	125	108	115	87	↓	
	Number of online HIV Tests completed	62	90	63	74	75	75	76	↑	
	Online HIV Test return rate	59.6%	60.0%	55.3%	59.2%	62.0%	59.1%	65.5%	↑	
	Episode Diagnosis - Number of Positive Gonorrhoea Results	16	37	46	37	67	63	54	↓	
	Episode Diagnosis - Number of Positive Syphillis Results	10	12	5	10	12	3	8	↑	
	No.of STI Tests requested online	Reported from 1st October								
	STI Test return rate									
	Number of Non-Emergency Contraceptive Methods Issued	2267	2477	2408	2392	2488	2423	2451	↑	
	Emergency Contraceptive Methods Issued by Type (IUD)	8.3%	0%	11.1%	5.4%	8.0%	8.0%	18.0%	↑	
	Emergency Contraceptive Methods Issued by Type (Oral)	91.7%	100%	88.9%	94.6%	92.0%	92.0%	82.0%	↓	
Chlamydia Screening Programme (15-24 year olds) *NB: Quarters for Screening Programme are Calendar Year*	No. of Chlamydia tests issued	6226			5516			3321	↓	
	No. of detected positive tests	511			461			549	↓	
	% of 15-24s population screened	3.3%			3.0%			3.5%	↓	
	% of Chlamydia tests resulting in positive result	8.2%			8.4%			8.4%	↑	
	Positive detection rate per 100,000 15-24 year olds	1100			992			1,181	↓	
Online Chlamydia testing - subset	No. of online Chlamydia tests issued	211	258	298	302	211	330	331	↑	
	% of online Chlamydia tests resulting in positive results (of those returned)	12.3%	10.1%	8.7%	8.3%	5.7%	7.0%	5.1%	↓	
	Number of people having a positive chlamydia result (online)	26	26	26	25	12	23	24	↑	
Psychosexual Counselling	Number of psychosexual therapy sessions delivered	138	162	159	167	135	139	184	↑	
	% of clients completing the full course of therapy	81%			100%				↑	
	Number reporting an improvement	7	7	12	5	8	12	10	↓	
	Percentage of clients reporting an improvement	100%	100%	90%	83%	100%	100%	100%	⇨	
Pharmacies	Total Number of EHC issued	468	467	443	422	385	401	433	↑	
	Total Number of EHC issued by type (Levonorgesterel)	242	211	178	158	132	157	182	↑	
	Total Number of EHC issued by type (Ulipristal)	226	256	265	264	253	244	251	↑	
	Levels of repeat EHC									
Metro online condoms	Number of condoms distributed	2,386			2,585				↑	
	Number of new Registrations	2,116			3,075				↑	
LARC Proceedures	Number of LARC fittings	656	795	718	680	616	755	712	↑	
	Number of LARC removals	501	678	623	555	528	589	620	↑	

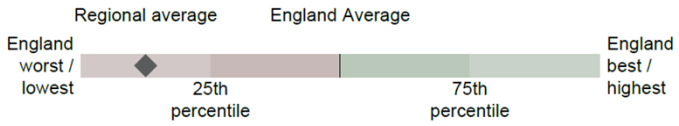
Appendix C – Outcome Indicators

	Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
Syphilis diagnostic rate / 100,000	2016	91	6.0	10.6	127.9		0.0
Gonorrhoea diagnostic rate / 100,000	2016	381	25.0	64.9	596.4		11.7
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) < 1900 1900 to 2300 ≥ 2300	2016	2,252	1212	1882	813		4,938
Chlamydia proportion aged 15-24 screened	2016	28,356	15.3	20.7	9.4		50.0
New STI diagnoses (exc chlamydia aged <25) / 100,000	2016	5,096	536	795	3,288		344
HIV testing coverage, total (%)	2016	20,944	65.4	67.7	26.7		86.3
HIV late diagnosis (%) (PHOF indicator 3.04) < 25 25 to 50 ≥ 50	2014 - 16	84	56.8	40.1	80.0		18.2
New HIV diagnosis rate / 100,000 aged 15+	2016	60	4.8	10.3	105.4		1.2
HIV diagnosed prevalence rate / 1,000 aged 15-59 < 2 2 to 5 ≥ 5	2016	1,096	1.26	2.31	16.40		0.33
Population vaccination coverage – HPV vaccination coverage for one dose (females 12-13 years old) (PHOF indicator 3.03xii) < 80 80 to 90 ≥ 90	2015/16	7,284	80.8	87.0	68.4		97.3
Under 25s repeat abortions (%)	2016	476	26.3	26.7	36.3		15.7
Abortions under 10 weeks (%)	2016	3,397	81.6	80.8	67.5		88.5
Total prescribed LARC excluding injections rate / 1,000	2016	13,294	47.8	46.4	6.1		80.4
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	2015	573	20.6	20.8	43.8		5.7
Under 18s conceptions leading to abortion (%)	2015	287	50.1	51.2	28.9		82.4
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2015/16	2,381	1.6	1.7	0.9		3.5

Key

Significance compared to threshold(s) / England average:

- Significantly worse
- Not significantly different
- Significantly better
- Significantly lower
- Significantly higher
- Significance not tested



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KENT PUBLIC HEALTH OBSERVATORY

Sexual Health

June 2017

Produced by

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Sexual Health

Introduction

Poor sexual health creates a significant burden of disease through sexually transmitted infections, particularly repeat, diagnosed late or undiagnosed infections.

Good access to emergency contraception and termination of pregnancy services can support women, but planned contraception makes for better sexual health.

Key Issues and Gaps

a rates of syphilis and gonorrhoea in Kent are increasing; locally mirroring the national trend
b high crude rate of hospital admissions for pelvic inflammatory disease (PID) amongst 15-44 year olds continues to increase in North and West Kent districts
c there is a single point of access for free termination of pregnancy services in Kent
d the populations where the burden of infections is greatest or increasing is changing.

Who is at Risk and Why?

There are different risks to wellbeing and sexual health for different sectors of the population including; sexuality, sexual preference, gender identification, lifestyle and behaviours, age and ethnicity. In turn these vary depending upon individual self-esteem, resilience or self-confidence.

Who is Most at Risk?

- men who have sex with men
- an individual who has unprotected sex, whether oral, anal or vaginal
- those with multiple or co-partners
- men who engage in unprotected chem-sex
- individuals questioning their gender identity
- specific ethnic groups where there is higher prevalence of HIV
- females and males misunderstanding relationships.

Risk of Infection

- Sexual health and wellbeing is affected by sexually transmitted infections (STIs). Everyone who is sexually active risks exposure to sexually transmitted infections. Some groups are at greater risk from exposure to infection, who may already have undetected viruses such as Hepatitis C, Hepatitis B or HIV. The greatest burden of infection is seen amongst men who have sex with men (MSM and amongst 20-24 year olds. The latter may be explained by the earlier introduction and acceptance of screening and testing for infections. Reinfection is a significant risk amongst MSM in

particular and therefore retesting, if positive or if there is a partner change, is encouraged.

Risk of Unwanted Pregnancy

- This is discussed in relation to under 18s in greater detail in the teenage pregnancy section. Inconsistent contraception use or no contraception puts all women of reproductive years at risk of pregnancy. Risks are increased when there is: no contraception used; non-compliance to take oral contraception at the same time each day; a gap in maintaining continuity of injectable contraception; poor or no use of barrier methods; lack of knowledge about emergency contraception, for example, when it can be used and how to access it.

There are factors that may increase the risk of sexually transmitted infections (STI) and/or pregnancy

- having unprotected sex
- having multiple sex partners
- having a history of one or more STIs
- sharing sex toys
- misusing alcohol or using recreational drugs
- chemsex
- transmission from mother to infant.

Contraception

There are currently 15 types of contraception available to suit the differing needs and lifestyles of females. The correct and consistent use helps prevent unwanted pregnancy. There has been a small increase in the use of long-term contraception over the last four years. The percentage of women in 2015 choosing injection as their main method of contraception at sexual reproductive health services in Kent was 16%, compared to England 9.2%. The implementation of a user self-injection option for *Noristerat* will reduce the need for access to services.

Long acting reversible contraception includes intrauterine contraceptive devices and subdermal implants. These can be effective for three to five years.

Emergency oral contraception is available free through many pharmacies to women under 30 years of age and is also available through general practice and sexual health services.

Condoms are the most commonly used barrier method.

Termination of Pregnancy

The methods of abortion available are surgical and medical. The rates of termination of pregnancy are measured per 1,000 resident female population aged 15-44 years and shown below. There is wide variation in the presented information across the CCGs which require

different responses. The most notable change is the increase over the time period; 2013-2015 in Canterbury amongst the age ranges 18-19, 25-29 and 30-34 years.

Table 1: Legal abortions: Rate per 1,000 resident women aged 15-44 years by CCG in Kent 2013- 2105

	crude rate per 1,000 women aged 15-44 years			rate per 1,000 resident women aged 15-44 years by CCG 2013-2015																	
				under 18			18-19 years			20-24 years			25-29 years			30-34 years			35 +		
	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015
Ashford	16.7	16	16	10	10	10	32	18	35	31	31	28	24	24	26	18	14	15	7	8	7
Canterbury	12.3	12	13	11	7	6	13	13	18	21	16	17	18	22	23	10	11	15	7	6	7
DGS	16.8	18	18	11	11	10	30	28	32	30	31	32	24	24	24	16	18	18	8	9	9
South Kent	17.1	17	17	15	10	13	25	29	26	33	35	29	22	21	26	17	17	17	8	7	8
Swale	17.5	16	18	10	13	15	42	32	30	31	34	31	27	18	25	17	18	16	7	5	8
Thanet	19.7	17	19	12	11	14	34	31	33	39	33	35	28	24	29	19	16	17	8	8	9
West Kent	14	15	14	9	8	7	20	25	23	29	28	25	19	22	22	13	17	14	7	6	7
Kent LA	15.7	16	16	11	10	10	24	24	26	29	28	26	22	22	24	15	16	16	7	7	7
England	16.6	17	16	12	11	10	25	24	24	29	28	28	23	23	24	17	17	16	7	8	7

Source: PHE

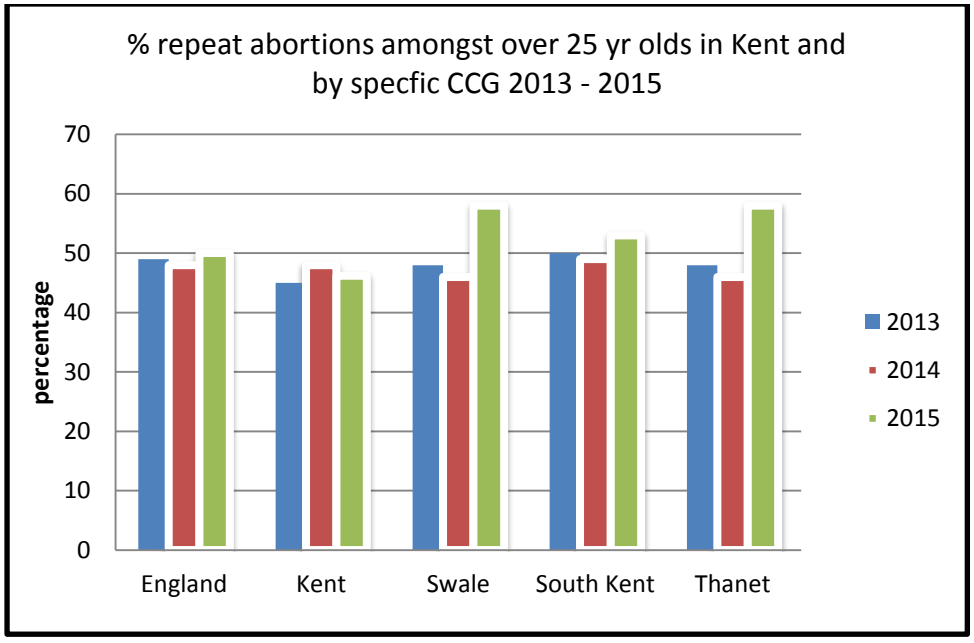
Table 2: Percentage of repeat terminations 2013-2015 by CCG in Kent

	% Repeat abortions all ages			% Repeat abortions under 25			% Repeat abortions over 25		
	2013	**2014**	**2015**	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**
England	37	37.6	38	27	27	45.8	45	45.6	46.2
Ashford	39	41	41	20	31	28	53	48	51
Canterbury	35	35	34	22	23	19	52	48	49
DGS	43	40	40	32	26	25	52	49	51
South Kent	37	37	42	23	25	28	50	49	53
Swale	45	38	44	37	27	32	53	50	55
Thanet	39	38	45	29	30	29	48	46	58
West Kent	36	37	34	26	23	22	44	47	43

Source: ONS

The percentage of repeat terminations has been consistently higher than the England average in Kent across the time frame. An increase in the percentage of repeat termination in the over 25s during this time period is seen in South Kent Coast, Swale and Thanet CCGs, which is shown below.

Figure 1: Percentage of repeat abortions amongst over 25 year olds in Kent and by specific CCG 2013-2015



Source: DH

Cervical Screening

Cervical screens are important to identify early cervical changes which may become cancerous. Females aged 25-64 years are encouraged to have a regular cervical screen every three or five years respectively. The number of women screened within the eligible population in Kent decreased by approximately 4,000 from 2013-14 to 2014-15.

Table 3: NHS cervical screening programme: Target age group 25- 64 Kent 2013-2015

	25-49 [000s]	50-64 [000s]	25-64 [000s]
2013/14	243.6	119	362.8
2014/15	244.1	122	366.1

Source: NHS digital

Human Papilloma Virus (HPV) Vaccination Programme

This national vaccination programme was implemented in 2008 with the offer of HPV vaccination to all Year 8 females (13 year olds), initially with requirement for three vaccines. Two vaccines became the requirement from September 2014 to offer protection against types 6, 11, 16 and 18 HPV. Type 6 and 11 HPV are associated with the most common viral sexually transmitted infection, genital warts. The presentation of information shows the HPV vaccination coverage for one dose (two doses can be up to 24 months apart) in 2014/15 was 83.1 in Kent and 89.4 in England.

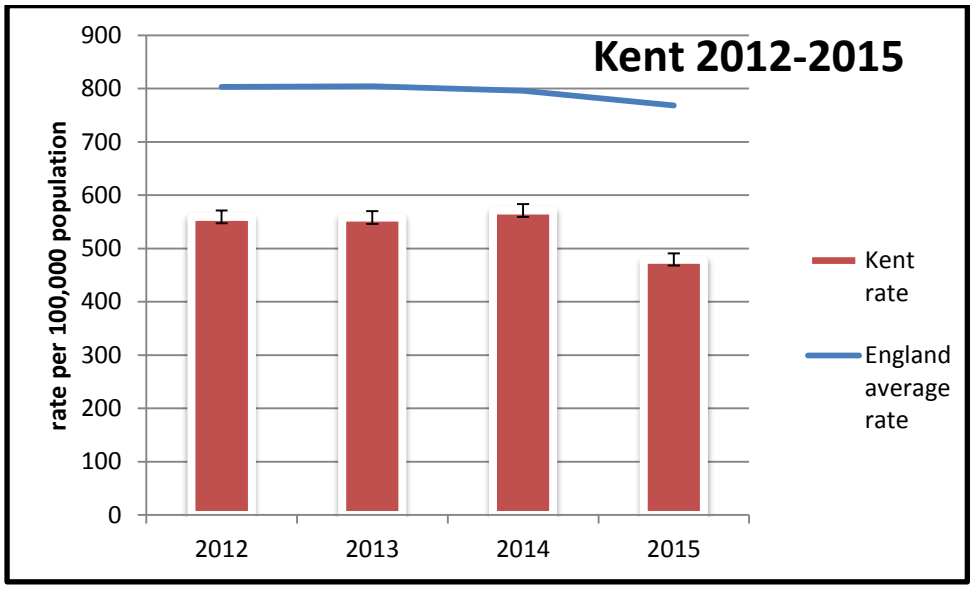
A phased HPV vaccination programme is expected to be introduced for MSM.

Sexually Transmitted Infections (STI)

Acute STI rates are collated from data collected from 12 STI groups including HIV, chlamydia, warts, herpes, gonorrhoea and syphilis.

In 2015, the rate of acute STI infections in Kent indicated that some districts bear a higher burden of acute infections compared to others, namely Thanet, Dartford, Maidstone and Canterbury.

Figure 2: Rates of new sexually transmitted infections per 100,000 population in Kent 2012-2015



Source PHE

STI Testing and Treatment

Provision of free STI testing, treatment and the notification of sexual partners of infected people are important in the control of sexually transmitted infection outbreaks.

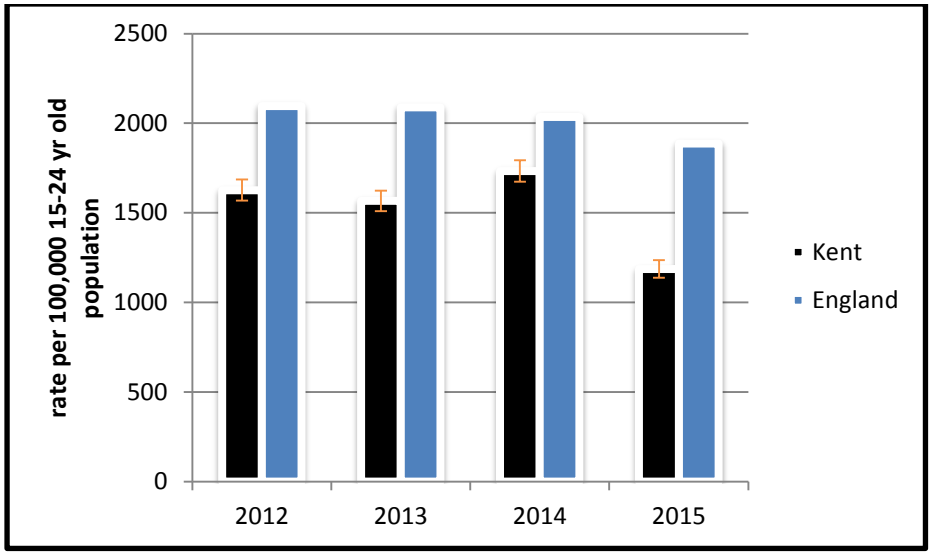
Higher rates of gonorrhoea and syphilis seen in a population reflect higher levels of risky sexual behaviour. The rates of gonorrhoea in Kent have increased, but still remain lower than the England average.

Chlamydia

Chlamydia is the most common bacterial sexually transmitted infection, with sexually active young people at highest risk. As chlamydia often has no symptoms and can have serious and costly health consequences (eg pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility) it is vital that it is picked up early and treated. There is a national programme of screening aimed at the highest prevalence age group, 15-24 year olds.

This age specific burden of infection will be due largely to the increase in targeted testing. The programme requires a diagnosis rate of 2,300 per 100,000 population in the target age group. Figure 2 illustrates that Kent has not yet met that target.

Figure 3: The rate of diagnosed chlamydia per 100,000 population aged 15-24 years in Kent 2012-2015

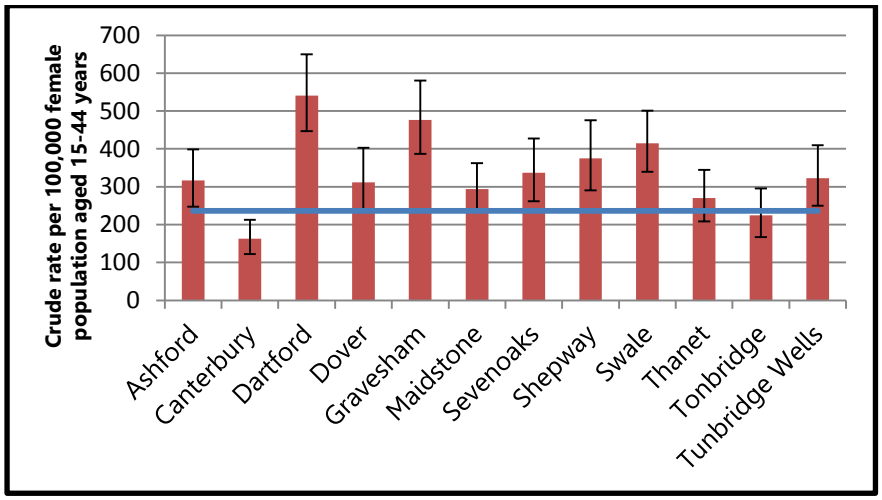


Source PHE fingertips

Pelvic Inflammatory Disease (PID)

This disease can be present without any symptoms and may become evident when conception is difficult or a conception results in an ectopic pregnancy. Kent has had a significantly higher rate of PID hospital admissions per 100,000 15-44 year old females, over the last five years with rates of particular concern in Dartford and Gravesham districts.

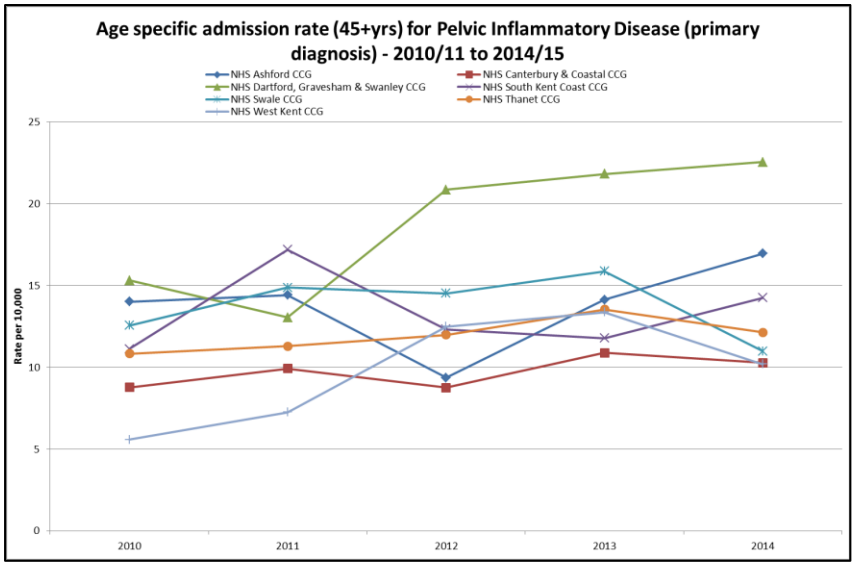
Figure 4: Crude rate of pelvic inflammatory disease (PID) admissions amongst 15-44 year olds by district, 2014-15



Source: PHE

The indicator above refers to a specific age group. Further exploration illustrates that PID related admissions are not specific to 15-44 year olds only. The higher rates in Dartford and Gravesham are mirrored amongst attendances of 45 year olds and over as shown below.

Figure 5: Age specific admission rate (45 + years) for PID 2010-11 to 2014-15 by CCG

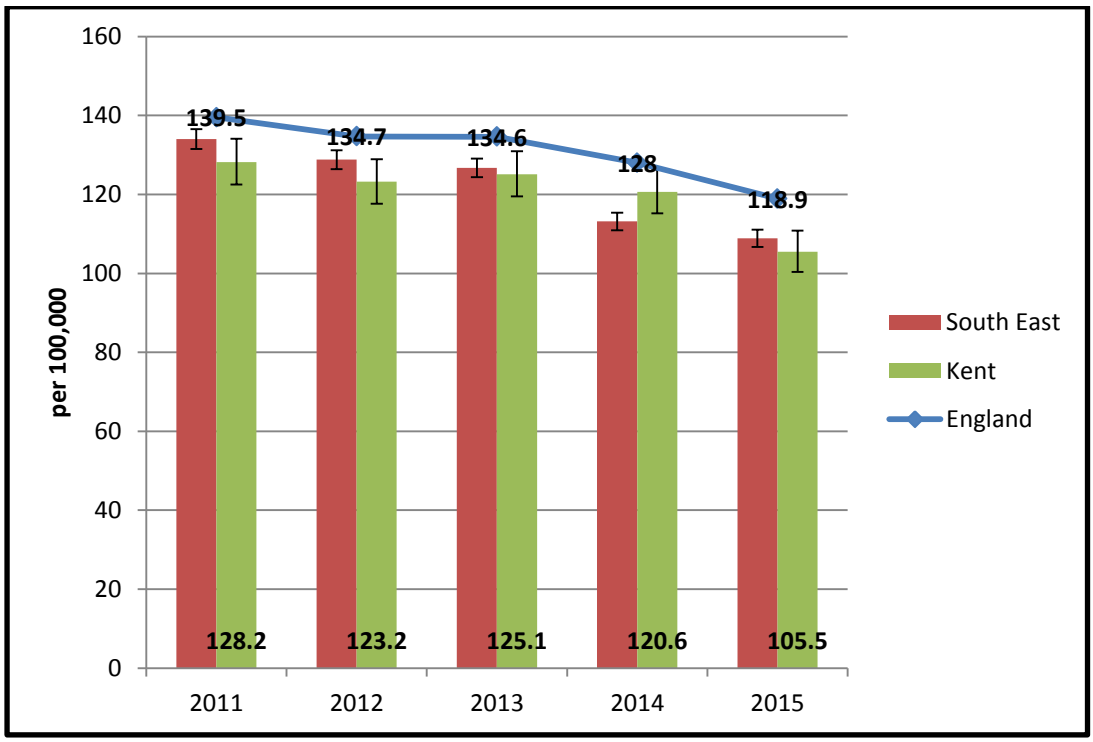


Source: PH observatory

Genital Warts

Genital warts are the most commonly diagnosed sexually transmitted infection. The burden remains highest in Canterbury district with Dover district showing the largest increase in the diagnosed rate of genital warts in 2015. The following table shows first episode only, although the condition presents in reoccurring episodes requiring long-term management.

Figure 6: Rates of first episode of genital warts per 100,000 population in Kent 2011-2015

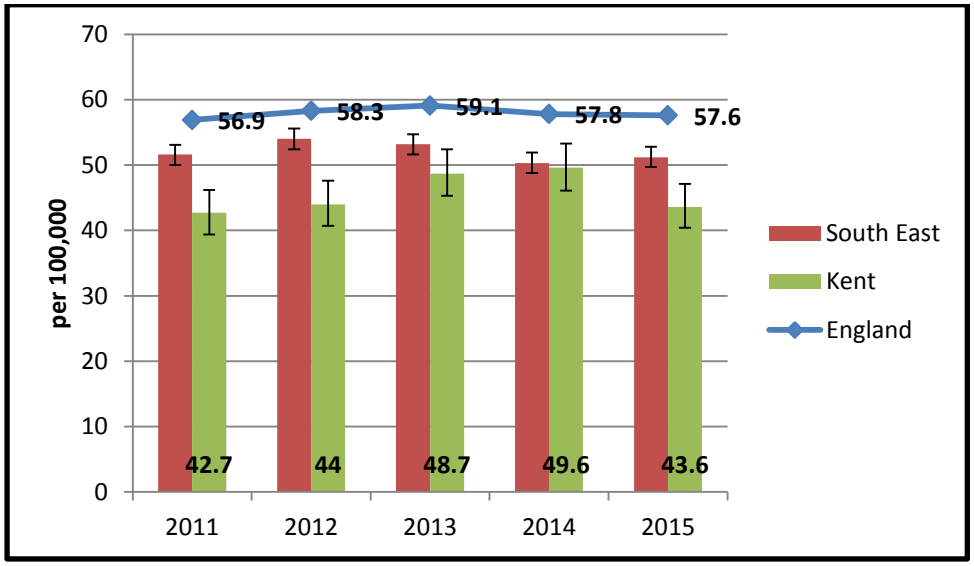


Source: PHE

Genital Herpes

Again this presentation does not reflect the true burden of this condition, as affected individuals have repeated outbreaks, possibly six or more a year, requiring longer courses of treatment, referred to as suppressive therapy. Diagnosis of first episodes remains highest in Maidstone district with the greatest increase seen in Dover district.

Figure 7: Rates of first episode of genital herpes per 100,000 population 2011-2015

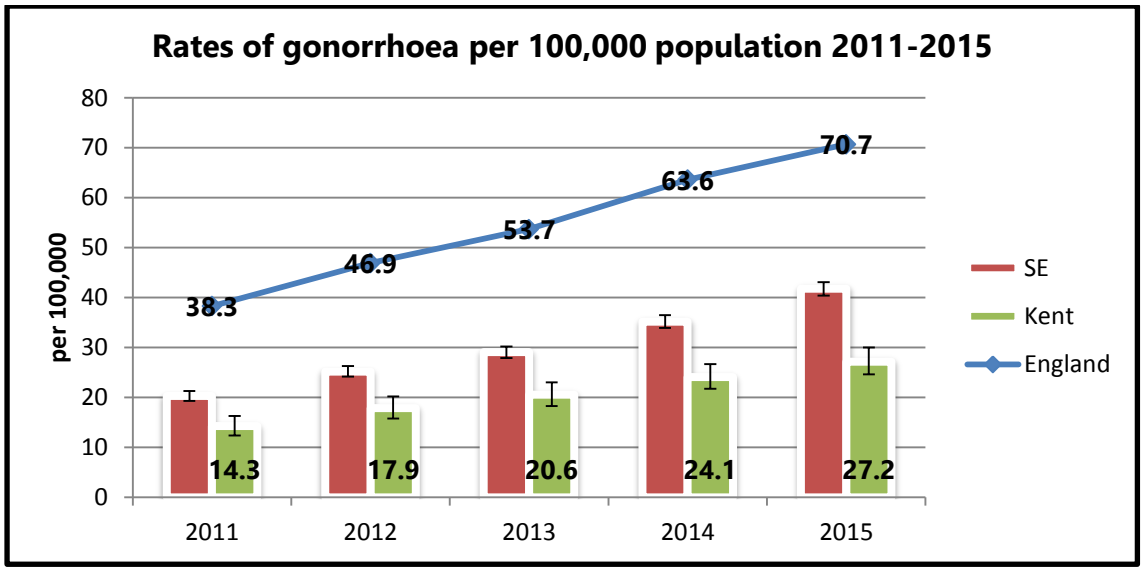


Source: PHE

Gonorrhoea

Detected rates of gonorrhoea in Kent are rising although the burden of infection is moving. In 2012 rates in Canterbury, Shepway and Ashford were higher than the South East region of 25.1 per 100,000 population. In 2015 rates were higher in Dartford and Maidstone with Maidstone being higher than the South East region rate of 41.8 per 100,000 population. The burden of diagnosed gonorrhoea in the population is highest amongst men who have sex with men.

Figure 8: Rates of gonorrhoea Per 100,000 population in Kent and England 2011-2015

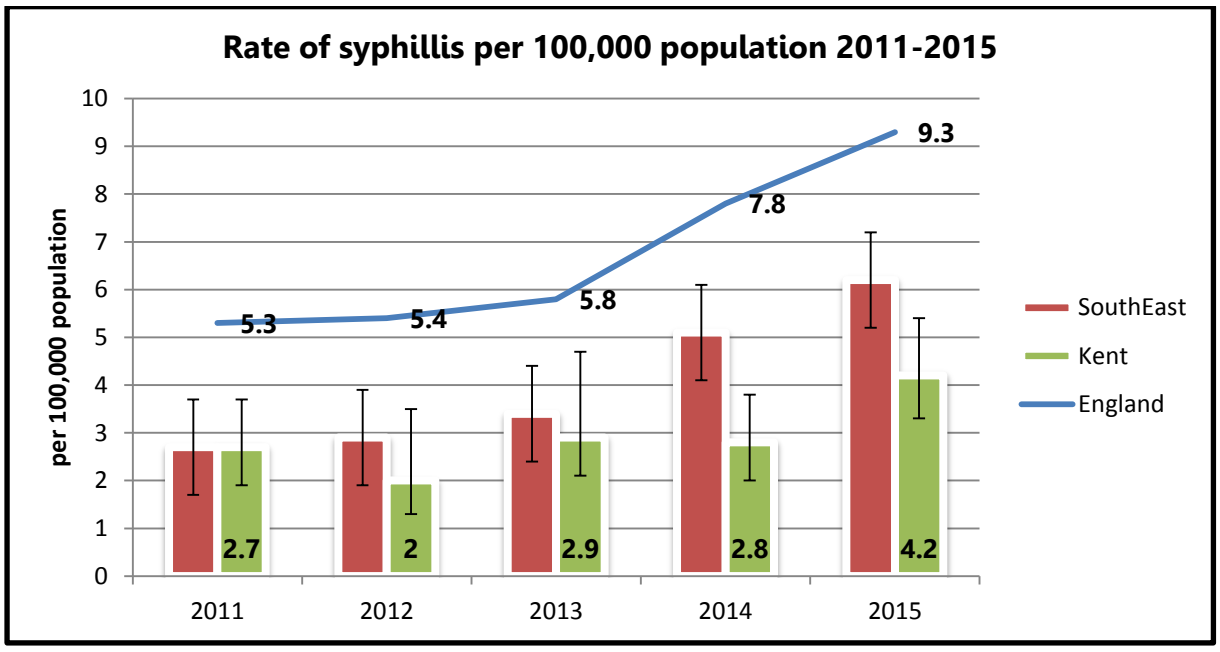


Source: PHE

Syphilis

Infection rates of syphilis in Kent have increased in the last two years mirroring the pattern seen in the region and nationally. The number of syphilis infections detected is small but the changing pattern should not be ignored with increased rates of infection observed in Maidstone, Shepway and Gravesham in 2015: with Gravesham higher than the England average with a rate of 9.7 per 100,000 population in 2015.

Figure 9: Rates of syphilis per 100,000 population in Kent



Source: PHE fingertips

The average rate of change over time 2011-2015 for syphilis in Kent was 3.9 over the regression line fitted over that period.

Human Immunodeficiency Virus (HIV)

HIV is considered a long-term condition and the prevalence of this condition continues to increase. The following figures illustrate that whilst Kent is not a high HIV prevalence area, which is a rate of two or more per 1,000 population, the rates of diagnosis of HIV in the later stages of the disease continue to be higher in Kent than the England rate.

The prevalence rate of diagnosed HIV amongst 15-59 year olds does not capture all diagnosed infections but is an indicator. In December 2016 the definition of high prevalence of HIV was revised. 'Local authorities in England are now categorised by diagnosed HIV prevalence levels into low prevalence (<2/1,000 among 15-59 year olds), high prevalence (2-5/1,000 among 15-59 year olds) and extremely high prevalence areas (>5/1,000 15-59 year olds).'[1]

The prevalence rate of HIV per 1,000 15-59 year old population is increasing across Kent. The prevalence rate in Ashford, Dartford and Gravesham is higher than the Kent average with increased burden in 2015 seen in Gravesham and Maidstone districts.

Partner notification

People with STIs and HIV can put their current partners at risk of infection and may have infected previous partners as well. Partner notification is an essential infection control component in terms of avoiding the consequences of untreated infection and protecting the wider community from onward transmission. It is important to make sure that partners who may be infected are offered the opportunity and encouragement to be tested and to obtain any necessary treatment.

Attendance at Genito Urinary Medicine (GUM) services

These services are open access, enabling clients resident in Kent to access services in different places across England and vice versa. The volume of service uptake from Kent residents in London is significant. However with an increase in access and availability of appointments locally, the percentage of this volume may reduce.

[1] PHE, HIV testing in England; 2016 report

Table 4: Number of Genito Urinary Medicine (GUM) Clinic attendances by Kent residents 2013 to 2015 in services outside of Kent LA

Year	Number of patients	New appointments	Follow up appointments	Total attendance	total percentage of patients accessing GUM services outside of Kent LA
2013	3939	4893	1263	6129	9%
2014	4337	5276	1104	6380	9%
2015	4888	5634	1043	6677	7.8%

Source: GUMCAD

Projected Service Use and Outcomes in Three to Five Years and Five to Ten Years

There is likely to be an increased demand on services across Kent as housing developments bring increase in populations particularly to Canterbury, Ashford and Maidstone districts and with the growth of the healthy new town development, Ebbsfleet in Dartford.

Improvement in the use of technology will:

- enable women to self-check their health, self-inject and manage their contraception
- improved communications through webchat to talk about concerns such as menstrual bleeding.

An increased use of pharmacies, including online, to provide treatment for diagnosed infections such as chlamydia will extend the choice of place for treatment and may contribute to a reduction in the demand on specialist sexual health services in the longer term. Specialist sexual health clinics will move toward a focus on more complex need and procedures; symptomatic diagnosis treatment and management.

Targeted social marketing campaigns to raise awareness about HIV, the promotion of HIV testing and the normalisation of testing amongst the heterosexual community would be expected to show an increase in the prevalence of HIV. This will result in some districts being identified as having higher prevalence rates.

Evidence of What Works and Assessment of Expected Impact

Offering open access through walk-in-and-wait services where providers have audited their walk-in GUM service have identified more STIs amongst those who attend this service compared to those who book an appointment. Increasing this type of delivery is likely, in the short-term, to identify more STIs in the population but, in the longer-term, will help to reduce the infections in the population.

The expansion in the availability of free emergency oral contraception through pharmacies has been seen in the volume of activity with highest demand continuing to be seen in Canterbury and Maidstone.

The introduction of access to testing online for chlamydia has found a higher rate of detection of chlamydia. Access to HIV has found some reactive tests suggesting a potentially higher positivity than that seen in the local prevalence rate. These services are likely to be accessed by individuals not contacting services.

User Views

- the review of services identified the need for a single telephone contact, it also identified the need for increased communication about the services available
- research on increasing use of condoms amongst over 20s reiterated the need to ensure that sexual health services are promoted across the life course
- young people have recommended having an app which is more interactive to enable them to order condoms if registered, book appointments, etc
- young people have expressed a preference for separate services and more support and guidance about relationships.

Recommendations for Commissioning

a further consider with the CCG commissioners for termination of pregnancy services, the delivery of medical terminations through the integrated sexual health services

b exploration of opportunities to raise awareness of the burden of poor sexual health from infections such as genital warts, or blood borne viruses including Hepatitis B and Hepatitis C

c continue to utilise opportunities to integrate sexual health services with drugs and alcohol services.

Recommendations for Needs Assessment Work

- the health needs of commercial sex workers
- the continued higher use of emergency contraception seen in primary care, pharmacy and specialist sexual health services in Canterbury district from 2012, and the rise in termination of pregnancy amongst age ranges, 18-19; 25-29 and 30-34 year olds in Canterbury CCG 2013-2015
- in-depth exploration of attendances for and access to free contraception services 2014/15 and 2015/16 by district and teenage pregnancies
- explore the incidence of STIs in districts specifically where there is an increase in the rate of change of diagnosed infections.

Key Contacts

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Wendy Jeffreys, Public Health Specialist

References

PHE http://fingertips.phe.org.uk/profile/sexualhealth

PHE GUMCAD

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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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From: Peter Oakford, Cabinet Member for Strategic Commissioning and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

24 January 2018

Subject: **Performance of Public Health commissioned services**

Classification: Unrestricted

Previous Pathway: This is the first committee to consider this report

Future Pathway: None

Electoral Division: All

Summary: This report provides an overview of key performance indicators (KPIs) for Public Health commissioned services. 12 of the 15 KPIs were RAG rated green in the latest quarter, 3 were amber, and none were red.

There has been some decline in the direction of travel although performance remains at or above acceptable levels. A range of campaigns are due to commence in 2018 and will be utilised by the providers to increase engagement in the services.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on the Q2 performance of Public Health commissioned services.

1. Introduction

1.1. This report provides an overview of the performance of the public health services that are commissioned by KCC. It focuses on the key performance indicators (KPIs) that are included in the Public Health Business Plan and presented to Cabinet via the KCC Quarterly Performance Report (QPR). Appendix 1 contains the full table of KPIs and the performance over the previous 5 quarters.

1.2. This report does not include data and commentary on the longer term measures of population health outcomes. This information will be presented to the Committee in a separate report in March 2017.

2. Overview of Performance

2.1. Of the 15 KPIs for Public Health commissioned services, 12 remained above target in Q2 17/18 (green), 3 fell below target but remained within acceptable

levels (amber), these were for adults completing substance misuse treatment successfully and the smoking cessation 4 week quit rate. No KPIs fell below the 'floor target' (red).

Health Visiting

2.2. The Health Visiting Service achieved all of the expected targets in Q2 with the greatest improvement in delivery seen on the antenatal contact. This has been achieved through improved information sharing processes with local maternity services leading to increased notifications of pregnancies to health visitors at an appropriate stage.

2.3. Breastfeeding continuation rate (at 6-8 weeks) has fallen slightly compared to Q1, but remain consistent with last year's performance. Completion of this data by the provider remains above 90% but just below nationally set levels for robustness and should be considered when looking at figures on breastfeeding rates in Kent.

Adult Health Improvement

2.4. The NHS Health Check Programme met its Q2 target and has continued to improve compared to the same time period last year. Developments intended to further enhance the service include rolling out a new IT system and using outreach and marketing to promote the checks to underrepresented groups in Kent. Health Checks will be offered as a core part of the One You Kent Lifestyle Services which went live in October 2017.

2.5. Health Trainers are now called 'One You Lifestyle Advisors', and will continue to work with clients from areas of high deprivation. The target for this KPI was not met in Q2 and was a reduction in comparison to Q1; however 61% remains a higher proportion than experienced in previous quarters.

2.6. Stop Smoking Services are also a core part of the One You Kent Lifestyle Services and despite a drop in performance in Quarter 2 the service will be able to utilise a number of campaigns running in January 2018 which aim to motivate people to make lifestyle changes including quitting smoking, including a Public Health England campaign highlighting the harms of smoking.

Sexual Health

2.7. Attendances at sexual health clinics have remained relatively stable. There are on average 6,500 clinic attendances each month across Kent. Services have maintained rapid access for cases requiring an urgent genito-urinary medicine (GUM) appointment.

2.8. A new online service went live on the 1st October 2017 and has extended the range of home testing kits that can be ordered online. The service asks E-users a series of questions to determine their risk profile and the tests they need to be sent. It can also help identify any areas of concerns from their answers so that the specialist team in the E-Bureau can follow this up with them. The service

aims to improve access, reduce unnecessary demand on clinic sessions and target those at greatest risk.

Drug and Alcohol Services

2.9. The numbers of adults accessing structured treatment for substance misuse has continued to decline to 4,445 in the 12 month to September 2017 compared to 4,999 in the same time period last year. Analysis has identified this decrease to be attributed to the decreasing number of alcohol-only clients and work is underway by providers to increase the number of alcohol-only clients accessing the services with targeted campaigns running in 2018. The number of opiate clients has remained relatively stable and at 2,120 is the largest population accessing structured treatment in Kent.

2.10. The decrease in the numbers of people accessing treatment is reflected in the reduced number of people successfully completing treatment, and these decreases are seen nationally. Kent has however seen a slight rise in the proportion of opiate clients successfully completing treatment. Whilst this in-year proportionate rate tells us something about the effectiveness of the treatment and the area in general in promoting recovery, it does not give the full picture.

2.11. Recovery from substance misuse, particularly of opiates such as heroin is a long-term process. Clients in treatment for alcohol only and opiates tend to be much older than individuals who have presented for problems with other substances. These groups are often in ill health and are less likely to have the personal and social resources that are known to aid recovery, such as employment and stable housing. Alcohol clients in particular are also not getting into structured treatment early enough and have other health related problems which makes recovery more challenging.

2.12. In East Kent, the Forward Trust is six months into the new contract and in the final stages of co-designing the new service model. In West Kent, the Drug and Alcohol Service (delivered by CGL) continue to promote a recovery community through their use of the newly appointed Recovery Co-ordinators. Both providers are continuing to develop a range of solutions to increase access into structured treatment services, build the recovery capital of clients and improve integration with other services.

2.13. The numbers of young people accessing the Kent Young Person's Substance Misuse service has remained fairly constant and in the 12 months up to the end of September 2017, there were 405 young people in structured treatment. In Quarter 2 of 2017/18, 93% of young people excited the service in a planned way.

2.14. The Young Person's Substance Misuse service has been competitively tendered and the new contract started on 1st January 2018.

Mental Wellbeing Service

2.15. Live Well Kent is jointly commissioned by Public Health, Adult Social Care and Clinical Commissioning Groups, and aims to engage a minimum of 50% of clients from areas of deprivation. In Q2, 53% of new sign ups were from the most deprived quintiles in Kent. This exceeded the target of 50% but is a decrease on the previous quarter. The service is open to anyone aged over 17 and fluctuations are expected in this KPI despite services targeting resources in areas of high inequality.

2.16. The service works with clients who have low level mental health problems such as stress and anxiety in addition to those with a mental health diagnosis including Schizophrenia or personality disorders. The support offered by the service is individually tailored and includes help to find employment, maintain tenancies or find suitable housing, advice on debt issues or to find local community activities to keep them healthy and well.

3. Quality

3.1. Quality assurance for KCC Public Health commissioned services is fundamental to delivering safe, high quality services and all commissioners are driving improvements in the quality and safety of commissioned services. The majority of providers are now achieving this. Action plans are in place where required.

3.2. There have been a number of serious case reviews, in recent months which have highlighted important learning for some Public Health commissioned services. The services are implementing various quality improvement actions which are being monitored by the Public Health team and will give assurance that identified issues have been addressed.

4. Conclusion

4.1. 12 of the 15 KPIs with targets stated in the Public Health business plan were rated green in Q2 and 3 were amber. All were performing within acceptable levels of the target. Where negative direction of travel occurred into Q2 further work with the providers has identified areas for improvement.

5. Recommendations

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on the Q2 performance of Public Health commissioned services.

6. Background Documents

None

7. Appendices

Appendix 1 - Public Health Commissioned Services KPIs

8. Contact Details

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Appendix 1: Public Health Commissioned Services – Key Performance Indicators Dashboard

Service	KPI's	Target 2017/18	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	DoT– 2 most recent
Health Visiting	No. of mandated universal checks delivered by the health visiting service (12 month rolling)	65,000	63,016	65,088	64,633	66,902 (g)	**68,837 (g)**	⇧
	No. and % of mothers receiving an antenatal contact with the health visiting service	30%	1,466 34% (r)	1,609 37% (r)	1,567 36% (r)	1,914 44% (g)	**2,457 54% (g)**	⇧
	No. and % of new birth visits delivered by the health visitor service within 30 days of birth	95%	4,184 99%	4,198 95%	3,864 97%	4,259 97% (g)	**4,459 97% (g)**	⇔
	No. and % of infants due a 6-8 week who received one by the health visiting service	80%	3,488 84% (a)	3,965 88% (a)	3,543 88% (a)	3,859 89% (g)	**3,989 89% (g)**	⇔
	No. and % of infants who are totally or partially breastfed at 6-8 weeks (health visiting service)	-	1,748 45%*	1,936 48%*	1,843 49%*	2,077 51%*	**2,025 49%***	-
	No. and % of infants receiving their 1 year review at 15 months by the health visiting service	80%	3,426 81%	3,547 81%	3,447 83%	3,666 86% (g)	**3,751 88% (g)**	⇧
	No. and % of children who received a 2-2½ year review with the health visiting service	80%	3,153 78% (a)	3,200 74% (r)	3,390 81% (a)	3,440 82% (g)	**3,520 84% (g)**	⇧
Structured Substance Misuse Treatment	No. and % of young people exiting specialist substance misuse services with a planned exit	85%	60 94% (g)	51 89% (g)	75 93% (g)	65 94% (g)	**76 93% (g)**	⇩
	No. and % of people successfully completing drug and/or alcohol treatment of all those in treatment	28%	1,468 29% (a)	1,330 28% (a)	1,256 27% (a)	1,221 27% (a)	**1,143 26% (a)**	⇩
Lifestyle and Prevention	No. of the eligible population aged 40-74 years old receiving an NHS Health Check (12 month rolling)	41,600	39,039 (a)	41,057 (a)	42,071 (g)	42,568 (g)	**43,677 (g)**	⇧
	No. and % of people quitting at 4 weeks, having set a quit date with smoking cessation services	52%	789 53% (g)	819 55% (g)	991 53% (g)	828 52% (g)	**708 46% (a)**	⇩
	No. and % of new clients accessing the health trainer service being from the 2 most deprived quintiles & NFA	62%	666 59% (a)	619 61% (a)	626 59% (a)	584 65% (g)	**414 61% (a)**	⇩
Sexual Health	No. and % of clients accessing GUM services offered an appointment to be seen within 48 hours	90%	100% (g)	100% (g)	100% (g)	100% (g)	**100% (g)**	⇔
Mental Wellbeing	No. and % of sign-ups to the Live Well Kent service from the most deprived quintiles	50%	1.006 61% (g)	864 60% (g)	880 62% (g)	844 60% (g)	**1,043 53% (g)**	⇩

*Coverage above 85% however no quarter met 95% for robustness expected for national reporting

Commissioned services annual activity

Indicator Description	2013/14	2014/15	2015/16	2016/17	DoT
Participation rate of Year R (4-5 year old) pupils in the National Child Measurement Programme	96% (g)	96% (g)	97% (g)	**97% (g)**	⇔
Participation rate of Year 6 (10-11 year old) pupils in the National Child Measurement Programme	94% (a)	95% (g)	96% (g)	**96% (g)**	⇔
Number receiving an NHS Health Check over the 5 year programme (cumulative from 2013/14)	32,924	78,547	115,232	**157,303**	-
Number of adults accessing structured treatment substance misuse services	4,652	5,324	5,462	**4,616**	-
Number accessing KCC commissioned sexual health service clinics	-	-	73,153	**78,144**	-

Key:

RAG Ratings

(g) GREEN	Target has been achieved
(a) AMBER	Floor Standard* achieved but Target has not been met
(r) RED	Floor Standard* has not been achieved
nca	Not currently available

* Floor Standards are set in Directorate Business Plans and if not achieved must result in management action

DoT (Direction of Travel) Alerts

⇧	Performance has improved
⇩	Performance has worsened
⇔	Performance has remained the same

Data quality note
All data included in this report for the current financial year is provisional unaudited data and is categorised as management information. All current in-year results may therefore be subject to later revision

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From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 24 January 2018

Subject: **Work Programme 2018/19**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

Summary: This report gives details of the proposed work programme for the Health Reform and Public Health Cabinet Committee.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to consider and agree its work programme for 2018/19.

1.1 The proposed Work Programme has been compiled from items on the Forthcoming Executive Decisions List, from actions arising from previous meetings and from topics identified at agenda setting meetings, held six weeks before each Cabinet Committee meeting, in accordance with the Constitution, and attended by the Chairman, Vice-Chairman and the Group Spokesmen. Whilst the Chairman, in consultation with the Cabinet Members, is responsible for the final selection of items for the agenda, this report gives all Members of the Cabinet Committee the opportunity to suggest amendments and additional agenda items where appropriate.

2. Work Programme 2018/19

2.1 An agenda setting meeting was held on 1 December 2017, at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion to the agenda of future meetings.

2.2 The schedule of commissioning activity which falls within the remit of this Cabinet Committee will be included in the Work Programme and considered at future agenda setting meetings. This will support more effective forward agenda planning and allow Members to have oversight of significant service delivery decisions in advance.

2.3 When selecting future items, the Cabinet Committee should give consideration to the contents of performance monitoring reports. Any ‘for information’ or briefing items will be sent to Members of the Cabinet Committee separately to the agenda, or separate Member briefings will be arranged, where appropriate.

3. Conclusion

3.1 It is vital for the Cabinet Committee process that the Committee takes ownership of its work programme, to help the Cabinet Members to deliver informed and considered decisions. A regular report will be submitted to each meeting of the Cabinet Committee to give updates of requested topics and to seek suggestions of future items to be considered. This does not preclude Members making requests to the Chairman or the Democratic Services Officer between meetings, for consideration.

4. Recommendation: The Health Reform and Public Health Cabinet Committee is asked to consider and agree its work programme for 2018/19.

5. Background Documents

None.

6. Contact details

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Last updated on: 16 January 2018

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE WORK PROGRAMME 2018/19

Items to every meeting are in italics. Annual items are listed at the end.

24 JANUARY 2018

- **2018/19 Budget and Medium Term Financial Plan**
- **'One You Kent' campaign update**
- ***Verbal Updates – could include STP update***
- ***Contract Monitoring*** *– regular item*
- ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)*
- ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings*
- ***Work Programme 2018/19***

ADDITIONAL SPECIAL MEETING – 8 FEBRUARY 2018

- **Petition debate – community infant feeding service**
- **17/00098 – outcome on Consultation on Community Infant Feeding Service**

13 MARCH 2018

- **Draft Directorate Business Plan**
- **Risk Management report** (with RAG ratings)
- **Tobacco Control in Kent** *(added at 22 Sept agenda setting)*
- **Air quality in Kent** (incl pollution from roads, and petro-chemical plants in continental Europe and 'turn off your engine' campaigns by schools) *(added at 22 Sept agenda setting)*
- **Report on Public Health outcomes** *(added at 22 Sept agenda setting)*
- **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)*
- **Deep Dive on NHS health checks** *(added at 22 Sept agenda setting)*
- **Model of how social care and public health link to local care and what an ideal social care model would look like** *(delayed from January agenda)*
- **17/00125 – Healthwatch Kent interim contract** *(if not to January mtg)*
- ***Verbal Updates – could include STP update***
- ***Contract Monitoring*** *– regular item* – Deep Dive on NHS Health checks? (tbc)
- ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)*
- ***Work Programme 2018/19***

3 MAY 2018

- ***Verbal Updates – could include STP update***
- ***Contract Monitoring*** *– regular item*
- ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)*
- ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings*
- ***Work Programme 2018/19***

27 JUNE 2018

- **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)*
- ***Verbal Updates – could include STP update***
- ***Contract Monitoring*** *– regular item*
- ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)*
- ***Work Programme 2018/19***

Last updated on: 16 January 2018

14 SEPTEMBER 2018

- **Annual Report on Quality in Public Health, incl Annual Complaints Report**
- **Annual Equality and Diversity Report**
- ***Verbal Updates – could include STP update***
- ***Contract Monitoring*** *– regular item*
- ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)*
- ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings*
- ***Work Programme 2018/19***

22 NOVEMBER 2018

- **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)*
- ***Verbal Updates – could include STP update***
- ***Contract Monitoring*** *– regular item*
- ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)*
- ***Work Programme 2019***

9 JANUARY 2019

- ***Verbal Updates – could include STP update***
- ***Contract Monitoring*** *– regular item*
- ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)*
- ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings*
- ***Work Programme 2019***

13 MARCH 2019

- **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)*
- ***Verbal Updates – could include STP update***
- ***Contract Monitoring*** *– regular item*
- ***Budget Monitoring report*** *(request from Leader's Group 12 6 17 that all Cabinet Cttees have regular item)*
- ***Work Programme 2019***

Pattern of items appearing annually

Meeting	**Item**
January	Budget and Medium Term Financial Plan Public Health Performance Dashboard – incl impact of STP now to alternate meetings *Budget Monitoring*
March	Draft Directorate Business Plan Risk Management report (with RAG ratings) *Budget Monitoring*
May / June	Public Health Performance Dashboard – incl impact of STP now to alternate meetings *Budget Monitoring*
June / July	*Budget Monitoring*
September	Annual Report on Quality in Public Health, incl Annual Complaints Report Annual Equality and Diversity Report Public Health Performance Dashboard – incl impact of STP now to alternate meetings *Budget Monitoring*
November / December	*Budget Monitoring*