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 on Tuesday, 13th March, 2018.

PRESENT: Mr G Lymer (Chairman), Mrs P A V Stockell (Vice-Chairman), Mr A Cook, Miss E Dawson, Mrs L Game, Ms S Hamilton, Mr S J G Koowaree, Mr K Pugh, Miss C Rankin, Dr L Sullivan and Mr I Thomas

OTHER MEMBERS: Paul Carter, CBE, Graham Gibbens and Peter Oakford

OFFICERS: Andrew Scott-Clark (Director of Public Health), Anne Tidmarsh (Director, Older People and Physical Disability) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

55. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Mr D S Daley and Ms D Marsh.

There were no substitutes.

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

Miss C Rankin declared that her son was employed as an economist by the Competition and Markets Authority, a body which was working in partnership with the County Council on the Local Care Implementation Plan (agenda item 6).

57. Minutes of the meetings held on 24 January and 8 February 2018.
(Item. 4)

It was RESOLVED that the minutes of the meetings held on 24 January 2018 and 8 February 2018 are correctly recorded and they be signed by the Chairman. There were no matters arising, but the Chairman commended the Democratic Services Officer on the comprehensive and precise minutes of the petition debate and discussion of the infant feeding item at the 8 February meeting.

58. Verbal updates by Cabinet Members and Director.
(Item. 5)

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:
Delivery of the Infant feeding service – next steps – the key decision to start implementing the new service had been taken on 12 March and he hoped the implementation would now move ahead successfully. Some parts of the new service had been adjusted to take account of feedback arising from the public consultation.
Joint Kent and Medway Health and Wellbeing Board – work to establish this was now complete and the new joint Board would start work in April. The Kent

Health and Wellbeing Board would continue to meet once a year to continue to undertake its statutory responsibilities.

2. Mr Oakford responded to questions from the committee, including the following:-

a) Mr Oakford was thanked for listening to the parents who had responded to the consultation and commented on the proposed new model and, in doing so, allaying some of their fears about the changes. It was hoped that users' confidence would grow as the new service bedded in; and

b) officers supporting the transition to the new model would work with health visitors and meet with all lactation consultants and peer supporters, and it was hoped that the transition would be smooth. To support the additional group sessions, more peer supporters were being sought, along with more funding to cover their recruitment and training.

3. The Leader and Cabinet Member for Traded Services and Health Reform, Mr P B Carter, CBE, gave a verbal update on the following issues:
Sustainability and Transformation Programme – Mr Carter advised that he was the Chairman of the new Local Care Implementation Board (LCIB), a body which included clinicians, GPs and representatives from mental health trusts. This Board would meet for the first time for a workshop on 20 March and would discuss how to set up multi-disciplinary teams to support GPs. As Chairman of the Board, he had been unequivocal that more resource was needed to support local care in Kent, and this need had been estimated as being between £100million – £140million. The Sustainability and Transformation Programme Board fully supported the local care agenda as this would take the pressure off hospitals, saving around £218million per annum and reducing or avoiding hospital stays for 30-35,000 patients per year. It had been identified that every additional £1million spent on local care would deliver some £3-4million of savings on hospital care. The LCIB would look at how to provide more support and deliver better value for public money. Recruiting and retaining well-qualified people to deliver local care presented a challenge. More detail of how the local care agenda would be delivered was set out in item 6 on today's agenda.

4. The Director of Public Health, Mr A Scott-Clark, then gave a verbal update on the following issues:-
NHS Prison Substance Misuse Contract – the County Council had previously commissioning this service on behalf of NHS England but the latter now sought to take back this role, meaning that it would also take from the County Council the risk element associated with commissioning.
Seasonal Influenza – the number of new cases being diagnosed had fallen dramatically from the January peak and was around the usual expected level for the time of year. Both the number of cases and the number of vaccinations had been particularly high this year.
Public Health messaging over the cold spell – Mr Scott-Clark thanked the County Council's communications team for its work in spreading the message about looking after oneself during the recent freezing weather.
Kings Fund publication – 'Tackling multiple unhealthy risk factors' – this had been published on 9 March and was recommended as a good read for Members. Kent's 'One You' programme had been cited as a case study of best practice. *Mr*

Scott-Clark undertook to supply a link to the document to all Members of the committee and this was subsequently done.

5. Mr Scott-Clark responded to questions from the committee, including the following:-

a) advice from NHS England was that vaccination, along with diligent handwashing, remained the best way to counter the 'flu virus, even if a different strain were to appear in the future;

b) there were two types of vaccination – quadrivalent and trivalent. Quadrivalent was used mostly for older people and trivalent use mostly for children. Children were now routinely vaccinated at school. Asked about the variations in cost of the two types, Mr Scott-Clark explained that surgeries were ordering vaccinations now for use next winter, and some community pharmacies also offered the vaccinations, and variations in cost may arise between earlier and later supply and perhaps the volume ordered; and

c) asked if GPs would be a first point of identification of the 'flu virus, as the public had been told in some instances to keep away from their GP if they had 'flu symptoms, Mr Scott-Clark explained that GPs were able to prescribe ant-viral medicines to patients with 'flu symptoms. However, patients may have 'flu-like symptoms but not actually have 'flu. GPs would also look for cases of norovirus as this was often an indicator of the presence of the flu virus.

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

59. Adult Social Care and Health Local Care Implementation Plan.
(Item. 6)

1. Mrs Tidmarsh introduced the report and set out some good early results and savings which had been achieved from a vanguard scheme at the Ribchester practice in Whitstable. These savings had amounted to £3.4million in the 2017/2018 financial year in the Whitstable area alone. The new model of local care implementation sought to achieve a seamless service provided by the County Council and NHS jointly, as service users were not concerned about who provided their care but just wanted to receive the care they needed. The changes set out in the summary of the new model would be delivered with existing domiciliary care providers as this had been tested successfully in the vanguard model. Multi-disciplinary working would be the key to the success of the new model, with good ICT links between professionals, and challenges to success would be funding and workforce issues.

2. The Cabinet Member for Adult Social Care, Mr G K Gibbens, added that this was the greatest change to health and social care services since the start of the national health service in 1947. The new model emphasised the importance of the person at the centre of the service. This followed the model used in Canterbury, New Zealand, which had worked well and was viewed by professionals as an example of best practice. A government green paper on older people's social care funding was expected by August 2018.

3. Mrs Tidmarsh responded to comments and questions from Members, including the following:-

a) good communication between partners in multi-disciplinary working teams was vital to ensure the success of the new model. West Kent had for some time been successfully running a model similar to the one proposed;

b) it was emphasised that the new model was not a vison but had a solid implementation plan. Examples of it already being in place had evidenced good outcomes, with 60% of older people being able to return to living independently, and had produced savings, showing that 'doing more with less' was achievable;

c) the map included in the appendices to the report showed NHS England test sites. Other areas in which the model was not yet so advanced were not yet shown but would come on board later;

d) the new ICT system was known as 'mosaic' but this had no connection to the demographic modelling tool of the same name;

e) asked when the new model would start, Mrs Tidmarsh explained that testing had been going on for one year (and was still going on for the safeguarding changes) but the new model would start in August 2018. Testing would continue once the model was in place as the only way to test its efficacy was to see how it worked once the whole system was up and running;

f) the recruitment of occupational therapists was progressing well;

g) the patient voice remained at the centre of the new model and the patient themself would define the goals they wished to achieve. Patients would be able to direct what care they wanted rather than have this dictated by a 'time and care' model. The emphasis upon the patient voice had been well received by domiciliary care providers and workers;

h) data security was vital when different services were sharing information, and the County Council had very thorough arrangements with the NHS to ensure that data was shared and handled securely;

i) a future County Council select committee would look at the issues of social isolation and could look into some very successful work carried out by the voluntary sector in the Netherlands to address this. A comprehensive model of local care provision would need to cover all elements of social care;

j) the Leader emphasised how important it was that GPs were on board with the delivery of the new model, and this issue would be addressed at the first meeting of the Local Care Implementation Board on 20 March. Multi-disciplinary teams would need to be built around GPs, and GPs also needed to commit to it to make it successful; and

k) recruitment of a local care workforce would continue alongside the implementation of the new model, and it was hoped that some staffing needs could be met by the County Council 'growing its own' workforce in-house. The new model could allow professionals more scope to excel in their specialist areas and could offer them a more attractive career path. Workforce was likely to be the biggest challenge and solving it would be a long-term issue as there had been insufficient training of workers historically and this would take some time to overcome. Mr Gibbens added that the County Council was required by the Care Act to have a sufficient workforce to cover all areas of social care work, and the Council should look to support the development of this workforce by engaging fully with the voluntary sector and local training providers, for example Canterbury Christ Church University.

4. It was RESOLVED that the Adult Social Care and Health Local Care Implementation Plan be welcomed and that Members' comments, as set out above, be noted.

60. Contract Monitoring Report - NHS Health Checks.
(Item. 7)

Mrs V Tovey, Public Health Senior Commissioning Manager, and Mr G Abi-Aad, Head of the Public Health Observatory, were in attendance for this item.

1. Mrs Tovey and Mr Scott-Clark introduced the report and clarified that health checks, which were a vital preventative measure, were a mandated cardiovascular screening programme with the aim of reducing the number of preventable deaths of people under 75. The current service was made up of three contracts; with the Kent Community Health Foundation Trust (KCHFT), with ICT services and with outreach service providers. KCHFT sub-contracted the provision of health checks to a network of providers, including around 180 GPs and 30 community pharmacies, KCHFT were also responsible for project management and quality assurance of the programme. The track record of providing health checks in Kent was good, and Kent was exceeding the target, with around 100,000 people being invited annually and 42% of them taking up the invitation. The annual cost to the County Council of the health checks service was £1.9million. A challenge for Kent's health check service was achieving equity of coverage, reaching those in areas of deprivation, who were known to be at greater risk of developing cardiovascular disease, and men, who were shown to be statistically less likely to take up an invitation for a health check. Outreach services were designed to help reach them and the service works local groups such as the Kent Sheds project.

2. Mrs Tovey, Mr Scott-Clark and Mr Abi-Aad responded to comments and questions from Members, including the following:-

a) pilot projects had been undertaken to identify good locations via which outreach services could reach those less likely to attend, and these had included shopping or town centres. To take the service into work places also reaches a 'captive audience'. The County Council was planning to work with Public Health England to identify the best communication methods to engage people who were less likely to attend, to ensure that the maximum audience was engaged and could benefit from the process. A national study sought to identify the most

effective way of wording an invitation letter to encourage attendance and this was the letter used in Kent;

b) committee Members would have the opportunity to have a health check after the committee's next meeting on 1 May 2018, and it was hoped that as many as possible would take up this invitation;

c) although engagement with GPs had been generally good, a few local medical practiceshad yet to commit, for various reasons. In such cases, the County Council could reach patients on their lists directly to invite them to attend health checks via NHS England. To have GPs as part of the service was vital, and GPs who maybe doubted that they could take on the full workload of managing the full health checks service can choose from a range of flexible contract types which included KCHFT delivering this service on their behalf;

d) health checks were a mandated service and were an important part of preventative work of the STP. By identifying potential problems early via a health check it could reduce later risk of stroke and other conditions. Addressing high blood pressure and high cholesterol were the two most vital actions to help reduce the risk of stroke;

e) patients who were already receiving treatment from their GP for any cardio-vascular condition would not be invited to have a health check, as they were not considered as needing further screening for the same condition, but such patients could still have a health 'MOT'. Any patient invited to and attending a health check would have their results sent to their GP for follow-up, even if their GP was not participating in the scheme and the invitation had come from KCHFT. Effective follow-up of data produced by a health check was vital, particularly in areas of greater deprivation. Follow-up of results should be as prompt as possible, to avoid unnecessary anxiety to the patient; and

f) health checks and health MOTs were a vital part of encouraging the behavioural change on which the 'One You Kent' campaign relied.

3. It was RESOLVED that the performance of the service and ongoing activities to deliver continuous improvement be noted.

61. Public Health Communications and Campaigns update.
(Item. 8)

Mr W Gough, Business and Policy Manager, was in attendance for this item.

1. Mr Gough introduced the report and acknowledged the great contribution made by the County Council's communications team to the success of the campaigns. There was much campaign activity going on with, for example, 100 One You Kent adverts running on social media, tailored to the needs and interests of different areas and groups of people, for example, grandparents, people moving home, or targeting districts and Towns. the 'One You Kent' website was currently being visited by 10,000 people per week. The percentage of visitors to the alcohol pages who were taking the 'Know Your Score' test had risen from 34% in 2016/17 to 54% in 2017/18. A large stakeholder event on 14 March would bring together the

County Council's partners to work on the promotion of the 'One You Kent' campaign. Mr Gough and Mr Scott-Clark responded to comments and questions from Members, including the following:-

a) all data gathered from website hits or calls to helplines would be anonymized, and staff evaluating the data would not be able to identify a call-back number or user's identity;

b) the public health team was congratulated on their innovative use of social media; and

c) the team used a range of methods of identifying and engaging with their target audience, working with partners. Consistency of message and co-ordination of work were important; for example, a borough council had linked the 'stop smoking' message to its own anti-littering campaign. Liaison with highways colleagues to make use of roadside hoardings to promote public health messages was still ongoing.

2. It was RESOLVED that the progress and the impact of public health campaigns in 2017/18 be welcomed.

62. Public Health Outcomes Framework (PHOF) Performance Report - Adults. *(Item. 9)*

Mr G Abi-Aad, Head of the Public Health Observatory, was in attendance for this item.

1. Mr Scott-Clark introduced the report and explained that, as part of the Health and Social Care Act, three sets of outcomes were recorded; for NHS, social care and public health. Kent's performance under these three headings would be compared to national outcomes. Mr Abi-Aad added that Kent mostly showed up well when compared to national outcomes, in areas such as life expectancy at birth and preventable premature mortality (i.e. under 75), but not so well in terms of increasing smoking levels, alcohol-related hospital admissions and depression. Kent also continued to be challenged in two areas: reducing the suicide rate, which was above the national average, and addressing late presentation of patients with HIV symptoms, with which Kent had struggled historically.

2. Mr Scott-Clark and Mr Abi-Aad responded to comments and questions from Members, including the following:-

a) links between poor mental health and higher suicide rates were well known but there had also been media coverage of the link between the use of certain anti-depressants and higher rates of suicide;

b) asked what could be done to address the late presentation of HIV symptoms, Mr Scott-Clark explained that cases of HIV were rarer now and GPs tended to look at and rule out other possible illnesses before considering HIV. Some GPs may never have seen a case of HIV. Mr Abi-Aad added that, although rarer now, HIV cases were increasing as screening for the disease had improved in recent years. Mr Scott-Clark added that the effectiveness of treatment was very good, and the pre-

exposure prophylaxis (PrEP) method of preventing infection, trialled in 2017, had had some impact. Many people still wanted to be able to take a pill rather than use a condom to protect against infection;

c) Public Health England was working on a more localised comparison of figures, using statistical neighbours and authorities of similar sizes, and was looking at combining several indicators into one to make recording easier. The figures recorded in the red, amber and green bandings were percentages of population, so fluctuations may reflect changes in population and not necessarily prevalence of conditions. Ratings were set by Public Health England rather than by the County Council. Ratings for Kent as a whole also did not reflect variations in rates in different areas across a large county. Mr Abi-Aad explained that regional figures were available and *a link to local health profiling would be supplied to all Members after the meeting. This was subsequently done*; and

d) work was going on to identify and measure the impact of adverse childhood experiences, for example, domestic abuse or child sexual exploitation, on a young person's later life, educational attainment and mental health. Studies in the United States of America had also highlighted a link between adverse childhood experiences and public health. Work was in hand between health, early years and specialist children's services colleagues to develop a holistic approach to addressing this issue

3. It was RESOLVED that:-

a) the public health trends and outcomes set out in the report be noted; and

b) the additional indicators listed in appendix 2 to the report be included in future reports.

63. Risk Management: Health Reform and Public Health.
(Item. 10)

Mr W Gough, Business and Policy Manager, and Mr M Scrivener, Corporate Risk Manager and Interim Corporate Assurance Manager, were in attendance for this item.

1. Mr Scott-Clark responded to a question about Kent's ability to deal with a biological attack of the sort recently experienced in Salisbury. He explained that the lead authority to co-ordinate the response to such an event was Public Health England. A key element of such a response was communication, as people potentially exposed to contamination could include not only local residents, who could be more easily advised of follow-up precautions, but potentially large numbers of visitors and tourists. Mr Scott-Clark explained that he co-chaired the group which would be involved in co-ordinating a response to such an event at a local level.

2. It was RESOLVED that the risks presented in appendices 1 and 2 to the report be noted.

64. Work Programme 2018/19.

(Item. 11)

1. The Chairman referred to and supported a request to add an update on the suicide prevention campaign and strategy to the work programme.

2. It was RESOLVED that, subject to the addition of the above, the committee's work programme for 2018/19 be agreed.