HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 13th March, 2018

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 13 March 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

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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 meetings held on 24 January and 8 February (Pages 7 - 24)

To consider and approve the minutes as a correct record.

5 Verbal updates by Cabinet Members and Director (Pages 25 - 26)

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 Adult Social Care and Health Local Care Implementation Plan (Pages 27 - 44)

To receive a report from the Leader and Cabinet Member for Traded Services and Health Reform, the Cabinet Member for Adult Social Care and the Director of Adult Social Care and Health, setting out an implementation plan which will deliver the new asset-based operating model for adult social care and health.

7 Contract Monitoring Report - NHS Health Checks (Pages 45 - 56)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, setting out the performance, outcomes and value for money of the NHS Health Check service. Committee Members are asked to note the performance and consider taking up the opportunity of a free health check.

8 Public Health Communications and Campaigns update (Pages 57 - 88)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health on the progress and impact of public health campaigns in 2017/18, on which the committee is asked to comment.

9 Public Health Outcomes Framework (PHOF) Performance Report - Adults (Pages 89 - 98)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, giving an overview of the latest trends across a sample of public health measures. The committee is asked to note and comment on the information set out and any additional indicators which it wishes to see included in future reports.

10 Risk Management: Health Reform and Public Health (Pages 99 - 114)

To receive a report from the Leader and Cabinet Member for Traded Services and Health Reform, the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health, the Cabinet Member for Adult Social Care, the Director of Public Health, the Corporate Director of Adult Social Care and Health and the Strategic Commissioner, setting out the strategic risks relating to health reform and public health in the County Council's corporate risk register or the public health risk register, together with the management process for reviewing key risks.

11 Work Programme 2018/19 (Pages 115 - 118)

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

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Benjamin Watts
General Counsel
03000 416814

Monday, 5 March 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 Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 24th January, 2018.

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

OTHER MEMBERS: Peter Oakford

OFFICERS: Dr Allison Duggal (Deputy Director of Public Health), Karen Sharp (Head of Commissioning for Public Health), Mark Gilbert (Interim Head of Public Health Commissioning), Michelle Goldsmith (Finance Business Partner), Wayne Gough (Business and Policy Manager, Public Health) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

36. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from the Leader and Cabinet Member for Traded Services and Health Reform, Mr P B Carter, who was attending a meeting in parliament.

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

There were no declarations of interest.

38. Minutes of the meeting held on 1 December 2017.
(Item. 4)

It was RESOLVED that the minutes of the meeting held on 1 December 2017 are correctly recorded and they be signed by the Chairman. There were no matters arising.

39. 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 Sustainability and Transformation Programme (STP), on behalf of the Leader. The STP Board had been in existence for some time and, whereas progress had previously been frustrating, work was now moving forward, steered by Glenn Douglas, Chief Executive of the Kent and Medway Sustainability and Transformation Partnership. The plan was for all eight clinical commissioning groups (CCGs) to work together as one with two ACPs based in East and North and West Kent. These would work

as an integrated commissioning body for the whole county, including Medway. This represented a good step forward. Much work was going on around the development of a local corporate partnership, in which local authorities had an integral role, and the STP had set up a local care work stream, made up of NHS partners and local authorities, which Mr Carter had been asked to chair, supported by the Leader of Medway Council as vice-chairman. This group would look at how to develop a good model of local care, and the Corporate Director of Adult Social Care and Health and the Cabinet Member for Adult Social Care had been asked to prepare a detailed report setting out an ideal model of integrated social care, health and public health, to be considered at the Cabinet Committee's March meeting.

2. Mr Oakford responded to questions and comments from Members, including the following:-

a) prevention work would be embedded across the entire system and, as such, should deliver savings and improved working. Joint working between professionals would be encouraged, but establishing this working would be a challenge. Concern was expressed that the type of joint working currently planned had not been successful when it had been tried previously;

b) the role of CCGs was clarified, and their commitment to the new model confirmed. One CCG had not yet fully committed to the programme but discussion was ongoing to try to bring them on board. Primary legislation had not changed, and all CCGs would continue to exist as legal bodies. However, each CCG would no longer have accountable officers, as at present, as these would move to a new role. The programme would create a single organisational structure, and more detail of this would be set out in the report to the March meeting; and

c) the involvement of Mr Carter as the chairman of the local care work stream would ensure that the County Council would have much input into and influence on the development of the programme, leading to integration and improvement.

3. Mr Oakford then gave a verbal update on the ***infant feeding consultation***. A special meeting of the Cabinet Committee had been arranged for 8 February, at which the petition received about the community infant feeding service would be debated.

4. The Deputy Director of Public Health, Dr A Duggal, then gave a verbal update on the following issues:-

Influenza and 'flu jabs – recent outbreaks of 'flu had been reported as mainly of a Japanese strain rather than the 'Aussie flu' mentioned in recent media coverage. It seemed likely in the near future that Public Health England may declare a flu epidemic. In response to questions, Dr Duggal confirmed that delivery of 'flu vaccinations was not currently causing a problem and the County Council would only become involved if a 'flu pandemic were declared. She undertook to find out and advise Members which of the two possible types of vaccine was mostly used in Kent.

Dry January; media coverage – this campaign, in which participants would give up alcohol for the month of January, was raising money for Cancer Research.

There had been press interest in and coverage of the campaign, including a radio interview with the Director of Public Health.
Public Health Funding update – public health funding would now be ring- fenced up to 31 March 2020, at which point it was expected that local authorities would start to fund public health activity from business rates. The budget for 2018/19 was £69,368 million but would reduce to £67,584 million in 2019/20.

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

40. Prevention in the Kent and Medway Sustainability and Transformation Plan. *(Item. 6)*

1. Dr Duggal introduced the report and explained that she had recently taken over the prevention work stream and that Andrew Scott-Clark and James Williams, the Directors of Public Health for Kent and Medway respectively, were the SROs for the project. The project initially had four key areas of work – obesity, smoking cessation, work place health and reducing alcohol consumption, with obesity and smoking cessation being the top priorities. A draft action plan and programme plan would be submitted to the STP work stream board for approval, but the budget for the project would need initial cash input before work could start. Dr Duggal then responded to comments and questions from Members, including the following:-

a) work on the various work streams (for example, obesity and smoking) would inevitably overlap to some extent, as behaviours tended to be linked, and tackling this work as part of the STP meant that it could happen at a higher level and could be co-ordinated across the south east. The embedding of prevention work as part of the STP was welcomed. Various speakers highlighted the links and overlaps between other prevention work streams named and concern was expressed that, beside work on smoking cessation, drug use should also be tackled.

b) Unhealthy behaviours were often developed as a crutch during times of hardship, so the partners involved in the work should include the Job Centre. Dr Duggal confirmed that all available partnership links would be exploited and that areas in which work should be prioritised in the STP work plan would be identified using statistics for deprivation and premature mortality (defined as death before age 75 from preventable causes);

c) the clarity of the report and the current activity described were both welcomed but concern expressed that funding available might ultimately prove insufficient to cover all the planned worked, so Directors of Public Health would need to seek additional funding for this purpose. Dr Duggal agreed that it was possible that the budget might be insufficient but the overlapping and streamlining of work should make the best use of the funding available, e.g. GPs could use a patient's visit to the surgery to introduce preventative work relating to other aspects of their lifestyle or habits;

d) asked what the County Council was doing to support and improve the health and fitness of its staff, as many worked long hours and could not afford gym prices, Dr Duggal explained that work on an integrated

approach to staff health, lifestyle and physical activity would be starting soon;

e) the importance of good communications and consistency of message across the county were emphasised. Other suggested partner organisations were churches, community advice centres and food banks. As well as the links already mentioned, there was also a link between obesity and a patient's mental health. Dr Duggal explained that the One You campaign had been designed to draw together the various aspects of public health and lifestyles and address them in an integrated way;

f) the wide range of preventative literature available at a local GP's surgery was welcomed by one speaker, who added that keeping fit did not need to involve gym fees and attendance, so cost was not an excuse; walking and keep-fit at home cost nothing;

g) public health work was vital to modern life and its role should not be underestimated. The active role taken by the public health team was welcomed, and the value of behavioural economics in seeking to influence people's behaviours was emphasised;

h) media coverage had shown that teenagers were smoking and drinking less than previously but instead used other substances which were more dangerous than alcohol and tobacco. The earlier suggestion that drug use be added to the work stream was supported. What was perhaps needed was a media message that smoking was not 'cool'. Dr Duggal advised that smoking was still the greatest cause of premature death in Kent. She suggested, and it was supported, that a *report on the use of psycho-active substances be submitted to a future meeting of the committee*; and

i) the Chairman commented that the consensus of views arising from the discussion of this item, e.g. supporting the four work streams and the importance of advertising, was most encouraging. He added that the film industry was responsible for presenting a number of risky behaviours as 'glamorous' and suggested that this also be borne in mind among campaign advertising.

2 It was RESOLVED that Members' comments on the progress of the Kent and Medway Sustainability and Transformation Programme prevention work stream and the future planned work, and suggestions for partner organisations which could be involved, be noted, and that a report on the use of psycho-active substances be submitted to a future meeting of the committee.

41. 'One You Kent' campaign update.
(Item. 7)

1. Mr Gough introduced the report and presented a series of slides *(included in the agenda pack)* which set out the national and local context of the One You campaign and the way in which it related to and reflected the links between behaviours, lifestyle elements and work streams discussed in the previous item. These also included an explanation of behavioural science and its role in identifying

patterns and triggers and contributing to campaign work to address ingrained behaviours. Research work had suggested that the Public Health message be established at key points in life, for example, when registering a birth, parents could be handed leaflets about healthy lifestyles so their child could start life with a good message and they as new parents could take the opportunity to adopt healthier habits. The Libraries, Registration and Archives service registered some 16,000 births every year. However, when habits were changed, the health benefit would be offset by the loss of what might have been a social network, for example, at the local pub, so to prolong the new habit, a replacement social activity might need to be established. Mr Gough updated some figures shown in the agenda pack: there had now been 89,000 sessions on the One You website and 27,000 referrals to the Public Health England 'How Are You?' quiz, and 30% of the target audience (particularly the 40 – 60 age group) had confirmed that they had seen the One You campaign. He then responded to comments and questions from Members, including the following:-

a) the suggestion of using hoardings beside highways to advertise the public health message was being explored with Environment and Transport colleagues. Achieving a good visual impact was vital to a successful campaign, although work to support and back up advertising campaigns was important;

b) some behaviours were associated with, or were symptomatic of, psychological distress, for example, stress, and if habits were once given up, they could easily re-start at the next episode of stress. It would be important to build resilience so the 'comfort' of smoking or eating junk food would no longer be needed;

c) GPs used to be able to prescribe free sessions of physical activity at leisure centres but this scheme was not well taken up and so had been discontinued. To prescribe health was better than to prescribe medicine;

d) two suggestions of partners which could work with the County Council on preventative work were volunteer bureaux and housing associations. Another speaker added that the seven million carers in the UK could also be a useful resource to spread the message. Mr Gough undertook to look into involving these, as well as Kent and Medway Fire and Rescue Authority and leisure centres. He explained that all such potential partners would be invited to a stakeholder event on 14 March;

e) GPs in west Kent had identified that 25% of patients coming to the surgery did not need to be there but were seeking social contact to assuage feelings of loneliness;

f) concern was expressed that the One You Kent campaign would be hard for some people to understand, although One You made more sense. Mr Gough explained that the One You campaign was a national one, with the by-line 'because there is only one you' – i.e. as there is only one of you, you should look after yourself, with each area adopting the national model and adding its name to make it a local project. Guidance on local branding was given by Public Health England;

g) the budget for this launch year of the campaign, to cover set-up costs, had been £200,000 from the public health grant campaign budget, but next year this sum would be lower. This funding had supported delivery of the campaign at 1,000 locations around Kent and development of tools which partners could use; and

h) the need to support long-term and sustainable habit change was emphasised. The complexity of implementing such a broad campaign meant that the involvement of behavioural scientists was necessary. Although the expense of the campaign may seem high, the cost of it not being successful would be higher in the long term as people with unaddressed damaging behaviours would develop long-term conditions which would be more expensive to treat.

2. It was RESOLVED that the progress and impact of the One You Kent campaign to date be noted, and Members' comments and suggestions of additional local organisations who could support the One You Kent campaign be noted.

42. Draft 2018-19 Budget and 2018-20 Medium Term Financial Plan.
(Item. 8)

1. Miss Goldsmith and Mr Gilbert introduced the report and explained that the public health budget differed from others in that it consisted entirely of grants and would always make full use of all grants available, leaving a zero balance. They added that briefing sessions had been held with party groups to answer questions about the content of the budget and the medium term financial plan.

2. It was RESOLVED that the draft 2018-19 Budget and 2018-20 Medium Term Financial Plan be noted. There were no 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 Medium Term Financial Plan.

43. Schedule of contract monitoring reviews.
(Item. 9)

1. Ms Sharp and Mr Gilbert presented a proposed two-year schedule of contract reviews, which had been requested by the committee to support its contract monitoring role. They explained that contracts had been listed for review based on their strategic importance, any areas of concern arising and the date on which they would be due for renewal. Ms Sharp and Mr Gilbert then responded to comments and questions from Members, including the following:-

a) overlaps between areas of contracting would be addressed when reports on each area were submitted to the committee; and

b) clarification was given of the role of the committee in monitoring contracts against key performance indicators (KPIs), and the importance of this role was emphasised. Contract management was a separate issue and was the responsibility of a separate Member group.

2. It was RESOLVED that the schedule of contract monitoring reviews to be presented to the Cabinet Committee over the next two years be agreed.

44. Considering information exempt from publication (agenda item 10).

The Chairman asked Members if, in discussing agenda item 10, they wished to refer to the information set out in the exempt appendix to the report, and hence if they wished to pass a motion to exclude the press and public from the meeting and discuss that item in closed session. Members confirmed that they did not wish to refer to the exempt information and, accordingly, discussion of the item took place in open session.

45. Contract Monitoring Report - Sexual Health Services.
(Item. 10)

1. Ms Sharp and Mr Gilbert introduced the report and emphasised that performance management of the contract was robust and that adjustments would be made to payments to the provider for any shortfall in performance. The service had delivered and was delivering very good value for money and had introduced innovative use of technology, including online testing kits. Ms Sharp and Mr Gilbert responded to comments and questions from Members, including the following:-

a) asked if young people were intimidated about attending a sexual health clinic, and if better engagement might be made if testing were to be done at a venue already familiar to young people, for example, a youth centre or gym, Mr Gilbert confirmed that young people's clinics were well attended and there was no data evidence of them staying away. Holding clinics which were just for young people meant that they would not be intimidated by attending a general clinic with older people. A pilot project to test the idea of taking clinics to other venues would run for 3 – 6 months and the feedback from this analysed. In response to concerns expressed, Mr Gilbert undertook to look into a specific example of local practice and liaise with the local provider if necessary;

b) the number of outreach sessions available reflected the staff capacity. Most outreach work took the form of drop-ins and opportunistic contacts rather than bookable sessions. Attendance varied but it was very rare to have a session at which there was no attendance;

c) usage levels of all services were monitored, with a guide level of 80% reflecting a sustainable level of provision. Trends would be identified and responded to, for example, sessions at one venue had been set up on Saturday mornings in response to local demand;

d) concern was expressed that service supply might not be able to meet demand. Mr Gilbert explained that, as the commissioner and provider were separate bodies, demand could be identified honestly, and commissioners were practised at doing this. Dr Duggal added that, as best practice, the public health team would also consult youth groups

such as Youth Advisory Groups to gain first-hand feedback from service users;

e) the 'condom distribution' programme had proved to be cost-effective and presented good value for money. Ms Sharp explained that the budget for this project had covered both the equipment and promotion work and clarified that the current project, which had replaced the previous 'condom card' programme, cost less. She added that it was unusual for the County Council to have statutory responsibility for this sort of provision, however, it sought to reduce costs where it could, for example, by optimising the use of online testing, to achieve best value for money. The current provision model had proved most successful and had expanded capacity in Maidstone and Canterbury. The ability to pioneer this sort of provision was a benefit of the flexible contracting arrangements which the County Council had negotiated with providers;

f) Mr Gilbert clarified that the contract values set out in Appendix A to the report, including for the condom programme, were the maximum possible value of each contract, assuming maximum activity; the actual amount paid for each would be lower than the price listed;

g) the target that sexual health support services aimed to meet was that every client requiring support urgently should be able to access it within 48 hours. The County Council strove not to be complacent and would always look for unmet demand and changing patterns of demand;

h) data gathered would contribute to the preparation of the Joint Strategic Needs Assessment (JSNA). Concern was expressed that some of the data in the JSNA was from 2013 and would need to be updated. Dr Duggal explained that public health data took a while to collate and evaluate but was of excellent clarity and value once it became available for use;

i) concern was expressed that Gravesend might need a campaign targeted particularly to that area, and Dr Duggal undertook to look into this and advise the questioner outside the meeting; and

j) clarification was sought of the total number of clients accessing psychosexual counselling sessions, and questions asked about the qualification of the counsellors delivering these sessions and what the sessions would cover. Mr Gilbert assured Members that counsellors delivering sessions were fully trained specialists in that field, and so their number was necessarily finite. The provider was paid per session for the provision of psychosexual counselling, and each client would attend 6 – 8 sessions, so the approximate number of clients could be calculated by dividing the total. Client satisfaction rates for this part of the service were high.

2. It was RESOLVED that the performance of the County Council-commissioned sexual health services, and the processes in place to manage the contract effectively, be noted and welcomed.

46. Performance of public health-commissioned services.
(Item. 11)

1. Ms Sharp and Mr Gilbert introduced the report and highlighted the fact that no indicators were rated red and those few rated amber were falling short in just one area of the county and hence were very close to meeting their target and achieving a green rating. In cases where performance was below the national level, an action plan was in place to support improvement.

2. It was RESOLVED that the Quarter 2 performance of public health-commissioned services be noted.

47. Work Programme 2018/19.
(Item. 12)

1. The Democratic Services Officer introduced the report and explained that, since publishing the agenda pack, the work programme had been updated to include the suggested schedule of contract monitoring discussed in agenda item 9.

2. It was RESOLVED that the committee's work programme for 2018/19 be agreed.

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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 Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 8th February, 2018.

PRESENT: Mr G Lymer (Chairman), Mrs A D Allen, MBE (Substitute for Mrs P A V Stockell), Mr A Cook, Mr G Cooke (Substitute for Mr I Thomas), Mr P C Cooper (Substitute for Ms D Marsh), Mrs T Dean, MBE (Substitute for Mr D S Daley), Miss E Dawson, Ms S Hamilton, Mr S J G Koowaree, Mr M J Northey (Substitute for Mrs L Game), Mr K Pugh, Miss C Rankin and Dr L Sullivan

OTHER MEMBERS: Paul Carter, CBE, Peter Oakford, Rob Bird, Dara Farrell, Graham Gibbens, Barry Lewis and Charlie Simkins

OFFICERS: Andrew Scott-Clark (Director of Public Health), Dr Allison Duggal (Deputy Director of Public Health), Wendy Jeffreys (Locum Consultant in Public Health), Karen Sharp (Head of Commissioning for Public Health) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

48. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Mr D S Daley, Mrs L Game, Ms D Marsh, Mrs P A V Stockell and Mr I Thomas.

Mrs T Dean was present as a substitute for Mr Daley, Mr M J Northey for Mrs Game, Mr P Cooper for Ms Marsh, Mrs A D Allen for Mrs Stockell and Mr G Cooke for Mr Thomas.

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

There were no declarations of interest.

50. Kent County Council Petition Scheme process.

The Chairman thanked the lead petitioners and others for attending and explained that, following the process set out in the County Council's petition scheme, the committee would be addressed by the lead petitioners and the Cabinet Member and would then have a time-limited debate of the issues raised in the petition.

51. Petition Scheme debate - infant feeding service.
(Item. 4)

The lead petitioners, Ms A Le Grange and Ms C Mitford, were present at the invitation of the committee and Ms K Sharp, Head of Public Health Commissioning, Ms W Jeffreys, Locum Consultant in Public Health, and Ms C Poole, Deputy Chief

Operating Officer and Community Services Director (Public Health), Kent Community Health Foundation Trust (KCHFT), were in attendance for this and the following item.

1. Ms Le Grange addressed the committee, explaining that she had started the petition in summer 2017 as she had been concerned that the proposed new model of support for the community infant feeding service would not provide support in a way which was required, including the number and geographical spread of clinics available, the training of those whom it was proposed would deliver the service and the speed of access to urgent and specialist support to address complex needs. Recognition of tongue-tie was welcomed but there was not confidence that this could be adequately treated in the new model of service. Ms Le Grange asked that the County Council extend its planned service to ensure that specialist and dedicated support was provided so mothers would continue to be encouraged to breastfeed and that mothers and children would continue to experience the health benefits of breastfeeding.

2. Ms Mitford added that she had struggled at first to breastfeed, had lacked confidence and had felt shame and stigma. She had attended a weekly group for eight weeks and described the support she had received there as 'brilliant'. She added that, when she had experienced problems with breastfeeding at the start, she could not have waited for a referral or been able to travel any distance to access support. She emphasised that all women needed to be able to exercise choice over how to feed and needed access to expert help and support. She asked that the County Council keep its breastfeeding support service unchanged.

3. The Cabinet Member, Mr P J Oakford, said that he needed to have the fullest possible information before taking a formal decision on the future of the infant feeding service, of which breastfeeding support services were a part. He assured the petitioners and mothers present that the County Council was committed to supporting and promoting breastfeeding, was taking the issue very seriously and had invested much work and officer time in preparing the proposed new model. The issue of breastfeeding had been discussed several times at committees during the formation of the current proposals. He added that an independent company had been engaged to evaluate the findings of the public consultation so the analysis would be clear and objective. He emphasised that the proposed new model was a co-ordinated whole-system approach, based on guidance from Public Health England and linked to the NHS, GPs and the maternity service. By embedding this into a health visitor service, commissioners would ensure the provision of more profession-led clinics, with the spread and frequency based on need. Adjustments had been made to the model as a result of comments arising from the consultation. The service would be an infant feeding service, offering women options, one of them being breastfeeding. The County Council would embark on a joint campaign with health visitors and the maternity service with a priority of providing clear and consistent information to families. He gave his personal commitment to oversee the new model.

4. The committee then debated the issues raised in the petition and sought clarification of details of the service from Ms Sharp, Ms Jeffreys, Ms Poole and Mr Scott-Clark. Comments made were as follows:

a) the attendance of mothers and children at the meeting was welcomed and they and the petitioners were thanked for their participation;

b) Ms Le Grange was asked, and confirmed, that she was a self-employed lactation consultant contracted to PSB Breastfeeding;

c) asked about the accessibility and placing of clinics, Ms Sharp explained that the new model had at its heart the aim of improving accessibility to the service in a variety of ways. Health visitors would continue to visit families following a birth and at 6 - 8 weeks after birth and would provide an additional 36 drop-in clinics per week across the county. In addition to these, there would be 6 dedicated specialist clinics across the county per week, equating to approximately 24 per month, with their locations being dictated by need. These would be supported, where required, by spot-purchasing of lactation consultants. Additional need would be identified via regular monitoring of service demand. Full-time lactation consultants, within the health visiting service, would be able to respond to demand in a more flexible way than they would when based solely at clinics. Additional funding would be made available to support spot-purchasing of lactation consultants to supplement other provision;

d) concern was expressed that new mothers leaving hospital on the same day as giving birth (i.e. within 6 hours) had less opportunity for support following skin-to-skin contact and breastfeeding initiation, and had less time and support than they once would have had to try breastfeeding. Once out of hospital, new mothers wanting to breastfeed would need help and support from a family and community network;

e) Ms Sharp explained that the proposed new model, although based on Public Health England and Department of Health guidance and in line with most other local authorities in the UK, had yet to be tested in Kent. The new model had been designed to provide more support to women who wished to breastfeed and had been built to respond to concerns expressed, for example, by additional investment to address concerns raise by lactation consultants. The aim was to smooth the transition from the maternity services, which looked after a mother for the first 10 days following birth, and the health visitor service, to which she would transfer after 10 days. The service would have the opportunity to connect to GPs' surgeries as this was where mothers would go first to seek help with health issues. The new model sought to combine the best of the previous model with new innovation. She emphasised that the transition period between the old and new models would be given dedicated resources and be carefully monitored;

f) concern was expressed that some 25% of mothers did not attempt to breastfeed once they had left hospital, so any help in smoothing the transition between the maternity and health visitor services was welcomed. Ms Sharp added that peer supporters were very important as a resource to visit and encourage new mothers, as mothers often preferred to speak to another mother rather than to a health professional. Ms Poole added that the KCHFT, which would be delivering the new service model, remained committed to retaining and encouraging the county's peer supporters, which currently numbered some 200, and to adding new ones. Peer supporters would be instrumental in supporting the 36 new drop-in clinics across the county;

g) one speaker said that the County Council seemed to be reluctant to promote breastfeeding but should champion it, as it was well documented as benefitting the short and long-term health of both child and mother. The UK had lower rates of breastfeeding than many other countries so needed to improve. Petitioners were thanked for the points they had raised as part of the consultation, which had led to changes being made to the proposed new model, however, some details of the new service were not yet clear. It was difficult to work out where and when the clinics mentioned would be held, the way in which an out of hours service would be provided, the level and accreditation of health visitor training and how this compared to the training undertaken by current lactation consultants, the workload of each health visitor and whether or not this was sustainable, how Kent's services compared to that of other local authorities, and the data modelling used to identify the number of clinics required. Spot-purchasing would need to be carefully monitored, and Members would need to be able to see how such contracts would be worded. Ms Sharp responded to these points and offered to provide the information requested. She added that the proposed new model would offer more flexibility to respond to demand, offering a combination of sessional and individual bookings, run by health visitors with a specialist interest in infant feeding and lactation consultants, supported by peer supporters, but would be firmly rooted in established best practice;

h) in response to a question about the service for the first 9 days following birth, Mr Scott-Clark explained that the responsibility for this part of the service rested with the NHS/clinical commissioning groups, and the County Council would take on the responsibility from day 10, when service provision transferred to the health visitor service. The rate of initiation of breastfeeding in Kent was below the national average for the UK and the County Council was working with NHS colleagues to address this;

i) one speaker said how much the breastfeeding support service had improved since she had given birth in 2000 and said the service now on offer to new mothers was outstanding;

j) another speaker reminded that, although it was recognised that 'breast is best', it must be remembered that not every mother was able to, or wished to, breastfeed;

k) the aim of a joined-up service, with the transition from maternity service to health visitors, was welcomed. Other speakers were assured that all health visitors were highly-qualified registered nurses with post-graduate qualifications;

l) it was difficult to picture, from the information provided, what exactly the service would look like on the ground and how and where a new mother seeking help would find out about the support she required. Ms Sharp offered to supply a list of the locations of clinics; and

m) the retention of peer supporters in the proposed new model was welcomed.

5. The Leader of the County Council, Mr P B Carter, agreed that rates of breastfeeding in the first 10 days following birth needed to be improved and that those who were unable to breastfeed should not be ostracised, and added that the committee should monitor access to, and use of, the new service. He emphasised the enormous amount of work which had gone into building the new service model and the need to listen to feedback from mothers using the service to identify problems and areas for improvement, which would then need to be addressed. He reminded Members that £100,000 of additional funding had been made available to support the spot-purchasing of lactation consultants. He added that the committee would monitor the embedding and operation of the new service.

6. At the conclusion of the petition debate, the Chairman summed up by saying that the committee was required to decide how it intended to respond to the petition, i.e. to recommend either that the action requested in the petition be taken, that it not be taken (or that some of it be taken), or that further investigation be undertaken. He suggested that, as there was a full report and recommendation in the next agenda item, the committee could defer a decision at this stage and move on to have that report presented by officers, discuss it and then return to the decision on how to respond to the petition.

7. It was RESOLVED that the next agenda item be considered before the committee set out its response to the petition.

52. 18/00003 - Delivery of the Infant Feeding Service.
(Item. 5)

1. Ms Sharp introduced the report and explained that she would be taking the lead on establishing and overseeing the new service to ensure it bedded in well. She set out the historical context of the breastfeeding support service and the background to the current proposed new service. The health visitor service had been the subject of concern in the past but work on improving their performance indicators had proved successful. She reiterated points made in the petition debate about the need to promote breastfeeding and improve rates of initiation and continuation and the new model being a blend of the most positive elements of the previous model and new aspects, such as spot-purchasing of lactation consultants and use of new technology. She emphasised the importance of careful monitoring of the transition period from the present service to the new and added that the new system was still a proposal; no decision about it had yet been made and would not be made until later in March. Ms Sharp, Ms Poole and Mr Scott-Clark then responded to comments and questions from Members, including the following:-

a) the use of the most positive parts of the current service to build the new one was welcomed but concern was expressed about training of health visitors to prepare them for their new role, the limited time available at appointments and the number of issues which might need to be covered in that time. Ms Sharp emphasised that the 36 weekly drop-in clinics were a new addition which would offer more capacity for appointments. Ms Poole explained that health visitors were committed to the Unicef Baby Friendly Initiative (BFI) and that 98% of health visitors had undertaken the latest additional BFI training required to achieve accreditation at stage 2 of this. She added that the 36 new drop-in clinics would be run by health visitors with a special interest in breastfeeding

and who championed breastfeeding. Peer supporters would also be encouraged to be part of the new model. Any complaints arising about the operation of the new clinics would be addressed by infant feeding leads (IFLs) but mothers would still have access to qualified, directly-employed or self-employed lactation consultants who could support them promptly with any complex breastfeeding issues. To employ lactation consultants to supplement planned specialist clinic sessions as part of a mixed model of fixed and flexible provision was considered to be the best way forward;

b) asked about health visitor qualifications, the accreditation of these and how many health visitors held such qualifications, Ms Poole explained that all health visitors were registered nurses, many were also trained midwives, and all were trained in Infant feeding as part of their additional public health training to become health visitors. The lactation consultants employed directly within the health visiting service would have the same additional qualifications as those held by lactation consultants. Lactation consultants would be both in-house and self-employed, to offer optimum flexibility of service. Mr Scott-Clark referred to the National Healthy Child Programme, which was delivered by health visitors, and explained how other services, such as the infant feeding support service, would link into this. He emphasised that the new model was supported by Public Health England and was comparable to the model used by most other local authorities in the UK;

c) asked about the importance of initiating breastfeeding in the first 10 days following birth, and how rates of initiation could be improved by pressuring NHS partners, Mr Scott-Clark explained that the first mandatory health contact for an expectant mother would be made by a health visitor pre-birth and a mother's relationship with a health visitor would start then, so breastfeeding could be raised then. Promotion of breastfeeding was part of the Sustainability and Transformation Programme prevention work stream, for which the Directors of Public Health of Kent and Medway Councils were jointly responsible, and preventative work would be embedded in all related services, (for example, breastfeeding, smoking cessation, etc). Via this preventative work stream, the County Council would hold the NHS to account to ensure that breastfeeding initiation rates were maintained. Ms Poole added that KCHFT supported and welcomed working with the midwifery service and had an established relationship with midwives. Health visitors were not prevented from making contact with new mothers within the first 10 days following birth, and if, from their pre-birth meetings with a mother, they predicted any problems, they would prepare in advance to offer her early, tailored support. Mr Scott-Clark added that Kent's breastfeeding initiation rates were not only below the national average but currently falling, and undertook to ensure that monitoring reports to the committee would keep Members appraised of work to improve this rate;

d) the importance of an early and good relationship between a new mother and a health visitor was emphasised, as a health visitor had a vital and close relationship with a family and would be in a position to identify and offer support for any health issues arising in a family with a new baby.

Although having changes made to a support service could be frightening, and this was understood, it was not necessarily the case that any change would be detrimental. The extensive work put into the development of the proposed new model was emphasised and the suggestion that the committee monitor the new service was supported;

e) a suggestion was made that responses to a number of questions put to officers during the petition debate and in discussion of agenda item 5, and information requested, be made available to Members before the Cabinet Member took the formal decision, and that the committee have the opportunity to discuss the issue again before a formal decision was taken. The Chairman advised that an additional meeting of the committee may not be feasible in the time available before the decision needed to be taken. Some speakers asserted that there was time to discuss the issue again when the requested information was available, while others said the decision to start the new service should not be delayed any further; and

f) speakers supported the suggestion that the committee monitor the new service but suggested various timespans for this, with some saying it should be done urgently and others asserting that the new service should be allowed time to bed in properly first so that patterns of use could start to be identified.

2. The Leader added that the new service model proposed represented an enhanced system, which he believed would improve the service, particularly the rates of breastfeeding initiation in the first 10 days following birth. He supported the links to the midwifery service which were built in to the new service.

3. The Cabinet Member thanked all participants for a good debate and the officers for the work they had put into developing the proposed new model of service delivery. He emphasised that keeping the status quo was not an option and said that he believed the proposed new model would deliver a better service. The County Council had undertaken much consultation and had adapted its proposals to respond to feedback arising from the consultation. He supported the suggestion to build in responses to the questions arising during the petition debate and the discussion of agenda item 5, and the additional information requested, to the decision paperwork before he took the final decision.

4. The Democratic Services Officer suggested that the provision of the information requested by Members during the petition debate and discussion of the report, i.e.:-

- details of locations and times of clinics;
- modelling to identify the number of appointments required;
- analysis of the need for an out-of-hours service;
- comparison between Kent's service and those of other local authorities;
- detail of accredited qualifications of health visitors, how many health visitors held these qualifications and how they compared to accredited qualifications elsewhere in the NHS; and
- establishment of regular monitoring of the new service by the Cabinet Committee, at a frequency to be determined.

be added to recommendation ii) in the report and for the information to be made available to Members as part of the decision paperwork before the formal decision

was taken by the Cabinet Member. This was accepted and the recommendation, with the addition of the above, was put to the vote.

Carried, 9 votes to 3

Mrs Dean, Mr Koowaree and Dr Sullivan asked that their opposition to this resolution be minuted.

5. It was RESOLVED that:-

a) the committee's comments on the findings of the consultation, the proposed model and the planned additional investment, as set out in paragraphs 1 a) to f) above, be noted; and

b) the decision proposed to be taken by the Cabinet Member for Strategic Commissioning and Public Health, to implement the new model for infant feeding support, be endorsed, subject to the information listed in paragraph 4 above being provided to Members and published with the pre-decision notice so that all Members could comment on it and ask questions before the Cabinet Member took the formal decision.

53. Committee response to the petition.

1. Returning to the requirement for the committee to set out its response to the petition, the Chairman then asked the committee whether or not, after passing the resolution above, it felt able also to support the action requested in the petition. Members indicated that they did not feel able to support the action requested and wished instead to note the petition.

2. It was RESOLVED that the action requested in the petition be not supported but that the petition be noted.

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 – 13 March 2018
Subject:	**Verbal updates by the Cabinet Members and 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 and Transformation Programme

Public Health

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

Delivery of the Infant feeding service – next steps
Joint Kent & Medway Health and Wellbeing Board

Director of Public Health – Mr A Scott-Clark:

NHS Prison Substance Misuse Contract
Seasonal Influenza
Public Health messaging over the cold spell

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From:	Paul Carter CBE, Leader and Cabinet Member for Traded Services and Health Reform Graham Gibbens, Cabinet Member for Adult Social Care Anu Singh, Corporate Director of Adult Social Care and Health
To:	Health Reform and Public Health Cabinet Committee – 13 March 2018
Subject:	**ADULT SOCIAL CARE AND HEALTH LOCAL CARE IMPLEMENTATION PLAN**
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	Corporate Board – 12 March 2018

Summary: This paper describes the Adult Social Care and Health Local Care implementation plan. The implementation plan delivers the new asset based operating model for Adult Social Care and Health. The operating model provides the basis for how adult social care will work in local Multidisciplinary Teams or hubs, as part of Local Care, which is a central pillar of the integration of health and social care under the Sustainability and Transformation Partnership.

A Sustainability and Transformation Partnership Local Care workshop will be held on 20 March 2018. This will present an opportunity for individual organisations to set out their commitments for taking Local Care forward at scale and pace, through three flagship Local Care pilots.

Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the Adult Social Care and Health Local Care Implementation Plan.

1. Introduction

1.1 The Health Reform and Public Health Cabinet Committee received an update from Cabinet Members on the Sustainability and Transformation Partnership (STP) at its meeting on 24 January 2018 and it was agreed that the Corporate Director of Adult Social Care and Health and the Cabinet Member for Adult Social Care, should prepare a detailed report setting out an ideal model of integrated social care, health and public health, to be considered at the Committee's March meeting.

1.2 This report presents the ongoing development of the Adult Social Care and Health (ASCH) Local Care Implementation Plan. The implementation plan sets out how the new ASCH asset based operating model will be delivered. This model builds on a person's strengths and their networks and connects them to the right professionals or universal offer. The model will be used as the basis for joining up health and social care locally with the aim of improving outcomes for residents and to help the Council and the NHS to achieve their respective financial and service objectives. These changes will enable health and social care to support more people to live independent and fulfilling lives, in their own homes and communities and to do so with the same resources or less.

1.3 This report provides the Cabinet Committee with the opportunity to consider details of the ASCH Local Care Implementation Plan and to be updated on how the asset based operating model will be rolled out in practice as part of Local Care. The report also offers the Cabinet Committee the opportunity to discuss the key issues that the Council may wish to raise at the Local Care Workshop on 20 March 2018, in relation to informing the Local Care pilots.

2. Policy context

2.1 Integration of health and social care is a high priority for the Government as stated in key policy documents such as the NHS Mandate and the Five Year Forward View. The integration agenda is also important for the Council as expressed in the its Strategic Statement. ASCH is continuing to play a leading and active role in driving this agenda.

2.2 Summary of the New Operating Model

2.2.1 We are in stage 1 of a managed migration into the new operating model for ASCH. Appendix 1 provides further details of the change activity and the internal change work in place to migrate to the new model.

2.2.2 This model will achieve the following changes:

- **Safeguarding change:** this will improve execution of safeguarding through clearer targeting this skill and specialism
- **Practice change**: this will enable staff to deliver asset or 'strengths' based social care and support
- **Structural change:** this will create locality working in multidisciplinary teams to drive population health
- **Infrastructure change**: this will create new tools and systems for financial and practice management
- **Commissioning change:** this will create a shift into a blended landscape of outcomes focused provision across the Voluntary Community and Social Enterprise (VCSE), Health and commercial sectors

- **Workforce change:** this will create an improvement in the blend and supply of roles needed for future integrated working.

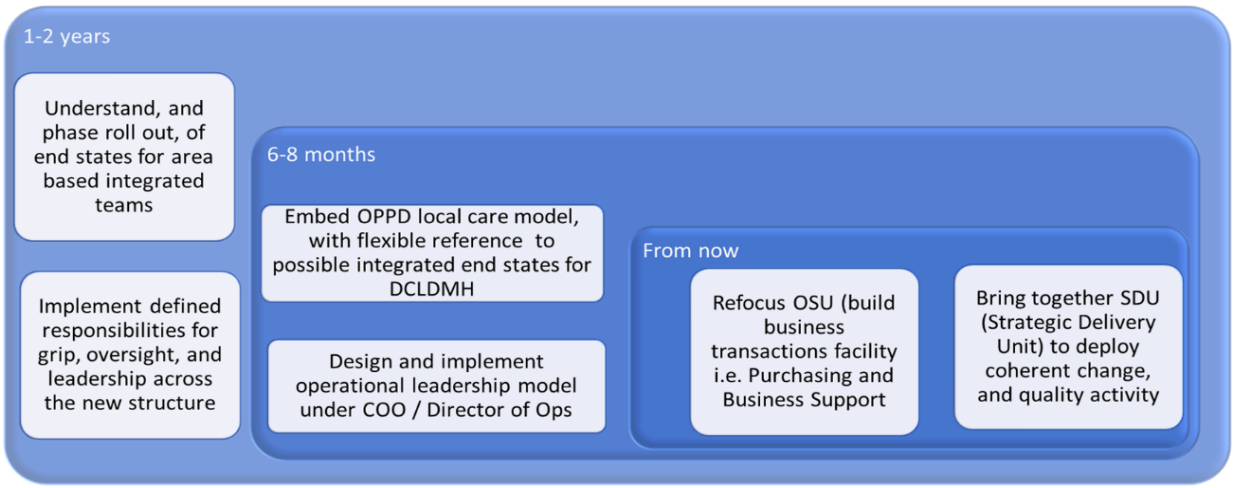
2.3 Implementation Timeline

2.3.1 The following key factors have shaped our implementation timeline:

1. Readiness of staff to absorb and deliver service changes (varying layers of transformation are already in place)
2. Delivery of the £18m savings detailed in the Medium Term Financial Plan (MTFP)
3. Fast track early implementation of two full blown Local Care Pilots in Kent;
4. Roll out of a Multidisciplinary Team (MDT) working Local Care model for 2019/20
5. Implementation of the Adult Social Care new client database (SWIFT) replacement ICT system in April 2019. The new system is known as Mosaic.
6.

2.3.2 These factors have meant that we are twin tracking (a) final design of new operating model with (b) phased early implementation of the new operating model for Older People/People with a Physical Disability (OPPD).

Fig 1
Phasing the change

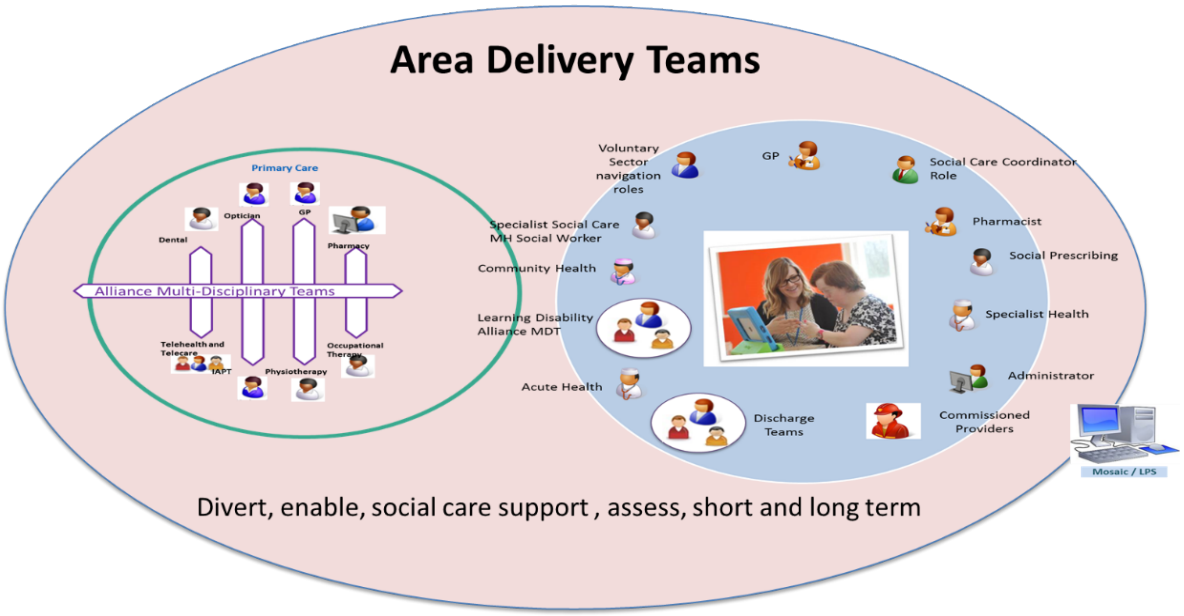


3. Current Transition and End State Operational Models

3.1 Asset based care and support is an approach that builds on what individuals, families and communities can do with the right support. It relies on different approaches such as social prescribing or time banking, and builds on a combination of support networks and community capital. By building on an individuals' strengths and capability, rather than focusing exclusively on their ***needs*** or ***problems***, asset based approaches make a meaningful difference. Under the Care Act the Council has a duty to prevent, delay, or reduce care needs. This approach promotes an individuals' wellbeing; supporting them to live independent and fulfilling lives in their own homes and communities.

3.2 We have been working with NHS colleagues to design the new operating model, along a 6-tier approach that delivers STP Local Care. The cornerstone of the approach is integrated MDTs, as illustrated in fig 2 below. Further detail of the STP Local Care models are attached to this report as Appendix 2.

Fig 2
MDT as developed through our work at Encompass Vanguard



3.3 It is anticipated that the new operating model for ASCH will be in place from August this year for OPPD and April 2019 for Disabled Children, Adult Learning Disability and Mental Health (DCLDMH). For transition purposes we are building a flexible local model, which can be easily locked and unlocked into MDTs as they come on stream, starting with two pilot Local Care sites. Each team will work with clients to focus on promoting independence goals, or work with providers on supporting independence goals and outcomes. Each team will be able to access specialist intervention from Social Work, Safeguarding, Quality Improvement, Mental Health, Sensory and Autism practitioners so the client has access to support required when required. This is a very different model from our current deployment of client specific teams.

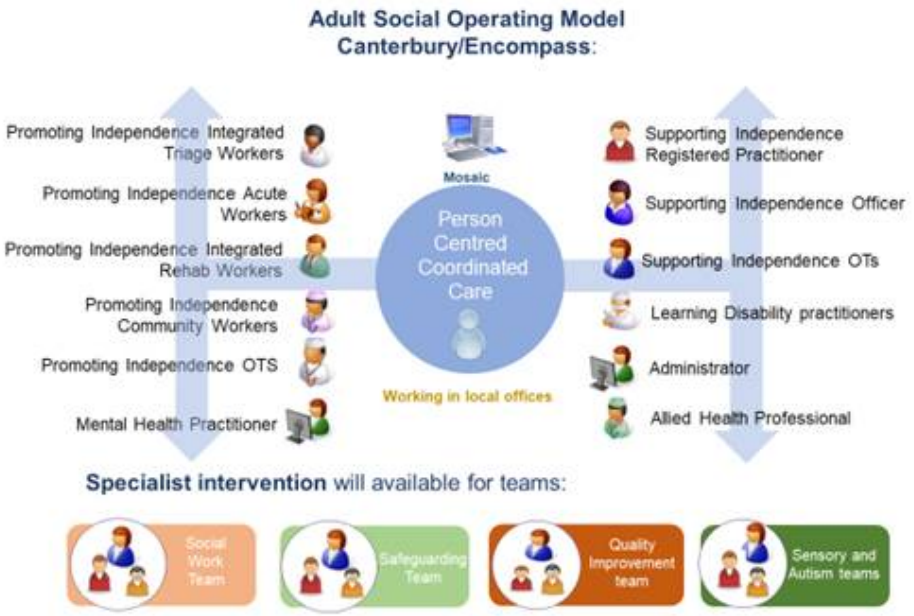
3.4 We have completed the design of the ASCH end state structure. It is envisaged that each team will become part of the emerging Local Care teams when they are set up. Currently we have this operating in shadow form, with named individual workers that attend a range of hub/cluster/multidisciplinary teams - some are based in GP practices and some based in local offices. The image below shows how one segment of this integrated working is unfolding. We are currently testing an Integrated Triage and Integrated Assessment model with Kent Community Health Foundation Trust (KCHFT) in Coxheath in West Kent focusing on Maidstone Central and Malling referrals and rolling this out to the rest of West Kent in the next month.

Fig 3
Integrated Triage and Integrated Assessment model process

3.5 The design we are implementing will work across a minimum of nine locality teams across the county. We will deploy social care staff into MDTs to focus on promoting independence, and provide short-term targeted support that aims to make the most of what people can do for themselves. This will reduce or delay their need for care, and provide the best long-term outcomes for people.

3.6 The ultimate aim is to bring all Adult Social Care teams together to work locally into an overall East and West geographical area – which maps across the emergent health management structures. These will work seamlessly within our new **community assets** work. Below is an example of what this might look like in one local area such as Canterbury.

Fig 4
Canterbury MDT



4. Financial Implications

4.1 ASCH has planned savings targets of £18m in 2018-19 towards the County Council's savings target of £48m in 2018- 19. This level of savings commitment depends on successful implementation of the service changes described in this report.

4.2 The new operating model is profiled to save £9.8m with an investment needed of £4m. The table below outlines where the net £5.8m fits into our total savings plan. We currently have plans for £15m, and plan to draw down £3.1 from reserves.

4.3 Ultimately, achieving integrated working through Local Care will save the Kent system £218m. We do not yet know what the future costs and savings may be for the Council. This is a piece of work that will be completed in three months. The key issues are that

(i) Local Care modelling has been based on the frail elderly population. Costs for ASCH fund other populations such as Mental Health and Learning Disability, and this modelling work is still to be initiated; and

(ii) the original financial modelling for Local Care did not segment out Social Care. Whilst we cover some similar populations, health needs and social care needs are set at different levels. It is possible that maintaining a population below health needs level, will mean more costs for social care. This modelling is critical work, as the Council will need to make an investment case to the STP.

4.4 The high-level savings identified in the Local Care Investment Case are as follows:

- Once in steady state, the gross annual savings are estimated at £218m
- Annual reinvestment costs are estimated at £75m (~35% of gross annual savings). As outlined above, these costs may be greater as social care costs have not yet been costed appropriately.
- Leaving estimated net annual savings of £143m
- Non-recurring investment is required of £39m revenue (for double-running costs etc) and £164m - £190m of up-front capital costs to fund the provision of local hubs (estates) and digital capabilities.

4.5 The gross savings are derived from a reduction in A&E activity, non-elective activity, outpatient activity and bed days. Social care savings or costs have not been modelled. The annual reinvestment costs are largely related to the workforce (annual costs estimated at £52m). This includes the costs of care navigators and care managers across Health and Social Care and approximately 415 generic health and social care workers. Therefore, whilst a proportion of social care costs have been reflected in the Local Care Investment Case, further work is now required to ascertain the full financial implications for Social Care (including income). This work is being progressed through detailed modelling in West Kent and an integrated implementation plan for Local Care has been developed.

4.6 Work is now underway within Health, with input from Social Care, to design, cost and implement individual Local Care models at a locality level i.e. covering populations levels of between 30,000 and 50,000. Working initially with West Kent Clinical Commissioning Group (CCG) the full costs/implications for Social Care are now being identified as part of the West Kent model and will include, but not be limited to changes in workforce costs, supplier costs, estates and digital costs.

5. Legal Implications

5.1 The ASCH Local Care Implementation Plan and the operational arrangements will be taken forward in a way which is consistent with the Council's legal obligations as a council with adult social care responsibilities and these will be discharged accordingly.

5.2 Furthermore, Member decisions about the ASCH Local Care implementation will be informed by the principles outlined in the County Council report titled 'KCC engagement with the Kent and Medway NHS Sustainability and Transformation Plan, 7 December 2017'. Depending on the issue at hand, The General Counsel's legal advice would be sought on necessary matters.

6. Equalities Implications

6.1 All the significant changes will be approached in a manner that respect and adhere to the Council's equalities responsibilities. All appropriate advice will be sought from the Strategy, Policy, Relationships and Corporate Assurance Division. Indeed, the Division has already been engaged for their advice on the initial Equality Impact Assessment

7. Other Corporate Implications

7.1 We can only deliver this ambitious plan with the support of key corporate functions, such as Human Resources, Finance, and Strategic Commissioning.

7.2 The appropriate management oversight and programme board arrangements have been established. These ensure that both ASCH and corporate services can identify issues which impact on respective services to be addressed in the most effective way.

7.3 The assessment of the impact on KCC businesses is an ongoing activity which is kept under regular review.

8. Governance

8.1 The model has been shared with the Council's Corporate Management Team (CMT) and Extended CMT. CMT's endorsement and full engagement with the ASCH Local Care Implementation Plan will continue to be crucial as we move into the phased implementation of the changes.

8.2 We will continue to report to the relevant formal and informal Member meetings regarding decisions about all key changes flowing from the ASCH Local Care Implementation Plan. All such matters will be considered within the framework as set out in the County Council paper of 7 December 2017, included as a background document to this report.

9. Conclusions

9.1 The ASCH Local Care Implementation Plan is a significant change programme providing the Council with a firm foundation for joining up health and social care, in response to the integration agenda.

9.2 There is a strong desire to fast track early of two full blown Local Care pilots. It is expected that the Local Care workshop to take place on 20 March 2018, will give the Council the ideal opportunity to move the system towards a firm decision.

10. Recommendation

10.1 Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the Adult Social Care and Health Local Care Implementation Plan.

11. Background Documents

https://democracy.kent.gov.uk/documents/s81453/STP%20Governance%20Report%20-%20Final.pdf

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High level Summary of internal change work in place to migrate to the new model

As described in section 2.2 of the main report we can summarise all the change activity into the following six headlines:

- **Safeguarding change:** this will improve execution of safeguarding through clearer targeting this skill and specialism;
- **Practice change**: this will enable staff to deliver strengths based social care and support;
- **Structural change:** this will create locality working in multidisciplinary teams to drive population health;
- **Infrastructure change**: this will create new tools and systems for financial and practice management;
- **Commissioning change:** this will create a shift into a blended landscape of outcomes focused provision across the VCSE, Health and commercial sectors;
- **Workforce change:** this will create an improvement in the blend and supply of roles needed for future integrated working.

We describe below the internal activities in place that are building transition into the new model.

High level summary of change activity

Safeguarding	A dedicated safeguarding team will be established to lead the frontline operational practice to prevent and protect adults at risk of abuse and neglect. The team will be responsible for the delivery of the statutory functions of safeguarding and work alongside other teams such as the social work and quality improvement teams in ASCH. The new team will focus exclusively on managing all aspects of active safeguarding enquiries, investigations, and post safeguarding support planning. The operational processes and the management of work flow will be such that the resultant increase in productivity should mean that case management, including safe and timely closure of case will be the norm and avoid drift as it has been common under current practice. The safeguarding team will be led by a single manager countywide; however, the practice will take place at the local level working in partnership with other agencies. The team will spearhead putting Making Safeguarding Personal into practice. The testing of the new safeguarding team commenced 26 February 2018 and it will end on 8 August 2018. The evaluation of the new way of working is planned to take place by 15 August 2018 The team will be expected to carry out the following functions:

	1. Act as a source of advice on safeguarding matters for other professionals and organisations at the local level, placing greater emphasis on prevention. 2. Work with the NHS and Kent Police as statutory bodies with their responsibilities for safeguarding to secure the most effective response in protecting adults at risk of abuse or neglect. 3. Participate in appropriate Local Care multidisciplinary discussions when it concerns a person that the MDT is working to help to keep them safe. 4. Act as the point of contact and advice for care homes, working in concert with the Quality Improvement team.
Practice	Will change the current case management approach to a 'strengths-based' approach that uses the skills and talents of people in their own communities. The culture change required will be led by practice leads to ensure a culture of openness, feedback and challenge that enables progression towards independence. Social care workers need the training, time and mandate to be able to utilise the whole of an individual's resources, and their family's or community's resources, rather than feeling restricted to a narrow range of service responses, this could result in changes to the way cases are managed and impact on future workforce requirements to deliver the new operating model. To support practice change Outcome Focused Practice will also develop new tools; a care and support plans that will recorded individual's current and potential activities, capabilities, support and goals. Providers will be required to provide progress against goal delivery and be performance managed against the contract. Commissioning reports will be in place to inform where goals cannot be set due to provision gaps, allowing the market to be continuously shaped to meet the demand for services. Purchasing reports in place to ensure that commissioned services are being delivered by providers to ensure value for money.
Structural	Adult social care will operate in a minimum of 9 locality teams across the county. It is envisaged that each locality team will be part of the Local Care MDTs as they come on stream. We will start with two pilot sites in East and West / North Kent. The local operational delivery units which will form part of the MDTs is modelled to comprise of:

	• East Kent-13 • West Kent-7 • North Kent-7
Infrastructure	The operational delivery of the new asset based approach relies the right systems and tools to be available. The implementation of the new Mosaic IT system is the critical component. It will enable staff to work more flexibly and efficiently with improved processes and workflow. The management of admission to and discharge from hospital will also benefit. Secondly, other digital developments are currently in design or early implementation phase. These are listed below. Working as part of the MDT and operating from multiple locations will demand a number of things: 1. Single point of access 2. Mobile devices 3. Electronic shared care records/integrated care 4. Self-Care and Asset focused apps 5. Summary care records 6. Virtual MDTs Thirdly, we are completely rebuilding our financial management systems. Bringing together new functions such as Purchasing, along with improvements to the Placements function, and a new dedicated authorisations function. These will be supplemented by a shift towards a single business management oversight of operations; along with new tools to better model and grip spend.
Blended Provision	In order to realise efficiencies and outcome improvements in the new operating model, we will need to see a new blend of provision. This starts with new pathways and provision around a 'universal core offer', including Public Health contribution. This covers both commissioned services such as the new wellbeing and resilience VCSE offer and also, crucially creating pathways into universal services, into arts, parks, libraries and community clubs through **social prescribing** and **care navigation**. This continues with integrating first points of contact – bringing referral paths together and locking in the VCSE early into integrated triage and diversion into universal services. Building on the pilot work already delivered bringing together ICT (Intermediate Care Teams) and KeaH (KCC Enablement service) - we will bring together a blend approaches and provision for short term recovery interventions. KCC, the NHS Community Providers, and Mental Health Provider all provide short term

	recovery. Through better blends of local provision, we will bring costs down and better target support. Moving towards better blends of NHS generic worker, Homecare and Supporting Independence packages (focused on outcomes and recovery) will be a key driver in how we manage the re-let of Homecare / SIS contracts. Accommodation is about to be completely refreshed – with a very different blend of innovative solutions around extra care and partnering – especially with the community hospital bed base. The following eight actions have been agreed to drive this change: Strategic Commissioning Board agreed to the following recommendations in relation to the Older Persons Care Home Market Analysis presented on 14 December: 1. Further spend and unit cost level analytics to identify the financial impact of enabling people to remain within their own home. Measured in terms of the increase in Domiciliary Care and the corresponding reduction in residential placements. 2. Further research to consider the implications of an increase in former self funders (wealth depleters) using the demography data to determine potential pressure areas. 3. Release £1.5m from the new monies budget allocation, for the next two years, into the operational budget to support the increase of placement costs as needs increase. CPT to monitor and track changes in need and impact on placement costs changes. 4. Further work with the market to consider risks and issues; and to determine how KCC's aligned outcomes can be achieved in order to increase local authority capacity and postcode linked surety of supply. 5. Exploration of the opportunities of Extra Care Housing to meet the needs identified including identification of land and potential new entrant provider meetings. 6. Development of Strategic relationship with the Competition and Markets Authority (CMA) to work in partnership with their consumer agenda. 7. Development of a revised Market Position Statement (MSP) and production of a Commissioning Plan for April 2018 to launch the recommissioning of these services for 2020. The MPS will include our short, medium and long

	term approach to the commissioning of these services. 8. Work with the NHS to develop plan for Community Hospitals and workforce integration.
Workforce	The new operational model calls for the retention, recruitment and development of staff with the right skills and capable of working across organisational boundaries and practice from multiple and multiagency locations. It is essential that we develop and promote career progression pathways opportunities across adult social care, health and the wider sector workforce. We will develop a multi-professional workforce, with staff equipped with right mind-set and skills to work with service users and patients. Appropriate support will be provided to staff during the transition to the new organisational arrangements brought about by the new operating model and the refreshed vision and strategy. Also, we are developing and introducing a career pathway and capability development framework for unregistered workers who work directly with service users. Developing the workforce will not be limited to KCC staff alone. Providers delivering home care will sit as part of Local Care cluster/hubs within or supporting the multi-disciplinary team with supporting independence team workers either managing or supporting the providers. As part of the changes we will require the sector to take on evolving role in line with the phased introduction: 1. 1st phase- KCC to hold responsibility to assess, set and review outcomes, monitor progress and co-ordinate required activity. Provider to deliver outcomes-focused care 2. 2nd Phase- KCC to hold responsibility to assess, set and review outcomes and co-ordinate required activity. Provider to deliver and monitor outcomes-focused care 3. 3rd Phase- KCC to hold responsibility to assess, set and review outcomes. Provider to deliver, to monitor and to co-ordinates outcomes-focused care Importantly, this will be underpinned by providing the right support to the care sector workforce (including voluntary sector staff) through introducing a learning and development hub.

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Local Care sits at the heart of care transformation across Kent and Medway

Prevention

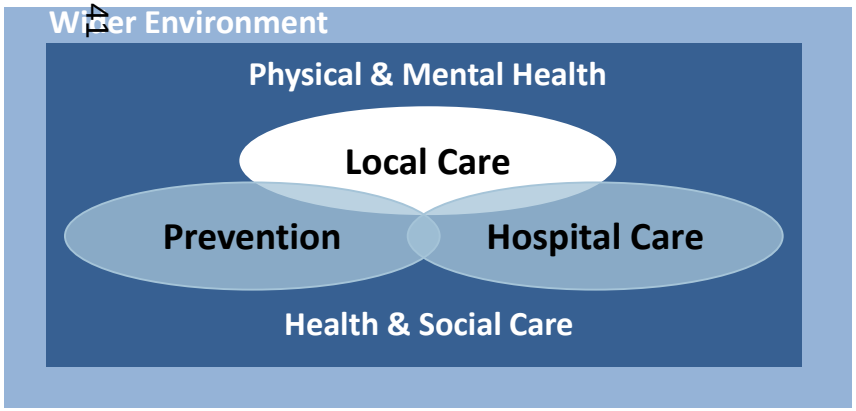
Enlisting public services, employers and the public to support health and wellbeing

Local Care

A new model of care closer to home for integrated primary, acute, community, mental health & social care

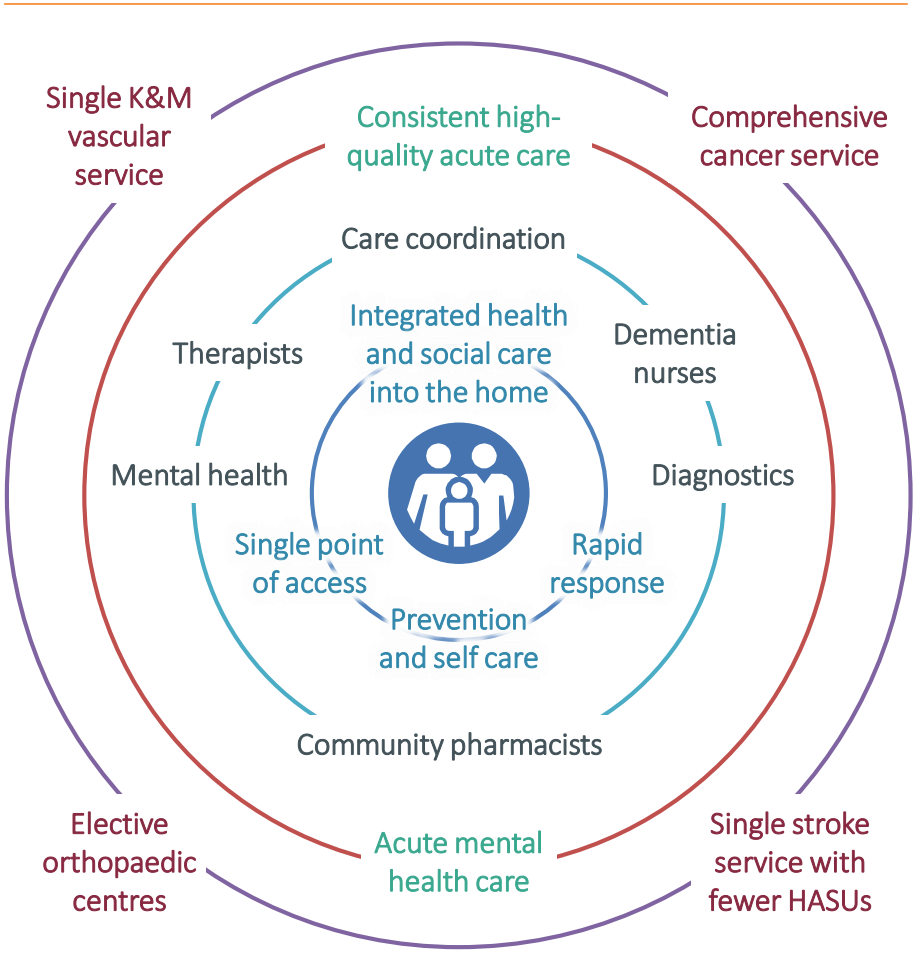
Hospital Care

Optimal capacity and quality of specialised, general acute, community & mental health beds (wave 1 consultation on EK emergency care / elective ortho and K&M stroke services)



Care Integration

Integrating physical and mental health services, integrating health and social care and supporting people to live fuller lives

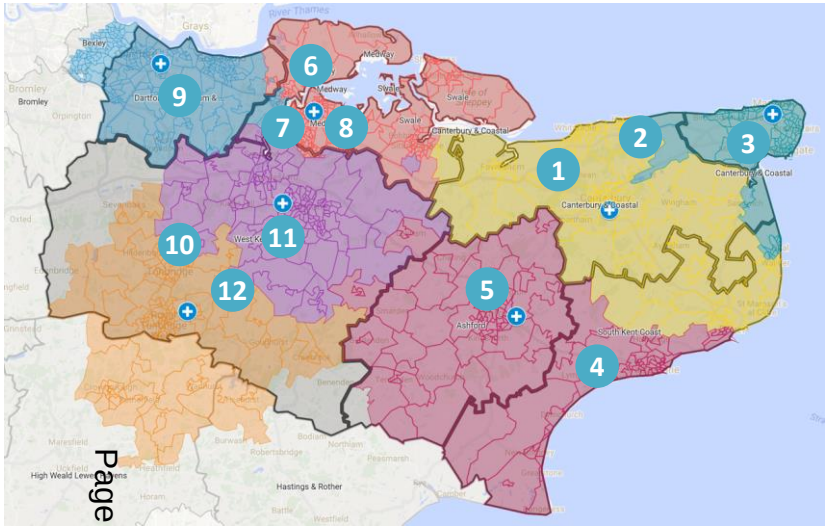


We have agreed that getting this right involves these ingredients

Supporting people to be healthy and independent	1 Care and support planning with care navigation and case management	Care navigators and case managers integrate health and social care service delivery, and work collaboratively with a wide range of community care colleagues, and also the people they care for, in order to coordinate care and support
	2 Self-care and management	Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention and engagement
	3 Healthy living environment	Work to ensure a healthy living environment to preserve long-term health & wellbeing e.g. falls prevention, housing improvements and alterations
Coordinated care for people who need it	4 Integrated health and social care into or coordinated close to the home	Person centered, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have care plans assigned dependent on their needs
	5 Single point of access	A number called by the person, the GP, community services and acute staff to support people with their care by gaining more efficient, coordinated access to services
	6 Rapid Response	The ability within an MDT to respond rapidly to people with complex needs who are experiencing a health or social care need that left unattended would result in a possible hospital admission
	7 Discharge planning and reablement	A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating
Supporting services	8 Access to expert opinion and timely access to diagnostics	The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to diagnostic services and the ability to ensure diagnostic results are full and timely will reduce the need for multiple outpatient appointments

Source: K&M STP Local Care workstream, Carnall Farrar

The strategy for development of Local Care is built on East Kent Models



New Care Model	Population Affected
Encompass MCP	170,000
Herne Bay Local Care	46,000
Thanet IACO	140,000
South Kent Coast IACO	200,000
Ashford Clinical Providers	126,000
Medway (MCP & 2xPACs)	390,000
DGS PACs	249,000
West Kent (MCP & 2xPACS)	466,000

East Kent (emerging ACP)

1. Encompass MCP
2. Herne Bay Local Care
3. Thanet IACO
4. South Kent Coast IACO
5. Ashford Clinical Providers

"Rest of Kent" (emerging ACP)

Medway

6. MCP
7. PACs – Hospital Care
8. PACs - MH

DGS

9. PACs

West Kent

10. MCP
11. PACs – Hospital CAre
12. PACs - MH

Moving towards a single commissioner, and two accountable care partnerships (ACPs)

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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 - 13 March 2018

Subject: **Contract Monitoring Report – NHS Health Checks**

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 NHS Health Check service. This contract was moved to KCC when Public Health transferred in 2013 and forms part of the Public Health Services Partnership Agreement with Kent Community Health NHS Foundation Trust (KCHFT).

KCC has a statutory responsibility to deliver NHS Health Checks which is a nationally mandated cardiovascular screening programme and supports the prevention strand of the Kent Sustainability and Transformation Plan. The programme provides a systematic approach to identifying people with previously undiagnosed high-risk conditions and helps reduce early death, disability and health inequality. It is excepted that 41,600 residents will benefit from a free NHS Health Check this year, with those who are not eligible able to access a free Health MOT. Both provide an opportunity to tackle behavioural risk factors such as drinking, smoking or being inactive and provide a route into local support services or signposting to digital resources.

KCC has effective monitoring arrangements in place to ensure the contract provides value for money, delivers continuous improvement and meets statutory obligations. The service has performed well against a five-year rolling target inviting around 100,000 eligible Kent residents every year. KCC and KCHFT are continuously working to improve efficiency, patient experience and equity in the programme.

Recommendation:

The committee is asked to NOTE the performance of the service and ongoing activities to deliver continuous improvement and CONSIDER taking up the opportunity of a free NHS Health Check.

1. Introduction

1.1 Since 2013, KCC has had statutory obligations, to take steps to improve the health of the people of Kent and deliver a number of mandated programmes including NHS Health Checks.

1.2 This report provides the Committee with an update on the performance, outcomes and value for money of the mandated NHS Health Checks programme. The report aims to complement previous Public Health Performance Reports by providing a more detailed commentary on the programme, and work to deliver service improvements and savings. The core NHS Health Check programme is supported by an outreach programme (Health MOT roadshow), and the One You Kent Service.

2 What is an NHS Health Check?

2.1 The NHS Health Check is a national cardiovascular screening programme for individuals aged between 40 and 74 who have previously not been diagnosed with stroke, kidney disease, heart disease, type 2 diabetes and dementia. Each eligible resident will be invited every five years for this free check and the eligible population in Kent equates to approximately 452,000 people during the period between 2013 to 2018[1].

2.2 The NHS Health Check programme aims are:

- promoting and improving the early identification and management of the individual behavioural and physiological risk factors for cardiovascular disease and the other conditions associated with these risk factors
- supporting individuals to effectively manage and reduce behavioural risks and associated conditions through information, behavioural and evidence based clinical interventions
- helping to reduce inequalities in the distribution and burden of behavioural risks, related conditions and multiple morbidities
- promoting and supporting appropriate operational research and evaluation to optimise programme delivery and impact, nationally and locally [2]

2.3 As people get older, they are at higher risk of developing a number of conditions many of which are preventable with lifestyle changes or clinical intervention. The NHS Health Check plays an important role in the prevention and early detection of these conditions especially cardiovascular disease (CVD) which is one of the main causes of death and disability in the UK and costs the UK billions every year.

3 Why invest

3.1 KCC is required by the Care Act to prevent the escalation of need and has a statutory duty to deliver NHS Health Checks. KCC is required to:

- Offer all eligible residents a free NHS Health Check once in every five years
- Ensure the results are communicated effectively to them

[1] https://www.healthcheck.nhs.uk/commissioners_and_providers/data/south_of_england/south_east/?la=Kent&laid=140

[2] NHS Health Check, Best Practice Guidance, Public Health England (December 2017)

- Record the data from the check and notify the person's GP practice
- Continuously improve the percentage of eligible individuals having an NHS Health Check [3]

3.1 The NHS Health Checks Programme is underpinned by NICE evidence-based recommendations and contributes to KCC's strategic aim to "Improve lives by ensuring every pound spent in Kent is delivering better outcomes for Kent's residents, communities and businesses. More specifically services contribute towards achieving Outcome 2; "Kent Communities feel the benefits of being in work, healthy and enjoying a good quality of life.

3.2 Significant inequalities still exist in Kent with up to a 10 years difference in life expectancy between men living in the richest and poorest wards and rates of CVD three times as high in deprived communities [4]The programme provides a significant opportunity to reduce early death, disability and health inequality by providing a systematic approach to identifying people with previously undiagnosed high-risk condition.

3.3 Around 80% of cases of CVD are caused by modifiable risk factors, such as smoking, obesity, high blood pressure and high cholesterol and the Health Check helps individuals to recognise and tackle these behavioural risk factors. The programme is a key part of the prevention strand of the Kent Sustainability and Transformation Plan.

4. How is it delivered in Kent?

4.1 Health Reform and Public Health Cabinet Committee supported proposals to enter into a Partnership arrangement with Kent Community Health NHS Foundation Trust (KCHFT), who deliver the core NHS Health Check programme. KCHFT oversee deliver of the programme managing arrangements across 180 GP surgeries, 30 Pharmacies, KHCFT/Wellbeing teams and District Councils. KCHFT provides support, training, quality assurance, project management across subcontractors. KCHFT monitors performance and issues payments escalating issues to KCC as required.

4.2 The majority (85%) of Health Checks are conducted in GP surgeries and subcontracted through the core Health Check contract with KCHFT. Surgeries choose from four contract types to meet the resource capacity of local practices and ensure universal coverage.

4.3 Pharmacies and the KCHFT Community Health Check team offer appointments for residents who would prefer not to visit their GP. KCHFT also work with Wellbeing People to take NHS Health Checks to busy town centre locations where there is a high footfall from target groups and supports uptake in people who may not respond their invitation for an NHS Health Check.

[3] NHS Health Check Programme: Health Equity Audit Guidance, Public Health England, December 2016

[4] Fair Society, Healthy Lives: The Marmot Review – Strategic Review of Health Inequalities in England post-2010. UCL Institute of Health Equity. 2010.

4.4 The programme is supported an IT system that links with GP clinical systems to invite patients, capture and feedback results. From the 1st April 2018, KCC will be contracting with Health Diagnostics who offer an efficient end to end solution.

4.5 The NHS Health Check delivery is closely linked with KCC's lifestyle service (One You Kent[5]) with referrals routinely made as part of the NHS Health Check. This aims to support people quit smoking, lose weight, be more active or address underlying issues preventing lifestyle change such as debt or housing.

4.6 The vision for the current contract is to; "provide a high quality and equitable programme with improved accessibility and choice, to help increase uptake of NHS Health Checks and improved outcomes for Kent residents".

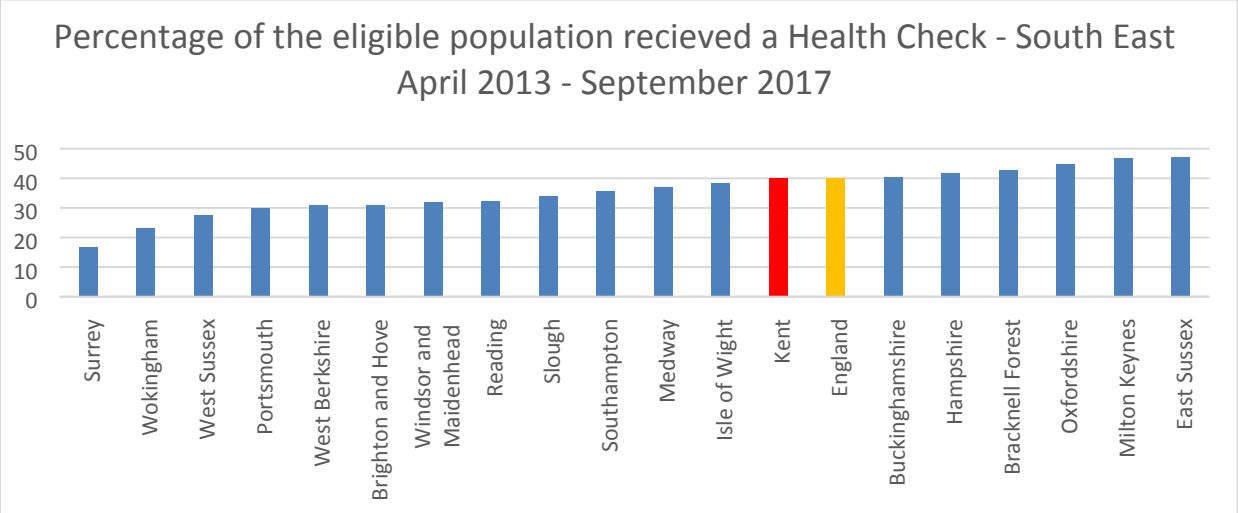
5. What does good look like and how does Kent perform?

5.1 The service specification sets out the outcomes, standards and key performance indicators (KPIs) that need to be delivered to meet the population needs. This is monitored by the Public Health team on a monthly and quarterly basis to provide assurance that the contract is performing well, and quality standards are met.

5.2 The key success factors for NHS Health Checks are to:

- **Invite the eligible population** - To date, 477,000 invitations have been sent[6] which is above the eligible population PHE estimated (452,000) for the five-year period from 2013 to 2018.

Chart 1: Update of NHS Health Checks in the South East

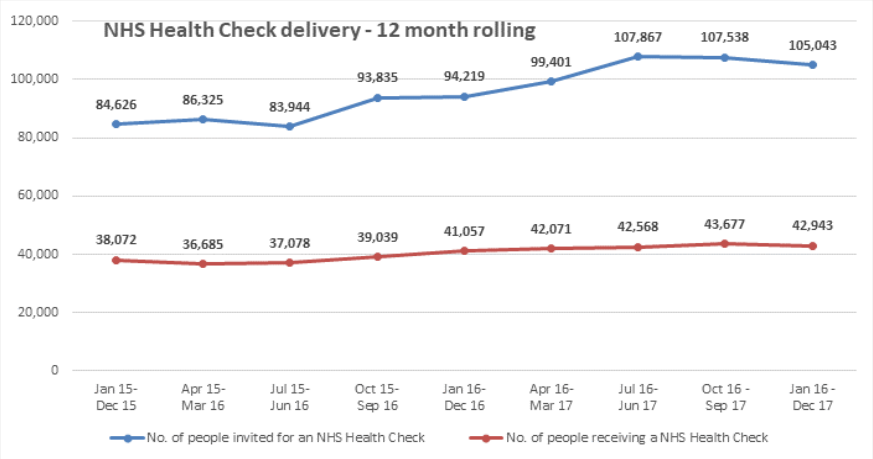


- **Demonstrate continuous improvement in the uptake of NHS Health Checks** - Between April 2013 to September 2017, 40% of the eligible population have

[5] https://www.kent.gov.uk/social-care-and-health/health/one-you-kent
[6] Health Check Target Tracker

received an NHS Health Check. This equates to over 180,000 checks and is representative of the average for England.

Chart 2: NHS Health Check performance since January 2015



- **Deliver an equitable programme –** In 2017, the Public Health Observatory published a report exploring equity differences in the uptake of NHS Health Checks across Kent[7] Findings showed that older people, men and those from less affluent groups (based on Acorn segmentation a tool) were proportionately less likely to have a Health Check. This analysis has been used to formulate an action plan and supports ongoing investment in the outreach programme which delivers 50% of NHS Health Checks to residents living in the most deprived quintiles of the population. (see appendix 3 for more information).
- **Ensure patients are satisfied with the service they receive –** Average satisfaction rates across the year illustrate that 96.1% of those surveyed were happy with the service against a target of 90 %.

6. Outcomes

- **Estimated benefits from national studies** - It is estimated that between 2013 and 2018, 13,310 people would be diagnosed with hypertension following an NHS Health Check in Kent and Medway. During the same period some 5,860 people at high risk of CVD would be prescribed an antihypertensive following an NHS Health Check[8]. The NHS Health Check is an enabler to other services leading to diagnosis, treatment and estimated savings are shown in appendix 1
- **Case studies -** The impact of these services can be illustrated by using case studies and an example can be found in appendix 4. Stephen was diagnosed with diabetes following his NHS Health Check which led to him being put on statins and making changes to his lifestyle to manage his condition
- **Use of the Kent Integrated data set** - The Health Equity Audit established parameters for accessing person level data via the Kent Integrated set. KCC will follow the cohort who attended a Health Check and explore their health outcomes compared to those who did not attend a Health Check. Many outcomes will not be instant, but this study will explore the number of people who

[7] Health Checks Equity Audit, Kent Public Health Observatory, June 2017, https://www.kpho.org.uk/__data/assets/pdf_file/0007/71638/Kent-Health-Checks-Equity-Audit_Final-Report-2017.pdf

[8] Combating CVD through the NHS Health Check programme, Public Health England, https://www.healthcheck.nhs.uk/commissioners_and_providers/data/size_of_the_prize_reducing_heart_attacks_and_strokes/ Accessed: 12th February 2018

went on to a clinical or lifestyle pathway or did not end up with a medical condition like CVD.

- **Improved systems to track outcomes** – The new IT system has outcome reports which will enable better tracking of health outcomes as result of an NHS Health Check such as the number of people who were prescribed statins

7. Service Costs

7.1 The total budget for 2018/19 is £1,982,638. The majority of this funding (£1,271,240) is an activity based budget which offers KCC excellent value for money by only paying for work carried out. This includes a payment to GP's of 50p for inviting patients and payments of between £15.00 and £23.70 for carrying out an NHS Health Check. The remaining funding covers equipment, staff costs, training, project management, quality processes overheads, IT and a targeted outreach programme.

7.2 This equates to an average cost of £47.66 per NHS Health Check carried out based on this year's activity, which is expected to be 41,600 checks.

7.3 KCC and KCHFT are continuing to work together to see how further efficiencies can be delivered including the roll out of a new system. This takes effect on the 1st April 2018 and includes a centralised invitation process reducing the administrative burden on primary care. It also offers opportunity to pilot the use of text messaging.

8. Delivering ongoing service improvements

8.1 Continuous improvement is an important component of the NHS Health Check programme and KCC and KCHFT are constantly working together to improve services for residents. This has included:

- **Launch of an NHS Health Check App** - this allows residents to view their results on their mobile phone and see how lifestyle changes affect their heart age score
- **E-learning module for practitioners** - to improve service quality and patient experience
- **Roll out of a new IT system** – offering a range benefits including; interactive tools and visual to improve engagement for both staff and patients. Streamlined administrative processes, increased functionality for performance and finance reporting, offline functionality, compatibility with STP digital developments and compliance with GDPR.
- **Increased patient choice -** The use of pharmacies has increased choice and out of hours availability for people to attend their check.

9. Risks

9.1 The biggest risk is a lack of GP engagement and there are only five surgeries in Kent not engaged in the programme. KCC works closely with the Local Medical Committee and runs a clinical engagement network with GP's to support continued support form primary care. KCC has also worked with NHS Digital to ensure patients from these five surgeries can still be invited, but this is not the most efficient method.

9.2 With any activity based contract there is a level of uncertainty in financial costs. This is managed through regular financial forecasting and tracking based on service trends and capacity. The new IT system will automate this process reducing staff time in both KCC and KCHFT.

9.3 Poor quality of delivery is a risk to KCC and Kent residents. To mitigate this KCC requires information on a quarterly basis from KCHFT to offer assurance that standards are being met. This includes information on customer experience, mandatory training, and maintenance of equipment and confirmation that point of care testing has been carried.

10. Conclusions and future considerations for this contract

10.1 KCC and KCHFT have worked effectively to drive coverage and improve uptake over the five-year cycle. Kent has performed well against the 5 year target and a key focus for this contract for next year is to improve equity of the programme for those groups identified by the equity audit.

10.2 NHS Health Checks is linked to a number of other workstreams and exploring opportunities for integration and efficiency for the programme would support the aspirations sets out in the STP. The cost implications of this must considered so that KCC does not incur additional costs at a time of reducing budgets. Work to measure the outcomes of the programme in Kent would support an invest to save approach.

10.3 NHS Health Checks are a key tool supporting the Kent population to live longer in better health and KCC will continue to work with KCHFT to deliver service improvements and efficiencies.

10.4 Members who are interested in having an NHS Health Check can take up this opportunity by contacting KCHFT on 0300 123 1220 or kcht.hicentraladmin@nhs.net.

Recommendation:

The committee is asked to NOTE the performance of the service and ongoing activities to deliver continuous improvement and CONSIDER taking up the opportunity of a free NHS Health Check

Background documents: none

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Appendix 1: Kent and Medway Size of the Prize

Combating CVD through the NHS Health Check programme

Kent and Medway

Public Health England

NHS England

What the evidence tells us

One in ten people continue to live with CVD[1]. It is the second biggest cause of death in England with 200 people dying each day from a heart attack or stroke.[2] Every day there are over 1200 admissions to accident and emergency because of heart problems[3] and 290 as a result of cerebrovascular problems.

What is the NHS Health Check programme?

The NHS Health Check is a national programme that systematically measures a range of risk factors driving the burden of CVD and other non-communicable diseases such as dementia, respiratory disease and some cancers.

Improving CVD outcomes

National research shows that the programme is cost effective, can prevent illness and has the potential to save 250 – 500 lives each year across England.[4,5] It also shows that there is equitable take up of checks among high CVD risk groups and prioritising these groups is cost effective.[6]

1. Current activity, 2013 – 2018[7,*]

Number of people invited for an NHS Health Check	451,339
Number of people who have had an NHS Health Check	185,117
Number of people still to benefit from an NHS Health Check	343,690

2. Disease detection, 2013 – 2018[8,*,]**

Hypertension	Estimated number of people that could be diagnosed with hypertension following a NHS Health Check	13,310
CVD risk	Estimated number of people that could be identified with a CVD risk score >20% following an NHS Health Check	66,570

3. Medication, 2013 – 2018[8,*,]**

Estimated number of people at high risk of CVD that could be prescribed a statin following an NHS Health Check	12,850
Estimated number of people at high risk of CVD that could be prescribed an antihypertensive following an NHS Health Check	5,860

Footnotes:
1 www.bhf.org.uk/health-care-professionals/bp-how-can-we-do-better
2 Office for national statistics. Death registrations summary tables – England and Wales, 2015
3 NHS Digital. Accident and emergency attendances in England 2014-15
4 http://dx.doi.org/10.1136/bmjopen-2015-008840
5 http://dx.doi.org/10.1016/j.ypmed.2015.05.22
6 For more information on activity go to www.healthchecks.nhs.uk
7 Disease rates calculated using the findings from www.healthcheck.nhs.uk/document.php?o=1251
8 Medication rates calculated using the findings from www.healthcheck.nhs.uk/document.php?o=1251
* Data in tables 1, 2 and 3 is based on the sum of local authority activity for the STP footprint
** Data in tables 2 and 3 is calculated using a take-up rate of 75%

The Size of the Prize in Cardiovascular Disease (CVD) Prevention

Kent and Medway

Public Health England

NHS England

1. The diagnosis and treatment gap, 2015/16

Hypertension	Estimated adult population with hypertension	448,300
	Estimated adult population with undiagnosed hypertension	181,500
	GP registered hypertensives not treated to 150/90 mmHg target	55,300
Atrial Fibrillation (AF)	GP registered population with Atrial Fibrillation (AF)	36,000
	Estimated GP registered population with undiagnosed AF	12,200
	GP registered high risk AF patients (CHA2DS2VASc >=2) not anticoagulated	5,900
CVD risk	Estimated adult population 30 to 85 years with 10 year CVD risk >20%	131,200
	Estimated percentage of people with CVD risk ≥20% treated with statins	49%

2. The burden: first ever CVD events, 2015/16

Coronary Heart Disease	4,250
Stroke	2,200
Heart Failure	1,450

3. The opportunity: potential events averted and savings over 3 years by optimising treatment in AF and hypertension, 2015/16

Optimal anti-hypertensive treatment of diagnosed hypertensives averts within 3 years:	330 heart attacks	Up to £2.50 million saved[2]
	500 strokes	Up to £7.10 million saved[1]
Optimally treating high risk AF patients averts within 3 years:	470 strokes	Up to £8.20 million saved[1]

What the evidence tells us

- Reducing blood pressure in all adults with diagnosed and undiagnosed hypertension by 5 mmHg: **reduces risk of CVD events by 10%**
- Statin therapy to reduce cholesterol by 1 mmol in people with a 10 year risk of CVD risk greater than 10%: **reduces risk of CVD events by 20-24%**
- Anti-coagulation of high risk AF patients: **averts one stroke in every 25 treated**

CVD: high risk conditions

High risk conditions like high blood pressure, atrial fibrillation and high cholesterol are major causes of heart attack and stroke (CVD events). In the high risk conditions preventive treatment is very effective, but late diagnosis and under-treatment is common.

Improving outcomes in CVD: case study

In Bradford Districts Clinical Commissioning Group: Over 24 months, more than 21,000 people had an intervention in lipid management, anti-coagulation or antihypertensive treatment to improve their health. Resulting in 137 fewer heart attacks and 74 fewer strokes compared to baseline.

Footnotes:
1 Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis. Technical report
2 Kent, M (2012). Chronic Kidney disease in England: The human and financial cost
Potential events calculated with NNT (theNNT.com). For blood pressure, anti-hypertensive medicines for five years to prevent death, heart attacks, and strokes: 1 in 100 for heart attack, 1 in 67 for stroke. For AF, warfarin over 1.5 years : 1 in 25 for stroke. Numbers may be lower, as some patients may be on prior treatment.

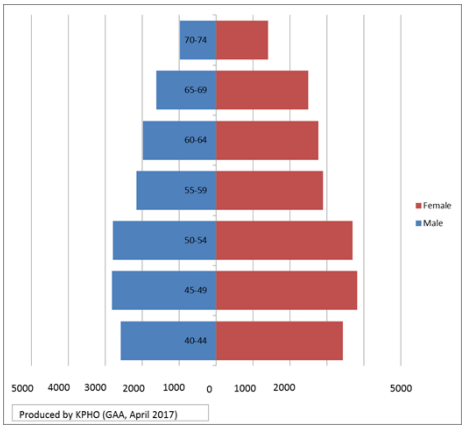
References:
Hypertension and AF populations and treatment estimates: QOF 2015/16.
CVD high risk estimate numbers: http://www.bmj.com/content/346/bmj.e8181.
CVD high risk statin treatment: http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002169

Appendix 2: Contracting arrangements

Contract	Provider	Arrangements
Core NHS Health Check Programme	Kent Community Health Foundation Trust	Managed by KCC via the Public Health (Prevention and Local Care) Partnership KCHFT provide Health Checks in the community and sub-contract with GP practices and pharmacies to deliver Health Checks
Targeted Outreach programme	Wellbeing people	Currently managed by KCC but will be managed by KCHFT as part of the Public Health Partnership from 1st April 2018
NHS Health Check System	Informatica – until 31st March 2018 only Health Diagnostics	A new improved system has been procured and will replace Informatica on 1st April 2018

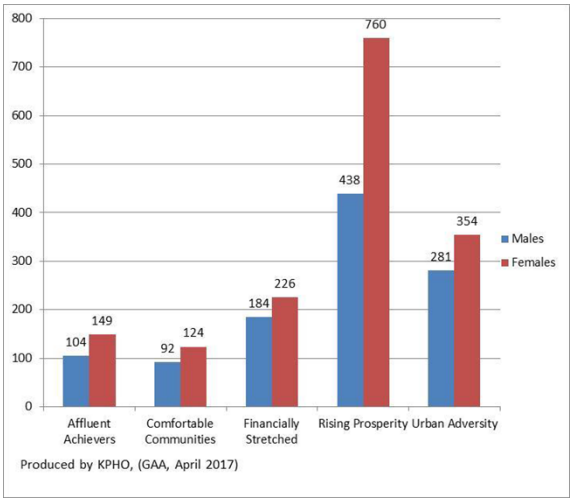
Appendix 3: Findings from the NHS Health Check Equity Audit

- The ratio of males completing a Health Check compared to females is 1 to 1.4. In other words, for everyone male completing a Health Check, 1.4 (95% CI 1.32 - 1.44) females completed a Health Check. This represents a 40% equity deficit with respect to males.



- The ratio of male to female inequity increases with age, with males becoming increasingly less likely to attend as they get older. For example, in the 65-69 age group, when female completion rates are compared with male completion rates, the equity deficit for males rises to over 50%.

- Patients in the White ethnic group were proportionately more likely than all other ethnic groups to complete their Health Check, whereas the Mixed/Multiple ethnic group were most likely not to complete their Health Check.



- Equity comparisons using the ACORN Wellbeing types showed that patients categorised as ‘Anxious Adversity’, ‘Poorly Pensioners’, Hardship Heartland’, ’Perilous Futures’ and ‘Struggling Smokers’ were significantly less likely to complete their Health Check when compared to higher wellbeing types

Appendix 4: Stephen's story – 'I didn't know I had Diabetes until I had my NHS Health Check'

My name is Stephen, I am 40 years old and I live in Maidstone. A few weeks ago, I received a letter inviting me for my NHS Health Check appointment. I had never had a Health Check before, so I thought why not to take this opportunity. Even though I didn't often see my GP because I felt healthy, I decided to call the number and book an appointment.

My NHS Health Check went well. My Cholesterol was little bit high, and so was my BMI but my blood pressure was fine. Health Check Advisor Rafal asked me some lifestyle questions.

We had a chat about my diet and physical activity. Rafal gave me some advice on healthier food options and on ways I could increase my physical activity.

He asked me how I felt about my BMI and my current weight, but I felt fine - I didn't feel like my weight was an issue.

I was referred to my GP for another fasting cholesterol test and, because my BMI was a bit high, for a diabetes test.

I decided to book an appointment with my GP as soon as I could.

My diabetes test revealed that my blood sugar levels were high. I was told by my GP that I had type 2 diabetes and I was prescribed Metformin to control my blood sugar levels. I was also put on statins to lower my cholesterol.

Since then I have been trying to keep my sugar levels under control by improving my diet and making healthier food choices. I've also become more active and I even lost some weight.

I had a phone call from Rafal few weeks later, he wanted to know how I was doing and he was pleased to hear that I was doing fine. I also have another follow up appointment with my GP in October.

I still wonder sometimes what would have happened if I hadn't had my NHS Health Check or how I would have found out that I had diabetes?! I would probably have collapsed somewhere one day, and someone would have called an ambulance and a blood test would have revealed that I had Diabetes.

I am really grateful that I had my appointment, and I found out that I had diabetes before this happened. It's definitely for me to have found out sooner rather than later.

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 - 13 March 2018

Subject: **Public Health Communications and Campaigns 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 the recent campaigns delivered through the KCC public health team.

Delivering effective campaigns and communication to the residents of Kent is one of the key priorities agreed for public health this year, with the core aim of driving behaviour change particularly in the communities with the highest need.

The approach that Public Health is developing and embedding 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 comment on the progress and impact of Public Health campaigns in 2017/18.

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

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

1.3 During 2017/18 the KCC Public Health department delivered a series of campaigns aimed at increasing awareness of public health issues, and directing people to sources of support

1.4 The Public Health department have recognised that there is a great opportunity for further development in this area, particularly through working with local partners and the following was one of the Division's strategic priorities for action in 2017/18.

> "Ensuring a coordinated and effective programme of Health Improvement Campaigns across the health and care sector, delivering consistent health improvement messages to the public. Raising awareness of key public health challenges both through proactive public relations and through a series of campaigns, with the aim of educating and supporting people to take more responsibility for their own health and wellbeing."

1.5 This paper will cover some of the recent campaigns, the coverage received and the evidence of impact, before looking at the key developments planned in the coming year.

2 Campaigns in 2017/18

2.1 When developing campaigns it is key to identify the problem, understand the behaviour change needed, the core audience to be reached and what drives their behaviour, and the best messages and channels that can be used to get the message across most effectively.

2.2 Wherever possible, national campaigns are supported, and their reach extended where needed, rather than trying to create something new, and therefore competing against national campaigns and brands such as Change 4 Life. The Public Health team work with partners, and our suppliers, wherever possible to ensure a co-ordinated approach to communicating messages to the public.

2.3 During 2017/18 a series of campaigns have been delivered, alongside targeted press releases that resulted in increased awareness of the role of KCC in delivering public health interventions, and the options available to improve their healthy behaviours.

2.4 The key campaigns delivered during the year were:

- Know Your Score – Alcohol Awareness
- Release the Pressure – Suicide Prevention

- Change 4 Life
- One You Kent
- What the Bump - smoking in pregnancy pilot on Sheppey
- Sexual Health – STI awareness

These campaigns (apart from What the Bump) are covered in more detail in appendices 1-5 of this document.

2.6 KCC Public Health campaign team have developed a strong reputation over the past year, and this success has been recognised in a number of ways, including:

- Change 4 Life work being selected by PHE as a case study for other local authorities to learn from
- Being asked to present to the PHE Marketing department on our work
- Being approached by other local authorities about licensing our campaigns in their areas

3 Headline results for 2017/18

One You

3.1 The One You Kent campaign has continued to deliver strong results, with over 110,000 visits to One You Kent since 1st April, and over 35,000 Kent residents taking the How Are You quiz.

3.2 The sign up rate for national One You support in Kent is 16.5 residents per thousand, compared to 9.4 per thousand England average rate (a 72% higher rate).

3.3 Over 130 people from public sector organisations across Kent have registered to attend the stakeholder event on 14th March to learn how they can promote One You to the people they work with.

Know Your Score

3.4 Over 38,000 people have visited the alcohol pages on kent.gov, with 20,313 of them taking the Know Your Score test (online version of Audit-C), and receiving advice on their drinking levels.

Release the Pressure

3.5 Introduction of an always on presence so that anyone searching high risk terms such as “I want to die”, “How to commit suicide” will be shown the Release The Pressure advert. Analysis of data shows that Monday mornings between 9-12 is the time when these searches are at their highest

Change 4 Life

3.6 Close working with Children’s Centres to produce an events kit and conversation tips for each centre, to enable frontline workings to talk to their communities about nutrition and exercise in fun, engaging ways.

3.7 Over 18,000 visits to the Change 4 Life pages

What the Bump

3.8 Since September, 84 pregnant smokers in Swale have sought to give up due to the What the Bump project (for context in 2016 there were 290 pregnant smokers in Swale). The project has attracted additional funding from Swale CCG.

Sexual Health

3.9 The STI campaign has led to a 55% increase in traffic to sexual health pages since 1st January, with 5,000 extra visits to the condom pages in seven weeks.

Financial Implications

4.1 The budget for campaigns and communications is £500,000 for this financial year.

4 Conclusion

4.1 Well planned, targeted campaigns can have a positive impact on people's behaviour. The campaigns that KCC Public Health have undertaken during 2017/18, as well as delivering strong results, have also provided excellent learning on the best methods to target groups, and on the benefits of utilising social media.

4.2 However, it is important to recognise that long term change requires long term, consistent messaging, and it will be important to work ever closer with local partners and to provide them with the leadership and resources to support strong social marketing in their area.

5 Recommendation

The Health Reform and Public Health Cabinet Committee is asked to comment on the progress and impact of Public Health campaigns in 2017/18

Background Documents
None

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Know Your Score – Alcohol Awareness Campaign

2017/18 Campaign

1. In 2017/18 activity to promote completion of the Know You Score Quiz focused on two key seasonal periods within the year;

   Burst 1. Alcohol Awareness Week (November 2017)

   Burst 2. Festive Drinking / Dry January (January 2018)

Where possible advertising was tailored to target residents by behaviour, for example;

- Those who stop at the pub before their train commute home
- Typically drink after a stressful workday
- Use alcohol to relax in the evening after they put their children to bed

Further, by gender and by individual motivations to reduce the amount of alcohol consumed, such as those wanting to live a healthier lifestyle.

The learnings from the initial campaign in 2016/17, and reliance on digital marketing techniques (primarily social media), have allowed us to deliver a much stronger campaign in 2017/18.

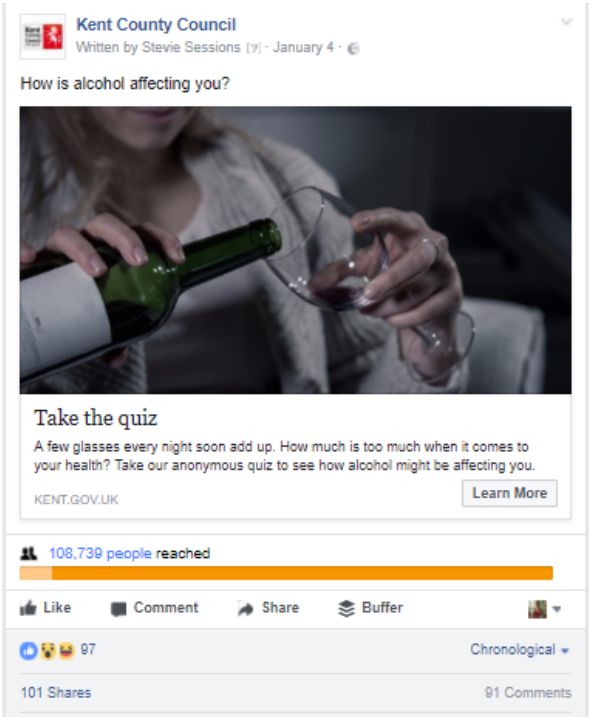
A combination of tactics were implemented for both Burst 1 & 2, including;

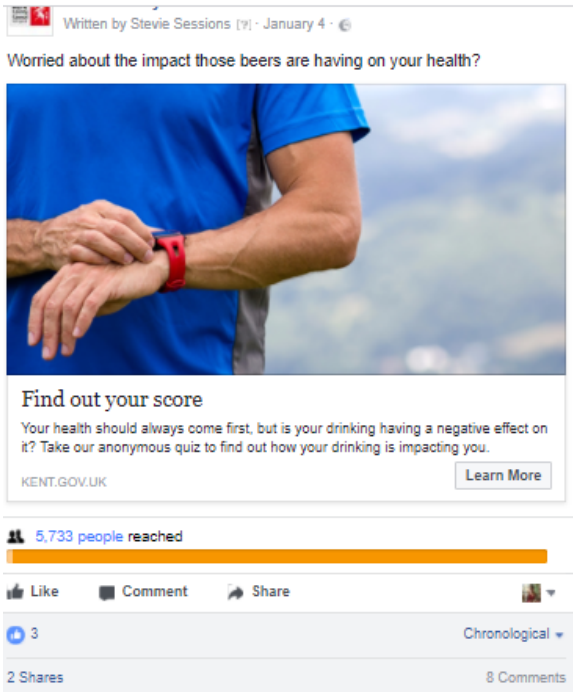
1. **Digital Display Banner Ads** – using the same artwork developed by Zest agency for 16/17 campaign.

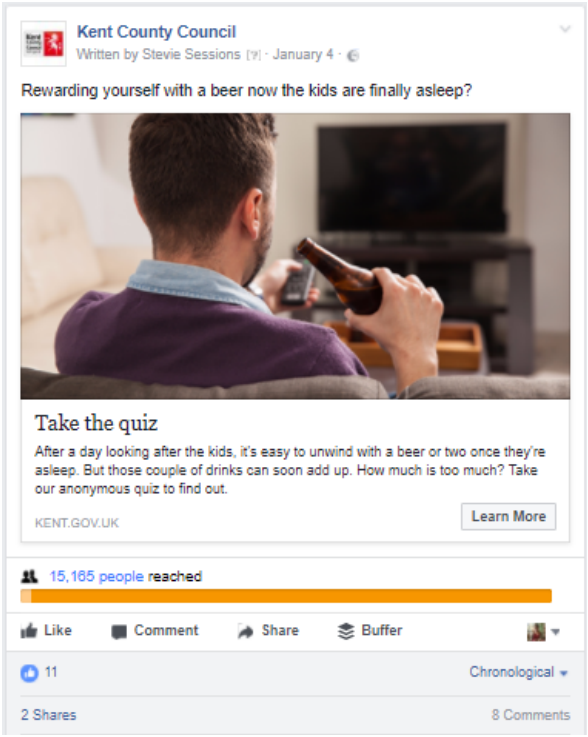
2. **Sponsored Articles in the KM** (supported by features in KM e-Newsletters)

KM articles were viewed a total of 3,603 times.

3.Facebook Ads







Facebook Ads typically generated a high engagement rate, with the female population typically 'tagging' their peers in the post to share the quiz amongst their network. The ads were low cost at an average Cost per Click (CPC) of £0.22.

4.Twitter Ads

Twitter Ads ran during Burst 2 and received a very high click through rate with a low cost per click at £0.09.

5.Google AdWords

The above activity was supported by Google AdWords Search advertising to ensure an always-on presence in search engines when residents searched phrases such as, “alcohol help”, “am I an alcoholic” or “limit drinking”.

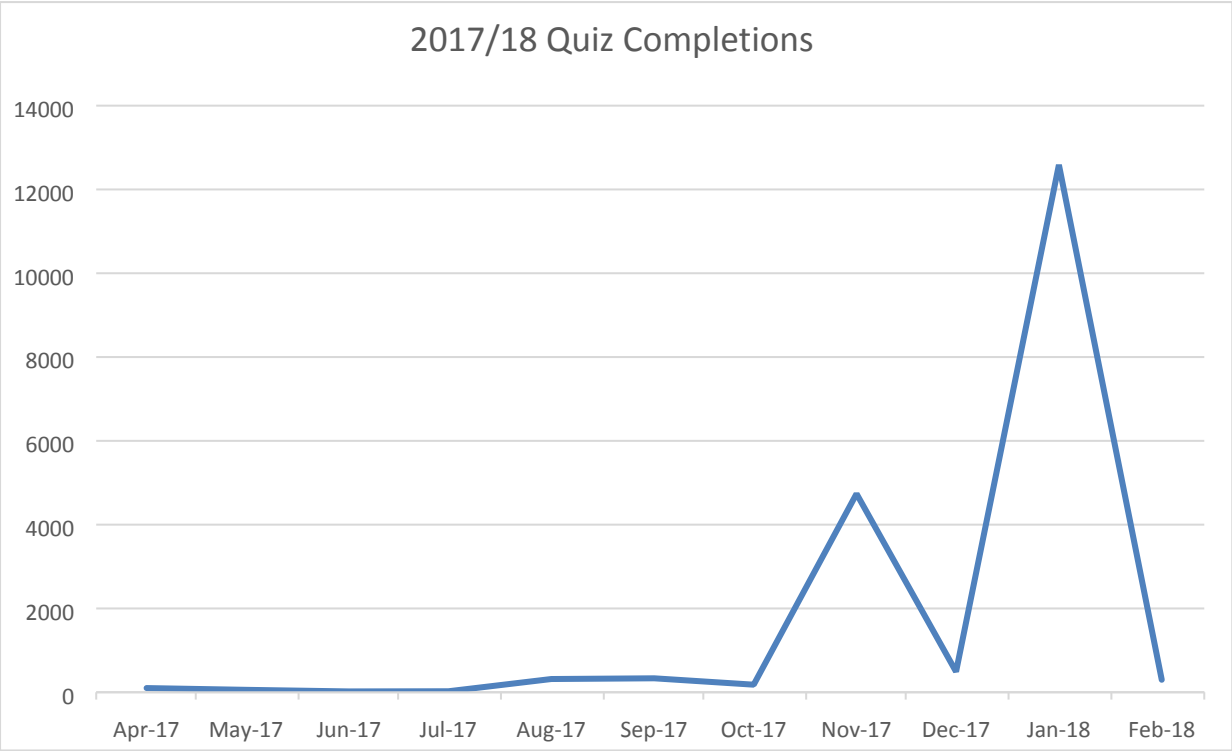
To date over 6,000 people have visited the webpage via a targeted search ad.

Example of the best performing ad.

Evaluation

	Total Sessions	Quiz Completions	Completion rate (%)
2016/17	44,601	15,506	34.8%
2017/18*	38,027	20,313	53.4%

**All figures correct at time of writing (12/02/18)*



	Total sessions - media referral				
Date	**Direct** (direct or unknown)	**Organic search**	**Social Media**	**Referral** (other websites and display ads)	**Paid Search**
Apr-17	87	80	126	7	0
May-17	21	26	16	44	0
Jun-17	10	17	6	22	0
Jul-17	13	14	6	19	0
Aug-17	25	13	358	9	9
Sep-17	12	95	172	5	179
Oct-17	22	162	48	6	2
Nov-17	917	174	4244	1096	1707
Dec-17	101	40	26	20	1378
Jan-18	2367	106	17684	611	2144
Feb-18	37	14	56	60	558

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Release the Pressure -suicide prevention campaign

1. 2017/18 Campaign details

Five bursts of activity were planned for 2017/18;

- **April 2017:** second wave of advertising started in March 2017 by Zest agency.
- **October 2017:** to support World Mental Health Day.
- **November 2017:** to coincide with Movember, Alcohol Awareness Week and International Men's Day.
- **December 2017 – January 2018:** to raise awareness of service during period of Christmas and new year's stress.
- **Late Feb – Early March:** awareness to stay top of mind.

2. 2017/18 Campaign Delivery

In 2017/18, the campaign was promoted across Kent, focusing on the high-risk groups (i.e. construction and transport trades), using a range of media to target at locations and situations where the men from these industries would have would have the greatest opportunity to see them;

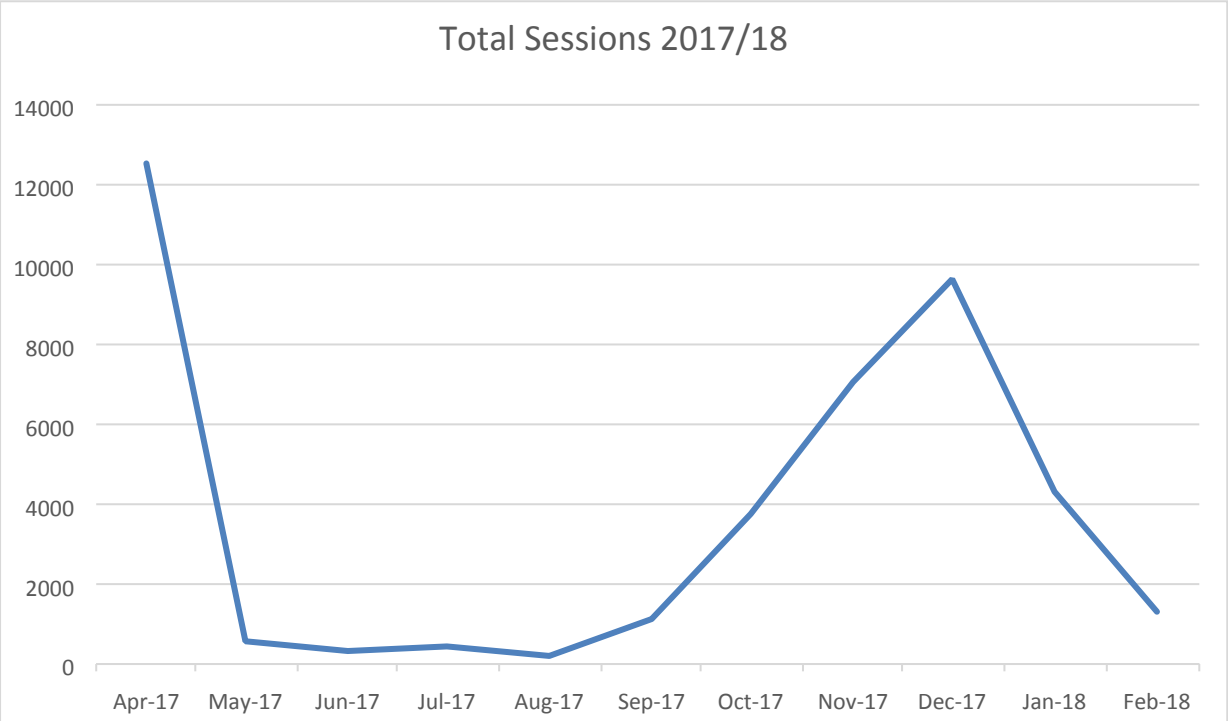
- Online advertising (Digital Banners, Facebook Ads & Twitter Ads)
- Mobile Advertising (Digital Alerts)
- TV (via Sky Adsmart)
- Radio (Heart & Smooth) and Digital Radio
- Washroom panels in male service station restrooms
- Supported by Google AdWords Search to ensure an always-on presence reaching those searching high-risk trigger words in Google, such as; "suicide" and "I want to die" .

All media used artwork created during previous year's campaign, with the CTA to visit the website or call the freephone number.

A web page releasethepressure.uk provides more details and case studies of men whose lives have been turned around after they decided to talk about their problems

3. Evaluation

3.1 The impact of the 2017 campaign (which started in March) can be seen by this graph which shows the increase in weekly visits to the campaign website

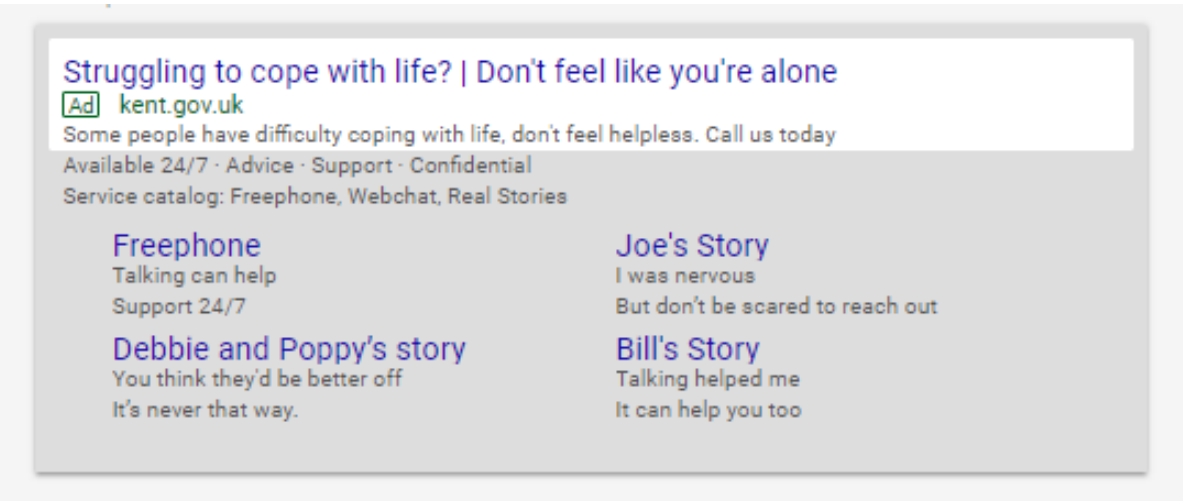


	Total Sessions	% new visitors	% increase in sessions YOY
2016/17	19,170	71%	
2017/18*	40,735	73.5%	112%

**All figures correct at time of writing (12/02/18)*

Results still being corroborated likely to exceed 4 million impressions across Kent.

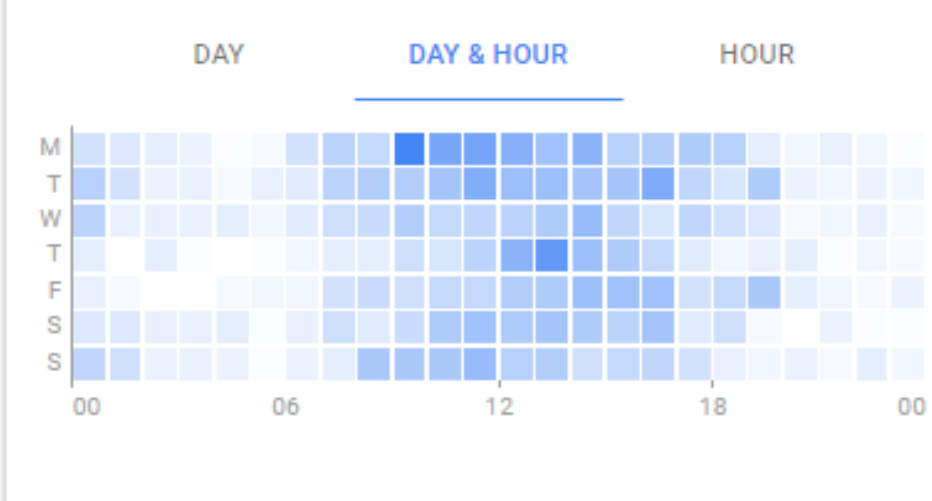
AdWords Search has been very important throughout the campaign to ensure an always on presence. Through key learnings and careful optimisation, we are consistently reaching a higher number of individuals finding the website when searching high risk keywords. For example, in November 2017 5% of clicks were from high risk keywords compared to 10% in February 2017.



These are the high risk keywords which have been clicked on the most

- Suicide
- Help me I feel suicidal
- I want to die
- How to commit suicide
- Help for suicidal
- Suicidal thoughts
- “suicidal”
- How to cope with suicidal feeling
- suicidal help lines
- Free suicidal help

This chart shows the times of day when most searches for high risk words were carried out:



The level of callers prior to the campaign beginning, and following the first year of the campaign can be seen in the chart below:

	Men	Women	Total
Total calls since in 12 months since campaign started in March 16	6577	12668	19245
Monthly average pre launch Mar15 - Feb 16	311	859	1172
Monthly average Mar16-Feb 17	548	1055	1605
%Increase in monthly numbers	76%	23%	37%

This increase in callers has been sustained over the current period of the campaign (until last report in mid-December)

gender	year_month	Total	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12
Total		**14884**	**1777**	**1717**	**1606**	**1729**	**1684**	**1969**	**1865**	**1766**	**771**
Not Specified		**1048**	135	120	88	131	134	125	146	115	54
Transgender		**6**	-	-	1	-	-	2	2	1	-
Male		**4788**	594	636	528	533	589	616	539	545	208
Female		**9040**	1046	961	989	1065	961	1226	1178	1105	509
Transsexual		**2**	2	-	-	-	-	-	-	-	-

The MHM helpline number is 0800 107 0160, the Release the Pressure web address is releasethepressure.uk

Change 4 Life

2017/18 Activity

1. Kent County Council Campaign Extension

1.1 The Campaign has three elements:

1. Traditional promotion to the public through various key locations (GPs, Children's centres, pharmacists) as well as online advertising (predominantly Facebook). In conjunction with developing content on the website that contains resources for parents and simple tips and tools – then onward referral to national resources (apps etc)

2. Support for frontline workers through amending resources, developing tools to aid good conversations, simple materials that help with onward referral, tools that can be used in Children's Centres – these are currently be distributed to 84 Children's Centres.

3. Support for wider system to ensure consistent messaging – campaign guides, standard articles, tweets, empty belly posters – these can be downloaded at www.kent.gov.uk/change4liferesources

Promotion to the public

2.1 To deliver the first element of the campaign calendar-relevant digital advertising campaigns were developed. These campaigns were low budget, each delivering simple, single messages about nutrition or activity on Facebook, local websites such as Kent Online.

2.2 A dedicated 'Change4Life Kent' Facebook page was created to build a community within Kent. This allows for additional opportunities for engagement with our residents away from the KCC corporate page.

2.3 Each campaign was designed to nudge the audience towards a specific positive behaviour and to help keep Kent County Council and Change4Life top of mind as a source of support.

2.4 Sticking to a formula of 'supportive, fun and one small change' the key message in each campaign has been adapted to be relevant to the specific time of year and to suggest a behaviour that might be likely and easy to adopt.

2.5 Campaigns have directed viewers either to ideas for physical activity and healthy eating at the Council's Change4Life homepage or to a specific resource or webpage linking directly with the campaign.

- **Summer 2017**
  Kent Families content - a series of short videos that feature three Kent families trying out some of the resources to help them move more, or eat more healthily. The videos are narrated by a Dr Sahota a Gravesend GP who describes the benefits that small changes can make.

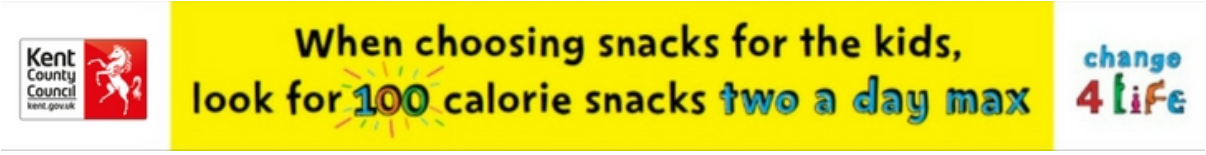
- **Autumn/Back to School 2017 – 'Healthier Packed Lunch Ideas'**

- **December 2017 – Advent countdown**
  - **S**haring a different activity or recipe every day during advent on the new Change4Life Kent Facebook Page.

- **January 2018 – 'Top tips for a Fitter 2018'**
  - Sponsored article, supported by Digital banners, on KM Online
  - Content also hosted on kent.gov, promoted with Facebook ads (to parents with children 0-12 years) generating 275,000 impressions and over 4,000 website visits.

- **February 2018 – '100 Calorie Snacks, Two Max'**

- Supporting launch of national nutrition campaign, focused on healthier 100 calorie snacks, with snack examples for parents.
- Primarily promoted via Facebook Ads and Digital Display Ads, generating 4,500 visits to content on kent.gov.



- **March 2018 - 'Put some steps in your spring**
- Encouraging families to get active in spring, particle during the Easter school holidays.
- Sponsored article "4 ½ ways to put some steps in your spring this Easter Holiday" to go live on My Kent Family highlighting local activities for families.
- New campaigns page on kent.gov, promoted via Facebook Ads.
- Additional activity promoting 10 Minute Shake Ups, to stay active at home.

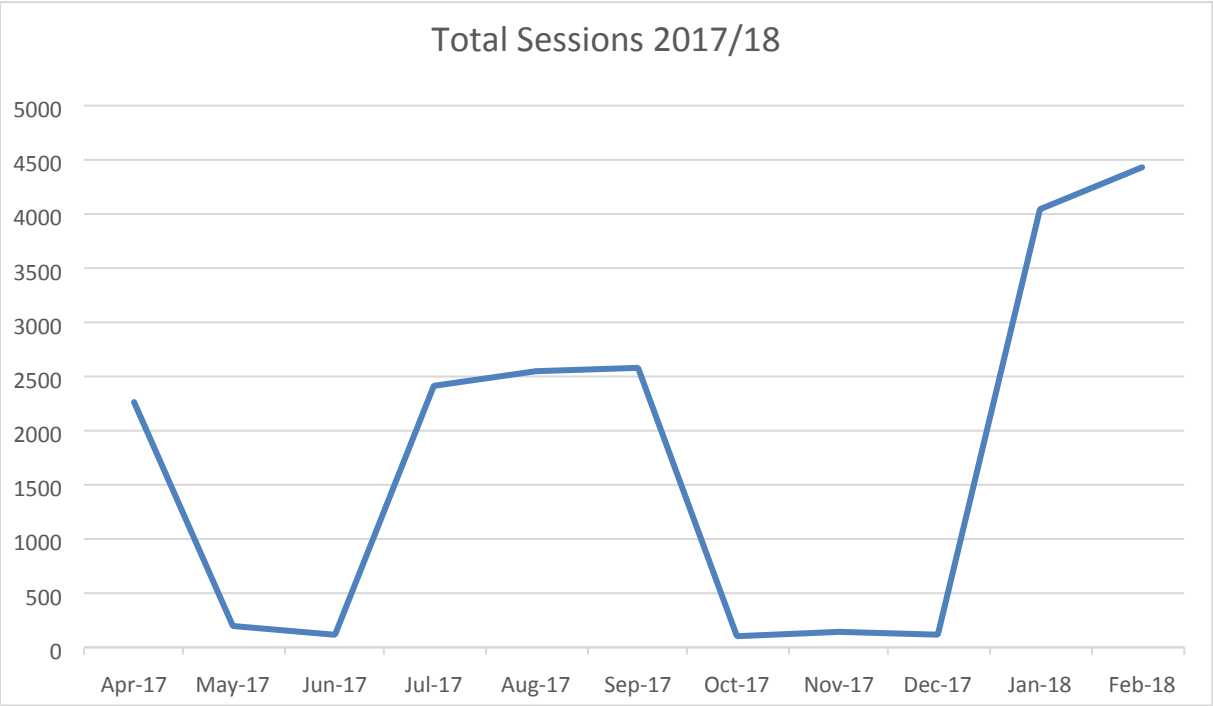
Start4Life

- **Late March 2018 – Breastfeeding Support**
- Planned activity to support launch of national breastfeeding support campaign.

3. Evaluation

Year	Total Sessions on kent.gov	% of returning visitors	Total. no Facebook Page Followers
2017/18*	18,958	24%	2,300

**correct at the time of writing (21/2/18)*


Total Sessions 2017/18
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18

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One You Kent Campaign 2017/18

This appendix has concentrated on the digital consumer marketing, adding to the information that was presented to the Health Reform and Public Health Cabinet Committee at it's January meeting

Campaign Strategy

The campaign aim is to get residents to initially complete one of three call-to-actions;

1. Take the HAY quiz
2. To visit the website for specific advice and support
3. To download a One You apps

By developing engaging content via the following strategies;

1. Localising content
2. Targeting individuals by motivations to make a lifestyle change
3. Develop messaging which ties to key seasonal periods, reaching residents during times when certain behaviours are triggered.

Examples of media aligned to strategies:

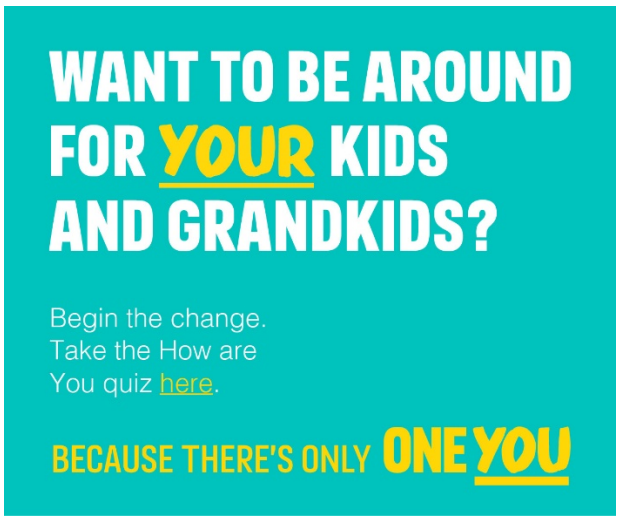
1a.

Quarter Page Press Ad, December 2017. Other versions include: Thanet, Sittingbourne, Sheerness, Gravesend & Dartford, Folkestone & Hythe, East Kent.

1b.

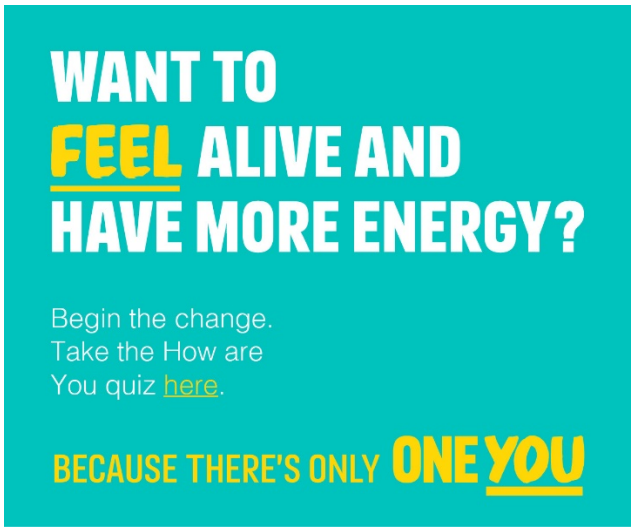
Alongside Facebook Ads targeting all Kent residents, over a 3-month period, residents in the following areas were delivered localised ads like that above; Sevenoaks, Tonbridge, Tunbridge Wells, Canterbury, Thanet, Dartford, Shepway, Gravesham, Maidstone, Swale and Dover.

2a. Life change/Trigger: becoming a Grandparent



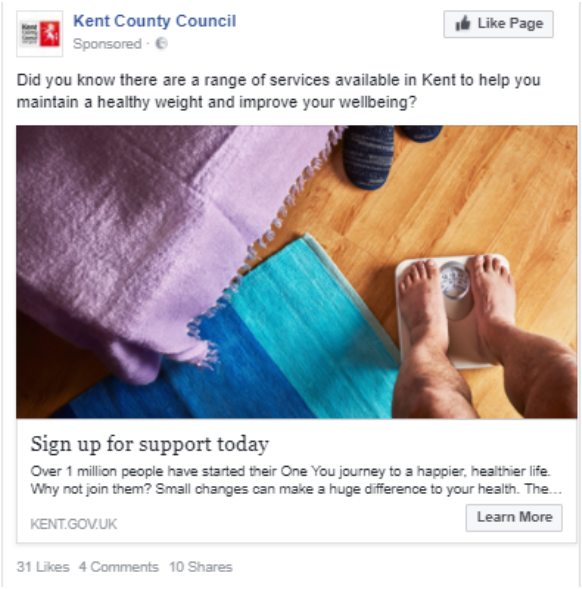
(left to right: Digital display ad, Facebook ad)

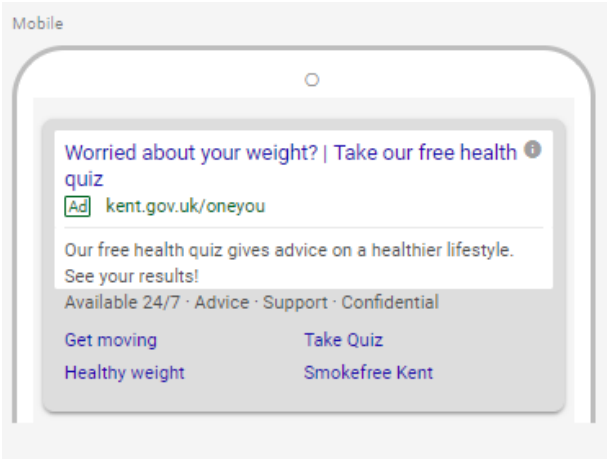
2b. Motivation: to feel more energised



(left to right: Digital display ad, Facebook ad)

2c. Motivation: Lose weight

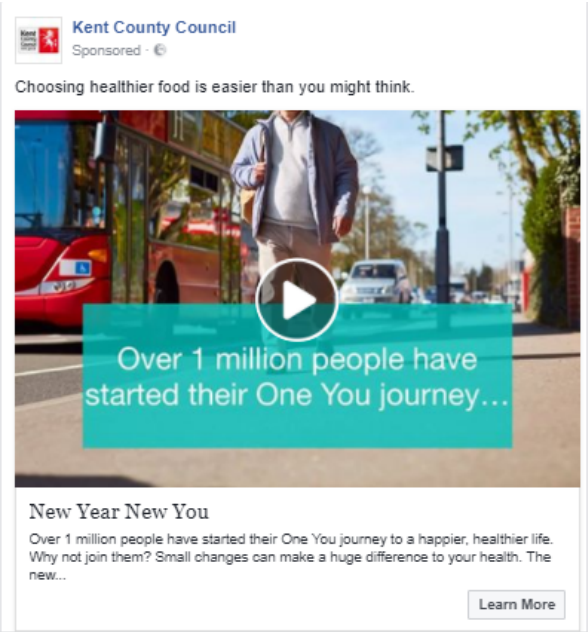




(left to right: Facebook ad, Google AdWords Search Ad)

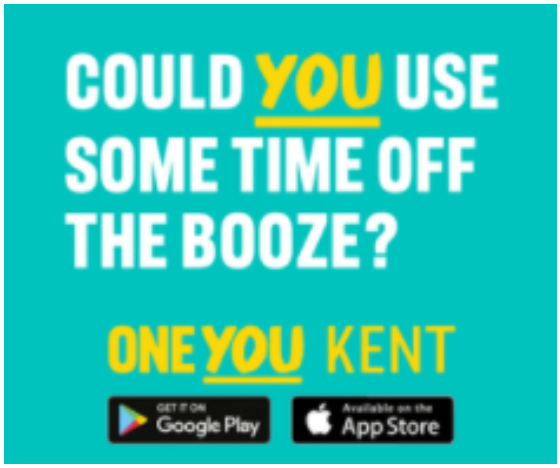
Other motivations and trigger include; aches and pains, ensure a sharp mind, be more social, for family, planning a holiday, wedding, moving house and starting a new job.

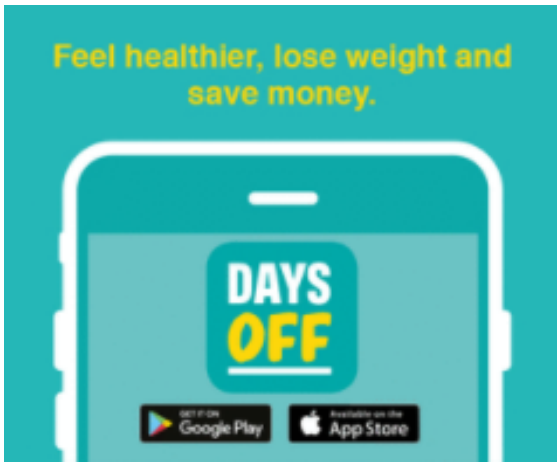
3a. New Year



(left to right: Facebook ad, Twitter Ad)

3b. Dry January



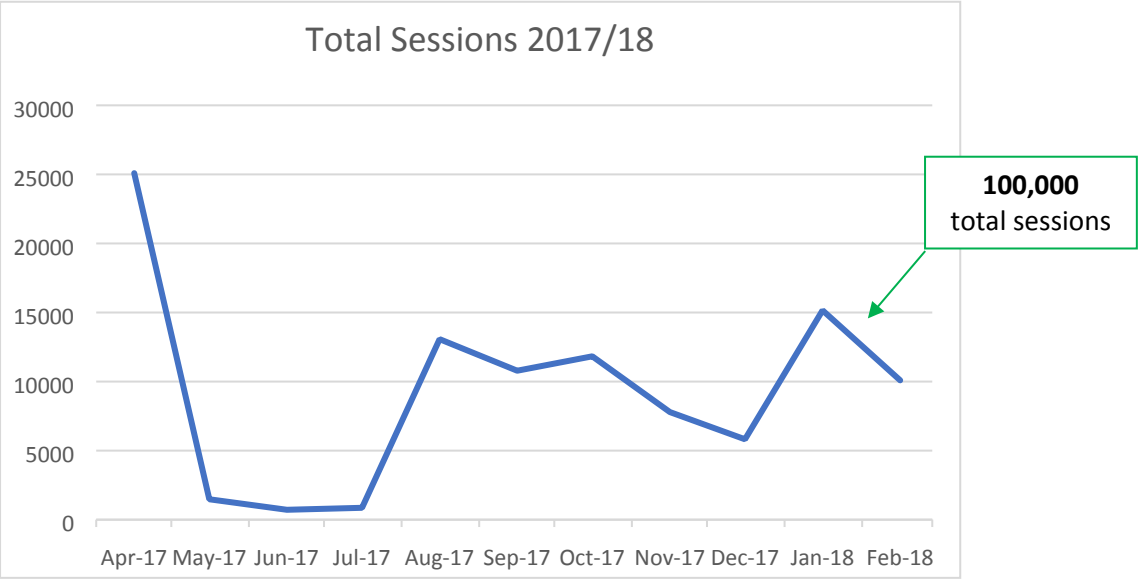


Digital display ad

3c. Post Dry January

Further Activity is planned in March 2018 around National No Smoking Day.

Results



One You Kent webpages have achieved approximatley the same total number of sessions as the Change4Life, Release the Pressure and Know Your Score combined, accounting for 2.3% of overall sessions on kent.gov.

Encouragingly, the number of returning visitors have continued to rise throughout the year – at 20% in April 2017 compared to 35% in January 2018 (at an average of 30% across entire year). This can be interpretated as an increased awareness and trust in the One You Kent brand, resulting in residents being more receptive to support from services.

Top 10 most visited One You Kent webpages

1. Homepage
2. Healthy Weight
3. Get Moving
4. Smokefree Kent
5. Alcohol
6. Healthy Weight Services
7. Alcohol and drug support
8. Get a Health Check
9. Know Your Score Quiz
10. How Are You Quiz

Sexual Health Campaign 2017/18

1. Campaign overview

1.1 In December 2017, Public Health England began a campaign to raise awareness of STIs, in particular chlamydia and gonorrhoea, showcasing the spread and severe health issues these STIs can cause. This is in the form of a new national awareness campaign targeted at 16-24 year olds which ultimately aims to reduce rates of STIs through increased condom usage.

1.2 The new campaign highlights the risks associated with not using condoms and will include a new advertising campaign on social and digital platforms, partnerships with sexual health organisations and clinics, commercial partnerships and PR.

1.3 The campaign aims to:

> **Get**: 16-24 year olds (especially 16-19 year olds and those with less sexual experience)
>
> **To**: use a condom (and so reduce rates of STIs)
>
> **By**: Increasing the perception of the risks and harms around sexually transmitted infections and position condoms as the solution.

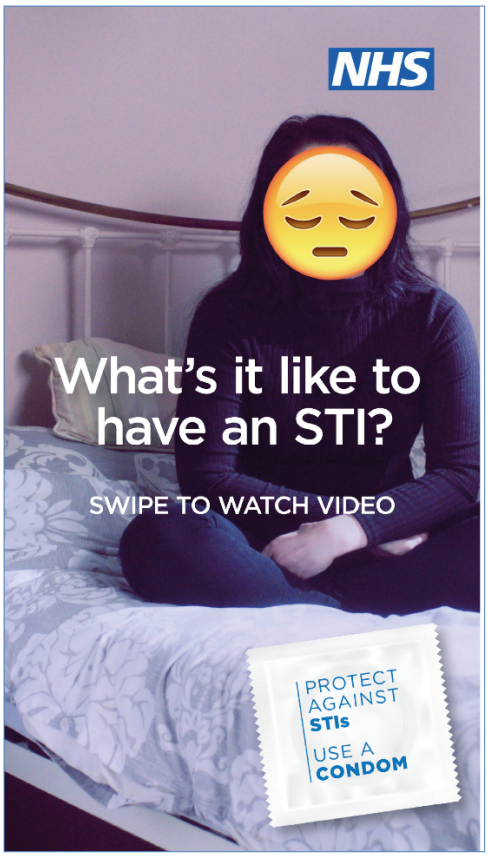
1.4 The broad aim of the campaign is to help normalise condom use among young people and, in the long-term, reduce rates of STIs among the main audience group.

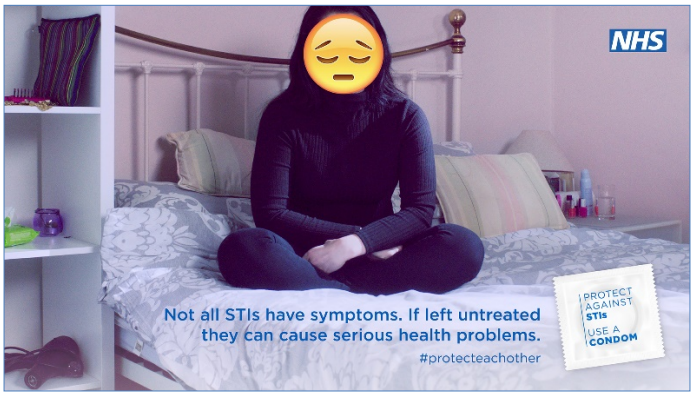
1.5 The first wave of the national campaign ran from 15th December to mid-January 2018. A second wave will take place in March 2018 with subsequent phases subject to PHE planning.

2. Campaign activity

2.1 PHE hopes to release additional assets from April 2018 for LAs to support the campaign, which will allow for placement through other media channels. In the meantime, a limited Kent campaign extension is being delivered until the end of March to ensure an always-on approach;

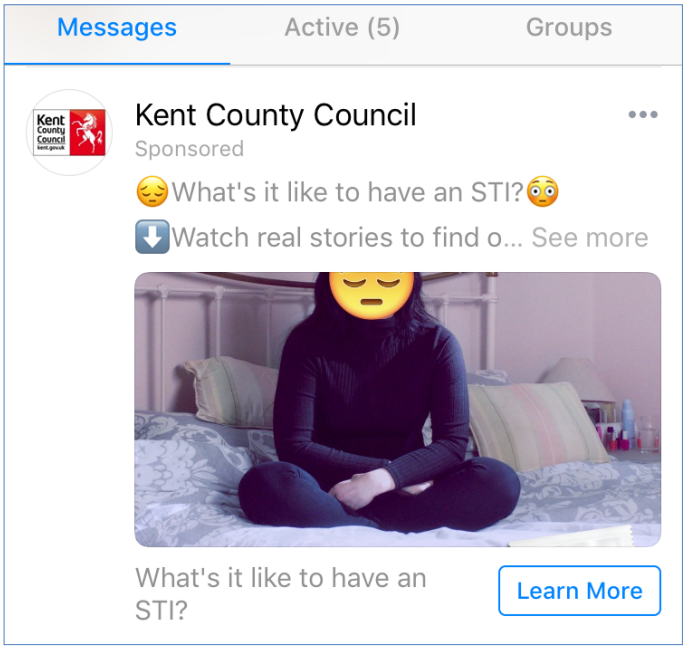
1. **Partnership with Metro**, consisting of:
   - Snapchat Ad, sent out weekly to network
   - TV screen in Universities across Kent
   - E-Newsletter send to 2k practitioners across Kent



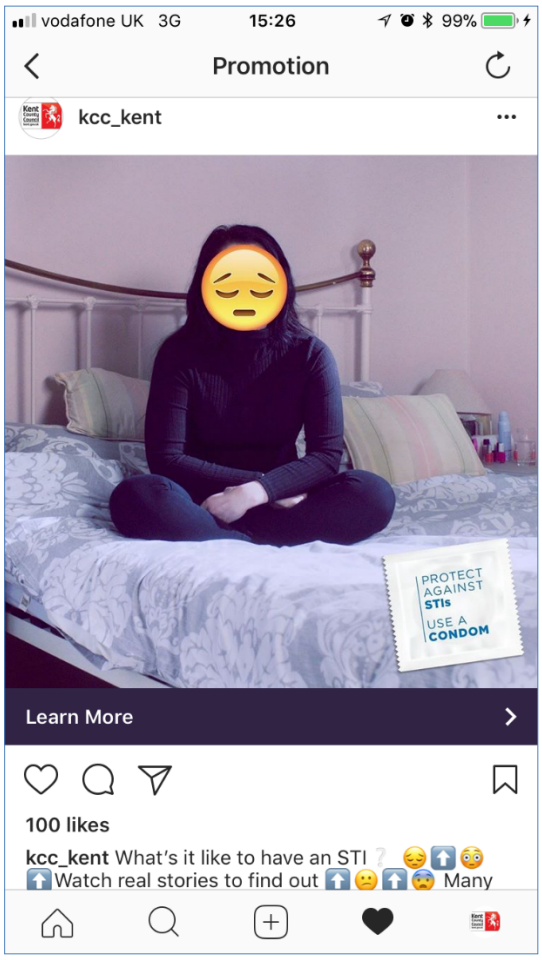


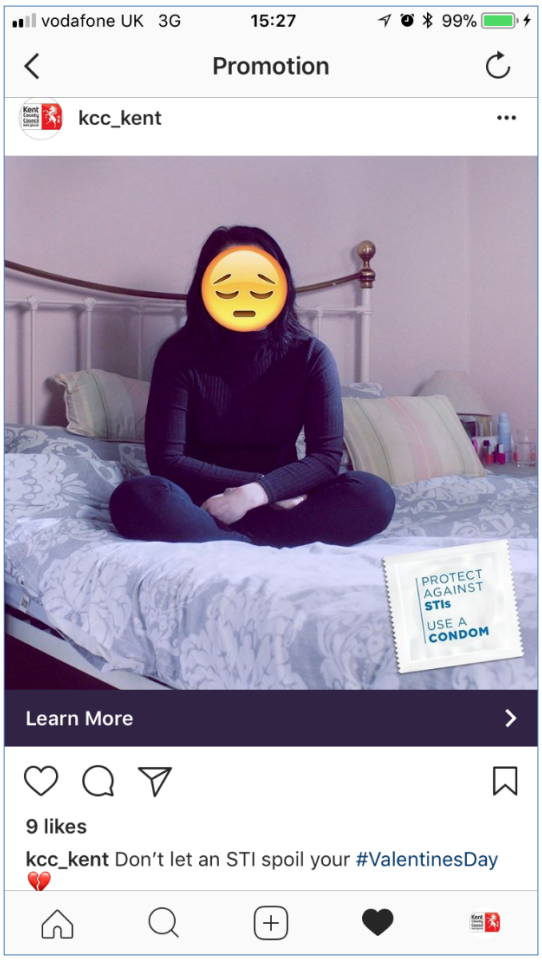
(left to right, Snapchat Ad, TV screen)

2. **Facebook Messenger Ads**



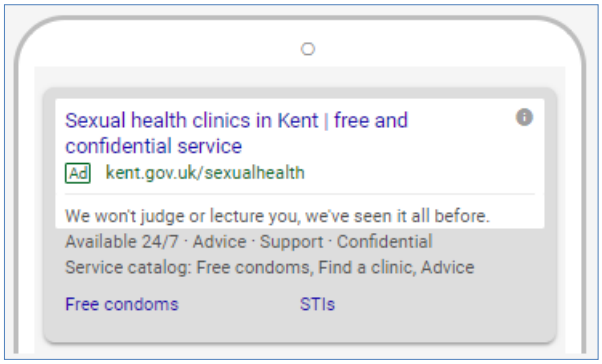
3. **Instagram Ads**

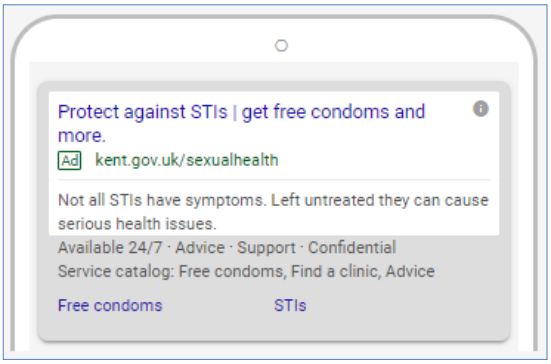




(Left to right: Campaign messaging, Valentine's Day messaging)

4. Google AdWords Search & Display



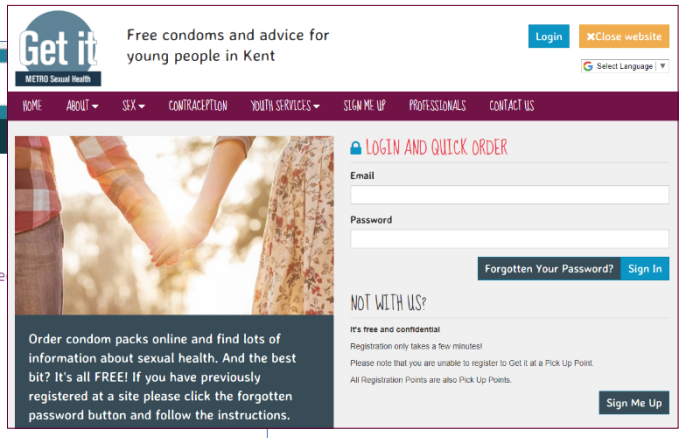


Search

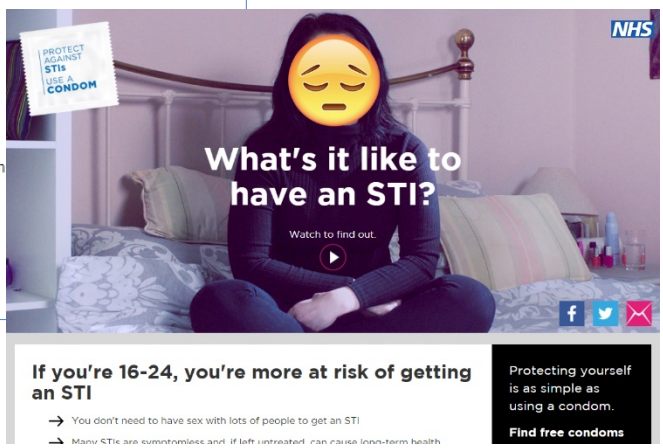
Display

5. **Mobile Alerts –** to run end February to March 2018.

Updates to kent.gov to support campaign



To commissioned service



To PHE campaign web content

3. Results

3.1 Between April to December 2017 the /sexualhealth ‘homepage’ on kent.gov received on average 1,777 sessions per week, with the /condoms page receiving 3.6% of that traffic.

3.2 Since 1st January 2018 the /sexualheath ‘homepage’ has received on average 2,752 sessions per week (+55% increase), with the /condoms page receiving 24.2% of traffic, equating to almost 5,000 visits in 7 weeks. The campaign has also directed over 1,000 young people directly to the NHS site.

3.3 The planned activity has proved insightful towards understanding how young people respond to our messaging, with Instagram delivering a high engagement rate, generating over 100 ‘Likes’ on a single ad.

3.4 To gain further insight the campaigns team have reached out to the KYCC to run a focus group with members in March.

3.5 Digital tactics have allowed for a very targeted approach, with all media set to reach 16-25s only, resulting in very little wastage and ensuring best use of budget. To date all measurable ads have received over 1.3 million impressions.

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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 - 13 March 2018

Subject: **Public Health Outcomes Framework (PHOF) Performance Report - Adults**

Classification: Unrestricted

Summary: This report provides an update of a range of key Public Health Outcomes Framework (PHOF) indicators. Most of the trends presented retain green or amber status. The exceptions to this are suicide rates and late HIV diagnoses.

Recommendation(s): The Cabinet Committee is asked to:

(i) **NOTE** and **COMMENT** on the Public Health trends and outcomes set out in this report;

(ii) **COMMENT** on any additional indicators (Appendix 2) it feels should be included in future reports.

1. Introduction

This report provides an overview of the latest trends across a sample of public health measures to provide an indication of how well public health is being improved and protected. The outcomes presented are intended to focus on quality of life in addition to life expectancy.

1.1 The indicators are drawn mostly from the Public Health Outcomes Framework (PHOF) and reflect the data published nationally by Public Health England on their fingertips tool.

1.2 The PHOF indicators focus on two key public health outcomes: Increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities.

1.3 The indicators are grouped into four areas: i) Improving the wider determinants of health, ii) health improvement, iii) health protection and, iv) healthcare public health and preventing premature mortality. The Framework was first published in 2012. Currently there are 159 indicators that straddle these four areas.

1.4 While in overall terms Kent retains green or amber status Kent is red for suicide and presenting with HIV at a late stage of infection.

1.5 Suicide: Kent's rate used to mirror the national position but diverged upwards from 2011/13. However, it is encouraging that the most recent trend suggests that rates are beginning to return to the status quo, with a small reduction and move towards convergence in 2014/16. Such fluctuations, while regrettable are not unexpected or unusual and are often ephemeral in nature.

1.6 HIV testing (presenting with HIV at a late stage of infection): Kent has remained an outlier compared to England for a number of years. Local research aimed at understanding the cause for this identified many missed opportunities to test. The research also concluded that most of the late diagnosis was in heterosexual men. In recent years increased opportunity to test for HIV may also have contributed to higher detection rates overall and increased detection of presentation at late stage.

When considering the outcomes presented, the Cabinet Committee are reminded to note that the values presented for Kent can vary considerably when compared with values at District level. For example, average male life expectancy in Thanet for the period 2014/16 is 77.8 whereas the value for Kent is 79.9.

In general terms differences in public health outcomes become more accentuated at lower geographic levels and the differences observed are driven to a large extent by an uneven distribution in the wider determinants of health and inequality across different health economies.

1.7 A full list of the indicators available within the Public Health Outcomes Framework (PHOF) has been provided in Appendix 2. The Cabinet Committee is invited to comment on any additional indicators it feels should be included in future reports.

2. Annual Public Health Outcomes Framework (PHOF) Indicators

2.1 The table below presents the most recent nationally-verified and published data; the RAG is the published PHOF RAG and is in relation to national figures, with the exception of late HIV diagnosis where RAG represents performance against goal <25%, 25% to 50%, ≥50%.

Indicator Description	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	DoT 2 most recent
Healthy life expectancy at birth (male) (0.1i)	nca		63.4	63.3	62.8	63.6	63.8	64.2	⇔
Healthy life expectancy at birth (female) (0.1i)	nca		65.7	66.3	65.8	64.5	65.5	65.1	⇔
Life expectancy at birth (male) (0.1ii)	78.7	79.0	79.3	79.8	79.8	80.0	79.8	79.9	⇔
Life expectancy at birth (female) (0.1ii)	82.5	82.6	83.0	83.3	83.5	83.5	83.5	83.4	⇔
U75 mortality rate Cardiovascular diseases considered preventable per 100,000 (4.04ii)	59.8 (g)	57.4 (g)	55.9 (a)	52.3 (a)	49.3 (a)	46.0 (g)	42.3 (g)	40.0 (g)	⇧
U75 mortality rate Cancer considered preventable per 100,000 (4.05ii)	85.4 (g)	84.8 (g)	83.6 (g)	81.5 (g)	79.3 (g)	78.4 (g)	78.8 (a)	77.5 (a)	⇧
U75 mortality rate Liver disease considered preventable per 100,000 (4.06ii)	12.4 (g)	12.1 (g)	12.0 (g)	12.4 (g)	13.2 (g)	13.7 (g)	14.4 (g)	13.3 (g)	⇧
U75 mortality rate Respiratory disease considered preventable per 100,000 (4.07ii)	17.4 (a)	17.4 (a)	17.6 (a)	16.6 (a)	16.7 (a)	16.5 (a)	17.8 (a)	18.5 (a)	⇔
Suicide rate (all ages) per 100,000 (4.10)	9.4 (a)	8.6 (a)	9.3 (a)	9.0 (a)	10.3 (a)	11.4 (r)	12.0 (r)	11.6 (r)	⇔

Proportion of people presenting with HIV at a late stage of infection (%) (3.04)	nca	50.7 (r)	47.3 (a)	52.8 (r)	55.1 (r)	54.4 (r)	56.8 (r)	⇩
Adults classified as overweight or obese (%) (2.12) *historical method **current method	nca				65.1* (a)	65.5 * (r)	61.4** (a)	nca

Indicator Description	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**DoT 2 most recent**
Prevalence of smoking in adults – current smokers (%) (2.14)	nca		20.7 (a)	19.2 (a)	18.6 (a)	17.0 (a)	15.2 (a)	⇧

Indicator Description	**2010/ 11**	**2011/ 12**	**2012/ 13**	**2013/ 14**	**2014/ 15**	**2015/ 16**	**2016/ 17**	**DoT 2 most recent**
Alcohol-related admissions to hospital per 100,000. All ages (10.1)	574 (g)	557 (g)	565 (g)	551 (g)	526 (g)	531 (g)	514 (g)	⇧
Proportion of adult patients diagnosed with depression (% - QOF Register)	Not available due to methodology changes		5.6	6.4	7.3	8.5	nca	⇩

2.2 Overall life expectancy at birth and healthy life expectancy for females continues to be above national levels.

2.3 Premature mortality rates (deaths in people aged under 75) for preventable cardiovascular disease and cancers have continued to decrease. Preventable cardiovascular disease premature mortality rates are also better than national rates.

2.4 Suicide rates continue to be above national, with the increase accounted for by increases in male suicides.

2.5 The proportion of people presenting with HIV at a late stage of infection has continued to increase, and remains above the national level.

2.6 Prevalence of smoking in adults has continued to decrease; mirroring national trends.

2.7 Alcohol-related hospital admissions have continued to decrease, and remain below the national level.

2.8 The proportion of adult patients diagnosed with depression has continued to increase.

3. Conclusions

3.1 Most performance is good and retains a green or amber status.

3.2 The exceptions to this are suicide rates and late HIV diagnoses.

4. Recommendation

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

(i) **NOTE** and **COMMENT** on the Public Health trends and outcomes outlined in this report;

(ii) **COMMENT** on any additional indicators it feels should be included in future reports.

Background Documents:
None

Report Author:
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- 03000 416659
- Andrew.scott-clark@kent.gov.uk

Appendix 1:

Key to KPI Ratings used

(g) GREEN	Target has been achieved or exceeded; or is better than national
(a) AMBER	Performance at acceptable level, below Target but above Floor; or similar to national
(r) RED	Performance is below a pre-defined floor standard; or lower than national
⇧	Performance has improved (by more than 1 point)
⇩	Performance has worsened (by more than 1 point)
⇔	Performance has remained the same (within 1 point either direction)
nca	Not currently available

Appendix 2

Table 1: Full list of Public Health Outcomes Framework (PHOF) Indicators

Indicator (PHOF)
Overarching Indicators
0.1i - Healthy life expectancy at birth (Male)
0.1i - Healthy life expectancy at birth (Female)
0.1ii - Life expectancy at birth (Male)
0.1ii - Life expectancy at birth (Female)
0.1ii - Life expectancy at 65 (Male)
0.1ii - Life expectancy at 65 (Female)
0.2i - Inequality in life expectancy at birth ENGLAND (Male)
0.2i - Inequality in life expectancy at birth ENGLAND (Female)
0.2i - Inequality in life expectancy at 65 ENGLAND (Male)
0.2i - Inequality in life expectancy at 65 ENGLAND (Female)
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Male)
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Female)
0.2iii - Inequality in life expectancy at birth LA (Male)
0.2iii - Inequality in life expectancy at birth LA (Female)
0.2iii - Inequality in life expectancy at 65 LA (Male)
0.2iii - Inequality in life expectancy at 65 LA (Female)
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)
0.2v - Inequality in healthy life expectancy at birth ENGLAND (Male)
0.2v - Inequality in healthy life expectancy at birth ENGLAND (Female)
0.2vi - Inequality in healthy life expectancy at birth LA (Male)
0.2vi - Inequality in healthy life expectancy at birth LA (Female)
0.2vii - Inequality in life expectancy at birth REGION (Male)
0.2vii - Inequality in life expectancy at birth REGION (Female)
0.2vii - Inequality in life expectancy at 65 REGION (Male)
0.2vii - Inequality in life expectancy at 65 REGION (Female)
Wider determinants of health
1.01i - Children in low income families (all dependent children under 20)
1.01ii - Children in low income families (under 16s)
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check
1.03 - Pupil Absence

1.04 - First time entrants to the youth justice system
1.05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known - current method
1.05 16-18 year olds not in education employment or training - historical method
1.06i - Adults with a learning disability who live in stable and appropriate accommodation
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation
1.07 - People in prison who have a mental illness or a significant mental illness - current method
1.07 - People in prison who have a mental illness or a significant mental illness - historic method
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate
1.08iv - Percentage of people aged 16-64 in employment
1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week
1.09ii - Sickness absence - the percentage of working days lost due to sickness absence
1.10 - Killed and seriously injured (KSI) causalities on England's roads
1.11 - Domestic abuse-related incidents and crimes - current method
1.11 - Domestic abuse-related incidents and crimes - historic method
1.12i - Violent crime (including sexual violence) - hospital admissions for violence
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population
1.12iii - Violent crime (including sexual violence) - rate of sexual offences per 1,000
1.13i - Re-offending levels - percentage of offenders who re-offend
1.13ii - Re-offending levels - average number of re-offences per offender
1.13iii - First time offenders
1.14i - The rate of complaints about noise
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65 dB(A) or more, during the daytime
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night -time
1.15i - Statutory homelessness - Eligible homeless people not in priority need
1.15ii - Statutory homelessness - households in temporary accommodation
1.16 - utilisation of outdoor space for exercise / health reasons
1.17 - Fuel Poverty
1.18i - Social isolation: percentage of adult social care users who have as much social contact as they would like
1.18ii - Social isolation: percentage of adult carers who have as much social contact as they would like
Health Improvement
2.01 - Low birth weight of term babies
2.02i - Breastfeeding - breastfeeding initiation
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - current method
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - historical

method
2.03 - Smoking status at time of delivery - current method
2.03 - Smoking status at time of delivery - historical method
2.04 - Under 18 conceptions
2.04 - Under 18 conceptions: conceptions in those under 16
2.05ii - Proportion of children aged 2-2 1/2 years offered ASQ-3 as part of the Healthy Child Programme or integrated review
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds
2.06ii - Child excess weight in 4-5 and 10-11 year olds – 10-11 year olds
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)
2.08i - Average difficulties score for all locked after children aged 5-16 who have been in care for at least 12 months on 31st march
2.08ii - Percentage of children where is a cause for concern
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)
2.09ii - Smoking prevalence at age - regular smokers (WAY survey)
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)
2.09iv - Smoking prevalence at age 15 years - regular smokers (SDD survey)
2.09v - Smoking prevalence at age 15 - occasional smokers (ADD survey)
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) - current method
2.11i - Proportion of the population meeting the recommended '5-a-day on a 'usual day' (adults) - historical method
2.11ii - Average number of portions of fruit consumed daily (adults) - current method
2.11ii - Average number of portions of fruit consumed daily (adults) - historical method
2.11iii - Average number of portions of vegetables consumed daily (adults) - current method
2.11iii - Average number of portions of vegetables consumed daily (adults) - historical method
2.11iv - Proportion of the population meeting the recommended "5-a-day" at age 15
2.11v - Average number of portions of fruit consumed daily at age 15 (WAY survey)
2.11vi - Average number of portions of vegetables consumed daily at age 15 (WAY survey)
2.12 - Percentage of adults (aged 18+) classified as overweight or obese - current method
2.12 - Percentage of adults (aged 16+) classified as overweight or obese - historical method
2.13i - Percentage of physically active adults - current method
2.13i - Percentage of physically active adults - historical method
2.13ii - Percentage of physically inactive adults - current method
2.13ii - Percentage of physically inactive adults - historical method
2.14 - Smoking Prevalence in adults - current smokers (APS)
2.15i - Successful completion of drug treatment - opiate users
2.15ii - Successful completion of drug treatment - non opiate users

2.15ii - Successful completion of alcohol treatment
2.15iv - Deaths from drug misuse
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
2.17 - Recorded diabetes
2.18 - Admission episodes for alcohol-related conditions - narrow definition
2.19 - Cancer diagnosed at early stage (experimental statistics)
2.20i - Cancer screening coverage - breast cancer
2.20ii - Cancer screening coverage - cervical cancer
2.20ii - Cancer screening coverage - bowel cancer
2.20iv - Abdominal Aortic Aneurysm Screening - Coverage
2.20v - Diabetic eye screening - uptake
2.20vii - Infectious Diseases in Pregnancy Screening - HIV coverage
2.20viii - Infectious Diseases in Pregnancy Screening - Syphilis coverage
2.20ix - Infectious Diseases in Pregnancy Screening - Hepatitis B Coverage
2.20x - Sickle Cell and Thalassaemia Screening - Coverage
2.20xi - Newborn Blood Spot Screening - Coverage
2.20xii - Newborn Hearing Screening - Coverage
2.20xiii - Newborn and Infant Physical Examination Screening - Coverage
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check
2.22iv - Cumulative percentage of the eligible proportion aged 40-74 offered an NHS Health Check who received an NHS Health Check
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health Check
2.23i - Self reported wellbeing - people with a low satisfaction score
2.23ii - Self-reported wellbeing - people with a low worthwhile score
2.23iii - Self-reported wellbeing - people with a low happiness score
2.23iv - Self-reported wellbeing - people with a high anxiety score
2.24i - Emergency hospital admissions due to falls in people aged 65 or over
2.24ii - Emergency hospital admissions due to falls in people aged 65-79
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+
Health Protection
3.01 - Fraction of mortality attributable to particulate air pollution
3.02 - Chlamydia detection rate (15-24 year olds)
3.02 - Chlamydia detection rate (15-24 year olds) (Male)
3.02 - Chlamydia detection rate (15-24 year olds) (Female)
3.03i - Population vaccination coverage - Hepatitis B (1 year old)
3.03i - Population vaccination coverage - Hepatitis B (2 years old)
3.03ii - Population vaccination coverage - BCG - areas offering universal BCG only
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)
3.03iv - Population vaccination coverage - MenC
3.03v - Population vaccination coverage - PCV
3.03vi - Population vaccination coverage - Hib / Men C booster (2 years old)
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)

3.03 vii - Population vaccination coverage - PCV booster
3.03 viii - Population vaccination coverage - MMR for one dose (2 years old)
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)
3.03x - Population vaccination coverage - MMR for two doses (5 years old)
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)
3.03xiii - Population vaccination coverage - PPV
3.03 xiv - Population vaccination coverage - Flu (aged 65+)
3.03xv - Population vaccination coverage - Flu (at risk individuals)
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old)
3.03 xviii - Population vaccination coverage - Flu (2-4 years old)
3.04 - HIV late diagnosis
3.05i - Treatment completion for TB
3.05ii - Incidence of TB
3.06 - NHS organisations with a board approved sustainable development management plan
3.08 - Adjusted antibiotic prescribing in primary care by the NHS
Healthcare and Premature Mortality
4.01 - Infant mortality
4.02 - Proportion of five year old children free from dental decay
4.03 - Mortality rate from causes considered preventable
4.04i - Under 75 mortality rate from all cardiovascular diseases
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable
4.05i - Under 75 mortality rate from cancer
4.05ii - Under 75 mortality rate from cancer considered preventable
4.06i - Under 75 mortality rate from liver disease
4.06ii - Under 75 mortality rate from liver disease considered preventable
4.07i - Under 75 mortality rate from respiratory disease
4.07ii - Under 75 mortality rate from respiratory disease considered preventable
4.08 - Mortality rate from a range of specified communicable diseases, including influenza
4.09i - Excess under 75 mortality rate in adults with serious mental illness
4.09ii - Proportion of adults in the population in contact with secondary mental health services
4.10 - Suicide rate
4.11 - Emergency readmissions within 30 days of discharge from hospital
4.12i - Preventable sight loss - age related macular degeneration (AMD)
4.12ii - Preventable sight loss - glaucoma
4.12iii - Preventable sight loss - diabetic eye disease
4.12iv - Preventable sight loss - sight loss certifications
4.13 - Health related quality of life for older people
4.14 - Hip fractures in people aged 65 and over
4.14ii - Hip fractures in people aged 65 and over - aged 65-79
4.14iii - Hip fractures in people aged 65 and over - aged 80+
4.15i - Excess winter deaths index (single year, all ages)

4.15ii - Excess winter deaths index (single year, age 85+)
4.15iii - Excess winter deaths index (3 years, all ages)
4.15iv - Excess winter deaths index (3 years, age 85+)
4.16 - Estimated dementia diagnosis rate (aged 65+)

From: Paul Carter, Cabinet Member for Traded Services and Health Reform

Peter Oakford, Cabinet Member for Strategic Commissioning and Public Health

Graham Gibbens, Cabinet Member for Adult Social Care

Andrew Scott-Clark, Director of Public Health

Anu Singh, Corporate Director of Adult Social Care and Health

Vincent Godfrey, Strategic Commissioner

To: Health Reform and Public Health Cabinet Committee – 13 March 2018

Subject: **Risk Management: Health Reform and Public Health**

Classification: Unrestricted

Electoral Division: All

Summary: This paper presents the strategic risks relating to health reform and public health that currently feature on either KCC's corporate risk register or the Public Health risk register. The paper also explains the management process for review of key risks.

Recommendation(s):

The Cabinet Committee is asked to consider and comment on the risks presented in appendices 1 and 2.

1. Introduction

1.1 Directorate business plans are reported to Cabinet Committees each March as part of the Authority's business planning process. The plans include a high-level section relating to key risks, which are set out in more detail in this paper.

1.2 Risk management is a key element of the Council's Internal Control Framework and the requirement to maintain risk registers ensures that potential risks that may prevent the Authority from achieving its objectives are identified and controlled. The process of developing the registers is therefore important in underpinning business planning, performance management and service procedures. Risks outlined in risk registers are taken into account in the development of the Internal Audit programme for the year.

1.3 Directorate risk registers are reported to Cabinet Committees annually and contain strategic or cross-cutting risks that potentially affect several functions. These often have wider potential interdependencies with other services across the Council and external parties. The Public Health risk register is attached in appendix 1.

1.4 Corporate Directors also lead or coordinate mitigating actions in conjunction with other Directors across the organisation to manage risks featuring on the Corporate Risk Register. The Corporate Director for Adult Social Care and Health is the designated 'Risk Owner' in collaboration with the Council's Strategic Commissioner for the corporate risk relating to the Sustainability and Transformation Partnership. This risk is presented for comment in appendix 2.

1.5 A standard reporting format is used to facilitate the gathering of consistent risk information and a 5x5 matrix is used to rank the scale of risk in terms of likelihood of occurrence and impact. Firstly the current level of risk is assessed, taking into account any controls already in place to mitigate the risk. If the current level of risk is deemed unacceptable, a 'target' risk level is set and further mitigating actions introduced with the aim of reducing the risk to a tolerable and realistic level.

1.6 The numeric score in itself is less significant than its importance in enabling categorisation of risks and prioritisation of any management action. Further information on KCC risk management methodologies can be found in the risk management guide on the KNet intranet site.

2. Financial Implications

2.1 Many of the strategic risks outlined have financial consequences, which highlight the importance of effective identification, assessment, evaluation and management of risk to ensure optimum value for money.

3. Policy Framework

3.1 Risks highlighted in the risk registers relate to strategic priorities and outcomes featured in KCC's Strategic Statement 2015-2020, as well as the delivery of statutory responsibilities.

3.2 The presentation of risk registers to Cabinet Committees is a requirement of the County Council's Risk Management Policy.

4. Risks relating to Public Health

4.1 There are currently eight risks featured on the Public Health risk register (appendix1), none of which are rated as 'High'. Many of the risks highlighted on the register are linked to risks on the Authority's Corporate Risk Register for example the risk of communicable disease outbreak is contained within the Corporate Risk Register, under risk number four, Civil Contingencies and are discussed as part of regular items to the Cabinet Committee.

4.2 Since December 2017 Public Health entered into a partnership agreement with Kent Community Health NHS Foundation Trust to deliver key public services. These include services for which KCC has a statutory responsibility such as Health Visiting, Sexual Health and NHS Health Checks Service. These developments have reduced the risks associated with the market for public health services therefore the following risks have been adjusted:

- New control added to PH00003 PHD02 maintaining performance and Quality of Services throughout the transformative period.

- New control added to PH0007 PHD07 managing and working the Market

4.3 The other changes made are:

- Withdrawal of Risk PH0081 Marginalisation of Public Health Intelligence with Public health priorities not reflected within CCG's mobilisation plans for a new linked dataset because CCG's have agreed to contribute funding to support the Kent Integrated Dataset until 2019.

- A new risk added PH0082 with one five supporting controls to ensure compliance with the General Data Protection Regulations which comes into effect from May 2018.

4.4 Risk and action owners review these actions regularly, and the Directorate Management Team monitors this as part of regular quarterly risk reviews.

4.5 Inclusion of risks on this register does not necessarily mean there is a problem. On the contrary, it can give reassurance that they have been properly identified and are being managed proactively.

4.6 Monitoring and review – risk registers should be regarded as 'living' documents to reflect the dynamic nature of risk management. Directorate Management Teams formally review their risk registers, including progress against mitigating actions, on a quarterly basis as a minimum, although individual risks can be identified and added to the register at any time. Key questions to be asked when reviewing risks are:

- Are the key risks still relevant?
- Have some risks become issues?
- Has anything occurred which could impact upon them?
- Have the risk appetite or tolerance levels changed?
- Are related performance / early warning indicators appropriate?
- Are the controls in place effective?
- Has the current risk level changed and if so is it decreasing or increasing?
- Has the "target" level of risk been achieved?
- If risk profiles are increasing what further actions might be needed?
- If risk profiles are decreasing can controls be relaxed?
- Are there risks that need to be discussed with or communicated to other functions across the Council or with other stakeholders?

5. Recommendation

Recommendation:

The Cabinet Committee is asked to consider and comment on the risks presented in appendices 1 and 2.

6. Background Documents

6.1 KCC Risk Management Policy on KNet intranet site.

7. Contact details

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Appendix 1 – Public Health Risk Register

Risk Register - Public Health

Current Risk Level Summary

Green	Amber	Red	Total
3	5	0	8

Current Risk Level Changes

Green	Amber	Red	Total
1 -3			1 -3

0	0	0	0	0
0	0	0	0	0
0	1	3	2	0
0	0	2	0	0
0	0	0	0	0

Risk Ref ***PH0001*** **Risk Title and Event** | **Owner** | **Last Review date** | **Next Review Date**

PHD 08 - CBRNE incidents and communicable diseases

Failure to deliver suitable planning measures, respond to and manage these events when they occur.

Andrew Scott-Clark | 02/01/2018 | 02/04/2018

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
The Council, along with other Category 1 Responders in the County, has a legal duty to establish and deliver containment actions and contingency plans to reduce the likelihood, and impact, of high impact incidents and emergencies. The Director of Public Health has a legal duty to gain assurance from the National Health Service and Public Health England that plans are in place to mitigate risks to the health of the public including outbreaks of communicable diseases e.g. Pandemic Influenza. Ensuring that the Council works effectively with partners to respond to, and recover from, emergencies and service interruption is becoming increasingly important in light of recent national and international security threats and severe weather incidents.	Potential increased harm or loss of life if response is not effective. Increased financial cost in terms of damage control and insurance costs. Adverse effect on local businesses and the Kent economy. Possible public unrest and significant reputational damage. Legal actions and intervention for failure to fulfil KCC's obligations under the Civil Contingencies Act or other associated legislation.	Medium 12 Serious (4) Possible (3)		• KCC jointly with Medway Council Public Health department maintain an on-call rota on behalf and with Public Health England to ensure preparedness for implementing the Scientific, Technical Advisory Cell (STAC) in the event of a major incident with implications for the health of the public.	Andrew Scott-Clark	Control			Medium 12
				• KCC and local Kent Resilience Forum partners have tested preparedness for chemical, biological, radiological, nuclear and explosives (CBRNE) incidents and communicable disease outbreaks in line with national requirements. The Director of Public Health has additionally sought and gained assurance from the local Public Health England office and the NHS on preparedness and maintaining business continuity	Andrew Scott-Clark	Control			
				• The Director of Public Health works through local resilience fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health.	Andrew Scott-Clark	Control			

				• Kent Resilience Forum has a Health sub-group to ensure co-ordinated health services and Public Health England planning and response is in place	Andrew Scott-Clark	Control			

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	Risk Title and Event	Owner	Last Review date	Next Review Date
PH0002	**PHD 01 - Implementation of new models** That the reduction in resource available to the new services will hamper the new services in their ability to deliver.	Andrew Scott-Clark	22/01/2018	22/04/2018

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
Public Health is working to transform both children's and adult's services, to deliver services more aligned with the need of the people of Kent. Whilst also facing reducing budgets	Reduction in outcomes for customers, and the ability of the services to meet key objectives, including the reduction of health inequalities	Medium 9 Significant (3) Possible (3)		• Develop a long-term resource allocation plan, taking account of likely financial resources over next four years	Andrew Scott-Clark	A -Accepted	06/04/2018		Low 4
				• Public Health commissioning function in place to ensure robust commissioning process is followed	Mark Gilbert	Control			
				• Opportunities for Joint Commissioning in partnership with key agencies and cross-directorate (health, social care) being explored.	Mark Gilbert	Control			
				• Regular meetings with provider and representative organisations (LMC, LPC). Regular meet the market events to support commissioning processes	Mark Gilbert	Control			
				• Working to a clear strategy, and to an advanced agenda allows for good communication with providers and potential providers	Mark Gilbert	Control			
				• Analyse long term financial situation, and developing services that will be sustainable	Andrew Scott-Clark	Control			

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	Risk Title and Event	Owner	Last Review date	Next Review Date
PH0003	**PHD 02 - Maintaining performance and quality of services throughout the transformative period** That the work to redesign services, may mean that quality and performance of current services drop	Mark Gilbert	14/09/2017	14/03/2018

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
Public Health are working to develop better, more integrated services, and have been working towards procuring new services in the coming year.	That customers and patients do not receive the highest level of service. That patient safety is compromised.	Low 6 Significant (3) Unlikely (2)		• Ensure procurement timetable is clear, and where times need to change that the impact of changes are quickly communicated	Mark Gilbert	A -Accepted	06/04/2018		Low 4
				• Regular quality meetings and robust quality process followed as routine	Andrew Scott-Clark	A -Accepted	06/04/2018		
				• Robust contract management meetings are held on a regular basis with providers to review performance and delivery.	Mark Gilbert	Control			
				• Ensure regular updates reported to committee on performance, and commissioning strategy	Mark Gilbert	Control	04/12/2017	85	
				• KCC and KCHFT have entered a partnership arrangement for all KCHFT's existing contracts until 2020	Mark Gilbert	Control			
				• Performance on key performance indicators is regularly reported to Cabinet on a quarterly basis, and to Cabinet Committees on a more regular basis	Mark Gilbert	Control			
				• Working to a clear strategy, and to an advanced agenda allows for good communication with providers. Contract extensions planned to give providers long term notice on decisions about future contracting	Mark Gilbert	Control			
				• A robust quality assurance system is in place, and a quality dashboard regularly monitored	Penny Spence	Control			

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	Risk Title and Event	Owner	Last Review date	Next Review Date
PH0004	**PHD 05 - Information Governance** The success of health and social care and the effective delivery of services in partnership, is dependent upon organisations being able to share information across agencies	Gerrard Abi-Aad	22/01/2018	22/04/2018

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
With New Ways of Working, flexible working and increased information sharing across agencies there are increased risks in relation to data protection. The Public Health Observatory has access to NHS data to allow it to deliver it's statutory responsibilities	This could lead to breaches of the Data Protection Act if protocols and procedures are not followed.	Medium 9 Significant (3) Possible (3)		• Information governance requirements are included as part of standard contracts with providers, where relevant. Annual Information Governance Statement completed by all contracted providers.	Mark Gilbert	Control			Low 6
				• Caldicott Guardian in place for PH and Caldicott Guardian Guidance and register in place. The Caldicott Guardian officers have regular formal meetings.	Gerrard Abi-Aad	Control			
				• Authority wide group in place to provide strategic leadership on Information Governance.	Gerrard Abi-Aad	Control			
				• Information sharing agreements and protocols for specific projects are in place.	Gerrard Abi-Aad	Control			
				• E Learning training for staff to raise awareness. All staff to complete the e-learning training on Information Governance and Data Protection.	Andrew Scott-Clark	Control			
				• Clause in employment contracts requiring compliance with data protection requirements.	Andrew Scott-Clark	Control			

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	Risk Title and Event	Owner	Last Review date	Next Review Date
PH0005	**PHD 03 Health Inequalities** These areas have high rates of premature mortality (deaths occurring under the age of 75 years) due to causes such as cardiovascular disease, respiratory disease and alcohol-related disease and cancer; causes that are strongly linked to unhealthy behaviours such as poor diet, physical inactivity, smoking and excessive alcohol. The risk is that whilst health is improving in general these communities' health would not improve at the same rate as less deprived communities	Andrew Scott-Clark	02/01/2018	02/04/2018

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
Analysis of health inequalities in Kent shows that health outcomes are much worse in the most deprived decile areas in Kent.	The average life expectancy in the most deprived decile areas in Kent is 76 years for men and 80 years in women, compared to 83 years and 86 years respectively in the most affluent areas. These inequalities will lead to rising health and social care costs for the council and its partners amongst those groups least able to support themselves financially	Medium 9 Significant (3) Possible (3)		• Work with commissioned communications agencies to ensure that campaigns are targeted effectively, and that they take account of the behavioural insights produced as part of the consultation exercise on the health improvement model, and the clustering of unhealthy behaviours	Andrew Scott-Clark	A -Accepted	03/04/2017	330	Low 6
				• Ensure that commissioning takes account of health inequalities when developing service based responses. For example, Health trainers have a target to work with 25% of people from most deprived wards	Mark Gilbert	Control			
				• Ensure that an analytical focus remains on the issue of health inequality, providing partners and commissioners with the detail needed to focus support on this issue	Gerrard Abi-Aad	Control			
				• Refresh action plan for the Mind the Gap strategy, work with partners, such as District councils and CCGs to coordinate efforts to tackle health inequalities	Andrew Scott-Clark	Control			
				• Where relevant use the Public Health England campaign and behaviour change tools, and expand this activity by targeting areas identified through Mind the Gap Analysis	Andrew Scott-Clark	Control			

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	Risk Title and Event	Owner	Last Review date	Next Review Date
PH0006	**PHD 06 - Business Disruption** Impact of emergency or major business disruption on the ability of the Division and its contracted service providers to provide essential services to meet its statutory obligations	Andrew Scott-Clark	14/09/2017	14/03/2018

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
Possible disruption to services	Such an event would impact on the customers of our services and possibility the reputation of the service would suffer	Low 6 Moderate (2) Possible (3)		• Business Continuity plans reviewed annually or in light of significant changes or events.	Mark Gilbert	Control			Low 6
				• Business continuity planning forms part of the contracting arrangements with private and voluntary sector providers	Mark Gilbert	Control			
				• Business Continuity Systems and Procedures are in place	Andrew Scott-Clark	Control			

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	Risk Title and Event	Owner	Last Review date	Next Review Date
PH0007	**PHD 07 - Managing and working within the market** Public Health contracts out to the market for its service delivery. insufficient market appetite for Public health Services and limited market for these services	Mark Gilbert	03/01/2018	03/04/2018

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
Managing and working with the market for PH services, many of which have not been market tested before.	Challenge in obtaining best value, or innovation required to improve and develop services	Low 6 Significant (3) Unlikely (2)	9 -3	• Opportunities for Joint Commissioning in partnership with key agencies and cross-directorate (health, social care) being explored.	Mark Gilbert	Control			Low 6
				• KCC and KCHFT have entered into a partnership arrangement for all service provided by KCHFT until 2020	Mark Gilbert	Control			
				• Public Health commissioning function in place to ensure robust commissioning process is followed	Mark Gilbert	Control			
				• Commissioning strategies have been developed for the two major areas of change, and consulted on extensively with Cabinet committees, and partners.	Mark Gilbert	Control			
				• Regular meetings with provider and representative organisations (LMC, LPC). Regular meet the market events to support commissioning processes	Mark Gilbert	Control			

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	Risk Title and Event	Owner	Last Review date	Next Review Date
PH0082	**Implementation of General Data Protection Regulations (GDPR)** Increased likelihood of breaching data protection law and having a negative impact on the right to a private life for the citizens of Kent	Gerrard Abi-Aad		23/05/2018

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
The General Data Protection Regulations (GDPR) increases obligations on data controllers such as KCC to document all data processing activity	A serious breach of GDPR might result in an inability to access key Public Health data sources by means of special conditions placed on access rights as a result of breach failures. A breach might also result in KCC incurring significant financial penalties, damage to KCC's reputation and its ongoing ability to support new analytic requirements in respect of strategic commissioning.	Medium 12 Serious (4) Possible (3)		• Commissioners to support the implementation of the GDPR programme	Mark Gilbert	A -Accepted	25/05/2018		Low 4
				• Update privacy notices to be GDPR compliant.	Gerrard Abi-Aad	A -Accepted	25/05/2018		
				• contract with Optum is awaiting sign off	Gerrard Abi-Aad	A -Accepted	25/05/2018		
				• Development of and maintaining a data processing register documenting data processing activity	Gerrard Abi-Aad	A -Accepted	25/05/2018		
				• KCC will want to satisfy itself through its contractual controls that these requirements and ICO's code of practice on Privacy Impact Assessments as well as the guidance from the Article 29 Working Party are complied with.	Mark Gilbert	Control	25/05/2018		

Appendix 2 - Kent and Medway Sustainability and Transformation Partnership

Risk Register - Corporate Risk Register

Current Risk Level Summary

Green	Amber	Red	Total
0	0	1	1

Current Risk Level Changes

0	0	0	0	0
0	0	0	1	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0

Risk Ref	Risk Title and Event	Owner	Last Review date	Next Review Date
CRR0005	**Kent and Medway Sustainability and Transformation Partnership**	Anu Singh	20/12/2017	20/03/2018

Failure to maximise opportunities for appropriate health & social care integration and ensure changes achieve maximum benefit.
Pressures within the acute health sector result in repercussions for social care and threaten successful implementation of joint working arrangements.
Improved Better Care Fund monies earmarked for social care geared to addressing pre-determined NHS targets and priorities.
Inappropriate level of Local Authority involvement. STPs have no formal role for local authorities, except by local agreement.
No changes to primary legislation. Current statutory responsibilities and duties remain and cannot be delegated, and are inconsistent with LA statutory responsibilities.
Failure to meet statutory duties around the sufficiency of the care market, care quality and safeguarding.
Opportunity cost from spending time and resources on STP and system design which is subject to change from NHS England.
Comprehensive plans to reform health services entail KCC Cabinet support for substantial variations of service in the NHS.
Lack of understanding within KCC of NHS policy and regulatory environment; and vice versa, lack of understanding of local authority legislative, policy and democratic environment in NHS.

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Days Overdue	Target Risk Level
The health & social care 'system' is under extreme pressure to cope with increasing levels of demand and financial constraints. National government policy for integration of health and social care as part of how to meet these challenges. NHS national policy is for health commissioners and providers to come together and develop place based plans. KCC is part of the Kent and Medway Sustainability and Transformation Partnership (STP). Sub-STP local planning and delivery arrangements are being developed through Accountable Care Partnerships (ACP). Development of NHS standard contract for Accountable Care Partnerships that could include public	Further deterioration in the financial and service sustainability of Health and Social Care system in Kent and Medway. Additional budget pressures transferred to social care as system monies are used to close acute and primary care service gaps. Legal challenge/judicial review of decisions and decision-making framework for integrated decisions. De facto transfer of LA commissioning and budgetary decisions to joint vehicles with NHS without appropriate safeguards. Existential challenge. Social care and public health service priorities determined by NHS, not KCC. Capitated provider contracts dominated by NHS budgets and targets. Focus on STP and ACP workstreams	High 16 Serious (4) Likely (4)		• Introduction of the Local Care Implementation Board	Paul Carter	A -Accepted	30/04/2018		Medium 12
				• Development of a joint KCC and Medway Health and Wellbeing Board for STP related matters/issues	David Whittle	A -Accepted	30/04/2018		
				• Engagement with the new NHS Strategic Commissioner for Kent and Medway and alignment of strategic commissioning intentions with KCC Strategic Commissioner	Vincent Godfrey	A -Accepted	30/04/2018		
				• Senior KCC level officer representation on the East Kent ACP, and emerging West, North and Medway ACP	Anu Singh	Control			
				• KCC STP Secretariat established to manage and monitor ongoing engagement and activity	Anu Singh	Control			
				• Senior KCC political and officer representation on the STP Programme Board	Paul Carter	Control			

health and social care. Major NHS policy announcements made every 12-18 months.	prevents more local and agile improvements/joint working being undertaken. Erosion of long-term working relationships between NHS and local government. Reputational damage to either KCC or NHS or both in Kent.			• County Council agreed framework for KCC engagement within the STP – ongoing monitoring and control taking place through STP Secretariat	Anu Singh	Control			
				• Senior KCC level officer representation across STP workstreams	Anu Singh	Control			
				• Regular internal STP co-ordination meetings chaired by the Leader	Paul Carter	Control			
				• KCC has a designated Cabinet Member Portfolio for Health Reform and Cabinet Member for Strategic Commissioning	Paul Carter	Control			
				• Establishment of a Health Reform and Public Health Cabinet Committee to provide non-executive member oversight and input of KCC involvement in the STP	Benjamin Watts	Control			

From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 13 March 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

2.1 An agenda setting meeting was held on 24 January 2018, 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 in agendas 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: 2 March 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.

3 MAY 2018
• **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)* • ***Verbal Updates – could include STP update*** • **Report on use of psycho-active substances** *(added at 24 Jan mtg)* • **Regular monitoring of bedding in of new infant feeding service model** *(timing tbc)* • ***Contract Monitoring*** *– Primary School Public Health Services* • ***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*** *– Postural Stability* • ***Work Programme 2018/19***
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*** *– Adult Drug and Alcohol Services* • ***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*** *– 0-5 Children and Young People's Services* • ***Work Programme 2019***
9 JANUARY 2019
• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Adult Health Improvement Services (incl workplace health)* • ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings* • ***Work Programme 2019/20***
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*** *– Adolescent Health Services* • ***Work Programme 2019/20***

remainder of 2019 – MEETING DATES NOT YET SET	
MAY	• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Domestic Abuse and Positive Relationships* • ***Work Programme 2019/20***
JULY	• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Mental Health* • ***Work Programme 2019/20***
SEPTEMBER	• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Workforce Development* • ***Work Programme 2019/20***
NOVEMBER	• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Young Persons' Drug and Alcohol* • ***Work Programme 2019/20***

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
March	Draft Directorate Business Plan Risk Management report (with RAG ratings)
May / June	
June / July	
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
November / December	