HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 27th June, 2018

10.00 am

Darent Room - Sessions House

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 27 June 2018 at 10.00 am
Darent Room - Sessions House

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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UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in items on the Agenda

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

4 Minutes of the meeting held on 1 May 2018 (Pages 7 - 16)

To consider and approve the minutes as a correct record.

5 Verbal updates by Cabinet Members and Director (Pages 17 - 18)

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 Workforce planning update (Pages 19 - 24)

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 work undertaken by NHS colleagues and Public Health to address NHS and Social Care and Public Health workforce and training issues, which the Cabinet Committee is asked to note and endorse.

7 Contract Monitoring paper for Postural Stability Services (Pages 25 - 34)

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 an overview of the Postural Stability services commissioned by the County Council and providing details of the purpose, performance, outcomes and value for money of the contracts, which the committee is asked to note and comment on.

8 Suicide Prevention update (Pages 35 - 44)

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 recent suicide prevention developments and highlighting £667,978 of new funding which has been secured for suicide prevention work across the Kent and Medway STP area in 2018/19. The committee is asked to note the recent progress and make comments and suggestions to strengthen future delivery.

9 Childhood Immunisations (Pages 45 - 50)

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 roles and responsibilities of partners around childhood immunisations, the local picture of childhood immunisations in Kent and current and future actions planned by NHS England to improve immunisation rates. The committee is asked to note progress and endorse the approach being taken.

10 Work Programme 2018/19 (Pages 51 - 54)

To receive a report from 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

Tuesday, 19 June 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 on Tuesday, 1st May, 2018.

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

OTHER MEMBERS: Peter Oakford

OFFICERS: Andrew Scott-Clark (Director of Public Health), Dr Allison Duggal (Deputy Director of Public Health) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

65. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Mr P B Carter, CBE, Mrs L Game, Mr S J G Koowaree, Ms D Marsh and Mr K Pugh.

Mr R H Bird was present as a substitute for Mr Koowaree, Mr M A C Balfour for Ms Marsh and Mr J Wright for Mr Pugh.

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

Mr J Wright declared an interest in agenda item 7 as a founder member of the Newington Air Quality Management Group, and he had been involved in a planning appeal case which had set national case precedence on air quality.

Mr I Thomas and Mr A Cook both then declared that they had been involved in the preparation of Thanet District Council's air quality action plan.

During agenda item 5, Mr Wright also declared that he was a County Council-appointed governor of Medway Hospital.

67. Minutes of the meeting held on 13 March 2018.
(Item. 4)

It was RESOLVED that, subject to the addition of Ms D Marsh to those Members having submitted apologies, the minutes of the meeting held on 13 March 2018 are correctly recorded and they be signed by the Chairman.

There was one matter arising: the committee had originally intended that Members would have the opportunity at the May meeting to have a health check, but it had not proved possible to arrange this. Discussion of other testing opportunities for Members followed in later agenda items.

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

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

The Local Care Implementation Board (LCIB), of which Mr Carter was the Chairman, had met three times thus far and was pursuing the agenda of improving the integration of health and social care.
Suicide Prevention Grant – Mr Oakford thanked Jess Mookherjee and the public health team for the enormous amount of work they had done on suicide prevention and for putting together a bid for government funding to support this work. Kent had been given a one-off grant of £668,000 of government funding for the 2018/19 financial year, and was one of only nine Sustainability and Transformation Programme (STP) areas to have been awarded this funding. 20% of this funding would be used to implement and improve the suicide action plan and the remainder to support campaign work, including workplace training and interventions, and expanding the work to address adolescent suicide.

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

Kent and Medway Measles outbreak – this had affected people of all ages, and the control measures being used were isolation and vaccination. Good communication was vital and guidance was being sent to schools and nurseries.
Sustainability and Transformation Programme (STP) Prevention workstream – Mr Scott-Clark and the Director of Public Health for Medway Council were jointly responsible for prevention work in Kent and were working together on the prevention plan and deep dive reviews. The establishment of the new workstream had raised the profile and importance of prevention work.
Stroke Prevention – this work brought together health indicators such as those covered by the NHS health check, plus blood pressure, irregular pulse and encouragement to reduce alcohol intake and increase physical activity, and aimed to improve the identification, diagnosis and treatment of atrial fibrillation, which was a key part of stroke prevention. This work was being supported by Public Health England.

3. Mr Scott-Clark and Ms Mookherjee responded to questions from Members, including the following:-

a) suicide prevention work would include work to address rates of adolescent suicide, and this was well covered in the Children's Emotional Wellbeing Plan. This work would make the best use of existing resources and networks across the County Council, using the Community Safety Partnership and the Kent Safeguarding Children Board;

b) asked about the percentage take-up of the measles vaccination, Mr Scott-Clark explained that the vaccination rate was below the 95% target. It was recommended that two different vaccines be given, as a double dose. He reassured Members that cases of measles were not frequent, there last having been cases in 2011 and 2016, but emphasised the highly contagious nature of the disease. Hospital staff were also being advised to be

vaccinated. Clusters of cases had shown up in Medway and Swale but had then spread across the county;

c) asked how Members would be advised of the detail of STP funding received and how this money was being spent, Mr Scott-Clark undertook to refer this question to Glenn Douglas, the accountable officer for the Kent STP. He emphasised that STP funding and the workstreams arising from it would apply to the whole of Kent;

d) it was suggested that, as part of stroke prevention activity, elected Members should set an example and undergo testing for atrial fibrillation to assess their risk of stroke;

e) concern was expressed about the number of GP practices around the county which were beyond capacity and unable to accept new patients, as well as the number of practices closing, and experienced GPs retiring, compared to the shortage of new GPs qualifying and taking up practice. This placed a huge strain on GPs as a first line of contact, at a time when so much was being asked of them as part of health improvement work. Mr Scott-Clark explained that the Primary Care Code emphasised the importance of good local care. A new medical school at Canterbury Christ Church University would help to address the shortage of GPs. Mr Oakford added that the workforce workstream in the STP had been set up to address the training, recruitment and retention in Kent of primary healthcare staff. Kent currently had a shortage of 247 GPs. Further concern was expressed that this shortage coincided with much new house building;

f) disappointment was expressed at the lack of health care apprenticeships;

g) asked about the gender profile of adolescents attempting suicide, Ms Mookherjee advised that most were boys aged under 18. However, rates of self-harm were much higher among women and girls than among boys. The additional grant funding made available this year would support more research into patterns of suicide; and

h) Mr Scott-Clark advised that the new medical school at Canterbury Christ Church University would use the premises of the former HM Prison Canterbury as student accommodation, which was adjacent to the university and had been acquired for that purpose. Teaching would start in a classroom setting and continue to a more advanced level of training in local hospital placements. The new medical school was required to partner with an established school so would link to Brighton medical school, and the County Council's public health team would have some involvement in providing training for students.

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

69. Kent Tobacco Control - working in partnership.
(Item. 6)

Ms D Smith, Public Health Specialist, was in attendance for this item.

1. Ms Smith introduced the report and, with Mr Scott-Clark, responded to comments and questions from Members, including the following:-

a) asked if the 40% of adults with serious mental illness who smoked could be using tobacco as a form of medication, and if they could be helped to find alternative support, such as mindfulness, Mr Scott-Clark advised that mental health trusts had a stated aim of reducing smoking among patients as this had been proven to reduce aggression and anxiety. Statistically, people with mental illness had poorer health outcomes and lower life expectancy as their tendency to smoke made them vulnerable to contract and die of other illnesses. Addressing addiction of any sort would always form apart of good medical care;

b) asked about research and current thinking on the safety of vaping, Mr Scott-Clark advised that Public Health England took the view that there was no evidence that vaping was safe in the long-term. Clinicians supported the use of vaping as part of an attempt to quit smoking as it was seen as being safer than tobacco, and vaping could be used to administer some drugs, for example, for asthma. However, while vaping could not be guaranteed to be completely safe, there was certainly no safe level of tobacco intake;

c) insurance providers did not view vaping as a long-term alternative to smoking and would not reduce insurance premiums for vapers;

d) concern was expressed that people quitting smoking might replace tobacco with some other substance, which could prove more damaging, but Mr Scott-Clark explained that it was hard to identify any causal relationship between giving up tobacco and turning to other substances. There was no evidence of a generation of young people who had never smoked but had adopted vaping as a habit. He reassured Members that vaping shops operated under a strict national code of practice which stated that anyone who had not previously smoked should not be given vaping products containing nicotine;

e) concern was expressed at the number of school children seen smoking outside school gates and the view put forward that what was needed to deter them was to show, perhaps as part of PHSE lessons, graphic images of the physical damage smoking could do. Mr Scott-Clark set out the measures taken in recent years to reduce the attraction of cigarettes, including plain packaging featuring graphic images and cigarettes in shops being locked out of sight behind shutters. He added that the STP targeted the groups among which smoking was most prevalent, including the lowest paid and manual workers, and pregnant women. The availability of illicit tobacco was a large problem in the South East and *it was suggested that a report on this subject be submitted to a future meeting of the committee;*

f) some people were more susceptible to addiction and this could be a matter of genetic predisposition. Clinicians supported this view and treated smoking as an addiction rather than a social issue. Specialist services were commissioned to address addiction;

g) education was a key issue, and it was known that, if a young person could get to the age of 16 without starting to smoke, they would be much less likely to smoke or use other substances in adulthood;

h) concern was expressed that education of young people should be left to professional educators, and Ms Smith confirmed that the public health team was working with youth workers to encourage young people to quit. However, some young people already addicted were resistant to this encouragement, and graphic images on packaging, with the hard-hitting message 'Smoking Kills' did not have the desired impact;

i) a view was expressed that, alongside the figures for smokers and quitters, it would be helpful to acknowledge and show the number of people who had never smoked;

j) concern was expressed about the number of medical staff, as well as patients, smoking outside hospital premises. The NHS could be trying to treat one condition while the patient further damaged their health by smoking. Mr Scott-Clark advised that several health trusts were working toward being totally smoke-free in the near future. He explained that the NHS could not use any patient's lifestyles choices as a reason to refuse them treatment;

k) health visitors would support expectant mothers not to smoke throughout their pregnancy and onwards through the child's formative years, so a child had a chance to grow up in a smoke-free environment; and

l) Mr Scott-Clark advised that the figures shown in the report for adult smoking prevalence across the districts of Kent were gathered from surveys and hence were not necessarily a reliable indicator of percentage of population.

2. It was RESOLVED that the information set out in the report, and given in response to comments and questions, be noted, and local measures being taken to tackle smoking and tobacco control be endorsed.

70. Air Quality.
(Item. 7)

1. Dr A Duggal introduced the report and, with Mr Scott-Clark, responded to comments and questions from Members, including the following:-

a) a view was expressed that, while formal liaison existed between county and district councils, whose responsibility it was to address air quality, the County Council's own directorates could work more effectively together to take account of air quality issues. Highways colleagues, for example, often did not take the opportunity to comment on or raise air quality issues when consulted about planning applications. Dr Duggal added that the availability of better quality data would help influence highways and secure more public health involvement in planning decisions. Mr Scott-Clark added that public health colleagues were part of the County Council's Environment Board and could promote the importance of public health considerations as part of the planning process. He advised, however, that poor air quality was not mentioned on death certificates as

a contributing factor to deaths from certain cancers and respiratory illnesses;

b) although air quality modelling was a very complex subject, what was more helpful from a public health point of view was the ability to quantify the impact of poor air quality upon health. The University of Kent at Canterbury was currently working towards this aim;

c) disappointment was expressed at the extent of local action being taken, and there was more which could be done, for example, by promoting drop-off zones for schools in which car engines must be switched off;

d) several of the Members of the Cabinet Committee served also on district and borough councils and spoke about their experiences in that role. District councils had responsibility for air quality but had not been given sufficient power by the Government to execute this role effectively. Another speaker said it was most important to remember that the responsibility to safeguard air quality was a district council (rather than a public health) function, and that much work went on in districts to undertake this role. Dr Duggal emphasised that there was no intention to criticise the work done by district councils; the report intended simply to indicate the way in which public health sought to influence the consideration of air quality issues. Mr Scott-Clark added that public health had had success in promoting smoke-free school gates as part of its campaign for smoke-free environments for young children;

e) a view was expressed that the County Council, in particular, environment and transport officers, could and should do more to support district councils to tackle air quality issues;

f) another speaker emphasised how far air quality had improved since the pollution of the 1950s, caused by domestic coal fires and petrol fumes, especially since the Clean Air Act of 1956. Much had been done, which was to be celebrated, but there was much more yet which could and should be done. Understanding of how to manage pollution, for example, the role of trees in absorbing carbon dioxide emissions, had increased much since the 1950s and 60s; and

g) the Chairman pointed out that the County Council was taking a lead in helping the council of the Nord-pas de Calais to address air quality issues with the help of an Interreg project.

2. It was RESOLVED that the information set out in the report and given in response to comments and questions be noted, and the approach taken by the County Council's public health team and partners to tackling air quality issues in Kent be endorsed.

71. Update on the use of Novel Psychoactive Substances in the UK and Kent. *(Item. 8)*

Ms J Mookherjee, Consultant in Public Health, was in attendance for this item.

1. Ms Mookherjee introduced the report and emphasised that, although the County Council had started to look at this subject after the Novel Psychoactive Substances Act of 2016, there was much detail still to be learnt about novel psychoactive substances (NPS) and their use. They were known to mimic mental health symptoms and to be used by vulnerable people and the homeless, but the scale of their use was not yet clear. There were four main themes to the use of NPS; recreational use (for example, in clubs), self-medication, mixing of drugs to get an extra high and self-harm and suicide attempts. NPS were covered by the County Council's Alcohol and Drug Strategy, as were self-harm and suicide in young people. Ms Mookherjee responded to comments and questions from Members, including the following:-

a) little was known, as yet, about the age profile of users of NPS overall, although users who had required medical intervention from their use had been of a wide age range. Many homeless people were known to use NPS;

b) NPS included a range of chemicals, which was changing all the time and included heroine, fentinol and fertilizers, so it was difficult to identify a regular 'recipe' and the scale and effect of any impurities;

c) concern was expressed that describing a type of use as 'recreational' would conceal its dangerous nature. Addaction, who delivered the County Council's drug and alcohol services, was engaged in much work to educate users and potential users of the dangers of NPS;

d) statistics for arrests and prosecutions *could be obtained from the police and supplied to Members after the meeting*;

e) a film, 'Licence to Kill', made by the Kent and Medway Fire and Rescue Authority, had been widely shown in schools to illustrate the effects of drug use. This could be used as a blueprint for other films. Ms Mookherjee added that she had seen a police training film, the content of which was such that viewers had first been asked to sign a disclaimer;

f) work was going on to improve surveillance, recording and links, for example, between drug and alcohol services and data generated by accident and emergency admissions for which NPS use had been identified as a contributing factor. To this would be added public reporting of local knowledge about dealing and 'cuckooing' behaviour, which involved a dealer taking over the home of a vulnerable person as a base from which to deal; and

g) Ms Mookherjee emphasised the links between the County Council's Drug and Alcohol Strategy and the Crime and Safety Partnership.

2. It was RESOLVED that the information set out in the report and given in response to comments and questions be noted, and local measures to tackle the use of novel psychoactive substances be endorsed.

72. Contract Monitoring Report - Primary School Public Health Service.
(Item. 9)

Mrs V Tovey, Public Health Senior Commissioning Manager, and Ms S Bennett, Consultant in Public Health, were in attendance for this item.

1. Mrs Tovey and Ms Bennett introduced the report and responded to comments and questions from Members, including the following:-

a) asked about the take-up of intervention plans, Mrs Tovey explained that any young person could request a lifestyle package of care and that the rate of take-up was currently about 10%, but she *undertook to check this figure and advise Members outside the meeting*;

b) Mrs Tovey also *undertook to give figures to Members about engagement between the Primary School Public Health (PSPH) service and children educated at home;*

c) every school had a named member of staff, not necessarily a school nurse but one of the school health team with relevant skills and training, who would offer a drop-in service and workshops;

d) in the first year of the service, following the award of contract, the service had borne set-up costs, but these had now ended and the service could move ahead to achieve best value and start to achieve savings;

e) Ms Bennett and Mrs Tovey advised that the needs of children would be identified via questionnaires and an assessment would then be made to identify the best sort of engagement for them. This assessment process was a new part of the plan;

f) statutory parts of the service included the national child measurement programme (NCMP), and figures for the proportion of spend allocated to these aspects *could be supplied to Members after the meeting;*

g) NCMP checks would be followed by a proactive phone call from the school health team to the parent of any child who had shown up as being above a healthy weight for their age. Approximately 10% of parents responded to this call and took up the opportunity to engage with the PSPH service to address their child's weight. Approximately 10% of Year R children and 20% of Year 6 children were overweight. Some parents took a while to accept that their child was overweight before accepting help from the service;

h) asked what collaboration there was between the PSPH service and the North East London Foundation Trust, Ms Bennett explained that there was general partnership and close links between the PSPH and providers of the CAMH services in the south east, and the relationship between the two bodies was complex; and

i) asked if future contract monitoring reports to the Cabinet Committee would include performance against targets, Mrs Tovey said that this

would indeed become the case, as the service bedded in beyond its first year. The Cabinet Committee had only recently started its programme of regular contract monitoring.

2. It was RESOLVED that:-

a) the information set out in the report, and given in response to comments and questions, be noted; and

b) the progress made to transform services through an effective contract management approach, and the ongoing activities to deliver statutory obligations, continuous improvement and meet performance expectations, be endorsed.

73. Transition of Infant Feeding Service.
(Item. 10)

Ms K Sharp, Head of Commissioning, Outcome 1 and Public Health, and Ms S Bennett, Consultant in Public Health, were in attendance for this item.

1. Ms Sharp and Ms Bennett introduced the report and set out how the new service was bedding in and was being monitored. The new service had received both welcoming and critical feedback from practitioners and service users. Ms Sharp and Ms Bennett responded to comments and questions from Members, including the following:-

a) the distribution of clinics around the county had been based on a complex picture of need and current use and was now based more on the availability of specialist advisors;

b) all lactation consultants formerly employed by the previous provider had met with Kent Community Health NHS Foundation Trust (KCHFT) and been offered a new contract and terms and conditions. The aim was to establish a model of full-time employment of lactation consultants with additional spot-purchasing, to offer optimum flexibility, in place of the previous arrangement, which relied on spot-purchasing only. There was a small number of lactation consultants, with two of these being part of the Health Visitor service. If any of the current lactation consultants chose not to take up the new contracts offered, KCHFT would look to employ lactation consultants from elsewhere;

c) progress on the new service was welcomed, and the officer team received thanks and congratulations from the committee on the work they had put in to building the new service model, given the complexity of the issue and the timescale involved. Ms Sharp explained that the new service would start on 1 June 2018, so arranging everything between the date of the key decision and this start date had been challenging. She advised that the performance metrics being developed as part of the transition plan would start to appear in the regular dashboard reports submitted to the Cabinet Committee. The Cabinet Member, Mr Oakford, added his thanks and congratulations to the officer team and emphasised the immense amount of work which had gone into setting up the new service;

d) it was requested that the metrics being established to measure performance include a measure of how many mothers requiring an appointment urgently had been able to access this within two working days. Ms Sharp added that the service was overseen by mothers who were themselves service users, one of whom had first-hand experience of tongue-tie. Ms Sharp *offered to bring to the Cabinet Committee a further report on the new service once it had commenced;* and

e) the joint working involved in setting up and delivering the new service was welcomed, and improvements to the service anticipated.

2. It was RESOLVED that the information set out in the report, and given in response to comments and questions, be noted, and the progress to date be endorsed.

74. Performance of Public Health commissioned services.
(Item. 11)

Ms K Sharp, Head of Commissioning, Outcome 1 and Public Health, was in attendance for this item.

1. Ms Sharp introduced the report and the Chairman noted that the performance against targets was very positive, overall.

2. It was RESOLVED that the Quarter 3 performance of public health commissioned services be noted and the proposed changes to key performance indicators to be presented in future Cabinet Committee reports be agreed.

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

It was RESOLVED that Cabinet Committee's work programme for 2018/19 be agreed.

By:	Mr P B Carter, CBE, Leader and Cabinet Member for Traded Services and Health Reform Mr P J Oakford, Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health Mr A Scott-Clark, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee – 27 June 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:

1. Update on new Infant Feeding Service
2. Joint Kent and Medway Health and Wellbeing Board

Director of Public Health – Mr A Scott-Clark:

1. Sustainability and Transformation Programme Prevention work stream
2. Measles

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

Allison Duggal, Consultant in Public Health and STP Prevention Lead

To: Health Reform and Public Health Cabinet Committee - 27 June 2018

Subject: **Workforce Planning update**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to note and endorse the work by the Local Workforce Action Board and Design and Learning Centre on the NHS and Social Care Workforce Challenge and the work of Public Health to develop the Public Health workforce and contribute to the development of Public Health skills in the NHS and Social Care workforce.

1. STP Workforce Workstream (NHS and Social Care)

1.1 The STP workforce workstream was mobilised in 2017/18 as an enabler to support the workforce transformation required for the delivery of the STP and new models of care. The workstream will continue to support health and social care in Kent and Medway to plan, recruit, inspire and retain the skilled health and social care workforce including the care sector to deliver high-quality services.

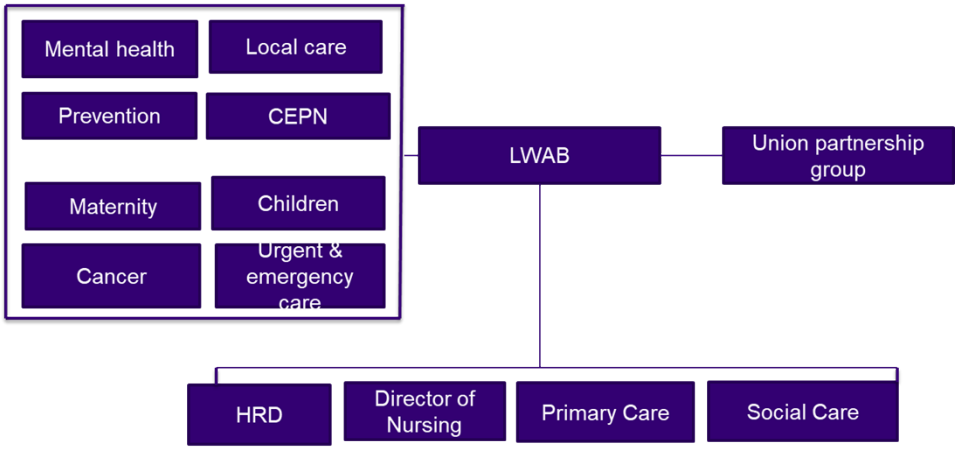
1.2 In Kent and Medway there are significant challenges in terms of vacancies and associated temporary staffing costs, variability in terms of skills, competencies and role definitions. The health workforce position is worse than the national average for nearly all staff groups.
Headline data for the challenges across Kent and Medway:

- There are over 40,000 employees in the social care sector
- 26% turnover in social care sector
- 31% turnover in nursing
- 2500 vacancies in secondary care (hospitals)
- Aging GP workforce – 29% (highest in England)
- 45% secondary care vacancies are in nursing
- 65% of the health budget is staff costs with 10% on agency

1.3 The workforce workstream has considered the challenges and constraints set out in 1.2 and is now developing and implementing supporting solutions. The STP workforce workstream will also support the care transformation programmes to develop and implement workforce models to underpin the implementation of the new models of care.

1.4 The Local Workforce Action Board (LWAB) has been set up to deliver the STP workforce workstream and to develop the Kent and Medway workforce strategy based on best practice, current evidence and engagement/collaboration with key stakeholders. The LWAB reports to the STP Programme Board and is supported by subgroups, shown in the governance diagram below.

LWAB Governance



1.5 Social Care is a key component within the STP workforce workstream and plans are in place to deliver our vision which is to establish an integrated, sustainable and competent social care workforce including the care sector to provide good quality care. The LWAB is also supported by the Design and Learning Centre for Clinical and Social Innovation (a facility set up and supported by Kent County County) which has been recognised as the service improvement and innovation facility for the Kent and Medway STP. Anne Tidmarsh has been identified as the Senior Responsible Officer for STP workforce and will be supported by a GP. Dr Allison Duggal has recently been invited to represent Public Health at the LWAB.

1.6 The following areas are included in health and social care LWAB plans for 2018/19, which continues to build upon the work delivered to date:

1. Growing the workforce for the future:
    - Continue to develop and utilise the Apprenticeship Levy across health and social care.
    - Develop up to 80 GPs per year.
    - Develop integrated career pathways across the system.
    - Test and implement Nurse Associate programme across Health and within nursing homes.

- Develop the unregistered and registered social care workforce through Open University sponsorship, developing Newly Qualified Social Workers and talent management programmes for senior practitioners.
- Introduce a work experience programme and work closely with schools, colleges, Higher Education Institutes, Skills and Employability and the Health and Social Care Guild to promote career opportunities and raise the profile of health and social care.
- Develop the Kent and Medway Medical School Implementation Plan.

2. Skills Development:
    - The Design and Learning Centre has secured funding from the Local Workforce Action Board to introduce the Learning and Development Hub which is a one stop shop for the care sector.
    - Support to the sector to innovate and utilise technology.
    - The Design and Learning Centre will continue to roll out the ESTHER model and explore workforce challenges through Innovation events and ESTHER cafes.
    - Signposting the sector to high quality training and development.

3. Integrated roles and new teams:
    - Definition of new integrated functions and roles, learning from the Buurtzorg and ESTHER models.
    - Offering organisational development support to Multi-Disciplinary Teams (MDTs) to support change management, leadership and staff engagement.

4. Recruitment and Retention:
    - Launch of “Take a Different View” recruitment website promoting living and working in Kent and Medway
    - Development of recruitment campaign for the care sector to raise awareness and increase interest in provider vacancies which is due to go live in July.
    - Return to practice nursing, between 90 and 100 places in Kent, Surrey and Sussex.
    - 130 GP’s will be recruited from overseas which will commence November 2018.
    - Implement system attraction and retention strategies including action plans for key staff groups.

5. Working with Social Care Providers:
    - Provider conference delivered to 200 delegates in March 2018 and a follow up event is planned for October 2018.
    - 2 dedicated staff recruited to work with providers and improve relationships.
    - Building links with Skills for Care, Health Education England and the Care Quality Commission to identify practice improvements and share with the sector.

6. System Leadership and Talent Management:
    - To explore the opportunities between the Medical School, KCC Social Care Academy, Health Education England Kent, Surrey and Sussex Leadership Programme and the Teaching Partnership to develop a health and social care leadership programme and career pathways.
    - Define common outcomes for successful leadership across all parts of the system including behaviours and culture.
    - Implement a leadership programme for care sector registered managers through the Design and Learning Centre.

1.8 There is a focus on how we utilise the apprenticeship levy across health, social care and care sector workforce. The following areas are included within a work plan:

- **Care Sector**: Apprenticeships are a key topic with the sector exploring how the levy works, barriers and actions to address identified challenges. Working in partnership with the sector to create myth busters, case studies and working with training partners to make the Maths and English exams more relevant to examples people working in the sector.
- **Health**: Exploring integrated apprenticeship roles and training opportunities. Currently mapping out career pathways with the Health Education England Kent, Surrey and Sussex Apprenticeship lead. Social Care is also utilising the nurse associate programme for placements in the care sector, and we are now exploring with health how the apprenticeship levy can be utilised to scale up the nurse associate programme within the sector.
- **Social Care:** Preparing the for the Social Work apprenticeship degree which will be available 2019.Currenlty commissioning a development programme with a higher education partner to develop children's and adults unregistered workers over the next year which will support these workers to progress to the social work apprenticeship degree.

2. Public Health Workforce Development

1.1. Health Education England has approved funding for KCC and Medway colleagues to train identified priority workforce to support the prevention agenda by encouraging changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and population.

1.2. The three projects which have been identified to support the work of the prevention workstream are:

- Motivational Interview Training (MIT)
- Cognitive Behaviour Therapy (CBT)
- Brief Solutions Focused Therapy (BSFT)

1.3. Key workforces:

Training	Priority Workforces	Rationale
MI	Primary care, social care staff, housing teams	Primary care to include care navigators and practice nurses and GPs delivering health checks. Social care and housing staff have

		regular contact with key population groups but are not sure how to hold those difficult conversations about behaviour change.
CBT	Midwifery, Hospital Discharge Teams, Public Health professionals and care navigators	Working with patients over a longer period and who might be more motivated (due to e.g. pregnancy or hospital stay) so can use CBT to effect behaviour change.
BSFT	Public Health professionals, including Smoking Cessation, Weight Management, Health Visiting	Working with patients over a longer period can build up a therapeutic relationship.

MI = Motivational interviewing, CBT= Cognitive Behaviour Therapy, BSFT = Brief Solutions Focussed Therapy

1.4. In order to help increase knowledge and skills in perinatal mental health, .Kent and Medway NHS and Social Care Partnership Trust's Mother and Infant Mental Health Service is providing training sessions for GPs.

Led by one of the Mother and Infant Mental Health Service (MIMHS) Perinatal Consultant Psychiatrists, the course includes information on prevention and the identification of perinatal mental disorder and perinatal prescribing principles (in pregnancy and breastfeeding), with information on services and referral pathways.

1.5. NHS England and Public Health England have awarded £667,978 funding to the Kent and Medway STP for suicide prevention across Kent and Medway. The funds are intended to improve suicide prevention strategies, signposting and raising awareness through to improving quality for safer services and will help drive better surveillance and collection of data on suicide, attempted suicide and self-harm.

The funding will be spent on a range of initiatives including:

- Extension of the 'Release the Pressure' campaign so that more people become aware of the 24/7 freephone support line for any issue
- Suicide Awareness and Prevention training so that more people have the confidence and ability to support someone they are concerned about
- research into the reasons why people attempt suicide so that opportunities to intervene and help can be identified
- strengthening mental health services at high risk points so help is available when people need it most.

2. Kent and Medway Medical School

2.1. The new Kent and Medway Medical School was approved by Higher Education Council for England (HECFE)/Health Education England (HEE) in March 2018.

2.2. The Medical School is a joint venture between the University of Kent at Canterbury and Canterbury Christ Church University, in partnership with Brighton and Sussex Medical School. The School will be located in Canterbury.

2.3. The curriculum will be based on that of Brighton and Sussex Medical School. For the first two years of study, the students will be placed one day a week with an approved educational setting in primary and community care. In years three to five, the students will be placed in an acute setting.

2.4. Public Health Consultants are already working with the universities to develop a public health curriculum for the Medical School.

2.5. Kent and Medway Medical School will open in 2020.

3. Considerations and Future development

3.1. We are exploring the development of a regional strategy for Public Health practitioner workforce development

4. Recommendations

4.1. The Health Reform and Public Health Cabinet Committee is asked to note and endorse the work by the Local Workforce Action Board and Design and Learning Centre on the NHS and Social Care Workforce Challenge and the work of Public Health to develop the Public Health workforce and contribute to the development of Public Health skills in the NHS and Social Care workforce.

Background documents: none

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee - 27 June 2018

Subject: **Contract Monitoring Report – Postural Stability Services**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

This report provides the Committee with an overview of the Postural Stability services that are commissioned by Kent County Council (KCC) and provides details of the purpose, performance, outcomes and value for money of the contracts.

Kent has experienced a higher than average rate of falls and hip fractures among older people. Postural Stability services are commissioned by KCC to help prevent falls and support the elderly to maintain independence, supporting KCC's Strategic Outcome "Older and vulnerable residents are safe and supported with choices to live independently". In 2017/18 KCC commissioned nine programmes for 144 people costing just over £90,000.

The commissioned services sit alongside other services funded by Clinical Commissioning Groups and are currently provided by Kent Community Health NHS Foundation Trust (KCHFT) in East Kent and Involve Kent in West Kent. Both providers demonstrate good performance and value for money through continuous market testing. The contract performs well and KCC works with the commissioned providers to continuously improve service quality and outcomes.

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on:

- the commissioning and provision of postural stability services in Kent
- the work to improve patient experience and service efficiency.

1. Introduction

1.1. Kent County Council (KCC) commissions community-based postural stability classes to help prevent falls among older residents. This programme contributes to KCC's strategic outcome that "Older and vulnerable residents are safe and supported with choices to live independently".

1.2. This paper forms part of the regular contract monitoring reports for the Cabinet Committee. It provides an overview of the performance, outcomes, value for money and further direction of the postural stability services that are commissioned by KCC.

2. Background - why invest

2.1. Health and social care organisations are facing unprecedented challenges and the need to focus on preventative measures through joint working has never been greater. Kent has an ageing population and over the next 10 years (to 2028) it is anticipated that the population over 65 years will increase by at least 26% (an additional 83,000 people) and over 85s will increase by 44%[1]. This will place further pressure on health and social care services.

2.2. The Kent-wide programme of postural stability classes was established in 2014/15 as part of the wider Kent Falls Framework with partners across public health, social care and the NHS. Many falls especially amongst the older population can be prevented by making changes to the environment (e.g. home modifications), giving advice on how to avoid a fall (e.g. changes to footwear) or/and by proving evidence-based interventions (e.g. falls prevention classes). NICE guidance also sets out the importance of identifying individuals at their first fall and putting in place effective interventions to reduce the risk of a secondary fall.

2.3. A series of postural stability classes have been commissioned by KCC in all districts in Kent since 2015/16. The classes were designed to prevent falls and support a reduction in the need for more specialist services such as reablement after a fall or social care services. Research by both the Kings Fund and Public Health England (PHE) demonstrate that postural stability classes are cost-effective and can reduce falls among older people[2]. Recent calculations by PHE indicated that there would be between a £1.20 and £1.28 return on investment for every £1 invested in these programmes. It also calculated that there would be of saving of between £45 and £87 to social care services for each client participating in a class[3].

2.4. Previously for Kent the rates of emergency hospital admissions due to falls in people aged 65 and over, specifically the over 80s, has either been significantly worse or similar to national rates. Kent has been experiencing a decrease in these rates since 2015/16, however they remain high at 2,054 per 100,00 for those aged over 65 and 5,441 for those aged over 80.

3. Service overview

3.1. The postural stability service is provided to people aged 65 or older and those aged 50-64 years who are judged by a clinician to be at higher risk of falling due to an underlying condition such as Multiple Sclerosis or Parkinson's disease.

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[1] http://www.kent.gov.uk/about-the-council/information-and-data/Facts-and-figures-about-Kent/population-and-census#tab-3, accessed 11th June 2018

[2] Exploring the system-wide costs of falls in older people in Torbay, https://www.kingsfund.org.uk/publications/exploring-system-wide-costs-falls-older-people-torbay, accessed 22th June 2018

PHE cost effectiveness resources https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning , accessed 11th June 2018

[3] PHE cost effectiveness resources https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning , accessed 11th June 2018

3.2. The service is aimed at people who are at highest risk of having a fall and sustaining an osteoporotic fracture. The service aims to achieve the following outcomes:

- improved balance strength, mobility and confidence leading to reduced risk (reduction) of falling;
- increased knowledge and awareness of causes of (injury from) falls, and the benefits of exercise and good nutrition;
- a reduction in acute hospital admissions due to falls prevention;
- older people living longer in their own home;
- older people to stay independent.

3.3. The services are currently delivered via two providers which are Involve Kent in West Kent and Kent Community Health Foundation Trust (KCHFT) in East Kent. KCC and KCHFT have now entered into a partnership arrangement which supports the Sustainability and Transformation plan and maximises limited resources. KCHFT will continue to deliver this service in East Kent as part of this partnership until otherwise agreed.

3.4. The classes are group exercise classes which are chair based and work on progression across 36 weeks. The content is built on evidence-based standards and exercises, Appendix A provides an overview of the class structure. Involve Kent have also produced a film which provides insight into the class structure and objectives. The film can be accessed at: https://www.youtube.com/watch?v=Jrk5pB2gjV4 (Falls Prevention commences at 14 minutes 52 seconds.)

3.5. The service forms part of the preventative element of the overall falls prevention pathway in Kent linking in with NHS services.

4. Service costs

4.1 Since 2014, KCC has commissioned postural stability classes through the Public Health Dynamic Purchasing System (DPS) which has enabled a quick response to changes in demand for classes, whilst securing the best possible price for each new class and testing the provider market.

4.2 KCC has spent £412,000 on 76 classes benefitting 1,043 people. The average cost of a 36-week postural stability class is approximately £5,421 for a class of around 16 clients, although the actual cost varies depending on location, cost of room hire, and travel costs. Providers who are commissioned to provide more than one class will also provide a discount to reflect efficiencies and economies of scale.

4.3 The spend in 2017/18 was £92,000 which funded nine classes benefitting 144 clients.

5. Does the contract perform well?

5.1. Service KPIs - The contract is monitored by the Public Health team on a quarterly basis to provide assurance that the contract is performing well, and quality standards are met. The KPIs are split into three key areas; activity, quality and outcomes, which are set out below.

5.1.1 **Activity –** Table 1 below demonstrates that providers delivered all nine classes commissioned during 2017/18 and had on average 16 clients per class, this meets class size requirements to maintain best value for money and quality for the clients.

Table 1: Service activity data for 2017/18

KPI	Metric	Target	Performance	RAG
1	No. of classes provided	Demand led	9 of 9	Aim met
2	No. of clients who start a programme	Min of 16 per class	144	Target met

5.1.2 **Quality -** It is expected that the client class will fluctuate, and the provider is expected to maintain at least 10 clients on average per week within the classes; this takes into account the existing commitments of those attending over a prolonged period of time, for example hospital appointments. Table 2 illustrates an average of 13.6 clients per class at six weeks and represents 94% of clients.

In addition, the service has high rates of satisfaction reported across providers of between 95% and 98%[4]. Providers also complete a digital quality return on a quarterly basis to ensure compliance with the public health digital indicators. This includes reporting on staff vacancies, policies and procedures, mandatory training, DBS checks etc.

Table 2: Service quality KPI data for 2017/18

KPI	Metric	Target	Performance	RAG
3	No. of clients who continue at 6 weeks	Min of 10 per class	136	Above target
4	Client satisfaction	90% are satisfied or very satisfied with the service	95% to 98%	Above target

5.1.3 **Outcomes –** Outcomes are monitored at 12, 24 and 36 weeks using the three measures set out in Table 4. These assessments are called “timed up and go”, “completing a four-point stand” (4PS) and “a chair stand”. During 2017/18, performance against target was achieved in all but one measure at 24 weeks in the 4PS which was just below target at 76%. By 36 weeks this was above expected levels. This is set out in table 4.

Table 4: Service performance outcome data for 2017/18

KPI	Time period	% of client maintained or Improved their TUAG score from last assessment		% of client participants maintained or improved their 4PS score from last assessment		% of clients maintained or improved their chair stand score from last assessment	
		Target	Actual	Target	Actual	Target	Actual
5	12 weeks	80%	90%	75%	77%	80%	81%
6	24 weeks	80%	89%	80%	76%	78%	87%
7	36 weeks - completion	87%	94%	87%	90%	87%	96%

5.2 In addition to improvements in mobility, public health is concerned with the wider determinants of health which contribute to overall physical and mental wellbeing. Clients are asked if they feel more confident as a result of attending the course and

[4] Data from 6-month period from November 2017- February 2018

82% of those surveyed at the end of the 36-week period report an increase in confidence. Providers receive qualitative feedback from patients which demonstrates how the service also contributes to key KCC outcomes such as reducing social isolation, improved wellbeing and living independently. Some examples can be found below:

"Many participants establish friendship groups and carry on in other local exercise activities beyond the life of the class.

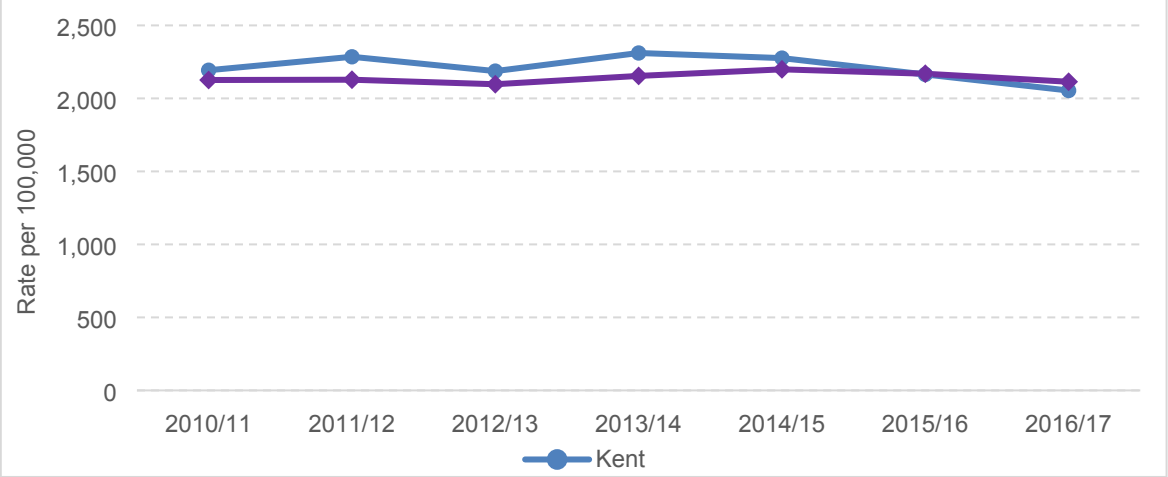
"A number have self-reported that they now able to get on a bus and/or complete shopping trips that previously they would have been unable to undertake.

"A number using mobility aids such as walking sticks, have reported reduced or no longer needing to use these in some cases"

5.3 **Value for money** – Procuring services through the Dynamic Purchasing System has allowed KCC to test the market extensively and streamline the purchase process to gain best value for money. Using the figures set out in section 4 of this paper the cost per class is £5,421, which equates to £395 per client attending or all 36 sessions or just under £11 per week. To maximise the funding available the service also uses volunteer transport schemes, community venues and asks participants for a contribution for refreshments that are offered after class. This optional element is well attended and support a reduction in social isolation and an opportunity to talk to clients about other health messages that support them to stay well (e.g. nutrition or hydration).

5.4 **Impact** – The impact of services can be measured by using data from the Public Health Outcomes Framework. The latest available public health outcomes data indicates that there is a positive downward trend in emergency hospital admissions due to falls for those aged over 65 (Figure 1)[5], this also applies to the specific age ranges within this of 65 to 79 years old and those aged over 80 years.

Figure 1: Emergency hospital admissions due to falls in people aged 65 and over – Kent and National



5.5 In addition to the above population measure, postural stability services can also contribute to the following public health outcomes – rate of emergency admissions for hip fractures in those aged 65+ (4.14i, ii, iii) where Kent currently have similar rates to national and have shown improvements since April 2015. Health related quality of life

5 https://fingertips.phe.org.uk/search/falls#page/4/gid/1/pat/6/par/E12000008/ati/102/are/E10000016/iid/22402/age/228/sex/4. Accessed: 13th June 2018

for older people (4.31) where Kent has a better and increasing average score than national.

5.6 As highlighted in this report, the commissioned services have also had a further impact on increasing social interactions, and this relates to the public health outcomes on Social Interaction: the percentage of adult social care users/carers who have as much social contact as they would like (1.18i, ii). This measure has fluctuated since the service was commissioned in 2015 but has seen an increase between 2016/17 and 2017/18.

6. Delivering ongoing service improvements

6.1. Continuous improvement is an important component of the contract monitoring arrangements for the postural stability service. The key points of learning have been incorporated into new commissioning arrangements as set out below:

- People drop out of the classes within the first few weeks and greater flexibility was needed within the service specification to allow new clients to join the programme at any point within the first 12 weeks. This maintains value for money, reduces waiting list times, improves atmosphere and quality of the sessions. This has had a positive impact on the average number of clients attending the classes delivered in 2017/18 and enabled 14 more people to replace the 16 clients who dropped out in the first 12 weeks.
- During several rounds of procurement, providers have changed venues to ensure value for money, minimise risk and increase accessibility for those attending. This has been informed by user feedback.
- KCC as the single referral point is currently under review. This was taken in-house to the Public Health team to minimise cost and avoid fragmentation. The team continues to look at other options to improve coordination in line with other service developments. These include the potential to align this function with the single point of access developing as part of the KCC Older Person's Wellbeing Service.
- KCHFT has proven that they can deliver high quality services which improve outcomes for clients at a competitive price. From July 2018, the East Kent postural stability services will therefore form part of the partnership already in place between KCC and KCHFT. This will reduce staff time needed to run procurements and reduce unnecessary spend, minimise disruption to users and support a joined-up user experience between CCG funded services (also provided by KCHFT).

7. Risk

7.1. The key risks for the programme are;

- **Drop out of participants** - Due to the health needs of individuals participating in the programme, people do have to withdraw from the service or are unable to start the programme after being referred. Providers have tailored their communications to ensure participants and referrers are aware of the requirements and carry out phone-based risk assessments with clients to prevent them unnecessarily being on a waiting list.

- **Low demand in some locations** - The minimum number of people starting a class needs to be 16 and, in some locations, it can take some time to accumulate sufficient referrals before the class can begin. This can result in some clients not engaging in

the service for a variety of reasons when space is available and having to remain on the waiting list for several weeks. To mitigate this, provider will conduct additional promotion in areas where demand is low and offer clients the opportunity to attend a venue at another location. (For example, Herne Bay clients could be offered the opportunity to travel to Thanet for a class.)

- **Staffing and provider stability** - Due to the dynamic nature of purchasing these services and fluctuation in levels of demand, providers have reported that finding staff to deliver additional programmes can be challenging when there is a spike in demand. To mitigate this risk KCC funded additional training to increase the number of trained instructors in Kent and maintains close dialogue with providers supporting them to plan effectively.

8. Conclusions

8.1. KCC has commissioned a programme of postural stability classes since 2015 which has benefitted over 1,000 residents. This service generates good outcomes for those participating in the service in both mobility, confidence, reduction in social isolation and wider health and wellbeing. Analysis of service costs indicates that the programme provides good value for money and contributes to KCC's strategic outcome for supporting older and vulnerable people. This in turn would have generated an estimated saving of between £46,935 and £90,741 to social care services[6].

8.2. Future priorities for these contracts will be to ensure alignment to KCC Older Persons services and work with agencies involved in delivering or supporting elements of the falls prevention pathway such as Clinical Commissioning Groups or the fire service.

Recommendations

The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on:

- the commissioning and provision of postural stability services in Kent
- the work to improve patient experience and service efficiency.

Background documents:

Buck et al (2013), Exploring the system-wide costs of falls in older people in Torbay, https://www.kingsfund.org.uk/publications/exploring-system-wide-costs-falls-older-people-torbay

Public Health England (2018), Falls prevention: cost-effective commissioning, https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning

Public Health Outcomes Framework (2018), https://fingertips.phe.org.uk/search/falls#page/4/gid/1/pat/6/par/E12000008/ati/102/are/E10000016/iid/22402/age/228/sex/4.

[6] PHE cost effectiveness resources https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning , accessed 11th June 2018

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Appendix A – Referral process and service provision in Kent

Accessing postural stability services

The access route into the service is through KCC. Historically there have been three providers delivering postural stability services across Kent. KCC acts as a single referral point to co-ordinate referrals and minimise service fragmentation.

Postural stability classes run for one and a half hours a week over 36 weeks. They are located in accessible and welcoming environments. Classes are comprised of exercises to improve core strength, balance, mobility and confidence to reduce the risk of falling. This can reduce the decline of clients and their need for more intensive falls prevention services such as physiotherapists. Part of each session is also dedicated to the wider public health agenda and ensuring every contact counts. Each week there is a section on increasing awareness of other factors to improve physical and mental wellbeing through information sharing and signposting to other services and interventions.

KCC receive referrals from a range of sources including the Fire Service (on the back of their home safety checks), GPs, other healthcare professionals and self-referral. Referrals are made through the Single Point of Access held hosted by KCC and a waiting list maintained until there is sufficient demand for the service in an area. A class is then procured using the Public Health's Dynamic Purchasing system to make the process more straightforward.

Referrals are received from a range of sources Referrals are checked for completeness and to ensure clients are suitable for the service. Clients outside of the threshold are referred on to the falls prevention service in their relevant area. Once sufficient referrals are received in a specific geographic area, a class is procured in the local area. There are currently two providers in the county commissioned by the Public Health team. Involve Kent provide classes in the west of the county and Kent Community Health Foundation Trust (KCHFT) in the east of the county. There are currently nine classes running across the county.

Service Provision

The service is delivered by appropriately qualified instructors with classes based on FaME or Otago exercises, which are proven to reduce falls significantly.

Classes are delivered in accessible locations although transport is available if required.

At the beginning of each course, clients are assessed on a number of points to assess their ability and the time it takes to stand up from sitting and walk a set distance. Progress against these objectives is monitored throughout the course with regular assessments at 12, 24 and 36 weeks.

At each session there is a group discussion to promote other wellbeing elements. This includes identification of trip hazards and assistance equipment, other local groups, relaxation techniques, referrals to appropriate services.

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee - 27 June 2018

Subject: **Suicide Prevention update**

Classification: Unrestricted

Past Pathway of Paper: N/A

Future Pathway of Paper: N/A

Introduction:

This paper updates Members of the Health Reform and Public Health Cabinet Committee on recent suicide prevention developments and highlights £667,978 of new funding that has been secured for suicide prevention work across the Kent and Medway STP area in 2018/19.

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to note the recent progress and make comments and suggestions to strengthen future delivery.

1. Introduction and statistics

1.1 Every suicide is a tragic event which has a devastating impact on the friends and family of the victim, and can be felt across the whole community.

1.2 As the latest data published by PHE in November 2017 shows, Kent has higher suicide rates than both the South East Region, and England as a whole (Table 1). Rates amongst men are particularly high compared to regional and national levels.

Table 1 – Suicide rate comparison

Indicator	Period		England	South East region	Kent
Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)	2014 - 16		9.9	9.8	11.6
Suicide: age-standardised rate per 100,000 population (3 year average) (Male)	2014 - 16		15.3	15.1	18.4
Suicide: age-standardised rate per 100,000 population (3 year average) (Female)	2014 - 16		4.8	4.8	5.3

Source http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0

1.3 A recent update in national data for 2017 shows a slight fall in the **number** of suicides and deaths by undetermined intent (which for statistical purposes are classified as *probable suicides*) registered by coroners in Kent (as shown in Table 2 below). Due to the way rates are calculated (using 3 year rolling averages) it is hard to know whether this is a real decrease as yet.

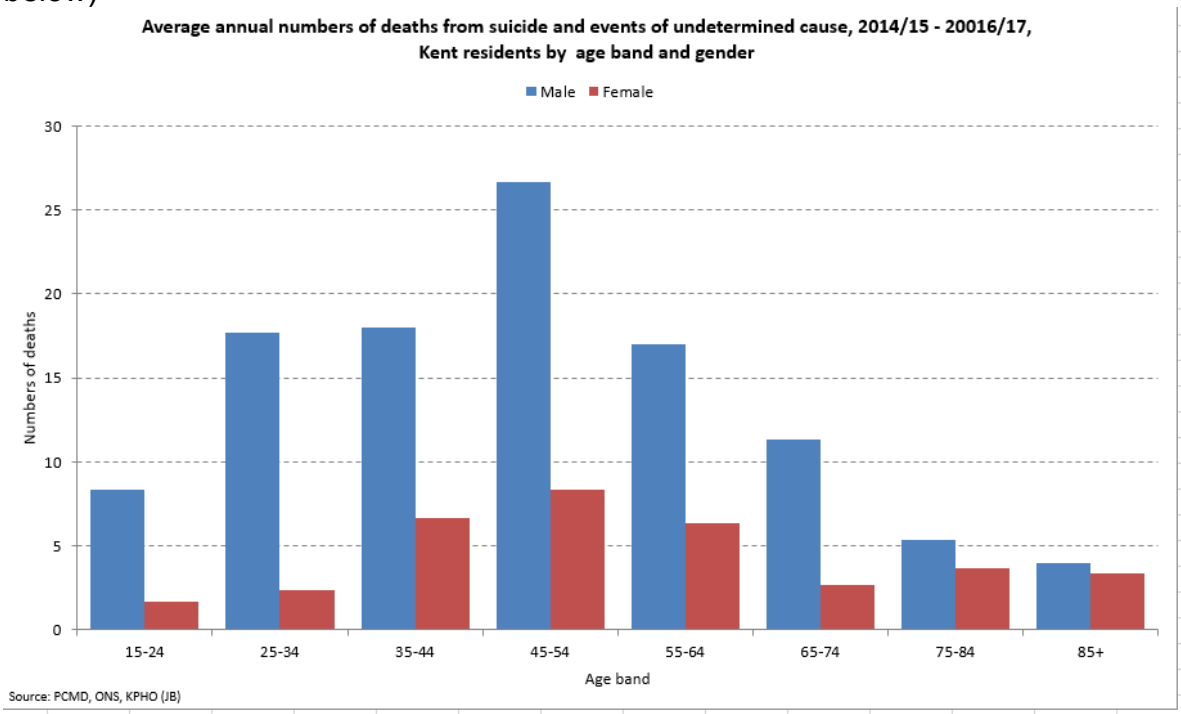
Table 2

Numbers of deaths from suicide and events of undetermined intent, 2010-2017 registrations, aged 15+ Kent residents, by gender

Area resident	Gender	2010	2011	2012	2013	2014	2015	2016	2017	Total
Kent	Male	73	85	97	119	130	116	104	85	**809**
	Female	27	34	26	31	35	36	36	38	**263**
	Total	100	119	123	150	165	152	140	123	**1072**

Source: Primary Care Mortality database, KPHO (JB); Medway Public Health

1.4 Middle aged men are at particular risk of completing a suicide. (Table 3 below)



1.5 As Kent is a large county, the Kent rate of suicide can mask the local variations. When viewed by clinical commissioning group areas within Kent, the variations show up, East Kent suicide rates being higher then West Kent.(Table 4 below).

Table 4

Numbers of deaths and rates from suicide and undetermined causes, Kent CCGs, 2014 -2016 registrations, by gender, - residents aged 15+

	Male		Female		Both sexes	
Clinical commissioning group	**Numbers**	**ASR / 100,000[1]**	**Numbers**	**ASR / 100,000[1]**	**Numbers**	**ASR / 100,000[1]**
NHS Ashford CCG	28	19.7	4	2.7	32	10.9
NHS Canterbury & Coastal CCG	40	16.4	12	4.7	52	10.5
NHS Dartford, Gravesham & Swanley CCG	63	20.7	8	2.4	71	11.4
NHS South Kent Coast CCG	54	21.1	14	5.5	68	13.0
NHS Swale CCG	33	24.0	9	6.7	42	15.5
NHS Thanet CCG	**40**	**25.7**	**17**	**9.4**	**57**	**16.8**
NHS West Kent	92	16.4	43	7.0	135	11.7

Source: PCMD, KPHO (JB)

[1] - Directly age-standardised mortality rate per 100,000 residents

1.6 According to the National Confidential Inquiry into Suicide and Safety in Mental Health Services (hosted by the University of Manchester) in the year before someone dies by suicide, and in relation to their contact with the NHS;

- Around 1/3 have contact with secondary mental health services
- Around 1/3 have contact with primary care only
- Around 1/3 have no contact with the NHS

1.7 The Secretary of State for Health has set a national target for a 10% rate reduction in the rate of suicide by 2020/21. To support this, NHS England has set aside £25m over the next three years. It is from this funding that Kent and Medway STP has successfully bid for £667,978 for suicide prevention work within 2018/19. (More details about how this funding will be used can be found later in Section 3).

2. 2017 / 18 suicide prevention review

2.1 KCC Public Health led a number of suicide prevention initiatives during 2017/18. These included;

- Continued promotion of the Release the Pressure social marketing campaign and the associated 24/7 freephone support line. Since the start of the campaign (in 2016) there has been an 82% increase in the number of male callers, and the support line currently receives nearly 2000 calls every month. Following national recognition of the campaign, the City of London asked for permission to use the campaign, and it can now regularly be seen in train stations and other locations within the centre of London.

- 811 people were trained in Suicide Awareness and Prevention (commissioned by KCC Public Health and delivered by West Kent Mind)
- New research – data shows that the suicide rate in the most deprived decile in Kent is more than double the rate in the least deprived decile
- Co-ordinating the multi-agency Suicide Prevention Steering Group to implement the 2015-2020 Suicide Prevention Strategy
- Working to identify and respond to high risk groups such as young people, students, prison populations and individuals known to secondary mental health services

3.0 New NHS England funding

3.1 The Kent and Medway STP has been awarded £667,978 for suicide prevention work in 2018/19. It is one of nine STP areas to successfully bid for this funding.

3.2 In line with guidance from NHS England, approximately 20% of the funding will go to Kent and Medway NHS and Social Care Partnership Trust (KMPT, the providers of secondary mental health services in Kent and Medway) to help develop and implement their Zero-Suicide Action Plan which has been requested by the Secretary of State. KMPT will be focusing on key high risk points such as the seven days following discharge from in-patient settings, and after attending A&E departments for self-harm.

3.3 The rest of the funding will be go towards community-based prevention and early intervention programmes (including primary care) as outlined by the table below. Highlighted in bold are the main links to KCC directorates and services, many other links will be made as the programme progresses.

Category	Rationale	Detailed proposals
Communications	Given that approximately 2/3rds of people who die by suicide are not known to secondary mental health services, social marketing campaigns are an effective way of raising awareness of available support and encouraging people at risk to seek help.	Extend and further target Release the Pressure. Commission a mobile app that allows people to build their own safety plan and easily access support when needed. **KCC: link to Public Health and KCC communications**
Training	NICE guidance recommends that health professionals as well as members of the public are trained to recognise suicide warning signs and to learn how to respond when risk is identified.	A range of training will be provided (including 3 hour, 2 day, online) at a range of venues across the county. Bespoke training for primary care teams will be delivered to GPs and practice staff in their own practices and through Protected Learning Time sessions. At least 1000 people will receive training during 2018/19. **KCC: Link to Live Well Commissioning and Social Care**
Workplace interventions	Workplaces offer an opportunity to identify people at risk and highlight the support mechanisms that are available.	Exisiting workplace health teams across Kent and Medway will be upskilled to deliver additional suicide awareness and prevention messages. Industries such as construction, transport and agriculture will be targeted given their increased risk of suicide. **KCC: Link to Human Resources teams.**
Innovation fund	Given that nationally there is a lack of evidence about what works within community settings, this fund will allow for innovative ideas to be tested. It is anticipated that effective projects will provide case studies and models of practice for other areas to follow.	This innovation fund will provide small grants to local groups to implement new (or extend existing) projects. It will be open to charities, schools, community groups, parish and district councils, and other organisations.
Suicide Safer Universities	University communities have been identified as a high risk group within the K&M Suicide Prevention Strategy. The three Kent Universities	This funding will support the Suicide Safer University project with a focus on men and help-seeking; social marketing campaigns to be developed and rolled out; work on post-vention as well as supporting

	and one Further Education College (with a combined population of over 50,000 students and in excess of 6,000 staff) have come together as part of a Suicide Safer Universities project.	additional training. **KCC: Link to Children's services, Safeguarding and public health**
Bereavement Support	Improving support for families bereaved by suicide has been identified as a priority in the Kent and Medway Suicide Prevention Strategy.	This funding will allow for current provision to be mapped and measured against national guidance. Recommendations will be developed to ensure high quality, equitable, bereavement support is provided. **KCC: Links to Coroners, Live Well Commissioning, Social Care and Voluntary Sector commissioning**
Research	Current data sets can provide good quantitative and demographic evidence regarding people who die by suicide. However, they don't provide the detail about why they died. By uncovering more regarding the motivations of people who die, future interventions can be designed more effectively.	This research will include a systematic audit of coroner confirmed suicide cases in Kent and Medway and uncover the motivations of people who die by suicide. A range of other research methods will also be used to understand the lives and behaviour of individuals in the months before their death in order to uncover opportunities for intervention. **KCC: Links to Social Care, Coronor's Office, Research and Development, Observatory, Public Health.**

3.4 Each of the above elements will be subject to individually designed evaluation methods, as well as being part of a national evaluation programme being developed by NHS England.

3.5 While the above actions meet recently published draft NICE guidelines on Preventing Suicide in Community and Custodial Settings[1], there is a recognition that the impact of many of them (for instance the training and research) will only be felt in the medium to long term.

3.6 Therefore, alongside this commissioned support, there will also be a programme of collaboration with stakeholders to make changes to the wider health system which will produce faster results towards the 10% reduction target. (For instance, ensuring that primary care settings are able to identify and better support those individuals who have made previous suicide attempts). To enable this to happen, suicide prevention is fully integrated into the mental health strand of the STP. The important issue for the suicide

[1] https://www.nice.org.uk/guidance/indevelopment/gid-phg95/documents

prevention programme is that mainstream services are improved ***together*** with innovation and community awareness raising.

4.0 KCC Cross Directorate Support on Suicide Prevention

4.1 All directorates are engaged and are supporting delivery of the strategy. Links are made via transport and community safety in order to strengthen outcomes on access to places of safety and securing suicide hotspots. Strong relationships also exist with Adult Social Care and Children's Services. Examples of work include:

4.2 *Crisis Care*
KCC Social Care and Public Health directorates are working with CCG and Police in strengthening places of safety for vulnerable people who are traditionally held in police custody or taken to A&E. This is the work of the Kent and Medway Crisis Care Concordat. KCC's commissioned Live Well Service and improved commissioning of housing support are critical aspects of keeping people safe and preventing suicide.

4.3 *Children and Young People*
Following discussions between Public Health, the Kent Safeguarding Children's Board and the Child Death Overview Panel, a process has been established to conduct a Thematic Review of Suicides amongst Children and Young People in Kent.

4.3 *Dual diagnosis (Co-occuring conditions)*
Kent Public Health has a commitment to ensure that system leadership in mental health and substance misuse is aligned to tackle service gaps that lead to worse outcomes and higher rates of suicide in this vulnerable population. KCC Public health are also principle commissioners for Substance misuse in Kent. National and local audit has found a 80-90% co-morbidity between suicidality and substance misuse. Work to date has included a successful public health led Serious Incident Learning Event (with over 100 partner delegates) and a clinical pathway group to 'deep dive' into a number of serious incidents and near misses (of death). This has resulted in a series of action points for both providers and commissioners e.g improving the current uncessasary extended wait times for access to specialist mental health support after in-patient substance misuse detox. Improving outcomes for people with Co-occuring conditions is also a priority for Kent and Medway STP.

4.4 *Kent Well Being and Resilience Plan*
A key priority for the STP Mental Health Programme is a strong overall Mental Well Being Strategy for Kent and Medway. This is currently being scoped by the Consultant lead for Public Mental Health and will include strengthing KCC's response to lonliness and social isolation, aging well and living well. This will link to all KCC directorates' work including use of green spaces, support for vulnerable groups and creative and efficient commissioning of current budgets to improve mental well being coutcomes. A current mapping of how mental health and wellbeing services interlink is

being developed by the mental well being team and due to be completed in Autumn 2018.

5. Recommendation(s)

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to note the recent progress and make comments and suggestions to strengthen future delivery.

6. Background documents: none

7. Contact details

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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 – 27 June 2018

Subject: **Childhood Immunisation**

Classification: Unrestricted

Summary: The aim of this report is to provide information on:

- Roles and responsibilities of partners around childhood immunisations

- The local picture of childhood immunisations in Kent County

- Current and future actions planned by NHS England to improve childhood immunisation rates

Recommendation(s):

The Health Reform and Public Health Cabinet Committee is asked to note progress and endorse the approach taken by Public Health England and NHS England to improve childhood immunisation in Kent.

1. Introduction

1.1 Responsibility for childhood immunisations was transferred to NHS England (NHSE) in April 2013 following the Health and Social Care Act 2012. Public Health England advises NHSE on the epidemiology of childhood diseases and immunisations and Local Authority Public Health teams have a statutory responsibility to provide assurance of the system for the delivery of immunisations.

1.2 This report provides an update on childhood immunisation and highlights the actions being taken by NHS England and other stakeholders. Note it does not cover seasonal flu immunisation or teenage immunisation.

The Immunisation Schedule is shown in the Appendix to this report.

2. The Local Picture

1.1 The data below have been published by the Public Health England. They are taken from the Child Health Information System which in turn is supplied with individual children's records of immunisation by general practice.

For children aged 1 year, October-December 2017

	Diphtheria/tetanus/pertussis/ polio/haemophilus influenza (DTP Hib) (% coverage)	Pneumococcus (% coverage)	Rotavirus (% coverage)	Meningitis B (% coverage)
England	93.1	93.5	90.6	93.0
Kent	**92.0**	**92.2**	**90.3**	**91.9**

For children aged 2 years, October-December 2017

	DTP Hib (% coverage)	Pneumococcal booster (% coverage)	Haemophilus influenza/ meningitis C (% coverage)	Measles/mumps/ rubella – dose (MMR) 1 (% coverage)	Men B Booster (% coverage)
England	95.2	91.3	91.3	91.1	87.4
Kent	**93.7**	**90.6**	**89.9**	**90.0**	**81.5**

For children aged 5 years, October-December 2017

	DTP Hib (% coverage)	MMR dose 1 (% coverage)	MMR - dose 2 (% coverage)	DTP/polio (% coverage)	Haemophilus influenza/ meningitis C (% coverage)
England	95.8	95.1	87.3	85.9	92.8
Kent	**93.0**	**94.5**	**86.2**	**81.1**	**88.4**

1.2 NHS England is responsible for meeting immunisation targets. Clinical services are responsible for making effective and acceptable offers of immunisation. The coverage targets for England as a whole for each childhood immunisation is in line with the World Health Organisation Target i.e. 95%. A 95% vaccination coverage will prevent the spread of most infectious diseases though “herd immunity”.

1.3 England only meets the 95% target for some vaccinations and within England there is variation. The Kent percentages should be seen in this context.

1.4 Local reviews of data held on general practice systems shows that the published data for Kent also underestimates the true coverage by around 3-5% depending on which immunisation. Not all immunisations given are coded correctly on practice systems or reported to the Kent Child Health Information System (CHIS) that reports figures for publication.

1.5 Factors that influence true uptake include parental attitudes and how information affects these, how accessible and well-organised services and reminder systems are.

1.6 Immunisation Improvement Plans, based on evidence from NICE have been agreed at the KSS level and shared with Directors of Public Health.

1.7 There is now a Kent Immunisation Board, in which KCC is represented, designed to coordinate and work together across health and social care and which has its own Action Plan to improve immunisation rates.

Other participants are the Screening and Immunisation Team (SIT) who Chair, organise and minute, CCGs, Practice Nurses and Practice Managers, the Health Protection Team, The Local Medical committee, the Health Visiting Immunisation Lead, Children's Centres, Child Health Records Department. All are engaged and contributing.

2 Local Actions

Outlined below are the main issues identified and the actions currently happening

2.1 Poor transfer of data from GP clinical systems to the Child Health Information Service

Recent developments include:

- The electronic query and extraction system (replacing a mix of paper and other methods) introduced 3 years ago still fails to reliably transfer all data.
- Years ago, a data challenge and checking system was introduced which most practices use but it is not compulsory. It greatly improves coverage statistics.
- Letters from the Screening and Immunisation Lead directly to parents of children remaining unimmunised have been trialled across Kent in 2017/18 and discontinued as they made no difference to coverage.

Current efforts focus on:

- Maintaining and improving the challenge and checking system. Targeted and detailed practice by practice data reconciliation is underway.
- Improving coding of immunisation in general practice (there are many possible codes and it can easily be confusing).
- Exploring procurement of a new electronic extraction and transfer service, as used successfully elsewhere is a high priority. Though the Digital Child Health Strategy (2017-2021) may improve data transfer, it is not clear when this will happen and unlikely to be for at least 2 years.

2.2 A local mixed picture of good immunisation practice and poorer immunisation practice

Continuing to improve and develop:

- Regular monitoring and communication with GP practices e.g. to inform them of new vaccines, good practice points and to encourage further attempts to vaccinate
- The SIT visiting practices and giving educational talks to make local systems more effective, including better coding and reporting.
- Practices reviewing and comparing their immunisation data with CCG support
- Better use of Children's Centres to promote immunisation

Newer developments:

- A new catch-up service for those unable or reluctant to attend general practice is currently being developed, to start in September 2018. Information to identify children for this service and to assess its effectiveness is being developed with the Child Health Information System.
- Systems to involve Health Visitors mores closely and systematically with children who need immunisation are being developed, both professionally with improved general practice links and through KCC, which commissions Health Visiting services.

4. Conclusions

4.1 Although immunisation rates for childhood immunisations continue to be below the England average rates and continue to be below 95% coverage, much work is being done to improve rates. KCC continue to assure the system via Health Protection Committee meetings and attendance at the new Kent Immunisation Board.

5. Recommendations

Recommendation

4.1 The Health Reform and Public Health Cabinet Committee is asked to note progress and endorse the approach taken by Public Health England and NHS England to improve childhood immunisation in Kent

Background documents:

Cover of vaccination evaluated rapidly (COVER) programme 2017 to 2018: quarterly data
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2017-to-2018-quarterly-data

Report Author:

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National Childhood Immunisation Schedule, as from September 2017

8 weeks
6-in-1 vaccine, given as a single injection containing vaccines to protect against six separate diseases: diphtheria; tetanus; whooping cough (pertussis); polio; Haemophilus influenzae type b, known as Hib, a bacterial infection that can cause severe pneumonia or meningitis in young children; and hepatitis B
Pneumococcal (PCV) vaccine
Rotavirus vaccine
Men B vaccine

12 weeks
6-in-1 vaccine, second dose
Rotavirus vaccine, second dose

16 weeks
6-in-1 vaccine, third dose
Pneumococcal (PCV) vaccine, second dose
Men B vaccine second dose

One year
Hib/Men C vaccine, given as a single jab containing vaccines against meningitis C (first dose) and Hib (fourth dose)
Measles, mumps and rubella (MMR) vaccine, given as a single jab
Pneumococcal (PCV) vaccine, third dose
Men B vaccine, third dose

3 years and 4 months
Measles, mumps and rubella (MMR) vaccine, second dose
4-in-1 pre-school booster, given as a single jab containing vaccines against: diphtheria, tetanus, whooping cough (pertussis) and polio

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From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 27 June 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, 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: 18 June 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.

14 SEPTEMBER 2018
• **Annual Report on Quality in Public Health, incl Annual Complaints Report** • **Annual Equality and Diversity Report** • **Mental Health needs assessment, eg in relation to suicide prevention, and liaison with other partners** (added at 1 5 18 agenda setting) • **Air Quality - more detail on issues and its impact, incl emissions from traffic and household fuels** (added at 1 5 18 mtg, request by L Sullivan/R Bird) • **Update on new infant feeding service, once started (on 1 June 2018)** • **Access to Dentistry service in Kent** and implications for public health – accessibility, difficulties of achieving accurate survey data, effect of poor childhood diet leading to premature extractions, and poor dental health leading to other conditions later in life (request R Bird, 6 6 18) • ***Verbal Updates – include STP update*** • ***Contract Monitoring*** *– Adult Drug and Alcohol Services* • ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings* • ***Update on Public Health Campaigns/Communications*** *(added at 1 12 17 agenda setting as an item to alternate meetings)* • ***Work Programme 2018/19***
22 NOVEMBER 2018
• **Work going on in South East on impact of illicit tobacco** (added at 1 5 18 mtg) • **Gambling debt and its impact on mental health, general health** etc (added at 1 5 18 agenda setting) • ***Verbal Updates – include STP update*** • ***Contract Monitoring*** *– 0-5 Children and Young People's Services* • ***Work Programme 2019***
9 JANUARY 2019
• **Budget and Medium Term Financial Plan** • ***Verbal Updates – include STP update*** • ***Contract Monitoring*** *– Adult Health Improvement Services (incl workplace health)* • ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings* • ***Update on Public Health Campaigns/Communications*** *(added at 1 12 17 agenda setting as an item to alternate meetings)* • ***Work Programme 2019/20***
13 MARCH 2019
• **Draft Directorate Business Plan** • **Risk Management report (with RAG ratings)** • ***Verbal Updates – include STP update*** • ***Contract Monitoring*** *– Adolescent Health Services* • ***Work Programme 2019/20***

Last updated on: 18 June 2018

remainder of 2019 – MEETING DATES NOT YET SET	
MAY	• ***Verbal Updates – include STP update*** • ***Contract Monitoring*** *– Domestic Abuse and Positive Relationships* • ***Work Programme 2019/20***
JULY	• ***Verbal Updates – include STP update*** • ***Contract Monitoring*** *– Mental Health* • ***Work Programme 2019/20***
SEPTEMBER	• ***Verbal Updates – include STP update*** • ***Contract Monitoring*** *– Workforce Development* • ***Work Programme 2019/20***
NOVEMBER	• ***Verbal Updates – include STP update*** • ***Contract Monitoring*** *– Young Persons' Drug and Alcohol Services* • ***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 Update on Public Health Campaigns/Communications (added at 1 12 17 agenda setting as an item to alternate meetings)
March	Draft Directorate Business Plan Risk Management report (with RAG ratings)
May / June	Public Health Performance Dashboard – incl impact of STP now to alternate meetings Update on Public Health Campaigns/Communications (added at 1 12 17 agenda setting as an item to alternate meetings)
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 Update on Public Health Campaigns/Communications (added at 1 12 17 agenda setting as an item to alternate meetings)
November / December	