HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Friday, 28th September, 2018

10.00 am

Darent Room - Sessions House

Kent County Council
kent.gov.uk

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Friday, 28 September 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 C Bell, Mr D Butler, Mr A Cook, Miss E Dawson, Mrs L Game, Ms S Hamilton, Ms D Marsh, Mr K Pugh and Mr I Thomas

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

Labour (1) Dr L Sullivan

Webcasting Notice

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

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

UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Membership - to note that Mrs C Bell and Mr D Butler have joined the committee in place of Miss C Rankin and Mrs P A V Stockell

3 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

4 Election of Vice-Chairman

5 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

6 Minutes of the meeting held on 27 June 2018 (Pages 7 - 16)

To consider and approve the minutes as a correct record.

7 Verbal updates by Cabinet Member and Director (Pages 17 - 18)

To receive a verbal update from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health.

8 Public Health Quality Annual Report 2017 - 2018 (Pages 19 - 36)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out a review of the quality activity and programmes between April 2017 and March 2018, which Members are asked to note.

9 Suicide Prevention Needs Assessment (Pages 37 - 58)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, introducing the draft Suicide Prevention Needs Assessment for Kent. Members are asked to comment on this and identify any areas in which they would like to see further research.

10 18/00051 a and b - Sexual Health Needs Assessment and Service Commissioning (Pages 59 - 86)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out the key findings of the needs assessment and changes in the delivery of sexual health services. Members are asked to either endorse or make a recommendation to the Cabinet Member on the proposed changes to the provision of sexual health services which are due to expire in March 2019.

11 Contract Monitoring Report - Adult Drug and Alcohol Services (Pages 87 - 102)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, giving an overview of the adult drug and alcohol treatment services which are commissioned by the County Council. Members are asked to note and comment on the commissioning and provision of adult drug and alcohol services in Kent and the service improvement initiatives being undertaken to improve quality and outcomes.

12 Placed-based Public Health and Ebbsfleet Healthy New Town (Pages 103 - 110)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, giving an overview of Place-Based Public Health and details of work undertaken with the Ebbsfleet Healthy New Town programme, other new developments in Kent and partners. The Cabinet Members are asked to note progress and endorse the approach taken by the County Council's Public Health team on Place-Based Public Health.

13 Performance of Public Health-Commissioned Services (Pages 111 - 116)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, giving an overview of key performance

indicators (KPIs) for Public Health-commissioned services. Members are asked to note the performance of services in Q4 of 2017/18 and Q1 of 2018/19.

14 Work Programme 2018/19 (Pages 117 - 120)

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

Thursday, 20 September 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.

This page is intentionally left blank

KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Darent Room - Sessions House on Wednesday, 27th June, 2018.

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

OTHER MEMBERS: Peter Oakford

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

UNRESTRICTED ITEMS

76. Introduction and Chairman's Announcements.

The Chairman opened the meeting and announced that Ms Issie Ferris was in attendance as an observer. Issie was studying at the University of Exeter and was working at County Hall for a week as an intern with Democratic Services.

The Chairman advised the committee that he would need to leave the meeting at about 12.00 noon and that the Vice-Chairman would preside over any remaining business.

77. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from the Leader, Mr P B Carter.

There were no substitutes.

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

Mrs L Game declared that she was the Chairman of Thanet District Council's Cabinet Health Advisory Group, working on the Sustainability and Transformation Programme.

Mr I Thomas declared that he was a Member of Canterbury City Council's Planning Committee, which may prove relevant if discussion of the potential new Kent and Canterbury Hospital and or new Medical school were to arise during the meeting.

79. Minutes of the meeting held on 1 May 2018.
(Item. 4)

It was RESOLVED that the minutes of the meeting held on 1 May 2018 are correctly recorded and they be signed by the Chairman. There were no matters arising.

80. 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:-

Update on new Infant Feeding Service – the new service had started on 1 June 2018 and provision was moving forward well. The Kent Community Health Foundation Trust (KCHFT) had won a national award for the way in which it supported its volunteers.
Joint Kent and Medway Health and Wellbeing Board – the first meeting of the new joint board would take place on 28 June in Medway. Wiltshire's Health and Wellbeing Board had recently been criticised by the Care Quality Commission (CQC) for not working sufficiently closely with the Sustainability and Transformation Programme (STP) and the NHS. The comments made by the CQC showed that Kent was ahead of some other Health and Wellbeing Boards. *Mr Oakford undertook to share an article and the CQC report with the committee and these are attached below:*

Article:
http://www.salisburyjournal.co.uk/news/16306679.Concerns_raised_over_council__39_s_management_of_health_and_social_care/

CQC report (in which, the main section about the Health and Wellbeing Board is on page 11):
https://www.cqc.org.uk/sites/default/files/20180611_local_system_review_wiltshire.pdf

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

Sustainability and Transformation Programme (STP) Prevention workstream – a report about this would be considered at the first meeting of the new joint Health and Wellbeing Board.
Measles – sporadic outbreaks had now occurred in Surrey and Sussex as well as in Italy and Eastern Europe. Public Health England had advised teenagers to be immunised to avoid passing on the virus when gathering in large numbers, for example, at festivals, and this message appeared to have been noted.
Air Quality – the development of the County Council's Energy and Low Emissions Strategy was being led by consultants and the public health team was working with the Growth, Environment and Transport Directorate. Workshops for Members would take place in August and September and a public consultation on the Strategy was expected in Spring and Summer 2019.

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

81. Workforce planning update.
(Item. 6)

Ms G Walton, Executive Support Manager Older People and Physical Disability and Design and Learning Centre Programme Manager, was in attendance for this item.

1. Dr Duggal introduced the report and emphasised that there were two aspects to workforce planning; work undertaken by NHS and social care partners, over which the Council Council had no direct control or influence, and work undertaken by the Council Council. Dr Duggal advised the committee that she served on the STP workforce workstream group. Ms Walton added that she was involved in the STP group, looking at the social care agenda. The STP had a development plan to focus on six areas and identify work for the future. The Local Workforce Action Board (LWAB) was co-chaired by Anne Tidmarsh and an NHS lead, and included Dr Duggal, so this supported good health and social care links. Mrs Tidmarsh had also been confirmed as the Senior Responsible Officer for the STP workforce work stream. Dr Duggal and Ms Walton responded to comments and questions from the committee, including the following:

a) the importance of liaising between health and social care to upskill the whole care workforce was emphasised. Ms Walton confirmed that she was working with Clare Maynard in the County Council's Adult Social Care Directorate to implement the strategy which already existed to ensure that this happened effectively;

b) concern was expressed about the high turnover of health service staff, and a question asked about how pay levels and more prescriptive job descriptions might be used to help reduce this. Kent could lead the way in being an attractive employer where people wanted to stay. Dr Duggal acknowledged the importance of achieving a good range of work skills and work-life balance and explained that part of the LWAB's work aimed to attract and retain good staff in Kent. Ms Walton added that work was ongoing on modelling a social care career pathway, and a campaign to raise the profile of the career and recruit more care sector staff would be starting shortly, using Government funding gained through the LWAB. *She undertook to share the plan and strategy for this work with Members when these were ready;*

c) concern was expressed that the plan to attract new GPs from overseas might be made more difficult by the fact that many overseas workers no longer felt welcome in the UK, and a question was asked about how they would be housed. Dr Duggal agreed that this was an important practical point;

d) concern was expressed that the new medical school, if opened in 2020, would take until 2026 to produce its first graduates, and those people would then need to be retained in Kent. Dr Duggal explained that past experience had shown that graduates tended to stay on in the area in which they had studied, so having a medical school based in Kent should benefit staff retention rates for Kent;

e) asked why people left health and social care careers, and about the importance of being aware of these reasons when modelling career pathways, Dr Duggal explained that exit interviews were undertaken by the NHS, and *an approach could be made via human resources teams in*

the County Council and NHS to see if the reasons stated in these interviews could be accessed. She undertook to look into this;

f) the problem was highlighted of Kent competing with London pay rates to attract and retain staff. London weighting made it attractive to work in London and live in Kent to saving housing costs. London also had large, prestigious teaching hospitals and research facilities. Dr Duggal acknowledged this but said that Kent's medical school would add to research options in the south east. She confirmed that liaison with the County Council's Growth, Environment and Transport Directorate would form part of this work;

g) Ms Walton clarified that GP development plans would apply to new and existing GPs. She also confirmed that Kent was part of the multi-disciplinary teams which were supporting change management;

h) work was ongoing to raise awareness and understanding of the role and value of apprenticeships in the health and social care sector. The Apprenticeship levy would be used to support this development; and

i) a question was asked about the apparent disparity in the way in which apprenticeships and degree courses were funded, and costs accrued by students but not apprentices, to achieve the same qualification and possibly the same salary at the end. Apprenticeships would be funded from the Apprenticeship Levy, with nominal costs to the student, while students taking a degree course would have to bear the expense of servicing and repaying a student loan. Ms Walton commented that the issue was one of valuing, developing and retaining the current workforce, and the social care degree standard provided that opportunity.

2. The Cabinet Member, Mr Oakford, commented that the number of current GP vacancies was of great concern and would take a long time to address. Mr Scott-Clark added that the County Council, via its involvement in STP work, needed to make clear this ongoing challenge. However, the County Council would need to be clear that addressing health and social care workforce issues was not part of its role and that the Council had no formal role in addressing these, although the Council would need to broaden the public's understanding of its own public health role. He added that he hoped that the Kent Medical School would copy the successful model of the Brighton school, with which it was linked. A request was made that Anne Tidmarsh be asked to raise within the STP workforce group concerns expressed that the GP recruitment plans were not sufficiently ambitious.

3. It was RESOLVED that 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, be noted and endorsed.

82. Contract Monitoring paper for Postural Stability Services.
(Item. 7)

Mrs V Tovey, Public Heath Senior Commissioning Manager, was in attendance for this item.

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

a) asked if community venues, including adult education centres, would be used for classes, Mrs Tovey explained that this would certainly be possible. Mr Scott-Clark added that the aim was to deliver the service as close to GPs' practices as possible;

b) asked if, as useful feedback, the reasons for people dropping out of courses were recorded, and if this was followed up, Mrs Tovey explained that people dropped out for a variety of reasons. Some went into residential or nursing homes, others had to stop due to illness or poor health, while others passed away. Many participants gave a reason if the drop out was planned but providers could not always follow up people who dropped out;

c) an aim of the postural stability service was to increase confidence, balance and posture and prevent falls, allow people to live independently for as long as possible and avoid needing a residential or nursing home placement. Dr Duggal explained that the service would prioritise frail elderly clients. Mr Scott-Clark highlighted the financial savings available to social care and public health budgets by avoiding home placements and further falls but emphasised that the greatest savings would be to service users and their families in terms of distress and poor health;

d) the cost of classes varied as block purchasing attracted discounts, so prices quoted in the report were average. Transport could be provided to assist people to attend, for instance, from rural areas, and costs fluctuated based on course locations;

e) it was reported that, in some areas, equipment delivered to a client sometimes failed to be collected once it was no longer needed, and to tighten up on collections of old equipment would help to eliminate waste in the service. Mrs Tovey advised that this service was not funded via public health;

f) the longer a client could manage to attend a class, the more benefit they would gain from it. The aim was for people to join in as close to the start of the 36-week programme as possible. Figures showed that, on average, 68% of participants were still attending at the end of the 36 weeks; and

g) Mrs Tovey explained that there were options about where to place the service to optimise access to it and streamline referrals as far as possible. To have it placed in-house with public health would allow optimum flexibility and support the alignment of related services, for example for older people, giving one point of contact.

2. It was RESOLVED that the commissioning and provision of postural stability services in Kent and the work to improve the patient experience and service efficiency be noted and welcomed.

83. Suicide Prevention update.
(Item. 8)

Mr T Woodhouse, Suicide Prevention Specialist, was in attendance for this item.

1. Mr Woodhouse introduced the report and received the committee's thanks for the work he and his team had put into developing the excellent suicide prevention strategy and the 'Release the Pressure' campaign work. He then responded to comments and questions from the committee, including the following:-

a) asked about police involvement and the justice system in terms of suicide awareness, Mr Woodhouse reassured the committee that services were very aware of the suicide risk of those in custody and confirmed that they would have access to mental health support. The police were looking at how to increase awareness through their staff training programmes;

b) concern was expressed that success in preventing suicide was difficult to identify and measure;

c) the need for quick access to qualified therapists was emphasised. Mr Woodhouse agreed that this was an important part of the service and explained that trained counsellors were available via helpline services, with callers being signposted to them. This was more than the Samaritans were permitted to do via their helpline. *He undertook to find out what work was being done on workforce development in relation to therapists, their caseloads and waiting lists and advise Members outside the meeting;*

d) concern was expressed about the difficulty of reaching men, who were most at risk from suicide but who were still traditionally not encouraged to talk about their feelings or seek help for mental health worries. Mr Woodhouse explained that the aim was to seek to raise awareness of non-traditional ways for men to talk about their mental health, for example by using online apps or webchats which could be accessed discreetly without having a conversation which could be overheard. Kent's 'Release the Pressure' campaign, aimed at men, had been taken up by the City of London Corporation, and posters displayed at London stations, so they would be seen by thousands of daily commuters as well as London residents. Previous campaign work had involved football clubs. Pubs would also be a place where men traditionally could go to unwind but the increase of drinking at home had led to many pubs closing and this networking opportunity being lost;

e) several speakers related personal examples of people who had committed suicide. From these experiences, some Members had become involved in various mental health and suicide prevention work;

f) the Suicide Prevention Steering Group was liaising with highways colleagues to address concerns about people using bridges and other structure as points from which to jump. Mr Woodhouse said arrangements were being made to display Samaritans contact details prominently at points which were known to be popular with those seeking to take their own life, for example, the Dartford Crossing. He added that Network Rail staff were also trained to identify and offer help to people loitering on platforms who may be intending to jump onto tracks;

g) people working in some occupations, for example, farming and construction, were known to be particularly at risk of suicide. Another group was train drivers and tube drivers as they were sometimes involved in incidents of people committing suicide on railway lines. Mr Woodhouse advised that it was notoriously difficult to access employees in the construction industry as many firms were small. However, some contact could be made via trade associations, of which most were members. The NFU would offer a means of contacting farmers, and Mr Woodhouse undertook to find out what work was being done by the NFU in this field;

h) innovation funding given by the Government to support suicide prevention work could be used to try to identify and reach small local projects. Mr Woodhouse emphasised that it was important to keep trying all sorts of projects, even very small ones, to see what was most effective;

i) asked if encouraging boys via school projects to express their feelings could start to address the traditional teaching that 'boys don't cry', Mr Woodhouse explained that work with CAMHS aimed to increase young people's emotional resilience. It was good that mental health was being spoken about by celebrities and sports personalities as this would help to reduce stigma among young people around talking about mental health. Feedback from callers to the helpline had shown that advice given was having a positive effect;

j) a major contributor to suicidal feelings was loneliness; having no-one to talk to, or talking and having no-one to listen. Physical pain was easier than mental health problems to identify and treat. Mr Woodhouse added that training in identifying and tackling mental health problems would make identification easier. The belief that asking someone about their suicidal thoughts would cause them to act on them was a myth; starting to talk about issues would always be a good start to dealing with them;

k) although many of those committing suicide were reported to have had no contact with secondary mental health services, many of them would have had contact with the health service. A good GP should be able to identify that a patient presenting at a surgery to talk about a physical ailment really wanted to talk about thoughts of suicide and could lead the conversation that way. Mr Woodhouse advised that statistics sought to identify age and geographical spread of cases of suicide;

l) the loss of much public open space in recent years had reduced opportunities for people to enjoy time outside to kick a ball or take a healthy walk. The perception of having space was as important as the space itself. Mr Woodhouse agreed that access to the environment was crucial to wellbeing. *It was suggested that an item on open space and what public health professionals could do to influence planning and development issues be included on a future agenda;*

m) concern was expressed that access to suicide prevention training was not equitable across the county. Mr Woodhouse explained that such training had been oversubscribed in every district; and

n) the Chairman referred to media coverage in 2002 of a link identified between the use of a prescribed anti-depressant drug and an increase in suicides. Mr Woodhouse explained that, following a suicide, a Coroner's inquiry would include an investigation of the drugs being taken by the victim. *He undertook to look into what data could be drawn from this to help with public health work.* Mr Scott-Clark added that Public Health England was working on identifying patients diagnosed with life-changing and life-limiting conditions such as cancer and the increase in risk of them committing suicide to avoid prolonged suffering.

2. It was RESOLVED that recent progress on suicide prevention work be noted and welcomed, and Members' comments on this work, set out above, be used to strengthen future service delivery.

The Chairman left the meeting at this point and the Vice-Chairman preside over the remaining two items of business.

84. Childhood Immunisations.
(Item. 9)

1. Dr Duggal introduced the report and added that she served on the panel which looked at improving the childhood immunisation programme and the measures being tried as part of this, including using health visitors to help encourage parents to have their children immunised and closer working with GPs. She responded to comments and questions from the committee, including the following:-

a) the aim was to immunise 95% of children, a rate which was achievable and should be sufficient to protect all children in the county. Immunisation relied on the principal of informed parental choice, and had never been compulsory in the UK. Some religious groups resisted immunisation as they believed that enduring childhood infections would strengthen a child. Past misinformation that the Measles, Mumps and Rubella (MMR) vaccine could cause autism was still remembered and had not helped improve immunisation rates. Mr Scott-Clark added that many studies had been undertaken in the USA and by the World Health Organisation to establish any link between the MMR vaccination and autism. He assured the committee that there was no such link;

b) asked if the rate of immunisation take-up was affected by the economic prosperity of an area, Dr Duggal said *this data should be possible to find and supply to Members outside the meeting;*

c) asked if parents were able to choose which immunisations their child received, and if some accepted some vaccines but not others, Dr Duggal *undertook to check the availability of data and advise Members outside the meeting.* Refusal to have children immunised would be recorded by a family's GP, who would speak to the parents about their reasons for refusing and tackle the issue of an individual child's need for the vaccines in question;

d) asked how many children developed illnesses despite receiving immunisations, Dr Duggal *undertook to look at national data held by Pubic Health England and advise Members outside the meeting.* She explained that one reason for developing an illness could be that a child did not receive both instalments of a two-stage immunisation; and

e) asked how the spread of misinformation on social media could be addressed, Dr Duggal advised that Public Health England was responsible for issuing official health advice and authorised campaign work. She had personally countered misinformation when she had seen it on social media but not in an official capacity as a County Council representative. Mr Scott-Clark added that a national committee of health professionals advised the Government on health issues and national policy setting and theirs was the most expert advice available.

2. It was RESOLVED that progress made be noted and welcomed and the approach being taken to improve childhood immunisation in Kent be endorsed.

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

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

This page is intentionally left blank

By: Mr G K Gibbens, Cabinet Member for Adult Social Care and Public Health

Mr A Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee – 28 September 2018

Subject: **Verbal updates by the Cabinet Members and Director**

Classification: Unrestricted

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

Public Health

Cabinet Member for Adult Social Care and Public Health – Mr G K Gibbens:

1. 12 September attended Public Health England Conference in Warwick.

2. Return of Public Health to portfolio.

3. Sent a letter to the Health Minister regarding the Public Health Grant. At the Public Health England Conference the Minister inferred the grant will be ringfenced until 2021/22.

Director of Public Health – Mr A Scott-Clark:

1. Measles
2. Commencement of the Influenza Vaccination Season
3. Public Health England Updated Public Health Profile published
4. Kent Community Healthcare Foundation Trust (KCHFT) Breast Feeding Friendly Accreditation

This page is intentionally left blank

From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

Date: 28th September 2018

Subject: Public Health Quality Annual Report 2017 -2018

Classification: Unrestricted

Electoral Divisions: All

Summary: This Public Health Quality Annual Report provides a review of the quality activity and programmes between April 2017 and March 2018. It provides assurance that quality activity within all commissioned services meets national standards and demonstrates a model of continuous improvement. This is reflected in local policy and procedure and reflected in the Public Health governance framework, quality dashboard and indicators, delivery and performance plans. Performance measures through key performance & quality indicators are reported to the committee every other meeting.

Recommendation: The Health Reform and Public Health Committee is asked to **COMMENT** on and **NOTE** the Public Health Quality Annual Report 2017-2018

1. Introduction

1.1 This Public Health Quality Annual Report 2017-2018 provides an overview of the Quality and Governance Strategy as well as the processes and controls that have been developed to deliver quality assurance for the providers of our commissioned services and the Public Health Directorate. Quality requires providers both in health and social care to deliver safe quality services and all commissioners to drive improvement in quality and safety.

1.2 The Health and Social Care Act (2012) defines quality in terms of three elements:

Clinical effectiveness - care is delivered to the best evidence of what works. Most interventions, support services and treatments will be provided at the right time to those patients/clients who will benefit. Our providers will have service / care outcomes which achieve those described in the Public Health Outcomes Framework and NICE Clinical, Public Health and Quality Standards.

Safety - care is delivered so as to avoid all avoidable harm and risks to the individual. This means ensuring that the environment is clean and safe at all times and that harmful events never happen.

Patient experience - care is delivered to give as positive an experience as possible for the individual. Patients will experience compassionate and caring communication from those who work in partnership with patients, relatives and their carers to achieve the best possible health outcomes.

High quality services require all three dimensions to be present.

1.3 Clinical governance and quality requires organisations to develop a culture where staff are supported to work safely and can utilise the best available evidence to guide and reflect on practice. It is reliant on strong leadership, effective partnership, continuous learning, and innovation to deliver safe and effective care and ensures that the essential standards of quality and safety are maintained and there is a drive for continuous improvement in quality and outcomes.

2. Quality and Governance Strategy

2.1 All KCC Public Health provider contracts have quality and safeguarding clauses that they are required to comply with which include policies, risk registrars, complaints and governance processes.

2.2 KCC Public Health has quality and safeguarding indicators that include NICE quality guidance as part of the quality dashboard. All providers from July 2016 provided their evidence using a digital reporting system. All quality and safeguarding issues are assured through the Quality Committee.

2.3 The KCC Public Health provider assurance process is managed through the provider's regular indicator reports and performance and quality meetings.

3. Quality & Governance Accountability and Assurance

3.1 The overall responsibility for delivery of the Governance, Clinical Governance and Quality agenda rests with the Director of Public Health. This responsibility is delegated to the Consultant in Public Health who has responsibility for ensuring that governance and clinical governance is delivered throughout the Public Health programmes, remains a priority, and is an integral part of Public Health's policies, procedures and commissioning.

3.2 The Public Health Quality Committee has been the main committee responsible for the accountability and assurance for quality and governance and the Head of Quality and Safeguarding provided quarterly quality assurance reports to the Quality Committee throughout 2017-18.

3.3 It is the responsibility of the Head of Quality and Safeguarding to coordinate the work of the committee and the safeguarding advisory group which met

quarterly in 2017-2018. In addition, the Public Health Safeguarding Group minutes are currently reported to the Quality Committee. There are plans to migrate the work of the Quality Committee to the Public Health Consultant and Specialist meeting which meets more regularly.

3.4 All providers have systems and processes that ensure that they can meet the quality and governance requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A), which are reflected in the Public Health quality dashboard and quality Indicators underpinning quality and continuous improvement. It exists to safeguard high standards of service and provide an environment in which excellence can flourish. The main components of governance are:

1. Risk Management and Safety
2. Effectiveness and Evidence based service
3. Client, Staff and Carer experience and involvement
4. Audit and due diligence
5. Education Training and Continued Professional Development
6. Staffing and staff management
7. Serious incident management
8. Complaints and Compliments
9. Human Resources including DBS checks and staff welfare
10. Informatics and Information governance
11. Policies and Procedures
12. Equality and diversity
13. Inclusive culture
14. Business continuity

3.5 Providers should have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service.

3.6 The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice.

3.7 Providers must securely maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity.

3.8 As part of their governance assurance, providers must seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that they can continually evaluate the service and drive improvement.

3.9 During 2017-18 all providers and the Public Health Directorate generally have evidenced a person–centred, accountable, safe and high-quality service in an open and questioning environment

4. Public Health Quality & Safeguarding successes - 2017-18

Quality

4.1 The PH Clinical Governance audit final report, which had only one comment and no outstanding actions, was completed during Quarter 2 and presented to the Cabinet Audit Committee by KCC Internal Audit Team. This review audit demonstrated the excellent improvement that Public Health has achieved since the previous 2016 poor audit.

4.2 Generic Quality & Safeguarding assurance clauses have been agreed and included for all PH contracts and specifications

4.3 All Quality and Safeguarding information and evidence including data is now accessible on a shared drive accessible to relevant public health staff and aligned to the performance data. This is GDPR compliant.

4.4 Quality and Governance Audits have been completed for a core group of providers who experienced budgetary and contractual changes in 2017/18. Action plans are in place and are being closely monitored to ensure quality and safety is maintained and any risks are mitigated appropriately

4.5 Quality and Governance for newly commissioned contracts are being closely monitored during the current directorate transformation process.

4.6 The Quality dashboard, digital Indicators and quality reporting and evidence systems are now embedded for Public Health and providers. This has meant that providers are not repeatedly asked for the same evidence.

4.7 All Public Health directorate staff have completed bespoke quality and safeguarding mandatory training and are compliant for 2017/18.

Safeguarding

4.8 Public Health achieved a totally compliant (green) Kent Safeguarding Children`s Board Section 11 audit of the Children`s Act 2004 which places duties on a range of organisations, agencies and individuals to ensure their functions and any services that they contract have regarding to the need to safeguard and promote the welfare of children.

Inspections

4.9 Kent was not inspected as part of the six joint targeted area inspections of Children living with Neglect, which involved Ofsted, Care Quality Commission, HMI Constabulary and HMI Probation during 2017-2018. These inspections evaluate the multi- agency response to all forms of child abuse, neglect and exploitation at the point of identification and the quality and impact of assessment, planning and decision-making in response to notifications and

referrals. Public Health assurance evidence and a crib sheet were made available for this area and are still available on request from a shared drive.

4.10 Ofsted and the Care Quality Commission (CQC): Public Health quality has led on ensuring that all our relevant providers are prepared for a joint Inspection, on SEND (Special Educational Needs and Disability), an inspection is expected during 2018/19.

4.11 A key quality and governance vehicle is the Kent Safeguarding Children's Board (KSCB) electronic (ECR) system for Serious Case reviews which Public Health as a commissioner has a log in and holds all the strategic assurance that all PH providers report and all the lessons learnt actions which ensure that providers provide assurance of completion. This is a key assurance improvement as Public Health will now be involved in the process.

4.12 All providers have a ratified child`s and adult safeguarding policy and an assurance framework. Public Health safeguarding group issues are reported through to the quality committee

4.13 Kent Safeguarding Children's Board (KSCB) are reviewing their Quality and Effectiveness Audit committee to ensure all lessons from the serious case reviews are learnt and to facilitate the embedding of the learning process and change in practice.

5. Serious Incidents

5.1 Any provider-reported serious incidents are discussed as part of the provider sections (below)

5.2 Serious Incidents Learning Partnership (SILP)

The membership and remit of the Serious Incident Learning partnership for substance-related deaths was refreshed and the new terms of reference have a strong focus on sharing and embedding learning within organisations. The availability of a thematic report, which includes Police data on reported deaths in Kent that involve substances, facilitates open and productive group discussions

There are two important improvements:

The sharing of knowledge from Police-reported substance misuse deaths in Kent. This facilities partnership learning and assists partners to use such learning to effect significant changes

Evidence is emerging of how substance misuse is changing. For instance, there is evidence that there has been a decrease in young male heroin users but an increase in heroin users with long term medical conditions/ chronic illness (LTCs). We are reviewing the types of LTCs involved from both local events and the national evidence base for possible correlations. E.g. we know

that many long-term substance misusers have respiratory diseases and we will look for assurance that primary and community NHS care support links are in place or improved.

5.3 **Review of Alert System in Kent** Following an Incident in Quarter 3 where several young men were admitted to Kent & Canterbury Hospital Intensive Therapy Unit after using an illegal synthetic Cannabinoid substance, our Kent-wide alert processes have been reviewed. They are now more robust with a new alert box and a Public health alert group with a supporting professional group which ensures that all the learning and information is disseminated to the relevant groups. This new process will be tested in Quarter 2 2018/19.

5.4 **Suicide Prevention -** KCC Public Health led, and coordinated, the Kent and Medway Suicide Prevention group for Kent, which during 2017/18 achieved:

- Delivered Suicide Awareness training to 811 individuals (including from many of our commissioned providers)
- Further extended the Release the Pressure social marketing campaign
- Developed a successful bid to NHS England for £660k of funding for the 2018/19 year.
- Analysed potential suicide clusters linked to railway lines, students and children and young people
- Developed a new Children and Young People's Suicide Prevention strategy and action plan

6. Public Health Provider Quality Summary

6.1 Kent Community Health NHS Foundation Trust (KCHFT)

Public Health commission the following programmes from KCHFT:
NHS Health Checks; Health Improvement, including the One You weight loss, smoke free and lifestyle services; Sexual Health Service; Public Health School Nursing and Health visiting:

6.1.1 NHS Health Checks

6.1.1.1 The NHS Health Check is a programme that delivers a free assessment of an individual's vascular health across Kent via Primary care and outreach. This Kent programme is part of the national primary presentation screening programme for Cardiovascular disease(CVD) risk assessment and risk management for adults aged 40-74 without a pre-existing condition; it checks the circulatory and vascular health and assesses the risk of developing vascular disease, to improve the health and quality of life for 40- 70-year olds whilst reducing overall health inequalities.

6.1.1.2 Clinical effectiveness – The NHS Health Checks service met and succeeded its invitation target. The service has moved the IT infrastructure system for 2018/19 which aims to reduce the uptake challenges experienced in 2017/18.

6.1.1.3 Patient safety - No serious incidents or incidents have been reported in the NHS Health Check service. 99.9% of the staff have completed their mandatory training and 100% have completed their appraisals.

6.1.1.4 Patient experience - 99.6% of the patients who used the NHS Health Check said they would recommend the service to friends or family. 98.0% of the patients accessing the services were satisfied with the service. 100% of the patients surveyed in the NHS Health Check service felt that they had been involved in decision making about their health. 100% felt they had been given the right information and 100% had been listened to and talked about life.

6.1.2 Health Improvement – The One You lifestyle programme is a localisation of a national programme specifically designed to tackle health inequalities. It is a targeted service focusing on areas of deprivation rather than an overarching approach. One Your Lifestyle Advisors reach out to people who are in circumstances that put them in a greater risk of poor health.

One You Kent delivered by KCHFT includes programmes for weight loss and smoking cessation and began reporting in Quarter 3 2017-2018. KCHFT reorganised and launched its new Health Improvement directorate to facilitate this change. During this time of change all the services maintained their service delivery but as expected there was an increase in both managed staff turnover and vacancy rates, by year end the figures were reducing.

6.1.3 KCHFT Healthy Weight Service (Quarter 1&2 2017/18) and One You weight loss programme Quarter 3&4 2017/18)

6.1.3.1 Introduction to the programme - KCHFT Weight loss programmes are commissioned to deliver services in East Kent. The team, along with a variety of partners, including community Pharmacies and localities, delivers seven distinct schemes of work across all three tiers of the healthy weight pathway (Health Walks, Exercise Referral Scheme, Food Champions and weight loss).

6.1.3.2 Clinical Effectiveness - KCHFT provides several programmes that support healthy weight:

- Tier 1 of the healthy weight service model, free trained volunteer-led walks, which in 2017-18 offered 3500 walking opportunities over many sites.
- A Community Weight Management Programme called Fresh Start is delivered by KCHFT Health Trainers and subsequently Health advisors are subcontracted by KCHFT to 34 pharmacies across Kent. 80% of people who engage in the programme complete it, which is in line with national guidance. The average weight loss is above 3%, as expected for an effective Tier 2 programme.
- KCHFT also provides a Family Weight Management programme which is targeted at families where there is one or more child who is overweight or very overweight. These programmes are proving difficult to recruit to, although the families that do participate show good outcomes with regards to behaviour change. The Healthy Weight Team has provided training for

all Kent School Public Health nurses on a nationally designed programme. This training aims at increasing the confidence of School Public Health nurses in raising the issue of weight and to be able to support families, schools and the wider community. KCHFT has also trained 16 Food Champions who are based in several settings, including Children's Centres.

6.1.3.3 Patient safety - There have been no reported complaints or serious incidents in the service during this period. The vacancy rate in the service at end of 2017-18 is 9.8%. KCHFT is achieving more than the year-to-date target for mandatory training and96.8% of the staff completed the mandatory training. The appraisal rate is 100% and83% of the staff working in the weight service completed children safeguarding training.

6.1.3.4 Patient experience - 98.0% of the patients who attended the service said they would recommend the service to friends or family. 96.2% of the patients accessing the services were satisfied with the service. 100% of the patients surveyed in the Healthy Weight service felt that they had been involved in decision making about their health, had been given the right information and had been listened to and talked about life.

6.1.4 One You Smoke-Free Service

6.1.4.1 Introduction to the programme - The service is commissioned to provide a universal service to smokers who want to quit. The service has a focus towards reducing smoking prevalence in people with mental health problems, pregnant women and people from routine and manual class. The service is also commissioned to provide training, support, and resources for its own in-house staff as well as for approximately 400 Advisors who are based within community settings. These vary from GPs, pharmacies, mental health workers, libraries, supermarkets, hospitals, Children Centres, prisons, and workplaces.

6.1.4.2 Clinical Effectiveness - 2017-2018 has seen a decline in the number of smokers accessing smoking cessation services. This is in line with a national trend and despite fewer people accessing the service, the success rate of those quitting was 51% A notable achievement is the Smoking in Pregnancy Home Visit Advisors in Thanet and South East Coast. This service may be extended to the whole of Kent during 2018/19.

The service is e-cigarette friendly in line with national and regional policies and Skype and telephone support are now widely available to ensure that anyone who wants to quit has a number of options available to them.

6.1.4.3 Patient safety - There have been no reported complaints or serious incidents in this service during this period. There has been a high staff turnover rate and the vacancy rate in the service is 12.8%. 99.5% of staff in the Stop Smoking service have completed their mandatory training and 96.6% of staff have completed the children safeguarding training.

6.1.4.4 Patient experience - 99.6% of the patients who attended the service would recommend the service to friends or family. 94.8% of the patients accessing the services were satisfied with the service. 94.7% of the patients surveyed in the Stop Smoking service felt that they had been involved in decision making about their health, 96.1% felt they had been given the right information and 94.7 % had been listened to and talked about life.

6.1.5 One You Lifestyle which was the Health Trainers service until quarter 3

6.1.5.1 Introduction to the programme – the One You Lifestyle Advisors have very similar objectives to the Health Trainer Programme, which is a national programme specifically designed to tackle health inequalities.

It is a targeted service focusing on areas of deprivation where One You Lifestyle Advisors work with people at greater risk of poor health. They work with clients on a one-to-one basis in a wide variety of community settings to help clients achieve their own goals and to make healthier lifestyle choices. Part of their role also includes signposting individuals to other services and activities that might be suitable to their interest and needs and promote the uptake of such facilities.

6.1.5.2 Clinical effectiveness - The service achieved the target in 2017/8 of 62% from 2 of the most deprived quintiles Good progress has been made within Job Centre Plus and Probation services where the One You service is seeing a sizable number of clients. The service is also experiencing an increase in the number of clients with mental health conditions, as a result of working more closely with Kent and Medway Partnership Trust (KMPT), Porchlight, Change Grow Live (GCL) and Turning Point. All Health Trainers/ One You Lifestyle Advisors have been trained and deliver NHS Health Checks and have moved to an electronic record system.

6.1.5.3 Patient safety - There have been no reported complaints or incidents in the service from April 2017 to March 2018. There has been a high staff turnover rate of 30.1%. This is due to promotion within KCHFT and the internal KCHFT Health Improvement restructure of the service. 96.8% KCHFT Health Trainer/ One You Lifestyle Advisors staff have completed mandatory training.

6.1.5.4 Patient experience - 99.3% of the patients who used the service said they would recommend the service to friends or family. 96.8% of the clients accessing the services were satisfied with the service. 99.9% of the clients surveyed in the service felt that they had been involved in decision making about their health, had been given the right information and had been listened to and talked about life.

6.1.6 Sexual Health Services

6.1.6.1 Introduction to the programme - The sexual health service provides a range of services delivered through clinical and non-clinical settings across Kent. The services provided include contraception services, genitourinary medicine (GUM), HIV treatment and support, psychosexual therapy,

pharmacy sexual health services and the National Chlamydia Screening Programme. In addition, services are available on-line such as chlamydia screening and HIV home sampling tests.

6.1.6.2 Clinical Effectiveness - There have been major improvements in the delivery of sexual health services after the roll out of the integrated sexual health model. The establishment of a clinical service lead for psychosexual therapy has enabled the provider to make improvements in recording service outcomes and expanding the service across Kent.

The delivery of training to pharmacists to provide a sexual health service has recently been improved and the availability of Emergency Hormonal Contraception (EHC) via pharmacies has improved. There is good coverage of this service across all districts, but there is a special focus on areas with the highest teenage pregnancies rates.

The Chlamydia screening programme is integral to all the community programmes, with the programme being delivered through clinics, outreach work, postal kits, websites, pharmacies, GPs and wider partners. This has positively impacted upon the volume of chlamydia screens undertaken amongst 15-24- year olds as the activity is more targeted and embedded into all components of sexual health services.

6.1.6.3 Patient safety - There have been no serious incidents, 1 incident which was successfully resolved, and the actions completed. and 0 near misses in the service. There are 8.2 WTE vacancies in the sexual health services, which equates to a vacancy rate of 9.6%. The staff turnover rate is 11.3%, an improvement on the position in 2017/18. 96.6% of staff have completed their mandatory training against an agreed trajectory of 85% with 86.6% of the staff have completing the adult safeguarding training and 95.9% of staff have completed the children safeguarding training. The appraisal rate is 100%.

6.1.6.4 Patient experience - 98.3% of the patients who attended the service said they would recommend the service to friends or family. 98.3% of the patients accessing the services were satisfied with the service. 98.5% of the patients surveyed in the Sexual Health service felt that they had been involved in decision making about their health, 97.5% felt they had been given the right information and 98.6% had been listened to and talked about life.

6.1.7 School Health Team

6.1.7.1 Introduction to the programme - The 5-19 element of the Healthy Child Programme is led by the School Public Health Nursing service. The universal reach of the Healthy Child Programme provides an invaluable opportunity from early in a child's life to identify families that need additional support and children who are at risk of poor outcomes.

School nurses have a crucial leadership, co-ordination and delivery role within the Healthy Child Programme. Following holistic assessment, interventions are planned in partnership with both the child/young person and other

agencies, to achieve outcomes. There is now a targeted emotional health and wellbeing provision for 5-19-year olds which brings together the integration of the School Nursing team with the Children and Wellbeing team.

6.1.7.2 Clinical Effectiveness - The new structure was implemented by the end of 2017/2018. However, the journey was at times challenging due to the streamlining of contracts to ensure an equitable and effective service.

6.1.7.2 Patient safety - There have been no serious incidents, incidents or near misses. The vacancy rate remains above the trust target and is reflected nationally due to shortage of qualified school nurses but is managed locally and the service remains safe. Mandatory training at 96.8% with 95.8% have completed the children safeguarding training is excellent. 86.7% of the school nurses have completed the adult safeguarding training which is within trajectory.

6.1.7.3 Patient experience - 96.3% of the (patients) children and their parents / guardians who used the service said they would recommend the service to friends or family. 88.8% of the patients accessing the services were satisfied with the service. 100% of the patients surveyed in the School service felt that they had been involved in decision making about their health, 96.3% felt they had been given the right information and 100% had been listened to and talked about life.

6.1.8 Health Visiting Service

6.1.8.1 Introduction to the programme - The 0-5 element of the Healthy Child Programme is led by Health Visiting services. The Health Visiting service employs Specialist Community Public Health nurses who provide expert advice, support, and interventions to families with children in the first years of life and help empower parents to make decisions that affect their family's future health and wellbeing.

The service is central to delivering Public Health outcomes for children. There are five universally offered mandated checks carried out by the Health Visiting service in the programme.

6.1.8.2 Clinical effectiveness - The Health Visiting service during 2017/18 developed a more systematic approach to partnership working with Children's Centres and other community providers to promote optimal health and wellbeing for all children.

6.1.8.3 Patient safety - In this period time there have been 4 serious incidents, 8 incidents and 3 near misses in the service. 2 complaints were received about the service which related to changes in serve provision and have now been successfully resolved.

The vacancy rate is high, which reflects the national picture, but staff turnover rates are improving. Health visiting resources are allocated based on need

and are reviewed regularly to ensure equity of provision based on changing demographics and deprivation weightings.

Workforce strategy development work was completed and embedded in quarter 2 of 2017/18. A new collaboration with Kent University for a fully accredited course to train newly qualified nurses to be Health visitors will commence in September 2018

96.9% of staff completed their mandatory training. 97.4% completed children`s safeguarding training with an end of year adult safeguarding training of 87.5%.100% of staff had appraisals

Serious Incident learning has been addressed and embedded throughout the service.

Supervision, which was a recurring concern in the first 2 serious incidents, was embedded and achieved for staff. Serious Incident learning has been addressed and embedded throughout the service.

6.1.8.4 Patient experience - 98.4% of the patients who used the service and responded to questionnaires said they would recommend the service to friends or family**.** 99% of the patients accessing the services and that responded to questionnaires were satisfied with the service and 100% felt they had been given the right information from the service.

6.2 METRO

6.2.1 Introduction to the programme - Metro provides preventative sexual health awareness programmes online, condoms (GETTIT) and training sessions for mainly young people across Kent.

6.2.2 Clinical effectiveness - During 17/18 the provider has evaluated their various programmes identified innovative and client- focussed improvements to support the delivery, promotion and monitoring of these programmes. This work from the provider has led to an increase in providing their expertise, support and collaboration with other providers working with young people.

6.2.3 Patient safety - No serious incidents or incidents or complaints were reported. There have been no reported issues with staffing levels in the service. All practitioners have completed their mandatory training including safeguarding and are assessed as being competent to deliver the service.

6.2.4 Patient experience - 99% of the clients who used the service said they would recommend the service to friends or family. 99% of the clients accessing the services were satisfied with the service. 100% of the patients surveyed felt that they had been involved in decision making about their health. 100% felt they had been given the right information and 100% had been listened to and talked about life.

6.3 MAIDSTONE AND TUNBRIDGE WELLS HOSPITAL NHS TRUST (MTW)

6.3.1 Introduction to the programme - MTW provides sexual health services in West and North Kent. The services provided by the trust include specialist HIV care and treatment, integrated sexual health service and sexual health outreach service.

6.3.2 Clinical effectiveness - Assurance was achieved in 17/18 despite the provider having to successfully manage various issues with clinical premises. These were, mitigated by being flexible in the approach to the delivery of safe services. Online services including screening have been very successful with an unexpected rise in reporting of adult safeguarding issues particularly domestic abuse.

6.3.3 Patient safety - No serious incidents, incidents, or near misses were reported by the service. All staff have completed their safeguarding and mandatory training. 95.6% of staff working in the sexual health services have completed their children`s and adult training. 2.5% vacancies have been successfully mitigated via internal skill mix.

6.3.4 Patient experience - 98.1% of the patients who used the service said they would recommend the service to friends or family. 98.0% of the patients accessing the services were satisfied with the service. 96.7% of the patients surveyed felt that they had been involved in decision making about their health. 100% felt they had been given the right information and 100% had been listened to and talked about life.

6.4 Substance Misuse Providers - Forward Trust & Change, Grow, Live (Formerly known as CRI)

6.4.1 Introduction to the programme - CGL (Change, Grow, Live) deliver substance misuse treatment services in West Kent (covering districts of Maidstone, Tonbridge and Malling, Tunbridge Wells, Sevenoaks, Dartford and Gravesham). Forward Trust delivers substance misuse treatment services in East Kent (covering districts of Swale, Ashford, Canterbury, Thanet, Folkestone & Hythe and Dover).

Forward Trust provides substance misuse services including access to detox and residential rehabilitation, whilst CGL deliver an integrated drug and alcohol service in West Kent. Both services help vulnerable adults to understand the risks their drug or alcohol use pose to their health and wellbeing and support them to reduce or stop their use safely. Once stability or abstinence has been achieved, an aftercare service is provided to help maintain recovery and prevent the possibility of a relapse. CGL offers support for people who use legal highs, illegal drugs, Over the counter (OTC) medication and multiple drug/or alcohol use.

Forward Trust, CGL and Addaction (the Provider of county-wide Young People's services) have reported no serious incidents in the given time period. The learning from root cause analysis is shared with wider partners via the

SILP meeting to ensure there is a continuous programme of service improvement. CGL, Forward Trust and Addaction have robust safeguarding and safety policies which they audit and review regularly

6.4.2 Forward Trust Clinical effectiveness – Forward Trust were awarded the East Kent contract, and this commenced in May 2017. Forward Trust have maintained professionalism throughout the transformation. All the clients received a safe, competent service with the majority of staff moving over to Forward trust via TUPE the service governance and policy structures are now fully embedded.

6.4.3 Forward Trust Patient safety -, incidents or complaints were reported. There have been no reported shortages in staffing levels in the service. All practitioners have completed their mandatory training with 85% completing children`s and 87% adults safeguarding. All staff are assessed as being competent to deliver the service.

6.4.4 Forward Trust Patient experience - 99% of the clients who used the service said they would recommend the service to friends or family. 99.0% of the clients accessing the services were satisfied with the service. 100% of the patients surveyed felt that they had been involved in decision making about their health, 100% felt they had been given the right information and 100% had been listened to and talked about life.

6.4.5 CGL Clinical effectiveness - CGL achieved a competent service during 2017/18 with significant improvement and quality assurance following their reorganisation during 2016/17. All practitioners have completed their mandatory training with 95% completing children`s and 97% adults safeguarding. All staff are assessed as being competent to deliver the service.

6.4.6 CGL Patient safety - incidents or complaints were reported. The providers have a very robust and active safety process within the organisation. All the staff are fully involved in the governance process and lessons learnt are actively embedded into the service improvement.

6.4.7 CGL Patient satisfaction - 99.1% of the patients who used the service said they would recommend the service to friends or family. 98.0% of the patients accessing the services were satisfied with the service. 98.7% of the patients surveyed felt that they had been involved in decision making about their health, 100% felt they had been given the right information and 100% had been listened to and talked about life.

6.5 Young Addaction

6.5.1 Introduction to the programme – Young Addaction provide advice on drugs and alcohol for young people aged 10 to 24 in 2017/18. Young Addaction support young people to understand the effects of their substance misuse and the harm might cause to them and the people around them. As well as one-to-one work, Addaction also offer a range of early intervention programmes in

schools, youth clubs and other settings, helping young people reach their full potential.

6.5.2 Clinical effectiveness – Performance data shows the provider is achieving effective results in engaging young people who are at risk of reoffending, at risk of exclusion and are children of substance misusing parents and Children in Care**.** The provider delivers structured treatment for those young people who have very complex needs around their substance misuse.

Young Addaction is successfully engaged in prevention with both of the more complex client groups, especially those with two or more vulnerabilities, and prevention and awareness generally with targeted young people using the latest appropriate technology. 100% of all staff have received their adult and children's safeguarding and all other mandatory training.

6.5.3 Patient safety – Young Addaction has not reported any serious incidents or complaints in the service in this time.

6.5.4 Patient satisfaction – Young Addaction conducts a young people's survey each quarter and have very active user groups. All feedback is used to inform development and reflected in the service governance. 98% of young people stated they would recommend the service to their friends and would be happy using the service in the future.

7. Discussion & Risk

During this very challenging year there has been a high level of engagement with the process from all providers of Public Health Services and the Public Health team, with all services providing a high-quality client experience and assurance. Most providers have been able to provide high level of quality assurance of their services.

The quality indicators have identified areas of good performance and those that need improvement have action plans which are closely monitored ...

8. Conclusions

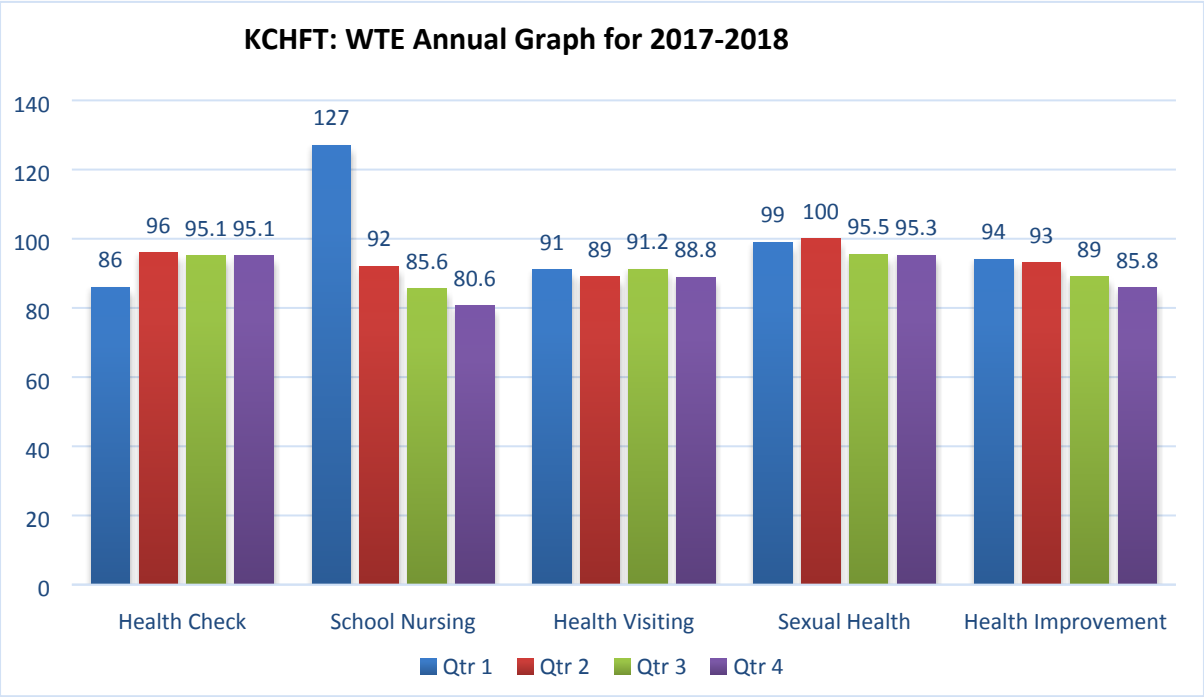
This report provides assurance that the quality of Public Health and commissioned services meet national standards and demonstrates that a model of continuous improvement has been achieved.

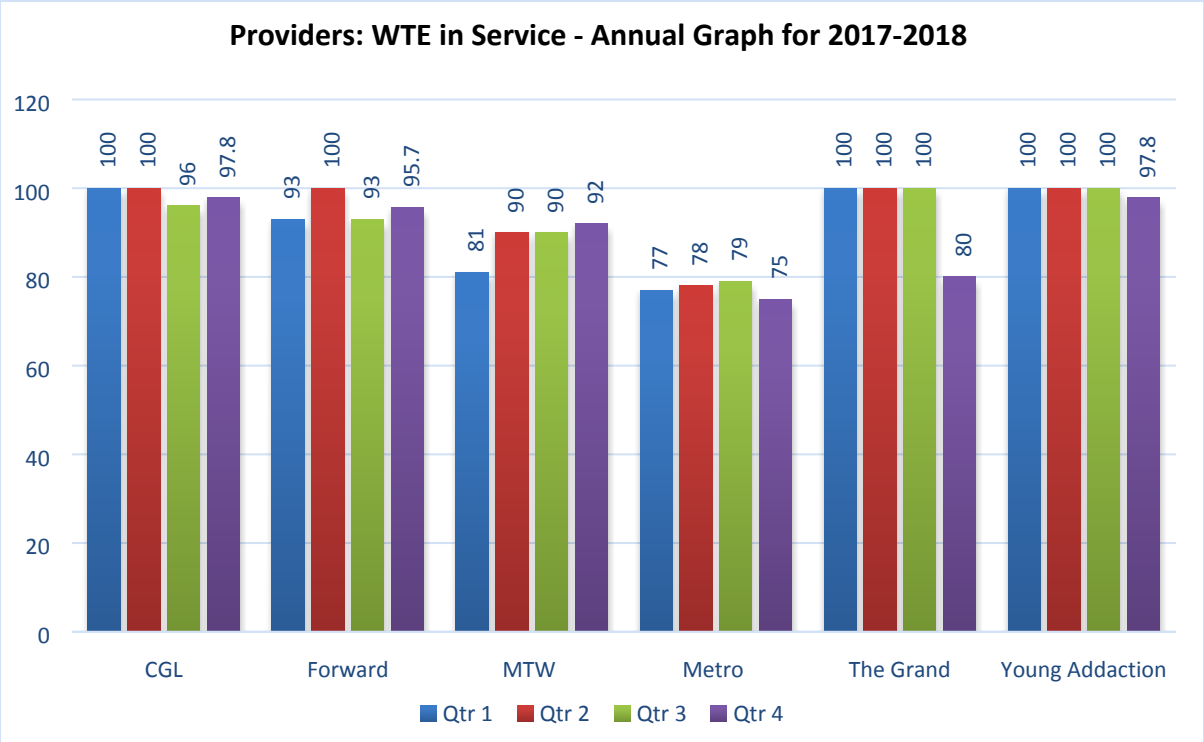
9. Recommendations

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **COMMENT** on and **NOTE** the Public Health Quality Annual Report 2017-2018

10. Background Documents: None

11. Appendices





KCC Public Health Quality Dashboard P

https://democracy.kent.gov.uk/documents/s86565/KCC%20Public%20Health%20Quality%20Dashboard.pdf

12. Contact details

Report Author
- Penny Spence, Public Health Head of Quality & Safeguarding
- 03000 419555
- Penny.spence@kent.gov.uk

Relevant Director
- Andrew Scott-Clark, Director of Public Health
- 03000 416659
- Andrew.scott-clark@kent.gov.uk

This page is intentionally left blank

From: **Graham Gibbens, Cabinet Member for Adult Social Care and Public Health**

Andrew Scott-Clark, Director of Public Health

To: **Health Reform and Public Health Cabinet Committee**

Date: **28th September 2018**

Subject: **Suicide Prevention Needs Assessment**

Classification: **Unrestricted**

Past Pathway of Paper: N/A

Future Pathway of Paper: N/A

Electoral Districts: All

Introduction:

This paper introduces the draft Suicide Prevention Needs Assessment for Kent.

Recommendation(s):

Committee Members are asked to provide comments on the needs assessment and identify any areas in which they would like to see further research.

1. Introduction

1.1 The Health Reform and Public Health Committee received an update in June 2018 regarding additional funding which the Kent and Medway STP had received in relation to suicide prevention.

1.2 During discussion it was mentioned that a needs assessment was to be produced. This is the needs assessment which sets out some of the latest suicide prevention statistics which have influenced the design of the STP funded programme.

1.3 The Committee has seen some of these statistics before but many have been updated and some are shown here in more detail.

1.4 Given the Committee's discussion of the suicide prevention programme activity at the June 2018 meeting, this paper doesn not repeat the details of the programme, rather it just introduces the needs assessment for Members to consider.

1.5 There is a wide variety of sources for suicide prevention data, therefore when new and updated information becomes available this Needs Assessment will be updated.

1.6 A wider Mental Health Needs Assessment is also being developed and will be presented to Members in due course.

2. Recommendation(s)

Recommendation(s):

Committee Members are asked to provide comments on the Needs Assessment and identify any areas in which they would like to see further research.

6. Contact details

Report Author

- Tim Woodhouse, Suicide Prevention Specialist, Public Health
- +44 3000 416857
- tim.woodhouse@kent.gov.uk

- Jess Mookherjee, Public Health Consultant
- +44 3000 416493
- Jessica.mookherjee@kent.gov.uk

Relevant Director

- Andrew Scott-Clark, Director of Public Health
- +44 3000 416659
- Andrew.scott-clark@kent.gov.uk

7. Background documents: none

Suicide Prevention Needs Assessment

Kent

September 2018

Produced by

Tim Woodhouse Suicide Prevention Specialist (tim.woodhouse@Kent.gov.uk)

Version Control

Version Number	Date	Reviewer	Change reference and summary
1	Sept 2018	TW	V.1

Contents

1. Executive Summary

1.1 Introduction

- Every suicide is a tragedy. The impact is devastating for the friends and family of the individual who died, as well as the wider community.
- Suicide prevention is a public health priority both nationally and locally, with a role for a wide range of statutory and community organisations.
- The current Kent and Medway Suicide Prevention Strategy runs from 2015 to 2020.
- The Kent and Medway STP was awarded £667,000 for additional suicide prevention programmes during 2018/19.

1.2 Key Findings

- Kent's suicide rate is higher than the national average, particularly amongst men.
- Men are at greater risk of dying by suicide than women, and middle-aged men are at the highest risk.
- Suicide rates vary across the different CCG areas within Kent and there is a socio-economic gradient to suicide with people in the most deprived communities experiencing higher rates of suicide.
- Other groups at higher risk include;
    - People in contact with secondary mental health services (particularly post discharge from inpatient settings)
    - People in contact with the criminal justice system
    - People experiencing social pressures (such as financial crisis or relationship breakdown)
    - People with co-existing substance misuse and mental health conditions
    - People with long term physical health conditions
    - Groups who experience discrimination or abuse (eg LGBT or some BME groups)
- The biggest single indicator of suicide risk is previous self-harm including previous suicide attempts
- 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

1.3 Recommendations

1. Continue to implement the Kent and Medway 2015-2020 Suicide Prevention Strategy and Action Plan

2. Continue to implement and evaluate the 2018/19 STP Suicide Prevention funding programme
3. During 2019, develop a new Kent and Medway Suicide Prevention Strategy for 2020-2025

2. Introduction

2.1 Overview

Every suicide is a tragedy. The impact is devastating for the friends and family of the individual who died, as well as the wider community.

Suicide prevention is a public health priority both nationally and locally, with a role for a wide range of statutory and community organisations. Public Health England guidance suggests that public health teams within local authorities should take the lead bringing together local stakeholders to coordinate local action.

There is a national target to reduce suicide rates by 10% by March 2021. This target has also been adopted by the Kent and Medway STP locally.

2.2 Kent context

Kent County Council's Public Health team co-ordinates and leads the Kent and Medway Suicide Prevention Multi-Agency Steering Group which includes a variety of agencies, charities and individuals affected by suicide including;

- Medway Council
- KMPT
- Kent Police
- Network Rail
- Mind
- Samaritans
- Canterbury Christ Church University
- CCGs
- Survivors of Bereavement by Suicide

The Steering Group developed the 2015-2020 Kent and Medway Suicide Prevention Strategy and is responsible for implementing the associated Action Plan.

The Strategy includes the following six priorities;

i. Reduce the risk of suicide in key high-risk groups
ii. Tailor approaches to improve mental health and wellbeing in Kent and Medway
iii. Reduce access to the means of suicide
iv. Provide better information and support to those bereaved or affected by suicide
v. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi. Support research, data collection and monitoring

In 2018, the Kent and Medway STP successfully bid for £667,000 from NHS England for additional suicide prevention programmes during 2018/19. Tim Woodhouse (Suicide Prevention Specialist within KCC) is responsible for implementing the agreed funded programme across the Kent and Medway STP footprint.

The funded programme has the following elements;

1) Extending the “Release the Pressure” social marketing campaign
2) Strengthening high risk points within secondary mental health services
3) Better support for those bereaved by suicide
4) At least 1000 people trained in suicide awareness and prevention
5) Innovation fund for grassroots projects
6) Suicide Safer Universities Programme
7) Workplace interventions in high risk industries
8) Qualitative research
9) Better identification and support for people in primary and local care settings

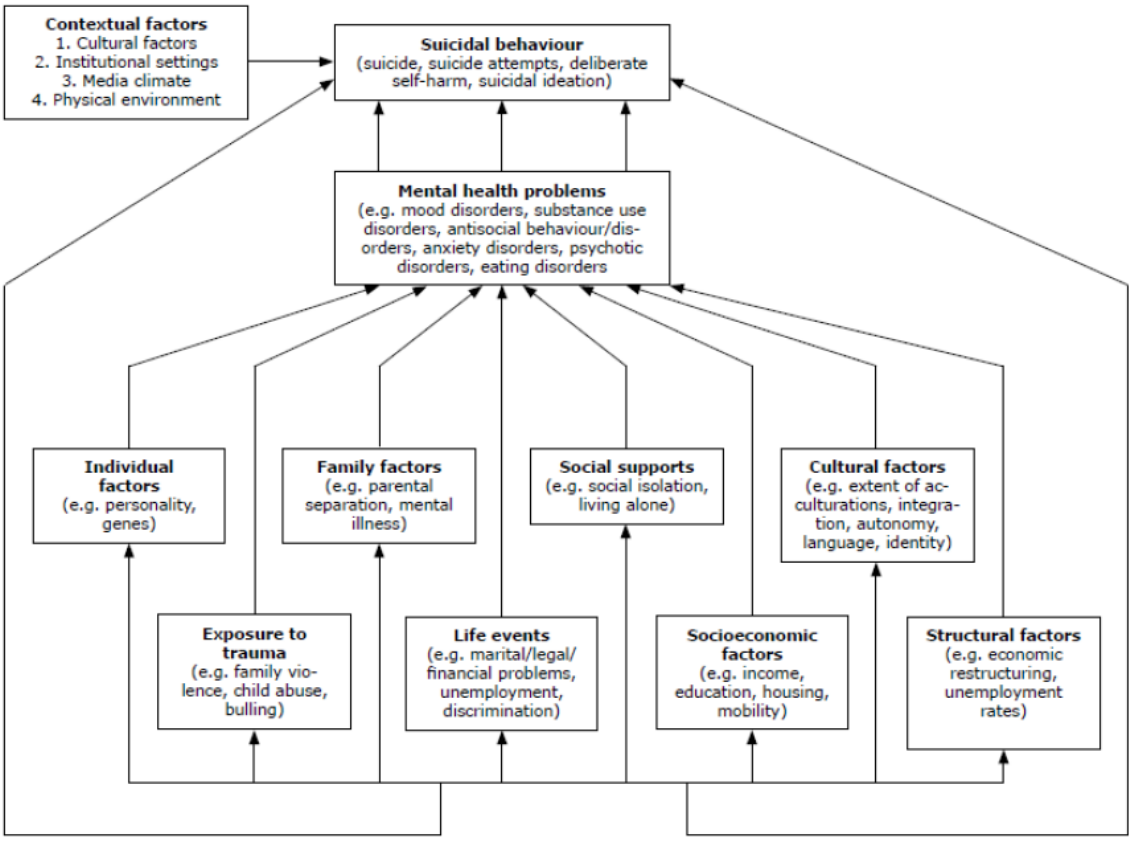
3. Key Findings

3.1 Who is at risk and why?

"There is no single reason why people take their own lives. Suicide is a complex and multi-faceted behaviour, resulting from a wide range of psychological, social, economic and cultural risk factors which interact and increase an individual's level of risk"[1]

This quote from a 2017 Samaritans report highlights the complexity of trying to identify who is at risk of suicide. In 2010, the Royal College of Psychiatrists further illustrated this complexity in their diagram of possible pathways to suicide (see Figure 1 below).[2]

Figure 1 Pathways to Suicide Behaviour



National and local research has shown that there are a number of factors which may mean that some individuals or groups are at higher risk of suicide than others. This needs assessment has been developed by analysing local and national data with the intention of identifying increased risk factors within the Kent population.

[1] Samaritans (2017) *Dying from inequality Socioeconomic disadvantage and suicidal behaviour* Available at http://bjp.rcpsych.org/content/early/2017/03/02/bjp.bp.116.189993

[2] Royal College of Psychiatrists (2010) College report CR158 *Self-harm, suicide and risk: helping people who self-harm* Available at http://www.rcpsych.ac.uk/files/pdfversion/CR158.pdf

3.2 Suicide statistics and data sources

Coroners are the only officials who can determine whether an individual death was a suicide or not. For a Coroner to reach a conclusion of suicide the intention of the person to end their own life must be beyond reasonable doubt.

However, to aid population level analysis of suicide behaviour, the Office of National Statistics recommend that suicide statistics include both Coroner confirmed suicides and deaths (of self-injury and poisoning) where the intent was undetermined.

To allow for accurate comparisons, suicide rates are reported as a rate per 100,000 (either as an annual or a three-year rolling average).

The statistics which make up this needs assessment come from a variety of sources. Each source will be identified when used, however the most frequent sources are as follows;

- Kent Public Health Observatory (using the Primary Care Mortality Database)
- Public Health England (using the FingerTips Online Tool)
- National Confidential Inquiry into Suicide and Homicide (based at the University of Manchester)

There is often a time delay (which could be months or even years) between the date of someone dying and the completion of a Coroner's inquest. To allow for the accurate inclusion of the most recent data, most of the statistics in this assessment are based on the date of suicide registration (rather than date of death).

During 2018 the KCC Public Health team is working with KCC's Coroner Service to analyse over 150 recent suicide verdicts. This will enable us to have a deeper understanding of what is happening in the lives of people who die by suicide in Kent in the months before they die. The results of this research will be added to future versions of this needs assessment.

3.3 Suicide numbers in Kent in recent years

The number of suicides registered by Coroners in Kent has fallen slightly over recent years. In 2017, the 123 registered suicides accounted for 0.8% of all Kent deaths.

Table 1 - 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
Kent	Male	73	85	97	119	130	116	104	85
	Female	27	34	26	31	35	36	36	38
	Total	100	119	123	150	165	152	140	123

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

3.4 National comparisons

As Table 2 (below) shows, the suicide rate in Kent is higher than the national average, particularly for men.

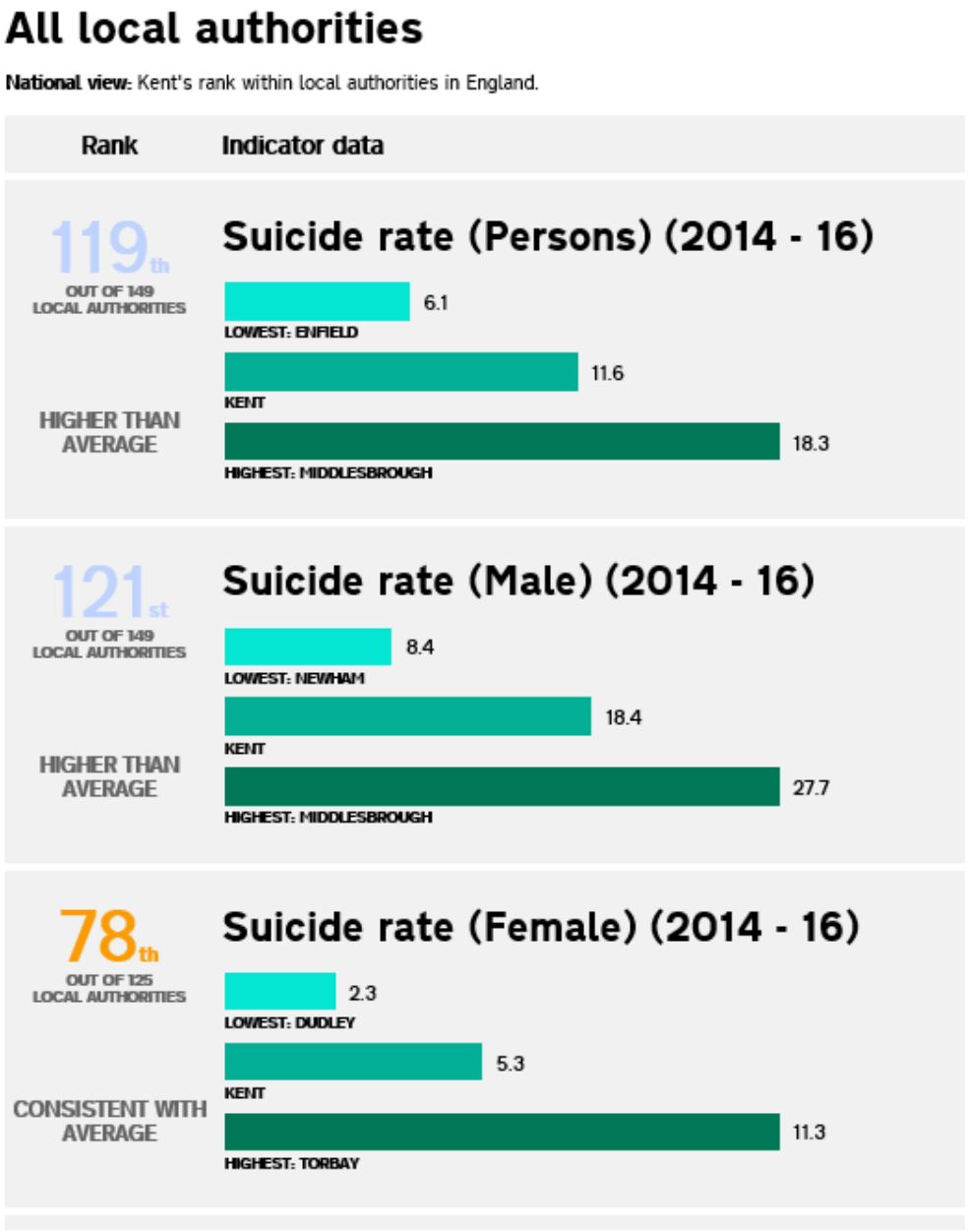
Table 2 – Age Standardised Suicide Rate per 100,000 (3 year average 2014-16) Kent compared to South East and England averages.

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

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data

Figure 2 below shows that Kent's male suicide rate ranks as the 121st highest out of 149 (top-tier and single-tier) local authorities.

Figure 2 – Suicide rate, local authority ranking



https://healthierlives.phe.org.uk/topic/suicide-prevention/area-details#are/E10000016/par/E92000001

3.5 CCG variation across Kent

There is wide variation in suicide rates across Kent (as shown in Table 5 below). Thanet, Swale and South Kent Coast CCG areas have the highest overall suicide rates. However West Kent CCG has the second highest female suicide rate.

Table 5 - Numbers of deaths and rates from suicide and undetermined causes, Kent CCGs, 2014 -2016 registrations, by gender, - residents aged 15+

Clinical commissioning group	Male		Female		Both sexes	
	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)

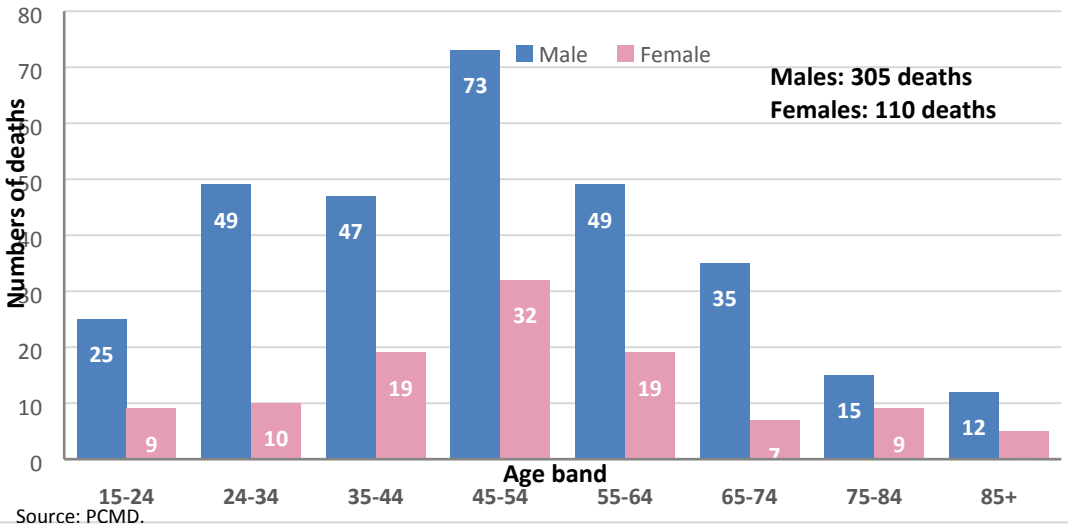
[1] Directly age-standardised mortality rate per 100,000 resident

3.6 High risk groups

3.6.1 Men

As Table 1 (above, page 8) shows over two-thirds (69%) of the individuals who died by suicide in Kent in 2017 were male. Chart 1 (below) shows that it is middle aged men who are at most risk.

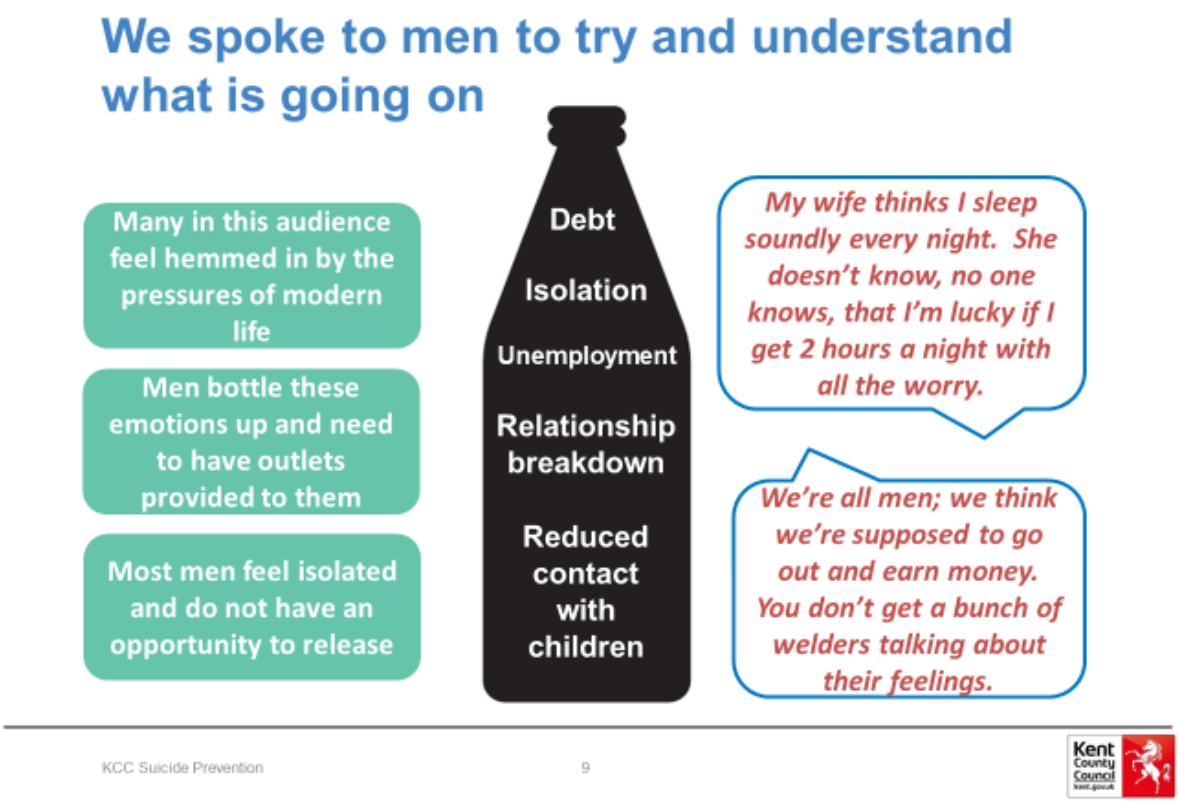
Chart 1 - Numbers of deaths from suicide and events of undetermined intent, 2015-17 by age band and gender



Source: PCMD.

Research in 2016 (in preparation of the Release the Pressure campaign) highlighted that many men felt depressed following life events such as relationship breakdown, money worries, isolation and were unable to express their feelings.

Slide 1 – Research with a focus group of men in 2016. KCC Public Health



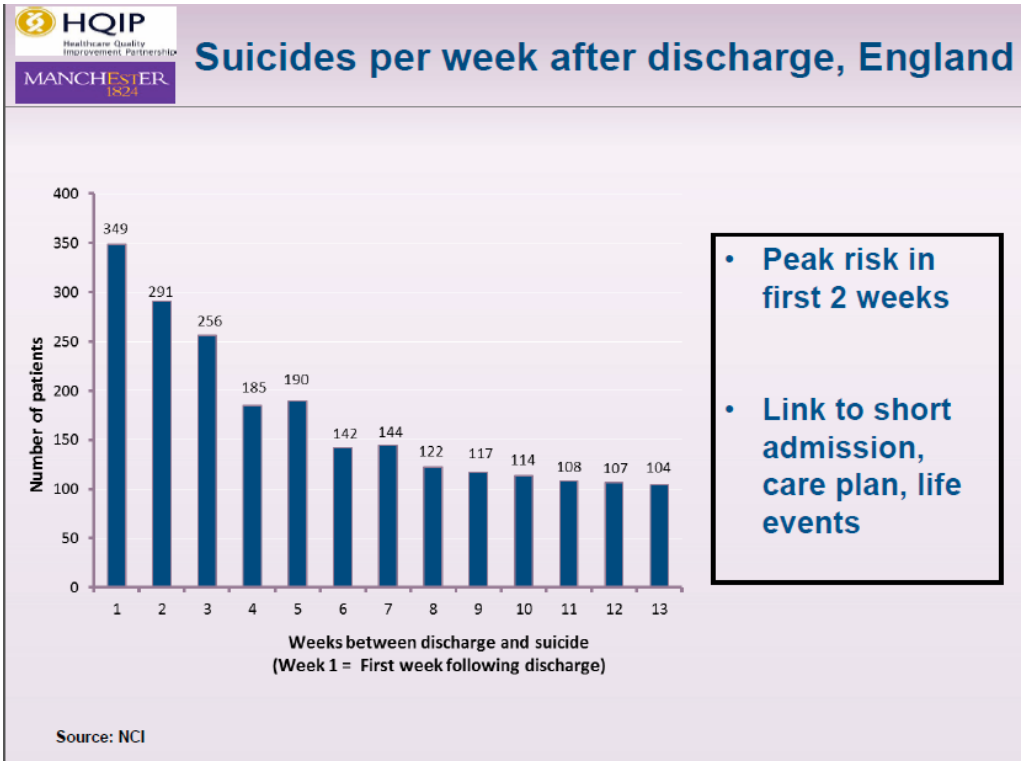
3.6.2 People in contact with mental health services

An analysis of the 2017 Kent suicide registrations has shown that 33% of people who died by suicide were known to KMPT (the local provider of secondary mental health services) in the year before they died. This corresponds well with national estimates (from the National Confidential Inquiry) that in the year before a death by suicide, and in relation to 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

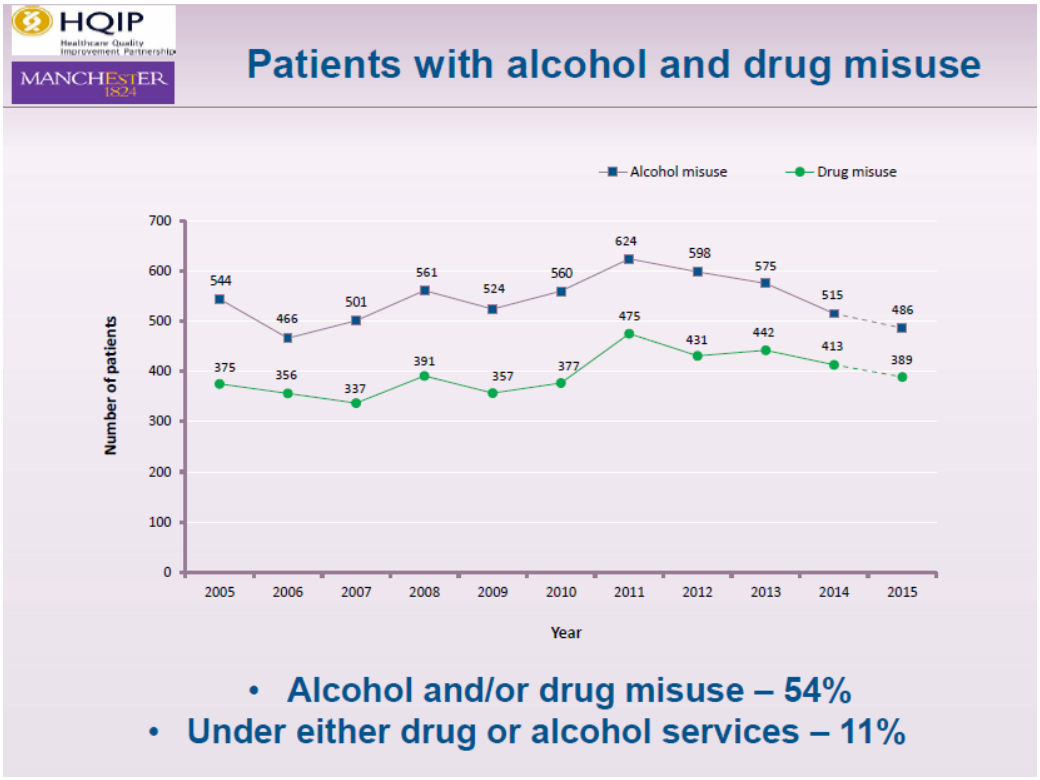
Further analysis from the National Confidential Inquiry has shown that 90% of suicides amongst people known to secondary mental health services are occur in community (rather than inpatient settings). Of these, and as Slide 2 shows below, one of the highest risk points is in the first two weeks after discharge from an inpatient setting.

Slide 2 – Suicides per week after discharge, patients known to mental health services



The National Confidential Inquiry has also identified that alcohol and drug misuse is also a risk factor for suicide. Amongst people known to secondary mental health services who die by suicide, alcohol and/or drugs were misused by 54% (as shown in Slide 3 below)

Slide 3 – Substance misuse in patients known to mental health services who die by suicide



3.6.3 People who have a history of self-harm

Not everyone who dies by suicide will have previously self-harmed, and not everyone who self-harms will go onto end their own lives. However, according to the National Confidential Inquiry into Suicide and Homicide it is the single biggest indicator of risk. As Slide 3 shows, 50% of people who die by suicide have a history.

Slide 3 – Self-harm links to suicide from the National Confidential Inquiry

Table 3 below shows the numbers of individuals in Kent attending A&E after self-harm incidents. The number of females between the ages of 10-19 attending A&E after self-harm is more than double the number of males aged 10-19. However, the number of males between 20-29 is higher than the number of females in the same age band.

Table 3 - Numbers and percentages of A&E self-harm attendances, Kent Residents, 2011/12 - 2015/16 (pooled), by gender and age band

	Males		Females		Total	
Age band	**Numbers**	**% of total**	**Numbers**	**% of total**	**Numbers**	**%**
10-19	1,059	7.7	2,158	15.7	3,217	23.4
20-29	1,799	13.1	1,635	11.9	3,434	25.0
30-39	1,235	9.0	1,011	7.4	2,246	16.4
40-49	1,242	9.0	1,296	9.4	2,538	18.5
50-64	1,072	7.8	614	4.5	1,686	12.3
65+	387	2.8	229	1.7	616	4.5
Total	**6,794**	**49.5**	**6,943**	**50.5**	**13,737**	**100**

Source: SUS, KPHO (JB)

Table 4 shows the numbers of individuals in Kent being admitted to hospital after self-harm incidents. The number of females between the ages of 10-19 being admitted to hospital after self-harm is more than four-times the number of males aged 10-19.

Table 4 - Numbers and percentages of emergency admissions for self-harm, Kent Residents, 2011/12 - 2015/16 (pooled), by gender and age band

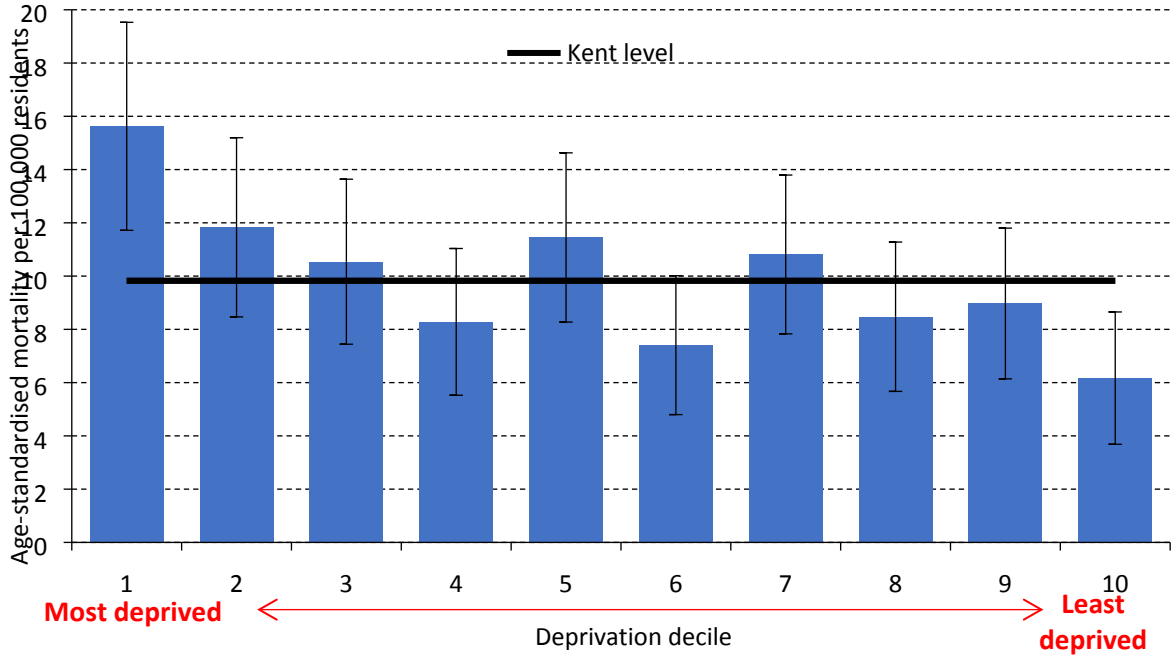
	Males		Females		Total	
Age band	Numbers	% of total	Numbers	% of total	Numbers	%
10-19	618	4.1	2,480	16.4	3,098	20.5
20-29	1,584	10.5	2,238	14.8	3,822	25.3
30-39	1,127	7.5	1,401	9.3	2,528	16.7
40-49	1,199	7.9	1,853	12.3	3,052	20.2
50-64	836	5.5	1,057	7.0	1,893	12.5
65+	303	2.0	426	2.8	729	4.8
Total	**5,667**	**37.5**	**9,455**	**62.5**	**15,122**	**100**

Source: SUS, KPHO (JB)

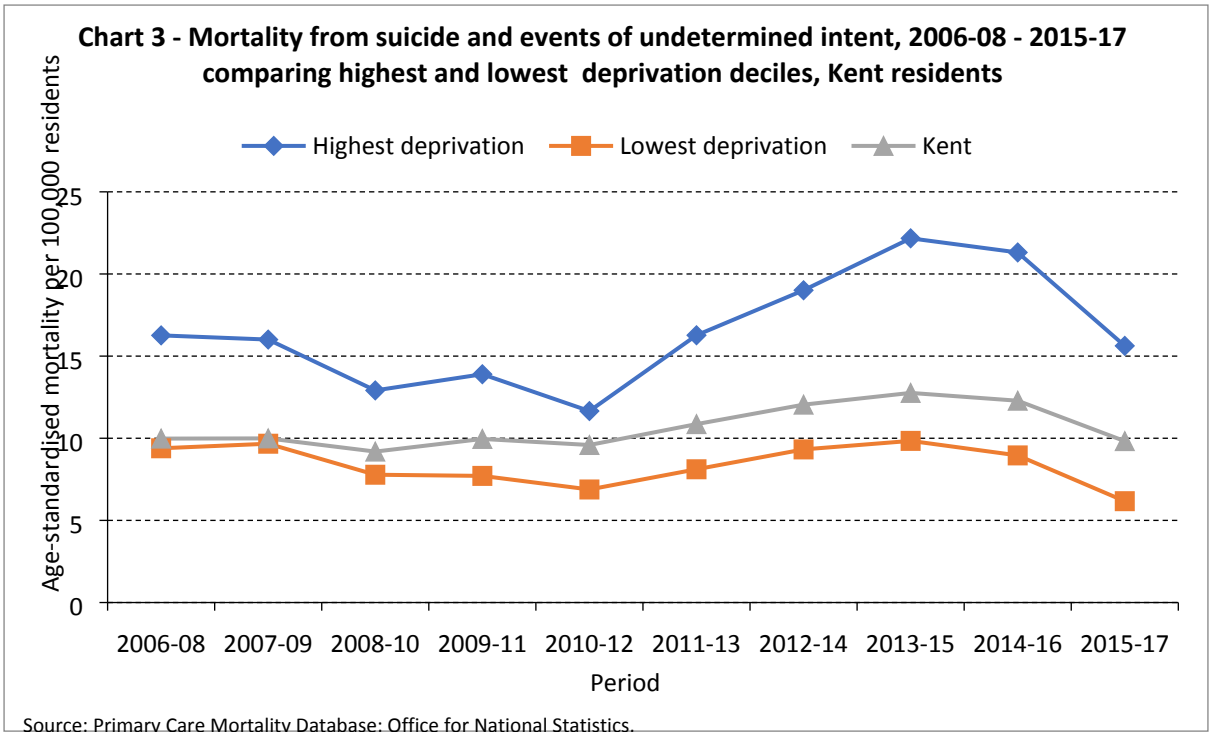
3.6.4 Deprived communities

There is a strong link between suicide rates in Kent and areas of greatest deprivation. Charts 2 and 3 show that the most deprived communities in Kent consistently have the highest suicide rates.

Chart 2 - Mortality from suicide and events of undetermined intent, 2015-17 by deprivation decile (Dn), Kent residents



Source: Primary Care Mortality Database; Office for National Statistics,



3.6.5 Children and young people

Between 2012 and 2016, 54 people aged 24 and under died due to suicide or undetermined causes in Kent. Of these, 8 (16%) were aged under 18. The number of people under 18 who die from suicide or undetermined causes is low, however the impact on family, friends and communities is so severe that they remain a group to prioritise for support.

The small numbers mean that providing analysis at a lower geographical level than Kent, or analyzing single year data is not possible.

3.6.6 Other high-risk groups

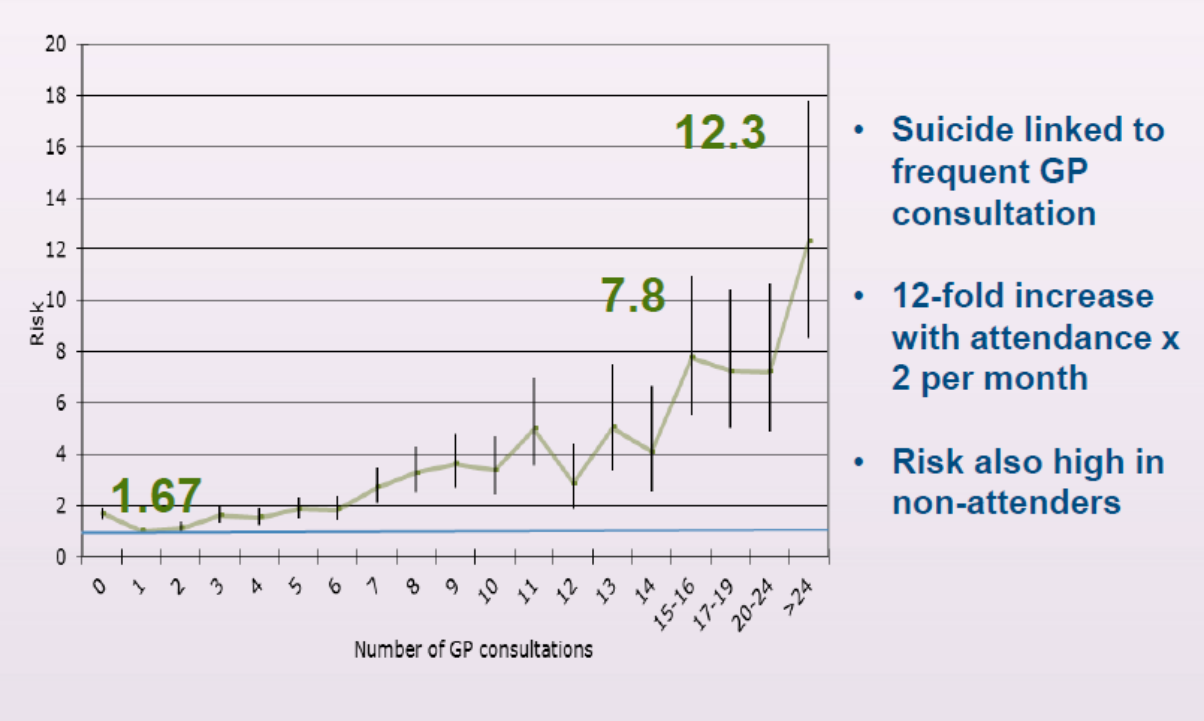
National evidence shows that the following groups also have higher rates of suicide that the general population:

- People in contact with the criminal justice system
- People with co-existing substance misuse and mental health conditions
- People who have been bereaved by suicide
- People with long term physical health conditions
- Groups who experience discrimination or abuse (eg LGBT or some BME groups)
- Students

3.7 Primary care

The National Confidential Inquiry has identified that individuals that visit their GPs more than 24 times a year have a much higher risk of dying by suicide than individuals who visit their GPs less often (see Slide 4 below).

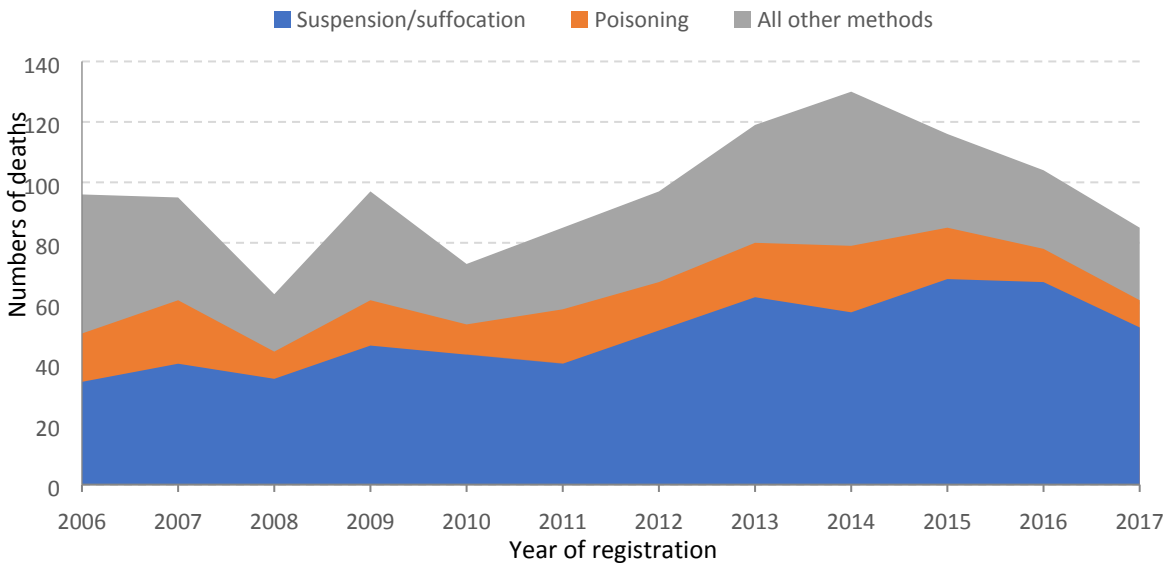
Slide 4 – Suicide risk and GP attendance



3.8 Suicide method

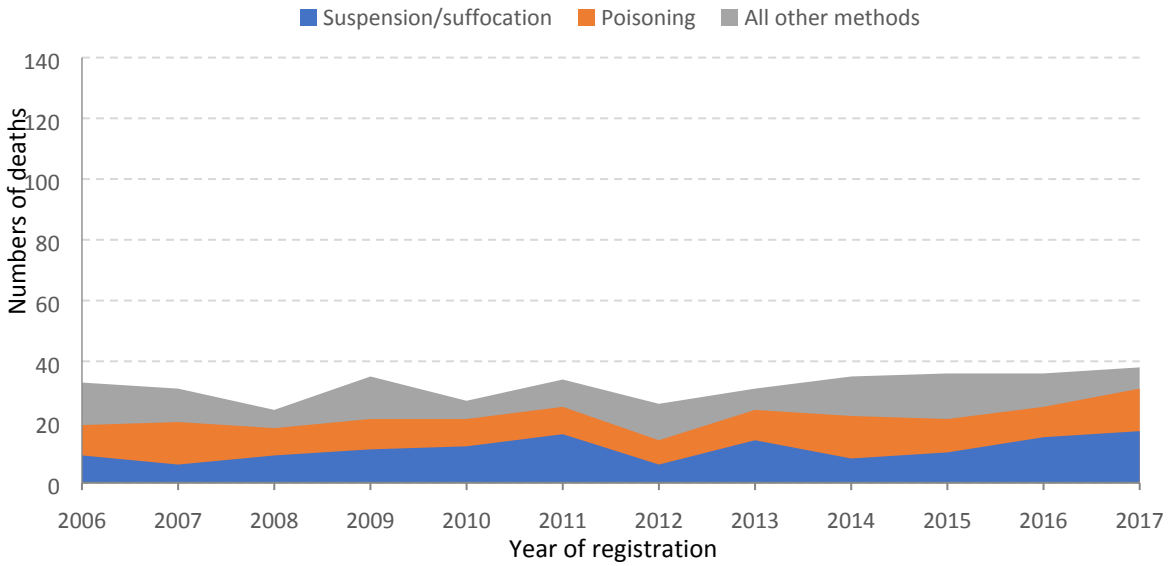
As shown in Charts 4 and 5 below, suspension and poisoning are the two most common methods of suicide for both men and women, however suspension makes up a larger proportion of deaths amongst men than women. Jumping (from a height or in front of a vehicle) makes up the largest part of "All Other Methods".

Chart 4 - Deaths from suicide and events of undetermined intent, Kent, 2006-2017 by method, MALES



Source: PCMD, KPHO (JB)

Chart 5 - Deaths from suicide and events of undetermined intent, Kent, 2006-2017 by method, FEMALES



Source: PCMD, KPHO (JB)

4. Conclusions

4.1 Conclusions

Despite small falls in the numbers of people taking their own lives in recent years, suicide remains a key public health priority, accounting for nearly 1% of all deaths in Kent.

The Kent and Medway Suicide Prevention Steering Group is a strong network of professional agencies, charities and individuals affected by suicide, however the current Kent and Medway Suicide Prevention Strategy is due to end in 2020. Plans should be put in place to develop a further five-year strategy.

The additional funding received in 2018/19 will raise the profile of suicide prevention issues within Kent and Medway, and is an opportunity for existing programmes to be strengthened, new innovations to be tested and system-wide changes to be embedded. The funding programme should be evaluated fully with key learning points transferred into future programmes.

4.2 Recommendations

1. Continue to implement the Kent and Medway 2015-2020 Suicide Prevention Strategy and Action Plan
2. Continue to implement and evaluate the 2018/19 STP Suicide Prevention funding programme
3. During 2019, develop a new Kent and Medway Suicide Prevention Strategy for 2020-2025

From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

Date: 28th September 2018

Subject: Sexual Health Needs Assessment and Service Commissioning

Classification: Unrestricted

Previous Pathway: A contracting monitoring report on sexual health services and their transformation was brought to this committee on 28 January 2018

Future Pathway: Cabinet Member Decisions – 18/00051 a and b

Electoral Division: All

Summary:
This report provides an overview of the sexual health needs assessment which has informed service commissioning plans. Key action includes increasing uptake of online services, reducing clinics with poor utilisation and improving levels of screening. By refining existing models, we will improve efficacy, accessibility and outcomes for residents. Proposals were supported by Kent County Council's (KCC's) Strategic Commissioning Board in July and the committee is asked to comment and endorse the future plans.
Services can be grouped broadly into three categories; a condom programme with targeted outreach, integrated Genitourinary Medicine (GUM) and related services and long-acting reversable contraception provided by Primary Care. The recommended approach to sourcing services after March 2019 includes: continued contracting via primary care for long-acting reservable contraception, a competitive procurement for the young person's condom scheme and continued delivery of the remaining services via existing providers.

The latter will incorporate parts of the integrated Genito Urinary Medicine/[GUM] and related services into the existing Public Health Services Partnership Agreement between Kent Community Health NHS Foundation Trust (KCHFT) and KCC and result in a new partnership with Maidstone and Tunbridge Wells NHS Trust. MTW is a trusted NHS provider well placed to work alongside KCHFT to provide these specialist services. This arrangement will provide stability of services, maximise funding and accelerate delivery of Sustainability and Transformation Plan (STP).

Recommendation:
The committee is asked to:
NOTE the key findings of the needs assessment and **COMMENT** on the changes in delivery of sexual health services.

ENDORSE or make a recommendation to the Cabinet Member on the proposed decision:

•The inclusion of integrated sexual health and related services into the existing Kent Community Health Foundation NHS Trust (KCHFT) partnership

•Formation of a new partnership agreement with Maidstone and Tunbridge Wells NHS Foundation Trust (MTW) and inclusion of integrated sexual health and online STI testing services

•Continued contracting directly with GP surgeries for Long Acting Reversible Contraception (LARC) services delivered within primary care

The committee is asked to **SUPPORT** the proposed plans for the continued delivery, of KCC commissioned sexual health services via KCHFT and primary care.

1. Introduction

1.1. This report provides the Committee with an overview of the findings of the sexual health needs assessment and a more detailed understanding of the breadth of service provision.

1.2. The committee has previously been informed of the performance, outcomes and ongoing work to transform the services to respond to changing patterns of demand. This paper presents an update on commissioning plans and route to market for providing sexual health services after 31st March 2019. Members are asked to help shape the service developments and endorse the approach set out in this paper.

2. Background

2.1. Since April 2013, KCC has had statutory obligations, under the Health and Social Care Act 2012, not only to take steps to improve the health of the people of Kent, but also to ensure provision of a range of open access sexual health and community contraceptive services across the county.

2.2. KCC also has a statutory obligation under the Care Act to prevent the escalation of needs.

2.3. Commissioning responsibility for sexual health services is split across KCC, NHS England, and Clinical Commissioning Groups (CCGs). KCC is responsible for the majority of testing and treatment of sexually transmitted infections (STIs). However, some testing and treatment takes place in other services, commissioned by other bodies, for example. HIV testing in termination of pregnancy services or blood borne virus screening in antenatal care. For this reason, KCC has worked with other statutory bodies to try to ensure services are as joined up as much as possible for the user and the impact of any service change is fully considered.

2.4. KCC's vision for services is to ensure that local residents have timely access to high quality services to improve and manage their sexual health through the delivery of a fully integrated, cost effective sexual health service model, accessed by a digital single point of access. Services include genitourinary medicine, HIV services, psychosexual therapy services and contraceptive services (please see appendix 4 for a full breakdown of services). The performance of providers are reported regularly to this committee and are generally within or above expected levels.

2.5. Since services were first commissioned by KCC there has been a number of significant changes including:

- the Kent and Medway Sustainability and Transformation Plan (STP)
- the development of new health structures and provider organisations
- improved digital offer
- changing patterns of use and reducing budgets.

2.6. Significant progress has been made to respond to these challenges and ensure services can be provided as efficiently as possible. This has included:

- the use of activity-based contracting
- launch of an extended STI testing service
- exploration of opportunities for co-commissioning with health partners

- work to reduce out of area activity
- the exploration of sourcing suitable sexual health premises to offer a comprehensive service.

2.7. Providers have illustrated a forward-thinking approach and worked collaboratively to deliver continued improvements and respond to changes in policy.

3. Sexual health needs assessment

'*Sexual health is a state of physical, mental and social wellbeing in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.*'[1]

3.1. A needs assessment is an important tool to inform service planning and commissioning. It is a systematic approach used to identify unmet healthcare and health needs in a population.

3.2. This sexual health needs assessment has considered:

- The epidemiology of sexually transmitted infections and reproductive health in Kent.
- The literature on Adverse Childhood Experiences, alcohol and sexual health, domestic violence and sexual health, mental health and sexual health, harmful sexual behaviours and preconceptual care
- Service utilisation and activity
- The Prevention of poor sexual health outcomes
- Stakeholder views and user insights.

3.3. The methodologies utilised have included: literature review, analysis of data sets, modelling estimates from data, formatting and presentation of data, review of national policy/guidance, stakeholder survey, stakeholder interviews, review of user insights report.

3.4. The needs assessment looks at the differences across the population in terms of access, need and health outcomes in relation to the protected characteristics of people. An EqIA of these has been undertaken with actions identified. The EQIA will be ready for sharing shortly and will be publicly available and signed off before the decision takes place. This will support the KCC equality policy objective to *'Ensure equity of access to Sexual Health services to improve health outcomes with regards to Age, Sexual Orientation, Gender Identity and Race'*[2]

3.5. The needs assessment has looked retrospectively at the last five years (2013 – 2017) which has reiterated the ever-changing need across the population for sexual health services and the relevance of having flexibility to respond to change and demand. For example, more diagnoses of infection were made in Canterbury district in 2017 than seen before and that STIs in Kent are at rates higher than the South East in 2017 which has not been observed previously.

3.6. The sexual health needs assessment makes clear that sexual health is not a single issue but is influenced and impacted upon by many issues including mental health,

[1] WHO http://www.who.int/topics/sexual_health/en/

[2] KCC Equality and Human Rights Policy and Objectives [2016:10] http://www.kent.gov.uk/__data/assets/pdf_file/0007/67075/Executive-summary-of-our-annual-equality-and-diversity-report-2016-2020.pdf

sexual abuse and adverse childhood experiences**.** Safeguarding therefore, is an integral part of service delivery.

3.7. The needs assessment has identified the following emerging themes:

- The continual lack of an individual's awareness for their own and potential partner's risk to sexually acquired infections. There is little awareness that most of the infections present with no symptoms and that all sexually active persons of any age are potentially at risk. Consequently, the need for protection is not considered. This would indicate that there are many undetected STIs in the population, this is supported by the low proportion of young people aged 15-24 years screened for chlamydia resulting in less detection.
- The impact on sexual health and wellbeing related to an individual's reluctance to disclose or share personal experiences. This is impacting on potential diagnosis of STIs, access to appropriate support and messaging on sexual health advice.
- The compelling evidence about the need for a renewed emphasis and focus on preconceptual care to help improve conception, maternal and offspring health outcomes.
- The need to further develop a more flexible clinical provision to support and implement policy change or clinical guidance which can impact on staffing, resourcing or equipment.

3.8. The unmet needs identified through the needs assessment are:

- The lack of appropriate and accessible emotional and relationship support for LGBTQ young people and their parents
- Insufficient levels of support for young people displaying harmful sexual behaviours
- Engagement and specific support for migrant, refugee and sex worker communities.

3.9. The unmet healthcare needs identified through the needs assessment are:

- Inequitable systematic offer of STI testing of first attendees to specialist sexual health services
- Inequitable gender access to HIV testing
- Robust pathways of care to mental health services for adults or young people
- Transparent, easy to navigate pathways of care for HIV positive clients with evolving needs – dementia, neurological, frailty
- Systematic processes for engaging and responding clients who have experienced adverse childhood experiences
- Indicative of lower uptake of services by Black, Asian, and Minority Ethnic (BAME) groups.

3.10. The access to and use of services is changing. Uptake and use of online facilities are rapidly growing as observed in: uptake and return of STI testing, registration to and use of the condom programme 'Get It'. There has been a reduction (4%) in the proportion of services accessed out of area since 2014.

3.11. Newly published data (September 2018) has indicated that the percentage of late diagnosis of HIV in Kent has further increased to 60.7% compared to 40.2% in England as a whole. Two districts, Dartford and Gravesham have an increasing prevalence of HIV, with a rate over 2 per 1,000 15-59 year olds. Further exploration for increasing testing in secondary care will be made along with testing all new GP registrants in the area.

3.12. There is an ever-changing picture of health conditions. For example:

- The diagnosis of syphilis in Kent has increased by 122.2% from 2014-2017 from a rate of 2.7 to 6.0 per 100,00 population
- The rate of diagnosis of gonorrhoea in Kent has increased by 24.9% from a rate of 24.8 to 31.0 per 100,00 population
- There has been an 18.7% decrease in the rate of admissions for pelvic inflammatory disease (PID) amongst females aged 15-44 years between 2013/14 and 2016/17 in Kent compared with a 2.8% increase in England.
- There has been a 27% increase in the rate of admissions amongst females aged 15-44 years for ectopic pregnancy in Kent between 2013/14 and 2016/17 compared with an 0.8% increase in England.

3.13. The spend on mandated sexual health services is approximately 18.5% of the local authority public health grant.

3.14. Recent PHE publication[3] of outcomes would suggest that Kent has worse outcomes when compared to similar local authority areas. The indicators presented relate to: Chlamydia detection amongst 15- 24-year olds; HIV testing; Percentage of LARC prescribed [excluding injections]; Under 18 conception rates; STI testing rate amongst 15- 64-year olds excluding chlamydia amongst 15-24 year olds.

3.15. The PHE Spend and outcomes tool [SPOT] for local authorities[4] published in June 2018, indicated for Kent's Sexual Health Services that outcomes are generally worse and for less spend compared to England. Considering specific indicators, this is the pattern for HIV testing amongst men and women and chlamydia detection amongst 15- 24-year olds. This issue was identified in the needs assessment. However, for the testing and diagnosis of genital warts, genital herpes, syphilis and gonorrhoea, there are better outcomes for a lower cost compared to England. Higher detection rates for these infections were identified in the needs assessment.

4. Commissioning implications

Kent has a comprehensive range of services delivered through quality assured providers offering choice to meet resident needs. A commissioning plan has been developed covering each of the service groups, a summary of this is presented below.

4.1 Integrated Genitourinary Medicine (GUM), HIV, Online STI testing, Psychosexual Therapy and Psychosexual counselling will provide:

- A flexible service which offers choice and reflects changing demands e.g. evening/weekend access for specialist clinics, increased drop in appointments
- A clearly defined offer that reflects local needs e.g. LGBTQ focus in Canterbury
- Increased utilisation of digital innovation including webchat, apps, Skype etc and developing a shared partner notification platform
- Online STI testing and increase screening at first attendance in clinics
- Effective premises which supports comprehensive service delivery via Hubs
- Pharmacy provision that meets user need and explore use of online treatment
- A tailored HIV service recognising changing and different needs of these clients. This will include piloting of peer support.

[3] PHE [2017] Public health Outcomes dashboard https://healthierlives.phe.org.uk/topic/public-health-dashboard/area-details#par/nn-1-E10000016/ati/102/iid//sexId//gid/1938133160/pat/102/are/E10000016/sim/nn-1-E10000016

[4] PHE SPOT for Local Authorities 2018 https://www.gov.uk/government/publications/spend-and-outcome-tool-spot

4.2 CYP Condom & Lesbian, gay, bisexual, transgender and Questioning (LGBTQ) Outreach will provide:

- An easy digital pathway between services e.g. condom programme (Get It), online testing and partner notification
- An effective online condom scheme for young people that offers value for money
- A clear brand that resonates and is recognised by young people
- A quality assured service that has robust safeguarding mechanisms in place.
- A dedicated outreach support service that has the skill set to respond to LGBTQ needs and ensure strong links to mental health services

4.3 Long Acting Reversible Contraception (LARC) via primary care

- Effective communication and engagement with the Local Medical Committee (LMC)/GP surgeries to promote the benefits of maintaining competence levels following training.[5]
- Engage with GP clusters to support streamline administration
- Ensure the integrated service offers coverage if GP surgeries do not extend their contract to provide LARC.

5. Routes to Market

5.1 Market engagement has helped to shape the revised service model and informed the recommended route to market for each group of services. All services have been competitively tendered since they were transferred to KCC in 2013 and where the market is strong a competitive process is recommended. The recommended approach varies for the different services' elements and is designed to offer stability of service, ensure KCC can deliver statutory requirements and maintain public trust through quality services. It will offer KCC a risk managed approach to achieve best value and ensure maximum flexibility to respond to changes in the health and social care landscape, changing patterns of demand and benefit from co-commissioning opportunities in the future.

5.2 A proposed record of decision has been included as an accompanying paper to this report and the recommended options are set out below:

5.2.1. **Integrated Genitourinary Medicine [GUM], HIV, Online STI testing, Psychosexual Therapy and Psychosexual counselling** - KCC would recommend working with existing providers to remodel services, working to review and agree collaboratively which elements of service each party is best placed to manage. This will build on existing strengths and remove competition to support further collaborative working. MTW and KCHFT already have an established partnership and a track record of delivering these services across Kent and this approach will drive further efficiencies by buying at a Kent level where this presents best value. (This may include drugs, consumables, pathology and IT.)

The rules that govern public sector procurement allow for contracts which establish co-operation between public sector bodies and do not require them to be concluded through competition. KCC has already established a successful partnership with KCHFT which was endorsed by the committee in June 2017. Since this time the collaborative arrangement has delivered a series of tangible benefits including:

- Significant financial savings and ongoing commitment to reduce overheads
- Progression on shared services (e.g. payroll) and premises (e.g. colocation in Ashford)

[5] An audit carried out demonstrated a 14% reduction when comparing like for like periods in 2015 and 2017

- Co-production of a number of new commissioning models designed to improve outcomes for local residents which includes Infant feeding and enhanced offer for vulnerable families
- Ability to accelerate progress on the objectives set out within the STP.

It is believed that a similar approach with MTW would bring additional benefits to sexual health service provision. (See appendix 3 for full details of the benefits of the MTW partnership proposal.) KCC legal team considers forming of a partnership with Maidstone Tonbridge Wells Foundation Trust is permitted by the regulations as both are key partners within the STP (so are pursuing common objectives of improving the health of the population in Kent) and also under s.82 of the NHS Act to co-operate with one another to secure and advance the health and welfare of the people of England and Wales.

5.2.2. **CYP Condom & LGBTQ Outreach** - The Get It condom programme is currently delivered by Metro and the contract for this expires in April 2019. The intention is to competitively tender this opportunity in autumn/winter 2018. The market for service is more competitive with several providers being able to provide this type of service; when tendered previously KCC received six bids. The competitive procurement may result in a rebrand which will need to be carefully managed. The brand awareness has increased access to services over the last three years, when there was a change away from the C-Card scheme. A maximum contract length of nine years will provide time for any brand and awareness to build and offer KCC flexibility with regular pricing reviews and break clauses. LGBTQ outreach has also now been included within this service to ensure dedicated support to this at-risk group. The inclusion of this element into the partnership was discounted as the skill set required for a LGBTQ street outreach is different to that of a clinical practitioner.

5.2.3. **Long Acting Reversible Contraception via Primary care** - LARC services are currently provided through primary care (in addition to integrated services) and the intention is to continue for another 12 - 36 months with this service and review the contract length in line with the changing footprint of primary care. KCC commissioned training for primary care practitioners which has resulted in 167 practitioners gaining letters of competence, increasing confidence and improving quality in the programme. The decision to continue with the GP contracts is to ensure maximum access and choice to women for this method of contraception which is 99% effective and will help to reduce unwanted pregnancies. It is expected that GP's may require a pricing review in the future and this will be considered as part of the extension and rationalisation of the 154 contracts held by KCC as options for contracting with GP federations or new models of care emerge.

6. Financial implications

6.1 It is clear that if demand continues to rise we could not afford the suite of current services without additional income. The intention is to keep within the financial envelope for the provision of sexual health services which is expected to be approx. £12,900,000 for 2019/20. NHS England (NHSE) co-commission HIV services to support an integrated offer for local residents.

6.2 To manage the increase in demand the following will be implemented:

- Review and uplift the NHSE contribution and explore co-commissioning opportunities
- Rationalisation of premises to reduce revenue spend
- Introduction of new tariffs and use of open book accounting for NHS providers
- Continued monitoring of out of area costs and implementation of the out of area policy will continue

- Communication about the local services in Kent will be promoted more widely, utilising the website
- Promote self-help strategies through effective digital channels and online triage
- Joint buying of sexual health across Kent where efficiencies can be gained (e.g. drugs)
- Reduce poorly utilised clinics and reduce wasted appointments
- Switch to more cost-effective approaches for services including online and virtual clinics.

6.3 It is worth noting that these services are mandated, open access and include many activity-based services. If demand continues to rise and cannot be fully managed by the above it may be necessary to draw on additional funding from the public health reserves or explore further changes or a cap on services. Commissioners will continue to effectively contract manage services and work collaboratively with providers to manage this.

7. Risk

7.1 There are several risks associated with this transformation programme. These include:

- External challenge on the decision to move to a partnership approach with MTW
- A change of provider which leads to a change of the Get It brand for young people.
- Changes in funding received from NHSE
- The inability to remodel successfully to manage changes in patterns of demand
- Securing appropriate premises for comprehensive services to be delivered.

7.2 These challenges can all be mitigated by a series of actions set out below:

- Transparency around contracting decisions and robust procurement mechanisms
- Detailed financial modelling and effective contract management
- Ongoing collaboration with key partners including KCC property and NHSE
- Partnership approaches with providers offering flexibility.

8. Conclusion

8.1. Sexual health is a mandatory and high cost service area for KCC where efficacies can be gained through a preventative approach. Rapidly changing patterns of use result in the need to reshape services to manage within budget constraints. The finding of the needs assessment gives clear recommendations for action which will now be taken forward by commissioners and providers to improve local services.

8.2 KCC will work collaboratively with MTW, KCHFT and NHS England over coming months to refine services for April 2019. Elements of service may be rolled out in a phased way including shared systems and partner notification. There is a clear opportunity for increasing access to online service so front facing services can be focused towards more specialised services.

8.3 The procurement of a CYP Condom Programme with Outreach Service is expected to conclude in December 2018, enabling the new service to start on 1st April 2019. The recommendation of the successful bidder will be presented to the Cabinet Member for sign off in line with KCC's delegation matrix and following award, an update can be presented to the committee should this be required. Officers will work closely with young people and related services to ensure a smooth mobilisation.

Recommendation

The committee is asked to:

NOTE the key findings of the needs assessment and **COMMENT** on the changes in delivery of sexual health services

ENDORSE or make a recommendation to the Cabinet Member on the proposed decision:

- The inclusion of integrated sexual health and related services into the existing Kent Community Health Foundation NHS Trust (KCHFT) partnership
- Formation of a new partnership agreement with Maidstone and Tunbridge Wells NHS Foundation Trust (MTW) and inclusion of integrated sexual health and online STI testing services
- Continued contracting directly with GP surgeries for Long Acting Reversible Contraception (LARC) services delivered within primary care

The committee is asked to **SUPPORT** proposed plans for the continued delivery, of KCC-commissioned sexual health services via KCHFT and primary care.

9. Appendices (Please see separate documents for Appendices 1 and 2)

Appendix 1 –

Sexual health needs assessment executive summary

Appendix 2 –

Proposed Record of Decision (PROD) for Sexual Health Services

Appendix 3 –

Partnership Proposal between KCC and Maidstone and Tunbridge Wells NHS Trust (MTW)

Appendix 4 –

Summary of Current Sexual Health Services

Appendix 5:

Key Commissioning Aims

10. Contact Details

Report Authors:

- Wendy Jeffreys, Public Health Specialist
- 03000 416310
- Wendy.Jeffreys@kent.gov.uk

- Karen Sharp, Head of Commissioning Portfolio Children and Public health

- 03000 416668
- Karen.Sharp@kent.gov.uk

- Vicky Tovey, Public Health Senior Commissioning Manager
- 03000416779
- Victoria.tovey@kent.gov.uk

Relevant Director:

- Andrew Scott-Clark: Director of Public Health
- 03000 416659
- Andrew.scott-clark@kent.gov.uk

11. Background documents: none

Appendix 3: Partnership Proposal between KCC and Maidstone and Tunbridge Wells NHS Trust (MTW)

1. Maidstone and Tunbridge Wells NHS Trust (MTW)

1.1 MTW is a large acute hospital trust in the south east of England which provides a full range of general hospital services, and some areas of specialist complex care to around 560,000 people living in the south of West Kent and the north of East Sussex. They are key partners in the Sustainability and Transformation plan and have demonstrated an excellent track record of collaborative working with KCC since contracts commenced in 2015.

1.2 They currently provide Integrated GUM services in North and West Kent and an Online STI testing service on costing approximately £4.9m p.a. All services were competitively procured and MTW have worked proactively deliver substantial improvements and better value since April 2015. This includes participation in the PrEP Impact Trial a funded by NHSE, offering more flexible and localise clinic times (e.g. Saturday mornings in Maidstone), collaboration with private sector provider to deliver online services and participation in a Rectal Chlamydia Research Trial.

1.3 The development of the STP presents KCC and its NHS partners significant opportunities for co-operation and collaboration where this is in the public interest and has challenged organisations to think differently about how services are provided. This approach is designed to deliver substantial improvements in health and care services and significant health gains for the population as well as better value for money. The enabling work streams in the STP include IT and premises require a coordinated approach between KCC and the NHS partners to deliver both the necessary efficiency and improvements in care for patients across Kent.

2. Partnership approach

2.1 The Public Contracts Regulations 2015 that govern public sector procurement allow for contracts which establish or implement co-operation between public sector bodies such as KCC and MTW and do not require them to be concluded through competition. KCC would be providing elements of the service including premises, public health advice, the website and campaigns and MTW would be providing the clinic elements of the service. The relevant extract from the legal regulations is as follows:

"12(7) A contract concluded exclusively between two or more contracting authorities falls outside the scope of this Part where all of the following conditions are fulfilled: —

(a) the contract establishes or implements a co-operation between the participating contracting authorities with the aim of ensuring that public services they must perform are provided with a view to achieving objectives they have in common;

(b) the implementation of that co-operation is governed solely by considerations relating to the public interest; and

(c) the participating contracting authorities perform on the open market less than 20% of the activities concerned by the co-operation."

2.2. KCC considers that these conditions are all fulfilled in the case of the KCC contracts for sexual health services, not least because of the STP and the proposals to pursue common objectives of improving the health of the population in Kent. The parties are both under a duty under the Health and Social Care Act to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales. The view from legal is set out below:

"I am writing to confirm my advice that the partnership model be adopted for the proposed delivery of the sexual health services by KCC and MTW. My reasons are as follows. Firstly, the need for a partnership model is driven by the existing requirements of the STP which requires a

collaborative approach, including sharing of resources and the need for innovation, in order to deliver the prevention outcomes. Secondly, the nature of the services to be provided are sufficiently specialist that it is unlikely they could be developed and delivered under a competitively tendered services level arrangement. Lastly, there is a track record of using the partnership model with another provider (KCHFT) providing the same services (utilising MTW as a sub-contractor) which has resulted in improved outcomes, efficiencies and consequent cost savings."

3. Maidstone and Tunbridge Wells Trust Objectives and Alignment with KCC

3.1 In addition to the formal duties and organisational priorities, there is a significant degree of overlap and commonality in the strategic objectives and outcomes of KCC and MTW. Both Parties are signatories to the Kent and Medway Sustainability and Transformation Plan ("STP") which support delivery of a sustainable health and social care system

3.2 MTW are a key partner of the STP and they outline their role in this on their Sustainability and Transformation Plan 'Transforming health and social care in Kent and Medway' 2016 in which they state:

MTW recognise there is a need to focus more on preventing ill-health and promoting good health and their Local Care model needs to deliver population-level outcomes through delivery at scale. This is needed to support individuals to lead healthy lives, as well as reduce demand and costly clinical interventions. They also recognise the need to focus on the populations where health outcomes are the poorest.

3.3 Key benefits of utilising a more collaborative approach include:

- Greater flexibility and accelerated opportunity to fit with the evolving structures MCP / Accountable Care Organisations (ACOs) and therefore meet local needs and accelerated STP implementation
- Transparency of funding and use of open book accounting would ensure value for money
- Minimising disruption to users of services and ensuring stability and reduced risk to KCC of not delivering statutory requirements. This is important for HIV clients who require ongoing care.
- Poor procurement outcome or provider failure could risk financial investment from NHSE
- Managing workforce transition to new models – this enables staff expertise to be retained including experienced clinical leads who are experts in HIV, GUM and Reproductive Health (consultants have years of experience having been on the forefront of research which can benefit the whole contract rather than just the services they provide).
- Avoidance of procurement cost and implementation of new model to deliver efficiencies.
- Continued access to equipment such as ultrasound screening that is not part a requirement of delivering sexual health services but offers benefit to patients and rapid diagnosis.

4. Conclusion

4.1 This arrangement has been very successful in enabling both KCC and KCHFT to achieve common objectives. It is believed that a similar approach with MTW would bring both benefits to the sexual health service provision in Kent and wider benefits to the system and public. The recent case of Lancashire Care NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust v Lancashire County Council provides further rationale for considering similar arrangements with other public health services where this is in the public interest.

Appendix 4: Summary of Current Sexual Health Services

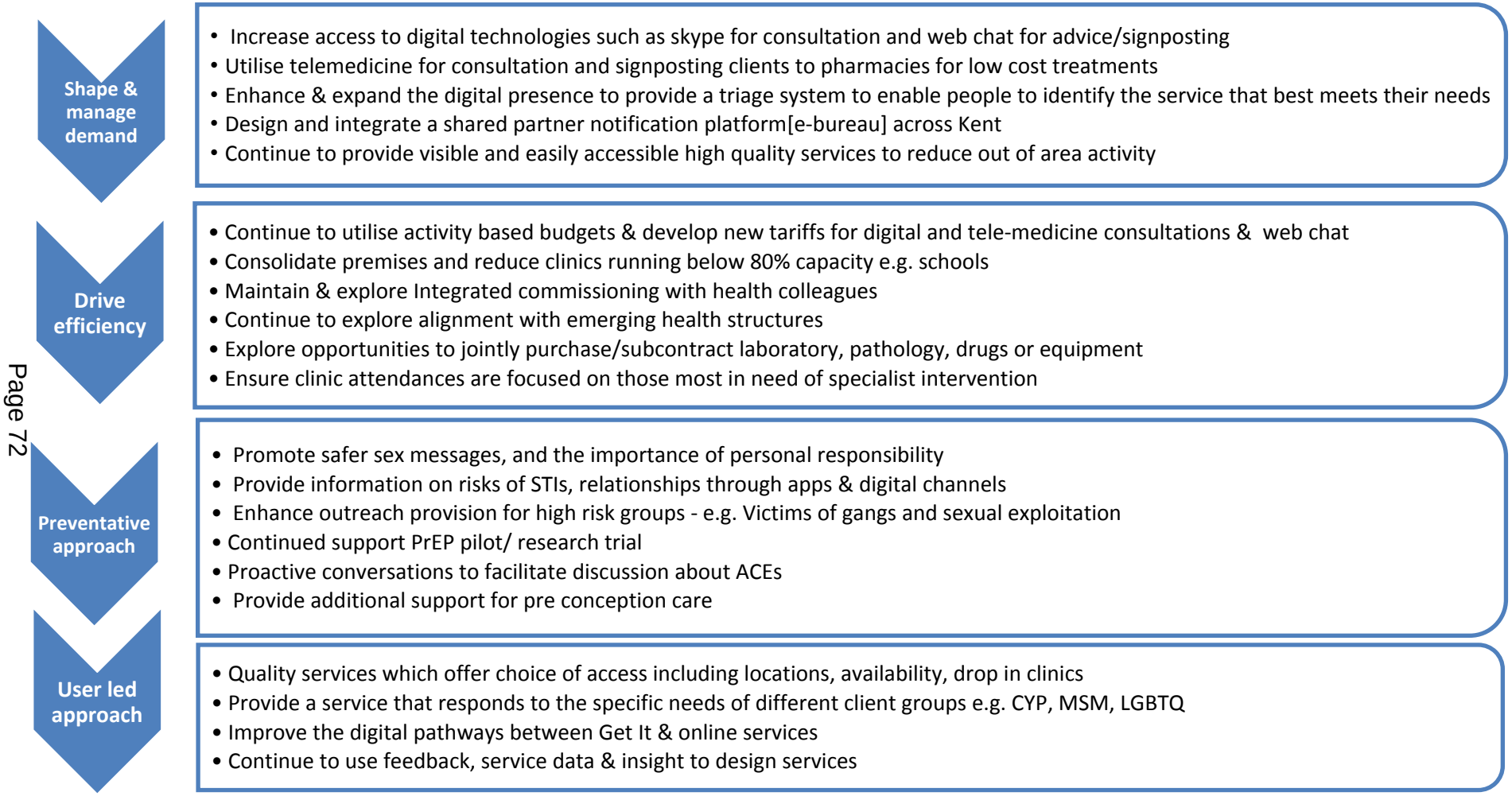
Contract	Contractor	Allocated budget for 2018/19	Scope
North and West Kent Integrated Specialist Sexual Health Service (Genito Urinary Medicine/Contraception/HIV) North and West Kent	Maidstone and Tunbridge Wells NHS Trust (MTW)	£4,195,547	Open access sexual health services across: • STI testing, diagnosis and treatment • Contraception • HIV outpatient care (on behalf of NHS England)
East Kent Integrated Specialist Sexual Health Service (Genito Urinary Medicine/Contraception/HIV) East Kent	Kent Community Health NHS Foundation Trust (KCHFT)	£3,806,002	• STI testing, diagnosis and treatment • Contraception • HIV outpatient care (on behalf of NHS England) • Co-ordinate National Chlamydia Screening Programme in Kent
Psychosexual counselling / therapy across Kent	Kent Community Health NHS Foundation Trust (KCHFT)	£293,580	Counselling services to support people with sexual health related concerns.
Online	Maidstone and Tunbridge Wells NHS Trust (MTW)	£482,000	Access to online STI testing services and E-bureau for positive management results and partner notification
Pharmacy contract	Kent Community Health NHS Foundation Trust (KCHFT)	£384,373	Subcontracting to pharmacy for the provision of: • Emergency oral contraception through pharmacies • Chlamydia treatment
Condom evaluation and establishment of a programme with outreach	METRO	£202,040	Online free condom scheme for young people aged under 25
LARC Programme including prescribing costs	154 GP Surgeries	£2,040,823	Provision of long acting reversible contraception and associated drugs
LARC Training	Navigate 2	£100,000	Training for practitioners on the insertion and removal of LARC systems and devices
Out of area charges	Various	£ 687,388	Charges for Kent Residents who use open access sexual health services outside of Kent.
Premises revenue	Various	£518,914	Various properties utilised for sexual health services cross Kent.
Premises Capital	Various	£191,600	Various properties utilised for sexual health services cross Kent.
Total		**£12,902,267**	

Note: The majority of the above operate on activity-based contracts and the above therefore represents anticipated spend

The capital spend is one off and dependant on timescales to develop new sites, this will deliver efficiencies in revenue spend by reducing the number of sites and provision of a Hub.

Appendix 5: Key Commissioning Aims

Figure 1 below highlights the key commissioning aims of the Sexual Health Transformation Programme:



Executive summary

This needs assessment has reviewed the changes that have taken place over the last five years. During this time the commissioning of specific sexual health services became a mandated responsibility of local authorities.

Sexual health is not a single issue: It is affected by varying things including childhood and adult experiences, vulnerability, lifestyle and mental health.

Mental health: This is a significant factor in sexual health behaviour and should not be underestimated. Identifying clear service referral pathways and understanding of harmful sexual behaviours across the system should be implemented.

Alcohol: There is much evidence on the impact of alcohol and sexual behaviour although much of this has focused on young people. Reviews suggested that sexual health services needed to look at alcohol use and as such Kent local authority have included these in-service specifications since April 2015. For example, the assessment which takes place for all receiving free emergency oral contraception through contracted pharmacies includes alcohol use. In 2016 a brief intervention took place with an average of 12% of clients per month.

Sexual abuse amongst children and young people has long lasting consequences not least for their future sexual health behaviours. There has been increase in the reporting of sexual abuse to police in Kent and greater awareness of child sexual exploitation. Supportive evidence-based programmes that work with children and young people to help them:

- understand and develop more healthy relationships
- have an increased awareness and confidence to respect themselves and others.

The NSPCC[i] have estimated that 16% of children aged under 16 experience some form of sexual abuse during childhood. This would equate to approximately 47,300 children under 16 years of age in Kent.

The police found a 36% [October 2015 - September 2016] increase in sexual offences reported by children and young people against the previous year. Those children and young people who were then in contact with the sexual assault referral centre [SARC] represent 12% of these cases reported to the police. There are fewer boys and young

men in contact with the SARC (7%). The majority of C&YPs seen in the SARC are aged 16-17 years.

Gender identity: That the differing needs of young LGBTQ are not being met locally is becoming more evident. There has been an observed increase in the number of people expressing or questioning their gender identity as seen through sexual outreach services and in forums identified to support individuals and their families/carers.

Reproductive health: A key public health outcome is to reduce the number of unwanted pregnancies. The NATSAL survey identified that 49% of pregnancies are unplanned or women are ambivalent towards them. Inconsistent contraception use or no contraception puts all women of reproductive years at risk of pregnancy.

The needs assessment highlights the availability of contraception. Contraceptives are accessible through a range of service providers in Kent: general practice, integrated sexual health services, 99 pharmacies offering emergency oral contraception, 152 general practices providing LARC and the Get it programme providing free condoms for young people from 264 sites and online.

Preconception care is an invaluable opportunity to proactively help reduce the level of excess weight amongst women of reproductive age.

Kent like England has decreasing teenage pregnancy rates with the rates in Kent (similar to England). In 2016 the rate of under 18 conceptions in England was 18.8 and Kent 18.5. In 2016 the rate of under 16 conceptions in England was 3.0 and Kent 2.9. In 2016 the districts with the highest rates of Under 18 conception rates per 1,000 15-17 female. population were Thanet (26.9), Swale (26.9) and Dover (23.9).

Genito urinary medicine: The data shows decrease in overall detected infections in Kent, but Kent is not meeting the two PHE public health outcomes which relate to health protection to reduce the:

- Rate of chlamydia detected per 100,000 young people aged 15-24 years. In Kent the rate is 1,272 compared to 1,882 in England in 2017
- Percentage of adults [aged 15 and above] newly diagnosed with HIV with a CD4 count less than 350 cells per mm^3.
  In Kent the rate is 56.8 compared to England 40.2 in 2014-16.

Chlamydia testing: Access to chlamydia testing for 16-24 year olds has changed in the last two years providing opportunity for home testing whilst the availability of testing kits in community settings stopped in October 2017. The average monthly detection from online testing was 11%. The importance of informing and advising young people/adults about perceived and actual risk is evidenced in the low rates of testing and detection. Lower percentages of sexual health screens amongst 16-19 year olds and 20-24 year olds on first attendances highlight the missed opportunities to screen for chlamydia infection.

Late diagnosis of HIV: A virus which does not necessarily present with symptoms HIV can remain undetected for years if testing is not undertaken. As seen in the prevalence rate of HIV diagnosis late in the stage of disease Kent is higher than England. Although actual numbers in Kent with late diagnosis of HIV are reducing the rates remain high when compared to the lowering England rate. The significance of appreciating personal risk and the opportunities to free HIV testing is understated. The reluctance of the population to test for HIV is evidenced in the sexual health services performance activity.

HIV: The increased use of protection against infection will help reduce transmission and effective partner notification will help reduce reinfection. However, when looking at the rate of change in the prevalence of diagnosed HIV per 1,000 population aged 15-59 years this is found to be highest in the districts of Maidstone, Gravesham and Thanet. That said there is a wide variation in prevalence rate and it is Dartford [1.98] and Gravesham [1.93] districts which have the highest prevalence rates. These areas should consider proactively testing all new GP registrants.

The burden of STIs is unevenly distributed across the county, geographically and amongst populations and is constantly changing.

- The districts with the highest rate of detected new sexually transmitted infections in 2017 were Canterbury and Thanet
- Canterbury and Swale districts had the highest rates of diagnosed genital warts in 2017.
- Canterbury district has the highest rate of diagnosed genital herpes with a rate of 61.5 per 100, 000 population, higher than the England average 56.7
- Dartford district had the highest rate of diagnosed gonorrhoea of 54.2 per 100,000 population higher than the South East average 45.9
- The districts of Dartford and Gravesham district had the highest rates of syphilis per 100,000 population 11.4 and 10.4 respectively, higher than the South East average of 9.5

- Young adults/people have the highest rates of detected STIs, 20-24 years, 15-19 years followed by 25-34 years.

Emerging themes

A key theme identified through this needs assessment is the continual lack of individual's awareness for their own and potential partner's risk to sexually transmissible infections. There is little awareness that most of the infections present with no symptoms and that all sexually active persons of any age are potentially at risk. Consequently, the need for protection is not considered. This would indicate that there are many undetected STIs in the population. This is seen in part through the rates of ectopic pregnancy and pelvic inflammatory disease in Kent which are and have been higher than the England average over the last three years. These conditions are more likely where there is undetected chlamydia or gonorrhoea.

A theme highlighted is the impact on sexual health and wellbeing, from those individuals reluctant to disclose or share personal experience. This is impacting on potential diagnosis of STIs, access to appropriate support and messaging on sexual health advice.

An important issue identified in this assessment is the change in the proportion of sexual health screens offered to first attendances at the specialist sexual health services. This has reduced significantly amongst females since the introduction of the integrated service model.

The need to further develop more flexible clinical provision to support and implement policy change or clinical guidance.

Compelling evidence about the need for a renewed emphasis and focus on preconceptual care to help improve conception, maternal and offspring health outcomes.

Service use suggests a changing use of sexual health services in terms of:

- increase in clinic attendances in Kent;
- reduction in the proportion of services used out of area;
- reduction in the percentage of young people 16- 24 years accessing clinics but similar use to England amongst under 16-year olds;
- increasing access to and uptake of online services – Get It and STI testing.

Service need is constantly evolving and specialist sexual health services are not necessarily best placed to provide the support needed. This includes individuals displaying harmful sexual behaviours or presenting with complex needs associated with long term conditions

Extended executive summary for commissioners

Service access

- To improve the uptake of cervical screening, through the expansion of cervical screening for those invited to attend for screening as part of the screening programme, once arrangements have been agreed nationally and regionally by NHSE to co commission this activity.

- Further work is needed to ensure pathways of care to specialist mental health services are clear specifically for those identified as LGBTQ

- Identifying clear service referral pathways and understanding of harmful sexual behaviours across the system should be implemented.

Service availability

- There is not the uniformity in service provision which is needed to address demand- specifically for symptomatic care in the evening and on Saturdays. This should be an aspect of service review.

- Review of service appointments only clinics from 2017/18 where DNA rates are high to help inform future service access

Service change

- Establishment with NHSE the assessment and care pathways for the ageing HIV positive population with multiple health needs.

- Support women to access planned contraception differently. Engage with NHSE and CCGs about the changing demands on specialist sexual health services from primary care to improve availability of and access to oral contraception differently such as online or rapid self-review whilst helping to reduce demand on primary care

- Engage with NHSE and CCGs about the changing 'referrals' for complex reproductive sexual health services [non-contraceptive procedures, lost threads]

- Provide evidence-based guidance and workforce development to enable sexual health services staff to respond to the need of clients from the impact of Adverse Childhood Experiences [ACE]s on their sexual health needs.

- Commissioning specialist service to support the specific identified and unidentified unmet needs of LGBT groups such as utilisation of the psychosexual services in colleges building on the model piloted.

- Proactive support working with the whole system to embed and improve preconception health.

Service information

- Development and distribution of a communication about what the clinical and non-clinical services do and do not offer.

- Increase the interactivity capability of the sexual health website to

    - enable persons to book clinic appointments online [This would need monitoring to review if this system reduces DNAs]
    - provide a search option for clinic opening times and service by days of the week/times /location
    - provide webchat as a key component of service provision and monitor impact on service use and providers

- Integrate further service analysis and feedback of young people [under 18s] for service development

Service investment

- Levels of investment and outcomes should be taken into account.

Recommended calls to action

For services

- Commencement of a six-month research programme to introduce and compare chlamydia diagnoses through vulval and rectal swabbing amongst women in MTW NHS Trust who have sought ethical approval to undertake this research

- There is a need to review provider approaches to testing, as variation was found in the provider survey, to ensure that there is consistent equitable screening at first attendances to females. Lower percentages of sexual health screens amongst 16-19 year olds and 20-24 year olds on first attendances highlight the missed opportunities to screen for chlamydia infection.

- HIV testing amongst new registrants to practices in North Kent.

- Collaborative review and shared learnings of late diagnosis of HIV across primary and secondary care should be supported by NHSE.

- Increasing awareness of the impact of smoking on sexual health through sexual health services and online could be beneficial.

- Targeted and focused preconception care to reduce the level of excess weight amongst women of reproductive age and promote the importance of preparing for conception

- Implementation of proactive dialogue to identify those clients accessing the services affected by Adverse Childhood Experiences [ACE]s to better understand sexual health behaviour and or risks

For public health

- There is a suspected gap in services for young people under and over 16 years of age displaying harmful sexual behaviours. An audit of the same should be undertaken with subsequent development of shared agreed pathways of care following NICE guidance for those children and young people displaying harmful sexual health behaviours making use of available evidence-based framework[ii] This will identify gaps in provision and workforce development need.

- Design and implementation of a campaign to increase awareness of common STIs, who is at risk of an STI and the fact that they are often not visible. The campaign would also need to shift a change in the attitude of those testing through someone else.

- In collaboration with the campaign activity, advise and promote information about those 'symptomatic' conditions which can be treated from over the counter treatment at pharmacies for example *thrush.*

- Focusing on the areas identified in chapter 3 of this health needs assessment are recommended for the sexual health network to help further improve service developments. This should continue to engage with providers, commissioners [NHSE, CCGs, KCC], mental health, alcohol and drug services, domestic abuse, sexual assault, prison health services and PHE.

- Engage in further research opportunities to inform and influence policy to promote and prevent poor sexual health outcomes.

- Action research is needed to understand how best to engage with and support asylum seekers, migrants and refugees to address their sexual health needs.

- Inclusion of preconception care as part of the strategy and priorities to proactively address obesity, nutrition and lifestyle behaviours amongst women in the reproductive years. This will include integration with the LMS and STP and require workforce development.

- Prioritising and embedding preconception health to improve understanding of the impact of poor conception health on population health.

[i] Cawson, P., Wattam, C., Brooker, S. and Kelly, G. Child maltreatment in the United Kingdom. NSPCC. 2000

[ii] Hackett, S., Holmes, D. and Branigan, P. (2016) Operational framework for children and young people displaying harmful sexual behaviours. London: NSPCC.

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Graham Gibbens, Cabinet Member for Adult Social Care and Public Health	18/00051a and 18/00051b

For publication

Key decision

Reason: Expenditure or savings of more than £1m, and affects more than two Electoral Divisions

Subject: Sexual Health Services Provision

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to agree the following changes to the provision of sexual health services which are due to expire in March 2019:

18/00051 a

- The inclusion of integrated sexual health and related services into the existing Kent Community Health Foundation NHS Trust (KCHFT) partnership
- Formation of a new partnership agreement with Maidstone and Tunbridge Wells NHS Foundation Trust (MTW) and inclusion of integrated sexual health and online STI testing services
- Continued contracting directly with GP surgeries for Long Acting Reversible Contraception (LARC) services delivered within primary care

18/00051 b

Agreement to award contract following a competitive process procurement for online condom scheme and outreach services

Reason(s) for decision:

Background: KCC is required to provide sexual health information and advice; contraception; testing, diagnosis, treatment and management of STIs and HIV; and raising awareness about the prevention of STIs. There are a number of these mandated services available in Kent, several which have been delivered by NHS providers for many years. The workforce required to deliver these services is very skilled and highly competent needing to deal with a complex array of issues and provide quality assured clinical expertise.

Outcomes: The commissioned services support KCC's outcome - Kent Communities feel the benefits of being in work, healthy and enjoying a good quality of life.
The following KCC Supporting Outcomes are also underpinned in this service:

- Physical and mental health is improved by supporting people to take more responsibility for their own health and well being
- Those with long-term conditions are supported to manage their conditions through access to good quality care and support
- Residents have greater choice and control over the health and social care services they receive.

The key outcome expected of the service is an improvement in the sexual health and wellbeing of the population of Kent and a reduction in sexual health inequalities. These are measured by using a range of metrics alongside service KPI's (including user satisfaction metrics).

Financial implications: The total budget for these services is expected to be £12,902,267 annually. However, all services are open-access, mandated and activity-based and therefore the budget may exceed this, based on user need.

Of this total budget, the total annual value of LARC services (decision number 18/00051a) is anticipated to be £2,140,823.

The total annual value for the CYP Condom programme (decision number 18/00051b) is anticipated to be £282,040, with a total of £2,538,360 over a potential 9 year contract (Initial 3 year term with 2 extensions of up to 3 years each).

Legal implications: Provision of this service is a statutory responsibility. TUPE may apply and if necessary legal advice will be sought.

Although the County Council has an initial review of up to 5 years with the partnership agreements under decision 18/00051 a, the agreements by nature are open ended and so there is no formal expiry date. However, the legal documentation will allow for breaks in contract and also for termination of contract if necessary. The public health budget is ringfenced until 2020, after this time there is no guarantee the funding will remain the same. This will be explicitly stated in all contracts and clear break clauses have been included.

Equality Implications: An Equality Impact Assessment for the service has been completed and any recommendations for improvements in service delivery have been incorporated in the service specification. The EQIA will be ready for sharing shortly and will be publicly available and signed off before the decision takes place.

Cabinet Committee recommendations and other consultation:

This matter will be discussed by the Health Reform and Public Health Cabinet Committee on 28 September 2018. The outcome of that meeting will be included in the decision paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered:

Other options for commissioning were considered, these included doing nothing and de-commissioning the service, providing the service in house, recommission the existing service as is and work in partnership to remodel an updated service. The service is a mandated service and so if we did nothing and let the contracts expire and the service was decommissioned we would not be meeting KCC's mandatory duties. Taking on direct responsibility for service delivery within KCC could have advantages of flexibility of service delivery however it is not a viable option as KCC do not have the clinical staff to be able to provide the services required. It would be a considerable investment in both time and cost to build this capability within KCC.

The contracts have been varied over the last few years to adapt to some of the changing needs however this transformation review of the whole of sexual health services offers an opportunity to look at the service as a whole and how this can be delivered in a more efficient way which meets the needs of the users.

Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

....
signed date

This page is intentionally left blank

From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

Date: 28th September 2018

Subject: Contract Monitoring Report – Adult Drug and Alcohol 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 adult drug and alcohol treatment services that that are commissioned by Kent County Council (KCC). The report provides details of the purpose, performance, outcomes and value for money of the contracts.

The data presented in the report show that drug and alcohol services are generally performing well and providing good value for money for KCC and Kent residents. The services continue to face a number of risks which are being managed through effective commissioning and contract monitoring.

Recommendation:

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

- the commissioning and provision of adult drug and alcohol services in Kent
- the service improvement initiatives that are being undertaken to improve quality and outcomes.

1. Introduction

1.1. Kent County Council (KCC) commissions a range of services to support Kent residents who suffer from drug or alcohol dependence. Adult community drug and alcohol services are funded by the Kent Public Health grant and a contribution from the Kent Police and Crime Commissioner.

1.2. The headline performance of Kent's drug and alcohol services is already reported regularly to the Committee. However, 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 drug and alcohol services that are commissioned by KCC.

2. Background - why invest

2.1. There is a compelling case for investing in local drug and alcohol services. Public Health England (PHE) estimates that the annual cost of drug misuse in the UK to be £10.7billion and alcohol misuse £21.5billion. This includes the costs of lost productivity, crime, policing and the NHS.

2.2. Although the rates of illicit drug misuse have declined in recent years, substance misuse is still a significant problem in Kent and across the country. People suffering from drug or alcohol dependence are far more likely to suffer poor physical and mental health, unemployment, and homelessness. Parental substance misuse can also present a significant risk to the safety and wellbeing of children and families in the county.

2.3. Drug and alcohol treatment has been shown to be very cost-effective. PHE data[i] indicates that:

- Alcohol treatment reflects a return on investment of £3 for every pound invested.
- Drug treatment reflects a return on investment of £4 for every pound invested.

2.4. As a Public Health Authority KCC also has an obligation to ensure provision of drug and alcohol treatment. The conditions of the Public Health grant require KCC to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services.[ii]

2.5. In addition, drug and alcohol treatment contributes to Kent's statutory responsibilities under the Care Act to prevent or delay the escalation of care needs. Services also play a critical role in child protection: research suggests that drug and alcohol misuse is a factor in up to 70% of care proceedings involving children.[iii]

2.6. Drug and alcohol services can therefore be shown to contribute to all three of KCC's strategic outcomes.

3. Service overview

3.1. KCC has two separate adult community drug and alcohol services in Kent. These are:

- West Kent Drug and Alcohol Service, delivered by Change Grow Live (CGL), previously known as CRI.
- East Kent Drug and Alcohol Service, delivered by Forward Trust, previously known as RAPT.

---

[i] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

[ii] Local Authority Circular LAC(DH)(2016)3, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/578906/LAC_DH__2016_3_v2.pdf

[iii] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669434/safeguardingprotocol2013.pdf

3.2. A list of the areas covered and links to service websites are included at Appendix A. Both services are commissioned to contribute to KCC's strategic outcomes to improve public health, reduce health inequalities and harm caused by drug and alcohol misuse in Kent.

3.3. People who suffer with drug or alcohol dependence often have complex physical and mental health needs. Kent's drug and alcohol services are therefore delivered by a range of staff including doctors, nurses, drug and alcohol professionals, and support staff. The service providers are both registered charities and benefit greatly from the contribution of volunteers, often as peer mentors.

3.4. The two providers tailor their service offer to meet the needs of local communities but as a minimum, both provide evidence-based interventions including:

- Advice and information on drug or alcohol misuse (for people worried about their own misuse or that of family or friends)
- Needle and syringe exchange via local pharmacy and provider fixed sites
- Provision of Naloxone (to help prevent opiate overdoses)
- Community based alcohol detoxification
- One-to-one and group-based talking therapy interventions, including motivational interviewing and relapse prevention
- Opiate Substitution Therapy (OST)
- Court ordered treatment (Drug Rehabilitation Requirements and Alcohol Treatment Requirements)
- Access to inpatient detoxification and residential rehabilitation
- Peer mentoring and referral into mutual aid (e.g. Alcoholics Anonymous, Narcotics Anonymous)
- Recovery support and aftercare
- Liaison with a range of partner agencies such as mental health services, police, probation, prisons, domestic abuse services, housing and employment support, Early Help and social care.

3.5. The services are open access. Individuals can access this support by contacting the services directly or via their GP or other professional referral.

4. Service costs

4.1. The 2018/19 contract values for the adult community drug and alcohol services and the number of people in treatment in the twelve months to the end of June 2018 are set out in the table below. The average unit cost has been included for reference.

Table 1: Service Costs Summary

Area	Cost	Number accessing structured treatment	Average unit cost[i]
East Kent	£4,923,300	2,749	£1,790.94
West Kent	£3,411,106	1,730	£1,971.74
Kent Total	**£8,334,406**	**4,479**	**£1,860.77**

4.2. The Kent average unit cost of £1860.77 compares well with the national average. According to local authority budget returns and drug and alcohol treatment data, the equivalent unit cost for England is approximately £2,470.

5. Performance

5.1. Drug and alcohol dependence usually has a range of underlying causes. Genuine recovery can usually only be sustained when individuals are motivated, supported and enabled to make long-term changes which address the causes of their substance misuse.

5.2. Drug and alcohol services can offer treatment and support to help people achieve and sustain their recovery. The performance of the services can therefore be measured in terms of the numbers of people that they support, the quality of treatment and outcomes that are achieved.

5.3. **Activity –** The number of Kent residents accessing drug and alcohol treatment has fallen by 1.4% over the past twelve months as reflected in the table below. This reflects a longer-term national trend of fewer people accessing treatment.

Table 2: Numbers in structured treatment

Substance Type	July 2016 – June 2017	July 2017 – June 2018	Annual Change
Opiate	2189	2141	-2.2%
Non-opiate only	357	386	+8.1%
Non-opiate and Alcohol	516	513	-0.6%
Alcohol only	1538	1494	-2.9%
Total[ii]	**4600**	**4534**	**-1.4%**

5.4. Although there have been fewer people accessing treatment over the past 12 months, the services report that many of those who do access treatment are increasingly complex. The level of activity and professional support needed per client has therefore risen and increasingly involves liaising with other services such as mental health, probation and social services. This professional liaison helps to ensure that service users receive more joined up and co-ordinated support. It also maximises the effectiveness of public resources.

[i] Calculated as total service cost per unique client accessing structured treatment in the year

[ii] The total number accessing treatment includes Kent residents over 18 who access treatment from the Kent Young Persons' Substance Misuse Service or service providers outside Kent. The numbers in Table 2 are therefore slightly higher than those in Table 1

5.5. The activity highlighted in Table 1 reflects some of the changing patterns of substance use. More people have engaged in treatment for non-opiate drug use. This includes drugs such as cannabis and cocaine.

5.6. **Quality -** Drug and alcohol service providers have maintained very good levels of access to treatment over recent years. The average waiting time is less than one week. Service providers maintain high standards of quality by ensuring effective governance processes and responding to service user feedback. Commissioners regularly attend service user involvement forums to help gauge the level of service user satisfaction and understand priorities and emerging issues for service users.

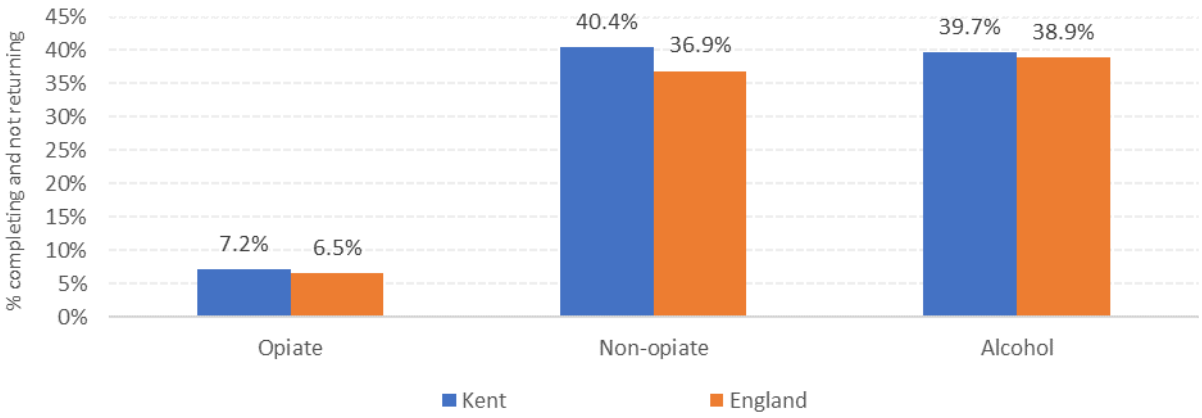
5.7. Service users who successfully complete treatment report satisfaction levels of more than 95%. A selection of service user case studies are included at Appendix A.

5.8. An important area for quality improvement is to better understand why some service users drop-out of treatment without completing successfully. People who have dropped out of treatment are often very difficult to contact but providers are asking peer mentors or volunteers to undertake routine surveys of people who drop out of treatment and seek feedback on how the service could be improved.

5.9. Feedback from service users suggest that people often drop-out of treatment because they have relapsed. Providers are addressing this by ensuring a clear focus on relapse prevention and peer support from the outset. This can include referrals into mutual aid groups such as Alcoholics Anonymous or Narcotics Anonymous.

5.10. More information about service quality can be found in the Annual Public Health Quality Report that is on the Committee's agenda.

5.11. **Outcomes –** Data from the National Drug Treatment Monitoring System (NDTMS) show that Kent's treatment outcomes are generally better than the national average. Chart 1 compares the proportion of Kent's performance on successful treatment completions[i] to the national rates.



5.12. This data forms part of the Public Health Outcomes Framework (PHOF) and is one of the key nationally reported measures of performance for drug and alcohol services.

[i] Source: NDTMS. Number of users of service users who completed treatment (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number in treatment.

5.13. PHE state that “Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health”[i] .

5.14. Kent’s performance on this indicator has fallen in recent years as it has nationally. This fall reflects the complexity of the client group and the challenge of providing a good quality treatment with the available resources and budget.

5.15. **Value for money** – The activity and outcomes data summarised above indicates that Kent’s drug and alcohol services are delivering good value for money for KCC. Over the past twelve months, the services have achieved similar or better than national average outcomes for their clients at around three quarters of the cost.

5.16. The drug and alcohol service sector has been very competitive for several years and has delivered substantial cost reductions and efficiency savings. Both of Kent’s adult community substance misuse services have been competitively retendered within the past three years. The proposed contract award decisions have been presented to previous Cabinet Committees and received member endorsement and key decisions.

5.17. The PHE Spend and Outcomes Tool (SPOT) for local authorities[ii] also highlights drugs and alcohol as being one of the key public health programmes that has lower spend and better outcomes than other local authority areas.

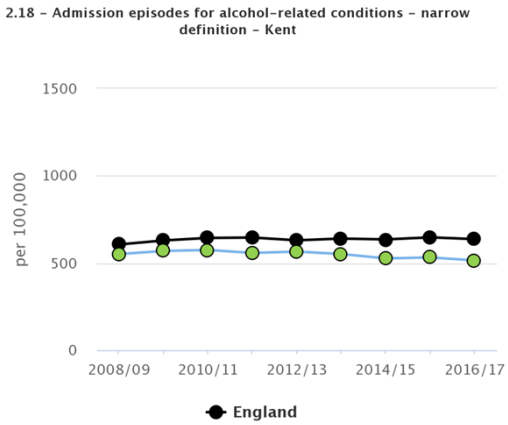
5.18. **Impact** – National research[iii] has demonstrated the significant social return on investment of drug and alcohol treatment. These estimates suggest that drug and alcohol treatment delivers social and economic benefits of more than £37m per year in Kent. This includes the benefits resulting from reduced crime, improved wellbeing, and improvements and health and social care

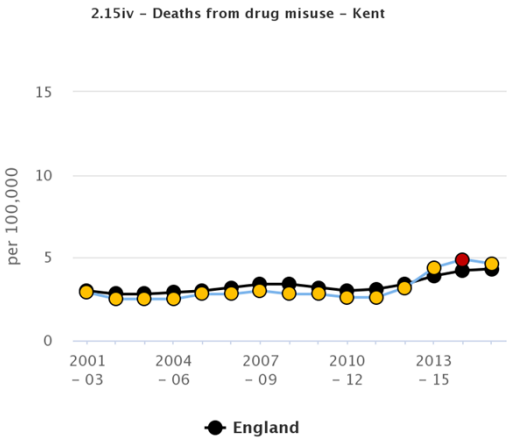
5.19. Whilst it is difficult to separate the contribution of drug and alcohol treatment from other developments, there have been some positive trends and some which are a cause for concern. The latest available Public Health Outcomes Framework data show that hospital admissions for alcohol related conditions (indicator 2.18 below) have begun to fall slightly in recent years. Deaths from drug misuse however, have risen sharply since 2010.

[i] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000008/ati/102/are/E10000016/iid/90244/age/234/sex/4

[ii] Available at https://www.gov.uk/government/publications/spend-and-outcome-tool-spot

[iii] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest





5.20. The drug and alcohol services work closely with partners agencies and health services to engage the most vulnerable people include those at risk of dying from drug overdoses. Both services are commissioned to distribute Naloxone, an emergency antidote for overdoses caused by heroin or other opioids.

6. Delivering ongoing service improvements

6.1. Service providers and KCC commissioners are working together on a wide range of initiatives to improve the quality and effectiveness of the drug and alcohol services.

6.2. Both services have a flexible contract which allows the services to adapt and respond to the changing patterns of drug and alcohol misuse in the county. Some key areas for improvement over the next year are:

- Close engagement with suicide prevention programme in Kent to reduce risk of suicide among people with substance misuse problems
- Improved support for service users with depression, anxiety and other mental health needs
- More effective joint working and co-ordination of support for people who are already known to local mental health services
- Development of joint-working protocol or pathways to support KCC's integrated children's services
- Improved access to effective online / digital support where appropriate
- Review of service delivery locations and exploring opportunities for co-location with other services, including Kent Community Learning and Skills
- Continuing to establish and strengthen links to the full range local services across the county, especially voluntary and community sector.

6.3. Each of these improvement initiatives involves working with the service providers and with a wide range of partners across Kent. Commissioners expect that each will help to sustain the good outcomes that the services and service users have achieved in recent years.

7. Risk

7.1. The current drug and alcohol service contracts are not due to expire until 2021 at the earliest. The key risks over the next two to three years include changing patterns of substance misuse and significant increases in demand.

7.2. The latest substance misuse needs assessment[i] highlights some significant changes in patterns of drug and alcohol use in Kent and across the country. The emergence of new psychoactive substances (previously known as legal highs), changing patterns of alcohol consumption, and prevalence of mental health problems among those needing drug or alcohol treatment all present major challenges for local services. Services in Kent have been commissioned to be responsive to changing population needs and develop suitable interventions that provide the support that people need.

7.3. If successful in responding to this need, there is a risk that services will experience a significant increase in demand without the additional capacity to respond effectively. This risk is managed by regular reviews of population need, close monitoring of referral volumes and service outcomes.

7.4. Commissioners and providers are working with the health services and other partner agencies to ensure that people are provided with the right level of support at the most appropriate level and that they are not referred into specialist treatment unless they need it.

7.5. KCC has commissioned or delivered public health campaigns to promote awareness and information about healthy lifestyles and avoiding excessive drinking. The KCC website includes the *Know Your Score* quiz[ii] and provides clear advice, links to relevant sources of support.

7.6. The advice encourages people to take responsibility for their own drinking and seek further help if they need it. Only those with the highest scores, and therefore possible alcohol dependence are signposted to the specialist drug and alcohol services for assessment and possible treatment. Commissioners are also working with providers that deliver the *One You Kent* Service to ensure that the medium to low risk are supported within this service.

7.7. In addition to those risks identified above there is a national shortage in drug availability for Buprenorphine which is used within the Kent services. KCC is working proactively with both providers, PHE and other Local Authorities to manage this cost pressure and ascertain when this issue will be resolved.

8. Conclusions

8.1. There is a clear and compelling case for KCC investment in drug and alcohol services as set out in this paper. The service is funded by the Public Health grant and a contribution from the Kent Police and Crime Commissioner and national evidence has demonstrated a substantial return on investment.

---

[i] Available at http://www.kpho.org.uk/health-intelligence/lifestyle/drugs-and-substance-misuse#tab1

[ii] Available at: http://www.kent.gov.uk/social-care-and-health/health/alcohol/know-your-score-quiz

8.2. Kent's local drug and alcohol services perform well and deliver good value for money for KCC. Comparisons with national data suggests that Kent delivers similar or better outcomes to national rates at substantially lower cost.

8.3. Commissioners and providers are working with partner agencies on a range of initiatives which aim to further improve service quality and sustain the good outcomes that are achieved.

8.4. The current service contracts are due to run until at least March 2021 although both providers are commissioned to adapt and respond to changing population needs. The risks of changing patterns of substance misuse and increases in demand are managed through close monitoring of service data and effective commissioning.

Recommendations

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

- the commissioning and provision of adult drug and alcohol services in Kent
- the service improvement initiatives that are being undertaken to improve quality and outcomes.

Report Authors:
Mark Gilbert, Senior Commissioner
03000 416148
Mark.Gilbert@kent.gov.uk

Relevant Director:
Andrew Scott-Clark, Director of Public Health
03000 416659
Andrew.scott-clark@kent.gov.uk

Background documents:

none

Appendix A – Service Providers

East Kent: covering districts of Swale, Canterbury, Ashford, Dover, Thanet, Folkestone and Hythe
http://eastkentdrugandalcohol.org.uk/

West Kent: covering districts of Maidstone, Sevenoaks, Tunbridge Wells, Tonbridge & Malling, Dartford and Gravesham)
https://westkentrecovery.org.uk/

You are here: Home

Welcome to West Kent Drug & Alcohol Wellbeing Service.

We are the local provider of adult drug and alcohol services in West Kent, and are part of the national social care and health charity change, grow, live (CGL).

Our service offers a wide range of support to meet the substance misuse needs of individuals living within the districts of Dartford, Gravesham, Maidstone, Sevenoaks, Tonbridge & Malling and Tunbridge Wells.

Appendix B – Case Studies

The real-life case studies presented below reflect the recovery journeys of some of the people who have accessed support from the Kent drug and alcohol services.

The individuals involved have given their consent for their story to be shared although names have been changed to protect their identity.

Dean

In my late teens I started suffering from severe depression, anxiety and suicidal thoughts. I was in and out of counselling and given medication, but nothing ever really worked.

Around the same time, I started having issues with alcohol. From the very first time I remember going to the pub, it was always about how much could I drink in the timeframe I had. All I wanted to focus on what how often could I get to a pub, how late could I stay out and carry on drinking. It was my way of escaping reality.

In my mid 20s - after always "hating" drugs, even though my friends took them - I tried cocaine for the first time. It took one line and I was hooked. Over the next several years it destroyed my life.

I lost everything. Relationships broke down and I almost lost access to seeing one of my daughters. I lost my job, my flat and got into thousands of pounds worth of debt. It was the lowest I had ever been and my mental health suffered greatly as a result.

The lowest point came when I attempted suicide, not once but twice. I really just felt like I had nothing to give to society anymore and even worse, nothing to give my little girls. I thought everyone would just be better off without me.

I moved in with my Mum and tried my hardest to get clean, sober and get back into looking after myself. I'd been to the drug and alcohol service in Canterbury before but I hadn't been in the right place to make a change. Forward were wonderful – as well as all the support they gave me with my substance misuse issues, they also linked me in with a mental health service to help me address my depression. Between the two services and the work they have done together to support me, things have improved massively.

It's taken time and my journey has not been easy. I've had relapses and struggled with major depression, but I'm in a really positive place now. I have been clean and sober since December 2017, back in work since January 2018 and I see my girls every weekend. Life is worth living now.

Without the support of these services and the people around me I wouldn't be here. I now see a future for myself, which I never used to. I take pride in myself and my recovery, as well as my ability to now be the best son, friend and father.

Jane

Jane was in a vulnerable place mentally and physically. She was dependent on alcohol and occasionally used cocaine. Jane was the mother of two children who were living with their father in his home.

Jane had previously been in an abusive relationship and had extremely low self-esteem. She had attempted suicide four times within a month and was facing eviction. On her last hospital admission, Jane was detoxed from alcohol and returned to the drug and alcohol service but abstinence from alcohol was something she had not been able to maintain in the community.

The people supporting Jane believed that her best chance of success was a place in a residential rehabilitation unit where she would have the support to deal with past trauma. The drug and alcohol services prepared Jane for rehab.

Working collaboratively with partner agencies, it was made possible to stop the eviction process and the local housing teams were very involved in supporting Jane into recovery.

With support from the service and other agencies, Jane has managed to achieve and maintain abstinence. She is currently engaged in an accredited peer mentor course and she hopes to join the drug and alcohol service as a volunteer on her return.

Mary

Mary started going to the drug and alcohol service to address her drinking which had been problematic for about two years. Mary had a daughter who was on a Child in Need Plan with Social Services.

Mary says that she drank to help with sleep as she experienced disturbing night mares. Although physically fit, she was diagnosed with Post Traumatic Stress Disorder (PTSD) following a childhood trauma and more recently Domestic Abuse. Mary suffered with depression and anxiety and had regular thoughts of suicide. Whilst in alcohol treatment, Mary disclosed that she had been self-harming as a form as punishment to herself. Mary had no immediate family support but had good support from her employer and a few friends.

Despite all the difficulties in her life, Mary started a community detox programme with the drug and alcohol service and attended daily groups. She also attended the Freedom Programme for Domestic Abuse. Mary successfully completed her detox and attended a relapse prevention group with the service.

Mary has maintained her recovery with support. She has returned to her family and has now returned to work.

Jack

Jack came in to treatment in his mid-thirties to get the treatment and support he needed to stay off the drugs GBL and methamphetamine. Jack was invited to attend the Relapse Prevention group in the evenings as he was working full time. The 12-week course was

designed to support clients who are abstinent from substances and equipping them with the tools to stay abstinent.

Jack struggled to engage with the groups, repeatedly missing or cancelling the sessions, stating that he felt uncomfortable leaving work early because he didn't want to tell them that he had a substance misuse problem. After missing several sessions, he came back stating that he relapsed and was arrested for drug driving. Jack told his father about his problems and his father attended the drug and alcohol service with him which helped Jack to commit to attending more sessions to help with his recovery. Jack's father regularly rang the service for guidance on how to support his son.

Jack became very anxious about his impending Court case and started using drugs again. Following a recommendation and professional advice form the drug and alcohol service, Jack was given a Community sentence with a Drug Rehabilitation Requirement (DRR) which required that he attend the drug and alcohol service for 6 months.

Jack attended his appointments and was referred for an inpatient detoxification (funded by the drug and alcohol service). Following a successful detoxification, Jack started attending the abstinent groups at the drug and alcohol service as well as Cocaine Anonymous. Like most clients, Jack recognised that he had several underlying issues from childhood that he wanted to start dealing with so referred himself to MIND for counselling. He has been able to start processing many of the issues he has been struggling with.

Jack is continuing with ongoing support and has been heavily involved in starting up a support group in the community for those who have graduated from the structured support groups.

Jack has recently successfully completed his 6 Month court ordered DRR.

Emma

Emma engaged with the drug and alcohol service in 2012 as an entrenched drug user. She had been using heroin and crack cocaine for many years, and had been in a relationship with another drug user. Emma had three children, all known to Social Services due to safeguarding issues.

Emma started engaging in treatment after a serious health problem relating to her drug use. Emma received Opiate Substitution Therapy (methadone) but continued to live a chaotic lifestyle, and continued to use illicit drugs. Emma's relationship had broken down and she was not allowed access to her children whist she continued to actively use illicit drugs. Emma was living in an area surrounded by drug dealers and her engagement with services was erratic.

However, the drug and alcohol service continued to support and encourage her to engage with treatment and to attend self-help groups, including support meetings with the service peer mentors. The drug and alcohol service helped Emma to sort out her benefits supported her to work with her GP when she had health problems caused by several years of injecting drugs.

After a long spell in hospital, the drug and alcohol service started to conduct home visits including medical reviews as she felt unable to leave her house where she felt unsafe.

The drug and alcohol service worked closely with the local authority on Emma's case. Emma was able to move to a new areas nearer to her family. Since moving, Emma is no longer using illicit drugs and is allowed to see her children. She says that she loves her flat and has made it a proper home. She has two dogs which get her out and about and she sees her children and family every day. Emma is very proud that he eldest daughter has started studying at university.

Emma constantly thanks the drug and alcohol service for their continued support. In her own words…. "I never imagined a life without illicit drug use and now I am living it".

This page is intentionally left blank

From:	**Graham Gibbens, Cabinet Member for Adult Social Care and Public Health and Andrew Scott-Clark, Director of Public Health**
	Allison Duggal, Assistant Director of Public Health
To:	**Health Reform and Public Health Cabinet Committee**
	28 September 2018
Subject:	**Place-Based Public Health and Ebbsfleet Healthy New Town**
Classification:	**Unrestricted**
Previous Pathway:	**This is the first committee to consider this report**
Future Pathway:	**None**
Electoral Division:	**All**

Summary: This report provides an overview of Place-Based Public Health and details the work of the County Council's Public Health team on Place-Based public health undertaken with Ebbsfleet Healthy New Town programme, other new developments in Kent and partners.

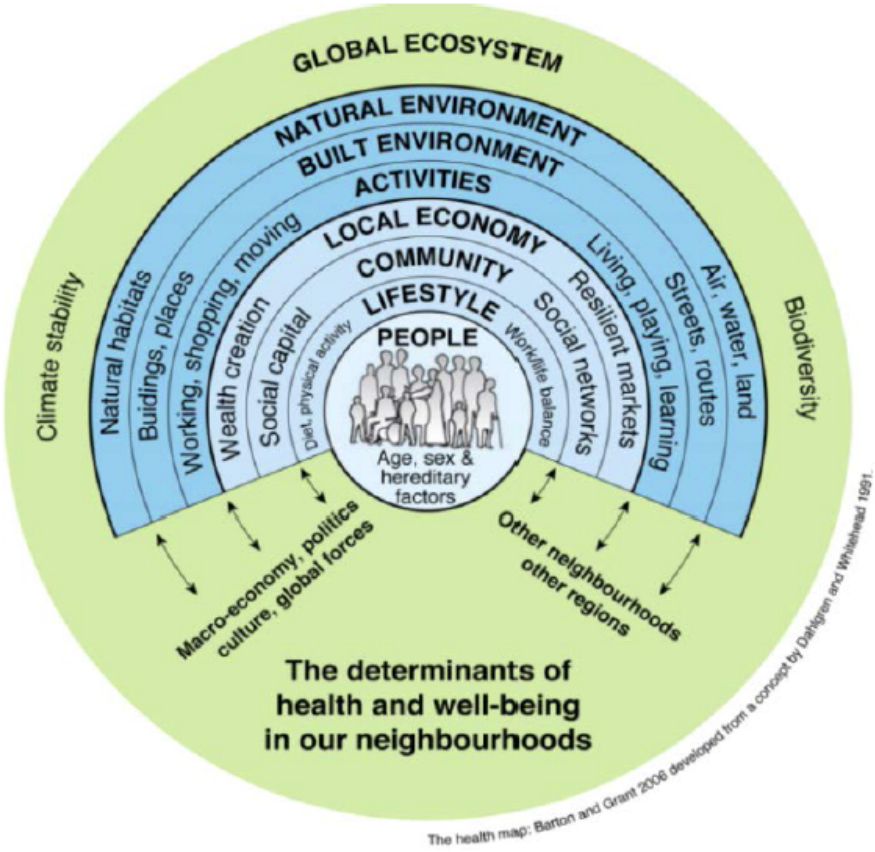
Recommendation: The Cabinet Committee is asked to **NOTE** progress and endorse the approach taken by the County Council's Public Health team on Place-Based Public Health

1. Introduction

The linkages between the built environment and health have been known for many years and it could be argued that the Public Health profession evolved from the work of Chadwick on the 'Report on Sanitary Conditions of the Labouring Population of Great Britain' which highlighted poor conditions in factory towns. The Royal Commission on the State of Large Towns and Populous Districts of 1845 recommended that local authorities should be responsible for drainage, paving, cleansing and water supply as well as they should have the authority to require that landlords clean and repair properties dangerous to public health. Certainly, Public Health was in the domain of the local authority (or their forerunners, the Sanitary Districts) from the time of 1875 to 1974 when the clinical role of public health was moved into the NHS.

It is well known that most health outcomes are explained by factors other than healthcare. Important aspects of this include neighbourhood design, housing, healthier food, natural and sustainable environment and transport.

The Health Map below demonstrates the determinants of health and well-being in our built environment.



Place based public health brings together expertise from local government, primary care services, the voluntary (VCS) sector, housing providers and other local services together to effectively confront the wider determinant of public health [1].

Integrating health, Local Government and housing across a geographic area should secure better outcomes for the population in a sustainable manner. Place-based approaches, with the renewed emphasis on prevention, are expected to reduce demand and deliver cost savings to healthcare and social care and there is evidence from other international health systems and from the findings of pilot sites such as Greater Manchester that a place-based approach with early intervention and prevention saves money and improves outcomes for residents.

2. National picture

In the NHS Five Year Forward View[2], a clear commitment was made to dramatically improve population health, and integrate health and care services, as new communities are built and take shape. The vehicle for this locally is the Sustainability and Transformation Plan (STP) for Kent and Medway.

[1] NLGN – Get Well Soon (http://www.nlgn.org.uk/public/wp-content/uploads/Get-Well-Soon_FINAL.pdf)
[2] NHS Five Year Forward View

The New Local Government Network have suggested three shifts in practise to move towards place-based public health. These are:

1. *Shifting from institutions to people and places*

At present, the power to determine the direction of service delivery sits with health and care institutions and with central Government, at a distance from the people receiving the service. If the systems shift towards prevention and embedding health a social movement, local resources and people need to be used more effectively and become an integral part of place-based health. This is localism in action.

2. *Shifting from service silos to system outcomes*

Moving from vertical silos of 'health' and 'care' to an integrated, horizontal place-based system will involve cultural and behavioural change. Enablers of this change need to be developed and supported so that the new system can develop.

3. *Enabling change from national to local*

Changes in local practice and behaviour need to be supported by the national policy. National bodies must focus on creating a long-term environment for prevention, approaching places as whole systems rather than reinforcing silos, and removing blockages for local practitioners.

3.Shifting from institutions to people and places

The most prominent programme of work where Place-Based Public Health is being applied in Kent is Ebbsfleet Garden City. This is one of the NHS Healthy New Towns Projects and a number of aspects of the development and projects within the programme of work contribute to Place-Based Public Health. KCC public health are represented on the HNT Steering Group for this project and advise on public health aspects of the Healthy New Town project in Ebbsfleet.

The Healthy New Towns Programme is led by NHS England and includes 10 new communities across England, including Ebbsfleet Garden City, which is a partnership between Ebbsfleet Development Corporation and Dartford, Gravesham and Swanley CCG with support from KCC. KCC Public Health and KCC Growth Environment and Transport are represented at the Ebbsfleet Healthy New Town (HNT) Steering Group, along with KCC Cabinet Member Roger Gough.

Ebbsfleet Garden City will deliver up to 15,000 new homes and 30,000 new jobs, building on Brownfield sites and should be completed by 2035. 11,000 of these homes will be completed by 2026. There will be 33,000 new residents and the development is focussed on 4 strategic sites, Ebbsfleet Central, Eastern Quarry, Northfleet Riverside and Swanscombe Peninsula. There are significant health inequalities in the surrounding areas and the development of the Health New Town will embrace the existing communities of Swanscombe and Northfleet and aim to provide strong multi-generational communities in these areas and reduce health inequalities.

Ebbsfleet Healthy New Town is the Lead National Site for 'Community Activation', aiming to demonstrate excellence to the other 10 Health New Towns on how best to work with communities including the utilisation of Art and Culture to improve well-being. This role is key to the National NHS Programme and case studies from this work will be promoted to the National Programme.

Quality of life baseline data have been established and the baseline healthcare service usage for the Garden City. Ebbsfleet Healthy New Town aims to use these data to improve Quality of Life indicators by 10% by 2021. These include:

- Reducing childhood and young adult obesity.
- Improving healthy eating adults.
- Improving access to green space and water for everyone.
- Reducing incidences of Diabetes related hospitalisations.
- Reducing health inequalities across and between neighbourhoods.
- Delivering new and refreshed health services which put local people in control of managing their health.
- Delivering new homes that allow residents to live independently.
- Delivering an accessible and inclusive blue and green infrastructure that promotes healthy lifestyles.
- Promoting and sustaining a vibrant civic life which fosters community activity and cohesion.

The work of the Healthy New Town includes:

Neighbourhood Design

Ebbsfleet Healthy New Town aims to bring new and existing Communities together by investing in and influencing partners and directly investing in existing communities to promote community cohesion. For example, Ebbsfleet Development Corporation has invested in public realm improvements to the Wallis Park Estate in the vicinity of the new development.

The development is being designed with walkability in mind and there are regular community walks at weekends, often held in places that the public would not usually have access to. These have been hosted by Ebbsfleet Development Corporation (EDC) and have been very popular.

The topography of Ebbsfleet does not lend itself easily to compact neighbourhoods with high street connectivity and ease of walking and cycling. EDC are holding a design competition to find innovative ways of using the quarry site at Ebbsfleet and recently held an exhibition of the shortlisted entries at the Housing Design Awards. Suggested designs have included a water sports facility and a zip wire.

The town will have commercial property in the centre, including retail space. There are also plans for a new Primary Care Hub and there have been successful stakeholder engagement sessions on the design and development of this new service. There is an aspiration for a Health Innovation Quarter in Ebbsfleet and the Strategic Business Case has been submitted for this which will provide an innovative health service, employment, and training for new health and social care staff. There are plans to develop strong ties between this development and the new Kent and Medway Medical School.

Housing

Ebbsfleet includes much affordable housing and a diverse range of housing, delivering an inclusive built environment that includes energy efficiency and good design in up to 15,000 'lifetime homes' in safe and attractive neighbourhoods where residents can choose to live independently at home throughout their life.

The Healthy New Towns Steering Group also aims to share learning and good practice with partners and peers. For instance, an Older People Housing Needs Workshop was held I October 2017 to consider the needs of this population group and how to meet the demands and Ebbsfleet Healthy New Town was asked to hold a workshop at the Building a Healthy Sustainable Society, held by NHS England in London, in October 2017.

The Ebbsfleet Garden City Kite Mark is being developed in partnership with targeted developers and landowners to help define the principles of a 21st century healthy garden city, including housing design and urban planning.

Food environment

Thought has been given to the food environment in Ebbsfleet and there is a thriving community garden in the surrounding area, in Northfleet. There is also a community allotment in Dartford which is run by the Dartford Healthy Living Centre.

Edible Ebbsfleet uses local interest in gardening and garden maintenance to improve community cohesion, involving local communities in community gardens and the cultivation of foods. For example, there are areas where strawberries can be picked from troughs as you walk along the street.

Natural Sustainable Environments

Ebbsfleet lies in an area with several significant roads and this has significant economic benefits to the area, but potential risks to health, such as poor air quality. Public Health have been meeting with partners to consider air quality in this area and £45 million is due to be invested by central government to improve the A2.

There will be seven new parks in Ebbsfleet with up to 192 hectares of City Parks, including disused quarries and lakes.

Transport

Ebbsfleet Garden City is developing the infrastructure for active travel and one of the major benefits of Ebbsfleet is the short travel times by high speed train from Ebbsfleet International to London and the Continent. A new bridge will be built to improve the links between Springhead Park and Ebbsfleet International Station to encourage the use of public transport and there will be upgrades to the Fastrack bus system with dedicated routes, to ensure 90% of residents live within five minutes of a Fastrack bus stop.

There will be a series of open spaces along the River Ebbsfleet, and the River Thames will have new promenade walks that will re-open that part of the Thames.

There has also been a move to improve the use of technology in the area, including the use of wearable technology such as Fitbit (the Digital Movement Project) to encourage greater activity. This provides useful data on movement and the usage of infrastructure in the Garden City and will provide data to inform investment in parks, green spaces and cycling routes etc. This project is also linked to an incentive scheme which is currently being evaluated.

4. Shifting from service silos to system outcomes

There are international examples of how services can shift from silo working to whole systems working to improve outcomes for their populations. These include the Montefiore Health System in New York and the Canterbury system from New Zealand. Both systems operate within a different culture and particularly in different healthcare systems, but both demonstrate how the shift to a new programme of delivery can result in efficiencies and better patient outcomes.

The Canterbury system is known as a good example of how to slow increasing demand for acute hospital care. There was an overarching vision for a single, integrated health asocial care system which worked around the needs of patients and reduced time waiting for access to services. They developed strategic goals:

- To enable people to take more responsibility for their own health and wellbeing;
- That people should stay well in their own homes and communities as far as possible;
- When complex care is required it should be timely and appropriate.

The key interventions were to integrate care across organisational boundaries, to increase investment in community-based services and to strengthen primary care. Although the Canterbury system has moderated demand for acute care, it has not cut beds or reduced resources from hospitals because, as in the UK, there was increasing demand for acute care. Elements of the Canterbury system are being implemented in the STP Local Care programme described below.

5. Enabling change from national to local – Local Care

Partners in Kent, including the NHS, KCC and the voluntary sector are implementing Local Care via the Sustainability and Transformation Partnership (STP). This will move care out of hospitals and mean better access to care and support in people's own communities rather than in the local hospital ward. Teams will come together in 'hubs' (which may be physical buildings or virtual) to focus on looking after individuals in their communities.
Public health is working as a system leader, with local partners, to assess the needs of our population and ensure safe, cost-effective, sustainable care within this new local care system.

In addition, Public Health is working with the STP to implement a prevention work plan that aims to prevent individuals developing conditions that will require care and to help people manage their long-term conditions without developing complications.

6. Other work on Place-Based Public Health and future developments

In addition to working with Ebbsfleet Healthy New Town Programme, KCC Public Health are also represented at meetings for the Chilmington Green and Otterpool Park developments. Chilmington Green is a new Garden City in Ashford, whilst Otterpool Park is a New Garden Town near Folkestone.

KCC Public Health are also contributing to the Kent Energy and Low Emissions Strategy and have, along with Public Health colleague in neighbouring authorities, secured the development of a Health Impact Assessment for the proposed development of the Lower Thames Crossing. Our team continues to liaise with the authorities affected by the development of the crossing and with Highways England.

Growth, Environment and Transport have worked to promote walking and cycling in and these efforts have been mirrored by work in public health and with partners in Public Health England (PHE) to increase physical activity in the County.

Kent has much housing development at present and although planning decisions are made at District or Borough level, there is much KCC Public Health can do to influence planning colleagues. Public Health are consulted and do comment on infrastructure projects, sometimes collaborating with neighbouring authorities, such as in the case of the Lower Thames Crossing.

7. Recommendations

The Cabinet Committee is asked to note progress and endorse the approach taken by the County Council's Public Health team on Place-Based Public Health.

Contact Details

Report Authors:

- Allison Duggal: Assistant Director Public Health
- 03000413173
- allison.duggal@kent.gov.uk

Background documents:

What is place-based public health? NLGN 2016:
http://www.nlgn.org.uk/public/2016/get-well-soon-reimagining-place-based-health

Spatial Planning for Health. An evidence resource for planning and designing healthier places. PHE 2017:
(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729727/spatial_planning_for_health.pdf

Useful links:

Ebbsfleet Development Corporation

Dartford, Gravesham and Swanley Clinical Commissioning Group

Twitter: @healthynewtowns

Facebook: Ebbsfleet Garden City

From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

28th September 2018

Subject: Performance of Public Health commissioned services

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: This report provides an overview of key performance indicators (KPIs) for Public Health commissioned services. 11 of the 15 KPIs were RAG rated Green in the latest quarter, 4 were Amber, and none were Red.

In the case of the 4 Amber KPIs, Commissioners are working with providers to build on existing service improvements and actions, for example on the partnership work with Maternity Services in the NHS Hospital Trusts to increase further the delivery and uptake of Antenatal visits delivered by the Health Visiting service.

Public Health Commissioning is continuing to direct the providers of universal services to ensure they target provision to Kent residents most at risk of poor public health outcomes or those who are unlikely to access health services.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the performance of Public Health commissioned services in Q4 2017/18 and Q1 2018/19

1. Introduction

1.1. A core function of the Cabinet Committee is to review the performance of services which fall within its remit.

1.2. This report provides an overview of the performance of the public health services that are commissioned by KCC. It focuses on the key performance indicators (KPIs) that are included in the Strategic and Corporate Services Directorate 2018-19 Directorate Business Plan and presented to Cabinet via the KCC Quarterly Performance Report (QPR). Appendix 1 contains the full table of KPIs and the performance over the previous 5 quarters.

2. Overview of Performance

2.1. Of the 15 targeted KPIs for Public Health commissioned services 11 achieved target (Green), none were below the floor standard and Red. 4 KPIs were below target but achieved the floor standard (Amber), these were for:

- the percentage of smoking cessation quits
- the number of NHS Health Checks delivered
- the percentage of antenatal visits delivered by the Health Visiting Service
- the percentage of those engaged with One You Kent Advisors being from the most deprived areas in Kent

Health Visiting

2.2. The Health Visiting Service completed more than 71,000 universal developmental reviews in the twelve months to June 2018. Of the six targeted health visiting metrics, only one did not achieve target.

2.3. The proportion of antenatal contacts completed for Kent has increased from the previous quarter to 48%, however this is lower than the new target for 2018/19 set at 50%. Within the districts there have been ongoing improvements in delivery, for example in Dover 76% received their check in Q1 2018/19 compared to 35% in Q1 2016/17.

2.4. The service has achieved significant progress with the implementation of an agreed action plan to increase the proportion of families who receive an antenatal contact. The service has developed links with maternity systems across Maidstone and Tunbridge Wells and Dartford and Gravesham NHS Trusts, and is exploring digital platforms to increase uptake and prioritise need.

2.5. The Health Visiting service has continued to implement a schedule of Baby Hubs across the county. Baby Hubs will provide families with children under the age of 1 with advice and support on a range of topics including infant feeding, behaviour and sleeping. The hubs will also run a range of monthly parenting education programmes which have been codeveloped with Early Help.

2.6. The Health Visiting Service is working closely with Children's Centres and breastfeeding peer supporters to provide infant feeding services across Kent. This includes breastfeeding drop-in clinics, home visits and peer support groups

Adult Health Improvement

2.7. The number of NHS Health Checks delivered in the 12 months to June 2018 did not achieve target, this followed a focus on assuring an effective roll-out of a new IT system across Kent. Although the actual number of Health Checks delivered decreased in Q1 2018/19, the take-up rate of invite to check was 27% compared to 22% in the same period last year. There were over 20,000 invites sent in Q1 and the programme is on track to invite 100% of the eligible population.

2.8. In Q1 the proportion of clients engaged with a One You Kent Advisor from the most deprived areas in Kent was 49%, achieving the floor target of 48%. Providers with low take-up in deprived areas will be working with commissioners to target their communications more effectively. For some

providers this is a new way of delivering services, striking a balance between universal provision with nuanced targeting.

Sexual Health

2.9. Following the publication of the sexual health needs assessment, commissioners are working alongside sexual health providers to transform services to meet the identified needs, this includes capitalising further on the work to increase access to and uptake of online services, particularly the condom programme and STI testing.

Drug and Alcohol Services

2.10. Please refer to agenda item 11 for the report on Adult Drug and Alcohol Services.

Mental Wellbeing Service

2.11. The Live Well Kent providers continue to ensure that the services deliver high levels of satisfaction with 98% of clients completing the NHS Friends and Family Test (FFT) indicating that they would recommend the service to family, friends or someone in a similar situation.

3. Conclusion

3.1. 11 of the 15 KPIs with targets stated in the Strategic and Corporate Services Directorate 2018-19 Directorate Business Plan were rated Green and 4 were Amber, none were Red.

3.2. Providers are building on existing work to progress delivery of services where performance is below the target or services have undergone transformation.

4. Recommendations

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the Q4 2017/18 and Q1 20187/19 performance of Public Health commissioned services

5. Background Documents

Strategic and Corporate Services Directorate 2018-19 Directorate Business Plan
http://www.kent.gov.uk/about-the-council/strategies-and-policies/corporate-policies/business-plans

6. Appendices

Appendix 1 - Public Health Commissioned Services KPIs and Key.

7. Contact Details

Report Authors:
- Helen Groombridge: Performance Monitoring Officer, Strategic Commissioning
- 03000 416180. helen.groombridge@kent.gov.uk

- Karen Sharp: Head of Commissioning Portfolio Outcome 1 & Public Health
- 03000 416668. Karen.sharp@kent.gov.uk

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

Service	KPI's	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target 2018/19	Q1 18/19	DoT**
Health Visiting	PH04: No. of mandated universal checks delivered by the health visiting service (12 month rolling)	66,902 (g)	68,837 (g)	70,456 (g)	71,495 (g)	65,000	**71,287 (g)**	⇩
	PH14: No. and % of mothers receiving an antenatal contact with the health visiting service	1,914 44% (g)	2,457 54% (g)	2,282 52% (g)	1,755 43% (g)	50%	**2,078 48% (a)**	⇧
	PH15: No. and % of new birth visits delivered by the health visitor service within 30 days of birth	4,259 97% (g)	4,459 97% (g)	4,346 98% (g)	3,954 98% (g)	95%	**4,094 98% (g)**	⇔
	PH16: No. and % of infants due a 6-8 week who received one by the health visiting service	3,859 89% (g)	3,989 89% (g)	4,199 92% (g)	3,809 91% (g)	80%	**3,628 89% (g)**	⇩
	PH23: No. and % of infants who are totally or partially breastfed at 6-8 weeks (health visiting service)	2,077 51%*	2,025 49%*	2,041 47%	1,788 46%*	-	**1,833 49%***	⇧
	PH17: No. and % of infants receiving their 1-year review at 15 months by the health visiting service	3,666 86% (g)	3,751 88% (g)	3,878 89% (g)	3,723 87% (g)	80%	**3,609 86% (g)**	⇩
	PH18: No. and % of children who received a 2-2½ year review with the health visiting service	3,440 82% (g)	3,520 84% (g)	3,634 83% (g)	3,725 82% (g)	80%	**3,546 80% (g)**	⇩
Structured Substance Misuse Treatment	PH13: No. and % of young people exiting specialist substance misuse services with a planned exit	66 94% (g)	79 92% (g)	76 92% (g)	55 85% (g)	85%	**84 94% (g)**	⇧
	PH03: No. and % of people successfully completing drug and/or alcohol treatment of all those in treatment	1,221 27% (a)	1,143 26% (a)	1,126 25% (a)	1,073 24% (a)	26%	**1,160 26% (g)**	⇧
Lifestyle and Prevention	PH01: No. of the eligible population aged 40-74 years old receiving an NHS Health Check (12 month rolling)	42,568 (g)	43,677 (g)	42,943 (g)	41,677 (g)	41,600	**38,021 (a)**	⇩
	PH11: No. and % of people quitting at 4 weeks, having set a quit date with smoking cessation services	873 54% (g)	761 49% (a)	746 54% (g)	809 49% (a)	52%	**601 50% (a)**	⇧
	PH21: No. and % of clients engaged with One You Kent Advisors being from the most deprived areas in the County	New Service, New Metric				60%	**413 49% (a)**	-
Sexual Health	PH02: No. and % of clients accessing GUM services offered an appointment to be seen within 48 hours	100% (g)	100% (g)	100% (g)	100% (g)	90%	**9,772 100% (g)**	⇔
Mental Wellbeing	PH22: No. and % of Live Well Kent clients who would recommend the service to family, friends or someone in a similar situation	New Metric				90%	**210 98% (g)**	-

*Coverage above 85% however quarter did not meet 95% for robustness expected for national reporting

Commissioned services annual activity

Indicator Description	2013/14	2014/15	2015/16	2016/17	2017/18	DoT
PH09: Participation rate of Year R (4-5 year olds) pupils in the National Child Measurement Programme	96% (g)	96% (g)	97% (g)	**97% (g)**	nca	⇔
PH10: Participation rate of Year 6 (10-11 year olds) pupils in the National Child Measurement Programme	94% (a)	95% (g)	96% (g)	**96% (g)**		⇔
PH05; Number receiving an NHS Health Check over the 5-year programme (cumulative from 2013/14 to 2017/18)	32,924	78,547	115,232	157,303	**198,980**	-
PH06: Number of adults accessing structured treatment substance misuse services	4,652	5,324	5,462	4,616	**4,466**	-
PH07: Number accessing KCC commissioned sexual health service clinics	-	-	73,153	78,144	**75,694**	-

Key:

RAG Ratings

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

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

DoT (Direction of Travel) Alerts

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

**Relates to two most recent time frames

Data quality note

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

This page is intentionally left blank

From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 28 September 2018

Subject: **Work Programme 2018/19**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

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

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

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

2. Work Programme 2018/19

2.1 An agenda setting meeting was held on 27 June 2018, at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion in agendas of future meetings.

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

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

3. Conclusion

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

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

5. Background Documents

None.

6. Contact details

Report Author:
Theresa Grayell
Democratic Services Officer
03000 416172
theresa.grayell@kent.gov.uk

Lead Officer:
Benjamin Watts
General Counsel
03000 416814
benjamin.watts@kent.gov.uk

Last updated on: 20 September 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.

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) • **Air Quality - more detail on issues and impact, incl emissions from traffic and household fuels** (added at 1 5 18 mtg, request L Sullivan/R Bird) moved at 27 Jun ag setting • **Report on available tuberculosis data** added at 27 Jun ag setting • **Update on new infant feeding service, once started (on 1 June 2018)** moved following 27 Jun ag setting, to tie in with 0-5 CYP service • **Mental Health needs assessment** added as a separate item when suicide prevention needs assessment was reported on 28 Sept • **Smoking in Pregnancy** deferred from 28 Sept meeting • ***Contract Monitoring*** *– 0-5 Children and Young People's Services* • ***Verbal Updates – include STP update*** • ***Work Programme 2019***
9 JANUARY 2019
• **Budget and Medium Term Financial Plan** • **Access to dentistry services 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) moved at 27 Jun ag setting • **Use of alcohol and drugs during pregnancy** *(added 2 9 18 at suggestion of Chairman)* • ***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***
remainder of 2019 – MEETING DATES NOT YET SET
• ***Verbal Updates – include STP update***

Last updated on: 20 September 2018

MAY	• ***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** this is part of the Strategic Commissioning Equality and Diversity, which goes to P&R Cab Cttee 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	