HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Thursday, 22nd November, 2018

9.15 am

Council Chamber - Sessions House

Please note the earlier start time and change of room

Kent County Council
kent.gov.uk

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Thursday, 22 November 2018 at 9.15 am	Ask for:	**Theresa Grayell**
Council Chamber - Sessions House	Telephone:	**03000 416172**

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

Membership (13)

Conservative (10):	Mr G Lymer (Chairman), Ms D Marsh (Vice-Chairman), Mrs C Bell, Mr D Butler, Mr A Cook, Miss E Dawson, Mrs L Game, Ms S Hamilton, Mr K Pugh and Mr I Thomas
Liberal Democrat (2):	Mr D S Daley and Mr S J G Koowaree
Labour (1)	Mr B H Lewis

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 Mr B H Lewis has replaced Dr L Sullivan on the Committee.

3 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

4 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

5 Minutes of the meeting held on 28 September 2018 (Pages 7 - 18)

To consider and approve the minutes as a correct record.

6 Meeting Dates 2019/20

The Committee is asked to note that the following dates have been reserved for its meetings in 2019/20:

Friday 10 May 2019
Friday 19 July 2019
Wednesday 18 September 2019
Friday 1 November 2019
Tuesday 14 January 2020
Friday 6 March 2020
Wednesday 6 May 2020

All meetings will take place at County Hall, Maidstone, and will commence at 10.00 am

7 Verbal updates by Cabinet Members and Director (Pages 19 - 20)

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

8 Stop Smoking Services (Pages 21 - 26)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out and seeking the committee's endorsement of work to reduce the number of smokers in Kent, including a needs assessment and review of support services.

9 Smoking in Pregnancy (Pages 27 - 34)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out and seeking the committee's support for a proposal to commission an advice service for pregnant women to encourage them to stop smoking.

10 Illicit Tobacco in Kent (Pages 35 - 38)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out and seeking the committee's support for a regional approach to tackle illicit tobacco in Kent and a proposed partnership approach between Public Health South East and Trading Standards South East to develop a regional plan to reduce the supply and demand of illicit tobacco.

11 Contract Monitoring Report - the Health Visiting Service (Pages 39 - 58)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out and seeking the committee's support for ongoing activities to deliver statutory obligations, meet performance expectations and ensure value for money, and work to support the integrated transformation of the Health Visiting service.

12 Impact of Gambling on Public Mental Health (Pages 59 - 64)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, briefing the committee on problem gambling and the issues involved in tackling this in Kent, and seeking the committee's comment and suggestions to strengthen future delivery.

13 Tuberculosis and Hepatitis C in Kent (Pages 65 - 76)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out current information on Tuberculosis and Hepatitis C and seeking the committee's support for the partnership approach taken by the County Council's Public Health team.

14 Work Programme 2019/20 (Pages 77 - 82)

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

Wednesday, 14 November 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 Friday, 28th September, 2018.

PRESENT: Mr G Lymer (Chairman), Mrs C Bell, Mr R H Bird (Substitute for Mr D S Daley), Mr D Butler, Mr A Cook, Miss E Dawson, Ms S Hamilton, Mr S J G Koowaree, Ms D Marsh, Mr K Pugh, Dr L Sullivan and Mr I Thomas

OTHER MEMBERS: Graham Gibbens

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

UNRESTRICTED ITEMS

86. Chairman's announcement.
(Item. 1)

The Chairman opened the meeting by passing on Paul Carter's apologies for absence as he had to attend a South East Local Enterprise Partnership Executive meeting in Thurrock The Chairman read out a 'verbal update' statement which Mr Carter had sent. This statement gave updates on the first meeting of the new Kent and Medway Joint Health and Wellbeing Board, Health and Social Care integration and hospital reconfiguration to modernise the hospital estate, and was circulated later to the committee.

87. Membership.
(Item. 2)

Members noted that Mrs C Bell and Mr D Butler had joined the committee in place of Miss C Rankin and Mrs P A V Stockell.

The Chairman welcomed Mrs Bell and Mr Butler to the committee.

88. Apologies and Substitutes.
(Item. 3)

Apologies for absence had been received from Mr P Carter, Mr D S Daley and Mrs L Game.

Mr R H Bird was present as a substitute for Mr Daley.

89. Election of Vice-Chairman.
(Item. 4)

Mr K Pugh proposed and Mr I Thomas seconded that Ms D Marsh be elected Vice-Chairman of the committee.

There were no other nominations and Ms D Marsh was duly elected Vice-Chairman.

90. Declarations of Interest by Members in items on the Agenda.
(Item. 5)

In case there should be any discussion around a proposed new hospital in Canterbury, Mr I Thomas declared that he was a Member of Canterbury City Council's Planning Committee.

The Chairman, Mr G Lymer, declared that he served on Cancer Back up, East Kent Cancer Action Group, at the Kent and Canterbury Hospital and the Macmillan Cancer Welfare benefits steering Committee with Citizen Advice Bureau, Canterbury and Ashford.

91. Minutes of the meeting held on 27 June 2018.
(Item. 6)

It was RESOLVED that the minutes of the meeting held on 27 June 2018 are correctly recorded and that they be signed by the Chairman. There were no matters arising.

92. Verbal updates by Cabinet Members and Director.
(Item. 7)

<u>Health Reform</u>

1. The update by the Leader and Cabinet Member for Health Reform, Mr P B Carter, had already been read out by the Chairman at the start of the meeting.

<u>Public Health</u>

2. The Cabinet Member for Adult Social Care and Public Health, Mr G K Gibbens, gave a verbal update on the following issues:

***Return of Public Health to portfolio* –** he said how pleased he was to have public health in his portfolio once again and wanted to raise the profile of public health issues, particularly smoking cessation and smoking in pregnancy, on Health Reform and Public Health Cabinet Committee and Joint Kent and Medway Health and Wellbeing Board agendas.
***12 September - attended Public Health England Conference in Warwick* –** at this conference, Steve Brine, Parliamentary Under Secretary of State for Public Health and Primary Care, had announced that public health grants would continue to be ring-fenced until 2021/22.
***Flu jab* –** Mr Gibbens had had his flu jab on the morning of the meeting and had been photographed having this done, to raise the profile of the annual vaccination programme. He encouraged all Members to have this done.
***Public Health and Mental Health* –** Mr Gibbens said that mental health support services were a key priority in his portfolio. 10 October was World Mental Health Day, which would raise the profile of mental health issues, through various activities.

3. Mr Gibbens responded to comments and questions, including the following:-

a) asked about the importance of social isolation on the Health and Wellbeing Board agenda, Mr Gibbens advised that the Board was following the work of the County Council's Loneliness and Social Isolation Select Committee with interest and wanted to see the Select Committee's report when it was ready. The Select Committee report would also be considered by either the Health Reform and Public Health or Adult Social Care Cabinet Committee. The issue of loneliness and social isolation was gaining prominence via the work of Tracey Crouch MP and the Jo Cox Foundation, and had cross-party support at Government level. He was keen to see this same level of support all through society; and

b) the news that that the public health budget was to be ring-fenced for longer was welcomed. Public health funding had effectively been reduced in real terms, which would cause problems in the future. The Government needed to be helped to understand the importance of public health and the need for increased funding in the future. Mr Gibbens agreed that public health work had produced many successful outcomes in recent years.

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

Flu Vaccination – the flu season for 2018/19 was just starting, and everyone who was eligible for a flu jab and who was concerned about their vulnerability to flu was being urged to be vaccinated, including all staff working in the health and social care sectors.
Measles – the number of outbreaks in Kent continued to be very small and sporadic. There was no evidence that young adults travelling to music festivals were particularly at risk of catching or spreading measles. Public Health England and the NHS were both promoting vaccination for children.
Public Health England Updated Public Health Profile published – this set out statistics about the general health of the UK population, including life expectancy, trends, children's health and health protection issues. *It was suggested that a link to the document be included in the minutes:*
https://fingertips.phe.org.uk/profile/health-profiles
Kent Community Healthcare Foundation Trust (KCHFT) Breast Feeding Friendly Accreditation – the Health Visiting service had achieved Level 2 accreditation for their baby-friendly work, which was welcomed. Health visitors, maternity and neo-natal nurses and universities were all now training to support mothers to breast feed. *A further paper on infant feeding would be submitted to the November meeting of the committee.*

5. Mr Scott-Clark responded to comments and questions, including the following:-

a) the report on infant feeding to the November meeting would cover access to consultants for parents whose babies had tongue-tie, and any problems in accessing these services, including complaints received about the service, although there had been few reported complaints;

b) GPs were being proactive about identifying children who had not had a measles vaccination, as some mis-match of records occurred, for example when a young person left their home surgery to go to university. Schools also had a role to play in highlighting the need for vaccination; and

c) as part of the annual NHS campaign, GPs were proactive in calling eligible patients in for a flu vaccination, community pharmacies were also participating and midwives were encouraging expectant women to be vaccinated. A national surveillance programme by clinical commissioning groups monitored the uptake of vaccinations. Flu vaccinations could be given at any time of year, so it was never too late to have one.

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

93. Public Health Quality Annual Report 2017 - 2018.
(Item. 8)

Ms P Spence, Public Health Head of Quality and Safeguarding, was in attendance for this item.

1. Ms Spence introduced the report and responded to comments and questions, including the following:-

a) introduction of the One You programme varied across the county, and would be audited locally, with assurance being undertaken by the County Council;

b) the high staff turnover experienced by the sexual health service had been caused by a change in provider. *Ms Spence undertook to look into the reasons for the turnover pattern in the health service and advise Members outside the meeting;*

c) the reasons for the low rate of satisfaction with the school health team would be investigated and an action plan drawn up to address them. This was an ongoing process, *and Ms Spence undertook to advise Members outside the meeting of the process for this;*

d) Ms Spence assured Members that all staff would always be fully trained and competent before starting work on any service; and

e) the Serious Incidents Learning Partnership (SILP) had seen evidence that there was an increase in the number of older heroin users developing long-term health conditions as a result of their habit, and this made the pattern of use more complex.

2. It was RESOLVED that the Public Health Quality Annual Report 2017-2018 be welcomed, and its content, and Members' comments on it, set out above, be noted.

94. Suicide Prevention Needs Assessment.
(Item. 9)

Mr T Woodhouse, Suicide Prevention Specialist, and Ms J Mookerjee, Public Health Consultant, were in attendance for this item.

1. Ms Mookherjee and Mr Woodhouse introduced the report and highlighted the links with other areas of work such as substance misuse, mental health services and social isolation, and the work going on to address these areas. They then responded to comments and questions from Members, including the following:-

a) to address the link between both legal and illegal substance misuse and suicide, work was being undertaken with the Police, and links made to the Police Strategy. Reports on the subject would be made regularly to the Crime Safety Partnership. Drug use was also closely linked with homelessness, and work was ongoing to seek to address this;

b) the likelihood of ex-servicemen and women experiencing homelessness, and the link to social isolation, was well acknowledged, and the outcome of the Select Committee currently running was awaited with interest;

c) a view was expressed that more information was needed about the link between homelessness, ex-offenders and ex-military and to seek to identify the reason for this link. It was known that 50% of those taking their own lives had a history of self-harm, and it would be helpful to be able to understand more about this link and how it could be addressed. Ms Mookherjee explained that men considering suicide were known not to tend to seek help. This tendency was deep-rooted among male occupations, not just in the military. Workplace health events could seek to encourage more openness;

d) the extra money allocated to Kent by the Government was welcomed as excellent news;

e) asked what follow-up work would be done after someone had been seen at Accident and Emergency after self-harming, Ms Mookherjee explained that a link would be made with the patient's GP, to seek ongoing supervision. However, this practice was not consistent across the county. Mr Woodhouse added that the Kent and Medway NHS and Social Care Partnership Trust had identified this as an area of high risk and work was ongoing to seek new ways in which to support such patients;

f) Mr Woodhouse explained that a major review was being undertaken with the Kent Safeguarding Children Board to seek to identify the impact of suicide upon families, and *the Children, Young People and Education strategy and action plan could be shared with the Health Reform and Public Health Cabinet Committee at a future meeting*;

g) asked how many cases there were of attempted suicide, Ms Mookherjee explained that these were hard to identify, as some people self-harmed without intending suicide;

h) a view was expressed that mental health support should be made available to all, not just those who were at high risk of suicide. Ms Mookherjee agreed that all lives saved were important. She advised that a pilot scheme in West Kent was improving the treatment of depression and piloting urgent and crisis care. Mr Woodhouse added that there were some countywide initiatives offering a 24-hour freephone helpline. These had been established using Government funding for innovation and it was hoped that they could be spread;

i) in response to a question about how local elected Members could support someone who had come to them as a local representative to seek help with thoughts of suicide, Ms Mookherjee said that some online guidance and signposting could be provided, perhaps in conjunction with the Jo Cox Foundation, training could be made available to Members and a wallet-sized card giving a few bullet-point guidelines could be produced;

j) a recent meeting between the NHS and Healthwatch had discussed signposting with existing initiatives, such as Live Well Kent, which was a key part of suicide prevention work;

k) comments were made on the online accessibility of campaigns and a request made that they be made easier to find on the County Council website by using smart links. Mr Woodhouse advised that links would be established with Google so that anyone searching for 'suicide' would find the Release the Pressure campaign, and the same could be done with the County Council website; and

l) asked if the Release the Pressure posters which had previously been displayed in the foyer of Sessions House could be reinstated, Mr Scott-Clark said he would liaise with the County Council press office to do this.

2. The Cabinet Member, Mr Gibbens, responded to comments made during the debate and highlighted the range of referral pathways available to ex-offenders, via the Probation Service, young people of 18+ transitioning from CAMHS to adults' mental health services, people with mental health needs accessing housing-related support via Porchlight, and support for ex-service personnel adjusting to civilian life as part of the Military Covenant between the County Council and the Armed Forces. The Men's Sheds projects around the county sought to address the need for men to network and find moral support, and he encouraged Members to visit their local Shed project. He undertook to look into the various points raised about the online accessibility and profile of suicide prevention campaigns.

3. It was RESOLVED that Members' comments on the Suicide Prevention Needs Assessment and suggestions of areas for further research, set out above, be noted.

95. 18/00051 a and b - Sexual Health Needs Assessment and Service Commissioning.
(Item. 10)

Ms W Jeffreys, Public Health Specialist, and Mr M Gilbert, Senior Commissioner, were in attendance for this item.

1. Ms Jeffreys and Mr Gilbert introduced the report and updated the statistics set out in para 3.11 of the report; the percentage of late diagnosis of HIV in Kent had increased to 61.7% compared to 41.1% in England as a whole. They and Mr Scott-Clark then responded to comments and questions from Members, including the following:-

a) the online ordering facility for testing kits allowed customers to access kits discreetly, without having to ask over a counter. It also reduced the demand for clinic visits, which were more expensive, as only those testing positive would then be invited to attend a clinic appointment. Members were assured that kits obtained through the online service would come only from reputable, quality providers, approved and commissioned by the County Council. This saved customers having to search randomly elsewhere on the internet and perhaps finding products which were not quite so reliable;

b) although the online 'Get It' programme was available only for people over 16, younger customers would be signposted to find support and products elsewhere. A young person logging in would be required to enter their date of birth and would be guided through the system in such a way that they could not then change the entry later to make themselves seem older;

c) young people would be told how to access the digital offer as it was part of the information provided by the school public health service. The 'Get It' programme had been widely promoted and was accessible through youth hubs and numerous outlets frequented by young people;

d) the County Council was seeking to have a longer contract for the new condom programme so the service would stay with the same provider for a longer period, thus minimising the frequency with which the access details would change. Members were assured that a longer contract would include the same rigorous performance clauses to ensure that a good quality service was maintained. Kent's digital offer had increased uptake above that of other neighbouring authorities and would continue to be developed. A longer contract period would also give service staff more stability of employment;

e) Kent's sexual health services were demand-led, and the County Council had a duty to provide treatment for all people testing positive. The Council had a reserve of cash to cover rises in demand;

f) in response to a question about the County Council's scope to own or 'brand' a campaign, Mr Gilbert explained that the 'Get It' campaign was owned by the provider, Metro. Where the County Council bought an existing campaign, it would not usually be possible to own the brand and continue to use it with a different provider. Mr Gilbert undertook to liaise with prospective contractors to explore the possibility of negotiating an agreement for Council ownership or perpetual right to use a new brand for the service. He cautioned, however, that potential providers would most likely not allow the Council to take over their existing brand and use it with another provider. It would, however, be possible for the Council to develop and own a new brand and use it with any chosen provider. This idea was supported by some

Members, with the suggestion that Kent could adopt an overall brand to cover its various sexual health services;

g) asked about statistics for the prevalence of syphilis, how soon cases were being identified and how the UK compared to other countries in the way in which it approached the provision of sexual health services, Ms Jeffreys *undertook to look into this and supply information to Members outside the meeting;*

h) sexual health service providers were being pro-active in liaising with universities and colleges, youth groups and early years support services to spread awareness of its sexual health services;

i) there was still some resistance to take up the offer of testing for STIs, due to the prevailing understanding of personal risk among many people; and

j) a view was expressed that Kent should raise the profile of HIV testing and reassure people that requesting a test was a responsible move and not one which need jeopardise insurance, mortgage or loan applications. The extent of change since the HIV campaigns of the 1980s was emphasised. Knowledge and understanding of HIV was just starting in the 1980s, but medical knowledge and public awareness had both increased greatly since then, along with the accessibility of testing and services.

2. It was RESOLVED that:-

a) the key findings of the needs assessment and changes in delivery of sexual health services be noted;

b) taking account of Members' comments and concerns set out above, and in particular about branding and ownership, the decision proposed to be taken by the Cabinet Member, to make changes to the provision of sexual health services due to expire in 2019:

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

ii. the formation of a new partnership agreement with Maidstone and Tunbridge Wells NHS Trust (MTW) and inclusion of integrated sexual health and online STI testing services;

iii. continued contracting directly with GP surgeries for Long Acting Reversible Contraception (LARC) services, delivered within primary care; and

iv. award of contract following a competitive process procurement for an online condom scheme and outreach services;

be endorsed; and

c) the proposed plans for the continued delivery of Kent County Council-commissioned sexual health services, via Kent Community Health Foundation NHS Trust and primary care, be supported.

96. Contract Monitoring Report - Adult Drug and Alcohol Services.
(Item. 11)

Mr M Gilbert, Senior Commissioner, Public Health, was in attendance for this item.

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

a) every £1 spent on adult drug and alcohol services in Kent would produce a saving of £3 - 4. Kent's service was performing better than the national average, at approximately 75% of the average national cost. Some areas of service delivery, for example residential rehabilitation, cost more per head than others;

b) although the use of drugs had reduced overall, the pattern of usage had changed, and the harm caused by drug use, for example, the associated crime and family breakdown, continued to be a problem;

c) concern was expressed that users of residential rehabilitation centres would try to negotiate a reduction in fees and that some centres may run at a loss and hence be at risk of closing, Mr Gilbert agreed that bargaining was not good and advised the committee that referrals were carefully screened and only patients who were assessed as being able to benefit from residential rehabilitation would be referred there. The availability and cost of residential rehabilitation was a problem faced across the UK, and as Kent provided good quality provision, it attracted people from elsewhere. Kent's contracts for residential rehabilitation services would build in a clause about maintaining access for Kent patients; and

d) asked what would happen next to someone who did complete a residential rehabilitation programme, Mr Gilbert advised that approximately 60% of non-opiate users tended to drop out of treatment programmes. People dropping out would have the opportunity to carry on in less structured services or mutual support groups. Once someone had dropped out of one course of treatment, they were statistically more likely to drop out again in the future.

2. It was RESOLVED that the commissioning and provision of adult drug and alcohol services in Kent, and the service improvement initiatives being undertaken to improve quality and outcomes, be noted and welcomed.

97. Placed-based Public Health and Ebbsfleet Healthy New Town.
(Item. 12)

1. Dr Duggal introduced the report and set out the historical and cultural context of place-based service provision. With Mr Scott-Clark, she responded to comments and questions from Members, including the following:-

a) district council colleagues had been fully involved in the project from an early stage. Linking the project into neighbourhood plans as they were produced was difficult as they had varying timetables, but links would be made to as many plans as possible. Mr Scott-Clark added that the aim was that public health considerations would be built into as many other policies as possible so the health impact of actions would be considered;

b) concern was expressed that as many people as possible should be able to share and benefit from healthy new developments, but the 'affordable housing' which was included in many modern developments was unaffordable to many. Dr Duggal advised that the County Council's public health team would seek to influence partners to make the new development as democratic as possible;

c) concern was expressed that many new developments in recent years had included very little open space or green space. Some houses had no gardens and a children's play area involved a journey of 1.5 miles. Although new towns such as Milton Keynes had been designed to encourage cycling, some modern developments did not offer sufficient safe room for people to walk or push a pram, and in some places it was not safe for people to walk or cycle. As part of encouraging active travel, it was important to ensure that roads and footways were safe for cyclists and walkers. Dr Duggal advised that there had been much work on active travel at Ebbsfleet, and the County Council's Energy and Low Emissions Strategy had been incorporated to protect air quality. *She undertook to find out how many car charging points would be provided across the development and advise Members outside the meeting;*

d) asked about the plans for the Lower Thames Crossing, near Ebbsfleet, *Dr Duggal undertook to look into the plans and timeframe for this and advise Members outside the meeting*. She confirmed that the public health team had been involved in the Health Improvement Assessment for the Lower Thames Crossing*;* and

e) asked about plans for 'lifetime housing', which paid particular attention to daylight and ventilation and had features built in which would support future independence and mobility as residents aged, Dr Duggal advised that there was a pilot kitemark scheme for healthy homes, to which developers had indicated they were willing to sign up.

2. The Cabinet Member, Mr Gibbens, advise Members that he fully supported the principal of health considerations being built into all policies, and encouraged Members to look at information about this on the Local Government Association website. The Local Government Association also had a group working on place-based commissioning, and a model of local care provision existed as the Whitstable Model.

3. It was RESOLVED that progress made be noted and the approach taken by the County Council's Public Health team on place-based public health be endorsed.

98. Performance of Public Health-Commissioned Services.
(Item. 13)

Mr M Gilbert, Senior Commissioner, Public Health

1. Mr Gilbert introduced the report and, in response to a question, *undertook to look into the provision of the Health Visiting service outside usual working hours, to help support working parents, and advise Members outside the meeting.*

2. It was RESOLVED that the performance of Public Health-commissioned services in Quarter 4 of 2017/18 and Quarter 1 of 2018/19 be noted.

99. Work Programme 2018/19.
(Item. 14)

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

This page is intentionally left blank

By: Mr P B Carter, CBE, Leader and Cabinet Member for Health Reform

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 – 22 November 2018

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

Classification: Unrestricted

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

HEALTH REFORM

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

1. Progress in working with health partners on local care and implementation

PUBLIC HEALTH

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

1. Key Developments in Sustainability and Transformation Programme:

   a) Appointment of Simon Perks as Director for System Transformation, progressing work on developing Integrated Commissioning and one Kent and Medway CCG.

   b) Development of Winter Pressure plan for Kent and Medway – Ivor Duffy is Operations Manager.

2. Kent and Medway Care Record moving to Phase 2 of the project which will start to work on procurement. The KMCR will be a new umbrella database that draws relevant information from existing systems; and then makes it available to those that need to use it – doctors, nurses, care workers, paramedics etc. and, importantly, to individual patients and the public so they can see their own data.

3. Local Care – two Deep Dives to take place in November and December to review the plans and £32m spend. New governance to start in January, placing more accountability on Local Implementation and with a revised senior leadership group chaired by Paul Carter.

4. Attended the National Children’s and Adults Social Care Conference in Manchester, 14-16 November

Director of Public Health – Mr A Scott-Clark:

1. Local Government Association publication on sector-led improvement in public health

2. Department of Health and Social Care publication ‘Prevention is better than cure’

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

22 November 2018

Subject: **Stop Smoking Services**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: Smoking prevalence is declining steadily in Kent (16.3%) and nationally (14.9%), but further work is needed to support more smokers to quit, particularly those from Routine and Manual Worker groups where smoking prevalence is 32.4% (the highest rate in the South East). Fewer people are engaging with Specialist Stop Smoking Services which still provide the most successful chance of quitting. Kent needs to adopt a wider approach that will motivate and engage more smokers to quit using a range of methods that meets their needs. This should include specialist stop smoking services, GPs offering appropriate medication for those who do not wish to engage with services and a range of self-help resources that are digitally available to assist those who wish to make a quit attempt alone. A Smoking Cessation Needs Assessment is being conducted and Review of Current Services undertaken to inform the commissioning of a smoking cessation model to achieve the target of 12% smoking prevalence in Kent. This will mean accomplishing 45,000 fewer smokers by the end of 2022.

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

a) **Comment on and Endorse** the contents of this report;
b) **Agree** to the proposal of the Smoking Plus model and to Kent's ambition of achieving 45,000 fewer smokers by 2022;
c) **Acknowledge** the Needs Assessment and Review of Stop Smoking Services that is currently being undertaken; and
d) **Seek** a further paper on the outcomes and recommendations of the review that will propose an effective model of smoking cessation provision that meets the needs of smokers who want to quit.

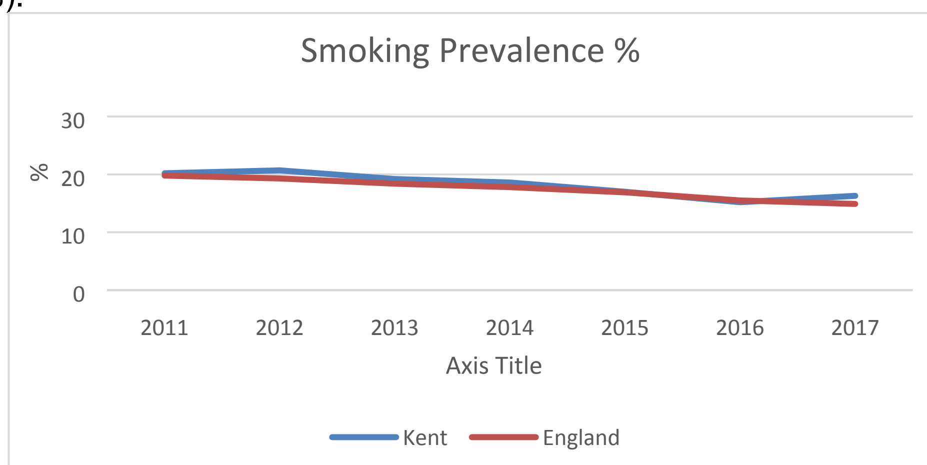
1. Background.

1.1 Smoking is still a major determinant of health inequalities and the main

preventable cause of premature mortality, accountable for 1 in 6 of all deaths in England. Mortality rates due to smoking are three times higher in the most deprived areas than the most affluent areas. Smoking also carries a financial burden; costing Kent £346.5m each year, £76.5m of which impacts directly upon the NHS[1]. Over the last 5 years, smoking prevalence has reduced in Kent by 4.4%. In 2012, 20.7% of the Kent adult population smoked; in 2017 rates are estimated to be 16.3[2]%.

1.2 **Introduction**

1.3 In Kent, there are 197,000[3] adults who smoke. Kent has a smoking prevalence of 16.3%; 1% increase on last year (2016) and 1.4% above the national average (14.9%).



Source: Annual Population Survey (APS)

1.4 Smoking estimates at a district level can be observed below, but should be noted that are less precise due to smaller survey numbers[4].

Locality	Prevalence 2017	Locality	Prevalence 2017
Kent	16.3%		
Ashford	18.1%	Sevenoaks	12.0%
Canterbury	14.8%	Shepway	16.5%
Dartford	10.2%	Swale	17.9%
Dover	18.7%	Thanet	23.7%
Gravesham	18.3%	Tonbridge & Malling	11.6%
Maidstone	17.1%	Tunbridge Wells	15.0%

Source: Public Health England, Local Tobacco Profiles 2017

[1] Action on Smoking and Health, ASH Ready Reckoner, September 2018
[2] Public Health England, Local Tobacco Profiles 2017 https://fingertips.phe.org.uk/profile/tobacco-control/data#page/4/gid/1938132886/pat/6/par/E12000008/ati/102/are/E10000016/iid/92445/age/183/sex/4
[3] As Above
[4] Surveys which use small numbers have wide confidence intervals and thus provide a more imprecise measure.

1.5 District level data and activity is reported to the Kent Tobacco Control Alliance and contributes to the Kent and Medway Sustainability and Transformation Plan (STP): Prevention Workstream Action Plan. Initiatives such as Smoke Free Parks and Smoke Free School Gates support the national Tobacco Control Plan: 'Towards a Smokefree Generation[5]' in its aim to promote smokefree public spaces frequented by children and young people.

2. Current Model

2.1 ASH reports that 68% of smokers want to quit. Despite this the number of people accessing stop smoking services continues to fall, with only 3% smokers choosing to quit using these services. Last year (2017/18) 6,196 smokers set a quit date with Kent NHS Stop Smoking Services and 3,126 successfully quit (51%[6]).

2.2 In 2018/19, the annual budget for commissioned stop smoking services in Kent is £1.7m allied to a target of 3,400 quits. In 2017/18, the service cost, on average, £500 per quitter[7].

Cost Per Quitter 2017/18	Kent	Surrey	E.Sussex	Medway
Cost per quitter (inc pharmacotherapy)	£529	£376	£842	£461

Source: NHS Digital, August 2018

2.3 Specialist Stop Smoking services provide the best chances of quitting successfully and referrals to the core services should be seen as best practice but it should also be acknowledged that some smokers may prefer other methods of quitting (such as going to a GP, vaping, self-help apps etc). The STP Prevention Action Plan details a range of additional evidence-based partnership initiatives to increase smoking quit rates in Kent. In the absence of STP funding, they are being delivered on a smaller scale and funded from the allocated Public Health Tobacco Control budget (£145,000 per year).

3.0 Achieving National targets

The National Tobacco Control Plan, 'Towards a Smokefree Generation' sets the following national targets by 2022:

- Reduce smoking prevalence amongst adults in England to 12% or less
- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population
- Reduce the prevalence of 15 year olds who regularly smoke to 3% or less

---

[5] Department of Health, Towards a Smokefree Generation – A Tobacco Control Plan for England, July 2017 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022__2_.pdf

[6] NHS Digital, Statistics on NHS Stop Smoking Services in England - April 2017 to March 2018 August 2018

[7] As Above

- Reduce the prevalence of smoking in pregnancy to 6% or less.

3.1 The 11 programmes in the Kent and Medway STP Prevention Action Plan will assist Kent in achieving the national targets. This means that in real terms, by the end of 2022, Kent will have 45,074 fewer smokers.
As a working guide for districts, this can be estimated as follows[8]:

3.2

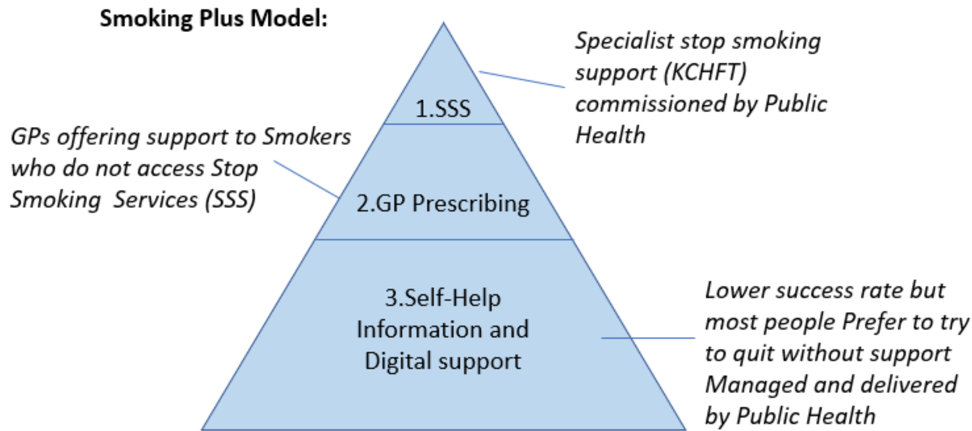
County/District	2017 smoking prevalence	2017 Est. No. of smokers	2022 Est. no of smokers @ 12% prevalence
Kent	16.3%	197,002	145,032
Ashford	18.1%	17,761	11,775
Canterbury	14.8%	19,782	16,039
Dartford	10.2%	8,199	8,199
Dover	18.7%	17,222	11,052
Gravesham	18.3%	14,868	9,749
Maidstone	17.1%	22,391	15,589
Sevenoaks	12.0%	11,136	11,136
Shepway	16.5%	14,876	10,819
Swale	17.9%	20,364	13,652
Thanet	23.7%	26,427	13,381
Tonbridge & Malling	11.6%	11,514	11,514
Tunbridge Wells	15.0%	13,694	10,956

Source: Office of National Statistics and Public Health England

3.3 Example of new Models of Working:

Professor Robert West of University College London has created the Smoking Plus model; an evidence-based Stop Smoking model designed to deliver future proof stop smoking support in response to the trend of fewer smokers engaging with stop smoking services. The model is being implemented across London Boroughs, optimising three tiers of cost-effective smoking cessation support based on user choice:

[8] Surveys which use small numbers have wide confidence intervals and thus provide a more imprecise measure.



3.4 Tier 1 core Stop Smoking Services are cost-effective and should be accessible to people who want to use them.

3.5 Tier 2, GP prescribing is featured in the Kent and Medway STP (Prevention) and there are plans to pilot the model in Ashford before rolling out across the whole of Kent. The pilot will need to take into account:

- That GP prescribing for NRT and pharmacotherapy is undertaken as partnership working to treat smokers to quit and not as a commissioned stop smoking service with GPs and CCGs
- the current Patient Group Directive (PGD) remains in place and is not undermined (under the PGD Public Health only reimburses prescribing costs for smoking to contracted providers)

3.6 Tier 3: the Kent Smoke free website will be expanded to provide information along with tools and resources (such as apps and vaping) to help smokers quit if they wish to do so alone.

3.7 Smoking Plus and the STP Action Plan will also form the basis of a Stop Smoking review that will be undertaken by KCC Commissioning, Public Health and KCHFT. It is proposed that the outcome of the review be presented to the Cabinet Committee in January 2019.
Other service models (such as Home Visit Advisers for pregnant women who smoke) are explained in the Smoking in Pregnancy paper presented to the Health Reform and Public Health Cabinet Committee on the 22nd November 2018.

4.0 Conclusion

4.1 Overall, smoking prevalence has declined since 2012. It is estimated that 16.3% of adults in Kent smoke. However, more needs to be done to reduce the numbers of those who take up smoking in the first place and to support smokers to quit as soon as possible, particularly those from Routine and Manual Worker groups where smoking prevalence is currently 32.4%.

4.2 Specialist Stop Smoking Services are reducing in popularity but still provide the most successful chance of quitting. Kent needs to widen its approach to ensure

that smokers are encouraged to quit smoking, receive consistent and effective support in their quit attempt and have a range of methods to access based on choice.

4.3 A review on stop smoking is being conducted by Public Health and will provide the focus for a new approach to support commissioning plans. The review will be aligned to the Smoking Plus model and the STP Action Plan.

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

a) **Comment on and Endorse** the contents of this report;
b) **Agree** to the proposal of the Smoking Plus model and to Kent's ambition of achieving 45,000 fewer smokers by 2022;
c) **Acknowledge** the Needs Assessment and Review of Stop Smoking Services that is currently being undertaken; and
d) **Seek** a further paper on the outcomes and recommendations of the review that will propose an effective model of smoking cessation provision that meets the needs of smokers who want to quit.

Background Documents
None

6.0 Contact Details

Report Authors:
Andrew Scott-Clark, Director of Public Health
03000 416180
Andrew.Scott-Clark@kent.gov.uk

Debbie Smith, Public Health Specialist
03000 416696
Debbie.Smith@kent.gov.uk

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

22 November 2018

Subject: **Smoking in Pregnancy**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

Smoking in pregnancy continues to be a significant Public Health issue in Kent with rates statistically above the national and south-eastern averages. The Public Health team have worked with partners across the maternity system to implement "BabyClear" in each maternity unit, have piloted Stop Smoking Home Visit advisers with very good success and delivered a social marketing campaign in Sheppey, "What the Bump", with again good success.

Based on the success of these three elements we now need to ensure this model is delivered across the whole population of Kent in order to meet our national obligation of reducing smoking in pregnancy to below 6% as set out in the national Tobacco Control Action Plan. Thus the NHS must ensure the continuation of the lead Midwives through their commissioning of the maternity units in Kent.

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

a) **Comment on and Endorse** the contents of the report;

b) **Agree** to the proposal to commission the Home Visiting Stop Smoking Advice service across Kent to support pregnant women who smoke to quit; and

c) **Acknowledge** the beneficial role of the Midwives with a Smoking in Pregnancy lead undertake and promote their continuation with permanent NHS commissioned service.

1. Background.

1.1 Smoking accounts for half the difference in life expectancy between the richest and poorest in society and is still the leading cause of preventable illness and premature death. Hence smoking and tobacco addiction are a continuing public health issue both locally, nationally and globally.

1.2 Smoking during pregnancy is also a major health inequality, with prevalence among routine and manual occupations five times higher than women in managerial and professional occupations. This means those from lower socio-economic groups are at much greater risk of stillbirth, miscarriage, premature birth, sudden infant death and complications during and after pregnancy.

1.3 Children who grow up with a parent are also more likely to become smokers themselves, further perpetuating the cycle of inequality and affecting their life chances.

1.4 Between 2014-2016 in Kent there were 7,381 smoking attributable deaths, including 233 stillbirths and 125 neo-natal mortalities recorded and 31,012 potential years of life lost due to smoking related illness.

2.0 Introduction

2.1 In 2016 the Department of Health published "Better Births Improving outcomes of maternity services in England which set out the vision for maternity services to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and the baby can access support that is centred around individual needs and circumstances. Maternity units are wholly commissioned by Clinical Commissioning Groups (CCGs) for their local populations.

2.2 This publication also acknowledged the major causes of health inequalities and outlined smoking as the biggest single modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health outcomes.

2.3 In July 2017 The Department of Health also published the Tobacco Control Plan for England titled "Towards a Smoke Free Generation". The plan set out ambitious targets to reduce smoking prevalence to create a smoke free generation, defined as prevalence at or below 5%.

2.4 The plan sets the national ambition to reduce prevalence of smoking in pregnancy from 10.6% (national rate) to 6% nationally.

2.5 This paper sets out the prevalence rates for smoking in pregnancy in Kent, outlines the initiatives and progress being made to reduce smoking in pregnancy and makes recommendations, and seeks endorsement of those recommendations.

3.0 Prevalence and Trends in Kent

3.1 Statistics on smoking in pregnancy are collected within the National Health Service (NHS) by NHS Trusts and submitted quarterly with data being reported at Clinical Commissioning Group (CCG) level. Reporting is at this level is because responsibility for commissioning services for women's smoking status at the time of delivery moved from Primary care Trust (PCT) to CCGs on 1st April 2013.

3.2 Smoking in pregnancy is defined as pregnant women who reported smoking at the time of delivery.

3.3 The number of maternities is the count of pregnant women who gave birth to one or more live or stillborn babies of at least 24 weeks gestation, where the baby is delivered by either a midwife or doctor at home or in an NHS hospital (including GP units).

3.4 The rate of smoking at time of delivery is calculated by dividing the number of women known to be smokers at the time of delivery by the total number of maternities.

3.5 The table below sets the most recent annual data published by NHS Digital for the year 2017/2018.

3.6

Commissioning region, region and CCG	No. of maternities	Women known to be smokers at time of delivery	
		Number	Percentage[1]
ENGLAND	**607,294**	**64,391**	***10.8***
NHS England South (South East)	**47,208**	**5,120**	***11.0***
NHS Ashford	1,519	224	***14.8***
NHS Canterbury and Coastal	1,818	273	***15.0***
NHS Dartford, Gravesham and Swanley	3,030	344	***11.4***
NHS Medway	3,592	624	***17.4***
NHS Swale	1,369	269	***19.6***
NHS Thanet	1,537	323	***21.0***
NHS West Kent	5,234	538	***10.3***

3.7 The chart below shows the trend in smoking at the time of delivery for Kent from 2010/11 to 2016/2017.

3.8

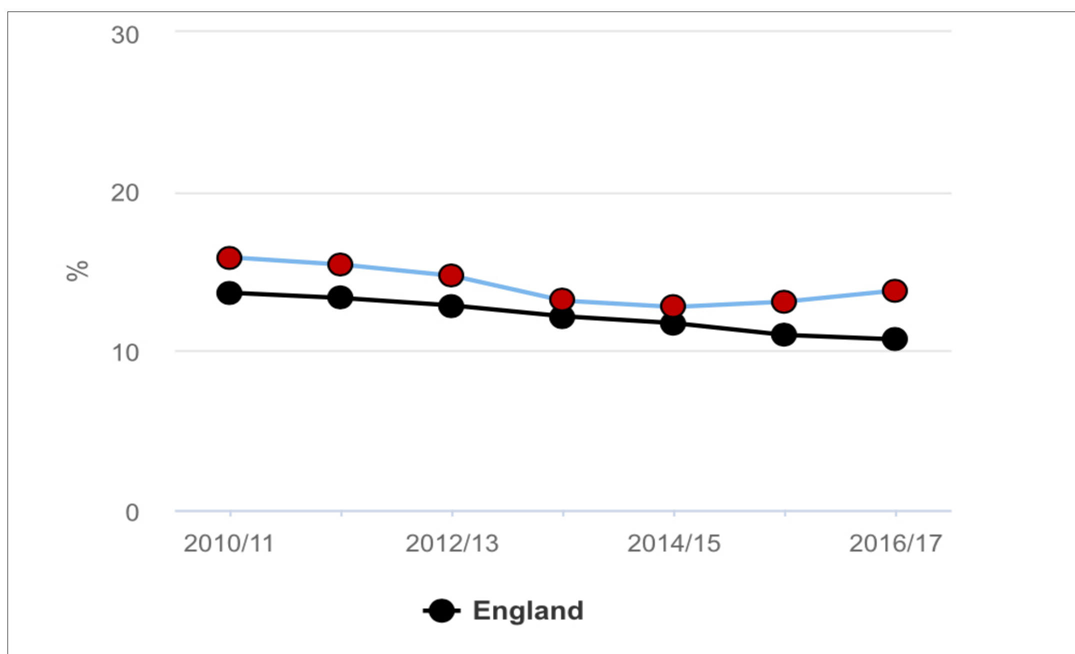


Chart 1: Trend in Smoking in pregnancy between 2010/11 and 2016/17.
Source: PHE Fingertips accessed 16/09/18

3.9 Thus, looking at the data, it is clear that smoking in pregnancy in Kent remains a significant issue; significant because all rates (except West Kent) are statistically significantly above the national average and the trend in Kent appears to be increasing from 2014/2015 and unchanged between 2010/11 and 2016/17. However some of the increasing trend can be attributed to all the work done so far, in that attainment of smoking status is much better leading to the conclusion that rates before 2014/15 under represent the true picture.

4.0 Public Health Working with Clinical Commissioning Groups, Maternity Units and Stop Smoking Service and Results

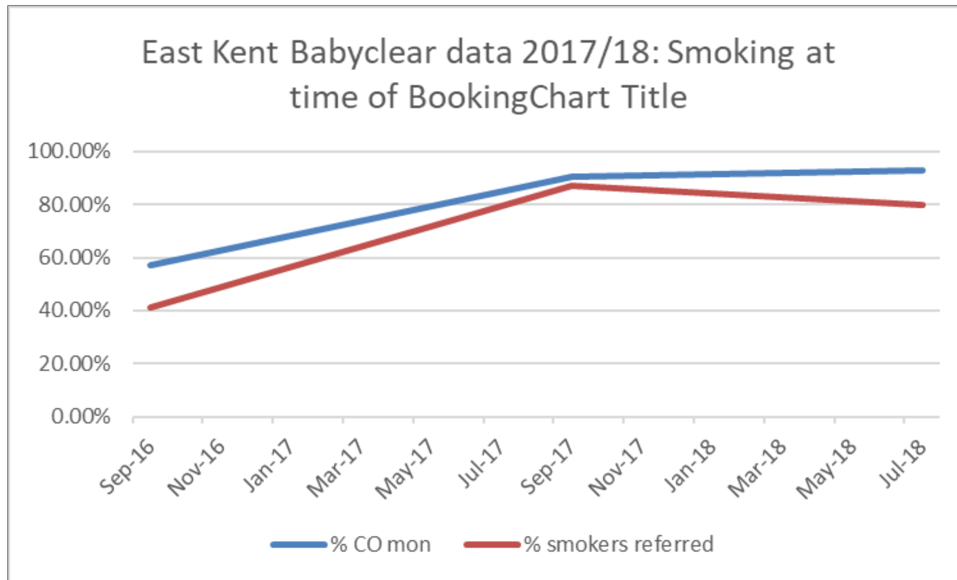
4.1 In relation to smoking in pregnancy NICE Guidance recommends the best practice approach and requires all midwives to carbon monoxide (CO) monitor all pregnant women at first booking appointment and to make automatic referrals into stop smoking services for all identified smokers.

4.2 In Kent, Public Health have supported the national evidence based “BabyClear” programme which, based on NICE guidance, aims to increase CO monitoring and referral to Stop Smoking services. To enable this the KCC Public Health team have funded a lead Stop Smoking midwife in each of the three Kent based Acute trusts, beginning with East Kent Universities Foundation Trust (EKHUFT) and more latterly Maidstone and Tunbridge Wells NHS Trust (MTW) and Dartford and Gravesham NHS Trust (DVH).

4.3 The roles have shown significant improvements in the identification of pregnant

smokers and compliance among midwives to refer into the stop smoking services and advise against smoking. The following chart demonstrates the incremental improvement in the East Kent Trust area over the last 22 months the lead Midwife has been in post.

4.4



Source: EKHUFT E3 database 2017/18

4.5 In line with the national picture, quit rates among women who are referred into stop smoking services are relatively low, with many either declining or not engaging at all in services, despite the service spending time and energy attempting to engage this group of women.

4.6 Having introduced BabyClear to the three Acute Trusts, it is now clear that some, if not all of the growth in prevalence rates since 2014/15 has been due to improved ascertainment rates through CO monitoring, and thus although on the face of it rates of smoking at the time of delivery have affectively not changed since 2010/11, we now have considerably more confidence that the rates are showing the true picture.

4.7.0 KCC Public Health have also, more recently, worked in partnership with East Kent Children's Commissioning Team for the East Kent CCGs and our commissioned Stop Smoking provider (Kent Community Health Foundation Trusts).

4.7.1 Using a short-term one-off NHS allocation made to East Coast Kent CCG and Thanet CCG based on their outlier smoking in pregnancy rate status we have piloted a new Home Visit Smoking Quit Adviser service in Thanet CCG and South Kent Coast CCG between September 2017 to April 2018. This model involves Stop Smoking Advisers providing quit support in the pregnant woman's home rather than expecting them to attend a local stop smoking clinic.

4.7.2 The Home Visit Advisers have delivered positive improvements with 450% more smoking in pregnancy quitters in these two areas alone than in the rest of Kent. The short-term NHS funding for this pilot ended in March 2018, however KCHFT have continued to provide this service using advisers delivering the adult stop

smoking service in East Kent.

4.8 Given the success of this pilot our aim must be to expand the Home Visiting model across the whole of Kent. The cost of this additional service delivery is estimated to be £300,000 per year based on more senior Stop Smoking advisers. This is necessary as the service, in visiting homes, are finding more need and issues that requires more senior practitioners to deal with.

4.9 Based on modelling work, we would expect to achieve over 550 Smoking in Pregnancy quits per year. This equates to £545 per quitter versus an annual cost of £1,886 pa per smoker.

4.10 This local target could potentially reach over 10% of pregnant women who smoke in Kent and on this trajectory, Kent could attain the national target of 6% by 2022.

4.11 There has been a significant lack of investment in national campaigns for smoking and in particular smoking in pregnancy. In 2017, Kent County Council used a community asset-based approach and behavioural insights to launch 'What the Bump' campaign targeting pregnant women who smoke in the Swale area. In 2017/18 Swale saw a 10 percent reduction in smoking at time of delivery rates, which equates to around 30 fewer babies born to mothers who smoke.

5.0 Model of Care

5.1 Given the success of the programmes described in 4.1 to 4.11 above, the evidence points now to a three-pronged model of care that:

- Provides for a lead midwife with a special interest in Tobacco Control in each of the three midwifery systems in Kent in order to provide information, support, training and audit of practice for each service maternity services using the evidenced based BabyClear methodology.
- Provides a Home Visit Stop Smoking Advisory model which seeks to support pregnant smokers in their own home on a one to one basis.
- Ensures that relevant campaigns and "What the Bump" are targeted effectively and rolled out to every area in Kent based on needs, prevalence and trends.

5.2 This model will require significant co-operation between NHS CCGs and NHS Children's Commissioners and KCC Public Health to implement given the general principle is that CCGS commission maternity services and Local Authorities commission Specialist Stop Smoking services.

6.0 Conclusion and Next Steps

6.1 This paper sets out recent trends in smoking in pregnancy, the results of local pilots and progress made to reduce the prevalence of smoking during pregnancy.

6.2 The National Tobacco Control Action plan sets the national ambition to reduce prevalence of smoking in pregnancy from 10.6% (national rate) to 6% nationally. This equates in Kent to fewer than 870 women smoking during pregnancy assuming the rate of maternities remains constant.

6.3 Work with partners shows we've now a proven model which now requires implementation through joint commissioning with the NHS universally across Kent.

6.4 KCC's Public Health responsibility is to ensure both a universal Stop Smoking Home Visit Adviser service is implemented in all KCC areas and we continue to deliver social marketing campaigns "What the Bump"

6.5 In the light of reducing Public Health budgets, finding an additional £300,000 presents an ongoing significant issue. However, this must be a priority given the impact smoking has on both the short term and long term health of both baby and mother. Further work needs to be undertaken to identify the resources to meet our statutory obligations to spend within the resources provided, whilst improving the health and reducing health inequalities of our local population.

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

a) **Comment on and Endorse** the contents of the report;

b) **Agree** to the proposal to commission the Home Visiting Stop Smoking Advice service across Kent to support pregnant women who smoke to quit; and

c) **Acknowledge** the beneficial role of the Midwives with a Smoking in Pregnancy lead undertake and promote their continuation with permanent NHS commissioned service.

8.0 Background Documents

8.1 Appendix 5, Health Reform and Public Health Cabinet Committee Paper, Friday 30th June 2017 – What the Bump
https://democracy.kent.gov.uk/documents/s77428/item%2011%20-%20Appendix%205%20What%20the%20Bump.pdf

8.2 Better births
https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

8.3 National Tobacco Control Action Plan
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714365/tobacco-control-delivery-plan-2017-to-2022.pdf

8.4 PHE Health Profiles
https://fingertips.phe.org.uk/profile/health-profiles

9.0 Contact Details

Report Authors:
Andrew Scott-Clark, Director of Public Health
03000 416180
Andrew.Scott-Clark@kent.gov.uk

Debbie Smith, Public Health Specialist
03000 416696
Debbie.Smith@kent.gov.uk

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

22 November 2018

Subject: **Illicit Tobacco in Kent**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: A recent survey conducted by NEMS Market Research reveals a unique profile of illicit tobacco use in Kent. The profile indicates that illicit tobacco sales are predominantly undertaken in local shops and that hand rolled tobacco is more prevalent than cigarettes in the illicit market. The illicit trade undermines the work and resources Public Health and other agencies deliver to reduce smoking prevalence, making cigarettes and tobacco affordable to the adult population and also available to children at "pocket money prices". Illicit Tobacco is often linked to organised crime, targeting criminal activity in the most deprived local communities. Kent Public Health and Kent Trading Standards are working collaboratively as part of a regional initiative to develop a wider strategy across the South East to unify resources and intelligence to tackle illicit tobacco trade at a larger scale.

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

a) **Comment on and Endorse** the contents of this report;

b) **Agree** to the proposal of a partnership approach between Public Health South East and Trading Standards South East to develop a regional plan to reduce the supply and demand of illicit tobacco;

c) **Acknowledge** the issues and concerns that illicit tobacco poses to Kent; and

d) **Seek** a further paper on the progress of a regional approach to tackle illicit tobacco

1. Background.

1.1 In the last year, smoking prevalence among adults in Kent has increased by

1.1% to 16.3[1]% in 2017, but the rate among Routine and Manual workers has increased at a higher rate (3.4%) in the same period to 32.4[2]%. Smoking is an indicator of health inequalities, so this demonstrates that inequalities is increasing in Kent and around 1/3rd of the lower socio-economic population are smokers. Increased pricing of cigarettes has shown to be a significant government lever to trigger smokers to quit. The sale of illicit tobacco undermines the work aimed at reducing smoking prevalence by offering a cheaper option for those who might otherwise see price as reason for stop smoking.

Children in areas with the highest deprivation are most vulnerable as they are targeted by criminals who sell illicit tobacco thereby perpetuating inequity. The Government's Tobacco Control Plan (2017) sets out the ongoing plans to tackle this at a national level to both reduce demand and disrupt supply.

As the illicit tobacco trade becomes more sophisticated in its endeavours to conceal and supply tobacco products, enforcement agencies have obtained evidence that suppliers of illicit tobacco are associated with organised criminal networks that also deal in people trafficking, Class A drugs and child sexual exploitation. It is important therefore that the issue of tackling illicit tobacco needs to be coordinated with other agencies in relation to other crimes.

1.2 **Introduction**

1.3 In 2017 Public Health England South East commissioned market research to understand the illicit tobacco market and to establish the baseline market share. The outcome of the research was presented in early 2018 providing results across the South East and at individual Local Authority level.

The research showed that the greatest prevalence of illicit tobacco smokers was among males aged 16-54 with presence across all demographic groups and areas. Although in most of the South East illicit tobacco was traded behind closed doors, intelligence from Kent shows that local shops are a significant source of illicit tobacco.

Q: Where do you Buy Illicit Cigarettes or Tobacco From?	Average response from SE Total survey	Kent Response
Shop	35.7%	69.8%
Street hawker (approached by seller)	10.3%	9.9%
Car Boot Sale	3%	7.5%
Pub/Club	16.7%	7%
Private Address	18.7%	2.9%
Social Media/internet	3.7%	0%

Source: NEMS Market Research, South East Illicit Tobacco Study 11.02.18

5.1% of those surveyed in Kent said they have bought illicit tobacco and of those

[1] Public Health England, Local Tobacco Profiles, September 2018 *taken from* APS 2017

[2] As Above

62.9% reported buying illicit tobacco at least once a week compared to 29% average across the South East. 22.4% of respondents buy less than a quarter of their cigarettes through illicit means although 50% said that all of the hand rolled tobacco they use is all from illicit means. The survey provides a unique profile for Kent revealing that an estimated 5% of smokers may be purchasing illicit cigarettes and tobacco, (the majority being hand rolled tobacco) with most of it being purchased regularly from shops.

Attitudes to illicit tobacco

Awareness of illicit tobacco was higher among smokers than non-smokers. Illicit tobacco was found to enable smokers to continue the habit when they could not otherwise afford to.

There was a significant number of people that were uncomfortable with illicit tobacco. 88% of the Kent illicit buyers were uncomfortable or very uncomfortable with the issue. Influences that affect concern include:

- Targeting of children in the sale of illicit tobacco increased the likelihood of reporting significantly, across all demographic groups and smoker types.
- The majority (even among smokers) did not want their children to start smoking and the majority thought that illicit tobacco increases the chances of children starting to smoke
- We know that the illicit tobacco trade is specifically targeting children, particularly vulnerable children, in order to sustain a local market.

Reporting
The police were seen to the go-to agency for reporting the sale of illicit tobacco, although in reality trading standards are more appropriate. A telephone hotline was the preferred reporting mechanism and combined, digital forms of reporting were preferred by almost a third of those likely to report. District Authorities were also seen as a potential source. They could potentially have a role in contacting leaseholders of shop premises where illicit tobacco has been found and access local cctv footage that may alert suspicious behaviour.

Tackling Supply
Kent Trading Standards have noted that criminals have become more sophisticated in their methods of concealment as enforcement steps up. Public Health England South East and Trading Standards South East (TSSE) are exploring ways of working to upscale resources to link up different enforcement and surveillance organisations across a larger area and sharing surveillance and intelligence between them. This approach will have a greater impact on the level to which criminal gangs can be infiltrated.

Recommendations to decrease demand, increase reporting:
The overall aim to tackle illicit tobacco is to:

i) Decrease demand – by raising awareness of the issues surrounding illicit tobacco, its targeted approach to children and attracting crime to the locality and reduce the number of smokers in Kent
ii) Increase reporting by developing and promoting a central intelligence

point and making reporting available in a range of ways

iii) Disrupt supply by building on and supporting the resources needed for Trading Standards to undertake seizures of illicit tobacco and to work with other agencies effectively to bring prosecutions.

Public Health England South East, TSSE and the HMRC are starting a co-ordinated approach to deliver a strategy to cover these aims across the South East region. There are economic advantages of delivering an approach at a regional level although resources to deliver this remain a challenge.

1.4 **Conclusion**

The illicit tobacco market in Kent represents an estimated 5.1% of smokers. The illicit market undermines the work and resources Public Health and other agencies deliver to reduce smoking prevalence, providing a cheaper option for those who might otherwise see price as a reason for stop smoking. There are advantages of working to scale across the South East to deliver regional and local initiatives through shared intelligence and resources. Kent Public Health and Kent Trading Standards are working collaboratively as part of a regional initiative to develop a wider strategy across the South East with Public Health England South East, TSSE and HMRC partners to tackle illicit tobacco trade on a greater scale.

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

a) **Comment on and Endorse** the contents of this report;

b) **Agree** to the proposal of a partnership approach between Public Health South East and Trading Standards South East to develop a regional plan to reduce the supply and demand of illicit tobacco;

c) **Acknowledge** the issues and concerns that illicit tobacco poses to Kent; and

d) **Seek** a further paper on the progress of a regional approach to tackle illicit tobacco

Background Documents

None

Contact Details

Report Authors:
Andrew Scott-Clark, Director of Public Health
03000 416180
Andrew.Scott-Clark@kent.gov.uk

Debbie Smith, Public Health Specialist
03000 416696
Debbie.Smith@kent.gov.uk

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: 22 November 2018

Subject: Contract Monitoring Report – The Health Visiting Service

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

This contract monitoring report provides the Committee with an overview of the Health Visiting Service commissioned by Kent County Council (KCC). The service performance is good and with completion of mandated reviews above the national average.

The Health Visiting Service supports over 90,000 families in Kent with children aged under the age of 5. Working in close partnership with KCC services has enabled delivery of key projects including co-location of staff in Ashford and Infant Feeding.

A collaborative approach with the commissioned provider, Kent Community Health NHS Foundation Trust (KCHFT), supports KCC to provide an efficient, effective and responsive service which offers value for money, flexibility and continuous improvement.

Recommendation:
The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on:
- ongoing activities to deliver statutory obligations, meet performance expectations and ensure value for money
- work to support the integrated transformation of the HV service including; implementation and delivery of the new infant feeding model, co-location with Children Centres and revised offer for vulnerable families

1. Introduction

1.1 Kent County Council (KCC) Public Health has a responsibility to deliver improved health and wellbeing and reduce inequalities for Children and Young People living in Kent. To support this, KCC commissions the Kent Health Visiting Service.

1.2 This contract monitoring paper provides details of the purpose, performance, outcomes, value for money and strategic direction of the Health Visiting Service. An update on the new Infant Feeding Service has been incorporated into this paper.

2. How is it delivered in Kent?

2.1 The service is delivered by Kent Community Health Foundation Trust (KCHFT) through an innovative contracting partnership put into place in June 2017. This supports accelerated delivery of the Sustainability and Transformation Partnership (STP),

flexibility to manage budget reductions while meeting statutory obligations and the delivery of continuous improvement.

2.2 The workforce includes Locality Clinical Managers, Team Co-ordinators, Health Visitors, Community Public Health Nurses, Community Nursery Nurses and an administration team allocated to District areas.

3. What does the service provide?

3.1 The Kent Health Visiting Service lead the delivery of the Healthy Child Programme (HCP), as part of an integrated approach working alongside maternity services, primary care and Early Help, to support families with children aged 0-5 years. There are around 17,500 live births in Kent each year[i] and an estimated 91,399 children under 5 in Kent in 2017, forecast to increase by 6,500 (9%ii) by 2023.

3.2 The universal offer includes 71,000 mandated developmental reviews which includes; an antenatal, new birth, 6 to 8-week, 1 year and a 2-2½ year contact. The HCP's universal reach provides an invaluable opportunity to identify families that are in need of additional support and safeguarding concerns. The service is family centred, flexible and focus on 6 early years high impact areas as detailed in Appendix A.

3.3 The service also provides a targeted offer including; Universal Plus, Universal Partnership Plus and a Vulnerable Families offer. The latter will be delivered under the Family Partnership Model across all Districts in 2019 to support greater equity and improve outcomes for a greater number of families. For more information please see appendix B.

3.4 The service has a key role in the protection and safeguarding of children, working with other agencies where there are safeguarding concerns and intervening early with families who are at risk.

3.5 On 1st June 2018 Health Visiting incorporated the delivery of Infant feeding services in Kent. The new model was designed to extend and expand the reach of breastfeeding support by utilising the skilled Health Visiting workforce and to improve links with key partners including Midwifery Services. Further information is provided in Appendix C.

4. Why invest?

4.1 The Health Visiting Service fulfils KCC's statutory obligations to offer five universal mandated developmental reviews which are funded via the Public Health ring fenced grant. It makes a significant contribution to achieving KCC's strategic vision to ensure that children and young people in Kent get the best start in life[iii] . For more information on how the service supports this outcome please see Appendix D.

4.2 There is a wealth of evidence for the return on investment that can be gained from early intervention in children's lives to support better outcomes[iv], and the Health Visiting Programme is one of a number of programmes that supports a preventative approach.

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

---

[i] in 2017 there were 17,467 births in Kent. Source: Births and deaths in Kent -2017, Strategic Business Development & Intelligence, Kent County Council

[ii] Source: Housing led forecast (Oct 2016) Strategic Business Development & Intelligence, Kent County Council

[iii] Increasing Opportunities, Improving Outcomes – Kent County Council's Strategic Statement 2015 - 2020

[iv] Source: National Health Visitor Programme (2017), PHE – Benefits Realisation http://qna.files.parliament.uk/qna-attachments/804278/original/PHE%20Benefits%20Realisation%20Report.pdf

5.1 The Service performance is monitored by the public health commissioning team on an ongoing and quarterly basis, reported nationally to Public Health England, KCC Cabinet and this committee. Key measures of success are as follows;

5.1.1 Provide five mandated development contacts to under 5's

5.1.1.1 Following transfer to KCC, the service has increased antenatal contacts completed and maintained performance at the new birth, 6-8-week, 1 year and 2-2.5-year contacts. Please see Appendix E for more information.

5.1.1.2 As demonstrated in table 1 below, the service has met or exceeded targets for all the mandated contacts, except for the coverage of antenatal contacts for quarter 1 of 2018/19. The activity delivered for this contact does not represent a drop-in performance due to an agreement between KCC and KCHFT to increase the target this year. The service is planning to increase performance this year by improvements made to the antenatal notification process.

Table 1: Delivery of universal contacts for Kent and Nationally in 2017/18 and 2018/19 (Q1)

Metrics	National Data 2017/18	South East Data 2017/18	Kent Target 2017/18	Kent 2017/18	Kent Target 2018/19	Kent 2018/19 Q1
PH04: No. of mandated universal checks delivered by the health visiting service (12 month rolling)	-	-	65,000	**71,495 (g)**	65,000	**71,287 (g)**
PH14: No. and % of mothers receiving an antenatal contact with the health visiting service	-	-	30%	**8,408 48% (g)**	50%	**2,078 48% (a)**
PH15: No. and % of new birth visits delivered by the health visitor service within 30 days of birth	98%	98%	95%	**17,018 97% (g)**	95%	**4,094 98% (g)**
PH16: No. and % of infants due a 6-8 week contact who received one by the health visiting service	84%	86%	80%	**15,856 90% (g)**	**80%**	**3,628 89% (g)**
PH17: No. and % of infants receiving their 1-year review at 15 months by the health visiting service	83%	83%	80%	**15,018 87% (g)**	80%	**3,609 86% (g)**
PH18: No. and % of children who received a 2-2½ year review with the health visiting service	76%	80%	80%	**14,319 83% (g)**	80%	**3,546 80% (g)**

5.1.2 Comparison to other Local Authority areas

5.1.2.1 As detailed in table 1, the Kent Health Visiting Service achieved similar or higher coverage rates than the national average in 2017/18 for the mandated contacts, excluding antenatal, for which comparison is not available.

5.1.2.2 In comparison to the South East in 2017/18, Kent achieved higher coverage on the 6-8-week, 1 year and 2-2.5 year contact and had a similar rate of coverage for the new birth visit.

5.1.3 Improved outcomes for families assessing the service

5.1.3.1 The service is multifaceted, and supports families work towards a number of short and long-term outcomes such as improved parental attachment, child development and health, improved parental lifestyle choice.

5.1.3.2 Outcomes of the service can be measured in a number of ways:

- Illustrated via case studies and feedback as illustrated in Appendix F.
- *Measuring changes to the population outcomes to which the service contributes, for example school readiness, minor injuries and A&E attendance[i].
- *Measuring change in access to other KCC children services.
- Using linked data to track personal outcomes over time (Kent Integrated Dataset).

*(*It is worth noting that a number of the above cannot be directly correlated to the service but be one of a number of contributing factors that support improvement in outcomes.)*

5.1.4 Provide a responsive service that meets user needs

5.1.4.1 The service continues to perform well with regards to patient experience. 99% of the parents who responded to questionnaires said they would recommend the service to friends or family, 98% were satisfied with the service and 99% felt listened to.

5.1.4.2 The service also collects regular feedback from staff and users and invites them to codesign changes to services. For example, KCHFT has recently added a search facility to the Infant feeding website pages in response to user feedback.

5.1.5 Delivery of the new Infant Feeding Model

5.1.5.1 The Infant Feeding Service has transitioned to the Health Visiting service and delivered several achievements:

- The Service has been awarded the UNICEF Baby Friendly Initiative Stage 2 accreditation, demonstrating skills and knowledge to effectively care for mothers and babies with regards to infant feeding.
- A new website was launched to promote services (kentcht.nhs.uk/service/kent-baby).
- Developed local timetables with Children Centres which offer a choice to families including baby hubs, drops ins, peer support groups and support at the home.
- Offer women a timely appointment - The service prioritises based on presenting need and to date those with an urgent need are offered an appointment within 48 hours.
- Held sessions with peer supports across to understand their views and support them.
- Identified staff within the service who will be a Breastfeeding Champion.
- Ensured all relevant staff have received training relating to the identification of tongue-tie using the evidence-based Bristol Tongue Assessment tool. This will support them to refer on to CCG funded Tongue Tie services.
- Appendix G provides three case studies of women using the new Infant Feeding services.
- An evaluation framework has been developed to support learning and measure the impact of the new model. Further information can be shared with this committee in due course.

5.1.5.2 Following the transition in June 2018, KCC received a number of complaints regarding the new Infant Feeding Service. Appendix C details the 4 complaints received in quarters 1 and 2. Improvements have been made in response to the feedback received and work will continue to embed and develop the service within the wider system.

6. Key improvements and service transformation

6.1 To maximise opportunities to integrate services and improve efficiency and outcomes, a transformation programme was developed. This resulted in the delivery of key service improvements (detailed further in appendix H) including:

---

[i] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133228/pat/6/par/E12000008/ati/102/are/E10000016

- Co-location and joint protocols between Children Centre and Health Visiting staff.
- Delivery of new Baby Hubs in Children Centres and co-designed parenting programmes.
- Clearly defined evidence-based pathways to ensure consistent experience.
- Development of a more equitable offer for vulnerable families.

7. How much does it cost?

7.1 The transformation programme described above has achieved £1.8 million of cashable savings and a further £0.7m of cost avoidance which has been delivered through better use of staff time and rationalisation of posts.

7.2 Despite a reduced operating cost, the service's performance has been consistent as presented in table 1 and has delivered a number of improvements within the Health Visiting Service and the wider 0-5 pathway as set out in appendix H.

7.3 The Partnership between KCC and KCHFT has implemented open book accounting and reviewed the service spend, capacity and priorities to identify further savings for 2019/20. The Public Health grant will reduce by £1.8M next financial year and this approach enables KCC to maintain front line services but deliver required savings.

7.4 The current contract value for 2018/19 of £22,344,268[i] will reduce by £200,000 per annum from 2019/20 and has been achieved though:

- A reduction in premise costs due to colocation.
- A decrease in overheads achieved through new systems and shared payroll with KCC.
- Removal of five performance incentive targets to reduce administrative burden.

7.5 The PHE Spend and Outcomes Tool (SPOT) for local authorities[ii] can be used to determine if the contract offers KCC value for money. It highlights that Kent spends slightly less than the national average for the prescribed and not prescribed 0-5 Children's services and that national performance (shown in table 1) demonstrates Kent performance being similar to or above national levels.

8 Risk

8.1 Risks are monitored using a shared risk register with the service. Key risks for the service are detailed in appendix I and include recruitment and retention of staff coupled with increasing demand and a national reduction of funded educational places for the Specialist Community Public Health Nursing programme.

8.2 The service has a number of mitigations to manage these risks. This includes targeted recruitment, robust retention policy, flexible working arrangements and collaboration with Canterbury Christchurch University to train qualified nurses in the Community Public Health Nurse role.

9 Conclusions

9.1 KCC has commissioned a Health Visiting Service since 2015 which supports over 71,000 families in Kent each year. KCC and KCHFT have taken a collaborative approach to monitor performance and ensure that the service offers value for money and continuous improvement.

9.2 Future priorities for the service are:

---

[i] KCC has also committed some other one off funding this year to support co-location and service improvements set out above.

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

- Develop innovative solutions to address risks relating to a reduced Health Visiting workforce.
- Exploration of opportunities to integrate with early help and specialist children services.
- Health Visiting to continue to embed and refine the infant feeding services.
- Pilot and roll out of the revised offer for vulnerable families.

Recommendations

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

- Ongoing activities to deliver statutory obligations, meet performance expectations and ensure value for money.
- The work to support the integrated transformation of the HV service including; the implementation and delivery of the new infant feeding model, co-location and the reshaping of the offer for vulnerable families

Background Documents

Public Health Transformation Programmes -Health Reform and Public Health Cabinet Committee - 30 June 2017
https://democracy.kent.gov.uk/documents/s77418/Item%208%20-%20PH%20Commissioning%20Strategy.pdf

Transition of Infant Feeding Service -Health Reform and Public Health Cabinet Committee - 1 May 2018
https://democracy.kent.gov.uk/documents/s83969/Item%2010%20-%20Infant%20Feeding.pdf

Performance of Public Health commissioned services -Health Reform and Public Health Cabinet Committee - 1 May 2018
https://democracy.kent.gov.uk/documents/s83970/Item%2011%20-%20Public%20Health%20Performance.pdf

The Healthy Child Programme – Pregnancy and the first 5 years of life
www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

Report Authors:
Victoria Tovey, Senior Commissioning Manager
Victoria.tovey@kent.gov.uk

Samantha Bennett, Consultant in Public Health
samantha.bennett2@kent.gov.uk

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

Appendix A – The 6 early years high impact areas:

- Transition to parenthood and the early weeks
- Maternal mental health
- Breastfeeding
- Healthy weight, healthy nutrition and physical activity
- Managing minor illnesses and reducing hospital attendance/admissions
- Health, wellbeing and development of the child aged 2 and supporting families to be 'ready for school'

Appendix B – Further Information on the Health Visiting Service Offer

The Health Visiting Service includes;

Level	Description	Example Services Delivered by Health Visiting
Universal	Working with parents and carers to lead and deliver the full HCP from antenatal care through to school entry.	5 mandated contacts Healthy Child Clinic Baby Hubs
Universal Plus	Delivery of advice and interventions when family have additional needs on a specific issue, including maternal mental health & wellbeing, parenting issues,	Breastfeeding Support Listening visits for perinatal mental health 1:1 session for healthy weight Solihull parenting courses
Universal Partnership Plus	To work with parents and agencies in the provision of intensive multi-agency targeted packages where there are identified complex health needs or safeguarding needs.	Case Conferencing Safeguarding Partnership interventions with families
Family Nurse Partnership	The FNP programme was introduced in 2007 in a number of locations in England. The service offer consists of up to 64 structured home visits to first time teenage mothers, delivered by specially trained Family Nurses, from early pregnancy until the child is two years old. FNP aims to improve pregnancy outcomes, parents' economic self-sufficiency, child health and development. Participation is voluntary, and participants must meet the strict eligibility criteria.	

The table below provides the average number of Universal Plus and Universal Partnership Plus caseloads that the Health Visiting service has per annum (17/18):

Universal Plus Caseload	Universal Partnership plus Caseload
39,192	7,308

Appendix C – The Infant Feeding Service

Overview
In October 2017 KCC developed and consulted on a new model for infant feeding support for families across Kent. This looked to embed and extend the range of breastfeeding support into the universal Health Visiting Service thereby offering support to more families. Following a discussion at Health Reform and Public Health Cabinet Committee in February 2018 and a subsequent Key Decision in March 2018, KCHFT implemented the new infant feeding model in June 2018.

KCHFT have worked closely with key partners to ensure that women are offered the right service in a timely manner and to build on the positive elements of the previous service, which includes the volunteer Peer Supporters. KCHFT continues to work with key partners including Children's Centres, Midwifery and local CCGs to embed the new model within the wider system.

The new approach aims to deliver a number of benefits, including:

- Provide a more 'joined-up' experience for families looking for advice and support on the full range of infant feeding issues
- Increased awareness and promotion of breastfeeding
- Offer an increased number of professional led clinics
- Offer additional access to telephone advice and home visits where identified as needed

Training
To ensure the effective implementation of the new model the service have also carried out the following training to develop the skills and knowledge of the Health Visiting Workforce;

- Health Visitors complete the E-Learning Nutrition Workbook
- Community Nursery Nurses attend Introducing Solid Food Training
- The phased roll out of the tongue tie training using the Bristol Tongue Assessment for Health Visitors
- All clinical staff must complete the 2-day Baby Friendly initiative training. This includes:
  - All new starters will receive training within 6 months of commencing in post
  - A Practical Skill Review 6 weeks post training.
  - On an annual basis Health Visitors and Community Nursery Nurses are offered refresher training and are assessed against a yearly Practical Skill Review

Complaints
Since transition, KCC has received complaints regarding the new service. The table below summarises the complaints received in quarters 1 and 2 following the transition of the service, and the resolution to each theme.

Theme	Number of Complaints	Resolution
Breastfeeding Service Changes	2	Referral process in place for Specialist Breastfeeding Service. Additional training has been delivered to Breastfeeding Champions relating to the management of tongue-tie. This training has meant that Health Visitors are equipped with a greater knowledge base around the identification and management of tongue tie which will make it easier for babies to be appropriately managed
Reduction in peer support groups	1	KCHFT to be proactive in the recruitment and retention of peer support volunteers across all districts primarily those with the greatest need. KCHFT and KCC are committed to continue to work collaboratively to ensure a high-quality service is provided to Kent residents.
Usability of the	1	KCHFT have made various changes to the website in response

Breastfeeding Support Pages on the KCHFT website		to the feedback received and will continue to make ongoing developments to improve the usability of the website.

Infant Feeding Service Challenges

The referral pathways for frenulum division requires two documented feeding assessments to identify a tongue tie. These can be undertaken by the Breastfeeding Champions and Breastfeeding Specialists within the Health Visiting Service. Breastfeeding Champions are equipped to provide this support, undertake feeding assessments and help in the management of tongue tie whilst waiting for referral for frenulum division. The services for division of the frenulum are the responsibility of the CCGs and there are currently delays in some areas of the county between a referral for division and the procedure taking place. With provision being varied across the county. KCC and KCHFT are working with CCG's to see how the pathway for the division of frenulum can be improved.

Future Plans for the Infant Feeding Service

The Health Visiting Service are now supporting Children's Centres to achieve the stage 2 accreditation and both Children's Centres and the Health Visiting Service will work towards achieving stage 3 accreditation by 2020.

The Local Maternity System Kent and Medway are developing a website where Kent wide information and resources regarding infant feeding will be sited. KCC are leading a workstream to develop the infant feeding pages, collating the information from all the relevant local services (Acute trusts, CCGs and KCHFT) to support the consistent provision of information and signposting for families across Kent.

A wider programme of public health initiatives led by the Kent Public Health team to increase initiation and maintenance rates of breastfeeding rates in Kent is being planned. This will include a pilot community engagement project to explore using peer supporters in wider community roles, the relaunch of the breastfeeding welcome scheme and the development of a suite of system wide communications tools about breastfeeding, to include a focus on the first hour after birth and sustaining breastfeeding for the first 6 weeks.

Continue to progress discussions with CCG's the pathway for the division of frenulum.
The service will continue to support women who are peer supporters or have recently completed training. The service is conducting a review using insights with peer supporters and breastfeeding mothers to identify how peer supporters can be support mothers to breastfeed and the development of the new peer support training programme. This will be offered to women who would like to volunteer as a peer supporter in 2019.

Appendix D – The Health Visiting Services' contribution to Public Health outcomes
Health visiting has the opportunity to have regular contact with families, including within the home environment early on in the child's life and this can be invaluable in support of the development and wellbeing of the whole family.

There are a number of challenging public health issues in the early years which Health Visiting can support families to address:

- Smoking at Delivery - The percentage of women recorded as smoking at delivery in Kent continues to remain higher than the England average. In 2017/18 the percentage in Kent was 14% compared to the England average of 11% which is slowly decreasing year by year[i].
- Healthy Weight – In 2017/18 8% of Kent's reception year children were obese, this is lower than the national average and similar to the South East average.
- Breastfeeding – Breastfeeding rates in Kent remain low with 49% of women partially or fully breastfeeding at 6-8 weeks which is similar to the national average at 44%[ii].
- Health Inequalities – The children of Kent experience significant health inequalities that will have lifelong impact. Deprived children in Kent are more likely to be obese, have a parent who smoked during pregnancy, be less likely to be breastfed and less likely to take up the offer of childhood immunisations. Data suggests that the health inequalities gap across Kent and England is increasing[iii].

Health visitors play a crucial role in reducing health inequalities and ensuring that children have the best possible start in life through delivery of the HCP. The effective delivery of the HCP leads to;

- strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children;
- care that helps to keep children healthy and safe;
- healthy eating and increased activity, leading to a reduction in obesity;
- increased rates of initiation and continuation of breastfeeding;
- positive oral health
- readiness for school and improved learning;
- early recognition of growth disorders and risk factors for obesity;
- early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety;
- identification of factors that could influence health and wellbeing in families; and
- better short- and long-term outcomes for children who are at risk of social exclusion.

---

[i] Source: PHE Fingertips NHS Digital

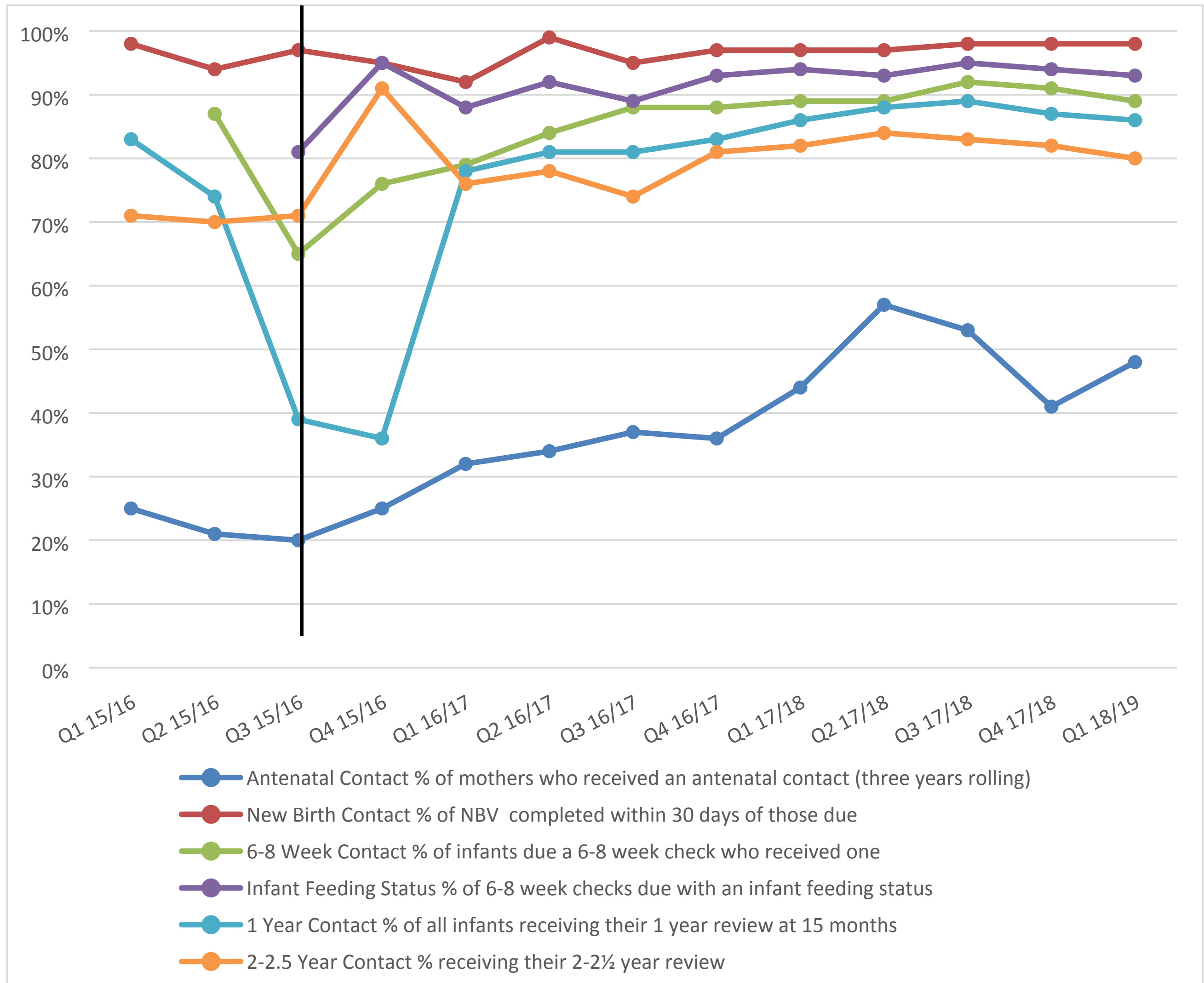
[ii] Coverage above 85% however quarter did not meet 95% for robustness expected for national reporting

[iii] Source: Kent Public Health Observatory Mind-the-Gap-Analytical-Report

Appendix E – Performance of the Health Visiting Service

Graph 1 below illustrates the performance of the service from quarter 1 2015/16 which fluctuates to reflect seasonal trends.

Graph 1 – Performance of the Health Visiting Service Quarter 1 2015/16 – 2018/19



*The vertical black line on the graph indicated the transfer of commissioning responsibility from NHS England to KCC.

Appendix F – Service Case studies on improving outcomes

Case studies – The Healthy Weight Discussion Tool, Canterbury

Case study 1

A mother of a 14-month-old child attended the Health Visiting Clinic for discussion about behaviour issues. He was noted to be overweight, the Healthy Weight Discussion Tool was initiated, and the mother decided on changes she felt she could make. She was invited to return to clinic for a review. On the return visit to the clinic her son had dropped his weight centile, from being considerably above the 98th to being on the centile. The mother was thrilled and explained that she had previously felt powerless to change her children's weight status, all 3 of whom were severely overweight. Since the contact 3 months ago, the family have changed their snacks to healthy ones, reduced portion sizes and all have bikes. The mother has also enlisted her obese 11-year-old onto a dance class to improve her weight. The mother asked if she could return to clinic in 3 months for another 'weigh-in' for her son.

Case study 2

During the delivery of a developmental review a Community Nursery Nurse (CNN) initiated the Healthy Weight Discussion Tool with a mother of an overweight 2 year old child. The mother was also overweight. Following this review the CNN has reviewed the child, in which the mother advised how helpful she has found the visit from the CNN as she felt that she did not know where to start in changing both her and her daughter's lifestyle. The CNN referred the mother to the dietitian and has another contact booked with the family.

Case study 3

The Health Visiting team in Canterbury have also been working with key partners with regards to supporting families to achieve and maintain a healthy weight. For example, a member of the Health Visiting Team visited a local nursery to discuss their mealtimes and portion-sizes and have shared useful interventions. The service have also provided training to local Children's Centre staff on Introducing Solid Foods, including a discussion on responsive feeding and cues.

Appendix G- Infant Feeding Service Case Studies published in Community Health Magazine, Autumn 2018.

Case Study 1

Health visitors offer a service to everyone regardless of need, but when someone needs extra support they are always there to turn to and that's what mum M and her husband G experienced.

"We'd been trying and trying for a baby," explains 45-year-old M, from Sevenoaks. "I thought at the age of 36 and being reasonably fit and healthy it would be easy to get pregnant. After a few years, we began to try IVF treatment. I also had a number of miscarriages – but when I got pregnant with J I just knew this time it was going to be fine. And it was."

A gave birth to baby J in May 2017 at Pembury Hospital, where she described the care as fantastic. However, when J was just a few-days-old, M found herself worrying about his development. "I was trying to breastfeed him, but I honestly didn't have a clue what I was doing. I had no idea if he was latched on properly or getting enough milk. He just seemed to fall asleep all the time when I was feeding him."

M visited a breastfeeding drop-in session at her local children's centre in Sevenoaks. "The volunteer peer supporters were incredible. They were kind, patient and gave me all the reassurance I needed to carry on breastfeeding.

"There's so much conflicting advice on the internet, it's so hard to know what to believe. Just being able to talk things through with a real person was amazing. I'm sure I would have given up without their support, but thanks to them and with more advice from the health visitor I was reassured that I was doing the right thing." Like most first-time parents, M and G also struggled with getting enough sleep, which can have a huge impact on emotional health. "When J was around four or five months I went along to a healthy child clinic and saw a lovely health visitor. I was so tired and feeling overwhelmed by everything. J wouldn't nap during the day unless he was in his buggy and I was exhausted. I was only there to get him weighed but I burst into tears.

"The health visitor couldn't have been kinder. She reassured me that I was doing well and boosted my confidence. She gave me some practical advice and I felt better about everything straight away." Returning to her full-time job, as an HR director for a London construction company, also presented a challenge to M: "J was exclusively breastfed and had never taken a bottle, not even expressed breastmilk. I had no idea how the nursery was going to manage. "So, I called the health visiting duty helpline for advice.

Claire answered, and she could not have been kinder or more supportive. Again, she gave me reassurance and practical strategies to help J and me to adjust. I called again when I needed help with weaning him off the breast at bedtime and once more they were fantastic; kind, reassuring, and non-judgmental. "All the tips I got paid off and J now eats well, sleeps well and is a lovely calm baby. The health visitors deliver common sense advice with compassion, and their help is available right on your doorstep. We're privileged to have these wonderful professionals as part of our community."

Case Study 2

K, 30, from Gravesend, has five daughters and by the time little A, 10 months, came along, she thought she would have all the answers.

She said “A had tongue tie and acid reflux, which my health visitor Becky quickly spotted and then made a referral. We’ve had a lot of challenges as a family and Becky has really helped us. She supported me when I left an abusive relationship, liaised with social services and my GP and put me on the right path. All the health visitors have helped us so much.
“I have been on a freedom programme and in a recovery group for survivors of domestic abuse and now I’m learning how to support and empower other mums through the EPEC programme. We used to stay indoors all the time; I felt like a nobody.”

“But we’re like a new family now as we’ve all been helped through difficult times with support from the health visitors. My older daughters used to be quiet and withdrawn. Now they are confident and chatty, a bit too chatty sometimes!’’

Case Study 3

V is just one of 150 women who provide an invaluable service to new mums across Kent.

Mum-of-two, V is a breastfeeding peer supporter – a trained volunteer providing help and advice to families, which are struggling with breastfeeding. “I became involved after having my son W, who’s now six,” explained V, 34. “I really wanted to breastfeed him and my plan was to do that, but unfortunately I had gestational diabetes and William had low blood sugar when he was born.

“The first priority of the health professionals looking after us was to get his blood sugar to the right level and I wasn’t given any support or help to breastfeed. I couldn’t get him to latch properly either, so we ended up giving him formula milk.

“When he was about one, I saw they were offering training to people to be a breastfeeding peer supporter. As I had my own experience with wanting to breastfeed and not being able to, I thought I would like to help others in the same situation. There just wasn’t any help for me so I wanted to make sure others received the help they needed.”

Peer supporters are trained to give breastfeeding mums support and encouragement. They also help by giving information to parents to help solve common breastfeeding problems, such as correct positioning. They receive training in listening skills and dispelling breastfeeding myths.

V thinks breastfeeding peer supporters are essential to the community: “There aren’t enough specialist professionals to see everyone who has a problem with breastfeeding, but we are able to help with the really common issues that people experience and then the specialists can deal with the more complex cases. For instance, if they come in to the clinic and say; ‘my baby is feeding all the time’, we can let them know that it’s perfectly normal for babies to go through a stage of feeding a lot and they are doing well. So, we can triage, listen to the mums and help where we can.”

When daughter S came along three years after her brother, V felt much more prepared: “I knew what I was doing, what to expect and where to get help. I immediately knew from the first feed that something wasn’t right. I saw a specialist when she was four-days-old who diagnosed a severe tongue-tie and it was snipped two days later. It wasn’t plain sailing, by any means, but I persevered and I still do night feeds three years later. A lot of the time it’s reassurance and encouragement mums really need. Sometimes it can be a really easy fix, I remember one mum who was really struggling, finding breastfeeding painful and was ready to give up. All it needed was just a tiny positioning tweak and it was all sorted – it was a real eureka moment.’’

Appendix H – Service improvements

Table 2: Summary of key improvements within the service

Improvement	Outcome
Integration and joint working between Children's Centre and Health Visiting	The Health Visiting service has developed a more systematic approach to partnership working with Children's Centres. Key workstreams collaborative work has included. • Co-location of services[i] • Protocols for information sharing and partnership agreement for integrated working • Local meetings between team leaders to support integrated working. Case studies demonstrating integrated working are included in Appendix J.
Delivery of Clinics in Children's Centres and development of Baby Hubs. They are designed to improve the support offered to families with services working together, fostering better professional networks and developing joined up pathways	Baby Hubs are now being delivered in every district in Kent and were developed in response to user feedback. A Baby Hub provides families with children under the age of one the opportunity to have contact with the Health Visiting Team on a drop in or bookable basis. They are based in Children's Centres to support the integrated offer for 0-5s. The service anticipates that Baby Hubs will deliver the following benefits: • Support early identification of families needing an enhanced level of support • Integrate access to universal services for under ones in one place • Take a targeted approach to meet the identified needs of the community • Give parents easy access to other services as appropriate e.g. English as a Second Language (ESOL), Speech and Language, baby and toddler groups due to co-location of services. • Provide additional opportunity for under ones to receive infant feeding support
Clearly defined pathways for priority areas supporting improved understanding and a consistent approach	KCC and KCHFT have develop clear evidence based pathways for priority areas. This includes: Breast feeding and nutrition, healthy weight, domestic abuse, adult alcohol and drug misuse, smoking, managing minor illness and reducing accidents and perinatal mental health. These will support a consistent approach to improve outcomes. The pathways will be audited to assess their implementation.
Early Help and KCHFT co-designed a new schedule of parent education programmes	Early Help and KCHFT co-designed a new schedule of parent education programmes. There are being implemented via a phased roll out across the county. The schedule includes antenatal programme entitled 'you and your baby', and post-natal programmes focussed on the 3-4 month and 3-4-year-old age groups. The sessions include preventing minor Illness and reducing accident, introducing solid foods, behaviour and the Solihull parenting

[i] The transformation programme identified opportunities to improve integration between Children's Centres and Health Visiting through co-location of the services. To explore this, the programme initiated the Ashford co-location project. Ashford was been identified by premise leads as the most appropriate area to initially test colocation principles and practicalities. Co-location is taking place November 2018. The benefits of this approach will be evaluated to identify the impact on colocation of services on joint working and service user outcomes.

	programme. The programmes are co-delivered between Early Help and the Health Visiting Service where possible and they are being evaluated to inform future delivery.
Co- design and review of the offer for vulnerable families	KCC and KCHFT have agreed that the Family Nurse Partnership (FNP) programme is not sustainable in its current form and therefore will move to a wider service offer for vulnerable families, including first time young parents. This will mean that a greater number of families with diverse needs can access different levels of support including an intensive offer from the Health Visiting Service. Many areas including Medway have already moved away from the FNP model and a multi-agency working group is supporting the design and effective transition to the new enhanced model. See Appendix K for further details.

Appendix I – Risk

Table 3: Summary of key risks to the service.

Risk	Mitigating Actions
Recruitment – It can be a challenge to recruit staff with the required skills to ensure full staffing levels across the country. Nationally there has been a reduction in the number of funded education places for the Specialist Community Public Health Nursing (Health Visiting) Programme.	• Health visiting resources are allocated based on the populations need. They are reviewed regularly to ensure equity of provision based on changing demographics and deprivation weightings. • KCC and KCHFT are working on the development of the workforce strategy. • A new collaboration between KCHFT and Canterbury Christ Church University has resulted in a fully accredited course to train qualified nurses in the Community Public Health Nurse Role. This commenced in September 2018 and will increase the skill mix of the workforce to help mitigate against the shortage of qualified Health Visitors. • KCHFT have a robust staff retention policy which offers a number of benefits to staff. In addition, they proactively advertise and offer relocation fees and including, flexible retirement.
Delivery of transformation projects	Vulnerable Families: • KCHFT and KCC are working with the Family Nurse Partnership National Unit, to ensure that the transition to the new services is safe and communicated to families. • The new vulnerable families offer uses the evidence based Family Partnership Model of delivery. • The new model will include a broader eligibility criterion and therefore support families with a range of vulnerability characteristics. • KCC and KCHFT are working with key partners including Midwifery, Early Help, and Specialist Children's Services to inform and develop the new vulnerable families pathway and ensure that this is effective and supports multiagency working. Co-location: • The services have been working together to agree new ways of working and joint operational processes to ensure the teams can work effectively together and integrate where possible. • The project evaluation will inform the financial and non-financial benefits of the project.
Out of County Housing stock in Kent - The service could receive an influx in the number of families with children aged 0-5 due to the out of county housing scheme, which will not necessarily be pre-empted	• KCHFT continue to monitor the demand of the service, allocate resource as required and identify solutions to recruit new staff into the service. • Introduction of Vulnerable Families offer Kent wide to provide additional support to families that may be high risk

Appendix J – Service Case studies on multiagency working
Background

M is a 23 year old single mother of G born in July 2015. M has a history of ADHD and learning difficulties. Initially she lived with maternal grandmother and great grandmother. Concerns were identified following M accessing healthy child clinic with dietary concerns regarding G in March 2017. Other concerns included maternal grandmother providing the majority of care of G and M not engaging with her child, M not keeping health appointments for herself and her child.

Later M commenced a relationship with an older man. Further concerns were raised regarding whether this relationship was controlling due to M working long hours in a take away shop for her partner and it is unclear whether there was any payment. Concerns were raised regarding new environment for G not being safe or stimulating and M unable to meet her needs.

Health Visiting- Obtained consent from M to refer to children centre for support and for sharing of information between children centre and health visiting. HV supported with dietary, behavioural advice and toileting through packages of care. HV completed developmental review for G. Referrals were made by HV to dietician and to social services. GP informed of referrals. HV supported family to access healthy start vitamins. Health visitor supported family with attendance for health related appointments. Health visitor contributed to Child in Need Plan until family closed to social services.

Children centre- supported family with free for two funding and finding suitable nursery provision, accessing parenting courses and cooking courses run at Children Centre. Community worker supported family with attending appointments and contributed to Child in Need plan until family closed to social services

Social Services- supported family with DNA confirmation of father of G. Father engaged well with social services and has regular contact with G along with the paternal grandmother. Agreement reached within family and appropriate court order obtained for G to live with maternal grandmother and M to have regular contact. Adult safeguarding of M also explored in respect of her relationship and being a vulnerable adult. Case closed to social services

Appendix K – The New Vulnerable Families Model

KCC and KCHFT are currently reshaping the offer provided for families identified as vulnerable to provide a more equitable, flexible and personalised offer.

The reshaped offer will be personalised to support families with a range of vulnerabilities, across Kent. The new model is expected to achieve the following benefits:

- Enhanced confidence and competence for practitioners within the health visiting service to support vulnerable families across Kent
- Increased number of vulnerable families being supported intensively with improved equity of access
- Increased good parent-infant attachment
- Improve child health & development, including speech, language and communication.
- Increased numbers of parents engaging appropriately with other services that are available to support them and their children.
- Improved parenting skills and self-efficacy
- Improved partnership working between health visiting, early help and SCS on an individual family basis.
- Reduce the need for specialist intervention
- Reducing the impact of adverse childhood experiences (ACE)
- Improvement in reported public health outcomes for children and families in Kent.

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: 22 November 2018

Subject: **Impact of Gambling on Public Mental Health**

Classification: Unrestricted

Previous Pathway: N/A

Future Pathway: N/A

Electoral Division: All

Summary:

This paper briefs cabinet members on the links between gambling and public mental health and other harms. The paper summarises the Gambling Commission's position on why gambling-related harm should be considered as a public health issue and makes recommendations for how this agenda could be advanced at a local level.

The supply of gambling outlets is the responsibility of the licencing authorities. The Gambling Commission is a national body that is set up to support the Department of Culture, Media and Sport to ensure UK gambling is legal, is fair and does not exploit the vulnerable.

The Gambling Commission has briefed local councils on taking a public health approach to gambling and set out key recommendations to council public health teams. These are summarised in this briefing. A plan of action is identified as a result of the national briefing which includes:

- Strategically working with Borough Council's licencing plans to challenge threats to vulnerable people
- Raise awareness by understanding gambling vulnerability via available data sources and front-line workers
- Raise awareness with communities by clear pathway to services and support.

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

a) **NOTE** the briefing on problem gambling and the issues involved in tackling these in Kent; and
b) **COMMENT** on and **ENDORSE** the contents of the report and make suggestions to strengthen future delivery.

1. Introduction

1.1 Gambling-related harms are often not recognised. The legislative framework for gambling recognises it as a legitimate leisure activity that many people enjoy. It generates income, employment and tax revenue. However, it also contributes to harm in the more vulnerable, e.g. working days lost through disordered gambling, the cost of treatment for ill-health caused by stress related to gambling debt, poor family relationships, stress on psychological development of children. The negative impacts are hard to assess and measure and currently Kent County Council does not collect data of harm in this way.

1.2 The national briefing to Local Authorities in 2018 from the Independent Gambling Commission says that a public health response should begin with effects on young and vulnerable people, aiming to reach them before they have gambled.

1.3 They urge for a strategy that not only focuses on individual risks to problem gambling but that tackles supply of products, environments and marketing and the wider context in which gambling occurs.

1.4 National research shows those who are likely to be more vulnerable to gambling harm. Amongst the groups where the evidence base for vulnerability is strongest are the following:

- Ethnic groups
- Youth
- Learning Disabilities
- Substance Abuse/Misuse
- Poor Mental Health

2.0 The Scale of the Problem

2.1 There are approximately 373,000 problem gamblers in England. To give a sense of the scale of the problem there are approximately 293,000 crack and opium addicts in England. However, there is no evidence that gambling alone leads to debt, mental illness, relationship breakdown and criminality –it is believed these issues are interrelated and are more prevalent in young males.

2.2 **Significant public health risks but as yet little known**
There are national experts who are developing a standard public health response to gambling. Leeds City Council found the following:

"With a few exceptions, and unlike other areas of advice and guidance in Leeds, these services (generic advisory services such as Citizens Advice Leeds, voluntary and charitable agencies, specialist addictions and recovery services) are not well joined up for problem and at-risk gamblers. Potential cross-referral pathways are patchy and informal and held back by a lack of understanding about who does what and may suffer capacity constraints. In both the generic and specialist addiction services, there is an almost total lack of any assessment or screening for gambling related harm and this misses opportunity for early (or any) diagnosis of specialist."

2.3 Mental health harms

- **Financial harms**: overdue utility bills; borrowing from family, friends and loan sharks; debts; pawning or selling possessions; eviction or repossession; defaults; committing illegal acts like fraud, theft, embezzlement to finance gambling; bankruptcy; etc
- **Family harms**: preoccupied with gambling so normal family life becomes difficult; increased arguments over money and debts; emotional and physical abuse, neglect and violence towards spouse/partner and/or children; relationship problems and separation/divorce
- **Health harms**: low self-esteem; stress-related disorders; anxious, worried or mood swings; poor sleep and appetite; substance misuse; depression, suicidal ideas and attempts; etc
- **School/college/work harms**: poor school, college or work performance

2.4 Co-morbidity with other addictions and conditions

In most cases, problem gambling can be co-morbid with other conditions such as mental health problems or substance misuse. It is often not recognised and/or undiagnosed. Data from the 2012 Health Survey for England on problem gambling as a co-morbidity shows that:

- For male gamblers, alcohol consumption is heavier in those classified as problem or at-risk gamblers with 17% drinking over 35 units versus 11% of male non-problem or non-at-risk gamblers.
- Problem gamblers are more likely to be smokers (33% versus 20% for non-problem or non-gamblers) and they are also more likely to be heavy smokers (11% for problem gamblers versus 4% for non-problem or non-gamblers).
- For self-reported anxiety and/or depression; 47% of problem gamblers said they are moderately or severely anxious or depressed versus 20% of non-problem or non-gamblers.
- For diagnosed disorders 11% of problem gamblers have a diagnosed mental health disorder versus 5% of non-problem or non-gamblers

2.5 Poor data and little known

Data is simply not collected in a way that is accurate enough to assess the issue in Kent. National studies will yield better recommendations later in 2019. It is safe to say this is not an area that is prioritised by current service delivery. However, it is important to note that the services that are available are 'person centred' and will tackle the range of issues with an individual when they come to light in one to one or group working but gambling is currently unlikely to be the primary focus of these services commissioned outcomes.

- One You services
- Kent Substance Misuse Services
- Kent and Medway partnership Trust – Mental Health Services
- Live Well Kent services
- Kent Social Services and Troubled Families/Early Help
- Treatment for young people with gambling problems needs separate consideration to adult treatment. In most cases it is likely to require lower-threshold intervention and to address other, co-occurring problematic

behaviours

3.0 What Treatment is Available for Problem Gamblers?

3.1 The majority of treatment for those affected by gambling-related harm in Britain is funded via GambleAware and currently consists of three main services offering psychosocial interventions ranging from brief information and advice, through counselling and Cognitive Behavioural Therapy (CBT), psychiatric care and residential treatment.

3.2 The largest of the funded providers is GamCare, which operates the National Gambling Helpline and a partner network of 15 treatment organisations across Great Britain providing counselling. The Gordon Moody Association offers 12 week residential care at centres in Dudley, West Midlands, and Beckenham, Kent. The National Problem Gambling Clinic, based within the Addictions Service at Central North West London NHS Trust, offers CBT and psychiatric care and is also largely funded by GambleAware. There is no other dedicated NHS provision.

3.3 The briefing from the Independent Commission states that GambleAware spent around £4.8 million on treatment services in 2016-17 and the services it funds saw around 8,800 clients across Britain. Waiting lists at GambleAware funded treatment agencies are relatively short. However only a very small proportion of adults who would be classified as problem gamblers access such treatment.

3.4 Not everyone wants or needs structured treatment. Some may be attempting self-help, for example through attending meetings of Gamblers Anonymous. Others will be receiving some form of intervention through the NHS or Councils, more usually directed at co-morbidities associated with problem gambling rather than at problem gambling itself. It is likely, however, that a significant number of those who would benefit from treatment are not receiving it. A screening tool is being piloted by GamCare and will be available in 2019.

4.0 Recommendations from the Independent Commission to Local Authority Public Health Teams

4.1

- That local public health teams recognise gambling-related harm as a public health issue and consider it as a key issue when assessing risk to the wellbeing of their communities
- Whilst public health is not listed as a responsible authority under the Gambling Act, we consider that they can have an important strategic role in informing the way that licensing authorities carry out their gambling responsibilities.
- LAs are required to publish a Statement of Principles as a part of their duties under the Act. The next Statement is required to be published in January 2019. The current Guidance to Licensing Authorities (Sept 2015) encourages LAs to develop a local area profile – currently Kent Council works with Borough Councils – who are the licencing authority.
- Inspection and enforcement are important alongside good data and intelligence to protect vulnerable people.
- Train front line professionals. Those working in agencies where problem

or at risk gamblers may present themselves, such as debt advice centres and CABs, should be trained to identify the signs of gambling issues. (For example, Newport, South Wales CAB delivers training to their staff along these lines and Sheffield Safeguarding Board deliver training to gambling staff and others on the protection of young people.

- Ensure KCC services are aware of GamCare services and are able to refer.
- Ensure safeguarding boards are equipped to understand and tackle gambling related issues and vulnerabilities for young people and families.
- Addiction and mental health services can screen for other addictions such as gambling at assessment.

5.0 Recommendation

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

a) **NOTE** the briefing on problem gambling and the issues involved in tackling these in Kent; and

b) **COMMENT** on and **ENDORSE** the contents of the report and make suggestions to strengthen future delivery.

6.0 Background Documents

6.1 https://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2017/reports/The-nature-of-gambling-related-harms-for-adults-at-risk-a-review.pdf

7.0 Contact Details

Report Author:

- 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

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

22 November 2018

Subject: **Tuberculosis and Hepatitis C in Kent**

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 Tuberculosis and Hepatitis C in Kent and details the partnership working to address these infections in the Kent population.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the current information on Tuberculosis and Hepatitis C and **ENDORSE** the partnership approach taken by KCC Public Health.

1. Introduction

1.1 Tuberculosis (TB), also known as consumption and 'white plague', is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body and if not treated properly, TB disease can be fatal.

1.2 TB is an ancient disease which has caused great epidemics and there is evidence of TB in the tombs of Ancient Egypt and Peru. It has been reported that TB may have killed more people than any other microbial pathogen in history.

1.3 TB spreads between people through the air. People with active TB disease can distribute the bacteria when they cough, speaks, or sing. If people nearby breathe in these bacteria, they can become infected. TB disease in the throat or lungs can be infectious, but TB in other parts of the body is not usually infectious. People with TB disease are most likely to spread it to people they spend time with every day. This includes family members, friends, and co-workers or schoolmates.

1.4 Not everyone infected with TB bacteria becomes sick. Latent TB infection occurs when someone is infected, but their body can fight the infection. They will have no symptoms and will not be infectious but could develop the disease later if they do not receive treatment, especially if they have or develop a weakened immune system. Overall, about 5 to 10% of infected persons who do not receive treatment for latent TB infection will develop TB disease at some time in their lives.

1.5 Persons at high risk for developing TB disease fall into two categories: Those that have recently been infected with TB and those with medical conditions that weaken the immune system such as HIV, diabetes or cancer treatments. Others at higher risk include people who are homeless or inject drugs and people who work or reside with people at higher risk such as in homeless shelters and prisons.

1.6 An increase in TB in the late 1980s was associated with a change in the epidemiology from a pattern of disease affecting the whole community to affecting specific high-risk groups. Rates of TB are higher in some non-UK born communities, mainly by virtue of their connection to parts of the world where TB is highly prevalent. In 2015, almost three-quarters of UK patients diagnosed with TB were born abroad and cases largely concentrated in urban areas.

2.0 Immunisation of TB (BCG)

2.1 TB immunisation with the Bacillus Calmette-Guérin (BCG) vaccine was introduced for children of school-leaving age (14yrs) 1953. A selective neonatal BCG programme to protect infants born in the UK to parents from high-prevalence countries was also introduced.

2.2 In 2005 it was decided that due to changes in the epidemiology of TB, the adolescent BCG programme should discontinue and be replaced by a risk-based programme that includes a targeted neonatal programme. Details of this programme can be found in Appendix 1.

2.3 In 2015 there were issues with vaccine supply which interrupted the neonatal BCG programme. An alternative vaccine was made available in 2016 and efforts have been made to catch up and ensure that those that missed their immunisations have received them. The vaccine supply issue has now been resolved.

3.0 Tuberculosis Policy

3.1 The rising TB in the 1990s and 2000s led to a comprehensive approach to TB control in England and in January 2015, Public Health England and NHS England jointly launched the ‘Collaborative Tuberculosis Strategy for England 2015-2020’. This strategy aims to achieve a year-on-year decrease in TB incidence, a reduction in health inequalities, and ultimately the elimination of TB as a public health problem in England.

3.2 The NHS is responsible for treating TB. PHE is responsible for the surveillance of TB and Multi-Drug Resistant TB (MDR-TB) and public health actions arising

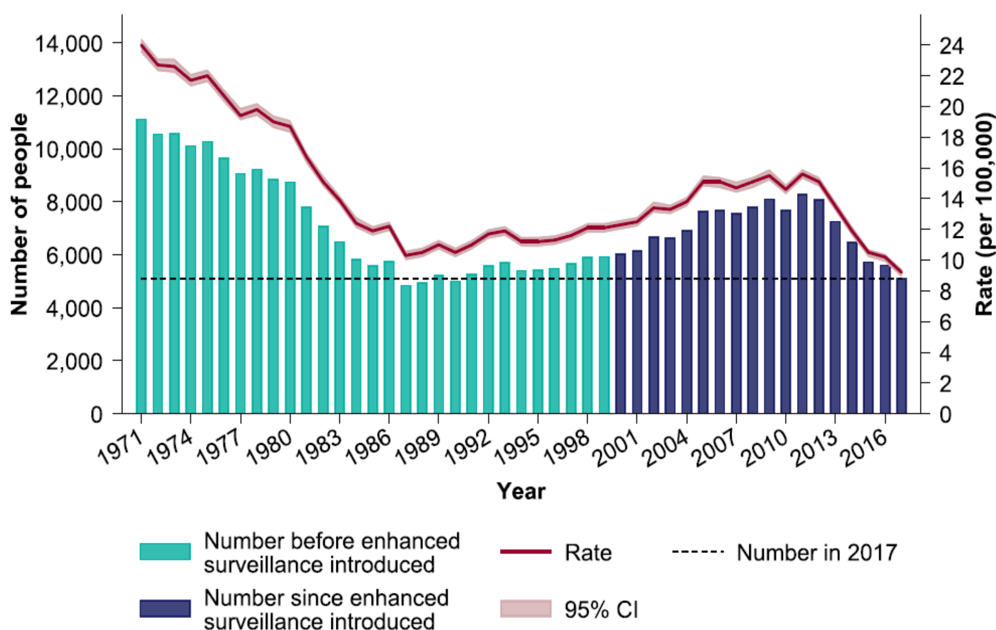
from a case of TB. PHE also works with the NHS to deliver immunisations (BCG) to the population according to national policy.

3.3 Public Health has the statutory responsibility to protect and improve the public's health. This duty is discharged through the local Health Protection Committee which is chaired by KCC (Allison Duggal) and attended by partners from the health protection system including the NHS and PHE.

4.0 National TB Data

4.1 TB is a notifiable disease and over most of the last century notifications of TB declined in the UK (from 117,139 new TB cases in 1913 in England and Wales to a low of 5,086 cases in 1987). In the late 1980s this trend reversed with TB activity rising by 65% with a peak of 8,411 newly reported TB cases in 2011. This increase was associated with a change in the pattern of disease from one affecting the whole community to affecting specific high-risk groups. Between 2001 and 2014 there were still between 387 and 518 TB deaths each year in the UK (data from Public Health England).

4.2 Since 2011 activity has declined, with 5,102 new cases reported in 2017 in England and Wales. In the UK, there has been a year-on-year decline in the number and incidence of TB cases between 2011 and 2017, down to an incidence of <10 per 100,000. This is a 38% decline in TB notifications since 2011 and qualifies the UK as a low incidence country.
Please see Figure 1 below.



4.3 Although levels of drug-resistant and multidrug-resistant (MDR) TB remain low in the UK, the proportion of MDR/rifampicin resistant (RR)-TB increased slightly between 2000 (1.3%) and 2011 (1.8%) but has since decreased to 1.5% in 2015 (Public Health England 2016).

5.0 Local TB Data

5.1 The TB incidence for Kent is significantly better than the England average (Figure 2), but the rates of TB are high in the South East and London (Figure 3).

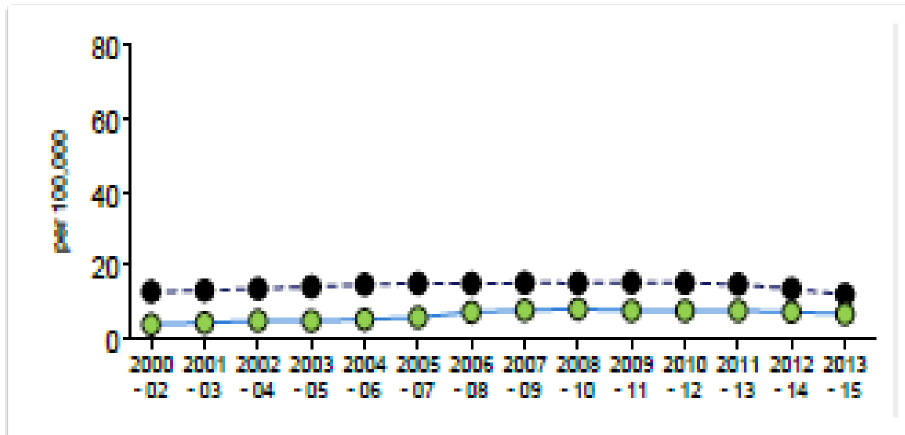


Figure 2: TB Incidence (3 -year average) for Kent 2000-2002 to 2013-2015

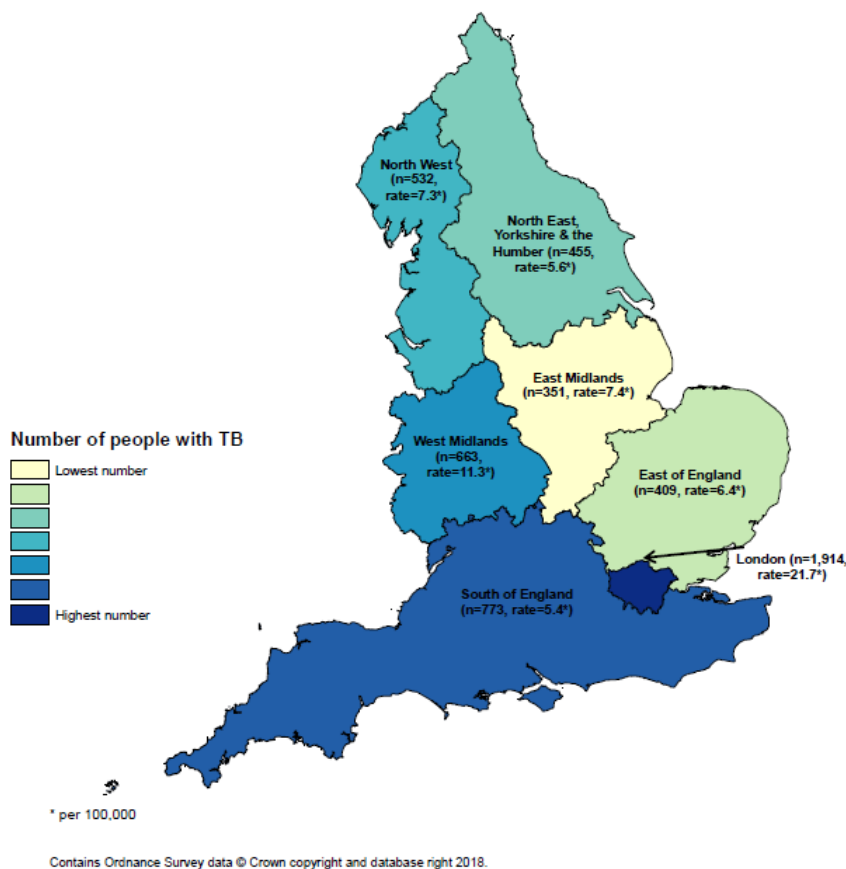


Figure 3. TB notifications and rates by TB Control Board, England 2017

5.2 In 2016, there were 94 cases of TB in Kent residents which is a rate of 6.1 per 100,000. Most of Kent has very low rates of TB, but one or two areas have higher rates. Please see figure 4.

5.3 The median age of TB cases in Kent was 37 years, with the greatest number of cases in the 30-39-year age group and the most common countries of birth for those notified in 2016 were the UK and India. See Figures 5 and 6.

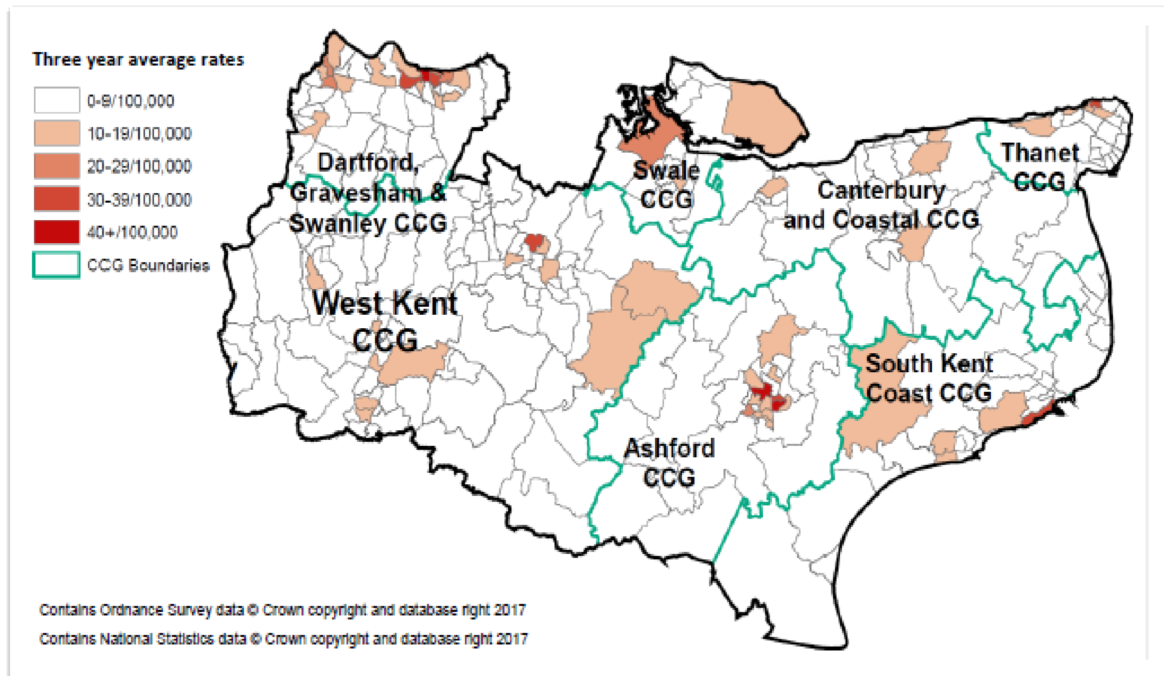


Figure 4. Three-year case numbers and average TB incidence rate by ward, 2014-2016

Country of Birth	TB Patients	
	Number	%
United Kingdom	26	28.6
India	19	20.9
Nepal	7	5.5
Lithuania	5	5.5

Figure 5. TB cases by most common country of birth, Kent 2016

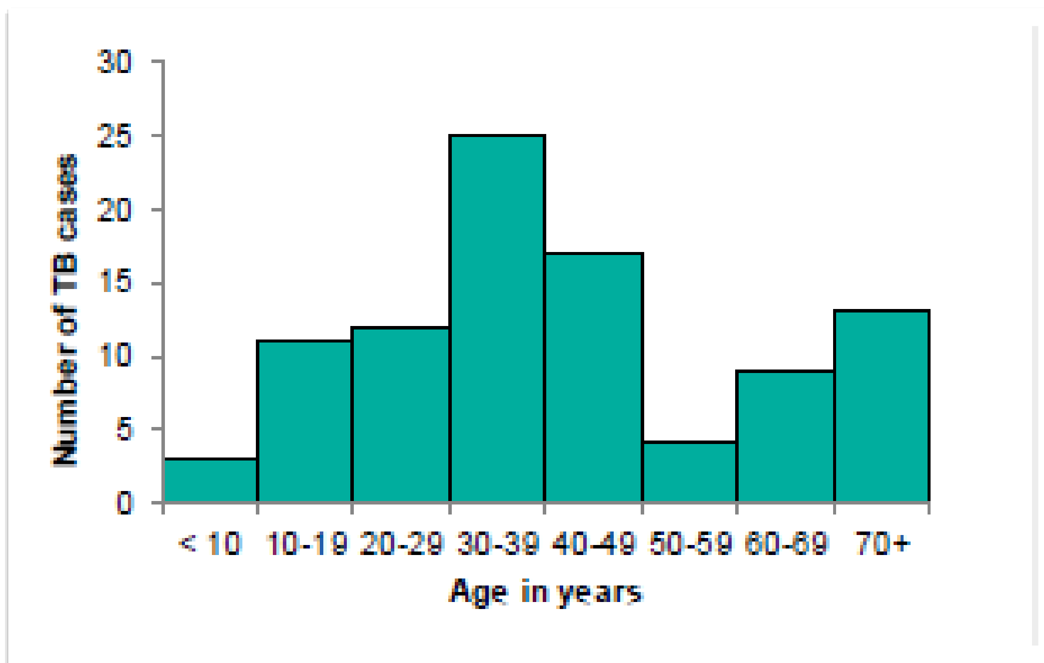


Figure 6. TB Notifications by age group, 2016.

6.0 Current Issues in TB Treatment and Prevention

6.1 There are issues regarding the appropriate discharge of patients from hospital following treatment of TB. This has been escalated to the Kent and Medway Quality and Safety Group and KCC Public Health are working with partners including the NHS and PHE to improve the discharge processes.

6.2 The TB Cohort review which is attended by KCC Public Health, PHE and NHS partners reviews cases to identify issues such as this and to identify actions to address them.

7.0 Introduction to Hepatitis and Hepatitis C

7.1 Hepatitis refers to inflammation of the liver, but the term is usually used to refer to viral hepatitis. There are several types of viral hepatitis, the most common being hepatitis A which is a highly infectious form of food poisoning spread by contaminated food and poor hygiene. Hepatitis B is highly infectious and is a blood-borne virus. It is spread by exposure with contaminated blood such as when sharing needles with an infected person, via infected blood transfusions or by sexual contact. Hepatitis C is another blood borne virus, spread by contact with contaminated blood such as tainted blood and can be spread via sex, but this is very rare.

7.2 Blood stocks in the UK are tested for both hepatitis B and C, but the test for Hepatitis C was introduced in the early 1990's and there is a cohort of individuals that received contaminated blood prior to routine screening.

7.3 Only one in every 3 or 4 people with have symptoms of acute hepatitis C; which include a high temperature, lethargy, loss of appetite, stomach pains and nausea and vomiting. About one in five of these people will also develop

jaundice (yellowing of the skin and eyes).

7.4 In about one quarter of people infected with hepatitis C, their immune system will successfully fight the virus and they will not have any further symptoms unless re-infected. The remaining three quarters of cases will develop chronic hepatitis. If left untreated, hepatitis C can cause potentially life-threatening damage to the liver and is a major risk factor for liver cancer.

7.5 The older hepatitis C treatments used a combination of a weekly injection with a capsule, but this was not well tolerated, and many people failed to keep up with the treatment which could last for several weeks. There are new treatments that can be taken as a tablet, are well-tolerated and do not need to be taken for as long, including simeprevir, sofosbuvir and daclatasvir. Using these new medications, 90% of people with hepatitis can be cured. There is no vaccine to protect against Hepatitis C.

8.0 Hepatitis C Policy

8.1 The UK is currently working to eliminate hepatitis C as a major public health threat by 2030.

8.2 NHS England Operational Delivery Networks (ODNs) have been formed to deliver treatment equitably across the country and the National Strategic Group on Viral Hepatitis, established by Public Health England, is bringing together partner organisations to help find the best ways work together at local, regional and national level to improve health services, minimise the number of new infections and reduce the health consequences of hepatitis infection for people in England.

8.3 PHE has worked with partners to introduce hepatitis C resources in different languages to help raise awareness. There is a poster campaign in GP surgeries and the Hepatitis C Trust hosts a quiz which helps people to find out whether they might have been exposed to the virus. As well as raising awareness of hepatitis C and trying to find people who do not know they have the virus, there is also work to find people who have been diagnosed in the past and ensure that they have cleared the virus and if not, that they have access to the new drugs. PHE and the NHS are working together to identify people on GP lists that have been diagnosed in the past so that they can be assessed.

8.4 The NHS is responsible for treating hepatitis C. Public Health England (PHE) is responsible for the surveillance of hepatitis C and public health actions arising from cases of hepatitis C. Local authorities commission substance misuse services where screening for hepatitis C is performed and hepatitis is discussed at the KCC Health Protection Committee.

9.0 National Hepatitis C Data

9.1 In the UK approximately 166,000 people in the UK have hepatitis C. The main risk factor for hepatitis C infections is injecting drug use and most hepatitis C infections occur in people who inject drugs or have injected them in the past. In 2016 a study showed that 54% of people who had injected drugs and

participated in the Unlinked Anonymous Monitoring (UAM) Survey of people who inject drugs (PWID), tested positive for antibodies to hepatitis C.

9.2 Over the period between 1996 and 2016, there has been a more than fivefold increase in the number of laboratory-confirmed reports of Hepatitis C virus in England, with 10,731 laboratory reports in 2016 (Figure 2). Around two-thirds of these reports were in men and almost one half were in people aged between 25 and 39 years old (Figure 3).

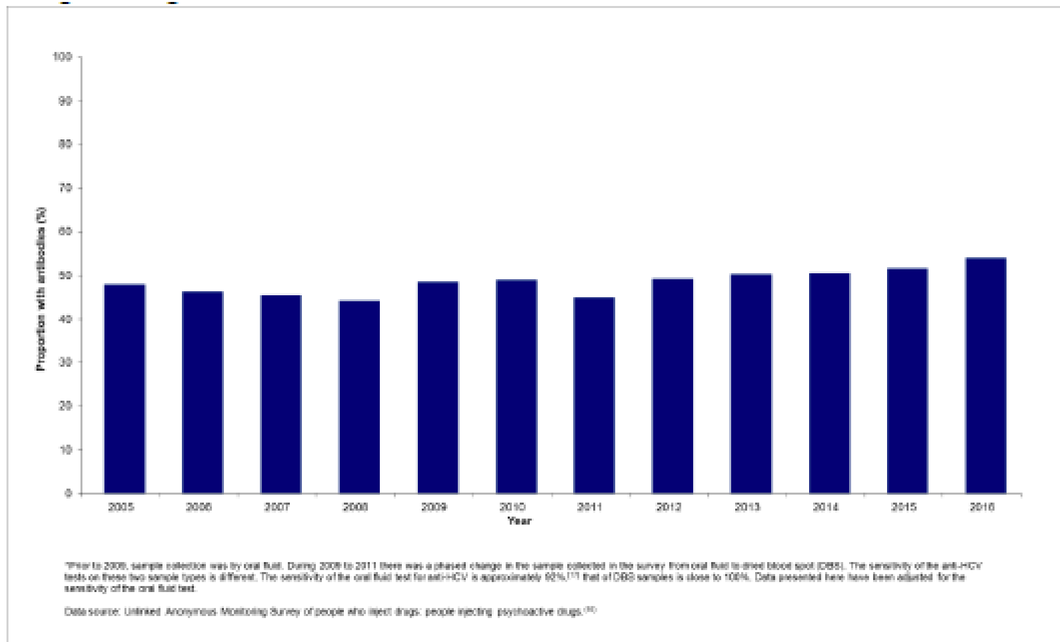


Figure 1. The trend in the presence of hepatitis C virus among people injecting psychoactive drugs in England 2005 to 2016 (PHE)

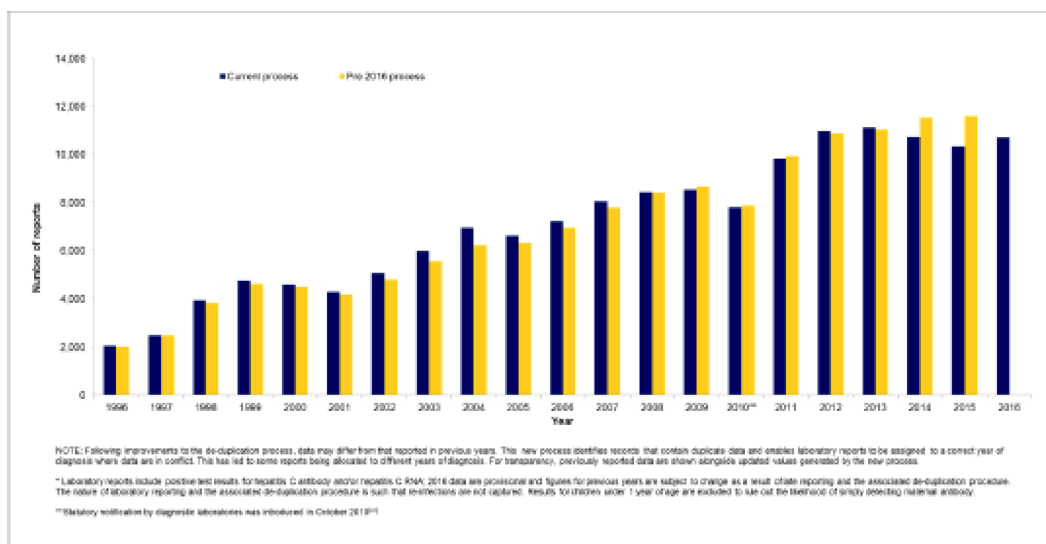


Figure 2. Number of laboratory reports of hepatitis C from England. 1996-2016.

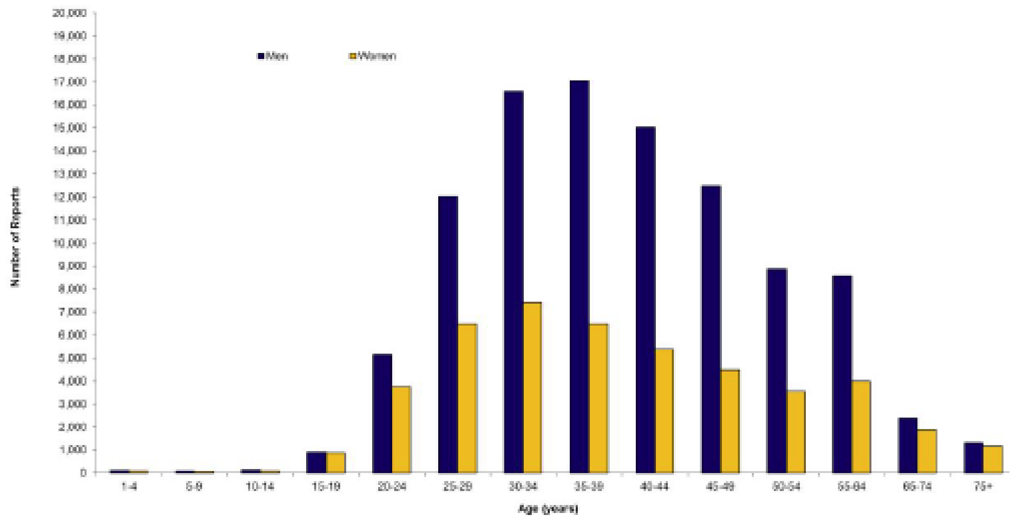


Figure 3. Age and Sex distribution of laboratory reports of hepatitis C from England. 1996-2016. (PHE).

9.3 The number of tests requested from GP surgeries rose by 20.8% between 2012 and 2016 suggesting that awareness of hepatitis C in primary care is increasing.

10.0 Local Hepatitis C Data

10.1 The estimated prevalence of Hepatitis C in Kent, derived from national models, suggests that we should have between 3,900 and 6,620 chronic infections in the county. The majority of these would be in people injecting drugs, or with a history of injecting drugs.
In Kent, our detection rate (10.2 per 100,000) is lower than the England average (19.7 per 100,000) (Figure 4). This probably reflects the complexity of working in such a large geography with a complex health economy and low awareness.

10.2 Laboratory reports show that there was an increase in detection 2007 and 2012 which levelled off in 2016. We are expecting to see an increase in the laboratory reports for 2017 to 2018, to reflect the work of ourselves and partners to increase awareness of hepatitis C and increase referral rates into treatment (Figure 5).

Area	Count	Value
England	10,565	19.7
South East PHE centre	1,179	14.0
Medway	50	18.2
Kent	147	10.2

Source: SGSS data (Second Generation Surveillance System) - Laboratory reporting. CIDSC, National Infection Service, PHE

Figure 4 – Hepatitis C Detection Rate (PHE)

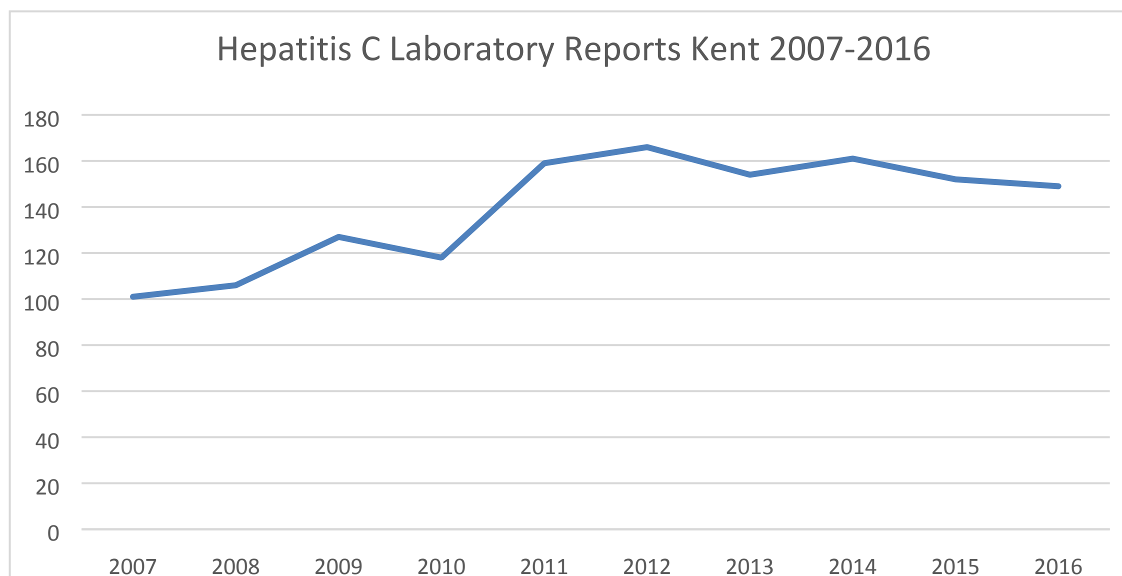


Figure 5 – Hepatitis C laboratory reports from Kent 2007-2016

10.3 The national model also allows us to estimate the disease stages and diagnoses in Kent and Medway and the estimates for the end of 2017 suggest that there would be 3,720 mild cases of hepatitis and 940 moderate cases. Approximately 7.2% of cases of hepatitis C in Kent and Medway would lead to cirrhosis of the liver. If the planned scale-up of services can be achieved in England (and Kent), statistical modelling predicts an 81% fall in hepatitis C-related cirrhosis by 2030.

11.0 Current issues in Hepatitis treatment and prevention

11.1 Less than half of people injecting drugs in England report adequate needle and syringe provision. This is something that is being reviewed by our local service providers, but we are confident that this is not a significant issue in Kent.

11.2 We continue to encourage targeted screening and offer of treatment to our substance misuse clients and work well with our partners. For example, HCV Action and PHE held a roadshow in September 2018 where NHS partners, PHE and KCC Public Health Commissioners presented.

12.0 Partnership working in Tuberculosis and Hepatitis C

12.1 KCC Public Health works with partners to assure the safety and quality of health services in Kent. This includes working with the Quality and Safety Group e.g. on appropriate discharge of TB patients, working the PHE on data and epidemiology of TB and on TB incidents that might require our assistance e.g. TB in educational establishments

12.2 KCC now attends the TB cohort review and this has been well received by our clinical and PHE colleagues. It allows us to help with relationships with other parts of the council such as social care.

12.3 In Kent, KCC Public Health have attended meetings with NHS specialised

commissioning, PHE Health Protection Team and Hepatitis C Operational Delivery Network colleagues to explore how to ensure our Public Health Commissioned Substance Misuse services.

12.4 Another example of partnership working is the roadshow in September 2018 held by HCV Action and PHE where NHS partners, PHE and KCC Public Health Commissioners presented.

13.0 Recommendation

The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the current information on Tuberculosis and Hepatitis C and **ENDORSE** the partnership approach taken by KCC Public Health.

14.0 Background Documents

14.1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675492/TB_leaflet.pdf

14.2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731848/_Greenbook_chapter_32_Tuberculosis_.pdf

14.3 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732469/HCV_IN_THE_UK_2018_UK.pdf

14.4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/693917/HCV_in_England_2018.pdf

15.0 Useful Links

15.1 https://www.cdc.gov/tb/topic/basics/default.htm

15.2 https://fingertips.phe.org.uk/profile/tb-monitoring/data#page/9/gid/1938132814/pat/104/par/E45000019/ati/102/are/E10000016

15.3 https://publichealthengland-immunisati.app.box.com/s/ae1wr0ck0jh77vgw5lrp0ukop5srrv9o

16.0 Contact Details

Report Author:

Allison Duggal, Deputy Director of Public Health
03000 413173
Allison.duggal@kent.gov.uk

Appendix 1

Current BCG Policy in England

Currently BCG immunisation is offered to:

- All infants (aged 0 to 12 months) with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater†

- All infants (aged 0 to 12 months) living in areas of the UK where the annual incidence of TB is 40/100,000 or greater e.g. London

- Previously unvaccinated tuberculin-negative individuals under 16 years of age household or equivalent who have been in close contact with a case of sputum smear-positive pulmonary or laryngeal TB

- Previously unvaccinated, tuberculin-negative individuals under 16 years of age who were born in or who have lived for a prolonged period (at least three months) in a country with an annual TB incidence of 40/100,000 or greater.

- Healthcare workers (HCW) or laboratory worker, who have either direct contact with TB patients or with potentially infectious clinical materials or derived isolates.

- Veterinary and staff such as abattoir workers who handle animals or animal materials, which could be infected with TB.

- Under 16-year-olds who are travelling to stay with friends / family or local people for over three months in a country where the annual incidence of TB is 40/100,000 or greater and/or where the risk of Multi-Drug Resistant TB is high

BCG should also be considered for people working with higher risk groups such as the prison population, homeless persons and refugees and asylum seekers.

From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 22 November 2018

Subject: **Work Programme 2019/20**

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 2019/20

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 2019/20

2.1 An agenda setting meeting was held on 28 September 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 2019/20.

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: 14 November 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.

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)* • **Air Quality –** HRPH can ask to comment when this goes to GEDCC – moved at 28 9 18 ag setting • **Childhood Obesity** – added at 28 9 18 agenda setting • ***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)** • **Mental Health Needs Assessment** – specific item on MHNA (new MHNA will have been to DMT in Jan 2019) • ***Verbal Updates – include STP update*** • ***Contract Monitoring** – Adolescent Health Services* • ***Work Programme 2019/20***
10 MAY 2019
• ***Verbal Updates – include STP update*** • ***Contract Monitoring – Domestic Abuse and Positive Relationships*** • ***Work Programme 2019/20*** • **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)
26 JULY 2019
• ***Verbal Updates – include STP update*** • ***Contract Monitoring – Mental Health Services*** • ***Work Programme 2019/20***

Last updated on: 14 November 2018

18 SEPTEMBER 2019

- ***Verbal Updates – include STP update***
- ***Contract Monitoring – Workforce Development***
- ***Work Programme 2019/20***
- **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)
- **Annual report – Quality in Public Health, incl complaints**

1 NOVEMBER 2019

- ***Verbal Updates – include STP update***
- ***Contract Monitoring – Young People's Drug and Alcohol Services***
- ***Work Programme 2020***

14 JANUARY 2020

- ***Verbal Updates – include STP update***
- ***Contract Monitoring – tbc***
- ***Work Programme 2020***
- **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)

6 MARCH 2020

- **Draft Directorate Business Plan**
- **Risk Management report (with RAG ratings)**
- ***Verbal Updates – include STP update***
- ***Contract Monitoring – tbc***
- ***Work Programme 2020***

6 MAY 2020

- ***Verbal Updates – include STP update***
- ***Contract Monitoring – tbc***
- ***Work Programme 2020***
- **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)

Last updated on: 14 November 2018

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	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)
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	

This page is intentionally left blank