HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 13th March, 2019

10.00 am

Darent Room - Sessions House

Kent County Council
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AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 13 March 2019 at 10.00 am
Darent Room - Sessions House

Ask for: **Theresa Grayell**
Telephone: **03000 416172**

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

Membership (13)

Conservative (10): Mr G Lymer (Chairman), 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

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UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in items on the agenda

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

4 Minutes of the meeting held on 15 January 2019 (Pages 7 - 18)

To consider and approve the minutes as a correct record.

5 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.

6 Contract Monitoring Report - Live Well Kent Contract (Pages 21 - 30)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, giving an overview of the Live Well Kent Service commissioned by Kent County Council Strategic Commissioning and the Kent Clinical Commissioning Groups. It includes details of the purpose, performance, outcomes and value for money of the contract. The committee is asked to comment on the commissioning and provision of the contract, the contractual performance to date and work to deliver continuous improvement.

7 Summary of the Data, Key Findings and Recommendations of the Kent Adult Mental Health Needs Assessment 2019: Focus on Chapter on Mental Health & Multi-Morbidity (Pages 31 - 84)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out the current Adult Mental Health Needs Assessment for Kent, which updates the 2013/14 version and supports the Kent and Medway Strategic Transformation Plan (STP) and its partners to deliver the NHS Long Term Plan by ensuring that services are accessible, timely and of high quality, that physical and mental health are tackled together, and that suicide and self-harm are significantly reduced and prevented. The committee is asked to comment on the report and suggest areas of further investigation and focus.

8 Health Inequalities (Pages 85 - 90)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out work to collaborate and coordinate a whole-systems approach through the Sustainability Transformation Partnership, and with wider partners, to address widening health inequalities. The committee is asked to comment on and endorse the approach outlined.

9 Childhood Obesity - report on joint working between agencies to tackle obesity (Pages 91 - 96)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, which follows up the overview of childhood obesity in Kent presented to the committee in January 2019. This sets out details of the joint working between agencies to tackle childhood obesity and asks the committee to comment on this work.

10 Oral Health (Pages 97 - 102)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, giving an overview of the oral health status of the population of Kent and information about action being taken to improve it. The committee is asked to note and comment on the overview and endorse the approach being taken by the Public Health team.

11 Development of the Strategic Delivery Plan (Pages 103 - 132)

To receive a report from the Cabinet Member for Corporate and Democratic Services and the Corporate Director of Strategic and Corporate Services and Head of Paid Service, setting out a summary of the Strategic Delivery Plan. This will be the strategic business plan for the County Council, supporting the delivery of the outcomes in the Strategic Statement. The committee is asked to consider and discuss the draft Strategic Delivery Plan summary.

12 Risk Management: Health Reform and Public Health (Pages 133 - 148)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out the strategic risks relating to health reform and public health which currently feature on either the County Council's corporate risk register or the Public Health risk register. The paper also explains the management process for the review of key risks. The committee is asked to consider and comment on the risks presented in the appendices to the report.

13 Work Programme 2019/20 (Pages 149 - 154)

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

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

Tuesday, 5 March 2019

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Darent Room - Sessions House on Tuesday, 15th January, 2019.

PRESENT: Mr G Lymer (Chairman), Ms D Marsh (Vice-Chairman), Mrs C Bell, Mr D Butler, Mr D S Daley, Miss E Dawson, Ms S Hamilton, Mr S J G Koowaree, Mr B H Lewis, Mr M J Northey (Substitute for Mrs L Game), Mr K Pugh, Mr I Thomas and Mr R J Thomas (Substitute for Mr A Cook)

OTHER MEMBERS: Paul Carter, CBE, Graham Gibbens and Paulina Stockell

OFFICERS: Dr Allison Duggal (Deputy Director of Public Health) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

16. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Mr A Cook and Mrs L Game.

Mr R J Thomas was present as a substitute for Mr Cook and Mr M J Northey as a substitute for Mrs Game.

The Director of Public Health, Mr A Scott-Clark, was also unable to attend and was represented by the Deputy Director, Dr A Duggal.

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

The Chairman, Mr G Lymer, declared that he was a member of the Macmillan Cancer Backup Committee and a cancer backup team operated by the NHS.

18. Minutes of the meeting held on 22 November 2018.
(Item. 4)

It was RESOLVED that the minutes of the meeting held on 22 November 2018 are correctly recorded and they be signed by the Chairman. There were no matters arising.

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

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

1. **The Cabinet Member for Adult Social Care and Public Health, Mr G K Gibbens**, referred the committee to the contract monitoring report on the Health Visiting service which had been considered at the 22 November meeting but for

which Members had had no time to ask questions. He summarised briefly that the report had set out the performance of the service, which was good overall, with targets for developmental reviews having been achieved, set out the innovative partnership approach of the County Council and the service provider, the Kent Community Health NHS Foundation Trust (KCHFT) and the development of the new infant feeding service. He explained that he had wanted to give Members the opportunity to ask any questions they had about the health visiting service.

2. Members made the following comments:-

a) concern about staffing levels, often expressed previously, was repeated, as the shortfall and vacancy levels across the whole NHS was an ongoing problem. Reassurance was sought that sufficient new staff were coming into the service and being trained to the appropriate level to support the service effectively. Mrs Tovey explained that the shortage of health visitors was a national problem as places had been cut centrally by Health Education England. Kent was addressing the challenge in a number of ways, including development of a conversion course for existing nurses to be qualified to take on a Band 5 role within the team. She emphasised that staff being trained as health visitors were experienced nurses rather than new graduates. Funding would be offered to help relocation costs, to encourage staff to take on a role in Kent, and incentive payments would be offered for areas where there is less demand to work and higher vacancies. These initiatives seemed so far to be working well to increase workforce capacity in addition to work to maximise public-facing time with clients, for example, by reducing staff travel time. Some health visiting services were now delivered in children's centres and parent feedback indicates satisfaction with this approach as this would give them the chance to meet other new parents; and

b) concern was expressed that reduced funding for children's centres would have an impact on this arrangement. Mr Gibbens clarified that there had been no cuts to children's centres but changes had been made to the way in which they were commissioned. He emphasised that the health visiting service was concerned only with new parents and children's development and affected no other area of health care.

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

Association of Directors of Public Health Annual Conference – this took place in early December and included a drive to encourage associate membership. All the County Council's consultants were encouraged to become associate members.

Public Health Ringfenced budget for 2019/2020 – agreement needed to be achieved on how the 3% rise in salaries for NHS staff delivering public health would be funded, and the Director of Public Health was consulting the Government about what effect this might have on the County Council's public health budget. The County Council may also need to cover increased pensions contributions due for these NHS staff. *This issue would be addressed in more detail in the Budget report later on this agenda.*

Sustainability and Transformation Programme (STP) Prevention update – the NHS 10-year plan had now been published and its effect on the delivery of the STP prevention workplan could be assessed. STP preventative work was continuing,

and meetings would be taking place shortly to address its implementation, working with other County Council directorates.
Increased local and national influenza activity – the number of cases in Kent had risen and the Chief Medical Officer had agreed that GPs be allowed to prescribe antivirals for 'flu cases. It was still possible for vaccinations to be given for this winter.

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

20. Update on Local Care.
(Item. 6)

Ms J Frazer, Sustainability and Transformation Programme Lead, Adult Social Care and Health, was in attendance for this item.

1. The Leader, Mr P B Carter, introduced the report and highlighted the latest developments in local care in the Kent and Medway STP footprint. He chaired the Local Care Implementation Board (LCIB), for which the Government's arrangements had recently been streamlined. The newly-constituted LCIB would meet shortly. It was well known that, in the vision for health and social care integration and transformation, the health economy had become divided into 'local care' and 'hospital care'. His focus was on local care, on which he had been tasked to work with health colleagues. In the integration of primary care, community services and social care, the voluntary sector would have an important role to play. He had previously told the committee about efforts to secure commitment to an extra £32m of revenue resource for the local care model, hopefully rising to an extra £100m in the medium term.

2. It had been very encouraging that, on the same day on which the NHS launched its 10-year plan, the Secretary of State for Health, Matt Hancock, had alluded to his wish to see a greater proportion of the £20+bn going into the NHS being spent on local and primary care. Mr Carter said his priority was to explore how the £32m in the current financial year would be spent, in the hope that Kent could recruit more district nurses and therapists to work with GPs. Ms Frazer and her team had met with Kent and Medway health economy and primary care practitioners and those who delivered local care. Mr Carter said he had been much encouraged that GPs had coalesced around more than 40 primary care networks across Kent and Medway and had bought into the concept of being supported in those networks by multi-disciplinary teams (MDTs). Within MDTs, £32m would increase trained staff to increase support for GPs in primary care networks. Money was starting to be invested in various ways, including in care navigators to help connect patients to third sector services. He said he would like to see a workforce plan to focus on more district nurses, physiotherapists, occupational therapists and mental health practitioners in outreach work in patients' own homes and residential and nursing homes. This coverage had been inconsistent in the past.

3. The biggest issue remained the recruitment, retention and training of staff to address the skills shortage across the health service. Having now secured extra funding, the challenge was to use it to recruit staff needed in the MDTs, including those delivering social care services. He was keen for the Cabinet Committee to have a further report setting out how the social care aspects would sit within MDTs to facilitate triage and assessment to help patients access the services they needed as soon as possible. The LCIB hoped to be able to identify how many patients had

been able to avoid hospital admission by accessing services provided by the MDTs, in their own homes or residential and care homes, and how they could be helped to leave hospital faster, with district nurses and enablement services, to return to their own homes or access step-down beds in residential homes. The County Council would seek to ensure that social care services were being delivered beside health services in a timely way, to make sure no patient was at risk.

4. The LCIB had had conversations around smaller GP practices being fragmented and the need to have new GP hubs, similar to those established in London and elsewhere in the UK. A capital program needed to be put in place to deliver the same model in Kent, using primary care hubs supported by MDTs. Examples of social prescribing had shown positive outcomes, for example, at the Estuary View surgery in Whitstable, including a reduction in hospital admissions.

5. In conclusion, the largest challenge now was to find qualified practitioners to join the MDTs, and Kent would need to trawl across the globe to find people with the right qualifications to complement the current workforce. Kent would need to recruit and train them quickly to meet the urgent need. The Secretary of State for Health, Matt Hancock, understood this and supported the use of applied technology to help and improve primary care, but it was most important that GPs were behind it and supported the MDT model, that the Government backed it with sufficient funding and it proved possible to recruit practitioners to deliver better local community health services alongside GPs.

6. Members made the following comments:-

a) the report and the introduction of different ways of working were both welcomed as being very timely. The establishment of MDTs around the patient was welcomed but the scale of the challenge ahead was enormous, and it was accepted that, to attract the number of suitably-qualified staff required, it would be necessary to look further afield. Kent's aim to secure additional funding above the £32m was supported, and it was hoped that the Government would provide full financial support to train these new staff. Mr Carter said Kent would need to present the right environment to be able to attract health practitioners to move here, for example, by using social housing to offer them good-quality homes. The Estuary View practice had no problems attracting staff as it was an innovative, exciting practice;

b) it was difficult to get appointments and prescriptions as very few of the 12 GPs at a local Ashford surgery worked full time. Calls were triaged and the wait for a call back or appointment could often be 4 – 7 days;

c) concern was expressed that a hub in Thanet would potentially serve 30,000 patients while the bus service which would serve that area was apparently earmarked to be discontinued. The speaker was advised by the Chairman that the local bus service was not to be reduced but taken over by a different local provider. If a service were to serve a potential population of 30,000, surely there should be sufficient custom to make a commercial bus service viable;

d) concern was expressed that social worker numbers were insufficient and some families could miss out on receiving the services they needed. The

Cabinet Member for Adult Social Care and Public Health, Mr Gibbens, asked that Members raise any concerns about specific social care service provision with him;

e) the developing ways of working were welcomed as good news for Kent and it was suggested that the Cabinet Committee have regular updates on the roll-out and monitoring of the new ways of working set out in the report;

f) the report was welcomed and Mr Carter thanked for his commitment to drive this forward. Asked if the GP 'buy-in' included social prescribing, and if health inequalities would be addressed by the new ways of working, Mr Carter said the Estuary View model had been at the forefront of directing the patient to the right service at the right time and had been a key factor in reducing Accident and Emergency attendance. Ms Frazer added that social prescribing had been delivered successfully in East Kent by Red Zebra for some time and was being rolled out across the county, so should soon start to show a positive difference; and

g) asked if a patient would need to be registered at a practice to access the innovative services available there, following a local case in which someone had been turned away, Ms Frazer explained that, if someone wanted to use a GP surgery, they would need to be registered as a patient there in the usual way. However, the new model would improve clarity for the public about where to go to access services locally, and the ideal for the future was that there would be 'no wrong door'. She undertook to look into the individual case mentioned.

7. Mr Carter advised the committee that he, Ms Frazer and Mr Gibbens were shortly to visit the Greater Manchester combined authority to see how health and social care services were being delivered within the new devolved powers. He also thanked Ms Frazer for the great amount of work she had put into developing the new work streams and for writing the report.

8. It was RESOLVED that the progress and direction within Local Care be welcomed and endorsed.

21. Contract Monitoring Report - Sexual Health Services.
(Item. 7)

Mrs V Tovey, Senior Commissioning Manager, and Ms W Jeffreys, Public Health Specialist, were in attendance for this item.

1. Mrs Tovey introduced the report and highlighted key areas of the ongoing transformation work, which was responding to the findings of the needs assessment. This included an increased digital and online presence and a newly-awarded nine-year contract at a very good price for an online condom scheme. The County Council worked closely with NHS partners to offer integrated services and optimum choice and to achieve best value for public money. All services were performing well against targets and feedback from users had been good.

2. Mrs Tovey and Ms Jeffreys responded to comments and questions from Members, including the following:-

a) young people, and in particular young women, were reported to have problems accessing sexual health services in Sheppey as the service had moved from the healthy living centre to a local hospital, which was harder to travel to. Ms Jeffreys explained that, in response to the needs of young people on the island, there had been targeted work to increase awareness in schools and colleges of the Get It programme, safe relationships and chlamydia infection for year 11 and sixth form pupils in schools, more GPs offering LARC contraceptives and pharmacies offering contraception and chlamydia treatment over the period of the current contracts. Condoms and contraception (excluding those which need oxygen therapy to be administered) were still available at the healthy living centre and condoms from other outlets. The service was moving generally to offering more services online, following feedback from young people, although these services would be accessible by over-16s only, with an opportunity for younger people to be able to access advice directly from the service;

b) asked about charges for services provided for people living outside Kent, Mrs Tovey explained that a cross-charging policy was agreed and implemented across the south east but there was ongoing discussion with neighbouring authorities about the level of such charges and how they would be managed. However, she added that the proportion of out-of-county activity in Kent was currently declining;

c) Ms Jeffreys explained that the figures presented in Appendix B to the report were diagnostic rates per 100,000 of the population. Kent's rates of syphilis whilst increasing, were following the pattern seen across England; and

d) asked about Kent's shortfall in screening rates, compared to those of its statistical neighbours, Ms Jeffreys explained that this shortfall was in the number of females attending the integrated service for a first appointment and taking up the offer of asymptomatic screening for sexually-transmitted infections, an issue identified in the process of conducting the needs assessment. Specific key performance indicators would be built into the service remodel to monitor this activity.

3. It was RESOLVED that:-

a) the commissioning and provision of sexual health services in Kent,

b) service improvement initiatives being undertaken to improve quality and outcomes, and

c) progress to date on the implementation of the commissioning strategy which includes the re-modelling of services and the outcome of the condom procurement process,

be noted.

22. Smoking Needs Assessment: Key Findings.
(Item. 8)

Ms C Mulrenan, Public Health Speciality Registrar, was in attendance for this item.

1. Ms Mulrenan introduced the report and explained that, since reporting to the November meeting of the Cabinet Committee, the ambition to reduce the number of smokers in Kent had been increased from 45,000 to 58,500. Another issue which had arisen at the November meeting was the absence of chewing tobacco from the needs assessment, which, Ms Mulrenan explained, was because smoking tobacco contributed a far greater burden of ill health locally, nationally and globally. Smoking tobacco was the biggest risk factor for ill health, far greater than chewing tobacco, so this was the focus of the needs assessment. *Ms Mulrenan undertook to supply a link for the Tobacco Dependency Needs Assessment for inclusion in the minutes of the meeting:*
file://invicta.cantium.net/kccroot/users/shq/shq6/MulreC01/Desktop/Smoking%20Needs%20Assessment/Smoking%20NA%20Final/Tobacco%20Dependency%20NA%20Final%20accessible%20merged.pdf.
The Smoking Plus model presented the best chance of reaching national targets for smoking quits, together with initiatives such as smoke-free school gates, shops, prisons, etc.

2. Ms Mulrenan and Dr Duggal responded to comments and questions from Members, including the following:-

a) asked if sufficient information was available about people's reasons for smoking, Ms Mulrenan explained that, although the majority of the population now understood that smoking was not a healthy choice, this knowledge would not necessarily lead to people making a healthy choice by avoiding smoking. The smoking ban in shops, pubs and workplaces in 2007 had made a difference in encouraging some people to stop smoking and it was hoped that the various smoke-free initiatives would continue to encourage quitters. Some groups resisted quitting, however, and it was known that some 30% of manual workers were smokers. It was believed that the current service model did not appeal to all groups and that the proposed three-tier model would offer alternatives to those smokers who did not wish to access traditional smoking cessation services. Dr Duggal added that more targeted work was needed to tackle pregnant women who smoked. GPs would be sent a 'script' to support them in having a conversation with smokers to raise the issue of them quitting;

b) concerns was expressed that, as vaping was not permitted indoors in many premises, and people were required to go outside, once outside they might then choose to smoke a cigarette instead. If people could vape inside, more might turn to it. Ms Mulrenan pointed out that vaping had been shown to be 95% less harmful than smoking and was a useful aid to quitting smoking. A Kent and Medway STP paper had recently been drafted in support of smoking cessation services taking an 'e-cigarette friendly approach' for those who wished to use e-cigarettes as a quitting aid. Dr Duggal added that Public Health England was currently lobbying the Government about vaping being permitted indoors. Vaping had not been mentioned in the 2007 smoking ban as it had not been a recognised practice at that time;

c) concern was expressed that many medical staff, to whom many people would look as role models of healthy behaviours, could be seen smoking outside hospitals. Ms Mulrenan advised that NHS premises should now be smoke-free as part of national public health strategy and that there had also been a move to have smoking cessation support housed in acute trusts on a full-time basis, both of which should encourage staff to quit. *Dr Duggal undertook to investigate statistics for the number of NHS staff known to be smokers;*

d) asked about the number of women smoking at the time of delivery (SATOD), and concern expressed that, according to the graph in the report, the figures had risen in 2017 and significant inequalities remained, Ms Mulrenan highlighted that the confidence intervals given in the graph meant that officers did not believe this was a true rise in smoking rates in pregnancy. However, it was agreed that rates remained too high. Efforts to improve SATOD data may also be contributing to any apparent rises. She concurred that smoking remained a significant source of health inequalities. Dr Duggal added that pregnant women who smoked would be targeted by working with maternity services to encourage expectant mothers to quit during their pregnancy;

e) a question was raised about the effectiveness of such campaigns and what statistics were available about how achievable and effective it could be to give up smoking at various stages of pregnancy. Dr Duggal *undertook to look into this and supply statistics to the committee*, and advised that the health benefits of giving up smoking were presented to expectant mothers at pre-natal appointments. The recording of the number of women smoking at the time of delivery was a national requirement, but Kent would always strive to tackle the issue earlier in pregnancy;

f) as many smokers had already given up, those remaining were the hardcore smokers who would find it harder to give up. Concern was expressed that some people giving up smoking would need something to help with anxiety and stress and may turn instead to illegal drugs and other substances;

g) a suggestion was made that, far from getting parents to give up as a way of preventing children from taking up smoking, children could be used a tool to get their parents to give up. Duggal acknowledged that this may well be a good way forward and advised that behavioural science had highlighted the need to identify the right campaign message for the right population. Ms Mulrenan highlighted that, as part of the needs assessment, a literature review had been undertaken to look at interventions to prevent smoking initiation among children and young people. Although it was known that one of the best ways to reduce smoking rates in children is to reduce parental smoking, public health were also considering education and prevention programmes for young people;

h) the cost of cigarettes was highlighted, with the average smoker spending over £2,000 per year on their habit. This cost could be targeted in future campaign work; if people would not give up to improve their health, they might be encouraged to save their money, especially if the cost over a

lifetime of smoking were to be highlighted. Ms Mulrenan advised that the smoking cessation programme did look at costs with current smokers accessing the service, but she was not aware of a campaign targeted solely at cost. Dr Duggal added that campaign work had identified the help which could be gained by raising the tax on tobacco;

i) the continued focus on discouraging young people from starting to smoke was welcomed, with the message seemingly now established that it was not cool to smoke. It was cool to vape, however, and this had become a recreational activity among young people. Concern was expressed that this could lead to smoking in later life as young people would become accustomed to nicotine from vaping. Ms Mulrenan advised that current evidence suggested vaping was not acting as a 'gateway' to smoking for young people, but agreed that public health should continue to monitor the situation closely. Dr Duggal advised that vaping products did not all contain nicotine. Retailers of vaping products operated under a strict code of practice which prohibited nicotine products being sold to anyone who had not previously used nicotine, and this would prevent vaping from being used as a gateway to smoking;

j) the inclusion of the costs of a smoking habit was welcomed, and a move to increase the tax on tobacco was supported. It was stressed focus should not be solely on quits to the detriment of preventing initiation, and Ms Mulrenan agreed. Smoke-free initiatives aimed to make smoking initiation less attractive, and the public health team were also looking into education programmes for young people;

k) reference was made to the 'One You' campaign which included a smoker whose body appeared to 'rot' from the inside as he inhaled nicotine, while the voice over described the effect of nicotine on the human body; and

l) questions were asked about whether quit rates among pregnant women changed at different stages of pregnancy. Dr Duggal highlighted that smoking was brought up with women when booking appointments, and that SATOD data was collected as it was a national statistic. She would be happy to clarify with public health colleagues about whether any 'pinch points' existed for quits within specific stages of pregnancy.

3. It was RESOLVED that:-

a) the overall approach to improve health and reduce health inequalities be noted and welcomed; and

b) the enhanced Smoking Plus model and the revised Kent ambition of achieving 58,500 fewer smokers by 2022, in order to achieve Kent's prevalence target of 12%, be supported.

23. Childhood Obesity.
(Item. 9)

Ms S Bennett, Consultant in Public Health, was in attendance for this item.

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

a) local initiatives sought to tackle childhood obesity, for example, the provision of bicycles so children could cycle to school, 'fizz-free February' to reduce sugar intake from fizzy drinks, 'beat the street' and the supply of vegetables to children at school, and these could be spread to other areas of the county in a co-ordinated programme;

b) the County Council was committed to a programme of preventative measures to tackle childhood obesity, including those services delivered by the school public health service, which pursued a 'whole school' approach, including PE and active playtimes. The Ofsted recommendation for the minimum amount of PE was two hours per week;

c) asked if the school public health service included a visiting nurse who would inspect children's teeth regularly, Ms Bennett advised that the aim of the school public health service, which was delivered by KCHFT, was to support schools to be healthier overall. Pupils would be weighed in Reception and Year 6 and the statistics used to build on overall picture of the health of the school. The inspection of children's teeth was not part of the service, but colleagues in Early Help were seeking to link a dentist to children's centres to offer regular checks;

d) obesity was known to exacerbate other health problems, and Ms Bennett was asked what the County Council could do to ensure that appropriate facilities were made available, for example, for children with complex needs. Ms Bennett explained that the lack of Tier 3 services, to support people with complex needs, including social needs, was an issue on which the County Council had undertaken research to identify the level of need across the county and was lobbying the STP prevention group to increase provision;

e) the role of parents in safeguarding their children's health was highlighted. 20% of children in Reception classes were obese, so this situation had arisen at home rather than at school; children consumed more meals at home than they did at school. Much was made of lifestyle choices but 3-year-olds did not make those choices. It was for a parent, not the state, to bring up their child. Ms Bennett advised that children's centres gave talks to parents about healthy diet at the time when babies moved on to solid food, but engaging with parents was a challenge, generally. When a Reception-age child was weighed at school and found to be overweight, the child's parents would receive a call from the school public health service, offering an appointment to talk and get advice about healthy eating, but this option generally had a low take-up. Some parents simply did not recognise the problem, as they had been brought up in the same poor food environment and had no better role model to offer their children;

f) a comment was made that the report had been titled 'childhood obesity' yet obesity did not represent the whole picture of children's health; and

g) attention was drawn to the need for a balance between the calories consumed in food and the level of physical activity which would use and burn off those calories. Weighing of children at regular intervals at school was useful to identify those who were overweight, but there was a risk that children who were a healthy weight might nevertheless develop an unhealthy body image as a result of frequent checks and focus on weight. Ms Bennett agreed that the causes of obesity were complex. She referred to various national and local measures which could be used to address the availability of junk food and promote a healthy eating message by food placement and advertising in supermarkets, and to ban junk food from being advertised on television before a 'watershed' time. Work such as the Headstart Kent programme would help to support children, teach them to be more resilient and learn to make their own healthy choices.

2. It was RESOLVED that:-

a) the information set out in the report, especially the profile of childhood obesity in Kent and the service offer currently available, be noted and endorsed; and

b) a further report be submitted to the committee on effective and systematic joint working between agencies, including children's centres, in order to tackle obesity.

24. Public Health Communications and Campaigns Update.
(Item. 10)

Ms G Smith, Campaigns and Communications Manager, was in attendance for this item.

1. Dr Duggal introduced the report and explained that the public health team now included a marketing manager. Dr Duggal and Ms Smith responded to comments and questions from Members, including the following:-

a) Kent's 'One You' campaign was a local incarnation of, and was linked to, the national 'One You' campaign and brought together many strands of activity. More information on 'One You' work would be available to report to the Cabinet Committee later in the spring; and

b) asked about the public health aspects of air quality, Dr Duggal advised that the Energy and Low Emissions Strategy had very recently been published and work on initiatives such as active travel were at an early stage.

2. It was RESOLVED that the progress on and impact of Public Health campaigns in 2018/19 be noted and welcomed.

25. Performance of Public Health-commissioned services.
(Item. 11)

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

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

26. Capital Programme 2019-22, Revenue Budget 2019-20 and Medium-Term Financial Plan 2019-22.
(Item. 12)

Mrs J Blenkinsop, Finance Business Partner, and Ms K Sharp, Head of Commissioning for Public Health, were in attendance for this item.

It was RESOLVED that the draft capital and revenue budgets and Medium-Term Financial Plan, including responses to consultation and the Government's provisional settlement, be noted.

27. Work Programme 2019/20.
(Item. 13)

It was RESOLVED that the Cabinet Committee's planned work programme for 2019/20 be agreed.

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 – 13 March 2019

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

On behalf of the Leader and Cabinet Member for Health Reform, Mr P B Carter, CBE, **the Cabinet Member for Adult Social Care and Public Health, Mr G K Gibbens, will give an update on the following Sustainability and Transformation Plan issues:-**

- The role of social care within multi-disciplinary teams
- The outcome of a recent visit to Manchester to observe the health and social care model

PUBLIC HEALTH

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

- 5 February – Attended Public Health Champions Celebration Event
- 7 February – Kent Health and Wellbeing Board meeting
- 27 February – Attended the Local Government Association's Annual Summit for Political Leaders in Health and Clinical Care

On behalf of the Director of Public Health, Mr A Scott-Clark**, the Deputy Director of Public Health, Dr A Duggal, will give a verbal update on the following issues:-**

- Illicit tobacco - set up of new joint committee, led by Trading Standards, and work starting to address the supply of illicit tobacco in Kent
- Air Quality – joint report with public health input to Growth, Economic Development and Communities Cabinet Committee
- Sustainability and Transformation Plan prevention work
- Health in Europe projects – future programme funding

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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 -13 March 2019

Subject: **Contract Monitoring Report – Live Well Kent Contract**

Classification: Unrestricted

Previous Pathway: This paper has been tabled at DMT on 20 February 2019

Future Pathway: None

Electoral Division: All

Summary:
This report provides the Committee with an overview of the Live Well Kent Service that is commissioned by Kent County Council (KCC) Strategic Commissioning and the Kent Clinical Commissioning Groups. It includes details of the purpose, performance, outcomes and value for money of the contract.

The Live Well Kent Service is delivered by two strategic partners; Porchlight and Shaw Trust, who both deliver services and subcontract to a delivery network of providers.

The contract performs well and KCC works with strategic partners to continuously improve service, quality, and outcomes. A review of the Live Well Kent Contract is due to commence in the next financial year, to inform the decision on the extension of the contract.

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

- the commissioning and provision of a Live Well Kent mental health and wellbeing service in Kent
- the contractual performance to date and work to deliver continuous improvement

1. Introduction

1.1 Kent County Council (KCC) and Clinical Commissioning Groups (CCGs) across Kent are responsible for providing mental health and wellbeing services in Kent.

1.2 In line with national guidance and the NHS Five Year Forward View, KCC and CCGs jointly procured an integrated offer of community mental health and wellbeing support called Live Well Kent. The contract commenced on the 1st April 2016 and will run to 31 March 2021 or 2023 if the two-year extension is implemented.

1.3 Prior to the contract, 66 grants were awarded to multiple providers, which had been rolled over on an annual basis for many years. Following a full and detailed public consultation, the new specification was developed in co-production with stakeholders and users.

1.4 This paper forms part of the regular contract monitoring report presented to this committee and provides an overview of the performance, outcomes, value for money and future direction of the service.

2 Background - Why invest?

2.1 Mental health is a priority for KCC and aligns to Strategic Outcomes set out below:

- Kent Communities feel the benefit of economic growth by being in work, healthy and enjoying a good quality of life; and
- Older and vulnerable residents are safe and supported with choices to live independently.

2.2 Mental Health is a workstream of the Kent and Medway Sustainability and Transformation Plan (STP)i, namely, to work to deliver integrated mental and physical health services and transform the mental health of the population.

2.3 There are an estimated 205,000 people living with common and severe mental illness in Kent and one in four adults' experiences at least one diagnosable mental health problem in any given year[ii].

2.4 The Kent adult Mental Health Needs Assessment (2017)[iii] has identified:

- 18.6% of Kent residents have been recorded by their GP as having anxiety and/or depression[iv],
- 29% of those recorded by their GP as having a Serious Mental Issue (SMI) are in the most deprived quintile,
- Adults with serious mental health problems tend to have more contact with other services, including; higher number of hospital and GP visits, higher social care costs and higher secondary mental health costs.

2.5 Live Well Kent aims to prevent entry into formal social care and health systems by keeping people well or alleviating factors causing poor mental health such as debt or housing concerns. It supports a reduction in suicide, prevents negative health outcomes associated with poor mental health and parity of esteem.

2.5 Live Well Kent also contributes to the public health outcomes including; PHE Outcome 1: Increased healthy life expectancy - taking account of the health quality as well as the length of life, where Kent currently have similar rates to national figures.

2.6 The Public Health England report estimates that commissioning effective mental health prevention[v] can provide a return on investment that varies between £1.26 and £39.11 per £1 spent.

3 Service Overview

3.1 The vision for Live Well Kent is to keep people well and provide a holistic offer of support for individuals living with and without a mental health diagnosis. The outcome-

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i https://kentandmedway.nhs.uk/workstreams/mentalhealth/

[ii] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

iii https://www.kpho.org.uk/__data/assets/pdf_file/0004/80266/Mental-Health-Needs-Assessment-Analytical-Report.pdf

[iv] but the true percentage is likely to be larger as this does not consider those who do not access their GP

[v] https://www.gov.uk/government/publications/mental-health-services-cost-effective-commissioning

based contract was designed to engage people in innovative ways to improve their mental health and wellbeing.

3.2 The service is delivered by 2 strategic partners; Porchlight and Shaw Trust; who take on a market stewardship role to build capacity and sustainability in amongst the voluntary sector network funded through the contract. The network has changed over the life of the contract responding to the needs of users and the contract limits the amount strategic partners can deliver themselves. A list of the organisations in the network can be found in Appendix A.

3.3 Live Well Kent is open to those 17 and over and offers support on:

- Managing money, including debt and benefits advice
- Housing support and guidance
- Improving relationships and social inclusion
- Lifelong learning, employment and accessing volunteering
- Brief advice and signposting to healthy lifestyle support
- Evidence based activities shown to improve health and wellbeing e.g. Arts, yoga, outdoor activities, poetry, reading etc

3.4 The service aims to provide individuals with the skills and confidence to self-manage their mental health and encourages those with enduring mental illness to engage in mainstream activities, in ordinary settings, alongside other members of the community who are not using services.

3.5 The service provides a universal offer across Kent supported by the Live Well Kent website[i]. Provider activity promote positive wellbeing messages to reduction in mental health stigma in communities. The service is targeted at individuals who reside in the most deprived quintiles (quintiles 1 and 2) where there are higher levels of mental illness as well as target groups identified in the need's assessment.

3.6 Live Well Kent interfaces closely with other KCC commissioned services through cross referrals and signposting. This includes One You Kent which offers support to people to quit smoking or improve their lifestyle, and the substance misuse providers for those who have a dependency on drug or alcohol problems.

4 Service costs

4.1 The annual value of the service is up to £4,043,001 which is jointly funded by KCC Public Health, KCC Adult Social Care and each of the Kent Clinical Commissioning Groups. Approximately 45% of the total is funded by Public Health, with 37% coming from Adult Social Care and the remaining 18% from Kent CCGs. The maximum total contract value over 5 years is £20,215,005.

4.2 This financial year KCC has spent £3,032,251 on this contract, which has seen 2,463 of Kent residents access the service, this calculates as £1,231 per head.

5 Does the contract perform well?

5.1 The contract monitoring is led by Adults commissioning (supported by Public Health and CCG commissioners), who are responsible for running monitoring meetings with Strategic Partners. A comprehensive set of performance and quality measures are used to provide assurance that the contract is performing well, and the quality standards are

[i] https://livewellkent.org.uk/

met. A few key metrics have been presented to illustrate service performance and impact to the committee.

5.2 **Activity –** Since the start of the contract the service has received 13,440 referrals which averages at 4,884 referrals a year. 75% of these referrals have resulted in individuals signing up to the service. The Kent wide yearly access target is 3158 individuals and in the last 12 month period[i], 3243 people accessed the service, which is above this target set.

5.3 **Early intervention**

The strategic partners are monitored on the response rate to new referral so to support early intervention and ensure people reach the right service in a timely way. Table 1 below illustrates performance against this target.

Table 1 : Service Activity data

KPI	Target	YTD Performance as at Q3 2018/19	RAG
% meeting attempted contact within 2 days, response rate of 2 days (vs referral)	95%	98.6%	Above Target

Quality –The strategic partners gather feedback on the service; both through satisfaction rates, representative group, such as the Metal Heath Action Group (MHAG) and case studies. Table 2 below illustrates the satisfaction rate of the service two case studies can be found in Appendix B.

Table 2 : Service Activity data

KPI	Target	YTD Performance as at Q3 2018/19	RAG
% service users that would recommend the service to a friend or family	90%	98.3%	Above Target

5.3 **Outcomes –**Key questions are recorded at the start and end of the service intervention to measure outcomes for individuals accessing the services. This includes evidence-based tool Short Warwick Edinburgh Mental Wellbeing Scale (SWMBS). As of Q3 2018/19, the service is achieving targets set out in Appendix C.

5.4 **Value for Money** – Using the figures set out in section 4 of this paper, the cost per individuals accessing the service is £1,231 which compares well to an estimated cost for individuals receiving secondary mental health service of £2,120[ii]. In addition, the service reports on added social value delivered which includes apprentices, use of volunteers, income generation.

6 Improvements and developments for 2019/2020

6.1 In preparation for the end of the initial contract term (March 2021), a review will commence in 2019/20. This will be led by Strategic Commissioning Outcomes two and three and will consider the findings of the latest Mental Health Needs Assessment.

[i] Q4 2017/18 - Q3 2018/19

[ii] https://www.kpho.org.uk/__data/assets/pdf_file/0004/80266/Mental-Health-Needs-Assessment-Analytical-Report.pdf

Commissioners covering Public Health will be fully involved in this process, alongside colleagues from Kent CCGs.

6.2 Strategic Partners have worked to deliver continuous improvement and innovation. An example is work to increase the number of sign ups by carers who have been identified by the need's assessment as a high-risk group. The service is proactively identifying careers in service and routinely asks new sign ups as to whether they have caring responsibilities which may inform the service they receive.

6.3 The Strategic Partners are currently offering a tender opportunity for organisations to bid for Housing Related Support. This service is aimed at helping people to develop skills to live independently which will support in meeting the contracts outcomes.

6.4 A re-design of the Mental Health Matters contract is currently underway which is a phone line and web-based support offering out of hours provision. This helpline has seen an increase in demand since the launch of the Release the Pressure Campaign funded by Public Health.

6.5 Strategic partners will continue to work with related services to support joined up pathways and effective sign posting. For example, a contract has recently been awarded to Activmobs for the Sheds Generation 3 programme; funded by the European Union. The programme has been running in Kent for a number of years and has been very successful to date. Activemobs will work closely with Live Well Kent to support in referrals and signposting.

6.6 A protocol is currently being developed to support service users with both mental health issues and drug and alcohol addiction. This will support and enable a smoother treatment journey for people who require access to both mental health and drug and alcohol treatment services.

7. Risks

7.1 Risks are logged, and mitigation measures are put into place through the contract monitoring framework. There are some potential risks, which are detailed below, that may impact upon the success of the contract:

- The contract sees a high proportion of people accessing the service with Severe Mental Illness (SMI), then was initially anticipated. The service is working with Kent and Medway Partnership Trust (KMPT) to ensure that robust pathways are in place for onwards referral so that individuals receive support from the most appropriate service. This will form a central part of the review that will take place in 2019/20.
- The contract is focused upon delivering the service to those in quintiles 1 and 2 as detailed in 3.6. Overall, this percentage has fallen from 69% across Kent at the start of the contract (quarter 1 2016/17) to 48% from the most recent quarter's data (quarter 3 2018/19). The strategic partners are targeting and advertising their service in GP surgeries, gateway, community hubs and public places that are in the most deprived wards to increase referrals from these quintiles.

7. 2 Considering the funding for this contract is secured via several different sources, there is a risk that any one of these budgets may be reduced which may have an impact on the service and delivery.

8 Conclusion

8.1 KCC has commissioned mental health and welling services through a strategic partners model since 2016 which has performed well and engaged with 13,440 people to date(referrals). This service generates good outcomes and there is a demonstrated need to continue to invest in to mental health and wellbeing services.

8.2 The recent amendments to the contract specification to include Housing Related Support, Mental Health Matters, and working with KMPT shall support a clear pathway and a more joined up approach for Kent residents to recover from mental health experiences.

8.4 The service review during 2019/20 will set out the future priorities and the provision for this contract.

Recommendation

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

- the commissioning and provision of a Live Well Kent mental health and wellbeing service in Kent
- the contractual performance to date and work to deliver continuous improvement

Background documents: none

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Appendix A – List of organisations across Kent within the Network

Delivery Network by Lot			
Strategic Partner - Porchlight Lot 1 DGS & Swale	Strategic Partner – Shaw Trust Lot 2 - West Kent	Strategic Partner – Shaw Trust Lot 3 – Ashford, Canterbury & Coastal	Strategic Partner - Porchlight Lot 4 Thanet & South Kent Coast
DGS • North Kent Mind • Springboard Employment Service • Rethink Sahayak • Megan CIC • Primary Care Mental Health Specialists • Porchlight Community Inclusion Service • Porchlight Community Link Service • Porchlight Housing Support • Porchlight Community Wellbeing Network • Carers First **Swale** • Swale Your Way • Shaw Trust Employment Service • MEGAN CIC • Primary Care Mental Health Specialists • Porchlight Community Inclusion Service • Porchlight Community Link Service • Porchlight Housing Support • Ideas Test • Christians Against Poverty	Tunbridge Wells Mental Health Resource Centre • TWMHRC • TWMHRC / Carers First Joint Project • Involve Kent • West Kent Mind • Maidstone and Mid Kent Mind • West Kent Housing • Shaw Trust Employment • Bore Place • Blackthorn Trust • MCCH Employment / Wellbeing • Fegans • Kent High Wield Partnership • Tonbridge YMCA • Tonbridge Citizens Advice Bureau • Tunbridge Wells Citizens Advice Bureau • Sevenoaks Citizens Advice Bureau • Maidstone Citizens Advice Bureau	• Take Off • MCCH • Maidstone and Mid Kent Mind • West Kent Mind • Centra Care • Shaw Trust Employment • Canterbury Art Studio • Ashford Umbrella • Canterbury Umbrella • Herne Bay Umbrella • MarchWood • Julie Rogers Counselling • Canterbury Citizens Advice Bureau • Speak Up) • Whistable Citizens Advice Bureau • Faversham Citizens Advice Bureau • Activity Box • Abbey Physic Gardens	**Thanet** • Take Off • Richmond Fellowship (including SpACe project) • Porchlight Community Inclusion Service (CIS) • Porchlight Community Link Service • Porchlight Housing Support • Porchlight Thanet Health Inclusion Service (THIS) • Rethink Thanet Way – Employment • SpeakUp CIC • Carers Support **South Kent Coast** • Folkestone & District MIND (Folkestone and Dover) • Take Off • Porchlight Community Inclusion Service (CIS) • Porchlight Community Link Service • Porchlight Housing Support • Porchlight JET - Employment • Shaw Trust – Employment • Maidstone & Mid Kent MIND • SpeakUp CIC • Shepway Sports Trust • Carers Support • Building Resilience

Appendix B – Case Studies

Anne's story

Before I contacted Live Well Kent I felt pretty much alone, it felt like such a relief to finally have someone listen to me. Someone who finally understood me. All my life people have not listened to me and have repeatedly told me I'm fine, when my life has never been normal. I've always struggled to maintain good mental health.

As well as autism, I have extreme sensory processing disorder which means I get overwhelmed easily. When there is too much happening, I can't process what is going on and I go into meltdown mode. I become very vulnerable and almost go into a child-like state when I try and get help people push me away because I appear threatening to them. Then what follows is depression and anger, and then I feel physically unwell. My body hurts and I feel sick.

My worker from Live Well Kent has understood more than others why I react the way I do sometimes, as she has worked with people with autism and complex needs before. She could read into my behaviours coaching me on how to cope better when I lose control.

Before I lived in Kent, doctors told me I was fine, so much that I believed it, and tried to live a normal life. I got a full time job and moved in with one of my friends. It didn't end well. I couldn't cope and things went downhill. I'd had enough of people not listening or understanding and I was getting no support at all.

I moved in with my brother to Kent and through live well Kent found the support I needed to move forward with my life. My worker from Live Well Kent helped me get my autism diagnosed. It was a relief to finally know why I always felt different to everyone else. Now I have an official diagnosis, I will be able to access support specifically for autism. My worker has also helped me apply for advocacy, as I'm not always able to be understood properly and need help communicating.

December is always hard for me because everywhere is busy, everyone gets stressed and normal routine is disrupted. All of this makes me feel stressed and my anxiety gets worse. It's a difficult month, but I know if things get out of hand, I can contact my worker to help me calm down.

One day I want teach yoga, meditation and mindfulness to SEN children. I want to help them feel hopeful and help them express themselves and be confident, like I was never able to as a child.

I am still processing everything that's been happening, so I am some way off from that, but I'm much closer to that goal than I was. I can now see how far I've come and get the right support, so I can lead a normal life.

Adrian's story

Adrian has borderline personality disorder and has suffered with depression and anxiety. He was very isolated, but since finding the courage to come to Live Well Kent's Music Appreciation Group things have become a lot better for Adrian.

I was really down with depression before. I wouldn't go out, I wouldn't speak to people. I found it hard to get out and about. I was stuck in this little bubble and I had so many barriers up. I wouldn't have thought about setting foot outside.

One day I just thought, I've got to get out and do something.

I found out about the Music Appreciation Group through the internet. My wife said there must be groups out there who could help, so she helped me look. When we found out about the group she helped me find the courage to go. She said "go for it, what's the worst that can happen?"

It was really scary at first. I had so many barriers up but I met nice people. After a few times, it made me realise I didn't need to worry so much about other people. I learned there are people out there just like me – nice, genuine people. I didn't have to be scared or frightened at these groups and I could come out of my shell. I didn't have to be shy me, not trusting anyone, I could just be who I am.

I owe a lot to SpeakUp and Live Well Kent for the help this past year. I've changed a hell of a lot. Being able to be around people again has helped me so much.

I've pushed myself so far outside of my boundaries. I've helped organise events with the group and have even started writing poetry. I'm not very good at reading or writing, so that was a big deal for me. I wouldn't have even thought about it before.

Me being able to be more independent has been good for my marriage too. I never want to be a burden on my wife and I know she's had to adapt her lifestyle for me. She has really been my rock over the past two years. She's able to have a bit more time to herself now and she can see the changes in me.

To anyone thinking of joining a local group who is afraid, I would say just try it. Don't say no to things before you've given them a chance. I know it's scary but there are friends out there. There are people who are willing to help.

Appendix C

KPI	Target	Kent Performance as at Q3 2018/19	RAG
% people maintained or improved on their Short Warwick-Edinburgh Mental Wellbeing Scale score in the quarter	70%	82%	Above Target
Number of unemployed people with SMI that have achieved Paid Employment (16hrs+ for 13 weeks +)	78	105	Above Target
Number of unemployed people that have achieved Paid Employment (16hrs+ for 13 weeks +) with CMI/prevention	20	54	Above Target
% of people maintaining tenancy or accommodation at the end of the reporting Quarter	75%	91%	Above Target
% of people maintaining /developing "I've been feeling close to other people"	50%	85%	Above Target

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 – 13 March 2019

Subject: **Summary of the Data, Key Findings and Recommendations of the Kent Adult Mental Health Needs Assessment 2019: Focus on Chapter on Mental Health & Multi-Morbidity.**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

Kent public health supports the NHS to commission effective mental health services. The current Adult Mental Health Needs Assessment for Kent updates the 2013/14 version by focusing on two main issues: Depression and Premature Mortality and Co-Morbidity.

It supports the Kent and Medway Strategic Transformation Plan (STP) and its partners to deliver the NHS Long Term Plan. The Kent and Medway STP's approach to improving mental health in Kent focuses on ensuring services are accessible, timely and of high quality, that physical and mental health of people are tackled together, and that suicide and self-harm are significantly reduced and prevented. It also aims to ensure that the Kent population is supported to have improved wellbeing and resilience.

The main findings of this report highlight the increase in severe depression and the importance of a high-quality treatment pathway for depression. The report also highlights the significant impact of co-morbidities that impact on people with mental illness and lead to premature death and health inequalities. This requires care to be co-ordinated across physical and mental health services and where possible the care and support to be integrated, linking up third sector, primary and specialist treatment with an aim to reducing social isolation and in so doing supporting the reduction in health inequalities.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **COMMENT** on the report and **SUGGEST** areas of further investigation and focus.

1. Background.

1.1 The mental health strategy “No Health Without Mental Health‟ was introduced by the coalition government in 2012. The adoption of some of the core principles in the strategy has been slow due in part to the major structural changes within the NHS in the past few years. The strategy acknowledges that poor mental health is both a determinant and a consequence of social and health inequalities. Deprivation is associated with increased risk of mental illness and poor mental health is associated with unemployment, lower educational attainment, and risky behaviour Mental illnesses account for the largest burden (23%) of diseases in England. The annual cost of mental disorder in England is estimated at £105 billion. The promotion of mental health has a positive effect on employment, education, relationships, and other important determinants of health and wellbeing. Given the above, one of the aims of commissioning mental health services is to ensure promotion, prevention and recovery all receive appropriate levels of investment to maximise the mental wellness within the population.

2.0 Introduction

2.1 Kent Public Health produces at least one needs assessment for a key mental health condition annually and every three years refreshes a full mental health needs assessment. In 2015/6 a needs assessment for perinatal mental health was produced, 2016/7 a needs assessment for Personality Disorder and in 2018 a needs assessment for suicide prevention.

2.2 In 2019 the focus is a generic refresh of mental health data and a deeper look at data for depression and for co-morbidity & co-occurring conditions. For many years data on mental health has been difficult to understand because one individual can have multiple mental health diagnoses, including untreated physical and mental health needs. Therefore, it is important to understand the whole person’s health needs and not just numbers of people with a specific condition e.g. anxiety. Data on mental illness is becoming more accurate and sophisticated, although there are still many challenges. This report highlights the findings on revised prevalence estimates and the analysis and recommendations on multi-morbidity and mental illness that will appear in the full report.

2.3 There are three main sources of data that are used in this needs assessment:

- The Adult Psychiatric Morbidity Survey (APMS) for England 2007 and 2014. These are conducted by the Office of National Statistics. This is a large scale national survey that covers both treated and untreated mental illness. The 2014 survey updates the data for individual diseases, the 2007 survey is used because it has ‘cluster data analysis’ on complex co-morbid conditions. This data is then applied to the Kent population
- The Quality and Outcomes Framework (QoF) data that comes from primary care. The limitation of this data is that it only covers those people that come forward for diagnosis and treatment.
- The Kent Integrated Dataset (KID); this is pooled data from a number of separate sources (e.g. hospitals) and linked to primary care data.

2.4 The Kent Adult Mental Health Needs Assessment 2019 has six main parts:

- It describes the policy and social context of mental illness in England including risk factors such as health inequalities and social isolation.
- It focuses on the prevalence (how much) of the various main mental illnesses there are in Kent.
- It focuses on the treatment of depression in Kent and assesses this against National Quality guidelines (NICE).
- It assesses co-morbidity between mental and physical illness because people with a mental illness die on average 20 years earlier than those without.
- It covers suicide and self-harm (not covered in this report as the needs assessment came to the September 2018 cabinet committee)
- A summary of recommendations and suggests a call to action. The full needs assessment when completed (April 2019) will be shared with all mental health commissioners and available on the Kent JSNA website.

The full needs assessment when completed (envisaged April 2019) will be shared with all mental health commissioners and providers via the mental health STP Workstream and available on the Kent Observatory Website.

2.5 The purpose of this needs assessment is to support commissioning planning and decisions for mental health services. Mental ill health currently represents 23% of the total burden of ill health in the UK and is the largest single cause of disability[1]. Nearly 11% of England's annual secondary health budget is spent on mental health[2] and estimates suggest that the cost of treating mental health problems could double over the next 20 years[3]. This report focuses on the mental health of adults and has a focus on mental health issues that may be dealt with in primary or secondary care mental health services. This report addresses the broader public mental health and well-being agenda in part as a context and risk factor. This report does not address the mental health of children and young people, specific vulnerable groups e.g. homeless people or older adults with dementia and excludes issues of substance misuse (other than dual diagnoses with mental health). These topics will have their separate needs assessments.

3.0 Policy and Social Context of Mental Health and Illness

3.1 The Five Year Forward View (2016) and its subsequent mandates pledge progress on the links between mental and physical health, health inequalities and social isolation. To this end there is a national pledge to bring partnerships together to tackle mental health and wellbeing. The direction of policy continues with the NHS 10 Year Plan which continues to focus on reforms of the Mental Health Act detentions: better care for vulnerable groups, better access to preventative mental health services including talking therapies and a reduction in suicide rates.

[1] WHO (2008) The Global Burden Of Disease; 2004 update, available at www.who.int/heathinfo/global_burden_disease

[2] Department of Health (2009) Departmental Report 2009: The Health and Personal Social Services available at www.official-documents.gov.uk/document/cm75/7593/7593.pdf

[3] McCrone P, Dhanasiri S, Patel A et al. (2008) Paying the Price; The cost of mental health care in England. London: King‟s Fund, 220 - 226

3.2 The 2016 Task Force that wrote the “Mental Health 5 Year Forward View” underlined that access to mental health services should be as good as access to physical health services. Mental health conditions often bring an enormous degree of co-morbidity which must be tackled together in a systematic way. People who suffer mental illness are often poorly equipped to manage the confusing array of fragmented services and their health outcomes show a 20-year mortality gap compared with those who don’t have mental illness.

3.3 The new NHS Long Term Plan for NHS Mental Health Services launched in January 2019 is ambitious and challenging and acknowledges that mental illness is often a chronic and relapsing condition demanding better continuity and co-ordination of care. The key ambitions are:

- A renewed commitment to grow investment in mental health services faster than the NHS budget overall for the next 5 years, worth in real terms at least a further 2.3 billion a year by 2023/24
- Continue to expand access to psychological therapies (IAPT) services for adults and older adults with common mental health problems.
- Set clear standards for patients requiring access to community mental health treatment and role them out to patients over the next decade.
- Develop new and integrated models of primary and community mental health care to support adults and older adults with severe mental illnesses.
- Expand services for people experiencing a mental health crisis and ensure a 24/7 community based mental health crisis response for adults and older adults is available across England by 2020/21.
- Ensure a single point of access in timely universal mental health crisis care for everyone and will increase alternative forms of provision for those in crisis for example, sanctuaries and safe havens.
- Specific waiting times targets for emergency mental health services which will take affect from 2020 and ambulance staff will be trained and equipped to respond effectively to people in a mental health crisis.
- Upgrade the physical environment for impatient psychiatric care.
- Continue with the focus in reducing suicides over the next decade including a reduction in mental health inpatients and bereavement support.

3.4 The Adult Mental Health Needs Assessment highlights the importance of reading this report alongside the Children and Adolescent Mental Health needs assessment. This is due to the impact of childhood trauma on adult mental health. The current research in to ‘Adverse Childhood Events’ such as bullying, neglect, sexual abuse, exposure to violence and parents with a mental health and or substance misuse problem can lead to a lifetime of mental illness. Exposure to 4+ Adverse Childhood Events gives an 80% likelihood of mental illness in adulthood[4].

[4] Hughes Et al 2017 https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30118-4/fulltext

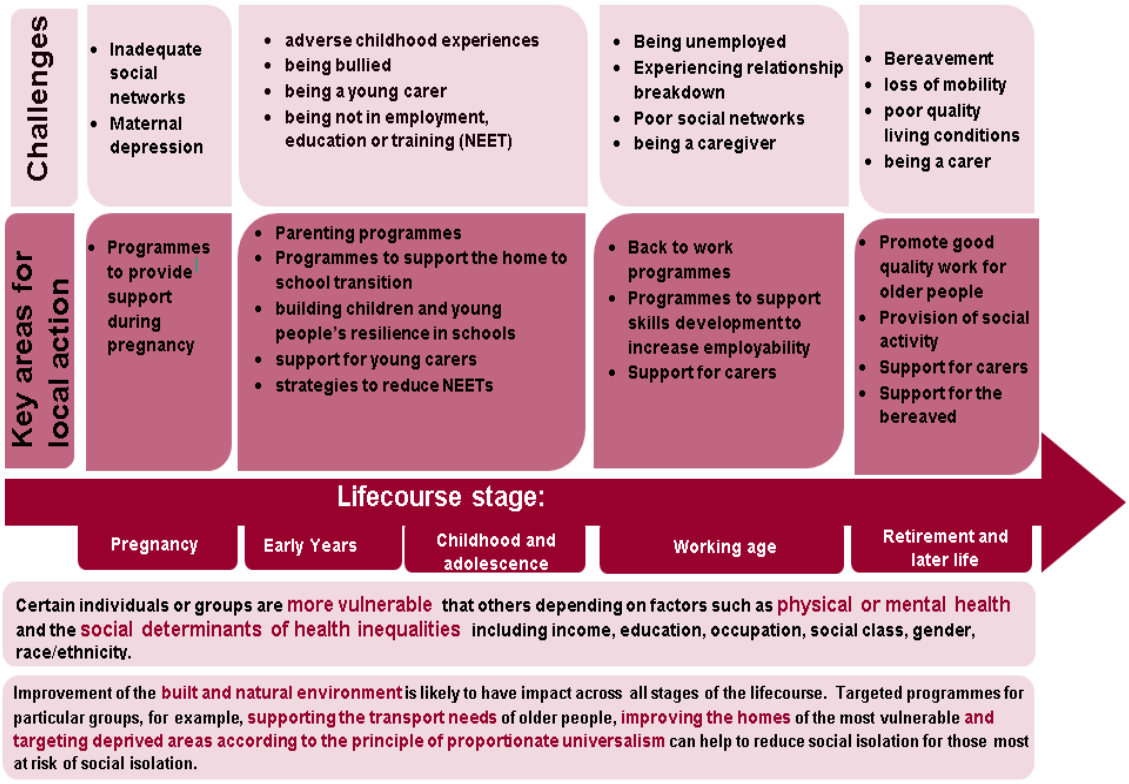
Table 1

	% of people with 4+ Aces in Services	
Substance Misuse Services	**64%**	**KCC Commissioned**
Mental Health Services	**60%**	**NHS Commissioned**
Employed in Social Care	**16%**	**KCC**
Homeless People	**55%**	**KCC & District**

Source: PHE 2017

3.5 The Adult Mental Health Needs Assessment shows that the group which has the highest levels of multi morbidity, depression the highest use of acute care and social care also have the highest risk of social isolation. The Mental Health Needs Assessment recommends using the PHE Schema (Fig 1) to develop a plan to tackle social isolation in Kent.

Fig 1 **Public Health England's Schema on Tacking Social Isolation**



4.0 The Extent of Adult Mental Illness in Kent

4.1 There are some important factors when considering needs in terms of prevalence in the report. There are overlaps and influences of need and supply;

- The definition of 'need' in a 'needs assessment' indicates where people can benefit from an intervention or service
- supply is what is actually provided. Supply may be influenced by historical patterns of provision and political priorities.

This needs assessment is to identify how closely these two factors are aligned, and therefore, how well needs are being addressed by the commissioners and

providers of mental health services.

4.2 **Limitations of Data in Mental Health Needs Assessments:** The severity, duration and impact of mental illness varies hugely, and so prevalence data alone for the various single disorders will not provide all of the information required to estimate medical and social care needs, or the extra considerations for education, employment, acceptance, understanding and accommodation by society plus the reasonable adjustments that are required for routine services for people who suffer with mental illness.

4.3 There are two key terms in defining the prevalence of mental illness: Common Mental Illness (CMI) and Severe Mental Illness (SMI). These terms can be confusing as they do not relate to the severity and duration of the illness. CMI refers mainly to depression and anxiety, called 'common' due to high prevalence rates (24% lifetime prevalence). SMI refers to psychosis (0.7% lifetime prevalence). The Adult Psychiatric Morbidity Survey 2014 does attempt to calculate estimates of severity for all conditions. The Cluster analysis of co-morbidity is used as people can have one or two severe conditions and a number of illnesses of a lesser severity that add to complications in treatment.

4.4 The APMS 2007 and 2014 looked at prevalence of single conditions and co morbidity across the surveyed population. The prevalence of the single conditions can be found in Fig 2. and are presented with estimated numbers in Table 2.

Table 2: APMS 2014 Estimated numbers of Adults (16+) with Mental Health Conditions in Kent.

Condition	Numbers of People (16+) in Kent
Generalised Anxiety Disorder (GAD)	40,254 (3.1%)
Mixed anxiety and depressive disorder	27,269 (2.1%)
Obsessive and Compulsive Disorder (OCD)	10,388 (0.8%)
Depressive episode, Panic disorder or any phobia (combined)	285,676 (22%)
Alcohol dependence	16,881 (1.3%)
Alcohol Hazardous Drinking	276,586 (21.3%)
Psychotic disorder	9,090 (0.7%)
Bi polar disorder	112,972 (8.7%)
Borderline Personality Disorder (BPD)	31,164 (2.4%)
Antisocial personality disorder, (ASPD)	42,851 (3.3%)
Post-Traumatic Stress Disorder (PTSD)	57,135 (4.4%)
Attention Deficit Hyperactivity	135,047 (10.4%)

Disorder (ADHD)	
Eating disorder	20,776 (1.6) (APMS 2007)
Adult Autism	9,090 (0.7%)

Source: APMS 2007/2014 applied to Kent GP registered population 2017.

4.5 One of the problems of trying to identify the prevalence of particular mental health conditions and applying them to Kent populations is that of co-morbidity. This is because a high level of people have more than one condition. The APMS (2007) used a method to explore levels of complex comorbidity called 'latent cluster analysis'. This is useful because it is a better predictor of the number of people who are in need of treatment and support.

4.6 Psychiatric comorbidity is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services and poorer resilience. The APMS 2007 grouped people together in 6 clusters in severity and complexity and this is useful to determine how many people will need support in Kent. The descriptions of the clusters are:

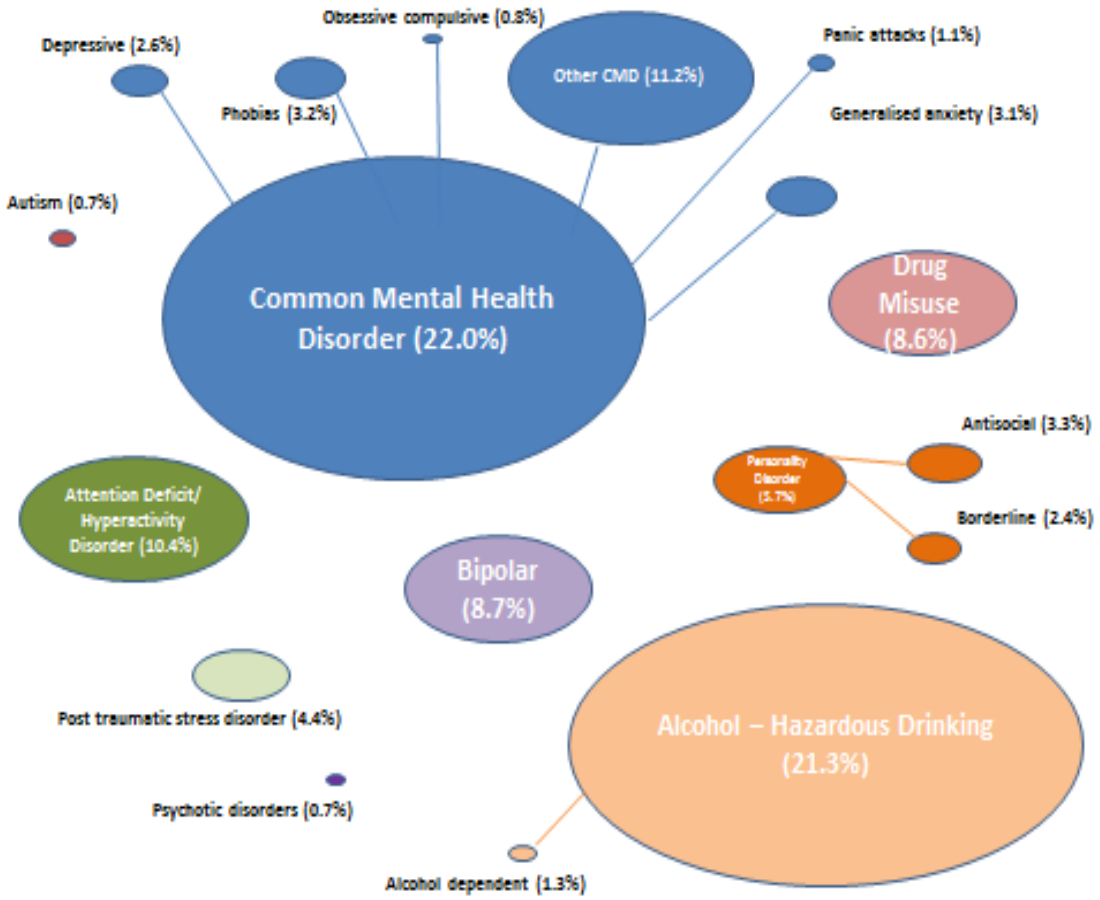
- Cluster 1: **Unaffected** (People with either 1 CMI condition – moderate or none) Usually depression/ anxiety or Moderate Substance Misuse
- Cluster 2: **Moderate Internalising** (people whose thoughts cause distress – Mainly Anxiety, Depression and PTSD)
- Cluster 3: **Cothymia** (Mixed Severe anxiety and depression)
- Cluster 4: **Co-morbid Internalising** (Anxiety, Mood, Phobias, PTSD, Depression, more severe and enduring – including substance misuse)
- Cluster 5: **Externalising** (Acting out behaviours of distress- Personality Disorders, Eating Disorders, Psychosis, Serious Substance Misuse)
- Cluster 6: **Complex and highly co-morbid problems** such as alcohol misuse disorder, psychosis, depression and PD.

Table 3**: Extent of Co-Morbidity and Severity of Mental Illness in Kent.**

Cluster	**% of Adult Population estimated to be in each cluster**	**Estimated numbers in Kent**	**Target Group**	**Expected Levels of service use.**
1.Unaffected	89%	**1,155,689** (of which 151, 395 people will have 1 MH issue) 4% 51,941 will have substance misuse dependency.	Broader Well Being and Prevention	Low
2. Moderate	5.8%	**75,314**	Mental health	Medium

Internalising			issues that may be dealt with in primary care or through psychological therapies	
3. Cothymia	2.1%	**27,269** This group has high rates 40% of serious substance misuse;10,907 14% will have eating disorder; 3,817	Mental health issues that may be dealt with in primary care or through psychological therapies	Medium
4. Co-Morbid Internalising	2.5%	**32,463** Depression, Suicidality and Substance Misuse were high in this group. **High Risk of Suicide.**	Severe mental illness dealt with in secondary mental health services	High
5. Externalising	0.5%	**6,492** 80% Substance Dependency 12% of this group had Gambling Addictions 3,817	Predominantly Co-occuring conditions with serious substance misuse	High
6. Highly Co-morbid and Severe	0.1%	**1,299** Depression was key factor in this group. **Highest Risk of Suicide.**	Severe mental illness dealt with in specialist mental health services	Very High

Source: APMS 2007 Cluster Analysis applied to Kent 16+ GP registered Population.



Prevalence of Psychiatric Conditions in Kent Population from APMS 2014.

4.7 The APMS Cluster Analysis (Table 3) gives strong insight into the complexity of treating mental illness in Kent. It shows that predictive models for single illnesses are less helpful than when the person is seen as a whole, and mental health services are planned to take co-morbidy into account. This is particularly relevant for suicide prevention, substance misuse services, eating disorders and depression. It will also enable whole population interventions e.g. Public Health One You services to align with primary care and community based mental health services for a significant section of the population.

4.8 The Adult Mental Health Needs Assessment for Kent highlights the gap in mental health treatment needs of people aged 65+ and carers. People over 65 are more likely to have a long term physical health condition and either be a carer or needing a carer. There are predicted 25% to 40% prevalence of depression in care homes[5] and 1% of people over 65 have psychosis. Carers were found to be at risk as they had higher rates of depression (24% higher) then those who had no caring role and 91% of carers were not receiving treatment (Singleton 2002).[6]

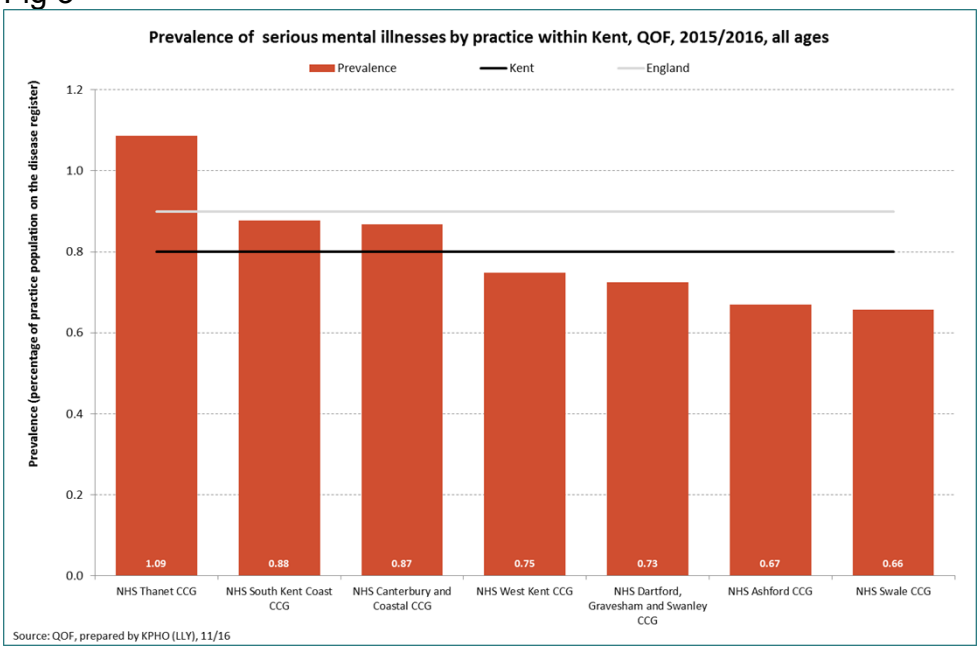
4.9 Tables 2 and 3 show the extent of the mental health need in Kent by applying the APMS 2014 to the Kent GP adult registered population (2017). Another way

[5] Age Concern. *Improving services and support for older people with mental health problems*. London: Age Concern; 2007

[6] Mental Health of Carers, Singleton, N. et al, , (ONS 2002)

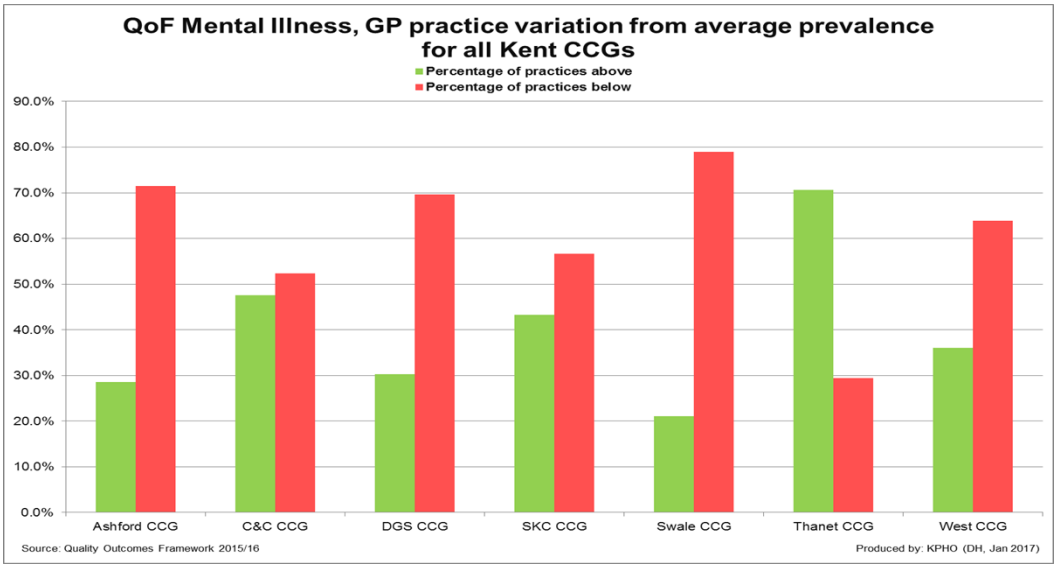
to assess mental health need and treatment is using the QoF data that is collected by GPs in primary care. For psychosis (SMI) the data in Table 2 show that this group will have very high health care needs. The data from the Public Health Kent Health Inequalities report and report on Social Isolation predict there will be highest mental health need in the most deprived communities in Kent. The Data from the QoF from 2015/6 shows that the highest prevalence rates for psychosis are in Thanet, South Kent Coast and Canterbury and Coastal CCGs. Thanet CCG has higher rates of psychosis in primary care then the England Average (Fig 3).

Fig 3



4.10 Overall the QoF data in Kent shows that psychosis recorded in primary care is at the predicted levels from the APMS survey. However, the recording of depression has marked variations. There is also considerable variation between primary care practices in the treatment and support of people with mental illness. In East Kent QoF data shows that the trend for all mental illness presenting in primary care is increasing. In West Kent there is considerable variation in depression prevalence and in North Kent there are fewer than expected people at primary care for depression. (Appendix 1). In 2017 the data for all QoF mental illness data in primary care was assessed relative to the Kent average QoF illness prevalence. This highlights the variation of outcomes in primary care in each CCG (Fig 4). Thanet CCG appears to have 70% of its primary care practices with more than Kent average mental illness QoF rates. This means that 70% of practices in Thanet are seeing more than the expected number of patients with mental illness. In Swale CCG only 20% of practices are seeing the expected rates of people with mental illness suggesting unmet needs. The data is from 2015/6 and there have been recent changes, however it shows the variations in practice that are challenges for the NHS CCGs.

Fig 4



5.0 Understanding the Nature and Extent of Depression in Kent

5.1 The NICE guidance 2018 says Depression is a broad and heterogeneous diagnosis. Central to it is very low mood, loss of interest and pleasure or loss of energy to be present. Severity of the disorder is determined by both the number and severity of symptoms, as well as the degree of functional impairment. Symptoms should be present for at least 2 weeks and each symptom should be present at sufficient severity for most of every day. Increasingly, it is recognised that depressive symptoms below threshold criteria can be distressing and disabling if persistent.

5.2 The severity of depression varies markedly. At its worst, it can have a profound effect on people's ability to lead normal lives. In terms of disability-adjusted life years, unipolar depression is responsible for more disability and suffering in high-income countries than any other health condition – accounting for 13 per cent of the total 'disease burden' among adults (WHO 2008). **Table 2**

Table 4 Estimated Numbers and Rates of Men with Severe CMD (Depression/Anxiety) in Kent

CIS-R score (severity)	2000		2014	
Moderate Severe (12-17)	6.7%	**28,948**	6.3%	**27,220**
Severe (18+)	6.7%	**28,948**	7.3%	**31,540**

Source : APMS 2014 % applied to Kent Census Data 2011- males over 16 years.

Table 5 Estimated Numbers and Rates of Women with Severe CMD (Depression/Anxiety) in Kent

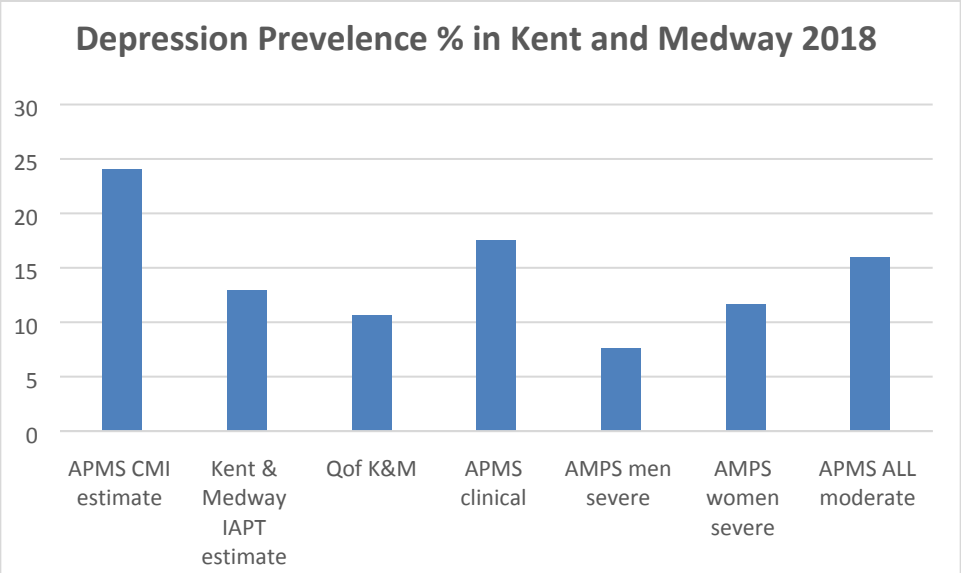
CIS-R score (severity)	2000		2014	
Moderate Severe (12-17)	10.2%	**47,386**	10.1%	**46,922**
Severe (18+)	9%	**41812**	11.3%	**52,497**

Source : APMS 2014 % applied to Kent Census Data 2011- females over 16 years.

5.3 Depression is not evenly distributed across the population. Consistent positive associations have been found between mental ill health and various markers of social and economic adversity such as low education, low income, low social status, unemployment and poorer material circumstances (Melzer *et al* 2004). There is a two-fold variation in the prevalence of depression between the highest and lowest quintiles of household income (McManus *et al* 2009).

5.4 There are various measures of prevalence of depression. The APMS (2014) is the best reliable large-scale survey of prevalence in England and indicates 24% of the adult population have a diagnosable depressive illness. The survey measures severity and duration and places a 'clinical' threshold of 17% and this is higher than the national estimates calculated for IAPT (NHS counselling). This means that there is a 'real' unmet need for psychological therapy of around 7% in the adult population. The rates of depression are not spread evenly across all groups. The APMS estimates for 'severe' depression are 7% for men and 11% for women (Fig 5). The incidence (new cases) of depression is 1.6% of the per year. There has been a slight fall in moderate depression across Kent but an increase in severe depression (Table 3 & 4) and this is more marked in women with an increase from 9% in 2000 to 11.3% in 2014. This highlights a critical issue for the commissioning of counselling services and primary care mental health for Kent CCGs.

Fig 5



Sources: APMS 2014, NHS Digital & PHE Fingertips 2017

5.5 Across all CCGs there are around 157,000 people in Kent with diagnosed depression (Fig 6). Ashford, Thanet and Swale have the highest CCG QoF recorded prevalence of depression in Kent. Incidence of depression in Kent is increasing. The annual incidence in Kent is 23,608 people (rate 1.6% of new diagnosis).

5.6 It is now well established that Moderate to Severe Depression is significantly associated with a wide variety of chronic physical disorders, including arthritis, asthma, cancer, cardiovascular disease, diabetes, hypertension, chronic

respiratory disorders, and a variety of chronic pain conditions[7]. Depression is also a causal risk factor leading to an increased prevalence of these physical disorders, with all their associated financial costs, impairments, and increased mortality risk particularly in first onset of coronary artery disease, stroke, diabetes, heart attacks and certain types of cancer (Kessler and Bormit 2014). [8]

5.7 There are elevated co-morbidities for depression and alcohol misuse, anxiety and suicide. A major study in the USA among Alcohol treatment dependent people found that 20.5% had co-occurring severe depression (three times more than the general population) and 40% had co-occurring mood disorder.[9] A recent audit of Kent substance misuse service users (2018) found the approximately 30% had suicidal ideation and 48% had a co-occurring mental illness.

5.8 Summary of Depression Data in Kent

- 24% of the adult population of Kent will have some form of CMI
- 17% of the adult population of Kent will have treatable serious depression.
- 10.6% of the adult population are on a treatment register in primary care for depression
- Almost 70% of people with moderate to severe depression will have chronic and relapsing conditions. [10]
- 20.5% will have Severe Depression and Alcohol Dependence.
- There has been a rise in the prevalence of severe depression in Kent (particularly for women: from 9% in 2000 to 11% in 2014).

5.9 **Treatment of Depression in primary care in Kent**.

The GP patient survey 2016/17 for Kent shows that more people are self-reporting depression then are being treated for depression (Fig 7) e.g in Thanet there are 13% of primary care patients on a register for depression and 18.3% report they have depression. NICE (2009) guidelines state that there are 5 main steps to treating depression in primary care:

- Be alert: Screen and case history of previous depression and self-harm and or suicide attempts.
- For Mild / Moderate consider self-help / physical activity and consider use of medication carefully – consider range of community and primary care services available.
- For Moderate / Severe : combination of medication and psychological therapy. Manage the condition via relapse prevention and monitoring.

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[7] The prevalence of comorbid depression in adults with diabetes: a meta-analysis.Anderson RJ, Freedland KE, Clouse RE, Lustman PJDiabetes Care. 2001 Jun; 24(6):1069-78

[8] The epidemiology of Depression across Cultures Kessler and Bromit 2014 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4100461/

[9] B*ridget F. Grant, Ph.D., Ph.D., is chief of, and Deborah A. Dawson, Ph.D., is senior clinician in the Laboratory of Epidemiology and Biometry, Division of Intramural Clinical and Biological Research, at the National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland*

[10] Prevalence and predictors of recurrence of major depressive disorder in the adult population. *Hardeveld F, Spijker J, De Graaf R, Nolen WA, Beekman ATActa Psychiatr Scand. 2010 Sep; 122(3):184-91.*

- Provide easy to understand information and support for self-care.
- Conduct Health checks and management of co-morbidity.

5.10 Follow Up

In 2017/8 65% of Kent GP patients (QoF data) received a follow up review 10-56 days after diagnosis. This is higher than the national average. Thanet CCG had the lowest rate of follow up in Kent (59.2%).

5.11 Bio-psychosocial assessment

In Kent in 2017/8 an in-depth assessment was conducted at primary care at or above the England average rate (76%) with only Swale and Thanet falling below (65% and 73%), indicating those localities may need extra primary care support.

5.12 Medication

Kent has increased its antidepressant medication prescribing in line with the national year on year increases. People in 2018 are taking higher doses of medication then in 2013. (see Appendix report).

5.13 Suicidality and Depression

In retrospective studies of people completing suicide (both National and Kent) there are high rates of people having contacted primary care about suicidal intent. In one national study[11] in 91% of cases the person had contacted primary care a year before completing suicide. People with a primary care diagnosis of depression, anxiety and alcohol dependency are most at risk.[12] This is backed up by current research on coroner verdicts being conducted via NHS Darzi Fellowship linked to Kent Suicide Prevention Strategy (report will be available in 2019).

5.14 Psychological Therapies

Kent as a whole has higher improvement rates (78.3%) for NHS counselling services then the national average (72.1%). There were 7680 people were referred and completed Cognitive Behaviour Therapy (High Intensity) in Kent and Medway in 2016/7. This is 32.5% of the registered GP population for depression (Data from NHS Digital). However, it is impossible to say whether those completing counselling/ therapy are the same cohort being treated for depression in primary care.

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[11] https://bjgp.org/content/59/568/825 Anna Pearson, Pooja Saini, Damian Da Cruz, Caroline Miles, David While, Nicola Swinson, Alyson Williams, Jenny Shaw, Louis Appleby and Navneet KapurBrGenPract 2009; 59 (568): 825832. **DOI:** https://doi.org/10.3399/bjgp09X472881

[12] Power K, Davies C, Swanson V, et al.(1997) Case-control study of GP attendance rates by suicides with or without a psychiatric history. Br J Gen Pract **47**(417):211–215.

Fig 6

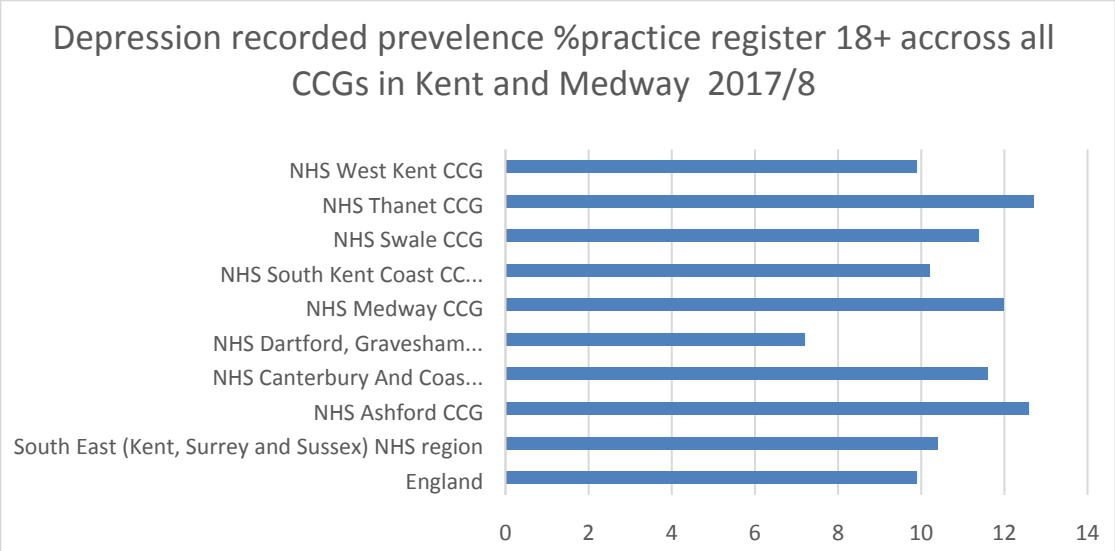


Fig 7

Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ 2016/7

Area	Value	Lower CI	Upper CI
England	13.7	13.7	13.8
Kent and Medway	13.7*	-	-
NHS Ashford CCG	13.7	12.2	15.4
NHS Canterbury And Coas...	15.0	13.7	16.3
NHS Dartford, Gravesham...	12.1	11.1	13.3
NHS Medway CCG	14.0	12.9	15.1
NHS South Kent Coast CC...	15.5	14.2	16.8
NHS Swale CCG	14.4	12.7	16.2
NHS Thanet CCG	18.3	16.6	20.1
NHS West Kent CCG	11.4	10.7	12.2

Source: GP patient survey, NHS England. The data used includes that from GP patient surveys undertaken in July - September and January - March, which is equivalent to a financial year's data.

6.0 Mental Illness Outcomes in Kent

6.1 The data in Fig 8 shows the number and rates of admission to hospital for mental illness (primary diagnosis) per quarter year in Kent and Medway. In 2017/8 there were 3,515 admissions to hospital from Kent and Medway. This roughly the same number of people recoded on Care Programme Approach (Case Management) in Kent. There are higher hospital admission rates in Thanet. Overall admission rates in Kent are lower than the England average and Fig 9 shows that the trend has continued to reduce compared to the national average from 2017 to 2019. For GP prescribing of antipsychotic medication all CCGs are under the England average (Fig 10). This indicates that there is less mental health management of psychosis in primary care in Kent then the England average. Only Thanet is different in Kent and Medway, showing a statistically significant higher rate of GP prescribing for anti-psychotic medication.

Fig 8: Mental health admissions to hospital: rate per 100,000 population 2018/19 Q2

Area	Value	Lower CI	Upper CI
England	273.5*	270.4	276.6
Kent and Medway	210.9*	196.1	226.5
NHS Ashford CCG	224.2*	168.9	291.8
NHS Canterbury And Coas...	253.6*	208.5	305.7
NHS Dartford, Gravesham...	227.9*	188.2	273.6
NHS Medway CCG	215.3*	177.7	258.4
NHS South Kent Coast CC...	201.7*	161.1	249.4
NHS Swale CCG	178.8*	127.7	243.5
NHS Thanet CCG	304.9*	243.5	377.0
NHS West Kent CCG	159.7*	135.2	187.4

Source: NHS Digital Mental Health Services Data Set monthly reports.

Fig 9: Hospital Admissions to Secondary Care Mental Health Beds: Trends 2017/18/19

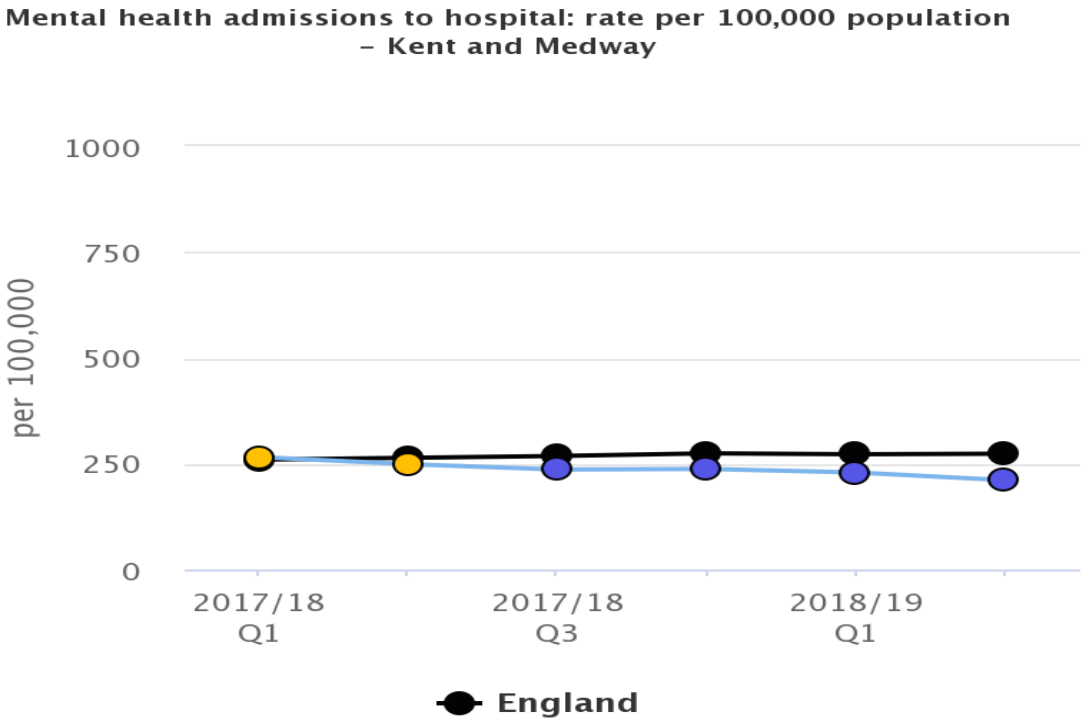


Fig 10 GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1,000 population 2017/18 Q4

Area	Value	Lower CI	Upper CI
England	62.4	62.3	62.4
Kent and Medway	53.7*	53.3	54.1
NHS Ashford CCG	40.9	39.6	42.1
NHS Canterbury And Coas...	43.0	42.0	43.9
NHS Dartford, Gravesham...	54.2	53.2	55.2
NHS Medway CCG	59.9	58.9	60.9
NHS South Kent Coast CC...	52.3	51.2	53.4
NHS Swale CCG	52.4	50.9	53.9
NHS Thanet CCG	69.0	67.5	70.5
NHS West Kent CCG	54.7	53.9	55.4

Source: NHS Digital

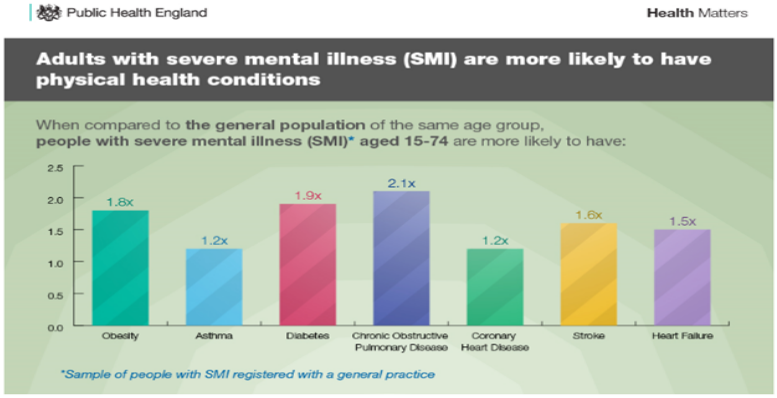
Fig 11 People subject to Mental Health Act: rate per 100,000 population aged 18+ (end of quarter snapshot) 2018/19 Q2

Area	Value	Lower CI	Upper CI
England	44.5*	43.9	45.1
Kent and Medway	27.9*	25.3	30.8
NHS Ashford CCG	10.2*	4.9	18.7
NHS Canterbury And Coas...	23.1*	16.5	31.4
NHS Dartford, Gravesham...	24.8*	18.4	32.7
NHS Medway CCG	23.4*	17.4	30.9
NHS South Kent Coast CC...	26.7*	19.5	35.7
NHS Swale CCG	33.5*	22.6	47.9
NHS Thanet CCG	49.3*	37.2	64.2
NHS West Kent CCG	31.9*	26.5	38.2

Source: NHS Digital

7.0 Mental Health and Physical Health Co- Morbidity and Premature Death.

Fig 12



7.1 People with serious mental illness have worse health outcomes, including

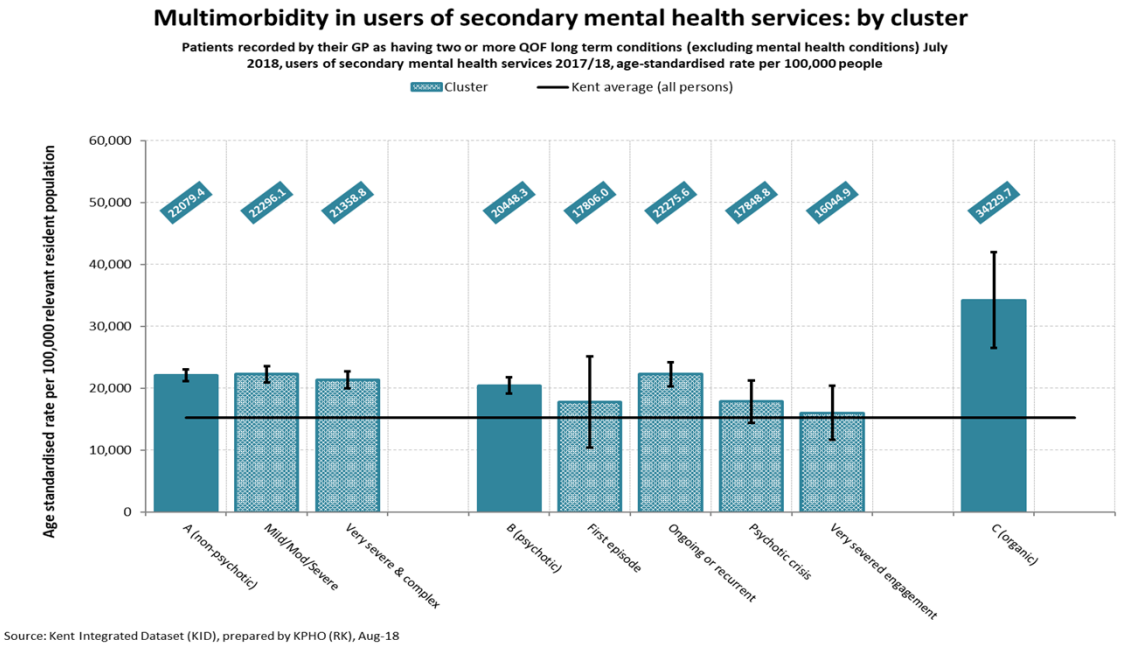
reduced life expectancy. Public Health England[13] have stated that excess premature mortality rates are 3.7 times higher amongst people with mental illness in England compared to the general population (Fig 12). It also states that adults with severe mental illness (SMI) die younger, from a range of conditions, than adults in the general population, with health disparities greatest for liver disease and respiratory disease.

7.2 People with long-term conditions and comorbid mental health problems disproportionately live in deprived areas and have access to fewer resources. The interaction between comorbidities and deprivation makes a significant contribution to generating and maintaining health and social inequalities.

7.3 Public Health in Kent conducted a study on the KID data comparing people who had 2+ long term conditions and people who had mental illness and other physical health illness (multi-morbidity). It found that people with a mental illness suffered greater multi-morbidity then those without mental illness and this impacted people with depression/ anxiety and psychosis equally (Fig 13).

7.4 The chart below (Fig 14) compares age standardised premature mortality rates for those with a serious mental illness with other adults aged 18-74, by Kent district and shows a great difference between those with a serious mental illness and their peers. Based on the age-standardised rates (i.e. adjusting for differences in the age profiles of those with a serious mental illness and the rest of the population), we see an odds ratio of 4.1 for Kent & Medway.

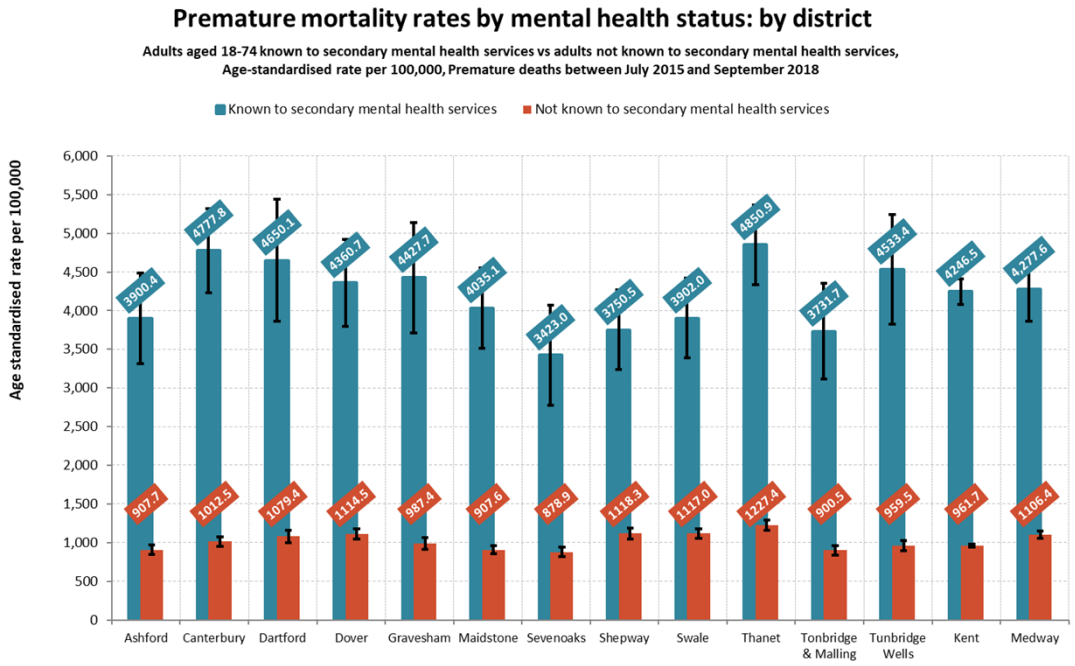
Fig 13.



Source: Kent Integrated Dataset (KID), prepared by KPHO (RK), Aug-18

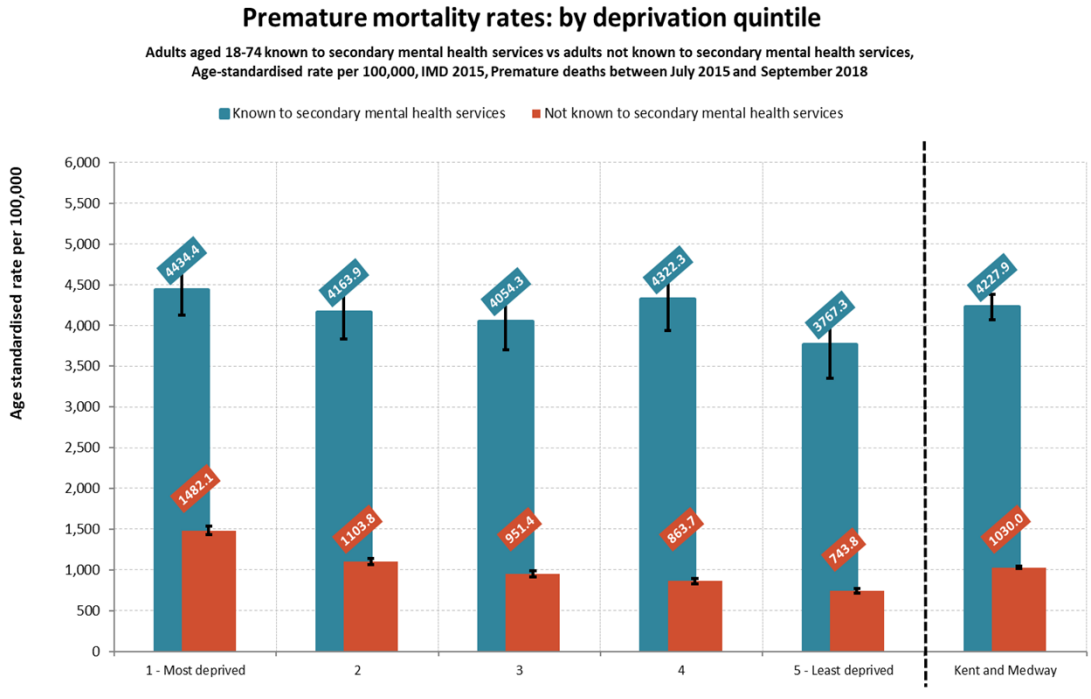
[13] Public Health England, December 2018, Health Matters: reducing health inequalities in mental illness. https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness (Accessed 31st December 2018)

Fig 14.



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

Fig 15.



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

7.5 Mental Illness and Health Inequalities: The health and mortality rates for people with mental illness interact with their health status and to living in areas of greater deprivation. The data in Fig 15 shows that premature mortality rates amongst those with a serious mental illness are higher for those living in more deprived areas, the gap is far smaller than is the case for the rest of the 18-74 population. Whilst age-standardised premature mortality rates amongst those

not known to secondary mental health services are 99% higher (i.e. around double) in the most deprived areas compared with the least deprived, this gap reduces to 18% for those with a serious mental illness. This indicates that mental illness in itself is a cause of health inequality.

8. Suicide in Kent

8.1 Whilst suicide is an important element of mental health the updated suicide needs assessment was reported to this cabinet committee in September 2018

9 Next Steps

9.1 A series of recommendations from this data will be developed and shared with relevant commissioners and providers as part of the strategic transformation programme for mental health.

9.2 This data will be shared with NHS STP Local Care in order to improve the health outcomes for people with mental health problems.

9.3 This data will be shared with NHS and Social Care commissioners to improve the pathway for depression and suicide prevention.

9.4 An action plan from the recommendations will be developed by the STP mental health programme.

10 Recommendation

The Health Reform and Public Health Cabinet Committee is asked to **COMMENT** on the report and **SUGGEST** areas of further investigation and focus.

11 Background Documents:

Chapter 5 of Adult Mental Health Needs Assessment 2019: Multi Morbidity and Premature Mortality.

12 Contact Details

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KENT PUBLIC HEALTH OBSERVATORY

Draft: Kent Adult Mental Health Needs Assessment

Chapter 5

Mental health, Multi-Morbidity and Premature Mortality

Produced by

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1. Executive Summary

1.1 Introduction

This report presents developmental statistics to explore the relationship between mental health and premature mortality in Kent and Medway.

1.2 Key Findings

Adults with a serious illness in Kent & Medway are around 4 times more likely to die prematurely than their peers

- The KID study shows that across Kent & Medway, 4.1% of those with a serious mental illness[1] died prematurely over the study period (September 2018) compared with 1.1% of the rest of the 18-74 population. This suggests that adults in Kent & Medway with a serious mental illness are 3.6 times more likely to die prematurely, in line with the England average (of 3.7)[2].
- Age-standardised premature mortality rates suggest an odds ratio of 4.1 (i.e. after adjustment for differences in age profiles).
- Survival analysis (incorporating age and deprivation) yields a hazard ratio for serious mental illness of 4.0 (i.e. after adjustment for age and deprivation).

Serious mental illness presents a greater risk of dying prematurely than deprivation or multimorbidity

- Discriminant analysis suggests that when the impact of age, deprivation, multimorbidity and serious mental illness on premature mortality rates is considered, serious mental illness is the next most important driver after age.
- Decision tree (CHAID) analysis based on age, serious mental illness, deprivation and multimorbidity demonstrates that whilst age is the biggest predictor of differences in premature mortality rates, having a serious mental illness is the next most important (of the characteristics considered) for adults aged under 55 and those aged 65-74, i.e. more so than multimorbidity overall and deprivation.

[1] For the purpose of this analysis, membership of the serious illness cohort is defined as individuals aged 18-74 recorded within KID as known to KMPT (i.e. listed within the Mental_Health_Contacts table)
[2] Public Health England, December 2018, Health Matters: reducing health inequalities in mental illness. https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness (Accessed 31st December 2018)

For those aged 55-64 multimorbidity is the second biggest predictor, followed by having a serious mental illness.

2. Introduction & Objectives

2.1 Mental Illness, Co-Morbidity and Poverty

2.1.1 Thresholds, Diagnosis and Co-Morbidity

In discussing prevalence in this report, the difficulty of mental health diagnosis must be noted. For example, mental health in primary care ranges from sub-syndromal symptoms (i.e. not reaching the definition for disorder), to clear cases of mental disorder which range significantly in the severity and the disability they cause. It is the existence of this spectrum that makes it hard to categorise mental ill health in primary care into simple groupings for service planning. In addition, there is an enormous co-morbidity between both physical and mental health conditions. This is the focus of this report.

2.1.2 Thresholds for Services

The health and social care burden of less severe, sub-syndromal, symptoms are considerable; up to 40-50% of days off work are thought to be stress related problems.[i] The analysis reflects existing evidence[ii] that the presence of a long-term condition increases the risk of a mental health problem; 30% of all people with a long-term condition also have a mental health problem. People with long-term conditions and comorbid mental health problems disproportionately live in deprived areas and have access to fewer resources. Common mental illness is more frequent in unemployed people.

2.1.3 Poverty

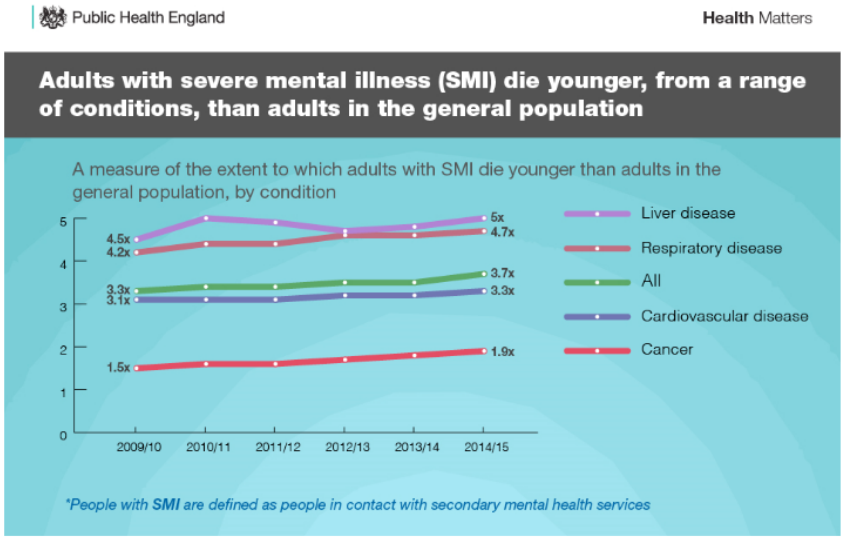
Poverty produces an environment that is extremely harmful to people's mental health. The primary health impacts of economic downturns are on mental health (including the risk of suicide) and people with no previous history of mental health problems may develop them as a consequence of having to cope with the ongoing stress of job insecurity, sudden and unexpected redundancy, and the impact of loss of employment (financial, social and psychological). Keeping people with mental health problems in work and getting people back to work are key policy and service responses to the economic downturn.[3]

2.1.4 Premature Mortality

[3] Royal College of Psychiatrists, Mental Health Network of NHS Confederation and London School of Economics (2009) in Mental Health Commission (September 2011) *The Human Cost. An Overview of the evidence on economic adversity and mental health and recommendations for action.* Dublin: Mental Health Commission

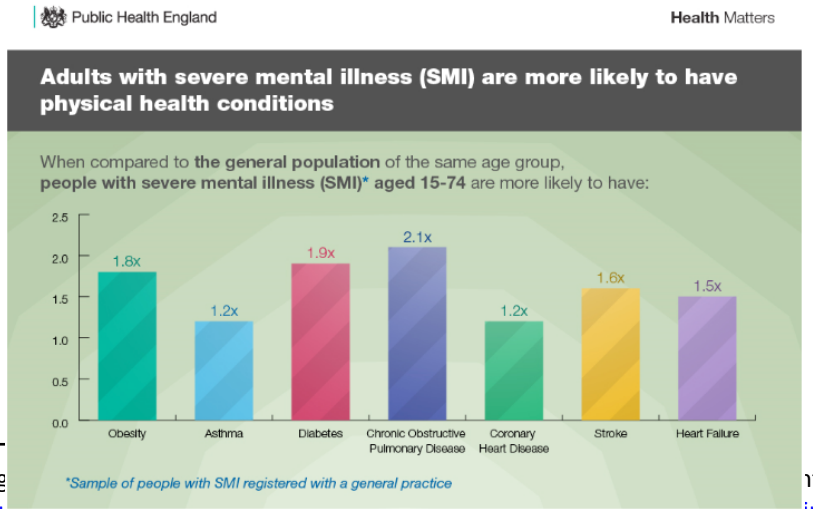
It has been widely documented that people with serious mental illness have worse health outcomes, including reduced life expectancy. Public Health England[4] have stated that excess premature mortality rates are 3.7 times higher amongst people with mental illness in England compared to the general population. It also states that adults with severe mental illness (SMI) die younger, from a range of conditions, than adults in the general population, with health disparities greatest for liver disease and respiratory disease.

Figure 1



The same report also identifies that there are physical health inequalities when comparing people with mental illness to the general population. It states that people with mental illness experience a greater burden of physical health conditions. It is estimated that for people with SMI, two in three deaths are due to physical illnesses such as cardiovascular disease (CVD) and can be prevented.

Figure 2



[4] Public Health Eng ...tal illness. https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness (Accessed 31st December 2018)

2.2 Summary of the Findings from the National Mental Health Task Force

There is an overwhelming body of evidence that **at least 30%** of all people with a long-term condition also have a mental health problem.

People with long-term conditions and comorbid mental health problems disproportionately live in deprived areas and have access to fewer resources. The interaction between comorbidities and deprivation makes a significant contribution to generating and maintaining health and social inequalities.

There are four key elements that are needed to understand the issue of 'parity of esteem' and the tackling of physical and mental health issues together. The Kings Fund Report 'Bringing it together' highlighted:

- **rising levels** of multi-morbidity
- **inequalities** in life expectancy
- **psychological** aspects of physical health
- **somatic:** medically unexplained symptoms.

2.2.1 Rising Levels of multi-morbidity:

A King's Fund Report in 2015 indicated that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health – most commonly in the form of *depression or anxiety disorders*, which if left untreated can significantly exacerbate physical illness and drive up the costs of care (Naylor *et al* 2012).

2.2.2 Inequalities in Health Outcomes:

Life expectancy for people with *bipolar disorder or schizophrenia* is 15 to 20 years below that of the general population, largely as a result of raised rates of cardiovascular disease and other physical health conditions (Laursen *et al* 2014; Miller and Bauer 2014).

Other mental illnesses that have significant co-morbidity with physical health are:

Eating disorders, personality disorders, substance misuse disorders & untreated depression.

2.2.3 Psychological Aspects of Physical Health

All health conditions have a psychological component and can impact on a person's wellbeing whether or not there is a diagnostic threshold for a mental illness being present. The body's stress-response system can be highly corrosive to physical health. Therefore, living with any long-term condition, functional impairment and social isolation can lead to a cycle of restricted physical and mental health. This is also a factor in **perinatal health** – where the interplay between mental and physical health also has a developmental consequence.

2.2.4 Current Research conclusions on interactions between mental and physical health

People with a long-term physical health condition are two to three times more likely to develop mental conditions, particularly depression and anxiety; conditions include:

- cancer
- atrial fibrillation (AF)
- chronic heart disease (CHD)
- cardiovascular disease (CVD)
- heart failure (HF)
- hypertension
- peripheral arterial disease (PAD)
- stroke
- asthma
- chronic kidney disease (CKD)
- chronic obstructive pulmonary disease (COPD)
- diabetes.

- (Kings College London Study) SMI and **Heart Disease**. Those with SMI had 53% higher risk of getting CVD and 83% higher risk of dying then those without SMI.
- (UCL & Edinburgh Study) CMI and **Cancer** Outcomes. Poorer mortality outcomes for those with high levels of common mental distress.
- Many studies have shown the link between **Diabetes** and Depression - this is not fully understood, yet there appears to be elevated risks for CVD where both diabetes and depression are present.
- SMI and Musculoskeletal problems. Bone density is effected by arthritis and osteoporosis. Having SMI more then doubles the risk of developing MSK and low bone density.

2.2.5 Summary of Key findings:

Mental health problems represent up to 23% of the total burden of ill health – the largest single cause of disability.

2.3 Physical Health of People Severe Mental Illness is worse with people without mental illness (apart from Dementia).

This analysis explores multimorbidity (number of different illnesses) in users of secondary mental health services, comparing them with multimorbidity rates amongst the Kent population as a whole. For the purposes of this analysis, users of secondary mental health services are those recorded within the Kent Integrated Dataset (KID) in the data provided by KMPT as having received a service during **2017/18 *and* coded into clusters 1-19**.

Multimorbidity is assessed using the read-coded long-term condition information contained within the GP records held within the KID. The analysis covers 16 QOF conditions (as the

categories serious mental health conditions, dementia and depression are the cohort assessed). Individuals recorded as having two or more of the 16 long-term conditions are classified as multimorbid.

Since data on multimorbidity is captured via GP records, the analysis has been restricted to Kent residents who are also registered at one of GPs flowing data into the KID. At the time of the analysis this represented around 93% of the total GP registered population living in Kent. The analysis covers **21,114** individuals and has been subdivided by mental health cluster groupings. Around 11% of these individuals received support from KMPT under more than one of these cluster groupings during 2017/18, and so appear under more than one category in the analysis.

This analysis shows age-standardised multimorbidity levels to be higher amongst users of secondary mental health services than for the population as a whole, and particularly for those falling into the organic cluster. Further analysis of dementia (organic) shows this is a different group to those with mental illness as they are typically far older.

3. Methodology

The analysis presented in this report is based on Kent & Medway residents registered with Kent or Medway GPs. It has been conducted using data from the Kent Integrated Dataset (KID). The KID is a whole population, person level, pseudonymised dataset that currently collects information from almost all NHS providers across Kent and Medway.

The majority of the analysis[5] presented in this report covers current Kent & Medway residents aged 18-74 registered with a Kent or Medway GP at September 2018, plus patients within this age group previously registered with a Kent or Medway GP but with a flag indicating that they died (i.e. with a patient deceased flag) between July 2015 and September 2018 (1,338,294 adults).

3.1 Serious mental illness

For the purposes of this analysis, membership of the serious mental illness cohort is defined as individuals aged 18-74 recorded within KID as known to KMPT (i.e. listed within the Mental Health Contacts table). KMPT provides mental health, learning disability and substance misuse services as well as other specialist services to 1.8 million people across Kent and Medway.

[5] The exception to this is analysis involving long term condition and multimorbidity prevalence, which is restricted to those registered with a GP flowing data into the KID at the time of the analysis and to deaths occurring between October 2017 and September 2018. Deaths prior to this date have incomplete GP records associated with them, and so identification of long term condition and multimorbidity prevalence is not possible.

3.2 Premature mortality

Premature mortality is defined as death in people under 75 years old. For the purposes of this analysis, premature mortality is measured as deaths of individuals aged 18-74.

3.3 Multimorbidity

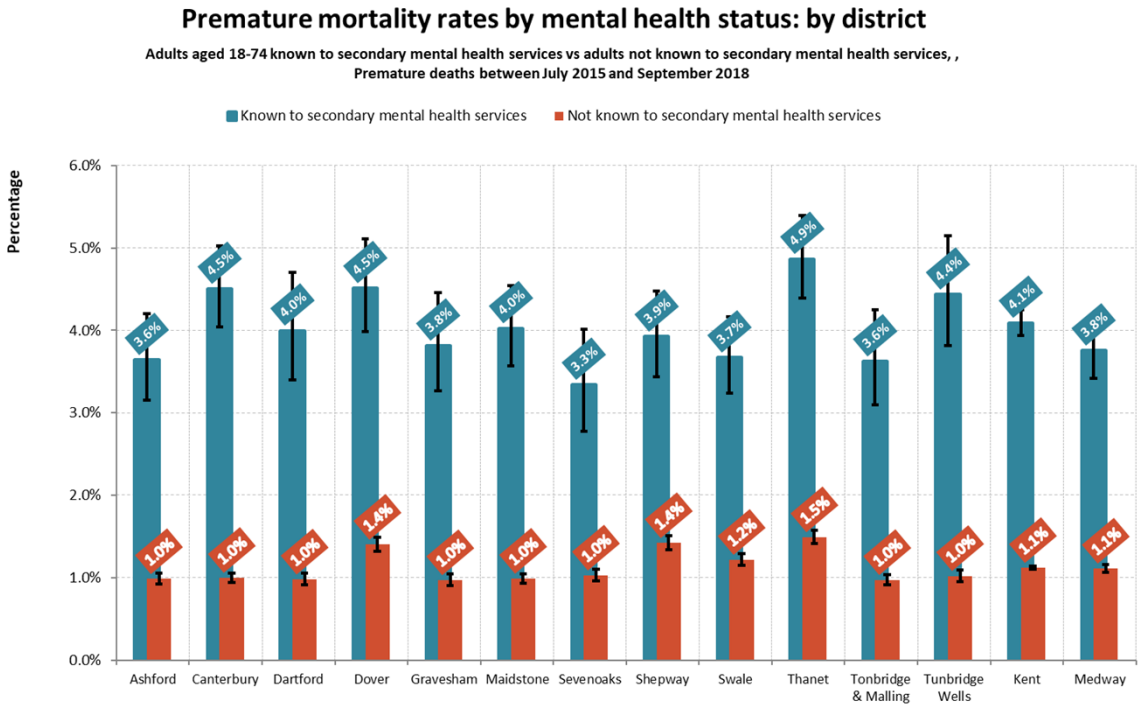
The multimorbidity analysis is restricted to those registered with the GPs flowing data into the KID at the time of the analysis. Individuals were considered multimorbid if they had two or more of the following 16 long-term conditions flagged within the GP records contained within KID: atrial fibrillation (AF), coronary heart disease (CHD), hypertension, heart failure (HF), peripheral artery disease (PAD), stroke, diabetes, asthma, chronic obstructive pulmonary disease (COPD), cancer, chronic kidney disease, (CKD), epilepsy, learning difficulties (LD), osteoporosis, rheumatoid arthritis (RA), or obesity.

4. Premature mortality rates

4.1 By District & CCG

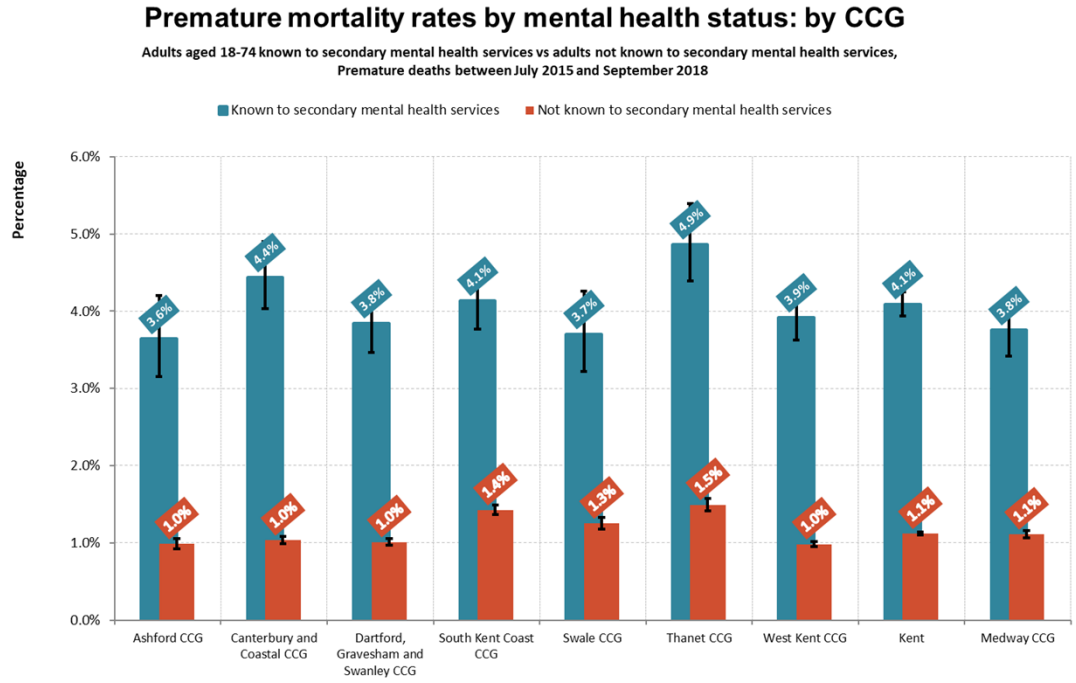
The charts below compare crude premature mortality rates for those with a serious mental illness with other adults aged 18-74, by district and CCG (of residence).

Figure 3



Source: Kent Integrated Dataset (KID), prepared by KPHO (RK), Dec-18

Figure 4



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Dec-18

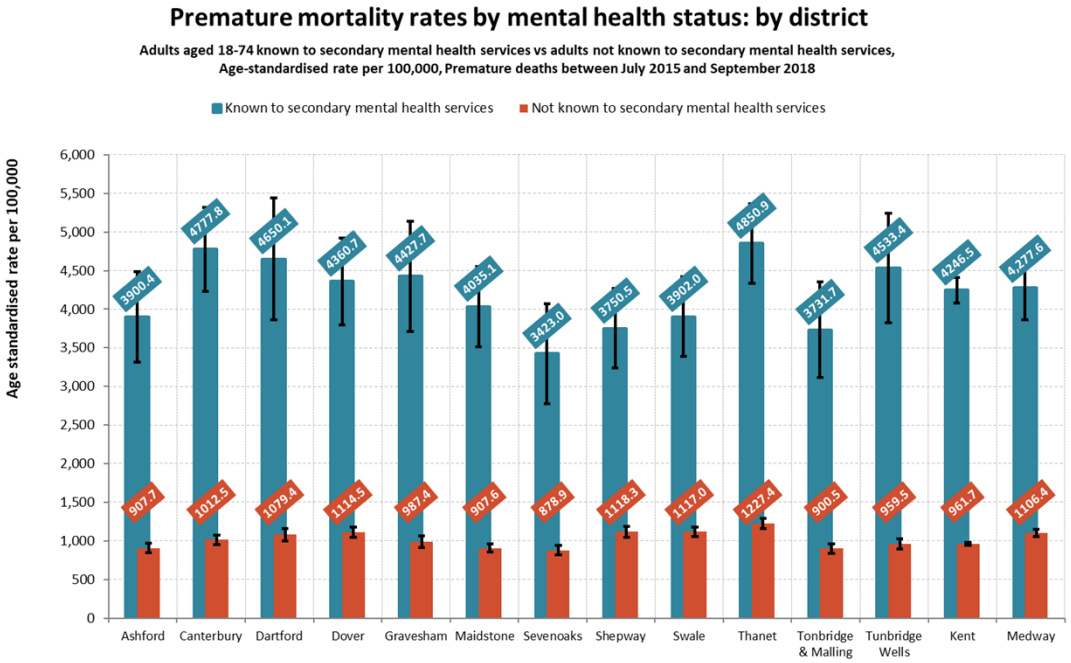
This analysis shows that those with a serious mental illness are much more likely to have died over the study period than the rest of the 18-74 population in every district and CCG.

For Kent & Medway as a whole, 4.1% of those with a serious mental illness died prematurely compared with 1.1% of the rest of the 18-74 population. This suggests that adults in Kent & Medway with a serious mental illness are 3.6 times more likely to die prematurely, in line with the England average (of 3.7)[6].

The chart compares age-standardised premature mortality rates by district and shows an even greater difference between those with a serious mental illness and their peers when adjustments are made for differences in age profile between the two groups. Based on the age-standardised rates (i.e. adjusting for differences in the age profiles of those with a serious mental illness and the rest of the population), we see an odds ratio of 4.1 for Kent & Medway.

[6] Public Health England, December 2018, Health Matters: reducing health inequalities in mental illness. https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness (Accessed 31st December 2018)

Figure 5

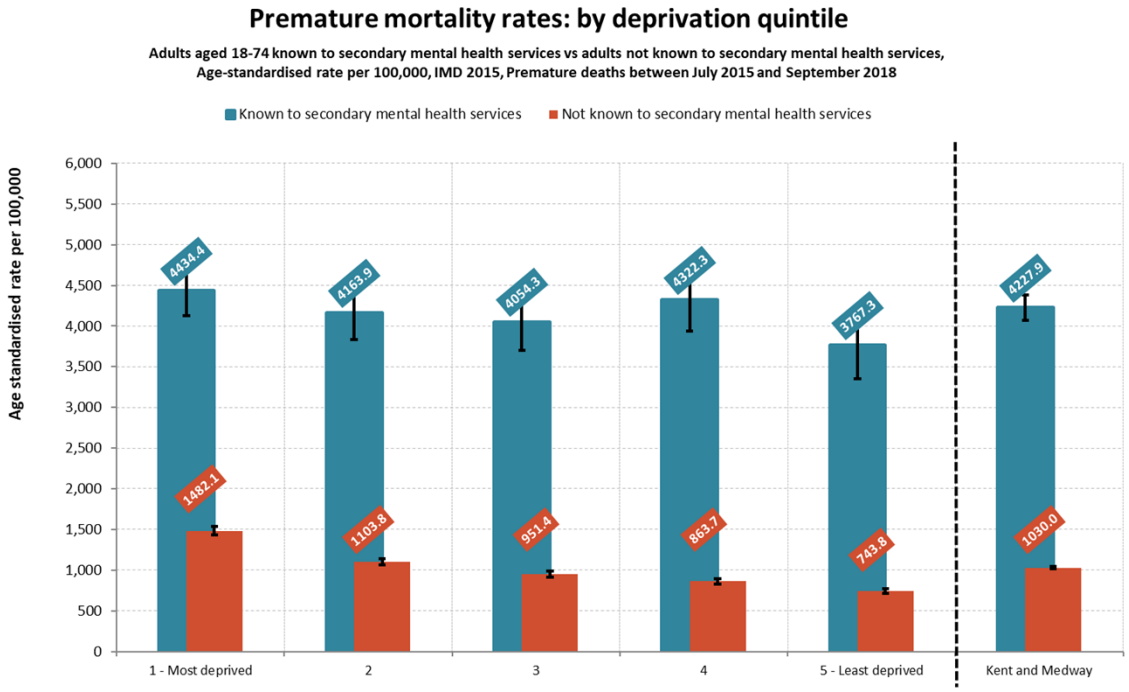


Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

4.2 By Deprivation

Whilst it is true to say that premature mortality rates amongst those with a serious mental illness are higher for those living in more deprived areas, the gap is far smaller than is the case for the rest of the 18-74 population. Whilst age-standardised premature mortality rates amongst those not known to secondary mental health services are 99% higher (i.e. around double) in the most deprived areas compared with the least deprived; this gap reduces to 18% for those with a serious mental illness.

Figure 6



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

5. Physical health conditions and multimorbidity

The analysis in this report that draws on long-term conditions and multimorbidity variables (i.e. GP records) is based on a slightly smaller cohort of individuals than the rest of the analysis in this report. These analyses are based on Kent & Medway residents aged 18-74 registered with one of the Kent & Medway *GPs flowing data into the KID* at the time of the analysis who died in the *12-month period* between October 2017 and September 2018[7], or were still alive at the end of the study period (1,233,847 adults).

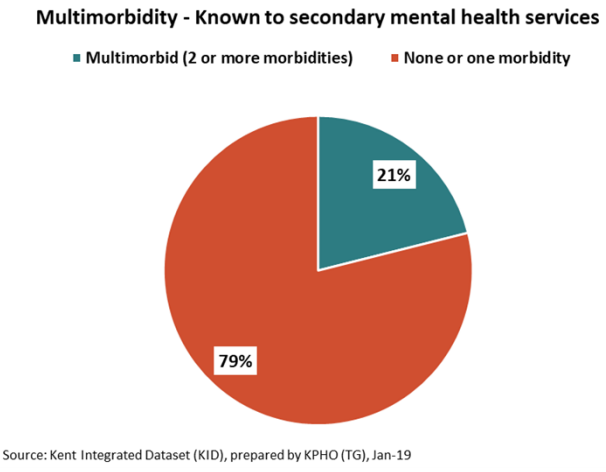
5.1 Multimorbidity prevalence

Recorded multimorbidity prevalence in Kent & Medway is around 50% higher amongst those with a serious mental illness than the rest of the population.

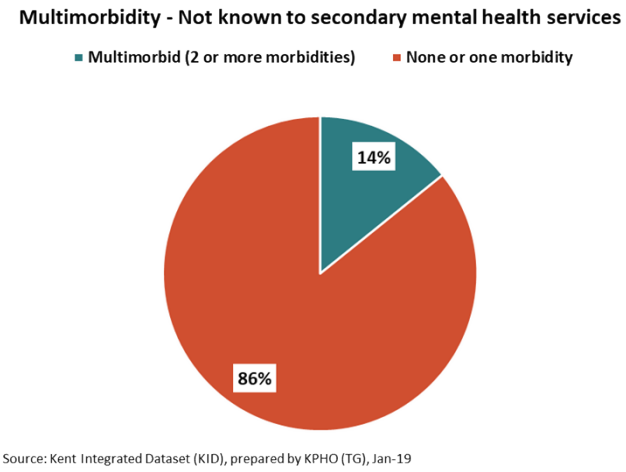
Across Kent and Medway, 21% of adults aged 18-74 with a serious mental illness[8] were recorded as multimorbid[9] by their GP compared to 14% of other adults aged 18-74.

[7] Deaths prior to this date have incomplete GP records associated with them, and so identification of long term condition and multimorbidity prevalence is not possible.
[8] And registered with one of the GPs flowing data into the KID at the time of the analysis.
[9] Patients were considered multimorbid if they had two or more of the following 16 long term conditions: Atrial Fibrillation (AF), Coronary Heart Disease (CHD), Hypertension, Heart Failure (HF), Peripheral Artery

Figure 7



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

5.2 Premature mortality and multimorbidity

Premature mortality rates are higher amongst those with a multimorbidity. Whilst the premature mortality rate was 1.4% for those in the study cohort[10] recorded by their GP as multimorbid, this reduces to 0.2% amongst those without two or more long-term conditions recorded.

Disease (PAD), Stroke, Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Cancer, Chronic Kidney Disease, (CKD), Epilepsy, Learning Difficulties (LD), Osteoporosis, Rheumatoid Arthritis (RA), or Obesity.

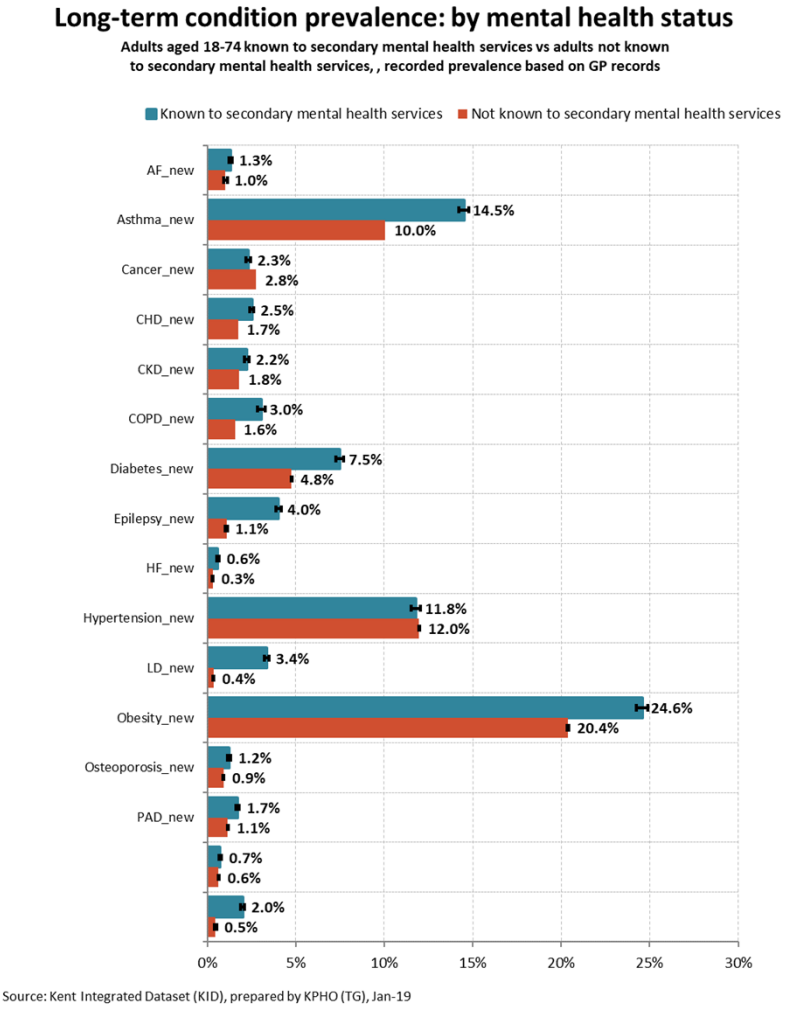
[10] Kent & Medway residents aged 18-74 registered with one of the Kent & Medway *GPs flowing data into the KID* at September 2018 who died in the *12-month period* between October 2017 and September 2018[10], or were still alive at the end of the study period (1,233,847 adults).

5.3 Long-term condition prevalence

Disease prevalence for adults aged 18-74 with a serious mental illness is particularly high in comparison with their peers for the following conditions:

- learning difficulties (odds ratio of 9.5)
- stroke (odds ratio of 4.3)
- epilepsy (odds ratio of 3.7)
- COPD (odds ratio of 2.0)
- HF (odds ratio of 1.9)
- diabetes (odds ratio of 1.6)
- peripheral arterial disease (odds ratio of 1.5)
- coronary heart disease (odds ratio of 1.5)

Figure 8



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

6. Drivers of inequalities in premature mortality rates

6.1 Survival analysis

Survival analysis techniques have been used to explore further the role of serious mental illness in inequalities in premature mortality.

In this analysis the impact of having a serious mental health condition on survival prospects is considered. A Cox regression has been performed with the following covariates:

- Serious mental illness (based on whether or not the individual has had contact with secondary mental health services)
- Age
- Deprivation (measured by Kent & Medway IMD decile)

This yields the following output, which suggests that all three of these covariates are statistically significant (i.e. that all three are associated with survival prospects).

Table 1

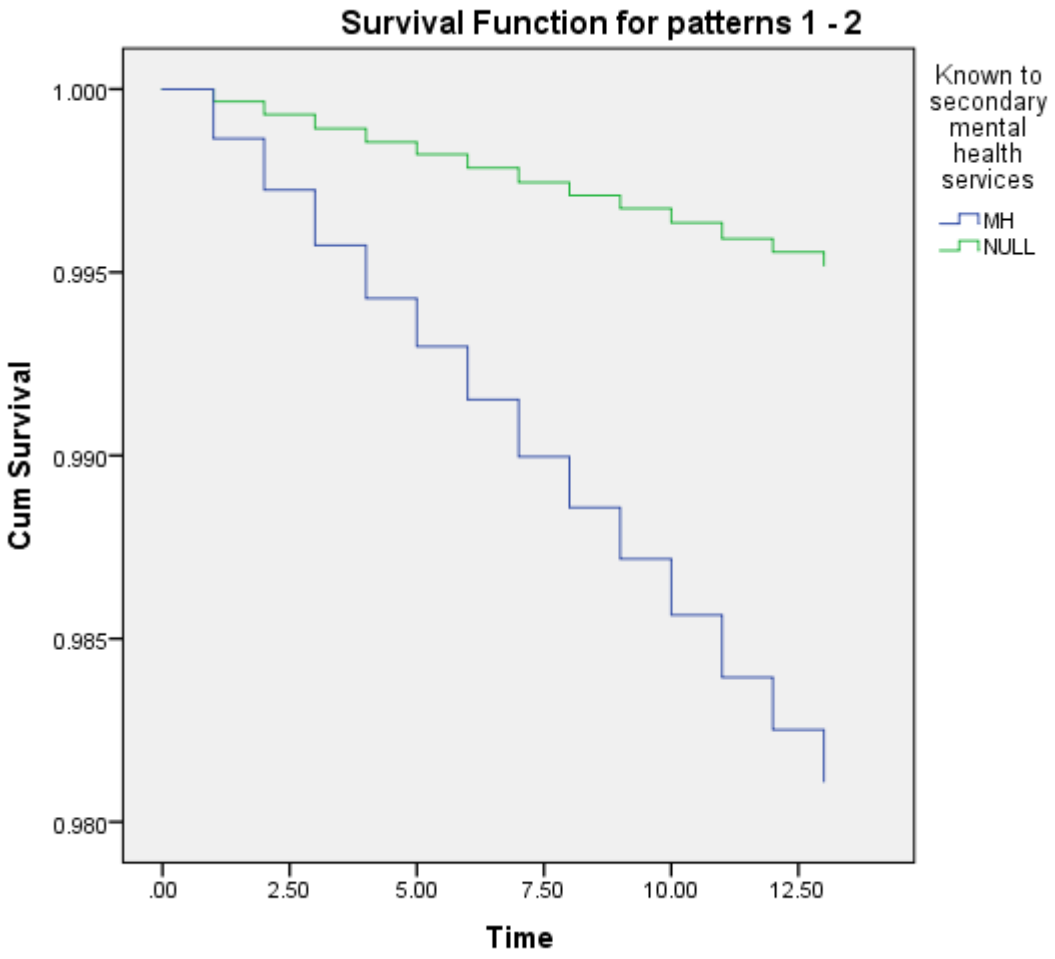
Variables in the Equation

	B	SE	Wald	df	Sig.	Exp(B)	95.0% CI for Exp(B)	
							Lower	Upper
Age	.088	.001	15356.794	1	.000	1.092	1.090	1.093
Deprivation (IMD)	-.144	.006	662.451	1	.000	.866	.856	.875
Known to secondary mental health services	1.375	.021	4489.875	1	.000	3.957	3.801	4.119

The hazard ratio for serious mental illness is 4.0 (95% confidence interval (3.8-4.1)), suggesting that the hazard of premature mortality for adults in Kent & Medway with a serious mental illness (after adjustment for age and deprivation) is four times that of their peers.

The chart below compares survival for those known to secondary mental health services with those who are not *adjusted for age and deprivation*.

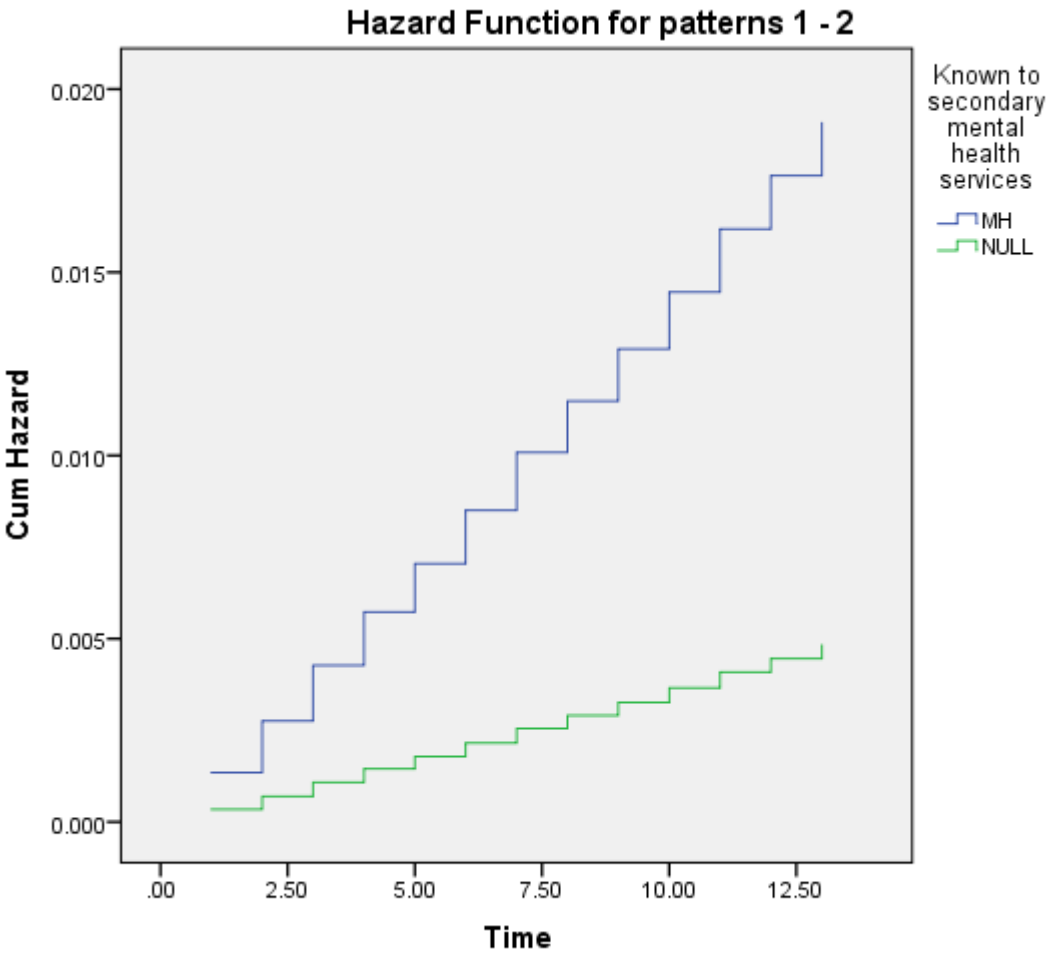
Figure 9



This clearly demonstrates inferior survival amongst those known to secondary mental health services (taken here as a proxy for those with serious mental health illness).

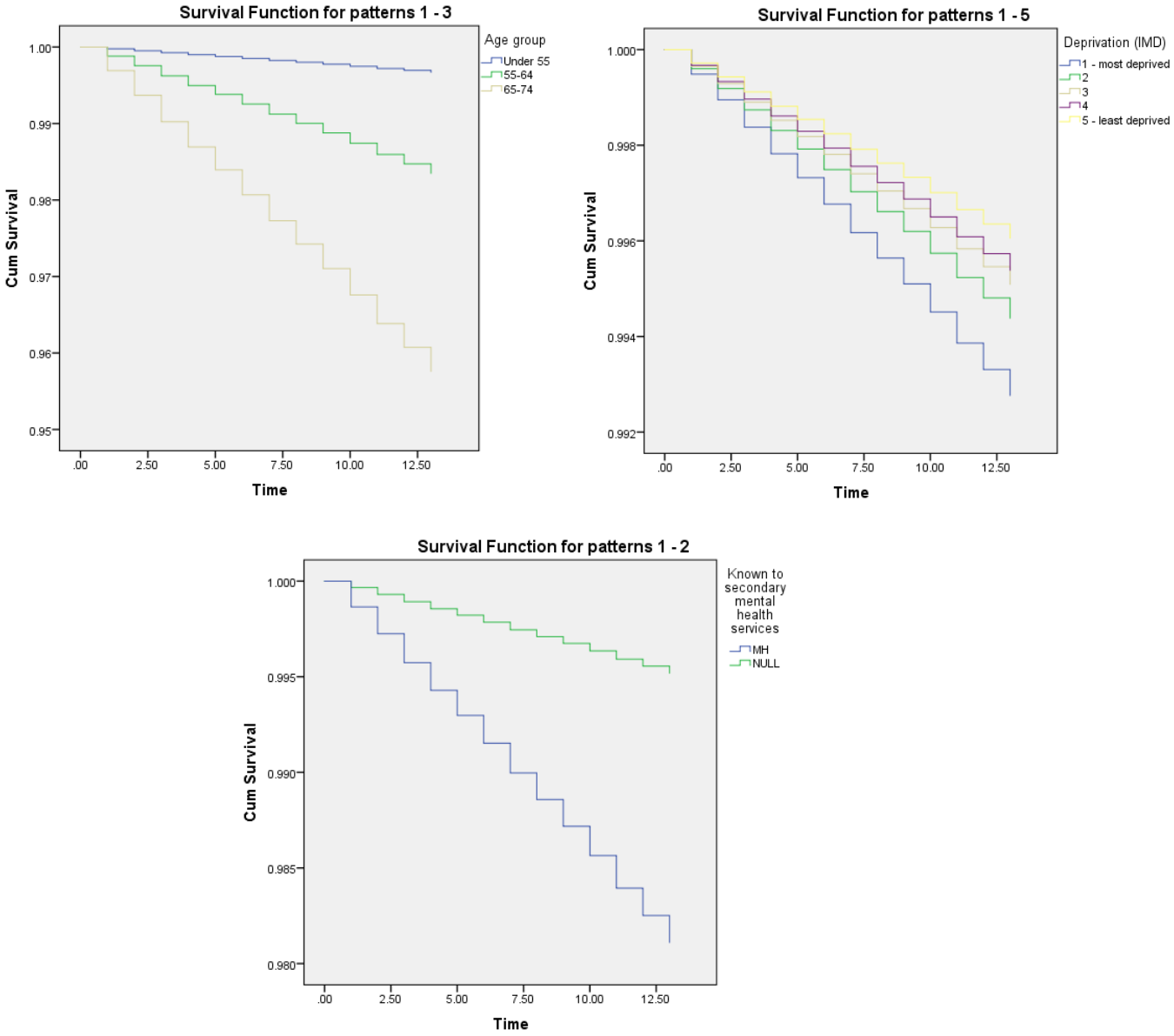
The chart below provides an alternative representation of this analysis, in terms of the hazard function. Again, this has been adjusted for age and deprivation.

Figure 10



The charts below show survival functions for age and deprivation, comparing them with the survival function for serious mental illness.

Figure 11



Whilst the greatest differences in the survival functions are seen for age (with older adults less likely to survive than younger adults), this is followed by whether or not they are known to secondary mental health services. Whilst there are differences between the survival functions based on IMD, there is less differentiation suggesting that serious mental illness has a greater impact on survival prospects than deprivation. This hypothesis has been tested further using decision tree analysis (CHAID) and discriminant analysis.

6.2 What Predicts Premature Mortality in Kent?: (Decision Tree Analysis).

A decision tree analysis, using CHAID, has been used to explore the relative importance of the characteristics that have been found to be associated with premature mortality rates (i.e. age, deprivation, multimorbidity and serious mental illness)[11]. This type of analysis considers which of a range of potential drivers of premature mortality is the most discriminating in respect of premature mortality rates, and in particular which *combinations* of potential drivers.

6.2.1 Age and Mental Illness

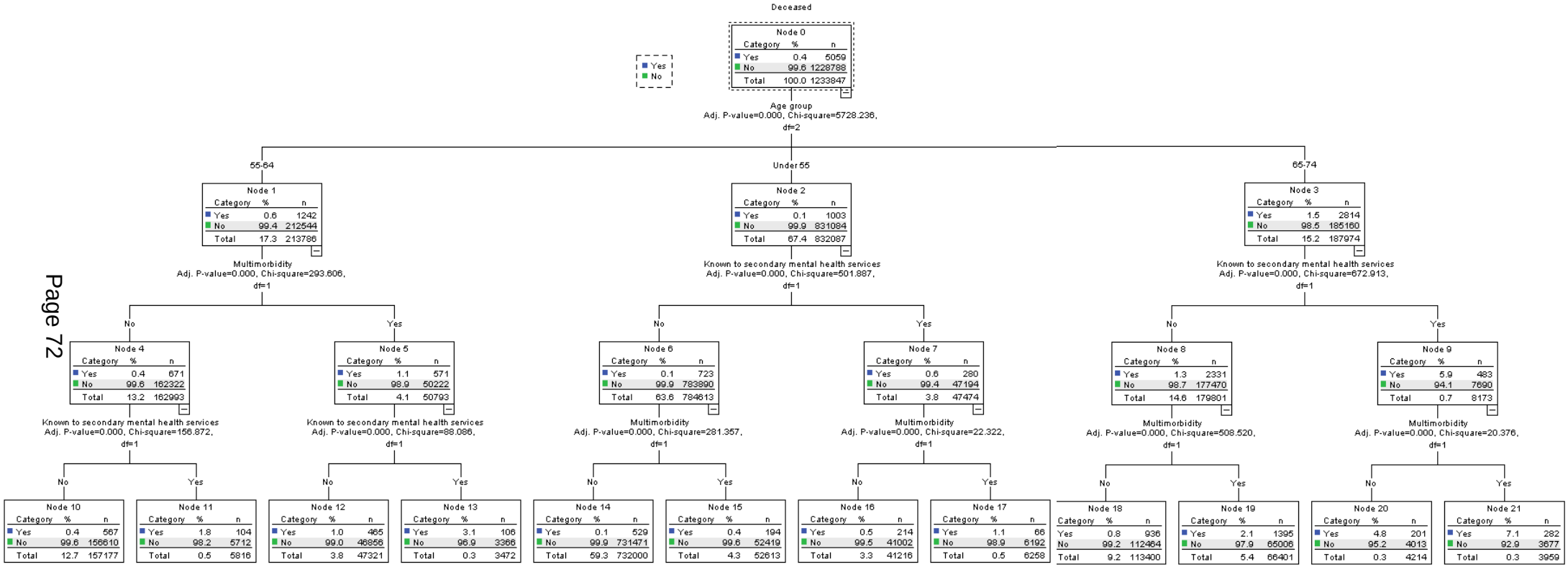
The analysis demonstrates that whilst age is the biggest predictor of differences in premature mortality rates, having a serious mental illness is the next most important (of the characteristics considered) for adults aged under 55 and those aged 65-74, i.e. more so than multimorbidity overall and deprivation. For those aged 55-64 multimorbidity is the second biggest predictor, followed by having a serious mental illness.

6.2.2 Cancer, Heart Failure and Mental Illness

If individual long-term conditions are considered (rather than multiple morbidity), cancer is shown to be more important than serious mental illness at predicting premature mortality rates in adults aged 55+. In the case of adults aged under 55, both heart failure *and* cancer are shown to be more important than serious mental illness, but *in both cases serious mental illness is the next most important predictor of premature mortality for those without these conditions.*

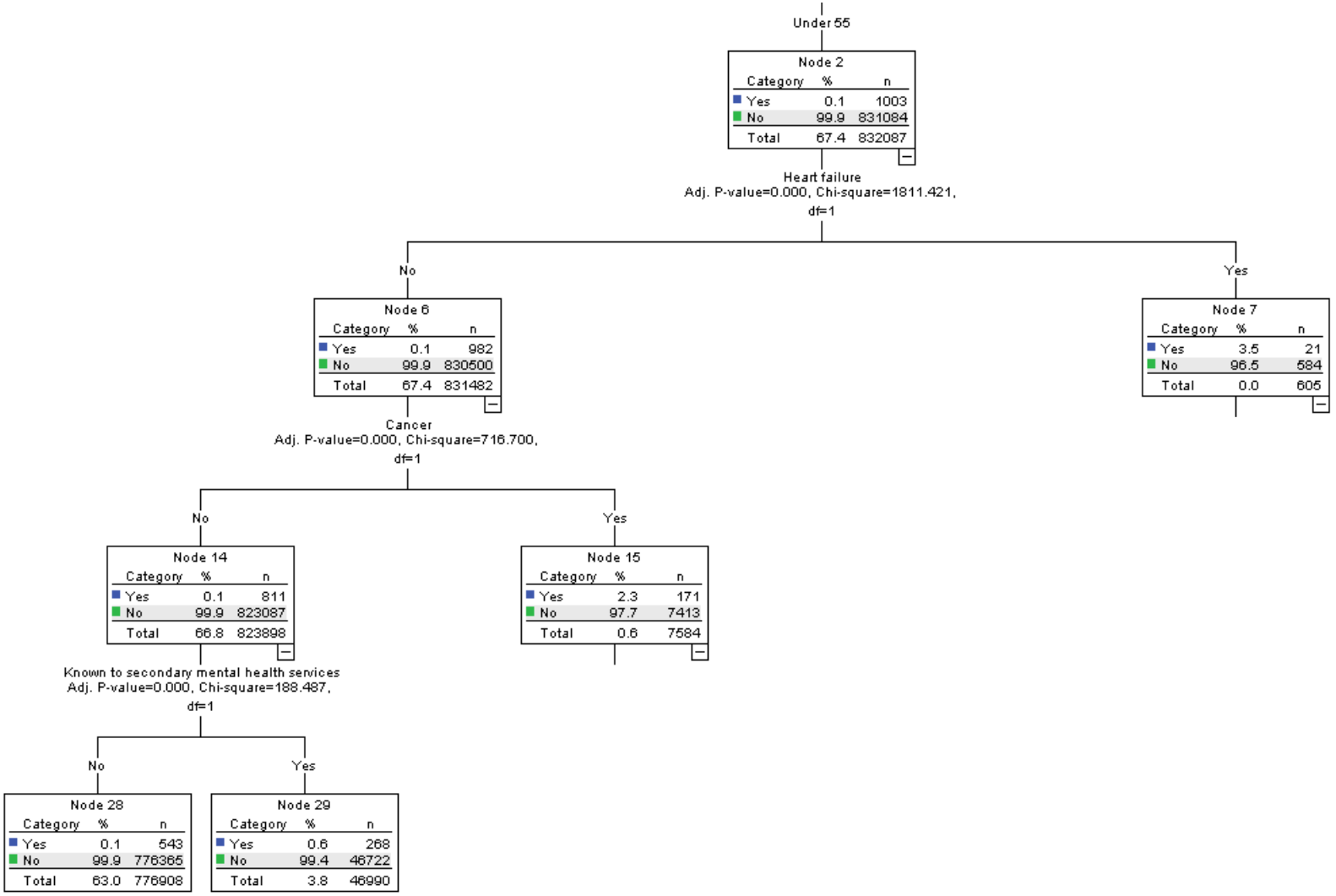
[11] As this analysis includes multimorbidity (i.e. information derived from GP records) it is restricted to Kent & Medway residents aged 18-74 registered with one of the Kent & Medway GPs flowing data into the KID at September 2018 who died in the 12-month period between October 2017 and September 2018 , or were still alive at the end of the study period (1,233,847 adults).

6.2.3 Decision tree analysis using age, deprivation, multimorbidity and serious mental illness

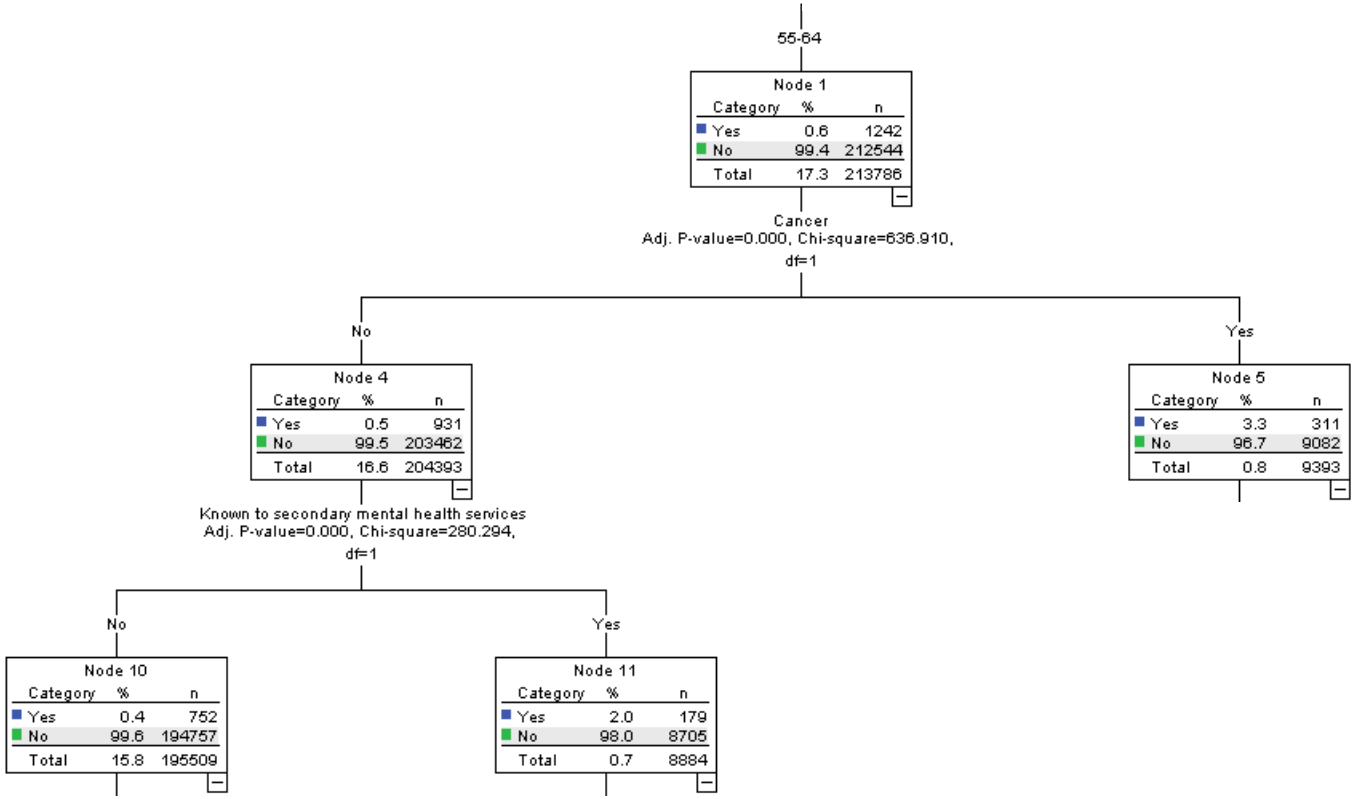


6.2.4 Decision tree analysis using age, deprivation, multimorbidity, serious mental illness and individual long-term conditions

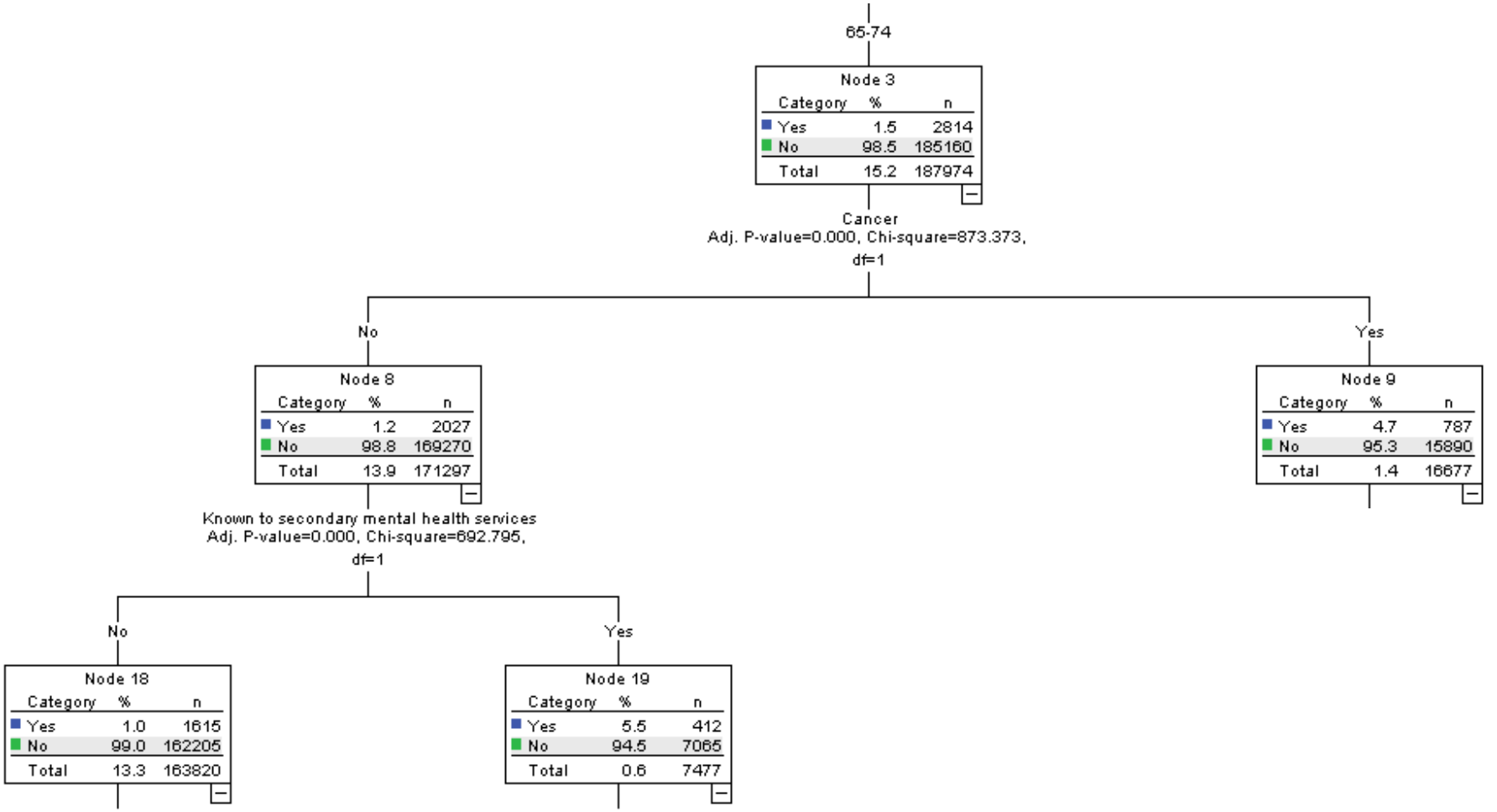
Under 55s



Ages 55-64


55-64
Node 1
Category % n
Yes 0.6 1242
No 99.4 212544
Total 17.3 213786
Cancer
Adj. P-value=0.000, Chi-square=636.910, df=1
No
Yes
Node 4
Category % n
Yes 0.5 931
No 99.5 203462
Total 16.6 204393
Node 5
Category % n
Yes 3.3 311
No 96.7 9082
Total 0.8 9393
Known to secondary mental health services
Adj. P-value=0.000, Chi-square=280.294, df=1
No
Yes
Node 10
Category % n
Yes 0.4 752
No 99.6 194757
Total 15.8 195509
Node 11
Category % n
Yes 2.0 179
No 98.0 8705
Total 0.7 8884

Ages 65-74


65-74
Node 3
Category % n
Yes 1.5 2814
No 98.5 185160
Total 15.2 187974
Cancer
Adj. P-value=0.000, Chi-square=873.373, df=1
No
Yes
Node 8
Category % n
Yes 1.2 2027
No 98.8 169270
Total 13.9 171297
Known to secondary mental health services
Adj. P-value=0.000, Chi-square=692.795, df=1
Node 9
Category % n
Yes 4.7 787
No 95.3 15890
Total 1.4 16677
No
Yes
Node 18
Category % n
Yes 1.0 1615
No 99.0 162205
Total 13.3 163820
Node 19
Category % n
Yes 5.5 412
No 94.5 7065
Total 0.6 7477

6.3 Conclusion and Recommendations: Health Inequalities: Health Inequalities will be worse where people age with mental illness: (Discriminant analysis).

Where Health Inequalities and premature mortality exists across Kent, in Kent's most deprived communities, people who are aging (over 50) with a mental illness are likely to be highly vulnerable to premature death.

Discriminant analysis provides an alternative analytical approach to exploring the drivers of premature mortality rates and produces similar overall findings.

With a stepwise approach, age is entered into the model first, followed by serious mental illness (then multimorbidity, then deprivation), and predicts 77% of cases correctly. This suggests that when the impact of age, deprivation, multimorbidity and serious mental illness on premature mortality rates is considered, serious mental illness is the next most important driver after age.

Recommendation: The mental health of a person must be as serious a consideration as their physical health in all health and social care treatments with a particular focus on joint management of mental and physical health conditions at primary care, increasing skills for front line clinical and social care staff in managing mental health and understanding medicines interactions. Prioritising areas of deprivation in Kent for integrated health and mental illness case management is also recommended. Ensuing there is increased and targeted support for lifestyle management in areas of deprivation targeted to people with mental health problems is also recommended – particularly alcohol, obesity and smoking for this group.

Variables Entered/Removed[a,b,c,d]

Step	Entered	Wilks' Lambda							
						Exact F			
		Statistic	df1	df2	df3	Statistic	df1	df2	Sig.
1	Age group	.994	1	1	1233845.000	7139.321	1	1233845.000	.000
2	Known to secondary mental health services	.992	2	1	1233845.000	4680.786	2	1233844.000	.000
3	Multimorbidity	.991	3	1	1233845.000	3753.331	3	1233843.000	.000
4	Deprivation (IMD)	.991	4	1	1233845.000	2848.658	4	1233842.000	.000

At each step, the variable that minimizes the overall Wilks' Lambda is entered.

a. Maximum number of steps is 8.

b. Minimum partial F to enter is 3.84.

c. Maximum partial F to remove is 2.71.

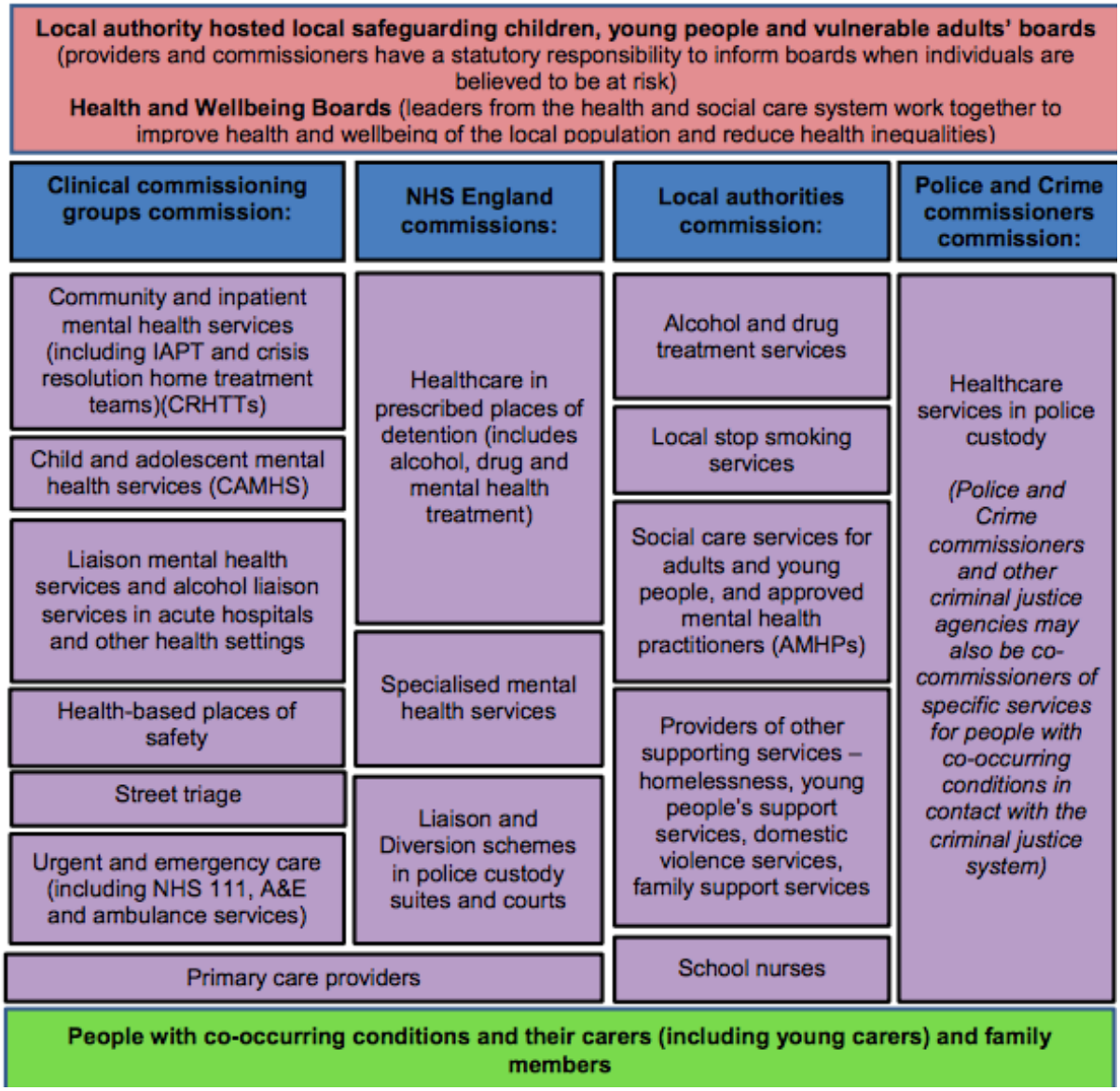
d. F level, tolerance, or VIN insufficient for further computation.

Classification Results[a]

		Deceased	Predicted Group Membership		Total
			Yes	No	
Original	Count	Yes	3769	1290	5059
		No	288288	940500	1228788
	%	Yes	74.5	25.5	100.0
		No	23.5	76.5	100.0

a. 76.5% of original grouped cases correctly classified.

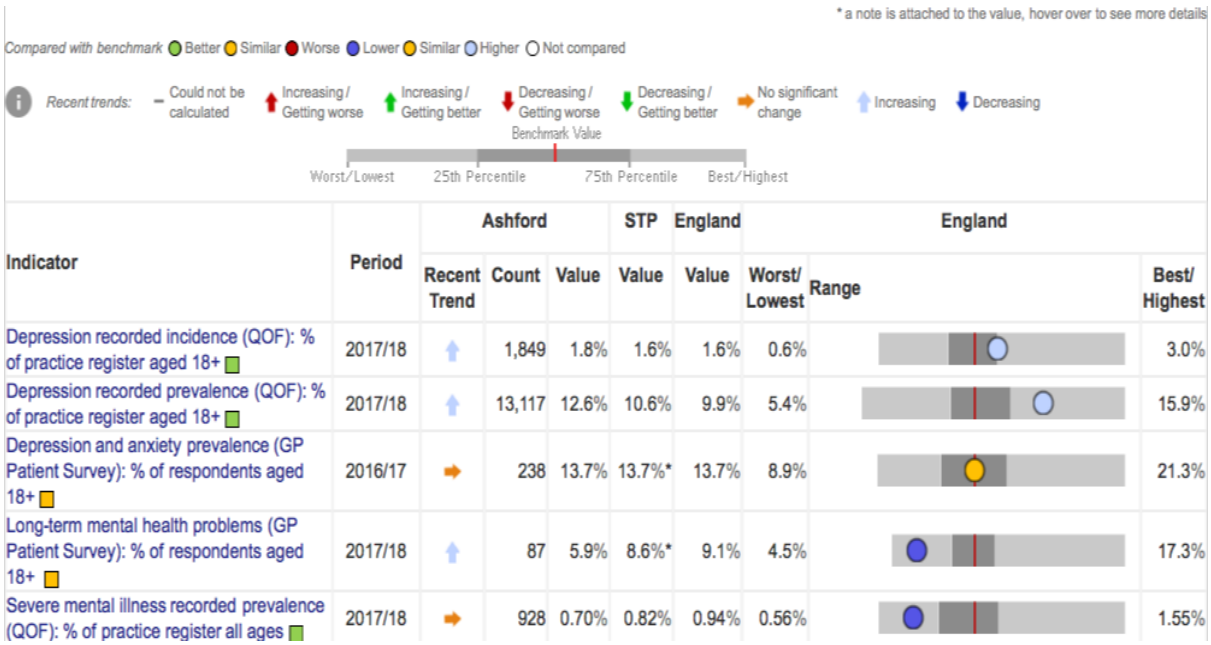
Appendix 1: Who commissions what in Mental Health



Appendix 2 **: Primary Care Data : Prevalence Rates of Mental Illness by Kent CCG**

East Kent

Fig 1

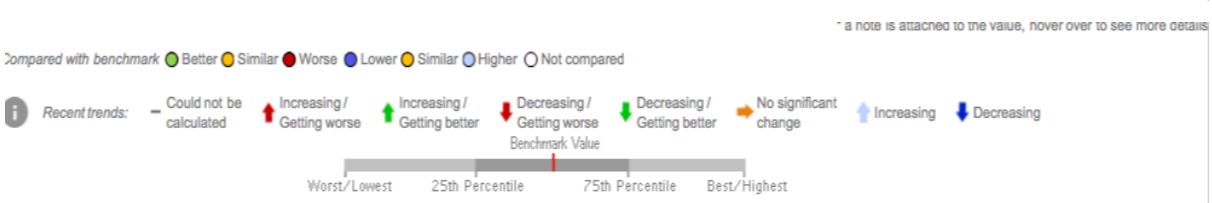


Indicator	Period	Ashford			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18	↑	1,849	1.8%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18	↑	13,117	12.6%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	→	238	13.7%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18	↑	87	5.9%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18	→	928	0.70%	0.82%	0.94%	0.56%		1.55%

In Ashford: Depression is increasing in primary care which indicates that there is a good coverage however QOF for SMI is lower expected prevalence.

In Canterbury the QOF prevalence of both Depression and SMI is as expected.

Indicator	Period	Canterbury And Coastal		STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		3,806	2.0%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		21,471	11.6%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		456	15.0%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		272	10.9%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		2,095	0.93%	0.82%	0.94%	0.56%		1.55%



Indicator	Period	South Kent Coast		STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		1,969	1.2%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		16,813	10.2%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		430	15.5%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		214	8.9%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		1,946	0.95%	0.82%	0.94%	0.56%		1.55%

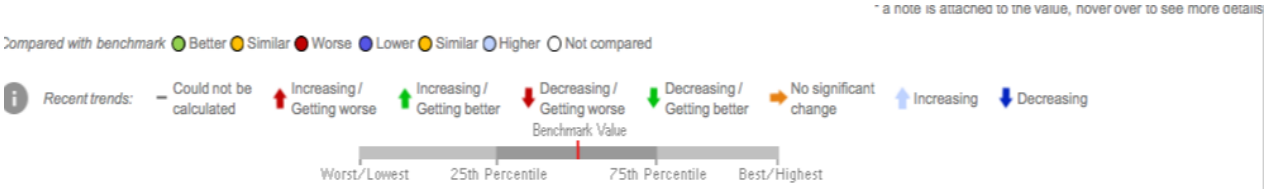
In South Coast Kent the trend for all conditions is increasing. There is below expected prevalence of recorded depression (although it is in line with East Kent CCGs). There appears to be good recording of SMI in South Kent Coast CCG.

Thanet has higher than average rates for CMI and SMI indicating both high demand and good recording at primary care.

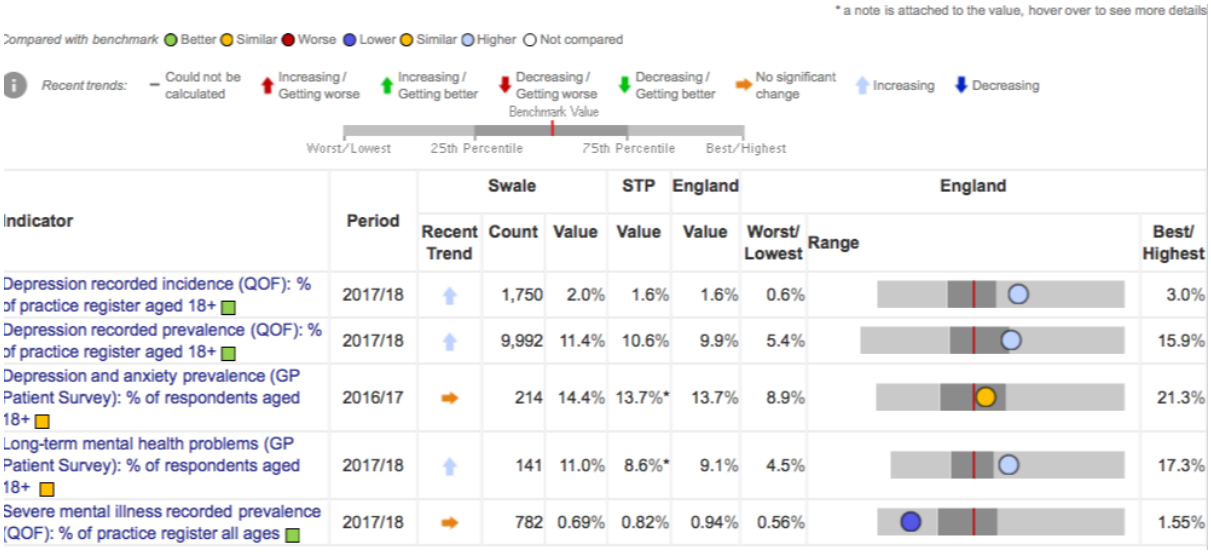
Indicator	Period	Thanet			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		2,523	2.2%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		14,650	12.7%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		347	18.3%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		147	8.9%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		1,699	1.17%	0.82%	0.94%	0.56%		1.55%

Overall East Kent is seeing increases in mental illness in primary care.

North Kent



Indicator	Period	Dartford, Gravesham And Swanley			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		1,700	0.8%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		15,045	7.2%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		426	12.1%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		230	7.5%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		1,986	0.74%	0.82%	0.94%	0.56%		1.55%



* a note is attached to the value, hover over to see more details

Compared with benchmark: Better, Similar, Worse, Lower, Similar, Higher, Not compared

Recent trends: Could not be calculated; Increasing / Getting worse; Increasing / Getting better; Decreasing / Getting worse; Decreasing / Getting better; No significant change; Increasing; Decreasing

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Swale			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18	↑	1,750	2.0%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18	↑	9,992	11.4%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	→	214	14.4%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18	↑	141	11.0%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18	→	782	0.69%	0.82%	0.94%	0.56%		1.55%

Swale and Dartford and Gravesham show somewhat differing patterns of mental illness in primary care. With DGS showing lower recording levels then expected and Swale showing higher. It may be important to understand the mental health primary care pathway in DGS given the demand in primary care to understand this better.

* a note is attached to the value, hover over to see more details

Compared with benchmark: Better, Similar, Worse, Lower, Similar, Higher, Not compared

Recent trends: Could not be calculated; Increasing / Getting worse; Increasing / Getting better; Decreasing / Getting worse; Decreasing / Getting better; No significant change; Increasing; Decreasing

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Medway			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18	↑	4,044	1.7%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18	↑	27,738	12.0%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	↑	550	14.0%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18	↑	318	9.3%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18	↑	2,172	0.73%	0.82%	0.94%	0.56%		1.55%

West Kent

In West Kent it appears that depression is well recorded in primary care as it is above the STP benchmark. However some investigation on the management of SMI may be important as recording is below the STP average.

Indicator	Period	West Kent			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		5,967	1.6%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		38,090	9.9%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		742	11.4%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		430	7.7%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		3,812	0.77%	0.82%	0.94%	0.56%		1.55%

[i] Cooper C, Cartwright S,. Mental health and stress in the worklace, a guide for employers. London HMSO, 1996

[ii] Kings Fund

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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 - 13 March 2019

Subject: **Health Inequalities**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:
Health inequalities are widening in line with the national picture due to the slowing of the increase in life expectancy, particularly for the most deprived communities. KCC Public Health continues to collaborate and coordinate a whole systems approach through the Sustainability Transformation Partnership, and with wider partners to address this trend systematically.

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

COMMENT on and **ENDORSE** the approach outlined.

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1. Background.

1.1 Health Inequalities are the differences in health outcomes across and between communities. They result from a wide variety of social determinants. Addressing these health inequalities is a key focus of local, national and global health policy and for Local Authorities enshrined in the Health and Social Care Act 2012 as a duty along with the National Health Service.

2.0 Introduction

2.1 It is now widely recognised that our health as individuals is shaped by the conditions in which we are born, grow, live, work and age. Whilst there are elements of our health that we can't change such as our genetic make up and gender there are numerous other conditions which are modifiable and influence our long term health.

2.2 The model of Social Determinants of Health (see appendix 1) explains these factors in some detail.

Health Inequalities are generally measured in populations using rates of all age all cause mortality by deprivation decile or differences in life expectancy at birth, usually measured at district level.

3.0 Progress in Kent

3.1 The most recent analysis suggests that health inequalities across the country are widening. Whilst rates of all age all cause mortality are improving for all populations in Kent, the improvements in the most deprived decile have slowed, whilst the improvements in the least deprived remain; thus a widening gap.

3.2 Further analysis of what is driving this widening locally at a clinical level suggests that cancers and particularly lung cancers makes a significant contribution. This reflects the cohort of people taking up smoking in previous decades who are now going on to be diagnosed with lung cancer related to their smoking.

3.3 This slowing of improvements is now well recognised as a national issue which Public Health England (PHE) reported on in December 2018[1].

4.0 National Policy

4.1 Health Inequalities and reducing health inequalities remain a national priority. The NHS Long Term Plan published in January 2019 includes a whole section on reducing health inequalities and outlines the action the NHS will take over the next five to ten years in order to address these.

These actions include significant NHS contributions to support:

- Making England smokefree
- A much greater focus on smokefree programmes for expectant mothers and their partners and in specialist mental health and learning disability services.
- Greater focus on obesity particularly for people diagnosed with type 2 diabetes or hypertension with a body mass index of 30+
- Support people with alcohol dependency related admissions through Alcohol Care Team provision.
- Contribution to action on air pollution.
- Delivery of the five year action plan on Antimicrobial resistance
- A higher share of funding towards geographies with higher health inequalities.
- Local planning through developing specific measurable goals for narrowing the gap in maternity services
- Support implementation of enhanced and continuity of care for the most vulnerable
- Enhance number of people in mental health services receiving physical health checks.
- The continued improved identification and support for carers, particularly

[1] Public Health England; Recent trends in Mortality in England. Published December 2018.

those from vulnerable communities.
- The expansion of NHS specialist clinics to help more people with serious gambling problems
- The commissioning, partnering and championing of local charities, social enterprises and community interest companies providing services and support to vulnerable and at risk groups.

4.2 We also expect PHE to publish a new reducing health inequalities strategy in the spring of this year.

5.0 Actions public health are working on

5.1 The following actions that the Public Health team are working on across partners and the Sustainable Transformation Partnership to ensure a continued focus on the reduction of health inequalities:

- To refresh the STP Case for Change to incorporate the NHS Long Term Plan including actions for prevention in primary and secondary care systems and reducing health inequalities.
- Work with emerging integrated care networks and primary care networks in order to translate strategic priorities for Kent and Medway to local action. This will fundamentally include an under-pinning approach to reduce health inequalities locally.
- We have contributed to the upcoming health inequalities strategy from PHE, expected to be published in Spring 2019.
- Review progress made on Mind the Gap and develop a new working plan based on a synthesis of Mind the Gap, the NHS Long Term Plan and the STP prevention workstream and ensuring that all actions arising from the forthcoming Health Inequalities Strategy are woven into the new plan.
- We are leading and supporting colleagues in other KCC Directorates to develop and deliver a cross-directorate programme which will align the local programmes of work to support the reduction of health inequalities.
- We will use health intelligence and evidence to review our commissioning arrangements going forward to match local need and assure evidence based quality delivery.
- To continue to work with our district partners to ensure a “Health in all policy” approach is adopted and maintained and that districts continue to be tied into local health and care delivery.

5.0 Recommendation

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

COMMENT on and **ENDORSE** the approach outlined.

6.0 Background Documents

PHE publication ‘A review of recent trends in mortality in England 2018’ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762623/Recent_trends_in_mortality_in_England.pdf

7.0 Contact Details

Report Author and Relevant Director:
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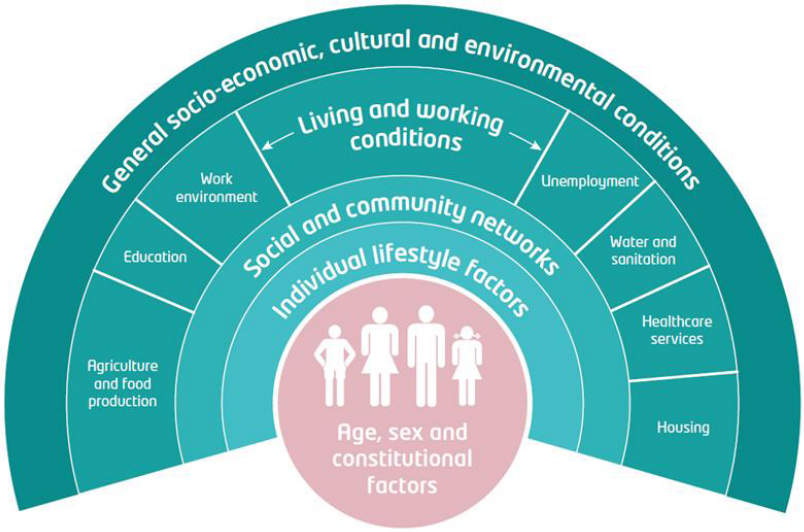
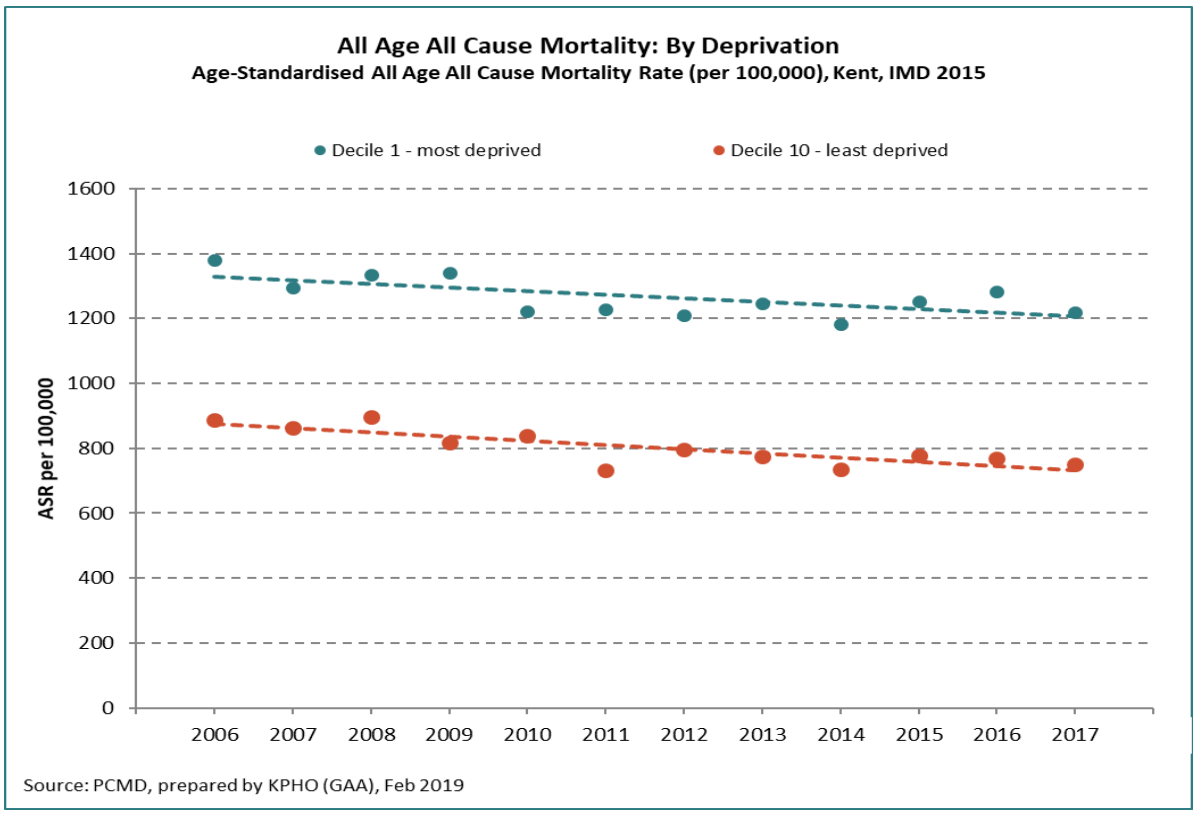
Appendices

Appendix 1



Dahlgren and Whitehead's Social Model of Health (1991)

Decile of deprivation on all age all cause mortality



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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 - 13 March 2019

Subject: **Childhood Obesity - report on joint working between agencies to tackle obesity**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

This report is presented as a follow up to the overview of childhood obesity in Kent presented at the meeting in January 2019. This report provides details of the joint working between agencies to tackle obesity.

Childhood obesity is a major public health challenge, it has a wide-ranging impact on health and wellbeing throughout the life course.The causes of childhood obesity are complex, they include biology and individual behaviour, but this is set within cultural, social and economic environment in which we live. These causes cannot be overcome by the action of single agencies alone, therefore there are a number of initiatives underway across Kent using a partnership approach. This includes a pilot service being delivered by the district councils and the School Health Service in Dartford and Gravesham and a whole systems obesity project being planned for Maidstone.

Recommendation:
The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on the joint work being undertaken by agencies to tackle childhood obesity.

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.

1.2 Childhood obesity is a major public health challenge, it has a wide-ranging impact on health and wellbeing. Children who are obese are more likely to have asthma and other respiratory problems, skin infections, type 2 diabetes and some cancers. Obesity in childhood is also linked to psychological disorders including poor self-esteem, eating disorders and anxiety. In the longer-term obese children are more likely to be obese in adulthood, carrying with them the increased risk of disease, disability and premature mortality.

1.3 The causes of childhood obesity are complex, they include biology and individual behaviour, but this is set within cultural, social and economic environment in which we live. Our environment provides us with access to cheap energy dense foods and less active ways of living[1]. Eating healthily and being active are not the most accessible ways for people to live their lives. Only focussing on changing individual behaviour is unlikely to lead to any large reduction in the prevalence of obesity. This was reflected in Making Obesity Everyone's Business – A Whole Systems Approach to Obesity (2017)[2]**.** This report highlighted the importance of local authorities adopting a Whole Systems Approach to tackling obesity. Referring to the Obesity Systems Map, the report argues that the complexity of the obesity issue makes it a difficult problem to tackle one component at a time.

1.4 This complexity means that even on a local level, working as a single agency is less likely to be effective in reducing childhood obesity than working in partnership with other bodies who have access to other levers which might help reduce and prevent obesity. Therefore, KCC works in partnership with a number of agencies to ensure that the programmes developed or commissioned maximise impact and deliver value for money.

2. Joint working across agencies

2.1. In the early years, the promotion and support of breastfeeding contributes to the prevention of obesity, as breastfeeding is known to be protective for the child. Through the Local Maternity System, a multiagency partnership of the Kent and Medway maternity services, CCGs, KCC Public Health, KCC Early Help and third sector organisations, an antenatal and postnatal infant feeding pathway has been developed. This pathway presents an evidence-based step by step journey for families, whatever the challenges they face, to provide support to both initiate and continue to breastfeed. This pathway has been in place since June 2018 and will be audited in summer 2019 to assess how effective the partnership has been in implementing the pathway. The LMS is also developing a Kent and Medway wide resource to provide easily accessible advice and support to families which will be supported by the whole partnership.

2.2. Delaying introducing solid food until 6 months of age and introducing food using appropriate portion sizes and healthy foods are key interventions to prevent obesity. The health visiting service and children's centres are committed to providing good quality information and support to families on this issue. Open access "introducing solid food" sessions are held in every district in children's centres delivered by the health visiting service, and where possible jointly with children's centres staff. The Health Visiting Service have provided training to children's centre staff on introducing solid foods.

2.3. Born to move is an award-winning initiative of the Health Visiting service. Its aim is to provide information about the early child development and the importance of providing early sensory and movement experiences from birth. The initiative has three key

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[1]Government Office for Science. (2007) *Tackling Obesities: Future Choices-Summary of Key Messages*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/287943/07-1469x-tackling-obesities-future-choices-summary.pdf [Accessed 10 December 2018]

[2] Local Government Association. (2017) *Making obesity everybody's business, A whole systems approach to obesity.* Available at: https://local.gov.uk/sites/default/files/documents/15.6%20Obesity-05.pdf. [Accessed 10 December 2018]

messages, the importance of awake tummy time from birth in preparation for crawling, eyes need to move too and chatter matters. One of the key aims is to increase activity from birth with a view to setting habits around activity for the rest of childhood. The key born to move messages are communicated at each mandated contact by health visitors. The health visitors have trained children's centre staff across the County. The Children's centre staff deliver the messages directly to families they are working with, through message and information boards in the centres and hold regular born to move open access sessions for families.

2.4. For primary school age children, a pilot began in mid-January 2019 to provide an intervention for children who are already overweight or obese in 8 schools across Dartford and Gravesham. This is partnership project, commissioned by KCC Public Health, utilises existing resources from the District Council family weight management programme and the school health public health service 1:1 package of care. Families are recruited by the school health service, via self -referrals and follow up from the national childhood measurement programme (NCMP) and by engagement with the school by the District Council Teams. Ten-12 families will attend 8 sessions and will engage with group practical nutrition and physical activity sessions led by the District Councils and receive 1:1 support from the school health support. School health staff will also be present at the group sessions, to support families and to be better able to embed the learning in the 1-1 sessions. As well as delivering the intervention, the Districts will be developing health lifestyles partnership groups in each school, to support the schools to become healthier environments and support other initiatives. This will run from January 2019 -July 2020 and is being evaluated by the University of Kent. This evaluation will inform the future commissioning plans.

2.5. Kent CCGs through Children and Young People's Mental Health Transformation Fund have developed the Good Mental Health Matters Campaign. KCC Public Health are key members of the Transformation programme. Two of the five key message of the campaign are Eat Well and Exercise. This campaign has run so far for secondary aged children, with booklets being sent to homes across Kent, the development of a website and events being run in schools and the community to promote the key messages. The campaign has also developed curriculum resources for schools to deliver the key messages. The campaign is now being rolled out to primary school children in school with the same key messages, reinforcing and delivering messaging about healthy eating and being active.

2.6. PHE provide healthy lifestyle messaging for children and young people through the Change4Life initiative. It aims to reduce adult and childhood obesity simultaneously by making health a family issue. The campaigns are promoted consistently across partners in Kent. Through the Public Health/Early Help Agreement Children's Centres promote the change for life messaging and run Change for Life events through the summer holiday. This year the summer campaign was to "train like a Jedi", over 1000 children across the county attended these events. The Change4Life messages are also used by the School Public Health service to promote messaging for schools to adopt and through their 1:1 and group activities. The messaging is also delivered by Districts in their healthy lifestyles work, for example the pilot in Dartford and Gravesham is using change for life resources.

2.7. Whole Systems Approaches work on smaller geographical areas to bring together stakeholders to develop a shared understanding of the local causes of obesity, identify

assets and opportunities to mitigate these and develop local action plans using the joint resources available across the partnerships. PHE are due to publish guidance imminently about how to deliver a whole systems approach. KCC Public Health have had sight of the draft guidance and are using this to plan the delivery of whole systems approaches in local areas. KCC Public Health are currently working with Maidstone Borough Council and Bright Futures/Healthy Systems Partnership to develop a social marketing campaign to deliver a whole systems approach to reducing obesity. This is with a view that if successful, the approach could be localised for other areas of Kent. This programme is supported by the Association of Directors of Public Health and enables us to trial this approach in Kent at a minimal cost.

2.8. The issue of childhood obesity is being considered by the Joint Health and Wellbeing Board and the STP Prevention Workstream. This is within the context of the planned whole systems obesity work and to consider the provision of targeted and specialist services including tier 3.

3. Next Steps

3.1. KCC Public Health is currently working on the implementation of the new draft guidance on the use of a Whole Systems Approach to obesity with partners from PHE and Leeds Beckett University. This approach will work on smaller geographical areas to bring together stakeholders to develop a shared understanding of the local causes of obesity, identify assets and opportunities to mitigate these and develop local action plans using the joint resources available across the partnerships. This is at an early stage as it will be challenging to implement this approach in such a large geographical area and complicated health economy.

3.2. The evaluation of the trial partnership service between the School Health Service and Dartford and Gravesham districts will be considered and used to inform the targeted service for children of primary school age who are already overweight or obese. An adolescent package of care for healthy weight will be developed by the School Health Service in the first quarter of the new year working in partnership with schools, early help and other local partners to both develop and support its use.

3.3. A full needs assessment for obesity across the life course will be published in the new year, informing where partnership action should be prioritised.

4. Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on the joint work being undertaken by agencies to tackle childhood obesity.

Background documents: none

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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 - 13 March 2019

Subject: **Oral Health**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

This report gives an overview of the oral health status of the population of Kent and information about action being taken to improve it.

Poor oral health in the population impacts upon individuals at many levels: socially, emotionally, financially, physically and is associated with poor dietary behaviours and nutrition, mental health outcomes, low self-esteem, social isolation, emergency hospital admissions amongst children and infections.

In Kent, children have better oral health at 5 years old than experienced by the population as a whole, with 16.3% estimated to have one or more missing decayed or filled teeth, compared to 23.3% across England. However, there is significant variation across the Districts of Kent. KCC promotes oral health to Children and Young People through consistent messaging across the partnership and is trialling linking Dentists to Children's Centres.

The available data for the oral health status of adults suggests that those living in Kent have better oral health than the population as a whole, however, it is known that those living in more deprived areas will have worse oral health. The oral health status of adults is changing as the population ages, and more complex dental work has been completed through the life course. KCC is developing a programme of work to promote oral health in those populations most at risk of poor outcomes.

Recommendation:
The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on the profile of oral health in Kent and **ENDORSE** the approach being taken by the County Council's Public Health Team. A paper providing a further analysis of the dental health of Thanet children will come back to the committee in due course.

1. Introduction

1.1. Poor oral health in the population impacts upon individuals at many levels: socially, emotionally, financially, physically and is associated with poor dietary behaviours and nutrition, mental health outcomes, low self-esteem, social isolation, emergency hospital admissions amongst children and infections. More deprived areas have greater disease burdens and treatment needs.

1.2. Oral diseases share common risk factors with other diseases such as Obesity, Cardiac disease and Diabetes. Most oral disease is preventable; the main risk factors include high sugar intake and poor oral hygiene, alongside other poor lifestyle factors. Deprived areas are likely to experience more adverse lifestyle outcomes than others and utilise more dental resources with greater financial impact to the services.

1.3. Dental services are commissioned by NHS England, however Local Authorities (LA) have a responsibility for oral health promotion and preventing escalation in oral health needs. They also have a responsibility to undertake an oral health survey of 5-year olds on a biennial basis.

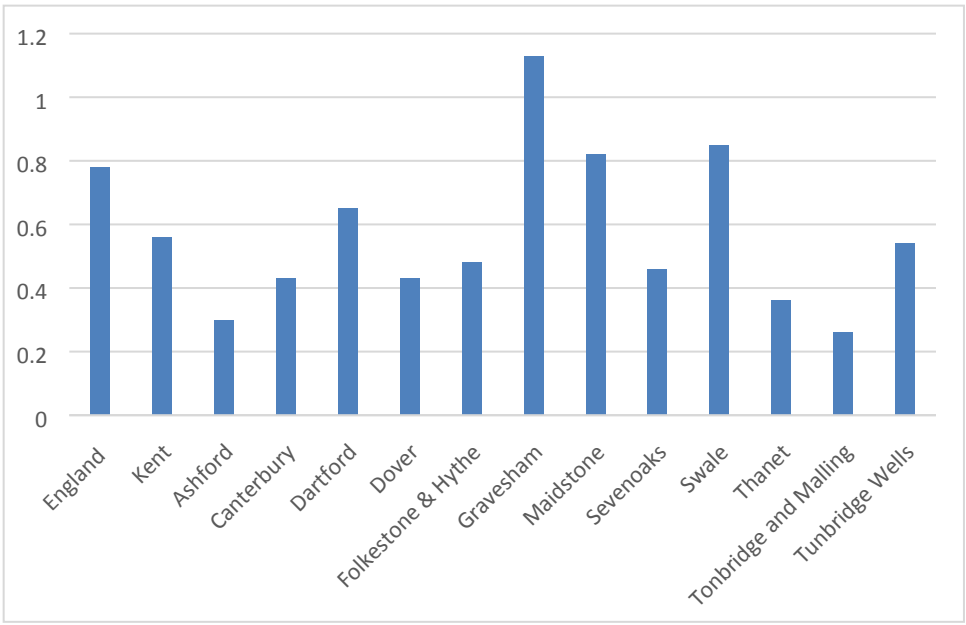
1.4. The methodology of dental health surveillance is nationally prescribed by Public Health England and uses a school-based sampling methodology which requires parental consent and physical examination. The minimum sample size is 250 examined children is required per lower-tier local authority, from a minimum of 20 mainstream schools. The next survey has commenced and is for the academic year 2018 to 2019.

1.5. A number of measures of oral health are used to assess local oral health profiles and this includes the proportion of five-year-old children free from dental decay and the number mean number of decayed, missing, or filled teeth in five-year-olds.

2. Oral Health in Kent -Children and Young People

2.1. Despite improvements in children's oral health over the past few decades, a significant proportion of children still experience tooth decay. In 2017, 23.3% of five-year-olds in England were found to have one or more missing decayed or filled teeth, compared to 16.3% in Kent, the same as found in the South East Region.[1] As figure 1 shows there is significant variation across the county with Gravesham having much higher rates compared with Tonbridge and Malling and Ashford. Gravesham has the third highest rate of any lower tier local authority in the South East.

Figure 1: mean Five-year-olds with one of more missing, decayed or filled teeth by Kent lower tier Local Authority



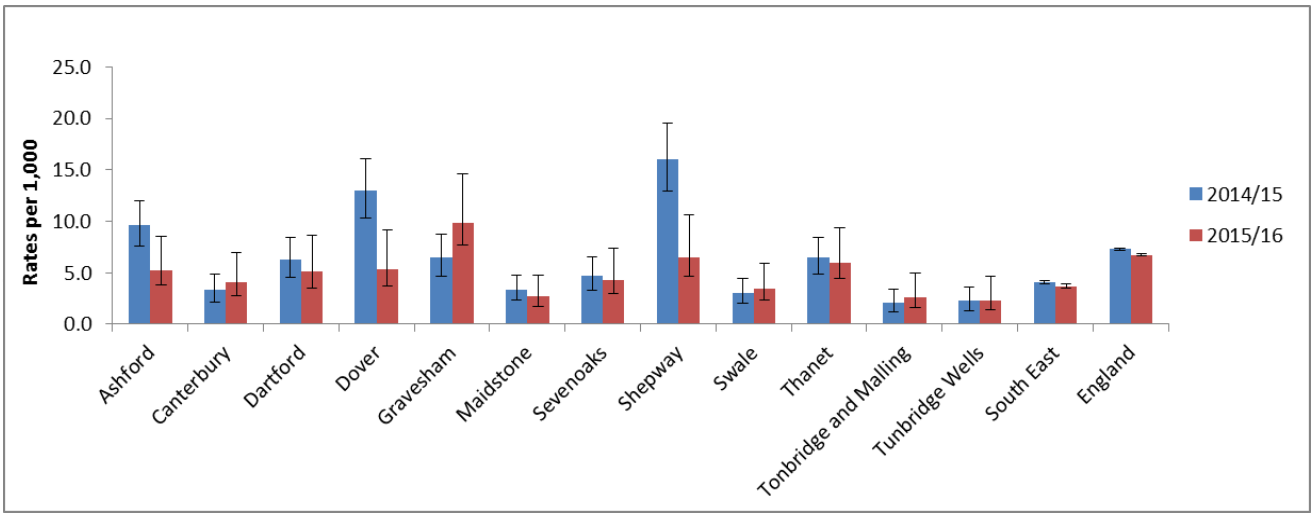
Source: PHE 2017

[1] PHE. (2019). *Oral health survey of 5-year-old children 2017*. Available at: https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2017. [Accessed 20.02.19].

2.2. Interestingly; Thanet shows on all measures to have relatively good dental health in five-year-olds, however this requires much further investigation, as we know there is a high correlation between deprivation and poor oral health. Whilst NHS dental access is relatively good in Thanet, and levels of varnishing are relatively high, this doesn't explain the relative good dental health in relation to the high deprivation of Thanet

2.3. Nationally, 20% of 5-year-olds nationwide experienced obvious untreated dentinally decayed teeth. The figure in Kent was lower at 12.8% of 5-year olds; despite being less than the national average, some areas in the County was much greater. Geographical variation ranged from 5.5% in Ashford to 24.1% in Gravesham.[1] Decay left untreated can consequently result in pain and discomfort on chewing, so impacting children's growth and development. In addition, stress and income loss of the family and school from work and pupil absence affects not just the child but the whole community. This level of disease is often managed as extractions under general anaesthesia (GA). The most common age group experiencing these extractions are 5-9-year olds, with the highest GA access rates in the county due to caries in Dartford (0.8%), Gravesham (0.8%) and Ashford (0.8%), which are equal to the national average (0.8%).[2]

Figure 2: Profile of General Anaesthesia extraction rate in 5 to 9-year-olds with Kent Local Authorities between 2014/15 to 2015/16.



Source: (Kent OHNA 2016 & PHE 2016)

2.4. Key preventative activities include reducing the consumption of food and drinks that contain sugar, brushing teeth daily with a fluoride toothpaste and taking a child to the dentist when the first tooth erupts and then on a regular basis.

2.5. One evidence-based intervention to prevent poor oral health is the application of fluoride varnish. From age 3, children should be offered varnishing treatment at least twice a year. In Kent, 37% of all clinical treatment given to 0-16 year olds was for fluoride varnishing. This ranged from 26.8% in Tunbridge Wells to 51.3% in Thanet.[3]

2.6. Local Authority support in increasing access to dental services and promoting oral health within existing social & health services (Children Centres, GPs, Pharmacies), can reduce dental decay risk factors. KCC is undertaking a range of activities with partners which is outlined below.

[2] Public Health England (2017). *National Dental Epidemiology Programme of 5 year old children*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/708157/NDEP_for_England_oral_health_survey_5yr_2017_report.pdf [Accessed on 21/11/18].

[3] NHS Business Authority (2018). Kent Fluoride Varnishing Statistics – Requested Data.

2.7. Health Promotion: KCC and partners promote the Change4Life oral health and other nationally supported campaigns. These have included the Change4Life sugar and oral health campaigns. Key messaging has been delivered through the Children's Centres and other partners. PHE have also developed teaching resources for Key Stage 1 and 2, using the Tilly the tooth character. This has been promoted to Kent schools and the School Public Health Service. A Dentist on placement with KCC public health has worked with children's centres to identify their training needs to enable them to feel more confident to deliver oral health promotion messaging. Using this information, a training session has been devised which is being piloted in Dover and Folkestone and Hythe with a view to rolling it out to the whole County. This pilot has also included engaging with local dentists to host an open morning for children to receive oral health promotion and to make links with their local dentist.

2.8. Access to dentistry: The British Society of Paediatric Dentists (BSPD)'s Dental Check by 1 campaign promotes dental attendance by the age of one. Posters promoting the campaign are in local children's centres and Health Visitors promote accessing the dentist at each mandated contact. It is planned to further embed this campaign in Kent, through further promotion and to provide a consistent suite of oral health promotion materials using the soon to be published PHE documentation. This campaign included the signing up of Dental Practices who would be happy to receive referrals from health visitors, 45 practices in Kent signed up. Promotional materials will be available shortly to increase awareness in the population about who is entitled to free NHS dental care to increase uptake.

2.9. Fluoride varnishing: Further work will be undertaken to identify areas with lower rates of fluoride varnishing to increase uptake in the community.

2.10. Surveillance: KCC has commissioned KCHFT to undertake the national 5-year old oral health survey in Kent schools to give an up to date picture of oral health in Kent and to feed in to the national picture.

3. Oral Health in Kent - Adults

3.1. Despite population improvements in oral health over the past few decades, not all have benefited. There is insufficient up to date data regarding oral health status and dental access in the Kent adult population, however, data is available for the South East or Kent, Surrey and Sussex. Compared to the national average, the South East population has generally better oral health: 28% of adults in England have untreated tooth decay, compared to 20% in the South East; 45% have moderate gum disease nationally compared to 49% in South East; 15% of adults nationally have moderate tooth wear compared to 10% in South East.[4] With an ageing population, people are living longer, retaining more natural teeth, and have complex restorations (crowns, bridges, dentures, implants).

3.2. Attendance for urgent care to relieve symptomatic oral disease indicates poor adult oral health: if you see a dentist regularly for check-ups you will not attend as often as an emergency. Compared to the national average of 14%, 13% of Kent adults have an urgent dental condition requiring care. Approximately 20% of Kentish adults presenting for urgent care have more extreme signs of oral disease of facial swelling & infection, measured by PUFA index (gross decay, ulceration, abscess & fistula), especially among those in low socioeconomic associated occupations.[5] The most deprived quarter of Kent, Surrey and Sussex's population saw the dentist for Urgent matters and complex restorative treatment (Band 3 treatment) more than for routine check-ups (Band 1 treatment).[6] This emphasises that those from low socioeconomic

[4] Health and Social Care Information Centre / NHS Digital. (2011). *Adult Dental Health Survey 2009, Theme 1: Oral Health and Function*. Available at: https://files.digital.nhs.uk/publicationimport/pub01xxx/pub01086/adul-dent-heal-surv-summ-them-the1-2009-rep3.pdf (Accessed on 21/11/18).
[5] KCC Public Health (unpublished, 2016) Oral Health Needs Assessment for Kent.
[6] PHE (unpublished, 2018) Kent Surrey and Sussex Oral Health Needs Assessment 2018.

backgrounds carry a greater burden of disease and have a greater treatment need than those from higher socioeconomic backgrounds. Those at greater risk of poor oral health, with low uptake of dental services and high treatment needs are the vulnerable population (including the homeless and the dependent in social care). Those attending regularly for check-ups tend to have fewer treatment needs and hence have a lower cost impact to the services.

3.3. Only half the adult population meets an NHS dentist. Compared to the national average of 50.7%, under half of the adult Kent population (40.3%) visited the dentist in the past 2 years.[7] This is significantly less than the national average and is likely due to patient barriers accessing dental services and insufficient dental service distribution and provision. There is variation in age groups accessing dental services: younger adults have a higher access rate than their older counterparts (53% of 18-24-year olds compared to 39% of 75+ years). An exception is shown in Canterbury for 18-24 years which is the lowest access rate in Kent, possibly due to health behaviour pattern of the university population. The East-West Kent divide is shown through a lower access rate of NHS dental services in Sevenoaks of 36.7 compared to Shepway of 50.9.[6] East Kent generally has a higher treatment need compared to West Kent, and West Kent has more accessible dental services and greater capability in accessing services, including private dental services.

3.4 The adults most at risk of developing oral health problems are:

- Adults requiring assisted living who have dementia and or cataracts
- Adults with non-communicable disease such as diabetes, coronary heart disease, cerebrovascular disease have poor oral health
- Adults who have had pneumonia particularly those who have ventilator acquired pneumonia have inadequate mouth care leading to poor oral health.
- Homeless individuals/families

3.5 To increase access to dentists KCC have commissioned KCHFT community dental services to provide some of the oral health promotion activity. This will advise and promote clear unambiguous information about who is eligible for free dental treatment. This is being shared on exemption z cards currently through winter shelters and in food banks. Information on exemption will be made available to disseminate more widely in poster formats for a range of venues to promote oral health across the wider system.

3.6 KCC intend to work with community pharmacies to explore extension of information on eligibility to free dental treatment with exemption to treatment cards being provided with dispended prescriptions.

3.7 KCC has engaged with a local dental committee representative which has enabled promotion of the free PHE resources on oral health for dental practices via the local dentist committee website. These resources are interactive and informative engaging with different age groups.

3.8 Public health is in the early stages of liaising with adult social care to enable, promote and support oral health assessment in practice and oral health promotion with the most vulnerable adults. It is intended that this will include accessible workforce development, available print and visual resources.

[7] NHS Digital (2018). Dental Activity in Local Authorities. Available at: https://app.powerbi.com/view?r=eyJrIjoiYTRlMzJiYTEtMTgwMi00ZTdiLTgzMWUtZGM5Y2NmMTI5MGE4IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9 (Accessed on 21/11/18).

3.9 KCC will proactively engage with secondary care providers and primary care to explore opportunities for and ways of promoting oral health.

4. Next Steps

4.1. KCC Public Health will continue to deliver the initiatives outlined above and evaluate their impact. We are continuing to develop a whole systems approach to oral health, with the aim of preventing poor oral health in the most vulnerable groups.

5. Recommendation

5.1. The Health and Reform and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on the profile of oral health in Kent and **ENDORSE** the approach being taken by the KCC Public Health Team. A paper providing a further analysis of the dental health of Thanet children will come back to the committee in due course

Background documents: none

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From:	Eric Hotson, Cabinet Member for Corporate and Democratic Services David Cockburn, Corporate Director Strategic and Corporate Services and Head of Paid Service
To:	Health Reform and Public Health Cabinet Committee, 13th March 2019
Subject:	**Development of the Strategic Delivery Plan**
Classification:	Unrestricted
Past Pathway:	Policy and Resources Cabinet Committee (29th June 2018)
Future Pathway:	Cabinet Committees (March 2019), Policy and Resources Cabinet Committee (13th June 2019)

Summary: The Strategic Delivery Plan will be the strategic business plan for Kent County Council, which supports the delivery of the outcomes in the Strategic Statement. As a rolling plan, it sets out the significant activity we need to deliver over the medium term, connecting strategy with the resources and capacity we need to deliver effectively at pace.

Recommendation(s):

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

(1) **Consider and discuss** the draft Strategic Delivery Plan summary.

1. BACKGROUND

1.1 In June 2018, the Policy and Resources Cabinet Committee endorsed the move from directorate business plans to a strategic business plan for the whole Council, which could better support the delivery of the outcomes in KCC's Strategic Statement.

1.2 The Strategic Delivery Plan is being collectively developed with services, Cabinet Members and Corporate Management Team. It is supported by a summary document and will be agreed by Corporate Board.

1.3 The Strategic Delivery Plan is designed to be outcome led, with a strong focus on accountability for the delivery of significant activity, including commissioning, service change and strategy/policy development. It focuses on action not words, clearly setting out what activity needs to be delivered, with a light-touch narrative of key themes.

1.4 It is driving a step change in business planning, looking ahead over a rolling three-year cycle, to progress activity through the right informal and formal governance arrangements. It is progressing management action on resourcing, capacity and compliance issues, in a disciplined way which supports KCC's new Operating Standards.

1.5 The Strategic Delivery Plan is supported by divisional/service 'Operating Plans'. The Operating Plans capture core business activity across the Council (e.g. statutory responsibilities) and align with activity within the Strategic Delivery Plan. These remain a management responsibility and will be made accessible to all elected members on KNet from April 2019.

Figure 1: KCC's business and financial planning cycle

2. THE STRATEGIC DELIVERY PLAN PROCESS

2.1 The Strategic Delivery Plan approach was endorsed by Policy and Resources Cabinet Committee in June 2018 and agreed with Cabinet Members and CMT in September 2018. A business change approach was developed to support the creation of the plan, maximising the potential of our Microsoft 365 tools to gather, analyse and store information across the Council in a simple, efficient way. Officer engagement began in October 2018, including briefings for Challenger, Directors and Extended CMT.

Identifying a long list

2.2 The first step in the process was to create a 'long list' of activity from all divisions across the Council. This included "significant" activity which was likely to be high value, profile, risk and complexity, and likely to meet the key decision criteria. This included people commissioning, infrastructure commissioning (including assets and technology), significant service changes and strategy/policy development.

2.3 The officer response was extremely positive, with proactive engagement with the business change approach from across the Council. A simple

online form was used to gather information from services, which was open for a 6 week submission period and only took a few minutes to submit. This allowed the instant collation of a vast amount of information on 183 different activities by the end of November, with automatic analysis of the data trends.

2.4 The breadth and volume of activity identified for the 'long list', enabled constructive discussions with Cabinet Members and CMT in early December about the resource and capacity implications for the Council. These are further considered in Section 4.

2.5 The discussion identified some activities which did not meet the criteria for the Strategic Delivery Plan as they were operational delivery or core business (e.g. statutory duties), not strategic activity. It is important that the plan does not become an exhaustive list of everything we do (already captured in documents such as Operating Plans, Budget Book and strategies/policies), but prioritises the most significant activity for the Council. An updated list of 171 activities was confirmed by Cabinet Members by the end of December.

Prioritising a short list

2.6 The aim was now to move from a 'long list' to a 'short list' which could inform the narrative for the draft Strategic Delivery Plan. The short list needed to prioritise activity with high strategic importance, value, risk and complexity. Any activity not prioritised for the short list would be used to inform the development of divisional Operating Plans. Detailed activity 'scorecards' were used to capture all the information about each piece of activity on a page, including financial information, decision authority and accountability.

2.7 In early January 2019, we assessed all the activity submitted by services, from a whole Council perspective to inform a relative prioritisation discussion with Cabinet Members and CMT. This was achieved using a simple, consistent framework which is considered best practice by the National Audit Office and has already proven valuable for prioritising project, programme and assurance work within the Council.

2.8 In early February, Cabinet Members and CMT confirmed 79 activities for the short list and highlighted key themes to include within the Strategic Delivery Plan. The majority of these activities (89%) are already in delivery and will form the 'pipeline' for CMT and Corporate Board, so management action can be progressed at pace. This pipeline will help to determine which activities will benefit from robust business case development and a disciplined focus through informal and formal governance arrangements, ahead of decision making.

Developing the plan

2.9 Once the short list was confirmed, this helped to identify shared themes, opportunities and challenges to include in the narrative for the draft Strategic Delivery Plan, including:

- Outcomes based commissioning
- Integration and partnership working

- Place-shaping
- The right infrastructure for a growing county
- Resilient services and communities
- Shaping future strategy

2.10 Brief 'headline' descriptions for each piece of activity were developed, to clarify what the activity intended to achieve, which will feature in the summary document. The information submitted by services was updated to provide clarity on what needed to be delivered and include the proposed informal governance route for each piece of activity.

2.11 Two versions of the Strategic Delivery Plan were developed:
- A full version which includes detailed activity submissions
- A summary which captures our ambition and activity to deliver better outcomes

2.12 Draft versions of the Strategic Delivery Plan were considered by Cabinet Members and CMT in February. The draft Strategic Delivery Plan Summary **(Appendix A)** was shared with elected members as part of briefings on the Strategic Delivery Plan process with Political Groups in late February. Feedback on the draft will be considered to develop the final versions of the Strategic Delivery Plan, ahead of approval by Corporate Board.

3. THE ROLE OF MEMBERS IN BUSINESS PLANNING

3.1 Elected members play an important role in considering activity within the Strategic Delivery Plan through the governance and decision making arrangements for the Council.

3.2 Members work with officers to provide input and advice on individual activities through the Council's informal governance arrangements and contribute to other task and finish groups to inform activity in advance of formal governance and decision making. This adds value by helping to inform options for strategic commissioning or service change and contributes to member's role in strategy and policy development. This is an important part of KCC remaining an effective member led and Strategic Commissioning Authority, with effective joint working between members and officers.

3.3 Members will consider individual activities within in the Strategic Delivery Plan as they progress through Cabinet Committees ahead of formal decision making. Officers are responsible for delivering and managing the activity that flows from decisions that are taken by members. Cabinet Committees provide oversight of activity throughout delivery, for example considering the effectiveness of contract management. Corporate Directors ensure members are engaged in oversight of activity within directorate arrangements, for example informal briefings on the Adult Social Care and Health Portfolio projects.

3.4 The Policy and Resources Cabinet Committee has oversight of the business planning framework for the Council. A review of the Strategic Delivery Plan process will be reported to this committee in June 2019.

4. BENEFITS AND CHALLENGES

4.1 The development of the Strategic Delivery Plan has highlighted benefits and challenges, which will inform future action and a review of the Strategic Delivery Plan process this Spring.

Benefits

4.2 One of the major successes of the Strategic Delivery Plan has been the collaborative engagement from across the Council. Officers and Cabinet Members have worked together to ensure it reflects the key issues in our operating environment and critical success factors for the Council. Officers have embraced new ways of working, proactively submitted a wealth of information and have been keen to support the new process.

4.3 The process has demonstrated the significant opportunities of business change. It has maximized our investment in the Microsoft 365 tools, proving these can be used in efficient, creative ways to support key business processes. The tools made it quick and simple to gather information in a structured way from across the council. Automatic analysis in Microsoft Forms provided early indications into how plan was shaping up, to issues could be swiftly addressed. This enhanced the productivity of the whole process and saved hundreds of hours compared to gathering and processing business planning information by traditional means.

4.4 The Microsoft Teams site has been a hub for officer information, allowing for real time updates and queries to be resolved instantly. It also facilitated engagement between officers in different teams on shared projects. The learning from this approach can now be applied to other business processes.

4.5 The plan has helped to identify clear shared themes, which will support the development of next Strategic Statement. The prioritisation short list process has ensured the right activity is in the plan and has the right focus through the informal governance arrangements. We will capture this learning for the next Strategic Statement to ensure we prioritise even more effectively in future business planning rounds.

4.6 The capacity and demand information that emerged through the plan process is now shaping resourcing decisions. CMT have taken a strategic leadership role on this issue, considering how to prioritise the right skills and capacity effectively. Corporate support services are using the plan to respond to future demand. For example, 73% of short list activity identified the need for Strategic Commissioning support, so the division is now using the Strategic Delivery Plan analysis to prioritise limited resources on the most significant activity.

Challenges

4.7 The volume of activity identified within the process, in addition to core business delivery, has exposed the need to carefully consider resources, impact and the value of activity to ensure a strong focus on outcomes. 32% of responses said they were still unsure about the capacity needed and needed to further assess what is required. This has demonstrated the need to prioritise and challenge what can be achieved within the year ahead, and over the medium term in the context of rising demand and financial pressures.

4.8 The volume issue is particularly significant in terms of demand for corporate support services, who not only need to deliver corporate enabling activity, but also support significant service activity. 71% of activity requires support for across KCC services for delivery, with particularly high levels of demand for Strategic Commissioning (73%) and Finance (63%) support. However, Directors are already responding to this issue by using the analysis of the Strategic Delivery Plan to effectively plan for future capacity and demand.

4.9 The volume has also indicated that there is insufficient prioritisation across the Council, both corporately and within services. It was noticeable during the analysis of the emerging plan, that the Strategic Statement outcomes were unbalanced (38% of activity is within Outcome 2), too broad and do not easily capture cross-cutting enabling activity (21% of activity), which is an increasing focus of a Strategic Commissioning Authority model. The breadth of activity reinforces the need to ensure the next Strategic Statement is clearer about member priorities, allowing greater prioritisation of business activity across the Council.

4.10 The quality of the financial information submitted by services in the process correlates with issues previously raised by Corporate Assurance about effectively defining costs and benefits. For example, only 54% of activity responses identified revenue investment costs. The gaps in financial information show that too often activity is initiated without a full appreciation of financial implications and there is a need for greater discipline on this through business case development.

4.11 The plan has also raised some compliance risks around the sufficiency of equalities and data protection analysis. Only 29% of activity has completed an Equalities Impact Assessment (EQIA) initial screening or has one in progress, and 21% have a Data Protection Impact Assessment (DPIA) completed or in progress. CMT and the General Counsel are providing leadership on this issue to ensure that activity is unable to proceed without having met these compliance requirements, address any immediate risks and continue to enhance the quality of our analysis.

5. DELIVERING THE RIGHT ACTIVITY, IN THE RIGHT WAY

5.1 By focusing on high value, complex activity, the Strategic Delivery Plan is an important part of managing organisational risk effectively. Recent National Audit Office reports have highlighted the financial and delivery risks in the local government operating environment. This plan means that

we can have a proactive and disciplined response to managing risk, with many activities within the plan linked to supporting mitigating actions in the Corporate Risk Register.

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5.2 To do so, we need to ensure we are managing the delivery of the right activity in the right way. The way we will achieve this is through better business case development. The HM Treasury Better Business Cases principles are being used to strengthen this in commissioning practice and assurance of change projects/programmes. Only 53% of the activity in the short list was identified as being part of a programme or project, which highlights the need to consider future change management capacity.

5.3 The short list will help to determine what activity requires robust business case development and ensure this is delivered effectively in line with KCC's Operating Standards as it proceeds through the informal and formal governance arrangements. The short list will now become the focus for the Corporate Assurance and Risk team to prioritise activities which need strong, effective business case development and delivery.

5.3 CMT are taking a leadership role on management action for the Strategic Delivery Plan, using this to drive forward agenda planning and taking a programmed approach, supported by collective business case development.

6. NEXT STEPS

6.1 This report, including the draft summary document, will be made available to Cabinet Committees during March 2019, where requested by the Cabinet Committee Chairman.

6.2 The final Strategic Delivery Plan and Strategic Delivery Plan Summary are due to be approved by Corporate Board. It is intended to publish the summary document on Kent.gov and the full plan and supporting Operating Plans on KNet, in April.

6.2 To build on the successful momentum of the Strategic Delivery Plan process and positively address emerging issues, a review of the process will be undertaken this Spring. This will be reported to the Policy and Resources Cabinet Committee in June 2019 and used to shape future business planning rounds, which will start later this year, informed by the Spending Review (2019).

7. RECOMMENDATIONS

7.1 The recommendations are as follows:

The Health Reform and Public Health Cabinet Committee is asked to: **(1) Consider and discuss** the draft Strategic Delivery Plan summary.

8. BACKGROUND DOCUMENTS

Appendix A: Draft Strategic Delivery Plan Summary document

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Strategic Delivery Plan (2019-2022)

Draft Summary (Version 0.4)

Kent County Council
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Introduction

The Strategic Delivery Plan sets out how we will achieve better outcomes for the people of Kent, by acting as a single business plan for Kent County Council (KCC), providing a clear sense of pace for delivery.

This is a public summary of the significant activity within the Strategic Delivery Plan, which support the outcomes in KCC's Strategic Statement. It includes a brief narrative of key themes in our wider operating environment that impact on delivery and a list of what needs to be delivered over the next three years, as a rolling plan which is updated annually.

The Strategic Delivery Plan connects strategy (the outcomes we want to achieve) and activity (what we need to deliver), with resources and capacity, aligned with the Medium Term Financial Plan (2019-2022).

The plan is owned by the Leader and Head of Paid Service. It has been collectively developed by Cabinet Members, Corporate Management Team (CMT) and services across the Council.

The activity has been prioritised to ensure that critical activity for the Council delivers at pace and the right activity is focused through our governance arrangements. Elected Members from all political parties will consider the activity within the plan as it proceeds through the Council's governance and decision making process.

The Strategic Delivery Plan is focused on the most significant activity for the Council. Our essential, day-to-day service delivery is captured in our Operating Plans (divisional/service business plans) and the Budget Book. The Strategic Delivery Plan is not an exhaustive guide of everything we do, but it is intended to provide a clear sense of how KCC will respond to changes in our operating environment to deliver significant activity successfully.

Progressing the Strategic Delivery Plan

Corporate Management Team and Cabinet Members have collectively developed the Strategic Delivery Plan to progress significant activity at pace.

It is important that the Strategic Delivery Plan is not just a 'plan' – it needs to progress major activity across the Council and build momentum to deliver better outcomes successfully. The future approach to business plan monitoring will be considered as part of a review of the Strategic Delivery Plan in Spring 2019, drawing on lessons learnt from the process to improve subsequent business planning rounds.

Our People

The Strategic Delivery Plan cannot be delivered without the hard work and contribution of our staff. Lead officers for each activity are responsible for ensuring it is delivered effectively. The detail of how and when activity in the Strategic Delivery Plan will be achieved sits in underpinning management documents, including commissioning strategies, business cases, programme/project plans, governance reports and other reporting processes.

Management Action

The responsibility for putting the plan into practice sits with Corporate Management Team (CMT), who will use the Strategic Delivery Plan as the future 'pipeline' for management action, ensuring appropriate resources and capacity are in place to support effective and timely delivery. Corporate Directors are responsible for delivering activity in the Strategic Delivery Plan and the Operating Plans within their Directorate.

The role of Corporate Board

Activity that has high risk, complexity and financial value within the Strategic Delivery Plan will be also be considered by Corporate Board, providing collective ownership of organisational issues to identify constructive action.

The role of the Executive (Cabinet Members)

Cabinet Members have ensured that the Strategic Delivery Plan prioritises significant activity for the whole Council from a political and business need perspective. This aligns to Cabinet Member priorities and informs a robust focus on activity through the Council's informal and formal governance and decision making processes.

The Executive has responsibility for the business planning framework for the Council. Cabinet Members will provide oversight of progress on the Strategic Delivery Plan, working closely with officers to ensure there are clear objectives, targets and timescales for delivery for activities within their portfolio responsibility.

The role of Elected Members

Elected Members play an important role in considering individual activities within the Strategic Delivery Plan through the governance and decision making arrangements for the Council. Members work with officers to provide input and advice through the informal governance arrangements and contribute to other task and finish groups to inform activity in advance of formal decision making. Corporate Directors also ensure members are engaged in oversight of activity within directorate arrangements, for example providing member briefings on the Adult Social Care and Health Portfolio projects.

Members will consider significant activity in the Strategic Delivery Plan in detail as it progresses through Cabinet Committees ahead of formal decision making, supporting their role in policy and budget development. The Cabinet Committees also enable members to have oversight of activity in delivery, for example examining commissioning arrangements. This supports members in their role of monitoring the effectiveness of service delivery and the appropriateness of policy across the County, for the benefit of Kent's residents and taxpayers. Members are also engaged in other informal task and finish group activity in this respect, including the Contract Management Review Group which is supporting improvements in the quality of commissioning standards.

Strategic Delivery Plan themes

The Strategic Delivery Plan has identified some shared themes, which require collaboration across KCC services to achieve better outcomes.

Outcomes based commissioning

As a Strategic Commissioning Authority, we want to continue to improve the quality and standards of commissioning and management of our providers to enable better outcomes for residents. We are shaping markets, driving best value and progressing joint commissioning arrangements. We will robustly review commissioning arrangements and undertake evidence-based analysis to inform new commissioning strategies. These will shape future commissioning decisions, moving away from traditional retendering processes to a more strategic, outcomes based approach.

Integration and partnership working

Achieving better outcomes cannot be achieved working in isolation. Quality public services require collaboration and integration between partners, working across the public, private and voluntary and community sector. We are building strong, valued relationships to develop new operating models and tackle whole system challenges. We stand up for Kent's interests nationally and regionally through proactive partnerships and joint lobbying.

Place-shaping

We have an important place-shaping role on behalf of Kent's residents and communities. We work collectively with our partners to protect and enhance our environment, develop community assets and influence master planning for new communities. We work together to ensure we serve those communities with the facilities and services they need, both now and in the future, including health, community wellbeing and education provision.

The right infrastructure for a growing county

A growing county needs the right infrastructure to enable growth and drive productivity. Delivering our capital programme is key to develop and maintain the County's physical infrastructure and assets. We want to be ambitious about the quality of our infrastructure projects, influence strategic planning, maximise development contributions and achieve best value for money for Kent's taxpayers.

Resilient services and communities

A fast changing operating environment means we need to be well-prepared and resilient for planned events, threats and emergencies. We focused on building resilient services and strong, safe communities, working together across KCC and with our partners to plan and respond effectively. We are working collaboratively with partners to enhance community wellbeing to achieve better health and wellbeing outcomes and address the population needs of all Kent's residents.

Shaping future strategy

Business planning connects strategy with action. We are shaping new strategy responses to emerging national policy and business change, which will influence future prioritisation and service delivery to ensure best use of resources and enhance productivity. This is important to re-shape the Council's future strategy and policy framework.

Outcome 1:

Children and young people in Kent get the best start in life

We want Kent to be the best place for children and young people to grow up, be educated, supported and safeguarded so that all can flourish and achieve their potential.

Below is a summary of the operating environment themes which influence the way we work together to achieve Outcome 1.

Change for Kent Children: This programme is an ambitious new practice framework and integrated operating model for services for children and families. It aims to improve outcomes for all children and their families in Kent. The programme will ensure that services effectively respond to improvements recognised by the Ofsted inspection process. It will develop clearly established pathways for families requiring assistance and ensure a coherent offer between statutory social work and early help, in addition to an understanding of how thresholds are managed in a seamless and supportive way. This will be supported by a differentiated approach to working with adolescents, based on a recognition of the different types of risk they face and a challenge from schools that a different way of working is required. We are re-commissioning a range of children and young people's services and shaping markets to support integration.

Supporting care leavers: The Children and Social Care Act (2017) extended support for care leavers up to the age of 25. We have ambitious aspirations for all young people leaving care, so we are reviewing our Care Leaver Offer, placement stability and sufficiency of accommodation to become more effective at shaping markets, supporting transition and discharging our statutory duties on market sufficiency for vulnerable children. It is important that all young people get the support they need, however delivering better outcomes for vulnerable young people has significant costs, for including supporting unaccompanied asylum seeking children (UASC) as care leavers. Therefore, will pursue full cost recovery and reimbursement from the Government, to fund quality service delivery.

Child and adolescent health and wellbeing: We remain committed to improving children and young people's physical and mental health, emotional wellbeing and resilience. We are transforming public health outcomes through the KCHFT Strategic Partnership to enable continuous improvement and deliver financial benefits. We are undertaking robust contract management to improve waiting times, timely assessment and provision for child and adolescent mental health, which is a national as well as local issue.

Partner service integration: We need to collectively build better outcomes for Kent's children and young people by working in an integrated way with our partners and tackling systems challenges together. Our strategic partnerships enable the continuous improvement of public health services, embedding new models of delivery, progressing joint commissioning approaches and co-locating teams. The 0-25 Health and Wellbeing Board brings together partners to deliver a joint work programme to improve outcomes and unlock barriers for specialist services, including SEND and speech and language services.

Supporting complex needs: We are re-commissioning services for children and young people with highly complex needs, supporting resilient carers and families. This is to respond to more children and young people living with increasingly complex conditions due to advances in medical science. We want to ensure people have the personalised care and support they need and support vulnerable service users to live as independently as possible. We will work with providers in complex supply markets, to commission better outcomes.

Transition: We want to design and commission services that create seamless pathways of transition and support from children's to adult services. We also want to support people in transition periods when changes occur between and within services as well as between age group categories. This is particularly important for vulnerable young people and those with complex needs, who require integrated support across local government and health services.

Education funding challenges: The National Funding Formula for Schools is a significant change, which requires considered financial management. The dedicated schools grant means funding for Kent pupils is below the national average and it does not sufficiently reflect growing demand for pupils with special educational needs. There remain significant challenges to manage SEND, home to school transport and High Needs Funding demands and pressures, with a need to respond to the recent Ofsted SEND Inspection to drive quality and practice improvements.

Education commissioning: The Education Commissioning Plan addresses the challenge to provide additional school places in the right locations to meet rapidly growing demand, including rising secondary rolls. It supports our statutory duty to provide sufficient education places and appropriate learning pathways for pupils at Post 16. Delivery will be dependent on appropriate Government funding and securing the maximum possible contributions from developers.

Education standards: We want to support Kent's schools to maintain progress in education standards and close the attainment gap for disadvantaged learners. We will need to work with schools to respond to the changes to Ofsted's new inspection framework for education, due to be introduced in September 2019, which may lead to a reassessment of standards.

The Education People: Our new trading company was launched in September 2018 to increase the long term sustainability of education services in Kent, allow schools a greater say in how services operate and enable opportunities for growth and future investment. There is strong focus on school improvement to help schools and early years providers raise standards and outcomes for all children and young people.

Post 16 choices: We want to facilitate the choices, pathways and education, skills and training destinations that young people deserve. This includes maximising the opportunities of the apprenticeships programme and forthcoming T-Levels for technical and vocational learning. We will collaborate with our partners to support an ambitious Post 16 skills agenda, that promotes opportunities, provides the skills businesses need and responds to national funding challenges.

Outcome 1: Activity Summary

This is a list of the significant activity within Outcome 1, including a headline summary of what needs to be delivered.

No.	Activity Title	Headline Summary
1	Delivering the Kent Commissioning Plan for Education Provision 2019-2023	The rolling commissioning plan is updated annually to ensure there are enough good school places for every child who needs one. The plan sets out how we discharge our statutory responsibilities to secure sufficient places and ensure appropriate learning pathways for post 16 pupils. It forecasts the need for future provision, so places are in the right location at the right time to meet increased demand and parental preferences.
2	Transforming Early Help and Preventative Services (EHPS) Commissioning	By April 2020, we will transform the commissioning of six contracts which support strategic priorities for Integrated Children's Services, including youth services, young carers, NEET's, family support, emotional health and wellbeing and commissioned children's centres. Evaluation of our service investment and previous phases of transformation will inform the recommissioning approach.
3	Re-commissioning services to support the Integration of Children's Services	Children, young people and families need to be able to access the right service at the right time. An options appraisal and needs analysis will be undertaken to inform recommissioning to enhance the Integrated Children's Service commissioning offer. As part of the Change for Kent Children programme, this will provide flexibility to respond to future needs and demand, targeting resources to support the most vulnerable.
4	Delivering the Total Placement Service Programme	The programme will transform placement sourcing arrangements for children and young people who need specialist support, enable collaboration with other local authorities and re-shape the market of provision. An annual review of placements will bring greater consistency and visibility of spend, to reduce cost variation and strengthen our negotiating position with the market.
5	Mobilising the Young Persons Supported Accommodation and Floating Support Service	The commissioning programme will mobilise the new service and ensure more cost-effective placements for Care Leavers, Children in Care and Homeless 16-17 year olds. This will move away from expensive spot-purchased placements to improve quality, safeguarding and that support young people to transition into independent accommodation and maintain independence in their own home.
6	Delivering the Commissioning Strategy for Disabled Children's Services	The delivery of the commissioning strategy will ensure provision of services which support highly complex children and young people, resilient carers and personalised care and support for families to live as independently as possible. Through joint commissioning in partnership, in a complex supply market, we will deliver integrated services to meet needs and secure best value.
7	Transforming Children and Young People Mental Health Service commissioning (CYPMHS)	This is a 3 year transformation programme to accelerate support, address gaps and blockages to ensure children, young people and families can access the mental health services they need. KCC jointly commissions services with health (CCG's), with a robust contract management approach to improve outcomes, reduce escalation into specialist services and prioritise Looked After Children.

No.	Activity Title	Headline Summary
8	Integrate and transform Public Health Services for Children and Young People across Kent (KCHFT Strategic Partnership)	We are mandated to use the Public Health Grant to improve health outcomes, developing the KCHFT Strategic Partnership to improve outcomes for children and young people, enable continuous improvement and deliver financial benefits to the Council. We will review the partnership approach and recommission services as part of a commissioning strategy.
9	Progressing integration and joint commissioning through the 0-25 Kent Health and Wellbeing Board.	This board facilitates better joint commissioning with health with a strong partnership focus on children's health and wellbeing outcomes across Kent. The joint work programme will drive improvements and unlock barriers in key services for those with complex needs, including SEND to respond to the recent Ofsted Inspection, speech and language therapies and mental health.
10	Development and delivery of the Sufficiency Strategy, Market Position Statement and Market Intervention Plan for accommodation services for vulnerable children	The delivery of the strategy supports our statutory requirements and identifies key actions to shape and progress new relationships with the Kent market. This will drive better value, support greater placement stability for vulnerable children and connect services with our partners. We will analyse the impact of market interventions to inform a business case with clear options for market intervention activity.
11	Full Cost Recovery of Unaccompanied Asylum Seeking Children (UASC) Costs to KCC	We are pursuing full cost recovery and reimbursement for asylum seeking children and care leavers, to address gaps in Government grant funding. A jointly developed business case with the Home Office aims to secure additional funding, identify new opportunities for investment and scope options for different models of delivery, including a review of Millbank Reception Centre.
12	Delivering school improvement support to maintain and enhance school standards through The Education People (TEP)	Our efforts to respond to performance in school standards services have delivered good and outstanding Ofsted results across Kent. We have positive ambitions for all Kent schools and are commissioning quality school improvement services to maintain good progress, enhance standards and tackle any slippages in performance.
13	High Needs Funding and SEND Action Plan	We are responding to rising demand, gaps in sufficient national funding and driving improvements in support for pupils with SEND, ensuring the right provision is in place to meet their needs. Our transformational SEND Action Plan will take decisive action to respond to the recent SEND Ofsted inspection and deliver the improvement required in Education, Health and Care Plans.
14	Delivering the Post 16 Education Review, to facilitate better education, skills and training opportunities for young people	We will scope and deliver a fundamental review of Post 16 Education in Kent, to facilitate the choices, pathways and destinations that young people deserve. We will collaborate with our partners to progress an ambitious Post 16 skills agenda, including working with schools, the HE/FE sector, business community and Education Skills and Funding Agency to tackle national funding issues.

Outcome 2:

Kent communities feel the benefits of economic growth by being in-work, healthy and enjoying a good quality of life

We want to work with our partners to create well designed housing, appropriate infrastructure and promote economic growth. We will strengthen Kent's resilience and promote health and wellbeing for local communities.

Below is a summary of the operating environment themes which influences the way we work together to achieve Outcome 2.

Standing up for Kent: We are strengthening our relationships at a local, regional and national level to stand up for Kent's interests and pursue shared outcomes with our partners. This includes collective partnership work and joint lobbying activity with key partners, including the Kent Leaders and Joint Chiefs, Kent Resilience Forum, South East Local Enterprise Partnership, Kent and Medway Economic Partnership, Kent and Medway Health and Wellbeing Board, Sustainability and Transformation Partnership, Transport for the South East, Kent Housing Group and Thames Estuary Growth Commission.

Planning for growth: We will work in partnership with the Kent Leaders and Kent Housing Group on the Kent and Medway Housing Strategy which aims to accelerate housing growth and develop affordable housing options. This aligns with the Council's work on the Growth and Infrastructure Framework, influencing Local Plans and maximising Developer Contributions, to deliver sufficient, resilient and appropriate infrastructure to support new and existing communities. We want to influence quality development through the Kent Design Guide and work collectively with partners to secure Government and LEP investment to meet Kent's housing and infrastructure needs.

Investing in our infrastructure: We want to promote safer journeys and deliver sustainable community assets. We are investing in our capital infrastructure and maintenance programmes to deliver critical transport, growth and flagship regeneration projects, including programme management of the Local Growth Fund schemes. We will continue to challenge the Government on their future strategy for tackling infrastructure funding gaps for essential community provision, including health and education facilities. Prioritising the right capital projects is important to address the needs of growing communities and respond to pressures from unprecedented levels of growth whilst delivering best value to the taxpayer.

Smart places: We need to seize opportunities presented by smart places and technology innovation to improve and future-proof digital infrastructure. We are supporting national investment and rollout in ultrafast broadband to enable future growth and service transformation.

Enterprise and Productivity: In 2019, we will be developing an Enterprise and Productivity Strategy which sets the long-term ambition for growth, supporting the delivery of the SELEP Strategic Economic Plan and the Government's Industrial Strategy agenda.

Keeping Kent moving: The Local Transport Plan 4 sets out our priorities for the highways capital programme and strategic planning that will shape solutions for freight management, sufficient overnight lorry parking, a permanent solution to Operation Stack/Brock and related highways infrastructure improvements. We will continue to lobby rail operators to maximise opportunities of new rail franchises to improve journey times and capacity for Kent's residents.

Better and safer journeys: The pothole blitz is improving the quality of Kent's roads and our highways maintenance commissioning will enable safer journeys for all road users. The Big Conversation will pilot and deliver new solutions for subsidised bus services in rural communities.

Brexit preparedness: We have proactively worked across KCC and with our partners on Kent's short-term preparedness and response in the event of a 'no deal' Brexit and longer-term impact and opportunities from the UK leaving the EU. This includes planning a managed highways response supported by government investment in key infrastructure and developing skills and capacity within Trading Standards services. We will initiate joint lobbying with our partners on the forthcoming UK Shared Prosperity Fund, to maximise opportunities to secure future funding.

Waste infrastructure and commissioning: We need to deliver essential waste commissioning and infrastructure projects, which support the development of the statutory Minerals and Waste Local Plan. This includes recommissioning a series of critical waste contracts, household waste recycling centre provision and implementing new waste partnership arrangements in East and West Kent.

Community resilience and wellbeing: Place based approaches will bring local services together to effectively confront the wider determinants of public health, reduce demand, deliver cost savings and improve outcomes for local communities. We want to create new models of local delivery which enable resilient, strong communities and promote individual and community wellbeing.

Improving public health outcomes: We are commissioning a range of preventative services to help adults make healthy choices and live longer in good health, supporting the delivery of the Kent and Medway Sustainability and Transformation Plan and the development of Integrated Care Systems. We will work with our partners to refresh the Kent and Medway Joint Health and Wellbeing Strategy, reflecting the emerging evidence base for public health outcomes in the updated Joint Strategic Needs Assessment, NHS Case for Change and Kent Integrated Dataset.

A sustainable Libraries, Registration and Archives service: Our new three-year strategy for Libraries, Registration and Archives offers an exciting and sustainable future for the service. Through this we will start to realise our ambitions to make sure our network of 99 libraries and our archive and register offices are used to their full potential for our communities, delivering projects that will increase our customer base and make a positive difference to people's lives.

Outcome 2:

Kent communities feel the benefits of economic growth by being in-work, healthy and enjoying a good quality of life

This is a list of the significant activity within Outcome 2, including a headline summary of what needs to be delivered.

No.	Activity Title	Activity Type
15	Planning for housing growth and infrastructure in Kent	We are working collectively with local planning authorities and strategic partners to plan to accelerate housing delivery to support long term growth across Kent and Medway, including exploring the potential of a housing deal. We want to secure Government capital investment to deliver the right sustainable infrastructure for growing communities.
16	Input to Local Plans and Significant Development across Kent and nationally	We are actively involved in strategic planning matters to ensure the right infrastructure is factored into Local Plans for growth and development across the county, working closely with national and local partners. This work will be supported by updates to the Kent Design Guide to influence quality development and consider emerging issues such as parking requirements in new developments.
17	Maximising opportunities of the Strategic Development Contributions process and updated strategy	We maximise the opportunities of securing developer contributions from S106 and CIL for appropriate community infrastructure investment. We are effectively managing the process and updating the strategy to consider both service and financial impacts and mitigations.
18	Delivering the Council's Infrastructure Capital Delivery Programme	The £500m capital programme drives the design and construction of vital community services, including education, libraries and flagship regeneration projects such as Thanet Parkway and Turner Contemporary. A robust, structured programme management approach supports effective delivery of projects within the MTFP, maximising best value.
19	Delivering Local Growth Fund schemes and projects	We are successfully progressing programme management of Local Growth Fund capital projects, working with SELEP and other partners on the delivery of essential highways, transportation and other regeneration projects to enhance infrastructure for a growing county. This includes schemes being funding from the National Productivity Investment Fund.
20	Delivering the Kent Broadband Programme	The programme aims to further extend the reach of superfast broadband to support digital inclusion in local communities and businesses. It will extend the national Broadband Delivery UK contract with additional investment and deliver pilot approaches to connect further properties.
21	Developing the Kent and Medway Enterprise and Productivity Strategy	With a 2050 time horizon, the Enterprise and Productivity Strategy will inform our response to changes in the living, working and business environment. It will act as a framework for efficient use of resources and future investment decisions, linked to the Local Industrial Strategy.
22	Responding to Thames Estuary Growth Commission Report	Collaboration with national and local partners aims to transform the area by attracting new investment, employment and new homes. We want to progress the new Thames Estuary Growth and Prosperity Board to promote and respond effectively to opportunities with Government.
23	Lobbying opportunities from the UK Shared Prosperity Fund, linked to the Local Enterprise Partnership (LEP) governance, strategy and funding	We will undertake joint lobbying with local and regional partners to maximise bidding opportunities from the forthcoming UK Shared Prosperity Fund, utilising the SELEP Local Industrial Strategy as evidence of Kent's funding needs and requirements.

No.	Activity Title	Activity Type
24	Highways Term Maintenance Contract commissioning project	The commissioning project will drive value for money and help maintain our highways assets for safer journeys for all road users. The project will review options for service delivery and solutions for key issues such as depots, ICT systems and operational delivery.
25	Improving our highway assets and fixing Kent's potholes	We are delivering a countywide planned programme of, pothole repairs and carriageway patching, using local contractors to improve our response to improving Kent's highways. We are improving the quality of our highway asset management, through increased drain clearance and general maintenance. We are maximising Government investment including the additional funding provided in the Autumn Budget.
26	Delivery of KCC's input to the development of Operation Stack/Brock and related infrastructure improvements	Highways England is responsible for delivering a permanent solution to Operation Stack/Brock. We will work with Highways England to shape the solution, including sustainable and appropriate provision for overnight lorry parking, in support of our Local Transport Plan 4 priorities.
27	Delivery of a solution to Overnight Lorry Parking	The Local Transport Plan 4 sets our intention to develop a strategy that will deliver solution for overnight lorry parking, working with private sector operators and Highways England to consider the expansion of existing sites and the delivery of new sites. This supports a permanent solution for Operation Stack/Brock and work on freight management.
28	HGV Bans/Freight Management options	The member-led HGV group is considering potential options for the control of lorry movements and freight management solutions. Members will consider the findings of the report and if appropriate implement agreed outcomes, including pilot schemes.
29	Highway response to Brexit	We are proactively preparing a robust highways response to keep traffic moving despite the uncertain impact of Brexit on the county's road network. We are working closely with national, regional and local partners to strengthen key routes with plans to manage any congestion and delays, divert and hold freight traffic as necessary.
30	Management of Brexit impacts/resilience planning for Trading Standards	Trading Standards will be impacted by Brexit related changes to the trading environment, legislation and import controls. The service is positively responding by building skills and capacity and considering legislative change to provide quality advice and guidance to businesses.
31	The Big Conversation – delivery and evaluation of rural discretionary subsidised bus service pilot schemes	We are exploring innovative and sustainable ways of providing transport to rural communities in Kent. We want to maintain and improve accessibility for those without an alternative means of travel in rural areas. We will deliver and evaluate local pilot schemes for discretionary subsidised bus services to shape future delivery opportunities.
32	Parking management and enforcement review	We are undertaking independent research to help inform options for on street parking management and lorry enforcement issues impacting local communities. Working together with our district partners the intention is to explore a broad range of potential solutions, including to the inappropriate parking of lorries in rural areas and how additional income might be generated and invested.
33	Development of the Minerals and Waste Local Plan	The development of the Minerals and Waste Local Plan follows a statutory governance process and requires decisions and monitoring from County Council. The plan will help review, update and clarify related waste management policies.
34	Waste Partnerships; implementation of West Kent (2019) and development of East Kent (2021) with a duration of ten years	We are progressing new waste partnership arrangements in East and West Kent, commissioning appropriate further capacity and maximising capital investment in essential waste infrastructure. This will support KCC to respond to significant market changes and financial pressures.

No.	Activity Title	Activity Type
35	Critical Waste contracts commissioning programme	The programme will secure practical, cost-effective and compliant ways to recommission a series of technical waste contracts during 2019/20 which are critical to service delivery for residents and businesses in Kent. We will consider price implications for recycling, haulage, processing and disposals contracts.
36	Charging for non-household waste materials at Household Waste Recycling Centres	The project to implement this policy change is designed to reduce demand on site, generate revenue streams and create clearer intelligence that will enable stronger and more successful enforcement actions against illegal disposal of trade and commercial waste.
37	Development and implementation of the Libraries, Registration and Archives Strategy	We are developing a three year strategy to deliver the service ambitions and secure a sustainable Libraries, Registration and Archives service. We will maximise outcomes for local communities, though a tiering approach for library opening hours and piloting technology assisted libraries.
38	Reviewing the JSNA to support commissioning, planning and delivery of improved health and wellbeing outcomes across the Kent and Medway health and care system	The review will examine how the JSNA can support the delivery of the Kent and Medway Case for Change, which underpins health and care system transformation and the delivery of the NHS Long Term Plan. The JSNA will also be reviewed to ensure it can meet the planning and implementation needs of all partners across the Integrated Care System.
39	Further development of the Kent Integrated Dataset	The Kent Integrated Dataset supports modelling of future population health and social care needs, and is now also supporting work on system integration and commissioning. The data warehouse infrastructure is being updated and the work aligned with the analytic, research and development capability within Sustainability and Transformation Partnership.
40	Development of a refreshed Kent Joint Health and Wellbeing Strategy	The strategy is a statutory requirement for the Health and Wellbeing Board. It needs to be refreshed to reflect the fast-changing integration and policy context for health and wellbeing outcomes and needs to be informed by the updated evidence base in the JSNA.
41	Transforming preventative services through the Adult Healthy Lifestyle Commissioning Strategy	This supports the Kent and Medway Sustainability and Transformation Plan through supporting adults to make and sustain healthy choices and live longer in good health. The commissioning strategy will drive up performance, quality and consistency. Needs assessments and reviews of existing contracts will remodel services and deliver efficiencies.
42	Continuing the transformation of Sexual Health Services in Kent	The refreshed commissioning plan for sexual health services will deliver service transformation through strategic partnership and contractual arrangements. This will deliver best value by managing increased demand, improving integration, productivity and embedding innovation.
43	Refresh and implementation of the commissioning strategy for Substance Misuse Services (Drug and Alcohol services)	The aim is to prevent harm and deliver effective, accessible and high quality drug and alcohol services. Collaboration, co-design and integration with partners will tackle system challenges and remodel services. The needs assessment will inform the refresh of the commissioning strategy to drive efficiencies, maintain performance, quality and manage clinical risk.
44	Reshaping homelessness support transition services	Adults and children's services have worked together to reshape support services for vulnerable homeless adults and create transition pathways for young people. We will review the effectiveness of prime contractor models and promote collaboration with landlords, districts and families.

Outcome 3:

Older and vulnerable residents are safe and supported with choices to live independently

We want to ensure that the people of Kent are at the centre of their care and support them to live as independent a life as is possible given their needs and circumstances.

Below is a summary of the operating environment themes which influences the way we work together to achieve Outcome 3.

Demand pressures: Demand on health and social care services continues to rise with a growing and ageing population with increasing complex needs. The number of people over 65 is forecast to increase by 57.5% and the number over 85 by 131% by 2036. There is also a growing number of younger adults with complex needs who require integrated support. Social care is by far the most significant proportion of spending for the Council, so any changes to social care funding, demand and service expectations will impact on our budget and service delivery. We need cost effective services where people remain at the centre of the care they receive.

Integration: Integrated Care Systems require a national and local response to move from reactive acute provision to proactive primary and community services, focusing on preventative practice, improving health and reducing health inequalities. This reflects the national policy shift set out in the NHS Long Term Plan, Prevention Green Paper and anticipated Social Care Green Paper. We are working together with our partners to design and develop a transformative Integrated Care System for Kent and Medway through the Sustainability and Transformation Partnership. There is a clear focus on three tiers of integration: local/team integration (through Primary Care Networks), provider integration (through Integrated Care Partnerships) and structural/system level integration (through Integrated Care Systems).

Local care: New Local Care models will put the patient at the centre of everything they do, empowering GP's and local teams to integrate practice and work together to reduce hospital admissions by supporting more people in their local community. Local Care means jointly developing innovative solutions, at the right time to support people to live independently and meet local community challenges in Primary Care Network geographies. Multi-agency staff will work together as one team through Multi-Disciplinary Teams to break down silos between health and social care services. This will help to create safer 'out of hospital' solutions to reduce the pressure on both health and social care services. We will engage with early adopters and enable teams at the local level to find the right bespoke model for communities across Kent. Local Care not only focusses on those who currently require support, it is also about promoting the importance of maintaining well-being and prevention, including maximising the potential of social prescribing models.

Market shaping: We have a statutory duty in the Care Act to ensure sufficient capacity within the social care market. The Kent care market has been under increased pressure due to price increases from the National Minimum/Living wage, issues with viability of providers and significant workforce gaps. We will refresh the Adult Social Care Community Support Market Position Statement to inform market shaping, market oversight, market growth and sustainability. The updated commissioning strategy will inform future commissioning, workforce development, improve the quality of care and ensure KCC is responsive to market conditions.

Your Life, Your Wellbeing: Our 'Your Life Your Wellbeing' strategy outlines how we will focus on 'a life not a service' by continuing with a person-centred, timely and integrated approach to care and support. We are focused on delivering high quality, outcome focused, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting.

Being Digital: We want to help people to achieve the best possible health and wellbeing outcomes, living independent and fulfilling lives in their own homes and communities by using digital innovation and technology. Our 'Being Digital' Strategy will deliver changes to complement more traditional forms of care and support. Technology will not be a replacement for care, however we believe it can bring improvements in efficiency, effectiveness and help improve the quality of care.

Public Health and Prevention: The Government's "Prevention is better than cure" Green Paper set the tone for the importance of prevention in the NHS Long Term Plan. Working together with our partners will make best use of limited resources to close health inequalities gaps, improve quality and deliver cost effective services. We use our public health responsibilities to put physical and mental health and wellbeing at the heart of everything we do, helping people to lead healthier lives.

Mental health: The NHS Forward View set the national objective of improving parity of esteem and reducing inequalities for people with mental health problems. Our statutory Care Act duties mean our focus is on supporting those eligible for mental health support through effective commissioning, improving access and service quality. The Mental Health Crisis Care Concordat is progressing a multi-agency response in Kent and Medway, reviewing existing and planned commissioning intentions and service delivery to review the outcomes of the Concordat and drive improvements in crisis care. Our effective Public Health campaigns are successfully highlighting important mental health issues, including suicide prevention.

Voluntary and Community Sector: The Voluntary and Community Sector in Kent has a vital role in providing innovative local support and solutions. We want to strengthen our strategic partnership and commissioning relationship with the sector, by reviewing historic grants arrangements, increasing grant compliance and exploring the most appropriate future arrangements to support community services.

A new operating model: The new operating model for the Adult Social Care and Health directorate goes live in April 2019. It aims to transform the current case load model into a more sustainable, client focussed and collaborative system. The multi-disciplinary teams focus on what people can do to identify the person's strengths and use meaningful community networks that can help them and their family in making decisions about care and support. This needs to be supported by effective business systems and improved practice, such as the implementation of MOSAIC - the Directorate's new case management and finance management system.

Outcome 3:

Older and vulnerable residents are safe and supported with choices to live independently

This is a list of the significant activity within Outcome 3, including a headline summary of what needs to be delivered.

No.	Activity Title	Activity Type
45	Development of KCC's approach to an Integrated Care System for Kent and Medway	We will develop KCC's policy, financial, strategic commissioning and service approach to an Integrated Care System for Kent and Medway, responding to the opportunities and challenges set out in the NHS Long Term Plan, Prevention Green Paper and forthcoming Adult Social Care Green Paper.
46	Supporting Local Care Implementation	Supporting the implementation of Local Care through engagement in the Kent and Medway Sustainability and Transformation Partnership (STP) at Primary Care Network level to integrate health and care provision by empowering GP practices and multi-disciplinary teams to put the patient at the centre of Local Care models.
47	Continue to build effective strategic partnerships to maximise resource and improve public health outcomes (KCHFT and District partnerships)	Our strategic partnership with Kent Community Health Foundation Trust (KCHFT) and districts aims to improve the health of Kent residents, whilst meeting statutory obligations, driving better value and supporting integration. A review will examine service improvements and contract management to inform future partnership and commissioning decisions.
48	Refresh of the Community Support Market Position Statement to inform market shaping, oversight and sustainability	We have a statutory duty in the Care Act to ensure sufficient capacity within the social care market to meet the needs of people who are funded by the local authority as well as self-funders (people who fund their own services). We will refresh the Adult Social Care Community Support Market Position Statement to inform market shaping, market oversight, market growth and sustainability. The updated commissioning strategy will inform future commissioning, workforce development and influence outcomes for people and the overall market conditions.
49	Effective Winter Pressures Commissioning that enables the right support in the right setting	We work in partnership to commission the appropriate use of acute hospital beds, enable people to return home with the right support to prevent readmission, or remain in their own homes. We are managing winter pressures in a planned, considered way with flexible commissioning to respond to limited resources.
50	Refresh of the Older Persons Accommodation Strategy and Delivery Plan	The right accommodation solutions are needed to support people to live independently or receive the right care and support in extra care housing. The refresh of the strategy will ensure the right provision is in the right places, with the appropriate type, build volume, tenure and size. We will commission quality placements in response to rising demand and increasingly complex needs.
51	Analysis of Housing with Care (Extra Care) Placements	To support the Accommodation Strategy there is a need to analyse demand for additional Housing with Care (extra care) units as an alternative to residential care. An evidence based business case will examine the right utilisation of units, district placement process, access and nomination rights and suitability for increasingly complex needs, to inform future commissioning.

No.	Activity Title	Activity Type
52	Reviewing adult social care grants and recommissioning Community Based Wellbeing Support services	We are transforming historic adult social care grants and recommissioning community wellbeing services that prevent or delay people entering into health and social care systems. We are moving to more open, transparent processes and examining existing contracts which support service user and carer wellbeing.
53	Review of Voluntary and Community Sector Grants across the Council	We will review adults, children's and public health grants to the Voluntary and Community Sector to establish compliance with the VCS Policy and Public Contract Regulations. The review will explore the most appropriate future arrangements to support important community services.
54	Recommissioning Care and Support in the Home Services and delivering associated projects.	We are recommissioning combined community home based services, to mitigate cost pressures, enhance consistency and create services that are more responsive to client needs. The projects will align services to support integration with health.
55	Commissioning Disability and Mental Health Residential Care Services	We are developing outcomes based commissioning of residential services for adults with learning disabilities, physical disabilities and mental health needs. This will involve a fundamental review of historic contracts and shaping new approaches through market engagement, informed by service users, carers and partners.
56	Dementia Service Redesign and commissioning - KMPT	We want to ensure the right support for people with dementia in Kent, particularly to respond to budget pressures, rising demand and increasingly complex needs. We are redesigning services to commission in partnership with Kent and Medway NHS and Social Care Partnership Trust (KMPT).
57	Kent & Medway Neurodevelopmental (ND) Health Service commissioning	We are jointly commissioning services with CCG's in the health service across Kent and Medway for adults with autism an Attention Deficit Hyperactivity Disorder (ADHD). We are forming a contractual alliance to create multi-disciplinary teams.
58	Delivering the Transforming Care Programme for children and young people with autism and/or learning disability	We work collaboratively with Medway Council and the NHS to deliver the national Transforming Care Programme to prevent unnecessary admissions to hospital, institutional settings or reduce the length of stay in hospital. This generates income and provides bespoke support for families.
59	Delivering the Transforming Care Programme for Adults with Learning Difficulties (LD)	We are working with Medway CCG to support the national Transforming Care Programme to reduce the number of people with learning disabilities in specialist in-patient units. This will expand community based support and develop a highly skilled workforce to support people with the most complex needs.
60	Recommissioning of Carers Short Breaks	We commission respite for adults who are caring for another adult, to enable carers to keep caring and prevent residential care home admissions. The intention is to extend the current contract and use evidence based redesign to inform recommissioning.
61	Deliver the Income Pathway projects and develop future policy on the contribution from Adult Social Care clients	The Income Pathway assessment has informed a series of projects which will improve financial management and will and develop the future policy position on the contribution from social care clients, for home care and other non-residential services.
62	Implementing MOSAIC Adult Social Care case management and finance system	We are implementing a flexible Adult Social Care case management and finance system to improve and streamline processes. This is critical to support service management, future digital delivery, the delivery of transformation and integration.

Corporate Enabling Activity

The Strategic Delivery Plan is underpinned by activity which enables the delivery of multiple outcomes and delivery of corporate services. This activity is typically cross-cutting across services and communities and supports KCC as a Strategic Commissioning Authority.

Below is a summary of the themes which influence the way we work together to achieve better outcomes.

The importance of our staff: We value our staff and their talents – we have a skilled and motivated workforce which is flexible and innovative. We want to work collaboratively with our communities and partners to deliver effective services and find collective solutions. We want to create a working culture that is ambitious and promotes effective leadership and responsibility at all levels. We will embrace business change opportunities to find more productive and effective ways of working, so people can focus on service delivery.

Strategy: The Strategic Delivery Plan has identified important new strategy and policy development and our response to significant national policy changes, including Fair Funding and Business Rate Retention. The learning from the Strategic Delivery Plan process will shape future strategy, including the development of the next Strategic Statement and the wider strategy and policy framework for the Council, to drive future prioritisation and outcomes based accountability.

Commercial opportunities: Our trading company arrangements provide flexibility to maximise growth and provide the Council with a sustainable dividend return. Our holding company governance arrangements will align our commercial interests, ensuring inter-company productivity, efficiency and maximise cross-cutting opportunities for commercial growth. This requires robust governance and democratic oversight and scrutiny.

Commissioning success: As a Strategic Commissioning Authority, service directorates and commissioners need to work collaboratively together with the external market to secure best value. We want to shape market development, examine market sufficiency and improve our commissioning relationships. We are undertaking rigorous contract reviews and stocktakes to promote quality commissioning standards and enhance value for money through our contracting arrangements. We want to create an efficient commissioning workforce, with the right professional capabilities, commercial judgement and leadership to deliver successfully.

Analysis: To understand and respond to changing demand and pressures, we need to have the right evidence base to inform new solutions. This involves services working together to identify the right analytical and diagnostic support, including robust evaluation and a critical understanding of spend and cost drivers.

Redesign: We are using evidence based decision making to redesign service delivery and progress new operating models. This supports the delivery of better outcomes through partnership working and requires the right capacity, capability and skills from our workforce.

Asset management: We are implementing an agile, innovative and forward thinking asset management approach, through the delivery of our Property Asset Strategy and associated asset utilisation projects. This will create an effective, efficient estate, to drive value for money, ensure statutory compliance and enable service transformation within KCC and with our partners. We are maximising value from capital receipts through our disposals programme for reinvestment, and

exploring opportunities for property development arrangements to generate financial return and stimulate development. We are carrying out essential works to keep our assets safe, warm and dry, efficiently targeting limited resources on maintenance and repair to meet business need.

Customer expectations: The way people access services is changing with growing digital and social media use driving changes in customer expectations over the choice and control of services and how they wish to access information. This provides opportunities to reform services to better meet customer needs and expectations. We want to improve digital platforms and support digital inclusion.

Business Change: We need to maximise new technology opportunities, transforming systems and championing new ways of working. We need a skilled, motivated workforce that can work in productive, innovative ways within KCC and with our partners. We need greater utilisation of existing assets and tools to capitalise on our investment and work more efficiently. We need to develop staff with the knowledge and confidence to deliver business change successfully.

Resilience: We have a duty of care to staff, service users and residents. We need to deliver our business continuity, compliance and emergency planning responsibilities, to ensure our services are well-prepared and resilient. This includes preparing for threats, issues and events such as Brexit, health and safety, counter-terrorism and cyber security.

Apprenticeships: We want to promote and expand the potential of apprenticeships across the Council and business community, with a particular focus on training opportunities for young people aged 17-25. We are embracing the opportunities of Apprenticeship Levy and working to meet our public sector target requirements.

Corporate Enabling Activity

Enabling better outcomes across all our services requires corporate support and significant commissioning, strategy/policy and service delivery changes.

This is a list of the significant enabling activity, including a headline summary of what needs to be delivered.

No.	Activity Title	Activity Type
63	Development of the new Strategic Statement for Kent County Council	The Council's new Strategic Statement for 2020 will set out our vision, outcomes and priorities, shaping the business planning, performance and strategy/policy framework for the Council over the medium term.
64	To input to, influence and take account of the impact of the Fair Funding Review and Business Rate Retention in the MTFP	The Fair Funding Review and Business Rate Retention are fundamental national policy changes to funding arrangements for local government. We work with our partners to influence the Government at a national level and assess the opportunities and challenges for our Medium Term Financial Plan.
65	Implementing outcomes based budgeting and accountability	Outcomes based budgeting and accountability ensures that resources are directly linked to the Council's outcomes. The approach will provide a clear evidence base to demonstrate the impact of strategic activity and whether outcomes are being achieved, to help prioritise resources.
66	Review of Company Governance	We are reviewing the ownership structure for wholly-owned trading companies within KCC's investment strategy. We are establishing a holding company to reduce overheads and increase commerciality, optimising governance arrangements to maximise return to the Council.
67	Strategic Commissioning: Whole Council Approach Stocktake and Future Delivery Options	To continue our journey to become a strategic commissioning authority, this project reviews the costs, benefits, lessons learnt and opportunities of current models and will develop optimum model options for delivery.
68	Good, Better, Best - Continuing evolution of Commissioning in KCC to enable better outcomes for the residents of Kent	We are continuing to evolve and improve our commissioning standards. We will develop a best practice commissioning standards framework, simplify processes and develop staff capability across the Council through the Chartered Institute of Procurement and Supply (CIPS) assessment.
69	Review of KCC's Voluntary and Community Sector (VCS) Policy	The policy reflects the crucial role of the Voluntary and Community Sector in Kent. We will review the policy to assess impact and effectiveness, and define the future approach to our relationship with the sector.
70	Delivery of the Property Asset Strategy	The Property Asset Strategy sets out how we will create an effective, efficient estate which provides value for money, reduces environmental impact and supports service transformation, both within KCC and with our partners. The implementation of the strategy will require an agile, innovative and forward thinking asset management approach.
71	Delivery of the Disposals Programme	The disposals programme manages the pipeline of Council properties which are no longer required and can be disposed to generate capital receipts for reinvestment. Using property investment expertise, each asset is assessed to determine appropriate options. Maximising value from capital receipts will support Property Development Arrangements.

No.	Activity Title	Activity Type
72	Delivering a business case for Property Development Arrangements, to maximise value from the disposal of appropriate Council assets	We are developing a business case to explore options to maximise value from the disposal of appropriate assets, by benefiting from property development activity. The business case will consider optimal governance and legal structures to maximise investment opportunities, financial return and stimulate development.
73	Developing a business case for the asset utilisation of Oakwood House	Oakwood House is being considered within the Asset Utilisation programme. A business case is being developed to identify best value options and service proposals, to determine the right asset approach.
74	Re-commissioning of Contracts to provide Facilities Management services to the KCC office estate.	The existing facilities management contract is being extended and this more fundamental re-commissioning will involve service delivery and procurement options based on good practice and comparable organisations. The new commissioning approach aims to implement a fit for purpose solution which achieves best value for the Council.
75	Delivery of the Capital Programme and Revenue Maintenance for KCC's Corporate Landlord Estate	The capital maintenance programme includes the Modernisation of Assets, Planned and Reactive Maintenance to carry out essential work to keep our assets safe, warm and dry. The revenue maintenance commissioning works ensure buildings remain compliant, targeting resources on essential upgrade and repair works to meet business need.
76	Delivering a compliance programme responding to Grenfell, Hackitt Review and Health and Safety reviews	A cross-directorate group is overseeing the delivery of actions from an asset management review to ensure compliance, take remedial action and provide assurance on KCC's fire safety and health and safety requirements. This includes delivering condition survey programmes and assessing service delivery and commissioning arrangements.
77	Delivering the KCC Brexit Resilience Emergency planning and Business Continuity programme	Robust business continuity and emergency planning arrangements are important to enable KCC to develop resilience to the impacts of Brexit. The programme has four phases, working collaboratively across the Council to ensure we are well-prepared and have effective plans in place.
78	Oracle contract review and planning for procurement	The Oracle contract is being renewed, which provides core business systems across the Council. However, over the medium term alternative products may become available. We need to review the options as part of the recommissioning process to assess business benefits and implications.
79	Maximise the number of staff accessing Apprenticeship training within Kent County Council	We want to promote and expand the potential of apprenticeships across the Council, with a focus on training opportunities for young people (17-25). This is an important part of responding to the Apprenticeship Levy and meeting our public sector target requirements.

Signposting

This document is a public summary of the Strategic Delivery Plan. The full Strategic Delivery Plan document sets out the detail on how activity will be achieved and is an internal document for KCC's staff and elected members. It is supported by key documents and processes.

Finance: The Strategic Delivery Plan is aligned with the Medium Term Financial Plan, which provides a detailed overview of capital and revenue spend, including a full list of capital programme and project activity. The annual Budget Book presents a detailed budget breakdown for all services.

Organisation Development: Our medium-term People Strategy and Organisational Development Plan, approved by CMT, sets out how we will improve workforce capacity and capability to deliver business change, through an annual action plan and centralised training budget. Directorate OD Plans inform and engage with the plan to manage skills development and will reflect the Strategic Delivery Plan.

Performance: We have robust processes in place to monitor performance indicators and activity indicators, including through the Quarterly Performance Report (for Cabinet), Directorate Dashboards (for Cabinet Committees) and the Annual Report Performance Report (for County Council). Detailed KPI's and milestones for individual activity are managed through these processes by the responsible officer, or through appropriate programme/project management governance.

Risk: The activity within the Strategic Delivery Plan requires robust risk management, reflected in Risk Registers which are reported through management and formal governance processes. Risks for individual activity may also be reflected in programme/project risk registers.

Programmes and Projects: Portfolio Boards and the Corporate Assurance team provide oversight of change activity including programmes and projects. This is supported by portfolio, programme and project governance within Directorates, with reporting to CMT and Policy and Resources Cabinet Committee.

Strategies and Policies: Our strategic activity is an important part of delivering our strategy and policy priorities and is reflective of our wider operating environment. KCC's Strategy and Policy Register provides an overview of the major strategic documents in the council.

Governance and decision making: Significant activity identified in the Strategic Delivery Plan will progress through KCC's governance and decision making process, with oversight and input from elected members, as set out in the Constitution.

Operating Plans: Our divisional and service Operating Plans cover both strategic activity and essential service delivery, acting as important business planning documents for the Council.

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 – 13 March 2019

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

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

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

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to consider and comment on the risks presented in appendices 1 and 2 to this report.

1. Introduction

1.1 Risk management is a key element of the Council's Internal Control Framework and the requirement to maintain risk registers ensures that potential risks that may prevent the Authority from achieving its objectives are identified and controlled.

1.2 The process of developing the registers is important in underpinning business planning, performance management and service procedures. Risks outlined in risk registers are taken account of in the development of the Internal Audit programme for the year.

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

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

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

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

2. Financial Implications

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

3. Policy Framework

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

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

4. Risks relating to Public Health

4.1 There are currently six risks featured on the Public Health risk register (appendix 1), none of which are rated as 'High'. Many of the risks highlighted on the register are linked to risks on the Authority's Corporate Risk Register for example the risk of communicable disease outbreak is contained within the Corporate Risk Register, under risk number four, Civil Contingencies and are discussed as part of regular items to the Cabinet Committee.

4.2 Since December 2017 Public Health entered into a partnership agreement with Kent Community Health NHS Foundation Trust to deliver key public services. These include services for which KCC has a statutory responsibility such as Health Visiting, Sexual Health and NHS Health Checks Service. These developments have meant that two risks associated from last years register

have been closed namely the challenges associated with the market for public health services, and the risk associated with the service delivery changing

4.3 The other changes made are:

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

- A new risk added PH0083 to further develop the process of assurance around Public Health grant, following the challenge faced by Northamptonshire council.

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

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

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

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

5. Recommendation

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to consider and comment on the risks presented in appendices 1 and 2 to this report.

6. Background Documents

6.1 KCC Risk Management Policy on KNet intranet site.

https://democracy.kent.gov.uk/ecSDDisplay.aspx?NAME=SD5533&ID=5533&RPID=27241285

Risk Management Policy and Strategy 2

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Full Risk Register

Risk Register - Public Health

Current Risk Level Summary

Green	Amber	Red	Total
0	6	0	6

Current Risk Level Changes

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

Risk Ref	*PH0082*	Risk Title and Event	Owner	Last Review da	Next Review
		Implementation of General Data Protection Regulations (GDPR) Increased likelihood of breaching data protection law and having a negative impact on the right to a private life for the citizens of Kent	Gerrard Abi-Aad	28/02/2019	28/05/2019

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Target Risk
The General Data Protection Regulations (GDPR) increases obligations on data controllers such as KCC to document all data processing activity	A serious breach of GDPR might result in an inability to access key Public Health data sources by means of special conditions placed on access rights as a result of breach failures. A breach might also result in KCC incurring significant financial penalties, damage to KCC's reputation and its ongoing ability to support new analytic requirements in respect of strategic commissioning.	Medium 12 Serious (4) Possible (3)		• Update privacy notices to be GDPR compliant. • Commissioners support the implementation of the GDPR programme • GDPR compliance is monitored through contract monitoring processes	Gerrard Abi-Aad Karen Sharp Karen Sharp	A -Accepted Control Control	25/05/2018	Low 4 Serious (4) Very Unlikely (1)

Review Comments this is continually being monitored through staff training and contract monitoring
28/02/2019

Risk Ref	*PH0083*	Risk Title and Event	Owner	Last Review da	Next Review
Public Health Ring Fenced Grant Ensuring/assuring the Public Health ring fenced grant is spent on public health functions and outcomes, in accordance within National Guidance			Andrew Scott-Clark	16/01/2019	16/04/2019

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Target Risk
Public Health Ring fenced Grant is spent in accordance within National Guidance	If it does not comply with national guidance could result in the DPH not being able to sign the Annual Public Health Grant declaration which could result in an external audit taking place leading to similar consequences to that of Northamptonshire County Council (i.e. Public Health England seeking a return of Public Health Grant)	Medium 12 Significant (3) Likely (4)		• Commissioners to conduct regular contract monitoring meetings with providers	Victoria Tovey	A -Accepted	31/03/2019	Low 2 Minor (1) Unlikely (2)
				• Providers to complete timely monthly performance submissions to ensure delivery of outcomes	Victoria Tovey	A -Accepted	31/03/2019	
				• Review of Memorandums of understanding where the public Health Budget is being used to deliver baseline services and where public health are commissioning to deliver public health outcomes	Victoria Tovey	A -Accepted	31/03/2019	
				• Agreed funding for Staff apportionment across Public Health, social care Adult, Social Care Children, business support and analytics functions to support public health outcomes functions and outcomes	Andrew Scott-Clark	A -Accepted	31/03/2019	
				• Agreement of money flow between Public Health ring-fenced grant and the Strategic Commissioning Division	Andrew Scott-Clark	A -Accepted	31/03/2019	
				• Continued budget monitoring through collaborative planning	Avtar Singh	Control		
				• Regular review of public health providers, performance, quality and finance are delivering public health outcomes	Victoria Tovey	Control		
				• DPH and Section 151 Officer are required to certify the statutory outturn has been spent in accordance with the Department of Health & Social care conditions of the ring fenced grant	Andrew Scott-Clark	Control		

Review Comments New control added to ensure certification is gained.
16/01/2019

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	PH0001	Risk Title and Event	Owner	Last Review da	Next Review
CBRNE incidents, communicable diseases and incidents with a public health implication Failure to deliver suitable planning measures, respond to and manage these events when they occur.			Andrew Scott-Clark	28/02/2019	28/05/2019

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Target Risk
The Council, along with other Category 1 Responders in the County, has a legal duty to establish and deliver containment actions and contingency plans to reduce the likelihood, and impact, of high impact incidents and emergencies. The Director of Public Health has a legal duty to gain assurance from the National Health Service and Public Health England that plans are in place to mitigate risks to the health of the public including outbreaks of communicable diseases e.g. Pandemic Influenza. Ensuring that the Council works effectively with partners to respond to, and recover from, emergencies and service interruption is becoming increasingly important in light of recent national and international security threats and severe weather incidents.	Potential increased harm or loss of life if response is not effective. Increased financial cost in terms of damage control and insurance costs. Adverse effect on local businesses and the Kent economy. Possible public unrest and significant reputational damage. Legal actions and intervention for failure to fulfil KCC's obligations under the Civil Contingencies Act or other associated legislation.	Medium 12 Serious (4) Possible (3)		• KCC and local Kent Resilience Forum partners have tested preparedness for chemical, biological, radiological, nuclear and explosives (CBRNE) incidents and communicable disease outbreaks in line with national requirements. The Director of Public Health has additionally sought and gained assurance from the local Public Health England office and the NHS on preparedness and maintaining business continuity	Andrew Scott-Clark	Control		Medium 12 Serious (4) Possible (3)
				• The Director of Public Health works through local resilience fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health.	Andrew Scott-Clark	Control		
				• Kent Resilience Forum has a Health sub-group to ensure co-ordinated health services and Public Health England planning and response is in place	Andrew Scott-Clark	Control		
				• DPH now has oversight of the delivery of immunisation and vaccination programmes in Kent through the Health Protection Committee DHP has regular teleconferences with the local Public Health England office on the communication of infection control issues DPH or consultant attends newly formed Kent and Medway infection control committee	Andrew Scott-Clark	Control		

Review Comments undated with additional control where the DPH has a greater oversight on immunisation and vaccination programmes across the county via Teleconference with Local PHE office and has representation on the Kent & Medway infection control committee
28/02/2019

Risk Ref	*PH0004*	Risk Title and Event	Owner	Last Review da	Next Review
Information Governance The success of health and social care , and the effective delivery of services in partnership, is dependent upon organisations being able to share information across agencies			Gerrard Abi-Aad	28/02/2019	28/05/2019

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Target Risk
With New Ways of Working, flexible working and increased information sharing across agencies there are increased risks in relation to data protection. The Public Health Observatory has access to NHS data to allow it to deliver it's statutory responsiblities	This could lead to breaches of the Data Protection Act if protocols and procedures are not followed.	Medium 9 Significant (3) Possible (3)		• Information governance requirements are included as part of standard contracts with providers, where relevant. Annual Information Governance Statement completed by all contracted providers.	Karen Sharp	Control		Low 6 Moderate (2) Possible (3)
				• Caldicott Guardian in place for PH and Caldicott Guardian Guidance and register in place. The Caldicott Guardian officers have regular formal meetings.	Gerrard Abi-Aad	Control		
				• Authority wide group in place to provide strategic leadership on Information Governance.	Gerrard Abi-Aad	Control		
				• Information sharing agreements and protocols for specific projects are in place.	Gerrard Abi-Aad	Control		
				• E Learning training for staff to raise awareness. All staff to complete the e-learning training on Information Governance and Data Protection.	Andrew Scott-Clark	Control		
				• Clause in employment contracts requiring compliance with data protection requirements.	Andrew Scott-Clark	Control		

Review Comments this is ongoing and reviewed as part of staff training and provider contract monitoring
28/02/2019

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	*PH0005*	Risk Title and Event	Owner	Last Review da	Next Review
Health Inequalities These areas have high rates of premature mortality (deaths occurring under the age of 75 years) due to causes such as cardiovascular disease, respiratory disease and alcohol-related disease and cancer; causes that are strongly linked to unhealthy behaviours such as poor diet, physical inactivity, smoking and excessive alcohol. The risk is that whilst health is improving in general these communities health would not improve at the same rate as less deprived communities			Andrew Scott-Clark	28/02/2019	28/05/2019

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Target Risk
Analysis of health inequalities in Kent shows that health outcomes are much worse in the most deprived decile areas in Kent.	The average life expectancy in the most deprived decile areas in Kent is 76 years for men and 80 years in women, compared to 83 years and 86 years respectively in the most affluent areas. These inequalities will lead to rising health and social care costs for the council and its partners amongst those groups least able to support themselves financially	Medium 9 Significant (3) Possible (3)		• Ensure that commissioning takes account of health inequlaities when developing service based responses. For example Health trainers have a target to work with 25% of people from most deprived wards	Karen Sharp	Control		Low 6 Moderate (2) Possible (3)
				• Ensure that an analytical focus remains on the issue of health inequality, providing partners and commissioners with the detail needed to focus support on this issue	Gerrard Abi-Aad	Control		
				• Refresh action plan for the Mind the Gap strategy, work with partners, such as District councils and CCGs to coordinate efforts to tackle health inequalities	Andrew Scott-Clark	Control		
				• Where relevant use the Public Health England campaign and behaviour change tools, and expand this activity by targeting areas identified through Mind the Gap Analysis	Andrew Scott-Clark	Control		

Review Comments work continues to reduce the health inequalities through commissioning services in relation to the information gathered through needs assessments and health promotion
28/02/2019

Strategic and Corporate Services

Risk Register - Public Health

Risk Ref	*PH0002*	Risk Title and Event	Owner	Last Review da	Next Review
Implementation of new models That the reduction in resource available to the new services will hamper the new services in their ability to deliver.			Andrew Scott-Clark	16/01/2019	30/06/2019

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Target Date	Target Risk
Public Health is working to transform both children's and adults services, to deliver services more aligned with the need of the people of Kent. Whilst also facing reducing budgets	Reduction in outcomes for customers, and the ability of the services to meet key objectives, including the reduction of health inequalities	Medium 9 Significant (3) Possible (3)		• Develop a long term resource allocation plan, taking account of likely financial resources over next four years	Andrew Scott-Clark	A -Accepted	31/12/2019	Low 4 Moderate (2) Unlikely (2)
				• Public Health commissioning function in place to ensure robust commissioning process is followed	Karen Sharp	Control		
				• Opportunities for Joint Commissioning in partnership with key agencies and cross-directorate (health, social care) being explored.	Karen Sharp	Control		
				• Regular meetings with provider and representative organisations (LMC, LPC). Regular meet the market events to support commissioning processes	Karen Sharp	Control		
				• Working to a clear strategy, and to an advanced agenda allows for good communication with providers and potential porivders	Karen Sharp	Control		
				• Analyse long term financial situation, and developing services that will be sustainable	Andrew Scott-Clark	Control		

Review Comments to be reviewed and completed in line with commissioning plans
16/01/2019

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Risk Register - Corporate Risk Register

Current Risk Level Summary

Green	Amber	Red	Total
0	1	0	1

Current Risk Level Changes

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

Risk Ref	*CRR0005*	Risk Title and Event	Owner	Last Review da	Next Review
		Implementation of Local Care and Prevention with Health partners in Kent Risk Event Failure to maximise opportunities for appropriate health & social care integration and ensure changes achieve maximum benefit. Pressures within the acute health sector result in repercussions for social care and threaten successful implementation of joint working arrangements. Improved Better Care Fund monies earmarked for social care geared to addressing pre-determined NHS targets and priorities. Performance issues in the Health Sector have knock-on implications for KCC. Failure to meet statutory duties around the sufficiency of the care market, care quality and safeguarding. Opportunity cost from spending time and resources on STP and system design which is subject to change from NHS England. Lack of understanding within KCC of NHS policy and regulatory environment; and vice versa, lack of understanding of local authority legislative, policy and democratic environment in NHS.	Penny Southern / Andrew Scott-Clark / Vincent Godfrey	02/11/2018	05/03/2019

Cause	Consequence	Current Risk	Previous Current Risk	Control / Action		Control / Action	Progress Review Date	Target Risk
Source / Cause of Risk The health & social care 'system' is under extreme pressure to cope with increasing levels of demand and financial constraints. National government policy for integration of health and social care as part of how to meet these challenges. NHS national policy is for health commissioners and providers to come together and develop place-based plans. KCC is part of the Kent and Medway Sustainability and Transformation	Consequence Further deterioration in the financial and service sustainability of Health and Social Care system in Kent and Medway. Additional budget pressures transferred to social care as system monies are used to close acute and primary care service gaps. Legal challenge/judicial review of decisions and decision-making framework for integrated decisions. Social care and public health service priorities determined by	Medium 12 Serious (4) Possible (3)		• Assess NHS 10-year plan and impact on the STP	David Whittle	A -Accepted	30/04/2019	Medium 8 Serious (4) Unlikely (2)
				• Delivery of the Adult Social Care and Health Local Care Implementation Plan	Penny Southern	A -Accepted	31/03/2019	
				• Public Health advice to new Service Commissioning Board as per KCC statutory requirement	Andrew Scott-Clark	A -Accepted	31/03/2019	
				• 10-year plan and Kent JSNA/Case for Change	Andrew Scott-Clark	A -Accepted	31/08/2019	
				• Delivery of Kent and Medway STP Prevention Plan	Andrew Scott-Clark	A -Accepted	31/03/2019	
				• Regular internal STP co-ordination meetings chaired by the Leader	Paul Carter	Control		

Partnership (STP) and this partnership will evolve to form an integrated care system (ICS). Integration can only happen at local level around GP clusters. It is important that KCC understands the opportunities and challenges of an ICS and also the upcoming NHS 10 year plan and social care Green Paper. Care Quality Commission now conducts reviews of health and social care 'systems' to find out how services are working together to care for people aged 65 and over.	NHS, not KCC. Capitated provider contracts dominated by NHS budgets and targets. Focus on STP and ICS workstreams prevents more local and agile improvements/joint working being undertaken. Erosion of long-term working relationships between NHS and local government. Reputational damage to either KCC or NHS or both in Kent. Adverse outcome from CQC local system review.			• KCC has a designated Cabinet Member Portfolio for Health Reform and Cabinet Member for Strategic Commissioning	Paul Carter	Control		
				• Local Care Implementation Board in place	Paul Carter	Control		
				• KCC has appointed an elected Member to the STP non-executive oversight group	Paul Carter	Control		
				• A joint KCC and Medway Health and Wellbeing Board for STP related matters/issues has been established.	David Whittle	Control		
				• Establishment of a Health Reform and Public Health Cabinet Committee to provide non-executive member oversight and input of KCC involvement in the STP	Benjamin Watts	Control		
				• Senior KCC level officer representation on the East Kent ICS, and emerging West, North and Medway ICS	Penny Southern	Control		
				• KCC STP Secretariat established to manage and monitor ongoing engagement and activity	Penny Southern	Control		
				• Senior KCC political and officer representation on the STP Programme Board	Penny Southern	Control		
				• County Council agreed framework for KCC engagement within the STP – ongoing monitoring and control taking place through STP Secretariat	Penny Southern	Control		
				• Senior KCC level officer representation across STP workstreams	Penny Southern	Control		
				• Public Health leadership for the STP prevention workstream	Andrew Scott-Clark	Control		

From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 13 March 2019

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 15 January 2019, 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

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Last updated on: 4 March 2019

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE WORK PROGRAMME 2019/20

Items to every meeting are in italics. Annual items are listed at the end.

10 MAY 2019
• ***Verbal Updates*** • ***Contract Monitoring – Adolescent Health Services*** • ***Work Programme 2019/20*** • **Public Health Performance Dashboard – incl impact of STP** • **Update on Public Health Campaigns/Communications**
20 JUNE 2019
• **Gambling addiction - follow up report on work to address issues arising from** gambling item at 22/11/18 mtg (request by B Lewis) • **Housing conditions and their effect on health inequalities, incl hidden homeless** (request by E Dawson, 15/1/19) • **Lack of open green space and its effect on mental health** (request by S Hamilton, 15/1/19) • **(separate from Air Quality item) lack of charging points for electric cars.** • ***Contract Monitoring – Domestic Abuse and Positive Relationships*** • ***Verbal Updates*** • ***Work Programme 2019/20***
24 SEPTEMBER 2019
• ***Verbal Updates*** • ***Contract Monitoring – Adult Health Improvement Services (incl workplace health)*** • ***Work Programme 2019/20*** • **Public Health Performance Dashboard – incl impact of STP** • **Update on Public Health Campaigns/Communications** • **Annual report – Quality in Public Health, incl complaints**
1 NOVEMBER 2019
• ***Verbal Updates*** • ***Contract Monitoring – Workforce Development*** • ***Work Programme 2020*** • **Regional approach to tackle illicit tobacco** (following item 10 at 22/11/18 mtg)
14 JANUARY 2020
• ***Verbal Updates*** • ***Contract Monitoring – Young People's Drug and Alcohol Services*** • ***Work Programme 2020*** • **Budget and Medium-Term Financial Plan**

- **Public Health Performance Dashboard – incl impact of STP**
- **Update on Public Health Campaigns/Communications**

6 MARCH 2020

- **Strategic Development Plan** (replaced former Directorate Business Plans)
- **Risk Management report (with RAG ratings)**
- ***Verbal Updates***
- ***Contract Monitoring – tbc***
- ***Work Programme 2020***

30 APRIL 2020

- ***Verbal Updates***
- ***Contract Monitoring – tbc***
- ***Work Programme 2020***
- **Public Health Performance Dashboard – incl impact of STP**
- **Update on Public Health Campaigns/Communications**

PATTERN OF ITEMS APPEARING REGULARLY

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	• Strategic Development Plan (replaced former Directorate Business Plans) • Risk Management report (with RAG ratings) • Health Inequalities – annual
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)
June/July	
September	• Annual Report on Quality in Public Health, incl Annual Complaints Report • *Annual Equality and Diversity Report** this is part of the Strategic Commissioning Equality and Diversity, which goes to the Policy and Resources Cabinet 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	

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