HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 1st May, 2018

10.00 am

Council Chamber - Sessions House

Kent County Council
kent.gov.uk

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 1 May 2018 at 10.00 am
Council Chamber - Sessions House

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

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

Membership (13)

Conservative (10): Mr G Lymer (Chairman), Mrs P A V Stockell (Vice-Chairman), Mr A Cook, Miss E Dawson, Mrs L Game, Ms S Hamilton, Ms D Marsh, Mr K Pugh, Miss C Rankin and Mr I Thomas

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

Labour (1) Dr L Sullivan

Webcasting Notice

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

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

UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in items on the Agenda

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

4 Minutes of the meeting held on 13 March 2018 (Pages 7 - 16)

To consider and approve the minutes as a correct record.

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

To receive a verbal update from the Leader and Cabinet Member for Traded Services and Health Reform, the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health.

6 Kent Tobacco Control - working in partnership (Pages 19 - 24)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, setting out current patterns of smoking and measures to tackle this and tobacco control. The committee is asked to comment on and endorse this work.

7 Air Quality (Pages 25 - 32)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, detailing some of the work the County Council is undertaking with partners to address the health effects of poor air quality in Kent. The committee is asked to comment on and endorse the approach being taken.

8 Update on the use of Novel Psychoactive Substances in the UK and Kent (Pages 33 - 38)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, setting out what is known about the current extent of misuse of Novel Psychoactive Substances (NPS) in the UK and Kent. The committee is asked to comment on and endorse local measures to tackle the use of such substances.

9 Contract Monitoring Report - Primary School Public Health Service (Pages 39 - 48)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, giving an overview of the Primary School Public Health (PSPHS) contract, including monitoring arrangements, performance outcomes and value for money. The committee is asked to comment on and endorse progress made to transform services through an effective contract management approach and ongoing activities to deliver statutory obligations, continuous improvement and meet performance expectations.

10 Transition of Infant Feeding Service (Pages 49 - 56)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health on work undertaken to implement the new model for infant feeding support, following the Cabinet Member decision taken on 12 March 2018. The committee is asked to comment on and endorse and progress to date.

11 Performance of Public Health commissioned services (Pages 57 - 62)

To receive a report from the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health and the Director of Public Health, setting out an overview of key performance indicators (KPIs) for Public Health commissioned services. The committee is asked to note and comment on the performance and agree the proposed KPI changes to be presented in future

reports

12 Work Programme 2018/19 (Pages 63 - 66)

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

Monday, 23 April 2018

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

This page is intentionally left blank

KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Darent Room - Sessions House on Tuesday, 13th March, 2018.

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

OTHER MEMBERS: Paul Carter, CBE, Graham Gibbens and Peter Oakford

OFFICERS: Andrew Scott-Clark (Director of Public Health), Anne Tidmarsh (Director, Older People and Physical Disability) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

55. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Mr D S Daley.

There were no substitutes.

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

Miss C Rankin declared that her son was employed as an economist by the Competition and Markets Authority, a body which was working in partnership with the County Council on the Local Care Implementation Plan (agenda item 6).

57. Minutes of the meetings held on 24 January and 8 February 2018.
(Item. 4)

It was RESOLVED that the minutes of the meetings held on 24 January 2018 and 8 February 2018 are correctly recorded and they be signed by the Chairman. There were no matters arising, but the Chairman commended the Democratic Services Officer on the comprehensive and precise minutes of the petition debate and discussion of the infant feeding item at the 8 February meeting.

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

1. The Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health, Mr P J Oakford, gave a verbal update on the following issues:
Delivery of the Infant feeding service – next steps – the key decision to start implementing the new service had been taken on 12 March and he hoped the implementation would now move ahead successfully. Some parts of the new service had been adjusted to take account of feedback arising from the public consultation.

Joint Kent and Medway Health and Wellbeing Board – work to establish this was now complete and the new joint Board would start work in April. The Kent Health and Wellbeing Board would continue to meet once a year to continue to undertake its statutory responsibilities.

2. Mr Oakford responded to questions from the committee, including the following:-

a) Mr Oakford was thanked for listening to the parents who had responded to the consultation and commented on the proposed new model and, in doing so, allaying some of their fears about the changes. It was hoped that users' confidence would grow as the new service bedded in; and

b) officers supporting the transition to the new model would work with health visitors and meet with all lactation consultants and peer supporters, and it was hoped that the transition would be smooth. To support the additional group sessions, more peer supporters were being sought, along with more funding to cover their recruitment and training.

3. The Leader and Cabinet Member for Traded Services and Health Reform, Mr P B Carter, CBE, gave a verbal update on the following issues:
Sustainability and Transformation Programme – Mr Carter advised that he was the Chairman of the new Local Care Implementation Board (LCIB), a body which included clinicians, GPs and representatives from mental health trusts. This Board would meet for the first time for a workshop on 20 March and would discuss how to set up multi-disciplinary teams to support GPs. As Chairman of the Board, he had been unequivocal that more resource was needed to support local care in Kent, and this need had been estimated as being between £100million – £140million. The Sustainability and Transformation Programme Board fully supported the local care agenda as this would take the pressure off hospitals, saving around £218million per annum and reducing or avoiding hospital stays for 30-35,000 patients per year. It had been identified that every additional £1million spent on local care would deliver some £3-4million of savings on hospital care. The LCIB would look at how to provide more support and deliver better value for public money. Recruiting and retaining well-qualified people to deliver local care presented a challenge. More detail of how the local care agenda would be delivered was set out in item 6 on today's agenda.

4. The Director of Public Health, Mr A Scott-Clark, then gave a verbal update on the following issues:-
NHS Prison Substance Misuse Contract – the County Council had previously commissioning this service on behalf of NHS England but the latter now sought to take back this role, meaning that it would also take from the County Council the risk element associated with commissioning.
Seasonal Influenza – the number of new cases being diagnosed had fallen dramatically from the January peak and was around the usual expected level for the time of year. Both the number of cases and the number of vaccinations had been particularly high this year.
Public Health messaging over the cold spell – Mr Scott-Clark thanked the County Council's communications team for its work in spreading the message about looking after oneself during the recent freezing weather.
Kings Fund publication – 'Tackling multiple unhealthy risk factors' – this had been published on 9 March and was recommended as a good read for Members.

Kent's 'One You' programme had been cited as a case study of best practice. *Mr Scott-Clark undertook to supply a link to the document to all Members of the committee and this was subsequently done.*

5. Mr Scott-Clark responded to questions from the committee, including the following:-

a) advice from NHS England was that vaccination, along with diligent handwashing, remained the best way to counter the 'flu virus, even if a different strain were to appear in the future;

b) there were two types of vaccination – quadrivalent and trivalent. Quadrivalent was used mostly for older people and trivalent use mostly for children. Children were now routinely vaccinated at school. Asked about the variations in cost of the two types, Mr Scott-Clark explained that surgeries were ordering vaccinations now for use next winter, and some community pharmacies also offered the vaccinations, and variations in cost may arise between earlier and later supply and perhaps the volume ordered; and

c) asked if GPs would be a first point of identification of the 'flu virus, as the public had been told in some instances to keep away from their GP if they had 'flu symptoms, Mr Scott-Clark explained that GPs were able to prescribe ant-viral medicines to patients with 'flu symptoms. However, patients may have 'flu-like symptoms but not actually have 'flu. GPs would also look for cases of norovirus as this was often an indicator of the presence of the flu virus.

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

59. Adult Social Care and Health Local Care Implementation Plan.
(Item. 6)

1. Mrs Tidmarsh introduced the report and set out some good early results and savings which had been achieved from a vanguard scheme at the Ribchester practice in Whitstable. These savings had amounted to £3.4million in the 2017/2018 financial year in the Whitstable area alone. The new model of local care implementation sought to achieve a seamless service provided by the County Council and NHS jointly, as service users were not concerned about who provided their care but just wanted to receive the care they needed. The changes set out in the summary of the new model would be delivered with existing domiciliary care providers as this had been tested successfully in the vanguard model. Multi-disciplinary working would be the key to the success of the new model, with good ICT links between professionals, and challenges to success would be funding and workforce issues.

2. The Cabinet Member for Adult Social Care, Mr G K Gibbens, added that this was the greatest change to health and social care services since the start of the national health service in 1947. The new model emphasised the importance of the person at the centre of the service. This followed the model used in Canterbury, New Zealand, which had worked well and was viewed by professionals as an example of best practice. A government green paper on older people's social care funding was expected by August 2018.

3. Mrs Tidmarsh responded to comments and questions from Members, including the following:-

a) good communication between partners in multi-disciplinary working teams was vital to ensure the success of the new model. West Kent had for some time been successfully running a model similar to the one proposed;

b) it was emphasised that the new model was not a vison but had a solid implementation plan. Examples of it already being in place had evidenced good outcomes, with 60% of older people being able to return to living independently, and had produced savings, showing that 'doing more with less' was achievable;

c) the map included in the appendices to the report showed NHS England test sites. Other areas in which the model was not yet so advanced were not yet shown but would come on board later;

d) the new ICT system was known as 'mosaic' but this had no connection to the demographic modelling tool of the same name;

e) asked when the new model would start, Mrs Tidmarsh explained that testing had been going on for one year (and was still going on for the safeguarding changes) but the new model would start in August 2018. Testing would continue once the model was in place as the only way to test its efficacy was to see how it worked once the whole system was up and running;

f) the recruitment of occupational therapists was progressing well;

g) the patient voice remained at the centre of the new model and the patient themself would define the goals they wished to achieve. Patients would be able to direct what care they wanted rather than have this dictated by a 'time and care' model. The emphasis upon the patient voice had been well received by domiciliary care providers and workers;

h) data security was vital when different services were sharing information, and the County Council had very thorough arrangements with the NHS to ensure that data was shared and handled securely;

i) a future County Council select committee would look at the issues of social isolation and could look into some very successful work carried out by the voluntary sector in the Netherlands to address this. A comprehensive model of local care provision would need to cover all elements of social care;

j) the Leader emphasised how important it was that GPs were on board with the delivery of the new model, and this issue would be addressed at the first meeting of the Local Care Implementation Board on 20 March. Multi-disciplinary teams would need to be built around GPs, and GPs also needed to commit to it to make it successful; and

k) recruitment of a local care workforce would continue alongside the implementation of the new model, and it was hoped that some staffing needs could be met by the County Council 'growing its own' workforce in-house. The new model could allow professionals more scope to excel in their specialist areas and could offer them a more attractive career path. Workforce was likely to be the biggest challenge and solving it would be a long-term issue as there had been insufficient training of workers historically and this would take some time to overcome. Mr Gibbens added that the County Council was required by the Care Act to have a sufficient workforce to cover all areas of social care work, and the Council should look to support the development of this workforce by engaging fully with the voluntary sector and local training providers, for example Canterbury Christ Church University.

4. It was RESOLVED that the Adult Social Care and Health Local Care Implementation Plan be welcomed and that Members' comments, as set out above, be noted.

60. Contract Monitoring Report - NHS Health Checks.
(Item. 7)

Mrs V Tovey, Public Health Senior Commissioning Manager, and Mr G Abi-Aad, Head of the Public Health Observatory, were in attendance for this item.

1. Mrs Tovey and Mr Scott-Clark introduced the report and clarified that health checks, which were a vital preventative measure, were a mandated cardiovascular screening programme with the aim of reducing the number of preventable deaths of people under 75. The current service was made up of three contracts; with the Kent Community Health Foundation Trust (KCHFT), with ICT services and with outreach service providers. KCHFT sub-contracted the provision of health checks to a network of providers, including around 180 GPs and 30 community pharmacies, and were also responsible for project management and quality assurance of the programme. The track record of providing health checks in Kent was good, and Kent was exceeding the target, with around 100,000 people being invited annually and 42% of them taking up the invitation. The annual cost to the County Council of the health checks service was £1.9million. A challenge for Kent's health check service was achieving equity of coverage, reaching those in areas of deprivation, who were known to be at greater risk of developing cardiovascular disease, and men, who were shown to be statistically less likely to take up an invitation for a health check. Outreach services were designed to help reach them and the service worked with local groups such as the Kent Sheds project.

2. Mrs Tovey, Mr Scott-Clark and Mr Abi-Aad responded to comments and questions from Members, including the following:-

a) pilot projects had been undertaken to identify good locations via which outreach services could reach those less likely to attend, and these had included shopping or town centres. To take the service into work places would also reach a 'captive audience'. The County Council was planning to work with Public Health England to identify the best communication methods to engage people who were less likely to attend, to ensure that the maximum audience was engaged and could

benefit from the process. A national study sought to identify the most effective way of wording an invitation letter to encourage attendance and this was the letter used in Kent;

b) committee Members would have the opportunity to have a health check after the committee's next meeting on 1 May 2018, and it was hoped that as many as possible would take up this invitation;

c) although engagement with GPs had been generally good, a few local medical practices had yet to commit, for various reasons. In such cases, the County Council could reach patients on their lists directly to invite them to attend health checks via NHS England. To have GPs as part of the service was vital, and GPs who maybe doubted that they could take on the full workload of managing the full health checks service could choose from a range of flexible contract types, which included KCHFT delivering this service on their behalf;

d) health checks were a mandated service and were an important part of preventative work of the STP. Identifying potential problems early via a health check could reduce later risk of stroke and other conditions. Addressing high blood pressure and high cholesterol were the two most vital actions to help reduce the risk of stroke;

e) patients who were already receiving treatment from their GP for any cardiovascular condition would not be invited to have a health check, as they were not considered as needing further screening for the same condition, but such patients could still have a 'health MOT'. Any patient invited to and attending a health check would have their results sent to their GP for follow-up, even if their GP was not participating in the scheme and the invitation had come from KCHFT. Effective follow-up of data produced by a health check was vital, particularly in areas of greater deprivation. Follow-up of results should be as prompt as possible, to avoid unnecessary anxiety to the patient; and

f) health checks and health MOTs were a vital part of encouraging the behavioural change on which the 'One You Kent' campaign relied.

3. It was RESOLVED that the performance of the service and ongoing activities to deliver continuous improvement be noted.

61. Public Health Communications and Campaigns update.
(Item. 8)

Mr W Gough, Business and Policy Manager, was in attendance for this item.

1. Mr Gough introduced the report and acknowledged the great contribution made by the County Council's communications team to the success of the campaigns. There was much campaign activity going on with, for example, 100 One You Kent adverts running on social media, tailored to the needs and interests of different areas and groups of people, for example, grandparents, people moving home, or targeting districts and towns. the 'One You Kent' website was currently being visited by 10,000 people per week. The percentage of visitors to the alcohol pages who were taking the 'Know Your Score' test had risen from 34% in 2016/17

to 54% in 2017/18. A large stakeholder event on 14 March would bring together the County Council's partners to work on the promotion of the 'One You Kent' campaign. Mr Gough and Mr Scott-Clark responded to comments and questions from Members, including the following:-

a) all data gathered from website hits or calls to helplines would be anonymized, and staff evaluating the data would not be able to identify a call-back number or user's identity;

b) the public health team was congratulated on their innovative use of social media; and

c) the team used a range of methods of identifying and engaging with their target audience, working with partners. Consistency of message and co-ordination of work were important; for example, a borough council had linked the 'stop smoking' message to its own anti-littering campaign. Liaison with highways colleagues to make use of roadside hoardings to promote public health messages was still ongoing.

2. It was RESOLVED that the progress and the impact of public health campaigns in 2017/18 be welcomed.

62. Public Health Outcomes Framework (PHOF) Performance Report - Adults. *(Item. 9)*

Mr G Abi-Aad, Head of the Public Health Observatory, was in attendance for this item.

1. Mr Scott-Clark introduced the report and explained that, as part of the Health and Social Care Act, three sets of outcomes were recorded; for NHS, social care and public health. Kent's performance under these three headings would be compared to national outcomes. Mr Abi-Aad added that Kent mostly showed up well when compared to national outcomes, in areas such as life expectancy at birth and preventable premature mortality (i.e. under 75), but not so well in terms of increasing smoking levels, alcohol-related hospital admissions and depression. Kent also continued to be challenged in two areas: reducing the suicide rate, which was above the national average, and addressing late presentation of patients with HIV symptoms, with which Kent had struggled historically.

2. Mr Scott-Clark and Mr Abi-Aad responded to comments and questions from Members, including the following:-

a) links between poor mental health and higher suicide rates were well known but there had also been media coverage of the link between the use of certain anti-depressants and higher rates of suicide;

b) asked what could be done to address the late presentation of HIV symptoms, Mr Scott-Clark explained that cases of HIV were rarer now and GPs tended to look at and rule out other possible illnesses before considering HIV. Some GPs may never have seen a case of HIV. Mr Abi-Aad added that, although rarer now, HIV cases were increasing as screening for the disease had improved in recent years. Mr Scott-Clark added that the effectiveness of treatment was very good, and the pre-

exposure prophylaxis (PrEP) method of preventing infection, trialled in 2017, had had some impact. Many people still wanted to be able to take a pill rather than use a condom to protect against infection;

c) Public Health England was working on a more localised comparison of figures, using statistical neighbours and authorities of similar sizes, and was looking at combining several indicators into one to make recording easier. The figures recorded in the red, amber and green bandings were percentages of population, so fluctuations may reflect changes in population and not necessarily prevalence of conditions. Ratings were set by Public Health England rather than by the County Council. Ratings for Kent as a whole also did not reflect variations in rates in different areas across a large county. Mr Abi-Aad explained that regional figures were available and *a link to local health profiling would be supplied to all Members after the meeting. This was subsequently done*; and

d) work was going on to identify and measure the impact of adverse childhood experiences, for example, domestic abuse or child sexual exploitation, on a young person's later life, educational attainment and mental health. Studies in the United States of America had also highlighted a link between adverse childhood experiences and public health. Work was in hand between health, early years and specialist children's services colleagues to develop a holistic approach to addressing this issue

3. It was RESOLVED that:-

a) the public health trends and outcomes set out in the report be noted; and

b) the additional indicators listed in appendix 2 to the report be included in future reports.

63. Risk Management: Health Reform and Public Health.
(Item. 10)

Mr W Gough, Business and Policy Manager, and Mr M Scrivener, Corporate Risk Manager and Interim Corporate Assurance Manager, were in attendance for this item.

1. Mr Scott-Clark responded to a question about Kent's ability to deal with a biological attack of the sort recently experienced in Salisbury. He explained that the lead authority to co-ordinate the response to such an event was Public Health England. A key element of such a response was communication, as people potentially exposed to contamination could include not only local residents, who could be more easily advised of follow-up precautions, but potentially large numbers of visitors and tourists. Mr Scott-Clark explained that he co-chaired the group which would be involved in co-ordinating a response to such an event at a local level.

2. It was RESOLVED that the risks presented in appendices 1 and 2 to the report be noted.

64. Work Programme 2018/19.
(Item. 11)

1. The Chairman referred to and supported a request to add an update on the suicide prevention campaign and strategy to the work programme.

2. It was RESOLVED that, subject to the addition of the above, the committee's work programme for 2018/19 be agreed.

This page is intentionally left blank

By:	Mr P B Carter, CBE, Leader and Cabinet Member for Traded Services and Health Reform Mr P J Oakford, Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health Mr A Scott-Clark, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee – 1 May 2018
Subject:	**Verbal updates by the Cabinet Members and Director**
Classification:	Unrestricted

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

Health Reform

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

Sustainability and Transformation Programme

Public Health

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

Joint Kent and Medway Health and Wellbeing Board

Director of Public Health – Mr A Scott-Clark:

Kent and Medway Measles outbreak.
Prevention Sustainability and Transformation Programme workstream.
Stroke Prevention.

This page is intentionally left blank

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee - 1st May 2018

Subject: **Kent Tobacco Control – working in partnership**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: Nationally, smoking prevalence rates are reducing, fewer people are taking up smoking but a lower percentage of smokers are quitting. Smoking remains the main cause of preventable disease in the UK, accountable for 1 in 6 of all deaths and costs Kent approximately £400m per year[1]. Evidence shows that commissioned stop smoking services provide the highest success rate of successful 4 week quits but the number of smokers accessing these services are decreasing. More evidence-based innovative approaches are needed to tackle smoking and meet the government's targets to reducing smoking prevalence to 12% or less by 2022. Kent and Medway Public Health have responded with an STP action plan that focuses on preventing ill health caused by smoking. This report provides further detail of the Plan and the imperative of collaborative working through Making Every Contact Count to achieve challenging outcomes that can benefit all sectors of society.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **comment on** the contents of this report and **endorse** local measures to tackle smoking and tobacco control.

1. Introduction

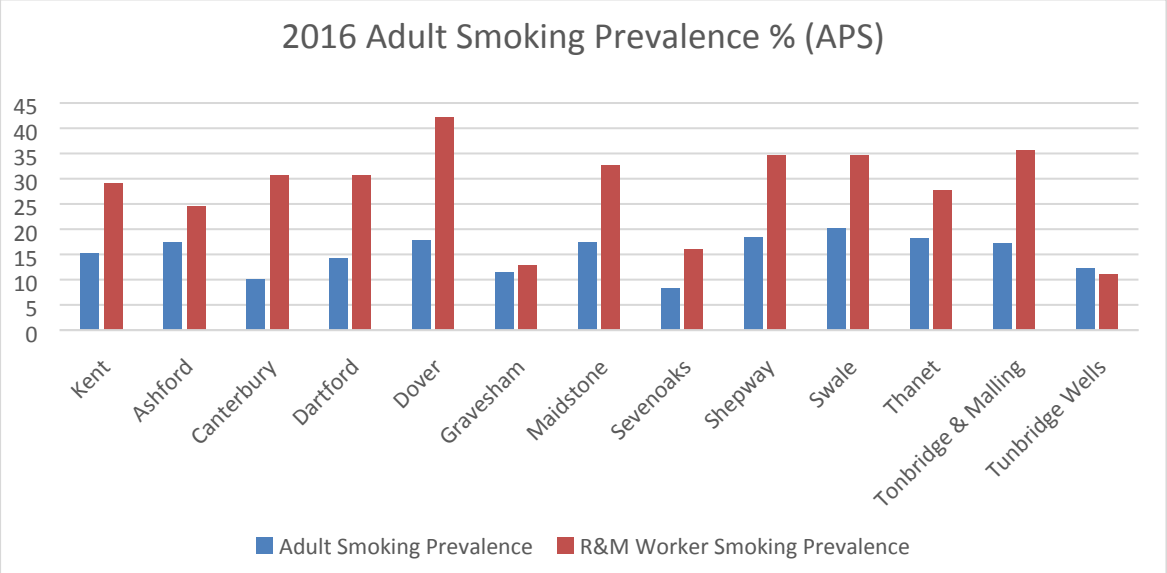
1.1. Smoking prevalence in England has reduced from 16.9% in 2015 to 15.5% in 2016[2], but still remains stubbornly high among certain groups, particularly among routine and manual workers (26.5% of whom smoke[2]) and the poorest in our society. More than 40% of adults with a serious mental illness smoke[2], as do 10% of pregnant women and 8% of 15-year olds[2]. There are approximately 225,000 adult smokers in Kent[1].

[1] ASH Ready Reckoner tool http://ash.org.uk/category/information-and-resources/local-resources/ accessed 4/4/18
[2] Public Health England Tobacco Control Profiles 2016

1.2. Smoking is an addiction which usually starts in childhood before young people understand the health risks and addictive nature of smoking. 77% of smokers start before the age of 18 and 82% of them are likely to live in a household where a family member smokes[3].

1.3. Despite the national decline in smoking prevalence, smoking still remains the main cause of preventable disease in the UK and is accountable for 1 in 6 of all deaths. Smoking is a major risk factor for lung cancer, chronic obstructive pulmonary disease (COPD), and heart disease; it is associated with cancers of the lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Mortality rates due to smoking are three times higher in the most deprived areas than in the most affluent areas, demonstrating that smoking is still intrinsically linked to inequalities. Therefore, tackling smoking and tobacco control is at the heart of the public health agenda.

1.4. The chart below shows the disparity of smoking prevalence across districts in Kent.



Source: Public Health England Tobacco Control Profiles 2016

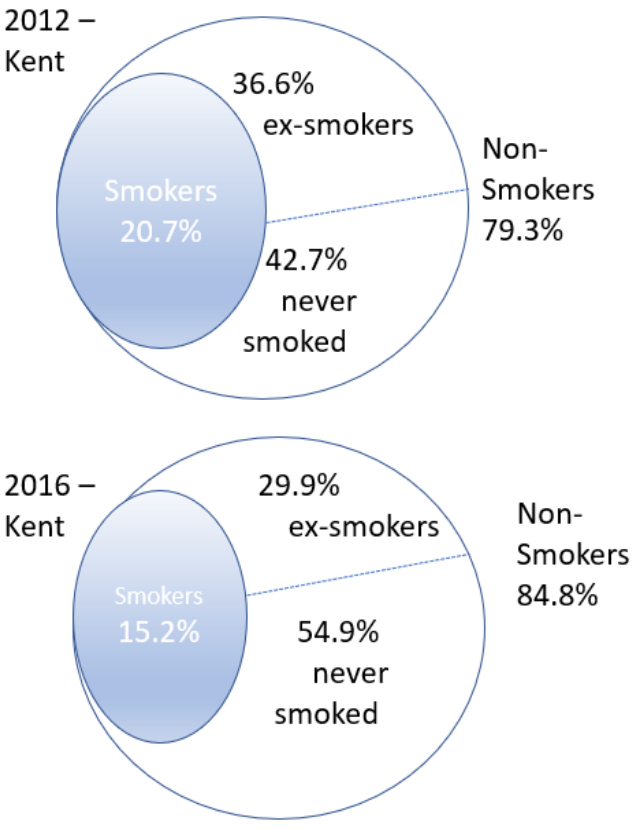
2. Overview of Performance

2.1. The smoking prevalence in Kent has reduced at a faster rate than the national average year on year since 2012. 2016 data shows that there are now 5.5% few smokers (15.2% of the Kent population) than in 2012 and 12.2% more people have never smoked, evidencing that fewer people are taking up smoking in the first place. This fits with the Department of Health's approach in the 2017 tobacco control strategy to promote a smokefree environment and to denormalise smoking in society: 'Towards a Smokefree Generation: A Tobacco Control Plan for England 2017'.

[3] NHS Digital. 'Smoking, Drinking and Drug Use Among Young People in England - 2014'. Figure 4.1. 23 July 2015) *in Towards a Smokefree Generation, Department of Health 2017*

2.2. Although fewer people are taking up smoking, there has been an overall decline in the number of people successfully quitting smoking. Kent stop smoking services have however, retained 3% of Kent's smoking population accessing their services in a climate of overall decline and in a period where it is estimated that there is 7.1% fewer ex-smokers in Kent. This trend negates the positive effects of tobacco control plans and demonstrates that despite being four times more likely to quit successfully with dedicated stop smoking services, additional and alternative approaches are needed to encourage and support people to address their nicotine addiction.

2.3. The following diagram shows the shift in smoking tend among the Kent population:



Data source: Local Tobacco Control Profiles, Public Health England 2017

3. Local Measures to tackle smoking and tobacco control

3.1 Kent and Medway Public Health have adopted the government's targeted ambitions set in the national tobacco control strategy, 'Towards a Smokefree Generation' and these have been localised in the Kent and Medway Sustainability and Transformation Plan (STP): Prevention Workstream. The STP sets out a range of partnership actions to tackle smoking and deliver the following outcomes supporting Making Every Contact Count (MECC) for Kent and Medway by 2022:

- Reduce smoking prevalence amongst adults in England to 12% or less
- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population

- Reduce the prevalence of 15-year olds who regularly smoke to 3% or less
- Reduce the prevalence of smoking in pregnancy to 6% or less
- Make all mental health inpatient services sites smokefree by 2018
- Help people to quit smoking by permitting innovative technologies that minimise the risk of harm
- Maximise the availability of safer alternatives to smoking

3.2 The above outcomes will be delivered across multi-agency partnerships and will complement the locally commissioned core stop smoking services. The STP is an opportunity for all sectors to realize their role and potential contributions in helping smokers to quit and to reduce the likelihood of people taking up smoking in the first place. A summary of the partnership actions and commitment are as follows:

i) Stop smoking advisers to be located in each of the 7 acute hospital sites in Kent and Medway to expediate referrals and access to stop smoking support.
ii) Supporting all trusts to have Smokefree Hospital Sites
iii) Develop tailored Quit support for people with mental health conditions
iv) Develop innovative Smoking + model with GPs to more effectively identify smoking status and provide Nicotine Replacement Therapy (NRT) or pharmacotherapy support for those who do not wish to access core Quit services.
v) Reduce smoking in pregnancy by supporting Midwifery teams to identify smoking status through CO monitoring and provide training and support to have critical conversations with women who smoke and encourage them to quit smoking
vi) Support all health care professionals to be aware of the risks caused by smoking and to refer into stop smoking services through the ASK, ADVISE, ACT approach.
vii) Deliver Stop before the Op programmes in line with Smokefree hospitals and other relevant initiatives (e.g. CQUIN)
viii) Maximise opportunities to promote greater public awareness of new initiatives through an effective campaigns strategy.

The successful delivery of the STP will depend on the cooperation and shared responsibility of all partners. Collaborative support has been sought at the STP Clinical and Professional Board, Kent and Medway Local Maternity Services (LMS), The East Kent and West Kent Public Health Prevention Groups and at the Kent wide Tobacco Control Alliance. The Alliance also has a broader remit to include tackling illicit tobacco with Trading Standards, promoting smoke free areas where children congregate (such as schools and play parks) with District Councils and providing up to date information on e-cigarette research. The outcomes from the Alliance CLeaR peer review highlighted innovation and partnership working as key strengths of the group in delivering effective tobacco control measures.

4. Conclusion

4.1 Although smoking rates have been and are continuing to reduce, there are still inequalities entrenched in smoking, where prevalence is three times higher amongst the lowest earners and accounts for approximately half the difference in life expectancy between the richest and poorest in society. It should be realized that the addictive nature of smoking means that smoking is a medical as well as a social

condition and as such, all partners must work together to eradicate the harms caused by smoking. The STP is the prime mechanism to deliver innovative evidence-based approaches and new models of working, endorsing Making Every Contact Counts. There is momentum between partners, but it will be essential to maintain good practice to ensure it is rolled out across Kent and Medway effectively and sustainably. The evidence of core stop smoking services is strong, although numbers accessing the service are at risk of declining. It is therefore important that commissioned services work flexibly and innovatively in the future alongside new approaches.

5. Recommendations

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **comment on** the contents of this report and **endorse** local measures to tackle smoking and tobacco control.

6. Background Documents

Towards a Smokefree Generation: a Tobacco Control Plan for England, DoH, 2017
https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

7. Appendices

None.

8. Contact Details

Report Authors:

- Deborah Smith: Public Health Specialist
- 03000 416696
- Deborah.Smith@kent.gov.uk

Relevant Director:

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

This page is intentionally left blank

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee - 1st May 2018

Subject: Air Quality

Classification: Unrestricted

Summary: This report details some of the work KCC Public Health is undertaking with partners to address the health effects of poor air quality in Kent.

Recommendation(s):
The Cabinet Committee is asked to **comment on and endorse** the approach taken by KCC Public Health and Partners to tackling Air Quality issues in Kent.

1. Introduction

1.1 This paper is to inform members of the work undertaken by Public Health and partners to tackle poor air quality in Kent. The report contains information on the relevant and history background to the control of air quality, on local actions in place to improve air quality and reduce poor health due to air quality issues.

2. Relevant History/background

2.1 Poor air quality is the largest environmental risk to public health in the UK and there is strong evidence associating air pollution with increased mortality and ill health. Older people, children and those with pre-existing illness are more vulnerable to the adverse health effects of air pollution. Studies have also suggested that the most deprived areas of Britain are more likely to experience poor air quality, which is supported by the Kent picture. Consequently, improving air quality will support reduction in health inequalities.

2.2 In 2010 the Department of Health's (DH) Committee on the Medical Effects of Air Pollutants (COMEAP) estimated the burden of particulate air pollution in the UK in 2008 to be equivalent to nearly 29,000 deaths and an associated loss of population life of 340,000 life years lost.

2.3 Air quality is increasingly an area of concern for the public and public authorities with over 1,000 early deaths across Kent and Medway attributed to poor air quality in 2013. A Kent-wide approach is needed if future growth is not to have unacceptable impacts on air quality and health.

2.4 Whilst KCC as a Public Health authority, has the responsibility for protecting and improving the health of residents, the responsibility for improving air quality lies with the District and Borough councils. Since December 1997, local authorities in the UK have been assessing air quality in their respective areas to ensure compliance with

national air quality objectives and EU ambient air quality directives. Where a district authority identifies an area or areas exceeding air quality targets and there is relevant public exposure, it is required to declare an Air Quality Management Area (AQMA) and to draw up an action plan to address the problem.

2.5 In April 2016, Department for Environment Food & Rural Affairs (DEFRA) re-issued its Local Air Quality Management (LAQM) Guidance and both the Policy (PG16) and Technical (TG16) guidance highlight the link between air quality and public health and encourage engagement between local authorities, public health teams, planning departments and other stakeholders, in order to improve air quality.

2.6 KCC Public Health are working in partnership with Districts to address air quality issues and work with colleagues in the KCC Growth, Environment and Transport Directorate on Kent-wide measures and strategies.

2.7 The most important primary air pollutants, in terms of evidence of detrimental health effects, are particulate matter (PM), nitrogen dioxide (NO2) and ozone (O3). There is now an indicator on mortality attributed to particulate matter (PM) air pollution in the Public Health Outcomes Framework. PM2.5 has the highest epidemiological link to health outcomes as at this size the particles can be inhaled deep into the lungs.

2.8 Common sources of air pollution include construction sites, aircraft emissions, industrial processes and road transport. In addition, farming, bonfires and fireworks, home and commercial heating and shipping contribute to air pollution/reduced air quality.

2.9 The UK has signed up to a legally binding target for emissions of five major pollutants with the goal of halving the number of deaths from poor air quality by 2030. Reducing Particulate Matter (PM) by 10 µg/m3 would extend lifespan in the UK by five times more than eliminating casualties on the roads, or three times more than eliminating passive smoking.

2.10 The technical expertise in preparing a range of air quality reports, including action plans and annual status reports lies with the district local authority (LA) air quality specialists, technical officers or Environmental Health Officers who undertake this role. DEFRA provides additional support to such staff through a dedicated helpdesk to ensure reports are of a suitable technical standard and quality. Appendix A has more information on particulate matter and nitrogen dioxide.

3. Local Picture

3.1 There are unprecedented levels of housing growth in Kent, with knock-on impacts on congestion, increasing energy prices and changes in the way energy is generated. These, together with growing concern about the impact of air quality on health, make energy and air pollution key priorities for KCC in 2018/19.

3.2 Most of the levers to affect air quality are to be found in borough and district Councils. These include planning permissions and building regulations. District and Borough councils monitor air quality and can declare of Air Quality Management Areas (AQMA).

3.3 Carbon dioxide emissions in Kent continue to fall, largely driven by the closure of a small number of energy intensive industrial sites and a national reduction in the use of coal in electricity generation. We are on course to reach our target of a 34% reduction in emissions by 2020 (2005 baseline). However, transport emissions remain stubbornly static and are currently the same as they were in 2009. Emerging digital technologies and the growth in the use of electric vehicles present Kent with an exciting opportunity to lead the shift to smart, flexible and low emission transport.

3.4 In July 2017, DEFRA and Department for Transport published the 'Air Quality Plan for nitrogen dioxide (NO_2) in the UK 2017'. This plan was focussed on bringing NO_2 air pollution levels within statutory limits in the shortest possible time. It expanded the number of Local Authorities required to take action from the initial five mandated Clean Air Zones (Leeds, Southampton, Birmingham, Nottingham and Derby) to include an additional 23 LAs plus London (now known as Air Quality Zones). On 21 February 2018 the High Court found that the approach taken in a further 45 LAs to reduce NO_2 by 2021 was not sufficiently robust. Mr Justice Garnham ruled that each of these local authorities had to have a plan to achieve compliance as soon as possible.

3.5 Dartford Borough Council was included in the 45 LAs required to produce draft plans to reduce nitrogen dioxide by 2021.

National Strategies and Plans

The focus on NO_2 in the 2017 plan is part of a wider approach to improve air quality across the UK. The following plans and strategies are of relevance:

- The Clean Growth Strategy published on 12 October 2017 by the Department for Business, Energy and Industrial Strategy (BEIS) outlines the Government's aspiration to accelerate the pace of 'clean growth' by nurturing low carbon technologies and setting efficiency targets for industry, low carbon home heating, low carbon transport, developing more sustainable and flexible sources of power and emphasising the responsibilities of the public sector in supporting these aspirations.

- 25 Year Environmental Plan published by DEFRA which provides an over-arching framework for the care of the natural environment.

- In 2018, DEFRA will consult on a Clean Air Strategy which will set out how the UK will meet international commitments to reduce emissions of five damaging air pollutants by 2020 and 2030 (nitrogen oxides, particulate matter, sulphur dioxide, non-methane volatile organic compounds and ammonia). It will have a broader scope than the Air Quality Plan for nitrogen dioxide (NO_2) and will cover emissions from domestic, industrial, farming and building activities. It will also outline a pathway to achieving zero emissions transport for all road vehicles and will be followed in 2019 by a draft detailed action plan on how this can be achieved.

- The Climate Change Act (2008) requires that the UK Government undertake a Climate Change Risk Assessment (CCRA) every 5 years, and that each assessment is followed by a cross-government National Adaptation Programme (NAP) designed to address these risks, one of which is the

potential risk of increased exposure to air pollution. The second NAP (NAP2) is currently under development and must be published by July 2018.

4. Local Actions

4.1 To address current priorities and to ensure a consistent and uniform approach to air quality and energy issues in Kent, an Energy and Low Emissions Strategy and Action Plan for Kent and Medway is being developed. Public Health consultants are collaborating with colleagues in Growth, Environment and Transport on this strategy. A Kent and Medway Low Emissions Strategy Working Group has been set up to develop the strategy, which aims to have a draft available for consultation in summer 2018. KCC Members will be involved through a Member Task Group and a Kent-wide Steering Group. The proposed strategy will identify priorities for targeted partnership action across the county, building upon existing and planned energy, transport, travel and air quality activities.

4.2 Kent County Council and its local partners also have an Active Travel Strategy that was launched by the cabinet member in 2016/17.

4.3 The Kent Public Health Observatory are currently working with Maidstone Borough Council to map and rank local mortality attributed to air pollution against local mortality due to other sources of disease. This analysis will cover Kent and will inform a Local Authority led strategic response to air pollution across the County. An additional piece of work is being undertaken with colleagues from University College London and Dartford Borough Council, using the Kent Integrated Dataset (KID), to explore air quality in Dartford and any detrimental effects on health. Additionally, both KCC's Growth, Environment & Transport and Public Health directorates have supported an application for research funding by the University of Kent also looking at air quality.

5. Conclusions

5.1 The Director of Public Health has duties to improve and protect the public's health and work on improving air quality is one area of this work. This can be enacted by ensuring that local plans are in place to address air quality in Districts and boroughs and this will also address health inequalities in the County.

5.2 KCC Public Health are working in partnership with many of the Districts and Boroughs and with colleagues in the KCC Growth, Environment and Transport Directorate on Kent-wide measures and strategies to improve air quality in Kent.

6. Recommendation

Recommendation
The Cabinet Committee is asked to **comment on and endorse** the approach taken by KCC Public Health and Partners to tackling Air Quality issues in Kent.

Background Document –

Environment and Transport Cabinet Committee report: Kent Environment Strategy progress, Energy and Air Quality.
https://democracy.kent.gov.uk/documents/g7548/Public%20reports%20pack%2031st-Jan-2018%2010.00%20Environment%20Transport%20Cabinet%20Committee.pdf?T=10

Appendix:

Appendix A – Particulate Matter and nitrogen dioxide

Report Author:

Dr Allison Duggal (Deputy Director of Public Health/Public Health Consultant)

Allison.Duggal@kent.gov.uk

03000413173

Appendix A – Details of common air pollutants

Particulate matter

Particulate matter (PM) is a complex mixture of very small solid particles and liquid droplets. The main source of PM is the combustion of fuels (vehicle, industry and domestic) and other human activities such as mining, quarrying, industrial processes and tyre and brake wear. Natural sources include wind-blown soil and dust, sea spray particles, volcanos and seismic events, and fires involving burning vegetation. Some particles are emitted directly (primary PM); others are formed in the atmosphere through complex chemical reactions (secondary PM).

PM is classified according to their diameter in micrometres:

Particles	Diameter
Nanoparticles/ultrafine particles	<0.1 µm
Fine particles $PM_{2.5}$	2.5 µm or less
PM_{10}	10 µm or less
Coarse particles	2.5-10 µm
Dust	75 µm or less

There is no evidence for a safe level of exposure to PM, suggesting that even very low concentrations may have a detrimental effect on health.

The size of particles and the duration of exposure are key determinants of potential adverse effects on health. Particles with a diameter of 10 µm or less (PM_{10}) pose a risk to health as they are able to lodge inside the lungs. There is some evidence that ultrafine particles (PM of 0.1 µm or less) can reach alveoli (small air sacs in the lung) and enter the bloodstream and therefore pose a greater risk.

Nitrogen dioxide

Nitrogen dioxide ($NO_{2)}$ is a gas that is produced with nitric oxide (NO) by combustion. Together they are often referred to as oxides of nitrogen (NO_x).

Local road traffic contributes substantially to outdoor air pollution, particularly in busy towns and cities. DEFRA estimates that 80% of NO_x emissions in areas where the UK is exceeding NO_2 limits are due to transport, with the largest source being emissions from diesel light duty vehicles (cars and vans).

A number of studies have reported associations with long-term exposure to NO_2 and adverse effects on health, including reduced life expectancy. Previously it was unclear whether these effects are caused by NO_2 itself or by other pollutants emitted by the same sources (such as road traffic). Evidence associating NO_2 with health effects has strengthened substantially in recent years and it is now thought that, on the balance of probability, NO_2 itself is responsible for some of the adverse health impacts reported in epidemiological studies.

Several factors are relevant when considering the impacts of air pollution on health:

- emissions of pollutants

- environmental concentrations of pollutants
- public exposures to pollutants (and associated health outcomes).

These are related but may operate independently; no one factor can fully predict the others. Emissions, concentrations and exposures all vary temporally and spatially. Improving air quality requires a dual focus: addressing ‘hotspots’ (areas of high concentration) and addressing population-level exposure. A high spatial resolution is required to detect local-scale effects. Health-effect thresholds differ depending on the exposure period (short or long-term). A high temporal resolution is required to account for short-term effects.

This report focusses on the impact of human exposure to air pollution. However, it also recognises that emissions of pollutants can also cause cumulative environmental degradation. Any action taken to mitigate a single issue (such as reducing NO_2) needs to take this into account to avoid creating additional longer term unintended consequences.

This page is intentionally left blank

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee - 1st May 201

Subject: **Update on the use of Novel Psychoactive Substances in the UK and Kent**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: The purpose of this report is to brief members on what is known about the current extent of misuse of Novel Psychoactive Substances (NPS) in UK and Kent. Although a relatively small issue in Kent for current treatment providers (1.5% approximately), there have been notable harms related to NPS. This is a growing problem and still little is known about the scope and scale of the issue. National reports state that NPS are used mainly as substitute recreational drugs (club drugs) and by more vulnerable populations e.g.; the homeless and offenders. In Kent the local drug and alcohol partnerships are tackling the issue with surveillance, joint understanding and partnership working and increased training and awareness for front line staff.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **comment on and endorse** local measures to tackle the use of Novel Psychoactive Substances.

1. Introduction

1.1. New psychoactive substances (NPS) are a world-wide problem, with growing concerns about the number of associated deaths. Public sale of these substances is banned, following the introduction of the Psychoactive Substances Act 2016, but NPS are readily available through the 'dark net' and on the streets. They are more affordable than other illegal drugs, and their proliferation has changed the drug scene in the UK. Trends in NPS use are uncertain, as records are poor. Such records that are kept show that NPS are used largely by the homeless community and by other vulnerable people, including those who offend.

1.2. The work to tackle the prevalence, impact and treatment of NPS is lagging behind NPS use. The UK government's new drug strategy and updated guidance for clinicians and substance misuse services are welcome developments. Substance misuse services do not generally offer NPS-specific work, and very few NPS users engaged fully with substance misuse services both locally and nationally. Few probation providers also routinely monitor ongoing NPS use. In Kent there are strong relationships between managers in substance misuse and probation

providers, but this varies for front-line practitioners both in substance misuse services and mental health and primary care.

1.3. New psychoactive substances, often incorrectly called legal highs, contain one or more chemical substances that produce similar effects to illegal drugs like cocaine, cannabis and ecstasy. NPS began to appear on the UK drug scene around 2008/2009 and fall into four main categories:

- **Synthetic cannabinoids** – these drugs mimic cannabis and are traded under names such as Spice, Clockwork Orange, Black Mamba and Exodus Damnation. They bear no relation to the cannabis plant except that the chemicals act on the brain in a similar way.
- **Stimulants** – these drugs mimic substances such as amphetamine, cocaine and ecstasy and include BZP, once commonly known as Meow Meow or M-Cat, Benzo Fury and MDAI.
- **'Downers' or sedatives** – these drugs mimic tranquilisers or anti-anxiety drugs, particularly those from the benzodiazepine family, and include Etizolam, Pyrazolam and Flubromazepam.
- **Hallucinogenic drugs** – these drugs mimic substances like LSD and include Bromo-Dragonfly and the more ketamine-like methoxetamine.

1.4. **The Legal Position**: While some of these substances had been made illegal under amendments to the Misuse of Drugs Act 1971, the continued introduction of different chemical compounds meant that many NPS could be sold legally. They could be easily bought online and on the high street, sometimes in 'head shops' (shops which sell drug paraphernalia) and sometimes in corner shops, convenience stores or garages. The drugs were sold in brightly coloured packaging under a variety of brand names, making it difficult to know what substance was being purchased; the contents of one branded package could change from week to week.

1.5. To help tackle the negative effects of these substances and risks they posed, the Psychoactive Substances Act 2016 made it illegal to produce, supply or import NPS (including for personal use) from May 2016. Following the changes in the law, supply has been driven underground and packaging changed to clear snap bags. Potency levels are much higher and more toxic (Linnell, 2017).

1.6. **Effects of the NPS:** Many of these drugs are unknown quantities and the effects depend on how much is consumed. Media reports have highlighted serious effects, including death and users being left in zombie-like states. Physical and psychological dependency can take hold after only a few weeks of NPS use. Acute effects can last thirty minutes to two hours, but symptoms may last until the next day. Factors that have an impact include body weight, gender, the strength of the drug, mood, physical and mental health, how the drug is taken, where it is taken and whether it is mixed with other drugs, including alcohol. The effects include loss of concentration and memory; anxiety and panic attacks; violent outbursts; symptoms consistent with psychosis; and altered mental state (Castellanos et al, 2016). These symptoms can be alarming and put people at risk if they are alone and cannot get help. There is also an increased risk of harm as the users cannot

control themselves or the situations they may be in. Treatment options are limited; there is no medicinal substitute available for NPS as there is for heroin.

2. Scale of the Problem in Kent

2.1. The prevalence of NPS is hard to quantify – both nationally and locally. This is because little is understood about how the NPS are manufactured worldwide. Users do not know what they are taking, are often misled and often passed off as more conventional drugs eg: ecstasy. Primary Care and A&E do not record NPS use. While the overall size of the NPS market is small in comparison with other drugs, an increasing number of countries are reporting seizures of NPS. There is also growing recognition of the harm associated with NPS use – often the result of crude manufacturing techniques and unpredictable dosage levels. As a result, they can be more lethal than other drugs. Concern is also rising about their use among marginalised populations such as prisoners and street homeless, attracted by the availability and low cost of NPS.

2.2. Treatment options are more limited than with other substances, for example opioids, where substitutes are available. In most cases, treatment involves psychosocial interventions to help people consider the health risks and the costs of using NPS, and to help them make behavioural changes to reduce harm and moderate their drug use.

2.3. In Kent from 2015 to current (March) 2018 service providers (CLG, Forward and Addaction) report that of the 90 people who have accessed the services for NPS, 32 people had NPS as their primary addiction. In other cases, NPS was recorded as being used with other substances such as opiates and/or alcohol. This is approximately 1.5% of all people in treatment services.

2.4. See Appendix 1 for National facts and figures.

3. Local Measures to tackle NPS

3.1 There is national guidance issued regarding the treatment of NPS. This centres on the treatment and identification of symptoms and training and awareness of front line staff. The guidance issued nationally also states that public health must ensure monitoring, alerts and surveillance are carried out appropriately and any learning from related harms are disseminated to all partner agencies. The national guidance also states the importance of joined up health and social care systems, close partnership working with police and crime and justice leads as well as other key community providers eg: homelessness and housing services.

3.2 In Kent the following are in place:

- A Kent wide Drug and Alcohol Strategy that identifies NPS as a priority
- A Kent Drug and Alcohol Partnership set up to steer the strategy and work closely together
- Regular meetings at a commissioning level with CCG and police partners to assess quality and risk

- A public health surveillance system and alert system that links with a large array of community partners.
- Regular learning partnerships (Serious Incident Learning Partnership) where serious incidents, drug and alcohol related deaths and near misses are discussed and learning disseminated
- Training and Toxicology alerts: in partnership with Public Health England latest information and advice on NPS is disseminated widely via local providers.

4. Conclusion

Although a relatively small issue in Kent for current treatment providers (1.5% approximately), there have been notable harms related to NPS. This is a growing problem and still little is known about the scope and scale of the issue. National reports state that NPS are used mainly as substitute recreational drugs (club drugs) and by more vulnerable populations e.g homeless and offenders. In Kent the local drug and alcohol partnerships are tackling the issue with surveillance, joined understanding and partnership working and increased training and awareness for front line staff. In addition, working practices between local police and public health have been strengthened with a new combined Drug and Alcohol Strategy and partnerships with Trading Standards. More work is needed in raising awareness with front line staff.

5. Recommendations

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **comment on and endorse** local measures to tackle the use of Novel Psychoactive Substances.

Contact Details

Report Authors:

- Jessica Mookherjee, Public Health Consultant
- 07809 321442
- jessica.mookherjee@kent.gov.uk

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

Background documents: none

Appendix 1

Key Facts on Novel Psychoactive Substances in UK

26 May 2016	The Psychoactive Substances Act 2016 came into effect, making so-called legal highs illegal to sell or give away for free
620	The number of new psychoactive substances being monitored by the European Monitoring Centre for Drugs and Drug Addiction, at the end of 2016
79	Deaths associated with the use of new psychoactive substances recorded by the Prisons and Probation Ombudsman between June 2013 and September 2016
147,000	Estimate from Crime Survey for England and Wales 2016/2017 of the number of people aged 16 to 59 years who had used new psychoactive substances
1.6%	Proportion of men aged 16 to 24 years who have used new psychoactive substances (compared to 0.4% of men and women aged 16 to 59 years)
1.7%	Proportion of adults aged 16 to 24 years who have used new psychoactive substances and have consumed alcohol in the past month (compared to 0.6% who abstain from alcohol)
75%	Proportion of those who had used new psychoactive substances who had used another drug.

This page is intentionally left blank

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee - 1st May 2018

Subject: Contract Monitoring Report – Primary School Public Health Service

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

This report provides the Committee with an overview of the Primary School Public Health (PSPHS) contract including monitoring arrangements, performance outcomes and value for money

The service is provided by the Kent Community Health NHS Foundation Trust (KCHFT) and in 2017/18 KCC invested just under £3.4M into the service.

The service delivers a Universal whole school health approach to all primary school aged children, providing Tier 1 interventions to meet specific health needs. It is responsible for delivering the mandated National Child Measurement Programme (NCMP) which weighs and measures all children in Year R and Year 6.

Following a competitive process, a new contract commenced on the 1st April 2017 and following a period of transition, the service has embedded a new model. The new service delivers a number of benefits including a dedicated outreach team, greater visibility, drop-in clinics in schools, and health assessments for pupils in Year R and Year 6.

KCC and KCHFT are continuously working to improve efficiency, ensure value for money and deliver improvements for users through contract management. KCC's effective monitoring arrangements ensure KCHFT delivers the requirements of the contract and performs within expected levels.

Recommendation:

The committee is asked to **comment on and endorse:**

- Progress made to transform services through an effective contract management approach.
- Ongoing activities to deliver statutory obligations, continuous improvement and meet performance expectations.

1. Introduction

1.1 Kent County Council (KCC) Public Health has a responsibly to deliver improved health and wellbeing outcomes for Children and Young People in Kent to ensure every child gets the best start in life. School public health services support this by offering a Universal service to all school age children and have been commissioned by KCC since April 2013 (when Public Health responsibilities transferred to the council)

1.2 The Children's Social Care and Health Cabinet Committee previously endorsed the proposal to re-commission school health services as part of a wider collaboration with health commissioners to implement 'The Way Ahead, Kent's Emotional Wellbeing Strategy for Children, Young People and Young Adults in Kent'.

1.3 Following a competitive tendering process, which was in part collaboration with CCG commissioners, KCC awarded the Primary School Public Health Service (PSPHS) contract to Kent Community Health NHS Foundation Trust (KCHFT) in February 2017. As this was the incumbent provider for most areas in Kent, it meant that KCHFT were able mobilise quickly and transitioned to the new model over a period of months. This change included a revised staffing structure and the restructuring of teams to separate Primary and Secondary School Health Services.

1.4 This report provides the committee with an overview of this contract monitoring arrangements, performance outcomes and value for money.

2. What does the service provide?

2.1 The service facilitates a Universal whole-school approach to health for all primary school-aged children in Kent (aged 5-11 years) and supports those who are home schooled or attending private schools.

2.2 The service co-produces whole School Public Health Plans with primary school leaders, across all Kent schools (454) which includes data from Year R and Year 6 health assessments to determine current need and plan future provision. The plans are tailored to the needs of the school and set out agreed priorities, planned activity, allocation of resources and work programmes to improve the overall health and wellbeing of children. A calendar of school-specific events and interventions will be agreed as part of the development of the School Public Health plans.

2.3 The Universal whole-school health improvement activity includes delivery of the mandated National Child Measurement Programme (NCMP) to all children in Year R and Year 6 in line with national guidance. Families identified through this programme will be contacted by the service, so they can be offered guidance and support.

2.4 As well as offering whole-school health, the service provides individual health improvement through offering tier one interventions to individual children and their families, signposting and referring to other services where required. These packages are person centred, flexible and support a preventative approach.

2.5 The service also takes a targeted approach to help reduce health inequalities and focuses resources on those schools and populations most in need. For example,

they may provide additional training or workshops for schools identified by the NCMP as having high numbers of children above a healthy weight.

2.6 The PSPHS includes:

Universal offer	Universal offer delivered based on need
Health Assessments at Year R and Year 6	Package of care on: Behaviour management Healthy eating and lifestyle Emotional health and wellbeing Puberty/PHSE Sleep Daytime and night-time wetting and soiling Complex health needs
Vision and hearing screening in Year R	Signpost/referral to additional services
Delivery of NCMP (weighing and measuring) in Year R and Year 6	Signpost/referral to additional services
Drop-in clinics	Attendance at Strategy and Child Protection conferences
School Public Health Plans – delivery of whole-school approach to improve pupil's health.	

3. Why invest?

3.1 The Primary School Public Health service directly supports the delivery of the KCC Strategic Outcome "*Children and young people in Kent get the best start in life"*, and the supports the following outcomes:

- Keep vulnerable families out of crisis and more children and young people out of KCC care.
- Kent's communities are resilient and provide strong and safe environments to successfully raise children and young people.
- Children and young people have better physical and mental health.

3.2 The PSPHS fulfils KCC's mandated duty to deliver the National Child Measurement Programme, providing a systematic approach to identifying those children who are not at a healthy weight, including those who are underweight.

3.3 A key focus of the service is to provide early intervention and preventative services for emotional wellbeing. The PSPHS delivers a universal emotional wellbeing service for all school-aged children as well as access to the more targeted service supporting KCC and partners to meet a key target set by NHS England. This target is to increase the proportion of children and young people with a diagnosable Mental Health condition who are able to access evidence-based treatment. (The definition of "accessing treatment" is any child or young person who has received 2 or more contacts from a provider of evidence-based treatment so would include the school health offer).

4. How is it delivered in Kent?

4.1 The service is provided by KCHFT and is delivered by a multi-skilled workforce across four area-based teams within Kent, alongside an outreach team that works with those children and young people who are outside of mainstream education. The workforce includes; area Clinical Managers, Specialist Community School Nurses, School Nurse Assistants and Health Improvement Practitioners.

4.2 The service is delivered to all Primary schools including Special schools. Those children who are home-schooled or educated through a pupil referral unit (PRU) may receive support through a dedicated outreach team.

4.3 Each school has a named practitioner to ensure that the service has a visible presence across the county and offers services all year round.

4.4 Referrals regarding support for individual children are made through the Single Point of Access (SPA) and are triaged by clinicians. The service accepts self- referral as well as referrals made by professional agencies (Early Help, schools, GPs). The service has a new website to make it easier for parents and schools to know where to go for advice. (See Appendix A)

4.5 The PSPHS works collaboratively with KCC's Early Help and HeadStart services to ensure that a partnership approach is taken to delivering improved health and wellbeing outcomes for children and young people.

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

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

5.2 Key measures of success for this contract are as follows:

- **Provide a Universal offer of support to primary age children, families and schools** Table 1 outlines a selection of service activity that has been developed during the first year of the contract and demonstrates that increasing levels of activity as the service develops further and the school year progresses. Unlike other traditional Public Health services, the PSPHS is focussed on an academic year.

Table 1: Key performance activity for PSPHS

	July - Sept 17	**Oct to Dec 17**
Number of Year R sent a health questionnaire	**-**	**18,104**
No. of new packages of care started - Total	**421**	**484**
No. of new packages of care started - Substance misuse	5 or less delivered	
No. of new packages of care started - Sexual health		
No. of new packages of care started - Domestic abuse		
No. of new packages of care started - Behaviour support	62	101
No. of new packages of care started - Tier 1 Enuresis Advice & Information	66	106

No. of new packages of care started - Weight management inc Change for life	39	29
No. of new packages of care started - Emotional Health and wellbeing	102	51
No. of new packages of care started - Parenting	12	47
No. of new packages of care started - Long Term Conditions	84	77
No. of new packages of care started - Continence	54	72

- **Carry out mandated services required by the Public Health Grant**
  The NCMP programme is conducted in two waves weighing Year 6 first and Year R so that both intakes have started school. The programme is expected to weigh and measure over 34,000 children and carry out proactive phone calls to parents who have a child identified as outside of the normal range. This is a new feature of the service designed to provide intervention and support.

- **Deliver a number of service improvements compared to previous models.**
  Service redesign identified a number of developments that were needed, and the service has worked to deliver against these since April 2017

Improved visibility	The service has a new website and each school is allocated a named school health lead https://www.kentcht.nhs.uk/service/school-health/
Ease of access	The service now has a single point of access and offers extended opening hours along with a central telephone and email address. nem-tr.kentchildrenandyoungpeoplehealthservices@nhs.net
Improved packages of care and focus on priority areas	The service now offers 1-1 packages of care and has an increased focus on priority areas such as emotional wellbeing and healthy weight
Proactive phone calls	Pro-active phone calls are made to parents who have a child outside of the healthy weight range. Parents are offered additional support and referred where appropriate to additional services.
Introduction of Lancaster screening tool for Year R and Year 6 pupils	The service has introduced an evidence-based screening tool which allows for early identification of needs on an individual and population basis. Parents of Year R children are asked to complete the questionnaires and Year 6 children and young people will complete the questionnaires independently

- **Provide a responsive service that meets user needs.**
  The service sends out health surveys to parents to support effective planning of services, meet user needs and listen to the voice of the child. The number of surveys completed is higher than in the previous contract and supports an intelligence led approach.

  The service also carries out satisfaction surveys and reports 96% overall satisfaction with the service. This satisfaction metric is calculated using feedback from child and parent carer surveys and includes feedback on a

number of indicators such as information, communication, if they felt listened to and involvement in decisions.

- **Delivers improved outcomes for Children and Young people**
  The service covers a population of 122,000 across Kent and the in addition to service data, the impact of these services can be illustrated by using case studies. An example can be found in Appendix B.

6. Service Costs

6.1 The contract value for 2018/19 is £3,345,154 which offers a saving of just under £400,000 compared to 2017/18.

6.2 Through the procurement process a total saving of £1.6M was made across the 5 years of the contract compared to the previous model offering excellent value for money.

6.3 The Health Reform and Public Health Cabinet Committee has previously agreed enter into a Partnership arrangement with Kent Community Health NHS Foundation Trust. This collaborative approach supports KCC to ensure an efficient and effective service that offers value for money.

7. Delivering ongoing service improvements

7.1 Continuous improvement is an important component of the Primary School Public Health Service. Since the start of the service, improvements have included:

- Performance reporting moving from an academic year focus to all year reporting model. This has changed how data is captured and recorded by KCHFT with a greater emphasis on service user access not just being available in term time only.
- Access to website and single point of referral (SPA) making self-referral easier through a single number contact point.
- Future actions will be to ensure that more children and young people benefit from the service resulting in improved outcomes. This aim is to increase visibility enabling quicker access to the relevant level of support whether universal or targeted.

8. Risks

8.1 The biggest risks to the programme are;

- A lack of support and engagement from schools: School support is crucial in facilitating access and communication with parents and pupils. To ensure schools are supportive KCHFT is further developing strong relationships and formalising shared expectations with Partnership Agreements.

- A lack of engagement from parents following the Year R health assessment: This health assessment is completed online by parents. To ensure good completion rates KCHFT are reviewing how they communicate with parents and how they promote the benefits of the assessment.

- Despite NCMP being a statutory function and a key part of identifying children who over overweight, some parents view NCMP in a negative light: The service follows national guidelines on how to word letters to parents which have been widely tested and approved by Public Health England as best practice. In addition, KCHFT are conducting focus groups with parents to ensure information provided alongside the letter and proactive phone calls are as helpful as possible.

9. Conclusions

9.1 The Service is close to completing its first year of delivery and progress has been strong. Where there have been challenges, such as how to ensure parents complete the online Year R health assessments, a clear set of actions has been agreed to improve relationships and develop new structures.

9.2 Future actions will see a service that is more visible with self-management strategies being put in place to ensure that a child/young person and family is able to receive the right level of support with a 'no wrong door' approach.

9.3 Commissioners continue to work with the service to monitor performance and work together to identify and deliver improvement opportunities.

9.4 KCHFT are working collaboratively with Early Help, HeadStart and NHS Commissioners to ensure that services and pathways for school health continue to be embedded and focused on improving outcomes.

Recommendations
The committee is asked to **comment on and endorse:**
- Progress made to transform services through an effective contract management approach
- Ongoing activities to deliver statutory obligations, continuous improvement and meet performance expectations

Background Documents:

'The Way Ahead' - Kent's Emotional Wellbeing Strategy for children, young people and young adults in Kent'
- http://www.kent.gov.uk/__data/assets/pdf_file/0003/46821/Emotional-Wellbeing-Strategy-part-1-strategic-framework.pdf

Appendix A: KCHFT Primary School Public Health Service referral routes

Contact us

We have school health teams across Kent. Referring to one of our teams is easy:

0300 123 4496
nem-tr.kentchildrenandyoungpeoplehealthservices@nhs.net
Online referral form

You'll find contact details of our team co-ordinators here.

Our teams are available from 8am until 6pm, Monday to Friday, including during school holidays.

School Health

- Health assessment for primary school-age
- Health assessments for secondary school-age
- National Child Measurement Programme
- School Health team contacts
- Support for schools
- Vision and hearing screening

Appendix B: Case Study

Background Context	**Health Assessment alert for year R child – parent had expressed worries regarding her daughter's emotional health.**
Intervention Action Taken	**School health contacted the child's mother- history of domestic abuse identified. daughter emotionally affected due to the breakdown of parent's relationship. Child seen in school for further assessment. Information shared with class teacher/SENCO – previously not aware of home situation. Mother given advice about children's services – concerns over father manipulating mother/daughter relationship.**
Results Outcome Impact	**School completed referral to Early help for additional support for both mother and daughter. School monitoring situation at home. SATEDA worker continuing to support mother with Legal advice School supporting child through play therapy to express worries/concerns Child's emotional health needs being supported in school.**
Lessons Learned	**The child's emotional health needs are now being met with support from school. Health Assessment allowed an opportunity for multi professional working to support the needs of a child.**

Report Authors:

- Vicky Tovey, Public Health Senior Commissioning Manager
- 03000 416779
- Victoria.tovey@kent.gov.uk

- Samantha Bennett, Consultant in Public Health
- 03000 416962
- samantha.bennett2@kent.gov.uk

Relevant Director:

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

This page is intentionally left blank

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee - 1 May 2018

Subject: Transition of Infant Feeding Service

Classification: Unrestricted

Previous Pathway: Health Reform and Public Health Cabinet Committee 8th February 2018

Future Pathway: None

Electoral Division: All

Summary:

This paper provides an update to Cabinet Committee Members on work undertaken to implement the new model for infant feeding support.

Following the Key Decision taken on 12th March 2018 a transitional plan has commenced to enable the new model to be in place by 1st June 2018.

Kent Community Health NHS Foundation Trust and PS Breastfeeding are working collaboratively to ensure a smooth transition and minimise any disruption to service users during this time.

A series of local district meetings are taking place with peer supporters and feedback will be used to help implement processes and protocols for the new infant feeding arrangements.

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to **comment on** the contents of this report and **endorse** and progress to date.

1. Introduction

1.1. KCC has developed and consulted on a new model for infant feeding support for families across Kent. This will embed and extend a range of breastfeeding

support into the Health Visiting Service, offering support to more families across Kent.

1.2 The approach builds on Department of Health national guidance, which has identified six areas in which Health Visitors can achieve high impact, one of these high impact areas is breastfeeding. The Health Visiting Service will be responsible for the provision of infant feeding services, including breastfeeding and will offer advice, information and specialist support.

1.3 This model will improve collaboration between the professionals that support mothers and families in the early years and will increase breastfeeding initiation and continuation rates across Kent

1.4 The new model is designed to extend and expand the reach of breastfeeding support by utilising the skilled Health Visiting workforce who already visit new families and to improve work with midwifery teams. The model includes working closely with Children Centres to offer women the right service quickly and builds on the positive elements of the existing service.

1.5 The new approach will deliver a number of benefits:

- Provide a more 'joined-up' experience for families looking for advice and support on the full range of infant feeding issues
- Increased awareness and promotion of breastfeeding
- Offer an increased number of professional led clinics
- Offer additional access to telephone advice and home visits where identified as needed
- Improve the rates and reporting of breastfeeding at 6-8 weeks

1.6 The new model was discussed by this Cabinet Committee on the 8th February 2018 and findings from the public consultation were shared. The changes were endorsed by this Cabinet Committee and subsequently the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health took a Key Decision on 12th March 2018 to implement the new model for infant feeding support.

1.7 This report provides the Cabinet Committee with an update on the progress made since the transition period commenced on the 19th March.

2. Progress since Key Decision

2.1. KCC Commissioners (Public Health and Early Help) have led a series of meetings with Kent Community Health NHS Foundation Trust (KCHFT) and the current provider of the Community Infant Feeding Service, PS Breastfeeding (PSB). A transitional period of two months has been mutually agreed between all parties which will enable the services to be fully operational from the 1st June 2018.

2.2 PSB, KCHFT and KCC are working in collaboration, drawing together a proposal for locations and times of lactation clinics and breastfeeding drop-in groups to best meet local needs. Children's Centres will continue to provide

space for these services and the revised timetable will be shared with peer support volunteers in the next few weeks. Appendix 1 outlines proposed breastfeeding drop-in groups. Appendix 2 outlines proposed lactation clinics.

2.3. A schedule of visits around the county has been established to discuss appropriate transition with peer supporters. Peers supporters are key to the success of the new model and many have attended and taken the opportunity to shape and discuss the new arrangements. To date, meetings have been held in Dover, Ashford and Maidstone districts with further meetings scheduled to take place during April 2018 with the remaining areas. These have been open discussions providing the opportunity to build understanding between peer supporters and representatives from the Health Visiting Service.

2.4. KCHFT met with lactation consultants on 28th March 2018 to explore how they might provide additional support as part of the new model. Options for spot purchasing have been put forward by KCHFT and are being worked through with the lactation consultants.

2.5 KCHFT and KCC recognise the importance of retaining skills and expertise of staff within the current contract and to facilitate this PSB have provided information needed for KCHFT to fully consider any staff transfer (TUPE) implications. Work will continue over the coming weeks with a meeting planned for 18th April 2018 for those staff who have been identified under TUPE regulations.

2.6 To support communication to service users, KCHFT have been given access to Facebook sites set up by PSB. This has enabled volunteers to raise questions outside of the meetings with KCHFT. KCHFT will continue to use Facebook as a two-way communication tool and one of the methods to support effective service delivery.

2.7 The local maternity system [LMS] is a transformation programme across all four trusts providing maternity services. Infant feeding is a workstream of the LMS Board. Activity was paused during consultation on infant feeding. The group met in March and a proposed antenatal pathway and postnatal pathway will be presented by Public Health to the LMS board on April 16th.

2.8 An outline of the proposed LMS website was presented to the LMS Board in March. The first stage of this will be to develop information on infant feeding for the public and health professionals.

3. Next steps

3.1 Commissioners will continue to monitor transitional plans to ensure key activities are delivered to meet the 1st June 2018 implementation date including transfer and recruitment of any staff by KCHFT. This will include weekly meetings between Public health, Early Help, KCHFT and PSB with communication shared with all relevant stakeholders on progress and key actions.

3.2 It is essential that KCC measures the impact of the new model. A series of specific metrics will be developed as part of the transition plan. Performance against these will be reported alongside the Health Visiting Service from 1st June 2018, this will provide assurance that the anticipated outcomes are being delivered.

3.3 Service User and Peer Supporters feedback will be a key part of measuring the impact of the new model and will drive a user led service that supports continuous service improvement.

3.4 A communication strategy will be developed between relevant organisations to help Kent parents access support simply and easily. This will also include joined up promotion or national campaigns such as Start4Life. *www.nhs.uk/start4life/baby/breastfeeding*. Session times and locations will also be finalised and shared, in addition to insight led targeted activity.

3.5 Remaining visits will be undertaken by KCHFT and commissioners to district peer support groups. KCHFT will share a suite of documents with Peer Support Volunteers including processes for supervision and ongoing management of volunteers.

4. Conclusion

4.1. Significant progress has been made over the past two months with KCC, KCHFT, PSB and Peer Supporters working closely and effectively together to ensure a smooth transition to the new model for infant feeding.

5. Recommendations

Recommendations:
The Health Reform and Public Health Cabinet Committee is asked to **comment on** the contents of this report and **endorse** and progress to date.

6. Background document:

Report to Health Reform and Public Health Cabinet Committee on 8th February 2018[1]

7. Report author:

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

[1] https://democracy.kent.gov.uk/documents/s82786/Item%205%20-%20report%20Infant%20feeding%20consultation%20final.pdf

Appendix 1: Proposed Kent Breastfeeding Drop in clinics from 1st June 2018

36 breastfeeding drop-in clinics across Kent each week (3 two-hourly sessions per district area)

District	Monday	Tuesday	Wednesday	Thursday	Friday
Ashford	9.30-11.30am RAY ALLEN Children Centre Stanhope Road Ashford TN23 5RN		12.30 - 2.30pm LITTLE EXPLORERS Children Centre Recreation Ground Road Tenterden TN30 6RA	12.30pm-2.30pm THE WILLOW Children Centre Brookfield Road Ashford TN23 4EY	
Canterbury & Coastal	12.30 - 2.30pm POPPY'S Children Centre Parklife Kings Road Herne Bay CT6 5RG	11-1pm RIVERSIDE Children Centre Kingsmead Road Canterbury CT2 7PH	1-3pm JOY LANE Children Centre Joy Lane Primary School Joy Lane CT5 4LT		
Shepway	1-3pm NEW ROMNEY Children Centre Craythorne Lane New Romney TN28 8BL	12.30 - 2.30pm THE VILLAGE Children Centre Denmark Street Folkestone CT19 6EQ	9.30am - 11.30am CATERPILLARS Children Centre Chart Road Folkestone CT19 4PN		
Dover/Deal	10-11.30am TRIANGLES Community Centre Poulton Close St Radigunds Dover CT17 0HL		1-3pm BLOSSOM Children Centre The Downs Primary School Downs Road Walmer CT14 7TL	10-12pm THE LINCES Children Centre St Nicholas Church The Linces Dover CT16 2BN	
Thanet		9.30-11.30am PRIORY Children Centre Cannon Road Ramsgate CT11 9SQ	10-12am MILLMEAD Children Centre Dane Valley Road Margate CT9 3RU		9.30-11.30am SIX BELLS Children Centre 201 High Street Margate CT9 1WH
Swale		9.30-11.30am SEASHELLS Children Centre Rose Street Sheerness ME12 1AW	1-3pm St MARYS Children Centre 2 Orchard Place Faversham ME13 8AP		10.30-12.30 pm MILTON COURT Children Centre Brewery Road Sittingbourne ME10 2EE
Maidstone	12.30-2.30pm MEADOWS Children Centre Furfield Close Park Wood Maidstone ME15 9JR	9.30-11.30am GREENFIELDS Children Centre Rutland Way Maidstone ME15 8DR	12.30-2.30pm Salvation Army Maidstone		

District	Monday	Tuesday	Wednesday	Thursday	Friday
Tunbridge Wells	9.30 -11.30am PADDOCK WOOD WOODLANDS Health Centre Allington Road Paddock Wood Tonbridge TN12 6AX		9.30 - 11.30am THE LITTLE FOREST Children Centre Friars Way Tunbridge Wells TN2 3UA	12.30 - 2.30pm CRANBROOK Community Children's Centre Health Clinic Jockey Lane Cranbrook TN17 3JN	
Sevenoaks			9.30am-11.15am SPRING HOUSE Children House Hospital Road Sevenoaks TN13 3PT 12.30-2.30 Peer Support Run Clinic from New Ash Green CC.	1-3pm SWANLEY Children Centre Northview Swanley BR8 7BT	9.30-11.15am EDENBRIDGE Children Centre High Street Edenbridge TN8 5AB
Tonbridge & Malling	9.30-11.30am WOODLANDS Children Centre Chapman Way East Malling ME19 6SD	10-12am SNODLAND Clinic Rocfort Road Snodland ME6 5NQ	10–12am SOUTH TONBRIDGE Children Centre Tonbridge Youth Hub Avebury Avenue TN9 1TG		
Dartford	1-2.45pm BRENT YMCA Roundhouse Overy Street Dartford DA1 1UP			1-3pm KNOCKHALL Children Centre Abbey Road Greenhithe DA9 9HD	9.30-11.30am OAKFIELD Children Centre Oakfields Lane Dartford DA1 2SW
Gravesend		1-3 pm BRIGHT FUTURES Children Centre Packham Road DA11 7JF	1-3pm LITTLE PEBBLES Children Centre Ordnance Road DA12 2RL		9.15-11.15am NEXT STEPS Children Centre Cedar Avenue DA12 5JT

Appendix 2: Kent Lactation Consultant Clinics

At least 6 slots per clinic will be available, with the length of appointments (and therefore total number) dependent on the issues women are being seen with. This will mean lactation consultants will provide at least 24 face to face appointments a week across Kent (approx. 100 appointments per month). As well as seeing mothers in the specialist clinics, the Infant Feeding Leads/ Lactation Consultants will be able to provide telephone advice and home visits.

District	Monday	Tuesday	Wednesday	Thursday	Friday
Ashford	Telephone advice and home visits		1.30-3.30pm THE WILLOW Children Centre Brookfield Road Ashford TN23 4E	Telephone advice and home visits.	
Canterbury & Coastal	Telephone advice and home visits			12.30-2.30pm Littlehands Children Centre 16 Hollowmede Canterbury CT1 3SD	Telephone advice and home visits
Shepway and Dover/Deal	Telephone advice and home visits				12.30- 2.30pm TRIANGLES Community Centre Poulton Close St Radigunds Dover CT17 0HL
Thanet	1 -3 pm PRIORY Children Centre Cannon Road Ramsgate CT11 9SQ				
Swale	9.45-11.15am SEASHELLS Children Centre Rose Street Sheerness ME12 1AW				
Maidstone		1 - 3pm MEADOWS Children Centre Furfield Close Park Wood Maidstone ME15 9JR			
Tunbridge Wells			9.30 - 11.30am THE LITTLE FOREST Children Centre Friars Way Tunbridge Wells TN2 3UA		

District	Monday	Tuesday	Wednesday	Thursday	Friday
Sevenoaks					9.30 - 11.30am SWANLEY Children Centre Northview Swanley BR8 7BT
Tonbridge & Malling		9.30-11.30am Little Foxes Children Centre Waveney Road Tonbridge TN10 3JU			
Dartford Gravesend				9.30 - 11.30am BRIGHT FUTURES Children Centre Packham Road DA11 7JF	

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee - 1st May 2018

Subject: Performance of Public Health commissioned services

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: This report provides an overview of key performance indicators (KPIs) for Public Health commissioned services. 13 of the 15 KPIs were RAG rated green in the latest quarter, 2 were amber, and none were red.

Changes are to be made to 4 KPIs for 2018/19. This includes a change in focus of one KPI to a satisfaction measure, one change to account for the new integrated lifestyle service – "One You Kent", and two changed targets to reflect local and national performance trends.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **note and comment on** the Q3 performance of Public Health commissioned services and **agree** the proposed KPI changes to be presented in future Cabinet Committee Papers.

1. Introduction

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

1.2. Revisions to the current KPIs for 2018/19 are outlined in section 3; 4 KPIS are changed to account for national and local trends or service delivery changes.

2. Overview of Performance

2.1. Of the 15 KPIs for Public Health commissioned services, 13 remained above target in Q3 17/18 (green), 2 were below target but remained within acceptable levels (amber), these were for adults completing substance misuse treatment

successfully and new clients accessing the health trainer service being from the 2 most deprived quintiles or NFA. No KPIs fell below the 'floor target' (red).

2.2. Appendix 1 provides the data for the following indicators.

Health Visiting

2.3. The Health Visiting Service achieved the expected targets in Q3 with more than 70,000 developmental reviews completed in the twelve-month period to December 2017. There were slight reductions in the proportion of antenatal visits and 2-2½ year reviews completed, although the performance remained above the target and above the national average for Q2 2017/18.

2.4. The service has been developing an action plan to improve communication with maternity services and increase the proportion of families that receive an antenatal visit. The service has also worked closely with KCC Early Help Services and started to jointly deliver a range of parenting programmes in children's centres across the county. The universal developmental review and the follow-up support and advice from health visitors are making a crucial contribution to ensuring Kent children get the best start in life.

Adult Health Improvement

2.5. The 31st March 2018 signals the end of the first 5-year cycle for the NHS Health Check programme. Quarter 3 data indicates that with 3 months left in the current cycle Kent has already sent 482,853 invites and delivered 195,745 checks. This exceeds the estimated eligible population of 452,000 to be invited as indicated by Public Health England and gives Kent a conversion rate of 41%.

2.6. Health Trainers, now working as One You Lifestyle Advisors, as part of One You Kent, continue to work with clients from areas of high deprivation, however the decreases experienced are being addressed by the providers through ongoing work around positioning of services and staff to maximise reach in Kent.

Sexual Health

2.7. Sexual health services continue to offer quick and convenient access to appointments around genito-urinary medicine (GUM) within 48 hours.

2.8. Patients are offered a choice of services to access including the new online STI testing service which was launched in October 2017. In the first 3 months of this new service 2,666 tests were requested, and 1,170 patients were tested with 6% having positive results; these tests identified cases of chlamydia, syphilis and HIV.

Drug and Alcohol Services

2.9. To better understand the decreasing adult treatment population, commissioners are working with providers to undertake a modelling exercise to determine capacity and to identify any barriers to accessing structured treatment in Kent.

The current decrease can be attributed to the decreasing number of alcohol-only clients which is reflective of national trends.

2.10. East Kent Services have completed their co-design process work with Rethink (a Mental Health charity) and priority areas were identified as - joined up service delivery, networks and communications, recovery and holistic care, dual diagnosis and mental health, long term opiate users, older adult drinkers and young users. Commissioners are working with the East Kent provider to prioritise the recommendations and embed them into the new service.

2.11. West Kent Services continue to identify areas for service development, currently the focus is on recruitment of recovery motivators and caseload segmentation to proactively monitor and review caseloads to ensure effective movement of clients through the service.

2.12. The young person's drug and alcohol service continues to deliver a wide range of interventions and as at the end of Q3 2017/18, DUST training was delivered to 617 professionals, 2,240 young people were engaged in Early Intervention group work, 61 young people completed the RisKit programme, and 223 sessions of an evidence-based parenting programme were delivered.

2.13. The numbers of young people accessing structured treatment remains stable with similar numbers each quarter exiting treatment and with a planned exit.

Mental Wellbeing Service

2.14. With the strong correlation between deprivation and mental illness, Live Well Kent continues to ensure a high proportion of new clients are from the most deprived areas of Kent, keeping their performance above the target of 50%.

3. Proposed KPI Changes for 2018/19

3.1. Table 1 outlines changes to the KPI's and their targets for 2018/19. Two metrics have changing targets to reflect national and/or local trends. One KPI now refers to One You Kent Advisors, rather than Health Trainers, following the change to an integrated lifestyle service. The Live Well Kent KPI will present levels of satisfaction via a recommendation measure, replacing the current one focussing on deprivation.

3.2. All other KPIs and their targets are to remain the same.

Table 1: Proposed KPI changes for 2018/19

KPI:	Change:
New clients engaged with the One You Kent Advisors from the most deprived areas in the County	New KPI with a change from Health Trainers to One You Kent Advisors. Target of 60% with a floor of 48%.
Successful completion of drug and alcohol treatment of all those in treatment	Target change to reflect national and local performance trends. New target of 26%, with a floor of 21%.
Mothers receiving an antenatal visit/contact with the Health Visiting Service	Target change to reflect improving performance. New target of 50% with a floor of 40%.

KPI:	Change:
Live Well Kent clients who would recommend the service to family, friends or someone in a similar situation	New KPI with a change from deprivation to satisfaction. Target of 90% with a floor of 72%.

4. Quality

4.1. There are no quality exceptions to report this quarter.

5. Conclusion

5.1. 13 of the 15 KPIs with targets stated in the Public Health business plan were rated green in Q3 and 2 were amber. All were performing within acceptable levels of the target.

5.2. Changes to 4 KPIs are recommended to reflect changes in service delivery, national and local performance trends.

6. Recommendations

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **note and comment on** the Q3 performance of Public Health commissioned services and **agree** the proposed KPI changes to be presented in future Cabinet Committee Papers.

7. Background Documents

None

8. Appendices

Appendix 1 - Public Health Commissioned Services KPIs and Key.

9. Contact Details

Report Authors:

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

- Penny Spence: Head of Quality & Safeguarding, Public Health. (Quality Section 4)
- 03000 419555
- penny.spence@kent.gov.uk

Relevant Director:

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

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

Service	KPI's	Target 2017/18	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	DoT*– 2 most recent
Health Visiting	No. of mandated universal checks delivered by the health visiting service (12 month rolling)	65,000	65,088	64,633	66,902 (g)	68,837 (g)	**70,456 (g)**	⇧
	No. and % of mothers receiving an antenatal contact with the health visiting service	30%	1,609 37% (r)	1,567 36% (r)	1,914 44% (g)	2,457 54% (g)	**2,282 52% (g)**	⇩
	No. and % of new birth visits delivered by the health visitor service within 30 days of birth	95%	4,198 95%	3,864 97%	4,259 97% (g)	4,459 97% (g)	**4,346 98% (g)**	⇧
	No. and % of infants due a 6-8 week who received one by the health visiting service	80%	3,965 88% (a)	3,543 88% (a)	3,859 89% (g)	3,989 89% (g)	**4,199 92% (g)**	⇧
	No. and % of infants who are totally or partially breastfed at 6-8 weeks (health visiting service)	-	1,936 48%**	1,843 49%**	2,077 51%**	2,025 49%**	**2,041 47%**	-
	No. and % of infants receiving their 1-year review at 15 months by the health visiting service	80%	3,547 81%	3,447 83%	3,666 86% (g)	3,751 88% (g)	**3,878 89% (g)**	⇧
	No. and % of children who received a 2-2½ year review with the health visiting service	80%	3,200 74% (r)	3,390 81% (a)	3,440 82% (g)	3,520 84% (g)	**3,634 83% (g)**	⇩
Structured Substance Misuse Treatment	No. and % of young people exiting specialist substance misuse services with a planned exit	85%	51 89% (g)	75 93% (g)	66 94% (g)	79 92% (g)	**76 92% (g)**	⇔
	No. and % of people successfully completing drug and/or alcohol treatment of all those in treatment	28%	1,330 28% (a)	1,256 27% (a)	1,221 27% (a)	1,143 26% (a)	**1,126 25% (a)**	⇩
Lifestyle and Prevention	No. of the eligible population aged 40-74 years old receiving an NHS Health Check (12 month rolling)	41,600	41,057 (a)	42,071 (g)	42,568 (g)	43,677 (g)	**42,943 (g)**	⇩
	No. and % of people quitting at 4 weeks, having set a quit date with smoking cessation services	52%	819 55% (g)	991 53% (g)	871 54% (g)	759 49% (a)	**736 53% (g)**	⇧
	No. and % of new clients accessing the health trainer service being from the 2 most deprived quintiles & NFA	62%	619 61% (a)	626 59% (a)	584 65% (g)	414 61% (a)	**354 59% (a)**	⇩
Sexual Health	No. and % of clients accessing GUM services offered an appointment to be seen within 48 hours	90%	100% (g)	100% (g)	100% (g)	100% (g)	**100% (g)**	⇔
Mental Wellbeing	No. and % of sign-ups to the Live Well Kent service from the most deprived quintiles	50%	520 60% (g)	549 62% (g)	609 70% (g)	684 66% (g)	**533 66% (g)**	⇔

*Relates to target measure. **Coverage above 85% however quarter did not meet 95% for robustness expected for national reporting

Commissioned services annual activity

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

Key:

RAG Ratings

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

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

DoT (Direction of Travel) Alerts

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

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

From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 1 May 2018

Subject: **Work Programme 2018/19**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

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

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

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

2. Work Programme 2018

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

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

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

3. Conclusion

3.1 It is vital for the Cabinet Committee process that the Committee takes ownership of its work programme, to help the Cabinet Members to deliver

informed and considered decisions. A regular report will be submitted to each meeting of the Cabinet Committee to give updates of requested topics and to seek suggestions of future items to be considered. This does not preclude Members making requests to the Chairman or the Democratic Services Officer between meetings, for consideration.

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

5. Background Documents

None.

6. Contact details

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

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

Last updated on: 23 April 2018

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE WORK PROGRAMME 2018/19

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

27 JUNE 2018	
• **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)* particularly update on the suicide prevention campaign and strategy *(requested by Diane Marsh)* • ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Postural Stability* • ***Work Programme 2018/19***	
14 SEPTEMBER 2018	
• **Annual Report on Quality in Public Health, incl Annual Complaints Report** • **Annual Equality and Diversity Report** • ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Adult Drug and Alcohol Services* • ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings* • ***Work Programme 2018/19***	
22 NOVEMBER 2018	
• **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)* • ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– 0-5 Children and Young People's Services* • ***Work Programme 2019***	
9 JANUARY 2019	
• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Adult Health Improvement Services (incl workplace health)* • ***Public Health Performance Dashboard – incl impact of STP*** *now to alternate meetings* • ***Work Programme 2019/20***	
13 MARCH 2019	
• **Update on PH Campaigns/Communications** *(added at 1 12 17 agenda setting as an item to alternate meetings)* • ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Adolescent Health Services* • ***Work Programme 2019/20***	
remainder of 2019 – MEETING DATES NOT YET SET	
MAY	• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Domestic Abuse and Positive Relationships* • ***Work Programme 2019/20***

Last updated on: 23 April 2018

JULY	• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Mental Health* • ***Work Programme 2019/20***
SEPTEMBER	• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Workforce Development* • ***Work Programme 2019/20***
NOVEMBER	• ***Verbal Updates – could include STP update*** • ***Contract Monitoring*** *– Young Persons' Drug and Alcohol* • ***Work Programme 2019/20***

PATTERN OF ITEMS APPEARING ANNUALLY	
Meeting	**Item**
January	Budget and Medium Term Financial Plan Public Health Performance Dashboard – incl impact of STP now to alternate meetings
March	Draft Directorate Business Plan Risk Management report (with RAG ratings)
May / June	
June / July	
September	Annual Report on Quality in Public Health, incl Annual Complaints Report Annual Equality and Diversity Report Public Health Performance Dashboard – incl impact of STP now to alternate meetings
November / December	