HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Friday, 10th May, 2019

10.00 am

Darent Room - Sessions House

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Friday, 10 May 2019 at 10.00 am
Darent Room - Sessions House

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

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

Membership (13)

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

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

Labour (1) Mr B H Lewis

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UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in items on the agenda

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

4 Minutes of the meeting held on 13 March 2019 (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 Health Reform, the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health.

6 Contract Monitoring report - the Adolescent Health and Targeted Emotional Health Service (Pages 19 - 38)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, giving an overview of service delivery. The committee is invited to comment on and endorse the progress made and the ongoing activity to deliver continuous improvement.

7 Health Inequalities and Place-Based Public Health (Pages 39 - 44)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out recent work on health inequalities and plans to develop a new strategy to address health inequalities in Kent, incorporating a new framework which is due to be published by Public Health England in the near future. The committee is asked to comment on and endorse the contents of the report.

8 Green Spaces and Physical Exercise (Pages 45 - 52)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out work across Kent County Council to encourage activity and the use of green spaces for physical activity, which the committee is asked to comment on and endorse.

9 Six Ways to Wellbeing update (Pages 53 - 56)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, giving an update on how the Six Ways to Wellbeing tool is currently being used. The committee is asked to comment on and endorse the progress made and suggest ways to strengthen future delivery.

10 Performance of Public Health commissioned services (Pages 57 - 64)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out performance against key performance indicators and proposed amendments to four of the targets for 2019/20, to reflect changes in delivery mechanisms. The committee is asked to note and comment on the performance and the proposed changes.

11 Progress and future plans regarding the "Release the Pressure" social marketing campaign (Pages 65 - 72)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out a review of recent campaign activity and details the future plans for *Release the Pressure.* The committee is asked to note progress and suggest ways to strengthen future delivery.

12 Work Programme 2019/20 (Pages 73 - 76)

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

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

Wednesday, 1 May 2019

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

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KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Darent Room - Sessions House on Wednesday, 13th March, 2019.

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

OTHER MEMBERS: Graham Gibbens

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

UNRESTRICTED ITEMS

28. Apologies and Substitutes.
(Item. 2)

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

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

Apologies for absence had also been received from the Leader and Cabinet Member for Health Reform, Mr P B Carter, CBE.

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

29. Declarations of Interest by Members in items on the agenda.
(Item. 3)

Mr I Thomas declared that his Rotary Club's fund raising project for this year was the Porchlight charity, which was mentioned in the report for agenda item 6 as one of the hosts of the Live Well project, and that he was a Member of Canterbury City Council's Planning Committee, in relation to plans for a new hospital site at Canterbury.

Mr R H Bird declared that he was a member of the Maidstone Citizens Advice Bureau.

The Chairman, Mr G Lymer, declared that he was a member of the Dover Citizens Advice Bureau, a member of the Macmillan Cancer Backup Committee and a member of a cancer charity based in Canterbury.

30. Minutes of the meeting held on 15 January 2019.
(Item. 4)

1. The Democratic Service Officer advised the committee that a correction to Minute 19 had been requested after the minutes had been published in the agenda pack. Paragraph 2 b) of minute 19 had subsequently been corrected to read '...the health visiting service *dealt with all families with a child under the age of five...'* instead of *'... was concerned only with new parents...'*. This change had been made to the minutes published online and in the copy which would be signed by the Chairman.

2. It was RESOLVED that, subject to the above, the minutes of the meeting held on 15 January 2019 are correctly recorded and they be signed by the Chairman. There were no matters arising.

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

1. On behalf of the Leader and Cabinet Member for Health Reform. Mr P B Carter, CBE, The Cabinet Member for Adult Social Care and Public Health, Mr G K Gibbens, gave a verbal update on the following health reform issues:-

Sustainability and Transformation Partnership (STP) – Mr Carter, Mr Gibbens and Mr Scott-Clark were all members of the STP partnership board, which held monthly meetings and was moving ahead on local care implementation. The board was looking at the model of health care used in Canterbury, New Zealand, and he suggested that Cabinet Committee Members might find it helpful to look at this model. The board was also continuing to pursue work to reduce attendance at Accident and Emergency departments by establishing alternative methods of accessing services. The Whitstable practice model offered a good example of these alternative methods.
Delayed Transfers of Care (DTOCs) continued to be a concern. A report on this subject would be considered by the Cabinet on 25 March 2019, and all Cabinet Committee Members were welcome to attend that meeting.
Multi-Disciplinary Teams (MDTs) – Mr Carter had been involved in much work to establish these teams across Kent, and these currently numbered between 34 and 37. Mr Gibbens had visited and seen their work at first hand.
Visit to Manchester – with Mr Carter and Mrs Tidmarsh, Director of Adult Social Care and Health Partnerships, he had recently visited Greater Manchester, a combined authority with the broadest range of devolved services among such authorities, to look at the model of health and social care used there. He said there was much information available online about Manchester's work in this field.

2. Mr Gibbens then gave an update on the following public health issues:-

5 February – attended Public Health Champions celebration event. Public Health Champions worked in partner organisations and sought to raise the profile and awareness of public health issues within those organisations.
7 February – Kent Health and Wellbeing Board meeting. This new board was just completing its first year and had tackled a number of important issues. Its work was being observed nationally. The Board had recently discussed the health profiles which were available for each district and for the whole of Kent. Mr Gibbens suggested that these be sent to all Members of the Health Reform and

Public Health and Adult Social Care Cabinet Committees. He advised that Kent had retained its own Health and Wellbeing Board which was statutorily required to meet once a year to consider organisational matters.
27 February – attended the Local Government Association annual summit for political leaders in health and clinical care. This summit had focused on making Health and Wellbeing Boards s as effective as possible by encouraging clinicians and politicians to work together.

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

a) it was emphasised that good signposting was important in helping the public to understand where to go, apart from Accident & Emergency, to seek urgent medical help. The locations and opening hours of sites would need to be more widely advertised than at present, and the 'Waitless' app which gave waiting time and real-time traffic information for East Kent sites was a good first step towards this. Opening hours could be shown on hospital signage and at highways information points; and

b) asked to which Cabinet Committees Delayed Transfers of Care would be reported, Mr Gibbens explained that the issue had been discussed by the Adult Social Care Cabinet Committee and that the Health Overview and Scrutiny Committee might also consider it. Cabinet had requested a report for its 25 March meeting as it had shown an interest in the issue and wanted to look at the originators of, and reasons for, delayed transfers.

4. The Deputy Director of Public Health, Dr A Duggal, then gave an update on the following public health issues:-

Illicit tobacco – a new joint committee, led by Trading Standards colleagues, had recently been established to look into tackling the supply chain of illicit tobacco. Directors of Public Health across the south east were also working on tackling this issue.
Air quality – the County Council's Energy and Low Emissions Strategy, to which the public health team had contributed, would be considered by the Environment and Transport Cabinet Committee on 24 May 2019. A quality standard for air quality had recently been published by the National Institute of Health and Care Excellence.
STP prevention – prevention work streams were starting to be woven into the NHS's long-term plan, starting with maternity work and microbial control.
Health in Europe – to build on the success of past initiatives which had looked at diabetes and mental health, new funding had now been secured for work on sexual health services. It was hoped that additional funding could be secured to support work on obesity.

5. Dr Duggal responded to comments and questions from the committee, including the following:-

a) asked if the use of illicit tobacco was linked in any way to the use of cannabis, Dr Duggal *undertook to look into the data available and advise the questioner outside the meeting;* and

b) it was hoped that work currently going on to 'look into' various issues would soon start to lead to action to 'deal with' the problems. Dr Duggal agreed that the language used in reporting progress was important and *offered to share with the committee the detailed Prevention work plan to reassure Members that progress was indeed being achieved.*

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

32. Contract Monitoring Report - Live Well Kent Contract.
(Item. 6)

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

1. Mrs Tovey and Ms Mookherjee introduced the report and responded to comments and questions from the committee. Mrs Tovey explained that although the service was part funded by Public Health, the contract was managed by Adults Commissioning, including the following:-

a) there was a range of ways in which an individual could access the service; via a helpline or GP referral or by walking in to one of the locations in the delivery network listed in Appendix A to the report. Anyone whose mental state made it difficult to search for service delivery points online or to walk into a service and seek help on their own could seek the help of their GP, who should be familiar with the most appropriate services to support them. It was important to note that this was not a crisis service. It was important, therefore, that GPs had full and up-to-date information about the named link person for each service and how to access the service and that signposting in surgeries was as clear as possible. Once someone had made initial contact with the Live Well service, they would be supported and helped to move forward with the most appropriate support, the aim being that there would be 'no wrong door';

b) a speaker who had accessed the Live Well service in their professional capacity as a carer said how good it was. Both the signposting and the helpline had been very helpful, with the latter allowing callers as much time as they needed to talk through their problems;

c) asked how offenders and ex-offenders living in the community would access the service, and if the service collected this information, Mrs Tovey *undertook to advise the questioner outside the meeting*. She explained that Live Well was an open-access service for people aged 17+ and the range of services offered would be adapted to accommodate the needs of those coming into it;

d) a request was made that the list of organisations within the delivery network be kept up-to-date as service providers changed, and Mrs Tovey explained that she would ask the contract management lead to undertake a review of the list;

e) concern was expressed that the expectations of the network should be realistic and deliverable, within the funding available. Mrs Tovey advised

that the cost quoted per head was for a service user's whole 'journey', from referral to exit, not an amount paid to one of the delivery network. She explained that someone would access a number of interventions and the service needed to treat the causes of mental ill health rather than just the symptoms. *She undertook to share more detailed and commercially-sensitive information about charges with Members outside the meeting;*

f) concern was expressed about the effectiveness of group sessions as a way of addressing mental health problems, and, in particular, debt issues. There was also no mention of those with gambling addiction. Mrs Tovey advised that Live Well was a general service for anyone experiencing mental ill health, regardless of the cause, and hence no data was collected by the service about the number of people coming into it due to gambling addiction or any other specific cause. Mrs Mookherjee advised that there were a number of national helplines. *She undertook to look into national data for gambling addiction and advise the questioner outside the meeting*;

g) concern was expressed about the ability of a non-NHS service provider to protect client data sufficiently. Mrs Tovey reassured the committee that staff in provider organisations would have been fully trained in the safe handling of client data and part of the strategic partner role was to ensure that the delivery network also adhered to the relevant standards, so the public could trust it as part of the familiar NHS 'brand';

h) reference was made to the ongoing need to address and reduce the stigma which still surrounded mental health issues, particularly in certain professions, such as teaching. Ms Mookherjee advised that this was being addressed by the 'Time to Change' campaign. The aim was always to achieve parity of esteem between physical and mental health;

i) the case studies included in the report helped to address stigma, and Mrs Tovey advised that there were many more case studies available to read on the Live Well Kent website;

j) a suggestion was made that signposting to the service could be placed at as many local community locations as possible, including community centres and food banks. Mrs Tovey advised that suggestions for additional locations would be welcomed and could become part of the main delivery network;

k) concern was expressed that funding for the service must be maintained so Kent could continue to uphold its quality of provision. Mrs Tovey reassured the committee that, despite the public health grant having been reduced in recent years, Kent's investment from all funders for the Live Well service had been maintained, demonstrating commitment to its mental health support services; and

l) the choice of partner organisations in the delivery network and the geographic spread and range of services were welcomed and commended.

2. The Cabinet Member, Mr G K Gibbens, thanked Members for their comments and said that he had always resisted budget reductions to mental health services.

3. It was RESOLVED that the commissioning and provision of a Live Well Kent mental health and wellbeing service in Kent, the contractual performance to date and work to deliver continuous improvement, be noted.

33. Summary of the Data, Key Findings and Recommendations of the Kent Adult Mental Health Needs Assessment 2019: Focus on Chapter on Mental Health and Multi-Morbidity.
(Item. 7)

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

1. Ms Mookherjee introduced the report and emphasised that the physical and mental aspects of conditions would be treated together, and that no one condition would be looked at in isolation. Mental Health issues made any physical condition harder to treat. She thanked Gerrard Abi-Aad and the Public Health Observatory for the quality of the data provided, which would shortly be shared with both the STP and the Local Care Partnership. Ms Mookherjee then responded to comments and questions from the committee, including the following:-

a) asked why poor mental health was an issue of particular concern in Thanet, Ms Mookherjee explained that this was due to its status as an area of deprivation with a concentration of low-income families, low pay, unemployment and poor housing;

b) suggestions of areas for further investigation were as follows:
   i) the heightened risk of depression among carers; and
   ii) the heightened risk of poor mental and physical health following bereavement.

   Investigation of these could make use of research on the correlation between certain personality types and patterns of physical disease;

c) data in the report referring to the risk of depression among carers had been published in 2002. It was important that data used was as up-to-date as possible; and

d) asked about the respite care available to carers, Ms Mookherjee *undertook to look into this and advise Members outside the meeting.*

2. It was RESOLVED that the information set out in the report be noted, and Members' suggestions of areas for further investigation and focus, set out above, be taken into account in future work.

34. Health Inequalities.
(Item. 8)

1. Dr Duggal introduced the report and advised the committee that guidance was expected to be published shortly by the Local Government Association and Public Health England. Work to address health inequalities was going on as part of the Sustainable Transformation Plan (STP) prevention work stream and to ensure

that action included in the NHS long-term plan was reflected in the STP prevention plan. A pilot project on place-based public health was being run across a selection of coastal, urban and rural areas and was also being undertaken by district councils. She then responded to comments and questions from the committee, including the following:-

a) a view was expressed that the County Council should be more proactive in addressing issues relating to air pollution and smoking. Dr Duggal reminded the committee that air quality was a district council responsibility but that the County Council would have input into this work;

b) the importance of cross-directory working in addressing health inequalities was emphasised. Dr Duggal agreed and added that the cross-directorate work going on in Kent was not being undertaken anywhere else in the UK. *She undertook to share the prevention work plan with Members outside the committee*. Physical activity would be promoted as a way of both decreasing car usage and boosting mental health;

c) asked if there was any clinical support to help people with gambling addiction, Dr Duggal *undertook to look into this and advise the questioner outside the meeting;* and

d) the importance of open space was emphasised and the point made that the perception of there being open space was as important as the space itself in supporting mental wellbeing. Dr Duggal advised that 'garden city' developments at Ebbsfleet, Chilmington and Otterpool were building in green space and were striving to achieve a kitemark accreditation.

2. The Cabinet Member, Mr Gibbens, thanked Members for their comments and for the support expressed for the work being undertaken to address health inequalities in Kent. He advised the committee that the 'Mind the Gap' strategy document was currently being re-written and, once ready, would form the basis of new work. He said how shocked he had been to realise that health inequalities in Kent had worsened and explained that this was his reason for urging this committee to look at the issue at the earliest opportunity. This early consultation was welcomed by the committee.

3. It was RESOLVED that the information set out in the report be noted and the approach outlined in the report be endorsed.

35. Childhood Obesity - report on joint working between agencies to tackle obesity.
(Item. 9)

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

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

a) asked if there was any correlation between early weaning and a higher risk of a child becoming obese in later life, Ms Bennett advised that there

was indeed evidence to support this. The World Health Organisation recommended delaying weaning until six months, and breast-feeding up to six months to give a child the best start in life;

b) the Summer Kitchen initiative being delivered in children's centres was welcomed and praised as a way of encouraging children to eat healthy food in the long summer holidays;

c) asked about stages in a child's life which might trigger weight gain, and if there were any recognised patterns of change, Ms Bennett explained that there were key points of intervention at which professionals in the Early Years, Health Visiting and School Public Health Services would seek to encourage families to take up a healthy diet. These were: 6 – 12 months, at the time of weaning, 2 – 2 1/2 years, and in Reception year and Year 6 at school, between which the level of childhood obesity was known to double. Obesity rates tended to rise thereafter, continuing into adulthood;

d) asked for a view on the availability of fast food, and what the County Council could do to influence the Government and district council colleagues, for instance in granting planning permission for such outlets, Ms Bennett agreed that both the demand for, and ready availability of, cheap, energy-dense snacks were key challenges to be addressed. This could be done by liaison with district council colleagues, to seek to address the location of fast food outlets, particularly near schools;

e) the limited range and poor nutritional value of food available on children's menus in many restaurants made it difficult to take children out to eat with any confidence that they would be able to eat healthily. Ms Bennett agreed that, although some outlets now strove to offer a healthier choice for children, this was an issue to look at in future work;

f) concern was expressed that children could use comfort eating as a way of dealing with emotional distress, and Ms Bennett assured Members that this subject was acknowledged in the Government's Childhood Obesity Action Plan, published in August 2016 and updated in January 2017; and

g) concern was expressed about the advertising industry targeting children with unhealthy foods. Ms Bennett agreed that advertising was a key element of a child's relationship with food. Many parents also used their children's favourite foods to treat and reward them but could be educated and encouraged to find other ways of rewarding their children.

2. It was RESOLVED that the joint work being undertaken by agencies to tackle childhood obesity be noted, and Members' comments, set out above, be taken into account.

36. Oral Health.
(Item. 10)

1. Ms Bennett introduce the report and advised the committee that, since publishing the report, data for the number of children in Kent aged 5-9 years old who had had teeth extracted had become available. Gravesham had the second highest rate of such extractions in the south east, while Thanet children enjoyed

some of the best oral health. Work was ongoing with children's centres to address these rates, by introducing regular visits from a dentist. Good oral health was important as it had far-reaching effects on a person's mental and physical health and wellbeing.

2. Ms Bennett then responded to comments and questions from the committee, including the following:-

a) it was pointed out that there was a large gap between measuring rates of dental decay in 5-year-olds and the oral health of adults, and a question asked about what could be done to encourage better dental health among teens. Ms Bennett advised that 5 years was a set point at which national data was collected, and that there tended to be less data available on older age groups. She emphasised the importance of establishing good dental habits at an early age, which the current measures were intended to support;

b) asked if the County Council had any leverage to improve the provision of NHS dentistry, Ms Bennett advised that there were no levers except to continue to highlight the public health outcomes of not being able to access NHS dentistry. Increasing numbers of dentists were moving from NHS to private-only practice, and hence had no incentive to open their lists to NHS patients;

c) asked about the origin of the data used in the report, Ms Bennett explained that this had been gleaned direct from contracts in the 2017/18 financial year. Some of the data had been surprising so would be analysed very carefully to investigate the reasons behind it;

d) asked if there was any correlation between poor dental health and the liking of some ethnic minority groups for very sweet foods, Ms Bennett commented that this could indeed be part of the picture; and

e) asked about the role of fluoride in drinking water in safeguarding dental health, Ms Bennett said there was evidence to support its usefulness. Kent, however, did not have fluoride in its drinking water.

3. It was RESOLVED that:-

a) the profile of oral health in Kent be noted;

b) the approach being taken by the County Council's public health team be welcomed and endorsed; and

c) a report providing a further analysis of the dental health of Thanet children be considered by the committee in due course

37. Development of the Strategic Delivery Plan.
(Item. 11)

Mr D Whittle, Director, Strategy, Policy, Relationships and Corporate Assurance, and Ms E Sanderson, Strategic Business Advisor (Corporate), Strategy, Policy, Relationships and Corporate Assurance, were in attendance for this item.

1. Mr Whittle and Ms Sanderson introduced the report and explained that the new whole-Council Strategic Delivery Plan process had replaced individual Directorate Business Plans.

2. The new process was welcomed as a way forward, but concern was expressed that part of the role for Members in business planning described in the report was not yet happening.

3. It was RESOLVED that the content of the draft Strategic Delivery Plan summary be noted and welcomed.

38. Risk Management: Health Reform and Public Health.
(Item. 12)

1. Dr Duggal introduced the report and emphasised the importance of ensuring that the public health grant was being used appropriately. All risks relating to public health work were currently rated 'medium'.

2. Concern was expressed that the public health grant, although previously ring-fenced, had reduced year on year, and it was vital that the County Council be proactive in planning ahead how future work would be funded, for example from business rates. Dr Duggal reassured the committee that an officer from the public health team was part of the consultation on the use of business rates.

3. It was RESOLVED that the risks set out in Appendices 1 and 2 to the report be noted.

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

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

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

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

Mr A Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee – 10 May 2019

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

Classification: Unrestricted

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

HEALTH REFORM

On behalf of the Leader and Cabinet Member for Health Reform, Mr P B Carter, CBE, **the Cabinet Member for Adult Social Care and Public Health, Mr G K Gibbens,** will deliver an update Health Reform issues.

PUBLIC HEALTH

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

- 27 March – Spoke at the Introduction to Public Health Course
- 16 April – Visited the One You Shop at Ashford Park Mall
- 23 April – Observed the Community Hub Operating Centre and Multi-Disciplinary Team Meeting at Northgate Medical Centre in Canterbury

The Director of Public Health, Mr A Scott-Clark:

- Measles
- Air quality
- Association of Directors of Public Health (ADPH) Workshop on Population Health Management and Integrated Care Systems.

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee
10 May 2019

Subject: **Contract Monitoring Report – The Adolescent Health and Targeted Emotional 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 an overview of the Adolescent Health and Targeted Emotional Health contract provided by the Kent Community Health NHS Foundation Trust (KCHFT) which has an annual value of approximately £1.6m.

The service delivers a universal whole school health approach to 98 schools to improve health and wellbeing of 172,420 secondary school-aged children in Kent. It provides a new integrated model for interventions for a range of health needs and a Targeted Emotional Health service.

KCC and KCHFT are continuously working to improve efficiency, ensure value for money and deliver service enhancements through contact management and service development. Performance has substantially improved in the second year of the contract.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **Comment on and Endorse** the progress made to transform services and ongoing activities to deliver continuous improvement.

1. Introduction

1.1 KCC commissions the School Public Health Services across Kent which offers both universal and targeted support. There was a move to a separate Adolescent School Public Health contract in 2017 to increase visibility of the universal offer that all secondary schools in Kent have access to. The Children's Social Care and Health Cabinet Committee previously endorsed this change which included closer integration with CCG commissioned services.

1.2 A joint procurement route was used for the purchase of School Public Health

Services and the Children and Young People's Mental Health Service (CYPMHS) due to interdependencies. The remit and contracts remain separate and additional information can be found in the background documents.

1.3 This contract monitoring paper focuses on the Adolescent Health and Targeted Emotional Wellbeing Service and provides details of the purpose, performance, outcomes, value for money and strategic direction of the service.

2.0 Why invest

2.1 The service has a crucial role in improving health and reducing health inequalities through leading delivery of the Healthy Child Programme (5-19) - systematically identifying those groups of young people who are at greater risk of poor health outcomes and working in partnership with other agencies to support health improvements locally. It makes a significant contribution to achieving KCC's strategic vision to ensure that children and young people in Kent get the best start in life[1] and a number of other strategic outcomes (Appendix 1.)

2.2 The National Institute for Health and Care Excellence (NICE) recommend that schools should be supported to adopt a comprehensive, 'whole school' approach to promoting the social and emotional wellbeing of children and young people. Good health and emotional wellbeing are closely linked to improved attendance and attainment at school, which in turn leads to improved outcomes into young adulthood and employment opportunities[2].

2.3 The service is an integral part of the Early Intervention and Prevention strand within Kent's Local Transformation [3](LTP) plan for Children, Young People and Young Adults' Emotional Wellbeing and Mental Health, supporting NHS Commissioners to meet key targets set by NHS England. These targets are to increase the proportion of children and young people with a diagnosable Mental Health condition who are able to access evidence-based treatment. Current national prevalence estimates suggest that 1 in 10 school-aged children has a diagnosable mental health condition.

3.0 What does the service provide?

3.1 The service facilitates a universal whole-school approach working with 98 schools (including Special Schools) to improve the health and wellbeing of 172,420 secondary school-aged children in Kent (11-18).

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

[2] Current national prevalence estimates suggest that 1 in 10 school-aged children (three in every class) has a diagnosable mental health condition (Green h, McGinnity A, Meltzer h et al. (2005) Mental Health of Children and Young People in Great Britain, 2004 Basingstoke: Palgrave Macmillan.)

[3] https://www.kent.gov.uk/about-the-council/strategies-and-policies/health-policies/transforming-health-and-social-care-in-kent-and-medway

3.2 The offer includes:

- A named school health service lead
- Developing District and School Public Health Plans
- Supporting the delivery of Personal, Social and Health Education (PSHE) including relationship and sex education
- Delivering training for school staff and governors on developing school health policies and managing health conditions
- Attending transition events
- Supporting sustainability of HeadStart Kent.

In addition, the service plays a key role in supporting schools to manage individual Health Plans for young people with ongoing health needs and/or long-term medical conditions and in the protection and safeguarding of children.

3.3 Referrals are made through the Single Point of Access (SPA) for universal, targeted and specialist services. The SPA undertakes daily multi-agency triage of the referrals which are accepted from: children and young people; parents or carers; schools, colleges and higher education institutes; other health care professionals or partner organisations; and voluntary agencies. A confidential texting service, ChatHealth, is also available for young people (by texting 07520 618850) to have a conversation with a nurse. The number is monitored by the School Health Service, Monday to Friday, 9am to 5pm.

3.4 The School Health Team provide individual health improvement through universal health assessments, signposting and interventions as set out as follows.

- **Assessment:** The service utilises the evidenced based Lancaster tool to provide a validated, systematic approach to assess health needs at key transition points. This includes details of any developmental delays, disabilities and long-standing illness and details of the support that is currently in place. Health assessments generate early Health Awareness Prevention and Intervention (HAPI) alerts which are triaged by School Nurses so to offer appropriate support to young people and their families.

- **Interventions:** The Team offer a range of drop-in clinics in schools, colleges and youth hubs providing information and advice to support young people with a focus on key transition points. Appendix 2 includes the School Health Service's service leaflets for young people – Moving to Secondary School and Leaving School.

Tier 1 Packages of Care are provided for young people referred via the Single Point of Access. These packages are person centred, flexible and support a preventative approach for: Emotional Health and Wellbeing, Sexual Health, Continence and Enuresis, Stop Smoking, Drug and Alcohol misuse, Complex Health Needs, Healthy Eating and Lifestyle, Behaviour Management, Domestic Abuse and Parenting. Young people are able to self-refer to the service.

Tier 2 consists of Targeted Emotional Health and Wellbeing support and is an

integral part of the service offer and forms part of the Emotional Wellbeing and Mental Health (EWMH) pathway across Kent. This intervention consists of up to 6 sessions of 1-1 counselling support based on the needs of the young person for those aged from 5 to 19 years of age.

- **Signposting:** The service signposts to local organisations that will provide additional support to the parent, carer and the young person e.g. METRO for sexual health and Addaction for substance misuse. Parents, carers and young people are also signposted to websites such as Change4life for additional information on healthy eating, HeadStart Kent Resilience Hub for emotional health and Kooth online counselling services.

4.0 How is it delivered in Kent?

4.1 Following a competitive procurement process, the contract was awarded to Kent Community Health NHS Foundation Trust (KCHFT) and runs from 1st April 2017 to 31st March 2022. There is the potential for the contract to be extended for a further 2 year period.

4.2 The multi skilled district workforce includes qualified nurses; school staff nurses; assistant practitioners; public health assistants; and an administration team. A dedicated outreach team works with those children and young people who are outside of mainstream education, for example, children who are home-schooled or educated through a pupil referral unit (PRU).

4.3 The Single Referral Point (SPA) provides a clear referral pathway between universal, (Tier 1) targeted (Tier 2) and specialist (Tier 3) CYP mental health service provision. This new integrated model for triaging emotional wellbeing and mental health needs is delivered by staff from both KCHFT and NELFT. This “no wrong front door” partnership approach was established to ensure that no young person can fall between services and that there is somewhere for everyone from universal support to specialist crisis level. In February 2019, the decision was made to move the daily triage of referrals to a multi-agency approach that is now undertaken inhouse within SPA. This is provided by clinicians from;

- KCHFT –Universal School Health Team (Tier 1)
- CHATTS (since February 2019 for daily triage) – Targeted Emotional Health and Wellbeing Service (Tier 2)
- North East London (NHS) Foundation Trust (NELFT) - Specialist Children and Young People Mental Health Services (CYPMHS) (Tier 3)

4.4 The Targeted Emotional Health service was initially subcontracted to CXK Limited (CXK) and was supported by KCHFT’s Child and Adult Talking Therapy Service (CHATTS). Since 1st February 2019 the service has been solely delivered by CHATTS. This change has been necessary to reduce wait times and ensure sufficient capacity to meet need going forward.

4.5 As part of the wider health pathway, school nursing teams work closely with:

- Specialist Community Nursing
- Community Paediatricians
- Community Health Nurses
- GPs
- Acute Trusts
- The Bladder and Bowel Service
- Integrated Children's Services including Early Help and HeadStart Kent.

5.0 What does good look like and how does Kent perform?

5.1 The Service redesign which followed the public consultation was based on the identified key areas for service improvement as outlined in Appendix 3. The Service has introduced all identified key changes during the first two years of contract which includes delivering a more visible and equitable service across Kent and increasing the proportion of children and young people with a diagnosable Mental Health condition who are able to access evidence-based treatment. (The Adolescent Health contract supports NHS Commissioners to meet this key target in Kent).

5.2 The Service performance is monitored by the public health commissioning team to ensure that it delivers against the expected outcomes. The KPI's and activity metrics include user satisfaction rates, uptake of the Lancaster screening tool, waiting times for access to interventions and numbers accessing tier 2 services. More information relating to these is set out below.

5.3 **Service user experience**: Has remained at a consistently high level and above the 95% target. Recent equity analysis illustrates that the service is serving high proportions of people in the most deprived areas of Kent. Over the long term, this will contribute to helping close the gap on health inequalities for young people. The service also collects regular feedback in the form of case studies (Appendix 4) and uses learning to improve services.

5.4 **Early identification of service user needs**: The service has created school and district-based health plans which draw on data from the Kent Public Health Observatory and the evidenced based Lancaster health needs assessment tool.

- The recent special educational needs and disabilities inspection reported that "school nurses use effective tools to measure the impact of their interventions".
- The uptake of health assessments in the first year (undertaken in September 2017) was low, however 100% of schools were offered the opportunity to complete the tool and it is worth noting that although the previous contract offered an element of health assessment screening, this was not fully accessed across all schools.
- Significant work has now been undertaken by KCHFT to increase engagement this year through the introduction of face to face sessions in schools. This has proved successful and increased uptake this year.
- The service is also exploring opportunities to use sponsored promotional activity on social media platforms such as Instagram and Snapchat and use alternative formats to support engagement.

5.5 **Engaging with and forming relationships with 98 Schools:** KCHFT support engagement in schools through a range of mechanisms set out in a comprehensive communications plan. This includes:

- Attendance at the Headteacher's briefings.
- Promotion through KELSI (online resource for education professionals in Kent) and bulletins.
- All secondary schools are offered the opportunity to have Health Days/market place events delivered by School Nurses throughout the school year.
- Individual schools are offered training tailored to areas identified and agreed as part of the development of the individual School Public Health Plan. In the 2017/18 academic year 55 Health Days/ market place events were delivered to schools.

5.6 **Universal offer of support to secondary age children, families and schools that offers choice of access and visibility (Appendix 5):** There has been an increase in contacts with parents, children and young people where information and advice has been given.

- Since April 2017, 12,141 referrals (universal and targeted) have been made to SPA and the average number of referrals has increased from 24 a day in 2017 to 30 a day in 2019.
- Between 1st September 2017 and 31st August 2018, 1261 Packages of Care were initiated including;
  - 62% (776) for Tier 1 Emotional Health and Wellbeing,
  - 9% (115) for Weight Management and
  - 9% (111) for Behaviour Support.
- The average wait time from referral to intervention for Tier 1 is 14 days which is below the NHS waiting time target of 18 weeks and within expected levels
- Approximately 140 confidential text messages are received and responded to each month by ChatHealth. The majority relate to emotional health, low mood, anxiety, stress and body image. The young people require support via messaging, and very few have taken up a face to face appointment offer.

5.7 **Provide a Targeted Emotional Health and Wellbeing Service - 5 to 18 years**

- All emotional health and wellbeing referrals are reviewed and allocated to the appropriate service within 1 working day of receipt of referral. KCHFT have a target of 1800 individual CYP to be seen over a 12-month period (financial year) to support delivery of access targets set by NHS England.
- KCHFT have exceeded this target with 2627 young people actively receiving a service between April 2018 and end March 2019. The agreed wait time for new cases is a maximum of twelve weeks, but the service has experienced challenges meeting this and has put in place a daily triage process and is recruiting extra staff to help reduce wait times.
- KCC have commenced a review of Tier 2 provision which should conclude in September 2019 and inform future arrangements. KCHFT,

KCC commissioners and CCG Commissioners are working together to identify further funding to increase provision and address unmet need and reduce wait times. This remains the priority for 2019/20.

5.8 **Schools and families are supported to manage individual Health Plans**: The service has extended provision to include a wider population to ensure equitable access, specifically for those who are not in school, are in Special Schools or are in alternative educational provision. Children with SEN-D and their families are given appropriate referrals, support and advice and are aware of the local offer. Between September 2017 and December 2018 Tier 1 Packages of Care were initiated for 137 young people with Long Term Conditions.

5.9 **Provides a responsive service focused on outcomes**: The Service has responded flexibly to support new priorities. For example, by embedding and sustaining learning from the HeadStart Kent programme. The service is leading the roll out of the Resilience Toolkit across Kent and is supporting schools to achieve a newly developed Resilient School Quality Mark. A copy of the resilience toolkit used by schools is available at https://www.headstartkent.org.uk/schools-and-practitioners/resilience-toolkit

6.0 How much does it cost?

6.1 The Partnership between KCC and KCHFT uses open book accounting to ensure KCC only pays for services delivered. Through this approach KCHFT transfers any identified savings into a pooled fund to support service improvements across all areas of Public Health. This arrangement covers School Health despite these services being delivered via a contract.

6.2 The total contract value is £8,364,268 (April 2017 – March 2022). The contract is structured to deliver year on year efficiency savings to ensure that the service remains affordable but still deliverable against outcomes. Efficiency savings of £522,678 were also identified as a result of both contracts being awarded to the same provider and related mainly to management and utility costs.

Contract Year	17/18 (1)	18/19 (2)	19/20 (3)	20/21 (4)	21/22 (5)	Service Total
	£1,781,738	£1,676,381	1,643,769.50	£1,604,959	1,657,420.50	£8,364,268

6.3 The PHE Spend and Outcomes Tool (SPOT) for local authorities4 can be used to determine if the contract offers KCC value for money. It highlights that Kent spends very slightly less than the national average for the non- prescribed 5-19 Children's services.

7.0 Risk and key improvements

7.1 Risks are monitored using a shared risk register with the service. Key risks for the service include staffing, engagement with schools, unmet demand for targeted emotional health and Brexit. Further detail is provided in Appendix 6

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

alongside a number of mitigations.

8.0 Conclusion

8.1 The Adolescent School Health Service has performed well in the majority of areas and exceed targets set for tier 2 mental health services. The service has introduced improved triage systems to support quick access and has reduced waiting times to be within the 14-day target.

8.2 The model continues to be refined so to respond to the needs of young people especially those requiring targeted emotional and mental health support and will look to expand use of technology.

8.3 KCC and KCHFT have taken a collaborative approach to develop a service action plan for 2019/20. Key priorities for the service include:

- Support whole system improvement for CYP MH in line with Kent's plan for transformation
- Increase the percentage of young people completing the Lancaster health assessments
- Further improve engagement with schools and support them to become a Resilient School (HeadStart Kent).

9.0 Recommendation

The Health Reform and Public Health Cabinet Committee is asked to **Comment** on and **Endorse** the progress made to transform services and ongoing activities to deliver continuous improvement.

10.0 Background Documents

10.1 10th November 2016 – Paper taken to CSCHCC for Key Decision and contract award

https://democracy.kent.gov.uk/documents/s72999/B1%20-%20School%20Public%20Health%20Services%20-%20contract%20awards.pdf

22nd March 2016 - Paper taken to Children's Social Care & Health Cabinet Committee (CSCHCC) on Emotional Health and Wellbeing Service
https://democracy.kent.gov.uk/mgCommitteeDetails.aspx?ID=830

11.1 Contact Details

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Appendix 1 – Strategic Outcomes:

Further information on the Healthy Child Programme 5-19 is available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/492086/HCP_5_to_19.pdf

KCC Strategic Statement:

Aims to ensure "Children and young people in Kent get the best start in life". Further information can be found at https://www.kent.gov.uk/__data/assets/pdf_file/0005/29786/Kent-County-Council-Strategic-Statement.pdf

Kent Children and Young People's Framework:

Aims to ensure Children and young people have good physical, mental and emotional health. Further information can be found at

https://www.kent.gov.uk/about-the-council/strategies-and-policies/childrens-social-work-and-families-policies/working-together-to-improve-outcomes

Kent Joint Health and Wellbeing Strategy:

Every child has the best start in life

Supporting outcomes:

- A reduction in the proportion of 4-5-year olds with excess weight
- A reduction in the proportion of 10-11-year olds with excess weight

https://www.kent.gov.uk/about-the-council/strategies-and-policies/health-policies/joint-health-and-wellbeing-strategy

Kent's Local Transformation Plan for Children, Young People and Young Adult's Emotional Wellbeing and Mental Health:

Early intervention and prevention – put in place Kent-wide adolescent targeted support offer and risk-taking behaviours programme delivered in schools.

Supporting outcomes:

- Increasing investment in early intervention and prevention interventions
- Reducing inequality in access rates across Kent
- Identifying and providing support for those children and young people at greatest risk

https://www.kent.gov.uk/about-the-council/strategies-and-policies/health-policies/transforming-health-and-social-care-in-kent-and-medway

"The Way Ahead" - Kent's Emotional Wellbeing Strategy for Children, Young People and Young Adults:

- Early Help: Children, young people and young adults have improved emotional resilience and where necessary receive early support to prevent problems getting worse
- Access: Children, young people and young adults who need additional help receive timely, accessible and effective support
- Whole Family Approaches: Children, young people and young adults receive support that recognises and strengthens their wider family relationships
- Recovery and Transition: Children, young people and young adults receive support that promotes recovery, and they are prepared for and experience positive transitions between services (including transition to adult services) and at the end of interventions.

https://www.kent.gov.uk/about-the-council/strategies-and-policies/health-policies/emotional-wellbeing-strategy

"Future in Mind" – NHS England and Department of Health, 2015

- To increase the proportion of children and young people with a diagnosable Mental Health condition who are able to access evidence-based treatment

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Public Health Outcomes Framework (PHOF) February 2018

- 1.01ii Children in low income families (under 16's)
- 1.05 16-17-year olds not in education, employment or training (NEET) or whose activity is not known – current method
- 2.04 Under 18 conceptions
- 2.07ii Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)
- 2.09i Smoking prevalence at age 15 – current smokers
- 2.10i Emergency Hospital Admissions for Intentional Self-Harm

https://www.gov.uk/government/statistics/public-health-outcomes-framework-february-2018-data-update

Appendix 2 – Example School Health Service Leaflets

Contact us

You can get in touch with us at any time, even during the holidays. You can text us too. Ask us for more information.

Phone 0300 123 4496

Email nem-tr.kentchildrenand youngpeoplehealthservices@nhs.net

Web www.kentcht.nhs.uk/schoolhealthh

Who's in the team

Our team consists of school nurses, school staff nurses, school nurse assistants and secretarial support.

All school nurses are qualified nurses, with specialist training in public health.

Do you have feedback about our health services?

Phone: 0300 123 1807, 8am to 5pm, Monday to Friday
Text: 07899 903499
Email: kentchft.PALS@nhs.net
Web: www.kentcht.nhs.uk/PALS

Patient Advice and Liaison Service (PALS)
Kent Community Health NHS Foundation Trust
Unit J, Concept Court
Shearway Business Park
Folkestone
Kent CT19 4RJ

If you need communication support or this leaflet in another format, please ask a member of staff or contact us.

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Leaflet code: 01020 Published: March 2017 Expires: March 2020

NHS
Kent Community Health
NHS Foundation Trust

Moving to secondary school

Your school nurse is still on hand to help

School Health Service

Age 11+

Moving schools can be exciting. There are a lot of things to think about: What will happen on the first day? What do I need to pack in my school bag? Will I make new friends? How much homework will I have? How do I get the bus by myself?

Don't bottle your feelings up – it's ok to be happy, anxious, excited, worried, nervous and confused, all at the same time!

If you want to talk to someone, your school nurse is there to help. They will listen to what you say and help you. Everything is confidential, which means they won't tell anyone else what you say (not even your parents), unless they think you or someone else is in danger.

What is a school nurse?

A school nurse is someone who promotes good health and wellbeing in school age children and young people.

Will I still get to see my school nurse once I start secondary school?

Yes, they are not going anywhere. They will still be there to support you with anything you need, so if life (or homework) is getting on top of you, make sure you tell them.

It's important to be happy and healthy so don't get caught up or worry about what your friends are or aren't doing. You'll be super busy at school so you need to make sure you have enough energy to get through the day. Make sure you eat a good breakfast and drink plenty of water too.

They also want to know how you're feeling – what's going on with your friends? What have you been up to?

I don't want to see the school nurse...

That's ok. The school nurse will be there to help until you are 19 so when you are ready, go and find them.

Why do I need to see the school nurse?

You can still see your school nurse whenever you like. Just go and find them for a chat. They can help with:

- making friends or problems with people at school
- bullying problems
- worries about weight and how you look
- healthy eating and eating problems
- worries and troubles – including changing schools
- puberty and growing up
- sexual health
- relationship advice
- smoking, drugs and alcohol
- other health problems, including long-term conditions
- and give advice about immunisations (injections)
- anything else you want to chat about.

I can't find my school nurse, I've looked everywhere... help!

School nurses see people at lots of schools so they might not be at your school all the time. That doesn't mean we don't want to see you too, so if you need us, just get in touch or ask your teacher to contact us.

Once we know you need help we can have a chat and if you want to, meet up – even during the school holidays!

What do I do if I feel sick at secondary school?

Speak to your teacher if you feel poorly or if you need help for something like a headache or blister.

If you want to talk to someone your school nurse is there to help.

Contact us

You can get in touch with us at any time, even during the holidays. You can text us too. Ask us for more information.

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Patient Advice and Liaison Service (PALS)
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Leaflet code: 01021 Published: March 2017 Expires: March 2020

NHS
Kent Community Health
NHS Foundation Trust

Leaving school

Don't worry your school nurse is still around

School Health Service

Age 15+

Now you're in year 11 it's almost time to say goodbye. You might be leaving to take up an apprenticeship, go to college or staying on at school.

Exams are a really stressful time, there is so much pressure and everyone wants you to do well. It's all people are talking about… are you revising? What subjects are you doing? Have you done all your homework?

Don't bottle your feelings up and let everything get on top of you. If you want to talk to someone, your school nurse is there to help. They will listen to what you say and help you. Everything is confidential, which means they won't tell anyone else what you say (not even your parents), unless they think you or someone else is in danger.

WHAT IS A SCHOOL NURSE?

A school nurse is someone who promotes good health and wellbeing in school age children and young people.

WHY DO I NEED TO SEE THE SCHOOL NURSE?

You can see your school nurse whenever you like though. Just go and find them for a chat.

They can help with:

- worries about weight and how you look
- healthy eating and eating problems
- worries and troubles – exams, problems at home or with friends and anxiety about going to college or university
- bullying problems
- sexual health
- relationship advice
- smoking, drugs and alcohol
- other health problems, including long-term conditions
- anything else you want to chat about.

If you want to talk to someone your school nurse is there to help.

HOW DO I FIND MY SCHOOL NURSE?

School nurses see people at lots of schools so they might not be at your school all the time. That doesn't mean we don't want to see you too, so if you need us, just get in touch or ask your teacher to contact us.

Once we know you need help we can have a chat and if you want to, meet up – even during the school holidays!

WHAT HAPPENS WHEN I FINISH YEAR 11?

We are here to help until you are 19 so you can contact us at any time for support and advice. We can chat on the phone, by email or text and even meet up if you need help.

Appendix 3 – Service Redesign 2016: Identified areas for service improvement

Following a detailed review of the School Nursing Service, which included a Public Consultation, the Children's Social Care and Health Cabinet Committee in January 2016 endorsed a new approach to the commissioning of School Public Health Services.

The approach included a move from a single contract (5 to 18 years) to two contracts, Primary School Public Health (5-11years) and Adolescent School Public Health (11-18 years) alongside the inclusion of targeted Tier 2 emotional health and wellbeing services for 5- 18-year olds in the Adolescent School Public Health Service.

Key changes:
Joint procurement with CCG's
Development of a single point of access where all referrals for Universal, Targeted, or Specialist provision go through a Single Point of Access (SPA) to ensure a no wrong front door approach to children and young people's emotional and mental health.
Increased focus on emotional health and wellbeing including roll out of the resilience toolkit developed as part of Headstart
Clearly defined packages of care e.g. bedwetting, long term conditions and new package of care around healthy lifestyles
Increased visibility e.g. named school nurse, uniform, school drops ins
Increased offer to include special schools and those not in mainstream school e.g. outreach team working with PRUs
Lancaster model to support early identification of need at key transition points This includes details of any developmental delays, disabilities and long-standing illness and whether support is currently in place.
Skill mix workforce to support reduction in vacancy rates with comprehensive training
Innovative ways to support engagement e.g. therapy dogs
Increased digital offer including a live chat service and improved website
Partnership focus with schools and other key agencies such as NELFT, early help and Headstart
Increased consistency and equity of across Kent e.g. vision screening now offered across Kent (previously only East Kent)

Appendix 4 – Service Case studies on improving outcomes

Case Study 1

Definition: *Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems that are studied holistically by one or more method*

Case studies one and two are written from the perspective of the school nurse.

Background Context	**School health referral received from school requesting support for 16-year-old male due to low mood and poor attendance.**
Intervention Action Taken	**This took place over two appointments instead of one: Young person met in school at his request. Discussed referral and discussed role of school nurse. Listening visit offered - during the initial appointment he discussed how he has been feeling and life events that have left him feeling low. Discussed strategies that might be beneficial in managing feelings and a health care plan was agreed – the young person had previously accessed their GP for support and was told to return if no improvement. The young person was reluctant to do this due to difficulties getting an appointment in the first place and also because he felt that he would be wasting the GP's time. Reassurance offered and clarified that reasons were valid for the appointment and that he was following the GP's advice by returning.**
Results Outcome Impact	**The young person stated that this was the first time he had been able to talk about his feelings. I was concerned that the interruption of the appointment would prevent the student from engaging at the follow up appointment due to the abrupt ending of the first appointment.** **Another appointment was arranged for the next working day and a brief action plan was put in place for the weekend. Details of School health's texting service and Kooth on-line counselling shared with student.** **The situation did not stop the student from engaging with school health at the next appointment. The health assessment was completed, and a clear action plan was put in place.**
Patient Experience	**The young person reported that they found the appointment beneficial as they stated that they had difficulties talking about their emotions and found it difficult to talk to their family. They felt reassured that it was appropriate to be further assessed by their GP.**

Case Study 2

Background Context	Referral received for a 17-year-old young person who attends a Special School in Kent for advice & support around toileting. On contacting the Parent who had **not** given consent I was soon to establish that Parent would not consent to this. Parent informed me that the young person had weakened Bladder & Bowel Muscles & had been informed by a Paediatrician that it would be very unlikely for this young person to ever achieve continence. I fed back to the referrer who was disappointed on young person's behalf & stated that the Young person had voiced themselves that they would like to be dry. I advised referrer to go back to Parent to discuss & if consent was obtained, I would gladly work with the young person, family & school. A further referral was received with Parental consent.
Intervention Action Taken	Initial meeting took place in school, present were Parent, Class Teacher, Referrer HCA From School & myself. Parent did show some resistance into establishing a toilet programme that could be followed both at home & school ensuring a consistent approach for the young person. School were very motivated & working collaboratively Parent agreed to try at home. Tier 1 Bladder Training Advice given & a programme agreed. It was also agreed to contact the Children's Continence Product Team to change day products to a pull up which would aid in the toileting process A request was put in & the change authorised. Following the meeting I met with the young person & the Teacher & Teaching Assistant I showed them an app, a social story of a young person who wished to become continent. This young person's enthusiasm was contagious, they clearly stated that they would like to become dry, they did not like the fact that they had to wear products & that they were bulky & visible to others Throughout the social story I stopped the app to discuss what was occurring which they clearly understood & could recognise that the young person needed to void or open their bowels. Pull ups have now been obtained for this young person, school have now taken a further step & during school time they are now wearing underwear The young person is toileted at regular intervals & is happy to sit on the toilet having had occasional success. A follow up meeting has been arranged for Mid-March.
Results Outcome Impact	Should this young person achieve continence it will have a huge positive impact on them for their independence & self-esteem & to protect their vulnerability in the future.
Patient Experience	The voice of the young person was listened too, advocated by school staff, who persisted to obtain support & completed two referrals for support for this young person in this sensitive matter.

Lessons Learned	To always put the best interests of the young person first, that Parents may not always agree that a successful outcome can be achieved but it is worth trying for that young person & if not completely successful in the end we have at least tried & given her the best advice & support that we can.

Case Study 3

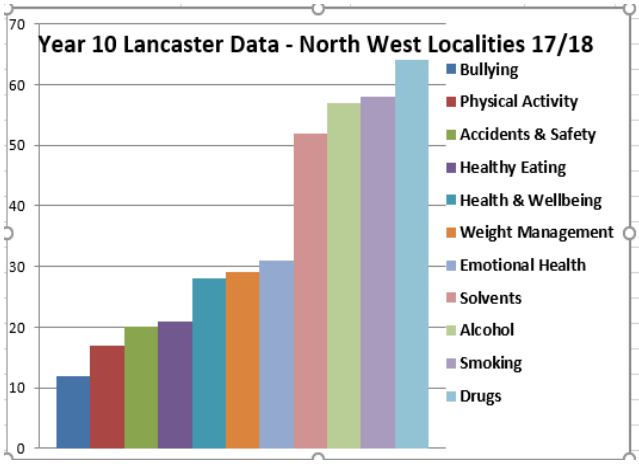
Definition: *Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems that are studied holistically by one or more method*

Background Context	Referral process for young person in Year 9 – parent had expressed worries regarding young person's emotional health and suicidal thoughts had been mentioned by young person. Previous referral from GP to CYPMHS had been declined and advised to contact Early Help. Early Help had declined referral and parent advised to self-refer to School Health
Intervention Action Taken	School Health referral triaged through SPA by Clinician. Clinician identified that the "voice of the child" was not present through any referral and no-one had asked young person what they wanted. Clinician spoke with young person and assessed that a Tier 2 Targeted intervention (counselling) would be suitable for the young person. Young person was also signposted to online resources for emotional health while waiting for counselling to begin.
Results Outcome Impact	Following discussion with young person it was agreed that young person did not require Tier 3 Specialist provision at that stage. Young Person accessed Tier 2 provision. Clinician was able to successfully determine the appropriate support for the young person quickly.
Patient Experience	Parent and young person were happy with the intervention
Lessons Learned	The voice of the child is paramount to determine and assess the correct and most appropriate intervention and support. The triage of referrals within SPA is essential to make sure that children and young people access the right provision first time and not get passed around but also that a clinician ensures any assessment includes the voice of the child/young person.

Appendix 5 – Analysis of Year 10 Health Assessments

In 2017/18 784 HAPI alerts were generated. At 1st March 2019 893 HAPI alerts had been generated. This assessment is currently open and will close at the end of the school year.

Question	September 2017 to August 2018			September 2018 to August 2019 (at February 2019)		
	Requested info (answered "Yes")	Requested info (answered "No")	Not answered	Requested info (answered "Yes")	Requested info (answered "No")	Not answered
Health & Wellbeing	54	213	< 5	71	217	< 5
Accidents & Safety	31	234	< 5	37	256	< 5
Emotional Health	58	204	11	77	216	< 5
Healthy Eating	32	231	11	42	250	< 5
Physical Activity	34	229	7	34	260	< 5
Bullying	30	245	< 5	31	261	< 5
Weight Management	52	213	10	44	249	< 5
Alcohol	109	138	19	132	158	5
Smoking	140	120	13	136	143	14
Drugs	141	114	18	154	124	17
Solvents	113	138	19	133	143	19
TOTAL	**784**	**2095**	**91**	**891**	**2277**	**78**



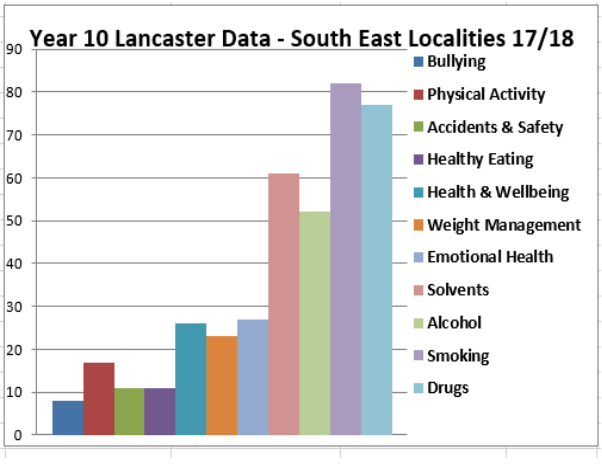


Table 2 – Tier 1 Packages of Care

	1st Sept'17 – 31st Aug 18	1st Sept 18 – 1st Dec'18
No. of new packages of care started – Total	**1261**	**264**
No. of new packages of care started - Substance misuse	**9**	**<5**
No. of new packages of care started – Sexual Health	16	< 5
No. of new packages of care started - Domestic abuse	8	<5
No. of new packages of care started - Behaviour support	111	24
No. of new packages of care started - Tier 1 Enuresis Advice & Information	47	< 10
No. of new packages of care started - Weight management inc Change for life	115	19
No. of new packages of care started – Tier 1 Emotional Health and wellbeing	776	151
No. of new packages of care started - Parenting	45	12
No. of new packages of care started - Smoking	<5	<5
No. of new packages of care started - Long Term Conditions	99	38
No. of new packages of care started – Continence	33	< 5

Appendix 6 – Key Risks

Risk	Mitigating Actions
Staffing – It can be a challenge to recruit staff with the required skills to ensure full staffing levels across the country.	• KCHFT have a robust staff retention policy which offers a number of benefits to staff. In addition, they proactively advertise and offer relocation fees and flexible working. • KCHFT are actively recruiting to vacant posts for both clinical and non-clinical appointments.
Engagement with schools	• Communications and marketing strategy • Updated offer on website • Revised school partnership agreement • Increased support in schools for health assessments • KCHFT have worked with schools to nominate a school lead • Termly newsletters are on KELSI to keep schools informed of service activity and developments • KCHFT are attending Head Teacher briefings during Spring Term alongside NELFT to ensure joined up approach to communication with schools
Unmet demand for Tier 2 Targeted Emotional Health service	• Discussions with CCG commissioners are in place to identify additional funding through Transformation Fund. • KCHFT have identified and costed for additional capacity within CHATTS to provide extra capacity • Establishment of daily multi-agency triaging of all referrals to ensure no wrong front door approach in place and quick access and prioritisation • KCC are currently undertaking a review of Tier 2 provision
Brexit – impact on business continuity	• KCHFT have a business continuity plan in place where any identified risks to service delivery have had mitigations put in place to ensure services to schools is able to be delivered across the county e.g. Staff based in district localities and not area based to allow flexible working and easier travel across the county. KCC will monitor this
Partnership relationship with NELFT – impact on Single Referral Point	• MOA is in place between NELFT and KCHFT to ensure that both organisations work towards joint strategic outcomes. • KCHFT and NELFT are currently reviewing and refining this document o to include operational arrangements

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

10 May 2019

Subject: **Health Inequalities and Place-Based Public Health**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

Health inequalities are widening and continue to be a concern, both nationally and locally.

This paper discusses recent work on health inequalities and plans to develop a new strategy to address health inequalities in Kent County, incorporating a new health inequalities framework which is due to be published by Public Health England in the near future.

The paper also covers the recent NHS Long Term Plan publication and highlights that reducing health inequalities is one of the key themes of the report and will help to ensure that the emerging Integrated Health and Care system will systematically focus on reducing health inequalities together with improving and protecting the health of the Kent population.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **Comment on and Endorse** the contents of the report.

1. Background

1.1 Local Authorities along with Clinical Commissioning Groups (CCGS) have a duty to work to reduce health inequalities. Kent County Council Public Health published the Mind The Gap Analytical Report in 2016 and a workplan to address health inequalities.

Unfortunately, there has been limited progress addressing health inequalities in the last 10 years both nationally and locally, in part due to the global financial crisis.

Local authorities working in conjunction with the broader health and care system

are well placed to address health inequalities through partnership working and this report explores some of the areas of work that Kent Public Health are involved in and that are being considered for action following a refresh of the Mind the Gap report and ongoing work with colleagues in Kent County Council, District Councils and the NHS.

2.0 Introduction

2.1 Health inequalities are avoidable differences in the health and wellbeing of individuals due to factors such as where they live and whether they have good quality employment.

2.2 The gap in life expectancy between the most and least deprived areas of England is 9.5 years for males and 7.4 years for females (PHE Health Profile 2014-2016). There is also a 19 year-gap in healthy life expectancy between the most and least deprived parts of England. These health inequalities are unfair and avoidable. They cut people's lives short and cost the NHS, social care and our national and local economies billions of pounds.

What is worse is that these gaps have widened since 2010-12 particularly for women.

2.3 While mortality rates in Kent have been falling over the past decade, the 'gap' in mortality between the most deprived and least deprived Lower Super Output deciles has persisted with the most deprived cluster of LSOAs experiencing an additional 400 deaths per 100,000 population per year on average.

Data on Kent health inequalities can be found in the refreshed Mind the Gap report which is appended.

2.4 Steep inequality gradients are also evident across many health and social indicators in Kent. On many measures the most deprived deciles fare disproportionately worse than their more affluent counterparts (i.e. there is a non-linear relationship with deprivation). For example, alcohol-related premature mortality more than five times higher in the most deprived decile than the most affluent decile.

2.5 There is a requirement for focused and sustained partnership action to stop the decline in the wider determinants of health and improve well-being and extend healthy life for our population.

We must, however, be mindful that there are few 'quick wins' when addressing health inequalities. The results of current interventions may only become evident long after the prevention programme began. For instance, the adverse effects of smoking can be broken down into immediate, intermediate and long-term outcomes. Some of the long-term impacts may include Cancer (colorectal, liver, lung, bladder, laryngeal, oral, and pharynx) which may manifest themselves decades after smoking in the individual was first started.

2.6 Health inequalities are complex and are caused by a mixture of environmental and social factors in a particular area or place. This has led to a drive for place-

based approaches to public health such as the Healthy New Towns programme and to a joined-up place-based approach to addressing health inequalities, working with many partners including public health leaders, the emerging new NHS structures such as the ICS and district and county councils.

The recent publication of the NHS Long Term Plan has, for the first time, put reducing health inequalities at the heart of the delivery of NHS services. The plan highlights not only highlights the key preventative strategies such as reducing smoking prevalence, reducing obesity prevalence, and excessive alcohol consumption, improving air pollution and addressing antimicrobial resistance, but also recognises the targeted of funding to areas of higher need, improved maternity outcomes for the most vulnerable mothers, targeted action on physical health for those people with severe mental health illness, a focus on people with learning disability, a focus on rough sleepers particularly with mental health services, and support people with more health service support who are carers.

3.0 What should we be doing?

3.1 It is currently not possible to compare the scale of impact of the different wider determinants on people's health due to their delayed effects and the long period of time for illnesses to develop. However, Michael Marmot developed a prioritised list for areas of action.

These include:

1. Best start in life - e.g. reducing infant mortality

2. Maximizing capabilities through skills and education over the lifecourse – e.g. improving educational attainment and resilience

3. Good employment – e.g. developing careers and good quality jobs

4. Healthy standard of living - e.g. reducing child poverty, improving access to healthy foods

5. Sustainable places and communities (including housing) – e.g. developing proper communities rather than dormitory towns, reducing overcrowding and improving access to green spaces for leisure

6. Prevention – e.g. lifestyle modification, targeted smoking cessation, better access to good quality clinical care

In addition, there might be advantages to using behavioural insights/behavioural economics in designing interventions. There is little evidence of outcomes in public health work at present, but it is an emerging area.

4.0 What are we already doing?

4.1 We already work with partners on health improvement and have strived to ensure that the most deprived areas of Kent are prioritised. This has included our work on One You and the Health Living Centres. We have also contributed to the costs of Kent Children's Centres to contribute to the early years agenda.

4.2 There have been targeted campaigns to reduce smoking in many parts of the County. These include assisting local hospitals to become Smoke Free, work to make school gates Smoke Free and the use of behavioural insights to develop campaigns for deprived areas aimed at pregnant women and encouraging them to give up smoking before they give birth (What the Bump? Campaign).

4.3 This are already plan in Kent to use a new partnership approach across the Council to align exiting local resources to effect change at a local level. This is not just about reducing existing health inequalities, but includes a focus on the protective factors that prevent these health inequalities.

4.4 There is a well-developed work plan for the prevention workstream of the Sustainability and Transformation Plan (STP). This is being progressed across Kent and Medway and includes areas such as smoking cessation, increasing physical activity, tackling anti-microbial resistance and cancer screening.

We have worked with all our District Councils on a health in all policies approach and continue to work with them on specific projects such as One You Kent.

5.0 Conclusions and Next Steps

5.1 It has proved difficult in times of austerity to tackle health inequalities. We now anticipate the publication of the new Joint Strategic Framework for addressing health inequalities to be published by Public Health England (PHE).

5.2 It is proposed to use this framework to develop a data led and evidence-based new Council-wide strategy and work plan to tackle health inequalities, pulling together the joint strategic framework, the work of the STP prevention workstream, the NHS Long-Term Plan and the Healthy New Towns Programme.

6.0 Recommendation

6.1 The Health Reform and Public Health Cabinet Committee is asked to **Comment on and Endorse** the contents of the report.

7.0 Background Documents

7.1 Davies SC. Annual Report of the Chief Medical Officer 2018 - Health 2040 – Better Health Within Reach. Department of Health and Social Care; 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767549/Annual_report_of_the_Chief_Medical_Officer_2018_-_health_2040_-_better_health_within_reach.pdf

7.2 Public Health England. Kent Health Profile for England 2018

https://democracy.kent.gov.uk/ecCatDisplay.aspx?sch=doc&cat=14815

7.3 Mind the gap 2016 – Analytical Report

https://democracy.kent.gov.uk/ecCatDisplay.aspx?sch=doc&cat=14815

8.0 Contact Details

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

10 May 2019

Subject: **Green Spaces and Physical Exercise**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: Being physically active is important for physical health, mental health and wellbeing. Regular physical activity can safeguard against some of the diseases that are currently on the increase and which are affecting people at an earlier age, for example cancer, diabetes, obesity, hypertension and depression.

Getting everybody active every day requires spaces – indoors and outdoors – that make daily physical activity the easy, efficient and cost-effective choice for all regardless of age, disability and other personal characteristics.

There is evidence that the use of green spaces for activity has additional benefits in terms of feelings of wellbeing and there is much work across Kent County Council to encourage activity and the use of green spaces for physical activity.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **Comment on and Endorse** the contents of the report

1. Background.

1.1 Being physically active is important for physical health, mental health and wellbeing. Regular physical activity can safeguard against some of the diseases that are currently on the increase and which are affecting people at an earlier age, for example cancer, diabetes, obesity, hypertension and depression.

Persuading inactive people (less than 30 minutes exercise per week) to become more active could prevent one in ten cases of stroke and heart disease in the UK.

2.0 Introduction

2.1 Our population is around 20% less active than it was in the 1960s and if this trend continues, we will be 35% less active by 2030. Physical inactivity is associated with increased risk of cardiovascular disease and other causes of mortality and ill-health such as Type 2 Diabetes. Inactivity is estimated to be responsible for one in six deaths in the UK and to cost the NHS £0.9 billion and the UK economy £7.4 billion.

Data on physical activity in Kent can be found in Appendices 1 and 2.

2.2 A review of evidence, including a return-on-investment analysis demonstrated the economic benefits of investing in physical activity. This has demonstrated that there are not only economic benefits in terms of health (both physical and mental), but also wider social benefits such as social care, regeneration, travel and transport, business and economic productivity, crime and education.

2.3 New evidence is emerging around the dangers of sedentary behaviour (sitting down for long periods time). An Expert Working Group set up for the Chief Medical Officer to assess the evidence found that there is strong evidence of a significant relationship between the greater time spent in sedentary behaviour and all-cause and cardiovascular mortality rates and cardiovascular incidents (e.g. stroke). A dose-response curve was seen - this means the more the sedentary behaviour, the higher the risk.

2.4 There was also strong evidence of a significant relationship between sedentary behaviour and a higher risk of type 2 diabetes, although there was not as clear a dose-response curve.

2.5 The evidence review found moderate evidence of a link between sedentary behaviour and some cancers, but limited evidence of a link between sedentary behaviour and overweight.

3.0 Physical Activity and Green Spaces

3.1 Green spaces include natural or semi-natural areas in, or near, urban areas that are at least partially covered by vegetation. These include parks, woodland, allotments and recreation spaces. 82% of the UK population now lives in urban areas and only half of the people in England live within 300M of a green space and this is under threat from the expansion of urban infrastructure.

3.2 There are no clear physical health benefits to outdoor activity compared to indoor activity, but a link has been found between people's physical environment and their activity, i.e. we know that levels of physical activity are higher in areas with more green space and that those living closer to a green space are more likely to use it and will use it more frequently.

This needs to be interpreted cautiously though: Often those areas closer to green spaces are more sought after and attract higher-income families. Those people using the green space may have actually chosen to live closer precisely so that they can use the space.

3.3 Low-income areas are associated with poorer health outcomes, but also lower quality housing and education, poor diet, and less access to good quality green space. A recent study suggested that in the most deprived groups mortality was halved in areas with the greenest space.

3.4 The mechanisms for the benefits from green infrastructure are not fully understood. We know that there are some physical benefits, such as improved air quality, lower noise pollution and reduced risk of flooding, but there is emerging evidence that the use of green space in promoting social cohesion (people from different social backgrounds interacting) has benefits for the individual such as reducing stress and depression.

3.5 Research has demonstrated that people who exercise outdoors report higher feelings of wellbeing and lower feelings of stress or anxiety that those doing the same activity

indoors.

3.6 The way land is used in communities has an immense impact on the public's health. Although it is the quality and not just the quantity of public parks and spaces that encourages people to be active, evidence shows just having ease of access to open space makes a crucial difference. Building more physical activity into daily routines – the commute, walking the dog, the journey to the shops, school or workplace – involves creating the kinds of environments that support active living

4.0 Current Programmes

4.1 Kent County Council currently promotes a range of services, programmes and campaigns that aim to encourage people to be more active. One You Kent and Explore Kent are just some examples of local authority led campaigns that aim to support people to find an activity that they want to do and encourage them to make it a regular part of their lives.

4.2 Kent County Council has a Sport and Physical Activity Services, which is a small service aiming to promote involvement in a wide range of physical activity opportunities, including sport. The service has combined it limited resources with those from Sport England and acts as the County Sports Partnership for Kent (Kent Sport). The current focus is on encouraging the least active and under-represented groups to become more active.

4.3 Explore Kent works alongside Kent Sport and other countryside operators and organisations to promote outdoor activities. These include projects such as physical activity sessions for people living with early onset dementia; Active at Work, a workplace health programme helping people build activity into their day using e.g. fitness trackers, and the Kent School Games.

4.4 Another project is Walk to Win, which used Mosaic to target people living in areas of deprivation in Thanet with a multimedia campaign of radio adverts, print and bus posters. People were encouraged to take regular health exercise accessing the coast and countryside around them and 2,500 people collected free pedometers and 600 people took up the Walk to Win challenge.

4.5 Social media channels are increasingly being used by sector partners to reach their target audience and promote physical activity and their own services. Kent County Council promotes national campaigns such as One You, Change 4 Life and Couch to 5k in addition to their own local campaigns.

5.0 Conclusions and Next Steps

5.1 Getting everybody active every day requires spaces – indoors and outdoors – that makes daily physical activity the easy, efficient and cost-effective choice for all regardless of age, disability and other personal characteristics.

5.2 There is much work to be done to encourage the residents of Kent to use the green spaces available to them in the County for physical activity. Doing so will reduce health inequalities and prevent long-term conditions in the County.

5.3 The promotion of physical activity needs to be targeted to those that stand to gain the most from moving more. Public Health England data suggest that 20% of Kent residents are sedentary and it is these individuals, who do less than 30 minutes of activity per week, that should be the primary target audience of new promotions.

5.4 Kent Public Health team is working with the NHS Healthy New Towns Programme to embed learning from the programme on community development and working with planners to make new developments, such as Chilmington Green and Otterpool healthier places to live.

6.0 Recommendation

6.1 The Health Reform and Public Health Cabinet Committee is asked to **Comment on and Endorse** the contents of the report.

7.0 Background Documents

7.1 https://researchbriefings.files.parliament.uk/documents/POST-PN-0538/POST-PN-0538.pdf

7.2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

8.0 Contact Details

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Appendix 1 – Physical Activity Indicators South East England

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

Compared with benchmark: Better | Similar | Worse | Not compared

Quintiles: Best | | | | Worst | Not applicable

Indicator	Period	England	South East region	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
Percentage of physically active adults - current method	2016/17	66.0	68.9	72.2	78.0	69.6	66.8	69.9	68.1	67.8	65.8	64.1	70.1	66.6	68.7	54.7	65.2	70.3	73.6	68.3	70.7	71.2
Percentage of physically inactive adults - current method	2016/17	22.2	19.3	14.9	12.4	17.5	21.5	17.9	21.7	20.0	22.5	21.6	18.6	22.5	17.2	33.3	24.2	18.6	16.3	19.3	16.7	17.3
Percentage of adults walking for travel at least three days per week	2016/17	22.9	22.1	17.2	36.7	19.6	19.3	20.2	18.3	22.3	20.4	20.0	24.6	29.1	27.5	18.2	29.1	22.2	17.0	21.2	18.7	21.9
Percentage of adults cycling for travel at least three days per week	2016/17	3.3	3.5	2.4	5.1	1.8	2.1	3.8	3.7	2.4	1.4	2.1	8.3	5.6	5.4	2.0	7.1	3.2	1.8	2.4	3.2	3.2
Percentage of 15 year olds physically active for at least one hour per day seven days a week	2014/15	13.9	14.8	14.8	15.8	14.1	15.3	14.8	15.8	13.7	13.4	16.2	15.9	14.1	15.6	13.5	12.5	15.3	15.2	15.1	18.3	15.5
Percentage of 15 year olds with a mean daily sedentary time in the last week over 7 hours per day	2014/15	70.1	67.8	68.6	67.9	60.8	69.0	68.6	73.1	69.7	76.3	70.7	63.5	73.3	71.0	68.5	74.1	62.8	66.1	70.3	58.7	62.9
Percentage of physically active adults - historical method	2015	57.0	60.2	63.8	68.4	62.8	58.7	60.9	55.9	59.0	53.3	56.3	60.9	60.5	59.3	49.8	54.2	62.0	62.6	60.2	61.3	63.9
Percentage of physically inactive adults - historical method	2015	28.7	25.1	20.3	19.2	22.0	26.6	24.7	28.3	26.7	29.4	27.3	23.4	25.7	29.7	31.1	33.2	22.9	24.4	25.6	22.3	21.0
Percentage of adults doing 30-149 minutes physical activity per week -historical method	2015	14.3	14.7	16.0	12.3	15.2	14.7	14.4	15.9	14.3	17.3	16.5	15.7	13.8	11.1	19.0	12.6	15.1	13.1	14.2	16.4	15.1
Percentage of adults who do any walking, at least five times per week	2014/15	50.6	49.9	43.6	51.7	49.1	51.7	48.7	52.6	49.9	46.3	47.7	51.6	54.8	53.6	48.0	53.1	49.8	49.7	49.8	46.1	46.5
Percentage of adults who do any walking, at least once per week	2014/15	80.6	81.7	82.9	83.3	83.1	82.1	81.5	82.4	81.1	77.6	79.4	84.3	83.6	80.3	75.8	79.0	82.5	82.5	81.0	86.1	82.2
Percentage of adults who do any cycling, at least three times per week.	2014/15	4.4	4.9	6.2	5.7	3.1	2.5	5.5	3.5	3.0	2.8	4.2	8.9	10.9	6.2	5.0	4.8	4.8	5.3	5.2	3.7	7.9
Percentage of adults who do any cycling, at least once per month	2014/15	14.7	16.8	19.4	14.5	14.5	13.5	19.0	14.1	13.5	9.8	15.4	26.1	20.4	16.3	12.5	12.4	17.5	19.0	17.5	14.6	23.3
Access to woodland	2015	16.8	-	47.0	12.3	25.0	20.9	23.5	15.6	12.0	35.5	18.3	6.8	3.5	25.8	7.6	61.9	25.3	13.3	16.7	12.7	19.3
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	17.9	18.2	*	18.3	17.4	15.7	16.8	19.4	18.7	17.2	13.5	24.4	16.2	14.8*	16.8	16.2*	20.5	17.4	20.3	5.1*	*

Physical Activity Indicators - CIPFA Nearest neighbours

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

Compared with benchmark: Better | Similar | Worse | Not compared

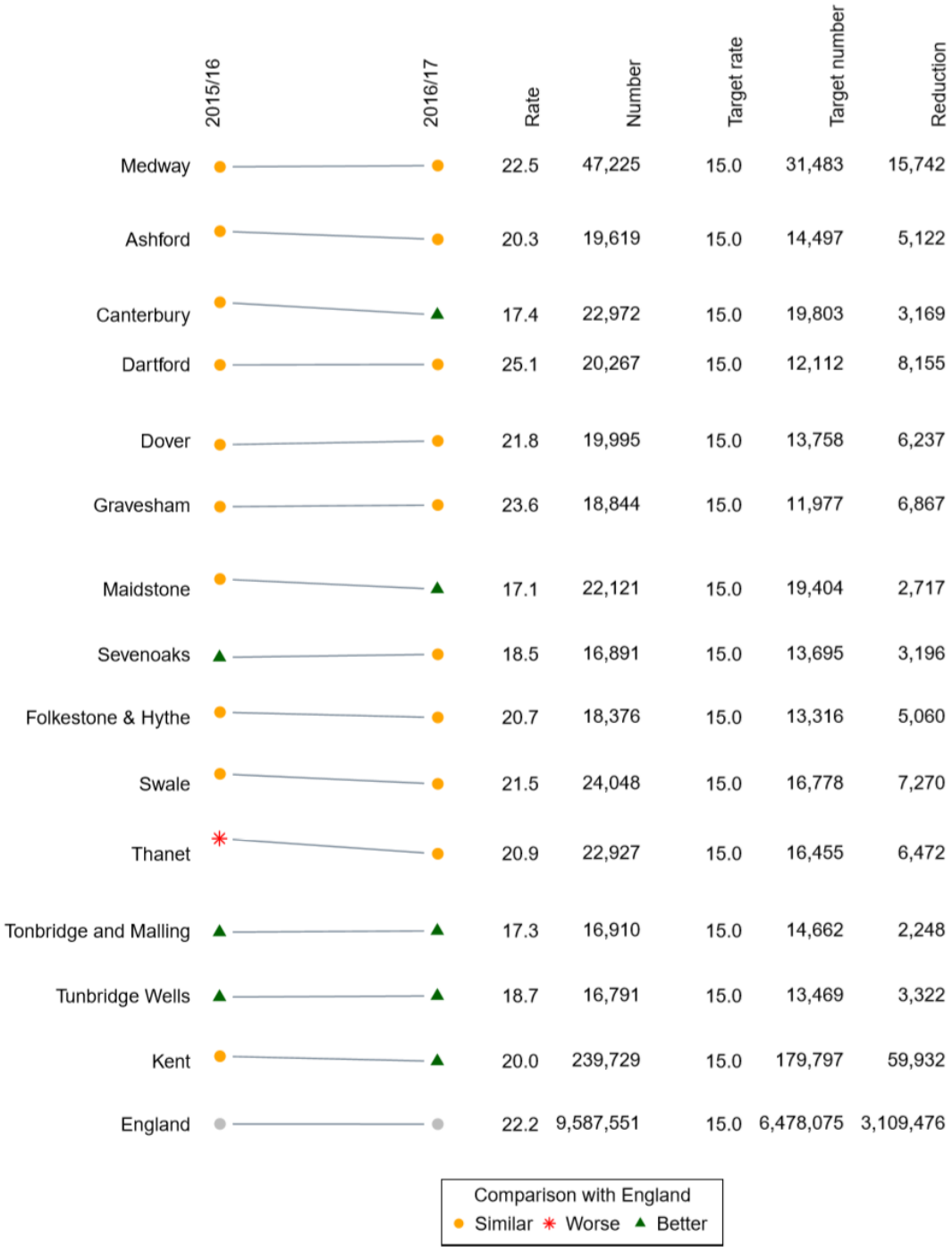
Quintiles: Best | | | | Worst | Not applicable

Indicator	Period	England	Kent	1 - Essex	2 - Lancashire	3 - Hampshire	4 - Northamptonshire	5 - Gloucestershire	6 - Worcestershire	7 - Warwickshire	8 - West Sussex	9 - East Sussex	10 - Suffolk	11 - Nottinghamshire	12 - Staffordshire	13 - Devon	14 - Hertfordshire	15 - Norfolk
Percentage of physically active adults - current method	2016/17	66.0	67.8	66.0	65.3	69.9	63.6	69.2	67.2	65.9	68.3	66.8	67.2	66.4	64.9	73.9	68.5	66.5
Percentage of physically inactive adults - current method	2016/17	22.2	20.0	22.6	22.9	17.9	23.6	18.5	21.1	22.3	19.3	21.5	20.8	23.2	23.2	16.8	20.3	22.3
Percentage of adults walking for travel at least three days per week	2016/17	22.9	22.3	21.3	19.0	20.2	14.5	18.4	17.5	18.0	21.2	19.3	18.5	20.2	14.8	21.2	24.0	18.6
Percentage of adults cycling for travel at least three days per week	2016/17	3.3	2.4	2.7	2.0	3.8	2.0	4.4	2.3	2.3	2.4	2.1	3.2	2.1	1.6	4.2	2.4	5.0
Percentage of 15 year olds physically active for at least one hour per day seven days a week	2014/15	13.9	13.7	14.5	15.0	14.8	15.1	15.9	15.7	14.4	15.1	15.3	13.0	14.2	13.2	17.5	11.7	14.3
Percentage of 15 year olds with a mean daily sedentary time in the last week over 7 hours per day	2014/15	70.1	69.7	72.3	67.7	68.6	70.7	66.8	71.3	67.5	70.3	69.0	70.3	70.8	72.0	63.2	67.9	73.0
Percentage of physically active adults - historical method	2015	57.0	59.0	57.5	52.5	60.9	56.8	61.5	58.3	61.2	60.2	58.7	57.8	59.5	57.6	60.7	58.7	56.5
Percentage of physically inactive adults - historical method	2015	28.7	26.7	28.0	31.7	24.7	27.6	23.8	26.4	24.4	25.6	26.6	28.3	26.1	28.3	25.4	25.9	29.0
Percentage of adults doing 30-149 minutes physical activity per week -historical method	2015	14.3	14.3	14.4	15.8	14.4	15.6	14.7	15.4	14.4	14.2	14.7	13.9	14.5	14.0	13.9	15.4	14.5
Percentage of adults who do any walking, at least five times per week	2014/15	50.6	49.9	48.4	48.9	48.7	47.6	49.8	49.5	52.6	49.8	51.7	49.1	49.3	44.6	53.1	50.5	50.5
Percentage of adults who do any walking, at least once per week	2014/15	80.6	81.1	78.9	78.3	81.5	77.5	82.6	80.4	81.3	81.0	82.1	80.8	81.6	76.7	84.0	82.5	78.9
Percentage of adults who do any cycling, at least three times per week.	2014/15	4.4	3.0	3.5	3.5	5.5	2.4	5.1	4.6	3.7	5.2	2.5	5.0	4.4	3.3	4.6	4.2	6.7
Percentage of adults who do any cycling, at least once per month	2014/15	14.7	13.5	13.9	14.4	19.0	13.3	18.0	14.7	14.7	17.5	13.5	16.2	15.8	13.5	18.1	15.6	18.2
Access to woodland	2015	16.8	12.0	15.7	19.9	23.5	7.9	13.0	14.7	7.9	16.7	20.9	8.5	13.0	14.3	8.7	22.1	10.7
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	17.9	18.7	19.2	18.0	16.8	21.1	15.3	14.2	20.6	20.3	15.7	18.6	16.7	17.8	19.7	18.3	18.8

Appendix 2 – Local data on Physical activity and physical inactivity

Physically inactive adults (%)

The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing less than 30 moderate intensity equivalent (MIE) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 19 and over.



Produced by Medway Public Health Intelligence Team (2019-03-28)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee
10 May 2019

Subject: **Six Ways to Wellbeing update**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

In 2014 Kent County Council's Public Health team designed and launched the Six Ways to Wellbeing tool and resources

It was designed to be used by groups, individuals, employers to start discussions about what it means to be in good mental health and remind people how to maintain and recover good mental health in times of stress.

This paper provides an update on how Six Ways to Wellbeing is currently being used.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **Comment on and Endorse** the Six Ways to Wellbeing progress **and comment on** and **suggest** ways to strengthen future delivery.

1. Background

1.1 The *Six Ways to Wellbeing* tool and resources were developed by Kent County Council's Public Health team (in association with the South London and Maudsley NHS Trust) in 2014.

1.2 The tool is based on evidence which shows that positive mental wellbeing requires more than just an absence of mental illness. Evidence also shows that having positive wellbeing has many benefits, including increased resilience meaning that individuals can cope with the everyday ups and downs of life. The evidence is well documented and now available from Public Health England, New Economics Foundation and the University of Warwick.

1.3 Public Health in Kent reasoned that having a tool and a programme to increase and strengthen the population's mental wellbeing was important, not only at the individual, but also at a societal level. Mental illnesses (including depression and

anxiety) are one of the leading causes of absence from work and therefore increasing wellbeing should also have economic benefits. It is also important to increase wellbeing awareness in the general population to also raise understanding that mental health – like physical health – can be optimised.

1.4 The *Six Ways to Wellbeing* are reminders about simple actions individuals can take to maintain and strengthen their wellbeing and resilience.

1.5 A colourful logo was designed to illustrate the *Six Ways*.

Figure 1 The Six Ways to Wellbeing

2.0 Promotion of Six Ways to Wellbeing

2.1 Between 2014 and 2016 Public Health ran a series of monthly seminars to introduce the *Six Ways* to hundreds of individuals, groups, employers, businesses and other interested stakeholders. Many of those who attended these seminars went back and hosted events of their own or used the principles in team meetings or in other informal group sessions.

2.2 Promotional literature (including lanyards, pens, z-cards and posters) were distributed and displayed by partners across Kent. Many Kent libraries also had *Six Ways to Wellbeing* areas, where individuals could relax, find books about self-care and take promotional literature.

2.3 Since the introduction of the Live Well service, Public Health have stopped running the community facing training, however, both of the delivery partners of Live Well (Shaw Trust and Porchlight) continue to promote the *Six Ways* through both the website and through their delivery networks. It is also shared on a number of third sector and partner agency websites across Kent.

Figure 2 – The *Six Ways to Wellbeing* promoted on https://livewellkent.org.uk/

2.4 The Public Health team continue to give presentations to internal KCC teams, events and conferences wherever managers feel that their teams would benefit from discussions about positive mental wellbeing.

2.5 Some internal KCC teams have used *Six Ways* materials to furnish staff quiet rooms.

3.0 Future plans for the *Six Ways to Wellbeing*

3.1 There are no plans to re-start the community facing monthly seminars, however the *Six Ways to Wellbeing* tools continue to be available to be used to facilitate discussions around mental wellbeing and Public Health staff regularly give presentations and facilitate events when requested.

3.2 Public Health England (PHE) are currently testing their own mental wellbeing campaign in other parts of the country[1]. Called "Every Mind Matters" this will be similar to the familiar "One You" campaign and Kent will be able to give the campaign a local flavour when PHE decide to roll the campaign out nationally. At this point KCC Public Health will consider promoting the *Six Ways* again to supplement and compliment the "Every Mind Matters" campaign.

3.3 KCC Public Health are also looking to develop a Kent-wide multi-agency mental health network during 2019/20. During the planning for this new network Public Health will consider whether there is a role for the Six Ways to Wellbeing.

4.0 Recommendation(s)

4.1 Cabinet Committee Members are asked to **COMMENT ON** and Endorse the Six Ways to Wellbeing progress and **COMMENT ON** and suggest ways to strengthen future delivery.

[1] https://www.gov.uk/government/news/new-mental-health-campaign-launched-across-the-midlands

5.0 Contact Details

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Background documents: none

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

10 May 2019

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. Ten of the fifteen KPIs were RAG rated Green in the latest available quarter, four were Amber, and one was Red.

Delivery of the antenatal face to face contact by the Health Visiting Service did not achieve the floor standard, and is RAG rated Red. Kent reflects the National trend in the decline of health visitor numbers, and in response the provider completed a prioritisation process and introduced a change in the way ante-natal contacts are delivered from Q3.

Delivery of the antenatal face to face contact has been prioritised to new mothers or those families identified as vulnerable; all families will receive a letter introducing the Health Visiting Service and providing the contact details of the local district team where they can still request a visit from the service or attend a health visitor drop in session at a local Children's Centre.

To increase capacity in the health visiting workforce the provider has been working with Canterbury Christ Church University to develop a fully accredited course to train registered nurses in the Community Public Health (CPHN) role and the first cohort of students have recently achieved the required competence level to start delivering services.

Due to changes in delivery mechanisms and current performance trends experienced by Kent and Nationally, the paper proposes amendments to four of the KPI targets for 2019/20.

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

- the proposed target changes for 2019/20
- the performance of Public Health commissioned services in Q3 2018/19

1. Introduction

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

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

2. Overview of Performance

2.1. Of the 15 targeted KPIs for Public Health commissioned services 10 achieved target (Green), 4 KPIs were below target but achieved the floor standard (Amber), and 1 did not achieve the floor standard (Red) and relates to delivery of the antenatal visits by the Health Visiting Service.

Health Visiting

2.2. Delivery of the face to face antenatal contact has reduced to 25% from previous levels of over 40%. The provider has reported that this drop in performance is due to the implementation of a revised service business continuity plan (BCP) which changes the approach to delivering the face-to-face antenatal contact. The BCP has been implemented to ensure consistent prioritisation of service activities across Kent based on available staffing levels.

2.3. The BCP prioritises the universal offer of the 4 postnatal developmental contacts, with the antenatal contact (face-to-face) prioritised for first time mothers and vulnerable families. The provider has given assurances within the BCP that safeguarding work continues to be the highest priority.

2.4. To ensure a contact is made at the antenatal stage, in Q3 the provider introduced sending a letter to all families with a pregnancy. The letter introduces the family to the Health Visiting Service and provides the contact details of the local district team where visits can be requested, or details can be provided of Health Visitor drop-in sessions at local Children's Centres.

2.5. In Q3 the provider sent 1,673 letters; Antenatal contacts, either via letter or face to face, reached 64% of the new birth numbers during that quarter.

2.6. There has been a national decline in health visitors and a reduction nationally in the funding available for health visitor training. Kent has, and continues to, experience challenges with the recruitment of qualified health visitors. The provider has implemented a number of activities to maintain and improve the capacity of the workforce, including the trial of recruitment and retention premiums within two areas of Kent. KCC Commissioners are working with the PHE South East CYP Network to gather insight in to how other local authorities are managing workforce challenges.

2.7. A collaboration between the provider and Canterbury Christ Church University has resulted in a fully accredited course to train registered nurses in the Community Public Health (CPHN) role. The first cohort of CPHN's started their training in Quarter 3 2018/19 and on completion of their training the CPHNs will support the delivery of the service and improve the capacity of the workforce. A number of the students have already achieved the required competence levels and are starting to deliver universal checks. Expressions have been made by these CPHN's in completing the full health visitor training.

2.8. The decrease in the delivery of universally offered health visiting checks (as a whole) is reflective of the decrease in antenatal face to face contacts; delivery of all the other visits remain above expected levels.

Adult Health Improvement

2.9. The number of NHS Health Checks delivered continues to increase following the drop in delivery in early 2018 with the roll-out of a new IT system across Kent; the service is on track to deliver the volume of Health Checks within acceptable levels and invite 100% of the eligible population.

2.10. The numbers accessing the One You Kent (OYK) service has been steadily increasing and work is continuing by the providers to ensure Advisors are working with those from the most deprived areas in the county. Following a refresh of the figures and data quality checks by the provider, OYK continue to work with over 50% of clients being from the most deprived areas.

Sexual Health

2.11. All clients needing to access an urgent genito-urinary medicine (GUM) appointment in Kent were offered within 48 hours. Levels of delivery have remained consistent over previous time frames.

Drug and Alcohol Services

2.12. The proportion of people successfully completing treatment has been sustained at 25% in the 12 months to December 2018. Overall the proportions completing treatment successfully, of all those in treatment, has been steadily decreasing, this trend follows National experiences. The national proportion for 2017/18 (most recently published figures) was 22%.

Mental Wellbeing Service

2.13. The Live Well Kent providers continue to ensure that the services deliver high levels of satisfaction with 98% of clients completing the NHS Friends and Family Test (FFT) indicating that they would recommend the service to family, friends or someone in a similar situation. Providers have completed a refresh of submitted figures following a deep-dive into recording mechanism and previous quarters have been amended, satisfaction remains at high levels.

3. Proposed KPI changes for 2019/20

3.1. Table 1 outlines proposed changes to four of the current KPI targets for 2019/20. It is proposed that the KPIs have the targets to reflect current performance trends and changes to current delivery mechanisms.

3.2. All other KPIs and their targets are to remain the same. Performance Indicator Definition forms (PIDs) are available on request.

Table 1: Proposed KPI changes for 2019/20

KPI:	Change:
Mothers receiving an antenatal visit/contact with the Health Visiting Service	Target change to reflect changes in delivery with a focus on new mothers and those identified by the midwifery teams as having concerns and/or vulnerabilities. 43% of the entire cohort have been identified by Public Health as families with vulnerabilities and/or new mothers in Kent. The target is set at 43% with the expectation that all of these families are to be seen. All pregnant women will be contacted via a letter
Infants due a 6-8 week check who receive one by the Health Visiting Service	Target increased to 85% due to consistent delivery above the previous 80% target.
Children receiving a 1 year review by 15 months, by the Health Visiting Service	Target increased to 85% due to consistent delivery above the previous 80% target.
Successful completion of drug and alcohol treatment of all those in treatment	Target decreased to 25%, from 26%, to reflect National trends and ongoing performance in Kent.

4. Conclusion

4.1. Delivery of the antenatal face to face contact provided by the Health Visiting Service did not achieve the floor standard of performance in Q3, the provider had implemented a revised service business continuity plan based on health visitor staffing levels which changed the delivery mechanism for this measure. Letters are being sent to all families in Kent due a contact, providing Health visiting service information and face to face contacts are being prioritised to new mothers and vulnerable families.

4.2. To reflect current performance trends and changes to current delivery mechanisms it is proposed that four KPIs receive target changes for 2019/20. Two are increases, two are decreases (Table 1).

5. Recommendations

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

- the proposed target changes for 2019/20
- the performance of Public Health commissioned services in Q3 2018/19

6. Background Documents

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

7. Appendices

Appendix 1 - Public Health Commissioned Services KPIs and Key.

8. Contact Details

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

Service	KPI's	Q3 17/18	Q4 17/18	Target 18/19	Q1 18/19	Q2 18/19	Q3 18/19	DoT**
Health Visiting	PH04: No. of mandated universal checks delivered by the health visiting service (12 month rolling)	70,456 (g)	71,495 (g)	65,000	71,287 (g)	70,639 (g)	**69,318 (g)**	⇩
	PH14: No. and % of mothers receiving an antenatal contact with the health visiting service	2,282 52% (g)	1,755 43% (g)	50%	2,078 48% (a)	1,804 41% (a)	**1,066 25% (r)**	⇩
	PH15: No. and % of new birth visits delivered by the health visitor service within 30 days of birth	4,346 98% (g)	3,954 98% (g)	95%	4,094 98% (g)	4,294 98% (g)	**4,250 98% (g)**	⇔
	PH16: No. and % of infants due a 6-8 week who received one by the health visiting service	4,199 92% (g)	3,809 91% (g)	80%	3,628 89% (g)	3,771 86% (g)	**3,885 88% (g)**	⇧
	PH23: No. and % of infants who are totally or partially breastfed at 6-8 weeks (health visiting service)	2,041 47%	1,788 46%*	-	1,833 49%*	1,852 48%*	**1,926 48%***	-
	PH17: No. and % of infants receiving their 1-year review at 15 months by the health visiting service	3,878 89% (g)	3,723 87% (g)	80%	3,609 86% (g)	3,907 87% (g)	**4,075 87% (g)**	⇔
	PH18: No. and % of children who received a 2-2½ year review with the health visiting service	3,634 83% (g)	3,725 82% (g)	80%	3,546 80% (g)	3,703 82% (g)	**3,605 82% (g)**	⇔
Structured Substance Misuse Treatment	PH13: No. and % of young people exiting specialist substance misuse services with a planned exit	76 92% (g)	55 85% (g)	85%	87 94% (g)	54 87% (g)	**56 89% (g)**	⇧
	PH03: No. and % of people successfully completing drug and/or alcohol treatment of all those in treatment	1,126 25% (a)	1,073 24% (a)	26%	1,160 26% (g)	1,139 25% (a)	**1,171 25% (a)**	⇔
Lifestyle and Prevention	PH01: No. of the eligible population aged 40-74 years old receiving an NHS Health Check (12 month rolling)	42,943 (g)	41,677 (g)	41,600	38,021 (a)	33,617 (a)	**33,917 (a)**	⇧
	PH11: No. and % of people quitting at 4 weeks, having set a quit date with smoking cessation services	746 54% (g)	809 49% (a)	52%	706 56% (g)	698 53% (g)	**740 51% (a)**	⇩
	PH21: No. and % of clients engaged with One You Kent Advisors being from the most deprived areas in the County	New Service, New Metric		60%	440 53% (a)	420 51% (a)	**456 55% (a)**	⇧
Sexual Health	PH02: No. and % of clients accessing GUM services offered an appointment to be seen within 48 hours	100% (g)	100% (g)	90%	11,136 100% (g)	11,356 100% (g)	**10,871 100% (g)**	⇔
Mental Wellbeing	PH22: No. and % of Live Well Kent clients who would recommend the service to family, friends or someone in a similar situation	New Metric		90%	300 99% (g)	317 97% (g)	**250 98% (g)**	⇧

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

Commissioned services annual activity

Indicator Description	2013/14	2014/15	2015/16	2016/17	2017/18	DoT
PH09: Participation rate of Year R (4-5 year olds) pupils in the National Child Measurement Programme	96% (g)	96% (g)	97% (g)	97% (g)	**93% (g)**	⇩
PH10: Participation rate of Year 6 (10-11 year olds) pupils in the National Child Measurement Programme	94% (a)	95% (g)	96% (g)	96% (g)	**96% (g)**	⇔
PH05; Number receiving an NHS Health Check over the 5-year programme (cumulative from 2013/14 to 2017/18)	32,924	78,547	115,232	157,303	**198,980**	-
PH06: Number of adults accessing structured treatment substance misuse services	4,652	5,324	5,462	4,616	**4,466**	-
PH07: Number accessing KCC commissioned sexual health service clinics	-	-	73,153	78,144	**75,694**	-

Key:

RAG Ratings

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

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

DoT (Direction of Travel) Alerts

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

**Relates to two most recent time frames

Data quality note

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

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee
10 May 2019

Subject: **Progress and future plans regarding the "Release the Pressure" social marketing campaign**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

In 2016 Kent County Council's Public Health team designed and launched the *Release the Pressure* social marketing campaign.

It was designed to raise awareness that support for any mental health problem (from just having an off day, through to crisis point) is available 24/7.

The imagery and words were designed to particularly appeal to middle aged men (who are at highest risk of suicide) but the support line is available to anyone aged 16 and over.

This paper provides a review of recent campaign activity and details the future plans for *Release the Pressure*.

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

a) **NOTE** the progress relating to Release the Pressure
b) Make **COMMENTS** and **SUGGEST** ways to strengthen future delivery

1. Introduction and background

1.1 The *Release the Pressure* social marketing campaign was launched in 2016 as a response to two main factors:

- Approximately three quarters of people who die by suicide are male
- Approximately 70% of people who die by suicide are not known to secondary mental health services

1.2 *Release the Pressure* was designed to use a social marketing approach to reach individuals not in touch with other services and encourage them to start talking about whatever is bothering them before the pressure becomes too great.

1.3 The campaign highlights that talking to anyone (e.g. friends, family, clinicians) is likely to help, but for those people that don't have anyone they feel that they can talk too, then trained and confidential support is available 24 hours a day, 7 days a week.

1.4 The 24/7 support can be accessed via a freephone telephone number (0800 107 0160) or via webchat through www.releasethepressure.uk. It is provided by a charity called Mental Health Matters and all staff are qualified to a minimum NVQ Level 3 in Counselling Skills.

2.0 Release the Pressure development and design

2.1 The campaign was designed in 2016 following focus groups with local residents who have had suicidal thoughts to identify the words which they felt would resonate with others in similar situations.

Figure 1 – Release the Pressure original imagery

2.2 The design was always intended to be adaptable and over the last few years it has been used in a number of different ways, across a range of mediums. For instance;

Figure 2 – Release the Pressure examples

2.3 The campaign also uses social media channels, and advertising online, on radio and on digital TV to raise awareness of the issues and the help available.

2.4 Paying for Google adverts has been particularly effective, with the *Release the Pressure* advert being shown when anyone in Kent searches for terms such as "suicide", "feeling suicidal" or "I want to die". As an illustration in 2018/19 the *Release the Pressure* advert was displayed 1307 times to Kent and Medway residents who had googled the term "I want to die". On 176 occasions the individual clicked on the advert and visited the website where they could access immediate help either via phone or webchat. In total nearly 7000 individuals clicked through to the website from a Google advert in 2018/19.

3.0 Release the Pressure in 2018/19

3.1 Although originally developed by KCC, the 2018/19 campaign was funded entirely externally by the Kent and Medway STP as part of the NHS England ring-fenced suicide prevention programme (which is led by KCC Public Health). Therefore the 18/19 campaign also covered the Medway area.

3.2 Approximately £80,000 was spent on the *Release the Pressure* campaign in 2018/19 (this figure includes some spending in Medway, a Kent-only figure isn't possible given the given the nature of TV, radio and online advertising). It is worth noting here that Public Health England have estimated that the average cost to the UK economy of each suicide is £1.67million[1].

[1] Public Health England, Local Suicide Prevention Planning, Oct 2016 http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf

3.3 1) The production of a wide range of materials which have been distributed by partners across the county. These include pens, banners, leaflets, business cards, posters, bags and infinity cards.
2) Paid for advertising (online, radio, digital TV, outdoor). There were two main periods of paid for advertising. The first was around World Mental Health Day in October 2018, and the second was between December 2018 and March 2019 during the festive season and into the new year
3) Promotion through the social media channels of KCC and other partners

3.4 Particularly positive was the support of Bluewater Shopping Centre which agreed to display the *Release the Pressure* posters in 56 restroom locations free of charge. This was a great vote of confidence in the campaign by a major commercial partner who saw the benefit of the campaign.

Figure 3 – Release the Pressure in Bluewater Shopping Centre

4.0 Release the Pressure impact

4.1 Since the introduction of the campaign in 2016 there has been a slight fall in the number of suicides across Kent and Medway. However, it would be too simplistic to claim a direct causal link between the campaign and the fall in suicides. The campaign has however contributed to a culture where people are more willing to speak about their mental health and to seek help when they are struggling.

4.2 ᵻ have also been unsolicited testimonies from individuals that say that speaking to the support line has kept them alive. For example, please see this exchange which played out on Facebook.

Figure 4 – Screenshots from Facebook relating to Release the Pressure

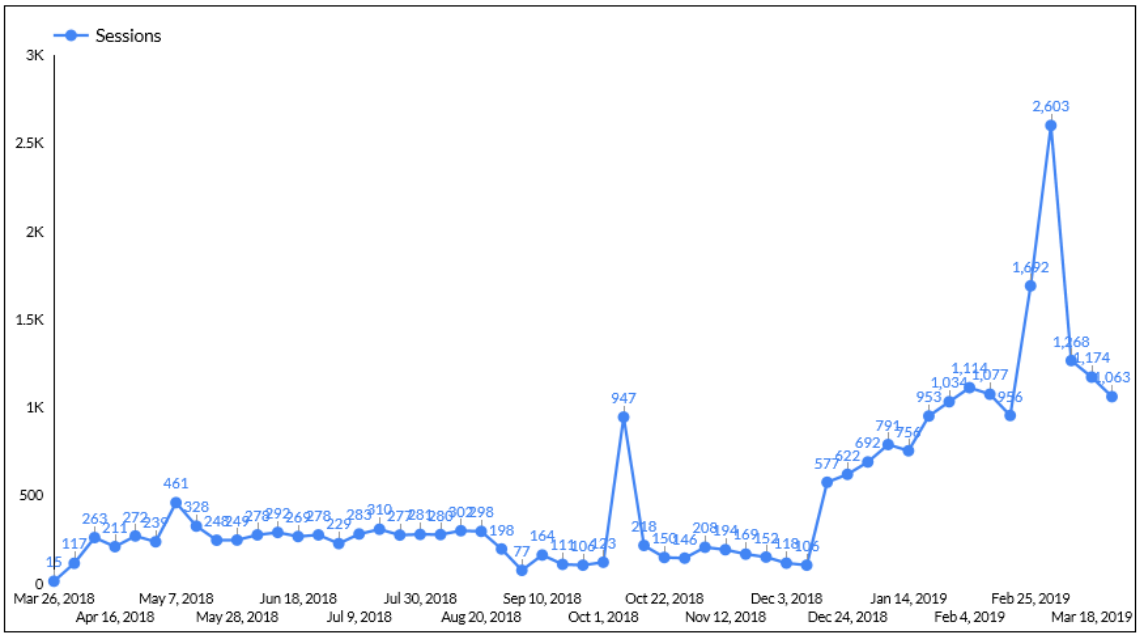
4.3 There is also evidence to demonstrate the impact that the campaign has on the number of people accessing the www.releasethepressure.uk website and the freephone number.

4.4 In the 12 months before the Release the Pressure campaign started in 2016 (when the Mental Health Matters helpline was promoted by Adult Social Services) the helpline received an average of 1172 calls a month (14,066 a year). During 2018/19, the helpline received an average of 1829 calls a month (21,956 a year). This equates to a 56% increase in the total number of calls being received per year.

4.5 In addition to the calls, the service is answering approximately 100 webchats a month and hundreds of people are visiting the website for information every week. Figure 5 below shows the impact that paid for advertising has on the

numbers of people visiting the website (there were 25,339 total visits during 2018/19).

Figure 5 – Total 2018/19 weekly visits to Release the Pressure website



4.6 Please note when looking at Figure 5 above that there were two main points of paid for advertising in 2018/19. The first was around World Mental Health Day in October 2018, and the second was between December 2018 and March 2019 during the festive season and into the new year. During those periods of activity website visits increased considerably.

Figure 6 below shows some of the other testimony given to the call handlers at the end of the call.

Release the Pressure testimony

5.0 Release the Pressure in 2019/20

5.1 KCC Public Health have led the application for additional 2019/20 suicide prevention funding on behalf of the Kent and Medway STP. This application has been successful, therefore the 19/20 Release the Pressure campaign will again be entirely funded by external ringfenced funds.

5.2 The 2019/20 campaign will continue to be a mix of paid for advertising, social media and the promotion and distribution of materials by partners.

5.3 The emphasis this year will be to secure high profile partnerships to help us reach target groups, as well as maintaining a population wide visibility.

5.4 Please Note: Future rates of completed Suicides may increase due to a change in how coroners are now asked to judge a death as a suicide. In the past there was an acknowledgment that the judgement of 'death by suicide' was a conservative one. Now a coroner is asked to include deaths where there is 'probable' cause of suicide. Time will tell whether this will impact on Kent rates.

6.0 Recommendation

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

a) **NOTE** the progress relating to Release the Pressure
b) Make **COMMENTS** and **SUGGEST** ways to strengthen future delivery

7.0 Contact Details

Report Authors:

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Background documents: none

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From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 10 May 2019

Subject: **Work Programme 2019/20**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

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

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to consider and agree its work programme for 2019/20.

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

2. Work Programme 2019/20

2.1 An agenda setting meeting was held on 13 March 2019, at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion in agendas of future meetings.

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

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

3. Conclusion

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

4. Recommendation: The Health Reform and Public Health Cabinet Committee is asked to consider and agree its work programme for 2019/20.

5. Background Documents

None.

6. Contact details

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Last updated on: 30 April 2019

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

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

20 JUNE 2019
• **Gambling addiction - follow up report on work to address issues arising from** gambling item at 22/11/18 mtg (request by B Lewis) • **Housing conditions and their effect on health inequalities, incl hidden homeless** (request by E Dawson, 15/1/19) • **(separate from Air Quality item) lack of charging points for electric cars** • ***Contract Monitoring – Young People's Substance Misuse Services*** • ***Verbal Updates*** • ***Work Programme 2019/20***
24 SEPTEMBER 2019
• ***Verbal Updates*** • ***Contract Monitoring – Adult Health Improvement Services (incl workplace health)*** • ***Work Programme 2019/20*** • **Public Health Performance Dashboard – incl impact of STP** • **Annual report – Quality in Public Health, incl complaints**
1 NOVEMBER 2019
• ***Verbal Updates*** • ***Contract Monitoring – Positive Relationships*** • ***Work Programme 2020*** • **Regional approach to tackle illicit tobacco** (following item 10 at 22/11/18 mtg)
14 JANUARY 2020
• ***Verbal Updates*** • ***Contract Monitoring – Oral Health*** • ***Work Programme 2020*** • **Budget and Medium-Term Financial Plan** • **Public Health Performance Dashboard – incl impact of STP** • **Update on Public Health Campaigns/Communications**
6 MARCH 2020
• **Strategic Development Plan** (replaced former Directorate Business Plans) • **Risk Management report (with RAG ratings)** • ***Verbal Updates*** • ***Contract Monitoring – Children and Young People's condom programme*** • ***Work Programme 2020***

Last updated on: 30 April 2019

30 APRIL 2020
• ***Verbal Updates*** • ***Contract Monitoring – Workforce Development*** • ***Work Programme 2020*** • **Public Health Performance Dashboard – incl impact of STP**

PATTERN OF ITEMS APPEARING REGULARLY	
Meeting	**Item**
January	• Budget and Medium-Term Financial Plan • Public Health Performance Dashboard – incl impact of STP • Update on Public Health Campaigns/Communications
March	• Strategic Development Plan (replaced former Directorate Business Plans) • Risk Management report (with RAG ratings) • Health Inequalities – annual
May	• Public Health Performance Dashboard – incl impact of STP • Update on Public Health Campaigns/Communications *(May or June?)*
June/July	• Update on Public Health Campaigns/Communications *(May or June?)*
September	• Annual Report on Quality in Public Health, incl Annual Complaints Report • *Annual Equality and Diversity Report** this is part of the Strategic Commissioning Equality and Diversity, which goes to the Policy and Resources Cabinet Cttee • Public Health Performance Dashboard – incl impact of STP
November	