# HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

**Friday, 6th March, 2020**

**10.00 am**

**Sessions House**

# AGENDA

# HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

**Friday, 6 March 2020 at 10.00 am**
**Sessions House**

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

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

**Membership (14)**

| | |
|---|---|
| Conservative (10): | Mr G Lymer (Chairman), Ms D Marsh (Vice-Chairman), Mr D Butler, Mr A Cook, Miss E Dawson, Mrs L Game, Ms S Hamilton, Mr M J Northey, 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 |
| Independent (1) | Mr P J Messenger |

## Webcasting Notice

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

## UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Membership - to note that Mr Northey has joined the committee to fill the Conservative vacancy

3 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

4 Declarations of Interest by Members in items on the agenda

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

5 Minutes of the meeting held on 14 January 2020 (Pages 1 - 10)

To consider and approve the minutes as a correct record.

6 Verbal updates by Cabinet Member and Director (Pages 11 - 12)

7 Contract Monitoring Report - One You Kent (Adult Healthy Lifestyle service) (Pages 13 - 46)

8 Risk Management: Health Reform and Public Health (Pages 47 - 66)

9 Health Inequalities in Kent (Pages 67 - 80)

10 Illicit Tobacco in Kent (Pages 81 - 84)

11 Suicide Prevention Programme update (Pages 85 - 94)

12 Kent and Medway Care Record (KMCR) Update (Pages 95 - 102)

13 Work Programme 2020/21 (Pages 103 - 106)

## EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

**Thursday, 27 February 2020**

*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.*

# KENT COUNTY COUNCIL

## HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Health Reform and Public Health Cabinet Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Tuesday, 14 January 2020.

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

ALSO PRESENT: Mrs C Bell

IN ATTENDANCE: Mr A Scott-Clark (Director of Public Health), Dr A Duggal (Deputy Director of Public Health), Mrs A Tidmarsh (Director of Adult Social Care and Health Partnerships), Mrs V Tovey (Public Health Senior Commissioning Manager) and Miss T A Grayell (Democratic Services Officer)

## UNRESTRICTED ITEMS

### 79. Apologies and Substitutes
*(Item 2)*

Apologies for absence had been received from Mr D Butler, Mr A Cook, Mr S J G Koowaree, Mr G Lymer and Mr P J Messenger.

Mrs P T Cole was present as a substitute for Mr Butler, Mr M J Northey as a substitute for Mr Cook, Mr R H Bird as a substitute for Mr Koowaree and Mr H Rayner as a substitute for Mr Lymer.

In the absence of the Chairman, Mr Lymer, the Vice-Chairman, Ms D Marsh, took the chair.

### 80. Declarations of Interest by Members in items on the agenda
*(Item 3)*

There were no declarations of interest.

### 81. Minutes of the meeting held on 1 November 2019
*(Item 4)*

It was RESOLVED that the minutes of the meeting held on 1 November 2019 are correctly recorded and they be signed by the Vice-Chairman. There were no matters arising.

**82. Meeting Dates for 2020/21**
*(Item 5)*

It was noted that the following dates had been reserved for meetings of the committee in 2020/21:

Friday 6 March 2020 (already in calendar)
Thursday 30 April 2020 (already in calendar)

Wednesday 8 July 2020
Wednesday 9 September 2020
Friday 20 November 2020
Friday 8 January 2021
Wednesday 10 March 2021
Wednesday 30 June 2021

All meetings will commence at 10.00 am at Sessions House, Maidstone.

**83. Verbal updates by Cabinet Member and Director**
*(Item 6)*

1. Mrs C Bell, Cabinet Member for Adult Social Care and Health, gave a verbal update on the following public health isues:-
***Forthcoming visits*** – she was shortly to visit Barnardo's, which delivered Sex Education Services for Children, Young People and Education, and Addaction, to which Cabinet Committee Members had also been invited. She recommended that Members visit service providers whenever possible as such visits were very helpful in showing front-line service delivery.
***Kent and Medway Joint Health and Wellbeing Board – update*** – the joint Health and Wellbeing Board was set up initially to run for 2 years. Members supported the continuation of the Board beyond 2020. The Chairmanship of the Board alternated between Kent and Medway and this year was Kent's turn. The next meeting would take place in March 2020, with the agenda focussing on the draft Kent & Medway Strategy Delivery Plan. She hoped the Board would also discuss its future role and priorities, looking at other HWBs around the UK and seeking views from the LGA.
***Public Health Campaigns*** – as people embarked on New Year's resolutions, to get fit or improve their diet, it was a good time to remind people of the range of public health campaigns which were around to support healthier lifestyles, healthy pregnancy, breastfeeding and good sexual health.

2. Mr A Scott-Clark, Director of Public Health, then gave a verbal update on the following issues:-
***Appointment of new Clinical Commissioning Group Accountable Officer*** – it was not yet possible to announce publicly who this officer would be as due diligence around the appointment had yet to be completed. The Chairman of the new clinical commissioning group (CCG) was Dr Navin Kumta, who had previously chaired the Ashford CCG.

***Update on Public Health Budget for 2020/2021*** – he had hoped to be able to announce the public health budget for 2020/21 but this was not yet possible as Department of Health and Public Health England had not yet announced the public health grant. He expected £1.8m to be added to the budget this year, but this would not be a net increase; it was the same amount as was taken out of the public health grant at the start of the 2019/20 financial year. Pressures accumulating since had already exceeded this additional funding.

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

a) asked what the expected £1.8m grant would include, he explained that it would cover the same as had been covered in previous years, and would be ring-fenced;

b) asked about continuity between the previous clinical commissioning groups and the new single CCG, he explained that there would be no gap in governance and that ongoing work would continue as before; and

c) concern was expressed that the expected increase in the public health grant might not be sufficient to cover the increasing needs of the Kent population. Mr Scott-Clark advised that the size of the grant was an issue to be determined by central government; it was for local government to make the best use of the available funds in serving the local population.

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

**84. Contract Monitoring Report - Targeted Relationships and Sex Education (RSE) and Emotional Resilience Intervention for Girls and Young Women aged 10-16**
*(Item 7)*

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

1. Mrs Tovey introduced the report and explained that the current provider was performing well against key performance indicators (KPIs) and that the current contract would end in September 2020, so was being reviewed with a view to taking advantage of an option in the current contract to extend it for another two years. Mrs Tovey and Ms Jeffreys then responded to comments and questions from the committee, including the following:-

a) a view was expressed that 'forming inappropriate or abusive relationships' should instead be worded 'being a victim of inappropriate or abusive relationships' in the list of risks to young women who had previously had adverse childhood experiences (ACEs). Mrs Tovey advised that young people who found themselves in such a situation might be deterred from coming forward and accessing the service due

to stigma. There may be more demand beyond the average 250-case workload which the service worked with annually. Counsellors were very aware that the first step for young people approaching such a service was always the hardest;

b) asked about the criminal nature of sexual relationships with young people under the age of 16, and if the service would report such activity to the police so perpetrators could be prosecuted, Mrs Tovey advised that the service included a safeguarding element and worked with schools and youth clubs on initiatives such as ‘stay safe online’;

c) another view was expressed that it was important to achieve a balance between making young women feel able to approach the service safely and of dealing with the criminal aspect of under-age sex without making them any more of a victim. Mrs Tovey acknowledged that the balance to be achieved was delicate and added that, if young women felt that engaging with the service would lead to criminal investigations, they would be less likely to seek help;

d) asked about the age range of the service and if this could be extended to include 16-18 year olds, Mrs Tovey advised that deciding a cut-off point for a service was always a challenge, and as the budget for the service for 2020/21 was not yet known, it was not possible at the moment to consider any extensions to the age group. Ms Jeffreys added that young women up to 25 had been identified as a high-risk group so would benefit from the service if it proved possible to extend it. Being able to address relationship issues early in adulthood would help later in life;

e) asked how the service linked to schools, and how this could be improved, Mrs Tovey said the School Health Service used a triage process to refer students on to other professionals but had to make a judgement about when and to where a referral was appropriate. It was important that the service was as easy to approach and use as possible;

f) a view was expressed that the KPIs used to measure performance did not take account of cases involving young people with more complex needs. Mrs Tovey explained that involvement with any young person would normally be for a maximum of 12 weeks, but this could be adjusted to suit their needs; many needed a shorter and less intense involvement. The individual nature of the support given was a key part of the service and the provider would always be asked to be as flexible as possible;

g) volunteer mentors would be recruited from among other professionals who were experienced at working with families, for example, Headstart, and were rigorously trained before taking on this specific role with the RSE service;

h) asked if a similar service was available to boys and young men who had had similar experiences, Ms Jeffreys explained that girls had been identified as having a greater need for the service, both in terms of the incidence of the type of relationship it dealt with and the mental health difficulties which could arise from it. Dealing with teenage pregnancy was also an issue which boys did not face in the same way. She advised that there were similar programmes available in Kent for young men but these were not commissioned by the County Council but by bodies such as Porchlight;

i) asked for more detail of services for boys, and if boys tended to be more reluctant or ashamed to report sexual abuse, Mrs Tovey explained that, as part of Headstart, there was a programme for young men who had experienced domestic abuse. Ms Jeffreys added that a pilot programme in Thanet sought to identify and respond to boys experiencing abuse;

j) asked how referrals were usually received by Barnardo's, what signposting took place and if some young people were deterred from approaching the service, Mrs Tovey explained there was a range of ways in which a young person could refer themselves to the service online, for example, by using email or clicking on the website, and that they could choose to have a one-to-one meeting with a support worker wherever they felt comfortable, for example, at school, at a youth club or sports centre. She added that the uptake of the service across districts would be looked at when the extension to the contract came up for consideration, to check that access across the county was as even as possible; and

k) a comment was made that a young person's background and home situation - birth family, foster family, etc - would have a bearing on how abuse would be handled, and some young people without a supportive home set-up would be more vulnerable than others to experience and struggle to cope with abuse. Young people from different backgrounds would also learn from each other's experiences at school. Mrs Tovey advised that schools were aware of the risk factors to look out for, and would of course know pupils' home situations, and would know the referral process. Pupils who were not in mainstream school but attended a pupil referral unit, for example, would also have teachers who knew their situation and the process.

2. It was RESOLVED that the performance of the contract and the initial findings of a review of the service, which will inform a commissioning decision in March 2020, be noted.

**85. Draft Capital Programme 2020-23 and Revenue Budget 2020-21**
*(Item 8)*
*Mrs J Blenkinsop, Finance Business Partner, and Mrs V Tovey, Senior Commissioning Manager, were in attendance for this item.*

1. The Vice-Chairman advised the committee that the report had been published late and had therefore not been in the public domain for the statutory minimum of five clear working days. She asked the committee if it would consider the item as urgent business and this was AGREED.

2. Mrs Blenkinsop introduced the report and advised the committee that it had not been possible yet to identify a budget for the County Council's public health function as the public health grant for 2020/21 had not yet been announced.

3. The budget would need to take account of pay costs for staff employed by the NHS, currently estimated at £4.1m. As the public health grant for 2020/21 was expected to be £1.8m, this figure had been included as an assumption when drafting the budget. However, the grant itself had been cut year-on-year since 2015, with the cuts totalling 11% of its total. If the public health grant, when allocated, was less than expected, it might be necessary to identify savings to cover the £4.1m cost and avoid an overspend, and these savings could be approximately £2.8m. To identify areas in which these savings could be made, the County Council would seek to minimise the impact on service users and would need to look at services which were discretionary rather than statutory.

4. Mr Scott-Clark added that the NHS pay rise and pension costs which the County Council needed to cover were not new this year but were a familiar part of the budget. They related to staff employed by the NHS to deliver services commissioned by the NHS on behalf of the County Council. A total of 70% of the County Council public health budget was spent on services commissioned in this way.

5. In response to a question about savings and how these would affect staffing, Mr Scott-Clark explained that he would work with providers and would take appropriate steps to address any necessary staff cuts, while protecting front-line services. He assured Members, however, that he was not expecting any redundancies as there were currently shortages in staffing, for example, of health visitors. Once the budget was known, he would take steps to ensure that statutory duties were met and that services could break even.

6. It was RESOLVED that the draft capital and revenue budgets and Medium-Term Financial Plan, including responses to consultation and the estimate of the government's funding settlement, be noted.

There were no suggested changes to be made before the draft budget is presented to Cabinet on 27 January 2020 and full County Council on 13 February 2020.

**86. Performance of Public Health-Commissioned Services**

*(Item 9)*

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

a) asked how the rates for breastfeeding at 6 – 8 weeks compared to the rest of the UK and Europe, and if more could be done to increase this figure, Mrs Tovey advised that, although Kent was not the only area in the UK to struggle to meet targets for antenatal services, it did not compare well to other areas. Support to encourage breastfeeding was as flexible as possible but encouraging mothers to continue was an ongoing challenge. Mr Scott-Clark added that much work had been done with NHS partners on commissioning such services and to increase breastfeeding initiation as well as continuation, and that the new single clinical commissioning group would focus on these issues as an area of development. Mrs Tovey added that there were several methods of reaching mothers, including health visitors, Children's Centres and the Midwifery service, and that the timing and tailoring of the message was important, to achieve the best engagement. The consistency of the message was also important; and

b) asked about the facilities across the county which people could attend to access advice and support with healthy living, Mrs Tovey advised that they could engage in a number of ways, for example, at health centres, citizens advice bureaux, etc, and could access NHS Health Checks and public health campaign materials there. In West Kent, the services were delivered by district councils. The Ashford One You shop was a useful centre and worked well as a centrally-located, community hub, which local people had requested and used well. Mr Scott-Clark added that the One You service was provided by Healthy Living Centres in North Kent and Thanet, using local leisure centres, and although it was desired that more centres be established, it was difficult to identify and establish suitable premises.

2. It was RESOLVED that the performance of public health-commissioned services in quarter 2 of 2019/20 be noted.

**87. Public Health Communications and Campaigns Update**
*(Item 10)*

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

1. Mr Scott-Clark and Mrs Smith introduced the report and emphasised that campaigns formed a large part of the public health workload. They then responded to comments and questions from the committee, including the following:-

a) it was pointed out that parish councils could be a useful ally in promoting health improvement campaigns to their local communities, and some of the online tools had been tried by local groups, with the encouragement of their local Member. People were more likely to engage with, and remember the information in, a campaign if there was a light-hearted, interactive or quiz element to it. Some media coverage of campaigns might not be seen and read by the intended audience.

Mrs Smith welcomed this information and explained that the team tried to use as wide a range of media and formats as possible, with the aim of tailoring the approach to the target audience. Social media, spotify and Kent online were all used. For some people, a lighter approach would engage their interest sufficiently to draw them in, while others needed a harder-hitting message, but avoiding a 'nanny' tone. To reach parish councils, campaign information was being sent out via the Kent Association of Local Councils (KALC);

b) asked why the current campaigns did not include any mention of gambling addiction, Mr Scott-Clark explained that the current report was looking back at the activity and performance of campaigns which had been running for some years; new activity would appear in future reports;

c) asked about the retention of personal and contact information of people taking part in online campaigns, and how such data was safeguarded, Mrs Smith explained that health and lifestyle questionnaires on any 'kent.gov' website did not record and retain any identifying data from those taking part. Mr Scott-Clark reassured Members that programmes which appeared to 'remember' a user on a subsequent visit did so by using cookies which allowed the user's computer and the County Council computer to 'speak to' each other electronically. This was the standard method of running any website and computer programme so was quite normal;

d) the 'Change 4 Life' programme had good local publicity and was welcomed as it included nutritional information and advice on healthy cooking, something which did not seem to be taught in schools now. Mrs Smith clarified that 'Change 4 Life' was a national campaign which had been adopted locally and had run successfully for many years. As PH England tended to refresh the programme each summer, Kent had opted to run its own local 'Change 4 Life' programme in January, using social media and signposting, to tie in with people making New Year's resolutions to get fit and live more healthily;

e) asked about the take-up rates of the flu vaccinations, Mr Scott-Clark *undertook to circulate this information to the committee after the meeting* and this was subsequently done*;*

f) there were local initiatives around the county which encouraged families to cook and eat healthily, for example, 'Summer Kitchen' in Thanet, which sought to feed children healthily over the summer holidays and reduce the use of sugar and salt, and 'Sheppey Matters' on the Isle of Sheppey. *Recipes used by the latter would also be shared with the committee;* and

g) the establishment of a working group to look at a campaign to improve air quality around school gates was welcomed.

2. It was RESOLVED that the progress and impact of public health campaigns in 2019/20 be welcomed and endorsed and the information about flu vaccinations and healthy eating recipes, referred to in paras e) and f) above, be circulated to the committee.

**88. Update on the Prevention Workstream of the Sustainability and Transformation Plan**
*(Item 11)*

*Ms Jacqui Moore was in attendance for this item, with Dr Duggal.*

1. Dr Duggal and Ms Moore introduced the report and highlighted the link between the development of the prevention workstream and the integrated care system. At a meeting on 13 January 2020, the Sustainability and Transformation Partnership had decided there would be an official sub-committee to look at workstream issues. Joint working on prevention included local authorities, the NHS and other partners, and it was hoped that an innovative approach could be developed. Mr Scott-Clark added that Kent's prevention work had been highly commended, particularly its plan to reduce smoking in pregnancy and the role taken in this by midwives. Kent and Medway would be putting more resources into their Prevention work stream and would set up a co-ordinating board to support this work.

2. In response to a question about including gambling addiction among the prevention work stream, Mr Scott-Clark advised that this would come under the mental health rather than the prevention workstream. He *undertook to find out about any clinic offering support with gambling addiction and advise the questioner outside the meeting.* Another speaker added that addiction to online gambling was the fastest-growing area of concern among local parents in his area.

3. It was RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks.

**89. Work Programme 2020/21**
*(Item 12)*

It was RESOLVED that the committee's work planned programme for 2020/21 be agreed.

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| By: | Mrs C Bell, 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 – 6 March 2020 |
| Subject: | **Verbal updates by the Cabinet Member and Director** |
| Classification: | Unrestricted |

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

**PUBLIC HEALTH**

**Cabinet Member for Adult Social Care and Public Health – Mrs C Bell:**

- Launch of “Beside You” online resource for infant feeding
- Attendance at Public Health Commissioning Team meeting
- Public Health campaigns

**Director of Public Health – Mr A Scott-Clark:**

- COVID-19 (Coronavirus)
- Public Health Budget 2020/2021
- Kent Association of Local Councils Health and Wellbeing Conference

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**From:** Clair Bell, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

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

6 March 2020

**Subject:** Contract Monitoring Report – One You Kent (Adult Healthy Lifestyle service)

**Classification:** Unrestricted

**Summary:**
This paper provides an overview of the delivery, performance and outcomes for the One You Kent (OYK) Adult Healthy Lifestyle service. Services are targeted to those in high areas of need and form a key part of the prevention offer for local residents and supports delivery of the prevention strand of the Sustainability and Transformation Plan (STP).

For the current financial year, the service has a combined annual value of just under £4.7m. A £900K recurrent saving was delivered during 2017/18 as services moved to a new integrated model and launched the OYK brand.

From April 2018 to December 2019, the service has received over 33,000 referrals. On average, each quarter, over 3,000 individuals are engaged in the service, from receiving Health MOTs and NHS Health Checks to accessing smoking cessation service, weight management programmes and Health Walks.

All aspects of the OYK programme are closely monitored to ensure the services are achieving expected outcomes and meet local need. The Adult Tier 2 weight management programme and the workplace health offer are both currently undergoing a review and may result in a change to the model by Autumn 2020. The recent needs assessment for substance misuse has highlighted a gap in provision with people drinking at medium to high risk. A new model has been developed for the OYK service which will see the advisors deliver behaviour change and motivational interviewing to residents in Kent who need to reduce their alcohol intake up to dependent levels. It is anticipated that delivery of this model will be rolled out in a phased approach from April 2020.

Increasing use of digital technology is a key focus for this service as it can drive efficiency, increase the reach wider than traditional service provision and benefit the environment. Work is underway to review digital support solutions to reduce alcohol consumption and support people to quit smoking. This would be designed to complement the comprehensive One You Kent website, suite of Public Health England (PHE) approved apps and support a self-help approach.

https://www.kent.gov.uk/social-care-and-health/health/one-you-kent

The Health and Social Care landscape is undergoing significant transformation as a result of the NHS Long Term Plan. These services will need to align to these changes and ensure

close connection with the social prescribers and Multi-disciplinary teams within the Primary Care Networks.

**Recommendation:**

The Health Reform Public Health Cabinet Committee is asked to **COMMENT** on the performance of the OYK Service and the initiatives being undertaken to improve quality and outcomes.

## 1. Introduction

1.1. The adult integrated healthy lifestyle service, known as One You Kent (OYK), aims to improve the health of adults across Kent. This service is designed to promote positive lifestyle choices and behaviour change to support individuals to lose weight, quit smoking and become more active. This will support the achievement of the following objectives:

- Extend healthy life expectancy through prevention of chronic conditions such as obesity, cardiovascular diseases and diabetes.
- Reduce health inequalities
- Reduce avoidable demand on the health and care system in Kent.

1.2. This contract monitoring paper focuses on performance, outcomes, value for money and strategic direction of the service.

## 2. Background - Why invest?

2.1. KCC has a statutory responsibility for public health which means KCC has a legal duty to improve the health and wellbeing of residents, prevent escalation of need and reduce health inequalities.

2.2. The Adults Healthy lifestyle service aligns to the KCC Strategic Outcomes (Appendix 1) set out below and is part of the council's Strategic Delivery Plan [i](Outcome 2, number 41 and Outcome 3 number 47),

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

2.3. Public Health commissions an integrated Adult Healthy lifestyle behaviour service to support adults address multiple unhealthy behaviours. Around 40%[ii] of all deaths in England are related to everyday habits and behaviours which are preventable such as eating too much unhealthy food, drinking too much alcohol, not being active enough or continuing to smoke. The cost to the NHS is estimated to be more than £11 billion every year so having an effective early intervention can help reduce the burden on the NHS and improving outcomes is key to supporting a sustainable health system. Health and social care services in Kent are undergoing a significant

[i] https://www.kent.gov.uk/__data/assets/pdf_file/0003/93711/Strategic-Delivery-Plan-summary.pdf

[ii] https://campaignresources.phe.gov.uk/resources/campaigns/44-one-you

transformation in order to meet the challenges of changing demographics, increasing financial pressures and opportunities to improve health outcomes for the population.

2.4. Research by The King's Fund[i] has shown that unhealthy behaviours tend to cluster in the population and are more common in individuals in high areas of deprivation. These factors therefore play a key part in health inequalities. They also found around seven in ten adults do not follow guidelines on tobacco use, alcohol consumption, healthy diet or physical activity. The current picture in Kent highlights pockets of deprivation where the clustering of unhealthy behaviours results in health inequalities as highlighted below:

- 63% of the adult population in Kent are overweight or obese (770,000 people) and only 57.1% of Kent residents consume at least five portions of fruit and vegetables a day with only 46.6% in Dartford[ii]

- The prevalence of smoking in Kent is 15% which is higher than the national average. Prevalence of smoking in pregnancy in Kent (2018/19) is 14.2%.

- 20%[iii]of adults in Kent are physically inactive, and a total of 32% [iv]do not currently meet the recommended levels of 150mins of physical activity per week (2017/18).

- There are an estimated 153,000 dependent drinkers and 16,700 severely dependent drinkers in Kent and Medway.

- Mental health is also a key contributing factor to poor physical health and in a GP Patient Survey for 2016/17[v], 13.6% of Kent adults aged 18+ reported feeling moderate or high levels of anxiety or depression (170,000 people).

2.5. By encouraging the nation's adults to take control of their health by eating a healthier diet, drinking less alcohol, exercising more, and quitting smoking, OYK will help them enjoy longer and healthier lives, reducing costs to the health and social care system

## 3. What does the service provide?

3.1. The service offers an holistic approach underpinned by wellbeing which supports people to stop smoking, maintain a healthy weight, drink sensibly, increase activity levels and improve diet offering a combined approach towards multiple behaviour

[i] https://www.kingsfund.org.uk/publications/tackling-multiple-unhealthy-risk-factors

[ii] https://fingertips.phe.org.uk/search/weight#page/3/gid/1/pat/202/par/E10000016/ati/201/are/E07000105/iid/93077/age/164/sex/4

[iii] https://fingertips.phe.org.uk/search/weight#page/4/gid/1/pat/202/par/E10000016/ati/201/are/E07000105/iid/93015/age/298/sex/4

[iv] https://fingertips.phe.org.uk/search/weight#page/4/gid/1/pat/202/par/E10000016/ati/201/are/E07000105/iid/93014/age/298/sex/4

[v] https://fingertips.phe.org.uk/search/anxiety#page/4/gid/1/pat/6/par/E12000008/ati/202/are/E10000016/iid/90647/age/168/sex/4

change. By addressing behaviours holistically and understanding the drivers and factors behind them, it is more effective in supporting long term behaviour change.

3.2. Motivational Interviewing methodologies are used to encourage long term lifestyle behaviour change. This is achieved by working in conjunction with clients to set goals, breaking down barriers to change, linking in with local community assets (such as signposting and referring to additional support), tackling social isolation and developing a personal health plan that suits the individual.

3.3. There are multiple ways in which an individual may engage with the service. Routes may include via their GP, other key professionals, self-referral or through the Kent.gov.uk website. Individuals may also sign up to the service through community settings, subcontractors (e.g. pharmacy) and outreach delivered by lifestyle advisors.

3.4. Following a brief discussion and triage, individuals are informed of the choice and interventions available. Clients are assessed for suitability and their journey depends on their needs, preferences and complexity, motivation and readiness to change.

3.5. The criteria for the Tier 2 weight loss programme is BMI >30, (lower for certain BME groups) in accordance with NICE recommendations. A Tier 2 programme is offered for up to 12 weeks, incorporating behaviour change interventions, physical activity, nutritional advice, and structure support. This can be via one to one sessions with OYK advisors and pharmacies in East Kent or through group sessions.

3.6. The stop smoking services provide individuals with support to change behaviour. They utilise a range of options and determine the most compatible to engage the individual and increase the likelihood of long-term behaviour change. The service offers pharmacotherapy and, where appropriate self-help resources. KCHFT also subcontract to GP and Pharmacies to provide a more flexible approach to support individuals to quit smoking. Evidence shows that you are four times more likely to quit smoking if supported through a service. The service is also e-cigarette friendly for those individuals who prefer this option.

3.7. KCHFT provide county wide targeted support to pregnant women who are smoking to quit by offering a home visit. This was due to poor smoking rates in Kent and Nationally. A successful Home Visit service was piloted in Swale, South Kent Coast and Thanet prior to the wider offer being rolled out across the county. The Home Visit service is supported by the ‘What the Bump’ campaign which provides resources to support pregnant women to quit (Appendix 6). The Service provides a 26 and 52 weeks follow up to track behaviour change and attainment of long-term achievement of healthy lifestyle goals.

## 4. Who is the service for?

4.1. The OYK offer is universal for adults aged 18 and over, with no upper age limit but the service does have a degree of flexibility to accept people under 18 where appropriate. For example, it may be more appropriate for a 17-year-old who wants to stop smoking to utilise the services.

4.2. The service delivers structured support to those living in the most deprived communities, this includes those in both quintiles 1 and 2 and in the 89 LSOA's identified in the Kent inequalities work.

4.3. Key target groups include pregnant women, routine and manual workers, smokers, men and Black Minority Ethnic groups who are at risk of having excess weight and are under-represented in services. In addition to individuals who have multiple unhealthy behaviours, which increases their risk of long-term conditions and premature mortality.

4.4. The service often needs to resolve challenges like mental health, housing, debt or employment before they can tackle people's unhealthy behaviours that are preventing people living longer in good health.

## 5. How is it delivered in Kent?

5.1. The service is delivered through a partnership agreement with KCHFT and grants to the Districts in West and North Kent. KCHFT deliver healthy lifestyle services across the county, but in West and North Kent, KCHFT work with the Districts to avoid duplication with their services. KCHFT alone deliver the smoking cessation services and OYK outreach NHS Health Checks across the county.

5.2. The Advisors use motivational interviewing techniques to understand health goals and the barriers faced by the individuals in achieving them, by acting as a mentor to support and influence lifestyle change through practical goal setting.

5.3. An OYK shop has been set up in Ashford in partnership with Ashford BC. This provides a point of access where people are encouraged to pop in, ask questions and take advantage of the free health services on offer.

5.4. Advisors deliver the service in a variety of community-based venues across Kent including Children's Centres, Libraries, GP surgeries and pharmacies and Healthy Living Centres (HLCs). The HLCs are grant funded via KCC and offer similar support as the OYK Shop.

5.5. Marketing and communications are a key element in the delivery of OYK and aims to increase reach of the front facing services. A Joint Facebook and Instagram account facilitated by KCHFT was set up in 2019, this supports targeted and local messaging regarding the OYK services and for key campaigns.

5.6. Collaborative working between KCHFT and the Districts delivering OYK is working well. The County meeting has been put in place with all partners, including KCC PH Commissioners to come together to explore trends, continuous improvement and to share best practice. KCHFT and Districts meet regularly at an operational level to ensure that they are working together as effectively as possible.

## 6. What does good look like and how is the service performing?

6.1 The Service performance is monitored by the Public Health Commissioning Team to ensure that it delivers against the expected outcomes and quality standards. The key performance indicators, activity metrics and quality indicators include user satisfaction rates, contact times, deprivation, smoking quits and weight loss. More

information relating to these is set out below and provided in further detail in Appendix 2.

6.1 **Responsiveness** - There have been over 33,000 referrals to the services since April 2018 and on average over 3,000 individuals are engaged in this service quarterly. Those who do not engage may still receive information and advice on healthy lifestyles including a brief intervention and/or be signposted to online or community resources. The providers have a target to contact people being referred within 48 hours, they consistently achieve and exceed the 70% target.

6.2 **Deprivation** - The service is designed to target individuals who need the most support and a challenging target was set with providers to achieve 60% of those seeing an OYK Advisor being from quintiles 1 & 2. Although there is variation across the providers, at Kent level between 54% and 56% are from quintiles 1 & 2, work is underway to focus on how this can be improved.

6.3 **Smoking** - The Core smoking cessation service continues to deliver against target, with 8,651 setting a quit date between April 2018 and September 2019, and of these, 4,854 people achieved a four-week quit. This was a 56% quit rate against a target of 52%. This figure is expected to increase following rationalisation of third-party data.

6.4 The smoking cessation service introduced a new Home Visit service for pregnant women which was rolled out across the county in 2019 following evaluation of a successful pilot in Swale, South Kent Coast and Thanet. From April 2019, 1,923 women have been referred, 238 have set a quit date and 101 have achieved a four-week quit. Once the service is established a baseline target will be agreed.

6.5 **Weight management -** All elements of the OYK service would cover weight loss and the importance of a healthy diet and physical activity. For example, 1,639 individuals have set a goal around physical activity. Key apps that would be promoted include Sugar Swaps, Couch to 5K and Active 10.

6.6 In addition, the service has an Adult Tier 2 Weight Management programme (WMP). This is currently under review as the providers have experienced difficulties in engaging the expected number of Kent residents into the service, and levels of weight loss have varied greatly across providers and time frames. The numbers engaged in the WMP is small in relation to the Kent population who are overweight or obese. Wellbeing - Since the start of OYK, 4,516 have received a brief intervention on wellbeing. All interventions are underpinned by a conversation about mental health to support behaviour change using the SWEMWBS wellbeing scale.

6.7 **Alcohol** – An audit C screening tool is completed with all clients entering the service with the expectation that 90% of those who are medium or high-risk drinkers are offered brief intervention. To date 2,453 have received a brief intervention on alcohol reduction, and the aim is to support those with higher levels of drinking to reduce their units by at least 12 following an extended brief intervention.

6.8 **Health Checks –** There were a total of 483 Health Checks delivered against a target of 1600. The target set was aspirational as this is opportunistic testing and therefore is impacted by eligibility. The target will be reviewed now that we have 18 months of data and a clearer indication of the potential reach. For those individuals who were

not eligible for a Health Check, 3249 received a Health MOT through the OYK service.

6.9 **Service user experience:** The percentage of people satisfied or very satisfied with the service at the end of their intervention has been consistently reported as exceeding the 90% target with, the last 5 quarters being over 98%. The service also collects regular feedback in the form of case studies and uses learning to improve service. Case Studies can be found in Appendix 3.

6.10 **OYK Ashford Shop** - The Ashford Shop has been open since February 2017, in 2019 it moved to a larger and more prominent position. Since February 2017 to December 2019 there have been 8,090 visits to the shop and 9,085 healthy lifestyle interventions delivered. Healthy weight services have been consistently the most popular. 31% of people who visited the shop live in the topmost deprived wards in Ashford. In addition, there have been a total of 643 interventions delivered in the shop by external providers.

## 7 How much does it cost?

7.1 The service has a combined annual value of just over £4,698.400?, this includes the cost of smoking pharmacotherapy. Smoking quits and outreach NHS Health Checks are paid against invoiced activity.

7.2 The move to an integrated model in 2018 delivered approximately £900k savings and a further £600k savings were achieved through moving to a patient group directive (PGD) model for prescribing NRT.

7.3 **Value for Money -** The contract delivers value for money through its interventions leading to potential cost avoidances in the future. A large portion of ill health is avoidable – potentially preventable risk factors such as smoking, alcohol consumption, physical activity, diet, and others explain 40% of ill health in England.

7.4 **Return on Investment -** The services are preventative and focus on keeping individuals in good health and avoiding the need for costly treatment services providing positive returns on investment. For example, for every £1 spent on motivational interviewing for those with harmful drinking habits there is a £5 return on investment. Around 30% of this is from a reduction in NHS demand, 45% in additional alcohol support services and small reductions in social care costs. Also, health walking groups have been estimated to return over £3 for every £1 invested over 2 years. Most of these returns are based on improved quality of life and productivity. [i]

## 8 Risks and Service Improvements

8.1 **Risks** - Risks are logged and mitigation measures reviewed in line with the contract monitoring framework. Key risks for the service include increased demand impacting wait times, changes in the local care system, potential confusion of offer and service with the introduction of social prescribing roles and the risk of reduction in funding. A number of mitigating actions are in place to address risks.

[i] https://healthinnovationnetwork.com/wp-content/uploads/2017/09/FINAL-AUG-16-SWLS-RoI-ON-PublicHealthInterventions.pdf

8.2 **Service Improvements** - KCHFT and the Districts are working alongside Commissioners and PH Specialists on a range of initiatives as part of the commissioning cycle which are focused on improving the quality and effectiveness of the service. Below are the service areas which have been reviewed to date and some which are currently in development for 2020 and beyond.

- A county wide smoking in pregnancy home visit model went live in August 2019. The service has seen 306 individuals with 238 of those having set a quit date and 101 having achieved a 4 week quit. This supports Public Health England's target to reduce smoking at the time of delivery to 6% by 2022 (Kent is currently 14.4%).
- An integrated pathway is being considered for the point of discharge from acute, maternity and mental health services for people who have been offered smoking cessation drugs and counselling whilst in hospital settings.
- A review of the alcohol support within the OYK services has commenced following the needs assessment which highlighted a gap in provision with people drinking at medium to high risk. Delivery of this model will be in a phased way from April 2020. Further information on the proposal can be found at Appendix 4.
- A review of the Tier 2 Weight Management Programme is in progress. Initial findings have identified the importance of tackling weight management across the life course.
- KCC are in the scoping phase of the whole systems approach (Appendix 5), this will be informed by the Obesity Needs Assessment.
- Commissioners are also reviewing the Workplace Health strand of OYK. Findings from the review are being considered and recommendations are expected imminently.

The aim of these service reviews and improvements is to ensure alignment to emerging local care priorities and to sustain and continue improving the outcomes for Kent residents.

## 9. Conclusions

9.1 There is a clear case for KCC investment in Adult Healthy Lifestyle services to improve outcomes for Kent residents as set out in this paper. The service offers a single point of access through the OYK Website. 23,109 people have engaged in the integrated service offer since April 2018 and have engaged across all aspects of the service from receiving a health MOT to quitting smoking.

9.2 Findings from the reviews currently being undertaken will shape future commissioning decisions. Commissioning plans will be reviewed with key partners to ensure we are in line with the emerging Primary Care landscape and STP priorities.

## 10 Recommendations

The Health Reform and Public Health Cabinet Committee is asked to **COMMENT** on the performance of the OYK Service and the initiatives being undertaken to improve quality and outcomes.

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## APPENDIX 1 – Strategic Outcomes:

**KCC Strategic Statement:**

The commissioned services support KCC's outcome - **Kent Communities feel the benefits of being in work, healthy and enjoying a good quality of life.**

The following KCC Supporting Outcomes are also underpinned in this service:

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

KCC also has a statutory obligation under the Care Act to prevent the escalation of need which includes prevention, early identification and treatment of sexual disease.

**Health Inequalities:**

The services also supports Kent's Health Inequalities Action Plan 'Mind the Gap' which sets out what we are going to do to fulfil our new responsibilities to tackle health inequalities in our communities and to help keep us all -especially those with fewer advantages - to feel well and stay healthy. It focuses on:

- the long-term effects of a disadvantaged social position
- differences in access to information, services and resources
- differences in exposure to risk
- lack of control over one's own life circumstances
- a health system that may reinforce social and economic inequalities.

These factors all affect a person's ability to withstand the stressors -biological, social, psychological and economic - that can trigger ill health. They also affect the capacity to change behaviour.

Measures of health inequality are not primarily about health but of socio-economic status which has an impact on health and can lead to disease. Relative deprivation impacts on a person's ability to participate in or have access to employment, occupation, education, recreation, family and social activities and relationships which are commonly experienced by the mainstream. People in

deprived circumstances often do not present with major health problems until too late. Barriers to presentation include structural issues such as poor access and transport; language and literacy problems; poor knowledge; low expectation of health and health services; fear and denial and low self-esteem.

**Public Health England Outcomes:**

KCC has a statutory role to keep Kent well. This service is fundamentally a return on investment agenda which supports the following PHE Outcome 1:

**'Increased healthy life expectancy - taking account of the health quality as well as the length of life'.**

KCC require partner organisation to deliver an integrated healthy lifestyle One You Kent services in order to achieve the common objective of promoting healthy lifestyles among the Kent population in order to:

- Extend healthy life expectancy through prevention of chronic conditions such as obesity, cardiovascular diseases and diabetes.
- Reduce health inequalities
- Reduce avoidable demand on the health and care system in Kent.

The service supports the following PHE Outcome 2:

**'Reduced differences in life expectancy and healthy life expectancy between communities through greater improvements in more disadvantaged communities such as those in the most deprived quintile.**

Although the One You Kent offer is universal offer for adult 18 plus, KCC requires partners organisations to target more structured support to those living in the most deprived communities, this includes those in both quintiles 1 and 2 and in the 88 LSOA's identified in the Kent inequalities work. The key target groups including pregnant and routine and manual smokers, men and BME groups who are at risk of having excess weight and are unpresented in services and individuals who have more likely to have multiple unhealthy behaviours.

Part of these services requires KCHFT to engage Kent businesses in Public Health, to deliver an effective and efficient service for Kent. This shall improve the health of their workforce and support a prosperous economy. With a target to engage 50 workplace per district. This is programme supports enables 'Kent communities to feel the benefits of economic growth by being in-work, healthy and enjoying a good quality of life through Workplace Health support for employers to improve the health of their workforce'.

The Workplace Health programme contributes to improvements in the Public Health Outcomes Framework and the KCC Strategic Outcomes as follows:

- economic performance through improved workforce health and wellbeing, measured by human resource indicators such as reduced sickness absence, reduced turnover and increased productivity;
- public health through increasing the number of adults who can return or stay in the workforce for longer, therefore stemming the flow of adults who fall out of employment due to ill health and long-term conditions; and
- physical and mental health is improved by supporting people to take more responsibility for their own health and wellbeing

The service takes a targeted approach to ensure that routine and manual occupations are targeted, as are micro enterprises (employing 9 people or fewer). Evidence shows that routine and manual workers have on average an additional 1.5 days off sick per year compared to office-based workers.

The national NHS Five Year Forward View highlighted the need to radically increase the role of prevention to achieve improvements in health outcomes for the public, reducing health inequalities and promoting healthier lifestyles generally. It outlines the importance of opportunistic prevention and making every contact count. The Service will support the

implementation of the NHS guidance on 'Making Every Contact Count'.  KCHFT is trained and has rolled this out across the trust.

**Sustainability and Transformation Plans**

Sustainability and Transformation plans, NHS Long Term Plan 2019 (and NHS Five Year Forward View) – set out the need for radical changes and increase the role of prevention to achieve improvements in health outcomes for the public, reducing health inequalities and promoting healthier lifestyles. They aim to significantly reduce England's rate of obesity within the next ten years and are aiming for long-term, sustainable change which will only be achieved through the active engagement of schools, communities, families and individuals.

National Physical Activity strategies aim to increase physical activity as this has the potential to improve the physical and mental health and wellbeing of individuals, families, communities and the nation as a whole. Public Health England (PHE) wants to see more people being physically active.

The Kent STP set out priorities for action – prevention strand includes the following priorities:

- Obesity and Physical activity, delivering an almost fivefold increase in capacity in tier 2 weight management programmes

- Tailored smoking cessation services including for young people, pregnant smokers and people with mental health conditions

- Workplace health, working with employers on lifestyle interventions

- Reducing alcohol related harm in the population

One You Kent healthy lifestyle services align to the sustainability and transformation plan for Kent and Medway as adult health improvement is and prevention are central part of this plan. There is a significant degree of overlap between the priorities identified in the prevention element and integrated lifestyle services, this including smoking, obesity, healthy weight and workplace health.

**NHS Long Term Plan**

The NHS 10 year plan sets out First, that the NHS will make a significant new contribution to making England a smoke-free society by: offering people admitted to hospital who smoke a NHS-funded tobacco treatment services, providing expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments, and provide new universal smoking cessation offer as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services. On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings.

The plan signals a clear focus on prevention, recognising that the NHS can take important action to 'complement' – but not replace – the role of local authorities and the contribution of government, communities, industry and individuals. A 'renewed' NHS prevention programme will focus on maximising the role of the NHS in influencing behaviour change, guided by the top five risk factors identified by the Global burden of disease study: smoking, poor diet, high blood pressure, obesity, and alcohol and drug use.

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| Service | KPI's and Activity Metrics | Target 19/20 | Q3 18/19 | Q4 18/19 | Q1 19/20 | Q2 19/20 | Q3 19/20 |
|---|---|---|---|---|---|---|---|
| Lifestyle Service – general | Number of referrals into the OYK Service with % contacted within 48 hours | 70% | 4,239<br>81% (g) | 5,166<br>81% (g) | 4,889<br>81% (g) | 5,349<br>79% (g) | 5,333<br>80% (g) |
| | Number of individuals active within the OYK Service | - | 3,447 | 4,210 | 3,951 | 4,207 | 4,243 |
| | Number and percentage of clients engaged with OYK Advisors being from the most deprived areas in the County | 60% | 433<br>56% (a) | 506<br>56% (a) | 524<br>55% (a) | 636<br>54% (a) | 677<br>55% (a) |
| | Number of MOTS taken up and delivered to clients | - | 491 | 770 | 679 | 653 | 656 |
| | Number and percentage of NHS Health Checks delivered, of those offered one | 1,600 | 86<br>45% (r) | 163<br>30% (r) | 79<br>19% (r) | 60<br>14% (r) | 95<br>52% (r) |
| | Number of eligible individuals receiving a brief intervention on alcohol | - | 143 | 163 | 562 | 739 | 569 |
| | Number of eligible individuals receiving a brief intervention on wellbeing | - | 507 | 727 | 672 | 813 | 736 |
| Smoking Cessation Service | Number of individuals referred to the smoking cessation service | - | 2,961 | 3,384 | 2,308 | 2,499 | 2,507 |
| | Number of people setting a quit date with the service | - | 1,455 | 1,649 | 1,493 | 1,519 | nca |
| | Number and percentage of people quitting at 4 weeks, having set a quit date with the service | 52% | 762<br>52% (g) | 981<br>59% (g) | 844<br>57% (g) | 898<br>59% (g) | nca |
| Weight Management Service | Number of individuals engaged in the Healthy Weight Programme in the quarter | | 277 | 231 | 260 | 186 | 135 |
| | Number and percentage of individuals who have lost up to 3% body weight | 60% | 191<br>69% (g) | 97<br>42% (r) | 123<br>47% (r) | 56<br>30% (r) | 80<br>59% (a) |
| Satisfaction | Number and percentage of individuals who were satisfied or very satisfied with the service receive, at the end of the intervention | 90% | 262<br>100% (g) | 266<br>100% (g | 432<br>99.5% (g) | 506<br>99.2% (g) | 543<br>98.9% (g) |

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## APPENDIX 3 – Case Studies and Quotes

### Service User Quote

"This has been life-changing. I feel like a completely different person to when I started. You've got to the be in the right place to do it. When I started, I set this target of weight loss and a walking goal. It almost seemed unachievable. To have done it is amazing and bring on the next."

### GP Feedback

"The One You service really helps my patients. As a GP I don't always have the time to talk to patients about some of the wider issues they may be experiencing. Knowing I can refer to a service that will give the person that time to talk and explore what is going on in their life is really helpful. Also some of my patients are really vulnerable so knowing that the One You service will accompany that person on a health walks or into a gym for the first time for example is great. I am seeing patients now that have benefitted from referrals to the One You team, because they are focussed around that person and they provide an holistic service."

### One You Lifestyle Service

Male, aged 72 years old, referred by the NHS Health Check Team to Hayley, One You Lifestyle Adviser to help with diet and lifestyle changes due to a raised BMI.
The client wanted to look at their diet specifically as they said they get confused by all the 'healthy eating' messages and wanted to hear factual, clear messages that he can put into his everyday life.

The client was really open and receptive at all of the appointments and attended on time and did not miss one. He embraced the messages and was open with regards to the lifestyle changes he would do and those he would not. He embraced a number of changes in his diet including cutting down on fruit juice, eating more fruit and vegetables and the importance of moderation and portion control.
Hayley, One you lifestyle adviser said "The client had lost his wife and was quite lost under all of the dietary guidelines, so I really wanted to ensure he had the correct information. His wife used to do all of the cooking and after losing her he said he found it quite difficult. Not only did he benefit from the appointments with me, he gained a lot from social interaction at the community group he attended first on a Thursday and then later on the Friday too. He was very engaging, responsive and open to discussion which made the appointments very enjoyable".

### One You Smoke Free Case Study

This client was referred for support with quitting by her GP; she has COPD, which was having quite a negative impact with her breathing. When Helen met her she was smoking 40 cigarettes a day, and would smoke also during the night.
The client was extremely anxious on the first meeting, not feeling very positive about giving up as she relied heavily on her habit, but due to her worsening health, knew she had to try. She quit within the first week of being on the products and gained so much support from the other clients, that this gave her the encouragement to continue. She also downloaded the smoke free app, and every week and would inform the group how much money she had

saved. She became quite a positive role model within the group and everyone was inspired by how well she looked and of the financial gains she had made.
Helen, Smoke Free adviser said “I learnt how to trust my instincts, and never give up trying to help the people within our service. I saw so much positivity and changes to this lady’s health and wellbeing. Taking time to talk and getting to know my client, created a positive rapport which I feel helped with her quit, and positive outcomes, she too felt confident with openly discussing her problems, which aided my responses with referrals and further support”

**Weigh Loss Case Study**

The main intention in joining Counter - Weight was to lose weight for good and mitigate any future health concerns in being obese. | was also looking to join a group that all had similar desire so we can support and motivate each other In session one we were told one of the goals was to lose over 5% of body weight by session 6. Which initially | thought was really difficult. However, | embraced the challenge by reducing my calorie count to below recommended daily intake to lose weight and | went from zero days of exercise to 3 to 4 days.

The sessions were well run by One You Maidstone and participants were encouraged to share their stories when we met every other week. We were given three handbooks which were simple and clear to follow. As you can suspect there were varying degrees of success, but everyone was given the same encouragement. Finally, the sessions with a degree of fun so it was enjoyable. I like to thank Pat and Sanyo for their patience and encouragement. Without One You and them | am sure | will still be struggling to meet the 5%. Happily, | reached the goal in session 5 and happily took the challenge to lose another 5%.
Thank you to you both

**Weight Loss Case Study**

My weight loss journey started almost 2 years ago when all 133.5 kgs (21 stone) of me waddled into my GPs, for an appointment to see a nutritionist. I had been diagnosed with type 2 diabetes, my eating and drinking had spiralled out of control and my general health was a mess. The Nutritionist I saw that day was Jade Howlett who would, over the coming months, guide and advise me on all aspects of a healthier lifestyle. She also set me a target. Get to 99 kgs. (Later I revised this to 88 kgs). Jade also introduced me to walking football and an organisation called WHY WEIGHT now called ONE YOU. Little did I know that this healthy lifestyle club would change my life. The One You Adult weight management program is totally free of charge. Normally you are referred onto it by your GP. We meet once a week and the course is12 weeks. Each session lasts 2 hours.1 hour is devoted to discussion on topics that include portion sizes, understanding food labelling, good and bad food and tips on avoiding seasonal excesses. A trained nutritionist would take the discussion.
The second hour is for exercise and is taken by a qualified Personal Trainer.
So now, finally, I have reached my two goals.
1...My GP has confirmed I no longer have type 2 diabetes.
2...I now weigh 87.5 kgs (13 stone 11 lbs) which means that I have reached my target of losing 100 lbs.

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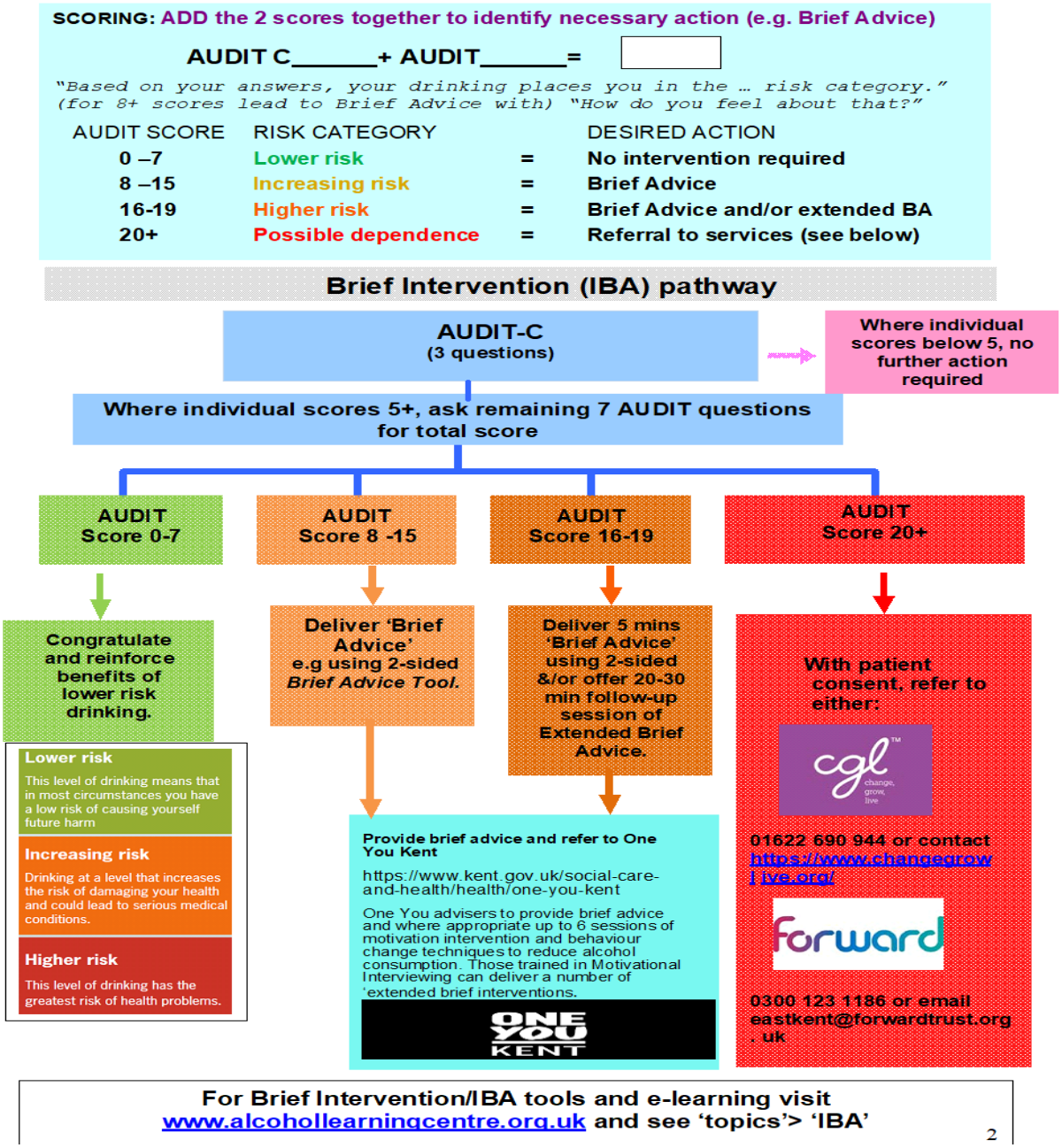
**Appendix 4 – One You Kent Transformation – Alcohol Interventions**

**Transformation aims**



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## APPENDIX 5 Whole Systems Approach to Obesity

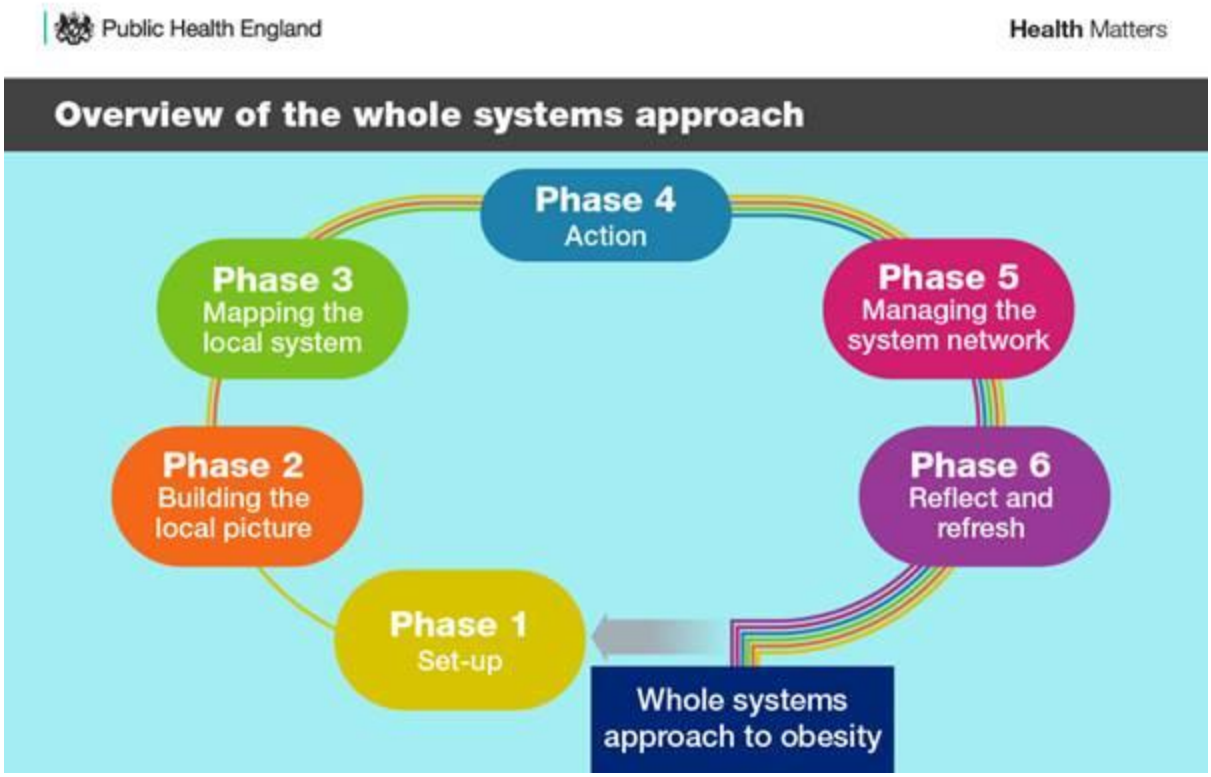
A growing body of evidence, including Foresight's Tackling Obesities: Future Choices report, suggests that a whole systems approach could help address complex problems like obesity. The Whole Systems Approach to Obesity Programme provides the following definition:

"A local whole systems approach responds to complexity through an ongoing, dynamic and flexible way of working. It enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change. Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long term systems change".

A local whole systems approach to obesity is a 'Health in All Policies' approach, which draws on local authorities' strengths, supports their leading priorities, and recognises that they can create their local approaches better and more effectively by engaging with their community and local assets.

Actions to address obesity at a local level do not just benefit people's health. Delivering a more health-promoting and vibrant environment can contribute to issues like reducing litter and improving the environment and support local businesses and workforces. Maintaining a healthier local workforce may also have positive impacts on other longer-term local agendas, including employability and productivity of local populations, and the demand for social care.

Adopting a whole systems approach is not something that can be achieved overnight; it can take up to 5 years to implement and imbed. PHE identifies 6 phases that are required in order to successfully implement the approach, as below:



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**APPENDIX 6 – Smoking Cessation – 'What the Bump campaign**

**What the Bump Leaflet (below)**

Campaign background

Key Public Health outcome:

Reduce smoking in pregnancy. Smoking status as time of delivery in Kent is 14.4% and the ambition is to reach 6% by 2022.

Target audience:

- Pregnant women and women who are trying to conceive.
- Between the ages of 18 to 40. Though smoking prevalence is more social class linked rather than age.

Previous campaigns have been audience specific – for example 'What the bump' which targeted pregnant mothers in Sheppey and Swale. This was a social marketing campaign based on evidence that showed more targeted intervention was required to help influence the choices made by younger pregnant women. We advise that this is used as the marketing support to the specialist midwife and home visit advisers across Kent (bearing in mind west Kent posts will be rolled out during the summer).

Public Health report 8,177 maternities per year in the East Kent and Swale area – this would be approximately 1,490[1] smokers. We should also target women smokers in these areas who may be trying to conceive.

More general promotion of smoking cessation services has included support for the national PHE Stoptober and Health Harms campaigns with media and PR channels utilised plus supporting Facebook advertising which reached over 143,000 users with 3,600 click throughs.

Messages have been tailored to raise awareness of the health harms to smokers including low weight babies and highlighting the risk to oxygen levels to the baby.

The One You Kent website hosted at kent.gov has been redeveloped and the smoking cessation pages will feature content about smoking in pregnancy. We should investigate and consider online support such as an app specific to this group.

We should also consider the potential of a PHE Kent campaign around women who smoke who are trying to conceive. We are in early discussions with PHE about Kent being one of three pilot areas where they will conduct a research project into behavioural insights of women who are trying to conceive. This could lead to a digital marketing media campaign and possibly some outreach activity later in 2019.

[1] Ibid

The approach to date has primarily been led by digital consumer marketing. The ‘What the Bump?’ campaign in Swale demonstrated the success of targeted communications and interventions through stakeholder engagement.

We recommend that the printed materials are tailored as appropriate to west and east Kent areas and delivered through the key intervention points – primarily the specialist smoking cessation midwifes and home visit advisors. Secondary communications channels include distribution to CCGs, GPs, hospital trusts, pharmacists and children’s centres.

The digital promotion will be timed to follow the rollout of home visitor posts in west Kent and delivery of printed materials. We will scope a three month digital and online campaign to launch in September which will support the ‘What the Bump?’ call to action key messages of contacting midwives for support and a secondary message theme through Stoptober in October to raise awareness of One You Kent smoking cessation services for pregnant women and their partners and families.

Key aims

The campaign aim is to:

Get: Pregnant mums – and women who are trying to conceive

To: Stop smoking

By: Accessing specialist support.

The calls to action are to:

- Encourage pregnant women who smoke to access the specialist services – the key message being ‘speak to your midwife’.
- Encourage women to use the apps and online support where available
- Encourage pregnant women who smoke to also visit the One You Kent website for specific advice and support.
- Encourage women who are trying to conceive to visit the One You Kent website for specific advice and support to quit.
- Encourage partners and families of pregnant women to access smoking cessation services if they smoke.

Engaging content can be delivered via the following strategies;

- Localising content and making the What the Bump messages relevant to women in specific areas of Kent.
- Delivering tailored messaging at key times when it is known certain behaviours are more likely to be triggered.
- Targeting our key audiences using known motivations that can help encourage women to consider quitting
- Social media and paid for advertising channels should also be used in Swale where WTB is already being rolled out by key professionals and stakeholders.

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What the bump?

Kent County Council kent.gov.uk

# What the Bump?

Reducing the number of babies born to smoking mothers by increasing dialogue between mums and midwives.

## The challenge

Smoking during pregnancy is a national health issue. The effects can have major and lasting health implications on both mother and baby, from premature delivery to increased chances of miscarriage, stillbirth and sudden infant death.

When we first started the project, Kent's smoking figures were above the national average and amongst the worst in the country (13%), equating to 2,000 babies born every year to smoking mothers. In particular, the Isle of Sheppey, had the highest rate in Kent and the eighth highest in the country, with more than 1 in 5 babies born to smoking mothers.

## The insight

Leveraging behavioural research conducted across Kent with mothers, pregnant women, midwives and service providers, we identified 2 critical barriers that were resulting in a lack of positive behaviour change. The first was a **'limited perception of risk'**; with women adopting a "it won't happen to me" mindset. The second was **'a difficulty with developing an emotional bond with their bump'**, perceiving that motherhood began at birth rather than conception.

Across both barriers, it was also clear that there was a lack of clarity and consistency in the communication of messages, with a mixed understanding of what was fact and what was fiction in relation to the implications of smoking whilst pregnant.

## The action

Through testing we identified midwives as the key vehicle to deliver effective and timely messages that demystified the facts surrounding pregnancy and smoking. It was apparent that giving women the real facts wasn't enough. They needed to delivered by people that they trusted and in ways that were relevant and personal to them.

The solution was a co-designed behaviour change campaign and intervention mix that formed part of a holistic service for women across channels and touchpoints, ensuring that they were give the correct information, at a time that was right for them. The campaign and intervention was unified by a powerful What The Bump? brand, and provided midwives and health service providers with tools, resources and guidance they needed to tailor information to the individual needs, knowledge or attitudes of women.

## What the Bump?

What the Bump? is a campaign delivered by midwives and service providers through:

**Out of home channels** – What the Bump? is an out of home campaign to demystify the facts about pregnancy and rebuild trust between health professionals, women and midwives.

**A new service intervention** – The Book of Bump is a service intervention to support delivery of What the Bump? and help women build an emotional bond with their baby before he or she is born.

The Book of Bump is a pregnancy journal for mothers to record their experiences and emotions through to the birth of their baby and beyond. Based on conversations with expectant mothers, midwives and health professionals are able to give personalised information, through tailored pages, based on an individual women's emotional or physical health needs, including smoking facts and ways to quit.

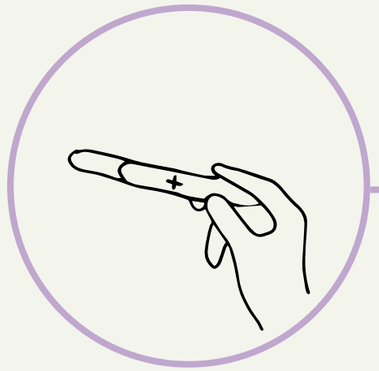
## Impact

The process engaged with over 50 women, midwives and service providers to create a tailored campaign for the Isle of Sheppey. What the Bump? is currently being tested with women across Kent with the likelihood of more national test areas being adopted in the near future.

Co-designed campaign with:

| 30 | 19 | 12 | 10 |
|---|---|---|---|
| Young mums | Health professionals | Stop smoking advisors and pharmacists | Staff at Children's Centres and mum's groups |

# Campaign journey



**1**

Woman finds out she is pregnant.


**2**

Women hears about campaign through GP surgery and pharmacist through posters, postcards, badges and stickers. All materials encourage women to start a conversation with their midwife.

**3**

Women meets midwife who talks to her about some of the risks of smoking whilst pregnant, using tailored postcards. They then work together to fill in the health and wellbeing questions on the reverse.


**4**

Midwife introduces the Book of Bump. A pregnancy journal encouraging women to start building a bond with bump. The midwife tailors the pages based on the needs of the individual women.




**5**

During ongoing visits the midwife continues to give pages throughout each trimester of the women's pregnancy. The first trimester pages include important contacts and details, top tips for quitting, 'How are you?' and a space for the women to include the baby's scan.


**6**

Second trimester pages include: 'How are you?', 'How big is your bump?' and writing a letter to baby.


**7**

Third trimester pages include: Naming, birth page and top tips for fitting in 'me-time' to encourage women to quit.


**8**

Pages provided for after the birth for Mum to continue to fill in the pages about how she is feeling, and how her baby is doing.

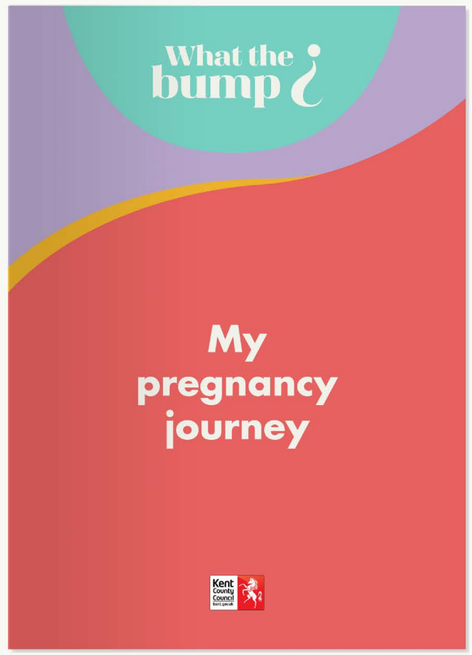
# Insights and outputs

**1** **Limited perception of risk**

## Print campaign


**2** **Difficulty developing an emotional bond with their 'bump'**

## Pregnancy journal



# 1

# Print campaign

A print campaign to demystify the facts about pregnancy. This campaign consists of factual posters and postcards which encourage women to start a conversation with their midwife and/or health professional. Midwives are also given support materials, including badges, stickers and magnets, to further increase dialogue.

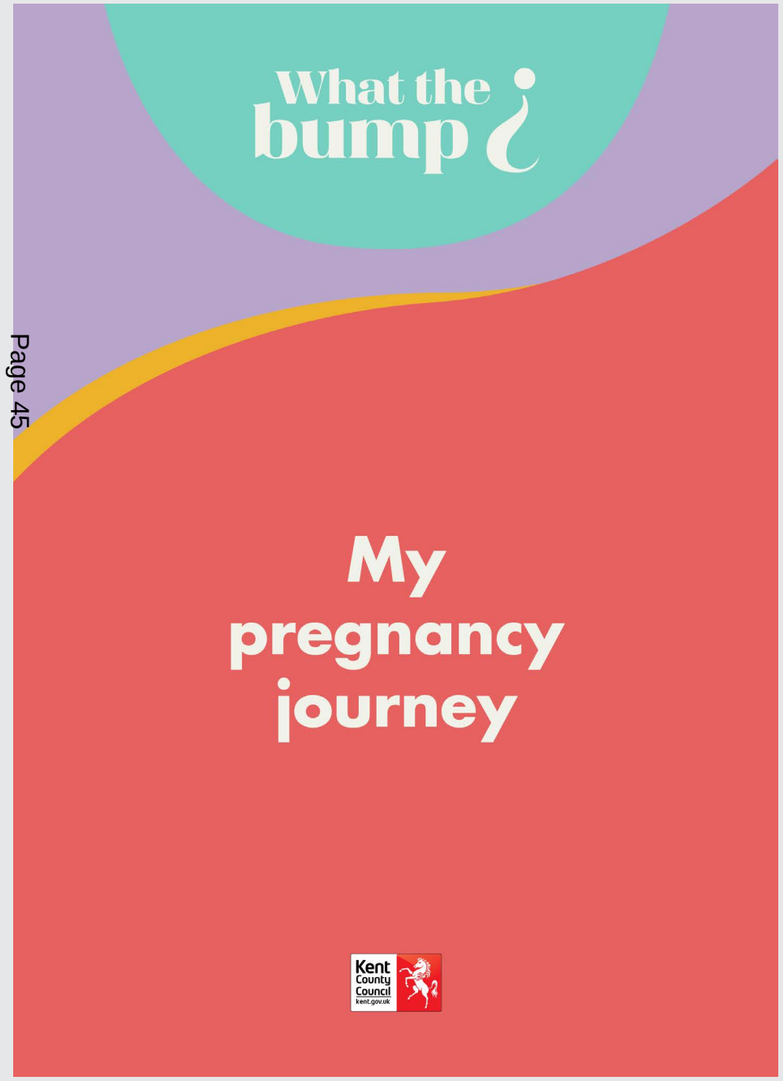



# 2

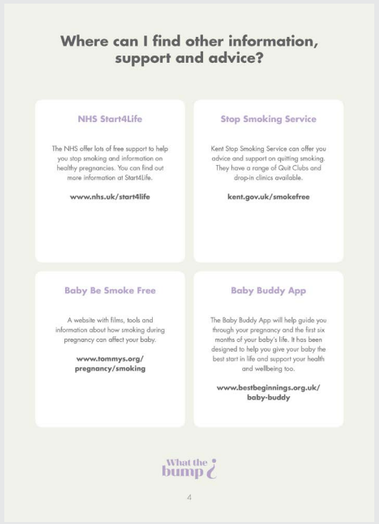
# Pregnancy journal

Whilst the print campaign aims to educate and build trust, the journal aims to grow the emotional bond between mother and bump. The journal folder will be given to expecting mothers at their first midwife appointment, with selected pages being given along the way during relevant trimesters. The journal includes pages for naming, scan image, 'how big is your bump?' and personal diary entries.

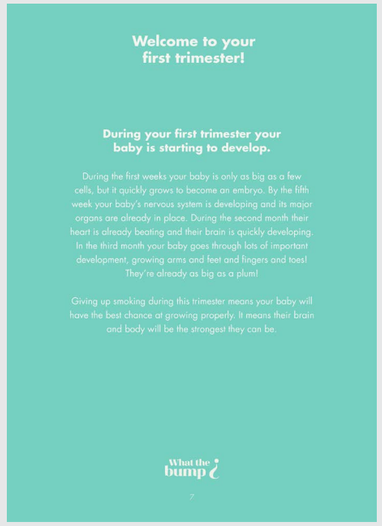
















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From: Clair Bell, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee – 6th March 2020

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

Classification: **Unrestricted**

**Past Pathway of Paper:** None

**Future Pathway of Paper:** None

**Electoral Division:** All

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

**Recommendation(s)**:

The Cabinet Committee is asked to consider and comment on the risks presented.

## 1. Introduction

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

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

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

1.4 Corporate Directors also lead or coordinate mitigating actions in conjunction with other Directors across the organisation to manage risks featuring on the Corporate Risk Register. The Director of Public Health is one of three

designated Risk Owners for the corporate risk relating to development of Integrated Care System / Integrated Care Programme in Kent and Medway, along with the Corporate Director for Adult Social Care and Health and the Council's Strategic Commissioner. This risk is presented for comment in appendix 2.

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

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

## 2. Financial Implications

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

## 3. Policy Framework

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

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

## 4. Risks relating to Public Health

4.1 There are currently 11 risks featured on the Public Health risk register (appendix1), none of which are rated as 'High'. Some of the risks highlighted on the register are linked to risks on the Authority's Corporate Risk Register. For example, the risk of communicable disease outbreak is contained within the Civil Contingencies and Resilience risk. Many of the risks are discussed as part of regular items to the Cabinet Committee.

4.2 The partnership agreement between the authority and Kent Community Health NHS Foundation trust has now been extended for a further five years to enable the continued delivery of key public services, which KCC has a statutory responsibility such as Health Visiting, Sexual Health and NHS Health Checks Service.

4.3 Public Health Commissioners have undertaken Risk management training to ensure that there is consistency and understanding when reviewing risks.

4.4 Changes to the Public Health register are listed below with most of the new risks added are in respect of service demand against contracted values.

- PH0091 increased demand on services including Sexual health and Health visiting.

- PH0088 increased demand for drug and alcohol services creating waiting lists within the Tier 4 element of service provision.

- PH0089 increase in Buprenorphine drug costs, which is one of the main drugs used in Opioid substitution treatment and as such has seen an increase in its price.

- PH0092 NHS England (NHSE) funding HIV services and PrEP pilot – There is a shortfall from the funding provided by NHSE for the delivery of these services. It has been identified that there is a risk regarding the additional costs for clinic time and testing for PrEP should this transfer to local authorities.

- PH0090 Health Visitor and School Nurses recruitment; This is a national issue resulting from a decrease in Health Education England (HEE) funding for training places. However, these staffing vacancy rates have seen an improvement since it was added to the register and will continue to be monitored through contract monitoring.

- PH0093 KCHFT new systems; this temporary risk has been added to highlight the implementation of a new system used to record and report on the delivery of PH Services. As with any system change there is a risk to both service delivery and reporting.

- PH0087 Brexit this risk was added in relation to a no-deal exit from the European Union.

- PH0082 Compliance with the General Data Protection Regulations has between withdrawn as this is now part of all contracts and is reviewed through contract monitoring meetings

4.5 Given the risk of the Corona Virus (Covid19) Public Health are continuously monitoring the situation in Kent and should there be any cases in Kent that sees a change in a sustained transition then the CBRNE corporate risk would be escalated with a review of the controls and

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

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

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

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

## 5. Recommendation

**Recommendation**:

**The Health Reform and Public Health Cabinet Committee** is asked to consider and comment on the risks presented in appendix 1

## 6. Background Documents

6.1 KCC Risk Management Policy on KNet intranet site.

## 7. Contact details


| **Report Authors:** | **Relevant Director:** |
|---|---|
| Pam McConnell<br>Pam.mcconnell@kent.gov.uk<br><br>Mark Scrivener<br>Mark.scrivener@kent.gov.uk | Andrew Scott-Clark<br>Director of Public Health<br><br>Andrew.scott-clark@kent.gov.uk |

| Risk ID | CRR0005 | Risk Title | Development of ICS/ICP in Kent and Medway NHS system | | |
|---|---|---|---|---|---|
| **Source / Cause of Risk** | **Risk Event** | **Consequence** | **Risk Owner** | **Current Likelihood** | **Current Impact** |
| The Kent & Medway NHS system is under significant pressure with increasing levels of demand driving across financial deficits across commissioner and provider budgets, placing pressure on the Kent & Medway NHS system control total.<br><br>In response the NHS in Kent and Medway forming an Integrated Care System (ICS) with 8 CCGs merging to form the basis of the System Commissioner, above four ICPs (Integrated Care Partnerships) and 42 PCN's (Primary Care Networks).<br><br>The policy intent of structural reform is to deliver better strategic planning and delivery of health and social care services at place-based community level and shift from acute to primary and community level services.<br><br>The relative roles and responsibilities between the proposed ICS and the emerging ICPs in Kent is still under development. The final legal structure and functional responsibilities of ICPs is still | Failure to develop more partnership and aligned health & social care services and commissioning at both ICS and ICP level places pressure on system finances and hinders highest possible quality of care<br><br>Development of four ICP generates additional demand/work on strategic leadership of KCC, particularly in ASCH and Public Health which has significant opportunity costs, including impact on business as usual activity.<br><br>Multiple ICP's leads to differences in form, function and relationships between ICPs and the ICS and/or KCC which increases system complexity and leads to variation which increase costs/risks.<br><br>System complexity leads to failure to meet statutory duties around the sufficiency of the care market, care quality and safeguarding. | Further deterioration in the financial and service sustainability of health and social care services in Kent and Medway.<br><br>Additional budget pressures transferred to social care as system monies are used to close acute and primary care service gaps.<br><br>Legal challenge/judicial review of decisions and decision-making framework for joint decisions.<br><br>Social care and public health priorities not sufficiently factored into/shaping emerging ICS/ICP plans and priorities, weakening integrated approach.<br><br>Focus on structural changes workstreams prevents more agile improvements/joint | Penny Southern, Corporate Director Adult Social Care & Health (ASCH)<br><br>Vincent Godfrey, Strategic Commissioner<br><br>Andrew Scott-Clark, Director Public Health<br><br>**Responsible Cabinet Member(s):**<br><br>Roger Gough, Leader of the Council<br><br>Clair Bell, Adult Social Care and Public Health | Possible (3)<br><br>**Target Residual Likelihood**<br><br>Unlikely (2) | Serious (4)<br><br>**Target Residual Impact**<br><br>Serious (4) |

| | | | |
|---|---|---|---|
| under development and may require primary legislative change.<br>Regulators (CQC / Ofsted) increasing review health and care services and the commissioning/performance of those services and 'system' level. | Lack of understanding within KCC of NHS policy and regulatory environment; and vice versa, lack of understanding of local authority legislative, policy and democratic environment in NHS. | working being undertaken.<br>Reputational damage to either KCC or NHS or both in Kent.<br>Adverse outcome from CQC local system review. | |

| **Control Title** | **Control Owner** |
|---|---|
| Health Reform and Public Health Cabinet Committee provides non-executive member oversight and input of KCC involvement in the STP | Ben Watts, General Counsel |
| Senior KCC political and officer representation on the System Transformation Executive Board and System Commissioner Steering Group | Penny Southern, Corporate Director ASCH<br>Andrew Scott-Clark, Director Public Health<br>Vincent Godfrey, Strategic Commissioner |
| Senior KCC level officer representation on the East Kent, West, North and Medway & Swale ICP Development Boards | Penny Southern, Corporate Director ASCH |
| County Council agreed framework for KCC engagement within the STP | Penny Southern, Corporate Director ASCH |
| A joint KCC and Medway Health and Wellbeing Board for STP related matters/issues has been established | David Whittle, Director SPRCA |
| Public Health Leadership for the STP Prevention workstream | Andrew Scott-Clark, Director Public Health |
| Working through KCC Public Health partnership with the Kent Community Healthcare Foundation Trust (KCHFT) to ensure Public Health improvement programmes are linked and delivered alongside Local Care through Primary Care Networks and other primary care providers (e.g. community pharmacy) | Andrew Scott-Clark, Director Public Health |

| Action Title | Action Owner | Planned Completion Date |
|---|---|---|
| Review appropriate level of KCC representation at subject specific ICP boards once the governance has been finalised in each ICP. | Penny Southern, Corporate Director ASCH | April 2020 (review) |
| Implementation of Adult Social Care and Health whole system Programme of change to deliver social care outcomes in a more efficient and sustainable way. | Penny Southern, Corporate Director ASCH | May 2020 (review) |

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# Full Risk Register

**Risk Register -** Public Health

| Current Risk Level Summary | Green 0 | Amber 11 | Red 0 | Total 11 |
|---|---|---|---|---|
| Current Risk Level Changes | | | | |

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 3 | 0 | 0 |
| 0 | 0 | 3 | 0 | 0 |
| 0 | 0 | 2 | 1 | 1 |
| 0 | 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 0 | 0 |

| Risk Ref | *PH0091* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **Increased Demand on Services**<br><br>There is a risk that services may not have the capacity to deal with the additional demand and there is also a cost pressure associated with this. | | | Victoria Tovey | 31/01/2020 | 29/04/2020 |

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| Increasing demand for Public Health Services due to changes in demography - for example growth in new births will increase the number of mandated contacts that Health visiting need to complete. Sexual health services have seen a continue rise of services. | We may be overspent on Sexual Health services or be unable to deliver against mandated requirements eg Health Visiting. | Medium<br>15<br>Significant (3)<br><br>Very Likely (5) | | • Transformation projects aim to introduce more digital solutions to assist with increasing demand.<br>• ongoing support from KCC property services to source appropriate sites for service delivery.<br>• Open book accounting with both providers and also NHSE to monitor costs. Quarterly meetings with NHSE to monitor this and wording in section 75 proposes that they meet any shortfall.<br>• Quarterly performance monitoring meetings provide opportunities to discuss service provision and for both parties to raise any concerns regarding levels of service, quality or risks can be discussed. | Victoria Tovey<br><br>Victoria Tovey<br><br>Victoria Tovey<br><br>Victoria Tovey | A -Accepted<br><br>Control<br><br>Control<br><br>Control | 31/03/2020 | Low<br>5<br>Minor (1)<br><br>Very Likely (5) |

**Review Comments** continuing to monitor as part of both contract and budget monitoring meetings
31/01/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | *PH0088* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **Increased demand on Drug & Alcohol Services**<br><br>There is a risk that services do not have capacity to see people being referred into the service, staff may also be required to attend the new MDT that are being set up and staff capacity for this may be difficult. | | | Victoria Tovey | 31/01/2020 | 24/04/2020 |

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| Increasing demand on services both with people coming into service and expectations of being part of the new health structures MDTs | Which will lead to: Increasing waiting list, quality of services may reduce as case loads increase, service may not be able to meet targets due to capacity of providing a good, quality interventions. Staff wellbeing reduce due to additional case loads/work | Medium<br>15<br>Major (5)<br><br>Possible (3) | | • Capacity models have been developed to ensure services have the ability to meet need and activity can be adjusted accordingly | Victoria Tovey | Control | | Medium<br>8<br>Moderate (2)<br><br>Likely (4) |

**Review Comments** drug costs are continuing to be reviewed at both contract and budget monitoring meetigns
31/01/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | *PH0087* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **Brexit** | | | Victoria Tovey | 31/01/2020 | 01/06/2020 |

There is a risk that:
- due to the close proximity to boarder of France, sever traffic congestions may occur.
-supply issues on medication for substance misuse may be limited, due to the drugs being made outside of the UK.

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| Britain's Exit from European Union | Staff not being able to drive or travel easily across Kent, service can be disruptive and target may not be met because of this<br>- People who need substitute medication for substance misuse may not be able to receive the medication resulting to people start using or using more illegal substances. | Medium<br>15<br>Significant (3)<br><br>Very Likely (5) | | • Services have updated their Business Continuity Plans and looked at workforce planning. | Victoria Tovey | Control | | Medium<br>8<br>Moderate (2)<br><br>Likely (4) |

**Review Comments** as Central Government has agreed a plan and a transitional phase in underway this will continue to be reviewed during this time
31/01/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | *PH0092* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **NHSE funding HIV services**<br><br>NHSE have agreed to fund up to £1.4m for HIV services but capacity modelling has indicated services cost up to £1.6m. PrEP pilot is funded by PHE but they only cover the cost of the drugs, therefore the clinic time and testing costs are a cost pressure to Local Authorities and there is an increasing demand for this service. | | | Victoria Tovey | 31/01/2020 | 29/04/2020 |

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| Financial uncertainty including NHSE funding for HIV services and PREP Pilot and also uncertainty over Pension Gap funding for NHS Staff | We may be overspent on Sexual Health services | Medium<br>15<br>Significant (3)<br><br>Very Likely (5) | | • Open book accounting with both providers and also NHSE to monitor costs. Quarterly meetings with NHSE to monitor this and wording in section 75 proposes that they meet any shortfall. | Victoria Tovey | Control | | Low<br>6<br>Moderate (2)<br><br>Possible (3) |

**Review Comments** this remains under review at budget monitoring meetings
31/01/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | PH0090 | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **Health Visitor and School Nurses staff recruitment**<br><br>There is a risk that high numbers of staff leave and that not enough new staff can be recruited to sustain the service. | | | Victoria Tovey | 31/01/2020 | 30/04/2020 |

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| Difficulties in recruiting and retaining nursing staff, specifically Health Visitors and School Nurses. There is a national shortage of qualified Health Visitors. The number of Health Visitor student places funded by Health Education England has declined. | Service delivery is impacted. Clinical and Safeguarding risk to children within the Health Visiting and Schol Public Helath Service. Some visits may have to be postponed or reprioritised. | Medium<br>12<br>Significant (3)<br><br>Likely (4) | | • Risk reviewed on a monthly basis at 0-5 Service Governance and Public Health Governance meeting. Progress with recruitment and retention reported at the Executive Performance Review meeting. | Victoria Tovey | Control | | Medium<br>8<br>Moderate (2)<br><br>Likely (4) |
| | | | | • A safe staffing, safe working protocol has been agreed to effectively manage the workload of the teams in a safe and consistent manner. | Victoria Tovey | Control | | |
| | | | | • Quarterly reviews of the operating model for health visiting undertaken. | Victoria Tovey | Control | | |
| | | | | • Band 5 Community Public Health Nurse role has been introduced to provide additional support to cover universal workloads. | Victoria Tovey | Control | | |
| | | | | • Bank and agency staff are being recruited to support teams where possible to cover vacant posts. | Victoria Tovey | Control | | |
| | | | | • Recruitment and retention action plan is in place and monitored through the Quality Action Team and governance meetings. | Victoria Tovey | Control | | |
| | | | | • Continual review on a weekly basis of the Health Visiting workload allocated to district teams overseen by the District Manager. | Victoria Tovey | Control | | |

**Review Comments** staffing vacancy rates have seen a reduction and will continue to be monitored
31/01/2020

| Risk Ref | *PH0093* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **KCHFT - new system implementation**<br><br>There is a risk that implementation may result in issues in data accuracy or downtime of services. | | | Victoria Tovey | 31/01/2020 | 29/04/2020 |

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| KCHFT is implementing a new system across the Trust. This will be used to record and report on delivery of PH services. | This would impact on KCC's ability report nationally on Health check, smoking and sexual health services. | Medium<br>12<br>Significant (3)<br><br>Likely (4) | | • Disucssion through contract management, phased by roll out by the trust and testing. Appointed a project manager for the roll out. | Victoria Tovey | Control | | Low<br>6<br>Moderate (2)<br><br>Possible (3) |

**Review Comments** continued to be reviewed and discussed as part of the contract monitoring meetings
31/01/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | *PH0083* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **Public Health Ring Fenced Grant**<br><br>Ensuring/assuring the Public Health ring fenced grant is spent on public health functions and outcomes, in accordance within National Guidance | | | Andrew Scott-Clark | 18/02/2020 | 18/05/2020 |

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| Public Health Ring fenced Grant is spent in accordance within National Guidance | If it does not comply with national guidance could result in the DPH not being able to sign the Annual Public Health Grant declaration which could result in an external audit taking place leading to similar consequences to that of Northamptonshire County Council (i.e. Public Health England seeking a return of Public Health Grant) | Medium<br>12<br>Significant (3)<br><br>Likely (4) | | • Commissioners to conduct regular contract monitoring meetings with providers | Victoria Tovey | A -Accepted | 31/03/2019 | Low<br>2<br>Minor (1)<br><br>Unlikely (2) |
| | | | | • Providers to complete timely monthly performance submissions to ensure delivery of outcomes | Victoria Tovey | A -Accepted | 29/03/2019 | |
| | | | | • Agreed funding for Staff apportionment across Public Health, social care Adult, Social Care Children, business support and analytics functions to support public health outcomes functions and outcomes | Andrew Scott-Clark | A -Accepted | 31/03/2020 | |
| | | | | • Agreement of money flow between Public Health ring-fenced grant and the Strategic Commissioning Division | Andrew Scott-Clark | A -Accepted | 28/02/2020 | |
| | | | | • Continued budget monitoring through collaborative planning | Avtar Singh | Control | | |
| | | | | • Regular review of public health providers, performance, quality and finance are delivering public health outcomes | Victoria Tovey | Control | | |
| | | | | • DPH and Section 151 Officer are required to certify the statutory outturn has been spent in accordance with the Department of Health & Social care conditions of the ring fenced grant | Andrew Scott-Clark | Control | | |

**Review Comments** Continuation of monitoring spend through budgetary meetings with commissioners and the DPH
18/02/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | *PH0001* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **CBRNE incidents, communicable diseases and incidents with a public health implication**<br><br>Failure to deliver suitable planning measures, respond to and manage these events when they occur. | | | Andrew Scott-Clark | 18/02/2020 | 18/05/2020 |

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

**Review Comments** The Risk owner has reviewed and no changes are currently required
18/02/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | *PH0089* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **Increase in Buprenorphine Drug Costs**<br><br>There is a risk that providers will not being able to fund the additional costs due to the spike in costs for Buprenorphine. | | | Victoria Tovey | 31/01/2020 | 29/04/2020 |

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| Increase price of Buprenorphine - one of the main drugs used in Opioid Substitution Treatment (OST) | Services being overspent on their contracted values | Medium<br>10<br>Moderate (2)<br><br>Very Likely (5) | | • Develop a plan for 2020/21 to support any decisions as to whether KCC will continue to fund from the PH reserves | Victoria Tovey | Control | 29/02/2020 | Medium<br>8<br>Moderate (2)<br><br>Likely (4) |

**Review Comments** being monitored through both contract and budget monitoring neetings
31/01/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | *PH0005* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **Health Inequalities**<br><br>These areas have high rates of premature mortality (deaths occurring under the age of 75 years) due to causes such as cardiovascular disease, respiratory disease and alcohol-related disease and cancer; causes that are strongly linked to unhealthy behaviours such as poor diet, physical inactivity, smoking and excessive alcohol. The risk is that whilst health is improving in general these communities health would not improve at the same rate as less deprived communities | | | Andrew Scott-Clark | 18/02/2020 | 18/05/2020 |

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

**Review Comments** The risk owner has reviewed and no changes are required.
18/02/2020

**Strategic and Corporate Services**

Risk Register - Public Health

| Risk Ref | *PH0002* | Risk Title and Event | Owner | Last Review da | Next Review |
|---|---|---|---|---|---|
| **Implementation of new models**<br><br>That the reduction in resource available to the new services will hamper the new services in their ability to deliver. | | | Andrew Scott-Clark | 18/02/2020 | 18/05/2020 |

| Cause | Consequence | Current Risk | Previous Current Risk | Control / Action | | Control / Action | Target Date | Target Risk |
|---|---|---|---|---|---|---|---|---|
| Public Health is working to transform both children's and adults services, to deliver services more aligned with the need of the people of Kent. Whilst also facing reducing budgets | Reduction in outcomes for customers, and the ability of the services to meet key objectives, including the reduction of health inequalities | Medium<br>9<br>Significant (3)<br><br>Possible (3) | | • Develop a long term resource allocation plan, taking account of likely financial resources over next four years | Andrew Scott-Clark | A -Accepted | 29/02/2020 | Low<br>4<br>Moderate (2)<br><br>Unlikely (2) |
| | | | | • Public Health commissioning function in place to ensure robust commissioning process is followed | Karen Sharp | Control | | |
| | | | | • Opportunities for Joint Commissioning in partnership with key agencies and cross-directorate (health, social care) being explored. | Karen Sharp | Control | | |
| | | | | • Regular meetings with provider and representative organisations (LMC, LPC). Regular meet the market events to support commissioning processes | Karen Sharp | Control | | |
| | | | | • Working to a clear strategy, and to an advanced agenda allows for good communication with providers and potential porivders | Karen Sharp | Control | | |
| | | | | • Analyse long term financial situation, and developing services that will be sustainable | Andrew Scott-Clark | Control | | |

**Review Comments** the risk owner has reviewed and no changes are required
18/02/2020

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**From:** Clair Bell, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

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

6 March 2020

**Subject:** Health Inequalities in Kent

**Classification:** Unrestricted

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

**Future Pathway:** None

**Electoral Division:** All

**Summary:**
Health inequalities are avoidable and unfair differences in health status between groups of people or communities. Local authority Public Health services are tasked with improving the health and wellbeing of the local population and both Public Health and Clinical Commissioning Groups are tasked with reducing health inequalities for their populations.

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

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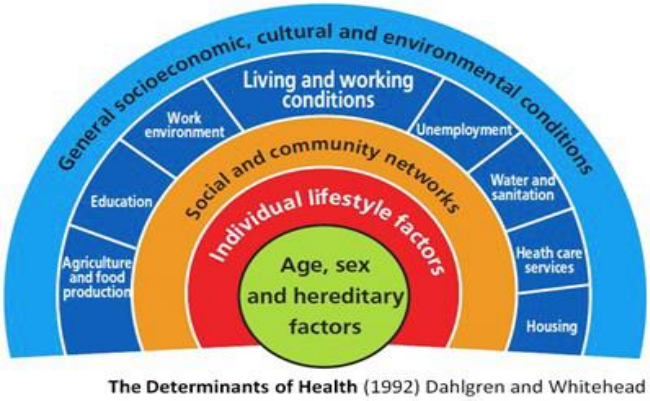
## 1. Background.

1.1 Our health is determined by many factors other than the healthcare we access, indeed only 10-20 % of our health is determined by healthcare, the rest being determined by the wider determinants of health, which include our physical, social and economic environment, including education and employment.




**The Determinants of Health** (1992) Dahlgren and Whitehead

1.2 Health inequalities are avoidable and unfair differences in health status between groups of people or communities.

1.3 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.

1.4 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, the provision of the Kent and Medway Health Needs Assessment and ongoing work with colleagues in Kent County Council, District Councils and the NHS including Kent Community Health NHS Foundation Trust, the four Integrated Care Partnerships and the single CCG.

1.5 Lifestyle behaviours such as drinking, poor diet and lack of exercise play a huge factor in the persistence of health inequalities and making changes to reduce health limiting behaviours plays a key role in reducing inequality. In addition, many of those living in areas of deprivation need to resolve challenges such as housing, debt or employment before they can address the issues preventing them living longer with good health.

1.6 Public Health England estimate around 18% of mortality in Kent is considered preventable (defined by PHE as deaths that could potentially be avoided by public health interventions) equating to approximately 2,600 deaths in Kent per year (based on average annual figure for 2015-2017)[1]

## 2.0 Introduction - Why Do Health Inequalities Matter?

2.1 Sir Michael Marmot makes it clear that health inequalities matter in this quote from his report Fair society, Healthy lives: "Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life."

2.2 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.

2.3 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.

[1] PHE fingertips, ONS, NHS Digital

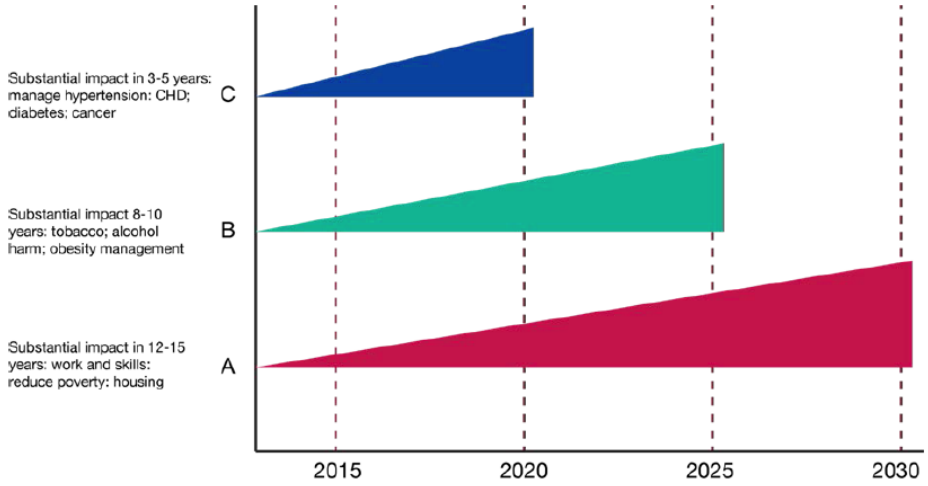



*Figure 1- Time needed to deliver outcomes from different interventions types - Marmot*

2.4 Health inequalities are an area of focus in the Industrial Strategy, the prevention green paper and the NHS Long -Term Plan.

## 3.0 Interventions to Address Health Inequalities

3.1 There are many ways of intervening to reduce health inequalities such as intervening at different levels of risk, intervening for impact over time and intervening across the life course.

In order to reduce health inequalities, it is important that strategies contain population level actions for physiological, behavioural and psychosocial risks that are sustainable and can be delivered at scale. These interventions have to be over sufficient time to allow outcomes to be measured and should be delivered across the life course

3.2 In his 2010 report, Prof. Michael Marmot identified six policy areas to address health inequalities:

1. **Giving every child the best start in life** e.g. targeted support from health visiting for families most at need
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

Many health inequality work plans are based on the above, which is a model that stresses the wider determinants of health and the early years.

3.3 In addition, there might be advantages to using behavioural insights/behavioural economics in designing interventions. There is little evidence of outcomes in this

area of public health work at present, but it is an emerging area.

3.4 **Population Intervention Triangle**
Currently, the Population Intervention Triangle (PIT) is the preferred framework. This is a new framework, published in summer 2019 that is based on the work of Chris Bentley. This model was developed through practical experience working to achieve measurable population level change in health and wellbeing outcomes, including addressing health inequalities between and within local geographies.

3.5 The PIT model consists of 3 segments:

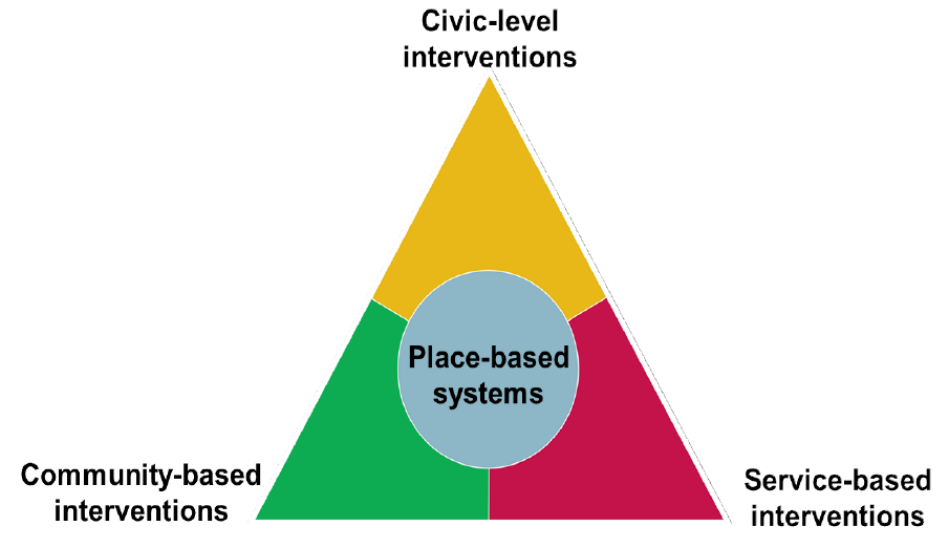
- Civic level interventions,
- Community-centred intervention
- Service-based interventions.

Combing these levels of intervention have a greater impact than each alone.

3.6 **Civic** interventions –through healthy public policy, including legislation, taxation, welfare and campaigns can mitigate against the structural obstacles to good health. E.g. Adopting a Health in All Policies approach can lead to action on health inequalities being embedded across the wide range of functions performed by local authorities such as transport and planning.

3.7 At a **community** level, encouraging communities to be more self-managing and to take control of factors affecting their health and wellbeing is beneficial. It is useful to build capacity by involving people as community champions, peer support or similar. This can develop strong collaborative/partnership relationships that in turn support good health.

3.8 Effective **service-based** interventions work better with the combined input of civic and community interventions, e.g. a tobacco control strategy will include civic regulation on smoking in public spaces, and contraband sales; support to community campaigns and smoking policies in workplaces; as well as smoking cessation services.




Credit: PHE Public Health Data Science based on the original concept created by Chris Bentley.

*Figure 2 The population intervention triangle*

3.9 All interventions, be they civic, community of serviced based, need to be:

- evidence-based
- outcomes orientated
- systematically applied
- scaled up appropriately
- appropriately resourced
- sustainable

## 4.0 Current Data for Kent

4.1 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.

4.2 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.

4.3 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 is more than five times higher in the most deprived decile than the most affluent decile.

4.4 Persistent health inequality in Kent is resulting in a poorer outlook and associated economic impact for Kent. The gap in life expectancy at birth between the most and least deprived quintiles in Kent is 6.5 years for males and 4.2 years for females (2013-2017). The gap in life expectancy at age 65 for between the most and least deprived quintiles in Kent is 3.2 years for males and 2.5 years for females (2013-2017)[2]. In the most deprived Kent quintile, the rate of premature mortality from all causes is 116% higher than the least deprived Kent quintile[3]. The Standardised Mortality Ratio (SMR) shows Margate Central and Cliftonville West have the highest deaths from all causes under 75 years old (2013-2017). In these two wards, the SMR is over 200 which means that you are twice as likely to die early in one of these wards compared to if the ward had the same age-specific rates as England [4]. These deprivation differences in life expectancy and premature mortality have remained broadly similar over the last 5 years.

[2] ONS, NHS Digital, PHE

[3] Primary Care Mortality Database

[4] LKIS data set

4.5 Kent has a relatively affluent population, but there are pockets of real deprivation in the County. See fig 4. Below. This income deprivation distribution is at Ward level, but we know that there can be stark differences across wards which can be measured at the level of Lower Super Output Area (LSOA). There are currently 89 LSOAs which are of particular concern i.e. have the highest deprivation in the County and these have been identified for focussed work to address health inequalities.

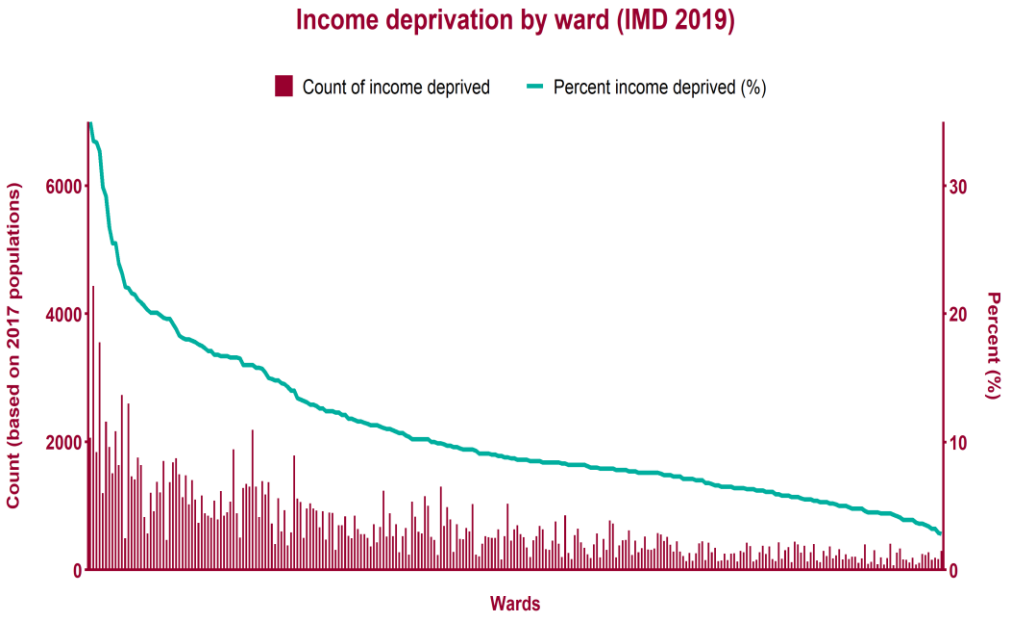



*Figure 3 - Distribution of income deprivation across Kent (IMD 2019)*

4.6 There are a number of indicators of health inequalities in Kent that show a particularly strong association with deprivation. These are shown in table 1

| **Indicator (SMR, SIR and SAR)** | **$R^2$ Value** | **Highest $R^2$ Value Ward** |
|---|---|---|
| Deaths from all causes, under 75 years old | 0.59 | Margate Central |
| Deaths from causes considered preventable (all ages) | 0.56 | Margate Central |
| Emergency hospital admissions for all causes | 0.54 | Margate Central |
| GCSE achievement | 0.53 | Longfield. New Barn and Southfleet |
| Incidence of lung cancer | 0.51 | Sheppey East |
| Emergency hospital admissions for COPD | 0.51 | Shepway South |
| Life expectancy at birth for males | 0.50 | Riverview |
| Hospital stays for alcohol related harm (Broad definition) | 0.50 | Margate Central |

| | | |
|---|---|---|
| Obese children, year 6 | 0.48 | Sheppey East |
| Deaths from circulatory disease, under 75 years | 0.46 | Cliftonville West |
| Emergency hospital admissions for CHD | 0.46 | Sheppey East |
| Deaths from coronary heart disease, all ages | 0.39 | Cliftonville West (for circulatory disease) |
| Hospital stays for alcohol related harm (narrow definition) | 0.37 | Cliftonville West |

**Table 1 - The Association of Health Inequalities with Deprivation in Kent**

## Global Burden of Disease indicators

| Condition | Percentage |
|---|---|
| Low back pain | 6.5 |
| Ischaemic Heart disease | 6.4 |
| Chronic obstructive pulmonary disease | 4.7 |
| Stroke | 3.7 |
| Alzheimer's disease and other dementias | 3.7 |
| Tracheal, bronchus and long cancer | 3.7 |
| Headache disorders | 3.1 |
| Depressive disorders | 2.5 |

**Table 2 - Global Burden of Disease Indicators ranked by percentage of total disability-adjusted life years for Kent**

## 5.0 Current Activities

5.1 As a public health team, we are committed to the use of data and analysis to aid our decision making. Services are regularly reviewed, and health needs assessments are performed in specific areas of public health to inform commissioning. One of the specific aims of needs assessment is to ensure that services are provided in a way to reduce health inequalities. For instance, the data can inform the Public Health team if there is under- or over-provision in some geographic areas, or for a particular age group.

5.2 There are already plans 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.

5.3 This partnership approach covers the well-developed work plan for the prevention workstream of the Sustainability and Transformation Plan (STP). which includes areas such as smoking cessation, increasing physical activity, tackling anti-microbial resistance and cancer screening. We are also working 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.

5.4 Three areas of current work to address health inequalities are of note. These are the NHS Health checks, the KCC/ KCHFT partnership and the work with the Roma community in Kent.

5.5 **NHS Health Checks**
Work has commenced to address health inequalities via the NHS Health Checks. An equity audit demonstrated that there is a lower percentage of people from deprived areas taking up the offer of an NHS Health Check. The uptake in each deprivation decile mirrors the percentages invited for their check and is lower for deprived cohorts. See figure 5.

5.6 NHS Health Checks are accessed by a higher proportion of people in the 'healthy' segment when compared to the general population. This could be expected, and reflective of need as NHS Health Checks are aimed at a-symptomatic/undiagnosed populations. It is however something that KCC and KCHFT are addressing through additional targeting and an outreach programme for communities not accessing the Health Checks. KCC and KCHFT have also successfully secured additional funding from the STP to increase the outreach programme.

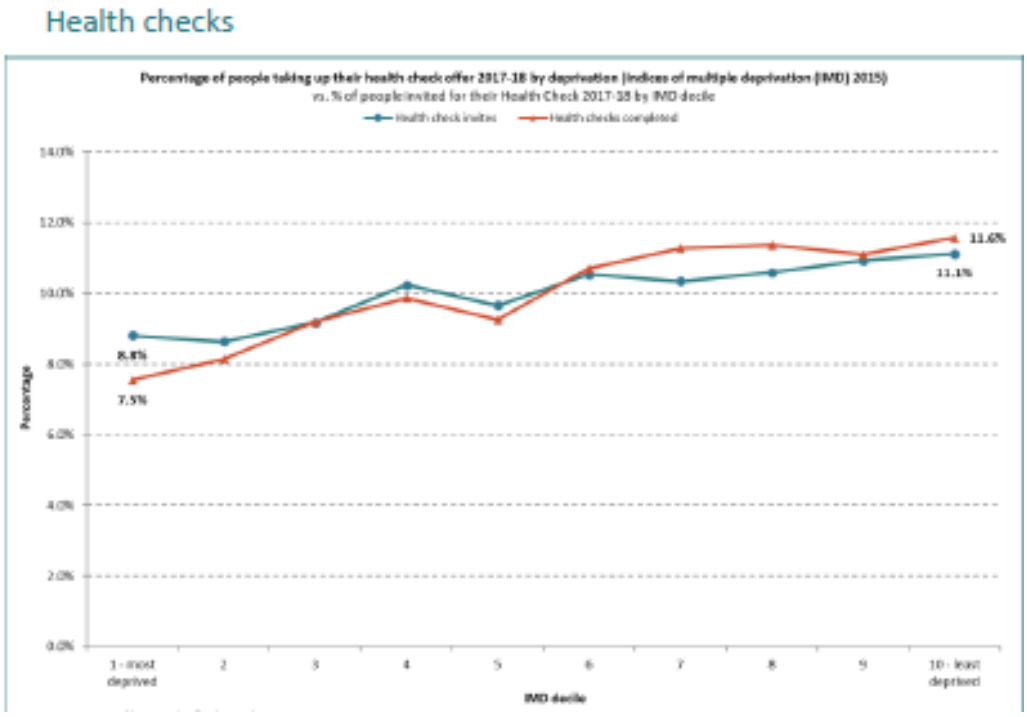



*Figure 4 – Percentage uptake of NHS Health Checks per IMD score 2017/8*

**KCC/KCHFT Partnership/Public Health Services**
KCC invested approx. £37.5M into community services including a number of mandated services such as National Childhood Measurement Programme and NHS Health Checks and sexual health. This funding, from the public health

grant, also equates to around 18% of the business for the Community Trust.

KCC funds other services with KCHFT, but these are not currently incorporated into the partnership. In 2017/18 an additional £3M (estimated) was spent on services by KCC including support for pupils with special educational needs, nursing and residential care for residents aged 65 and in-house provision. KCHFT also receive an additional £5.6M via the learning disability partnership with health, which includes KCC funding.

5.7 The services provided by KCHFT within the KCC/KCHFT partnership via the Public Health Grant have all been reviewed. These include all the services shown below:

- Start Well: Health Visiting, school health, oral health
- Live Well: Health Checks, One You Kent, smoking cessation[5]
- Age Well: postural stability
- Life Course: sexual health and oral health

5.8 In contrast to the NHS Health Checks, the School Nursing service and Health Visiting service are used more by people living in the most deprived parts of the County (Figure 6).

5.9

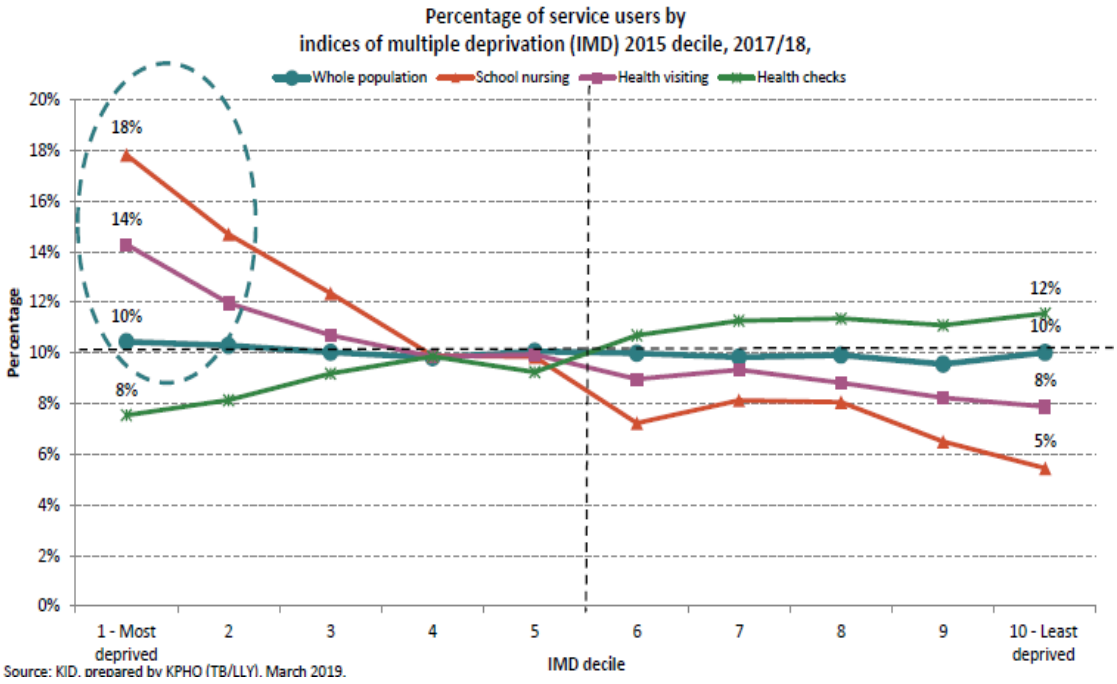



*Figure 5*

5.10 The percentage of people accessing health visiting services in Kent mirrors the birth data, as would be expected for a universal service i.e. there are more children born in the most deprived areas of the County, and hence a higher usage of health visiting services (figure 7).

[5] This forms part of One You Kent however has been separately reviewed due to significant redesign in the service model

5.11

Health visiting

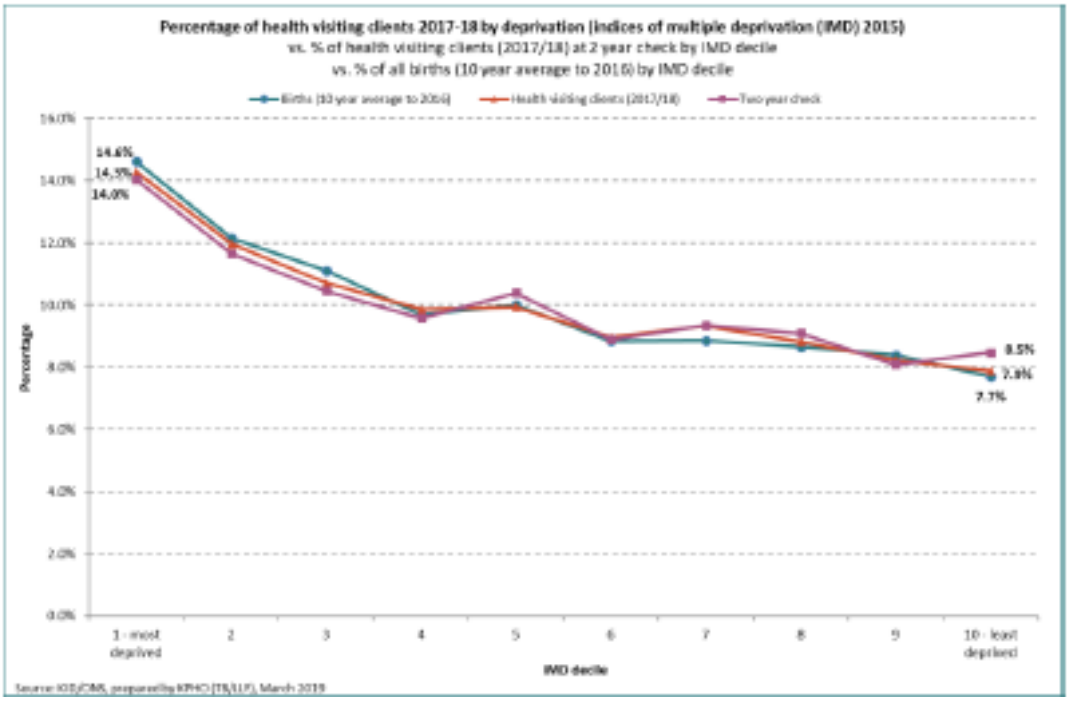



*Figure 6 – use of health visiting services by IMD decile.*

The data suggest that we are addressing health inequalities via the School Nursing Service, as there are more clients for the service in the more deprived areas of the County (figure 8)

5.12

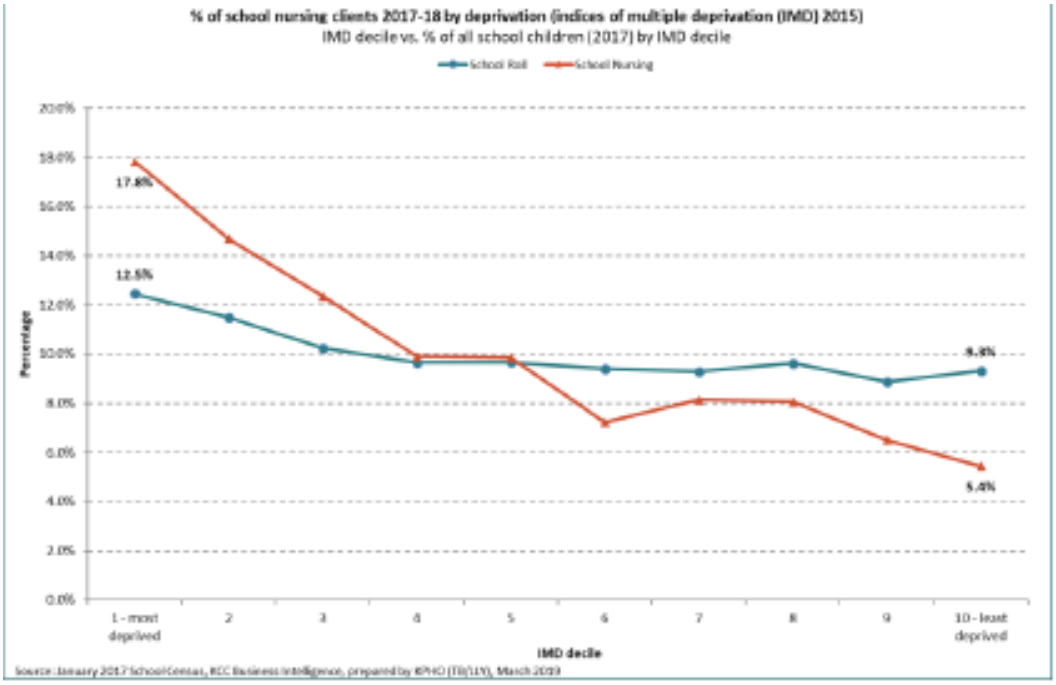



*Figure 7 – use of School Nursing by IMD decile*

By performing needs assessments, Public Health identified that there were higher numbers of women smoking during pregnancy in South East Kent,

Thanet and Swale. Using behavioural insight, a campaign was developed (the 'What the Bump' campaign) to address this issue in those areas with the most need for smoking cessation in maternity services. KCC has now been successful in influencing the new single CCG/STP to provide funding for smoking cessation midwives in maternity units who will further reduce health inequalities in these areas via their targeted smoking cessation work including outreach and home visits (see figures 9 and 10).

5.13

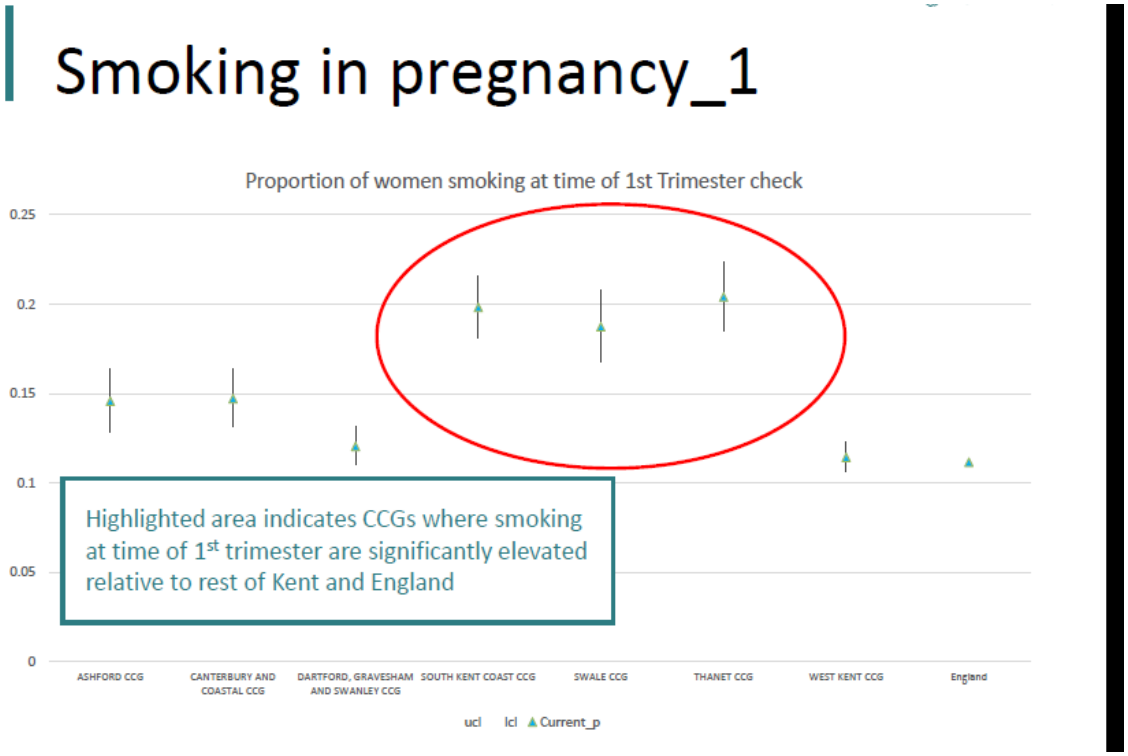
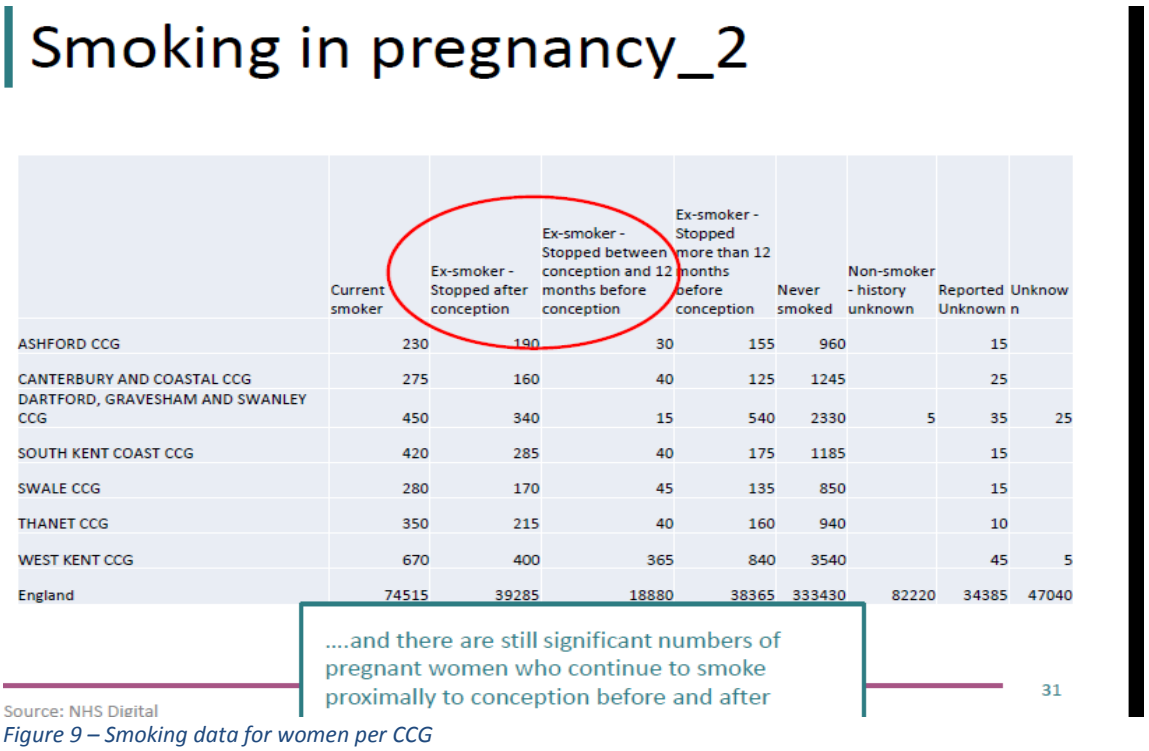



*Figure 8 – Smoking in first trimester of pregnancy per CCG*




| | Current smoker | Ex-smoker - Stopped after conception | Ex-smoker - Stopped between conception and 12 months before conception | Ex-smoker - Stopped more than 12 months before conception | Never smoked | Non-smoker - history unknown | Reported Unknown n | Unknow |
|---|---|---|---|---|---|---|---|---|
| ASHFORD CCG | 230 | 190 | 30 | 155 | 960 | | 15 | |
| CANTERBURY AND COASTAL CCG | 275 | 160 | 40 | 125 | 1245 | | 25 | |
| DARTFORD, GRAVESHAM AND SWANLEY CCG | 450 | 340 | 15 | 540 | 2330 | 5 | 35 | 25 |
| SOUTH KENT COAST CCG | 420 | 285 | 40 | 175 | 1185 | | 15 | |
| SWALE CCG | 280 | 170 | 45 | 135 | 850 | | 15 | |
| THANET CCG | 350 | 215 | 40 | 160 | 940 | | 10 | |
| WEST KENT CCG | 670 | 400 | 365 | 840 | 3540 | | 45 | 5 |
| England | 74515 | 39285 | 18880 | 38365 | 333430 | 82220 | 34385 | 47040 |

*Figure 9 – Smoking data for women per CCG*

**Work with Roma population**

KCC, in partnership with KCHFT, was successful in winning £850,000 to address health inequalities in the Roma population in the County. The programme was designed to address the early years by employing members of the Roma community to work with their peers and improve registration with a GP, improve immunisation uptake and breastfeeding. The data have not been fully analysed, but there are indications of improvements in all of the outcomes. In addition to the main programme of work, there is a programme of work to improve cultural awareness in NHS and Local Authority staff and there has been good uptake and feedback in this area.

5.14 We are working with partners in the emerging Integrated Care System (ICS), single CCG and with the Individual integrated Care Partnerships to supply data on health inequalities and advise on how to address them.

5.15 In particular we have influenced the emerging ICS to prioritise children's services across the NHS and Local Authority Services and create a workstream of the STP to oversee children's services and consider what actions can be taken to reduce health inequalities and give children the best start in life. Of particular note is the agreement across the system to prioritise those lower super output areas that have the highest deprivation.

5.16 We also work with our Healthy Living Centres and our partners in Kent Community Health NHS Trust on the prevention of disease and increasing wellbeing.

## 6.0 Conclusion

6.1 It has proved difficult in times of austerity to tackle health inequalities, but with the recent publication of the NHS Long Term Plan, the development of the Kent and Medway Health Needs Assessment and other policy papers on place-based public health and community action to address health inequalities, we are further developing our data led and evidence-based Council-wide strategy and work plan to tackle health inequalities.

6.2 One of our priorities will be to work with the Integrated Care System/ one CCG to address child health and there are already structures in place for joint working in this area which will include working with health visitors and school nursing.

6.3 There are also a number of initiatives such as the whole system approach to obesity which indirectly address health inequalities and the transformation of the NHS gives us a huge opportunity to work with the new Integrated Care Partnerships, which include district and borough councils, the voluntary sector and primary and secondary NHS services. We shall also explore how we can work with Primary Care Networks to address health inequalities in the 89 most deprived LSOAs.

6.4 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 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. Public Health in KCC will continue to support NHS partners to implement health inequality initiatives in the County, as required by statute.

6.5 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.

6.6 The Marmot report is due to be updated in late February 2020 and will be considered alongside the refresh of Mind the Gap and the guidance on Place-Based Approaches for Reducing Health Inequalities

6.7 The public health team will continue to work with partners to deliver these initiatives, implementing new frameworks such as the PIT model and will continue to monitor progress on addressing health inequalities.

## 7.0 Recommendation

The Health Reform and Public Health Cabinet Committee is asked to:
**COMMENT** on and **ENDORSE** the contents of the report.

## 8.0 Further Reading

8.1

- The data in this paper are published by PHE as Health inequalities slides in January 2020
- The Marmot review can be found at: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review
- Mind the Gap refresh: https://democracy.kent.gov.uk/documents/s90251/Mind%20The%20Gap%20Data%20Refresh.pdf
- https://publichealthmatters.blog.gov.uk/2019/06/18/what-do-phes-latest-inequality-tools-tell-us-about-health-inequalities-in-england/
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/825133/Tool_A.pdf

## 9 Glossary of Technical Terms Used

### 9.1 Linear Regression Model

Linear regression has been used in the analyses presented in this slide set in an attempt to model the relationship between deprivation, as measured by IMD 2019, and outcome indicators from Local Health. The results from the linear regression models are presented as scatter plots with the line-of-best-fit and R-squared value shown for the observed data. The rank of IMD 2019 overall score

for wards has been used as the independent variable in the models and all of the regression models in this presentation are weighted by ward population size (2017).

**R-Squared**
This is a statistical term which indicates how close the data is to a line-of-best-fit in linear regression. It represents the proportion of variation in the dependent variable (in this case, indicators from Local Health) that is explained by the independent variable (in this case IMD 2019 rank of score). It ranges from 0 (no relationship between the variables) to 1 (a perfect relationship).

**Standardised Mortality Ratio**

SMR = Observed/Expected x 100

An SMR is the ratio of observed number of deaths in a ward to the number expected if the ward had the same age-specific rates as England

**Standardised Admission Ratio**

SAR = Observed/Expected x 100

An SAR is the ratio of the observed number of admissions in a ward to the number expected if the ward had the same age-specific rates as England.
Standardised Admission Ratio

**Standardised Incidence Ratio**

*SIR = Observed/Expected x 100*

*An SIR is the ratio of the observed number of incidences in a ward to the number expected if the ward had the same age-specific rates as England.*

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**From:** Clair Bell, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

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

6 March 2020

**Subject:** Illicit Tobacco in Kent

**Classification:** Unrestricted

**Previous Pathway:** This report follows the report of the 22 March 2018.

**Future Pathway:** None

**Electoral Division:** All

**Summary**: In 2018, NEMS Market Research conducted a survey to provide a local profile of illicit tobacco use in Local Authority areas in the South East. In Kent illicit tobacco sales are predominantly undertaken in local shops and hand rolled tobacco is more prevalent than cigarettes in the illicit market. The illicit trade undermines the work and resources Government and Public Health deliver to reduce smoking prevalence, making cigarettes and tobacco affordable to the adult population and also available to children at "pocket money prices". Illicit Tobacco is often linked to organised crime, targeting criminal activity in the most deprived local communities. Kent Public Health and Kent Trading Standards have worked collaboratively to commissioning Illicit Tobacco Roadshows in the districts, undertake illicit tobacco raids using local intelligence and delivering informative puppet theatres in primary schools to raise awareness of the risks and dangers of smoking.

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

**COMMENT ON** and **ENDORSE** the contents of this report.

## 1. Background.

1.1 There are currently around 184,000 smokers in Kent (2018). This represents a smoking prevalence of 15%, slightly above the national average of 14.4%[1]. Although smoking prevalence is slowly decreasing, the smoking rate is higher in deprived areas and among Routine and Manual workers (28.7%) marking smoking as a major factor of health inequalities.

Increased pricing of cigarettes has shown to be a significant government lever to trigger smokers to quit but the sale of illicit tobacco undermines the work aimed

[1] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/4/gid/1938132885/pat/6/par/E12000008/ati/202/are/E10000016

at reducing smoking prevalence by offering a cheaper but illegal option for those who might otherwise see price as a reason to stop smoking.

Children are often targeted by criminals who sell illicit tobacco thereby perpetuating inequity. Suppliers of illicit tobacco are associated with organised criminal networks that also deal in people trafficking, Class A drugs and child sexual exploitation. It is important therefore that the issue of tackling illicit tobacco needs to be coordinated with other agencies in relation to other crimes.

## 2 Introduction

2.1 In 2015/16, HM Revenue & Customs estimated 13% of cigarettes and 32% of hand-rolled tobacco in the UK market were illicit resulting in a £2.4billion tobacco tax gap. The tobacco industry routinely uses the threat of illicit trade in lobbying against tobacco control.[2]

The UK has particularly high levels of tobacco taxation as high prices are known to be the most effective policy driver to encourage smokers to quit. This is supported by public health grounds as smoking becomes increasingly unaffordable and encourages smokers to quit. However, it can also provide an incentive to engage in the illicit tobacco trade where lower prices mean that smoking can be affordable to adults on low income and as a gateway to smoking for children and young people.

2.2 In 2018 NEMS Market Research reported to Public Health England South East on the results of the survey's illicit tobacco market indicating that local shops are the most significant source of illicit tobacco supply and under-age sales in Kent. It revealed that 5.1% of those surveyed in Kent said they have bought illicit tobacco and of those 62.9% reported buying illicit tobacco at least once a week compared to 29% average across the South East. 22.4% of respondents buy less than a quarter of their cigarettes through illicit means although 50% said that all of the hand rolled tobacco they use is all from illicit means. Although each Local Authority in the South East has a unique illicit tobacco profile, it was agreed that the Regional Public Health group and Trading Standards South East would work collaboratively to deliver a regional illicit tobacco strategy. The strategy would pool resources and broaden opportunities to tackle illicit tobacco by:

i) **Decreasing demand** – by raising awareness of the issues surrounding illicit tobacco, its targeted approach to children and attracting crime to the locality and reduce the number of smokers in Kent

*ii)* **Increase reporting** by developing and promoting a central intelligence point and making reporting available in a range of ways

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

[2] ASH fact sheet Illicit Trade in Tobacco, March 2017, https://ash.org.uk/wp-content/uploads/2019/10/Illicit-Trade-Tobacco.pdf

2.3 All partners remain supportive of a regional collaborative approach which is being co-ordinated by Trading Standards South East, but some authorities have to date, been unable to commit to funding or resourcing the strategy. This has resulted in delays at a regional level, but Kent has continued to deliver an active Illicit Tobacco Action Plan in East Kent in November 2019 to January 2020. The activities comprise the delivery of Illicit Tobacco Roadshow events raising awareness of the illicit tobacco trade being associated with organised crime in the community (to reduce supply and demand) and 'Meet The Stinkers'; a puppet theatre raising awareness to children of the harms of smoking and this has been well received in two primary schools in each of the East Kent district areas.

## 3 Conclusion

3.1 The Regional Illicit Tobacco strategy is still being finalised with funding and resources being sought from each of the local authority areas.

The East Kent activities of 2019/20 have been delivered and some of the results have been publicised (for example, the seizure of illicit tobacco and the prosecution of the suppliers) but the final report on the Roadshow outcomes and the feedback from the school puppet theatres is currently being finalised and will be available from April 2020, highlights will also be shared as part of the verbal report accompanying this paper.

## 4 Recommendations

The Health Reform and Public Health Cabinet Committee is asked to:
**COMMENT ON** and **ENDORSE** the contents of this report.

## 5 Background Documents

None

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**From:** Clair Bell, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

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

**Date:** 6 March 2020

**Subject:** Suicide Prevention Programme update

**Classification:** Unrestricted

**Past Pathway:** N/A

**Future Pathway:** N/A

**Introduction**:

This paper provides an update on the suicide prevention programme and includes;

1) the latest suicide statistics and commentary
2) a discussion on the link between debt and suicide
3) a discussion about the link between domestic abuse and suicide
4) an update on NHS England funding for suicide prevention in 20/21 and beyond
5) a proposal regarding the 2020-2025 Suicide Prevention Strategy

**Recommendation(s)**:

Committee Members are asked to provide comments and recommendations regarding any aspect of the suicide prevention programme.

## 1. Introduction

1.1 The Health Reform and Public Health Committee previously received information about the suicide prevention programme in October 2018.

1.2 This update provides Committee Members with;
1) the latest suicide statistics and commentary
2) a discussion on the link between debt and suicide
3) a discussion about the link between domestic abuse and suicide
4) an update on NHS England funding for suicide prevention in 20/21 and beyond
5) a proposal regarding the 2020-2025 Suicide Prevention Strategy

## 2. Latest suicide statistics

2.1 In November 2016, the Secretary of State for Health Jeremy Hunt wrote to all local authorities highlighting their role in suicide prevention planning and the national target to reduce the numbers of suicide by 10% by 2020/21. Statistics released in September 2019 indicate that since that point the three-year rolling aggregate rate per 100,000 in Kent continues to fall.

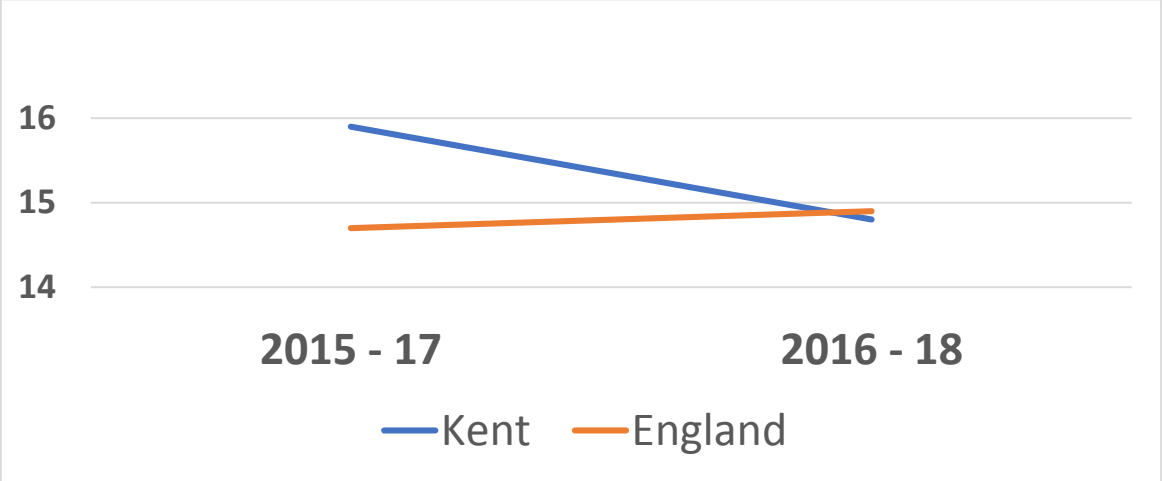
**Chart 1: 3 year rolling suicide rates per 100,000**

| | 13-15 | 14-16 | 15-17 | 2016-2018 |
|---|---|---|---|---|
| ENGLAND | 10.1 | 9.9 | 9.6 | 9.6 |
| Kent | 12.0 | 11.6 | 10.5 | 10.0 |

Source: ONS
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

2.2 For the first time in a number of years, the male suicide rate in Kent is lower than the national average.

**Chart 2 3-Year rolling male suicide rate per 100,000**




Source – Public Health England https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/4/gid/1938132828/pat/6/par/E12000008/ati/102/are/E10000016/iid/41001/age/285/sex/1

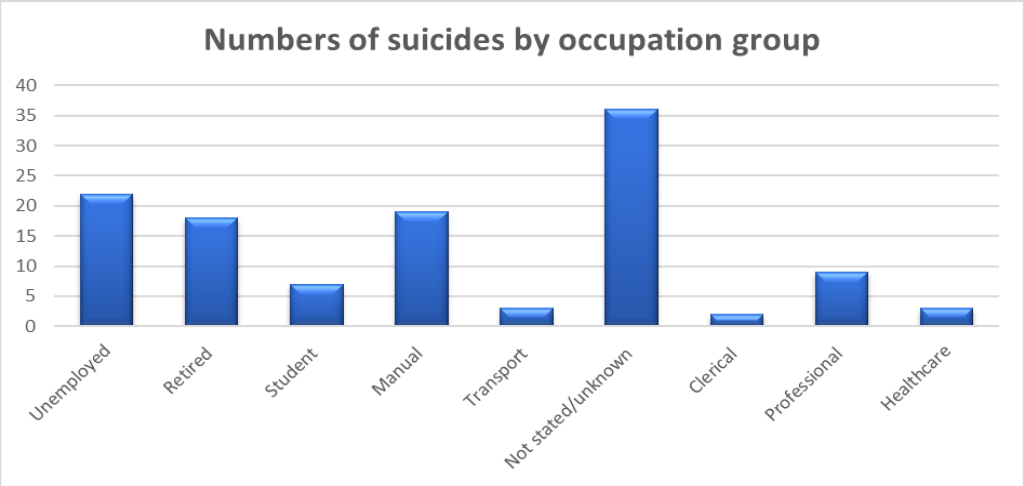
2.3 This 3-year rolling rate is what NHS England use to measure progress against the 10% national reduction target. This is the preferred measure because it is a more reliable statistic than comparing the relatively small numbers of suicides in any one particular year.

2.4 However there was an increase in the number of suicides recorded across England in 2018 (up to 5021 from 4451 in 2017), and early indications for 2019 suggest that the increase has continued. Public Health will continue to monitor all available data to ensure patterns and trends are identified and responded to.

2.5 During 2019 research was conducted with the Coroners Service was to try and establish what had been going on in the lives of people who died by suicide in the months and years before they died, with the ultimate aim of identifying opportunities for possible interventions.

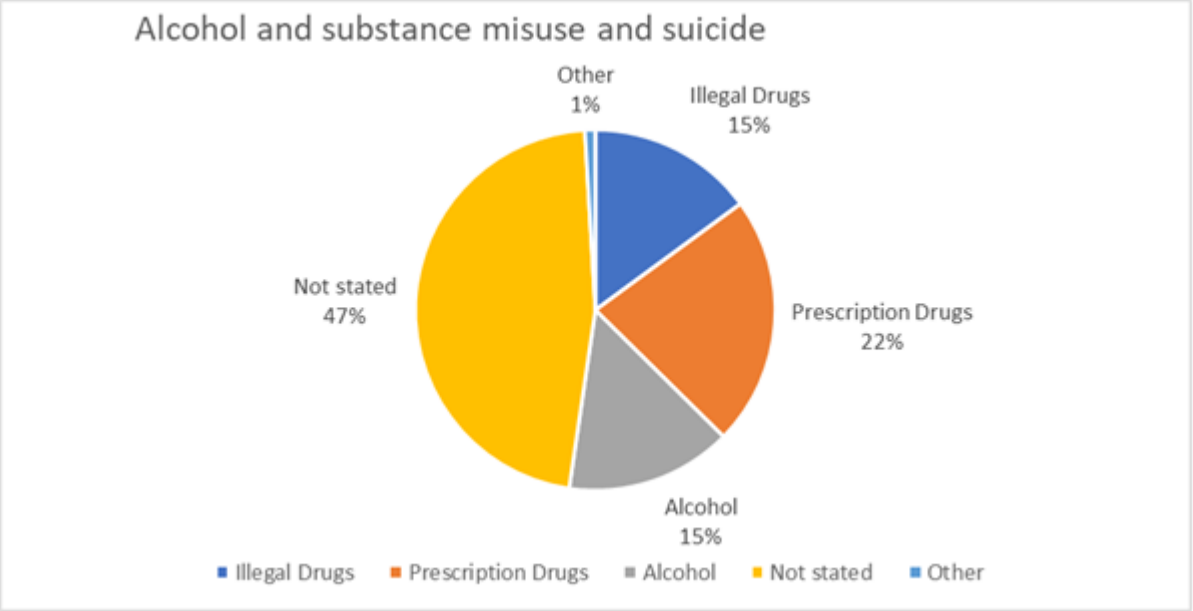
2.6 A sample of 119 inquests were listened to, from a time period ranging from Jan 2017 to June 2018. A number of interesting points were identified.

**Chart 3 Number of suicides by different occupations (sample size 119)**




2.7 Of the 119 inquests investigated, the most prevalent occupation status were unemployed, manual workers and people who were retired. Employment status was not known for 30% of cases.

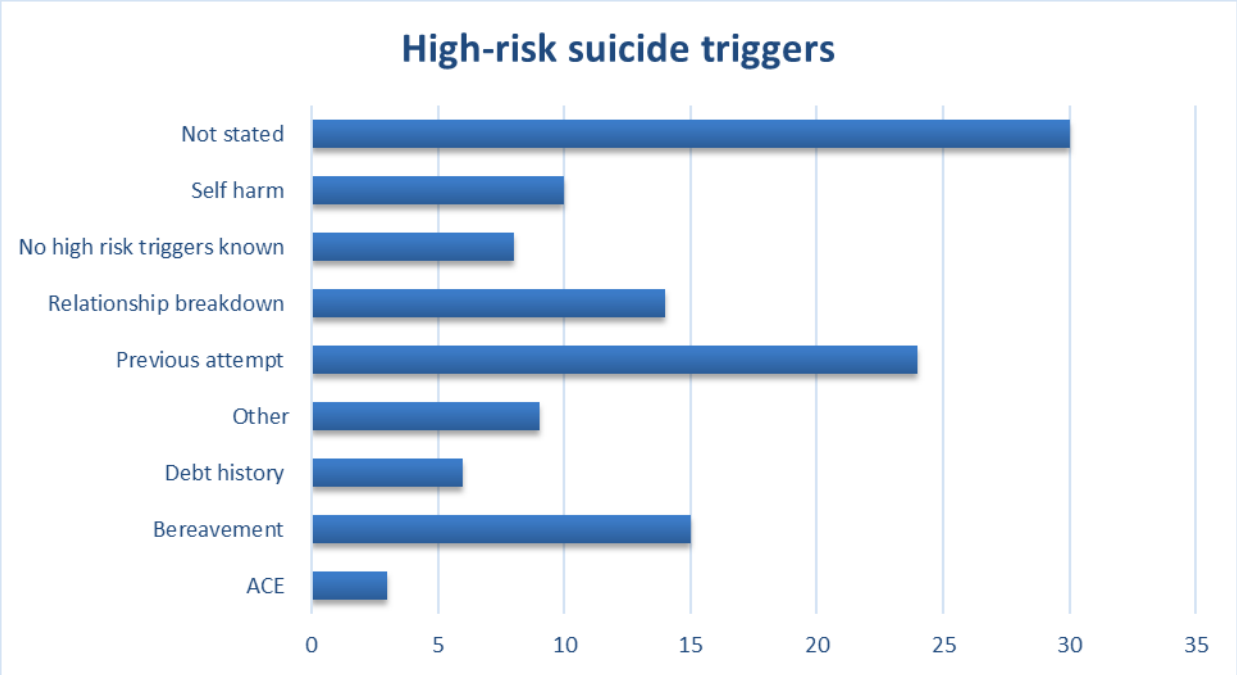
**Chart 4 Percentage of deaths involving drugs or alcohol**




2.8 From the 119 coroner inquests, 22% had history of prescription drugs, although it is unclear the exact numbers regarding correct medication taking and prescription drug misuse. 15% of individuals had a history of illegal drug use and a further 15% had a history of alcohol use (although it is unclear the severity of this). From the information available during the coroner inquests,

47% were 'not stated' as to whether there had been a history of alcohol or substance misuse.

**Chart 5 Numbers of deaths which involved suicide triggers (sample size 119)**




2.9 During the 119 inquests that were listened to, a number of life events were identified that contributed to the death. Bereavement, relationship breakdown, debt and previous abuse were stated as contributing factors in cases. The most common factor was previous suicide attempts. Some case studies which illustrate these factors are as follows;

*'His relationship broke down with his long-term partner. It was also thought that he was in debt due to bills and letters found.'*

*'He had previous suicide ideation, having previous attempts that his family knew of. He had severe work-related stress.'*

*'He had a previous history of debt problems. There were numerous suicide notes left for the police saying his reason behind his death was his bankruptcy.'*

2.10 Given the links with debt and domestic abuse that came up during the research with the Coroner Service, it was decided that further work was needed in these areas.

## 3. The link between debt and suicide

3.1 National research from the charity Money and Mental Health Matters also found a link between problem debt and suicide. Their report (A Silent Killer, 2017) found that 13% of people in problem debt thought about suicide. This equates to over 420,000 people in England thinking about suicide with 3% saying that they had attempted suicide. The report highlights that living in persistent poverty or financial insecurity often contributes to feelings of hopelessness and suicidal thoughts.

3.2 These thoughts can be triggered by unexpected income shock, insensitive or aggressive collection practices or the rapid accumulation of fees and charges on existing debt. The report sets out recommendations how organisations can assist people in financial difficulty and help reduce the risk of suicide. For local authorities they suggest;

i. Local public health teams should recognise financial difficulty as a risk factor for suicide
ii. Local authorities should improve collections practices.
iii. Essential services providers should offer suicide prevention training
iv. Advice providers should offer suicide prevention training, improve referral pathways to support services and review service delivery models to ensure they offer adequate support to the most vulnerable clients.

3.3 Within Kent, we will be recognising financial difficulty in the forthcoming Strategy refresh (See Section 6), and we are recommending to district and borough councils that they should consider adopting the Citizens Advice "Council Tax Protocol" which they have written in partnership with the Samaritans. (https://www.citizensadvice.org.uk/about-us/our-campaigns/all-our-current-campaigns/council-tax-protocol/)

3.4 Through the Saving Lives Innovation Fund (part of the suicide prevention programme) we are currently supporting two Citizens Advice pilots. One in Tunbridge Wells where they are providing a money advice service in a mental wellbeing community café, and the other with North and West Kent Citizens Advice branch who are working directly with Tonbridge Jobcentre to provide mental health first aid and practical debt support for at-risk people identified by the Jobcentre.

## 4. The link between domestic abuse and suicide

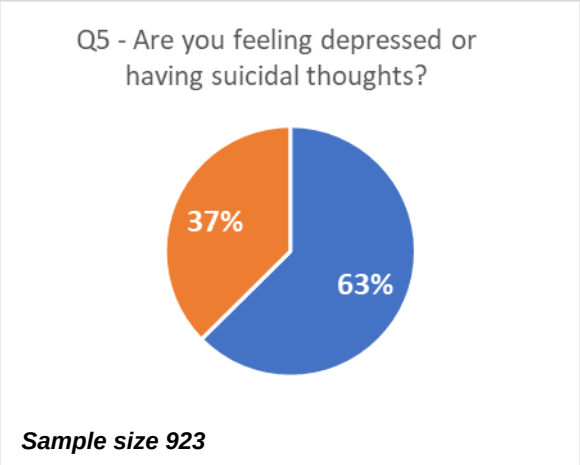
4.1 Discussions with Kent County Council's Community Safety Team have highlighted that over the last two years they have instigated a number of Domestic Homicide Reviews where the death has been as a result of suicide rather than homicide. While the exaxct number can't be recorded here (to preserve anonymity) it is strong evidence of a relationship between domestic abuse and suicide.

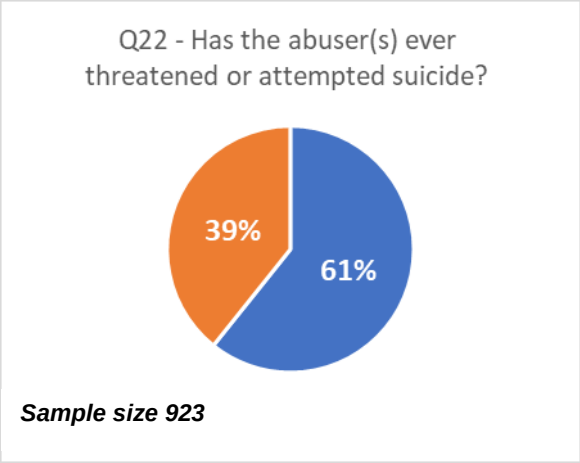
4.2 To understand how strong the relationship may be, three commissioned Domestic Abuse support providers in Kent (Clarion, Look Ahead and Oasis) were asked to provide data regarding domestic abuse and mental health/suicidality. Specifically, the providers were asked to provide data on two questions from the DASH risk assessment (that should be used with all suspected victims of domestic abuse).

4.3 Between the three providers there is a total sample size of 923 for the following questions:

- Q5 – *Are you feeling depressed or having suicidal thoughts?*

- Q22 – *Has the abuser(s) ever threatened or attempted suicide?*



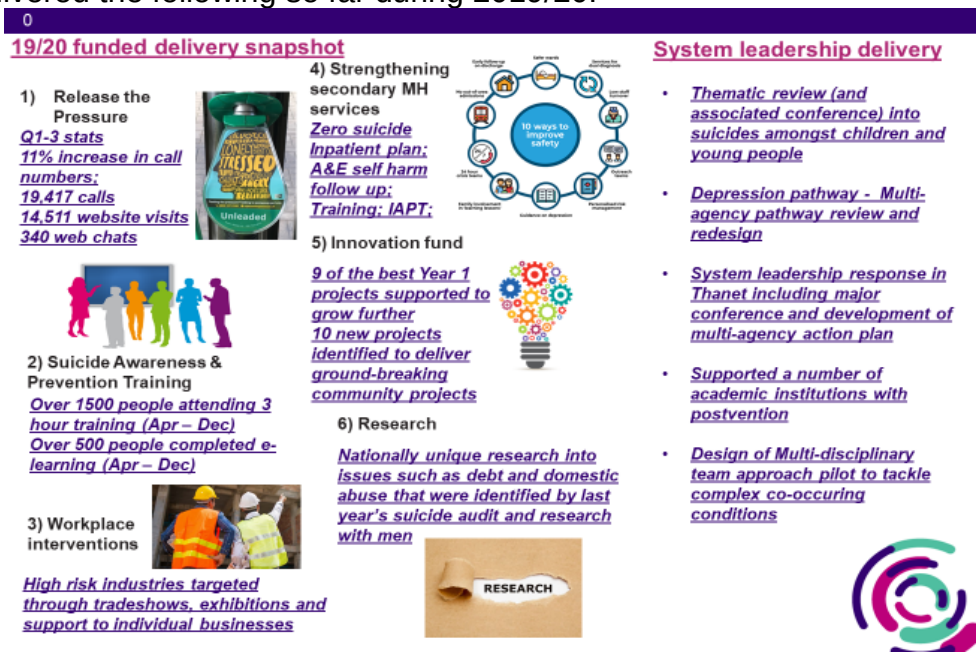




4.4 A working group of domestic abuse charities, the Community Safety team and mental health workers was established to understand what could be done in response. Recommendations from the working group included ensuring mental health teams had domestic abuse training, and domestic abuse staff have mental health training.

4.5 In addition, as part of the Suicide Prevention Programme we have provided funding to Oasis Domestic Abuse charity to pilot a project with a group of women experiencing domestic abuse to understand the impact of trauma on their mental health.

## 5. NHS England funding for suicide prevention in 20/21 and beyond

5.1 During 2018/19 and 2019/20, the NHS England have provided the Kent and Medway STP with £668,000 per year, ringfenced for programmes to reduce suicide and self-harm. This external source has funded the suicide prevention team (based in Public Health) and the work programme that has delivered the following so far during 2019/20.

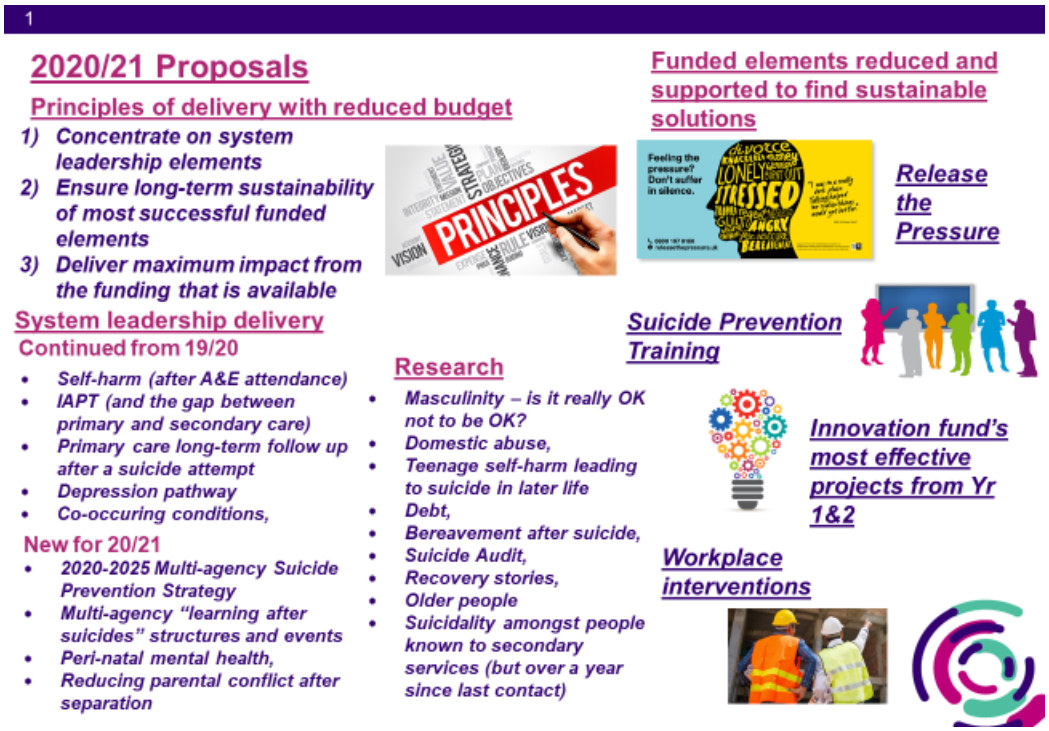


5.2 In January 2020 NHS England announced that they are reducing the funding awarded to Kent and Medway to £356,000 in 2020/21 and then to £0 in 2021/22. Their reasoning is to ensure that all areas of the country can benefit before the funding stream ends.

5.3 Given the reduced funding for 2020/21, and confirmation that there will be no national funding available for following years, three principles have been adopted which will guide the programme in Year 3;

- Concentrate on system leadership elements
- Ensure long-term sustainability of most successful funded elements
- Deliver maximum impact from the funding that is available

A simple overview of our 2020/21 proposals can be seen below.




5.4 The focus on system leadership will remain in 2020/21 and the Programme will work closely with the emerging CCG & Integrated Care Partnerships, Public Health and KMPT to ensure that work to redesign pathways and strengthen high-risk points continues.

5.5 Discussions will take place with all partners to develop a plan for sustaining progress once the national funding expires. Some elements of the programme may be able to be incorporated into business as usual (budgets permitting), but other elements may require additional responsibilities being taken on by local partners. Or it may be that local contributions are found to ensure that the Programme and core team can be kept active in some form.

## 6. A proposal regarding the 2020-2025 Suicide Prevention Strategy

6.1 Whatever happens regarding annual funding decisions, Public Health teams across the country are expected to develop and deliver multi-agency suicide prevention strategies. The current Kent and Medway Suicide Prevention Strategy runs to 2020 and therefore Public Health are currently preparing the draft 2020-2025 Strategy for consultation later in the spring.

6.2 The consultation for the new strategy will include a full review of the previous five years, as well as consider changes to national priorities.

6.3 Recent updates to national guidance suggest an increased focus on self-harm would be beneficial, as would stronger support for families bereaved by suicide.

6.4 Local evidence suggests that links with substance misuse, domestic abuse and suicides amongst teenagers will require additional scrutiny.

6.5 Despite these changes in the detail (and others that emerge during consultation), the overarching priorities are likely to remain the same.

| | Proposed 2020-2025 Kent and Medway Suicide Prevention Priorities |
|---|---|
| 1 | Reduce the risk of suicide and self-harm in high risk groups |
| 2 | Tailor approaches to improve mental health and wellbeing in Kent and Medway |
| 3 | Reduce access to the means of suicide |
| 4 | Provide better information and support to those bereaved by suicide |
| 5 | Support the media in delivering sensitive approaches to suicide |
| 6 | Support research, data collection and monitoring |

6.6 Governance arrangements for the new strategy will include regular reporting to KCC and Medway Council Cabinet Committees, as well as to the Kent and Medway Health and Wellbeing Board.

6.7 Public Health are working with KCC's Engagement and Consultation Team to design an appropriate consultation schedule. This is likely to start in April and conclude in June 2020.

## 7. Recommendation(s)

**Recommendation(s)**:

Committee Members are asked to provide comments and recommendations regarding any aspect of the suicide prevention programme.

## 8. Contact details

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**From:** Clair Bell, Cabinet Member for Adult Social Care and Public Health

Rebecca Spore, Director of Infrastructure

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

6 March 2020

**Subject:** Kent and Medway Care Record (KMCR) Update

**Classification:** Official

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

**Future Pathway:** None

**Electoral Division:** All

**Summary:** This report provides an update on progress towards the deployment and implementation of the Kent and Medway Care Record (KMCR)

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

## 1.0 Introduction

1.1 The aim of the Kent and Medway Care Record (KMCR) project is to develop, procure and mobilise a single shared care record solution for deployment across the Kent and Medway STP area that will enable health and care professionals involved in an individual's care to view an electronic record of their patient / service. The record will pull data, that is currently held in numerous provider point of care systems into a single role-based access view.

1.2 The KMCR vision is that:
"Regardless of who employs them, health and care professionals are able to quickly and easily view their patient's digital records (or relevant components of them) from wherever they are, and without the need to navigate multiple systems / user interfaces, regardless of the local health or care provider who holds them."

## 2.0 Kent and Medway Care Record System Benefits Summary

2.1 The KMCR is a single solution that will be deployed across Kent and Medway to enable the sharing of health and social care data. The specific benefits for health and social care professionals and providers have been identified as:

- Delivery of the Kent and Medway Delivery plan for the NHS Long Term Plan including meeting the expectations of a LCHR in every area.
- Improved safeguarding: ensuring that children and vulnerable adults that are at risk are immediately known as being so, enabling care decisions to be better informed and reducing the level of risk.
- Improved quality of clinical and professional decision making, taking into account all relevant information, especially in complex cases.
- Reduced care costs through avoiding repeated tests and unnecessary treatment; more effective use of out-of-hospital care packages; reducing pressure on emergency care, shorter hospital stays through multi-agency discharge planning; more effective medication reconciliation.
- Facilitates integrated care by sharing information across the System between multiple health and social care partners and enabling new models for delivering integrated care, actively facilitating cross-organisational workflows.
- Gives patients access to their records through a patient portal.
- Provides analytic capability enabling care to be commissioned and delivered effectively and efficiently.
- Single consecutive timeline of events across all Kent and Medway providers integrated across all providers.
- Quicker communication between care organisations: less wastage of professional and clinical time identifying and contacting other professionals involved in the care of that individual.
- More efficient communication between care organisations: immediate access to key data.
- More efficient workflows: enabling visibility of workflows between care professionals.
- Access to robust care information to better plan care and the support for multi-disciplinary care plans that can be shared with all care professionals involved in the care of an individual.
- Provide an information system that is consistent with the internet; first aspiration of the long term plan, KMCR, being a web based application will be quick to log on, will be integrated (context sensitive single sign on), where possible, into providers point of care systems, be designed to be easy to use and support care professionals in the delivery of safe and effective care.
- Facilitates population health management and a reduction in health inequalities.
- Assurance that care is provided consistently, safely and in accordance with the needs and wishes of the individual.
- Provide facilities to facilitate care delivery at the most appropriate place for the individual, for example, provide information to paramedics to obviate the need for unnecessary conveyancing to A&E.

2.2 Benefits for Local Authorities in particular relate to improved access to client information in the delivery of the relevant Council services and more efficient business processes. Other areas which have adopted the KMCR have sighted improved staff productivity and client outcomes as a result of redesigning care pathways and information flows between agencies.

Specific areas of focus are:

- Improve efficiency of integration of adult acute and community short term pathways, such as discharge and step up/down
- Improve local care planning and operational delivery particularly through MDTs
- Improve social workflows and safeguarding
- Enable the integrated work of children's front door and specialist services, including maternity and health visiting

2.3 There is a statutory 'duty to share' information for direct care. This is set out in s251B of the Health and Social Care Act 2012 (as cited by the Health and Social Care (Safety and Quality) Act s3). This places an obligation on all health and social care organisations to provide access to the health and social care records they hold to their employees and other providers working with the patients / service users. Although the statute does not explicitly refer to a shared care record, it is implied, and it is hard to conceive that any other solution could meet these requirements for the system as a whole. The KMCR will be a key tool to effectively discharge these responsibilities.

2.4 The KMCR also provides analytic capability and further options for the integration of data through the Kent and Medway Integrated Data Set.

## 3.0 Implementation

3.1 The KMCR has been procured using the NHSE Health Systems and Support Framework. It is part of the NHSE Local Health and Care Record (LHCR) programme. The national programme consists of three waves: wave 1 includes six exemplars; wave 2 are fast followers, and wave 3, the rest. The KMCR is in wave 3 but is likely to deliver before some of the exemplars. A competitive procurement using the NHS Health Systems Support Framework has resulted in the appointment of a preferred bidder, Graphnet.

3.2 Detailed implementation project plans are now being agreed ahead of contract award. Joint commissioners of KMCR are the Kent and Medway CCGs (shortly to become a single CCG), the two LAs and Kent Community Health NHS Foundation Trust (KCHFT).

3.3 The seven-year contract will be managed by KCHFT on behalf of the joint commissioners and will have an option to extend an additional three years. KMCR implementation project management support is being separately tendered and is underway.

3.4 A Collaboration Agreement will sit under the Call-Off contracts and provide partnership governance between the joint commissioners who will form a Collaboration Board. An implementation Programme Board will manage risks and issues during deployment phases 1-3.

3.5 KCHFT will provide a KMCR contract management board, which will oversee operations, with sub-groups including clinical and professional curation, service management, risk management and citizen engagement. Technical sub-groups

include both technical and data and analytics representation.

3.6 NHS Providers will be mandated to use the KMCR through their provider contracts with the CCG. PCN agreements are expected to provide appropriate governance clauses for primary care use of the KMCR.

3.7 Organisations providing feeds to, or consuming services from the KMCR are responsible for their own costs of implementation of the KMCR, and for 1st line support to users.

3.8 KCCs financial contribution is set at £50K per annum, excluding the internal costs of technological and organisational implementation and associated business change.

3.9 NHS Providers and LAs are currently completing technical and organisational readiness assessments and initiating internal projects to support implementation. Mobilisation is currently expected to commence in April this year. KCC is scheduled to connect live feeds from KCC's adults and children's systems is due between April and May this year and is in phase 1 of the deployment.

3.10 The system operates according to a role-based access control policy which will be developed as part of the implementation, Graphnet have installed its systems in a number of areas and have mapping of roles to access groups, and the minimum expectation is that these will be implemented and users mapped to appropriate access groups.

## 4.0 Conclusion

4.1 The KMCR has a number of potential benefits across the system and for KCC as outlined in the paper. KCC is in the first wave of implementation and the detailed plans are currently being developed to support the implementation of the KMCR.

## 5.0 Recommendation

The Health Reform and Public Health Cabinet Committee is asked to: **NOTE** the contents of the report.

## 6.0 Contact Details

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**Appendix A – Provisional Outline Implementation Timetable**

- Phase 1 (Core installation, GPs and first 6 feeds)
    - Core solution installed – Feb – Mar 2020
    - KMPT: Feb 20 – Apr 20
    - MTW: Oct 20 – Mar 21
    - NELFT: Feb 20 – May 20
    - EKHUFT: Mar 20 – May 20
    - KCC: Mar 20 – May 20
    - Primary Care (GP/OOH): Feb 20 – Jun 20
    - WK Care Plan Management System migration planning: Feb 20 – Mar 20

- Phase 2 (Initial use, roll-out, BI)
    - MedOCC: Sep 20 – Oct 20
    - BI/Analytics: Oct 20 – Nov 20
    - D&G Acute: Sep 20 – Feb 21
    - Medway Council: Sep 20 – Nov 20
    - IC24 (111/UEC): Nov 20 – Dec 20
    - KCHFT: Oct 20 – Dec 20
    - MFT: Sep 20 – Mar 21

- Phase 3 (Remaining feeds, data, roll-out, PHR)
    - SECAMB: Jan 21 – Feb 21
    - MCH (CIC): Jan 21 – Mar 21
    - NK Adult Community Services / Virgin Care: Dec 20 – Mar 21
    - Personal Health Record: Apr 21 – Sep 21

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**Appendix B – Example Technical Readiness Work-Plan**

- Local database setup / KCC set up automated file transfer to Graphnet.
- KCC agree data feed configuration / policies and install exporter tools.
- User Acceptance Testing environment configured (e.g. configure social care hub tiles, develop test scripts, end to end testing.
- Automated running of export scheduled / live data import scheduled.
- Graphnet provide SSO details (i.e. tenancy ID, URLs etc.)
- KCC add URLs to browser trusted sites and configures firewalls.
- Single Sign-On
- KCC provide Graphnet with details of at least one user to test.
- KCC admin user agreed.
- KCC provide user list (csv).
- Graphnet run a bulk upload to provision new users to the KCC tenancy.

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From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 6 March 2020

Subject: **Work Programme 2020/21**

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 planned work programme for 2020/21.

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 2020/21

2.1 An agenda setting meeting was held on 14 January 2020, 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 from 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 planned work programme for 2020/21.

## 5. Background Documents

None.

## 6. Contact details


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Last updated on: 24 February 2020

# HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE WORK PROGRAMME 2020/21

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

| |
|---|
| **30 APRIL 2020** |
| • ***Verbal Updates***<br>• ***Contract Monitoring – Oral Health***<br>• ***Work Programme***<br>• **Public Health Performance Dashboard – incl impact of STP**<br>• **Future agendas will need to cover updates/more information on STP issues arising at 20 June mtg**: digital, estates, multi-disciplinary team models, mental health services, communications and raising public understanding, future of the voluntary sector, staff recruitment and training moved from November |
| **8 JULY 2020** |
| • ***Verbal Updates***<br>• ***Contract Monitoring – Adult Substance Misuse contracts***<br>• ***Work Programme***<br>• **Update on Public Health Campaigns/Communications**<br>• **Strategic Delivery Plan monitoring** – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019)<br>• **Future agendas will need to cover updates/more information on STP issues arising at 20 June mtg**: digital, estates, multi-disciplinary team models, mental health services, communications and raising public understanding, future of the voluntary sector, staff recruitment and training moved from November |
| **9 SEPTEMBER 2020** |
| • ***Verbal Updates***<br>• ***Contract Monitoring – Children and Young People's condom programme and online Sexual Health services***<br>• ***Work Programme***<br>• ***Public Health Performance Dashboard – incl impact of STP***<br>• **Annual Report on Quality in Public Health, incl Annual Complaints Report**<br>• ***Annual Equality and Diversity Report**** for Public Health, this is part of the Strategic Commissioning Equality and Diversity, which goes to the Policy and Resources Cabinet Cttee |
| **20 NOVEMBER 2020** |
| • ***Verbal Updates***<br>• ***Contract Monitoring – Health Visiting***<br>• ***Work Programme***<br>• ***Public Health Performance Dashboard – incl impact of STP***<br>• **Strategic Delivery Plan monitoring** – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019) |
| **8 JANUARY 2021** |

- ***Verbal Updates***
- ***Contract Monitoring – Primary School Health Services***
- ***Work Programme***
- ***Public Health Performance Dashboard – incl impact of STP***
- **Budget and Medium-Term Financial Plan**
- **Update on Public Health Campaigns/Communications**

**10 MARCH 2021**

- ***Verbal Updates***
- ***Contract Monitoring – NHS Health Checks***
- ***Work Programme***
- ***Public Health Performance Dashboard – incl impact of STP***
- **Risk Management report (with RAG ratings)**
- **Health Inequalities** – annual

**30 JUNE 2021**

- ***Verbal Updates***
- ***Contract Monitoring – Integrated Sexual Health services***
- ***Work Programme***
- ***Public Health Performance Dashboard – incl impact of STP***
- **Update on Public Health Campaigns/Communications**
- **Strategic Delivery Plan monitoring** – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019)

**PATTERN OF ITEMS APPEARING REGULARLY**

| **Meeting** | **Item** |
|---|---|
| January | • Budget and Medium-Term Financial Plan<br>• Public Health Performance Dashboard – incl impact of STP<br>• Update on Public Health Campaigns/Communications |
| March | • Risk Management report (with RAG ratings)<br>• Health Inequalities – annual |
| April/May | • Public Health Performance Dashboard – incl impact of STP |
| June/July | • Update on Public Health Campaigns/Communications<br>• Strategic Delivery Plan monitoring – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019) |
| September | • Annual Report on Quality in Public Health, incl Annual Complaints Report<br>• *Annual Equality and Diversity Report** this is part of the Strategic Commissioning Equality and Diversity, which goes to the Policy and Resources Cabinet Cttee<br>• Public Health Performance Dashboard – incl impact of STP |
| November | • Strategic Delivery Plan monitoring – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019) *(January?)* |