HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Thursday, 20 June, 2019

10.00 am

Darent Room - Sessions House

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Thursday, 20 June 2019 at 10.00 am
Darent Room - Sessions House

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

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

Membership (13)

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

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UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Membership - to report that the committee has a vacancy, following Mrs C Bell becoming Cabinet Member for Adult Social Care and Public Health.

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 10 May 2019 (Pages 5 - 16)

To consider and approve the minutes as a correct record.

6 Kent and Medway Integrated Care System (Pages 17 - 26)

a) Kent and Medway Integrated Care System - Introduction to the meeting. Andrew Scott-Clark (Director of Public Health, Kent County Council)

b) Strategic and Policy Overview - Michael Ridgwell (Deputy Chief Executive of the Kent and Medway Sustainability and Transformation Partnership)

c) Primary Care and Primary Care Networks -

i. Dr Fiona Armstrong (Chair of the Primary Care Board, STP)

ii. Dr Gaurav Gupta (Chair of the Kent Local Medical Committee)

d) Local Care – Cathy Bellman (Local Care Lead, STP)

e) System Commissioning – Dr Bob Bowes (Chair of the System Commissioner Steering Group, STP)

7 Work Programme 2019/20 (Pages 27 - 30)

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

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

Wednesday, 12 June 2019

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

KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Darent Room - Sessions House on Friday, 10th May, 2019.

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

OTHER MEMBERS: Paul Carter, CBE and Graham Gibbens

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

UNRESTRICTED ITEMS

40. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Mr D Butler. Mrs P T Cole was present as a substitute for Mr Butler.

The Leader, Mr P B Carter, had given apologies but would attend the first part of the meeting before leaving for another meeting.

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

There were no declarations of interest.

42. Minutes of the meeting held on 13 March 2019.
(Item. 4)

It was RESOLVED that the minutes of the meeting held on 13 March 2019 are correctly recorded and they be signed by the Chairman. There were no matters arising.

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

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

27 March, spoke at the Introduction to Public Health course – this course sought to spread awareness of public health issues and had attracted a good attendance from district and borough councils, voluntary organisations and others. The course had involved some discussion of health inequalities.
16 April, visited the One You Shop at Ashford Park Mall – the town-centre location of this provided encouraging evidence that it was starting to raise public

awareness of healthy living. Health monitoring such as blood pressure checks were offered.
23 April, observed the Community Hub Operating Centre and Multi-Disciplinary Team Meeting at Northgate Medical Centre in Canterbury – he had visited with Mr Carter and welcomed plans to expand the site to provide a minor injuries unit in central Canterbury. This would enhance health facilities to cover those with more complex needs and avoid the need for local people to travel to accident and emergency departments. The centre offered an MDT with a good range of professional involvement.
12 May 'oysters to cloisters' cycle ride - he would attend this annual ride from Whitstable to Canterbury and planned to hand out literature about the Release the Pressure campaign, which was displayed around the meeting room in connection with item 11 on the agenda (minute 49, below).

2. In response to a question, Mr Gibbens confirmed that he was always willing to visit events around the county to promote the public health agenda.

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

One You Shop, Ashford – the scheme referred to by Mr Gibbens was a good example of partnership working between the County Council, Ashford Borough Council and the Kent Community Health NHS Foundation Trust (KCHFT). Footfall at the central location was being monitored and was proving to be a good location.
Measles – statistics provided by Public Health England had shown that, in the last 12 months, there had been 54 cases in the Kent and Medway area, mostly occurring between April and September 2018, with 34 of those being in Medway. Vaccination was key, and the aim was to achieve 95% coverage in order to reach the whole population. Vaccination consisted of two separate doses, both of which needed to be administered to achieve immunisation. Take-up of the first dose was 90% but for the second was only 70% on average. A push to raise awareness of the need for vaccination and boost take-up rates would be made before the start of the new academic term in September, as the arrival of large numbers of new students at universities and colleges often brought a rise in cases. GPs were also offering a catch-up service for those who had not received both doses.
Air quality – work was continuing on air quality and Public Health England had published new guidance in March 2019 which would support the work being done by the Growth, Environment and Transport directorate. The draft Energy and Low Emissions Strategy would be considered by the Environment and Transport Cabinet Committee on 24 May, prior to being published for public consultation, which would start on 11 June and run for 12 weeks.
Association of Directors of Public Health (ADPH) Workshop on Population Health Management and Integrated Care Systems – this sought to ensure that all those who needed a public health service were receiving it, rather than just those who requested a service. More information on this work stream would be made available to the committee at future meetings.

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

a) asked if there was any way to monitor what health checks universities would make, and what advice they would give to new students arriving, he advised that universities would normally advise new students to

register with the medical centre on campus, at which point their health records would be transferred from their own GP. The KCC public health team would run a promotion at the start of the new academic year to encourage students to update their vaccinations, particularly for MMR;

b) asked about what geographical gap might remain if 95% coverage were to be achieved, he advised that coverage across the county was even. He added that much work went on to counter anti-vaccination lobbying as there was no evidence to support the assertion that the MMR vaccination was harmful in any way. Health visitors also used their contact with parents to remind them to vaccinate their children;

c) asked how the vaccination service would cover the catching up of those who had missed vaccinations in the past, he advised that work to catch up was in addition to the ongoing vaccination programme. This presented a challenge but it was most important that as much of the population as possible had the vaccination as measles could be very serious if contracted in adulthood. Children were much more able to cope with the illness; and

d) asked about the use of social media to spread the message about vaccination, and if this was a good use of public money, he advised that, as social media was very widely used, it offered a good way of reaching a large number of people. Messaging was sophisticated and programming could include the facility to display helpline numbers as pop-ups on screen, in the same way as that used by advertising agencies to display material which related to users' preferences. Another speaker cautioned that, as young people tended to believe everything they read on social media, health messages always needed to be very carefully presented.

5. The Leader and Cabinet Member for Health Reform, Mr P B Carter, CBE, gave a verbal update on health reform issues:

6. Mr Carter highlighted the need to do more to articulate the significant and major changes which were going on, not just with the structure of the health service, but what this meant in terms of delivering better local care and community care.

7. He chaired the Local Care Implementation Board (LCIB), which was focussing on how the current changes could make a difference to patient care and patient outcomes. Good progress was now being made and it was important to raise the profile of this work in the agenda of the Health Reform and Public Health Cabinet Committee. He suggested that, at the committee's 20 June meeting, it would be good to invite health partners and one or two GPs who sat on LCIB to explain how the implementation programme was progressing and set out the improved outcomes which were being sought from those changes, accepting that the workforce issue was the most major challenge.

8. The new structure would bring one integrated care system for the whole of the Kent and Medway area, which would be one of 43 such systems across the country, and an amalgamation of clinical commissioning groups to make one integrated care system (ICS), four integrated care partnerships (ICPs) across the county and a network of 42 - 43 primary care networks.

9. The Sustainability and Transformation Partnership Board, at a recent meeting, looked at targets for delivering the primary care networks, and where GPs would be coalescing to make up those networks to build the health economy across the whole of the Kent and Medway area. This would be set out at the committee's next meeting, to raise understanding and set out the functions and purpose of the integrated care system, the integrated care partnerships and the primary care network. Federations and partnerships of GPs were coming together well, although there was still a lack of clarity around some areas. The target date for these to be identified was the end of May 2019. An update could be made at the 20 June meeting so Members could understand the primary health and social care networks in their local areas.

10. These networks would be serviced by multi-disciplinary teams (MDTs), made up of a combination of third sector, social care and other providers, including social prescribers, care navigators and pharmacists. MDTs would be real rather than virtual teams, working together around GPs as a resource upon which GPs could call for support. These MDTs needed to recruit many more district nurses, physiotherapists and occupational therapists in order to be properly resourced. The primary care networks also needed to be properly resourced.

11. It was disappointing to learn that the additional investment of £23bn in local and primary care had been allocated only from 2022/23 onwards. Funding needed to flow alongside the enthusiasm to support the MDTs and the new networks, with the appropriate resources and workforce, otherwise what had been planned and promised would not be able to come about and the public would be very disappointed. Mr Carter was continuing his campaign to secure ongoing support for the restructure and was due to meet the Secretary of State for Heath, Matt Hancock, in the near future to seek to bring forward the promised investment and support the recruitment of a range of suitably-qualified staff, as this recruitment needed to be happening now.

12. Kent, particularly East Kent, was closer to having a primary care crisis than anywhere else in the country as it had the largest shortage of GPs. The number of GPs taking early retirement, and the resultant increasing age profile of the profession overall, was becoming a massive issue, for which there was no quick fix. This needed to be addressed alongside the establishment of the new structures.

13. With Mr Gibbens, Mr Carter had attended an MDT meeting and discussion in Canterbury, which had included a discussion of cases of patients with complex needs, including weekly updates on the care they were receiving and where more support might be needed. Discussion included the need for services, including step-down care and other care and support to help patients leave hospital and live safely at home. He had been enormously impressed with the wealth of knowledge of the professionals involved in the MDT and the power of MDTs as a model of partnership working. Discussion had also highlighted the need for more investment from the County Council on the social care side, as an integral part of the structure. He was keen to explore with Mr Gibbens, Clair Bell and Penny Southern to make sure that the County Council was doing all it could to support the development of MDTs. He would seek a major report and discussion to cover this well at the committee's next meeting and invite health partners and possibly the third sector along to talk about how they saw it rolling out.

14. With Mr Gibbens, he had also recently visited Red Zebra in Whitstable, a social prescribing provider, and had been very impressed with their work.

15. Recent additional funding had been announced, as part of the NHS 10-year plan, to go into primary care networks, to fund social prescribing and a GP to be a lead clinician to support social prescribing and care navigation so these could be available to GPs, when and in whatever way they need to access them. It was important to look into how this money could be used as meaningfully as possible. The third sector would need more funding overall to allow it to play a full part, for example, in social prescribing, as part of the provision of good local care.

16. Mr Carter responded to comments and questions from the committee, including the following:-

a) asked how the local care plan fitted with local district plans, and if the County Council could help secure section106 contributions from developers to support the development of health care facilities, Mr Carter explained that developer contributions was a much broader issue, which the County Council had been seeking to address for a while. From land values per acre, which varied greatly across the county and rose to very high values in some areas of the county, the County Council was allocated only 3% - 12 % as a contribution, to fund the related infrastructure. What would be more helpful and realistic would be 30 – 40%. Primary care provision was also too low down the list of priorities, behind roads and schools, which the Council had a statutory duty to provide. Primary care provision did not have this statutory status. Developers were supportive of the Council securing a higher percentage of the land value but it would be some time before this could start to happen. Mr Carter confirmed that he would continue to promote an increased percentage contribution. Another option to help build new surgery accommodation to support the new GP networks was to seek investment from the private sector, which could fund building and lease the premises back to the health service;

b) there was much vision and optimism in the plans for the new health structures but the County Council did not have the money to achieve what it needed to do. Recruitment of doctors, nurses and carers was vital to support the new structures but would take much money, and that money was simply not forthcoming. Medical staff would take years to train and there was no guarantee that they would stay to work in Kent once they had completed their training. Mr Carter acknowledged this concern and explained that much of the work going on in GPs' surgeries was to make better use of existing resources. This could be done by using the practice nurse, pharmacist, physiotherapist, etc, to see some patients who did not necessarily need to see the GP, thus allowing better use of the GP's appointment slots. The Kent Community Health NHS Foundation Trust (KCHFT) was setting up a nursing apprenticeship which would recruit trainee nurses and pay them a salary while they worked in placements for 3 days a week and studied for 2 days a week with the Open University. Canterbury Christ Church University would also need to offer a similar work-based degree course. Things were starting to happen now, although it would have been helpful if this could have started 12 -15 years ago. The NHS 10-year

plan included an aim that a greater percentage of the NHS budget would be spent on primary care and local care. It was encouraging that many practices were exploring new ways of working, supporting the MDT model and working with the third sector, pharmacists, etc;

c) the work to address land value issues was welcomed, and the payment of bursaries for nurses could be re-introduced to encourage more nurses to train. West Kent benefitted from London weighting for GPs while East Kent did not, which was a disincentive for people to work as GPs in East Kent. It was now almost impossible for people to get a home visit from their GP but more use could be made of skype and other modern technology to make more efficient use of GPs' time and to allow those who found it hard to travel to a surgery to access their GP remotely. Mr Carter gave an example of the Canterbury practice which had a permanent paramedic who would travel out to see patients who had made emergency calls and to either get them into hospital or arrange for a GP to visit later in the day. This system worked very impressively and the paramedic was one of the professionals on the local MDT; and

d) it had proved difficult for this Cabinet Committee to access information on what was happening in the health economy, so it had been most helpful to hear Mr Carter's update. It would be most helpful to have a presentation at the next meeting to set out more detail on the health restructuring. Clinical commissioning groups used to update districts on a regular basis on what was happening but this practice seemed to have ended. Mr Carter agreed that more information was needed and hoped that this could be rectified at the next meeting. He hoped that one of two GPs who sat on the LCIB would be able to attend and tell the committee at first-hand what was happening.

17. It was RESOLVED that the verbal updates be noted, with thanks, and that the committee's next meeting be dedicated to integrated care issues, with input from NHS partners.

44. Contract Monitoring report - the Adolescent Health and Targeted Emotional Health Service.
(Item. 6)

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

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

a) it would be possible to make available information about which schools had taken part in healthcare marketing events;

b) parents would be invited to attend appointments about their child's needs, as relevant, so support could be offered for the whole family;

c) a key point which had emerged from engagement work was the issue of how the service could engage with children who had been excluded from school. A dedicated outreach team sought to encourage them, and

children at special schools, to access the service, and having a single point of access would help with this;

d) use of the evidence-based Lancaster model, described in the report, was not mandatory, but completion in school time and running workshops had proved beneficial to encourage uptake;

e) although the range of services covered within the current contract did not specifically mention gambling addiction, young people could seek help with any issue. The school nursing service could help by signposting;

f) Mrs Tovey undertook to share further details of the equity work completed for areas of deprivation and from the Health Challenges group with Members outside the meeting. Mr Scott-Clark added that the Public Health Observatory was undertaking some work to see if the service was meeting the needs of those in the most deprived areas, and data suggested that the most needy did indeed received the most service;

g) achieving timely access to services was important. Kent's target was 12 weeks for Tier 2 and referrals for Tier 1 were commonly seen within 4 weeks. The single point of access offered a triage service which could fast-track urgent cases; and

h) one of the services with which school nursing teams worked was the bladder and bowel service. There were many reasons why children and young people could experience continence issues, and case study 2 in Appendix 4 of the report referred to continence issues.

2. It was RESOLVED that the progress made to transform services and ongoing activities to deliver continuous improvement be noted and endorsed.

45. Health Inequalities and Place-Based Public Health.
(Item. 7)

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

a) variations in life expectancy were now widening where they had previously been narrowing. Data to show the pattern across the county had been used as the basis of an action plan, and areas of high variance, for example, Swale, would be used to pilot work to address health inequalities;

b) one issue which must surely contribute to health inequalities in Kent was the practice of London boroughs of resettling high numbers of families in Kent, which placed a strain on local services. Dr Duggal agreed that a whole-system approach was needed, with links between services and the Government taking a leading role, although it would take a long time to address the issues currently facing Kent. The NHS 10-year plan included a section addressing health inequalities experienced by specific sections of the community, for example, travellers and those with learning disabilities; and

c) the list of areas for action drawn up by Michael Marmot, which were set out in the report, included improving access to healthy foods, but access to projects such as the summer kitchen, which encouraged children to prepare and eat healthy foods in the long school holidays, were not helped by the availability of local bus services. Dr Duggal pointed out that work was ongoing to tackle the placing of fast food outlets, particularly near schools, and Mr Scott-Clark added that, by 2021, all primary care networks would need to have an action plan to address health inequalities, and this would bring an opportunity to address such issues.

2. It was RESOLVED that:-

a) the content of the report be endorsed and Members' comments, set out above, be noted; and

b) further reports on the progress of work to address health inequalities be presented to future meetings of the Cabinet Committee.

46. Green Spaces and Physical Exercise.
(Item. 8)

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

a) the use of sensory rooms as a space in which office staff could take a break from their desks and computer screens was a new idea and would be investigated as part of ongoing work;

b) the promotion of cycling among school children, to reduce car journeys to school, was being supported by an initiative run by the Growth, Environment and Transport directorate and could be supported by the public health team. The use of good quality second-hand bikes would also make the point to young people that not everything needed to be new to be good, and learning how to repair and restore an old bike could be a rewarding project for a young person;

c) the perception of there being green space was as important as the space itself; having a view from a window was important. Mr Scott-Clark added that there was a recognised 'hierarchy' of healthy environments in which to take exercise, with 'blue space' (for example, walking near the sea or a lake) being first, forests second, green space third and urban environments fourth. Visiting a gym was still helpful as a way of improving fitness but spending time out of doors was more beneficial for a person's mental and general health; and

d) it was important to be realistic, however, about people's ability to travel to and exercise in coastal or rural areas. Some people could not afford transport or were physically unable to travel to and access such places. People would do as much as they could to increase healthy activity but it had to be a matter of personal choice and personal capability.

2. It was RESOLVED that the information set out in the report be noted and that Members' comments, set out above, be taken into account.

47. Six Ways to Wellbeing update.
(Item. 9)

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

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

a) the Six Ways tool was intended for use as the basis for starting a conversation about wellbeing and how behaviours and actions could affect mental health. Most of the Six Ways encouraged some form of engagement with a person's environment and community. The headings were purposefully broad to encourage individual interpretation;

b) a view was expressed that many people in deprived areas would have many more pressing concerns, like unemployment and debt. People in deprived areas simply would not relate to the headings. Ms Mookherjee advised that the Six Ways tool was not intended to replace any other sort of support or advice on other issues, for example, debt, but was intended as a way of starting to address emotional issues which might otherwise lead to anxiety and depression;

c) another speaker added that starting to address bigger issues in small daily doses was a good way forward. Projects supported by healthy living centres included a café, allotments, volunteering groups and training courses. These were all positive, useful ways of opening people's minds to other ways of living. Ms Mookherjee agreed that connecting to others and starting to acknowledge and talk about mental health was a key starting point;

d) Kent has added the sixth way, 'care for the planet', and this was welcomed. Connecting to other people to improve the local environment, for example by maintaining a local traffic roundabout or verges, would benefit society as well as the individual undertaking the activity;

e) the committee had been asked to suggest ways to strengthen future delivery, and one way to strengthen the connection would be to connect via community food banks, and for people whose only companion was a dog to connect daily with other local dog walkers; and

f) asked if district and borough councils were linked in to the Six Ways tool, for example, in their community development programmes, Ms Mookherjee advised that local connections would be tailored to suit local projects.

2. The Cabinet Member, Mr Gibbens, thanked members for their comments and suggestions and emphasised that the themes contained in the Six Ways were helpful as a basis for developing other ideas. Ms Mookherjee added that people to whom she had spoken about the tool had understood it and its purpose.

3. It was RESOLVED that the progress made on the Six Ways to Wellbeing be noted and endorsed, and Members' suggestions for ways of strengthening future delivery be taking into account in future work.

48. Performance of Public Health-commissioned services.
(Item. 10)

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

It was RESOLVED that the performance of Public Health-commissioned services in quarter 3 of 2018/19, and the proposed target changes for 2019/20, be noted.

49. Progress and future plans regarding the "Release the Pressure" social marketing campaign.
(Item. 11)

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

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

a) asked how Release the Pressure compared to the service offered by the Samaritans, Ms Mookherjee advised that the latter were trained to listen but not offer advice or seek to intervene, whereas Release the Pressure would actively link callers to sources of further help. Both services, however, shared the key principal of being non-judgemental;

b) asked what support the County Council offered its own staff to cope with mental health problems, Ms Mookherjee advised that online training and e.learning were available. This training was provided free to users and was available also to district and borough councils. Mr Scott-Clark added that discussion was going on with Corporate Directors to address mental health issues;

c) work was going on among a number of agencies to find ways of encouraging discussion of mental health issues and ways of directing people to find help, for example, patients visiting their GP with mental health issues would need to have a co-ordinated programme of follow-up counselling and medication;

d) the promotional material for Release the Pressure was praised, and had been noticed in a variety of locations, including the foyer of Sessions House;

e) any contact made with Release the Pressure would remain confidential, in common with any frontline service, unless the patient was judged to be at direct risk of harming themselves or others. This was good clinical practice and was standard for any mental health service. Links and referrals made to other services would be made with the patient's permission and only after they had had the purpose of the referral clearly explained to them;

f) it was suggested that a link be made to housing associations and to the armed forces, to reach ex-servicemen and women re-entering civilian life, and Ms Mookherjee advised that good links were already in place with the armed forces and would shortly be established with district council homelessness teams. The police force was also very supportive of work to promote and protect good mental health;

g) it was suggested that promotional material be displayed in all shopping centres, and the logo and a contact number could also be displayed on vehicles used by highways staff and community wardens, who visited every part of the county. Ms Mookherjee added that discussions were going on to display promotional material in libraries, and also to promote it to the many contractors who visited council premises;

h) a comment was made that the telephone number for Release the Pressure - 0800 107 0160 - wasn't as easy to remember as the Samaritans' number - 116 123 – but, like the Samaritans', was free to call;

i) a view was expressed that some people making their first contact with the service might prefer to do this by text rather than by having a conversation, while others would prefer to hear a human voice. It was important that people had options and felt able to make a choice;

j) the campaign was praised and a question asked about the service available to prisoners, prison staff and ex-offenders. Ms Mookherjee advised that public health services in prisons were commissioned by Public Health England rather than the County Council, although the two worked closely together. However, she advised the committee that those serving a sentence in a Kent prison tended to stay in the county after release, and could then engage with the County Council's public health team. Mr Scott-Clark added that it was known that many people taking their own lives had not made contact with Tier 2 services. The regime in a prison was important, with exercise and time out of cells being vital for prisoners' mental wellbeing;

k) a suicide prevention conference was due to take place on 14 May, at which the Release the Pressure promotional materials could be displayed. Members needed to be advised of how they could promote the campaign at events and at venues in their local areas. It was suggested that, by liaising with district councils, promotional material could be included in council tax bills when these were sent out. Ms Mookherjee advised that some district councils had already offered to do this. To reduce paper use, the logo could be printed on the outside of the envelope and would then be seen by postal workers as mail passed through the postal system; and

l) it was pointed out that many people living with depression and other mental ill health became very skilled at masking this with humour. On so many occasions, when a suicide had been reported, friends, neighbours and co-workers had said that they had simply not been aware that there had been any problem.

2. It was noted that an update on public health campaigns would in future be reported to the committee every six months rather than to alternate meetings.

3. It was RESOLVED that:-

a) the progress relating to Release the Pressure, and Members' comments and suggestions of ways to strengthen future delivery, be noted; and

b) update reports on the progress of public health campaigns be made to the committee every six months.

50. Work Programme 2019/20.
(Item. 12)

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

From: Paul Carter, Leader of the Council and Cabinet Member for Health Reform

To: Health Reform and Public Health Cabinet Committee - 20 June 2019

Subject: **Kent and Medway Integrated Care System**

Classification: Unrestricted

Summary:
The Public Health and Health Reform Committee has agreed to have a single item agenda focusing on health reform and specifically:

- exploring national policy and how the publication of the NHS Long Term Plan in January 2019 has impacted on the local health and social care system and is shaping the transformation of health services across Kent
- setting out progress in integrated working, particularly development of Local Care and its links to Primary Care to understand the outcomes we are trying to achieve for patients in Kent.

This paper is intended to provide the national and local context in which the County Council is currently working and will be supported by presentations from leaders across the system:

1) Strategic and Policy Overview- Michael Ridgwell (Deputy Chief Executive, Kent and Medway Sustainability and Transformation Partnership- STP)
2) Primary Care and Primary Care Networks-
    a. Dr Fiona Armstrong (Chair of Primary Care Board, STP)
    b. Dr Gaurav Gupta (Chair of Kent Local Medical Committee)
3) Local Care – Cathy Bellman (Local Care Lead STP)
4) System Commissioning- Dr Bob Bowes (Chair of System Commissioner Steering Group STP)

Recommendations:

The Health Reform and Public Health Cabinet Committee is asked to:
a) Comment on this report and the presentations received today
b) Comment on the progress being made in Health and Social Care integration across the County in line with the Long-Term Plan
c) Comment on and agree what areas the Committee would like regular updates on for the forward agenda

1. Introduction to the National Context

1.1 On 7 January 2019, the NHS Long Term Plan was published setting out key ambitions for the service over the next 10 years. The Plan was written in response to growing pressures in the Health and Social Care system driven by rising numbers of frail elderly people requiring support and a complex system of competition and payments that incentivise activity in hospitals. Alongside this, reductions in spend in primary and community settings mean that many people are not getting the support they need to manage their own health effectively, and turn to their local hospital when community provision,

including in some areas seeing a GP, is hard to access. However, research has shown that especially for the frail elderly, who use most NHS resources this is not always the best pathway:

- 30% of patients in acute hospital beds are better looked after in an alternative location of care, either in a short term bed or at home with health or social care support
- 12% of admissions through A&E are avoidable through more consistent decision making at the front door, or better health and social care provision in the community
- 25% of community hospital patients would be better cared for at home or in a community setting

1.2 In response to these challenges the aim of the Long Term Plan is to increase capacity in community services and in primary care, provide more responsive care, reduce upstream pressures (especially on overstretched acute hospitals) and to move towards a rebalanced NHS morphing gradually from cure to prevention.

1.3 The plan makes clear that funding is needed to help rebalance the system and indeed NHS budgets received a boost last Autumn with the announcement of 3.4% uplift (£20bn over 5 years) from the Government. The Long Term Plan sets out how the additional money will be fed into primary medical and community health services, and into a host of clinical priorities (especially mental health).

These reforms will be backed by a new guarantee that over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget. This commitment – an NHS 'first' – creates a ringfenced local fund worth at least an extra £4.5 billion a year in real terms by 2023/24. (LTP Summary Extract)

1.4 This is good news. However, this investment has not been mirrored for Social Care or Public Health. So, although the Plan sets out its ambitions to develop prevention, tackle health inequalities and improve population health, it recognises that significant progress on the wider determinants of health relies on action elsewhere and is clear in limiting its ability to cover ongoing cuts in local council funding.

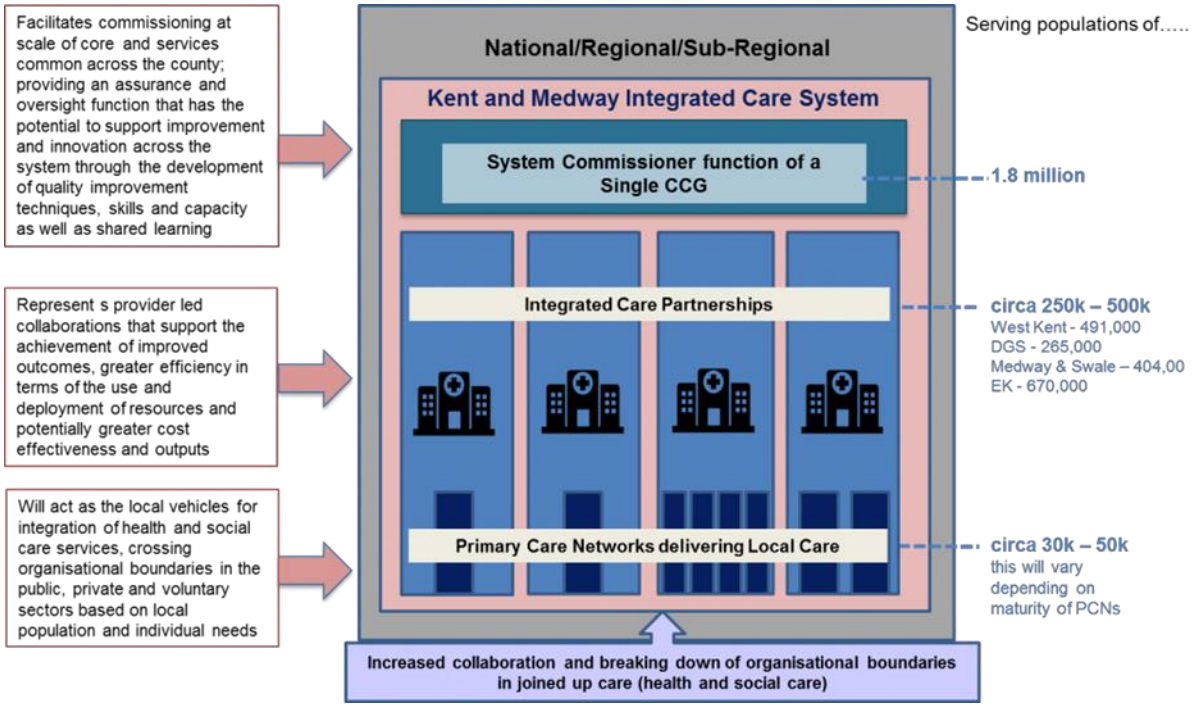
Both the wellbeing of older people and the pressures on the NHS are also linked to how well ***social care*** *is functioning. When agreeing the NHS' funding settlement the government therefore committed to ensure that adult social care funding is such that it does not impose any additional pressure on the NHS over the coming five years (Long Term Plan extract*).

1.5 The purpose of this single agenda item meeting is to set out how the aims of the Long Term Plan are being implemented in Kent and Medway in line with national policy and how we will realise our ambitions to shift service delivery from acute to primary care resulting in a substantial reduction in the number of people using hospitals for unplanned care.

2 The Local Impact of the Long Term Plan

2.1 The Kent and Medway Sustainability and Transformation Partnership formed in 2016. The Long Term Plan sets out the next stage of NHS transformation with a greater proportion of the NHS budget moving into primary and community or local care. It places a requirement on local areas to create one Integrated Care System (ICS) – which brings together health and care commissioners, providers and GPs into new relationships to create a population-based health system encompassing prevention and care – but which will also encompass local authority services such as public health, adult and children's social care. Each ICS will have one Clinical Commissioning Group (CCG) that will become leaner, more strategic organisations that support providers to partner with local government and other community organisations.

2.2 The structure in Kent and Medway is emerging in three layers:



- A single system commissioner, delivered through the establishment of a single Kent and Medway CCG covering our population of circa 1.8 million (i.e. the number of people registered with our GP practices)
- Four integrated care partnerships, that integrate the delivery of care operating across populations of around 250,000 to 700,000:
    - East Kent Integrated Care Partnership
    - Dartford, Gravesham and Swanley Integrated Care Partnership
    - Medway and Swale Integrated Care Partnership
    - West Kent Integrated Care Partnership

- Primary Care Networks (PCNs), as outlined in the NHS Long Term Plan and enabled through the new GP contract, which support delivery of primary care at scale, including local care. (Currently between 41-45 potential PCNs) Commissioners will continue to plan and fund services whilst PCNs focus on service delivery.

2.3 Kent County Council is a key partner to the STP and remains fully engaged with the transformation of services across the emerging structures. Senior leaders are progressing on the alignment and joint commissioning of services at all levels, wherever it makes sense to do so.

2.4 Cabinet Members and Corporate Directors are members of the STP Programme Board and there is good Local Authority representation across the STP workstreams. As well as the Leader of KCC chairing the Local Care Implementation Board, KCC Directors are acting as the senior responsible officers (SRO) within the STP for the Workforce and Estates workstreams. The Director of Public Health is the joint SRO for the STP Prevention workstream with the Director of Public Health from Medway Unitary Authority. Together they are also leading on a refresh of the Kent and Medway Joint Strategic Needs Assessment as part of Public Health's statutory duties to support and advise the NHS in the commissioning of services. The JSNA will underpin the Kent and Medway STP Five Year Plan that is currently in development.

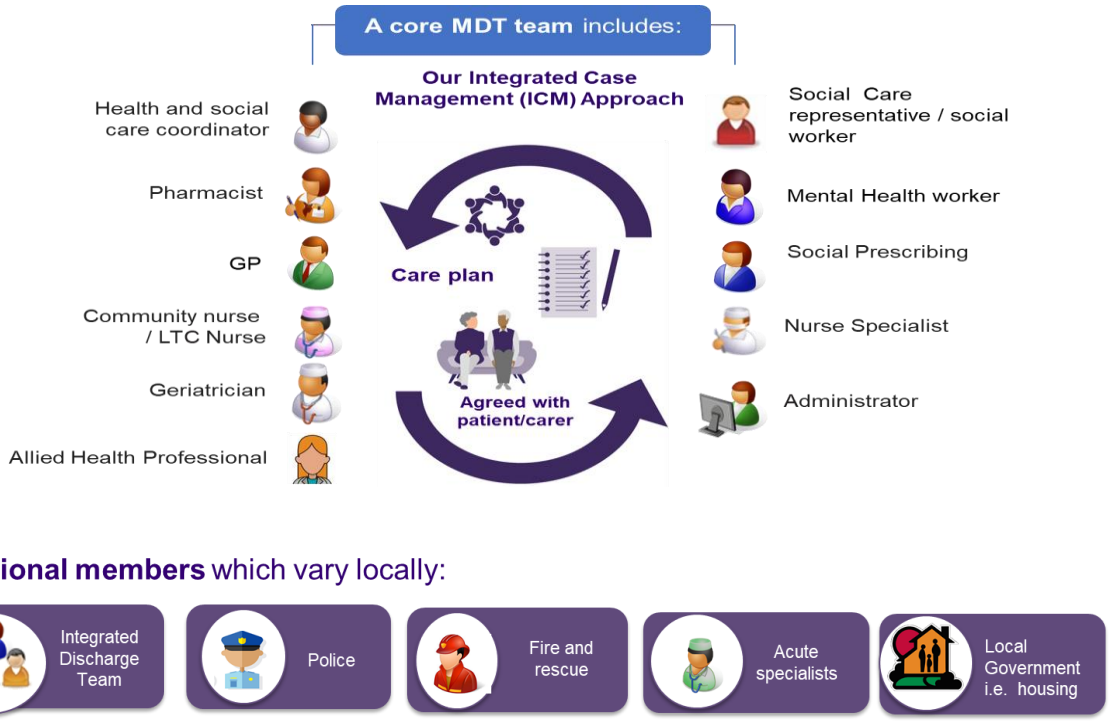
2.5 The reorganisation of Adult Social Care structures has provided opportunities for closer working. It has ensured that the Directorate is ready to support the emerging Primary Care Networks and Multi-Disciplinary Team (MDT) working with GPs at scale. The restructure has organised staff along a frailty pathway to ensure a seamless transition for patients experiencing Health and Social Care services, particularly on discharge from hospital. Adult Social Care staff are attending the emerging Multi-Disciplinary Team meetings taking place across the county.

3. Integrated Working- Exploring Primary Care Networks (PCN)

3.1 A primary care network consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. Networks would normally be based around natural local communities typically serving populations of at least 30,000 and not tending to exceed 50,000. They should be small enough to maintain the traditional strengths of general practice but at the same time large enough to provide resilience and support the development of integrated teams. PCNs will become the building blocks around which Local Care will operate and a key feature will be integrated community-based teams known in Kent and Medway as Multi-disciplinary Teams.

3.2 MDTs are at different levels of maturity across the County. Building professional relationships and ensuring consistency and quality of practice are

key strands of activity as organisations come together to work in new ways. Activity will happen through two stages- which will both include a range of professionals including social care staff. A multi-disciplinary meeting will take place led by the GP and including key professionals to discuss care plans for people who have been assessed as at risk of hospitalisation or who have complex long-term needs. Actions taken at the meeting will include identifying and ensuring that referrals are made to other agencies across a wider multi-disciplinary team to ensure that an individual receives support in a way that helps them to live their life as fully, independently and in the best health possible for them. The wider MDT team could include, for example the voluntary sector, District Housing officers or the Police. Community and Mental Health services will also be expected to configure their services around the PCN boundaries and take part in multi-disciplinary meetings as and when required.



3.3 PCNs will also need a wider range of staff to operate in this new model and deliver support into their community. Each PCN will have an accountable clinical director. This role is not yet clearly defined but they will be the link between general practice and the wider system. PCNs will also be expected to recruit additional staff including clinical pharmacists and social prescribing link workers, (with funding attached in 19/20), physiotherapists, physician associates and paramedics (with funding attached from 20/21 onwards). 70% of the cost of additional roles will be funded centrally, except for social prescribing link workers, where 100% will be reimbursed.

3.4 The main funding for PCNs will come through the directed enhanced service payment (DES) which is an extension to the GP core contract. This is worth

up to £1.8bn nationally with £891 million of that identified to fund additional staff. Additional funding was announced in June 2018 for community services and this will be channelled through PCNs.

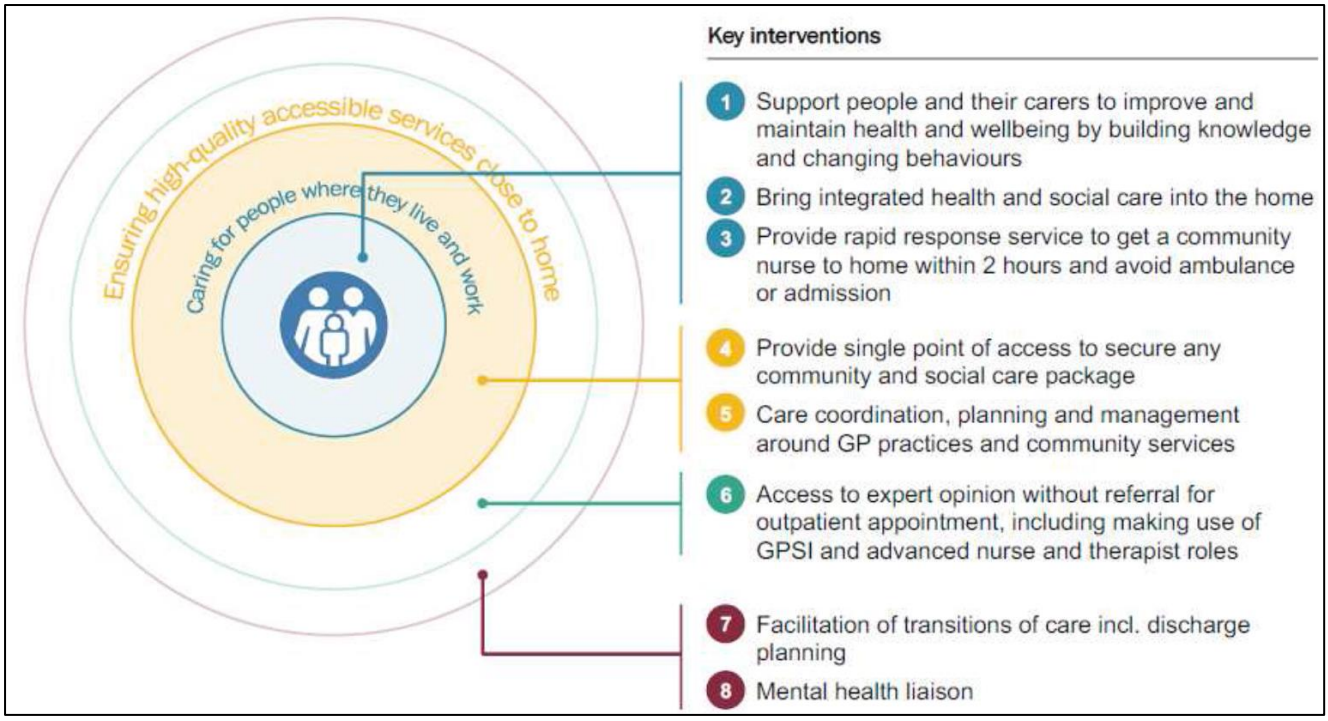
3.5 The configuration of PCNs across Kent and Medway is due to be announced at the end of June 2019.

4. Integrated Working- Exploring Local Care

4.1 Local Care brings together the activity associated with supporting people to remain well at home wherever possible and moving care out of hospital, into the community**.**

4.2 Local Care is a workstream of the STP and has already made good progress in the past year. £32m has been invested by Health to support development of Multi-disciplinary Teams, discharge planning and support, extended access and community wellbeing, including care navigation and social prescribing services.

4.3 The Local Care Model: 8 Interventions for "Dorothy":



4.4 The focus to date has been predominantly on the elderly frail and there is still much to do with priorities for 19/20 identified as:

- Fully functioning Multi-disciplinary Teams supporting Primary Care Networks
- developed models of care to deliver all 8 elements of the Local Care model known as the 'Dorothy Model' (including rapid response, falls prevention, reactive discharge planning and reablement)
- To have increased the number of individuals with an integrated case management 'care plan'

- To have embedded the dementia pathway within the model for Local Care
- Begin working on an MDT model for children with complex needs, adults with learning disabilities and autism
- To ensure community navigation and social prescribing are embedded as part of the model and are being delivered at scale
- Build on the 2018/19 support offer for paid and unpaid carers
- Build on local care workforce actions already underway as part of the 19/20 deliverables identified in the STP Workforce Transformation Plan.

4.5 The Local Care Delivery Framework has been agreed to track activity, progress and impact and will be in place by the end of 19/20. The framework will track:

- Number of people whose cases are being considered through MDTs with targets:
    - For Medway: 2282.
    - For North Kent: 3,053
    - For West Kent: 1,840
    - For East Kent: 12,703
- Anticipatory care plans in place
- A reduction in falling in frail adults
- A reduction in A&E admissions associated with falls, UTIs, catheter related issues and from care homes
- An increase in the uptake of social prescribing opportunities for high need groups
- Increased numbers going home after admission
- Reduction in admissions to long term care
- Reduction in Length of stay in hospital
- Reduction in non-elective admissions
- Nos people still independent 90 days after they received reablement
- Increase in dementia diagnosis rate
- Carers rate the Help4Cares app positively
- Agreed strategy for an MDT model for children with complex needs (linked to children's strategy)
- Begin to develop an MDT approach for adults with Learning Disabilities and Autism.

4.6 As Chair of the Local Care Implementation Board the Leader of the County Council receives progress reports from the 4 Local Care Local Implementation Groups that operate across the County. Discussions are already taking place with the Chair of the Primary Care Board to ensure that the Primary Care Strategy and the developing PCNs are fully linked to the Local Care workstream and that the system emerges with a cohesive and practical structure for the delivery of local care services through PCNs.

5. Challenges

5.1 There is no doubt that such a system wide reconfiguration is driving significant risk. The STP governance takes place through the STP Programme Board where senior leaders across the system oversee progress and manage risk. Elected Members from both KCC and Medway Unitary Authority are part of this Board along with Corporate Directors.

5.2 However, the national and local context that we are operating in means that we continue to grapple with a range of risks including the significant areas explored here:

- Funding: Our ability as a local authority to work more jointly with Health is rooted in the issue of funding. Local Authorities continue to face an uncertain funding position and are managing within far smaller budgets. The publication of a Green Paper to set out how Social Care could be sustainably funded has again been delayed, if not shelved. Similarly, Public Health budgets have also faced reductions from Central Government. Investing money and resources into local care and community or voluntary sector services will be crucial to the success of our ambition to move care closer to home, but it remains unclear where long term funding will come from.
- Workforce: Both the NHS and Social Care are facing workforce shortages. There is no doubt that to make Local Care a success the system will need to increase the numbers of staff in the community, including Health Visitors, District Nurses, Occupational Therapists and Social Workers as well as GPs. Meanwhile in hospitals there are shortages of all types of medical staff, including nurses and consultants. The STP has produced a workforce plan to encourage recruitment and retention but training requirements can produce a time lag which will mean the system only has one, already stretched workforce from which to recruit. There is, however good news as Kent will benefit from a new medical school based in Canterbury and KCHFT are launching a new apprenticeship scheme for nurses.
- Technology and digital services: The Long Term Plan highlights digital advancement as a high priority to support transformation of Health and Social Care and the success of Local Care will depend on the right technology being in place. A shared care record underpinned by information sharing protocols is vital, not only for professionals to provide the best possible care but also for individuals who tell us they expect the professionals they are working with to have access to their records and not to have to repeat their case history to everyone who is involved in their care. Equally, good, up to date information that will support people to manage their own health and access information and advice when necessary should reduce demand on front line services. The Carers app that has recently been launched is an excellent example of this approach but continued investment in digital services and an ambitious programme of joint working will be crucial to realising the benefits that new technology can offer.
- Estates: Shifting care closer to home will require local facilities where people can go for treatment or to meet a professional involved in their care. Much of

the NHS estate is ageing and unfit for purpose, both in hospitals and in the community and significant capital investment is required to update or provide adequate facilities.

6. Conclusion

6.1 The challenges are clear but the fundamental transformation of the NHS and integration of Health and Social Care services also provides opportunities for us to work together in new ways to benefit our citizens. A shared understanding of our financial position as one system where we recognise and make best use of our resources will lead to efficiencies and more cohesive service provision through joint commissioning and aligned working arrangements. Our ambition is to create a system that is easier to understand and navigate, can provide the right services at the right time and works together across all agencies to improve and protect the health and wellbeing of our population.

7. Next Steps

7.1 The NHS will continue to transform its services as identified in the Long Term Plan with the ambition to have:

- a single CCG in place by April 2020
- 4 x ICPs operational by 2022
- PCN configurations identified and the networks in place and evolving from June 2019.

Recommendations:

The Health Reform and Public Health Cabinet Committee is asked to:
a) Comment on this report and the presentations received today
b) Comment on the progress being made in Health and Social Care integration across the County in line with the Long-Term Plan
c) Comment on and agree what areas the Committee would like regular updates on for the forward agenda

Background Documents:

- **Kent and Medway Integrated Care System update,** County Council, 23 May 2019 available at https://democracy.kent.gov.uk/documents/s90388/Item%209%20-%20Kent%20and%20Medway%20Integrated%20Care%20System%20update.pdf

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From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 20 June 2019

Subject: **Work Programme 2019/20**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

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

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

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

2. Work Programme 2019/20

2.1 An agenda setting meeting was held 10 May 2019, at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion in agendas of future meetings.

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

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

3. Conclusion

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

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

5. Background Documents

None.

6. Contact details

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Last updated on: 12 June 2019

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

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

24 SEPTEMBER 2019
• ***Verbal Updates*** • ***Contract Monitoring*** – ***Adult Health Improvement Services (incl workplace health)*** • ***Contract Monitoring – Young People's Substance Misuse Services*** • **Gambling addiction - follow up report on work to address issues arising from** gambling item at 22/11/18 mtg (request by B Lewis) • **Housing conditions and their effect on health inequalities, incl hidden homeless** (request by E Dawson, 15/1/19) • ***Work Programme 2019/20*** • **Public Health Performance Dashboard – incl impact of STP** • **Annual report – Quality in Public Health, incl complaints**
1 NOVEMBER 2019
• ***Verbal Updates*** • ***Contract Monitoring – Positive Relationships*** • ***Work Programme 2020*** • **Regional approach to tackle illicit tobacco** (following item 10 at 22/11/18 mtg) • **Request for report about the 'Make Every Contact Count' contract** (request by D Marsh, 9/5/19) • **Kent Community Health NHS Foundation Trust - key decision on the extension of the partnership**
14 JANUARY 2020
• ***Verbal Updates*** • ***Contract Monitoring – Oral Health*** • ***Work Programme 2020*** • **Budget and Medium-Term Financial Plan** • **Public Health Performance Dashboard – incl impact of STP** • **Update on Public Health Campaigns/Communications**
6 MARCH 2020
• **Strategic Development Plan** (replaced former Directorate Business Plans) • **Risk Management report (with RAG ratings)** • ***Verbal Updates*** • ***Contract Monitoring – Children and Young People's condom programme*** • ***Work Programme 2020***

Last updated on: 12 June 2019

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

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