HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 15th January, 2019

9.00 am

Darent Room - Sessions House

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 15 January 2019 at 9.00 am
Darent Room - Sessions House

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

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

Membership (13)

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

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

Labour (1) Mr B H Lewis

Webcasting Notice

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

UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in items on the Agenda

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

4 Minutes of the meeting held on 22 November 2018 (Pages 5 - 16)

To consider and approve the minutes as a correct record.

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

To receive a verbal update from the Leader and Cabinet Member for Health Reform, the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health.

6 Update on Local Care (Pages 19 - 28)

To receive a report from the Leader and Cabinet Member for Health Reform, giving an outline of the implementation of Local Care within the Kent and Medway Sustainability and Transformation Partnership and the key areas in development and those enablers required to deliver Local Care at pace.

7 Contract Monitoring Report - Sexual Health Services (Pages 29 - 38)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, giving an update on the performance, outcomes and value for money of the sexual health services commissioned by the County Council, on which the committee is asked to comment.

8 Smoking Needs Assessment: Key Findings (Pages 39 - 48)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, which sets out the approach being taken to improve health and reduce health inequalities. The committee is asked to endorse this approach and support the enhanced Smoking Plus model and the revised ambition to reduce the number of smokers in Kent by 2022.

9 Childhood Obesity (Pages 49 - 62)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out an overview of childhood obesity in Kent, the services available to support families and areas of consideration for future action. The committee is asked to endorse the work going on and agree to a further report to the committee on joint working between agencies to tackle obesity.

10 Public Health Communications and Campaigns Update (Pages 63 - 70)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out the recent campaigns and communications delivered through the County Council's public health team and outlining some plans for 2019/20. Members are asked to comment on the progress and impact of campaigns in 2018/19.

11 Performance of Public Health commissioned services (Pages 71 - 76)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, setting out an overview of key performance indicators (KPIs) for Public Health commissioned services in the last quarter, on which the committee is asked to comment.

12 Capital Programme 2019-22, Revenue Budget 2019-20 and Medium-Term Financial Plan 2019-22 (Pages 77 - 88)

To receive a report from the Cabinet Member for Adult Social Care and Public

Health and the Director of Public Health, setting out the draft capital and revenue budgets and Medium-Term Financial Plan, including responses to consultation and government provisional settlement. The committee is asked to note these and suggest any changes which should be made before the draft is presented to Cabinet on 28 January and full County Council on 14 February.

13 Work Programme 2019/20 (Pages 89 - 94)

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

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

Monday, 7 January 2019

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

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KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Council Chamber - Sessions House on Thursday, 22nd November, 2018.

PRESENT: Mr G Lymer (Chairman), Ms D Marsh (Vice-Chairman), Mrs C Bell, Mr D L Brazier (Substitute for Mrs L Game), Mr A Cook, Mr D S Daley, 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

1. Chairman's Announcements - agenda order.

The Chairman announced that, as the Cabinet Member for Adult Social Care and Public Health had to leave the meeting early to attend an event in Gravesend to celebrate the 550th anniversary of the birth of Guru Nanak, the three items on Smoking and Tobacco Control had been placed first on the agenda and would be considered together.

2. Membership.
(Item. 2)

Members noted that Mr B H Lewis had joined the committee in place of Dr L Sullivan.

3. Apologies and Substitutes.
(Item. 3)

1. Apologies for absence had been received from Mr D Butler, Miss E Dawson and Mrs L Game.

2. Mr D L Brazier was present as a substitute for Mrs Game.

4. Declarations of Interest by Members in items on the Agenda.
(Item. 4)

1. Mr B H Lewis declared an interest in agenda item 12 as he had worked in the gambling industry for many years.

2. The Chairman, Mr G Lymer, declared that he served on Cancer Back up, East Kent Cancer Action Group, at the Kent and Canterbury Hospital and the Macmillan Cancer Welfare Benefits Steering Committee with the Citizens Advice Bureau, Canterbury and Ashford.

5. Minutes of the meeting held on 28 September 2018.
(Item. 5)

It was RESOLVED that the minutes of the meeting held on 28 September 2018 are correctly recorded and they be signed by the Chairman. There were no matters arising.

6. Meeting Dates 2019/20.
(Item. 6)

1. The Democratic Services Officer advised the committee that, since publishing the list of reserved meeting dates in the agenda pack, it had been necessary to change some of them. Members had been sent a revised list of dates before the meeting.

2. It was RESOLVED that the dates reserved for meetings of the committee in 2019/2020, as set out below, be noted:

Friday 10 May 2019
Thursday 20 June 2019
Tuesday 24 September 2019
Friday 1 November 2019
Tuesday 14 January 2020
Friday 6 March 2020
Thursday 30 April 2020

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

7. Verbal updates by Cabinet Members and Director.
(Item. 7)

<u>Public Health</u>

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

Key Developments in the Sustainability and Transformation Programme:

a) Appointment of Simon Perks as Director for System Transformation, progressing work on developing Integrated Commissioning and one Kent and Medway Clinical Commissioning Group.
b) Development of Winter Pressure Plan for Kent and Medway – Ivor Duffy had been appointed as Operations Manager.

Kent and Medway Care Record was moving to Phase 2 of the project, which would start to work on procurement. The care record would be a new umbrella database which would draw relevant information from existing systems and make it available to those who needed to use it, including doctors, nurses, care workers and paramedics, and, most importantly, individual patients.

Local Care – two deep dives to take place in November and December 2018, to review the plans for spending £32million of additional Government spending. New governance arrangements would start in January 2019, placing more accountability on local implementation, and with a revised senior leadership group chaired by Paul Carter.

Attended the National Children's and Adults Social Care Conference in Manchester on 14-16 November 2018. Kent would seek to make Kent a good place in which to grow old.

2. The Chairman asked that, to support his early departure, any questions on his updates be directed to him outside the meeting.

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

Local Government Association publication on sector-led improvement in public health. Mr Scott-Clark reminded the committee that he chaired the Association of Directors of Public Health, South East network.
Department of Health and Social Care publication 'Prevention is Better than Cure' included funding for a ten-year plan to raise the profile of preventative medicine.

Health Reform

4. The Leader and Cabinet Member for Health Reform, Mr P B Carter, gave a verbal update on the following issues:

He welcomed the ***additional Government funding,*** in the current and next financial years, for children's services and adult social care and to support earlier discharge from hospital. Meetings with clinical commissioning groups were awaited and would discuss how additional resources for the current financial year were being and could be invested to enhance local care. The ambition was to grow the £33million investment in the current financial year to £100million of additional resource in the medium term, and this new funding must be used to improve staffing, for example advanced-skills district nurses and community therapists of all types, to support enhanced community and local care. Spending must also be carefully monitored and audited. The new Secretary of State for Health, Matt Hancock, appeared to share the County Council's aim to reduce hospital admissions and hasten hospital discharge, and this was to be welcomed. The County Councils Network, which Mr Carter chaired, was currently running a campaign to secure for local care, community care and primary care a larger percentage of the additional health service funding which was announced in the autumn conference season.

Good ***joint working*** was continuing to build trust and new relationships between the County Council and its health partners to co-design a local care and community care model. Many GPs did not necessarily want to replicate the leadership model, delivering multiple services around a GP practice, as in the successful, Canterbury-based 'Encompass' model. Multi-disciplinary teams would deliver joined-up community services, including social care support and social prescribing, for catchment areas of approximately 50-60,000 population, and GPs could call upon these services when required. This multi-disciplinary team model was currently developing well and Mr Carter supported this integrated health and social care approach. Some GPs may want to take up the leadership model, and this could work well, but this option was not universally popular. The aim was to achieve seamless support around the patient, both in their own home and in the community, including social prescribing to address acute loneliness and social isolation. Where GPs did not want to adopt the leadership model, the County Council, as a strategic

service commissioner, would need to provide the infrastructure to join up services to ensure that contractors were delivering good quality, integrated services which were available when GPs needed to call upon them. A report on the development strategy would be made to the County Council's Health Overview and Scrutiny Committee on 23 November 2018.

5. Members then made the following comments:

a) reference was made to the existence of a few cottage hospitals in the county, and a suggestion made that these could play a useful role in providing respite care as a mid-way point between hospital and a patient's own home, particularly for the elderly and frail. However, what was vital to make any new system work was the recruitment, retention and training of a good workforce. Mr Carter agreed with other speakers that the issue of workforce was a major concern. As fewer newly-qualified GPs replaced those retiring and leaving the county, Kent and Medway was currently 265 short of the national average number of GPs for its size, and addressing this shortfall was a big challenge. The medical school planned for Kent was a step in the right direction in addressing training, but this would take several years to produce its first graduate suitably-qualified district nurses and GPs, so the shortfall would need to be addressed in the meantime. Respite care and convalescence was a major area of work. Mr Carter said he hoped that Community Trusts would shortly be able to report the number of beds in community hospitals which were occupied by patients who might be better accommodated elsewhere. He had talked to the Corporate Director of Adult Social Care and Health, Penny Southern, about the possibility of using beds in residential homes for short-term/enablement and convalescent care before a patient returned to their own home, as long as district nurses, physiotherapists and occupational therapists were available to support them there;

b) local care and community care needed to be available 24 hours a day, every day of the year, but at the moment many elderly frail patients were being admitted to hospitals as no other suitable service was available in the community. The Sustainability and Transformation Partnership had estimated that 30% of hospital admissions were unnecessary, but this situation was sure to continue until suitable investment in community and local care was available to safeguard patients in the community and their own homes, and this could include short-term observation beds in accident and emergency departments. In the Encompass model, it had been estimated that multi-disciplinary teams had reduced hospital admissions by 20%;

c) a comment was made about the importance of, and the apparent shortage of, qualified pharmacists. Mr Scott-Clark advised that many pharmacists were being trained and could work independently of a chemist shop, and so would be removed from the dispensing role, but would be able to give pharmaceutical advice. It was known that over-subscribing and over-medication for elderly and frail patients was an issue to be addressed, and this would be helped by having good clinical, pharmaceutical advice available locally;

d) asked about the feasibility of having a pharmacy and GP surgery open to the public at a hospital site, possibly to save a patient needing to be admitted, Mr Carter said that this model had been piloted in Medway. Some GPs were also offering extended opening hours, and if a GP hub were to be established, it would make sense for this to be as near a hospital site as possible;

e) the multi-disciplinary team model was welcomed as a way of relieving the immense pressure on GPs' current workloads. Many GPs seemed to work on a part-time basis, which made continuity difficult. Mr Carter commented that technology could play a part in addressing this and was starting to help patients and professionals to navigate the care service and for patients to access services without needing to attend their GP's surgery. The County Council needed to do all it could to support the development of the multi-disciplinary team model, and Mr Carter said he was optimistic that this was possible for the future;

f) the Secretary of State for Health, Matt Hancock, had recently set out detailed plans of how the additional £3.5billion announced by the Prime Minister would be used. This included community-based 24-hour rapid response teams, including GPs, nurses and physiotherapists, to treat people at home, and a national programme in which health care professionals, including pharmacists and GPs, would be assigned to care homes to offer out-of-hours care;

g) reference was made to 'Waitless', an online information service currently operating in East Kent, which gave real-time information on waiting lists at accident and emergency departments as well as real-time traffic information. This was welcomed as an excellent scheme which the County Council should promote and publicise; and

h) asked about how developer contributions were being used or could be used to provide health care facilities, Mr Carter commented that such facilities seemed to be low on the list of priorities when providing infrastructure for new and expanding developments. He commended a recently-published paper arising from work led by Oliver Letwin which set out recommendations to change the way in which developer contributions were used. Mr Carter said he supported the report's recommendations and hoped they may lead to increased allocations for health care services. The Government's response to the paper was currently awaited.

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

8. Agenda items 8, 9 and 10.

The Chairman advised the committee that agenda items 8, 9 and 10 would be discussed together as their content was closely related, and this would allow Mr Gibbens to attend for these items and then leave the meeting early. The recommendations for the three reports would be considered separately at the end of the discussion.

9. Stop Smoking Services.
(Item. 8)

Ms D Smith, Public Health Specialist, was in attendance for this and the following two items.

1. Ms Smith and Mr Scott-Clark introduced the reports for this and the following two items and highlighted the following key points:-

Stop Smoking Services:

a) statistics for quits cited in the stop smoking report were based on self-reporting and were therefore estimates, although more was known about the numbers seeking to quit and the methods they sought to use;
b) Kent generally had a good rate of smoking quits, 51%, and this compared well to the national average;

Smoking in Pregnancy:

c) work being undertaken had so far produced a number of successes and it was planned that this work would be rolled out across the county;

Illicit Tobacco in Kent:

d) the public health team was working together with trading standards colleagues to tackle the supply of illicit tobacco in Kent; and
e) it was known that this supply was closely linked to organised crime.

2. They then responded to comments and questions from Members, including the following:-

a) smoking was not the only way to ingest tobacco but other forms of tobacco such as chewing tobacco and snuff were not mentioned in reports about smoking. These methods still involved nicotine and still caused cancers. Smoking was by far the most prevalent method of taking tobacco into the body. Other methods could be looked into as part of future work but were not expected to be as significant an issue as smoking. Vaping had been identified by Public Health England as being 95% as safe as smoking, and other chemicals in cigarettes were more responsible than nicotine for causing cancers. NHS England supported the inclusion of vaping as part of a programme to stop smoking;

b) concern was expressed that children, girls in particular, were still taking up smoking, many of them at school. The cost of tobacco products must surely be difficult for children to afford. Campaign work should target young people and dissuade them from starting to smoke. Illicit cigarettes were often very cheap, and suppliers would target children Although work was being done with schools to address the problem, one good way to stop children from smoking was to dissuade their parents from smoking, using campaigns such as smoke-free school gates;

c) the costs per head of quitting services delivered in Kent and Surrey varied due to the amount of therapy each quitter was given, some requiring more than others, and the number of quitters coming to the services to be served within the finite resources and funding available. Surrey received less funding per head than Kent and, as a result, operated a smaller overall service than Kent. Stop Smoking services were a major indicator of health inequalities across the south east;

d) asked how a health visitor would approach the task of talking to a pregnant woman about giving up smoking, it was explained that a mother would be asked if she was aware of the dangers smoking posed to her unborn child, and a health visitor would then seek to increase her knowledge and understanding of the dangers, using facts and figures. Advisors were trained to national gold standard to do this effectively. Anyone not responding to a referral to a clinic appointment would receive an offer of a home visit from a health visitor, which would normally be taken up, as many women found a home visit more convenient than attendance at a clinic. The 'What the Bump' campaign, to raise awareness of the dangers of smoking in pregnancy, would be included in future campaigns to raise its profile;

e) the report and the work going on to address smoking prevalence were welcomed, but the point made that anyone feeling that they desperately needed a cigarette would not care at that moment about its damaging effects. People needed to be educated to reduce their dependence on cigarettes. Smoking was an addiction rather than a lifestyle choice and needed treatment to address it;

f) some Members of the committee related their own experiences of smoking in the past and their reasons for giving up. For some it was the realisation that they were putting their health at risk, for example with an increased risk of heart attack, while for others it was the advent of parenthood and concerns about giving children as healthy a start as possible;

g) the role of a pregnant woman's partner in supporting her to give up smoking had not been mentioned, but it would be very difficult for her to give up if her partner continued to smoke. Health visitors had noted when checking a woman's carbon monoxide readings that having another smoker in the house would raise her reading. Support was available for partners wishing to give up. An example was given of a family recording high carbon monoxide readings, where it was realised that those levels were being caused by a faulty boiler in the family home. The family was then supported in getting this fixed;

h) a question was raised about the attainability of the targets set out in the report for the reduction in the number of smokers by 2022, and if this high target wasn't tempting failure. Pilot programmes had been set challenging targets, but these targets were achievable if work were to start promptly now;

i) asked how passive smoking would be addressed, it was explained that smoke-free school gates, parks and play areas, and smoke-free homes, sought to reduce the extent to which children could breathe in second-hand smoke;

j) a popular belief was that smoking relieved stress but in fact it actually caused stress by causing blood levels to fluctuate dramatically. Observation of smokers with mental health problems had shown that their levels of aggression dropped when they gave up smoking; and

k) it was hoped that current projects and successful work could be continued and made more sustainable by achieving ongoing funding for the health visiting service and other areas of work, which had yet to be secured.

3. The Cabinet Member for Adult Social Care and Public Health, Mr Gibbens, thanked Members for their comments and asked that they consider supporting their local smoke-free school gates campaign using their Member grant money.

4. It was RESOLVED that:-

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

b) the proposal of the Smoking Plus model and Kent's ambition of achieving 45,000 fewer smokers by 2022 be supported;

c) the needs assessment and review of the stop smoking services currently being undertaken be acknowledged; and

d) a further paper be submitted to the next meeting of the committee on the outcomes and recommendations of the Stop Smoking review, which would propose an effective model of smoking cessation provision to meet the needs of smokers wanting to quit.

10. Smoking in Pregnancy.
(Item. 9)

Having discussed the report with those for items 8 and 10, it was RESOLVED that:-

a) the contents of the report be endorsed, and Members' comments, set out in minute 9 above, be noted;

b) the proposal to commission the Home Visiting Stop Smoking Advice service across Kent, to support pregnant women who smoke to quit, be supported; and

c) the beneficial role of midwives with a lead for Stop Smoking in Pregnancy be acknowledged and promoted and the committee recommend that they be a permanent fixture of NHS-commissioned maternity services in Kent.

11. Illicit Tobacco in Kent.
(Item. 10)

Having discussed the report with those for items 8 and 9, it was RESOLVED that:-

a) the contents of the report be endorsed, and Members' comments, set out in minute 9 above, be noted;

b) the proposal of a partnership approach between Public Health South East and Trading Standards South East to develop a regional plan to reduce the supply and demand of illicit tobacco be supported;

c) the issues and concerns that illicit tobacco poses to Kent be acknowledged; and

d) a further paper on the progress of a regional approach to tackle illicit tobacco be submitted to a future meeting of the committee.

12. Contract Monitoring Report - the Health Visiting Service.
(Item. 11)

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

1. Mrs Tovey and Ms Bennett introduced the report and emphasised that the service was performing well and represented good value for money, compared to other local authorities. Surplus funding would be re-invested and savings identified for 2019/20. Drop-in sessions and breastfeeding support services were both working well, and health visitors were working intensively with vulnerable families.

2. The Cabinet Member for Adult Social Care and Public Health, Mr Gibbens, said he was happy for Members to come to see him at any time to ask any question or seek any further information arising from reports to the committee, and offered to set up a briefing session if any Members wished for one.

3. It was RESOLVED that ongoing activities to deliver statutory obligations, meet performance expectations and ensure value for money, and work to support the integrated transformation of the health visiting service, including implementation and delivery of the new infant feeding model, co-location with children's centres and revised offer for vulnerable families, be noted.

Mr Gibbens left the meeting at the conclusion of this item.

13. Impact of Gambling on Public Mental Health.
(Item. 12)

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

1. Ms Mookherjee introduced the report and Members then made the following comments:-

a) data on the number of people addicted to gambling was not systematically collected in Kent, and there was no agreed definition of a 'problem gambler' other than the national guidance. It was agreed that addiction to gambling needed to be understood in the same way as addiction to drugs or alcohol;

b) large professional gambling outlet chains seemed to target the most deprived areas of the county in which to set up shops. Traditional bookmakers were being replaced by larger companies which had little relationship with their clientele;

c) fixed-odds betting terminals (FOBTs) were a cause for concern as they took so much money from users while offering very limited pay-out. Tracey Crouch, MP for Chatham and Aylesford, had submitted a report to the Treasury seeking to have the play limit on FOBTs set at £2. It would be useful to be able to access the data used by Mrs Crouch;

d) the Leader, Mr P B Carter, supported the comments made and added his concerns about the prevalence of gambling, as well as other addictions, including targeting workers in the construction industry. He suggested that gambling should have a higher priority among public health work streams;

e) there was a huge difference between someone who could afford to enjoy an occasional 'flutter' at the races and those with a daily habit of spending their pay in betting shops instead of spending it on food and bills. The potential impact of gambling addiction on family life was huge;

f) concern was expressed that the advertising campaign 'When the fun stops, STOP' was insufficient to convey the dangers and potentially-destructive nature of a gambling habit;

g) online gambling sites had no upper stake limit and players could spend, and lose track of, a lot of money very quickly. Younger teenagers with good computer skills could access these sites illegally by making themselves appear older;

h) reference was made to a planning application submitted for a betting shop in a small and mostly-affluent rural town in Kent which was approved despite much local opposition. In another location, a betting shop had been established next to a post office, surely encouraging people to spend in one the money they had just withdrawn from the other; and

i) use of betting shops and gambling apps was now seen as a 'normal' and acceptable recreational activity, whereas visiting a betting shop used to be clandestine, and not something one would wish to be seen doing. Members agreed that online gambling sites were advertised on television as being glamourous and fun, and a way of making like-minded friends. Advertising of such sites was currently run throughout the day but could be limited to after a 'watershed', in a similar way as adult content in television programming.

2. Ms Mookherjee thanked Members for their comments and said that, now the County Council had responsibility for public health work, it could promote and move forward on work streams to achieve its aim of integrated, person-centred services in which addictions of all kinds would have a greater focus. A good source of localised data, specific to Kent, would support this, as could the insights and experience apparent from Members' comments. She advised the committee that approximately 1.5% of the adult population were believed to have compulsive behaviour patterns, with those who had had negative childhood experiences being more at risk of developing such behaviours.

3. It was RESOLVED that:-

a) the briefing on problem gambling, the issues involved in tackling these in Kent, and Members' comments on the issue, set out above, be noted; and

b) the work being undertaken to address these issues be endorsed.

14. Tuberculosis and Hepatitis C in Kent.
(Item. 13)

1. Dr Duggal introduced the report and the work being undertaken by Public Health England and the NHS to eradicate and prevent both. In response to a question, Dr Duggal explained that a problem experienced with the supply of the tuberculosis vaccine in 2015 had been caused by a quality control issue and had not been repeated since.

2. It was RESOLVED that current information on tuberculosis and hepatitis C be noted and the partnership approach taken by the County Council's Public Health team be endorsed.

15. Work Programme 2019/20.
(Item. 14)

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

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By:	Mr P B Carter, CBE, Leader and Cabinet Member for Health Reform Mr G K Gibbens, Cabinet Member for Adult Social Care and Public Health Mr A Scott-Clark, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee – 15 January 2019
Subject:	**Verbal updates by the Cabinet Members and Director**
Classification:	Unrestricted

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

HEALTH REFORM

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

Update on Sustainability and Transformation Partnership (STP) work

PUBLIC HEALTH

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

No issues to update but Mr Gibbens offers the committee the opportunity to ask any questions arising from the 22 November 2018 meeting.

Director of Public Health – Mr A Scott-Clark:

1. Association of Directors of Public Health Annual Conference
2. Public Health Ringfenced budget for 2019/2020
3. STP Prevention update
4. Increased local and national influenza activity

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

To: Health Reform and Public Health Cabinet Committee, 15 January 2019

Subject: **Update on Local Care**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary: An outline of the implementation of Local Care within the Kent and Medway Sustainability and Transformation Partnership - this paper outlines the key areas in development and those enablers required to deliver Local Care at pace.

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to consider and endorse the progress and direction within Local Care.

1. Introduction

1.1 Central to the delivery of integrated care under the Kent and Medway Sustainability and Transformation Partnership [STP] is Local Care, community-based services made up of multi-disciplinary teams [MDTs] built around GP led primary care networks, that keep people safe and well in their own homes and avoid admission to hospital.

1.2 Each locality area across Kent is supported by a Local Care Implementation Board, focused on delivering an ambitious plan, supported by significant investment in key areas, totalling c.£32million of NHS investment across Kent and Medway.

This paper outlines the key areas in development and those enablers required to deliver Local Care at pace.

2. Financial Implications

2.1 The NHS investment has been identified for Local Care in 2018/19, with clear timelines for identifying the key deliverables in 2019/20 and beyond.

3. Policy Framework

3.1 The Kent and Medway Sustainability and Transformation Partnership outlines the vision “Quality of Life, Quality of Care” with an intention the Kent and Medway health and care system will deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting.

3.3 The NHS 10 Year Plan and the forthcoming Green Paper on Older people will both focus on better integration of health and social care, so that care is seamless when patients are moved between systems.

4. Local Care

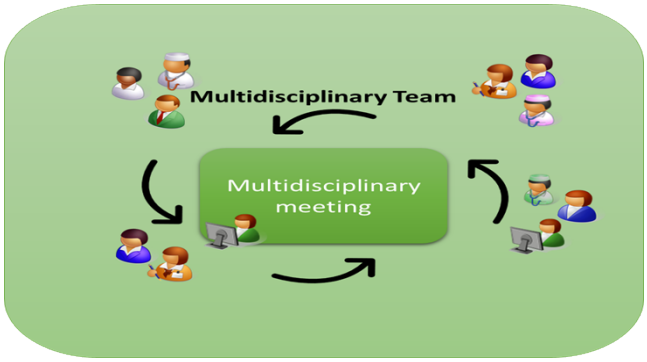
MDTs

4.1 Central to the delivery of Local Care is the implementation of MDTs working together around a GP. These are teams made up of community nurses, social care, specialists like physio-therapy or pharmacists and care navigators with links into the voluntary and community sector. They are based on a 30-50k population footprint and centred around what are now called primary care networks.

There are currently 109 social care practitioners who attend Local Care Multi-Disciplinary Team Meetings (MDMs) across the nine localities, these practitioners are the voice of social care at these meetings and co-ordinate social care and support from the Council's specialist services as required.

The vision is for all services to be part of these Local Care Multi-Disciplinary Teams.

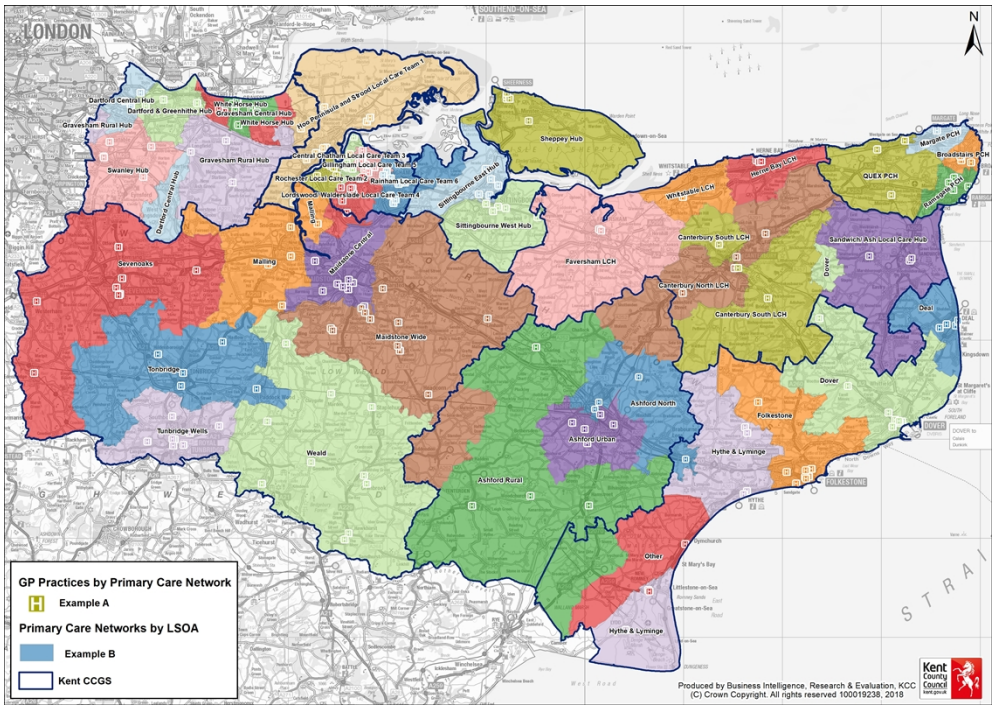
Fig 1. Multi-Disciplinary Team Meeting (MDMs)



4.2 Different models of team working are being trialled through new models of care, such as ESTHER and Buurtzorg, which focus on putting the patient at the heart of delivery, with a team wrapped around them for care and support.

The challenges and solutions for these new ways of working have been brought together in an integrated organisational development toolkit which has been developed through the STP workforce stream. The new models call for the retention, recruitment and development of staff with the right skills who can work across organisational boundaries and who can practice from multiple and multiagency locations. It is essential that career progression pathway opportunities across adult social care, health and the wider sector workforce are developed and promoted.

Fig 2: Emerging Primary Care Networks Geography



Hubs

4.3 The MDTs will be supported by a network of Hubs across primary care networks. These Hubs will follow the vanguard model of Encompass and will bring supporting services together enabling improved out of hospital care and reducing the duplication of work completed by professionals. Further work is required to understand what can be delivered from the Hubs and to align existing estates activity – for example linking to sheltered housing provision.

Prevention

4.4 In addition, the development of an Integrated Community Navigation Service brings together the different services involved in guiding people through the health and social care system, providing information and advice, signposting to services that support their wellbeing, supporting people to maximise their income, connecting people to community resources and carrying out statutory carers assessments.

Urgent Care

4.5 Within Urgent Care, work continues through the Integrated Discharge Teams, who are located in the acute and community hospitals and work hand in hand with all rapid response and enablement services across the county, to prevent admissions to and facilitate timely discharges from hospitals. At a locality level social care is working with Kent Community Health Foundation Trust (KCHFT), Virgin Care and Kent and Medway Partnership Trust (KMPT) to embed Integrated Screening Services to ensure the right support is available by the right professional when required. This ensures a quicker response time for the individual, reduces multiple referrals to different organisations and promotes joint working.

The Role of the GP

4.6 Central to the success of Local Care is involvement and buy-in from GPs. The Local Care workstream is working to align the newly formed Primary Care Board with the delivery of Local Care. Across Kent and Medway, Primary Care Networks are emerging, largely through coming together in Federations. By aligning the Local Care and Primary Care workstreams it:

- Provides support for implementation
- Helps with consistency of practice
- Helps sharing learning and building on best practice
- Improves primary care recruitment and retention

Enablers

4.7 Local Care is underpinned by several enablers, supported through additional STP workstreams: Digital, Estates and Workforce. Specific developments are already underway including the implementation of a Carers App, the development of the Kent and Medway Care Record, the Kent and Medway Workforce Strategy and an Estates plan to support Local Care.

Adult Social Care and Health has also implemented a new management structure in order to support the integration agenda, with a dedicated partnership team led by the Director of Partnerships, Anne Tidmarsh.

Measuring Success

4.8 The implementation of Local Care also needs to be supported by the right governance and funding streams. The STP governance structure for Local Care has been revised with a new Local Care Executive Board that has closer links with the GP led Locality Boards.

Further work has also taken place with the Clinical Commissioning Groups (CCG) to identify their allocated funding for Local Care through a series of deep dives. This has confirmed the allocation of £32m of NHS investment across existing plans. In addition for Social Care, £29.8m of the Better Fund (BCF), £17.4m of the improved Better Care Fund (iBCF) and £6.1m of Winter Pressures money funds joint initiatives such as Discharge to Assess, Home to Decide and Home to Settle.

4.9 It is important that across Local Care there is a consistent way of monitoring progress and an agreed Local Care Delivery Framework. This needs to focus on key outcomes for people, alongside measuring success in developing our workforce and avoiding hospital admissions. Further work is taking place on this framework following the deep dives and a draft will be presented to the first Local Care Executive Board in February.

5. Conclusion

Considerable progress has been made within Local Care and the recent deep dives have highlighted that plans are in place to progress this at pace and scale over the next year. This will be supported by the new Governance within Local Care, with the aim of improved decision making and greater transparency of progress.

Reinforced by the implementation of the Local Care Delivery Framework to monitor the outcomes of spend and ensure progress is made across key areas such as workforce.

6. Recommendation

Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to consider and endorse the progress and direction within Local Care.

7. Background Documents

none

8. Contact details

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Local Care in Practice

Developing locally based teams, working in a multi-disciplinary way centred around GPs

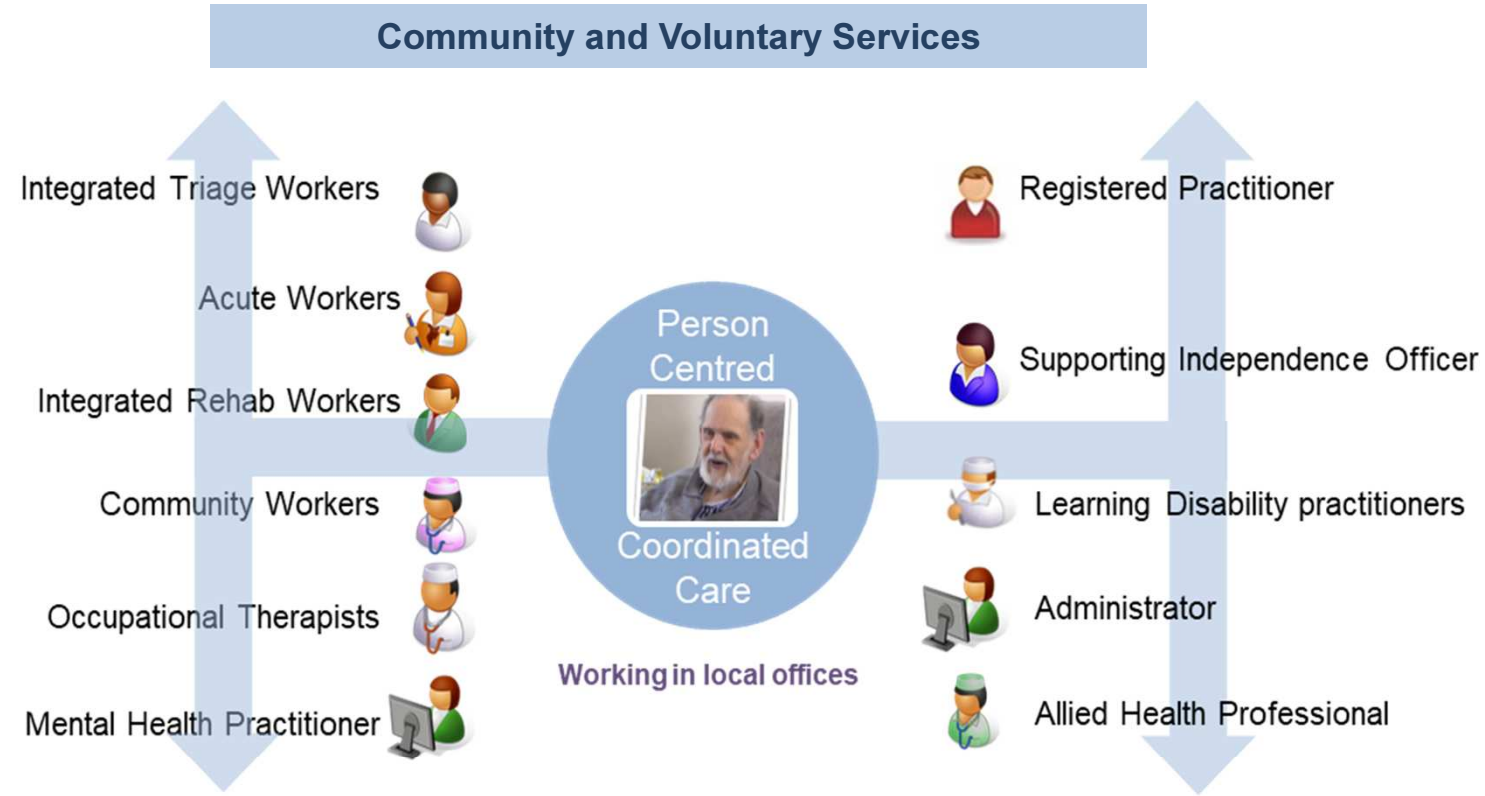
£32m additional spend to support increased workforce and changes in how workforce delivers services

Creation of Hubs – buildings that bring services together enabling improved out of hospital care

Better use of the voluntary sector through schemes that guide people through the health and social care system, providing information and advice, signposting to services that support their wellbeing

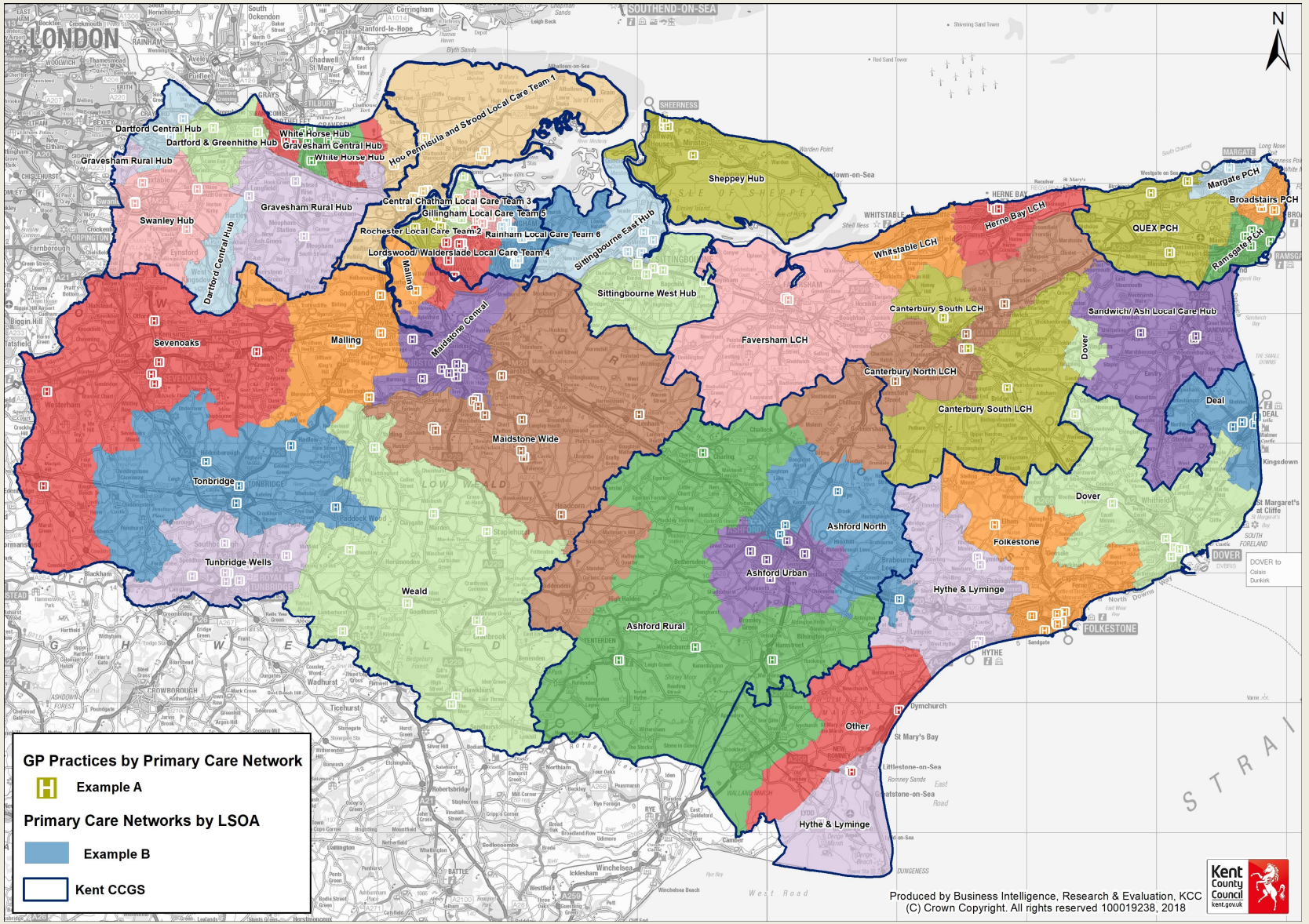
Supported by the Kent and Medway Care Record

Integrated Multi Disciplinary Teams



Specialist intervention will available for teams:

GP Primary Care Networks



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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

Date: 15 January 2019

Subject: **Contract Monitoring Report – Sexual Health Services**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

This report provides the Committee with an update on the performance, outcomes and value for money of the sexual health services commissioned by KCC.

These statutory services are performing well, and commissioners are in the process of remodelling services to respond to the needs assessment and revised Commissioning Strategy presented to this Committee in September 2018.

The Committee endorsed the decision to incorporate elements of the sexual health services into the existing KCC and KCHFT Partnership and to form a new partnership with MTW to deliver the remaining services. A competitive tendering exercise has now been undertaken for the Children and Young People's (CYP) condom programme and a new contract will commence on 1st April 2019.

KCC's chosen contracting approach offers flexibility, value for money continuous improvement and delivery outcomes.

Recommendation

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

- the commissioning and provision of Sexual Health services in Kent
- service improvement initiatives being undertaken to improve quality and outcomes
- progress to date on the implementation of the commissioning strategy which includes the re-modelling of services and the outcome of the condom procurement process.

1. Introduction

1.1. This report provides the Committee with an update on the performance, outcomes and value for money of the sexual health services commissioned by Kent County Council (KCC). It includes detail of the contracting and management arrangements in place for these services.

1.2. The committee has previously commented on the commissioning strategy for sexual health and this paper includes an update on the progress made to implement the agreed approach.

1.3. As with previous contract management papers, this report presents an update on performance, outcomes and ongoing work to transform the services and respond to changing patterns of demand.

2. Background

Sexual health is not a single issue as it is affected by varying things including childhood or adult experiences, vulnerability, lifestyle and mental health. Poor sexual health creates a significant burden of disease through sexually transmitted infections, particularly repeat or undiagnosed infections.

2.1. Since 2013, KCC has a statutory obligation to provide a range of open access sexual health services across the county. This includes providing sexual health information and advice; contraception; testing, diagnosis, treatment and management of sexually transmitted infections (STIs) and HIV; and raising awareness about the prevention of STIs. 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.

3. Service Outcomes

3.1. The two key risks that sexual health services aim to address are:

- **Risk of sexually transmitted infections** - good access to effective testing and treatment is essential to reduce the burden of disease and to prevent escalation of needs
- **Risk of unwanted pregnancy** - good access to planned and emergency contraception is also essential to help reduce unwanted pregnancy and improve sexual health and emotional wellbeing.

3.2. Key outcome are set out below. A number of these link directly back to the Public Health Outcomes which are nationally reported https://fingertips.phe.org.uk/profile/public-health-outcomes-framework (PHOF).[1]

- Improved access to all sexual services amongst those at highest risk of sexual ill health
- Increased use of planned contraception
- Reduce unwanted pregnancies among women of fertile age
- Reduce rates of STI diagnoses in the population
- Increase uptake of effective methods of contraception
- To reduce inequalities in sexual health
- To contribute to a reduction in unplanned pregnancies especially amongst under 18s (PHOF)
- Reduce repeat terminations
- Reduce rates of people presenting with HIV at a late stage of infection (PHOF)
- Reduce chlamydia detected in 15 – 24-year olds (PHOF)

[1] The Public Health Outcomes Framework *Healthy lives, healthy people: Improving outcomes and supporting transparency* 2016-2019

4. Overview of services

4.1. KCC spends approx. £12.9m p.a. (supplemented by income from NHS England[2]) to commission a range of sexual health services. These are delivered in a number of settings, include an online offer, Children & Young People (CYP) specific services and includes clinics outside of core working hours.

4.2. Services provided are detailed in Appendix A but include:

- Open access integrated sexual health service
- Provision of a condom programme with access online
- Psychosexual counselling
- Emergency contraception
- Chlamydia treatment through community pharmacies
- General Practice provision of long acting reversible contraception

4.3. Most of these are clinical services and are commissioned through contracts with local NHS providers and the table at Appendix A provides a breakdown of the providers and contract values for each of these services.

4.4. In addition to its commissioned services, KCC is responsible for paying the costs of STI testing and treatment (via GUM clinics) of Kent residents even when the service is provided outside Kent. This presents an additional demand pressure on the sexual health budget.

5. Contracting Arrangements

5.1 Public Health are in the process of remodelling services and in September 2018 the Committee agreed to include a number of the sexual health services into the existing KCHFT partnership, to form a new partnership with MTW for the provision of integrated sexual health services (many of which are specialised clinical services) and an online STI testing service.

5.2 The proposal for LARC is to continue contracting directly with GP surgeries and for the condom scheme we will be awarding a new contract by early January 2019 following a competitive procurement process.

5.3 As part of the last round of retendering in 2015, KCC took on responsibility for leasing the main sexual health service premises. This arrangement has given KCC a greater degree of control over where the services are located to meet the need of the population. The leasing arrangements are managed through KCC's Property Commissioning team and GEN2.

6. Contract Management Approach

6.1. The service outcomes, requirements and standards are set out in contractual documentation and include a number of key performance indicators (KPIs). An overview of the key public health outcomes associated with sexual health services are included at Appendix B.

6.2. KCC has an effective contract management process in place and uses activity based contracting and open book accounting to ensure value for money. KCC only pays for services delivered and this support service meets changing patterns of demand.

6.3. This commercial strategy has enabled us to get a clearer idea of the demand for services which has informed commissioning strategies for service post April 2019.

[2] NHS England contribution funds HIV outpatient services delivered through the KCC contracts

7. How are contracts performing?

7.1. Performance data from the past two years illustrates good performance, excellent levels of access for urgent GUM cases and has good levels of clinic and outreach capacity.

7.2. The increasing numbers of STI diagnoses, continuing increase in demand for the online services and the high levels of service user satisfaction all indicate that the services are effective and compliant with contractual requirements. Figures 1 and 2 below shows KPIs on service offering and uptake.

Figure 1 – Clinic appointments offered within 48 hours

HRPHCC & QPR Sexual Health Services KPI	Floor Target	Target	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19
% of clients accessing GUM services offered an appointment to be seen within 48 hours	72%	90%	100% (g)	100% (g)	100% (g)	100% (g)	9,772 100% (g)	10,024 100% (g)

Figure 2 – Number of people accessing Sexual health services

HRPHCC Sexual Health Service Activity Measure	2015/16	2016/17	2017/18
Number of people accessing KCC commissioned sexual health services	73,153	78,144	75,694

7.3 Data produced by Public Health England on Healthier Lives shows a national comparison of key health indicators and allows for comparison by region. Appendix C shows Kent's rank within its CIPFA nearest neighbours (most similar local authorities) on Sexual and Reproductive health. Kent is ranked 15 out of 16 and from the data it is clear that this is due to reduced levels of screening at first attendance. There is a need to increase uptake of screening through remodelled services and introduce a new KPI to address this issue. Kent performs well on other unrelated metrics and this change should improve its ranking.

7.4 The services are well received by the users and regular feedback is received by the providers. Appendix D highlights a selection of user feedback on the service on both the integrated sexual health services and the CYP condom programme.

8. Transformation and continuous improvement

8.1 A key part of contract management is striving for continuous improvement in service delivery and outcomes. KCC has worked closely with service providers to find innovative ways to provide services in a cost-effective way and ensure that local services meet current needs.

8.2 The online home-testing service is one such example which offers residents the ability to test themselves for STIs confidentially in the comfort of their own home. Not only is this quicker for the user, it provides a service that young people said they wanted and offers a financial saving.

8.3 Sexual health services aim to offer choice and trys to respond to user feedback from service data. This includes increasing drop in clinics, additional provision at evenings and weekend and introduction of PrEP - (HIV Pre-exposure Prophylaxis) which is a new way for people to reduce their risk of acquiring HIV.

8.4 KCC has also worked to progress property projects and a new clinic in Dartford will open in 2019 and provide a wider service in an area that we know has increased needs.

9. Risks

9.1. There are a number of risks associated with the commissioning and delivery of sexual health services which are set out below. These are managed through the commissioning cycle and contract monitoring process including the transformation and mobilisation process.

- **Demand-led services** – sexual health services must respond to population needs. A key risk going forward is the inability to remodel successfully to manage changes and increased demand within the budget available.
- **Transformation** – the potential risk of loss of staffing due to transition and changes in models
- **Premises** - pose an additional risk. These are provided by KCC and managed through GEN[2]. The services rely on these in order deliver quality services. An additional risk for this programme of work includes changes in funding received from NHSE for the provision of HIV services.

9.2. These risks are managed by effective commissioning and contract monitoring, working collaboratively with providers to identify and examine emerging trends and to plan and monitor service capacity and usage. Ongoing collaboration with KCC property representatives ensures that we have effective premises available for services and commissioners are currently in dialogue with NHSE on the HIV services in order to ensure sufficient funding.

10. Conclusion

10.1. The KCC-commissioned sexual health services are currently performing well and KCC has effective contract management arrangements in place to ensure that KCC secures best value for money and continuous improvement.

10.2. The sexual health needs of the population are changing, and it is crucial that commissioned services adapt to new trends and emerging needs. Work is already currently underway to adapt the service to meet the needs of the users within the budget available and it is clear there is considerable opportunity to utilise technology advancements to develop the service.

10.3. KCC will need to continue to manage the risks to effective service delivery in order to ensure it complies with its statutory obligations and NHS guidance to ensure provision of comprehensive open access sexual health services.

Recommendation

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

- the commissioning and provision of Sexual Health services in Kent
- service improvement initiatives being undertaken to improve quality and outcomes
- progress to date on the implementation of the commissioning strategy which includes the re-modelling of services and the outcome of the condom procurement process.

Background Documents:
Sexual health needs assessment -
https://www.kpho.org.uk/__data/assets/pdf_file/0006/89151/Kent-sexual-health-needs-assessment-Final.pdf

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Appendix A – Contract values

Contract	Contractor	Allocated budget for 2018/19	Scope
North and West Kent Integrated Specialist Sexual Health Service (Genito Urinary Medicine/Contraception/HIV Outpatient Service)	Maidstone and Tunbridge Wells NHS Trust (MTW)	£4,195,547	Open access sexual health services across North and West Kent: • STI testing, diagnosis and treatment • Contraception • HIV outpatient care (on behalf of NHS England)
East Kent Integrated Specialist Sexual Health Service (Genito Urinary Medicine/Contraception/HIV Outpatient Service)	Kent Community Health NHS Foundation Trust (KCHFT)	£3,806,002	Open access sexual health services across East Kent: • STI testing, diagnosis and treatment • Contraception • HIV outpatient care (on behalf of NHS England) • Co-ordination of the National Chlamydia Screening Programme in Kent
Psychosexual counselling / therapy across Kent	Kent Community Health NHS Foundation Trust (KCHFT)	£293,580	Counselling services to support people with sexual health related concerns.
Online	Maidstone and Tunbridge Wells NHS Trust (MTW)	£482,000	Access to online STI testing services and E-bureau for positive management results and partner notification
Pharmacy contract	Kent Community Health NHS Foundation Trust (KCHFT)	£384,373	Subcontracting to pharmacy for the provision of: • Emergency oral contraception through pharmacies • Chlamydia treatment
Condom evaluation and establishment of a programme with outreach	METRO	£202,040	Online free condom scheme for young people aged under 25
LARC Programme including prescribing costs	154 GP Surgeries	£2,040,823	Provision of long acting reversible contraception and associated drugs
LARC Training	Navigate 2	£100,000	Training for practitioners on the insertion and removal of LARC systems and devices
Out of area charges	Various	£ 687,388	Charges for Kent Residents who use open access sexual health services outside of Kent.
Premises revenue	Various	£518,914	Various properties utilised for sexual

			health services cross Kent.
Premises Capital	Various	£191,600	Various properties utilised for sexual health services cross Kent.
Total		**£12,902,267**	

Note: The majority of the above operate on activity-based contracts and the above therefore represents anticipated spend.

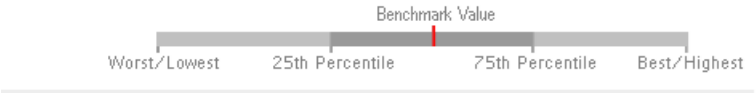
The capital spend is one off and dependant on timescales to develop new sites, this will deliver efficiencies in revenue spend by reducing the number of sites and provision of a sexual health Hub. The public health grant can be used for both revenue and capital spend.

Appendix B - Outcome Indicators

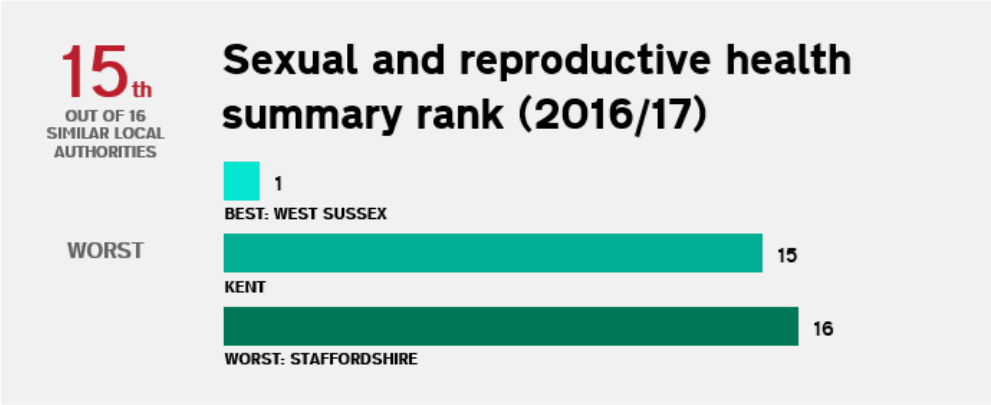
Indicator	Period	Kent			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate / 100,000	2017	↑	93	6.0	9.5	12.5	154.1		0.7
Gonorrhoea diagnostic rate / 100,000	2017	↑	478	31.0	45.9	78.8	654.4		12.1
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300	2017	↓	2,339	1,272	1510	1882	939		4,463
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) (Male)	2017	↓	729	776	1018	1264	551		3,350
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) (Female)	2017	↓	1,606	1,788	1961	2502	1,179		5,410
Chlamydia proportion aged 15-24 screened	2017	↓	25,943	14.1%	17.1%	19.3%	9.1%		44.8%
Chlamydia diagnostic rate / 100,000	2017	↓	3,411	221	278	361	174		1,224
Chlamydia diagnostic rate / 100,000 aged 25+	2017	↑	1,068	99	135	189	67		1,012
Genital warts diagnostic rate / 100,000	2017	↓	1,415	91.9	100.4	103.9	249.5		55.0
Genital herpes diagnosis rate / 100,000	2017	↓	638	41.4	51.4	56.7	168.0		22.7
All new STI diagnosis rate / 100,000	2017	↓	7,177	466	596	743	322		2,925
New STI diagnoses (exc chlamydia aged <25) / 100,000	2017	↓	4,777	499	648	794	3,215		329
STI testing rate (exc chlamydia aged <25) / 100,000	2017	↑	107,675	11,253	15061	16739	8,021		59,480
STI testing positivity (exc chlamydia aged <25) %	2017	↓	4,777	4.4%	4.3%	4.7%	3.0%		8.1%
HIV testing uptake, total (%)	2017	↓	22,299	74.8%	80.6%	77.0%	30.5%		91.9%

Better Similar Worse Lower Similar Higher Not Compared * a note is attached to the value, hover

– Could not be calculated ↑ Increasing / Getting worse ↑ Increasing / Getting better ↓ Decreasing / Getting worse ↓ Decreasing / Getting better → No significant change ↑ Increasing ↓ Decreasing



Appendix C – Healthier Lives Public Health England National Comparisons



Key for summary rank indicators

Group	Definition	Label
1st quartile	Lowest 25% of LAs (low rank is good)	Best
2nd quartile	LAs with values that lie between 25% and 50% in the rankings	Better than average rank
3rd quartile	LAs with values that lie between 50% and 75% in the rankings	Worse than average rank
4th quartile	Highest 25% of LAs	Worst

https://healthierlives.phe.org.uk/topic/public-health-dashboard/area-details#are/E10000016/par/nn-1-E10000016/sim/nn-1-E10000016

Appendix D – User Feedback

User feedback from the Integrated Sexual Health services

Sexual Health Service - Dartford	I was able to get an appointment quickly. The healthcare professional who dealt with me was very understanding and empathetic, and also very thorough in ensuring I got the right treatment. I felt well informed and walked away feeling very positive.
Sexual Health Service - Thanet	Wonderful, felt better walking out, no judgement and made me feel really comfortable.
Sexual Health Service - Gravesend	Wonderful, helpful nurses who saw me with short notice and gave me emergency treatment and good support.
Sexual Health Service - Swale	All staff have been wonderful, kind and caring. They have been nothing but helpful and really are a credit to the NHS.
Sexual Health Service - Dover	I was treated by (staff name). She was a lovely lady and talked me through each step and reassured me and helped with issues I had. Extremely amazing nurse. Definitely would recommend and would have again.
Sexual Health Service - Canterbury	Easily accessed, drop in service, friendly non-judgmental staff, and discreet punctual delivery of test results.
Sexual Health Service - Ashford	Very professional, but also kind and warm service. Fairly prompt even though it is a walk in clinic. Easy to get to, loads of services available.
Sexual Health Service - Folkestone	Great service, friendly and helpful staff with a high standard of care.

User Feedback Young Persons on the Condom Programme across Kent

"This was one of the best workshop's I have been to! Can they come back again? Was great we spoke about so much"

"Really friendly staff who understand how awkward it is to talk about"

"Session was helpful and delivered in a sensitive way, making sure not to assume gender or sexuality"
"Easy to talk to and made me feel less awkward"

"Informative, helpful and offers a very good service for people that need to know. Very helpful and interesting"

"I found this all very easy to understand and the service was excellent"

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

15 January 2019

Subject: **Smoking Needs Assessment: Key Findings**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:
The tobacco landscape is changing. A decline in the rates of referral to traditional smoking cessation services has been seen alongside a dramatic increase in the use of e-cigarettes at the local and national level. A previous cabinet paper presented on 22 November 2018 set out a proposal for a new 'smoking plus' model of cessation for Kent in order to achieve a target prevalence of 12% by 2022. Alongside this, it estimated the need to accomplish 45,000 fewer smokers to achieve these targets.

The recent smoking needs assessment offers an update on these projections and builds on the evidence for a new model of care. It suggests that to achieve 2022 targets we need to accomplish 58,495 fewer smokers, an average of 11,699 per year. Achieving the 2022 targets would have a significant positive impact on health outcomes for the Kent population including a reduction in lung cancer, Chronic Obstructive Pulmonary Disease (COPD), coronary heart disease, acute myocardial infarction and stroke. Based on 'Number Needed to Treat' (NNT) analysis, smoking cessation is one of the most cost-effective interventions for health. Smoking cessation also confers financial benefit at the level of the individual and can reduce financial strain, lifting households out of poverty.

If we are to achieve 2022 targets, the smoking plus model offers the best chance of success. To maximise the impact of our services we must build on smokefree initiatives, exploring new and innovative schemes such as smokefree homes to create an environment that encourages and supports successful quits.

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

COMMENT on and **ENDORSE** the overall approach in order to improve health and reduce health inequalities; and
SUPPORT the enhanced Smoking Plus model and the revised Kent ambition of 58,500 fewer smokers by 2022 in order to achieve our prevalence target of 12%.

1. Background

1.1 Despite declines in smoking prevalence both locally and nationally over the last decade, smoking continues to be a significant driver of health inequalities and remains the single biggest cause of cancer in the UK and globally[1].

1.2 Although we have seen a decline in smoking over the last 5 years, smoking prevalence is currently estimated at 16.3% of the Kent population (a total of 197,000 smokers). This figure hides significant variation within Kent. Those in routine and manual occupations are nearly 3.5 times more like to smoke than their counterparts in other occupations, and prevalence in districts such as Thanet are significantly higher at 23.7% compared with the England benchmark of 10.2%.[2]

1.3 Smoking in pregnancy remains a concern for Kent, with an estimated 13.8% of women smoking at time of delivery (significantly higher than the England estimate of 10.8%). Measuring Smoking at the Time of Delivery (SATOD) is not without its challenges but, as outlined in the November cabinet paper titled 'Smoking in Pregnancy'[3], we believe recent increases in figures may be due to improved reporting measures. Improved data collection methods will enable us to better understand the scale of the problem.

1.4 As outlined in a previous cabinet paper[4], the government has set out ambitious targets with the long-term aim of achieving a 'smokefree generation'. These targets include a reduction in overall smoking prevalence in adults to 12% or less, a reduction in smoking in pregnancy rates to 6% or less and reducing the gap in smoking between those in routine and manual occupations and the general population.

1.5 The same cabinet paper gave approximations of the number of quits we need to achieve in order to achieve the 12% prevalence target by 2022, proposing a new model of care for Kent known as 'smoking plus'[5]. The recent smoking needs assessment offers an update on these estimations and builds the case for recommissioning smoking cessation services from both a financial and health perspective.

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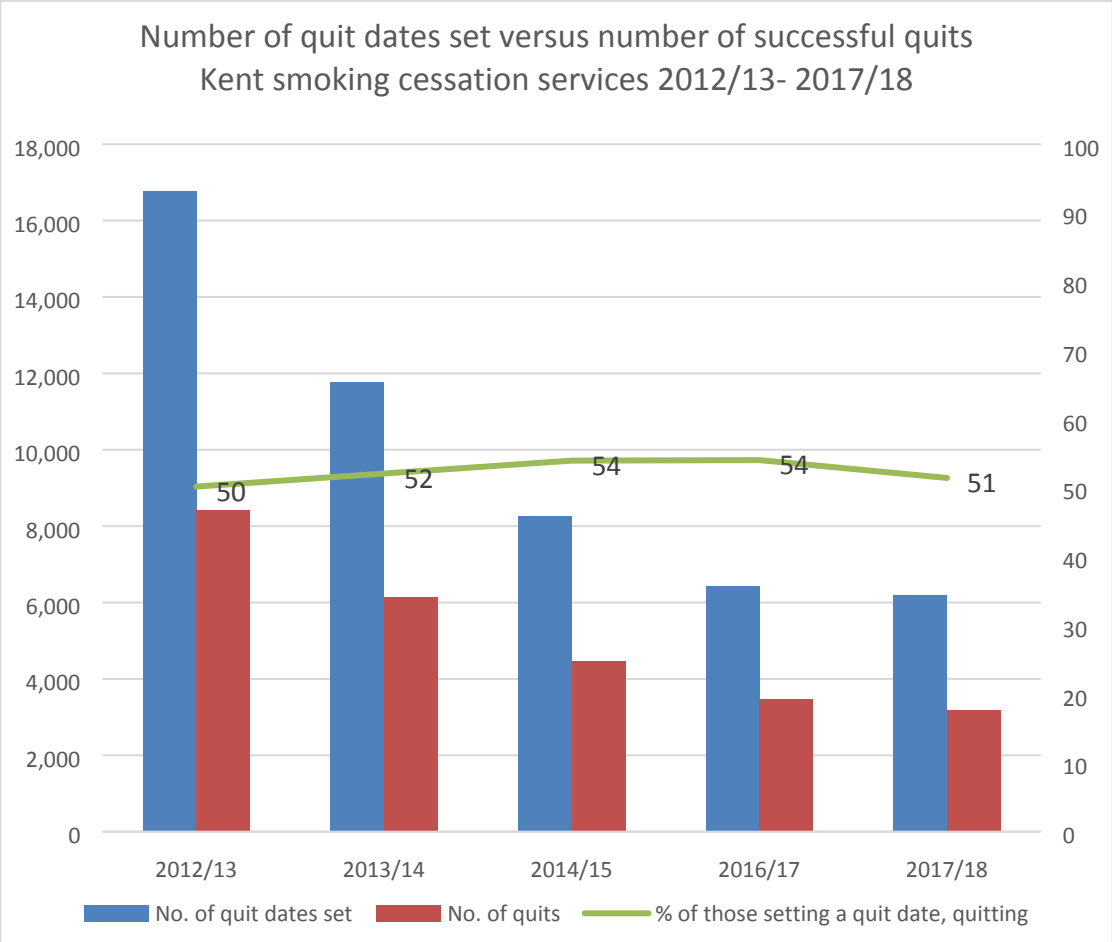
[1] Brown, K. et al., 2018: The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. British Journal of Cancer.
[2] Fingertips: Local Tobacco Control Profile for Kent. Accessed October 2018 https://fingertips.phe.org.uk/profile/tobacco-control
[3] Smoking in Pregnancy – Cabinet paper (A. Scott-Clark, D. Smith) 22 Nov 2018
[4] Stop Smoking Services – Cabinet paper (A. Scott-Clark, D. Smith) 22 Nov 2018
[5] Stop Smoking Services – Cabinet paper (A. Scott-Clark, D. Smith) 22 Nov 2018

2.0. Introduction

2.1 The tobacco landscape is changing. A decline in the rates of referral to traditional smoking cessation services has been seen alongside a dramatic increase in the use of e-cigarettes at the local and national level. While traditional stop smoking services continue to offer the best chances of successful quits, the number accessing these services has dropped to just over 3% of our current smoking population[6].



** Number of quits includes both self report and CO verified*

2.2 The case for commissioning a new model of care for smoking cessation in Kent continues to build. The recent smoking needs assessment concludes that smoking plus, a new evidence-based model developed by Professor Robert West of University Collect, London (UCL), offers the best chance of achieving the 2022 targets set out in the tobacco control plan for England.

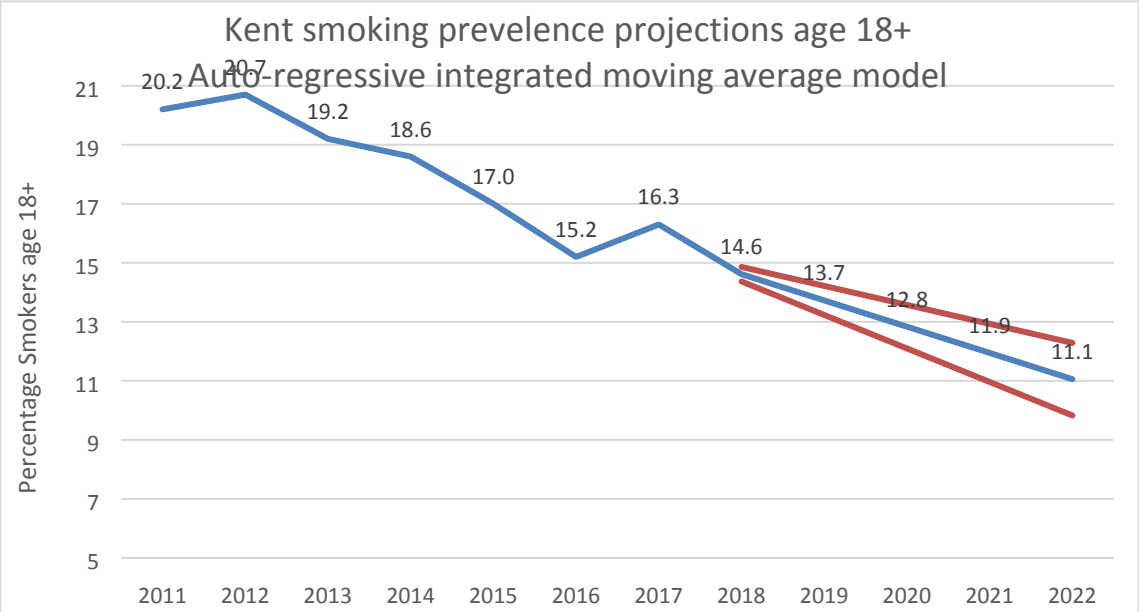
2.3 This needs assessment also builds on the projected prevalence forecasts given in the November cabinet meeting and offers an updated target for number of quits needed to achieve our 2022 goals. It outlines a business case for investing in the smoking plus model from both a health and financial perspective. It also highlights the need for change to happen in a context of broader environmental shifts that encourage and support quit attempts.

[6] NHS Digital, Statistics on NHS Stop Smoking Services in England - April 2017 to March 2018 August 2018

3.0 Modelling future prevalence: Updated projections to 2022

3.1 To maximise our chances of achieving 2022 targets, we must understand what these figures translate to in the context of the Kent population. Using Office of National Statistics (ONS) population data[7] it is possible to project the number of quits we need to achieve over the next 4-5 years to ensure we are on target to reach the 2022 goals. While the previous cabinet paper on stop smoking services[8] estimated that achievement of the 2022 targets would mean 45,074 fewer smokers in Kent, the recent smoking needs assessment has reviewed and updated these projections based on the best information we have.

3.2 Updated projections based on ARIMA modelling (autoregressive integrated moving average) outline projections to 11.1% (95% confidence interval 9.8-12.3%). These figures are based on us maintaining our current average rate of quits and allow us to capture uncertainty and maximise our chance of falling below the 12% marker. According to this model, to achieve 2022 targets we need to aim for a prevalence reduction of 0.89% per year and a total of 58,495 additional quits by 2022 in Kent (95% CI 50,934- 66,057). Per year, this equates to an average of 11,699 quits per year (95% CI 10,186- 13,211).



Source: PHE - APS survey, prepared by KPHO (MP), Nov 18

*Note - the ARIMA model determined 15.5% to be an appropriate start point for projected reductions. -0.89% was deducted from this for 2018.

Confidence intervals (data for 2018 onwards based on modelling predictions)

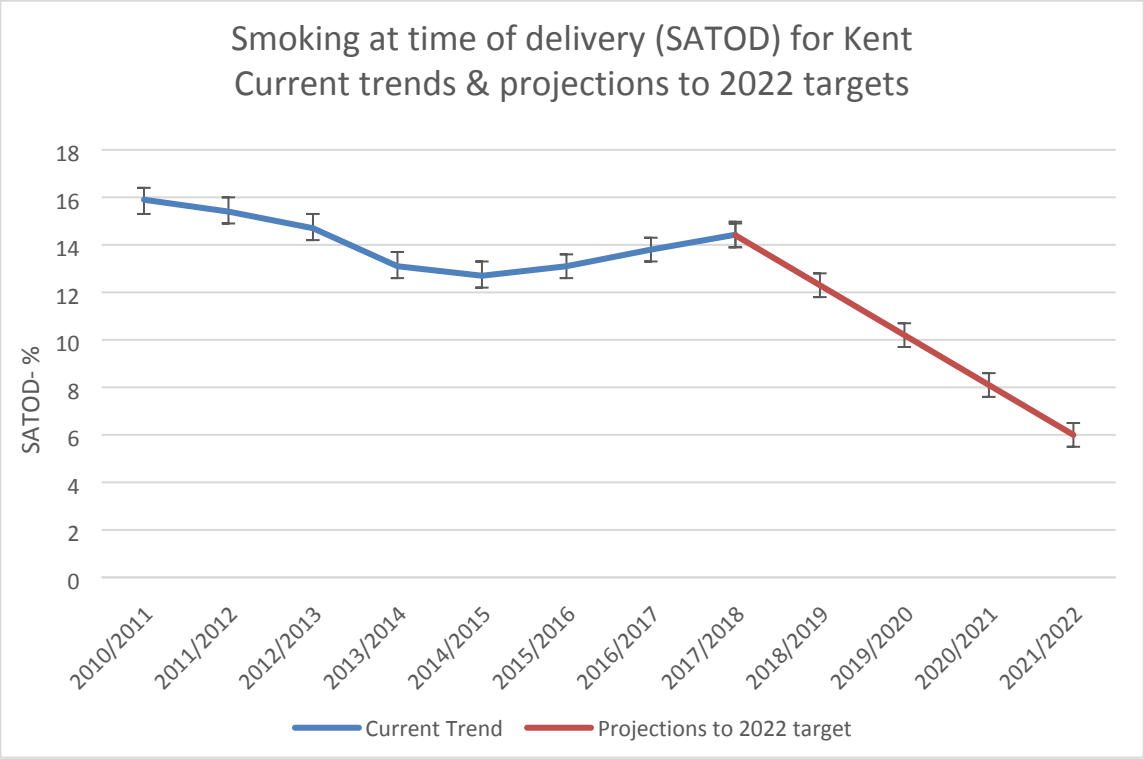
3.3 Although these projections suggest we should achieve our targets if we continue with our current rate of quits in Kent, the reduction in smokers accessing traditional smoking services means we will need to look for new and innovative approaches to ensure these trends continue. It should also be noted that, given the variation in smoking prevalence across the county, if we are to achieve a reduction in inequalities we will need to achieve a greater magnitude of quits in certain districts, particularly Thanet.

[7] ONS population projections. Accessed Dec 2018: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1

[8] Stop Smoking Services – Cabinet paper (A. Scott-Clarke, D. Smith) 22 Nov 2018

3.4 It should be highlighted that there are a myriad of factors beyond quit rates that influence smoking prevalence, including smoking initiation and population change (both migration and death can influence numerator and denominator). We would not expect smoking cessation services to deliver all the quits needed to achieve our target (we know that many individuals will attempt to quit alone, for example, a significant number with the use of e-cigarettes as a quit aid). However, we believe an innovative smoking cessation model, placed in the context of a wider tobacco control system, should be driving Kent quit behaviour and quit rates.

3.5 While we are broadly on course to deliver the 12% prevalence target for the general population, the same cannot be said for smoking in pregnancy. Projections based on ONS birth predictions[9] suggest that, in order to achieve a prevalence rate of 6% or lower, we will need a reduction of 2.1% each year. As you can see from the graph below, this will require a significant acceleration of current quit trends. Estimates suggest we currently have 2,372 women smoking in pregnancy in Kent and we will need to get this figure down to 971 (95% CI 890-1,068) by 2022 to achieve our 6% target. Per year, this translates to an average target reduction of 350 women.



3.6 Continuing to reduce the overall prevalence of smoking in Kent is important but we must also be mindful of increasing inequalities. We know from equity audits both locally and nationally that successful quit rates are greater among higher socio-economic groups; more affluent individuals are more likely to successfully quit. If we are to achieve the 2022 target of reducing the inequality gap in

[9] ONS- Population projections incorporating births, deaths and migration for regions and local authorities, May 2018: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/componentsofchangebirthsdeathsandmigrationforregionsandlocalauthoritiesinenglandtable5

smoking prevalence, we will need to find ways to accelerate quits among our most deprived populations, particularly groups such as routine and manual workers.

4.0. Modelling health outcomes for Kent

4.1 Understanding how we achieve the targets is important, but we must also understand why. Achieving these targets would have a significant impact on the health outcomes of the Kent population.

4.2 Using the JSNA population cohort model[10] it is possible to predict the difference we would see in Kent by 2032, given as:

- 620 fewer cases of lung cancer
- 832 fewer cases of COPD (chronic obstructive pulmonary disease)
- 480 fewer cases of coronary heart disease, and
- 461 fewer cases of stroke.

4.3 We would also expect achievement of these targets to translate into improved health outcomes for Kent in the shorter term. Studies have consistently shown the introduction of smokefree legislation in public and work settings is associated with a significant reduction in acute myocardial infarction events in a timeframe of months not years. In a systematic review conducted by Lin et al., they estimate that a 1% decrease in smoking prevalence leads to an estimated reduction of 2.8% in acute myocardial infarction rates[11].

4.4 We can apply these estimates to the Kent population. Data suggests there were 126.9 emergency hospital admissions for myocardial infarction per 100,000 registered population in 2015/16 across Kent[12] (so, in a population of just over 1.5 million, this translates to approximately 1,904 admissions). If we were to achieve a 4% decrease in smoking prevalence to reach 2022 targets, this would mean approximately 213 fewer hospital admissions for MI per year, and almost 3,000 less by 2022 (current estimate- future projection= 1,904- 1,691).

5.0 The economic case for investment: NNT

5.1 Smoking cessation is not only good for the health outcomes of the population. Research has demonstrated that it makes financial sense too. One method of demonstrating this is through the 'Number Needed to Treat' indicator, or NNT.

5.2 NNT can be defined as ''the number of patients you need to treat to prevent one additional poor outcome'[13] (for example death or stroke). In the context of smoking cessation, it is typically calculated as NNT to achieve a long-term quit or NNT to prevent one premature death.

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[10] JSNA Population Cohort Model for Kent. Accessed October 2018 https://www.thewholesystem.co.uk/systems-thinking-modelling/hosted-online-models/kent-cc-cohort-test/

[11] Lin H, Wang H, Wu W, Lang L, Wang Q, Tian L. The effects of smoke-free legislation on acute myocardial infarction: a systematic review and meta-analysis. BMC Public Health. 2013;13:529. doi: 10.1186/1471-2458-13-529.

[12] Kent Public Health Observatory: Cardiovascular disease. June 2017: https://www.kpho.org.uk/__data/assets/pdf_file/0017/72602/Cardiovascular-Disease-2017.pdf

[13] Centre for Evidence Based Medicine (CEBM): Numbers Needed to Treat. Accessed 6th Dec 2018 https://www.cebm.net/2014/03/number-needed-to-treat-nnt/

5.3 NNT analysis shows that smoking cessation remains one of the most cost-effective interventions for health. With an NNT value as low as 20, as outlined in the table below, smoking cessation compares extremely favourably with other routine medical interventions. Given this, it has been cited as the single most effective thing a clinician can do to improve health outcomes for patients that smoke[14].

Table: Comparison of number needed to treat (NNT) to prevent one premature death. Adapted from Van Schayck et al., 2017[15]

Intervention	Outcome	NNT
Behavioural support plus - NRT - Bupropion (zyban) - Varenicline (champix)	Long term quitter/ premature death	 23/46 18/36 10/20
Statins as primary prevention	Prevention of one death over 5 years	107
Antihypertensive treatment for mild hypertension	Prevent one stroke/ MI death over 1 year	700
Cervical screening	Prevent one death over 10 years	1140

Note: Smoking cessation medication is normally used for 3-6 months, while statins or antihypertensive medication may be used across a patient's lifetime.

5.4 There are also economic benefits at the level of the individual and family. The average smoker spends over £2,000 on cigarettes every year[16]. There are 1.4m households with a smoker in England that fall below the poverty line. A third of these would be lifted out of poverty if the smoker in these households were to quit[17]. With ongoing transition to universal credit currently underway, it is worth considering opportunistic interventions that offer support and signpost to smoking cessation services as a means of reducing financial strain on households.

[14] Towards a Smokefree Generation. A Tobacco Control Plan for England.

[15] Van Schayck OCP, Williams S, Barchilon V, et al. Treating tobacco dependence: guidance for primary care on life-saving interventions. Position statement of the IPCRG. *NPJ Prim Care Respir Med*. 2017;27(1):38. Published 2017 Jun 9. doi:10.1038/s41533-017-0039-5

[16] ASH Ready Reckoner http://ash.lelan.co.uk/

[17] Smoking in the Home: New solutions for a Smokefree Generation. Nov 2018 http://ash.org.uk/wp-content/uploads/2018/11/FINAL-2018-Smokefree-Housing-report-web.pdf

6.0. The wider context: Smokefree initiatives

6.1 Any changes to smoking cessation support should happen in a context of broader environmental shifts that encourage and support quit attempts. Smoking prevalence, as with all health behaviours, is shaped by our environment, and the importance of smokefree legislation and initiatives cannot be underestimated. Smokefree initiatives have an important role to play in shifting social norms alongside reducing exposure to the dangers of second-hand smoke[18].

6.2 In addition to ongoing efforts to create smokefree healthcare settings, prisons and school gates, there are other initiatives that have significant potential to effect change. A recent e-cigarette pilot involving a partnership between housing associations and stop smoking services in Salford saw a dramatic increase in people accessing smoking cessation support, most markedly among the most deprived. Compared with figures from the same quarter in the previous year, participating NHS services saw 4 times as many people and 5 times as many successful quits from the most deprived quintile.

6.3 There is a need to work proactively and pragmatically with the housing function at district level in Kent to support a smokefree housing vision. A report released by ASH in November 2018 offers practical steps towards achieving this goal[19]. There are now ongoing discussions with the Kent housing group to confirm and clarify plans, of which one element will be related to smoking and tobacco control.

7.0 Conclusion and Next Steps

7.1 Given the decline in those accessing smoking cessation support we cannot take current rates of decline in prevalence for granted. If we are to achieve the 58,495 fewer smokers in order to achieve 12% population prevalence, alongside a concurrent reduction in inequalities, a 'business as usual' approach is not sufficient.

7.2 Smoking plus, a new evidence-based model of care developed by Professor Robert West of UCL, offers our best chance of success. Implementation across Kent will require close collaboration between the Local Authority, the Sustainability and Transformation Partnership (STP), CCGs and GP practices to maximise our chances of success. It will require consistent delivery at scale.

7.3 Alongside a revised model of smoking cessation we will need a broader partnership effort to continue and build on wider tobacco control. Initiatives should encompass a broad range of settings including the workplace, homes, schools, healthcare settings and high streets.

7.4 Smoking cessation continues to be one of the most cost effective interventions that can be delivered for health. Achievement of the 2022 targets would confer

[18] Smoking in the Home: New solutions for a Smokefree Generation. Nov 2018 http://ash.org.uk/wp-content/uploads/2018/11/FINAL-2018-Smokefree-Housing-report-web.pdf

[19] Smoking in the Home: New solutions for a Smokefree Generation. Nov 2018 http://ash.org.uk/wp-content/uploads/2018/11/FINAL-2018-Smokefree-Housing-report-web.pdf

significant health and financial benefits to the Kent system and population.

8.0. Recommendation

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

COMMENT on and **ENDORSE** the overall approach in order to improve health and reduce health inequalities; and
SUPPORT the enhanced Smoking Plus model and the revised Kent ambition of 58,500 fewer smokers by 2022 in order to achieve our prevalence target of 12%.

9.0. Background Documents

Stop Smoking services - Health Reform and Public Health Cabinet Committee – 22 November 2018
https://democracy.kent.gov.uk/documents/s87730/Item%208%20-%20Stop%20Smoking%20Service.pdf

Kent Smoking Needs Assessment. C Mulrenan, Dec 2018 (Link to KPHO)

9.0 Contact Details

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Relevant Director

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

Date: 15 January 2019

Subject: **Childhood Obesity**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:

This report gives an overview of childhood obesity in Kent, the services available to support families and areas of consideration for future action.

Childhood obesity is a major public health challenge, it has a wide-ranging impact on health and wellbeing throughout the life course.The National Child Measurement Programme in 2017/18 in Kent found that 12.4% of reception aged children to be overweight and 8.3% to be obese, the figures were 14.4% and 18.8% for Year 6 children respectively. Living in a deprived area, being male, being from a Black, Minority, Ethnic (BME) group or living in an urban area were factors associated with greater levels of obesity. Inequalities in weight status by socio-economic deprivation status have increased over time.

Healthy lifestyle messages are delivered by health visiting, school health and early help services. Services to provide support to children who are already overweight or obese, are provided by the school health service and some districts. There are challenges to deliver services consistently across the County related to engaging with families and delivering outcomes. There are no services in Kent to support children who are obese with complex needs, which is a clinical service which the NHS has responsibility for providing.

A full needs assessment will be published in the new year and contain expanded recommendations for future action.

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

COMMENT on and **ENDORSE** the contents of the report, especially the profile of childhood obesity in Kent and the service offer currently available; and

AGREE that a further paper be submitted to the Health Reform and Public Health Cabinet Committee on effective and systematic joint working between agencies, including children's centres, in order to tackle obesity.

1.0. Introduction

1.1 Kent County Council (KCC) Public Health has a responsibility to deliver improved health and wellbeing and reduce inequalities for Children and Young People living in Kent.

1.2 This paper presents a profile of childhood obesity in Kent and the services provided to prevent children becoming an unhealthy weight and to support those who are already overweight or obese.

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

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

1.5 Poor diet and low levels of physical activity are the primary causal factors for childhood excess weight. The low levels of physical activity exacerbate the problems of poor diet and nutrition. The amount of sugar that children consume on a daily basis is a major contributing factor to gaining weight. The environments that children are raised in is a main risk factor for childhood obesity, children who live in family where at least one parent or carer is obese are at increased risk of becoming obese themselves. [3] The recently published 2016 Health Survey for England data found that 28% of children of an obese mother were also obese, compared with 8% of children whose mother was not overweight or obese. Similarly, 24% of children of an obese father were also obese, compared with 9% of children where the father was not overweight or

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

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

[3] PHE (2015) Childhood obesity: applying All Our Health. Available at: https://www.gov.uk/government/publications/childhood-obesity-applying-all-our-health/childhood-obesity-applying-all-our-health. [Accessed 10 December 2018].

obese.[4]

1.6 The Government have published a two-part childhood obesity plan of action, with the aim of significantly reducing England's rate of childhood obesity in the next 10 years.[5][6] The first part focused on working with industry to cut the amount of sugar in food and drinks and to get more primary school children to eat healthily and stay active. This included the introduction of a soft drinks levy, taking 20% of sugar in products by 2020, and introducing a new nutrient profile labelling system. The impact of the plan is not known yet, however the goal to reduce sugar in products by 5% in one year was not achieved. The second part of the plan published in 2018 reaffirmed the previous goal and included plans for calorie reduction programme with industry and a consultation regarding advertising and promotion of unhealthy foods.

2.0. Childhood obesity in Kent

2.1 Nationally, the prevalence of overweight and obesity among children (2-15), as measured by the Health Survey for England, has increased from 25.0% in 1995 to 33.4% in 2005 and the trend has been stable since.

2.2 The National Child Measurement Programme (NCMP) in 2017/18 found 12.4% of reception aged children in Kent (aged 4-5) to be overweight and 8.3% to be obese. This is lower than England as a whole (12.8% and 9.5%), but similar to the South East (12.4% and 8.2%).[7] The percentage of reception year pupils classified as overweight or obese (20.7%) ranks 4th amongst the 16 statistical neighbours (Appendix 1 Table 1).

2.3 In 2017/18, 14.4% and 18.8% of Year Six pupils (aged 10 to 11) were classified in Kent as overweight or obese respectively. Overweight levels were similar to England (14.2%) and obesity levels were lower (20.1%); they were higher than the South East (13.6 and 17,3%). The percentage of Year 6 pupils classified as overweight or obese (33.2%) ranks 15th amongst the 16 statistical neighbours (Appendix 1 Table 2).

2.4 The NCMP figures have consistently identified an increase in the percentage of children who are overweight or obese from Year R to Year 6. A report by Public Health England tracking children's weight status from Year R to Year 6 in four local authorities attributed the doubling in obesity rates to the numbers of children in Year R who are overweight and at a healthy weight who become obese by Year 6, 43% and 8%

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[4]NHS Digital. (2018) *Health survey reveals association between parent and child obesity*. Available at https://digital.nhs.uk/news-and-events/latest-news/health-survey-reveals-association-between-parent-and-child-obesity. Accessed[19 December 2018].

[5]HM Government (2016) *Childhood obesity: a plan for action.* Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/546588/Childhood_obesity_2016__2__acc.pdf. Accessed [10 December 2018].

[6] HM Government (2018) *Childhood obesity: a plan for action part two*. Available at https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2. Accessed [10 December 2018].

[7] KPHO (2018) *National Child Measurement Programme Data release 2017/18.* Available at: https://www.kpho.org.uk/__data/assets/pdf_file/0003/88167/NCMP-2017-18-Data-Report-Accessible-version_FINAL.pdf. Accessed [10 December 2018].

respectively. Only a small number of children with excess weight will return to a healthy weight by Year Six, around 27% of overweight and 10% of obese children.[8]

2.5 The overall trend in the prevalence of overweight, obesity and excess weight (overweight or obese) amongst Year R and Year 6 pupils in Kent between 2010/11 and 2017/18 was stable.

2.6 In 2017/18, for the majority of Districts, the proportion of Year R children with excess weight was similar to Kent. In Dartford, Dover and Swale the prevalence is higher than Kent and the South East figures. In Maidstone, Tonbridge and Malling and Tunbridge Wells the prevalence is lower than Kent, the South East and England as a whole.

2.7 For Year 6 children in Sevenoaks, Tonbridge and Malling and Tunbridge Wells the prevalence of excess weight was lower than Kent and England. Sevenoaks and Tunbridge Wells were also lower than the South East. Dartford, Gravesham and Thanet had a higher prevalence of excess weight than for Kent, the South East and England. Further details about districts can be found at (Appendix 1 Table 3).

2.8 In Year 6, boys in Kent are slightly more obese than girls (21% boys vs 17% of girls).

2.9 In both Year R and Year 6, children living in the most deprived areas in Kent are more likely to be obese (26%) than those living in the least deprived areas (12%). The gap is largest in Year 6 (14.1%), there is evidence of this gap increasing, the gap was only 6.6% in 2008/09.

2.10 In year 6, children of Black or Asian ethnic origin are more likely to be obese than their white classmates, 18% of White pupils are obese compared to 29% of Black pupils and 24% of Asian Pupils. This association is likely to be confounded by the impact of deprivation on obesity, as deprived urban areas in England tend to have a higher proportion of individuals from non-White ethnic groups.[9]

3.0. Service Provision

3.1 Services are provided at a universal and targeted level. In the early years, Universal healthy weight messages and interventions for 0-5s are provided by the Health Visiting Service and Children's Centres. The Health visiting service provides the infant feeding support service, this service contributes to the prevention of obesity, as breastfeeding is known to be protective for the child. The service gives healthy lifestyle advice messages given at the five mandated contacts and at other opportunities, including when the child is weighed.

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[8] PHE (2018) Changes in the weight status of children between the first and final years of primary school. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/609093/NCMP_tracking_report.pdf. [Accessed 10 December 2018]

[9] KPHO (2018) *Inequalities in Obesity & Excess Weight in Childhood. NCMP: Kent – 2017/18 update*. Available at: https://www.kpho.org.uk/__data/assets/pdf_file/0009/88371/NCMP-Equity-201718.pdf. Accessed [10 December 2018].

Delaying introducing solid food until 6 months and introducing food using appropriate portion sizes and healthy foods are key interventions to prevent obesity. Open access “introducing solid food” sessions are held in every district delivered by the health visiting service in partnership with children’s centres.

3.2 The health visiting service also provide a brief targeted intervention for those children at an unhealthy weight using a healthy weight discussion tool. This has been trialled to enable the health visiting service to carry out brief interventions with families to identify where changes could be made and to provide follow up. There have been challenges in embedding this in the service and it is currently been reviewed. There are no further targeted intervention for 0-5 year olds where an issue is already presenting. There is developing evidence around the HENRY programme, a targeted parenting programme focused on developing health lifestyles, and this has been used on a small scale in Kent. Further work needs to be undertaken to embed the healthy weight tool and develop a targeted 0-5 offer to enable children to be at a healthy weight by the time they start primary school.

3.3 At primary school age, the school health service offers support to schools to promote healthy school environments and increase children’s knowledge about healthy lifestyles. This is supported by messaging from the children’s centres and youth hubs. The school health service also delivers a targeted 1:1 package of care with families where children are already overweight or obese, using goal setting techniques to change behaviours. This is offered to children identified through the NCMP programme and through professional or self-referral. Despite the offer, there is very low take up. Further work is being undertaken to understand how to better engage families in the offer and the programme is being evaluated.

3.4 NICE guidance compliant family weight management services were until recently provided across Kent for those children with who are overweight or obese. In 2017/18, Tier 2 family lifestyle weight management services had 120 engagers. The percentage completing was 83.3%, achieving the target of 60%. 75% of the child completers reduced or maintained their BMI z-score status. These services struggled to engage families, as a result, currently, only Maidstone, Dartford and Gravesham Districts have an offer for families. Tunbridge Wells, Tonbridge and Malling and Sevenoaks Districts provide a service on a 1:1 basis when they receive a referral. There is no offer in East Kent apart from the School Health package of care. The reduction of family weight management services is reported nationally with local authorities facing reducing public health budgets choosing not to fund family weight management services where they struggle to engage families or show good outcomes.

3.5 In response to this issue, a trial is currently being run to create a hybrid service combining the school health public health 1:1 package of care and the family weight management intervention in Dartford and Gravesham. This will utilise existing resources, to see whether using a combined approach of the District and school health services will increase engagement. As well as providing the intervention, it will be embedded through a partnership approach with a limited number of schools. This will run from January 2019 -July 2020 and is being evaluated by the University of Kent. This evaluation will inform the future

commissioning plans.

3.6 The School Health Service also provides support for whole school approach in secondary schools. A package of care is currently being developed for this aged group, to include emotional health element and a digital element. The service will engage with young people for 1:1 support if they are referred.

3.7 Tier 3 weight management services are the responsibility of the CCGs. These provide more intensive interventions by multidisciplinary teams for those children who are obese or severely obese with complex needs. There are no tier 3 services provided in the Kent.

3.8 PHE provide health lifestyle messaging for children and young people through the Change4Life initiative. It aims to reduce adult and childhood obesity simultaneously by making health a family issue. The Change4Life Sugar Smart campaign which launched in 2016 aimed to engage families to reduce the amount of sugar they consume. The campaign has been promoted widely by early help, health visiting and children's centres. District Councils have also promoted the campaign.

3.9 Across Kent, there were nearly 1,800 registrations to the Sugar Smart campaigns in 2016, this is in the context of a target population of 111,200 families with the youngest child under 10 years of age. Equating to 1.6% for Kent, this was higher than the national figure for registrations as a percentage of target families (See Appendix 1, Table 4).

3.10 A new Change4Life Sugar Smart campaign will be launched in January 2019 and KCC will be working with partners to promote the messages and gain wide engagement across the County.

4.0. Oral Health and Obesity

4.1 Oral Health has a major influence on eating, drinking, speaking and quality of life. The most prevalent oral disease is decay; it is preventable and shares common cause with obesity, poor diet with high sugar intake. More deprived areas have greater disease burdens and treatment needs.

4.2 In areas of greater deprivation in Kent there are poorer dental access rates, greater decay rates, greater numbers of General Anaesthesia (GA) extractions and obesity levels. Gross dental decay in Kent's 5-year olds exist at the highest levels in Gravesham (24.1%) and Maidstone (21.8%), which are higher than the national average (20.0%). Such disease is often managed as GA extractions; the most common age group being 5-9-year olds, with the highest GA access rates in the county due to caries in Dartford (0.8%), Gravesham (0.8%) and Ashford (0.8%), which are equal to the national average (0.8%).[10] Reception children in Dartford (10.8%), Gravesham (10.9%) and Swale (9.8%) have

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

greater obesity levels than the national average (9.5%).[11] There are unsurprisingly given the common cause, correlations between poor oral health and obesity for children by district.

4.3 Dental services are commissioned by NHS England, however Local Authorities (LA) have a responsibility for oral health promotion and preventing escalation in oral health needs. The existing barriers in dental service uptake result in reduced opportunities for key health communication to prevent common risks impacting obesity and oral health: only half of Kent's 0-17-year olds (52.4%) saw a dentist in the past 12 months with the lowest rate of 44.5% in Thanet. This is compared to the English average of 58.6%.[12]

4.4 Local Authority support in increasing access to dental services and promoting oral health within existing social & health services (Children Centres, GPs, Pharmacies), can reduce obesity and dental decay risk factors. The British Society of Paediatric Dentists (BSPD)'s Dental Check by 1 campaign promotes dental attendance by the age of one. Posters promoting the campaign are in local children's centres and Health Visitors promote accessing the dentist at each mandated check. It is planned to further embed this campaign in Kent, through further promotion and to provide a consistent suite of oral health promotion materials using the soon to be published PHE documentation. The work outlined above to improve diet and reduce sugar intake will also have an impact on the rates of poor oral health.

4.5 It is also planned to work with dentists in those areas with the greatest levels of decay to link with Children's centres to provide positive messaging, encourage attendance at Dentists and increase access to fluoride varnishing which is available to children aged 3 and above. Through a combination of upstream and downstream interventions to 'put the mouth back in the body', a positive environment can be created to provide patients with the tools to improve their health, and barriers to accessing health services can be diminished.

4.6 A further paper on oral health will be submitted to the next cabinet committee in March 2019.

5.0. Next Steps

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

[11] Kent Public Health Observatory (2018). *National Child Measurement Programme*. Available at: https://www.kpho.org.uk/__data/assets/pdf_file/0003/88167/NCMP-2017-18-Data-Report-Accessible-version_FINAL.pdf [Accessed on 05/12/18]

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

implement this approach in such a large geographical area and complicated health economy.

5.2 Further work is being undertaken to embed the healthy weight discussion tool in health visitor conversations with families with children under 5. Opportunities will be explored to develop targeted approaches to support where children are identified at being at an unhealthy weight.

5.3 The evaluation of the trial partnership service between the School Health Service and Dartford and Gravesham districts will be considered and used to inform the targeted service for children of primary school age who are already overweight or obese. An adolescent package of care for healthy weight will be developed by the School Health Service in the first quarter of the new year.

5.4 The East Kent Districts have identified obesity as a cross District priority. KCC Public Health are supporting the districts to develop local action plans.

5.5 A full needs assessment for obesity across the life course will be published in the new year.

5.6 The programme of work to improve oral health for children under 5 will be implemented by the end of March 2018 and the learning used to support a County wide approach. An update on this will feature in the oral health paper to be submitted to the March Cabinet Committee.

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

6.0. Recommendation:

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

COMMENT on and **ENDORSE** the contents of the report, especially the profile of childhood obesity in Kent and the service offer currently available; and

AGREE that a further paper be submitted to the Health Reform and Public Health Cabinet Committee on effective and systematic joint working between agencies, including children's centres, in order to tackle obesity.

7.0. Background Documents

See attached documents.

8.0. Contact Details

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Key:

RAG Ratings

(g) GREEN	Higher
(a) AMBER	Similar
(r) RED	Lower

Trend significance

⇧	increasing
⇩	decreasing
⇔	remained the same

Table 1

Percentage of reception year pupils classified as overweight or obese						
	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Kent	3,500 23.0 (a)	4,300 24.4 (r)	3,400 20.7 (g)	- 3.7	⇔	4th
National	22.6	22.6	22.4	- 0.2	⇔	

Table 2

Percentage of year six pupils classified as overweight or obese						
	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Kent	4,700 33.3 (a)	5,100 32.8 (g)	5,400 33.2 (g)	+ 0.4	⇔	15th
National	33.4	34.2	34.3	+ 0.1	⇔	

Table 3

Percentage of reception year pupils classified as overweight or obese						
	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Ashford	270 21.1 (a)	400 25.7 (a)	310 21.0 (a)	- 4.7	⇔	7th
Canterbury	290 20.9 (a)	290 19.5 (g)	270 20.2 (a)	+ 0.7	⇔	3rd
Dartford	270 23.9 (a)	370 24.9 (a)	320 23.3 (r)	- 1.6	⇔	11th
Dover	230 23.2 (a)	300 25.6 (a)	270 23.5 (r)	- 2.1	⇔	6th
Folkestone & Hythe	230 22.2 (a)	280 24.8 (a)	250 22.9 (a)	- 1.9	⇔	8th
Gravesham	290 24.2 (a)	390 28.0 (r)	280 21.8 (a)	- 6.1	⇔	5th
Maidstone	350 22.7 (a)	470 23.9 (a)	330 17.5 (g)	- 6.4	⇔	2nd
Sevenoaks	240 20.5 (g)	340 25.5 (a)	230 19.0 (g)	- 6.4	⇔	10th
Swale	330 22.4 (a)	380 21.0 (g)	400 23.8 (r)	+ 2.9	⇔	7th
Thanet	330 23.0 (a)	430 26.7 (r)	330 22.2 (a)	- 4.5	⇔	2nd
Tonbridge & Malling	380 29.1 (r)	350 23.5 (a)	240 16.6 (g)	- 6.9	⇩	2nd
Tunbridge Wells	260 23.0 (a)	310 25.0 (a)	170 16.4 (g)	- 8.5	⇩	1st
Kent	23.0	24.4	20.7	- 3.7	⇔	

Percentage of year six pupils classified as overweight or obese						
	2010/11	2016/17	2017/18	Difference from 2016/17*	Trend since 2010/11 significance**	Nearest neighbour rank***
Ashford	430 34.6 (a)	440 32.2 (a)	450 32.0 (a)	- 0.2	⇔	9th
Canterbury	330 28.1 (g)	430 31.4 (a)	440 32.2 (a)	+ 0.7	⇔	7th
Dartford	370 36.5 (r)	440 36.9 (r)	490 38.0 (r)	+ 1.1	⇔	16th
Dover	370 36.8 (r)	360 34.6 (a)	390 34.9 (a)	+ 0.3	⇔	10th
Folkestone & Hythe	370 35.3 (a)	380 35.9 (r)	350 32.8 (a)	- 3.2	⇔	6th
Gravesham	370 33.5 (a)	470 38.3 (r)	490 37.5 (r)	- 0.9	⇧	15th
Maidstone	500 32.1 (a)	510 31.7 (a)	570 32.8 (a)	+ 1.2	⇔	14th
Sevenoaks	310 30.7 (a)	330 27.8 (g)	340 27.6 (g)	- 0.2	⇩	10th
Swale	450 31.5 (a)	500 32.6 (a)	570 35.2 (a)	+ 2.6	⇔	12th
Thanet	490 35.9 (a)	560 37.1 (r)	570 38.6 (r)	+ 1.5	⇧	16th
Tonbridge & Malling	400 33.1 (a)	390 29.1 (g)	420 29.1 (g)	0.0	⇩	9th
Tunbridge Wells	310 31.7 (a)	280 26.1 (g)	320 26.9 (g)	+ 0.9	⇩	5th
Kent	33.3	32.8	33.2	+ 0.4	⇔	

Table 4

Change4Life Sugar Smart 2016		
Key Indicator	Kent	National
No. total registrations	1,800	58,000
Registrations as a percentage of families with youngest child aged under 10	1.6% (g)	1.4%
No. total individuals sent at least one email	4,200	138,900
One email opened as a percentage of individuals	3,600 84.3% (a)	117,800 84.8%
Three emails opened as a percentage of individuals	1,700 40.6% (a)	55,700 40.1%
Percentage of individuals clicking on at least one content link	1,000 23.1% (a)	31,200 22.4%

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

15 January 2019

Subject: **Public Health Communications and Campaigns Update**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary:
Marketing and communications continue to play an important role in delivering successful public health interventions. This paper reports on the recent campaigns and communications delivered through the KCC public health team and outlines some plans for 2019/20.
Delivering effective campaigns and communication to the residents of Kent is a public health priority and future success is reliant on long term, consistent messaging which requires a whole systems approach and two-way support between key partners and providers.
We will continue to promote healthy lifestyles by delivering messages to the whole population with awareness raising and where possible, a call to action and signposting to support to enable people to find information, resources and eventually local services to help them if needed.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **Comment on and Endorse** the progress and impact of Public Health campaigns in 2018/19.

1. Introduction

1.1 Marketing and Communications continues to be a key element of the public health strategy to support Kent residents to improve both their physical and mental health.

1.2 The Public Health Marketing and Communication has three score drivers:

- Promoting healthier behaviours
- Giving information and advice
- Promoting local services

Three guiding principles direct the work in Kent:

- Marketing campaigns and communications should form a key part of the customer (behaviour change) journey
- Where Public Health England already has a relevant campaign brand, this will be extended and amplified in Kent to take advantage of the national investment into social marketing, tools and resources, and to ensure that residents are not confused by competing brands.
- There should be a consistent approach to marketing and communications across the local system to maximise campaign reach and effectiveness

1.3 During 2018, the KCC Public Health department delivered a range of campaigns and communications aimed at increasing awareness of public health issues, making it easier for people to make small changes that can help improve their health and directing people to sources of support.

1.4 It should be noted that more activity has been through PR and earned media rather than paid for marketing channels following the Public Health restructure in March 2018 when the existing Campaigns and Business Manager changed roles, and a review into how we deliver campaigns identified a more effective way of working. There has also been a budget underspend this year and the forecast budget for Campaigns and Communications in 2019/20 has been reduced.

1.5 The Public Health department has recognised that there is a great opportunity for further development in this area, particularly through working with local partners, and explore new partnerships, some of which are already in the planning stage for 2019/20.
This approach seeks to continue to support and build on the service strategic priority of: “Ensuring a coordinated and effective programme of Health Improvement Campaigns across the health and care sector, delivering consistent health improvement messages to the public. Raising awareness of key public health challenges both through proactive public relations and through a series of campaigns, with the aim of educating and supporting people to take more responsibility for their own health and wellbeing.”

1.6 This paper covers some of the 2018 campaigns so far, along with key activities and plans for the coming year.

2.0 Background

2.1 When developing campaigns, it is key to identify the problem, understand the behaviour change needed, the target audience to be reached, what drives their behaviour, and the best ways to get messages across most effectively.

2.2 Wherever possible, national campaigns are supported, and their reach extended where needed, rather than trying to create something new, and therefore competing against national campaigns and brands such as Change 4 Life and One You. The Public Health team works with partners, and our commissioned service providers, wherever possible to ensure a coordinated approach to communicating messages to the public.

2.3 During 2018, a series of campaigns have been delivered alongside targeted PR and media activity which reinforce our reputation and role in delivering public health interventions, and the options available to residents to improve their healthy behaviours.

2.4 The key campaigns delivered during the year were:

- One You Kent – healthier lifestyles, especially for adults aged 40 to 60
- Know Your Score – Alcohol awareness and harm reduction in adults
- Stoptober – Smoking cessation and health harms caused by tobacco smoking
- Heart Age and Health Checks – encouraging people to identify their specific health risks
- Release the Pressure – Suicide prevention, especially amongst men
- Change 4 Life and Sugar Swaps – reducing childhood obesity and encouraging dental-oral health care, focusing on primary school aged children
- Sexual Health – STI awareness and prevention
- Severe weather communications – staying safe and well, and avoiding hospital admissions, during severe weather in the summer and winter months (also includes the flu immunisation campaign).

2.5 Following a restructure earlier this year, a new Campaigns and Communications Manager role has been created and appointed. As well as overseeing all communications and campaigns for public, health the role is also the lead KCC representative at several public health communications partnerships and networks, locally and regionally.

2.6 We have identified the importance of working with partners on campaigns, both nationally – with Public Health England (PHE) and other regional Local Authorities – and locally, through the STP Prevention workstream and the Kent and Medway Health Communications network. This includes development of partnerships with district councils, commissioned providers and other organisations in the charity sector, to ensure sharing and support of key communications messages and objectives.

2.7 We continue to use existing internal and external communications channels for promoting Public Health services and messages including:

- Stakeholder engagement including partners and providers
- KCC services such as children's centres, libraries, schools, gateways, adult disability centres, adult education centres, Community Wardens, frontline health and social care staff
- Traditional media and Public Relations opportunities
- Digital and online platforms including KCC website and social media channels including Twitter, Facebook, Instagram and Linked-In.

3.0 Campaigns and Communications 2018/19

3.1 One You

3.1.1 The One You Kent campaign has continued to deliver strong results in 2018,

with nearly 77,000 visits to One You Kent in 2018, and over 35,000 Kent residents taking the How Are You quiz.

3.1.2 The KCC stand at the Kent County Show focussed on the One You campaign and was staffed by partners and providers. It received 1000 visitors and won the Best Large Trade Stand award. We also supported the national Stoptober campaign with digital marketing and a local PHE extension of promotion of the Heart Age tool with KM advertorials in October.

3.1.3 A planned partnership with the Kent Football Association in 2019 will see promotion of the One You Kent brand to its 60,000 players of all ages – focussing on signposting to smoking support services with providers Kent Community Health NHS Foundation Trust (KCHFT).

3.1.4 Key messages will continue to raise awareness of health issues including obesity, heart disease and stroke; and signpost to support services, online assets and promote NHS Health Checks.

3.1.5 A project plan has been created by Digital Services to develop and improve the One You Kent website with input from commissioned partner organisations on structure, layout and content.

3.2 Know Your Score

3.2.1 Almost 32,000 people have visited the alcohol pages on kent.gov, with 18,936 completing the 'Know Your Score' test (online version of Audit-C) and receiving advice on their drinking levels.

3.2.2 PR and media opportunities included Alcohol Awareness Week in November and Dry January, supporting social media campaigns from charities including Alcohol Concern, and commissioned providers CGL, Forward Trust and AddAction.

3.2.3 Plans are underway in 2019 to refresh the videos with new health professionals (who feature at the end of the 'Know Your Score' test). Further partnerships with providers and partners are being explored to raise awareness among drinkers below the high-risk groups about long term health messages including stroke.

3.3 Stoptober

3.3.1 The national PHE campaign was extended in Kent with media and PR promotion plus supporting advertising on Facebook which reached over 143,000 users and achieved approximately 3,600 click throughs.

3.4 Heart Age and Health Checks

3.4.1 PHE requested a regional extension in Kent after it was selected for extra funding to promote the Heart Age tool. We supported a partnership with the KM newspaper/online news group including advertorials and digital marketing.

3.4.2 Targeted outreach activity by commissioned providers KCHFT in Thanet and

Swale during December and January will be promoted by KCC through Facebook advertising, KM online and DAX radio paid for inserts, alongside organic media, social media and PR opportunities. There is potential for similar outreach activity and promotion to be rolled out across Kent in 2019.

3.5 **Release the Pressure**

3.5.1 Continuation of Google search terms and an always on presence so that anyone searching high risk terms such as “I want to die”, “How to commit suicide” will be shown the Release The Pressure advert. Calls to the Release the Pressure helpline average 2,000 per month.

3.5.2 Partnership working and promotion of new Kent and Medway STP funding for the campaign continues across the county and now also encompasses Medway. PR and media opportunities included new grant awards to community groups with innovative ways of raising awareness of the campaign and the issues. Further campaign bursts due in January and March 2019 to include materials highlighting tips on what people can do to help people who might be feeling under pressure.

3.5.3 Building relationships with key community groups remains an important part of the activity. Current focus is on grassroots football in the county, with a view to broadening this to other sports during 2019.

3.6 **Change 4 Life**

3.6.1 KCC’s Children’s Centre colleagues have been working closely with PHE to develop an events kit and conversation tips for each centre, to enable frontline workers to talk to their communities about nutrition and exercise in fun, engaging ways. This will be rolled out nationally as part of a new campaign due in the New Year.

3.6.2 The Change4life pages have been seen 21,333 times this year and ‘Snack ideas’ was the most viewed page with 9,031 pageviews. We also supported promotion of the summer PHE campaign ‘Train Like a Jedi’.

3.6.3 A planned partnership for January 2019 with KCHFT and the Kent FA will see an extension of the national PHE Sugar Swap campaign to its younger players. The campaign will include social media promotion, digital platforms, marketing, shared branding, and PR opportunities at local events.

3.6.4 Extension of the 2019 Change4Life Sugar Swap campaign will also incorporate messaging around dental/oral health care.

3.7 **What the Bump**

3.7.1 The campaign provides women with a link to Stop Smoking services, and a journal to keep track of their pregnancy and their efforts to stop smoking.

3.7.2 In 2017/18, Swale saw a 10% reduction in the numbers of women smoking at the time of delivery, which equates to around 30 less babies born to smoking

mothers. The project has attracted additional funding from Swale CCG and discussions are underway with NHS partners KCHFT regarding the development of the programme in the future. This will determine future campaign work to support reducing smoking in pregnancy across Kent.

3.8 Sexual Health

3.8.1 Over 83,000 views of the sexual health pages and 21,000 visitors to the webpage for home testing kits.

3.8.2 Plans for the future include an awareness raising campaign in 2019/20, alongside development of digital assets and signposting to online services including home testing kits.

3.9 Seasonal Campaigns

3.9.1 We have a “warn and inform” responsibility during heatwave and cold weather alerts and lead on the communications for public health messaging. We also support national PHE and NHS campaigns, providing partners with appropriate social media, marketing and digital asset support for level two and three alerts in Kent during summer heatwave and winter cold weather periods, offering advice and signposting support to enable residents to manage their health during extreme weathe
r conditions.

3.9.2 We also support the ‘Stay Well This Winter’ national campaign, sharing organic NHS content advising residents on steps to stay healthy and avoid A&Es. This includes extending promotion of the national NHS flu campaign – utilising KCC social media, news media and internal communications channels (including children’s centres, libraries, gateways and adult disability centres) to promote the vaccine to high risk groups.

4.0 New Campaigns for 2019/20

4.1 Air Quality

4.1.1 The KCC Environment Strategy identified a need for marketing activity around air quality to support the new low emissions strategy. This will require a social marketing approach as outlined in section 2 and Public Health will work with the Environment Board, Kent communications, district councils and partners from the Kent and Medway Air Quality Partnership, to develop outcomes and communications objectives.

4.2 Infant Feeding Services/Breastfeeding

4.2.1 We are working with commissioned providers KCHFT to promote infant feeding services through health visitors and children’s centres. This may include a more general public campaign to raise awareness of breastfeeding and signpost to support services.

4.3 Developing Public Health’s online presence

4.3.1 The Public Health team will continue to work with Kent Communications, Digital Services and commissioned partners to develop and improve the customer journey to and through its websites. Our websites support marketing and communications campaigns while also providing an online access route through to our commissioned services and those of our partners. Development of the One You Kent, quitting smoking and sexual health services web pages is already underway. Working closely with commissioning partner,s we aim to

4.3.2 make the "offer" clearer for residents, and make it easier for people to access the most appropriate offer for them.

Targeting using digital media

Digital marketing activity will be even more closely targeted, based on priorities taken from the JSNA and Health and Wellbeing Strategy and on data from Strategic Commissioning, the Public Health Observatory and other sources. We will continue to work with local partners to extend the reach and effectiveness of core campaigns, building on the more locally targeted work done to date by partners such Sevenoaks District Council who targeted One You Kent messages at specific communities, with a view to reaching those people who are likely to benefit the most from the One You Kent initiative.

5.0 Financial Implications

5.1 The budget for campaigns and communications is £145.2k for this financial year.

6.0 Conclusion and Next Steps

6.1 Well planned, targeted campaigns can have a positive impact on people's behaviour.

6.2 The campaigns that KCC Public Health have undertaken during 2018 have been reduced following the restructure, with a greater emphasis being placed on earned media activity. However, previous successes and learning will be used for future campaigns, focussing on the most effective communications methods and channels to target key groups and issue areas, and on the benefits of developing and utilising social media and digital platforms.

6.3 It has also been recognised that long-term change requires long term, consistent messaging, and it is important to work ever closer with local partners – particularly through the Kent and Medway STP – and nationally with other local authorities and Public Health England, to provide all stakeholders with the resources.

7.0 Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **Comment on and Endorse** the progress and impact of Public Health campaigns in 2018/19.

8.0 Background Documents

8.1 None

9.0 Contact Details

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

15 January 2019

Subject: **Performance of Public Health-commissioned services**

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: This report provides an overview of key performance indicators (KPIs) for Public Health commissioned services. 11 of the 15 KPIs were RAG rated Green in the latest quarter, 4 were Amber, and none were Red.

In the case of the 4 Amber KPIs, providers have been looking to focus delivery towards those Kent residents who are most deprived or in most need.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the performance of Public Health commissioned services in Q2 2018/19

1. Introduction

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

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

2. Overview of Performance

2.1. Of the 15 targeted KPIs for Public Health commissioned services 11 achieved target (Green), none were below the floor standard and Red. 4 KPIs were below target but achieved the floor standard (Amber), these were for:

- the number of NHS Health Checks delivered
- the percentage of antenatal visits delivered by the Health Visiting Service

- the percentage of those engaged with One You Kent Advisors being from the most deprived areas in Kent
- the percentage of people successfully completing drug and/or alcohol treatment.

Health Visiting

2.2. The Health Visiting Service met all but one of the mandated contact targets in Q2. Delivery of antenatal contacts continues to be challenging for the provider.

2.3. The provider has advised that this reduction in antenatal contacts in Q2 has been due to the reduced capacity of the workforce. The service undertakes targeted recruitment, has a robust retention policy, flexible working arrangements and a collaboration with Canterbury Christchurch University to train qualified nurses in the Community Public Health Nurse role to improve succession planning and recruitment. The service is also completing an antenatal SBAR (Situation, Background, Assessment, Recommendation) review to identify any additional actions that can be taken to further improve performance.

Adult Health Improvement

2.4. The number of NHS Health Checks delivered has been steadily increasing following a drop in delivery in early 2018 with the roll-out of a new IT system across Kent. The numbers remain lower than last year and as a result action plans to provide targeted outreach in areas of deprivation are underway to increase uptake and increase awareness. The Provider has committed to target males aged over 50 years, in line with the findings of the Health Equity audit and will be working in Thanet and Swale, focussing on local pubs, during December and January

2.5. KCC is working proactively with the provider and GP's across the county to ensure that 100% of those eligible for a Health Check receive an invite by the end of the financial year.

2.6. There has been an increase in the proportion of individuals engaged with One You Kent Advisors being from the most deprived areas in the county, from 49% in Q1 to 52% in Q2. All providers delivering One You Kent continue to work together and with KCC to increase targeted uptake of this service.

Sexual Health

2.7. 100% of the 10,000 appointments requiring an urgent genito-urinary medicine (GUM) appointment in Kent were offered within 48 hours. Contracts for Sexual Health Services expire in March 2019 and work is underway to transform and remodel services in line with findings of the needs assessment in order to meet the changing demand and needs of users

Drug and Alcohol Services

2.8. The number of adults accessing structured treatment for substance misuse has increased in the 12 months to September 2018 to 4,587 from 4,445 in the same time period last year. Analysis of these figures has identified increases in clients using opiate and/or non-opiates. The number of opiate clients has increased to 2,159, the highest number since August 2017.

2.9. The proportion of people successfully completing treatment has decreased from 26% to 25%. Providers are seeing a reduction in service users with very-low to low levels of complexity and an increase in medium and very-high levels of complexity for opiate clients. Providers are reviewing their offer to support service users in finding employment and stable housing which can aid recovery.

Mental Wellbeing Service

2.10. The Live Well Kent providers continue to ensure that the services deliver high levels of satisfaction with 98% of clients completing the NHS Friends and Family Test (FFT) indicating that they would recommend the service to family, friends or someone in a similar situation.

3. Conclusion

3.1. 11 of the 15 KPIs with targets stated in the Strategic and Corporate Services Directorate 2018-19 Directorate Business Plan were RAG rated Green and 4 were Amber, none were Red.

3.2. Services continue to innovate and focus delivery to ensure they meet targets and support Kent residents who are most deprived or in most need.

4. Recommendations

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the Q2 2018/19 performance of Public Health commissioned services

5. Background Documents

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

6. Appendices

Appendix 1 - Public Health Commissioned Services KPIs and Key.

7. Contact Details

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

Service	KPI's	Q2 17/18	Q3 17/18	Q4 17/18	Target 18/19	Q1 18/19	Q2 18/19	DoT**
Health Visiting	PH04: No. of mandated universal checks delivered by the health visiting service (12 month rolling)	68,837 (g)	70,456 (g)	71,495 (g)	65,000	71,287 (g)	**70,639 (g)**	⇩
	PH14: No. and % of mothers receiving an antenatal contact with the health visiting service	2,457 54% (g)	2,282 52% (g)	1,755 43% (g)	50%	2,078 48% (a)	**1,804** **41% (a)**	⇩
	PH15: No. and % of new birth visits delivered by the health visitor service within 30 days of birth	4,459 97% (g)	4,346 98% (g)	3,954 98% (g)	95%	4,094 98% (g)	**4,294** **98% (g)**	⇔
	PH16: No. and % of infants due a 6-8 week who received one by the health visiting service	3,989 89% (g)	4,199 92% (g)	3,809 91% (g)	80%	3,628 89% (g)	**3,771** **86% (g)**	⇩
	PH23: No. and % of infants who are totally or partially breastfed at 6-8 weeks (health visiting service)	2,025 49%*	2,041 47%	1,788 46%*	-	1,833 49%*	**1,852** **48%***	-
	PH17: No. and % of infants receiving their 1-year review at 15 months by the health visiting service	3,751 88% (g)	3,878 89% (g)	3,723 87% (g)	80%	3,609 86% (g)	**3,907** **87% (g)**	⇧
	PH18: No. and % of children who received a 2-2½ year review with the health visiting service	3,520 84% (g)	3,634 83% (g)	3,725 82% (g)	80%	3,546 80% (g)	**3,703** **82% (g)**	⇧
Structured Substance Misuse Treatment	PH13: No. and % of young people exiting specialist substance misuse services with a planned exit	79 92% (g)	76 92% (g)	55 85% (g)	85%	87 94% (g)	**54** **89% (g)**	⇩
	PH03: No. and % of people successfully completing drug and/or alcohol treatment of all those in treatment	1,143 26% (a)	1,126 25% (a)	1,073 24% (a)	26%	1,160 26% (g)	**1,139** **25% (a)**	⇩
Lifestyle and Prevention	PH01: No. of the eligible population aged 40-74 years old receiving an NHS Health Check (12 month rolling)	43,677 (g)	42,943 (g)	41,677 (g)	41,600	38,021 (a)	**33,617 (a)**	⇩
	PH11: No. and % of people quitting at 4 weeks, having set a quit date with smoking cessation services	761 49% (a)	746 54% (g)	809 49% (a)	52%	699 57% (g)	**684** **54% (g)**	⇩
	PH21: No. and % of clients engaged with One You Kent Advisors being from the most deprived areas in the County	New Service, New Metric			60%	413 49% (a)	**391** **52% (a)**	⇧
Sexual Health	PH02: No. and % of clients accessing GUM services offered an appointment to be seen within 48 hours	100% (g)	100% (g)	100% (g)	90%	9,772 100% (g)	**10,024** **100% (g)**	⇔
Mental Wellbeing	PH22: No. and % of Live Well Kent clients who would recommend the service to family, friends or someone in a similar situation	New Metric			90%	210 98% (g)	**252** **96% (g)**	⇩

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

Commissioned services annual activity

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

Key:

RAG Ratings

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

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

DoT (Direction of Travel) Alerts

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

**Relates to two most recent time frames

Data quality note

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

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

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee

15 January 2019

Subject: **Capital Programme 2019-22, Revenue Budget 2019-20 and Medium-Term Financial Plan 2019-22**

Classification: Unrestricted

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

Summary: County Council received a report and presentation on the Autumn Budget Statement on 18 October 2018. That report set out an update to the Medium-Term Financial Plan (MTFP) for 2019-20 including progress on proposals to resolve the unidentified gap in the original plan and high-level outline plans for 2020-21 and 2021-22. The report marked the start of a communication and consultation campaign to support decisions on the final budget in February.

The final draft budget proposals were published on 2 January 2019 to support the scrutiny and democratic process through Cabinet Committees, Cabinet and culminating in the annual County Council budget setting meeting on 14 February. This report provides Health Reform and Public Health Cabinet Committee with an opportunity to comment on the draft budget proposals and make recommendations to Cabinet Members as part of this process.

Members are asked to bring to this meeting the draft (black combed) 2019-20 Budget Book document published on 2 January 2019 as information from this document is not repeated in this report.

Recommendation:
Members of the Health Reform and Public Health Cabinet Committee are asked to:
a) **NOTE** the draft capital and revenue budgets and Medium-Term Financial Plan, including responses to consultation and government provisional settlement; and
b) **SUGGEST** any changes which should be made before the draft is presented to Cabinet on 28 January and full County Council on 14 February.

1. Introduction

1.1 The Local Government Finance Act 1992 and KCC Constitution requires the Council to consult on and ultimately set a legal budget and council tax precept for the forthcoming financial year, 2019-20. The accompanying draft Budget Book and MTFP document (hereafter referred to as the

Budget Book) sets out the detailed draft proposals. This document is designed as a reference document and includes a number of sections/appendices. This report is produced as a guide to help navigate the document. We have reduced the amount of information included in the draft Budget Book for Cabinet Committees to help focus on the key budget issues.

1.2 The democratic process through Cabinet Committees, Cabinet, and ultimately full Council is the culmination of the budget setting process which takes almost a year to evolve beginning almost immediately after the budget is approved in February. This starts with the forecasts for the subsequent year(s) in the MTFP as set out at the same time as the approved budget for the forthcoming year, including the indicative central government settlement. These are based on estimates and subject to regular revision and refinement. It has become common that the MTFP usually has an unidentified savings gap for the future years which needs to be resolved, particularly so when future years are in a new spending review period.

1.3 In the last three years we have reported an interim update of the MTFP to County Council through the Autumn Budget Statement report. This includes updates to the forecasts and progress on identifying solutions to the unresolved gap. This also marks the launch of formal consultation as required under the Council's Constitution and is necessary to set a legal budget and council tax. The draft budget published in January for the final democratic process reflects the response to this consultation, further updates to forecasts, and final proposed resolution of any outstanding gap. Even then, this final draft can be subject to further changes leading up to the full Council meeting in February (including any amendments agreed at the meeting).

1.4 The final approved budget and MTFP is published in March.

2. Fiscal and Economic Context

2.1 The national fiscal and economic context is an important consideration for the Council in setting the budget. This context does not just determine the amount we receive through central government grants, but also sets out how local government spending fits in within the totality of public spending. This latter aspect essentially sets the government's expectations of how much local authorities would raise through local taxation.

2.2 In previous years we have set out a full analysis of the national economic and fiscal context in section 2 of the draft Budget Book. This analysis has been based on the Chancellor of the Exchequer's Autumn Budget and the Office for Budget Responsibility's (OBR) economic and fiscal outlook. The Autumn Budget is now the government's main annual tax and spend policy instrument. The March statement is now just an update to economic and fiscal forecasts.

2.3 The Autumn Budget 2018 (AB18) was announced on 29th October (nearly a month earlier that previous years) and was made against a highly

uncertain economic climate. Consequently, we are not convinced of the value of publishing the full analysis in the draft Budget Book publication in January bearing in mind the risk of further changes by the time of the February Council meeting. Instead we will include a short summary in this report for cabinet committees and provide the fuller analysis closer to the County Council meeting in February.

2.4 The Chancellor retained his two main fiscal rules in AB18; the cyclically adjusted budget deficit to be below 2% of Gross Domestic Product (GDP), and total debt as % of GDP to be falling, both by 2020-21. The latest OBR report suggests a stronger fiscal performance with total debt already peaking at 85.2% in 2016-17 and reducing to 83.7% forecast for 2018-19 and 79.7% for 2020-21. The annual deficit is predicted to reduce from 1.9% in 2017-18 to a forecast 1.2% in 2018-19. This improved performance is derived from higher than previously forecast economic growth (despite poor performance in first quarter of 2018 due to adverse weather), lower than planned public spending in 2017-18, and higher forecast tax yields for 2018-19 and beyond.

2.5 This improved performance allowed the Chancellor additional headroom to increase public spending plans and reduce some taxes in AB18. Most of the additional spending was allocated to the NHS, although some additional monies were allocated to local government including extra funding for social care in 2018-19 and 2019-20, road maintenance in 2018-19, one-off injection for schools in 2018-19, and removing the borrowing cap on local authority social housebuilding. There was also additional spending to support the implementation of Universal Credit and defence spending.

2.6 The tax reductions included increases in personal allowances on income tax, freezing fuel and alcohol duties, increases in business investment allowances and new buildings allowances, and reductions in business rates for medium sized high street premises. Some additional tax is planned to be raised from extending the reforms to off-payroll working (IR35) to larger private sector organisations, and introduction of new digital services tax on the revenues of digital businesses, both from April 2020.

2.7 The changes result in the forecast budget deficit initially increasing from £25.5bn in 2018-19 to £31.8bn in 2019-20 (1.2% of GDP to 1.4% of GDP), before then reducing in later years. The Chancellor retained £15.4bn (0.7%) of the headroom to the 2% deficit target to hedge future economic and fiscal uncertainty.

2.8 The provisional local government finance settlement was announced on 13th December. This announcement is one of the key elements of the Council's budget process as it includes several significant grants and council tax referendum principles.

2.9 In previous years the settlement has included changes to the distribution of government grants. The 2019-20 settlement had only minor changes to the indicative allocations for 2019-20 in the 2018-19 settlement, notably affecting business rate top-up following the 2017 revaluation and New

Homes Bonus (supported by additional money to maintain the 0.4% baseline). The settlement included an additional distribution to all authorities from the excess business rates levies paid to central government and additional Rural Services Grant (the latter does not affect KCC).

2.10 The provisional settlement confirmed the additional money announced in AB18 for social care. The 2019-20 settlement includes further substantial reductions to the Revenue Support Grant (RSG) as per previous indicative allocations (KCC's RSG is reducing from £37.6m to £9.5m in 2019-20) although the negative RSG for 162 has been redressed, indexation uplift in business rate top-up, the final tranche of the Improved Better Care Fund, and additional compensation for the business rate reliefs announced in AB18.

2.11 The settlement also confirmed that the council tax referendum threshold for 2019-20 will be 3% (unchanged from last year's announcement), and the final year of the social care council tax precept is also unchanged (this allowed for a 6% increase over the three years 2017/20, with no more than 3% in each of the first two years). The Autumn Budget Statement report included KCC's proposals for an increase up to but not exceeding the referendum threshold, and final 2% social care council tax precept. The settlement means the council tax proposals in the final draft budget are unchanged from that report. The only changes to council tax from the Autumn Statement are the notification of the estimated council tax base and collection fund balances from districts (the Autumn Statement was based on KCC's own forecasts).

2.12 The settlement also confirmed that the Kent business rate pool between KCC, 10 Kent district councils, and Kent and Medway Fire and Rescue Authority, will be re-instated following the 2018-19 100% retention pilot and the failed bid for a further pilot in 2019-20. The pool announcement increases the County Council's share of retained business rates from the assumption included in the Autumn Statement report. The Kent and Medway bid for a further business rate retention pilot for 2019-20 was not approved.

2.13 We have no indicative grants or council tax referendum limits for 2020-21 and beyond. We will not know these until after the outcome of the Spending Review anticipated sometime during 2019. We are also awaiting further details on the proposed 75% business rate retention arrangements, and the reforms following the Fair Funding review. These are likely to have a significant impact on future year's budgets and the Council's MTFP, this uncertainty makes forward financial planning very imprecise. The high-level three-year plan (appendix A(i)) in the final draft Budget Book is based on prudent assumptions about the outcome of the Spending Review, additional business rate retention, Fair Funding review, and council tax referendum principles consistent with the OBR assumptions in their latest fiscal and economic outlook report.

3. Revenue Budget Strategy and Proposals

3.1 The Council's revenue expenditure is what we spend on the provision of day to day services e.g. care for the elderly and vulnerable adults, supporting children in care, maintain and managing the road network, library services, etc. It includes the cost of salaries for staff employed by the Council, contracts for services commissioned by the Council, the costs of servicing debt incurred to support the capital programmes, and other goods and services consumed by the Council. Revenue spending priorities are determined according to the Council's statutory responsibilities and local priorities as set out in the MTFP, with the ultimate aim of delivering the vision set out in the Strategic Statement.

3.2 The final draft budget book includes the following sections in relation to the revenue budget proposals:

- Section 2 – Revenue Budget Summary by Directorate
- Section 3 – Key Service Analysis by Directorate
- Appendix A(i) – High Level 2019-22 three-year Revenue Plan
- Appendix A(ii) – Detailed 2019-20 Revenue Plan by Directorate
- Appendix B – Budget Risk Register
- Appendix C – Assessment of Levels of Reserves

The revenue budget sections set out the planned spending on services, the revenue plans in the appendices show the main reasons for year on year changes.

3.3 In order to meet the legal requirement to set a balanced budget the Corporate Director of Finance must be satisfied that it is based on robust estimates and includes adequate provision for reserves to cover risks and uncertainties. The 2019-20 draft budget includes provision for £59.5m of additional spending demands (realignment of existing budgets plus forecasts for future demand and cost increases) and £12.9m to replace the use of one-offs on the 2018-19 approved budget. This combined £72.4m of spending demands together with the £28.1m reduction in RSG (referred to in paragraph 2.9) make up the total £100.5m budget challenge for 2019-20.

3.4 The spending demands have only marginally increased from the £52.85m forecast in the Autumn Statement report to County Council on 18th October (after taking account of the additional £6.2m of spending from the extra ring-fenced adult social care winter monies). This reflects the very latest update in order to satisfy the robustness requirement. These spending demands include the need to realign budgets based on current activity/costs, future known unavoidable cost increases (including contractual price increases, legislative changes and financing capital programme), contingent sums for future eventualities (including estimated demand, non-specific price increases and contract retender), and local choices (including investment in services, and Kent pay scheme).

3.5 The 2019-20 draft budget includes savings and income proposals of £42.9m. This is less than the £57.5m identified in the Autumn Statement report to County Council and resolves the £16.4m unidentified gap reported at the time. The reduced savings are possible following the additional grant announcements in AB18 (paragraph 2.9 above), as well as a higher than forecast council tax base estimate (paragraph 2.10) and the additional proceeds from the reapproval of the business rate pool (paragraph 2.11).

3.6 The revenue budget can be summarised in the updated version of the equation reported to County Council in the Autumn Statement and presentation by the Acting S151 Officer at the meeting (as shown below). This equation assumes the Council agrees the proposed council tax precept increases up to but not exceeding the 3% referendum limit and the 2% social care levy. Section 6 of this report sets out the main revenue spending demands and savings/income proposals for the Public Health directorate.

FINANCIAL CHALLENGE			SOLUTION		
	£'000	£'000		£'000	£'000
• Spending Demands		59,527.5	• Council Tax		40,355.1
- realignment	-9,491.4		• Business Rates		-4,482.4
- unavoidable	31,249.6		• Savings		42,855.3
- contingent sums	28,967.5		- Identified	32,005.3	
- local decisions	8,801.8		- Use of reserves	10,850.0	
• One-offs 2018-19		12,858.6			
• Grant Reductions		28,153.0	• Grant Increases		21,811.1
		100,539.1			**100,539.1**

3.7 The 2020-21 and 2021-22 plans are presented at a high level for the whole council in appendix A(i). As identified in paragraph 2.12 this represents a prudent estimate of future funding following the Spending Review and possible changes to the funding distribution for local government as a whole. The plans also include forecasts for future spending pressures, replacing the use one-offs to balance the previous year's budget, forecast council tax base and council tax referendum limits, and the estimated need for further savings (including full year effect of previous years, future identified options and unidentified gap). There are so many uncertainties that there is little to be gained from setting future plans in any more detail at this stage.

4. Budget Consultation

4.1 As described in paragraph 1.3 consultation on the Council's revenue budget and council tax proposals was launched on 11th October to coincide with the publication of the Autumn Budget Report to County Council. The consultation closed on 21st November. This consultation sought views on council tax and KCC's budget strategy. The consultation was web based supported by a social media campaign. This approach achieved the aim of increased engagement at lower cost and received a total of 1,717 responses (compared to 965 responses last year). Furthermore, there were fewer numbers who started a response but did not complete (698 compared to 953 last year).

4.2 The campaign also aimed to increase public understanding of the Council's budget and the financial challenge arising from rising demand for/cost of providing Council Services, reductions/changes in central government funding, the need to find cost savings whilst at the same time protecting valued services, and impact on council tax. We will need to undertake further evaluation of the extent to which these aims were achieved.

4.3 Overall there were fewer proportion of respondents supporting council tax increases than in previous years although in general the suggestions where the Council could make alternative savings would not balance the budget equation. In relation to the budget strategy a significant majority either agreed or strongly agreed that this should support delivery of the three strategic outcomes outlined in the Council's Strategic Statement. A comprehensive report on consultation activity and responses is published on the Council's website (see link in background documents).

5. Capital Programme

5.1 Capital expenditure is spent on the purchase or enhancement of physical assets where the benefit will last longer than the year in which it is incurred e.g. school buildings, roads, economic development schemes, IT systems, etc. It includes the cost of purchasing land, construction costs, professional fees, plant and equipment and grants to third parties. As with revenue, capital spending plans are determined according to the Council's statutory responsibilities and local priorities as set out in the MTFP, with the ultimate aim of delivering the vision set out in the Strategic Statement.

5.2 Capital spending has to be affordable as the cost of interest on borrowing and setting aside sufficient provision to cover the initial investment funded by loans over the lifetime of the asset, are borne as revenue spending each year over a very long period. This affordability would also apply to invest to save schemes which need to have a reasonable payback.

5.3 Section 1 of the draft Budget Book sets out the proposed 2019-22 programme and associated financing requirements. The summary provides a high-level overview for the whole council, and the individual directorate pages provide more detail of rolling programmes and individual projects.

5.4 The 2018-21 programme was developed assuming a limit of no more than £100m of additional borrowing for new schemes over the three-year period. All of this capacity was used up in the three-year plan leaving no room for new schemes in subsequent years. Since the original programme was agreed some new projects have been committed e.g. additional capital spending on highways schemes approved by full Council in July 2018. We have also re-evaluated the programme where spending can be reduced or can be fully externally funded.

5.5 However, some further additional capital spending is essential to meet statutory responsibilities or will be an invest to save for the future. This spending would have to be funded from additional borrowing of £64.5m over the three-year programme. We can fully mitigate the revenue impact over this period through refinancing other schemes, but in the longer term beyond 2021-22 this additional borrowing would have an estimated £4.5m additional revenue cost for another 20/30 years.

6. Public Health Proposals

The Public Health grant, which funds the majority of the spend on Public Health, has been subject to annual reductions totalling £11.0m (or 14.3% of the total grant in 2015/16) since 2015/16. This includes a reduction of £1.8m in 2019/20. The total grant for 2019/20 has been confirmed as £65.8m[1]

6.1 With additional pressures in 2019/20 due to:

- Increasing drug costs, particularly buprenorphine (used in substance misuse services) which has resulted in an average price increase of just under 500% (between March and September 2018) resulting in an estimated budgetary pressure of approximately £250k
- Increasing demand for services, particularly sexual health services (approximate current spend £13m) where there is rising demand and a need to increase screening levels
- An agreement to increase the uncommitted ring-fenced Public Health reserve to £2m to provide for significant/unexpected increases in demand
- The Kent STP, which has a focus on prevention and a commitment to fund a number of elements which will support system wide savings. These include smoking, NHS Health Checks and healthy weight services
- General inflationary pressures including pay increases which affect both the commissioning team and the commissioned Public Health services (that have not been absorbed)

Public Health have been required to deliver significant savings, generate income and think creatively in 2019/20 to reduce expenditure within budget.

6.2 The savings have been achieved through the following:

- Reshaping of services for School Health and Positive Relationships and the Voluntary Sector Infrastructure services.
- Review of discretionary spend including
    - KCC internal funding and historic grants, resulting in a recurrent £360K saving

[1] Subject to any increases yet to be announced relating to the 3% NHS pay awards for 18/19 and 19/20.

    - Review and reduction of non-contracted spend resulting in reduced budgets for health intelligence and Public Health observatory
    - Reduction in the contribution to shared partnership post resulting in a saving of £62K.
    - Amalgamation of similar contracts to generate savings in overheads and back office functions
- Savings generated through transformation or efficiency programmes, for example, introduction of a central invites process for NHS Health Checks, implementation of a new prescribing policy for smoking and £200k saving on overheads in Health Visiting Services
- Better utilisation of national public health campaigns to reduce spend locally.
- Increase in income generation target to be achieved through co-commissioning, external grant funding and commissioning on behalf of other organisations.

The above savings have been achieved largely through forward planning (within contracts) and various invest to save initiatives that have been funded through the partnership agreement with KCHFT. The partnership agreement has an emphasis on delivering savings for both Public Health and KCHFT and is founded on open book accounting principles. In 2017/18, KCHFT transferred one-off savings of £1.8m back to KCC with a further one-off saving of £800k (largely due to staff vacancies) forecast in 2018/19.

6.3 Significant Risks for 2019/20

In 2018/19, the government lifted the public sector pay cap on the NHS and recommended a three year above inflation pay increase (of 3%) for NHS staff. Whilst the NHS Planning Guidance indicated that this would be centrally funded in 2019/20 (as it was in 2018/19), with the assumption that this would include additional funding for Local Authorities where the NHS is the service provider, the recent 2019-20 Public Health Allocations (announced on 20th December 2018) failed to indicate that this would be the case. If this funding fails to materialise then, subject to discussions with the relevant NHS providers, this could represent a significant in-year budget cut (estimated at £1.8m).

Other contract providers have been required to absorb their inflationary increases including pay awards. Whilst these providers have been able to absorb these costs to-date, this also represents a risk to KCC both in terms of future cost pressures and/or a reduction in service levels.

6.4 The ongoing reductions in the Public Health Grant continue to create a significant challenge for KCC to meet statutory functions within the resource available. Some of the proposed savings will undoubtedly impact on services delivered to the public, for example a reduced presence in

terms of campaigns and an increase in digitisation, however this will be carefully managed to minimise any impact.

7. Recommendations

Members of the Health Reform and Public Health Cabinet Committee are asked to:
a) **NOTE** the draft capital and revenue budgets and Medium-Term Financial Plan, including responses to consultation and government provisional settlement; and
b) **SUGGEST** any changes which should be made before the draft is presented to Cabinet on 28 January and full County Council on 14 February.

8. Background Documents

8.1 KCC's Budget webpage
https://www.kent.gov.uk/about-the-council/finance-and-budget

8.2 KCC's approved 2018-19 Budget and 2018-20 Medium Term Financial Plan
https://www.kent.gov.uk/__data/assets/pdf_file/0010/79714/medium-term-financial-plan-and-budget-information.pdf

8.3 Autumn Budget Report to County Council 18th October 2018
https://democracy.kent.gov.uk/documents/s86875/Autumn%20Budget%20Statement%20Final%20version.pdf

8.4 KCC Budget Consultation launched 11th October 2018
https://www.kent.gov.uk/about-the-council/finance-and-budget/our-budget

8.5 Chancellor's Autumn Budget 2018 29th October 2018
https://www.gov.uk/government/topical-events/budget-2018

8.6 Office for Budget Responsibility fiscal and economic outlook 29th October 2018
https://obr.uk/efo/economic-fiscal-outlook-october-2018/

8.7 Provisional Local Government Finance Settlement 13th December 2018
https://www.gov.uk/government/collections/provisional-local-government-finance-settlement-england-2019-to-2020

8.8 KCC report on 2018 Budget Consultation

8.9 KCC Draft Budget Book 2nd January 2019

9. Contact details

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From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 15 January 2019

Subject: **Work Programme 2019/20**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

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

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

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

2. Work Programme 2019/20

2.1 An agenda setting meeting was held on 22 November 2018, at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion in agendas of future meetings.

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

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

3. Conclusion

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

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

5. Background Documents

None.

6. Contact details

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Last updated on: 4 January 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.
Dates from June 2019 onwards have been updated.

13 MARCH 2019
• **Draft Directorate Business Plan** • **Risk Management report (with RAG ratings)** • **Mental Health Needs Assessment** – specific item on MHNA (new MHNA will have been to DMT in January 2019) • **Oral Health** – delayed from January agenda at request of Cabinet Member • **Public health aspects of, and issues about, air quality –** this committee could seek more information on any item of public health concern on the report on the Energy and Low Emissions Strategy to the Environment and Transport Cabinet Committee on 28 11 18 • **Childhood Obesity** - report on joint working between agencies to tackle obesity (arising from item at 15 1 19 mtg). • **Regional approach to tackle illicit tobacco** (following item 10 at 22 11 18 mtg) • ***Verbal Updates*** • ***Contract Monitoring*** – *Adult Health Improvement Services (incl workplace health)* • ***Work Programme 2019/20***
10 MAY 2019
• ***Verbal Updates*** • ***Contract Monitoring*** – *Adolescent Health Services* • ***Work Programme 2019/20*** • **Public Health Performance Dashboard – incl impact of STP** now to alternate meetings • **Update on Public Health Campaigns/Communications** (added at 1 12 17 agenda setting as an item to alternate meetings)
20 JUNE 2019
• **Follow up report on work to address issues arising from gambling addiction** – after gambling item at 22 11 18 mtg • ***Verbal Updates*** • ***Contract Monitoring – Domestic Abuse and Positive Relationships*** • ***Work Programme 2019/20***
24 SEPTEMBER 2019
• ***Verbal Updates*** • ***Contract Monitoring – Mental Health Services*** • ***Work Programme 2019/20*** • **Public Health Performance Dashboard – incl impact of STP** now to alternate meetings • **Update on Public Health Campaigns/Communications** (added at 1 12 17 agenda setting as an item to alternate meetings)

- **Annual report – Quality in Public Health, incl complaints**

1 NOVEMBER 2019

- ***Verbal Updates***
- ***Contract Monitoring – Workforce Development***
- ***Work Programme 2020***

14 JANUARY 2020

- ***Verbal Updates***
- ***Contract Monitoring – Young People's Drug and Alcohol Services***
- ***Work Programme 2020***
- **Budget and Medium Term Financial Plan**
- **Public Health Performance Dashboard – incl impact of STP** now to alternate meetings
- **Update on Public Health Campaigns/Communications** (added at 1 12 17 agenda setting as an item to alternate meetings)

6 MARCH 2020

- **Draft Directorate Business Plan**
- **Risk Management report (with RAG ratings)**
- ***Verbal Updates***
- ***Contract Monitoring – tbc***
- ***Work Programme 2020***

30 APRIL 2020

- ***Verbal Updates***
- ***Contract Monitoring – tbc***
- ***Work Programme 2020***
- **Public Health Performance Dashboard – incl impact of STP** now to alternate meetings
- **Update on Public Health Campaigns/Communications** (added at 1 12 17 agenda setting as an item to alternate meetings)

PATTERN OF ITEMS APPEARING ANNUALLY

Meeting	Item
January	Budget and Medium Term Financial Plan Public Health Performance Dashboard – incl impact of STP now to alternate meetings Update on Public Health Campaigns/Communications (added at 1 12 17 agenda setting as an item to alternate meetings)

Last updated on: 4 January 2019

March	Draft Directorate Business Plan Risk Management report (with RAG ratings)
May	Public Health Performance Dashboard – incl impact of STP now to alternate meetings Update on Public Health Campaigns/Communications (added at 1 12 17 agenda setting as an item to alternate meetings)
July	
September	Annual Report on Quality in Public Health, incl Annual Complaints Report *Annual Equality and Diversity Report** this is part of the Strategic Commissioning Equality and Diversity, which goes to the Policy and Resources Cabinet Cttee Public Health Performance Dashboard – incl impact of STP now to alternate meetings Update on Public Health Campaigns/Communications (added at 1 12 17 agenda setting as an item to alternate meetings)
November	

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