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

Dr Anjan Ghosh Director of Public Health

To: **Health Reform & Public Health Cabinet Committee 12 July 2022**

Subject: **Development of a Kent System Wide Public Health Strategy**

Key decision: Not applicable at this time

Classification: **Unrestricted**

Past Pathway of Paper: CMT , Kent and Medway Integrated Care Partnerships

Future Pathway of Paper: Nil

Electoral Division: Whole County

Summary: The Cabinet Committee is asked to endorse and support a radical shift in the breadth and scale of public health action within the council and wider system of partners.

The health of the people of Kent is not improving as we would wish it to and inequalities persist and in some areas are increasing. This is driven by a range of wider determinants including socio-economic and lifestyle factors. A historic commissioning focussed public health approach will not significantly impact on this challenge and a new system wide strategic approach is required.

The paper discusses the Case for Change, a model to consider the impacts of health and a proposed approach to developing a Kent Public Health Strategy that will be owned by the whole system. It is proposed this strategy becomes the Kent Joint Health and Welbeing Strategy. A timescale for production is included with a plan to launch the five year strategy in October 2023.

Recommendation:
The Cabinet Committee is asked to **CONSIDER, COMMENT** on and **ENDORSE** the development of the Kent Public Health Strategy as outlined in the report.

1. Introduction

1.1 This report outlines for consideration by colleagues the approach proposed to develop a Kent Public Health Strategy for the years 2023 to 2028.

1.2 The Strategy will not start from a blank page but will build on the considerable work that has already taken place across system partners to define key issues, priorities and actions.

1.3 Colleagues are asked to consider, comment and endorse the proposed approach.

1.4 Reducing health inequalities and improving health and wellbeing outcomes of those we serve will require a clear strategic approach owned by partners and stakeholders across and within the whole System.

1.5 Kent is faced with a range of key health challenges, many of which are common across the country. There are widening inequalities in health and wellbeing across both geographical areas and amongst people with different vulnerabilities influenced by a range of wider determinants of health.

1.6 The new Kent County Council (KCC) Strategy "Framing Kent's Future" outlines an ambitious plan to improve the lives of those we serve. Improving health and well being and particularly reducing inequalities is a key theme. The public health strategy will start with recognition of the importance of wider factors such as employment, skills and education in health improvement. These areas are discussed further below

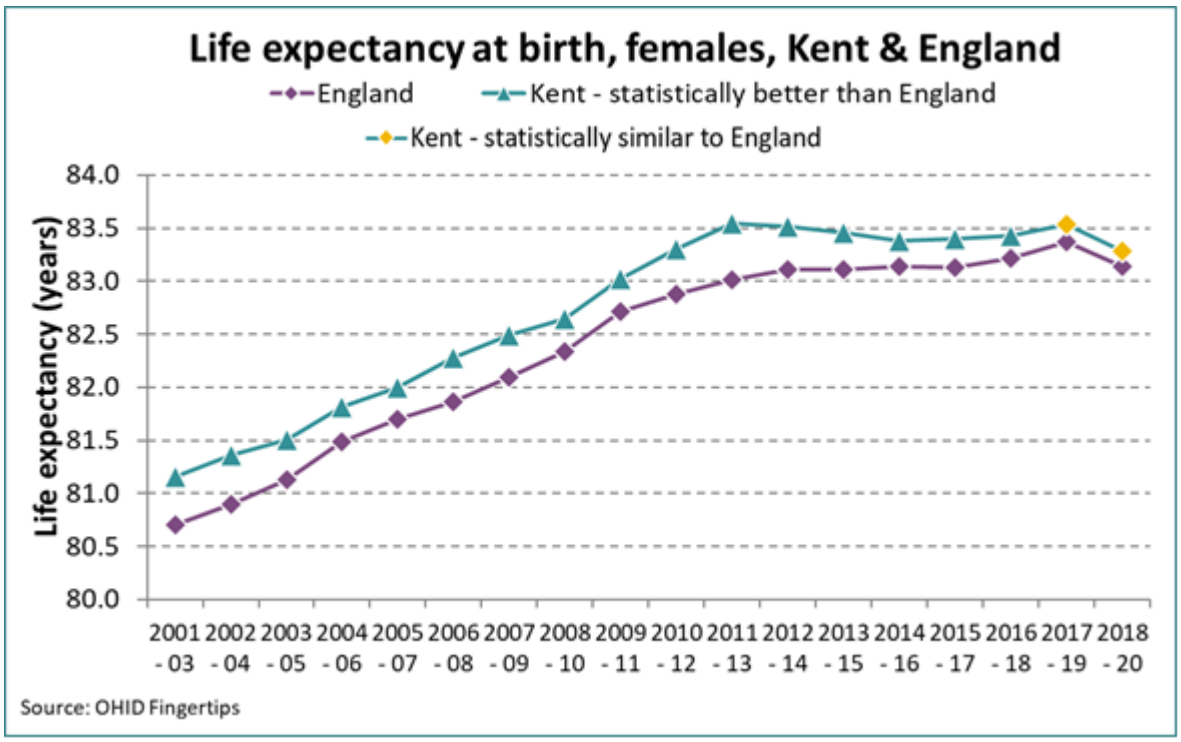
1.7 "Framing Kent's Future" makes clear the vital importance of joined up system wide working in delivering its ambitions. The Kent Public Health Strategy will be system wide and owned by all key stakeholders to ensure coordinated system delivery.

1.8 The wide impacts on health, the challenges we face and our opportunities to secure improvement mean a system wide strategy rather than a county council strategy is required

2. Background

2.1 Health Challenges in Kent

2.1.1. While overall the people of Kent continue to enjoy somewhat better health than the England average, there are many causes for serious concern within the trends and levels we are seeing. The graph below shows that the life expectancy for females in Kent has levelled out and is starting to decline. It is also no longer significantly better than the England average. (Green dots are significantly better than England average and amber are not significantly different). The picture for males is also showing a worrying closing of the gap between England and Kent but the life expectancy in males is still significantly higher than the England average. The most recent figure is impacted by Covid and there will be some improvement from this in future years..

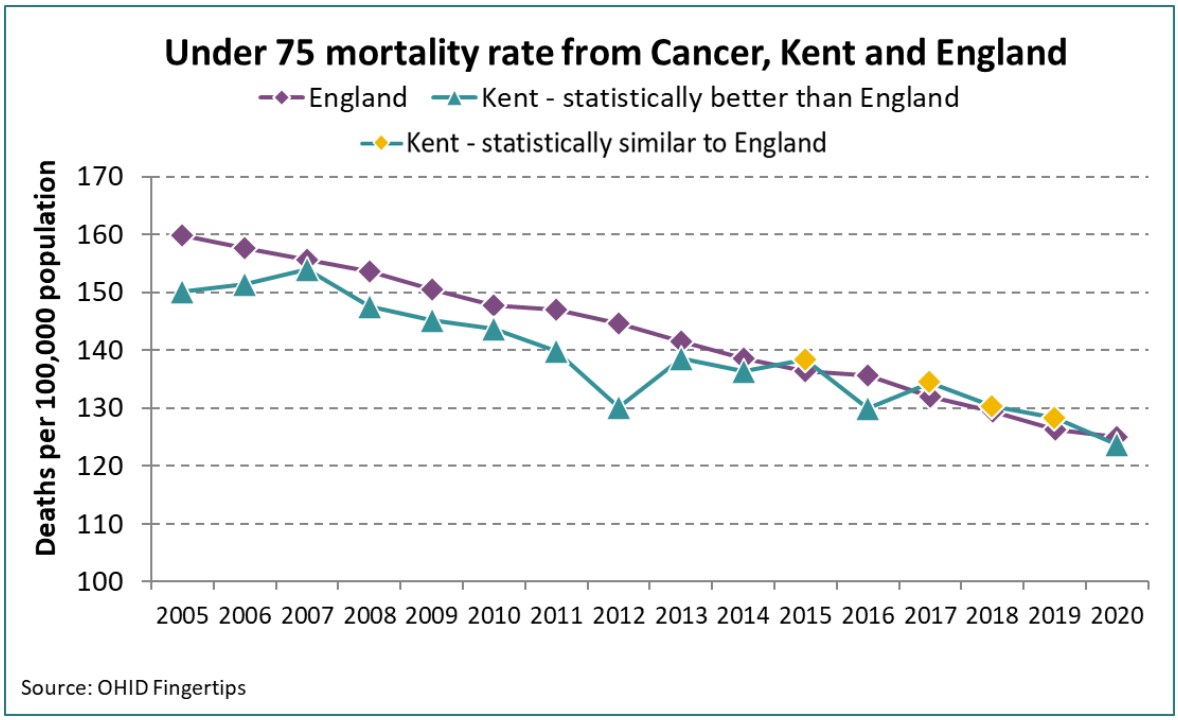


2.1.2 Life expectancy also varies considerably within Kent.

2.1.3 There are a number of areas with significantly lower life expectancy in females than the national average including Dartford, Swale and Thanet as well as many with rates less favourable compared to the national average than in the past including Ashford, Maidstone, Canterbury and Folkestone and Hythe all of which at some point over recent years has a life expectancy in females significantly better than the England average but now have rates that do not significantly differ from the National rate.

2.1.4 The position for life expectancy in men within Kent districts shows a similar pattern with Thanet men historically and still suffering significantly lower life expectancy than the England average and with Swale recently deteriorating to significantly below national average. Ashford, Canterbury, Folkstone and Hythe and Gravesham now have male life expectancy similar to the national average having at some time in recent years been significantly better than the England average. The pattern is somewhat less consistent in men however with Dartford (was significantly below England and now similar) and perhaps Maidstone (was at England average and now significantly better) showing some evidence of improvement.

2.1.5 Similarly, while the rate of cancer deaths in Kent in people under 75 is thankfully still falling, it has slowed so much less than elsewhere that rates are now slightly above the England average having historically been significantly below. The percentage of cancers diagnosed at stages 1 and 2 in Kent had not improved in 2018 compared to 2014, and data for England shows an increase in the gap between the most and least deprived deciles from 5 percentage points in 2014, to 6 percentage points in 2018.

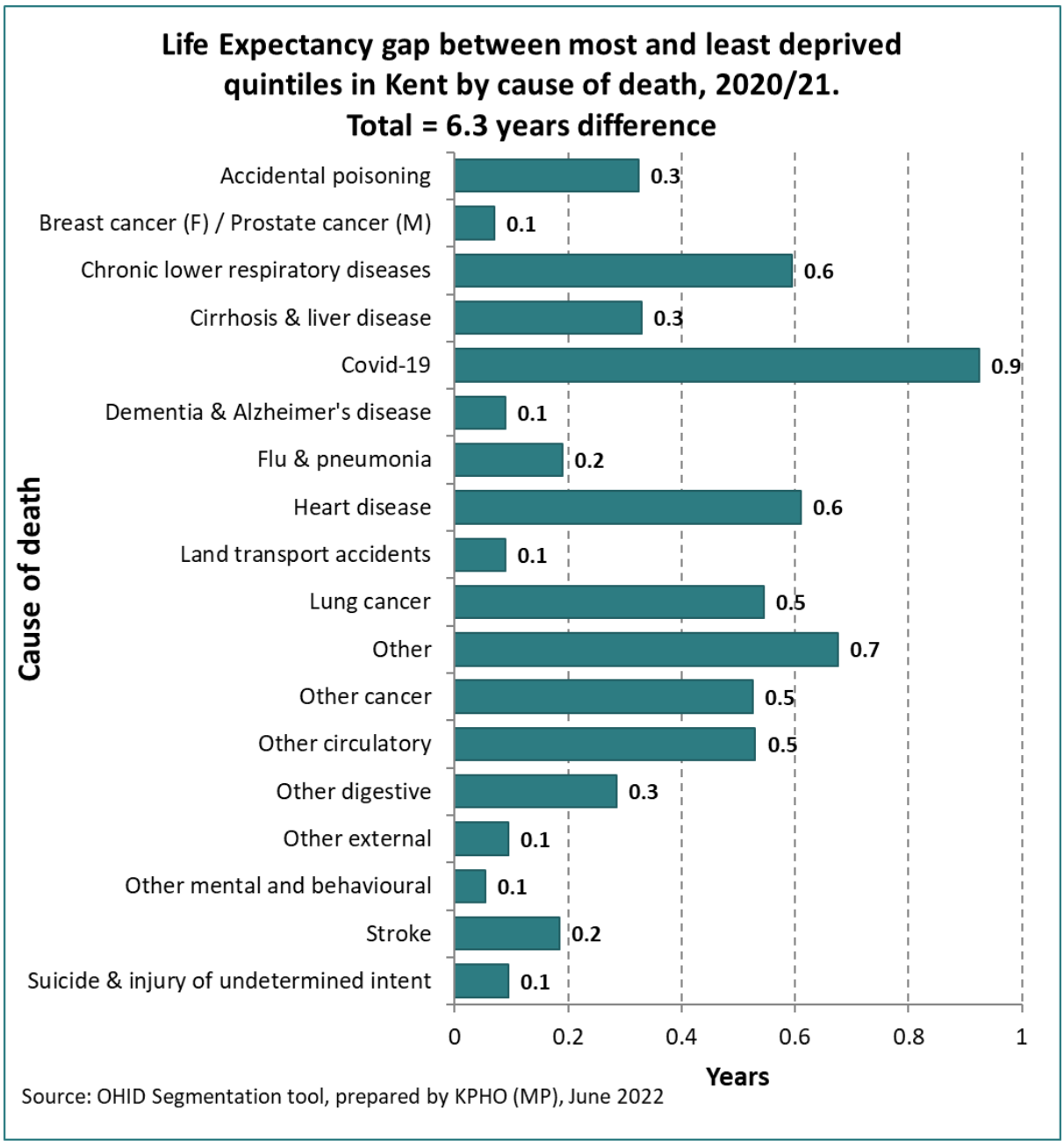


2.1.6 The situation is also of concern in mental health, and we are now seeing significantly higher rates of suicide than the England average across Kent. This is driven by a very high rate in Thanet, 50% above the England average.

2.1.7 If we look at life expectancy in Kent from 2020 to 2021, the level of inequality (or gap) between the most and least deprived areas was 7.3 years for males and 5.4 years for females. COVID-19 was the single biggest contributor to these inequalities in life expectancy, accounting for around one seventh of the gap in males and one sixth of the gap in females.

2.1.8 This gap in life expectancy between the most and least deprived areas has widened since 2010-12, with an increase of 0.8 years for males and 1.2 years for females. Furthermore, not only has the gap widened, but life expectancy itself has fallen over this period for both males and females in the most deprived areas.

2.1.9 The causes of death contributing to the differences in life expectancy in the whole Kent population can be summarised:



2.1.10 It must be remembered however that upstream wider determinants such as low income, poor education, unemployment and lifestyle choices in large part underline these differences.

2.1.11 Life expectancy inequality varies within districts as well. Broadly speaking, those districts which are most deprived also have the largest disparity in life expectancy within their boundaries.

2.1.12 In males, Gravesham has the highest life expectancy gap at 9.1 years, above the Kent average but below the England average of 9.7 years. Thanet and Folkestone and Hythe also have differences in Life expectancy above the Kent average at 8.5 years. In contrast the difference in Tunbridge Wells and Sevenoaks is 3.3 years.

2.1.13 In females the greatest inequality in life expectancy is in Thanet at 9.7 years, higher than the England level of 7.9 years and the Kent level of 5.6 years.

Dover has the second highest inequality at 6.1 years while Tunbridge Wells and Sevenoaks the gap is 1.6 years and 1.5 years respectively.

2.1.14 There is also data of concern within the elements impacting on the wider determinants of health. Kent is seeing a more rapid rise in violent crime leading to hospital admissions than the England average, although the rate is still lower. In Maidstone however levels of violent crime leading to hospital admission are significantly above the national average.

2.1.15 It is well recognised that wider determinants and in particular deprivation are major drivers of health. Additionally educational attainment is a key driver of future affluence and deprivation. Education is measured using the Attainment 8 score[1] at the end of key stage 4 in all maintained secondary schools, academies and free schools, by local authority of pupil residence.

2.1.16 Kent has an average attainment 8 score of 47 with a national average score of 46.9 and is in fact improving relative to that national average. However, Kent is a relatively affluent area with an Index of Multiple Deprevation (IMD) of 18.8 against the England average of 21.8. The level of educational attainment is therefore somewhat below what one would expect given the county's level of overall affluence. This could be of concern as it may mean Kent's children may struggle to achieve the same relative level of affluence their parents enjoy.

2.1.17 Further, attainment 8 scores are particularly low in Thanet, Dover and Swale perpetuating some of the challenges to health in these areas. Improvement in school readiness will be key with currently the proportion of children having not reached a good level of development by the end of Year R across Kent - 20 percentage points higher in those eligible for free school meals.

2.1.18 While Kent overall has a lower-level of children living in poverty than the England average, the latter is seeing a marked decrease that is much less evident in Kent. This means that the lot of our children is improving less year on year than the national average. As the graphs below show the decline in low income families is worse in almost all Kent areas than the England average. The gap has closed considerably in Ashford, Canterbury and Gravesham and has become significantly worse than the England average in

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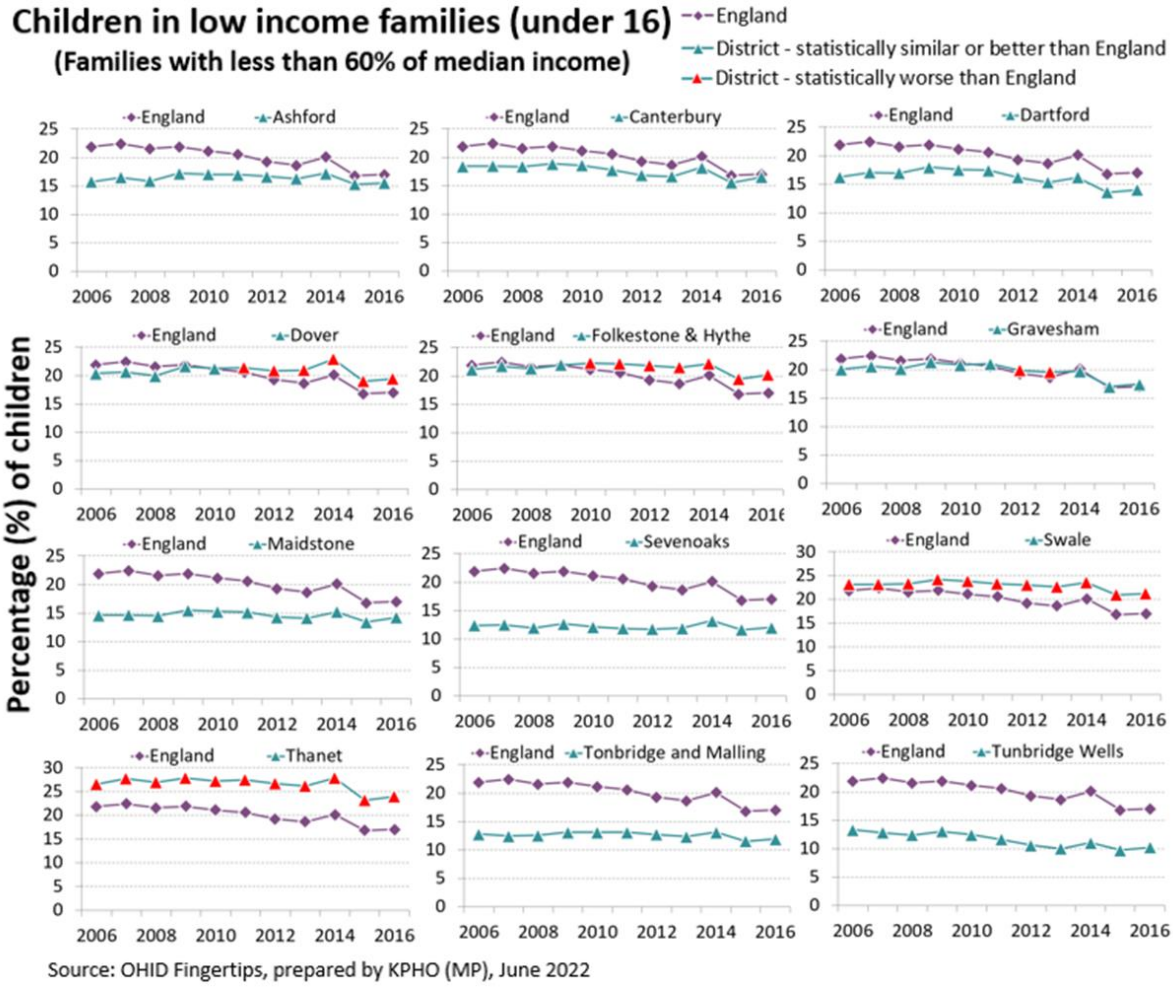
[1] **Attainment 8 measures the achievement of a pupil across 8 qualifications.**

1. A double weighted maths element that will contain the point score of the pupil's English Baccalaureate (EBacc) maths qualification.
2. An English element based on the highest point score in a pupil's EBacc English language or English literature qualification. This will be double weighted provided a pupil has taken both qualifications.
3. An element which can include the three highest point scores from any of the EBacc qualifications in science subjects, computer science, history, geography, and languages. For more information see the list of qualifications that count in the EBacc. The qualifications can count in any combination and there is no requirement to take qualifications in each of the 'pillars' of the EBacc.
4. The open element contains the three highest point scores in any three other subjects, including English language or literature (if not counted in the English slot), further GCSE qualifications (including EBacc subjects) or any other DfE approved technical awards.

Dover, Folkstone and Hythe and Swale as well as remaining very high in Thanet. While still well below national rates, the reductions in Maidstone, Sevenoaks and Tonbridge and Malling are far less than those seen across England.



2.1.19 In summary then, the people of Kent are not in absolute terms seeing improved health and there are serious and increasing levels of inequality. A public health strategy that can impact at scale on this position will require a radical departure from traditional public health approaches that have often been limited in both breadth and scale.

2.2 What impacts on health?

2.2.1 The Robert Wood Johnson (RWJ) model is increasingly recognised as a good starting point for identifying the factors contributing to health.

SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

2.2.2 Factors that need to be addressed to improve health therefore include Socio-Economic Factors, Health Behaviours, Clinical Care and the Built Environment

2.2.3 The RWJ model ascribes 40% of what impacts on health to socio-economic factors. The importance of these factors is recognised in “Framing Kent’s Future” and is increasingly recognised by the Kent ICS as a key area. Key elements, covering 30%, include income, which is linked to employment and this in turn to education. Long term strategy requires best start in life and school readiness to drive optimal educational attainment and then realisation of potential in the workplace. Income will also include ensuring maximum availability and access to benefits for those who require additional support. Adult Community learning is also key to help people achieve what they can in the workplace, as well as the development of local public sector anchors especially where private sector employment is limited. We also need ensure people with vulnerabilities including people with mental health issues of learning difficulties have the best chance to gain and retain employment.

2.2.4 The remaining 10% includes Community Safety (highlighting a key role for the Office of the Kent Police Crime Commissioner (OPCC) and Kent Police and local safety partnerships), and the benefit of families, friends and communities. Evidence shows social contacts are as strongly associated with good health outcomes as are controlling high blood pressure or smoking.

2.2.5 The second key area are the Lifestyle choices more commonly linked with public health. These include diet and exercise, smoking, alcohol misuse and sexual health. While there is some success in reducing the use of tobacco across the developed world and indeed the whole world now, we are seeing little progress around diet and exercise. This will require preventative approaches in early life that can be delivered at scale such as the Daily Mile

programmes and where two thirds of adults are already overweight, peer led weight loss support at scale with better signposting from primary care.

2.2.6 Access and quality of clinical care account for around 20%. The development of Population Health management offers the opportunity to better understand the needs of populations and could form a powerful resource allocation tool to ensure that spend is in the areas of greatest need. Clinicians can also support wider determinants including loneliness, lifestyle and access to benefits using social prescribers and other services. For example, families attending paediatric clinics from areas of high child poverty could be signposted as required to benefits and loneliness support.

2.2.7 The final 10% is associated with the built environment and environmental quality. This includes access to green and blue spaces as well as the quality of housing. Key factors will include affordable transport where this may be a barrier to employment, education and social contact as well as active transport opportunities to improve physical activity.

2.2.8 In summary, it is of note that much is broadly within the gift of local authorities. This includes the commissioning of lifestyle services, and early years including opportunities especially around school readiness, family and social support, community safety and the built environment as well as influence around employment, income and benefits.

2.3 Strategic approaches

2.3.1 The role of wider determinants and the action required to tackle inequalities forms a key part of a number of important national documents and approaches. These include the Marmot Review, the Public Health England work “COVID-19, Health Inequalities and Recovery” and the Governments work on Levelling Up.

2.3.2 The Marmot report highlighted inequalities across the country and proposed a range of areas where action was required. In 2019 a Review was published 10 years on from the initial report highlighting that the position had not improved.

2.3.3 The review sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.

2.3.4 Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life. This is reflected in the 6 policy objectives and to the highest priority being given to the first objective:

1. Giving every child the best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives
3. Creating fair employment and good work for all
4. Ensuring a healthy standard of living for all
5. Creating and developing sustainable places and communities
6. Strengthening the role and impact of ill-health prevention

2.3.5 The erstwhile Public Health England (Now UKHSA – UK Health Security Agency) led by Prof. Kevin Fenton considered the unequal impact of Covid on society highlighting how those in ethnic minority groups and poorer communities suffered disproportionately as the disease exacerbated existing inequalities. While focussed largely on London a key set of Outcomes to optimise recovery are of wider value:

1. Reverse the pattern of rising unemployment and lost economic growth caused by the pandemic
2. Narrow social, economic and health inequalities
3. Help young people flourish with access to support and opportunities
4. Support our communities including those most impacted by Covid
5. Accelerate delivery of a cleaner greener London.

2.3.6 The Government recognise the importance of addressing differences across the country and introduced the Levelling Up and Regeneration Bill. The Levelling Up White Paper unveiled an ambitious programme to reduce inequality and close the gap – in productivity, health, incomes, and opportunity across the country. It set out four broad objectives for achieving this:

1. Boost productivity, pay, jobs and living standards by growing the private sector, especially in those places where they are lagging
2. Spread opportunities and improve public services, especially in those places where they are weakest
3. Restore a sense of community, local pride and belonging, especially in those places where they have been lost
4. Empower local leaders and communities, especially in those places lacking local agency

2.4 Our Ambition

2.4.1 There are many opportunities to improve health where public health leadership sits within a Local authority. However there has been limited real evidence of gains to date because of this move, almost ten years ago, in any system across the country. Kent has the opportunity to significantly shift the dial, but this will require a bolder and more ambitious approach to what has been done historically.

2.4.2 Much work to date while of merit has expectedly had limited impact. Tier 2 weight loss services, the key tool in managing people who are overweight and obese reach around 3000 adults per year in Kent while over 600, 000 are overweight. Traditional commissioning models will not work in addressing very common wellbeing challenges such as obesity, low physical activity and loneliness

2.4.3 The RWJ model gives us a sense of where we need focus our work to deliver change. Securing progress does not in many areas sit within the public health team and success will require delivery of wider council and system-wide actions. “Framing Kent’s Future” with its key priorities of Levelling up, Infrastructure for Communities, Environmental Step Change and New Models

of Care and Support will help deliver improved public health outcomes. The focus on Levelling Up is particularly important as a way to tackle economic and educational challenges that are key underlying determinants of health.

2.4.4 We cannot deliver on improved public health outcomes alone – especially when dealing with intractable and wicked issues such as health inequalities, inequity and multifactorial issues like obesity, poor mental health, etc. All our key statutory and third sector partners and stakeholders have a role. This strategy is only likely to succeed when all partners understand and embrace it and play their part. This means that everyone must be engaged and own it and it must be supported by a single page output that people will ideally hold close to them.

2.4.5 While this paper will not "second guess" the contents of the strategy, a successful approach is likely to require several areas of progress. These would need to shift from traditional public health practice and commissioning to whole system action to tackle key challenges. These could include for example (list not exhaustive):

- Development of public sector anchors to deliver local social value in employment and procurement with particular focus on areas with higher unemployment and less job opportunities.
- Political and Officer Action at district and county level to secure increased public and private investment in employment in Kent and especially in areas with higher unemployment and less job opportunities.
- Accelerated work with communities based on our work to date including work with the Kent Association of Local Councils (KALC) to enable communities to identify and act on local issues. This could include at scale peer support for weight loss, movement to tackle loneliness, improved physical activity. Co-production and collaboration will be key.
- New commissioning models that are user led where possible.
- System-wide prevention across all aspects of people services, policies and practices, place, communities and growth.
- Enhanced links between health providers and community groups to enable more holistic assessment and interventions linked to social prescribing.
- New infrastructure developments to be planned with consideration to health and health impacts and opportunities for existing local communities.
- Optimal support in Early Years to ensure school readiness.

2.4.6 In order to play a full role in contributing to improving health and wellbeing, and tackling health inequalities and inequities in Kent, there will additionally be a need to repurpose and develop the Council's public health function. The ambition is to improve health in Kent at scale driven by a Centre of Excellence in Public Health developed in the council. Through delivery and action research Kent will become a major force in informing public health service

practice delivering demonstrable impact on reducing inequalities, examples of best practice, education and training, and research, innovation and improvement. This will involve enhanced approaches to partnership working, to systems solutions, to the role of communities and to new commissioning models.

2.5 Partnership and Stakeholders

2.5.1 To tackle the above factors requires the engagement of a wide range of stakeholders including (indicative list);

- **District and Boroughs**, as Anchor institutions, system leadership, around Lifestyles and around housing, planning and development including access to green spaces
- **NHS including the Integrate Care System ((ICS) Integrated Care Board (ICB) and Integrated Care Partnership (ICP)), and the four Kent ICP Health Care Partnerships,** as Anchor institutions, system and clinical leadership, around health and care services, and lifestyles as well as mental health
- **Parish and town councils** including Kent Association of Local Councils (KALC)
- **Communities**
- **Employers** (Chamber of Commerce)
- **Voluntary Sector**
- **Kent Police, OPCC**
- **Kent Count Council** - Growth, Economy and Transport, Children's services, Education, Adult Education, Adult social care, corporate role as an Anchor Institution
- **Academic partners** – University of Kent, Canterbury and Christchurch University, University College of London (Institute of Health Equity), National Institute of Health Research (NIHR), Health Education England (HEE)

2.6 Existing Priorities

2.6.1 Key to delivering the Strategy will be to identify shared and agreed priorities. We are not starting with a blank sheet. Most partners have already defined the areas that they feel are most important to health locally and that they wish to prioritise. Our starting point must be these agreed areas. These will be a balance of local priorities agreed by districts and boroughs as well as the national priorities defined by the NHS.

2.6.2 ICS has four key stated "purposes". These are Improving Population health and healthcare, Tackling Unequal Outcomes and Access, Supporting Broader Social and Economic Development and Enhancing Productivity and Value for Money. Below these, key priorities identified in work across the system are Mental Health and Areas of High Deprivation. It is also essential to understand local priorities agreed at District, Borough and Health Care Partnership level.

2.6.3 As discussed “Framing Kent’s Future” with its key priorities of Levelling up, Infrastructure for Communities, Environmental Step Change and New Models of Care and Support will help deliver improved public health. There are clear alignments between the ICS purposes and the KCC priorities around inequalities and Levelling Up and around new models of services.

2.6.4 The evolving public health strategy needs to recognise agreed priorities within the ICS and KCC and to embrace agreed County Council ambitions and priorities around Levelling up, Best Start in Life, Adult Social Care, Education, skills, and economic growth.

2.6.5 The Strategy will also help inform ICP thinking around tackling health inequalities through local flexibilities built into the national Core 20 plus 5[2] approach. There is flexibility to define local vulnerable and high-risk populations who would be subject to the identified areas of intervention. Additionally in Kent we plan to further expand the opportunity using a Core 20 plus 5 PLUS approach with additional focus on the “vital five” areas defined by the King’s Health Partnership. The additional PLUS will include reducing obesity, tobacco control and stopping smoking, identifying and improving poor mental health, and reducing alcohol dependency and other addictions.

2.6.6 We need to further consider what priorities might be informed by evidence, this will include both local epidemiological data with a focus on the impact on communities of the covid pandemic and qualitative data from the people and communities we serve. This will be further considered in the section below

2.7. Development of the Strategy

2.7.1 This will require:

- ✓ Partner engagement at District, Borough and Health Care Partnership level using existing organisational boards and groups where they exist
- ✓ Work with the ICS ideally through the existing and proposed system Health Inequalities groups (one health service and one wider focussed)
- ✓ Work with Communities including with KALC, Healthwatch and through the Council’s Engagement team
- ✓ Work with the voluntary sector
- ✓ Work with the Chamber of Commerce and SELEP (South East Local Enterprise Partnership)
- ✓ Work with OPCC and Kent Police

2.7.2 There will need to be full ownership and engagement with Kent County Council leadership colleagues around economic growth, children services, education and adult social care.

2.7.3 The work will benefit from analysis of epidemiological data and trends including:

[2] NHS England » Core20PLUS5 – An approach to reducing health inequalities

- Geographical variations
- Experience of vulnerable groups
- Impact of deprivation
- Impact of Covid

2.7.4 Analysis will need to be of relevance to key stakeholders including particularly at district and borough level.

2.7.5 Priorities will need to be shared and agreed.

2.7.6 Actions required by each organisation to deliver agreed improvement in the priority areas will be surfaced by partners with reference to the RWJ model. This will ensure that all the wider determinants that impact on health, identified by the RWJ model, where a partner may positively influence, are identified and actions agreed

2.7.7 An analysis of current policy and strategies, both national and local is being undertaken to best frame the wider policy context for the strategy. This is being led by the public health team and is considering a long list of over two hundred possible policy documents. These will be considered and those that are most key will be summarised within a detailed supporting paper. This will allow the new system public health strategy to be clearly framed within the local and wider strategic and policy context. This will help ensure alignment of opportunities and synergies, identify gaps and ensure duplication with existing strategies and actions.

2.7.5 The third planned input will be detailed qualitative data. There will be three elements to this:

- ✓ a population wide residents survey,
- ✓ a focussed listening campaign (Community Conversations)
- ✓ stakeholder workshops with key groups led by Healthwatch.

2.7.6 The process of Community Conversations has been used for this purpose elsewhere. The planned process would involve community connectors as well as key officers meeting with and listening to individuals and groups within Kent. This would involve pairing senior staff with community connectors and working in pairs meeting local people. It would be framed by workshops before and after the meetings and would take place after summer.

2.7. While it is likely that the agreement of priorities will be driven by existing partner thinking, there will be more discussion about what actions will be agreed that individual organisations and system partners will put in place to deliver agreed health improvement.

2.8 Proposed Process and Governance

2.8.1 Process

2.8.1.1 While the work above around defining policy context and seeking qualitative information progress, early informal discussions will take place with key partners to better understand their key issues, challenges, and priorities. An

operational delivery group and steering group (see governance section below) will be established including key partners at officer level to start to plan next steps.

2.8.1.2 A kick start event is then planned for system partners including elected leaders where the need for the strategy and the approach to its production will be discussed and agreed. This will be a listening event where all partners can share their aspirations and priorities for health in Kent.

2.8.1.3 Development of the strategy will include public consultation on the developed draft likely in early 2023 followed by formal adoption through each partners corporate mechanisms as appropriate. The strategy will also be proposed for adoption by the Kent Health and Wellbeing Board as the Joint Health and Wellbeing Strategy (JHWS). A draft proposed timeline detailing the process within KCC has been developed. This will be further refined over time to include dates when partners will be able to sign off as appropriate.

2.8.2 Structure

2.8.2.1 It is helpful to agree a framework in which priorities might be considered. This could helpfully embrace a life course approach as well as the Robert Wood Johnson Framework. Proposed themes, successfully used elsewhere, could frame a starting place to consider key agreed and evolving local priorities and key actions to address these.

2.8.2.2 The Framework might encompass:

People – Healthy children, healthy adults

Place – Economic growth and work, environment and communities

Policy and practice – System and partner approaches including anchor role, MECC and evidence- based action. HIAP, social value in contracts, workplace wellbeing (examples for anchor institution role)

2.9 Content

2.9.1 The proposal is to have a short, accessible Strategy document that would include a simple plan on a page. This would summarise key, themes, priorities, actions and targets.

2.9.2 The strategy would cover in broad outline

- Where we are now, with key health issues and challenges
- Vison and aspiration for the health of those we serve
- Key enablers and our approach Including subsidiarity, coproduction, partnership, digital, evidence based, community led and delivered
- How we will get there~ Themes, Priorities, Outcomes and Supporting Actions
- How we know we will be on track with key performance indicators

2.10 Strategic Environment

2.10.1 The public health strategy for Kent will be delivered within a system that is already benefitting from a raft of strategies. These will include local organisational strategies, system wide strategies and indeed national strategies. It is essential that this strategy does not duplicate the work being undertaken to deliver these strategies nor supplant them nor create additional delivery mechanisms where these already exist. It will however need to ensure that all areas identified as priorities and the key strategic actions agreed to tackle these are addressed somewhere within the system.

2.10.2 It is important too to recognise that imperative within the NHS that ICS develop Integrated Strategies by December 2022. This sets an external target within the system by when we need to be able to usefully input to that document the evolved considerations falling from the developing Kent Public Health Strategy. It is recognised that this will be prior to any public consultation or sign off of the strategy.

2.11 Governance

2.11.1 The Kent system is complex with county and district organisations as well as a new NHS structure with an ICS footprint covering both Kent County Council and Medway Unitary Council. There is more thought needed around governance and delivery within the Kent County system and the right balance of workload between the ICS and the Health Care Partnerships. It is likely that some actions within the strategy will require leadership at ICS and County level and others at Partnership and District/Borough level.

2.11.2 There also needs to be close working with Medway to inform both the ICS Strategy and the work of the Health Care Partnership covering Medway and Swale

2.11.3 Consideration is needed as to the role of the Kent Health and Wellbeing Board and the ICP in overseeing this strategy although it is likely that the new ICP may discharge many elements of the Kent HWB responsibilities around overseeing delivery of the agreed strategy. The Kent System Public Health Strategy proposed will also be the Kent Joint Health and Wellbeing Strategy.

2.11.4 The work will be overseen by a Steering group chaired by the DPH. This will include Senior KCC Directors, District and borough CEOs and ICP executives. It will report to the Health Inequalities, Improvement and Population Health Committee of the ICB and to the ICP.

2.11.5 The Steering Group will be supported by an operational delivery group with representatives from each DC/BC, ICS and Healthcare partnerships, OPCC, VCS and Kent CC officers in GET, ASC and Children services, Strategy, communications and public health. This group will meet fortnightly.

3. Financial Implications

3.1 There are no direct financial implications to this paper although the developing strategy will likely make recommendations that may have

implications around future use of public health, county council and wider system resources.

4 Legal implications

4.1 There are no legal implications in developing this strategy.

5. Equalities implications

5.1 The proposed strategy will have a strong focus on addressing inequalities in health which in turn are driven by inequalities in opportunity, education and socio-economic factors. The strategy will specifically focus on vulnerable groups and those with protected characteristics as well as geographical inequalities. Development will involve engaging particular vulnerable groups including using Healthwatch.

6. Other corporate implications

6.1 There is a real challenge, that no council over the last decade, has fully tackled how best to optimise the impact of public health within a Local Authority. The Strategic Approach proposed recognises the key importance of wider determinants in impacting on health including economic growth, parenting and school readiness, education, social support, community safety, housing and infrastructure, and lifestyle choices. It is expected therefore that this strategy will have implications for the wider council and our role together in optimally improving public health.

7. Governance

7.1 Adoption of the Strategy by KCC will be via Key Decision, in accordance with the Decision-making rules set out in the Constitution. The development of the Strategy, as per the details in this paper, will be administered by relevant senior officers, in consultation with the Cabinet Member as required.

7.2 Details of the required processes for approval or adoption of the Strategy by other agencies and partners will be outlined once the Strategy is finalised and prepared for adoption by KCC and this will be clarified in relevant committee and decision reports at that stage.

8. Conclusions

8.1 The health of the people of Kent is not improving in the way we would want it to. There is a stalling of improving life expectancy, levels of inequity in health across geographies and vulnerable groups, high levels of unhealthy lifestyles and increases in many upstream wider determinants of health.

8.2 There is therefore a strong case for a new system-wide approach to tackling public health with a strong focus on addressing wider determinants in place. The Robert Wood Johnson model is a helpful starting point defining the importance and contribution of different socio-economic, lifestyle, clinical and environmental determinants of health.

8.3 A new strategic approach would require all partners to understand and play a full part in tackling those key priority areas in which they can make a difference. This would include all Council directorates.

8.4 A process is described to develop the strategy with wide ownership of partners, building on work undertaken across the system to date and existing partner and system priorities supported by a robust public health approach.

8.5 The evolving strategy would inform the Integrated Care System Strategy and would become the Joint Health and Wellbeing Strategy for Kent.

9. Recommendation:

9.1 The Cabinet Committee is asked to **CONSIDER**, **COMMENT** on and **ENDORSE** the development of a Kent Public Health Strategy as outlined in the report.

10. Contact details

Report Author: Mike Gogarty
Name and job title: Interim Pubic Health Consultant
Telephone number: 07594985620
Email : mike.gogarty@kent.gov.uk

Relevant Director: Anjan Ghosh
Name and job title :Director of Public Health
Telephone number
Email : Anjan.ghosh@kent.gov.uk