KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Darent Room, Sessions House, County Hall, Maidstone on Friday, 30th June, 2017.

PRESENT: Mr G Lymer (Chairman), Mrs C Bell (Substitute for Miss C Rankin), Mrs P T Cole (Substitute for Ms D Marsh), Mr A Cook, Mr D S Daley, Miss E Dawson, Mrs L Game, Ms S Hamilton, Mr S J G Koowaree, Mr K Pugh, Mrs P A V Stockell, Dr L Sullivan and Mr I Thomas

OTHER MEMBERS: Paul Carter, CBE and Peter Oakford

OFFICERS: Andrew Scott-Clark (Director of Public Health) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

2. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Ms D Marsh and Miss C Rankin.

Mrs P T Cole was present as a substitute for Ms Marsh and Mrs C Bell as a substitute for Miss Rankin.

3. Election of Vice-Chairman.
(Item. 3)

Mrs P T Cole proposed and Mr K Pugh seconded that Mrs P A V Stockell be elected Vice-Chairman of the Cabinet Committee. There being no other nominations, this was *agreed without a vote.*

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

1. Mrs L Game declared an interest as the Chairman of a Thanet District Council advisory group working on the Queen Elizabeth the Queen Mother Hospital Sustainable Transformation Plan programme and the East Kent Hospital Trust programme.

2. Mrs P T Cole declared an interest as a Director of a Healthy Living Centre in Dartford.

5. Minutes of the meeting held on 25 May 2017.
(Item. 5)

RESOLVED that the minutes of the inaugural meeting of the Cabinet Committee on 25 May are correctly recorded and they be signed by the Chairman. There were no matters arising.

6. **Introduction to Public Health - presentation by the Director of Public Health.**
(Item. 7)

1. The Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health, Mr P J Oakford, welcomed the establishment of a Cabinet Committee dedicated to Public Health and the Health Reform agenda, as both areas were very important to the work of the County Council.

2. The Director of Public Health, Mr A Scott-Clark, presented a series of slides *(included in the agenda pack)* which outlined the County Council's statutory role as a public health authority, the breadth of the public health role and the variety of campaign activity undertaken each year to tackle such issues as health improvement, health inequalities and life expectancy across Kent.

3. Concern was expressed that the Sustainability Transformation Plan (STP) may prove not to be sustainable, being a 'wish list' which could not be resourced or staffed, given long-standing resource pressures in primary care and across the NHS. The Health Reform and Public Health Cabinet Committee could perhaps look to see what help it could give to implement the STP, but there was concern was that it might prove to be too late.

4. RESOLVED that the presentation be noted.

7. **Verbal Update by the Leader and Cabinet Member for Traded Services and Health Reform.**

1. Mr P B Carter also welcomed the establishment of the new Cabinet Committee and expressed the view that this was long overdue, after several years of struggle to build good governance around health issues via the Health and Wellbeing Board, the Health Overview and Scrutiny Committee and work with Clinical Commissioning Groups (CCGs) to deliver better health outcomes for the people of Kent. It was important to raise the profile of the vital work the County Council was doing with its NHS and district council partners.

2. He gave a verbal update on the progress of the STP's work streams and its role in integrating social care and hospital care. STPs had evolved from the NHS Five Year Forward Plan published in 2014 as a necessary way of driving forward change. There were 44 STPs across England.

3. The quality of Kent's STP had been praised by the CEO and Board of NHS England as being a vehicle to achieve good local care (previously called 'out of hospital care') and primary care. Approximately one third of hospital beds were occupied by people who should be able to move elsewhere, but lack of suitable placements for them to move into was an historic problem. Health services in Kent and Medway were known to overspend by some £120m per year.

4. The STP had been drafted and agreed and was now being implemented via a Programme Board, with a 2 – 4 year action plan. Work streams of the STP had been built on pioneering work on commissioning done by the Whitstable Medical Practice. Progress was currently good, and he and Peter Oakford, Andrew Scott-Clark and Andrew Ireland all served on the STP Programme Board, which undertook a monthly deep-dive exercise. Additional funding had been secured from NHS England and Mr Carter was determined that this be used to support

recruitment, reduce hospital admissions and cut delays in discharging patients to step-down services or to their own homes.

5. He said he hoped the work streams emerging from this STP work could be explored in detail at future meetings of the Cabinet Committee.

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

8. Agenda item 8 - considering exempt information.

The Chairman asked Members if, in debating this item, they wished to refer to the exempt appendix which accompanied agenda item 8, and if they wished to pass a motion to exclude the press and public from the meeting. Members confirmed that they did not wish to refer to the exempt information and discussion of the item was thus able to take place in open session.

9. 17/00065 - Public Health Transformation Programmes.
(Item. 8)

Ms K Sharp, Head of Commissioning Transformation, Mr V Godfrey, Strategic Commissioner, and Mr G Singh, County Council Barrister, were in attendance for this item.

1. Mr Godfrey introduced the report and explained the rationale for the way forward which was being proposed and for which the committee's support was being sought. He assured the committee of the past and ongoing excellent performance across a range of services of the key strategic partner, Kent Community Health NHS Foundation Trust (KCHFT), with whom the County Council was proposing to enter into contractual arrangements prior to reviewing its commissioning plans in 2020.

2. Ms Sharp added detail of the transformation programme and reiterated the good relationship KCHFT had with the County Council and the confidence with which the proposals were being put to Members for their support. Previous contracting activity with KCHFT had been reported to and supported by the former Adult Social Care and Health Cabinet Committee. Ms Sharp emphasised that the new organisational arrangements would allow flexibility through a period in which the market would be changing in response to the STP and would allow the County Council to focus on implementing the STP. She assured Members that the County Council would retain the ability to give notice to the provider, if performance were to fail to reach the required standard, and to re-trigger the procurement process if necessary.

3. Ms Sharp responded to comments and questions from Members, including the following:

a) performance measures, required outcomes and the method used to monitor these would all be clearly set out in the contractual arrangements and would be rigorously enforced;

b) the provider's performance would be measured against a series of five developmental checks, with performance targets being linked to

payment. Any underperformance by a provider would attract a financial penalty, as part of the conditions built into the contract;

c) in response to a concern that performance indicators measured the number of checks made rather than the quality of those checks, Ms Sharp explained that the County Council had a statutory duty to measure and report the number of checks made in each quarter but would also monitor the quality of those checks and, in addition, would seek to find out the reasons for any parent not taking up the opportunity to have checks done. Developmental checks were a vital way by which a health visitor could make contact with and get to know a family and this relationship could be a way of identifying other issues with which new parents or the wider family might need support. The health visitor service had capacity to undertake more than the 60,000 visits per year currently being made; and

d) current work to closer integrate health and social care services was welcomed, and the significant role of GPs in this process was emphasised. However, surgeries were under much pressure and it was vital that they receive support to maintain their role.

4. Mr Carter thanked Members for their comments and agreed with the need to invest in and support good local care and support GPs' surgeries. Workforce issues in the NHS presented a major challenge, and more doctors needed to be encouraged to become GPs. In an era characterised by austerity, investment in the health visitor service had in fact doubled.

5. RESOLVED that the decision proposed to be taken by the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health, to authorise the County Council to enter into contractual arrangements with Kent Community Health NHS Foundation Trust, pursuant to the relevant exemptions in the Public Contract Regulations 2015, for (i) NHS Health Checks, (ii) the National Childhood Measurement Programme, (iii) open access sexual health services, (iv) Public Health advice to NHS clinical commissioning groups, (v) provision of health protection advice and information and (vi) universal health visitor reviews at five key developmental stages, be endorsed.

10. Health Visiting Service Transformation.
(Item. 9)

Mr M Gilbert, Interim Head of Public Health Commissioning, and Ms C Winslade, Acting Consultant onPublic Health, were in attendance for this item.

1. Mr Gilbert introduced the report and corrected a reference made in the report to the community infant feeding service, advising the committee that this service was not yet integrated into the health visitor service and could not be so until the proposed move had been the subject of public consultation. Ms Winslade added that the aims of the programme were to fully integrate services and deliver savings and Mr Gilbert emphasised that the public health transformation programme, discussed in the previous agenda item, underpinned the proposed changes in all individual services. Mr Scott-Clark added that, in the STP, work planned for

children's services had yet to start. He emphasised the importance of the health visitor service as a vital link between the County Council's public health role and GPs.

2. Mr Gilbert, Ms Winslade and Mr Scott-Clark responded to comments and questions from Members, including the following:-

a) the quality of the health visitor service was measured using a number of indicators, including the high satisfaction rates reported by service users. Public consultation in 2015 had asked people what they most valued in such a service;

b) a Member of the committee who had recently used the health visitor service reported the good experience she had had of it and supported its further development and growth;

c) a detailed time study undertaken of the health visitor service as part of a piece of work to identify the capacity of the service could be supplied to Members outside the meeting or could be brought back to a future meeting of the committee;

d) the quality of housing was known to be a major factor in determining a person's health, and work with district councils was being planned to improve the quality of housing by using a selective licensing scheme;

e) concern was expressed that some troubled families may not be willing to admit a health visitor to their home and thus may slip through the net, missing out on vital support that they much needed. Work with vulnerable families was starting in some areas of the county, and, it was hoped, would be extended to cover the whole county;

f) concern was expressed that the development of the health visitor service would need to be sustainable. The service was already good, but in the face of any future reductions in funding, it would need to be able to sustain its performance; and

g) the move to place health visitors in children's centres was welcomed and the roll-out of this model across the whole county was supported. Mr Gilbert explained that the project had started at the Ashford Children's Centre as the premises leant itself most easily to adaptation, and it was hoped that the joint arrangements there would be up and running by September 2017. The timescale and capacity to roll this out to all children's centres had been difficult to identify, and it might be that not all centres had space to accommodate the health visitor service, although it was hoped this could be achieved, where possible, in the next twelve months or so.

3. Mr Oakford commented that, in his previous role as the Cabinet Member for Specialist Children's Services, he had visited children's centres across the county and met mothers and health visitors, so knew what an excellent service they delivered in supporting new mothers. From these visits he had learned that children's centres staff went door-to-door and distributed leaflets to encourage young parents to come to their local centre.

4. RESOLVED that the progress on the Health Visiting Transformation Programme be noted.

11. 17/00057 - Kent Drug and Alcohol Strategy 2017-2022.
(Item. 10)

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

1. Mr Scott-Clark and Ms Mookherjee introduced the item and explained that the presentation of the Strategy to the new Cabinet Committee was the culmination of much work, previously reported to the Adult Social Care and Health Cabinet Committee, and successful projects. As the complexity and pattern of drug and alcohol use had changed - for example, regular users of drugs were now in an older age bracket, and health conditions arising from long-term drug use were starting to appear, making treatment more complex - joint working with partners to develop the strategy had increased. Ms Mookherjee responded to comments and questions from Members, including the following:-

a) the reduction in drug and alcohol use by children and young people was welcomed, but concern expressed that the temptation of 'legal highs' was still a danger among young people. Ms Mookherjee explained that service providers working with young people reported that the general quality of drug education needed to be improved, and that young people knew more about the subject than the adult trying to advise them. It was hoped that a scheme of peer mentors could be established, in which young people could advise other young people about the dangers of substance misuse;

b) in response to a concern that the price of drugs had reduced, Ms Mookherjee explained that police efforts were focussed on catching suppliers of drugs and disrupting supply;

c) a view was expressed that users may move away from illegal to legal drugs, which were hopefully better controlled; and

d) concern was expressed about people starting to use drugs while in prison, how such drugs were being obtained within the prison service and the realistic scope to control this use.

2. RESOLVED that the decision proposed to be taken by the Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health, to approve the Kent Drug and Alcohol Strategy 2017 – 2022, be endorsed, noting that a full delivery plan will be available in August 2017.

12. Public Health Communications and Campaigns Update.
(Item. 11)

Mr W Gough, Business and Policy Manager, was in attendance for this item.

1. Mr Gough introduced the report and emphasised the value of campaigns as a key part of the preventative agenda, using a range of media and a flexible approach. Displayed in the meeting room was a selection of materials from current

campaigns, including 'Change 4 Life' and 'Release the Pressure'. These campaigns, targeting various aspects of health and wellbeing, were all part of the overall approach to public health. Campaign activity in 2016/17 and 2017/18 so far had been very successful, with the 'Release the Pressure' campaign having won an award and attracted the attention of other local authorities, including the City of London, who viewed it as an example of best practice which they could use and adapt. The County Council worked closely with its health and district council partners to spread its campaigns across the county, using a range of media to reach people in their everyday lives.

2. Mr Gough responded to comments and questions from Members, including the following:-

a) the extent of the work put into campaigns, and the success of them, was praised. It was a challenge to identify and keep pace with changing patterns of behaviour among age groups and sections of society, for example, consumption of alcohol among teenagers had reduced but other issues such as smoking and obesity had replaced alcohol as a concern among this age group. Accordingly, it was important to address this and establish healthy habits with young people as early as possible, liaising with schools and being frank about the resultant risks in later life. Young people had fed back that they appreciated a frank and clear message. Mr Scott-Clark explained that the school nursing service and the 'healthy schools' initiative had recently been re-commissioned and the model for these services was evolving. In addition, PHSE lessons had been reinstated in the school curriculum. However, the biggest risk to young people's health was unhealthy behaviours learnt from parents, and this could be addressed by the Headstart service;

b) asked about how the need for a campaign would be identified, and how its effectiveness would be monitored, Mr Gough explained that 'Release the Pressure' and 'Know Your Score' had emerged from work on the County Council's Suicide Prevention Strategy and Alcohol Strategy, respectively, the Kent Health and Wellbeing Board Plan had identified the need for interventions on smoking in pregnancy, which had led to the 'What the Bump?' campaign, while 'One You' and 'Change 4 Life' were national campaigns which had been adapted for use in Kent;

c) asked how the 'Change 4 Life' campaign, which seemed to have lapsed, could be reactivated, Mr Gough explained that work was going on to support children's centres to promote the Change 4 Life messages in Kent. Mr Scott-Clark added that campaigns would naturally have peaks and troughs of activity as they appeared as fresh new campaigns and then became more familiar, and keeping up interest levels over a longer period of time was a challenge. Taking advantage of key days and events in the year, for example National No Smoking Day and Stoptober, gave an opportunity to remind people of a campaign;

d) the 'House' project which ran 8 – 9 years ago across Kent had been effective in relating to young people and could be resurrected. The County Council could attract marketing and public relations companies to help with rejuvenating the project, perhaps by running a competition. A similar project

was still running on the Isle of Sheppey and was much used by young people, as was a similar project in Sevenoaks;

e) the value of PHSE lessons in tackling health and lifestyle issues with young people was supported. Research by behavioural scientists and psychologists had shown the value of establishing and reinforcing good habits early in life. *Members could be given a briefing on this subject at a future meeting*;

f) the upbeat, positive tone of the report was welcomed, and the development of further campaigns supported. However, surely it was important to emphasise that the long-term use of e.cigarettes was just as addictive as the use of traditional tobacco products. Mr Scott-Clark clarified that, although e.cigarettes contained no cancerous chemicals or carcinogens, the public health message was that their use should be short-term only, as part of the process of quitting smoking altogether. E.cigarettes had been shown to be a better aid to quitting than prescribed nicotine-reduction therapy, and vaping shops operated within an ethical code of practice, refusing to sell nicotine-containing products to anyone not already a smoker. Smoking had historically had a huge impact on the NHS but had seen a large reduction recently as a result of the popularity of e.cigarettes; and

g) much use was made of social media to reach young people, and the campaigns website had recorded 100,000 visits during 2016. Usage figures included the time of day at which the site had been accessed, allowing campaigners to build up a detailed picture of patterns of use.

3. RESOLVED that the progress and impact of the public health campaigns in 2016/17 be noted and welcomed and the key developments planned for 2017/18 be endorsed.

13. Performance of Public Health Commissioned Services.
(Item. 12)

Mr M Gilbert, Interim Head of Public Health Commissioning, was in attendance for this item.

1. Mr Scott-Clark and Mr Gilbert introduced the report and explained that future reports would show separately two areas of monitoring activity – monthly performance and action relating to the annual Public Health Observatory Framework (PHOF). Performance had been generally good, and providers had a requirement built into their contract that they optimise performance.

2. Mr Carter added that future reports would include the impact of the STP and suggested that the next meeting of the Cabinet Committee could discuss which issues Members wanted to monitor, to make the performance monitoring function meaningful.

3. RESOLVED that the Quarter Four performance of public health-commissioned services be noted, and the proposed selection of key performance indicators (KPIs) to be included in future performance reports for the committee, and the split in reporting between performance of the

public health-commissioned services and public health outcomes, as described in the Public Health Outcomes Framework, be agreed.

14. The Kent Integrated Dataset.
(Item. 13)

Mr G Abi-Aad, Head of Health Intelligence, was in attendance for this item.

1. Mr Abi-Aad presented a series of slides (not included in the agenda pack) which set out the work and structure of the Public Health Observatory (PHO) and the data it generated. The Kent Integrated Dataset (KID) was part of the PHO's work and allowed data from different sources to be brought together and used for a range of strategic purposes, including monitoring of services, for example NHS health checks. Most of the data in the KID was generated by the NHS. The PHO also undertook deep-dive studies, for example on childhood obesity.

2. Mr Scott-Clark explained how the KID related to the Dahlgren and Whitehead model used to explain the role of public health, as set out in item 7 of the agenda (Minute 6, above). Kent's Integrated Dataset had been identified as an example of best practice and many other local authorities sought to copy it. STP consultants had also praised Kent's ability to analyse data once collated.

3. Mr Scott-Clark and Mr Abi-Aad responded to comments and questions from Members, including the following:-

a) asked who held children's health data, and how well protected this was, Mr Scott-Clark explained that the County Council was the data holder for Specialist Children's Services and Adult Social Care data;

b) asked what would happen if people did not want to 'opt in' to have their data included in the KID, Mr Abi-Aad explained that every patient had the right to request that their data be segregated and not used, but this provision was to be reviewed. Mr Scott-Clark assured Members that data used was always anonymised and would be related to local areas but not to a level at which an individual's address could be identified. Providers already shared some data on a regular basis, for example for safeguarding purposes;

c) concern was expressed that, although data was pseudonymised before sharing, the full data was lodged somewhere on an IT system and could be vulnerable to cyber attack. Mr Scott-Clark reassured Members that the County Council would always mitigate against cyber attack and its data handling procedures complied with Information Governance Standards and NHS Digital guidelines for data security . Mr Abi-Aad explained that the County Council did not have the scope to re-identify any pseudonymised data collated by the NHS and would only ever have access to the pseudonymised version; and

d) concern was expressed that, the more people chose to opt out of having their data added to the KID, the less accurate the data would be, overall, but Mr Abi-Aad explained that only a small number of people chose to opt out and that these numbers were monitored and could be 'adjusted' for.

4. RESOLVED that:-

a) the progress to date on the development of the KID and the opportunities this provides for the County Council and Kent public service partners be noted;

b) the KID become the underpinning dataset upon which County Council strategic commissioning decisions and planning are based;

c) the need to speed up progress on ensuring County Council datasets flow into the KID, and that the Strategic Commissioner will co-ordinate this be noted; and

d) that the County Council support the system-level governance of the KID through the NHS Sustainability Transformation Plan/Partnership governance arrangements.

15. Work Programme 2017/18.
(Item. 14)

RESOLVED that the Cabinet Committee's work programme for 1027/18 be noted.

Mr Oakford advised Members that an agenda setting session for the committee's next meeting would usually take place on the rising of the main meeting but that this had not proved possible on this occasion. A date for an agenda setting would be set and announced to Members later. *POST MEETING NOTE: An agenda setting subsequently took place on 25 July.*