HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 17th September, 2024

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 17 September 2024 at 2.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Kay Goldsmith**
Telephone: **03000 416512**
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Membership (17)

Conservative (12): Mrs L Game (Chair), Mr P Cole (Vice-Chairman), Mr D Beaney, Mrs P T Cole, Ms S Hamilton, Mr A R Hills, Mr A Kennedy, Mr J Meade, Mrs L Parfitt-Reid and Ms L Wright and 2 vacancies

Labour (2): Ms K Constantine and Ms K Grehan

Liberal Democrat (1): Mr R G Streatfeild, MBE

Green and Independent (2): Ms J Hawkins and Vacancy

UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Apologies and Substitutes

3 Declarations of interest by Members on items on the Agenda for this meeting

4 Minutes of the meeting held on 2 July 2024 (Pages 1 - 6)

5 Verbal updates by Cabinet Member and Director

6 Public Health Performance Dashboard - Quarter 1 2024/25 (Pages 7 - 14)

7 Strategic indicators report - Kent and Medway Integrated Care Strategy (Pages 15 - 48)

8 Public Health Communications and Campaigns update (Pages 49 - 56)

9 Update on Gypsy Roma Traveller health, including child immunisations and suicide prevention (Pages 57 - 62)

10 Public Health and Adult Social Care joint working on prevention (Pages 63 - 68)

11 Kent Weight Management Strategic Action Plan (Pages 69 - 112)

12 Public Health Service Transformation and Partnerships (Pages 113 - 126)

13 Work Programme (Pages 127 - 130)

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
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Monday, 9 September 2024

KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Health Reform and Public Health Cabinet Committee held in the on Tuesday, 2 July 2024.

PRESENT: Mrs L Game (Chair), Mr P Cole (Vice-Chairman), Mr D Beaney, Mrs P T Cole, Ms K Grehan, Ms S Hamilton, Ms J Hawkins, Mr A R Hills, Mr J Meade, Mrs L Parfitt-Reid and Ms L Wright

ALSO PRESENT: Mr D Watkins

IN ATTENDANCE: Dr A Ghosh (Director of Public Health) and Ms H Savage (Democratic Services Officer)

UNRESTRICTED ITEMS

322. Apologies
(Item 2)

Apologies were received from Mr Richard Streatfeild MBE.

Mr Beaney, Ms Grehan, Mr Hills, Ms Hawkins, Ms Hamilton and Ms Wright were in attendance virtually.

323. Declarations of Interest
(Item 3)

There were no declarations of interest.

324. Minutes of the meeting held on 15 May 2024
(Item 4)

RESOLVED that the minutes of the meeting held on 15 May 2024 were a correct record and that they be signed by the Chair.

325. 24/00058 - Nurturing little hearts and minds: a perinatal mental health and parent-infant relationship strategy
(Item 5)

Ms Wendy Jeffreys (Consultant in Public Health) and Dr Anjan Ghosh (Director of Public Health) were in attendance for this item.

1. Dr Ghosh indicated that items 5 and 6 of the agenda could be dealt with in quick succession as they both related to the ongoing Family Hub programme and the Public Health element, Start for Life.

2. Ms Wendy Jeffreys introduced the report and confirmed that:

    - The strategy had been out for public consultation and cocreation with the public and stakeholders, as required by the Department of Education (DFE).

    - The key themes for Nurture Little Hearts and Minds were featured in the circulated report. The responses to the consultation and Equality Impact Assessment had also been provided to members.

RESOLVED to endorse the Cabinet Member for Adult Social Care and Public Health's proposed decision to:

(a) Adopt the co-created strategy in regard to low to moderate perinatal mental health and parent-infant relationships, as detailed in the report.

(b) Delegate authority to the Director of Public Health to take necessary actions, including but not limited to, allocating resources, expenditure, entering into contracts and other legal agreements, as required to implement the decision.

326. 24/00057 - Nourishing our next generation: a 5-year infant feeding strategy
(Item 6)

Ms Wendy Jeffreys (Consultant in Public Health) and Dr Anjan Ghosh (Director of Public Health) were in attendance for this item.

1. Ms Jeffreys introduced the report and confirmed that the strategy was out for public consultation at the same time as item 5, allowing the public to respond to either strategy, or both.

2. Ms Jeffreys provided the following update:

    a. Since the agenda was published, colleagues within the local maternity neonatal system (part of the integrated care system within Kent and Medway) had taken the Infant Feeding Strategy through their ICB (Integrated Care Board) Strategy Policy and Planning Group and the following changes had been proposed:

        i. On page 23 of strategy replace with: *each maternity and neonatal service to have an infant feeding team with sufficient time and expertise provide additional support in hospital and at home until discharge including with the unique challenges faced by mothers with babies on the neonatal unit*.

ii. The request for this change was down to the strategy being for a duration of 5 years and there was an expectation that neonatal commissioning would move from NHS England to the Integrated Care Board.

iii. On page 25 replace with: *review accessibility of tongue-tied division clinics for families.*

iv. This change was required as this was a specialised procedure and they wanted to ensure public expectation was maintained as this was not available in every clinic.

b. The strategy refers to the *draft* of the Integrated Care Strategy but should refer to the Integrated Care Strategy.

3. The ICB confirmed that they wished to submit a statement in support of the proposed feeding strategy to accompany Dr Ghosh's statement.

4. Ms Jeffreys responded to a question from the Chair and confirmed that some changes had been suggested by the ICB since the report was published.

5. Mr Watkins commented that the proposed changes were relatively minor and the public consultation provided a positive reception.

6. Dr Ghosh confirmed that, although the proposed changes were minor, they future proofed the strategy. He explained that commissioning within the NHS was going to be delegated to the ICB (Integrated Care Board) and the language used in the proposed changes would allow for this adaptation.

RESOLVED to endorse the Cabinet Member for Adult Social Care and Public Health's proposed decision to:

(a) Adopt the Infant Feeding Strategy, 'Nourishing our next generation.'

(b) Delegate authority to the Director of Public Health to take necessary actions, including but not limited to, allocating resources, expenditure, entering into contracts and other legal agreements, as required to implement the decision

327. 24/00056 - Kent Young Persons Drug and Alcohol Contract Commissioning
(Item 7)

Ms Victoria Tovey (Assistant Director of Integrated Commissioning), Ms *Rebecca Eley (Senior Commissioner - Integrated Commissioning) and Dr Anjan Ghosh (Director of Public Health) were in attendance for this item.*

1. Dr Ghosh introduced the report and confirmed that this item and item 8 both related to the spectrum of the drugs and alcohol service.

2. Dr Ghosh stated that these were significant services in the county and were commissioned in a mixed way; the bulk being commissioned by the core public health grant and other parts commissioned by new money from the Government, being part of the Dame Carol Black review and national strategy.

3. Ms Eley presented the report which set out the need to recommission all three Kent Community Drug and Alcohol Services, as part of the Public Health Service Transformation Programme and highlighted the key points to Members.

4. In response to a member's question concerning 1.9 of Appendix B of the report, Ms Eley confirmed that the prevention of vaping was also a priority for commissioners and would be explored further in collaboration with young persons' services.

5. In response to a member's question regarding the mention of extended services and changes included on page 303 of the report, Ms Tovey confirmed that the report set out the changes and enhancements of the services which followed the National Institute for Health and Care Excellence (NICE) guidelines. She commented that the key elements of the service and how they operate would be similar.

6. Ms Eley explained that the changes were proposed however there would be collaboration with stakeholders and providers.

7. Mr Watkins drew Member's attention to the summary outlined on page 313 of the agenda pack which set out the list of changes.

RESOLVED to endorse the Cabinet Member for Adult Social Care and Public Health's proposed decision to:

a) Approve the procurement and award of a contract for the Kent Young Persons Drug and Alcohol Service effective from 1 February 2025 to 31 January 2027 (two years with two additional extension options, one for two years and the second for one year)

b) Delegate authority to the Director of Public Health to take relevant actions, including but not limited to, entering and finalising the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

c) Delegate authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract.

d) CONFIRM that future Office for Health Improvement and Disparities (OHID) grant funding (if received) be deployed against this area of work in accordance with key decision 22/00041.

328. 24/00055 - Kent Adult Drug and Alcohol Treatment Contracts - re-commissioning
(Item 8)

Ms Victoria Tovey (Assistant Director of Integrated Commissioning), Ms Rebecca Eley (Senior Commissioner - Integrated Commissioning) and Dr Anjan Ghosh (Director of Public Health) were in attendance for this item.

1. Ms Eley introduced the report and highlighted additional points which had not already been covered under item 7.

2. Ms Tovey confirmed the recommendations of how to take the recommissioning model forward were set out in the report.

3. In response to a member's question concerning 1.4 in Appendix B, Ms Eley explained that in East Kent, the service was supporting research on the use of technology within Naloxone (an antidote to an opiate overdose), which is looking at how technology could assist, for example: the practicalities of the immediate alert of emergency services once a Naloxone seal was broken.

RESOLVED to endorse the Cabinet Member for Adult Social Care and Public Health's proposed decision to:

a) Approve the procurement and award of contracts for the East and West Kent Community Drug and Alcohol Services effective from 1 February 2025 to 31 January 2029 (four years with two additional two-year extension options),

b) Delegate authority to the Director of Public Health to take relevant actions, including but not limited to, entering into and finalising the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

c) Delegate authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract.

d) Confirm that future Office for Health Improvement and Disparities (OHID) grant funding (if received) be deployed against this area of work in accordance with key decision 22/00041

329. Public Health Performance Dashboard - Quarter 4 2023/24
(Item 9)

Dr Ghosh (Director of Public Health) and Ms Victoria Tovey (Assistant Director of Integrated Commissioning were in attendance for this item.

1. Dr Ghosh and Ms Tovey introduced the performance report for Quarter 4 2023/24. Ms Tovey confirmed there were 10 green indicators and 5 amber and highlighted the key points included in the paper, including a date reporting issue (contained in 3.2 of the paper).

2. In answer to a Member's question, Ms Tovey explained that several of the KPIs (Key Performance Indicators) presented to the committee were mandated, nationally reported and published. She explained that Integrated Services monitored many different areas but the KPIs were there to hone, refine and focus the committee on a revised set of indicators for the services.

3. Dr Ghosh commented that the first level of accountability for the indicators was Mr Watkins, but as a service they would look to continue to bring any items that Members wished to know about and which related to the committee.

RESOLVED to note the performance of Public Health commissioned services in Q4 2023/2024 and the proposed KPI target changes for 2024/2025.

330. Work Programme
(Item 10)

RESOLVED to note the work programme.

From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Health Reform and Public Health Cabinet Committee – 17 September 2024

Subject: **Performance of Public Health Commissioned Services (Quarter 1 2024/2025)**

Classification: Unrestricted

Previous Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Is the decision eligible for call-in? *N/A*

Summary: This paper provides an overview of the Key Performance Indicators for Public Health commissioned services. In the latest available quarter, April to June 2024, of 14 Red Amber Green (RAG) rated Key Performance Indicators, four were Green, three Amber, and two Red. Five Key Performance Indicators were not available at the time of writing this report. These are detailed below:

- Number of people successfully completing drug and/or alcohol treatment of all those in treatment
- Number of adults accessing structured treatment substance misuse services
- Number of all new first-time patients receiving a full sexual health screen (excluding online referrals)
- Participation rate of Year R (4–5 year olds) pupils in the National Child Measurement Programme
- Participation rate of Year 6 (10–11 year olds) pupils in the National Child Measurement Programme.

Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the performance of Public Health commissioned services in Q1 2024/2025.

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1. Introduction

1.1 A core function of the Health Reform and Public Health Cabinet Committee is to review the performance of services that fall within its remit.

1.2 This paper provides an overview of the Key Performance Indicators (KPI) for the Public Health services commissioned by Kent County Council (KCC) and includes the KPIs presented to Cabinet via the KCC Quarterly Performance Report (QPR). Appendix 1 contains the full table of KPIs and performance over the previous five quarters. This table includes benchmarking (England, region, nearest neighbour) where available.

2. Overview of Performance

2.1 Of the 14 targeted KPIs for Public Health commissioned services, four achieved the target (Green), three were below target although did achieve the floor standard (Amber), and two were below target and did not achieve the floor (Red). The red KPIs are:

- Number of mothers receiving an antenatal contact by the health visiting service
- Number of clients currently active within One You Kent services being from the most deprived areas in Kent

3. Health Visiting

3.1 In Q1 2024/2025, the Health Visiting Service delivered 16,391 mandated universal health and wellbeing reviews, slightly lower than the previous quarter (16,587). In this quarter, the service delivered 66,724 (86.7% of those due) mandated health and wellbeing reviews (12 month rolling), slightly lower than the same quarter of the previous year (68,446; 88.0% of those due). Therefore, the service completed fewer mandated health and wellbeing reviews than the annual target of 68,000. Notably, the total number of mandated health and wellbeing reviews will fluctuate due to changes in the birth rate. In Q1 2024/2025, the number of reviews due (76,987) was 1.05% (818) lower than the same quarter of the previous year (2023/2024).

3.2 Three of the five mandated contacts met or exceeded the target. The proportion of new birth visits delivered within 10–14 days at 94.1%, was slightly below the 95% target. The proportion of antenatal contacts delivered during this quarter was 36%, below the 50% target. The 50% target for this indicator was established using previous performance (which averaged 54.7% in the five quarters to Q3 2023/2024). Following work to improve data quality in Q4 2023/2024, the provider (KCHFT) identified a data reporting error related to the way data has been recorded since migration to a different IT system. This data reporting error has contributed towards a reduction in current and historic performance (averaging 21%).

3.3 The provider has action plans in place to enhance service delivery for antenatal performance and this is being closely monitored by commissioners. KCHFT has completed three actions from its action plan including reviewing current staffing levels, caseload management, and developing a proposal for centralising antenatal contacts to support the achievement of the indicator. KCHFT are currently working on six actions to review the impact of recruitment and

retention premiums which are in place for north/west Kent teams and to address staffing challenges in Dartford, Gravesham, Sevenoaks, Tunbridge Wells, and Tonbridge and Malling. The antenatal offer will be reviewed and revised through the transformation process.

3.4 The antenatal contact serves as the initial touchpoint of the Healthy Child Programme, delivered through Health Visiting. The service takes a risk stratified approach, prioritising antenatal contacts for families assigned to a targeted or specialist caseload upon receiving a maternity notification form from Midwifery, with a special focus on first-time parents. Expectant parents remain under the maternity caseload during this period and families are offered regular care and support. Families that are not offered an antenatal contact are sent a welcome letter to introduce them to the service. This letter promotes free universal support via family hubs (online and in-person), Chat Health, Kent Baby, and parenting courses.

4. Adult Health Improvement

4.1 In Q1 2024/2025 there were 8,516 NHS Health Checks delivered to the eligible population. This represents a reduction of 4% (−378) from the 8,894 checks delivered in the previous quarter, however, an increase of 15% (+1,120) from the 7,396 checks delivered in the same quarter of the previous year (2023/2024).

4.2 The number of first invitations sent out during the current quarter was 26,296 compared to 18,607 in the same period of the previous year (2023/2024). Of the first invitations sent in Q1 2024/2025, 3,789 were sent via text message as part of the SMS invitation pilot. This pilot has now concluded, and the service is awaiting the final data analysis to ascertain the impact on uptake rates for an NHS Health Check. Commissioners continue to progress the Public Health Transformation Programme and have hosted two successful market engagement events so far this quarter, generating useful insights that will support ongoing model development for the NHS Health Check Programme.

4.3 The Stop Smoking Service supported 812 people to successfully quit smoking this quarter, achieving a quit rate of 57%. In Q1 2024/2025, the service began to transition its Smoking in Pregnancy team to support a wider range of individuals with complex health needs, for example, individuals identified through the lung health check programme with potential early signs of cancer or housebound clients. As the NHS have started to embed smoking support directly with Maternity services as part of the NHS Long Term Plan, there is no longer a need for the KCC commissioned service to have a dedicated Smoking in Pregnancy team. The service has continued to support pregnancy referrals whilst these changes take place.

4.4 The service is currently exploring the offer around pharmacotherapy as new medications become available, increasing the potential choice of treatment options available to service users looking to quit smoking. Further updates will be provided as these develop further.

4.4 In Q1 2024/2025, the One You Kent (OYK) Lifestyle Service engaged with 1,763 (51%) people from Quintiles 1 & 2, below the 55% target. In this quarter, the total number of people supported in OYK services (3,479) has increased by 15.7% (473) compared to the same quarter of the previous year (3,006). The total number of people from Quintiles 1 & 2 (1,763) has remained stable when compared to the same quarter of the previous year (1,794); however, due to the increased number of people active within OYK services the proportion of those from Quintiles 1 & 2 has reduced. The OYK Lifestyle Services continue to receive a high number of referrals from GPs for weight management services.

4.5 These referrals are not necessarily for people residing in areas of deprivation, particularly in districts with lower levels of deprivation. However, service providers continue to hold engagement activities within these areas. In this quarter, 462 (7%) fewer referrals were received than the same quarter of the previous year. The complete data submission for the Maidstone OYK service was not available at the time of writing this report due to changes in personnel within Maidstone Borough Council, largely explaining the reduction in the number of referrals. However, they are currently in the process of hiring to the vacant manager position for the service which will support future data submissions.

4.6 The OYK KPI introduced for 2024/2025 (PH27: Number (%) of clients that complete the Weight Loss Programme) will be retrospectively reported due to the nature of reporting (one quarter behind). The Weight Loss Programme is 12-weeks in duration, therefore there are a considerable number of people yet to finish the programme at the end of the quarter (e.g., people who commenced the programme in June will not have had the opportunity to complete at the time of reporting). In Q4 2023/24, performance exceeded target with 736 (71%) of people completing the Weight Loss Programme.

5. Sexual Health

5.1 The Integrated Sexual Health Services data for Q1 2024/2025 was not available at the time of writing this report. One of the providers has moved to a new data system and there have been unforeseen issues extracting the data. The data is expected imminently and will be shared with the Committee in the Q2 2024/2025 report. Activity in other sexual health services includes 9,529 kits being ordered from the Online STI testing service, which is 12% fewer than the 10,876 kits ordered in the previous quarter. Elsewhere, Outreach teams continue to target underserved people in the community and are reaching a range of demographics across Kent.

6. Drug and Alcohol Services

6.1 The Community Drug and Alcohol Services data for Q1 2024/2025 was not yet released at the time of writing this report. The number of people accessing drug and alcohol treatment within Kent is improving overall, however work is continuing in conjunction with national Office for Health Improvement and Disparities (OHID) colleagues to improve the number of opiate users accessing treatment.

6.2 Successful completion rates (Table 1) indicate that performance is close to target in all substance groups excepting those people who use non-opiate drugs, which is consistently below target; this may be impacted by increased numbers of non-opiate users accessing treatment whilst the providers are still experiencing recruitment challenges. However, specific non-opiate pathways have recently been refined to ensure that these people have a treatment plan specifically tailored to their needs.

Table 1. Successful completion rates for the substance groups

Substance Group	Target	Q4 22–23	Q1 23–24	Q2 23–24	Q3 23–24	Q4 23–24	Benchmarking	
							National	Regional
Opiate	8%	7.9%	7.7%	7.4%	7.5%	8.4%	5.4%	6.6%
Non-opiate	48%	38.1%	39.2%	38.6%	37.9%	37.9%	32.5%	33.7%
Alcohol	40%	35.6%	36.1%	36.6%	36.8%	39.4%	35.2%	35.7%
Alcohol & Non-opiate	33%	33.7%	31.1%	30.4%	30.4%	30.4%	28.8%	29.6%

6.3 In Q1 2024/2025, the proportion of young people exiting treatment in a planned way was 83%, slightly below the 85% target. This represents 54 planned exits, 1 transfer, and 10 unplanned exits, the latter mainly due to non-engagement with treatment although these people have engaged in some interventions.

6.4 Every unplanned closure must be reviewed by a manager to ensure every available route to re-engage has been explored. This will include calls, texts, letters, and discussion with the referrer where appropriate. Of those young people who exited treatment in a planned way, 13% reported abstinence (target = 24%). It is recognised that not all young people wish to achieve abstinence (some may only require harm reduction), therefore the service also monitors health and wellbeing outcomes. This quarter, based on 61 responses, 62.3% of young people indicated an improvement in their satisfaction with life, 26.2% reported an improvement in their anxiety levels, and 55.7% reported feeling happier.

6.5 With regard to young people receiving support for substance misuse, Kent has previously tracked the national trend of declining numbers between 2018–2022. However, since January 2023 there has been a steady increase in Kent, supported by additional OHID grant funding. KCC commissioners have set an ambitious target of 400 young people per year receiving structured support. In Q1 2024/2025, the service supported 136 young people, which puts them on track to exceed the annual target. In addition to structured treatment, the service also supported 237 young people through group work this quarter.

7. Mental Health and Wellbeing Service

7.1 Entering the second year of the contract, Live Well Kent & Medway (LWKM) continues to see high demand whilst maintaining strong outcomes. In this quarter, 96% of people completing the exit survey reported improvements in their personal goals. Following the successful pilot in Thanet, Community Mental Health Framework (Community Mental Health Transformation) continues to be a developing area for the service with meet and greet events now held in Tonbridge and Maidstone.

8. Conclusion

8.1 Four of the 14 KPIs remain above target and were RAG-rated Green.

8.2 Commissioners continue to explore other forms of delivery, to ensure the current provision is fit for purpose and able to account for increasing demand levels and changing patterns of need. This will include ongoing market review and needs analysis.

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9. Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the performance of Public Health commissioned services in Q1 2024/2025.

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10. Background Documents

None

12. Appendices

Appendix 1: Public Health commissioned services KPIs and activity.

13. Contact Details

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

Indicator Description		Target 23/24	Target 24/25	Q1 23–24	Q2 23–24	Q3 23–24	Q4 23–24	Q1 24-25	DoT	Benchmarking* England	Region	Neighbour
► Health Visiting												
PH04	No. of mandated health and wellbeing reviews delivered by the health visiting service (12 month rolling)	65,000	68,000	68,446 (G)	67,949 (A)	67,011 (A)	66,846 (A)	66,724 (A)	↓	-	-	-
PH14	No. (%) of mothers receiving an antenatal contact by the health visiting service	43%	50%	1,634 48%(G)	1,391 42%(A)	1,152 37%(A)	1,226 39%(A)	1,266 36%(R)	↓	-	-	-
PH15	No. (%) of new birth visits delivered by the health visitor service within 10–14 days of birth	95%	95%	3,550 94%(A)	3,730 94.6%(A)	3,604 94%(A)	3,596 94.8%(A)	3,611 94%(A)	↔	84%	84%	87%
► Substance Misuse Treatment												
PH13	No. (%) of young people exiting specialist substance misuse services with a planned exit	85%	85%	37 88%(G)	53 84%(A)	52 84%(A)	41 84%(A)	54 83%(A)	↓	-	-	-
PH06	No. of adults accessing structured treatment substance misuse services (12 month rolling)	-	5,998	5,108 (A)	5,269 (A)	5,422 (A)	5,480 (A)	NCA	↑	-	-	-
PH03	No. (%) of people successfully completing drug and/or alcohol treatment of all those in treatment (12 month rolling)	25%	25%	1,291 25%(G)	1,349 26%(G)	1,407 26%(G)	1,503 27%(G)	NCA	↑	21%	23%	22%
► Lifestyle and Prevention												
PH01	No. of the eligible population aged 40–74 years old receiving an NHS Health Check (12 month rolling)	23,844	31,000	26,565 (G)	28,722 (G)	30,188 (G)	31,379 (G)	32,499 (G)	↑	-	-	-
PH26	No. of people setting a quit date with smoking cessation services (cumulative)	-	-	1,124	2,500	3,691	5,230	1,431	-	-	-	-
PH11	No. (%) of people quitting at 4 weeks, having set a quit date with smoking cessation services	55%	55%	612 54%(A)	690 50%(A)	690 58%(G)	879 57%(G)	812 57%(G)	↔	55%	55%	57%
PH25	No. (%) of clients currently active within One You Kent services being from the most deprived areas in Kent	55%	55%	1,794 62%(G)	1,833 52%(A)	1,896 58%(G)	2,046 56%(G)	1,763 51%(R)	↓	-	-	-
PH27	No. (%) of clients that complete the Weight Loss Programme	-	60%	369 64%(G)	392 56%(A)	401 59%(A)	736 71%(G)	NCA	↑	-	-	-
► Sexual Health												
PH28	No. (%) of all new first-time patients receiving a full sexual health screen (excluding online referrals)	-	72%	2,969 71%(A)	3,170 70%(A)	3,133 70%(A)	3,211 69%(A)	NCA	↓	-	-	-
► Mental Wellbeing												
PH22	No. (%) of Live Well Kent clients who would recommend the service to family, friends, or someone in a similar situation	98%	98%	NCA	271 99.6%(G)	250 97%(A)	374 94%(A)	631 99.8%(G)	↑	-	-	-

* The benchmarking figures represent the latest available data and may not reflect the quarter reported in this paper. The 'Region' (South East) benchmark is determined from the Bracknell Forest, Brighton and Hove, Buckinghamshire, East Sussex, Hampshire, Isle of Wight, Kent, Medway, Milton Keynes, Oxfordshire, Portsmouth, Reading, Slough, Southampton, Surrey, West Berkshire, West Sussex, Windsor and Maidenhead, and Wokingham LAs. The 'Neighbour' benchmark reflects the statistical neighbours for Kent determined by the Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbour Model: Devon, East Sussex, Essex, Gloucestershire, Hampshire, Hertfordshire, Kent, Lancashire, Norfolk, Northamptonshire, Nottinghamshire, Staffordshire, Suffolk, Warwickshire, West Sussex, and Worcestershire.

Commissioned Services Annual Activity

Indicator Description		2018/19	2019/20	2020/21**	2021/22	2022/23	2023/24	DoT	Benchmarking England	Benchmarking Region	Benchmarking Neighbour
PH09	Participation rate of Year R (aged 4–5 years) pupils in the National Child Measurement Programme	95% (G)	95% (G)	85% (G)	88% (A)	93% (G)	NCA	↑	94%	95%	94%
PH10	Participation rate of Year 6 (aged 10–11 years) pupils in the National Child Measurement Programme	94% (G)	94% (G)	9.8% (A)	87% (A)	90% (G)	NCA	↑	93%	91%	93%
PH05	No. receiving an NHS Health Check over the 5-year programme (cumulative: 2018/19 to 2022/23, 2023/24 to 2027/28)	36,093	76,093	79,583	96,323	121,437	31,379	-	-	-	-
PH07	No. accessing KCC-commissioned sexual health service clinics	76,264	71,543	58,457	65,166	58,012	61,508	↑	-	-	-

**In 2020/21 following the re-opening of schools, the Secretary of State for Health and Social Care via Public Health England (PHE) requested that local authorities use the remainder of the academic year to collect a sample of 10% of children in the local area. PHE developed guidance to assist local authorities in achieving this sample and provided the selections of schools. At the request of the Director of Public Health, Kent Community Health NHS Foundation Trust prioritised the Year R programme.

Key(s)

RAG Ratings

(green)	(G) Green: Target has been achieved
(amber)	(A) Amber: Floor standard achieved but Target has not been met
(red)	(R) Red: Floor standard has not been achieved
NCA	Not currently available

DoT (Direction of Travel) Alerts

↑	Performance has improved
↓	Performance has worsened
↔	Performance has remained the same
-	No performance direction

Relates to two most recent time frames

Date 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.

From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Health Reform and Public Health Cabinet Committee, 17 September 2024

Subject: Strategic indicators report – Kent and Medway Integrated Care Strategy

Decision no: N/A

Key Decision : No

Classification: Unrestricted

Past Pathway of report: None

Future Pathway of report: None

Electoral Division: All

Is the decision eligible for call-in? No

Summary: This report aims to monitor progress of a selection of 'strategic' indicators identified in the Kent and Medway Integrated Care Strategy. Kent County Council has adopted this strategy as the Joint Health and Wellbeing Strategy.

Recommendations:
The Health Reform and Public Health Cabinet Committee is asked to NOTE the findings from this report.

Due to infrequent updates of most indicators, it is recommended to generate this report annually. If the committee would find it useful, a different set of indicators from the strategy could be presented in six months.

---

1. Introduction

1.1 The Kent and Medway Integrated Care Strategy describes the priority areas for improvement in health and care services. Ambitions which can only be achieved through effective partnership working.

1.2 It comprises six shared outcome areas

- Give children and young people the best start in life
- Tackle the wider determinants to prevent ill health

- Support happy and healthy living
- Empower people to best manage their health conditions
- Improve health and care services
- Support and grow our workforce

1.3 A set of indicators referred to as the 'LogFrame' has been developed to help monitor the progress of objectives within each of these shared outcomes. The latest version is provided (see "appendix 2 Logframe K&M ICS 2024-07-01"). This report presents a selection of these indicators. The workforce outcome has been excluded because the indicators have not yet been finalised. A visual representation of these indicators is provided in the PowerPoint document "appendix 1 Health Reform Public Health (HRPH) report 2024-08-15". It presents the latest value for Kent (or Kent and Medway combined) against the target and current England average. It also shows the trend and the variation within Kent wherever possible.

1.4 These indicators should be treated differently to traditional performance measures. Differences between areas are due to several reasons, some of which relate to the underlying population characteristics and socio-economic circumstances of residents. Consequently, indicators are categorised as being 'higher' or 'lower' compared to England, rather than 'better' or 'worse'. Wherever possible, the indicator has been shown by district council or crime and safety partnership. It should be noted that targets have not been agreed with these areas. They have been included to inform the committee about the variation within the Kent average (which is often considerable).

1.5 In most cases, the targets or 'levels of ambition' in the Logframe have been set over a five year period, ending in the calendar year 2028 or financial year 2028/29.

1.6 Due to infrequent updates of most indicators, it is recommended to generate this report annually.

2. Indicator summary

The following indicators are included in this report:

- Child healthy weight and severe obesity
- School readiness
- Loneliness
- Violent crime and domestic burglary
- Physically inactive adults
- Alcohol-related hospital admissions
- Ambulatory care sensitive conditions hospital admissions
- Waiting for NHS diagnostic services
- Deaths in hospital
- People aged 65 and over who were still at home 91 days after discharge from hospital into reablement services

There are about 90 indicators within the 'LogFrame' indicator set, designed to underpin the strategy. Some of these are still being developed with system partners. Of those that have been finalised, there are too many to present in one go. The indicators in this report correspond to public health priorities and /

or are intended to represent a sample from each shared outcome area. Two further factors have been considered in choosing indicators: 1) whether longitudinal data is available for Kent / Kent and Medway and 2) whether smaller area data (usually district) is available to highlight variability within the Integrated Care System.

2.1 Child healthy weight:

2.1.1 Indicator: By 2028, the proportion of children in Year 6 who are healthy weight will be maintained at the current level of 63% and severe obesity will have reduced from 5%.

2.1.2 Numerator 1: Number of children in year 6 (aged 10 to 11 years) with a valid height and weight measured by the National Child Measurement Programme (NCMP) with a BMI classified as healthy weight. For population monitoring purposes children are classified as healthy weight if their body mass index is between the 2nd and less than the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

2.1.3 Denominator 1: Number of children in year 6 with a valid height and weight measured by the NCMP.

2.1.4 Numerator 2: Number of children in year 6 (aged 10 to 11 years) with a valid height and weight measured by the NCMP (National Child Measurement Programme) with a BMI classified as severely obese. For population monitoring purposes children are classified as living with severe obesity if their body mass index is on or above the 99.6th centile of the British 1990 growth reference (UK90) according to age and sex.

2.1.5 Denominator 2: Number of children in year 6 with a valid height and weight measured by the NCMP.

2.1.6 Rationale: There is a long-term downward trend in the healthy weight category both locally and nationally, exacerbated by the COVID-19 pandemic. The proportion categorised as ‘healthy weight’ is yet to recover to pre-pandemic levels. Severe obesity among the same age group has steadily increased since 2015.

2.1.7 Summary: The latest time period is the 2022/23 academic year. The next update to this indicator should be available in January 2025. There are significant differences within Kent. Healthy weight ranges from approximately 60% in Dartford, Gravesham and Thanet to over 70% in Tunbridge Wells. Severe obesity ranges from about 2% in Tunbridge Wells to 7% in Thanet and Gravesham.

2.2 School readiness

2.2.1 Indicator: By 2028, pupils achieving a good level of development at the end of the Early Years Foundation Stage will have improved from 65.8% in 2021/22 to at least 70%.

2.2.2 Numerator: All children defined as having reached a good level of development at the end of the early years foundation stage (EYFS) by local authority. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy.

2.2.3 Denominator: All children eligible for the Early years foundation stage (EYFS) Profile by local authority
2.2.4 Rationale: Also referred to as ‘School readiness’, Children are defined as having reached a good level of development if they achieve expected early learning goals. The aspiration of achieving 70% is intended to match the best among our The Chartered Institute of Public Finance and Accountancy (CIPFA) nearest neighbour authorities in 2020/21.
2.2.5 Early Years Foundation Stage (EYFS) reforms were introduced in September 2021. As part of those reforms, the EYFS profile was significantly revised. It is therefore not possible to directly compare 2021 to 2022 assessment outcomes with earlier years.
2.2.6 Summary: The latest time period is the 2022/23 academic year. The next update to this indicator should be available in February 2025. The overall rate for Kent has improved to 68%. Thanet is significantly lower than the England average. Other districts are similar or higher than the England average.

2.3 Loneliness

2.3.1 Indicator: By 2028/29, the proportion of people who feel lonely often or always will have reduced from 7.3% in 2020/21 to no more than 5% across Kent and Medway.
2.3.2 Numerator: People who report they feel lonely often or always in the Sport England Active Lives Adult survey.
2.3.3 Denominator: Valid responses to the question: "How often do you feel lonely?"
2.3.4 Rationale: Since the earliest figures were released covering the period from November 2019 to November 2020, the proportion has increased by fractions of one percent each survey. Reducing to 5% therefore constitutes a significant challenge.
2.3.5 Questions about loneliness are routinely asked as part of the Active Lives survey conducted by Sport England. The figures are shared at a ‘partnership’ level and the Kent Partnership includes Medway Council. The number of people surveyed locally ranges between 4,000 and 6,300 respondents.
2.3.6 Summary: The latest survey covers responses between November 2021 and November 2022. The Kent partnership value is 6.1% which is statistically similar to the England value (6.8%). The small increase in the Kent value observed recently is not statistically significant.

2.4 Violent crime and domestic robbery

2.4.1 Indicator: By 2028, the (crude) rate of serious violence will be lower or similar compared to the national average.
2.4.2 Numerator: Recorded crimes in Kent for homicide, assault with injury and robbery of personal property
2.4.3 Denominator: Office for National Statistics (ONS) mid-year population estimates
2.4.4 Rationale: This indicator has been suggested by the Kent Violence Reduction Unit. It includes police recorded crimes relating to homicide, assault with injury and robbery of personal property.

2.4.5 Summary: The latest published time period is April 2023 to March 2024. To produce more robust figures, the quarterly data has been aggregated into distinct four quarter periods. The next update to this indicator should be available in late October 2024. The Kent average (excluding Medway) is statistically significantly lower than the England average. However, this masks disparity within Kent. The rate in Thanet is significantly higher than England. Sevenoaks, Tonbridge and Malling, Tunbridge Wells, Ashford, Maidstone and Folkestone and Hythe are all lower.

2.5 Physical inactivity

2.5.1 Indicator: By 2028, the proportion of adults in Kent and Medway who are physically inactive will have fallen from 22.3% in 2020/21 to 20%.
2.5.2 Numerator: Weighted number of respondents aged 19 and over to Sport England Active Lives Adult survey, with valid responses to questions on physical activity, doing less than 30 MIE (moderate intensity equivalent) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days.
2.5.3 Denominator: Weighted number of respondents aged 19 and over, with valid responses to questions on physical activity.
2.5.4 Rationale: Physical inactivity is defined as engaging in less than 30 minutes of physical activity per week. The Chief Medical Officer recommends that adults undertake a minimum of 150 minutes of moderate physical activity per week, or 75 minutes of vigorous physical activity per week or an equivalent combination of the two, in bouts of 10 minutes or more. The aspiration of achieving 20% is intended to match the best among our CIPFA nearest neighbour authorities in 2020/21.
2.5.5 Summary: The latest time period is 2022/23. The next update to this indicator should be available in May 2025. The Kent proportion is significantly lower than the England average (23%) and just above the 20% ambition. The proportion in Gravesham and Swale is above 25%. Half of the 12 Kent districts are lower than the England average.

2.6 Alcohol-related hospital admissions

2.6.1 Indicator: By 2028, hospital admissions in Kent and Medway due to alcohol will have fallen from 418.7 in 2021/22 to 395 per 100,000.
2.6.2 Numerator: Admissions to hospital where the primary diagnosis is an alcohol-related condition. For each episode identified, an alcohol-attributable fraction is applied to the primary diagnosis field based on the diagnostic codes, age group, and sex of the patient.
2.6.3 Denominator: All age ONS mid-year population estimates aggregated into five-year age bands.
2.6.4 Rationale: This is the ‘narrow’ definition of alcohol admissions. The narrow measure estimates the number of hospital admissions which are primarily due to alcohol consumption and provides the best indication of trends in alcohol-related hospital admissions. The ‘broad’ definition considers contributory causes of the admission but is sensitive to changes in coding practice over time. The ambition to reduce to a rate of 395 per 100,000 represents a reduction of at least 5%.
2.6.5 Summary: The latest time period is the 2022/23 financial year. The next update to this indicator should be available in May 2025. Kent has been

lower than the England average for the past 7 years, although Gravesham is higher. The overall Kent rate is still above the target, although there has been a small reduction since the previous year.

2.7 Ambulatory Care Sensitive Conditions

2.7.1 Indicator: By 2028, the deprivation gap in terms of the rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions will be reduced from current levels.
2.7.2 Numerator: the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, Angina, Chronic Obstructive Pulmonary Disease (COPD), Asthma, Diabetes, Epilepsy, and high blood pressure.
2.7.3 Denominator: ONS mid-year population estimates
2.7.4 Rationale: Ambulatory care sensitive conditions are conditions for which effective management and treatment should prevent admission to hospital. It typically includes types of respiratory and heart disease, diabetes and selected acute conditions. The rate of hospital admission among the most deprived 20% is approximately double that of the least deprived.
2.7.5 Summary: The latest time period is 2022/23 financial year. The next update to this indicator should be available in October 2024. The latest published national data is 2020/21 financial year. In Kent, the ratio between the most and least deprived is 2. It has reduced very gradually over the past 10 years. The gap between most and least deprived is largest in Swale.

2.8 NHS Diagnostic test waiting times

2.8.1 Indicator: By 2028, waits for diagnostics will meet national ambitions.
2.8.2 Numerator: Patients who have waited six weeks or more for a diagnostic procedure.
2.8.3 Denominator: All patients waiting for a diagnostic test/procedure funded by the NHS. This includes all referral routes (i.e. whether the patient was referred by a GP or by a hospital-based clinician or other route) and also all settings (i.e. outpatient clinic, inpatient ward, x-ray department, primary care one-stop centres etc.) It should exclude planned diagnostics as part of a series of procedures in a treatment plan, screening programme activity, pregnancy diagnostics and patients currently occupying a hospital bed.
2.8.4 Rationale: According to NHS England 2024/25 priorities and operational planning guidance 95% patients should receive their diagnostic test within 6 weeks from the time the request has been sent.
2.8.5 Summary: The latest time period is June 2024. The next update to this indicator should be available in late August 2024. At Kent and Medway ICB level, 26% are waiting more than six weeks which equates to roughly 16,000 patients waiting more than six weeks. To meet the target, this needs to reduce to around 3,100. At an acute Trust level, the target is being met by Dartford and Gravesham and Maidstone and Tunbridge

Wells NHS Trusts but not by East Kent Hospitals and Medway NHS Foundation Trusts.

2.9 Deaths in hospital

2.9.1 Indicator: By 2028, the proportion of deaths in hospital across Kent and Medway will reduce from 41% to 36%.
2.9.2 Numerator: Number of registered deaths by calendar year, in each area in all age groups where the place of death is recorded as hospital.
2.9.3 Denominator: Total number of registered deaths by calendar year
2.9.4 Rationale: To understand the trends and variations in place of death as proxy indicator for quality of end of life care. The level of ambition has been set In line with the best performing CIPFA nearest neighbour in 2020 calendar year. Although 2020 was not a typical year due to the COVID-19 pandemic, it was not dramatically different from the years before and after and the long-term trend is downwards in nearly all areas.
2.9.5 Summary: The latest time period is 2022. The next update to this indicator should be available in December 2024. Overall, Kent (37%) has one of the lowest proportions of deaths in hospitals among other counties and unitary authorities in England. Rutland is the lowest (33.5%). This masks variation within Kent between the extremes of Dartford (45%) and Tunbridge Wells and Canterbury (~32%). This pattern of disparity is repeated in previous years.

2.10 Reablement services

2.10.1 Indicator: By 2028/29, the percentage of people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services will have increased in Kent to at least 85% (2021/22: Kent 84.5%).
2.10.2 Numerator: Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator.
2.10.3 Denominator: Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).
2.10.4 Rationale: This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services.
2.10.5 Summary: The latest time period is 2022/23 financial year. The next update to this indicator should be available in December 2024. The Kent figure has dropped from 84% in 2021/22 to 81%, England is 82%.

3. Other corporate implications

3.1 Other departments within the Council and partners across the Integrated Care System report regularly on some of these indicators. It is possible that figures reported elsewhere differ slightly from the equivalent in this report due to time lag in publication.

4. Conclusions

4.1 This report summarises a selection of indicators from the Kent and Medway Integrated Care Strategy / Joint Health and Wellbeing Strategy. It presents the latest value for Kent (or Kent and Medway combined) against the target and current England average. It also shows the trend and the variation within Kent wherever possible.

4.2 The Kent average often masks considerable variation within Kent. Smaller geographical areas such as district and borough councils are convenient ways to highlight this. But it should be noted that the underlying reasons are usually due to socio-economic characteristics in the population and the effects of living within different NHS Acute Trust catchment areas. Therefore, these disparities will be experienced by people in particular neighbourhoods and communities across the whole of Kent.

4.3 There are three areas of particular concern for Kent overall:

- 4.3.1 There is an ongoing rise in severe obesity among children aged 10 or 11. Eight years ago the Kent figure was about 3%, now it is over 5%. In Thanet and Gravesham, the figure is nearer 7%. The long-term trend for ‘healthy weight’ children is worsening.
- 4.3.2 NHS patients in East Kent and Swale are waiting longer for diagnostic tests than the rest of the population.
- 4.3.3 The gap in hospital admissions for ambulatory care sensitive conditions between most and least deprived populations is stubbornly fixed.

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5. Recommendation(s):

5.1 The Health Reform and Public Health Cabinet Committee is asked to NOTE the findings from this report.

5.2 Due to infrequent updates of most indicators, it is recommended to generate this report annually. If the committee would find it useful, a different set of indicators from the strategy could be presented in six months.

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6. Background Documents

6.1 Office for Health Improvement & Disparities. Public Health Profiles. [Accessed 2024-08-05] https://fingertips.phe.org.uk © Crown copyright [2024].

- 6.1.1 Child Healthy Weight
- 6.1.2 Child Severe Obesity
- 6.1.3 School readiness
- 6.1.4 Physically inactive adults
- 6.1.5 Alcohol-related hospital admissions
- 6.1.6 Deaths in hospital
- 6.1.7 Discharged into reablement services 91 days at home

6.2 Home Office

- 6.2.1 Police recorded crime Community Safety Partnership open data, year ending March 2016 to year ending March 2024

6.3 Sport England. Active Lives Adult survey

- 6.3.1 Feeling lonely often or always

6.4 Kent County Council

- 6.4.1 Ambulatory Care Sensitive conditions hospital admissions. Available from Health and Social Care Maps online Power BI tool on Kent Public Health Observatory website.
- 6.4.2 School readiness by district produced by Kent Analytics team from Integrated Children's Dataset (unpublished)

6.5 NHS England

- 6.5.1 Diagnostics Waiting Times and Activity.
- 6.5.2 Adult Social Care Outcomes Framework. Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services.

7. Contact details

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Strategic indicators
HRPH cabinet committee

Kent Public Health Observatory – produced in August 2024

Kent County Council
kent.gov.uk

Child healthy weight

Year 6 prevalence of healthy weight, Persons, 10-11 yrs. Latest time period: 2022/23. A higher value is desirable.

Kent

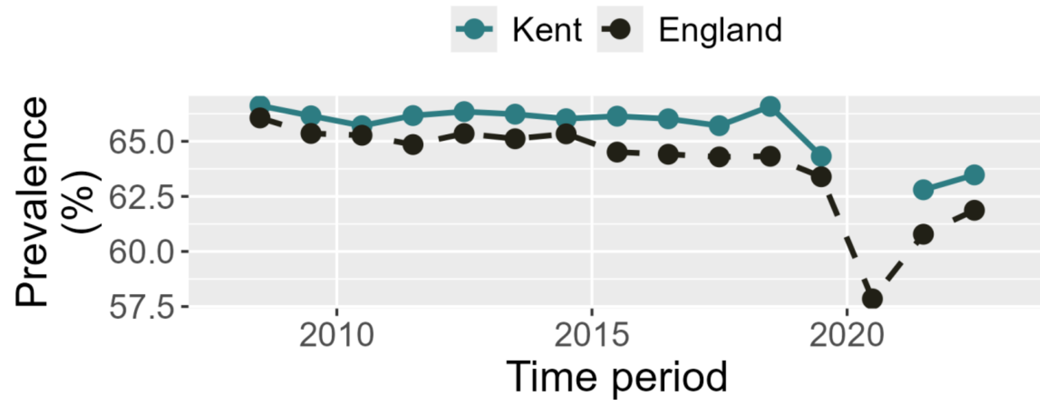
63

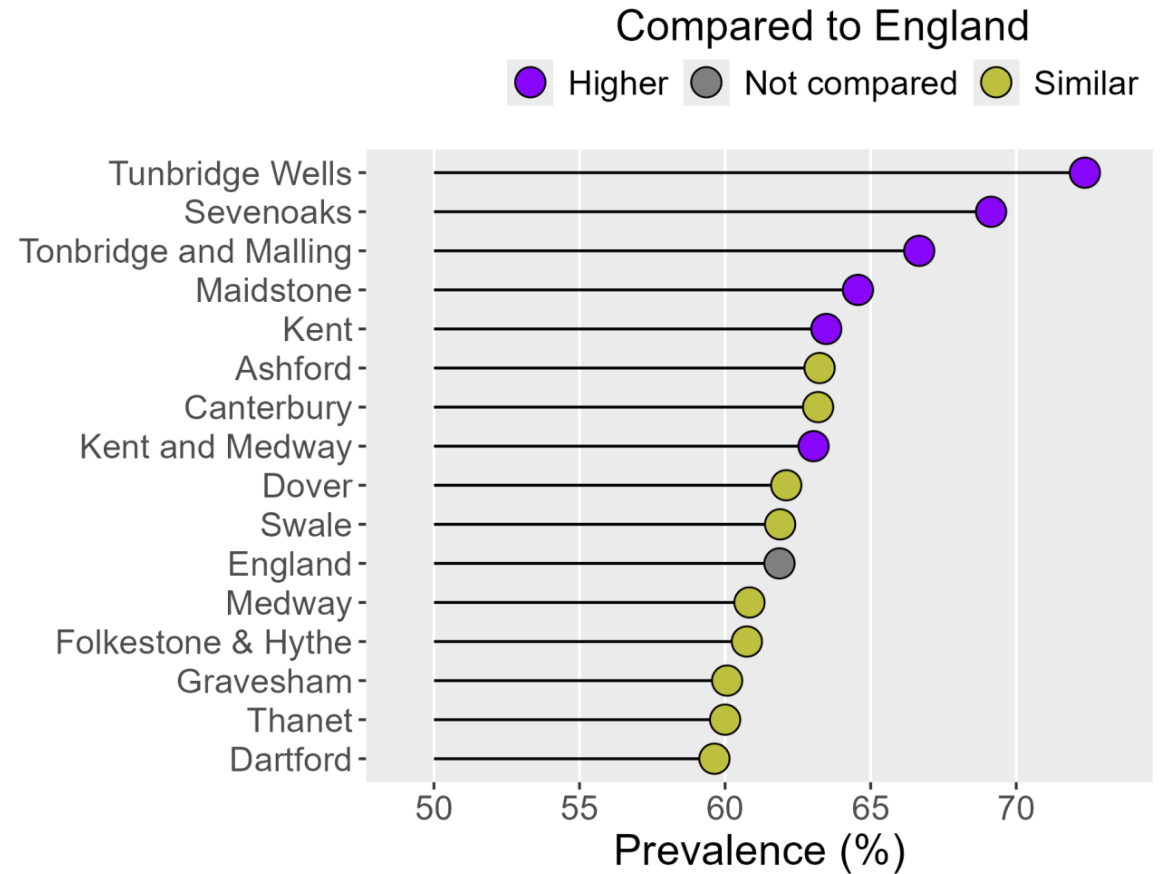
England

62

Target

63





Source: Office for Health Improvement & Disparities. Public Health Profiles. [Accessed 2024-08-05] https://fingertips.phe.org.uk © Crown copyright [2024].

Kent County Council kent.gov.uk

Child severe obesity

Year 6 prevalence of severe obesity, Persons, 10-11 yrs. Latest time period: 2022/23. A lower value is desirable.

Kent

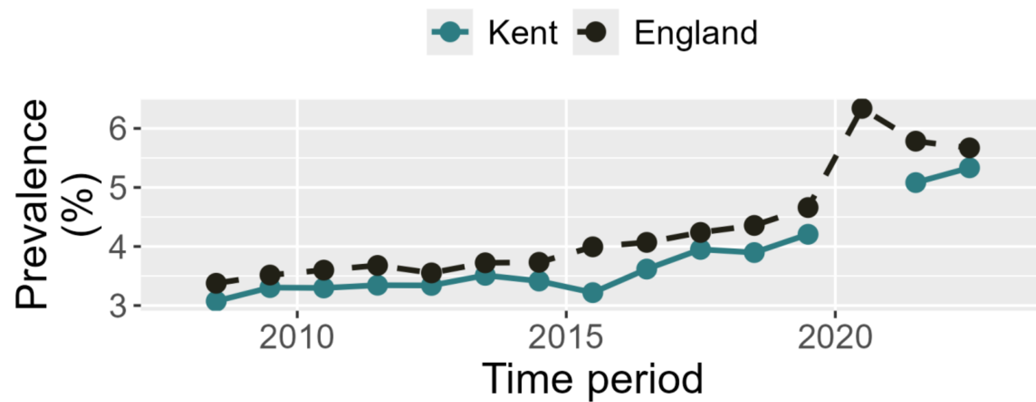
5.3

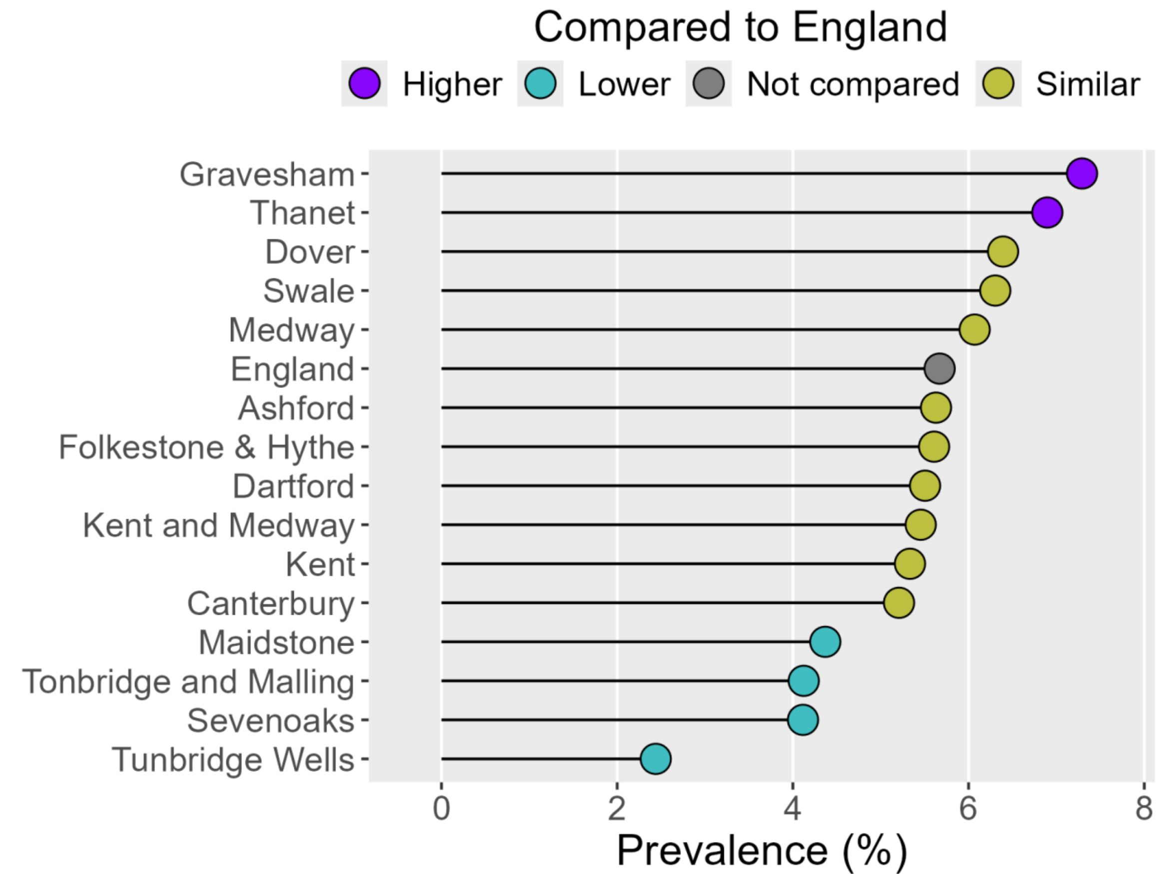
England

5.7

Target

5





Source: Office for Health Improvement & Disparities. Public Health Profiles. [Accessed 2024-08-05] https://fingertips.phe.org.uk © Crown copyright [2024].

Kent County Council kent.gov.uk

School readiness

School readiness: percentage of children achieving a good level of development at the end of Reception, Persons, 5 yrs. Latest time period: 2022/23. A higher value is desirable.

Kent

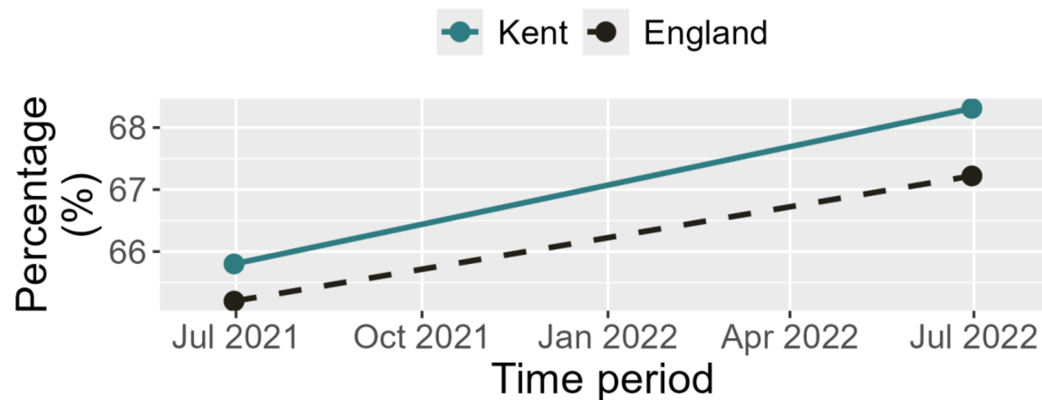
68

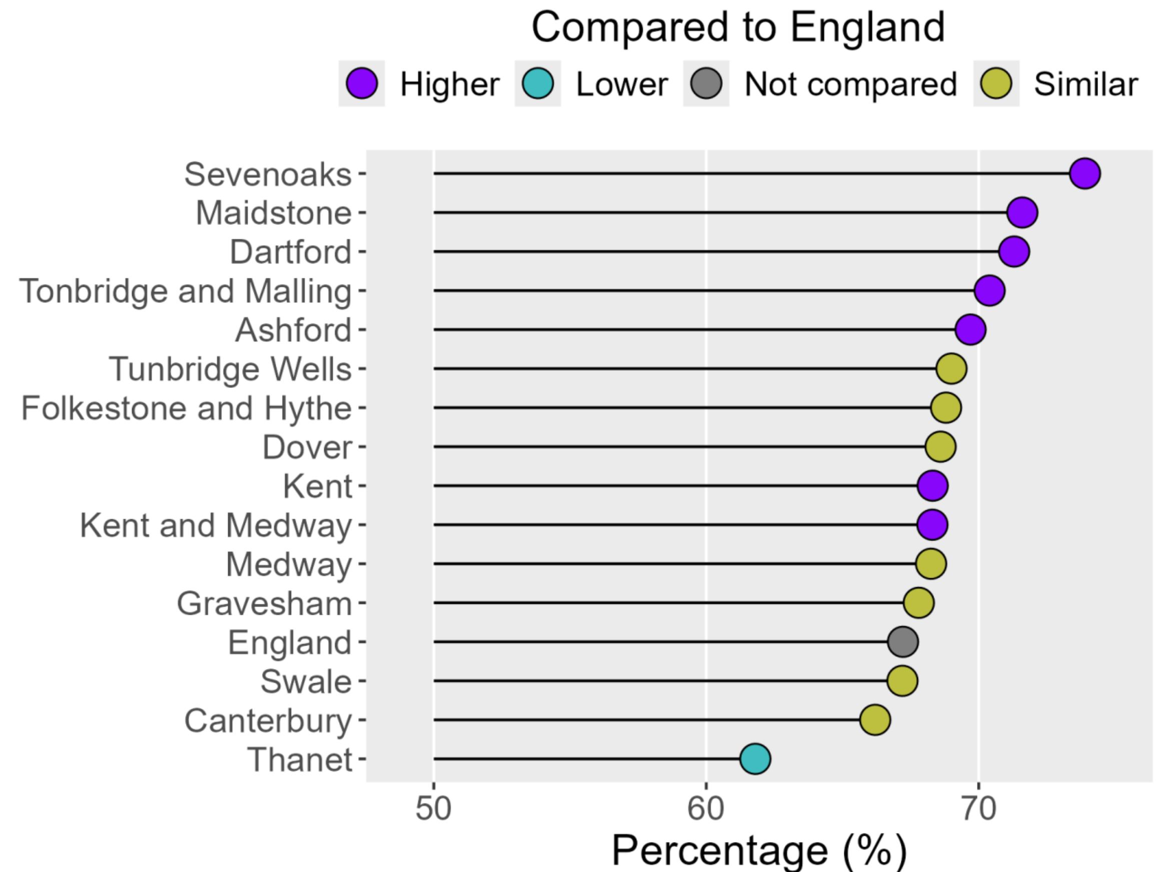
England

67

Target

70





Source: Office for Health Improvement & Disparities. Public Health Profiles. [Accessed 2024-08-05] https://fingertips.phe.org.uk © Crown copyright [2024] and Kent County Council Kent Analytics team. Integrated Children's Dataset. [Accessed 2024-08-14].

Kent County Council kent.gov.uk

Violent crime and domestic robbery

Violent crime and domestic robbery, Persons, All ages. Latest time period: 4 quarters ending Q4 2023/2024. A lower value is desirable.

Kent

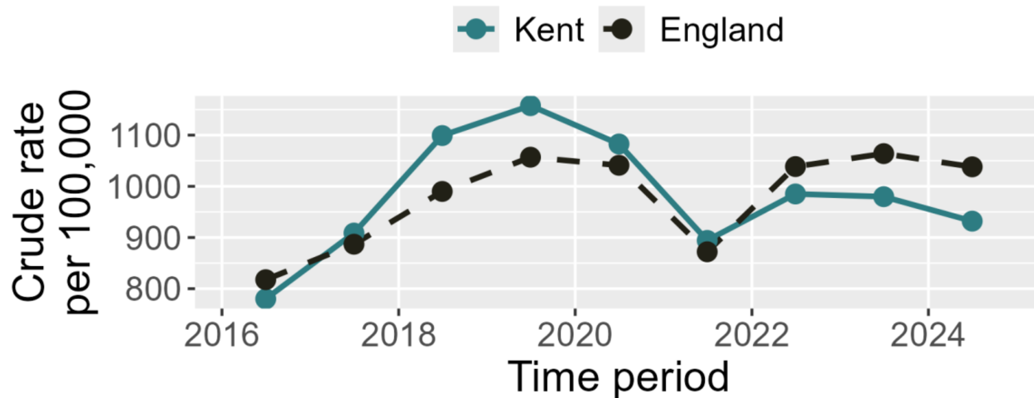
932

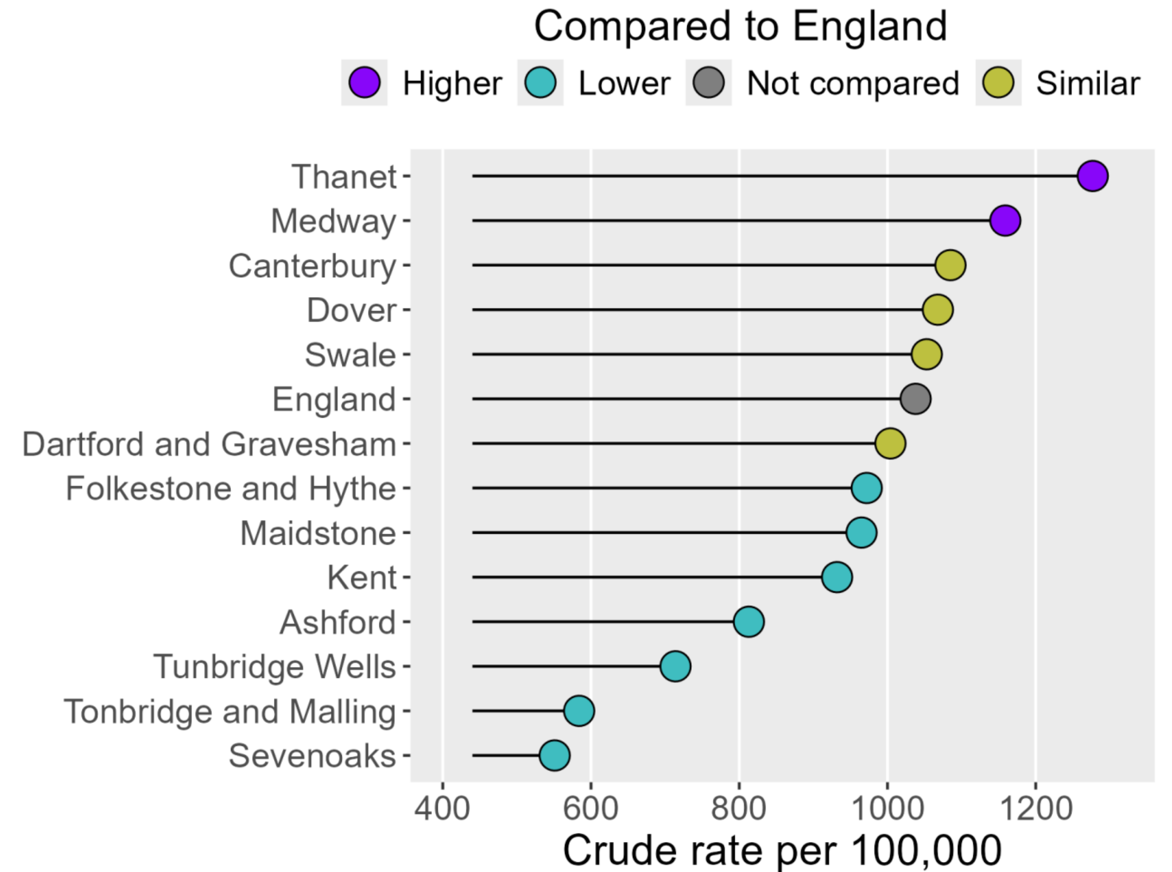
England

1038

Target

1038





Source: Home Office. Police recorded crime and outcomes open data tables. [Accessed 2024-08-14] https://www.gov.uk/government/statistics/police-recorded-crime-open-data-tables

Kent County Council kent.gov.uk

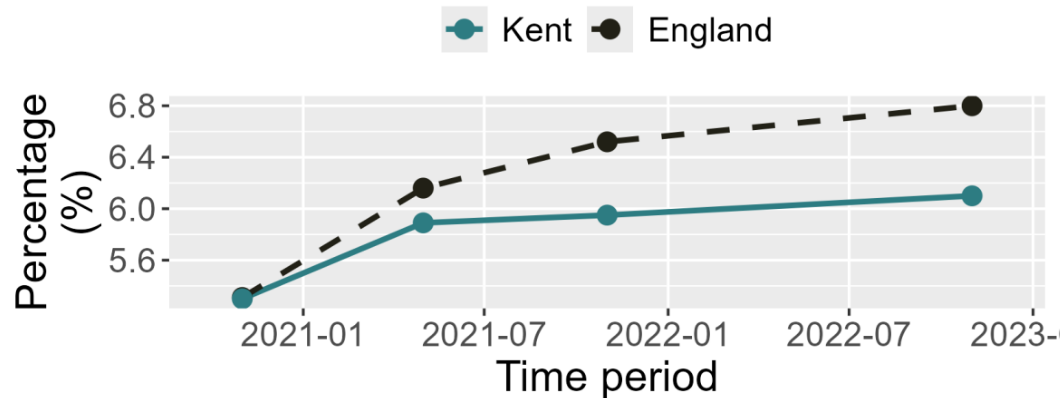
Feeling lonely often or always

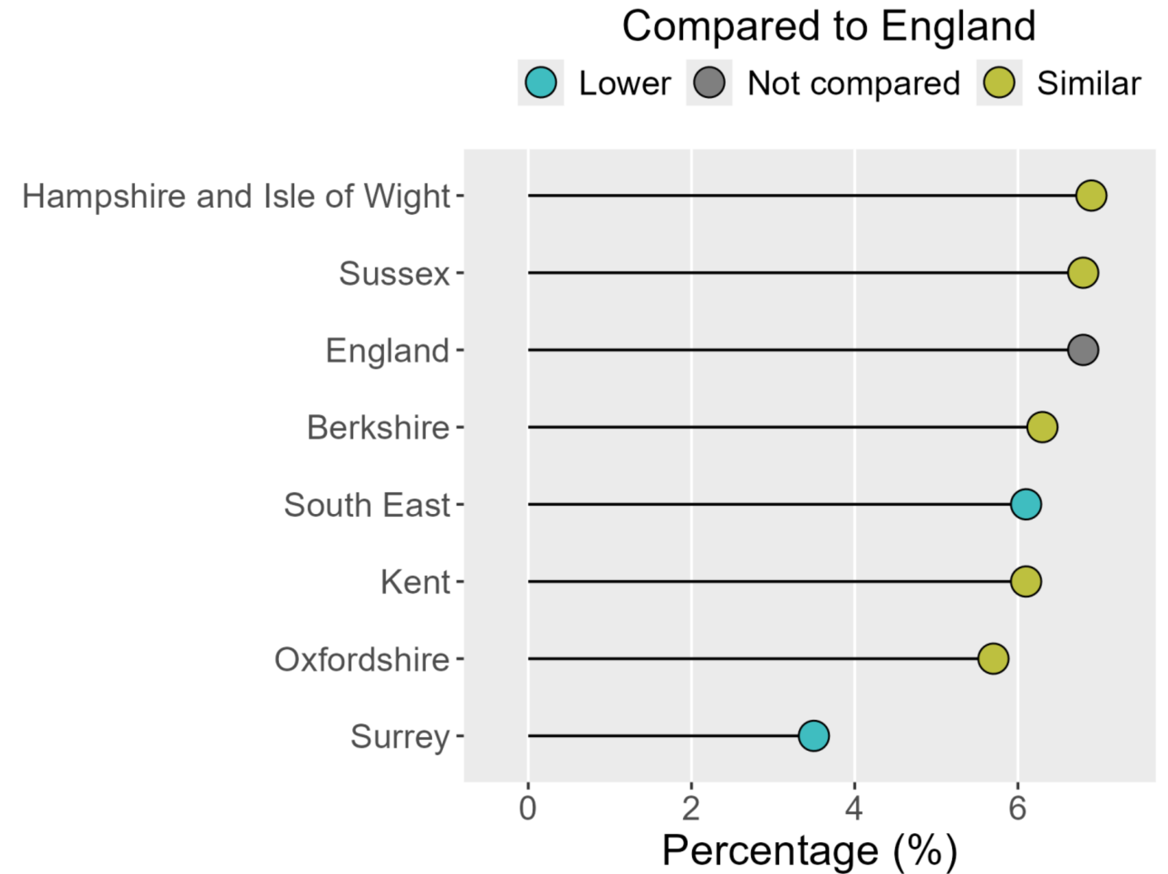
Feeling lonely often or always, Persons, 16+ yrs. Latest time period: Nov 2021 to Nov 2022. A lower value is desirable.

Kent
6.1

England
6.8

Target
5





Source: Sport England. Active Lives Adult survey. [Accessed 2024-08-05] https://www.sportengland.org/research-and-data/data/active-lives/active-lives-data-tables

Kent County Council kent.gov.uk

Physically inactive adults

Percentage of physically inactive adults, Persons, 19+ yrs. Latest time period: 2022/23. A lower value is desirable.

Kent

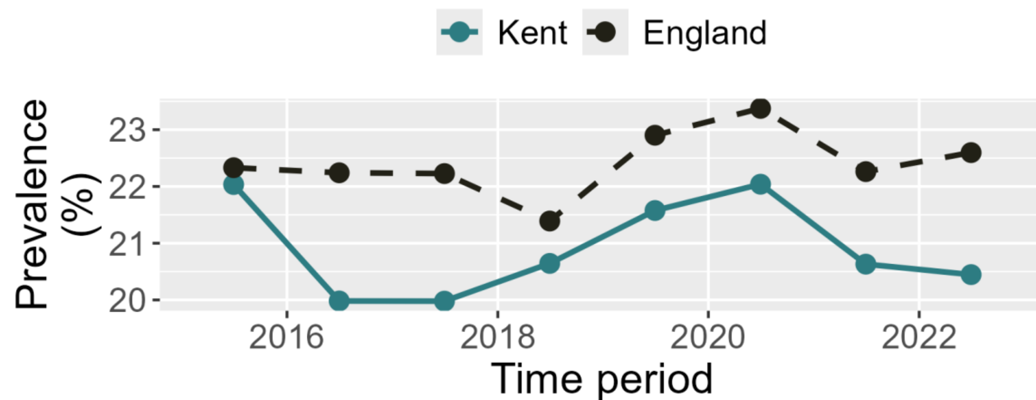
20.4

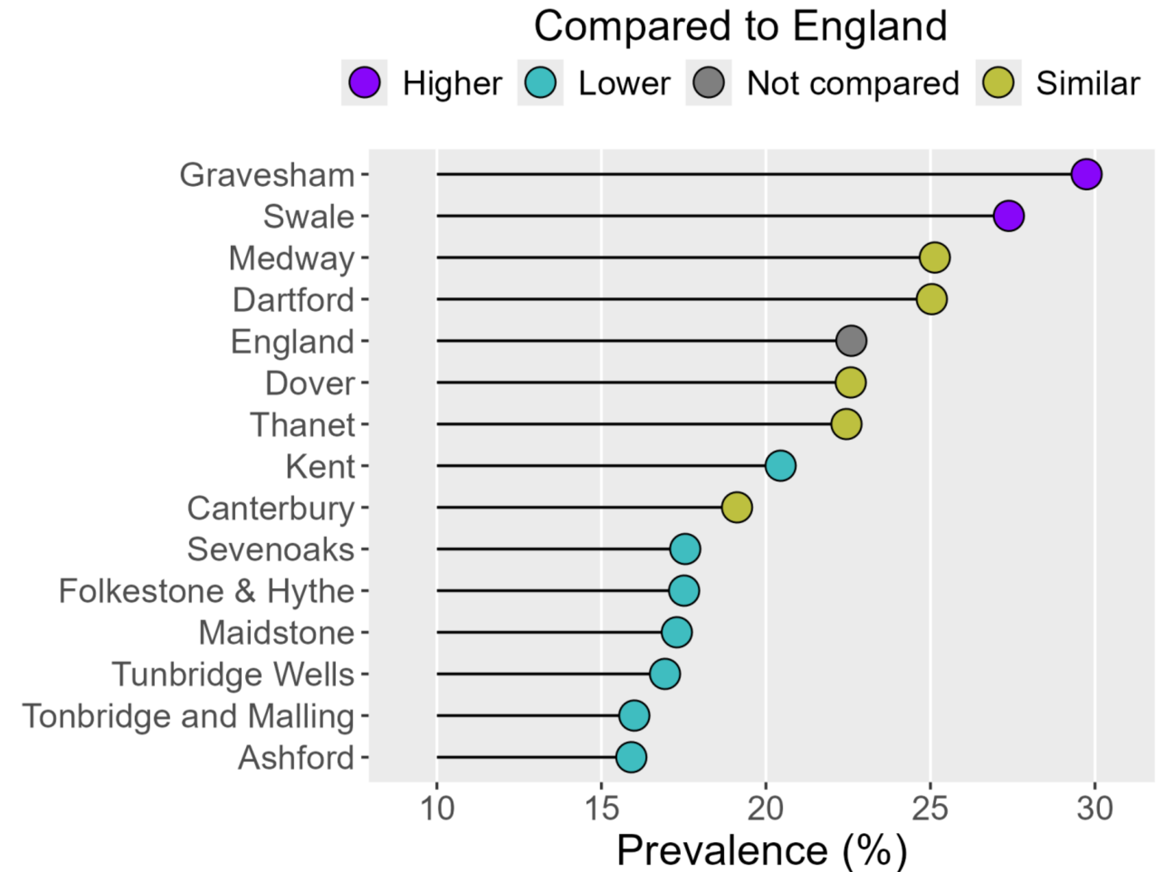
England

22.6

Target

20





Source: Office for Health Improvement & Disparities. Public Health Profiles. [Accessed 2024-08-05] https://fingertips.phe.org.uk © Crown copyright [2024].

Kent County Council kent.gov.uk

Alcohol-related hospital admissions

Admission episodes for alcohol-related conditions (Narrow), Persons, All ages. Latest time period: 2022/23. A lower value is desirable.

Kent

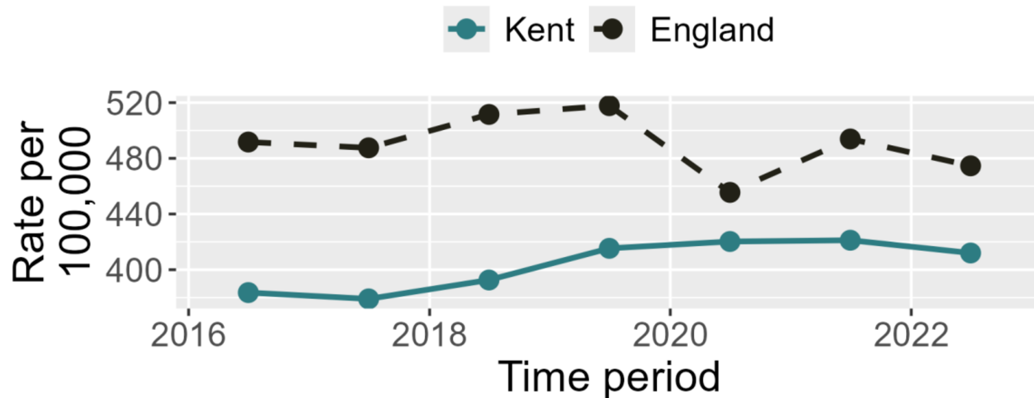
412

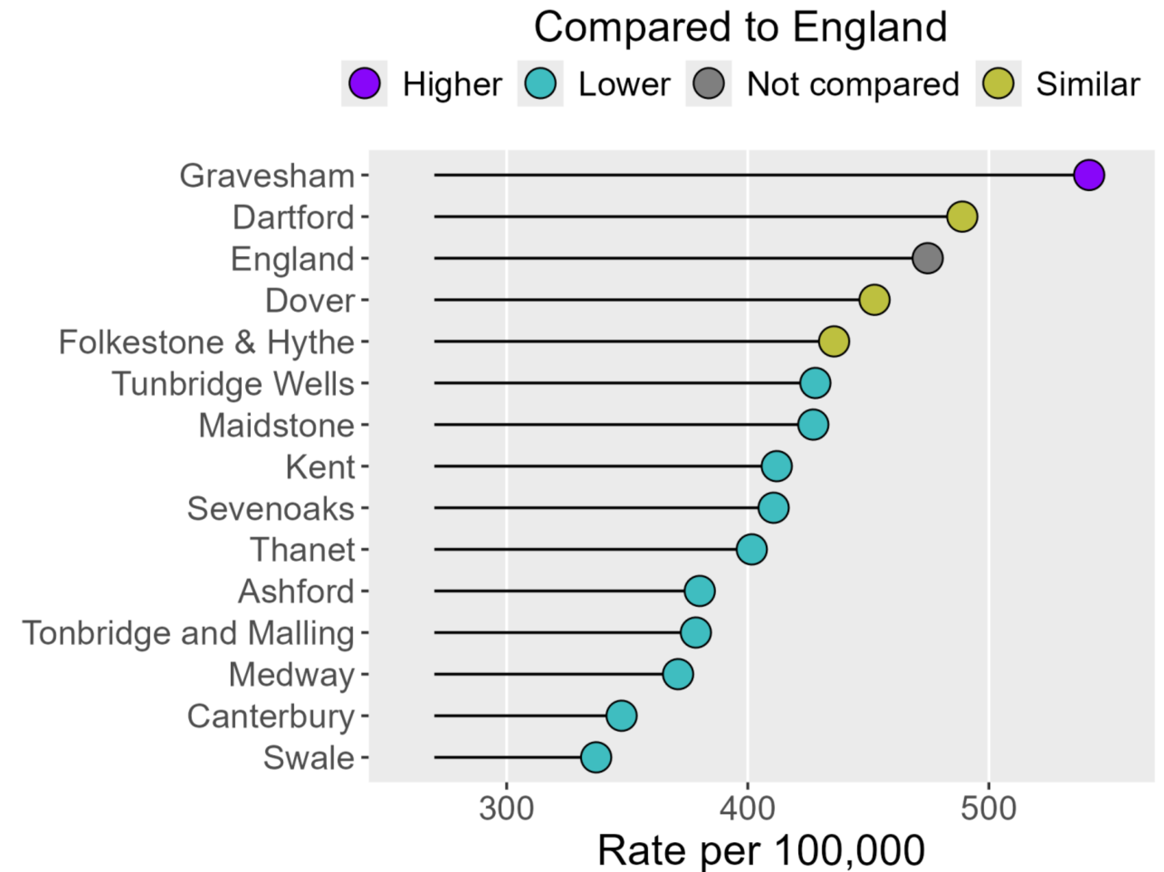
England

475

Target

395





Source: Office for Health Improvement & Disparities. Public Health Profiles. [Accessed 2024-08-05] https://fingertips.phe.org.uk © Crown copyright [2024].

Kent County Council kent.gov.uk

Ambulatory Care Sensitive conditions

Ambulatory Care conditions deprivation gap, Persons, All ages. Latest time period: 2022/23. Both the ratio and absolute gap are presented. A lower value is desirable.

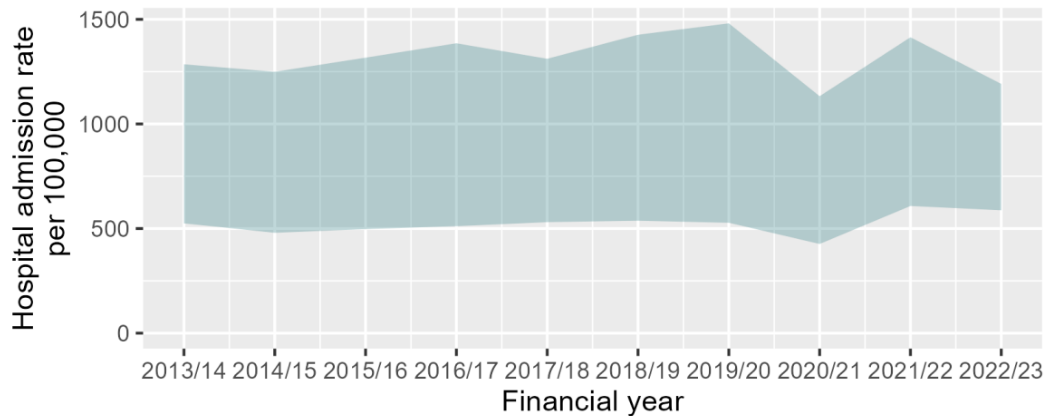
Kent

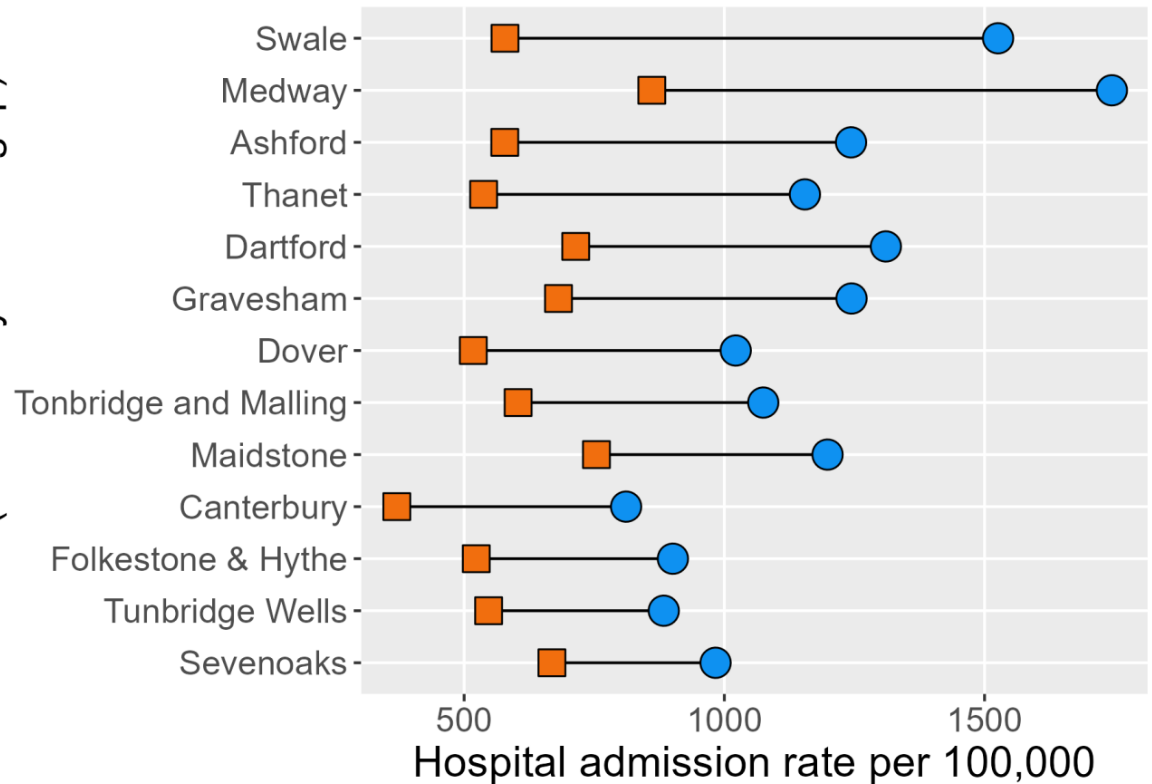
2:1

England

Target

<2:1





Source: Kent County Council Kent Public Health Observatory. Hospital Episode Statistics.

Kent County Council kent.gov.uk

Waiting longer than 6 weeks for NHS Diagnostics

Patients waiting six weeks or more for a diagnostic test, from time of referral, Persons, 16+ yrs. Latest time period: June 2024. A lower value is desirable.

K&M ICB

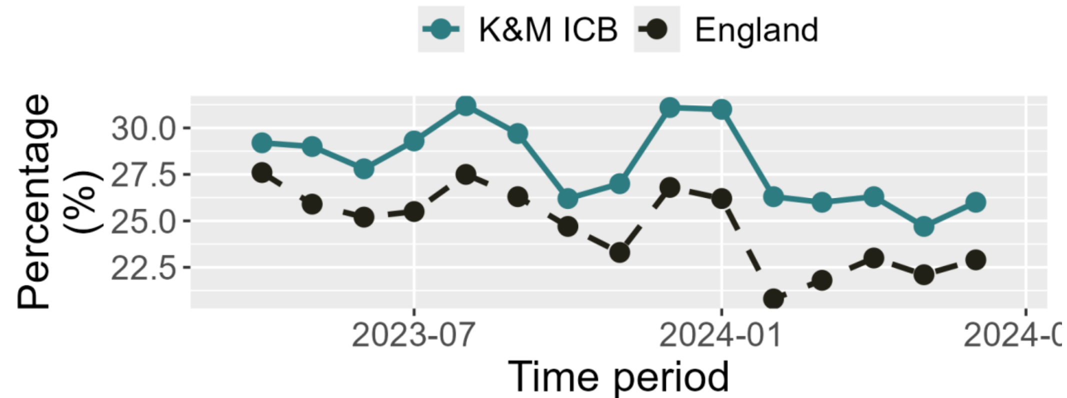
26

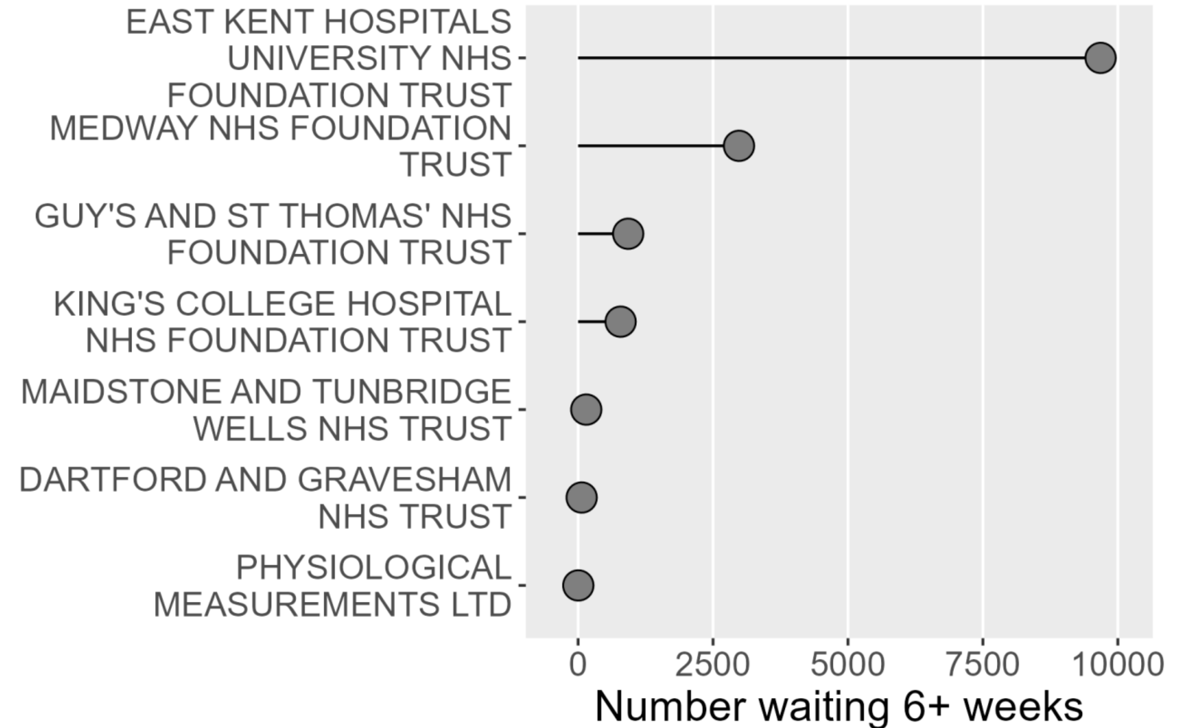
England

22.9

Target

5





Source: NHS England. Diagnostics Waiting Times and Activity. [Accessed 2024-07-22] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/diagnostics-waiting-times-and-activity-dm01

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Deaths in hospital

Percentage of deaths that occur in hospital, Persons, All ages. Latest time period: 2022. A lower value is desirable.

Kent

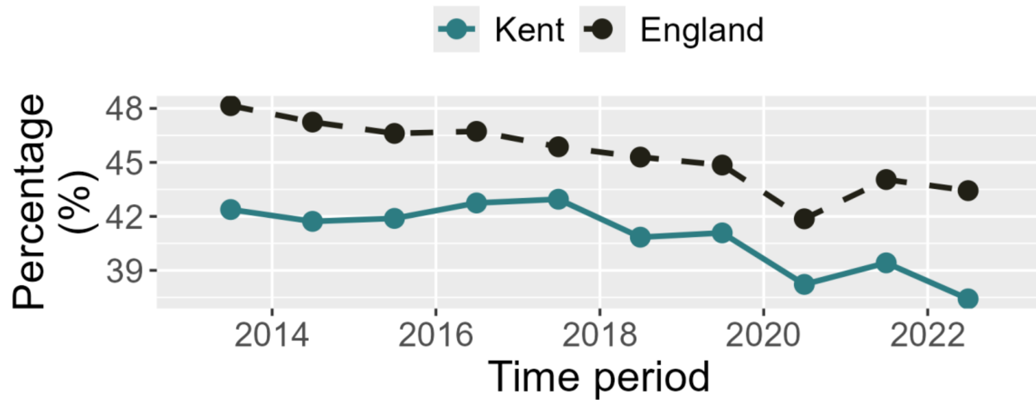
37

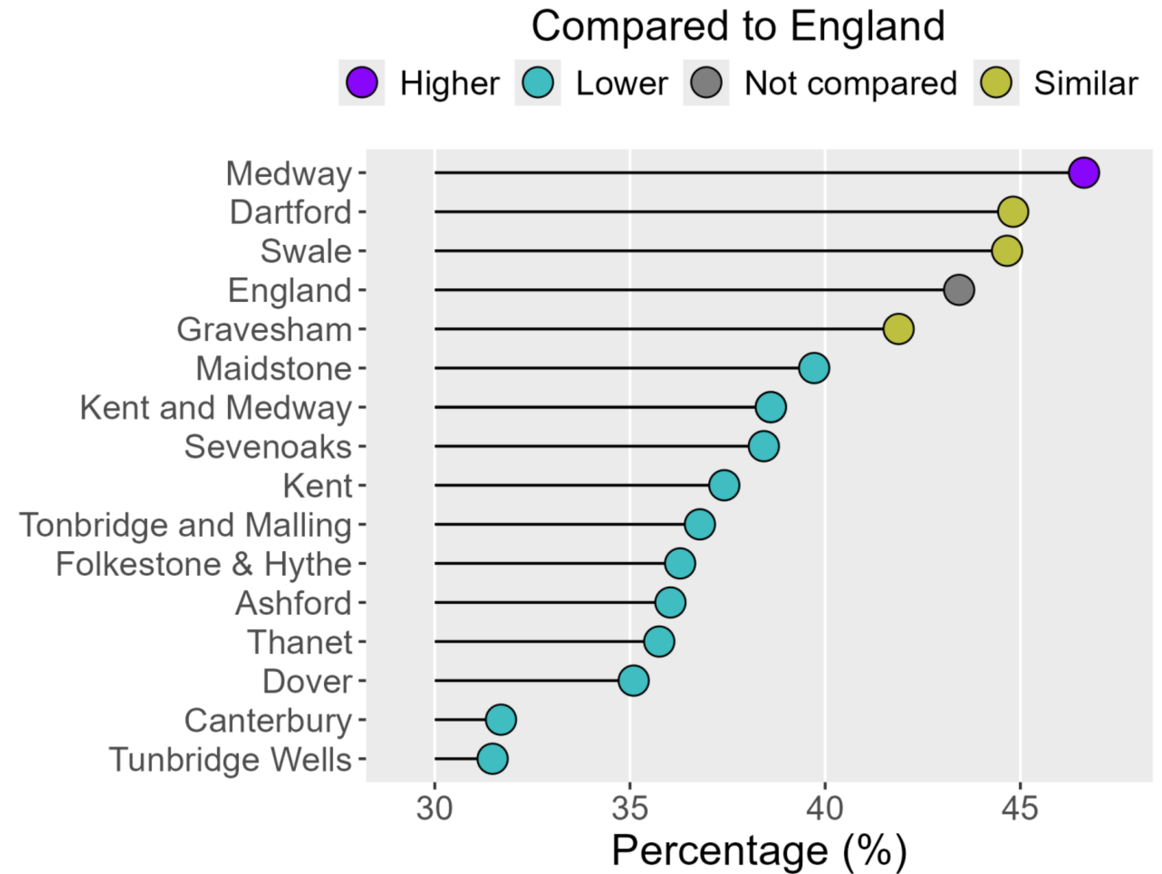
England

43

Target

36





Source: Office for Health Improvement & Disparities. Public Health Profiles. [Accessed 2024-08-05] https://fingertips.phe.org.uk © Crown copyright [2024].

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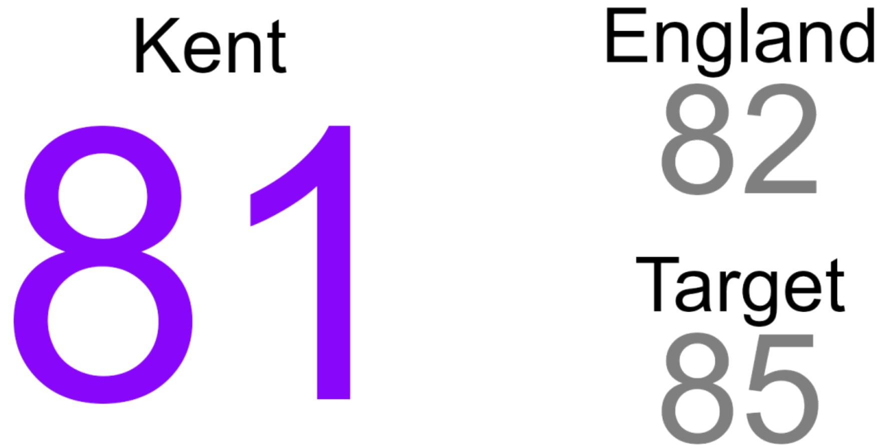
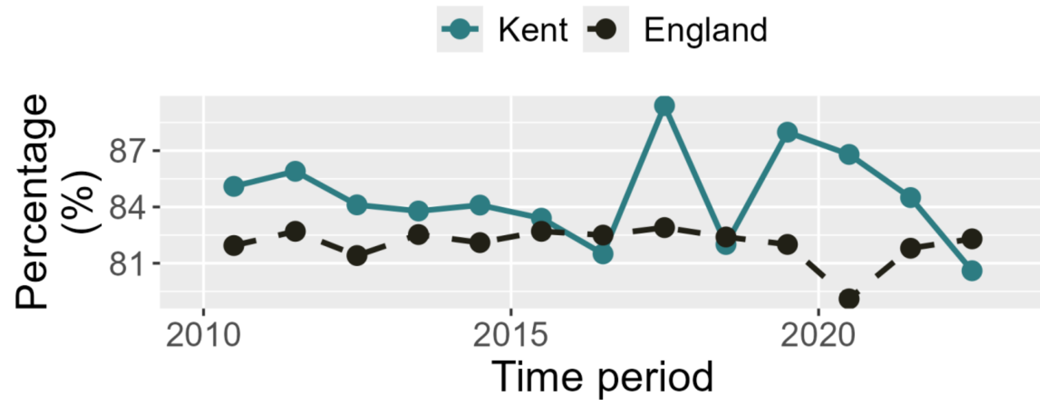
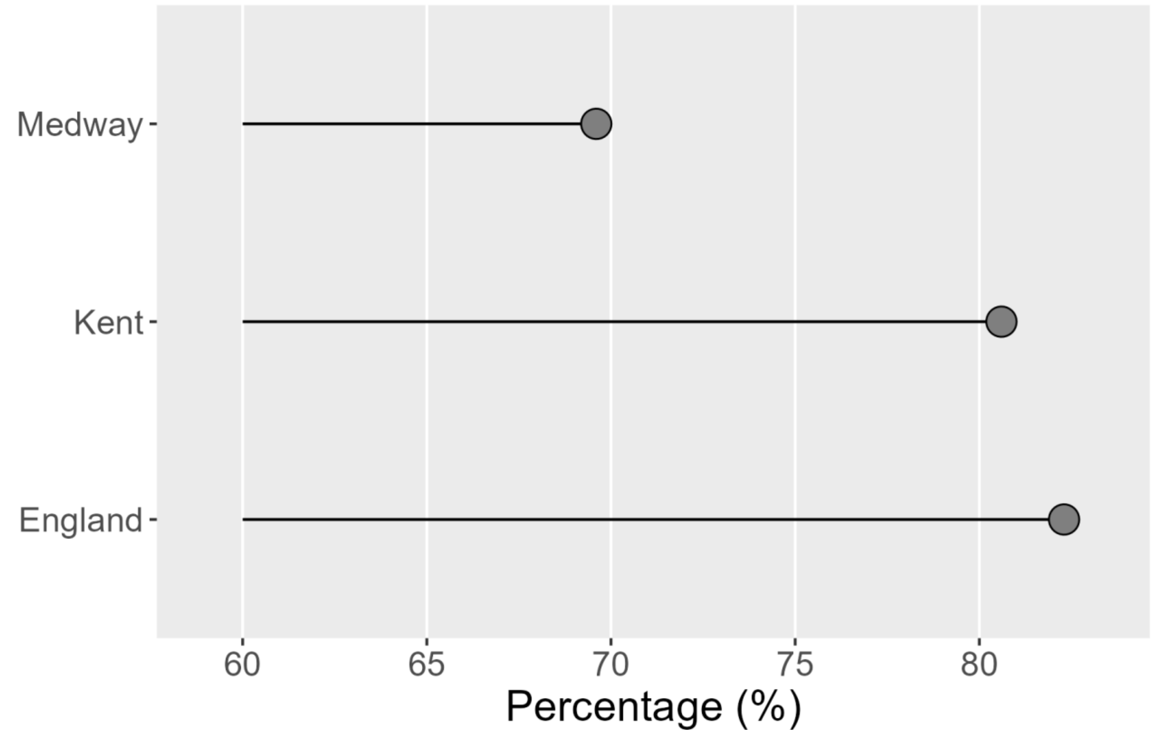
Reablement services

Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services, Persons, 65+ yrs. Latest time period: 2022/23. A higher value is desirable.







Source: NHS England. Adult Social Care Outcomes Framework. [Accessed 2024-08-14]https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2022-23 and Office for Health Improvement & Disparities. Public Health Profiles. [Accessed 2024-08-05]https://fingertips.phe.org.uk © Crown copyright [2024].

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Kent and Medway
Integrated Care System

Logframe Matrix for the Kent and Medway Integrated Care Strategy

■ Indicators highlighted grey are still work in progress.

Version control

Version date	Details
2024-05-20	Working draft shared widely for comment
2024-06-18	Indicator 3.3 (adult overweight / obese) wording clarified to specify the measurement of interest is the gap between most and least deprived
2024-07-01	Removed text 'Included in Strategy' from multiple indicators because these do not hold any special status compared to the other indicators.

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Kent and Medway Integrated Care System

Goal

Narrative: To reduce economic and health inequalities in Kent and Medway

No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
G.1	By 2032, the Index of Multiple Deprivation rank of average score will have increased by 15 places so that both Kent and Medway become relatively less deprived.	Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government. English indices of deprivation. Align more closely with best performing CIPFA nearest neighbours in 2019. Swindon (Medway) and Hampshire (Kent).	
G.2	By 2026-28, life expectancy at birth in Kent and Medway will increase by 1.5 years for males and 1 year for females. Additionally, the slope index of inequality for life expectancy at birth will decrease by 2 years for males and 0.5 years for females.	Office for Health Improvement and Disparities (OHID). Fingertips. Life expectancy at birth (indicator ID 90366) and inequality in life expectancy at birth (indicator ID: 92901). *Align more closely with best performing CIPFA nearest neighbours in 2018-20. Swindon (Medway) and Hampshire (Kent).*	
G.3	By 2026-28, healthy life expectancy at birth in Kent and Medway will increase by 3 years for males and 1.5 year for females.	*Align more closely with best performing CIPFA nearest neighbours in 2018-20. Plymouth (Medway) and Surrey (Kent).*	New indicator added following stakeholder feedback.
G.4	By 2031, the proportion of people from minority ethnic groups living in less deprived neighbourhoods will increase by 1 percentage point in Kent and 2 percentage points in Medway to align more closely with the underlying minority ethnic group population distributions.	Deprivation: Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government. English indices of deprivation. Ethnicity: Nomis. Office for National Statistics. Census. TS021 - Ethnic group. *Match CIPFA nearest neighbours in 2019. Swindon (Medway) and Hampshire (Kent).*	

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Purpose

Narrative: To support social and economic development, improve public service outcomes, and ensure services for citizens are of excellent quality and good value for money

No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
P.1	By XXXX, the spend by public sector organisations in Kent and Medway that is in K&M will be a%, with b% of the total spend with local SMEs.	OVI work in progress. Should be possible to develop an indicator around anchor institutions and the commitment to boost K&M SMEs	Indicator to be changed to align with priorities in the Kent & Medway Economic Framework. The Kent & Medway Economic partnership has committed to 5 high level ambitions with 21 action areas. The targets have not yet been agreed. Following approval at scrutiny committee recently, these will be turned into an implementation plan by June 2024. Indicator monitoring is being provided by the Kent Analytics team.
P.2	By 2028, average income in Kent and Medway will be 5% higher than the national average, up from 2% higher in 2022.	Average weekly earnings - Annual Survey of Hours and Earnings ($ASHE), Office for National Statistics. Public health profiles - OHID (phe.org.uk)	Indicator to be changed to align with priorities in the Kent & Medway Economic Framework. See comment above.
P.3	By 2028, the proportion of children living in relative poverty in Kent and Medway will be reduced from 18% in 2022 to 17%.	Children in Low Income Families: local area statistics, United Kingdom, financial years ending (FYE) 2015 to 2022. https://www.gov.uk/government/collections/children-in-low-income-families-local-area-statistics *Relative low income is defined as a family in low income before housing costs in the refence year. A family must have claimed Child Benefit and at least one other household benefit at any point in the year to be classed as low income in these statistics.*	

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Shared outcome 1: Give children and young people the best start in life

Narrative: We will ensure that the conditions and support are in place for all children and young people to be healthy, resilient and ambitious for their future.

No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
1.1	By 2028, pupils achieving a good level of development at the end of the Early Years Foundation Stage will have improved from 65.8% in 2021/22 to at least 70%.	Department for Education (DfE). Fingertips, Indicator ID: 90631 In line with best performing CIPFA nearest neighbour in 2021/22	
1.2	By 2028, the proportion of children in Year 6 who are healthy weight will be maintained at the current level of 63% and severe obesity will have reduced from 5%.	OHID, using National Child Measurement Programme, NHS Digital. Fingertips Indicator ID: 90323 A return to pre-pandemic levels.	
1.3	By 2028, the difference in rates of overweight and obesity in year 6 children in the top and bottom local quintiles of deprivation in Kent and Medway will have reduced from 13.2% in 2021/22 to 10%. This will be achieved by a reduction among the most deprived groups.	National Child Measurement Programme (NCMP) Return to gap in 2016/17	Original wording updated to highlight a reduction is needed among the most deprived group.
1.4	By 2028/29, the percentage of pupils who meet the expected standard in reading, writing and maths at Key Stage 2 for both SEN and non-SEN pupils will have increased and the gap between the two will be lower than or similar to the national average.	Department for Education (DfE)	New indicator added following stakeholder feedback.
1.5	By 2028/29, the average attainment 8 scores for both SEN and non-SEN pupils will have increased, and the gap between the two will be lower than or similar to the national average.	Department for Education (DfE): Pupils' attainment across eight government approved qualifications. In line with best performing CIPFA nearest neighbour in 2021/22	Wording updated following stakeholder feedback. Was: *By 2028/29, the average attainment 8 scores for both SEN and non-SEN pupils will have increased, and the gap between the two groups will be 5 points lower than the national average.*
1.6	By 2028/29, the percentage of pupils who meet the expected standard in reading, writing and maths at Key Stage 2 will have increased for both disadvantaged and non-disadvantaged pupils, and the gap between the two will be lower than or similar to the national average.	Department for Education (DfE)	New indicator added following stakeholder feedback.
1.7	By 2028/29, the average attainment 8 scores for both disadvantaged and non-disadvantaged pupils will have increased, and the gap between the two will be lower than or similar to the national average.	Department for Education (DfE)	New indicator added following stakeholder feedback.
1.8	By 2028 pupil absence rates will have fallen from 7.9% in 2021/22 to below 5%.	Department for Education (DfE). The overall absence rate in state funded primary, secondary and special schools. In line with national targets.	
1.9	Asthma - Address over reliance on reliever medications; and decrease the number of asthma attacks in children.	TBC. Awaiting national agreement on CORE20PLUS5 indicators.	Indicator wording to be confirmed. Awaiting national agreement on CORE20PLUS5 indicators. To be reviewed against national inequalities metrics. Also, consider switching to asthma admissions deprivation gap as a proxy.
1.10	Diabetes - Increase access to real-time continuous glucose monitors and insulin pumps for children across the most deprived quintiles and from ethnic minority backgrounds.	TBC. Awaiting national agreement on CORE20PLUS5 indicators.	Indicator wording to be confirmed. Awaiting national agreement on CORE20PLUS5 indicators. To be reviewed against national inequalities metrics.

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No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
1.11	Increase proportion of children with Type 2 diabetes receiving recommended NICE care processes.	TBC. Awaiting national agreement on CORE20PLUS5 indicators.	Indicator wording to be confirmed. Awaiting national agreement on CORE20PLUS5 indicators. To be reviewed against national inequalities metrics.
1.12	Epilepsy - Increase access to epilepsy specialist nurses and ensure access in the first year of care for children with a learning disability or autism.	TBC. Awaiting national agreement on CORE20PLUS5 indicators.	Indicator wording to be confirmed. Awaiting national agreement on CORE20PLUS5 indicators. To be reviewed against national inequalities metrics.
1.13	Oral health - Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.	TBC. Awaiting national agreement on CORE20PLUS5 indicators.	Indicator wording to be confirmed. Awaiting national agreement on CORE20PLUS5 indicators. This is now part of the NHSE mandated health inequalities metrics: Reduce the gap for tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under caused by deprivation. There are likely to be significant data quality issues with this indicator as many extractions are performed in high street dentists on behalf of hospitals, but the data isn't necessarily available in hospital data.
1.14	Mental health - Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation.	TBC. Awaiting national agreement on CORE20PLUS5 indicators.	Awaiting national agreement on CORE20PLUS5 indicators. Going to review against national inequalities metrics. Also, exploring creating an indicator related to children in care and mental health needs following stakeholder feedback.
1.15	By 2028/29, the proportion of mothers smoking at time of delivery will have reduced from 10.2% in 2021/22 to no more than 6%.	Office for Health Improvement and Disparities (OHID). Fingertips. Indicator ID: 93085.	
1.16	By 2028, the proportion of children who are up to date with the vaccinations in the NHS routine list meets the national benchmark (95%).		
1.17	By 2028, the proportion of children in care who are up to date with the vaccinations in the NHS routine list meets the national benchmark (95%).	Office for Health Improvement and Disparities (OHID). Fingertips. Indicator ID: 811.	
1.18	By 2028, 80% of initial health assessments completed within 28 calendar days (20 working days) of a child or young person becoming looked after.	Department for Education (DfE)	New indicator added following stakeholder feedback.

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Shared outcome 2: Tackle the wider determinants to prevent ill health

Narrative: Address the wider determinants of health (social, economic and environmental), to improve the physical and mental health of all residents, tackle inequalities, and focus on those who are most vulnerable.

No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
2.1	By 2028/29, the proportion of people who feel lonely often or always will have reduced from 7.3% in 2020/21 to no more than 5% across Kent and Medway.	Office for Health Improvement and Disparities (OHID). Fingertips. Indicator ID: 93758.	
2.2	By 2028/29, the percentage of the population who are in contact with secondary mental health services that are in paid employment (aged 18 to 69) will increase from 8% in 2020/21 to above 10% in Kent and Medway.	Office for Health Improvement and Disparities (OHID). Fingertips. Indicator ID: 93886. NHS Digital. ASCOF indicator 1F.	
2.3	By 2028/29, the percentage of the population who are in receipt of long-term support for a learning disability that are in paid employment (aged 18 to 64) will increase and go from worse than the national average to similar or better than the national average.	Office for Health Improvement and Disparities (OHID). Fingertips. Indicator ID: 93884. NHS Digital. ASCOF indicator 1E.	
2.4	By 2028, the proportion of closed safeguarding enquires where risk is reduced or removed is better than the national percentage.	NHS Digital. Safeguarding adults. Section 42 and other enquiries.	
2.5	By 2028, smoking prevalence in adults in routine and manual occupations (18-64) will have decreased by 9 percentage points from 28.1% in Kent and 20.1% in Medway in 2021.	Office for Health Improvement and Disparities (OHID). Fingertips. Indicator ID: 92445. Match best performing CIPFA nearest neighbours in 2020. Bury (Medway) and Hampshire (Kent).	
2.6	For the emissions we control directly, to achieve net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032		Replacement indicator suggested by Kent and Medway Strategic Environment and Sustainability Steering Group to replace: *All NHS organisations and local authorities will make progress towards their net-zero targets.*
2.7	For the emissions we can influence to achieve net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.		Replacement indicator suggested by Kent and Medway Strategic Environment and Sustainability Steering Group to replace: *All NHS organisations and local authorities will make progress towards their net-zero targets.*
2.8	By 2028, prevent or relieve more than 60% of homeless households where a homeless duty has been triggered	HCLIC statistical returns	Indicator suggested by Medway Council to replace: *By 2028, the rate of households owed a homelessness prevention or relief duty will have decreased in Medway from is 15.8 per 1,000 households to 12.0 per 1,000, and the rate in Kent rate will not exceed 12.0 per 1,000.*
2.9	By 2028, XXX of new affordable homes will be delivered each year in Kent and Medway.		Alternative housing indicators suggested by Kent Housing Group. Level of ambition to be added and awaiting approval by stakeholders.
2.10	By 2028, X% percentage of social homes meet the Decent Homes Standard in Kent and Medway.		Alternative housing indicators suggested by Kent Housing Group. Level of ambition to be added and awaiting approval by stakeholders.
2.11	By 2028, X% privately rented homes in Kent and Medway have a category 1 hazard identified using Housing Health and Safety Rating System (HHSRS).		Alternative housing indicators suggested by Kent Housing Group. Level of ambition to be added and awaiting approval by stakeholders.
2.12	By 2028, the rate of serious violence will be lower or similar compared to the national average.	Home Office Police recorded crime and outcomes open data tables • Homicide (Offence Subgroup) • Assault with injury (Offence Subgroup) Robbery of personal property (Offence Description)	Indicator amended to focus on serious violence following stakeholder feedback.
2.13	Increase employment rates in Kent and Medway.		Indicator to be added to align with priorities in the Kent & Medway Economic Framework. See comment in P.1.

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No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
			Also suggested that this should be a purpose level indicator.
2.14	Attract and support businesses in Kent and Medway, i.e. providing new employment opportunities		Indicator to be added to align with priorities in the Kent & Medway Economic Framework. See comment in P.1. Also suggested that this should be a purpose level indicator.

Shared outcome 3: Supporting happy and healthy living

Narrative: Help people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years.

No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
3.1	By 2028, the proportion of adults in Kent and Medway who are physically inactive will have fallen from 22.3% in 2020/21 to 20%.	OHID (Active Lives Adult Survey Sport England) Fingertips, Indicator ID: 93015. The weighted number of respondents aged 19 and over, with valid responses to questions on physical activity, doing less than 30 moderate intensity equivalent physical activity per week in bouts of 10 minutes or more in the previous 28 days. In line with best performing CIPFA nearest neighbour in 2020/21	
3.2	By 2028, the proportion of adults in Kent and Medway who are overweight or obese will have fallen from 64.1% in 2020/21 to 62%.	OHID (based on the Active Lives Adult Survey, Sport England), Fingertips ID 93088. the number of adults aged 18+ with a BMI classified as overweight (including obesity). In line with best performing CIPFA nearest neighbour in 2020/21	
3.3	By 2028, the gap in overweight and obesity rates in adults between the top and bottom local quintiles of deprivation in Kent and Medway will have reduced to 2%, from 3.3% in 2021/22.	Quality and Outcomes Framework (QOF), Fingertips, Indicator ID: 92588. The percentage of patients aged 18 or over with a BMI greater than or equal to 30 in the previous 12 months. Smallest combined gap in past 7 years	Change made 18/06/2024. Wording edited to improve readability.
3.4	By 2028, hospital admissions in Kent and Medway due to alcohol will have fallen from 418.7 in 2021/22 to 395 per 100,000.	OHID, Fingertips indicators 91414 and 93764. Admissions to hospital where the primary diagnosis is an alcohol-attributable code, or a secondary diagnosis is an alcohol-attributable external cause code. In line with best performing CIPFA nearest neighbour in 2020/21	
3.5	By 2028, 75% of cancers will be diagnosed at stage 1 or stage 2 (CORE20PLUS5).	NHS Digital's National Disease Registration Service. Fingertips, Indicator ID: 93671 In line with national target	
3.6	By 2028, maintain the rate of emergency admissions for those with one or more long term condition to the level it was in 2024.	OBH LTC3	Data source will need to change.
3.7	By 2028, the rate of emergency admissions for those who are frail will	OBH FD33	Data source will need to change.

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Kent and Medway
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No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
	have reduced by at least 1.5% to the rate it was in 2018 (4,556 per 100,000).		
3.8	By 2028, diabetes complications such as stroke, heart attacks, amputations, etc., will have reduced by at least 10% (baseline 2018-19: 177 per 100,000).	OBH DM49	Data source will need to change.
3.9	By 2028, the suicide rate for persons will be similar or better than the England average (England currently 10 per 100,000).	OBH MH69	Due to data quality issues for self-harm admissions, indicator switched to suicide.
3.10	By 2028, we will increase the proportion of people who receive long-term support who live in their home or with family.		
3.11	By 2028, the mortality rate from drug misuse in Kent and Medway will remain at a similar level, which is similar to or better than the national average.	OHID. Fingertips. Indicator ID: 92432.	
3.12	By 2028, the STI testing rate will increase, going from worse than the national average to similar or better.	OHID. Fingertips. Indicator ID: 91307.	
3.13	By 2028, flu vaccination uptake for healthcare professionals will reach or exceed the WHO target of 75%.		
3.14	By 2028, flu vaccination uptake for at-risk groups will reach or exceed the WHO target of 75%.		
3.15	By 2028, bowel cancer screening will meet or exceed the national acceptable performance level of 52%. Bowel cancer screening programme standards.	OHID. Fingertips. Indicator ID: 91720.	
3.16	By 2028, cervical cancer screening will meet or exceed the national acceptable performance level of 80%. Cervical screening programme screening standards.	OHID. Fingertips. Indicator ID: 93560 & 93561.	
3.17	By 2028, breast cancer screening will meet or exceed the national acceptable performance level of 70%. Breast screening programme screening standards.	OHID. Fingertips. Indicator ID: 22001.	
3.18	By 2028, at least 75% of people aged 14 or over with a learning disability will have had an annual health check.	NHS Digital. Learning Disabilities Health Check Scheme.	New indicator added following stakeholder feedback.

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Shared outcome 4: Empower people to best manage their health conditions

Narrative: Support people with multiple health conditions to be part of a team with health and social care professionals working compassionately to improve their health and wellbeing.

No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
4.1	By 2028, 67% of patients with long term conditions say they have had enough support from local services or organisations in the last 12 months.	GP survey	
4.2	By 2028, the people describing their overall experience of making a GP appointment as good will have increased from 49% in 2022 to at least 60%.	GP survey	
4.3	By 2028/29, the inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions will have reduced. The ratio of the rate between the most and least deprived 20% of the population will have fallen below 2.0, and will be similar to or lower than the national average.	NHS Digital. Hospital Episode Statistics.	Indicator wording amended to focus on reducing the deprivation gap, not just the rate.
4.4	By 2028, the proportion of carers who report that they are very satisfied or extremely satisfied with social services will have improved from 32.3% in 2020/21 to at least 45%.	Survey of Adult Carers in England (SACE) In line with best performing CIPFA nearest neighbour	Wording amended slightly to reflect survey question.
4.5	By 2028, reduce the rate of emergency admissions for those with learning disabilities from the 2024 baseline.		
4.6	Maintain the Talking Therapies recovery rate at the 2024 value		
4.7	There will be an increasing percentage of patients with high or very high needs being supported through INTs as evidenced by having active care plans.		
4.8	By 2028, the proportion of deaths in hospital across Kent and Medway will reduce from 41% to 36%.	OHID, Fingertips indicator 93474. The annual percentage of registered deaths in each area for persons and where the place of death is recorded as hospital. In line with best performing CIPFA nearest neighbour in 2020/21	
4.9	By 2027 we will have implemented our organisational carers strategies.		

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Shared outcome 5: Improve health and care services

Narrative: Improve access for all to health and care services, providing services as locally as possible and creating centres of excellence for specialist care where that improves quality, safety and sustainability.

No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
5.1	By 2025 we will meet national expectations for patients with length of stay of 21+ days who no longer meet with criteria to reside.	SUS data	
5.2	By 2028, reduce readmissions for frail patients.		
5.3	By 2025, percentage of 2-hour urgent community response referrals that achieved the 2-hour standard will be at or above the national standard.	UCR stats available from nationally at ICB level	
5.4	Inappropriate out of area mental health placements will be at or close to zero.	Available nationally	
5.5	By 2028, the percentage of patients spending more than 12 hours in an emergency department before admission matches best performing nearest neighbours.	Available nationally	
5.6	By 2028, ambulance handover delays greater than 60 minutes matches best performing nearest neighbours.	Available nationally UEC sitrep	
5.7	By 2028, waits for diagnostics will meet national ambitions.	Available nationally	
5.8	By 2028/29, the percentage of people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services will have increased in Kent to at least 85% (2021/22: Kent 84.5%) and in Medway to be similar to, or higher than, our statistical neighbours (2021/22: Medway lower at 61.7%).	Office for Health Improvement and Disparities (OHID). Fingertips. Indicator ID: 90584. NHS Digital. ASCOF indicator 2B(1).	Wording amended slightly following stakeholder feedback. Wording was: *By 2028/29, the percentage of people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services will have increased in Kent to at least 85% (2021/22: Kent 84.5%) and in Medway to be in line with the national average (2021/22: Medway lower at 61.7%).*

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Shared outcome 6: Support and grow our workforce

Narrative: Make Kent and Medway a great place for our colleagues to live, work and learn

No.	Objectively verifiable indicators (OVIs)	Means of verification (MOV)	Notes
6.1	By XXXX, all organisations achieve a staff retention rate of at least X%.	Individual organisation HR data	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.2	By XXXX, the staff vacancy rate of all organisations will have reduced by X%.	Individual organisation HR data	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.3	By XXXX, X% of employees report that their managers/organisation support their learning and development.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.4	By XXXX, X% of employees have completed their organisation's mandatory leadership training.	Individual organisation workforce development data.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.5	By XXXX, X% of employees would recommend their organisation as a place to work.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.6	By XXXX, all organisations will have made progress towards workforce mobility.	TBC	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.7	By XXXX, all organisations will achieve a minimum staff survey participation rate of X%.	Individual organisation staff surveys.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.8	By XXXX, X% of employees feel that their role makes a difference to patients / service users / residents.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.9	By XXXX, X% of employees feel that their manager/organisation takes positive action on health and wellbeing.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.10	By XXXX, the staff sickness rate will have reduced by X%.	Individual organisation HR data	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.11	By XXXX, the staff survey diversity declaration rates will have increased by X%.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.12	By XXXX, each organisation's workforce is representative compared to the general working age population by each protected characteristic (TBC).	Individual organisation HR data. ONS/Census population data.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.13	By XXXX, X% of employees rate their inclusion and fair treatment in their organisation positively.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.14	By XXXX, X% of employees feel their organisation acts fairly regarding career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.15	By XXXX, the proportion of staff who experienced internal harassment, bullying or abuse will have reduced by X%.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.
6.16	By XXXX, the proportion of staff who experienced external harassment, bullying or abuse will have reduced by X%.	Individual organisation staff surveys. Wording currently different. Look to align in time.	Draft wording created during recent working groups. Final wording and level of ambition TBC.

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From:	Dan Watkins, Cabinet Member for Adult Social Care and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee – 17 September 2024
Subject:	**Public Health Communications and Campaigns Update**
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Summary: This paper reports on the campaigns and communications activity delivered through the Public Health Team in 2024 and outlines plans for the remainder of the financial year.

The report notes the ongoing health protection communications (heat health and vaccinations) and other Public Health priorities. A campaign completed over summer to raise awareness of alcohol consumption, mental health awareness days activity and planning for increased campaign activity to promote stop smoking services in Quarters 3 and 4 2024/2025

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to NOTE the progress of Public Health communications and campaigns in 2024 and the need to continue to deliver throughout 2024/2025.

1. Introduction

1.1 Marketing and Communications activity continues to play a critical role in supporting the people of Kent and providing trusted, timely information throughout the year.

1.2 Our communications includes both reactive and proactive support. Through reactive communications such as media opportunities and amplifying partner content we can inform the people of Kent on the impact of severe weather, Covid-19 and other infectious outbreaks. This year there has been an increase in whooping cough cases and measles outbreaks in children and young people. Between April – August 2024, Kent County Council (KCC)’s Marketing and Resident Experience team has shared 15 media releases and coordinated 6 media interviews across the health and wellbeing portfolio.

1.3 Proactive campaign activity supports the public health division in reaching the people of Kent. KCC provides trusted information and signposting to preventative services including lifestyle services such as weight management, stop smoking services, sexual health, drugs and alcohol, children and family public health services (health visiting and school nursing).

1.4 We support the work to reduce health inequalities within Kent, using targeted communications methods to reach different geographical areas and groups of individuals across the county.

1.5 Our statutory warn-and-inform responsibilities, as lead for the Kent Resilience Forum Outbreak Control Management Plan, has seen KCC's Director of Public Health and the KCC communications team at the forefront of media and Public Relations (PR), social media and marketing, stakeholder and partnership engagement.

1.3 As we work across public health communications, we can identify opportunities to work more efficiently where we want to reach similar audiences. This also helps us purchase advertising space at more competitive rates.

1.4 Marketing and Communication activity has continued to focus on three main drivers:

- Promoting healthier behaviours and self help
- Giving information and advice
- Promoting local services where available and also highlighting online and digital support.

1.5 This paper covers communications activity for 2024, along with key activities and plans for this financial year.

2. Public Health Campaigns and Communications 2024/2025

2.1 Overview of activity from April 2024:

- Alcohol awareness summer campaign – promoting the 'Know Your Score' online tool and local support services
- Health protection – summer health (heat health alerts), whooping cough and Measles, Mumps and Rubella (MMR) vaccinations and air quality.
- Mental health and wellbeing – promotion of 'Release the Pressure' helpline and text service, Every Mind Matters online tool and Live Well Kent Services
- Healthy weight – National Walking Month, 'One You Kent' local support services and promote online tools
- Smoking cessation – targeted signposting to 'One You Kent' local support services

2.2 Alcohol Reduction – 'Know Your Score' online tool promotion app

2.2.1 A campaign to promote the 'Know Your Score' Audit C online tool at www.kent.gov.uk/knowyourscore has been developed to support a summer awareness raising campaign in line with Alcohol Awareness Week in July through to August. During Alcohol Awareness Week, we generated 15,000 impressions with 300 engagements over Facebook and X.

2.2.2 Key messages continue to raise awareness among all adults about long term health messages linked to alcohol, including the risk of stroke, and the impacts on mental health, work and relationships. Content is focused around key behaviours with some targeted assets for parents and middle aged men. Channels for promotion included audio (DAX, Heart FM, Spotify), digital (Mobile alerts, Mumsnet, Facebook, Instagram and geo-targeted mobile adverts) along with media and PR opportunities and sharing encouraged by partners across Kent. A further campaign burst is due to run in January, signposting to support services through commissioned providers Change Grow Live (CGL),Forward Trust and One You Kent.

2.2.3 Interim campaign data as of 14 August 2024:

- 3,374 webpage views: kent.gov.uk/knowyourscore
- 550 webpage views: kent.gov.uk/lowermydrinking
- 1,546 'Know Your Score' Quiz completions through the website (1,455 of these between July-Aug to date as part of paid campaign activity). Data shows an increase in completions of the Know Your Score quiz compared to the same period in 2023.

2.3 Health Protection – Heat health alerts, vaccinations and air quality

2.3.1 Throughout the summer we have reshared the UK Health Security Agency (UKHSA) and the Met Office warnings about hot weather and 'Heat Health Alerts', and we generated our own refreshed content for social media and kent.gov.uk/heatwave. Through organic KCC social media (posted directly from KCC channels), we have reached 56,000 people and engaged with 1,500 people this to date. The Director of Public Health (KCC) features in heat alert videos issued to help inform the public and support those more vulnerable.

2.3.2 Due to a national rise in Measles, we have been working closely with the Kent Community Health Foundation Trust (KCHFT) and NHS partners to promote community clinics where people aged under 19 can get a Measles, Mumps and Rubella (MMR) vaccination. Media releases alongside NHS and UK Health Security Agency (UKHSA) social media posts were shared to raise awareness of this issue and ways to get vaccinated.

2.3.3 With whooping cough cases continuing to rise across England, a joint media release with Kent and Medway NHS was shared to increase vaccinations with pregnant women and children. The Deputy Director of Public Health at KCC completed an interview on BBC Kent and UK Health Security Agency social media content was also shared.

2.3.4 Video content was co-created with the Gypsy Roma Traveller (GRT) community to highlight the importance of immunisations such as MMR (Measles Mumps and Rubella) and Whooping cough to protect their families. A member of the GRT community took part in the filming and was integral in sharing these videos across GRT groups/networks to raise awareness and engage with the community.

2.3.5 As part of 'Clean air day' on 20 June 2024, social media content was shared across channels and with partners over the week. Signposting to kent.gov.uk/cleanairday, tools to help you walk/cycle more (Kent Connected) and the Kent and Medway Air Quality Partnership air-quality email alerts. These generated 14,974 impressions with 130 engagements over Facebook and X and were shared across partners channels. A media release was also shared - Celebrate Clean Air Day - News & Features - Kent County Council

2.3.6 Where possible, health inequality research and lived experience form the basis of campaign and communications engagement, finding new innovative ways to reach people who are most at risk of serious illness.

2.4 Mental Health and Wellbeing – Release the Pressure, Live Well Kent & Every Mind Matters

2.4.1 Communications for Mental Health Awareness Week (MHAW) in May signposted to local support services including Live Well Kent, One You Kent and Every Mind Matters at www.kent.gov.uk/everymindmatters. This also coincided with 'Hoarding Week' supported via social media through the Kent and Medway Safeguarding Adults Board (KMSAB). We also reshared content through Mind, promoting their mental health online training. During MHAW, we generated over 20,000 impressions through our social media posts and over 200 engagements.

2.4.2 Themes have included tackling loneliness, and finding tools and local support to empower people to find help with anxiety, stress, low mood and sleep issues.

2.4.3 The 2024 Better Mental Health and Wellbeing Community Grants were given to support suicide prevention across Kent and Medway. This was promoted with a media release - Grants to support suicide prevention and give hope - News & Features - Kent County Council

2.4.4 In preparation for World Suicide Prevention Day (WSPD) on 10 September 2024, the Kent and Medway Suicide Prevention Programme commissioned a follow up film to the one released 4 years ago, featuring updated stories from the Living Warriors talking about their lived experience around mental health and suicide. This is currently in editing and due to be released on World Suicide Prevention Day, with wider communications promoting Mind Suicide prevention training and 'Release the Pressure' signposting.

2.4.5 KCC Public Health has ongoing promotion of the suicide prevention 'Release the Pressure' campaign through Social media and Google AdWords.

2.4.6 Advertising boards at selected football grounds in areas of deprivation have also been agreed to target males, with Dartford FC, Folkestone Invicta FC and Dover Athletic FC featuring 'Release the Pressure' pitch side advertising boards and match day programme ads for the 2024/2025 season. Further targeted paid-for promotion is being planned for December and January. In the 2023/2024 season attendance at these clubs combined achieved approximately 50,000 visitors.

2.4.7 We also shared promotion of partners' campaigns such as Kooth mental wellbeing for children and young people.

2.5 Healthy Weight - One You Kent/Better Health

2.5.1 New creative assets including animated videos have been developed with One You Kent partners to promote physical activity and healthy eating including meals on a budget. Creative targets older adults and families.

2.5.2 Animated videos and images are planned to be shared in GP surgeries, through social media and selected paid for advertising screens in hospitals in Kent.

2.5.3 As part of 'National Walking Month' in May, we created a social media tool kit for our social channels and to share through our 'One You Kent' and NHS partners. The content included links to 'Kent Connected' the free walking app, local walking groups and 'Living Streets' who lead the awareness month. Over May, we reached 23,000 people with our social media content.

2.5.4 We also share promotion of partner's campaigns around healthy weight and staying active for children and families through Better Health Families and KCC partners.

2.6 Smoking Cessation – One You Kent services promotion

2.6.1 As part of our ongoing social media activity, we share content around stop smoking services signposting to One You Kent commissioned support services. Key messages focus on the physical and mental health harms of smoking plus the financial impact and the quitting benefits to these. The call to action signposts people to www.kent.gov.uk/smokefree where they can refer to the One You Kent support services plus self-help tools including the NHS Quit Plan app.

2.6.2 Between 1 April 2024 and 14 August 2024 there have been 2,056 webpage views: kent.gov.uk/smokefree (41% increase in visits compared to the same period in 2023).

2.6.3 As a result of additional central Government funding , we have been planning multichannel campaigns across Kent and targeting key audiences in areas of deprivation and targeted elements to reach routine and manual workers. This includes brand awareness activity such as stadium advertising and google

ads and well as targeted advertising through social media and digital channels.

2.6.4 New creative materials such as videos from people who have quit smoking through One You Kent service are currently being planned for September ahead of ‘Stoptober’ and another campaign in the New year (January).

3. Integrated Care System

3.1 KCC plays an integral role in how the health and care system communicates with the public As the Integrated Care Board develops its delivery plans, an engagement programme is being planned to support the development of the key themes and priorities. The first piece of activity planned is to engage with people in Kent to understand more about how current factors are affecting their wellbeing. This engagement will help KCC to shape future Public Health priorities and will provide meaningful qualitative feedback to ensure that the person’s voice plays a critical role in decision making within the Integrated Care System. More information on the engagement programme will be provided in future reports.

3.2 KCC Marketing and Resident Experience Team is a key member of the Communications and Engagement Board which reports directly to the Integrated Care Board and Steering Group and continues to play an integral role in planning and delivering integrated communications activity to people across Kent.

4. Financial update

4.1 £110,000 has been allocated to campaign and marketing activity in 2024/25 which some additional funds available directly from service budgets.

5. Conclusion and Next Steps

5.1 We continue to develop key Public Health campaigns based on priorities identified by the Director of Public Health. These include:

- Mental Health and Wellbeing
- Start for Life (Family Hubs)
- Obesity – adult and children
- Smoking
- Alcohol
- Breastfeeding and infant feeding
- Seasonal health – heatwave and winter
- Sexual health

5.2 Data, insight and localised information is used to shape these campaigns.

5.3 Previous successes and learning will be integrated in future campaigns, focusing 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.

5.4 It has long been recognised that long-term change requires long term, consistent messaging, and it is important to continue working with local partners and nationally with UK Health Security Health Agency (UKHSA) to create and deliver consistent Public Health campaigns and marketing activity.

6. Recommendation

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

NOTE the progress of Public Health communications and campaigns in 2024 and the need to continue to deliver throughout 2024/25.

7. Report Author

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From:	Dan Watkins, Cabinet Member for Adult Social Care and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee - 17 September 2024
Subject:	Update on Gypsy Roma Traveller Health, including child immunisations and suicide prevention
Key decision :	No
Classification:	Unrestricted
Past Pathway of report:	N/A
Future Pathway of report:	N/A
Electoral Division:	All

Is the decision eligible for call-in? *N/A*

Summary: This report was requested by members of the committee to provide an update on the work of the Public Health Team with Gypsy, Roma and Travellers in Kent, following the Health Needs Assessment completed in September 2023. This report highlights the ongoing commitment of the Public Health Team towards improving health outcomes for Gypsy, Roma and Traveller communities in Kent through research, community engagement, and coordinated action.

Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **NOTE** ongoing efforts and progress made to date to address the observed health inequalities identified in the Health Needs Assessment.

1. Introduction

1.1 This report provides an update on the work underway with Gypsy, Roma and Travellers (GRT) in Kent. Gypsies and some Traveller ethnicities have been recognised in law as being ethnic groups protected against discrimination by the Equality Act 2010. Migrant Roma communities are protected both by virtue of their ethnicities and their national identities.

1.2 The GRT communities experience multiple overlapping risk factors for poor health, such as poverty, health inequalities, low uptake of services such as vaccination, violence, and complex trauma. The Houses of Parliament Commons Select Women and Equalities Committee inquiry (completed in April 2019) into tackling inequalities faced by Gypsy, Roma, and Traveller communities, noted there was a lack of focus on these communities within Joint

Strategic Needs Assessments (JSNAs) nationally and highlighted that this omission resulted in GRT communities being overlooked when planning services. The Select Committee stated this was unacceptable given the poor health outcomes faced by GRT communities.

1.3 The Public Health Team completed a Health Needs Assessment (HNA) for the GRT community during the spring/summer of 2023.

1.4 The HNA objectives were as follows:

- Describe, and where possible quantify, the scale of health needs faced by GRT communities across the life-course in Kent.
- Obtain stakeholder views on the needs for health and care services amongst GRT communities and elicit views on the extent to which these needs are currently being met and barriers faced.
- Map current community, health, and care services available to GRT communities against evidence-based/best practice standards in order to make an assessment of met and unmet need.

1.5 The 2021 Census recorded that 5,405 people in Kent (0.3%) identified themselves as being from Gypsy and Irish Traveller ethnic groups, while the figure for England was 60,073 (0.1%). Maidstone, Swale and Ashford rank in the top five of England local authority districts with the highest proportion of people from the Gypsy or Irish Traveller ethnic group (0.6%, 0.6% and 0.5% respectively). In the UK, around 3/4 Gypsy and Travellers now live in bricks and mortar settled accommodation, and 1/4 live in caravans or mobile structures, either residing on private and public (council) caravan sites or on unauthorised encampments. Information and data about the GRT community is not adequate to guide proper public health planning for programme and services.

1.6 Key Findings of health needs assessment:

- GRT communities in Kent experience significantly poorer health outcomes than the general population including high rates of childhood illness, non-communicable diseases, poor mental health, and unhealthy lifestyle behaviours such as smoking and obesity.
- These poorer health outcomes are the result of interactions between adverse environments (living, working and social), lifestyle behaviours and poor access to health and social care services and wider support services.
- Kent has a higher percentage of Gypsy and Traveller populations than the England average and sizeable Roma communities.
- GRT communities face multiple issues in relation to access to healthcare, meaning health issues often get dealt with when they become urgent, and people aren’t accessing routine screenings and appointments. The reasons are multiple and complex; the needs assessment focused on approachability, acceptability, affordability and appropriateness of services and related recommendations.

1.6 The full report is available on the [Kent Public Health Observatory (KPHO) website](#).

2. Overview of Performance

2.1 Key recommendations from the Gypsy, Roma and Travellers Health Needs Assessment

2.1.1 Addressing the stark health inequalities as recorded in the HNA, is in line with the Public Health Business Plan which aims to develop a systemwide approach to reduce poor outcomes and reduce health inequalities through the Kent Joint Health and Wellbeing Strategy and the Integrated Care Strategy.

2.1.2 The table below outlines some of the main recommendations from the HNA with some ongoing activities in response to them. Key to all these activities is the need to increase community engagement in order to strengthen trust and confidence of the GRT communities with public services.

Key recommendations from HNA	Ongoing efforts/Activities coordinated by Kent County Council
A lack of a system-wide approach	The Public Health Team has produced culturally sensitive and appropriate materials which will be used to share key findings from the HNA with the GRT communities. Other ongoing planned activities is to use the Whole System Obesity (WSO) approach of introducing activities such as 'grow your own', healthy recipe and cooking class and support with food vouchers.
Overreliance of short-term projects	A GRT Project Officer will be recruited in the Autumn of 2024 with support from external funding. The purpose of the role will be to • develop trusted and sustained relationships with the Gypsy Roma and Traveller community members, collaborating closely with key stakeholders and utilizing already established links into the community to improve health and wellbeing. • support the design and implementation of a programme of work to understand the location and health needs of Gypsy, Roma and Traveller people across Kent and with the communities, co-design and deliver a programme of work to improve their health and wellbeing. • raise awareness of wider health and social care services by seeking out opportunities to promote and tailor services and community engagement to make them more accessible to Gypsy, Roma, and Traveller communities. • work with colleagues to introduce the research agenda to Gypsy, Roma, and Travellers, and act as a source of advice and guidance regarding research related activities.

	The Project Officer will support efforts to draw in additional grants to sustain health and wellbeing programme activities.
Invest in developing trust and culturally competent services	There are ongoing efforts to train and deploy community champions as facilitators and health and wellbeing points of contacts. In addition, through the GRT Community of Practice (COP) group, Members and those working with the community have been encouraged to undertake the cultural awareness training. Many have undertaken the training and demonstrating learning by the use of language and constructive engagement when in the community. In addition, the GRT Toolkit for GPs which was developed last year and based on the HNA, has been further circulated. The aim is to disseminate more through the COP.
Low uptake of services, such vaccination and health checks	A short video to promote Measles Mumps and Rubella (MMR) vaccination uptake, have been produced and deployed to the GRT community. The video, which was produced with the support of a staff member of KCC who identifies as a GRT community member, has been well received by GRT communities as well as the UK Health Security Agency (UKHSA) and other key stakeholders. Link to video as below. https://vimeo.com/user/18906734/folder/21090643
Address barriers to accessing primary care	Twenty GP practices, known to be within the vicinity of Traveller sites, have been surveyed by the Kent and Medway (K&M) screening inequalities team to understand the challenges practices may face in identifying and providing services for GRT communities. The K&M screening team has identified which GP practices are actively engaging with local GRT communities and this is an opportunity to widen good practice through peer support.
Lack of knowledge and uptake of eligible wider support for community members.	KCC's Growth Environment and Transport (GET) Gypsy and Roma Traveller Residents Service are working with KCC Traveller site liaison managers to disseminate information about help and support such as with managing utility bills and negotiating how to resolve outstanding bills. Kent Police has provided routine security advice and Kent Fire and Rescue Service has installed and provided guidance on use of smoke and fire alarms.

	Plans are underway to use the health bus to provide blood pressure readings and other health checks. Wider work is in the scoping phase to improve asthma treatment, provide cooking lessons and 'grow your own' activities to promote healthy eating. Scoping feasibility and funding options to identify and train community members to become peer educators, ambassadors and/or health champions allowing them to share reliable and accurate information to the wider community.

2.3 Additional Activities to address health inequalities and gaps

2.3.1 **Community of Practice (COP)**: Re-established to coordinate activities among stakeholders, the COP has held four meetings since April 2024, leading to:

- Promotion of cultural awareness training for members.
- Updates on KCC resident services.
- Discussion about findings of a GP survey on service challenges and a tool to help identify which GP practices are located close to and could serve people from GRT communities.
- Information sharing to discuss integrated approaches to mental health, Cardiovascular Disease (CVD) checks and suicide prevention.
- Improved coordination, joint planning of events and strengthening collaboration.

2.3.2 **Increased research engagement**: Since October 2023, efforts have been made to increase participation in National Institute for Health and Care Research (NIHR) portfolio studies, recruiting five Research Connectors and one Research Champion. This engagement has fostered a more positive view of research within the GRT communities.

2.3.3 One of the key recommendations from the HNA was to undertake Wave 2 analysis – a health survey with GRT community members to understand the lived experience of people from these communities and, in the absence of system wide data, to accurately capture the health needs of different groups and triangulate these findings with Wave 1 (stakeholder engagement findings) to help determine priority areas of focus. However our community interaction has informed us that the GRT community is feeling over-researched.

3. Conclusions

3.1 The work with GRT communities in Kent highlights the persistent health inequalities faced by these groups. The Public Health Team conducted a Health Needs Assessment (HNA) in 2023, revealing significant health disparities across the life course.

3.2 Further engagement with GRT communities is needed to build trust and confidence which is the foundation required for a broad health improvement programme to address the observed health inequalities.

3.3 The focus of the Public Health Team will be to build a system wide community of practice who can help deliver visible health improvement work which will help build relationships and trust. The proposal to engage with particular community members who may wish to be health champions will also develop a strong foundation. From this, further work can be undertaken to deepen our insight of the health needs of the communities.

3.4 The next steps will be to further engage with GRT community members to prioritise action to be taken to ensure we understand which health outcomes are most important to them and how we can most effectively work together.

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4. Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **NOTE** ongoing efforts and progress made to date to address the observed health inequalities identified in the Health Needs Assessment.

5. Background Documents

Gypsy Roma Traveller Health Needs Assessment
Ethnicity - Kent Public Health Observatory (kpho.org.uk)

6. Contact details

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From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Health Reform and Public Health Cabinet Committee, 17 September 2024

Subject: **Public Health and Adult Social Care Joint working on Prevention**

Decision no: N/A

Key Decision : No

Classification: Unrestricted

Past Pathway of report: N/A

Future Pathway of report: N/A

Electoral Division: All

Is the decision eligible for call-in? N/A

Summary: This report has been requested by the cabinet committee to provide an update on how Public Health (PH) and Adult Social Care (ASC) are working together on the prevention agenda to increase health and wellbeing and change the trajectory of care needs for the people of Kent.

Recommendations: The Health Reform and Public Health Cabinet Committee is asked to NOTE the content of the report and the work underway with the Prevention Programme.

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1. Introduction

1.1 Kent County Council (KCC) has an ambition to look at overall patterns of need for social care amongst adults in Kent and consider systematically, what 'prevention' work is underway which could be strengthened and what else might be done with individuals, groups of people, communities and at a whole population level to increase health and wellbeing and change the trajectory of care needs for the people of Kent.

1.2 Strengthening community resilience and partnerships' is one of the focus areas in the 'Making a difference everyday' Kent Adult Social Care strategy (2022-2027). The core purpose outlined in this strategy is supporting people to lead the lives they want to live, and in a place they call home, by putting people at the heart of everything we do. Promoting a person's wellbeing, preventing,

reducing or delaying the development of the need for care and support is core to Kent's way of working, in line with the Care Act.

1.3 This paper outlines the objectives of this work and the progress made to date.

2. Background

2.1 Within the Care Act, prevention is broken down into three general approaches termed prevent, reduce and delay which can be aligned with primary, secondary and tertiary prevention approaches as outlined below. There are other forms of prevention but these three are the areas focused on in the Care Act:

- Primary prevention/promoting wellbeing (prevent)
  These actions are aimed at people who have no current particular health or care and support needs. These are services, facilities or resources provided or arranged that may help a person avoid developing needs for care and support, or help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing.

- Secondary prevention/early intervention (reduce)
  These are more targeted interventions aimed at people who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down or reduce any further deterioration or prevent other needs from developing. Some early support can help stop a person's life tipping into crisis, for example helping someone with a learning disability with moderate needs manage their money, or a few hours support to help a family carer who is caring for their son or daughter with a learning disability and behaviour that challenges at home.

- Tertiary prevention/formal intervention (delay)
  These are interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions, (including progressive conditions, such as dementia), supporting people to regain skills and manage or reduce need where possible.

2.2 Prevention is a word that is interpreted differently by different professionals. Our common language is focus on the impact we can have working for the people of Kent

Our joint focus	Derek is 53 Overweight, inactive, drinks moderate amounts of alcohol Mortgage, anxiety about bills, lives with wife	Derek is 68 Retired Now lives alone Bereaved Isolated and lonely Diabetes Inactive, poor diet	Derek is 73 Stroke, signs of cognitive impairment Poor diet, inactive, lonely Lives alone ASC package

Social care language (Care Act)	**Prevent** To promote the wellbeing of people we support, by providing information to help them link in with their communities.	**Delay** Support people to remain healthy, so that people can remain in their own homes and communities for as long as possible.	**Reduce** Provide early support to help people remain independent by providing equipment/adaptations, technology, or short-term services.
Public health language	**Primary prevention** Preventing disease or injury before it ever occurs to help avoid the need for care and support developing.	**Secondary prevention** Slowing the impact of a disease, injury or illness that has already occurred and preventing other needs from developing.	**Tertiary prevention** Softening the effects of illness or injury, supporting people to regain skills and to reduce their needs wherever possible.

3. Programme objectives and governance

3.1 A ‘prevention delivery group’, made up of representatives from Adult Social Care, Public Health and Growth Environment and Transport (GET), has been established to oversee a programme of work to improve understanding of the patterns of demand for social care amongst the people of Kent, and join up, initiate and evaluate further action to prevent, reduce or delay the need for care in higher-cost, more intensive settings and which promotes people’s quality of life and their engagement with the community.

3.2 The objectives of the work are as follows:

- Development of a population profile of those who currently draw on care and support in Kent, the drivers for those needs and how this might change in the future.
- Prioritisation of interventions to be trialled with specific population groups based on the expected impact they could have on improving people’s quality of life and preventing, reducing and delaying need for adult social care.
- Production of a prevent, reduce, delay delivery plan which captures priority projects being trialled and evaluated and oversight of all task and finish groups implementing.
- Identification and resolution of the enablers and barriers to implementation of the delivery plan and appropriate communications to Adult Social Care and Health Directorate Management Team and other senior stakeholders.
- The development of a learning culture across KCC focused on promoting wellbeing and preventing further.

4. Programme progress to date

4.1 Current preventative work relevant to adult social care has been mapped in relation to three key areas which are considered to be important initial priorities:

- Creating community capacity for wellbeing and prevention
- More people with co-occurring physical and mental health conditions are identified early and supported to live well and safe from harm and neglect
- More people age and live well at home with the right care at the right time in the right place.

4.2 A Public Health and Social Care Innovation and Prevention Manager, jointly funded by adult social care and public health, has been recruited and will collaborate with people with lived experience as well as health and social care partners to develop programmes which will promote independence amongst adults and demonstrate impact on preventing, delaying and reducing the need for care. They will be responsible for the development, delivery and evaluation of the prevent, reduce, and delay plan.

4.3 One of the first areas which the Prevention Delivery Group is exploring is the potential to prevent falls in adults in Kent. Falls prevention may not be the single biggest area for preventing, reducing and delaying need for health and social care in Kent but it is a good place to start to establish the processes and analytics which would need to be applied to any prevention programme area.

4.4 Falls are a significant concern in Kent. There is an opportunity to improve health and wellbeing and independence and reduce need for health and care services by preventing falls. This programme is important in Kent because:

- Falls are associated with a decline in physical and mental capacity, reduced function and loss of confidence.
- It is estimated that around a third of all people aged 65 and over, fall each year, increasing to half of those age 80 and over[i].
- In 22/23 in Kent, there were more than 6500 emergency admissions due to falls in people aged 65+ and Kent has higher rates of hip and leg fractures than national and regional average[ii].
- Falls are the largest cause of emergency hospital admissions for older people (although not all falls will result in an hospital attendance or admission) and this can result in deconditioning and escalation of care needs, including people moving from their own home to long term nursing or residential care.
- The number of falls is expected to grow in the future.
- Many falls are not reported so there is an opportunity for proactive identification of those at risk and action to prevent a fall, prolong health and wellbeing and prevent escalation of health and social care need.
- Falls in Kent are likely to be a significant driver of health and social care costs.
- Falls are a quantifiable event which can be measured.
- There is good evidence on what we can do to prevent falls.
- Other areas have achieved significant health improvement as a result of systematic and systemwide work on falls prevention.

4.5 The Prevention Delivery Group is currently exploring the use of integrated data to identify people at risk of falls who could benefit from an intervention(s) to reduce that risk. Interventions known to influence the risk of falls include environmental adjustments, promotion of health behaviours, enabling social connection, specific health and care services, action on the core determinants of health including transport and housing, digital and communications and policy, strategy and workforce considerations.

4.6 The next stage is to review and prioritise with system partners, the interventions already available/where new innovation is possible, consider where the greatest opportunities for impact are and implement a programme of work to identify a group of people who could receive the proposed interventions and a control group who will receive usual care, to robustly evaluate the impact of the action. Once findings are evaluated, the actions could be reviewed and potentially scaled up for broader impact across Kent.

4.7 In so doing, it is hoped that this approach will become the start of a prevention 'blueprint' – a way of testing the impact of preventative action on improving the health of the population and reducing the need for adult social care.

5. Other corporate implications

5.1 In KCC's Framing Kent's Future there is a commitment to "work with our partners to hardwire a preventative approach into improving the health of Kent's population and narrowing health inequalities."

5.2 The Kent and Medway ICS Strategy "recognises citizens' health, care and wellbeing are impacted by economic, social and environmental factors more than the health and care services they can access, we pledge to bring the full weight of our organisational and individual efforts to collaborate to enable the people of Kent and Medway to lead the most prosperous, healthy, independent and contented lives they can. Through this collaborative movement, we will work together to reduce economic and health inequalities, support social and economic development, improve public service outcomes and make sure services for citizens are excellent quality and good value for money."

6. Conclusion

6.1 Kent County Council is embarking on an ambitious programme to look at overall patterns of need for social care amongst adults in Kent and consider systematically, what 'prevention' work is underway which could be strengthened and what else might be done with individuals, groups of people, communities and at a whole population level to increase health and wellbeing and change the trajectory of care needs for the people of Kent.

6.2 A Prevention Delivery Group has been established to oversee the work, a Delivery Plan is in draft form, focusing initially on three priorities and a joint Public Health and Social Care Innovation and Prevention Manager has been recruited to lead the programme. The Prevention Delivery Group aims to establish a 'prevention blueprint' and with this in mind, has started to look at the potential benefit of identifying groups of people who are at risk of falls, could and could benefit from an intervention to prevent the fall. The approach will be

to test the impact of preventative action compared with usual care on improving the health of the population and reducing the need for adult social care.

Recommendation(s):

The Health Reform and Public Health Cabinet Committee is asked to NOTE the content of the report and the work underway with the Prevention Programme.

Contact details

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[i] NICE. Falls in older people: assessing risk and prevention | Guidance and guidelines | NICE [Internet]. 2013 [cited 2016 Nov 25]. Available from: www.nice.org.uk/guidance/cg161
[ii] OHID, based on Office for National Statistics and NHS England data. Available from Fingertips | Department of Health and Social Care (phe.org.uk)

From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Health Reform and Public Health Cabinet Committee – 17 September 2024

Subject: Kent Weight Management Strategic Action Plan

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary: This paper presents the weight management strategic action plan (appendix 1) for adults across Kent, focusing on tier 1- 4 services for eligible local residents. The action plan was jointly developed by Kent County Council and NHS Kent and Medway Integrated Care Board (ICB) and provides the opportunity for future collaboration on improving the health and care of local people by driving improvements in weight management services. The paper provides an overview of the current local picture of overweight and obesity, describes the current weight management services in Kent and highlights seven strategic actions (key lines of enquiry) which will be implemented to address the issue of weight management, what success looks like and incorporates a strong governance structure to ensure successful implementation and maximal results.

Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the Weight Management Strategic Action Plan presented.

1. Introduction

1.1 The paper provides an overview of the weight management strategic action plan for the Kent adults, with a focus on tier 1- 4 interventions.

1.2 Partners from Kent County Council (KCC) and the Integrated Care Board (ICB) have been working independently to tackle obesity in their various capacities. However, in recognition that they are stronger together, both organisations collaboratively developed the Kent Weight Management Strategic Action Plan.

1.3 The plan is to provide the best available weight management services and ensure equity of access for eligible Kent residents, appropriate to their needs within the context of the current landscape challenges and address the complexity of obesity.

1.4 The Weight Management Strategic Action Plan details work done to date to clarify eligibility and better understand the local picture, outlining seven key lines of enquiry or 'strategic actions' which are now necessary to make further progress in this to inform service optimisation for local people.

2. The current local context

2.1 The approach and scope of the Weight Management Strategic Action Plan.

- The strategic action plan is jointly owned, led and overseen by KCC and the ICB.

- Weight Management Services are multicomponent interventions which provide support for people whose Body Mass Index (BMI) is in the overweight, obese or severely obese range. Depending on their severity, they can be referred to appropriately tailored support.

- These elements are expected to be brought together in time to an overarching strategy for healthy weight in Kent, taking a holistic approach, encompassing both children and adults, sitting within the wider Kent and Medway Integrated Care Partnership's (ICP) Integrated Care Strategy which has just been launched.

2.2 The current local context – the case for change

- In Kent, the percentage of adults classified as overweight or having obesity increased from 63.1% in 2020/2021 to 65.8% in 2021/2022. While the percentage of adults classified as obese only increased from 26% in 2020/2021 to 27.3% in 2021/2022, this increase was statistically significant[1]

- The majority of Kent districts had higher prevalence of overweight and obesity compared to the Southeast regional average (62.7%) and England average (63.8%) however Folkestone and Hythe (72.8%), Thanet (72%), Dover (69.4%) and Gravesham (68.3%) had the highest overweight and obesity prevalence. The prevalence of overweight and obesity was below the England average in Tunbridge Wells (57%), Sevenoaks (58.5%) and Ashford (62.1%)

- Obesity is a significant risk factor for many physical and mental health conditions such as type 2 diabetes, other metabolic diseases, cardiovascular disease, liver disease, some forms of cancer and osteoarthritis, depression, low self-esteem, posing a high burden to health and social care. As a result, there is an increased risk of disability and premature death for individuals living with overweight and obesity[2]

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[1] Obesity Profile - Data - OHID (phe.org.uk)
[2] Adult obesity: applying All Our Health - GOV.UK (www.gov.uk)

- The increasing number of people living with obesity in Kent and recognising there are inter-dependencies and a need for creating more seamless flow across the four tiers and create

2.3 In Kent, all four Tiers of weight management services are provided for local people. KCC commissions Tier 1 and 2. The ICB commissions Tier 3 and 4. These tiers are described in further details with eligibility criteria in appendix 2.

- Tier 1: Universal, behavioural interventions focused on obesity prevention and promotion of healthy eating and physical activity (for example through public health campaigns and providing brief advice in primary care/community settings) -One You Kent - Kent County Council Healthy Lifestyle service fits into the Tier 1 element of the weight management pathways.

- Tier 2: Community-based lifestyle, weight management services. These are typically group-based and are focused on behaviour change including diet, nutrition, and physical activity. Typically, limited time, up to 12 weeks - Healthy weight - Kent County Council is commissioned by KCC, other available Tier 2 services are included in appendix 2.

  Tier 3: Specialist weight management services. Provide non-surgical, intensive lifestyle management programmes, delivered by a multidisciplinary team, typically including specialist physicians, nurses, dieticians, psychologists, and physiotherapists/ exercise therapists. Tier 3 is commissioned by the NHS Kent and Medway ICB through TBC Healthcare tier 3 services.

- Tier 4: Surgical and non-surgical interventions. Typically, bariatric surgery, with multidisciplinary lifestyle support pre- and post-operatively. Tier 4 is commissioned by the NHS Kent provided across six NHS acute trusts. Currently, we do not have access to Tier 4 data. This is why we the KCC and ICB teams are working together on developing the Strategic Action Plan. The plan will include steps to improve our understanding and work in seven key strategic areas. This includes gathering and reviewing data to improve weight management services for eligible local people in Kent.

2.3.1 Table 1 illustrates 2022/23 data on numbers supported and outcomes of weight management services (tier 1, 2, 3 and 4). Please note that the Enrolled is a percentage of referrals that we "signed up" from referrals to the course. The numbers supported are the numbers this equates to. So, for Tier 2, of the total referrals, 38% enrolled, which equates to 2,038.

Table 1: 2022/23 data on numbers supported and outcomes of weight management services (tier 1, 2, 3 and 4)

	Numbers supported	Enrolled	Completed interventio n	Participant s who lose weight	Participant s that lost at least 5% of the body weight

Tier 1	3,787 Diet and physical activity support	No data available	24% complete their exit goal within 6 months of finishing the service	No data available	No data available
Tier 2					
Kent - Core	2,038	38%	63%	62%	22%
Nationa l - All	85,605	65%	37%	43%	16%
Tier 3	2723	1111	92%	89%	66%
Tier 4	No data available				

2.4 **Seven strategic actions**

2.4.1 The seven strategic weight management actions have been identified through collaborative efforts. A rigorous process was followed, which involved engaging with relevant stakeholders, conducting benchmarking, considering learning from the KCC Public Health Service Transformation Programme, and ensuring the actions are evidence-based. These actions will be instrumental in helping to deliver better weight management services to the people of Kent. These are the seven actions:

- **Strategic Action 1:** Embedding the Weight Management Strategic Action Plan into the wider context of prevention, clinical pathways and whole systems obesity approach, and building strong cross-system collaboration and leadership to oversee and deliver this together.

- **Strategic Action 2:** Use the best of collective skills across partners to understand in depth the needs of local people and plan together priority action to best meet these needs.

- **Strategic Action 3:** Create a more seamless pathway for flow across the tiers and a single referral form to optimise referral, working across existing pathway areas which are led by different partner organisations to understand the state of play in more detail at each tier of the pathway and factors affecting quality, impact and flow across the tiers.

- **Strategic Action 4:** Improve self-referral access, including information provision for local people and suitability checks by providers.

- **Strategic Action 5:** Improve primary care understanding about the pathway, its needs and their engagement with this.

- **Strategic Action 6:** Enhance our approach to service user engagement and use of insights gained from this by providers to optimise services further.

- **Strategic Action 7:** Ongoing learning, knowledge sharing and innovation across local providers, internal and external stakeholders, national and international approaches to optimise continuous improvement approach to weight management.

3. Governance of this Weight Management strategic action plan

3.1 The implementation group will be led by a new Kent Weight Management Strategic Action Plan Implementation Leadership Group with ICB and KCC staff members representing public health, commissioning, clinicians, ICB managers and other teams.

3.2 In KCC, the Public Health Consultant and the Healthy Lifestyles team in the Public Health Directorate will lead this work. The ICB will be led within the out of hospital programmes under the elective team.

4. Measures of Success

4.1 Adapting a Donabedian approach is used to evaluate healthcare quality to measure the basis for the metrics framework **looking specifically at** structure **(resources/accessibility),** process **(activities) and** outcomes **(desired results of programme/ performance)**.

4.2 Currently, there are no Key Performance Indicators (KPIs) available for Tier 1 (Lifestyles Service). This is part of the rationale for undertaking this work and building this Strategic Action Plan jointly across KCC and ICB teams, proposing steps to strengthen our understanding and work in seven key strategic areas, including data gathering and review, to optimise weight management services for eligible local people in Kent. The table below shows measures used for tier 2 and tier 3. These metrics can also be analysed by demographics to determine and monitor inequalities, as well as working with providers to share or collect data on other populations which we know to have higher risks from excess weight such as those with mental health conditions or learning disabilities. However, having a consistent dataset will also need to be agreed across providers. We are currently not aware of any Key Performance Indicators (KPI) for tier 4.

	Process	**Outputs**	**Outcomes**
Tier 1	No metrics or data available	No metrics or data available	No metrics or data available
Tier 2	100% of participants enrolled in the service meet the eligibility criteria.	60% of participants complete the active intervention.	75% of participants will have lost weight at the end of the active intervention
	Referrals to the service	% of individuals enrolled in the service are from identified	30% of all participants will lose a minimum of 5% of their (baseline)

		high risk groups (BME; men; people with learning difficulties)	initial body weight, at the end of the active intervention
		100% of enrolled participants are invited to provide feedback at the end of the active intervention.	50% of completers will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention.
		Patient satisfaction	35% of completers provide a weight measure at 6 months
			20% of completers provide a weight measure at 12 months
			% of completers at 12 months have a body weight which is lower than their baseline body weight
Tier 3	Number of individuals referred to the service	% of people attending and who are referred to the Multi Disciplinary Team (MDT) within 6 weeks	Referrals to Tier 4 based on pathway recorded at MDT.
	Inappropriate referrals to the service	Number of people who have attended within 6 weeks of referral	% participants who successfully achieve weight loss
		Number of people attending MDT within six weeks of referral	Reduction in medication use after active intervention
		Patient satisfaction (by patient questionnaires or surveys)	
Tier 4	No metrics or data available		

- Other measurement of success includes Public Health Outcomes Framework relating to obesity and obesity related conditions.

5. Conclusions

5.1 KCC and the ICB worked together to develop the Kent Weight Management Strategic Action Plan. The plan aims to address the complex issue of weight management and provide the best possible adult weight management services to eligible Kent population.

5.2 This paper provides an overview of the current context of excess weight and weight management services in Kent. It describes seven strategic actions which will be implemented to address the issue of weight management. The plan also aims to ensure clarity about the referral pathway and criteria and incorporate a strong governance structure to ensure successful implementation and sustained results.

6. Recommendation(s)

6.1 The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the Weight Management Strategic Action Plan presented.

7. Additional Documents

7.1 Appendix 1 – Weight Management Strategic Action Plan

8. Contact details

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DRAFT

Optimising Weight Management Services Provision in Kent

Weight Management Strategic Action Plan

May 2024

Version 5.0

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Executive summary

Obesity-related health issues pose a significant risk to local people, increasing the likelihood of chronic diseases and living with co-morbidities. In 2021/22, 65.8% of adults in Kent were overweight or obese, which was higher compared to England (63.8%). It is a national priority with government commitment to tackle obesity building on the Obesity Strategy (July 2020) and the NHS Long Term Plan outlining key commitments in tackling obesity. Partners across Kent County Council and Integrated Care Board (ICB) have been working locally to tackle this in a variety of ways through our individual organisations and efforts, but in recognition of the fact that we are stronger together for this, we have been working together for the last six months to develop this Joint Kent Weight Management Strategic action plan , proposing our plan for driving improvements and equity in weight management services across Kent for our eligible local population. Despite the challenges of the current health and social care context, we believe that it is important to combine our efforts, working together to find ways despite this, to maximally optimise health and equity locally.

The purpose of this paper is to update Executives on the proposed outline for a weight management strategic action plan for adults across Kent, with a focus on tier 1- 4 interventions. It informs Executives of the collaborative work between Kent County Council (KCC) and NHS Kent and Medway (Integrated Care Board, (ICB) to produce a weight management strategic action plan with aspirations to go even further for improving the health and care of local people. It highlights seven key lines of enquiry or 'strategic actions' that will be implemented to address the issue of weight management and incorporates a strong governance structure to ensure successful implementation and sustained results. These are:

- **Strategic Action 1:** Embedding the Weight Management strategic action plan into the wider context of prevention, clinical pathways and whole systems obesity approach, and building strong cross-system collaboration and leadership to oversee and deliver this together.

- **Strategic Action 2**: Use the best of our collective skills across partners to understand in depth the needs of local people and plan together priority action to best meet these needs.

- **Strategic Action 3:** Create a more seamless pathway for flow across the tiers and a single referral form to optimise referral, working across existing pathway areas which are led by different partner organisations to understand the state of play in more detail at each tier of the pathway and factors affecting quality, impact and flow across the tiers.

- **Strategic Action 4:** Improve self-referral access, including information provision for local people and suitability checks by providers.

- **Strategic Action 5:** Improve primary care understanding about the pathway, its needs and their engagement with this.

- **Strategic Action 6:** Enhance our approach to service user engagement and use of insights gained from this by providers to optimise services further.

- **Strategic Action 7:** Ongoing learning, knowledge sharing and innovation across local providers, internal and external stakeholders, national and international approaches to optimise continuous improvement approach to weight management.

Through this strategic action plan, our aim is to empower adults to achieve and maintain healthy lifestyles, enabled by timely quality support as needed, ultimately leading to improved overall well-being and reduced health inequalities locally. Our strategic action plan represents a steadfast commitment to offer the best possible adult weight management services for our Kent population, appropriate to their needs and within the context of the current landscape challenges.

Our aim for Weight Management in Kent

Our aim for this Weight Management strategic action plan is to create the best possible adult Weight Management services for our eligible Kent population, appropriate to their needs and within the context of the current landscape challenges. This includes ensuring equity of access for everyone who needs our services living locally and using the best available evidence from local and external populations. Through collaboration, innovation and a person-centred approach we can empower our population to make healthier lifestyle choices, create environments that promote healthier behaviours and enhance the quality of their life.

We recognise that this will not be easy given the financial, workforce capacity to deliver, and wider challenges faced by the health and care system in Kent, like England more generally. However, we believe it is important to combine our efforts to do what we can within these limitations to ensure the very best possible weight management support for our eligible local people.

Definitions, scope and governance of this Weight Management strategic action plan

Defining healthy weight

Obesity is a complex health and social problem caused by multiple intersectional factors[1]. It can be determined using the BMI, which is a measure. The BMI calculation divides weight in kilograms (kg) by height in meters (m) squared. The result can be classed into the following categories:

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[1] Adult obesity: applying All Our Health - GOV.UK (www.gov.uk)

- Underweight – BMI below 18.5 kg/m².
- Healthy Weight Range – BMI 18.5 to 24.9kg/m²
- Overweight – BMI 25 to 29.9 kg/m²
- Obese – BMI 30 to 39.9 kg/m²
- Severely obese – BMI over 40 kg/m²

It is important to note that in South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background the following lower BMI scores should be used to measure overweight and obesity:

- Overweight – BMI 23 to 27.4 kg/m²
- Obese – BMI above 27.5 kg/m²

This is because there is evidence that obesity-related health risks are higher in these ethnic groups compared to others.

The approach and remit of Weight Management services

Weight Management services provide support for people whose BMI puts them in an overweight, obese or severely obese range and, depending on their severity, they can be referred to appropriately tailored support. Weight management services are multi-component interventions that include programmes, courses, clubs and groups provided by a variety of providers in Kent. The aim is to help people to lose weight and to become more physically active, eating healthy diets in order to reduce the risk of obesity-related conditions.

Scope of this Weight Management strategic action plan

This Weight Management strategic action plan aims to address the complex issue of weight management and the strategic action plan is jointly owned, led and overseen by Kent County Council (KCC) and NHS Kent and Medway Integrated Care Board (ICB). Enhanced partnership working on this strategic action plan provides an in-depth focus to this important area for our local population. The focus of this strategic action plan is on adult weight management rather than the wider concept of obesity. The Whole System Approach to addressing obesity more generally is governed by obesity prevention and associated health promotion strategies. Furthermore, in time it is anticipated that these elements will be brought together and included within a wider holistic approach to a healthy weight in Kent as a whole, looking at children as well as adults, sitting within the wider ICB strategy that is currently being developed.

Governance of this Weight Management strategic action plan

This governance structure and approach to this strategic action plan is purposely designed to be one that fosters collaboration between stakeholders, enabling shared decision-making,

greater coordinated efforts and more efficient allocation of resources for the successful implementation and ongoing management of the strategic action plan, ensuring a holistic approach to tackling weight management challenges within the region. It aims to link with local systems and ensure dedicated programme/project management resource for weight management with clear reporting and governance mechanisms.

The development of this strategic action plan has been undertaken by an ICB-KCC Task and Finish Group detailed in Appendix B. Following the approval of this strategic action plan from all the necessary parties, the implementation of the strategic action plan will then be led by a new Kent Weight Management Strategic Action Plan Implementation Leadership Group with ICB and KCC staff members representing public health, commissioning, clinicians, ICB managers and other teams also (Appendix C). In KCC this work will be led by the Public Health Consultant and their Healthy Lifestyles team in the Public Health Directorate. In the ICB this work will be led within the out of hospital programmes for implementation jointly with the elective team. The Kent Weight Management strategic action plan Implementation Leadership Group will be jointly chaired by the Public Health Consultant leading Weight Management and an equivalent senior member of the ICB.

It is important to note that at present the governance of this strategic action plan focuses on ICB and KCC reporting and oversight through our teams and executive boards to the Joint Commissioning Management Group (JCMG), within the context of our existing Public Health and healthcare service provision frameworks. Over time, we believe that as the ICB strategy develops further, it will include greater focus on healthy weight across our local population, and it is likely that this strategic action plan will sit within that as a key strategic conceptual framework. It may be that at that time, our governance structure will need to be refined further to optimally work with and fit into this. Our teams will remain aware of local developments around this and are proactively aligned to ensure maximal support overall for improving population health and tackling inequalities locally.

Aspiration of this Weight Management strategic action plan

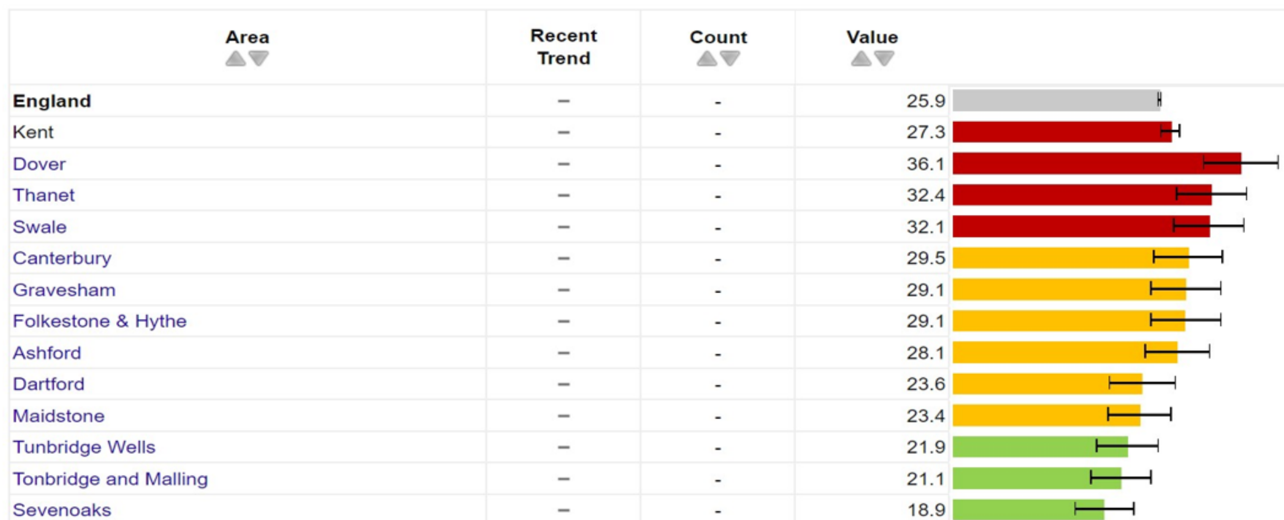
It is intended that through collaborative partnership efforts, the implementation of the strategy will make a positive impact on local service provision and in the development of a new model of care. Learning from implementation will inform future strategic and collaborative actions.

The current local context – the case for change

In Kent, the percentage of adults classified as overweight or having obesity increased from 63.1% in 2020/21 to 65.8% in 2021/22. While the percentage of adults classified as obese only increased from 26% in 2020/21 to 27.3% in 2021/22, this increase was statistically significant. The majority of Kent districts had higher prevalence of overweight and obesity compared to the South East regional average (62.7%) and England average (63.8%) however Folkestone and

Hythe (72.8%), Thanet (72%), Dover (69.4%) and Gravesham (68.3%) had the highest overweight and obesity prevalence. The prevalence of overweight and obesity was below the England average in Tunbridge Wells (57%), Sevenoaks (58.5%) and Ashford (62.1%). Figure 1 illustrates the percentage of adults (aged 18+) classified as obese (2021/22) by district, compared to Kent and England average.[2.]

Figure 1: Percentage of adults (aged 18+) classified as obese (2021/22) by district, compared to Kent and England average.



Area	Recent Trend	Count	Value
England	–	-	25.9
Kent	–	-	27.3
Dover	–	-	36.1
Thanet	–	-	32.4
Swale	–	-	32.1
Canterbury	–	-	29.5
Gravesham	–	-	29.1
Folkestone & Hythe	–	-	29.1
Ashford	–	-	28.1
Dartford	–	-	23.6
Maidstone	–	-	23.4
Tunbridge Wells	–	-	21.9
Tonbridge and Malling	–	-	21.1
Sevenoaks	–	-	18.9

Source: Office for Health Improvement and Disparities (based on the Active Lives Adult Survey, Sport England)

This is particularly important as obesity is a significant risk factor for many chronic diseases including type 2 diabetes, other metabolic diseases, cardiovascular disease (mainly coronary artery disease and stroke), liver disease, some forms of cancer and osteoarthritis, posing a high burden to health and social care. As a result, there is an increased risk of disability and premature death for individuals living with overweight and obesity[3]. Obesity can also be a risk factor for psychological problems such as depression, low self-esteem and can impair a person's well-being, quality of life and ability to earn. Approximately nine years of life is prematurely lost to obesity-related conditions. Obesity is strongly associated with deprivation and health inequalities.

QOF and hospital episode data: Other relevant data include the Quality Outcome Framework (QOF), which is a reward and incentives programme for GP surgeries. QOF recorded obesity as the 3rd highest (9.52%) health condition for Kent and Medway ICB in

[2] Obesity Profile - Data - OHID (phe.org.uk)

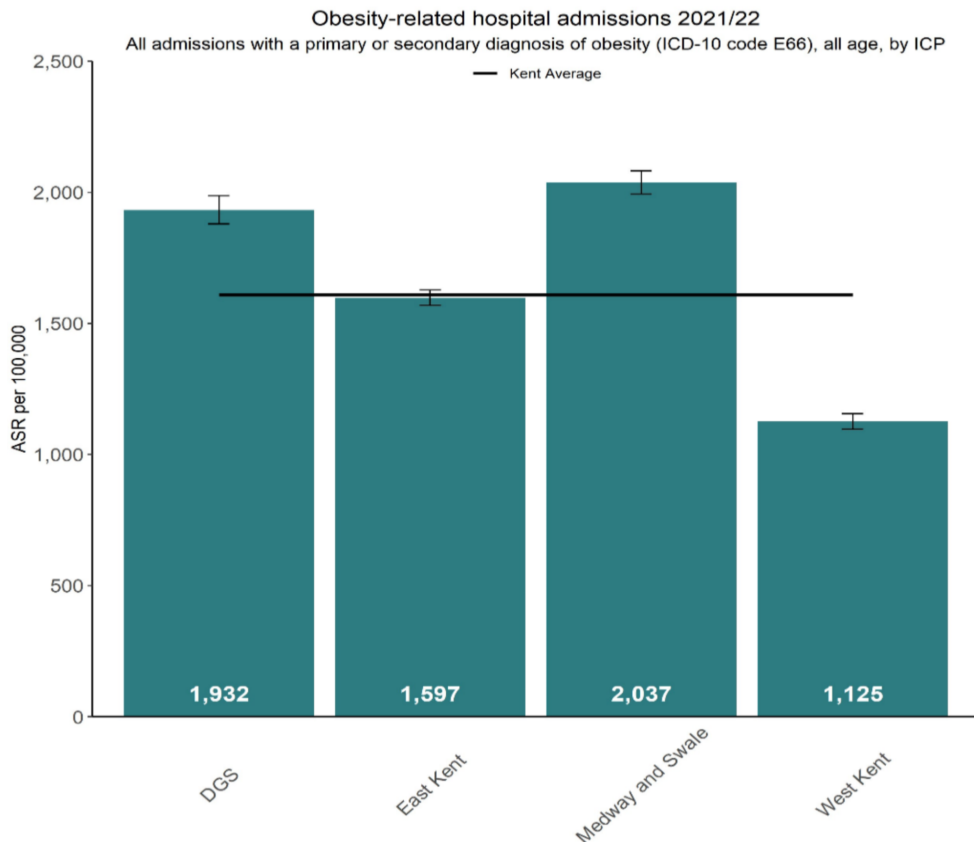
[3] Adult obesity: applying All Our Health - GOV.UK (www.gov.uk)

2021/22 compared to England 9.72%[4]. This data is likely to underrepresent the scale of the problem in Kent because it is only recorded for those that have regular contact with primary care/GP services.

Hospital admission related to obesity: Across Kent and Medway in 2021/22, the number of admission episodes related to obesity data indicate that admissions are higher in Medway & Swale and Dartford, Gravesham & Swanley Health and Care Partnerships (HCP) compared to the Kent average. East Kent is similar to the Kent average, while West Kent is lower than Kent average. Overall, this suggests greater Public Health need in the areas of Dartford, Gravesham, Swanley, Swale and East Kent. Figure 2 shows the 2021/22 obesity related hospital admission data.

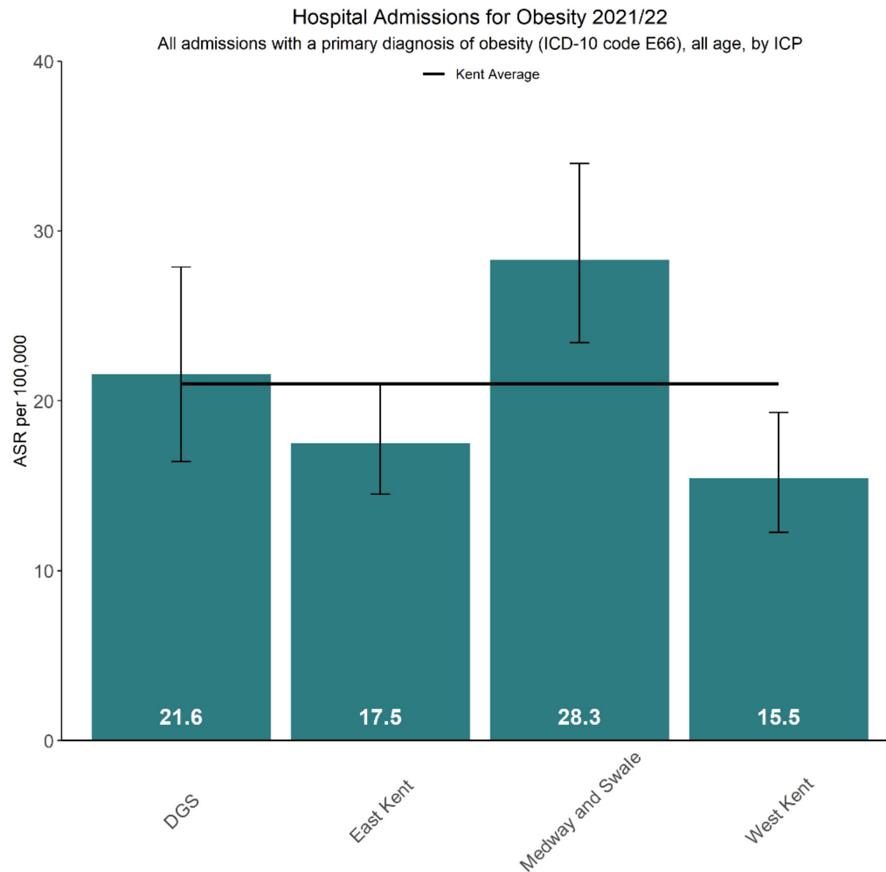
NHS Digital reports admissions directly attributable to obesity, which are admission episodes with a primary diagnosis of obesity. Admissions directly attributable to obesity, were higher within Medway & Swale HCP in comparison to Kent. Figure 3 illustrates hospital admissions with a primary diagnosis of obesity.

Figure 2: Obesity Related Hospital Admission Data



[4] Microsoft Power BI

Figure 3: Hospital Admissions for obesity 2021/22 (ASR, age standardised rate)



It is also important to note that although anyone can develop excess weight, there are some people at higher risk and having increased risk of comorbidities at lower BMI classifications. Some of these groups are described below:

Deprivation: There is a strong association between deprivation and obesity. Nationally, the gap in obesity rates between women from the most and least deprived areas was 17%, while for men the deprivation gap was 8%. According to Health Survey for England 2021, in Kent, obesity prevalence was lowest among adults living in the least deprived areas (20%) and highest in the most deprived areas (34%). 12.3% of the obese population in Kent and Medway are in the 10% most deprived segment of the population compared to 6.5% in the 10% least deprived segment.

Coastal effect: Obesity prevalence was 22% higher in Kent coastal towns compared to Kent non-coastal towns. To be clear, this does not mean there is an absolute gap of 22% between coastal and non-coastal towns but rather the proportion is 22% higher. The coastal effect remains after adjusting for demography and deprivation but reduces to 16%. Sheerness and Minster (Swale) had 52% and 54% respectively higher prevalence of obesity compared to non-coastal towns. At the other end of the scale, Hythe and Whitstable had 6% and 5% respectively higher prevalence of obesity compared to non-coastal towns.

Age: Obesity increased with age, from 8% of adults aged 16-24 to 32% of those aged 65-74, before decreasing in those aged 75 and over to 26%.

Ethnicity: Nationally, the prevalence of obesity was highest among black women (53.6%) compared to their white counterparts (27.5%). A greater percentage of Black and Asian adults compared to white and mixed ethnic groups have lower BMI ($27kg/m^2$) at increased or high risk of comorbidities such as hypertension and type 2 diabetes[5]. A Joint Strategic Needs Assessment (JSNA) on the Gypsy, Roma and Traveller population in Kent reported a higher prevalence of unhealthy behaviours such as obesity among the Gypsy and Traveller communities and a greater proportion of Roma men and women between 18-55 with an obesity diagnosis than their counterparts in non-Roma populations[6].

Education: The odds of those with no qualifications having all four risk factors (smoking, excessive alcohol use, poor diet and low levels of physical activity) were five times greater than for those with higher education.

Mental health conditions: In Kent, there was a 24.6% obesity prevalence recorded on GP records among people with a mental health condition. The above 24.6% obesity prevalence are only people with mental health conditions based on the GP record. The QOF record indicates 9.5% obesity prevalence for the Kent and Medway ICB[7].

Disabilities: There is currently no available data on obesity and disability, however national data indicate that the prevalence of overweight and obesity was 72.2% among those with disabilities compared with 61.7% for people with no disabilities in 2021/22[8].

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[5] Ethnicity-specific BMI cutoffs for obesity based on type 2 diabetes risk in England: a population-based cohort study (thelancet.com)

[6] https://www.kpho.org.uk/__data/assets/word_doc/0003/154803/Gypsy-Roma-Traveller-HNA-2023.docx

7 Microsoft Power BI. Mental-Health-NA-Kent-2019.pdf (kpho.org.uk)

[8] Public health profiles - OHID (phe.org.uk)

Policy context – opportunity for change

The government has articulated a commitment to tackle obesity, building on the Obesity Strategy (July 2020). The NHS Long Term Plan outlines key commitments in tackling obesity. There is a clear emphasis on working collaboratively alongside local partners to establish effective, whole systems approaches to tackling obesity and improving population health.

In 2023, the Office for Health Improvement and Disparities set up various initiatives to start to tackle preventable conditions including obesity more proactively[9]. This includes work to restrict placement of less healthy products in stores and online to reduce impulse purchases, to introduce greater levels of calorie labelling in restaurant menus, creating a new diet for people with Type 2 Diabetes and researching new treatments and digital technologies to support people to achieve a healthier weight. They are working with NHS organisations and local authorities to support people living with obesity reach a healthier weight by developing effective preventative care plans for those at high risk of weight gain and diet-related illness through weight management services ranging from behavioural weight management programmes to consideration of weight loss drugs and bariatric surgery. It is therefore an opportune time to focus on optimising weight management services across Kent through this strategic action plan.

In Kent, good work had already begun in individual organisations, and collectively. For example, the KCC Public Health team have been working with other council departments and partner organisations to review Tier 1 and 2 services to ensure they are optimally in keeping with national guidance and best practice, as part of the Public Health Service Transformation Programme. Work by the council has been recognised as innovative and there is much learning from the work of the Whole Systems Obesity Approach programme which started in 2020 and aims to make tackling obesity everyone's business. Across the wider system, obesity is also a priority. For example, it is included as part of the ICS's Inequalities, Prevention and Population Health group's priority area and features in the Integrated Care System strategy.

Current Weight Management services in Kent – arrangements and resources

In Kent, all four Tiers of weight management services are provided for local people. KCC commissions Tier 1 and 2. The ICB commissions Tier 3 and 4. This includes:

[9] Government plans to tackle obesity in England - Department of Health and Social Care Media Centre (blog.gov.uk)

Tier 1 services (commissioned by KCC Public Health Team) are provided within the One You Kent service help to support the service's mission statement "to *motivate people to achieve and maintain a healthy lifestyle by supporting them to make positive lifestyle choices".* The service is designed to assess an individual and holistically provide them with the tools to make long lasting behaviour change allowing them to achieve a healthier lifestyle. Interventions are evidence-based and are based on the individual's strengths rather than their deficits.

Tier 2 Healthy Weight services (commissioned by KCC Public Health Team) are provided within the One You Kent service and aim to help support individuals to reach and maintain a healthy BMI, whilst also promoting the benefits of being a healthy weight. Services use motivational techniques over a 12-week course of interventions to help individuals set and achieve manageable goals around physical activity, diet and implementing behavioural change techniques. As part of this, KCC was awarded grant funding to meet the needs of harder to reach groups of people who may not readily access the existing Tier 2 weight management services already in operation. Due to insufficient funding, the provision of these additional services from the grant funding has now ceased.

Tier 1 and Tier 2 services are delivered by Kent Community Health Foundation Trust (KCHFT) in East Kent and the six Borough/District Councils in West Kent (Maidstone Borough Council, Tonbridge & Malling Borough Council, Tunbridge Wells Borough Council, Sevenoaks District Council, Dartford District Council and Gravesham Borough Council). At Tier 2 level, there is also a digital weight management programme that is nationally commissioned available for eligible local people. Further information about this national offer for our local residents can be found at: https://www.england.nhs.uk/digital-weight-management/how-to-access-the-programme/.

Tier 3 services (commissioned by the ICB) are delivered by TBC Ltd for eligible people in Kent and Swale. These services provide a face-to-face service over a 12-month period, including dietician and psychiatric support. This service also delivers access to weight management medication.

Tier 4 services (commissioned by the ICB) are delivered by Maidstone & Tunbridge Wells NHS Trust for non-complex cases. These are delivered by a number of London borough Trusts and are based on their treatment needs as well as choice.

These tiers are described in further details with eligibility criteria in appendix A.

It is increasingly recognised that there are inter-dependencies and a need for creating more seamless flow across the four tiers. Currently there is a waiting list for Tier 3 services which is causing bottlenecks and impacting on flow and access to support through the stages, mainly attributed to the pandemic back log. Work is being undertaken by the ICB to better understand the composition of this backlog both in terms of size, duration of waiting times,

reason for any delays and appropriateness of referrals to this service. It is likely that the waiting times are a combination of these factors and understanding this will help to inform not only the work of the ICB in addressing these waiting lists, but also in the team delivering on this strategic action plan to optimise delivery at all parts of the Weight Management pathway locally for Kent residents. It provides an opportunity to review the whole pathway as there is feedback from primary care and other colleagues across the county that they would like greater clarity about the referral pathway and criteria, particularly in light of the latest NICE guidelines and opportunity afforded by the digital capabilities for increasingly simplified and automated triage processes.

Given the importance of this work for meeting the current and future needs of our local population, KCC and ICB partners came together in September 2023 to commence work scoping opportunities for improving local services through our joint efforts. This strategic action plan, which has been built on insights through this phase so far and in collaboration with wider partners and stakeholders, outlines actions that we plan to take to deliver on our vision for Weight Management services across Kent.

As part of this, a phased strategic action plan has been developed. Following phase 1 (August 2023 to strategic action plan launch in March/April 2024), we will continue with efforts to deepen understanding and build plans for implementing improvements against each of the strategic actions outlined. In the section that follows the strategic actions (key lines of enquiry) are outlined, including those that have been started through this process already (Phase 1), what more is needed (Phase 2), and how this will be achieved and measured.

The Tier 3 service waiting lists have been through a process of validation to confirm peoples' needs and whether they still need to be on the waiting list.

Unlocking a healthier future for our local people – seven strategic actions

To achieve our aim for weight management services in Kent, we have established the need for seven strategic weight management actions (key lines of enquiry). These were identified through a comprehensive study of existing research and reviewing successful weight management strategies, and communication and engagement with key stakeholders helped us to better understand the challenges faced by local communities and gather their perspectives on potential solutions, as well as gaps needing further work. Also, the strategic action plan has tapped into the learning from the KCC Public Health Service Transformation Programme and workshops. Through this collaborative approach, we refined the seven strategic Weight Management actions (key lines of enquiry) that we believe will be instrumental in helping us to deliver better Weight Management services for the people of Kent.

It is important for us to adopt the principle of equity as we review our approach to the weight management pathway. This includes ensuring that our actions take a proactive focus on understanding and tackling existing health inequalities. This also means ensuring that any interventions taken take care not to widen health inequalities further.

The seven key strategic actions (key lines of enquiry) are:

Figure 4

Strategic Action 1: Embedding the Weight Management strategic action plan into the wider context of prevention, clinical pathways and whole systems obesity approach, and building strong cross-system collaboration and leadership to oversee and deliver this together.

Strategic Action 2: Use the best of our collective skills across partners to understand in depth the needs of local people and plan together priority action to best meet these needs.

Strategic Action 3: Create a more seamless pathway for flow across the tiers and a single referral form to optimise referral, working across existing pathway areas which are led by different partner organisations to understand the state of play in more detail at each tier of the pathway and factors affecting quality, impact and flow across the tiers.

Strategic Action 4: Improve self-referral access, including information provision for local people and suitability checks by providers.

Strategic Action 5: Improve primary care understanding about the pathway, its needs and their engagement with this.

Strategic Action 6: Enhance our approach to service user engagement and use of insights gained from this by providers to optimise services further.

Strategic Action 7: Ongoing learning, knowledge sharing and innovation across local providers, internal and external stakeholders, national and international approaches to optimise continuous improvement approach to weight management.

These seven areas will now be outlined in more detail. In the development of this strategic action plan, we have commenced some of the work in these actions to ensure that we do not delay progress in the meanwhile. The actions underway in this interim period are classified as Phase 1 and will likely need to continue to be completed before moving into Phase 2 actions on the launch of this strategic action plan.

It is also important to note, although not an action in itself, the thread of maximising equity, understanding, and reducing health inequalities and ensuring that actions do not widen inequalities further runs throughout all the strategic actions (key lines of enquiry).

It is envisaged that the implementation group will look at every strategic action (key lines of enquiry) to take a proactive focus on understanding what more is needed, including for tackling health inequalities, and for each of these they will establish and start to implement concrete actions for change. Proposed steps and updates about progress will be provided through the governance routes articulated above, including measurement and evidence of impact. Where actions designed by this group signify considerable changes to services, at that stage the implementation group will design optimal methods for engagement and involvement specifically to inform this, including any public consultation as necessary going forwards also.

Strategic Action 1

Embedding weight management efforts into the wider context of prevention, clinical pathways and whole systems obesity approach and building strong cross-system collaboration and leadership to oversee and delivery this together.

This includes identifying, developing and strengthening partnerships with regional leaders and local networks to create a shared vision for change, which in turn will enable and support the right people to lead local change.

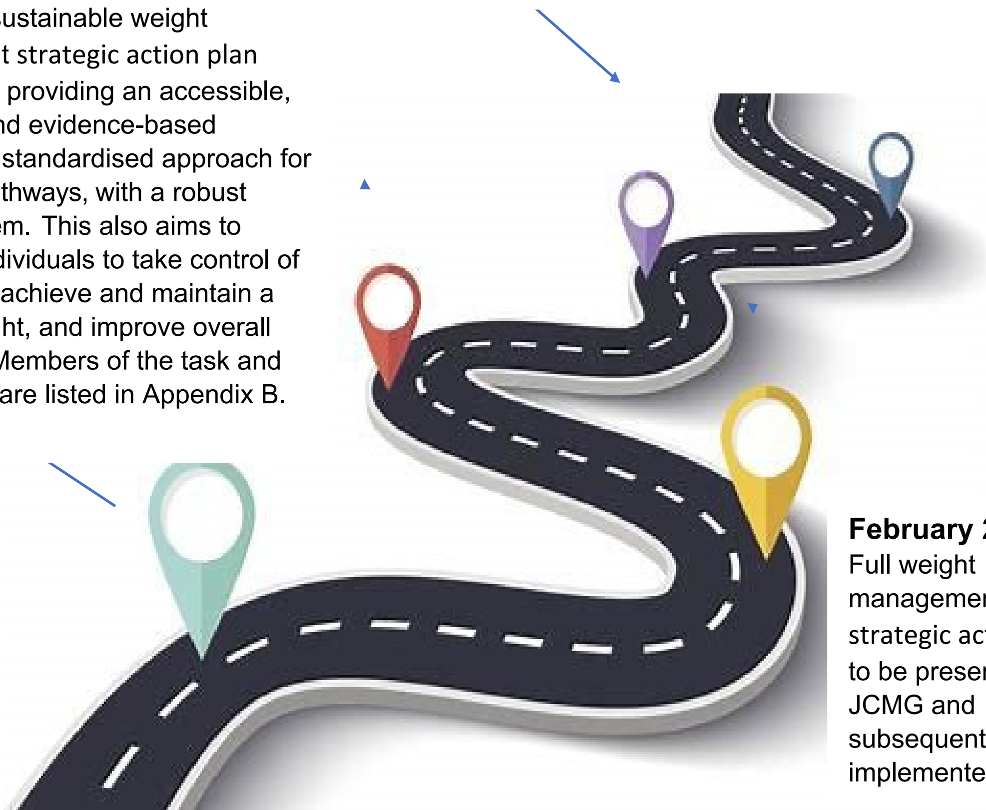
KCC and the ICB have been working together since September 2023 to build the foundation blocks for this strategic action plan (Phase 1 of this strategic action). We have developed a core group across both our organisations (and with input from others, including primary care) to commence work to plan the path to delivering the vision (illustrated below in Figure 5)

Figure 5 : Roadmap: starting well for success

September 2023

Task and Finish group established between KCC and ICB, with the aim to establish a sustainable weight management strategic action plan across Kent, providing an accessible, equitable, and evidence-based support and standardised approach for tier 1 to 4 pathways, with a robust referral system. This also aims to empower individuals to take control of their health, achieve and maintain a healthy weight, and improve overall well-being. Members of the task and finish group are listed in Appendix B.

December 2023 – Draft proposal for an interim weight management strategy to be presented at the JCMG.



February 2024 – Full weight management strategic action plan to be presented at JCMG and subsequently implemented.

For Phase 2, the cross-system core group will be reviewed and be refined to focus on implementation of the strategic action plan and provide longer-term oversight to create and sustain efforts for effective weight management services for our local population.

This action there will be focus on building greater strategic discussion with providers to build clarity to support the operational detail ensuring greater sharing of learning and insights about challenges as well as feedback from service users. This action will also ensure that weight management services are linked in with other services or stakeholders to maximise prevention, equitable provision and links to the Whole System Approach to Obesity programme. This also ties in with the aims of the ICS strategy where there is an emphasis on tackling the wider determinants to prevent ill health. Commissioned services to tackle the problem of excess weight will not reach the number of people required, which is why ensuring collaboration with the Whole System Approach to Obesity and wider determinants is extremely important.

For Tiers 1 and 2, an initial holistic assessment is undertaken to ascertain what support can be delivered by One You Kent services and what other support needs the individual may have. With consent, they would refer the individual to other services that meet other identified needs such as Drug and Alcohol services, Mental Health support, Debt and Housing services. In phase 2, KCC and the ICB will work together to identify potential joint commissioning opportunities.

Strategic Action 2

Use the best of our collective skills across partners to understand in depth the needs of local people and plan together priority action to best meet these needs.

Obesity is a complex health and social problem caused by many intersectional factors that requires a long-term plan and partnership across the system. The current local context around what we currently know has been described in an earlier section in this strategic action plan , but further work still needs to be done to understand the complexities around local needs. This is especially important as the trends in obesity are predicted to continue upwards, nationally, not just in Kent.

Based on national modelling and the increasing prevalence of overweight and obesity in Kent, it is clear that we need to do more to maximise the potential of the current Weight Management service, explore new methods of delivering a cost-effective service, and promote healthy weight among Kent residents.

In phase 1, the Public Health team at KCC will explore commissioning a multi-year survey that aims to understand more fully prevalence of obesity, associated risk factors (including physical activity and eating habits) and attitudes to weight related behaviours. With the research team within KCC Public Health, we are also exploring collaborations with academic institutions or submissions for calls for research that will help us understand specific cohorts that are affected by health inequalities within our population better (for example, specific ethnic groups or deprived geographical areas) or improve our weight management services.

The Kent Public Health Observatory (KPHO) are in the early stages of trialling the use of a system dynamic modelling tool, which can model or simulate population health impacts of behavioural determinants and specific outputs, for example the effect on services, disease prevalence or financial resources. As part of phase 2, we can explore how this modelling can help us understand the needs of the population better and plan specific changes to our services to the greatest benefit. To get the maximum benefit from the modelling, it would be pertinent to try to ensure the data from the services is linked to the NHS shared care records. This can help us to consider for example the proportion of people currently supported within the service and the number of people experiencing excess weight in Kent, and help us to explore questions such as:

- Are we doing enough to tackle the problem?
- What is the current reach?
- How could we take a more Proportionate Universalism approach to this work and what are the options for doing this (through options modelling and prioritisation)
- Consider the opportunity to link the dataset and tabulate the current services data.
- Reviewing the Tier 4 data available within the strategic action plan.

The task and finish group has already commenced preliminary conversation with KPHO leads to scope options for their involvement using SDM and so this is something that the Implementation Leadership Group should pick up following necessary strategic approvals.

Further discussion on gathering intelligence from stakeholders, service users and metrics to measure the services, and therefore improve our knowledge of gaps issues with the service, are addressed in strategic actions 5, 6 and 7.

This work will include establishing greater clarity about the data picture across all tiers (needs, service activity and how well they are meeting local needs, health inequalities that exist, experience, and impact on outcomes for people in the short, medium and longer term in terms of health and wellbeing). This is especially necessary for Tier 4 where at present there is paucity of data at this level due to commissioning arrangements to an external provider. This data picture will inform a process of ongoing review and improvement, supported by the work articulated on system dynamic modelling and thinking. This inform will

then help to inform commissioning and delivery discussions about targeting of services to optimise equity including optimal models of delivery for maximum benefit for local people.

Strategic Action 3

Create a more seamless pathway for flow across the tiers and a single referral form to optimise referral, working across existing pathway areas led by different partner organisations to understand the state of play in more detail at each tier of the pathway and factors affecting quality, impact and flow across the tiers.

In Phase 1, the core group have commenced mapping local providers and data about service use across our organisations to establish a picture across the entire pathways from Tiers 1-4 (see table 1).

Table 2 below shows the number of individuals supported in 2022/23 across the tiers of Weight Management support. For Tier 2, data has also been shared around those who have successfully completed the Weight Management programme, lost weight and also those that have lost 5% of their original body weight.

A draft single referral form has been developed by KCC and the ICB for Tiers 1-3. The form will require further refining in Phase 2 and user acceptance testing to ensure all services have the relevant information to accept these referrals onto their programme. A link to the draft form is included here:

https://kentcc-self.achieveservice.com/AchieveForms/?form_uri=sandbox://AF-Form-7ea9d684-1680-48e5-a1f2-a20a76abd8d8&category=AF-Category-8a1487bd-7362-458b-97f5-c8cfdce1e5f7&isPublished=false

The service criteria for each tier have been reviewed through looking at various models for best practice from other Integrated Care Systems. Conversations have begun with providers to test these.

As can be seen from this data:

- For Tier 2, data indicates a higher than national average percentage of people who enrol onto the 12-week programme completing it and achieving weight loss (62%). 22% of people who completed the programme lost more than 5% of their body weight which compares positively to the national average of 16%.

- However, from this data is seems that there is locally a lower percentage of enrolments compared to national average. There is also still a low update from target groups (BAME, LD, males).
- However, further work across all the Tiers 1-4 would be helpful to understand the local situation more clearly as part of this strategic action plan . For example, the following areas:
    - Trends in the level of activity
    - Comparison with other weight management programmes
    - Breakdown of activity by provider locally
    - Data about waiting times – including source of referral, time on waiting list, reason for waiting, intervention and impact to reduce excess waiting, data about unwarranted variation
    - Provider performance and growth
    - Tier 4 data (currently none available)

In Phase 2, focus will be given to these areas and also considering the potential for further growth and innovation. This includes closer work with the KPHO to consider pathway modelling and scenario testing for improving flow through the pathways and seeking opportunities to better target under-represented groups using population segmentation and mapping methods. This will also include building more proactive review of this data between commissioners and providers to review areas of high performance and areas needing more attention.

Table 1: Overview of current Tier 1-4 specialist weight management in Kent and Medway

Kent and Medway ICS Adult Weight Management Services							
Tier 1		Tier 2		Tier 3		Tier 4	
Provider	Which districts have access?	Provider	Which districts have access?	Provider	Which districts have access?	Provider	Which districts have access?
Better Health - NHS (www.nhs.uk) Digital online resources, also available via One You Kent - Kent County Council NHS	All Kent	• National Diabetes Prevention Programme (Kent and Medway ICB) • Lifestyle intervention for people with non – diabetic hyperglycaemia (NDH). • Referral via healthcare professional (HCP) • Kent & Medway ICB	Kent & Medway	TBC Website | Home (tbchealthcare.co.uk) A fully comprehensive clinically led service that incorporates a dietetic, activity and behaviour change support program that all face and lasts for 12 months The service also provides a patient pathway for preparation and referral to weight loss surgery	All Kent	Maidstone & Tunbridge Wells NHS Trust	All Kent
Exercise - NHS (www.nhs.uk) Free online physical activity resources NHS	All Kent	Kent and Medway Marketing Engagement | Xyla Health & Wellbeing (xylahealthandwellbeing.com) • Low Calorie Diet – 12 weeks total diet replacement for people with type 2 diabetes • Kent & Medway ICB	Kent & Medway			Lewisham & Greenwich NHS Trust	All Kent
The Eatwell Guide - NHS (www.nhs.uk) Online resource on Healthy nutrition NHS	All Kent	NHS England » The NHS Digital Weight Management Programme 12 - Week online support for adults having obesity plus either diabetes, or hypertension, or both, to help manage their weight and improve their health. Referral from GP	Kent & Medway			Imperial College London NHS Trust	All Kent
Everyday Active Active Kent and Medway website providing information on locally available physical activity resources.	Kent &Medway	Healthy weight - Kent County Council • 12-week multicomponent community weight management service • Health professional and self-referrals • Kent County Council	All Kent			Chelsea & Westminster NHS Trust	All Kent
One You Kent - Kent County Council Kent One You Kent Healthy lifestyle for advisers provide brief interventions between 1 and 4	All Kent					Kings College Hospital London NHS Trust	All Kent
						St Georges Hospital NHS Trust & UCLH NHS Trust	All Kent

NB: Whilst this table provides a high level overview it is designed to be indicative (to give an idea of the rich mix of services on offer) rather than exhaustive. The production of a comprehensive catalogue of services available may form part of the next stage of this work.

Table 2: 2022/23 data on numbers supported and outcomes of weight management services (tier 2, 3 and 4)

	Numbers supported	Enrolled	Completed intervention	Participants who lose weight	Participants that lost at least 5% of the body weight
Tier 1	3,787 Diet and physical activity support	No data available	24% complete their exit goal within 6 months of finishing the service	No data available	No data available
Tier 2					
Kent - Core	2,038	38%	63%	62%	22%
National - All	85,605	65%	37%	43%	16%
Tier 3	2723	1111	92%	89%	66%
Tier 4	No data available				

For Tier 2, further information about OHID target groups is provided below -

		Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
% from Target Group (BAME)	%	7.4%	13.4%	13.3%	14.7%
% from Target Group (Males)	%	11.0%	10.6%	9.4%	14.6%
% from Target Group (LD)	%	2.4%	1.4%	1.5%	1.8%

In Phase 2, there will be a commitment to jointly review services, identify any gaps in data and undertake user engagement activities to ensure that services meet the needs of the Kent population. For Tiers 1 and 2, there will be a review of the data collected, in order to

ensure that reporting evidences outcome achievement, value for money and service impact.

As part of Phase 2, we plan to finalise and implement referral routes, pathways between Tiers and the criteria for each.

Strategic Action 4

Improve self-referral access including information provision for local people and suitability checks by providers.

For Tiers 1 and 2 people can self-refer through the OYK referral form, hosted on the KCC website. Social media campaigns occur throughout the year to promote access to these services, with a dedicated weight management newspaper, social media and radio campaign occurring every January.

In Phase 1, we have commenced conversation with the providers of the Tier 2 services to establish current approaches to self-referral and ways to optimise this. In particular we are seeking to understand:

- awareness about self-referral and promotion of this to local people who may wish to access services
- current use of the forms and people's experiences about its ease of use
- current processes in place by providers to check the suitability of potential service users who are self-referring
- review of the criteria being used and to ensure both service safety by testing this against national guidelines and also other models of practice, as well as working with primary care to assess suitability, and working with the various providers and some service users to test ease of use
- over time developing automated methods for filtering people to the relevant tiers but ensuring manual checks for safety

Strategic Action 5

Improve primary care understanding about the pathway, its needs, and their engagement with this

Research has shown that brief, opportunistic interventions delivered in primary care can result in a five-fold increase in the proportion of eligible people engaging in weight management services. Simple advice from a health or care professional to lose weight

increases people's' intentions to lose weight. However, referring people to weight management services can more than double the amount of weight they lose. This requires that referral to weight management services needs to be simple and effective. Hence it is important that we make the referral processes smooth and simple.

In Phase 1 we have started working with primary care professionals in the ICB and in local GP practices to understand their current experiences and to help shape our plans for improvement. This will help prevent any confusion around referrals to different tiers as, for example, people already on weight loss medications being referred to Tier 2 inappropriately, or people being referred to multiple tiers.

In Phase 2 we plan to conduct more widespread engagement with primary care and to create a more live dialogue about the ongoing oversight of weight management services in Kent. This includes understand more about the opportunity to link with Integrated Neighbourhood Teams and Health Alliances and the role that they can play in this plan. This action will include focus on how partners can work together to consider best ways of utilising existing resources and opportunities to work together to increase system capacity through existing resourcing to maximise positive impact for local people.

Strategic Action 6

Enhancing our approach to service user engagement and use of insights gained from this by providers to optimise services further

We believe that core to building optimal weight management services locally is in partnership with local service users, residents and communities. As part of this strategic action plan, we plan to:

- establish what the current practice and information held amongst providers is
- Consider the gaps and ways to fill them across the entire pathway (including under-represented groups)
- Use opportunities afforded by the KCC Public Health Services Transformation Programme to engage with a wide range of stakeholders, including service users.
- Build a plan for service user engagement for the medium and long term also to help ensure the services we commissioned are user informed (increasingly thinking about digital for this too plus keeping in mind minimising digital exclusion)

As mentioned in section 3, certain groups are at higher risk of having excess weight, for example those with learning disabilities or those with medication conditions. It would be important to ensure that services are considering their specialist needs, for example

managing their weight in the context of medications that may make it more difficult for them to lose weight.

Services should also be inclusive and adaptive where possible, for example those with learning disabilities, those with different cultural background or do not speak English may need specific adaptations.

Strategic Action 7

Ongoing learning, knowledge sharing and innovation across local providers internal and external stakeholders, national and international approaches to optimise a continuous improvement approach to weight management

We know from our work already that we have a good, diverse range of providers locally delivering weight management services. However, we also know that they vary greatly in terms of size, strengths and also the challenges they face.

In Phase 1, we have engaged with over 40 stakeholders from the KCC Public Health Transformation Programme across our range of geographies locally, interest areas and sectors. We have heard about the opportunity to create a learning community amongst our providers to learn and grow together, share good practice, and unblock issues as they emerge, supported and enabled by us as the commissioners. We also know from our Whole Systems Obesity work that there is great value in creating and sustaining a network like this. However, we recognise that this takes careful planning and resource to do well.

In Phase 2, we will start to scope the options for supporting providers to develop together and start work to implement this in practice for the benefit of our local people. It is likely that we can use and share learning for other areas as well, and it may also be that we can combine our efforts. We will consider the use of digital media to support this and also consider the research and funding opportunities for unlocking innovations in so doing.

We are also keen to ensure that we are also aware of good practice and learning from other regional, national, or even international models, including academia.

In Phase 1, exploring different case examples, learning about good practices, and connecting with regional and national communities are vital steps towards achieving the best practices in weight management services. By examining successful interventions, adopting evidence-based approaches, considering community needs, and working together, we can effectively address weight management challenges and improve the overall health and well-being of individuals across diverse communities. This collective

effort will pave the way for a healthier future and contribute to the advancement of weight management services on a broader scale.

Exploring case examples

Exploring different case examples provides valuable insights into effective strategies and approaches employed in weight management services. It allows us to examine diverse scenarios, including successful interventions and programs that have yielded positive outcomes. Through careful analysis, we can identify common factors that contribute to success and learn from the experiences of others. Case examples offer practical guidance and serve as a foundation for developing evidence-based practices.

Learning about best practice

Learning about best practice is essential for effective Weight Management services. These practices may include comprehensive lifestyle interventions, personalised dietary plans, regular physical activity, behavioural therapy, and creating supportive environments. Understanding best practice allows us to establish guidelines and standards to ensure consistent and high-quality care for individuals seeking weight management services.

Connectedness to regional and national communities

Effective weight management services must be contextually relevant and tailored to the unique needs of communities. It is crucial to actively engage with regional and national communities throughout the process. By doing so, we foster a sense of connectedness and gather diverse perspectives, enabling us to consider cultural and environmental factors that influence weight management practices.

Working together to achieve best practice

Working together is the key to achieving best practices in weight management services. Collaboration facilitates the exchange of knowledge, expertise and resources among stakeholders. Regional and national communities can come together to share successes, lessons learned, and challenges faced in implementing weight management programs. Through collective problem-solving and open dialogue, innovative solutions can be developed, tailoring best practices to specific community needs and resources.

7. Measures of Success

For us to measure success and understand progress against our key objectives and targets, it is crucial to establish clear metrics and regularly evaluate outcomes. By setting specific objectives and targets, and by analysing interpreting relevant data, such as weight loss metrics, improvements in health care, with a focus on health inequalities, and service user feedback, we can measure progress accurately.

Adapting a Donabedian approach as a basis to the framework of metrics, Table 3 shows measures used for tier 2 and tier 3. These metrics can also be analysed by demographics to determine and monitor inequalities, as well as working with providers to share or collect data on other populations that we know to have higher risks from excess weight such as those with mental health conditions or learning disabilities. However, having a consistent dataset will also need to be agreed across providers. We are currently not aware of any KPIs for tier 4.

Table 3: Key measure for success for tier 2, 3 and 4 weight management services based on current KPIs for the services.

	Process	Outputs	Outcomes
Tier 1	No metrics or data available	No metrics or data available	No metrics or data available
Tier 2	100% of participants enrolled in the service meet the eligibility criteria.	60% of participants complete the active intervention.	75% of participants will have lost weight at the end of the active intervention
	Referrals to the service	% of individuals enrolled in the service are from identified high risk groups (BME; men; people with learning difficulties)	30% of all participants will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention
		100% of enrolled participants are invited to provide feedback at the end of the active intervention.	50% of completers will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention.
		Patient satisfaction	35% of completers provide a weight measure at 6 months
			20% of completers provide a weight measure at 12 months
			% of completers at 12 months have a body weight which is lower than their baseline body weight

Tier 3	Number of individuals referred to the service	% of people attending and who are referred to the Multi Disciplinary Team (MDT) within 6 weeks	Referrals to Tier 4 based on pathway recorded at MDT.
	Inappropriate referrals to the service	Number of people who have attended within 6 weeks of referral	% participants who successfully achieve weight loss
		Number of people attending MDT within six weeks of referral	Reduction in medication use after active intervention
		Patient satisfaction (by patient questionnaires or surveys)	
Tier 4	No metrics or data available		

We will work together in the early part of Phase 2 with colleagues from KPHO to review these metrics and to create a wider dashboard to capture the impact of our work and contribution to improving the health and wellbeing of the local population and tackling inequalities locally. For example, we will consider the indicators that are measured nationally and locally within our public health team including those from the Public Health Outcomes Framework relating to obesity and obesity related conditions:

- Percentage of adults classed as overweight or obese (excess weight)
- Percentage of physically active and inactive adults
- Percentage of adults meeting '5-a-day' fruit and vegetable consumption recommendations
- The Quality & Outcomes Framework (QOF) includes an indicator for obesity as recorded in general practice disease registers, in those aged 18 and over.
- Hospital admissions for obesity
- Newly diagnosed type 2 diabetes
- Percentage of people with type 2 diabetes, as recorded on practice in general practice registers, in those aged 18 and over
- Percentage of people with type 2 diabetes who are of minority ethnic group
- Percentage of people with established hypertension, as recorded in general practice disease registers, in those aged 18 and over.

In addition to this we will also consider other metrics available, which together will help us to understand the impact of our work overall (accepting that given the multiple initiatives in some of these areas that it may be hard to attribute specifically to our work in places, but we would at least like to monitor trends and contributions to the best of our abilities):

1. Reduction on overall obesity rates in K&M and those of obesity related conditions – in year, and over time modelling the impact of this on the estimated disease prevalence locally also
2. Reduction in the gap of obesity prevalence between the most and least deprived areas
3. Reduction in number of people with hypertension utilising primary care datasets such as reduction of mmHg and the cost of prescribed medicines also (thus estimating financial savings and the creation of a more sustainable and quality model of care delivery)
4. Reduction in patients with Diabetes again both clinically and in savings of prescribed medicines
5. Reduction in number of people with acute disease prevalence and impact on service utilisation, for example people presenting with stroke or TIA
6. Shifting in the model of care from investment and focus on reactive care delivery to prevention and proactive care
7. Quality of care provision and engagement for planning delivery at all parts of the pathway as evidenced by staff and service user feedback
8. Measurement of the equity of service and the specific effectiveness against weight loss in terms of equity and completers.

We recognise that metrics are not only quantitative, and also include testimonials and success stories from service users. By sharing these and, in conjunction with the stories derived from quantitative figures, we can inspire and motivate others on their weight management journey. We also recognise that the formulation of this dashboard will in itself be an opportunity to strengthen relationships across the system as we will start by collating metrics that are currently collected by partners but also work to understand aspirations and build a dashboard that can enable the capture of not just activity but also delivery against these wider aspirations for and with local people.

Furthermore, staying informed about current models of weight management allows us to tap into best practices and innovative strategies that can enhance our programs. Regularly assessing progress and adapting approaches based on data and participant feedback enables us to continuously improve and achieve optimal outcomes in weight management services.

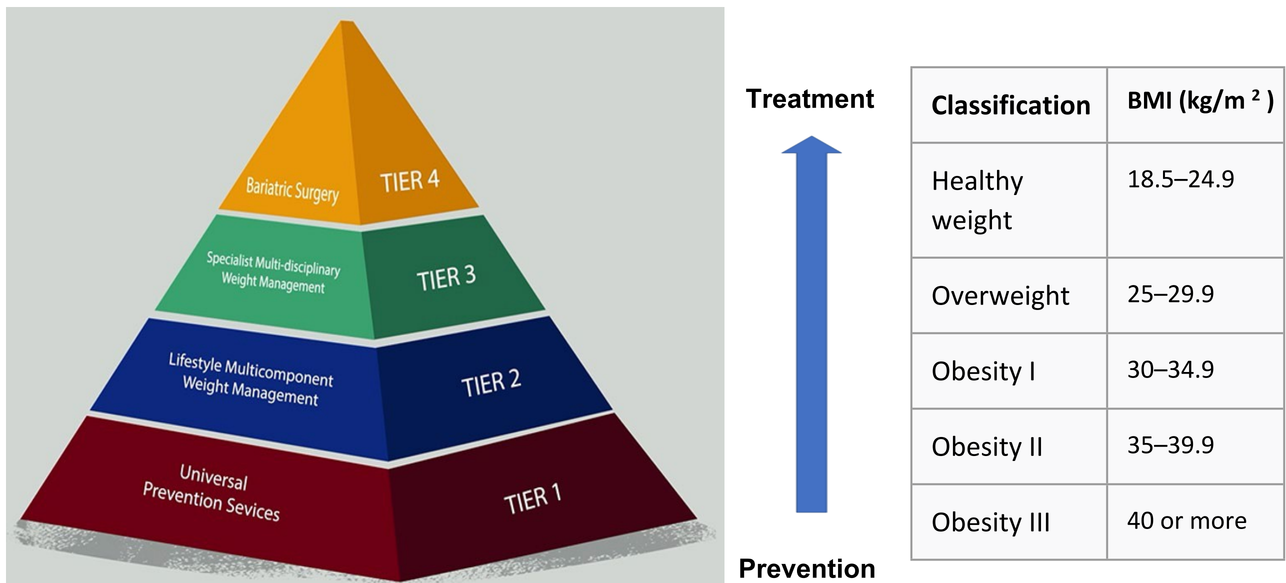
8. Appendices

A: Overview of current provision for weight management and obesity

B: Core members of the task and finish group

Appendix A: Overview of current provision for weight management and obesity

A stepped-care approach to tackling obesity



Classification	BMI (kg/m ^{2})
Healthy weight	18.5–24.9
Overweight	25–29.9
Obesity I	30–34.9
Obesity II	35–39.9
Obesity III	40 or more

From prevention to treatment:

When individual support or treatment is required for those who are overweight or obese, they are referred to weight management services.

There are different levels, or tiers, of weight management services.

Description of the tiered system of weight management services based on NICE guidelines

Tier 4

Type of service

- Surgical and non-surgical interventions
- Typically, bariatric surgery, with multidisciplinary lifestyle support pre- and post-op

Who can benefit/ who should be referred

- NICE guidelines (2016) state that bariatric surgery is the option of choice for adults with a BMI of more than 50 kg/m2 when other interventions have not been effective. Adults with BMI of ≥40, or ≥35 with other significant disease (e.g., Type 2 diabetes or high blood pressure) that could be improved if they lost weight, should also be considered for referral.
- Typically, referral to a Tier 4 is only considered if the person has already tried all appropriate non- surgical measures and received intensive management in Tier 3 service.
- See https://www.nice.org.uk/guidance/qs127 for further details.

Tier 3

Type of service

- Specialist weight management services. Provide non-surgical, intensive lifestyle management programmes, delivered by a multidisciplinary team, typically including specialist physicians, nurses, dieticians, psychologists, and physiotherapists/ exercise therapists.

Who can benefit/who should be referred

- NICE guidelines (2016) state that adults with a BMI of ≥30 for whom Tier 2 interventions have been unsuccessful should discuss the choice of alternative interventions for weight management, including Tier 3 services.
- Referral criteria for Tier 3 varies depending on locality. See https://www.nice.org.uk/guidance/qs127 for further details.

Tier 2

Type of Service

- Community-based lifestyle, weight management services. These are typically group-based and are focused on behavior change including diet, nutrition, and physical activity.
- Typically, limited time, up to 12 weeks

Who can benefit/who should be referred

- Anyone with BMI >= 25 (or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes).
- May be particularly beneficial for those with BMI > 30 or from BAME groups or with other risk factors.

<u>Tier 1</u>

Type of Service

- Universal, behavioural interventions focused on obesity prevention and promotion of healthy eating and physical activity (for example through public health campaigns and providing brief advice in primary care/community settings)

Who can benefit/who should be referred

- The aim is to benefit the whole population through healthy lifestyle and physical activity public health strategies.
- In parallel, those who are overweight or at risk of becoming overweight may be identified within primary care/ community settings and offered brief advice (for example, from GPs, school nurses etc), together with support from local organisations, leisure centres and/or community-based groups through social prescribing.

Appendix B: Core members of the task and finish group

Name		Role	Organisation
Malti	Varshney	Director of Strategic Change and Population Health	NHS Kent and Medway ICB
Jules	Bole	Senior Programme Manager	NHS Kent and Medway ICB
Luke	Edwards	Senior Commissioner	Kent County Council
Abimbola	Ojo	Public Health Specialist	Kent County Council
Amrit	Matharu	GP Fellow with Public Health Team	Kent County Council
Durka	Dougall	Interim Consultant Public Health	Kent County Council
Dan	Coleman	Deputy Director of Elective Care	NHS Kent and Medway ICB
Constance	Wou	Consultant in Public Health	Kent County Council
Chris	Beale	Commissioner	Kent County Council
Lynette	Merry	Strategy Team Administrator	NHS Kent and Medway ICB

Appendix C: Core members of the Implementation Leadership group

Name		Role	Organisation
Ashwani	Peshen	Deputy Chief Medical Officer (Primary Care)	ICB
Sukhbir	Singh	Director of Primary Care Commissioning	ICB
Luke	Edwards	Senior Commissioner	Kent County Council
Abimbola	Ojo	Public Health Specialist	Kent County Council
Durka	Dougall	Interim Consultant Public Health	Kent County Council
Rutuja	Kulkarni-Johnston	Consultant in Public Health	Kent County Council
Chris	Beale	Commissioner	Kent County Council
Rachel	Parris	Deputy Director Out of Hospital Care	ICB

Version	Date	Changes/commentary	Agreed
1.0		Interim Weight Management strategic action plan for agreement presented to JCMG Group in December 2023	
2.0		Weight Management for strategic action plan agreement presented to JCMG Group in March 2024	
4.0	8 March 2024	Changes made by Prof D Dougall and Dr Abimbola Ojo (Public Health, KCC)	

Appendix 2: Overview of current Tier 1-4 specialist weight management in Kent and Medway

Kent and Medway ICS Adult Weight Management Services							
Tier 1		Tier 2		Tier 3		Tier 4	
Provider	Which districts have access?	Provider	Which districts have access?	Provider	Which districts have access?	Provider	Which districts have access?
Better Health - NHS (www.nhs.uk) Digital online resources, also available via One You Kent - Kent County Council NHS	All Kent	• National Diabetes Prevention Programme (Kent and Medway ICB) • Lifestyle intervention for people with non – diabetic hyperglycaemia (NDH). • Referral via healthcare professional (HCP) • Kent & Medway ICB	Kent & Medway	TBC Website | Home (tbchealthcare.co.uk) A fully comprehensive clinically led service that incorporates a dietetic, activity and behaviour change support program that all face and lasts for 12 months The service also provides a patient pathway for preparation and referral to weight loss surgery	All Kent	Maidstone & Tunbridge Wells NHS Trust	All Kent
Exercise - NHS (www.nhs.uk) Free online physical activity resources NHS	All Kent	Kent and Medway Marketing Engagement | Xyla Health & Wellbeing (xylahealthandwellbeing.com) • Low Calorie Diet – 12 weeks total diet replacement for people with type 2 diabetes • Kent & Medway ICB	Kent & Medway			Lewisham & Greenwich NHS Trust	All Kent
The Eatwell Guide - NHS (www.nhs.uk) Online resource on Healthy nutrition NHS	All Kent	NHS England » The NHS Digital Weight Management Programme 12 - Week online support for adults having obesity plus either diabetes, or hypertension, or both, to help manage their weight and improve their health. Referral from GP	Kent & Medway			Imperial College London NHS Trust	All Kent
Everyday Active Active Kent and Medway website providing information on locally available physical activity resources.	Kent &Medway	Healthy weight - Kent County Council • 12-week multicomponent community weight management service • Health professional and self-referrals • Kent County Council	All Kent			Chelsea & Westminster NHS Trust	All Kent
One You Kent - Kent County Council Kent One You Kent Healthy lifestyle for advisers provide brief interventions between 1 and 4	All Kent					Kings College Hospital London NHS Trust	All Kent
						St Georges Hospital NHS Trust & UCLH NHS Trust	All Kent

From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Health Reform and Public Health Cabinet Committee, 17 September 2024

Subject: Public Health Service Transformation and Partnerships

Classification: Unrestricted

Past Pathway of Report: N/A

Future Pathway of Report: N/A

Electoral Division: All

Is the decision eligible for call-in? Not applicable

Summary:

The Public Health Service Transformation Programme aims to improve all services in receipt of the Public Health Grant, to ensure that services are efficient, achieving best value, evidence-based and delivering the right outcomes for the people of Kent.

The programme is an opportunity to review the current Public Health service models, alongside engagement from stakeholders, people who draw on care and support services and those who do not. A key outcome will be designing services that meet the needs of the people of Kent whilst balancing increasingly challenging financial and demand pressures, now and in the future.

The purpose of this paper is to update the committee on the progress of the programme to date, share the plan for future work and share the early themes which are emerging across services. It follows a series of other papers and updates shared with the committee. The committee should note that a public consultation will go live shortly relating to Therapeutic Services for Children and Young People. At least one other consultation is anticipated to follow later this year. Members of the committee are asked to support the promotion of the consultation to help inform the future offer.

Service models are being refined following input from the local engagement phase of the programme. The preferred new models will be presented to future cabinet committees for comment following a financial appraisal, external peer review and finalisation of the business case.

The intention is for new commissioning arrangements for each service to be in place no later than 1 April 2026, with many starting before this date. The team are also being mindful of scheduling of activities to mitigate risks and to balance internal and

external resources.

Recommendation(s):

The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the information contained within this update report, and to **COMMENT** on the programme and the next steps.

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1. Introduction

1.1 Kent County Council (KCC) Public Health is leading a Public Health Services Transformation Programme to improve service delivery to communities, particularly targeting underserved communities. The transformation work aims to ensure that new service models are efficient, evidence-based and deliver Public Health outcomes for best value.

1.2 It is important to ensure that future Public Health services are innovative, sustainable, and responsive to the needs of our communities. The last time services were reviewed in this way was in 2017 and since then many factors have changed. There are increasingly challenging funding pressures, new requirements or needs and in some areas, greater complexity and/or rising demand. Within some prescribed services, such as smoking and substance misuse, ambitious targets to increase the numbers are being set nationally. There are also many opportunities such as digital developments, closer working with local structures (community neighbourhood teams, Health Care Partnerships) or new emerging provider markets.

1.3 The Health Reform Public Health Cabinet Committee were previously updated on the programme in May 2024 and will have the opportunity to shape and engage with this programme of work as it develops.

2. Public Health Services Transformation Programme progress

2.1 The Public Health Service Transformation Programme commenced in July 2023 and has completed the first four phases of activity: planning, information gathering, delivering workshops (with providers to review services) and options appraisals. The programme is in its fifth stage (at the time of writing), which is local engagement. The local engagement phase involves testing the preferred service model through internal engagement. The local engagement includes discussions with current providers, wider market providers, people who use Public Health services and identified groups of those who do not access services and could benefit from accessing them, to gather views on the proposed, preferred service model.

2.2 The purpose of Phase 5 - Local Engagement is to test the feasibility of the commissioning models and to refine the preferred models based on feedback received in this phase.

3. Internal Engagement

3.1 Officers are currently engaging with a variety of internal stakeholders, including the Corporate Management Team, Divisional Management Teams, Finance Business Partner, Human Resources, Democratic services, Legal, Commercial and Procurement, Marketing and Communications, Public Health Performance, Kent Public Health Observatory and the Consultation Team and operational staff across directorates (i.e. operational leads in Children and Young People directorate).

3.2 These stakeholders are being informed about the programme's progress and are advising on matters such as the requirement for a Public Consultation, the preferred service model's feasibility (efficiencies, affordability, performance and market considerations), Transfer of Undertakings (Protection of Employment) Regulations (TUPE), and opportunities for integration and alignment into other areas or services.

3.3 The feedback to date and engagement from internal teams has been positive, with colleagues sharing views and evidence about how Public Health services could be enhanced or improved to meet the changing needs of the population.

4. External Stakeholder Engagement

4.1 As part of the current local engagement phase, Consultants and Commissioners are engaging, or plan to engage, with a variety of external stakeholders. This includes District and Borough Councils, the Kent and Medway Integrated Commissioning Board (ICB), current providers, the wider provider market, the Local Medical Committee, the Local Pharmacy Committee, Health Care Partnerships (HCPs), Voluntary Community and Social Enterprise (VCSE), the Police and Crime Commissioner and other local authorities. This engagement will provide the chance to capture potential opportunities, comments on feasibility and/or impacts of proposed changes.

5. Market Engagement

5.1 A review of market providers has been conducted for each service area, alongside benchmarking to inform the engagement approach of alternative suppliers. Some service areas have limited alternative providers and previous procurements have resulted in the same suppliers being awarded the contract, for example sexual health. In other areas there is greater choice which should be explored to support best value. A few examples of this work are shared below.

5.2 Adult Lifestyles, Weight Management and NHS Health Checks - KCC held two market engagement events in July 2024 which was attended by 38 organisations. The events included facilitated conversations to shape the thinking around service models. Market providers, in summary, outlined that the service should; include multiple support options/access points, increase the availability of digital solutions, including the use of apps, be targeted to specific cohorts, include support options for all age groups, be holistic, aim to reduce

stigma. This mirrors some of the feedback from insights work which highlighted the need to provide a tailored offer that people identify with to attract underserved groups.

5.3 Children and Young People – an Infant Feeding survey has been shared with market providers to gather feedback and support the procurement approach.

5.4 Based on the market engagement conducted, it is clear there is a strong market of quality providers to deliver some services (e.g. lifestyle services), though in some areas, due to the specialist and clinical nature of services, there are fewer providers (e.g. Health Visiting).

5.5 Feedback has also shown that providers are open to working with KCC to improve services and implement the recommendations that have emerged from the analysis and in some areas have the skills and expertise to do so.

6. People with Lived Experience Engagement

6.1 Understanding the views of the people who use Public Health services is critical to ensure that improvements are person centred – that they meet the needs of the Kent population and that KCC responds to those needs effectively. The reach of people who benefit from Public Health services each year is large. For example, in 2023/24, 66,308 universal development checks were delivered by the Health Visiting Service[1] and 31,379 eligible people aged 40 – 74 received an NHS Health Check[2]. Many of these people will have experiences and views of how the service could be improved. As part of the transformation work, existing insight from people with lived experience has been reviewed and considered and teams will continue to explore how they can work with these people to inform services

6.2 In relation to children's wellbeing and in partnership with the NHS Kent and Medway Integrated Care Board (ICB), we have undertaken a range of engagement activities with children, young people, families and carers, professionals and providers to understand what they think is important to support children's and young people's emotional wellbeing and mental health. KCC and the NHS in Kent heard from 1,000 children and young people in 2023, this includes the Big Conversation Event in Detling. The NHS Kent and Medway Have Your Say survey 2023 was promoted to children, young people, families, carers and health professionals.

6.3 Moving forward, where there is significant change proposed, views from people across Kent will be collated via Public Consultation. These views will be analysed, duly considered and reflected within the full business case which will be in place before being presented at a future Health Reform and Public Health Cabinet Committee seeking endorsement of the proposed key decision.

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[1] Reporting period – discrete periods
[2] Reporting period - rolling 12 months

7. Engagement with People who do not use Public Health Services

7.1 Gathering insights from seldom heard people can be challenging and is vital to help inform new service model design. In June 2024, a total of 1,098 responses were collected from 721 people through online surveys, one-to-one interviews, community pop up events and focus groups as part of external insights commissioned to support this programme.

7.2 The approach for the work (which was mainly focused on Adult Lifestyles and Sexual Health) was to target people who do not currently use Public Health services and could benefit from doing so, particularly focusing on Kent's coastal districts and targeting the NHS (National Health Service) CORE20PLUS[3] demographics which include deprivation, protected characteristics and inclusion health groups.

7.3 The full report is in the process of being disseminated for use by wider stakeholders. The main strategic recommendations from the insights work are:

- To continue to deliver marketing and communications across Public Health services, co-designed with people and providers, to ensure they resonate and are relevant to target segments. This includes continuing to work with providers to make use of digital chat – particularly important for neuro-diverse people, providing information in different languages, ensuring supplier's staff reflect and/or understand Kent's diverse population and their needs. KCC needs to refresh its use of social media. For example, social media platforms change in popularity and change depending on age and it is important to keep abreast of changes to target parts of the population effectively.

- To continue to regularly review flexible services in communities through asset mapping the voluntary and community sector to understand what services are available locally, what can be capitalised or built upon to support Public Health priorities and to feed this into commissioning plans. For the NHS Health Checks service, it was highlighted that people would like to receive Health Checks in settings that are 'hyper' local and familiar and not just offered via the traditional route of accessing GPs (General Practices). This is particularly important for routine and manual workers who have varied shift patterns.

- To increase targeted support for seldom heard groups - it was recommended to co-design, enhance and target support with people from priority segments to help reduce health inequalities alongside commissioning a wide selection of open access and self-directed universal support.

[3] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

- To work with voluntary groups to identify opportunities to develop local volunteer peer support networks and/or community ambassadors to support access for people.

- To increase awareness and understanding of services. The research emphasised the need to co-design materials, to codesign marketing and communication campaigns and workforce training.

8. Public Consultation Plans

8.1 The Public Health Service Transformation Programme has sought advice from the KCC Consultation Team and plan to undertake a consultation on proposed changes to the Emotional Wellbeing and Mental Health Service (for children and young people aged 5 to 19 with mild to moderate mental health needs). This is currently known as the Kent Children and Young People's Counselling Service.

8.2 The proposal is to develop a new KCC Therapeutic Support Service to replace the Counselling Service. The consultation will run from 18th September 2024 to 18th November 2024. Details of how to feed into the consultation will be available here Let's talk Kent.[4] There will be an opportunity for people across Kent to respond to the Public Consultations online or at events across the county.

8.3 The responses will be analysed and incorporated into the business case and the new service design proposals will be presented to this cabinet committee seeking support to the Key Decision.

8.4 Onward service model development and discussion may result in two further consultations.

9. Key Themes

9.1 From the evidence gathered in the early stages of the programme (performance and data collection, benchmarking, stakeholder workshop feedback and market engagement), common themes across Public Health services have been identified and are outlined below:

- **Changes in demand across all Public Health services** - The Kent population is increasing in size and projected to continue, which means increases in demand are more likely over time. For example, the number of referrals into the current Children and Young People Emotional Wellbeing and Mental Health Service has almost doubled in the last two years which has meant that children and young people are now waiting longer to be assessed for the service. It will be necessary to manage within the existing budget as we do not anticipate funding to significantly increase.

[4] Let's talk Kent

- **Increase in need** – There is also a potential increase in need, for example in Sexual Health, there are increases in STI (sexually transmitted infection) rates and abortion rates alongside a lower-than-expected uptake of HIV testing. At the same time, there is a lower-than-expected uptake of chlamydia testing among women aged 15 to 24 and lower uptake of LARC (long-acting reversible contraception). A proactive approach to address these needs will be most cost effective.

- **Complexity of need** – Caseloads in some Public Health services are more complex, with more prevalence of comorbidities and multiple needs. Evidence suggested this is better supported via a holistic approach.

- **Access** – The insights work, and other evidence suggests that different residents want to access Public Health services in different ways. There is a preference for face-to-face local access in some areas but some segments of the population would prefer an initial contact through digital chat or text message (this is particularly relevant for neuro-diverse people for example). For other segments, 'hyper local' community settings are important, this is true for shift-based and manual workers who prefer fewer formal settings. Mapping the need and demand for services across the county and across population segments will help to target resources and respond to need more effectively.

- **Equitable access –** Overall performance across services is very good, however, there is an inconsistency of delivery in some parts of Kent. Key reasons include multiple providers delivering, workforce shortages (reflecting national workforce recruitment challenges and proximity to London). It is therefore important that new commissioning arrangements are consistent across the county, equitable access is offered, and proactive approaches are in place to address workforce issues.

- **Value for money** – Services across Kent generally offer good value for money (based on financial benchmarking), however in some services there is an opportunity to improve efficiencies whilst still achieving the same outcomes. This could be achieved by using a provider who is able to deliver the same quality with lower overheads via a competitive procurement.

- **Funding** – Funding for all the services in scope is dependent on the Public Health Grant, which increased by 1.3% this financial year (2024/25). It is assumed that the grant value and conditions will remain broadly consistent.

10. Early Thinking Across Services

10.1 Common themes from the workshops are that commissioners, consultants and providers all articulate that services need to be safe, effective, sustainable, equitable (and consistent), and accessible for all the people of Kent.

10.2 This is particularly challenging for mandatory services in an environment of increasing demand and financial constraints. In terms of how Public Health is responding to these challenges, the early thinking includes (but is not limited to):

- Re-profiling spend and prioritising need – Across services it has been recognised that there is a need and opportunity to prioritise inviting people at high risk of poor health outcomes. This is true for NHS Health Checks (i.e. cardiovascular risks) and for Health Visiting (i.e. prioritising safeguarding need). This can be achieved whilst also providing a mandated and universal service across the whole Kent population by seeing those with most need first or by putting in place a skill mixed workforce where more specialist staff work with the highest need.

- Cross promotion of services – It is recognised that there is an opportunity to enhance cross promotion and brief advice within services. For example, promoting good oral hygiene or healthy lifestyles in services. Each new service model will specify that the provider needs to build on the existing cross promotion of services and ensure this opportunity is maximised such as Make Every Contact Count[5] towards behaviour change. Some services may have dedicated roles to support this.
- Working with existing providers – It is beneficial to continue working with existing partners where the service is demonstrating good outcomes, performance and best value. Providers benefit from greater stability by avoiding staff changes at a time when staff recruitment and retention can be challenging. This is permitted under new procurement rules.

- Alignment to external opportunities or providers – By working with other commissioning bodies, such as the Kent and Medway Integrated Care Board (the ICB), there are opportunities for sharing insight, improving alignment, ensuring pathways are joined up and duplication does not occur. Additionally, by developing informal networks between providers, voluntary sector and community settings it is possible to strengthen communication, awareness and information about the importance of services. Sexual Health services are a good example of this.

10.3 Furthermore, there are opportunities for services to re-profile existing expenditure and allow more focus in areas that can align with new, long-term health-related strategies or national imperatives.

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[5] NHS England » Making Every Contact Count (MECC): Consensus statement

11. Legal

11.1 Most services within the scope of this programme are mandatory and KCC has a legal duty to deliver these Public Health services under the Health and Social Care Act 2012. KCC's Legal Team have been engaged with throughout the programme and in relation to; a) the decision surrounding the legal requirement for a Public Consultation and b) relevant procurement legislation and terms and conditions.

11.3 Many of the services within scope of the transformation programme were procured through a Partnership Agreement with KCHFT (Kent Community Health NHS Foundation Trust) and MTW (Maidstone and Tunbridge Wells NHS Trust) based on Regulation 12(7) of the Public Contracts Regulations (PCR) to establish a cooperation agreement. As replacement legislation for PCR 2015, the new Provider Selection Regime (PSR) does not contain the same opportunities to continue the cooperation agreement. The agreements will need to be procured using alternative routes under the appropriate legislation. The KCHFT and MTW Partnerships have been extended in compliance with Regulation 72[6] until the end of March 2026.

11.4 This allows the time and internal capacity to re-model and re-commission individual services that will go live ahead of the expiry of the KCHFT and MTW Partnerships. Each service will go through the appropriate governance processes alongside commercial and procurement via Commercial Procurement and Oversight Board (CPOB).

12. Performance and Quality

12.1 Public Health service performance is regularly reported to the Health Reform and Public Health Cabinet Committee and services consistently meet or exceed set targets.

12.2 During the programme period Public Health will work with existing providers to ensure efficiencies and best value are met across services. KCC will closely monitor budgeted expenditure alongside contracted performance during the period of change through regular contract management with existing providers, to ensure that performance and cost are carefully managed during the time of programme.

13. Commercial Considerations

13.1 The Programme Team is working with Commercial and Procurement on procurement routes and commissioning arrangements such as payment mechanics, supplier sustainability, risk allocation and strategies to manage inflationary price rises.

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[6] https://www.legislation.gov.uk/uksi/2015/102/regulation/72/made

13.2 Early thinking around procurement routes and commercial arrangements has been tested with the market to ensure whilst they are affordable to KCC, sustainable for providers and will not result in unacceptable compromises in service quality or be detrimental to the supplier and service in the future. If the service is being competitively procured, the commercial terms need to balance value-for-money for KCC and be favourable enough to be attractive for providers. These procurement and commercial considerations will be presented to CPOB (Commercial Procurement and Oversight Board) and will also be included in the business case.

13.5 During the transformation work, the KCC partnership agreements with KCHFT (Kent Community Health Foundation NHS Trust) and MTW (Maidstone Tunbridge Wells NHS Trust) will remain in place until new commissioning arrangements are approved and mobilised.

14. Governance

14.1 All decisions relating to this programme of work will be taken in line with the Council's governance processes and regular updates will be shared with this committee.

14.2 The plan is to bring a Key Decision report for each new service model to the Health Reform and Public Health Cabinet Committee, for members to consider and endorse. The table below, which is subject to change gives a rough indication of timeframes.

Public Health Service(s)	HRPHCC indicative Key Decision date
Children and Young People – Health Visiting and Infant Feeding services	January 2025
Sexual Health Services	March 2025
Children and Young People – School Health and proposed Therapeutic Support services	March 2025
Adult Lifestyles – Smoking	March 2025
Adult Lifestyles – Weight Management and Healthy Lifestyles	July 2025
NHS Health Checks	July 2025

15. Next Phases of Transformation Work

15.1 Following the current local engagement phase, each service model will be refined and re-costed based on feedback. Once a final, new service model is established, it will be presented at CPOB (KCC's Commercial Procurement and Oversight Board) for commercial scrutiny and a review of the commercial

strategy before then being taken to Health Reform and Public Health Cabinet Committee seeking endorsement of a Key Decision. A full business case will be in place at this time. Procurements will commence and then post procurement there will then be time to transition to new models, which will vary across services.

15.2 It is worth noting both Oral Health and Postural Stability services are low value services and as such new commissioning arrangements will be put in place in-line with KCC policy and the committee will be updated on plans for these services in due course.

16. Conclusions

16.1 The Public Health Service Transformation Programme presents an opportunity to improve services and health outcomes.

16.2 The programme has made good progress and work will continue to ensure timeframes are met. Working closely with Finance and Commercial colleagues will help to fully explore the efficiencies and value for money in each service. Whilst also ensuring services are sustainable and fit for the future.

16.3 The next steps will be external rigour through a peer review process, internal governance through the Public Health Service Transformation Programme's Steering Group and presentations relating to commercial considerations at CPOB (Commercial Procurement and Oversight Board) before then being shared at Health Reform and Public Health Cabinet Committee for members to consider and endorse the proposed key decision for each service.

Recommendation(s):

The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the information contained within this update report, and to **COMMENT** on the programme and the next steps.

Contact Details

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Appendix 1 - Risks

- **Delivery within timeframes** – A project management approach has been applied to the transformation work, and a dedicated Project Manager and Project Officer support the programme. In terms of scheduling, where there is little change and low risk, services will be scheduled to go live sooner and where there is likely to be a significant change, Public Consultation and/or a change in provider, these will be scheduled later.

- **Resources** – there is a risk around the capacity of staff and stakeholders to engage in the programme of work within the timescales, particularly given that the majority of work is within existing resources. This has been mitigated by the extension of the KCC KCHFT Partnership agreement, under which many of the services in scope for this work are delivered, however timescales will still be challenging to meet. This is particularly the case for services where a Public Consultation and a competitive procurement is required.

- **Stability of supplier workforces** – developing a sustainable workforce is key to being able to deliver services efficiently, effectively and safely. There are a few changes that could impact the stability of the service provider and in turn the service such as high turnover towards the end of the contract, the new Provider Selection Regime (PSR) legislation, changes in the health system landscape and the uncertainty of future contracts.

- **Provider stability** – KCHFT provides services to KCC and the NHS Kent and Medway Integrated Care Board. It is important that any change in KCC service provision is managed carefully to ensure there are no unintended consequences across the system or to the supplier's ability to deliver. KCC's investment with KCHFT represents a significant proportion of their turnover and as such potential service change needs to be carefully managed.

- **Costs** – the preferred new service models (which will be shared with HRPHCC) will not exceed the current financial allocations and the review will consider the best way to achieve value for money, whilst still achieving the same outcomes and service quality. However, if budgets are not set high enough then there may not be a market or providers to deliver services, because it will not be financially viable to do so. In addition, planning for increasing costs is challenging, because future inflation is unknown.

- **Missing opportunities to jointly commission** – the result of planning new commissioning arrangements to a timescale that does not include external factors, could mean missing out on potential future joint commissioning opportunities, resulting in continued and fragmented commissioning. Ongoing conversations to identify joint opportunities with other commissioners and building flexibility into contracts will help to mitigate this risk.

- **External funding security** – a series of additional investments have supported the enhancement and development of new services. This includes Start for Life, substance misuse, weight management and stop smoking services. In addition, the Public Health Grant allocation (for commissioned health services) is received

annually, and this creates a lack of clarity for future funding levels and challenges in confirming budgets for these services. All new commissioning arrangements will have clauses stating that funding for services is reliant on expected Public Health Grant allocations and mitigations will include regular pricing reviews and contractual break clauses.

- **Health Visiting** – National 'Working together to safeguard children' guidance[1] has been updated. The guidance introduces the proposal to extend the role of lead practitioner beyond social care to those working with the family from other organisations such as health and education. The proposal is that, alongside other professionals, Health Visitors could be required to become lead practitioners for children subject to Child in Need – section 17 arrangements. This proposal could have a significant cost impact on the Health Visiting budget.

- **Changes in national guidance** – there may be the risk of national policy changes or changes in programme guidance for delivery. To mitigate this, staff will engage with national service-related networks and will develop mechanisms for managing change through contracts.

- **Procurement risks** –include risk of challenge, failed procurements i.e no suitable bidders or no bids received. We will work closely with commercial and legal colleagues to mitigate key risks.

In summary, due to the complexity within Public Health services, the growing demand and a changing commissioning and financial environment, the programme is subject to several risks. These risks are being actively managed to reduce the likelihood and potential impact on service delivery throughout the period of change and through to the mobilisation of new services.

[1] Working together to safeguard children - GOV.UK (www.gov.uk)

From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 17 September 2024

Subject: **Work Programme 2024**

Classification: Unrestricted

Past and Future Pathway of Paper: Standard agenda 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 2024.

1. Introduction

1.1 The proposed work programme, appended to the report, has been compiled from items in the Future Executive Decision List and from actions identified during the meetings and at agenda setting meetings, in accordance with the Constitution.

1.2 Whilst the chairman, in consultation with the cabinet members, is responsible for the programme's fine tuning, this item gives all members of this cabinet committee the opportunity to suggest amendments and additional agenda items where appropriate.

2. Work Programme

2.1 The proposed work programme has been compiled from items in the Future Executive Decision List and from actions arising and from topics, within the remit of the functions of this cabinet committee, identified at the agenda setting meetings. Agenda setting meetings are held 6 weeks before a cabinet committee meeting, in accordance with the constitution.

2.2 The cabinet committee is requested to consider and note the items within the proposed Work Programme, set out in appendix A to this report, and to suggest any additional topics to be considered at future meetings, where appropriate.

2.3 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 to support more effective forward agenda planning and allow members to have oversight of significant service delivery decisions in advance.

2.4 When selecting future items, the cabinet committee should consider the contents of performance monitoring reports. Any 'for information' items will be

sent to members of the cabinet committee separately to the agenda and will not be discussed at the cabinet committee meetings.

3. Conclusion

3.1 It is vital for the cabinet committee process that the committee takes ownership of its work programme 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 for 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 2024.

5. Background Documents: None

6. Contact details

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HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE
WORK PROGRAMME

Item	Cabinet Committee to receive item
Verbal Updates – Cabinet Member and Corporate Director	Standing Item
Work Programme 2024/25	Standing Item
Key Decision Items	
Performance Dashboard	January, March, July, September
Update on Public Health Campaigns/Communications	Biannually (January and July)
Draft Revenue and Capital Budget and MTFP	Annually (November)
Annual Report on Quality in Public Health, including Annual Complaints Report	Annually (November)
Risk Management report (with RAG ratings)	Annually (March)

19 NOVEMBER 2024		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Draft Revenue and Capital Budget and MTFP	Annual Item
7	Annual Report on Quality in Public Health, including Annual Complaints Report	Annual Item
8	Young People and Mental Health (to include body image)	Member Requested Item
9	Implications of Climate Change for Public Health	Member Requested Item – deferred from September agenda
10	Local Stop Smoking Services Update (to include vaping survey report)	
11	Service Transformation Key Decisions	Key Decision
12	KYDAS Recommissioning	Key Decision
13	Work Programme	Standing Item
21 JANUARY 2025		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item

6	Draft Revenue and Capital Budget and MTFP	
7	Public Health Performance Dashboard – Quarter 2 2024/25	Regular Item
8	Update on Public Health Campaigns/Communications	Regular Item
9	Sexual Health services	Key Decision
10	Work Programme	Standing Item
	11 MARCH 2025	
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Public Health Performance Dashboard – Quarter 3 2024/25	Regular Item
7	Risk Management report (with RAG ratings)	Annual Item
8	Lifestyle Services and NHS Health Checks	Key Decision
9	Work Programme	Standing Item
	1 JULY 2025	
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Public Health Performance Dashboard – Quarter 4 2024/25	Regular Item
7	Update on Public Health Campaigns/Communications	Regular Item
8	Work Programme	Standing Item

ITEMS FOR CONSIDERATION THAT HAVE NOT YET BEEN ALLOCATED TO A MEETING
Substantive item on Social Prescribing – added 31/03/2023