KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

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

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

OTHER MEMBERS: Paul Carter, CBE and Graham Gibbens

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

UNRESTRICTED ITEMS

1. Chairman's Announcements - agenda order.

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

2. Membership.
(Item. 2)

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

3. Apologies and Substitutes.
(Item. 3)

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Public Health</u>

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

Key Developments in the Sustainability and Transformation Programme:

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

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

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

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

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

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

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

Health Reform

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

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

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

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

5. Members then made the following comments:

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

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

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

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

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

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

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

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

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

8. Agenda items 8, 9 and 10.

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

9. Stop Smoking Services.

(Item. 8)

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

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

Stop Smoking Services:

a) statistics for quits cited in the stop smoking report were based on self-reporting and were therefore estimates, although more was known about the numbers seeking to quit and the methods they sought to use;

b) Kent generally had a good rate of smoking quits, 51%, and this compared well to the national average;

Smoking in Pregnancy:

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

Illicit Tobacco in Kent:

d) the public health team was working together with trading standards colleagues to tackle the supply of illicit tobacco in Kent; and

e) it was known that this supply was closely linked to organised crime.

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

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

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

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

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

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

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

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

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

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

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

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

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

4. It was RESOLVED that:-

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

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

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

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

10. Smoking in Pregnancy.
(Item. 9)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. It was RESOLVED that:-

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

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

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

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

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

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

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