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 Microsoft Teams on Wednesday, 8 July 2020.

PRESENT: Mr G Lymer (Chairman), Ms D Marsh (Vice-Chairman), Mr D Butler, Mr A Cook, Mr D S Daley, Ms S Hamilton, Mr S J G Koowaree, Mr B H Lewis, Mr P J Messenger and Mr K Pugh

ALSO PRESENT: Mrs C Bell and Mr R H Bird

IN ATTENDANCE: Mr A Scott-Clark (Director of Public Health), Mrs V Tovey (Public Health Senior Commissioning Manager), Miss T A Grayell (Democratic Services Officer) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

102. Chairman's welcome

The Chairman welcomed everyone to the first meeting of the committee to be run as a Live event using Microsoft Teams.

103. Membership
(Item 2)

1. The Chairman reported that, following the recent passing of Mr Ian Thomas, the committee had a vacancy.

2. Also, since publication of the agenda, formal notice had been given that the new Vice-Chairman of the County Council, Mr Michael Northey, had left the committee, leaving a second vacancy.

104. Mr Ian Thomas

The Chairman paid tribute to Mr Thomas, saying what a valuable contribution he had made to the work of the committee and how much he would be missed by Members and officers.

105. Apologies and Substitutes
(Item 3)

Apologies for absence had been received from Mrs L Game and Mr K Pugh.

There were no substitutes.

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

There were no declarations of interest.

107. Minutes of the meeting held on 6 March 2020
(Item 5)

It was RESOLVED that the minutes of the meeting held on 6 March 2020 are correctly recorded and that a paper copy be signed by the Chairman as soon as safely practical. There were no matters arising.

108. Protocols for Virtual Meetings
(Item 6)

1. The Democratic Services Officer introduced the report and explained that all committees were being asked to agree to adopt and follow the protocols for all future meetings held virtually.

2. It was RESOLVED that, in order to facilitate the smooth working of virtual meetings, the protocols be adopted.

109. Cabinet Member update
(Item 7)

1. The Cabinet Member for Adult Social Care and Public Health, Mrs C Bell, gave a verbal update on the work of the Kent Resilience Forum (KRF). The KRF had set up a multi-agency Recovery Coordinating Group, to comply with Government guidance, to co-ordinate with partners across Kent and Medway to produce an overall Recovery Strategy. The KRF consisted of several 'cells', of which Health and Social Care Recovery was one. Each cell had first to undertake an impact assessment identifying both the negative and positive impacts of the pandemic. A KRF report on 22 June, which was not yet publicly available, had identified strengths, weaknesses, opportunities and threats resulting from COVID-19.

2. The main public health themes identified in the report were:

a) Latent and generated demand, where services had not been available or people had chosen to wait before contacting services, as well as new demand arising from COVID-19. Activity in key services had dropped as some had been stood down during lockdown, but if activity in preventative services were to reduce, the demand for acute services could rise. Some problem areas, for example, domestic abuse and antisocial behaviour, had

shown a rise during lockdown, and it was expected that, once the current hold on evictions ended on 23 August, there would be a sudden increase in those at risk of eviction seeking support, all of which was likely to increase the demand for services.

b) Implications for mental health. Several groups appeared to be at risk of adverse mental health outcomes, including those with chronic physical and mental health conditions, those who had lost a family member, those with lower levels of education and those living in outbreak hotspots. Additional factors which appeared to influence mental health status were the duration of the quarantine period and associated financial losses incurred. Demand for mental health services had originally reduced but was already rising to pre-COVID-19 levels, and some cohorts, for example, young people, had already been identified as having extra risk factors.

c) There had been an increase in attempted and actual suicide by young people as well as an increase in mental health concerns in new mothers. People with dementia had experienced some disruption to services, including access to assessments and Deprivation of Liberty Safeguards (DOLs) assessments. Family carers were known to have poorer physical and mental health than the general population and it was expected that the strain of caring during the pandemic would have worsened the situation for many carers. Local housing associations were reporting a significant percentage of the client group exhibiting mental health difficulties and/or substance and alcohol misuse. A lack of coordinated strategic approach to addressing these needs had resulted in varying degrees of response across Kent.

d) Impact on communities - the full impact was not yet understood, and a further impact assessment needed to be undertaken. It was identified that COVID-19 would disproportionately affect different groups within society, including those already living in poverty, those most financially impacted by COVID-19, black and minority ethnic people, those experiencing domestic abuse, family and informal carers, children and adults with learning disabilities, families with children with special educational needs, people with dementia, those already mentally unwell, those experiencing digital poverty and neighbourhoods which had been at the centre of an outbreak.

e) Health inequalities already existed across Kent and Medway, with areas of deprivation most affected. Preventative services had been less accessible and there had been an impact on the physical wellbeing of those already experiencing health inequalities.

f) There was also the likelihood of poor outcomes for those who were obese or smokers. Older vulnerable groups had also experienced different impacts from the wider population, for example, some vulnerable groups like those with dementia or learning disabilities, had had difficulty accessing testing. There was no co-ordinated county-wide testing in place for those accommodated under the rough sleepers initiative. Some

children with disabilities had been unable to return to school as they would be unable to follow social distancing guidance, young carers had taken all caring responsibilities as they've been concerned about letting home care workers into their homes, carers had not had access to short breaks or respite care, and some people would have found themselves taking on new caring duties during lockdown. Informal care would significantly reduce the demand on frontline services, and carers needed to be supported to be resilient in case of a second surge. People ineligible for services due to them having no recourse to public funds remained a challenge, and delay in the disabled facilities grant process would delay adaptations to people's homes to allow them to live independently for as long as possible.

3. Positive outcomes were:

a) The impact assessments clearly identified how the workforce had risen to the demands of the pandemic in unprecedented ways and there was significant positive learning for an improved multi-disciplinary team approach.

b) The use of digital technology had been accelerated across many services and people had received support which otherwise simply could not have been provided to them. There was emerging evidence that many people, for example, young people and those accessing mental health services, had found support through technology a very positive experience. Use of technology had created time and offered the opportunity of further efficiency. Partners had come together in far more imaginative ways due to the time created through holding virtual rather than physical meetings.

c) The report also identified positives in terms of partnership working and collaboration. Much of the feedback recognized the approach across partners to come together against COVID-19. Improvements in system communication, trust and an unprecedented swiftness of decision-making, the absence of big set-piece meetings replaced by frequent and purposeful decision-making forums were widely welcomed. There had been a multi-agency approach to communication and partners clearly recognized that technology had enabled much of the agility and decision-making, creating significantly increased availability. There was a plea for ‘digital by default’ for future partnership meetings.

d) The report also identified community resilience. This was a significant positive reason for changing demand due to an increase in individual family or community resilience. Extraordinary community spirit had been shown and had the potential to be sustained through the development of new community models.

e) Forecasting and modelling - the system should analyse, forecast and model demand intelligently across the health and social care system in the short-, medium- and long-term and take account of a possible second wave of infection and the potential for local lockdowns. This work should

build on the integrated datasets available to identify people receiving both health and social care services and to take account of the public voice. The report recommended that health and social care services should work together to understand the public view of the impact of the pandemic and how their experience of changes to service delivery could shape new models of care. Consultation and engagement should be linked wherever appropriate to identify and act on priorities identified and a system needed to be prepared for a possible second and further waves of infection and the impact of winter pressure.

4. Quick wins identified were: Digital opportunities, mental health joint commissioning approach, building on volunteer workforce, communication with the public to support self-management and reduce demand, and encouragement of flu vaccinations. Process should be reduced and decision-making at the point closest to the issue enabled.

5. The next stage of work would be to identify critical success factors to achieving recovery.

6. The Chairman thanked Mrs Bell for her detailed update and it was RESOLVED that the update be noted, with thanks. There were no questions.

110. Public Health update - presentation by Director of Public Health
(Item 8)

1. The Director of Public Health gave a verbal update on the following issues:

COVID-19 response – the average 7-day case numbers for all areas of the population and all areas of the county were now falling and there had been no spike increase in cases following the easing of lockdown. Data had been shared with all district council partners across the county, including Medway.

Outbreak Control plans - COVID-19 was a notifiable disease and any institution suspecting a case was obliged to advise a local Public Health England team immediately so the latter could provide appropriate support and guidance on the steps which should be taken. Most cases reported were only single cases rather than clusters, and clusters, where found, were small and were mostly in care settings. Data was monitored daily to identify how cases had arisen.

Media Campaign on COVID-19 – called 'Protect Kent, Play Your Part', this sought to remind the public that COVID-19 had not gone away and that they still needed to be vigilant and act responsibly to avoid a repeat surge of cases and second, localised lockdown, as experienced in Leicester. The public was reminded of the need to continue observing 2-metre social distancing, to stay at home as much as possible, to wash hands regularly and use hand sanitiser gel where provided. The campaign would seek to be as flexible as possible and identify and address local concerns. The flu vaccine would be made available earlier than usual this autumn and had been launched on 2 July.

Testing – an additional testing site had been established at Manston airport and launched on 6 July, and coverage of the Kent population with static, mobile and postal testing facilities was good. If a cluster of cases were to be identified, a mobile testing unit could be deployed without delay. The Department of Health was working to provide more walk-in and cycle-in testing sites and increase testing for vulnerable groups.

Data analysis and modelling work – much data analysis was being done to identify patterns of infection and help to prepare for various scenarios in which rates might increase in any one sector of the population or area of the county. Looking ahead to winter, when national levels of respiratory illness always increased, work would seek to identify more of those in the population who would be eligible for a flu vaccine. The vaccination programme would also start earlier than usual, in September rather than October.

Work with Partners – excellent partnership working had ensured that services could continue to be delivered. An Outbreak Control Plan had been published, to comply with Government requirements, and would be shared with all partners, and close joint working meant that all partners had an opportunity to learn from each other. With other local authorities, Kent had held outbreak control team meetings, in particular to address issues relating to the homeless. This would also seek to avoid the situation experienced in Leicester and issues which had arisen in meat packing plants in Europe and the USA.

2. Mr Scott-Clark responded to comments and questions from the committee, including the following:-

a) evidence of the effectiveness of face masks in limiting the spread of the virus was not strong, despite them now being compulsory on public transport. A face mask would lower the risk of the wearer infecting others around them rather than them being infected by others. Even if wearing face masks, the public must comply with Government guidance about distancing, use of hand sanitising gel where provided and frequent hand washing. The risk of spreading the virus was much less outdoors, with social distancing;

b) the outstanding role of care workers and care managers in supporting the elderly, disabled and vulnerable was applauded. The risk of infection among this client group, especially those living closely together in care homes, had been identified early, and teams consisting of NHS, Public Health England and Adult Social Care professionals had been deployed to identify outbreaks and provide advice and guidance to those caring for them. It was known that COVID-19 affected the frail and elderly more than younger people and that quite a lot of transmissions were asymptomatic. Asked how what proportion of Kent's care home population had died from the virus, Mr Scott-Clark explained that Kent was known to have a lower percentage of infection than many other local authorities. Figures were updated weekly by the Office of National Statistics and he undertook to provide the latest figures to the committee outside the meeting;

c) elected Members were proud of the work done by County Council staff and providers throughout the pandemic, particularly given the lack of information at the start about the nature of the virus and how it spread;

d) asked to share the best practice discovered to deal with infection in the homeless population, Mr Scott-Clark explained that many who spent their days on the streets were not necessarily without homes but just chose not to stay in them. Spending a lot of time outside without access to washing facilities made them vulnerable to picking up the virus, and, if they showed symptoms, they would not follow advice to go home and stay home for seven days to avoid passing it on to others. Teams working with the homeless had the challenge of tracking them to test and follow up, including tracing those with whom they had had closest contact, but many homeless people did not want to be traced. To enforce self-isolation, the police and public health partners would have to prove that an individual posed a threat to others and would need to build a sufficient case for a magistrate to consider taking enforcement action. It was much easier for the police and public health to keep to the positive approach of 'Engage, Explain and Encourage' rather than enforce; and

e) regular testing at care homes was welcomed and Mr Scott-Clark was asked if and how this could be extended to those using domiciliary care services. Mr Scott-Clark explained that regular testing had indeed been widened beyond the original 65+ age group to include people with learning disabilities, and would hopefully soon include those using domiciliary care services, as well as the carers delivering the service. This group already had access to testing but it was hoped that testing could be made more regular for them.

3. It was RESOLVED that the update be noted, with thanks.

111. Public Health commissioning update, including digital inclusion and wellbeing hub
(Item 9)

1. Mrs Tovey presented a series of slides which set out how service delivery had adapted to accommodate the working changes and social distancing enforced by COVID-19, including new ways for the public to contact and access services remotely, including digital access. Some people wishing to access services chose to telephone rather than use the internet as they preferred to speak to someone, or else could not afford to use mobile data to use video access. A multi-agency project group had been established to look at digital access and user preferences and understand how best to support those who wished to access services in this way. A survey had been launched to look at equity of online access to public health, mental health and wellbeing and children and young people's services. The aim was to identify the challenges involved and why someone may not access; for example, some people shared a computer at home and could not always use it privately, while others might not have

broadband or might need training and support to use digital services effectively. An update on this work would be supplied to the committee at a later meeting.

2. A new wellbeing hub had been launched to give the public easy, localised access to trusted health information which could help keep them well. This information continued to be updated and tailored to optimise its relevance to key groups. A multi-agency group had been established to launch the hub at the start of April 2020, shortly after lockdown had started. In the first three months, there had been 4,801 page views, and initial feedback from use of the hub had identified anxieties around returning to work or school, families juggling childcare and work, those in the shielding community or with existing mental health and wellbeing issues Local Members were asked to promote the wellbeing hub in their area and build public awareness of the information and guidance which was available there.

3. The Cabinet Member, Mrs Bell, added that its development fitted well with the work of the Kent Resilience Forum recovery cell and emphasised the effectiveness of good local engagement and the importance of listening to residents. The aim was that as many people as possible should be able to benefit from digital inclusion, including people in care homes, for example, by a videocall with their GP, to save them the need to travel and to save both parties time. Staff in homes would be trained to help residents to use devices and there should be a device available in every home.

4. It was RESOLVED that the update be noted, with thanks.

112. Performance of Public Health commissioned services
(Item 10)

1. Mrs Tovey introduced the report, which had been issued to the committee as a supplement to the main agenda pack, and highlighted the good performance of most services in the quarter leading up to the start of the COVID-19 pandemic and the start of lockdown. Data for four of the indicators had not been available at the time of writing the report due to the difficulties of collecting data during the pandemic.

2. The committee was being asked to support a change to key performance indicators (KPIs): to remove the existing indicator PHO2, which referred to the number and percentage of clients accessing GUM services offered an appointment to be seen within 48 hours, and replace it with a new indicator, to measure the proportion of all new first-time attendances taking up the offer and being screened for chlamydia, gonorrhoea, syphilis and HIV. This was something identified as a priority as part of the health needs assessment.

3. Asked about home visiting services for parents of new babies, Mrs Tovey explained that responsibility for these services was shared by various bodies. If there was a health need or any concerns or vulnerabilities about the family, it was likely they would have had increased face to face contact. The maternity service would support leading up to the birth and continue to support women for the first

ten days. They would carry out checks while in hospital, in addition to those undertaken in the home, and some visits in the antenatal period have been virtual during the pandemic. The health visitor service was now conducting new birth visit in the home, however these were delivered virtually over the last few months, following national guidance. The service continued to offer face to face and virtual checks up to the age of two. The GP would make checks in the first 6 – 8 weeks, including immunisations. Communication between all agencies was critical to support effective care. Mrs Tovey undertook to provide more detailed information outside the meeting.

4. It was RESOLVED that:-

a) the performance of Public Health commissioned services in Quarter 4 2019/20 be noted; and

b) the suggested change to key performance indicators, to remove the existing indicator PHO2, which referred to the number and percentage of clients accessing GUM services offered an appointment to be seen within 48 hours, and replace it with a new indicator, to measure the proportion of all new first-time attendances taking up the offer and being screened for chlamydia, gonorrhoea, syphilis and HIV, be supported.

113. Work Programme 2020/21
(Item 11)

It was RESOLVED that, subject to future adjustments to reflect ongoing COVID-19 recovery work, the committee's planned work programme be agreed.