HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 8th July, 2020

10.00 am

Microsoft Teams Live

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 8 July 2020 at 10.00 am
Microsoft Teams Live

Ask for: **Theresa Grayell**
Telephone: **03000 416172**

In response to COVID-19, the Government has legislated to permit remote attendance by Elected Members at formal meetings. This is conditional on other Elected Members and the public being able to hear those participating in the meeting. This meeting will be streamed live and can be watched via the media link on the webpage for this meeting here

County Councillors who are not Members of the Committee but who wish to speak at the meeting are asked to notify the Chairman of their questions in advance.

Membership (13)

Conservative (9):	Mr G Lymer (Chairman), Ms D Marsh (Vice-Chairman), Mr D Butler, Mr A Cook, Mrs L Game, Ms S Hamilton, Mr M J Northey, Mr K Pugh and Vacancy
Liberal Democrat (2):	Mr D S Daley and Mr S J G Koowaree
Labour (1)	Mr B H Lewis
Independent (1)	Mr P J Messenger

UNRESTRICTED ITEMS

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

1 Introduction

2 Membership - the committee has a Conservative vacancy following the recent passing of Mr Ian Thomas

3 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

4 Declarations of Interest by Members in items on the agenda

To receive any declarations of interest made by Members in relation to any matter on the agenda. Members are reminded to specify the agenda item number to which their interest refers and the nature of the interest being declared

5 Minutes of the meeting held on 6 March 2020 (Pages 1 - 12)

To consider and approve the minutes as a correct record.

6 Protocols for Virtual Meetings (Pages 13 - 18)

7 Cabinet Member's verbal update

8 Public Health update - presentation by Director of Public Health

9 Public Health commissioning update, including digital inclusion and wellbeing hub

10 Performance of Public Health commissioned services

11 Work Programme 2020/21 (Pages 19 - 22)

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

Tuesday, 30 June 2020

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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 Council Chamber, Sessions House, County Hall, Maidstone on Friday, 6 March 2020.

PRESENT: Mr G Lymer (Chairman), Mr M J Angell (Substitute for Mrs L Game), Mr I S Chittenden (Substitute for Mr S J G Koowaree), Mr A Cook, Mr D S Daley, Ms S Hamilton, Mr B H Lewis, Mr P J Messenger, Mr M J Northey and Mr K Pugh

ALSO PRESENT: Mrs C Bell

IN ATTENDANCE: Mr A Scott-Clark (Director of Public Health), Dr A Duggal (Deputy Director of Public Health) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

91. Membership
(Item 2)

The committee noted that:-

a) Mr M J Northey had joined the Committee to fill the long-standing Conservative vacancy; and

b) since publishing the agenda, Ms E Dawson had left the committee and formal notice has been given by the Leader, via the Whip, that the Conservative membership of the committee had been reduced by one, to 9 Members.

92. Apologies and Substitutes
(Item 3)

Apologies for absence had been received from Mr D Butler, Mrs L Game, Mr S J G Koowaree and Ms D Marsh.

Mr M J Angell was present as a substitute for Mrs Game, and Mr I S Chittenden as a substitute for Mr Koowaree.

The Chairman recorded his and the committee's best wishes to Mr Koowaree for a quick recovery to full health.

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

There were no declarations of interest.

94. Minutes of the meeting held on 14 January 2020
(Item 5)

It was RESOLVED that the minutes of the meeting held on 14 January 2020 are correctly recorded and they be signed by the Chairman. There were no matters arising.

95. Verbal updates by Cabinet Member and Director
(Item 6)

1. Mrs C Bell, Cabinet Member for Adult Social Care and Public Health, gave a verbal update on the following issues:-

Launch of "Beside You" online resource for infant feeding – this was a service delivered by Kent and Medway in partnership with the midwifery service, PSB Breastfeeding and the La Leche League, aiming to support mothers who wished to breastfeed for as long as possible, and to raise awareness of issues around breastfeeding in public. The project would seek to make optimum use of social media.
Attendance at Public Health Commissioning Team meeting – this covered campaign work and monitoring of the effectiveness of past work. The main area of investment was with the Kent Community Health NHS Foundation Trust (KCHFT), with whom the County Council had several large contracts totalling some £37.5m. The inclusion of young people in the commissioning team was encouraging to see as good healthy habits were best established when young and young people could encourage their peers. The visit had also included a session on postural stability, which had been most interesting.
Public Health campaigns – good communications were vital to achieving effective campaigning, and social media was used extensively. *National guidance on how to deal with the Coronavirus would be shared with all Members, so they in turn could share it with their local communities.*
Public Health champions – those who championed public health issues in their local communities were celebrated and had been presented with certificates to thank them for their work in spreading positive health messages and encouraging others to take responsibility for their own health. Mrs Bell recorded her thanks to the county council staff who had taken part in this initiative.

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

Public Health Budget 2020/2021 – he had expected to be able to report this by now but the figure had yet to be announced by the Government. It was hoped that this would become clear in the budget announcement on 11 March. Providers had been advised that, to ensure continuity of service provision, the previous year's budget arrangements would be rolled over until the new budget was known.
Kent Association of Local Councils Health and Wellbeing Conference – this event had demonstrated that there was much energy and enthusiasm among parish and town councils to support health and wellbeing issues and to work with

the County Council to deliver initiatives. It had been suggested that the Kent Association of Local Councils could have a seat on the Health and Wellbeing Board.

COVID-19 (Coronavirus) – on 2 March he had written, setting out the latest public health advice on coronavirus, to all County Council Members, to district and parish councils, via the Kent Association of Local Councils, and to Kent MPs. Guidance and information to the public was changing daily, to reflect the unfolding situation as cases of coronavirus were confirmed; as the future spread was unknown, a dynamic response needed to be ready to be deployed when required. However, there had been no new cases of coronavirus reported in Kent since 2 March. Public Health England (PHE) was the lead agency in terms of containment. The latest PHE advice was that people showing symptoms of coronavirus should self-isolate and ring 111 for advice, which would trigger the testing process. PHE's advice to protect oneself from contracting the virus was to wash hands frequently with soap and warm water for a minimum of 20 seconds and to be ready to self-isolate, if this should prove necessary, by building up supplies of food and daily requisites. The Government would be liaising with supermarkets about managing supplies of basic groceries and household essentials and advising the public about using the NHS wisely to avoid overloading, as hospitals were still experiencing the usual winter pressures. Local resilience plans were being tested to ensure they would work, if needed, and County Council directorates were working together to ensure that business continuity plans were in place. Although the worse-case scenario could see up to 20% of County Council staff being unable to work, he emphasised that the majority of people contracting the virus would experience only mild symptoms for a few days and should be able to continue work from home. Directors of Public Health (DPHs) across the UK were in daily contact with the Chief Medical Officer (CMO) and the NHS.

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

a) although the UK was currently still in the containment stage, the next stage - delay - was expected to start soon;

b) asked with what authority or permission people would self-isolate, and their eligibility for sick pay for missed work during self-isolation, Mr Scott-Clark explained that employers were being advised to take a pragmatic approach. For those self-employed and on zero-hours contracts, the Government was expected to advise shortly on eligibility for statutory sick pay. This could be a big issue for those employed in the social care sector. DPHs had flagged this issue with the CMO to look into;

c) asked about the difference between the containment and delay stages, Mr Scott-Clark advised that there was not much difference. Only those who had had close contact with someone with the virus were currently being recommended to self-isolate. Mitigation measures would not assume that a person had been tested for the virus, unless they were already in hospital with a pre-existing condition. Current advice was for people to self-isolate as soon as they felt unwell. Some people being

tested were found just to have flu, and spotter practices were testing flu cases for signs of coronavirus. Asked to clarify if people with flu-like symptoms should self-isolate, Mr Scott-Clark confirmed that this should happen as a matter of course. Although this advice had not been issued officially among current Government guidance, he expressed the view that it should be;

d) asked what checks would be made on vehicles coming into the county from mainland Europe, Mr Scott-Clark advised that PHE were working with ports and airports to apply testing for the virus to people entering the country, particularly if they had travelled from an infected area;

e) asked if random double-testing would be used to check an earlier result, in case someone who believed they were clear resumed normal activity and spread the virus to others, Mr Scott-Clark advised that the CMO had been asked on 5 March to advise on this. Work was going ahead to identify a vaccine and treatment but this could take up to 18 months to develop, and would then need to be tested and licensed before being safe for use;

f) asked about patients in hospital with pre-existing conditions, who were most vulnerable to contracting the virus, Mr Scott-Clark advised that hospitals were practiced at avoiding cross-contamination and had clear strategies to manage this. Some cohorts of patients, for example, older people, would need hospital care for specialist support. Some hospitals were offering 'drive-through' swabbing, which would swab people without them having to leave their cars, and they could then drive home to self-isolate. A swabbing service could visit those who were housebound;

g) asked about herd immunity for the virus, Mr Scott-Clark advised that the herd immunity threshold for this virus would be very high, approximately 95 - 100%; and

h) asked about the possible contribution of hot-air hand driers in public toilets to spreading the virus, as they were known to recycle air, Mr Scott-Clark advised that the best way to protect against catching the virus from public facilities was to wash hands thoroughly with warm water and soap for a minimum of 20 seconds. Soap and warm water were more effective than hand sanitiser gel in killing the virus.

4. The Cabinet Member, Mrs C Bell, added that online resources available were helpful in raising awareness and understanding of the virus and how the public could protect themselves, meetings between DOPHs and the NHS would explore the long-term plan to manage and address the spread of the virus, advice about the importance of handwashing was clear and easy to follow, and work to manage and address the current pandemic would raise the profile and awareness of the general prevention agenda.

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

96. Contract Monitoring Report - One You Kent (Adult Healthy Lifestyle service)
(Item 7)

Mrs V Tovey, Senior Commissioning Manager, was in attendance for this item.

1 Mrs Tovey introduced the report and responded to comments and questions from the committee, including the following:

a) the One You programme was seeking to change people's behaviours in a sustainable way. Many goals would be long-term, for example, smoking. Some people continued to smoke even during a stay in hospital, surely an ideal place to be encouraged to give up. Mrs Tovey advised that pharmaceutical therapies were prescribed to inpatients to help them quit smoking while in hospital;

b) asked about vaping being advocated as a safer alternative to smoking, Mr Scott-Clark clarified that vaping was only suggested as a step-down as part of a route to quitting, not as a long-term alternative to smoking. Although vaping was known to be much less harmful than smoking, its use was still an area of concern and something to be addressed as an addiction;

c) concern was expressed at the number of young people smoking, and the need for education programmes at schools to be frank in setting out the dangers and antisocial nature of smoking. The Chairman suggested that children be shown a comparison between a healthy lung and a smoker's lung, and have emphasised to them how unpleasant a smoker's breath, hair and clothes would smell;

d) Mr Scott-Clark commented that an effective way to get young people to stop smoking was to get their parents to stop smoking. He reassured the committee that vaping was not known to be used by young people as a route into smoking. Mrs Tovey added that measures to make smoking less normal, for example, smoke-free school gates, aimed to help encourage parents to quit smoking;

e) a view was expressed that young people may not follow the lead of their parents in giving up; young people tended more to rebel against what their parents did and wanted them to do. It might be possible to channel this rebellious nature in some way to support anti-smoking campaigns. Mrs Tovey advised that selling cigarettes in plain packaging had had an effect on the number of young people buying them, and that young people who had given up and were enthusiastic about not smoking could be used to advocate among their friends;

f) using psychology with the public rather than lecturing them could have a greater impact, for example, in campaigns such a 'what the bump', about smoking during pregnancy. It was important to consider that parenthood started not at birth but at conception, and both parents

should start to look after their health before considering parenthood. Mrs Tovey added that, via digital and services and the health visitor and midwifery services, expectant parents would be supported through pregnancy to make healthy changes to their life style;

g) the dangers of passive smoking were still a concern, as was the danger of those giving up smoking adopting potentially more damaging habits instead. Asked about the number of hardcore smokers who resisted giving up, Mrs Tovey advised that hard-core smokers were indeed harder to tackle but would be targeted via campaigns, GPs, KCHFT core services and NHS Health checks, with support being ready to help those who chose to quit. Mr Scott-Clark added that the aim was to reduce the number of smokers in Kent to fewer than 5% of the total population by 2030. It was encouraging that smoking prevalence in Kent was at the lowest rate ever achieved there, partly due to the link between smoking and cardiovascular disease, cancer and reduced life expectancy now being more clearly understood. The aim was to create as many environments as possible in which smoking was not acceptable. The 5% target was welcomed;

h) the reduction in the prevalence of smoking had surely been helped by the large number of places in which people were not permitted to smoke, including pubs and in cars with children. It could be helpful to find out what had encouraged people to stop smoking, or not to take it up, for example, the popularity of sports and fitness, or the fact that smoking was no longer seen to be 'cool'. Mrs Tovey advised that this data might be available via the public health observatory;

i) a view was expressed that some young people may take up smoking to help them cope with emotional problems in adolescence;

j) prevalence rates for smoking in Kent were higher than the national average, partly due to rates being higher generally in areas of deprivation, such as Thanet; and

k) funding for campaign work would be included in the public health grant, so was not yet known. A response to the Government green paper on prevention was also awaited.

2. It was RESOLVED that the performance of the One You Kent Service and the initiatives being undertaken to improve quality and outcomes be noted and welcomed.

97. Risk Management: Health Reform and Public Health
(Item 8)

1. The Chairman asked Members if, as there had already been much discussion of the risks in the public health work area in previous items, they were happy to forego any discussion of this item and refer any questions of detail to Mr

Scott-Clark via email. Members agreed that they were happy to do this and it was RESOLVED that the risks presented be noted.

98. Health Inequalities in Kent
(Item 9)

1. Dr Duggal introduced the report and added that, since the report had been published with the agenda, the Marmot report had been published, advocating the use of the population intervention triangle method. For men in Kent, there was an average of 6.5 years' difference in life expectancy between the most and least wealthy, and for women, an average of 4.2 years' difference. Measures to address health inequalities were included in the prevention work stream of the sustainability and transformation programme.

2. Asked what could be done to address areas of the county in which health inequalities were higher than the average, for example, Sheppey, which had an average of 10 years' difference, and Thanet, which, in Margate and Cliftonville, had the highest rate of deaths in under-75s as well as a range of problems around poor quality and contaminated housing and access to GP services, Dr Duggal advised that the range of issues presented in Thanet required a multi-disciplinary approach, including the district council housing provider and the health visiting service, working with local residents' groups. Mr Scott-Clark added that a working party would be set up to address health inequalities, and this would include NHS and district council partners. He undertook to liaise with the Chairman and local Thanet Members to address the issues presented in Margate and Cliftonville, but reminded Members that other areas of Kent also experienced similar issues and deprivation. Members asked to have regular feedback reports on the progress of this work and Mr Scott-Clark undertook to report back to future meetings. He also offered to respond in writing to any further questions Members had about the subject.

3. It was RESOLVED that the information set out in the report and given in response to questions be noted, with thanks.

99. Illicit Tobacco in Kent
(Item 10)

Ms D Smith, Public Health Specialist, was in attendance for this item

1. Ms Smith introduced the report and summarised the progress of the campaign to address the illicit supply of tobacco in Kent. She responded to comments and questions from the committee, including the following:-

a) asked if imported cigarettes would automatically be checked to see if they were counterfeit, Ms Smith explained that counterfeit and imported cigarettes shared some risks in that neither was regulated in terms if content and safety. Some non-regulated cigarettes presented a fire risk as they would not auto-extinguish and their presence in the market

undermined the authorised tobacco industry as well as depriving the Government of tax which would be payable by legitimate producers. As tax on cigarettes rose, there was a risk that users would switch to using cheaper, counterfeit cigarettes;

b) asked how people would know how and where to obtain illicit tobacco, Ms Smith explained that Kent was unique, compared to the rest of the UK, in having known shops where it could be bought. Public health was working with trading standards partners to monitor and tackle sales of cigarettes to under-age children and to issue Closure Orders to offending premises. However, such activity took time to organise and offenders would use their contacts to re-stock and resume sales by some other means, with plenty of willing customers for their cheap products;

c) asked if counterfeit cigarettes were produced exclusively outside the UK, Ms Smith undertook to look into and advise Members outside the meeting but advised that many were known to be imported from Eastern Europe; and

d) asked what penalty would be handed to people caught importing illicit tobacco, and if penalties could be more obviously advertised to deter offenders, Ms Smith advised that penalties were mainly financial. She undertook to liaise with trading standards partners to explore what more could be done to publicise penalties.

2. It was RESOLVED that the information set out in the report and given in response to questions be noted, with thanks, and the progress of work so far to address the illicit supply of tobacco in Kent be endorsed.

100. Suicide Prevention Programme update
(Item 11)

Mr T Woodhouse, Suicide Prevention Programme Manager, was in attendance for this item.

1. Mr Woodhouse introduced the report and highlighted the following:-

- Suicide rates in Kent and Medway had fallen consistently since 2014 and latest figures, including 2018 data, showed that Kent was now close to the national average rate. However, the 130 cases a year was 130 too many.

- Research had identified the main motivators – debt, domestic abuse, deprivation, family breakdown, social isolation, etc – and work with a wide range of partners would seek to mitigate these factors and provide access to support.

- Kent's current 5-year Suicide Prevention Strategy would be reviewed in 2020 and the revised document would give greater emphasis to the support which was available and successes which had been achieved, for

example, the lowering of suicide rates, set out above. Members would have an opportunity to comment on the new draft strategy and would be asked to help promote it, once published.

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

a) asked to what extent people's debt problems could be linked specifically to the introduction of Universal Credit, Mr Woodhouse acknowledged that debt was a feature in suicidal ideation but it was unclear how much debt was related to Universal Credit rather than issues such as gambling, family breakdown or housing;

b) the reduction in the number of suicides in Kent was welcomed, and the importance to mental health of having access to open green space, either private or public, was emphasised. Feeling unable to access or even see green space, or the perception that one did not have access, seemed a small issue but could have a large impact on people's mental wellbeing; and

c) asked where suicide prevention work would access sufficient funding if the public health grant were to be reduced, Mr Woodhouse explained that Kent had been one of eight pilot areas to receive dedicated funding from NHS England, initially for two years but then for a third year, and this funding would now be moved on to benefit other areas of the UK.

3. It was RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks, and the progress made in reducing suicides in Kent be welcomed.

101. Kent and Medway Care Record (KMCR) Update
(Item 12)

Mrs R Spore, Director of Infrastructure, and Mr A Day, Technology Commissioning and Strategy Manager, were in attendance for this item.

1. Mrs Spore introduced the report and explained that local authorities had been required to develop a method of sharing health and social care data in the best way to meet the requirement to share data under the Health and Social Care Act 2012, and the development of the Kent and Medway Care Record (KMCR) was Kent's response to this need, as part of the NHSE Local Health and Care Record programme. Development of the KMCR had offered a way to review and improve the way in which client data was accessed, and to improve care outcomes and productivity. The procurement process had been completed in 2019, with Graphnet being the chosen provider.

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

a) asked how data would be safeguarded from any unauthorised access or use, for example, commercial use by insurance companies, Mr Day advised that a key feature of the information governance was a checklist of safety measures. The data would be stored in a secure cloud, rather than web, environment and would be encrypted in transit. Only those authorised to use it would be able to access it;

b) asked about a data sharing programme established by the NHS about ten years ago, which had not worked successfully as the IT systems of the different NHS organisations had proved to be incompatible, Mr Day advised that, although there was some element of risk in any shared system, ensuring that data systems would join up successfully had been a priority. What was being proposed for Kent was already working well elsewhere in the UK. When a patient was away from home, anyone treating them, including paramedics and multi-disciplinary teams, would be able to see, in real time, at least a summary care record. The extent of the information able to be accessed would be increased in the future;

c) Members sought to be reassured about what would happen to a patient's data once it was sent to another organisation, and that it would be safe there. Use or misuse of a patient's health records raised similar concerns to those related to the use or misuse of a person's bank records. Mr Day explained that potential users of the data would be required to meet Government cybersecurity standards before they would be able to access it, and must have a system which had been certificated as suitable for use with health data. This would mean the new KMCR would be better than any sharing systems tried previously;

d) asked what access a patient would be able to have to their own records, and to what extent they would know who was sharing that data, Mr Day explained that a patient would be able to access their data via an NHS app and would be able to update their own data, for example, by entering data from a fit-bit. A GP would then be able to see that data. The aim was to achieve a system which was official and secure but sufficiently user-friendly;

e) asked what permission would be sought from a patient before their data was shared, and if they could object to it being shared, Mr Day explained that the NHSE Local Care and Health Record programme had been established in response to a statutory duty to share data. Under General Data Protection Regulations, a patient could object to their data being used, and their record would be flagged accordingly. Whereas a patient could have opted out of the previous NHS data sharing programme, in the new system they would be able to direct only some of the purposes for which their data could be shared;

f) asked how the public would be made aware of the new system, how their data would be used and how much say they would have about it, Mr Day advised that there would be a communications campaign to raise awareness, including getting GPs on board, but that the statutory

duty to share data would be emphasised. Most people now seemed to expect their data to be shared in some way anyway, and were familiar with the concept of this happening, so this was not expected to be a surprise to the public; and

g) a view was expressed that to make this assumption was unwise and that the public would need to be, and would expect to be, fully appraised of the new system, how it would work and their rights within it.

3. It was RESOLVED that the information about the KMCR set out in the report and given in response to comments and questions be noted, with thanks, and a further report on the development of the system be made to a future meeting of the committee.

102. Work Programme 2020/21
(Item 13)

The committee discussed its planned work programme in an agenda setting session after the main meeting.

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From: Ben Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 8 July 2020

Subject: Protocols for Virtual Meetings

Classification: Unrestricted

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1. Introduction

(a) In line with provisions in the Coronavirus Act, regulations have come into force giving local authorities the ability to take a more flexible approach to holding meetings.

(b) However, the core governance requirements for meetings remain. Notice still needs to be given for meetings and the Agendas need to be made available online. The public's right to observe meetings remains the same and so provision needs to be made for the public to hear the discussion and see it where possible as well.

(c) The regulations are written so that each local authority can tailor their ability to hold virtual meetings to the technology they are able to put into place. Use of the technology needs to ensure the business of the Council can be conducted fairly and without any participant or observer being unduly disadvantaged.

(d) Formal meetings held virtually are still formal meetings, and while the procedures and rules remain the same as when all Members are present in the same room, it will be a different way of working.

2. Protocols for Virtual Meetings

(a) Each Committee is being asked to adopt a set of supplementary protocols to guide how virtual meetings will be run. These are geared to explaining how the requirements of the Constitution will be put into effect in a virtual setting.

(b) Adopting these Protocols will enable Members to have a common point of reference and to understand how business will be conducted. For members of the public observing our virtual meetings, this will improve transparency and understanding of the democratic process.

(c) A set of Protocols for this Committee are attached as an Appendix to this report.

3. Recommendation:

That, in order to facilitate the smooth working of its virtual meetings, the Committee agrees to adopt the appended Protocols.

4. Background Documents

The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) England and Wales) Regulations 2020 - SI 2020 392, http://www.legislation.gov.uk/uksi/2020/392/contents/made

5. Contact details

Report Author and Relevant Director:

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Draft – Protocol for Meetings of the Health Reform and Public Health Cabinet Committee held under SI 2020 392

General

1. Part Three of the Constitution (Standing Orders) shall continue to apply for all virtual meetings except where there is a requirement, implied or otherwise, for Members to be physically present in the same location.
2. These Protocols supplement but do not replace the Standing Orders in the Constitution and exist to make meetings held under SI 2020 392 more effective and efficient.
3. Reference to Chair or Clerk relate to the Chair or Clerk of the specific virtual meeting.
4. The Monitoring Officer or his deputies are available to assist and advise the Chair and the Clerk as necessary.
5. Members are respectfully reminded to ensure that the electronic device through which they are attending the virtual meeting has sufficient battery charge.

Rules of Conduct

6. The Chair's ruling on the meaning or application of these Protocols or any other aspect of the proceedings of a meeting held virtually cannot be challenged.
7. The Chair may give any direction, or vary these Protocols, when they consider it appropriate to do so in order to allow for the effective and democratic management of the meeting but must take advice from the Clerk before so doing.
8. Immediately before the commencement of the virtual meeting, all participants must switch the video and microphone settings to "off" and only turn them on when invited to speak by the Chair.
9. Members are reminded that any member of the public may observe the meeting.
10. The conversation function referred to in the Protocols is also known as the 'meeting chat'. Members should proceed as if the content can be viewed by participants and the wider public and only use the function for procedural matters as set out below. It should not be used to discuss the substantive issue – this should be done verbally.

Attendance

11. Members must affirm their presence by typing the word 'Present' in the conversation function of the meeting. This shall be accepted by the Clerk as the equivalent of the Member having signed the attendance list.
12. Where a Member is leaving the meeting permanently or temporarily, the word 'Absent' shall be typed in the conversation function. Where the Member joins the meeting once more, 'Present' shall be typed once more.
13. Where a Member has declared a DPI or other interest which means they need to absent themselves for part of the meeting, the Member shall leave

the meeting completely at the appropriate time. The Clerk shall email the Member when they are able to re-join. The Clerk will confirm the absence by checking the meeting attendees and confirming the same to the Chair.

14. The standard quorum of one third of the total voting membership applies and this number must have indicated they are 'Present' for the meeting to commence or continue. The Clerk will conduct electronic checks on quoracy periodically throughout the meeting.

Substitutes

15. In order to ensure that Members have access to the virtual meeting, it is requested that formal notification of substitutes to the Clerk be made at least 48 hours prior to the start of the meeting. The start time of the meeting will be affected if this is not done.

Speaking

16. Members and other participants in the meeting must wait to be called on by the Chair before speaking.
17. Attendees may indicate a desire to speak through use of the conversation function. The Clerk will ensure these are brought to the attention of the Chair in the order received.
18. Members not part of the Committee wishing to speak shall request permission from the Chair in advance so that the Clerk is informed 24-hours ahead of the meeting.

Motions and Amendments

19. Except where the motion before the Committee is set out in the Agenda, any Member is entitled to request that a motion or amendment before the Committee be typed out in the conversation function by the proposer. Where this is done, the Clerk shall read out the motion/amendment.
20. All proposed motions/amendments will need to be seconded by a Committee Member present in line with usual practice.
21. The Chair shall ask for Members' views on the motion/amendment. Where the view of the Committee is unclear, the Chair shall call for a vote.

Voting

22. Voting will be through a rollcall of all Members taken in alphabetical order, or through a poll overseen by the Clerk through the conversation function, with the Clerk announcing whether the motion/amendment was agreed or not agreed once this has concluded. The Chair will announce at the start of the meeting which of these methods is to be used.
23. Where a poll is the chosen method but is not able to take place, the Chair shall ask Members to record whether they are for, against, or abstaining in the conversation function. No response shall be taken as an abstention.
24. No votes shall be recorded in the Minutes unless sections 16.31 or 16.32 of the Constitution apply.

Clerking

25. There will normally be a minimum of two Officers supporting the Chair and Committee during a virtual meeting. One will act as a facilitator to support the Chair. The other will be taking minutes.

Other Provisions

26. Where the minimum legal requirements apply and Members are only able to hear each other and be heard, the Chair shall be responsible for identifying speakers etc., and will be supported in this by the Clerk as facilitator. A rollcall shall be held at the start of the meeting, and at other times as deemed necessary by the Chair, to establish quoracy in these circumstances.

Part Two Meetings

27. At the start of any formal meeting, or part of any formal meeting, from which the press and public have been excluded in accordance with section 15.17 of the Constitution, Members shall type the words ‘Present - Alone’ to verify that no unauthorised person is able to hear, see, or otherwise participate in the meeting.
28. A Part Two meeting will normally be anticipated and will be scheduled in advance as a separate virtual meeting. Where the need to move into a Part Two meeting only becomes apparent during the meeting, the item affected should be adjourned to a later date.

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From: Benjamin Watts, General Counsel

To: Health Reform and Public Health Cabinet Committee – 8 July 2020

Subject: **Work Programme 2020/21**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard 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 planned work programme for 2020/21.

1.1 The proposed Work Programme has been compiled from items on the Forthcoming Executive Decisions List, from actions arising from previous meetings and from topics identified at agenda setting meetings, held six weeks before each Cabinet Committee meeting, in accordance with the Constitution, and attended by the Chairman, Vice-Chairman and the Group Spokesmen. Whilst the Chairman, in consultation with the Cabinet Member, is responsible for the final selection of items for the agenda, this report gives all Members of the Cabinet Committee the opportunity to suggest amendments and additional agenda items where appropriate.

2. Work Programme 2020/21

2.1 The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion in agendas of future meetings.

2.2 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. This will support more effective forward agenda planning and allow Members to have oversight of significant service delivery decisions in advance.

2.3 When selecting future items, the Cabinet Committee should give consideration to the contents of performance monitoring reports. Any 'for information' or briefing items will be sent to Members of the Cabinet Committee separately from the agenda, or separate Member briefings will be arranged, where appropriate.

3. Conclusion

3.1 It is vital for the Cabinet Committee process that the committee takes ownership of its work programme, to help the Cabinet Member 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 of 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 planned work programme for 2020/21.

5. Background Documents

None.

6. Contact details

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Last updated: 30 June 2020

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE WORK PROGRAMME 2020/21

Items to every meeting are in italics. Annual items are listed at the end.

30 APRIL 2020 – meeting cancelled due to Covid-19 outstanding items are shaded

- **Contract Monitoring – Oral Health**
- **Public Health Performance Dashboard – incl impact of STP** – to JULY meeting
- **Update on gambling addiction –** added by Mr Lewis on 6 March 2020

8 JULY 2020 – shortened agenda outstanding items are shaded

- **Contract Monitoring – Adult Substance Misuse contracts**
- **Update on Public Health Campaigns/Communications**
- **Future agendas will need to cover updates/more information on STP issues arising at 20 June mtg**: digital, estates, multi-disciplinary team models, mental health services, communications and raising public understanding, future of the voluntary sector, staff recruitment and training moved from November
- ~~**Strategic Delivery Plan monitoring** – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019)~~ moved to September meeting

9 SEPTEMBER 2020

- ***Verbal Updates***
- ***Contract Monitoring – Children and Young People's condom programme and online Sexual Health services***
- ***Work Programme***
- ***Public Health Performance Dashboard – incl impact of STP***
- **Annual Report on Quality in Public Health, incl Annual Complaints Report**
- ***Annual Equality and Diversity Report**** for Public Health, this is part of the Strategic Commissioning Equality and Diversity, which goes to the Policy and Resources Cabinet Cttee
- **Review of Suicide Prevention Strategy** – Sept or Nov? added at 6 March mtg
- **Strategic Delivery Plan monitoring** – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019) moved forward from July meeting

20 NOVEMBER 2020

- ***Verbal Updates***
- ***Contract Monitoring – Health Visiting***
- ***Work Programme***
- ***Public Health Performance Dashboard – incl impact of STP***
- **Strategic Delivery Plan monitoring** – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019) this will need to move forward in 2020 as the previous report was delayed due to Covid-19
- **Review of Suicide Prevention Strategy** – Sept or Nov? added at 6 March mtg

8 JANUARY 2021

- ***Verbal Updates***
- ***Contract Monitoring – Primary School Health Services***
- ***Work Programme***
- ***Public Health Performance Dashboard – incl impact of STP***
- **Budget and Medium-Term Financial Plan**
- **Update on Public Health Campaigns/Communications**

10 MARCH 2021

- ***Verbal Updates***
- ***Contract Monitoring – NHS Health Checks***
- ***Work Programme***
- ***Public Health Performance Dashboard – incl impact of STP***
- **Risk Management report (with RAG ratings)**
- **Health Inequalities** – annual

30 JUNE 2021

- ***Verbal Updates***
- ***Contract Monitoring – Integrated Sexual Health services***
- ***Work Programme***
- ***Public Health Performance Dashboard – incl impact of STP***
- **Update on Public Health Campaigns/Communications**
- **Strategic Delivery Plan monitoring** – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019)

PATTERN OF ITEMS APPEARING REGULARLY

Meeting	**Item**
January	• Budget and Medium-Term Financial Plan • Public Health Performance Dashboard – incl impact of STP • Update on Public Health Campaigns/Communications
March	• Risk Management report (with RAG ratings) • Health Inequalities – annual
April/May	• Public Health Performance Dashboard – incl impact of STP
June/July	• Update on Public Health Campaigns/Communications • Strategic Delivery Plan monitoring – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019)
September	• Annual Report on Quality in Public Health, incl Annual Complaints Report • *Annual Equality and Diversity Report** this is part of the Strategic Commissioning Equality and Diversity, which goes to the Policy and Resources Cabinet Cttee • Public Health Performance Dashboard – incl impact of STP
November	• Strategic Delivery Plan monitoring – to all Cabinet Committees six-monthly (agreed by Corporate Board, June 2019) *(January?)*