KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of A meeting of the Health Reform and Public Health Cabinet Committee held at Darent Room - Sessions House on Tuesday, 15th January, 2019.

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

OTHER MEMBERS: Paul Carter, CBE, Graham Gibbens and Paulina Stockell

OFFICERS: Dr Allison Duggal (Deputy Director of Public Health) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

16. Apologies and Substitutes.
(Item. 2)

Apologies for absence had been received from Mr A Cook and Mrs L Game.

Mr R J Thomas was present as a substitute for Mr Cook and Mr M J Northey as a substitute for Mrs Game.

The Director of Public Health, Mr A Scott-Clark, was also unable to attend and was represented by the Deputy Director, Dr A Duggal.

17. Declarations of Interest by Members in items on the Agenda.
(Item. 3)

The Chairman, Mr G Lymer, declared that he was a member of the Macmillan Cancer Backup Committee and a cancer backup team operated by the NHS.

18. Minutes of the meeting held on 22 November 2018.
(Item. 4)

It was RESOLVED that the minutes of the meeting held on 22 November 2018 are correctly recorded and they be signed by the Chairman. There were no matters arising.

19. Verbal updates by Cabinet Members and Director.
(Item. 5)

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

1. **The Cabinet Member for Adult Social Care and Public Health, Mr G K Gibbens**, referred the committee to the contract monitoring report on the Health Visiting service which had been considered at the 22 November meeting but for

which Members had had no time to ask questions. He summarised briefly that the report had set out the performance of the service, which was good overall, with targets for developmental reviews having been achieved, set out the innovative partnership approach of the County Council and the service provider, the Kent Community Health NHS Foundation Trust (KCHFT) and the development of the new infant feeding service. He explained that he had wanted to give Members the opportunity to ask any questions they had about the health visiting service.

2. Members made the following comments:-

a) concern about staffing levels, often expressed previously, was repeated, as the shortfall and vacancy levels across the whole NHS was an ongoing problem. Reassurance was sought that sufficient new staff were coming into the service and being trained to the appropriate level to support the service effectively. Mrs Tovey explained that the shortage of health visitors was a national problem as places had been cut centrally by Health Education England. Kent was addressing the challenge in a number of ways, including development of a conversion course for existing nurses to be qualified to take on a Band 5 role within the team. She emphasised that staff being trained as health visitors were experienced nurses rather than new graduates. Funding would be offered to help relocation costs, to encourage staff to take on a role in Kent, and incentive payments would be offered for areas where there is less demand to work and higher vacancies. These initiatives seemed so far to be working well to increase workforce capacity in addition to work to maximise public-facing time with clients, for example, by reducing staff travel time. Some health visiting services were now delivered in children's centres and parent feedback indicates satisfaction with this approach as this would give them the chance to meet other new parents; and

b) concern was expressed that reduced funding for children's centres would have an impact on this arrangement. Mr Gibbens clarified that there had been no cuts to children's centres but changes had been made to the way in which they were commissioned. He emphasised that the health visiting service was concerned only with new parents and children's development and affected no other area of health care.

3. The Deputy Director of Public Health, Dr A Duggal, gave a verbal update on the following issues:-

Association of Directors of Public Health Annual Conference – this took place in early December and included a drive to encourage associate membership. All the County Council's consultants were encouraged to become associate members.

Public Health Ringfenced budget for 2019/2020 – agreement needed to be achieved on how the 3% rise in salaries for NHS staff delivering public health would be funded, and the Director of Public Health was consulting the Government about what effect this might have on the County Council's public health budget. The County Council may also need to cover increased pensions contributions due for these NHS staff. *This issue would be addressed in more detail in the Budget report later on this agenda.*

Sustainability and Transformation Programme (STP) Prevention update – the NHS 10-year plan had now been published and its effect on the delivery of the STP prevention workplan could be assessed. STP preventative work was continuing,

and meetings would be taking place shortly to address its implementation, working with other County Council directorates.
Increased local and national influenza activity – the number of cases in Kent had risen and the Chief Medical Officer had agreed that GPs be allowed to prescribe antivirals for 'flu cases. It was still possible for vaccinations to be given for this winter.

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

20. Update on Local Care.
(Item. 6)

Ms J Frazer, Sustainability and Transformation Programme Lead, Adult Social Care and Health, was in attendance for this item.

1. The Leader, Mr P B Carter, introduced the report and highlighted the latest developments in local care in the Kent and Medway STP footprint. He chaired the Local Care Implementation Board (LCIB), for which the Government's arrangements had recently been streamlined. The newly-constituted LCIB would meet shortly. It was well known that, in the vision for health and social care integration and transformation, the health economy had become divided into 'local care' and 'hospital care'. His focus was on local care, on which he had been tasked to work with health colleagues. In the integration of primary care, community services and social care, the voluntary sector would have an important role to play. He had previously told the committee about efforts to secure commitment to an extra £32m of revenue resource for the local care model, hopefully rising to an extra £100m in the medium term.

2. It had been very encouraging that, on the same day on which the NHS launched its 10-year plan, the Secretary of State for Health, Matt Hancock, had alluded to his wish to see a greater proportion of the £20+bn going into the NHS being spent on local and primary care. Mr Carter said his priority was to explore how the £32m in the current financial year would be spent, in the hope that Kent could recruit more district nurses and therapists to work with GPs. Ms Frazer and her team had met with Kent and Medway health economy and primary care practitioners and those who delivered local care. Mr Carter said he had been much encouraged that GPs had coalesced around more than 40 primary care networks across Kent and Medway and had bought into the concept of being supported in those networks by multi-disciplinary teams (MDTs). Within MDTs, £32m would increase trained staff to increase support for GPs in primary care networks. Money was starting to be invested in various ways, including in care navigators to help connect patients to third sector services. He said he would like to see a workforce plan to focus on more district nurses, physiotherapists, occupational therapists and mental health practitioners in outreach work in patients' own homes and residential and nursing homes. This coverage had been inconsistent in the past.

3. The biggest issue remained the recruitment, retention and training of staff to address the skills shortage across the health service. Having now secured extra funding, the challenge was to use it to recruit staff needed in the MDTs, including those delivering social care services. He was keen for the Cabinet Committee to have a further report setting out how the social care aspects would sit within MDTs to facilitate triage and assessment to help patients access the services they needed as soon as possible. The LCIB hoped to be able to identify how many patients had

been able to avoid hospital admission by accessing services provided by the MDTs, in their own homes or residential and care homes, and how they could be helped to leave hospital faster, with district nurses and enablement services, to return to their own homes or access step-down beds in residential homes. The County Council would seek to ensure that social care services were being delivered beside health services in a timely way, to make sure no patient was at risk.

4. The LCIB had had conversations around smaller GP practices being fragmented and the need to have new GP hubs, similar to those established in London and elsewhere in the UK. A capital program needed to be put in place to deliver the same model in Kent, using primary care hubs supported by MDTs. Examples of social prescribing had shown positive outcomes, for example, at the Estuary View surgery in Whitstable, including a reduction in hospital admissions.

5. In conclusion, the largest challenge now was to find qualified practitioners to join the MDTs, and Kent would need to trawl across the globe to find people with the right qualifications to complement the current workforce. Kent would need to recruit and train them quickly to meet the urgent need. The Secretary of State for Health, Matt Hancock, understood this and supported the use of applied technology to help and improve primary care, but it was most important that GPs were behind it and supported the MDT model, that the Government backed it with sufficient funding and it proved possible to recruit practitioners to deliver better local community health services alongside GPs.

6. Members made the following comments:-

a) the report and the introduction of different ways of working were both welcomed as being very timely. The establishment of MDTs around the patient was welcomed but the scale of the challenge ahead was enormous, and it was accepted that, to attract the number of suitably-qualified staff required, it would be necessary to look further afield. Kent's aim to secure additional funding above the £32m was supported, and it was hoped that the Government would provide full financial support to train these new staff. Mr Carter said Kent would need to present the right environment to be able to attract health practitioners to move here, for example, by using social housing to offer them good-quality homes. The Estuary View practice had no problems attracting staff as it was an innovative, exciting practice;

b) it was difficult to get appointments and prescriptions as very few of the 12 GPs at a local Ashford surgery worked full time. Calls were triaged and the wait for a call back or appointment could often be 4 – 7 days;

c) concern was expressed that a hub in Thanet would potentially serve 30,000 patients while the bus service which would serve that area was apparently earmarked to be discontinued. The speaker was advised by the Chairman that the local bus service was not to be reduced but taken over by a different local provider. If a service were to serve a potential population of 30,000, surely there should be sufficient custom to make a commercial bus service viable;

d) concern was expressed that social worker numbers were insufficient and some families could miss out on receiving the services they needed. The

Cabinet Member for Adult Social Care and Public Health, Mr Gibbens, asked that Members raise any concerns about specific social care service provision with him;

e) the developing ways of working were welcomed as good news for Kent and it was suggested that the Cabinet Committee have regular updates on the roll-out and monitoring of the new ways of working set out in the report;

f) the report was welcomed and Mr Carter thanked for his commitment to drive this forward. Asked if the GP 'buy-in' included social prescribing, and if health inequalities would be addressed by the new ways of working, Mr Carter said the Estuary View model had been at the forefront of directing the patient to the right service at the right time and had been a key factor in reducing Accident and Emergency attendance. Ms Frazer added that social prescribing had been delivered successfully in East Kent by Red Zebra for some time and was being rolled out across the county, so should soon start to show a positive difference; and

g) asked if a patient would need to be registered at a practice to access the innovative services available there, following a local case in which someone had been turned away, Ms Frazer explained that, if someone wanted to use a GP surgery, they would need to be registered as a patient there in the usual way. However, the new model would improve clarity for the public about where to go to access services locally, and the ideal for the future was that there would be 'no wrong door'. She undertook to look into the individual case mentioned.

7. Mr Carter advised the committee that he, Ms Frazer and Mr Gibbens were shortly to visit the Greater Manchester combined authority to see how health and social care services were being delivered within the new devolved powers. He also thanked Ms Frazer for the great amount of work she had put into developing the new work streams and for writing the report.

8. It was RESOLVED that the progress and direction within Local Care be welcomed and endorsed.

21. Contract Monitoring Report - Sexual Health Services.
(Item. 7)

Mrs V Tovey, Senior Commissioning Manager, and Ms W Jeffreys, Public Health Specialist, were in attendance for this item.

1. Mrs Tovey introduced the report and highlighted key areas of the ongoing transformation work, which was responding to the findings of the needs assessment. This included an increased digital and online presence and a newly-awarded nine-year contract at a very good price for an online condom scheme. The County Council worked closely with NHS partners to offer integrated services and optimum choice and to achieve best value for public money. All services were performing well against targets and feedback from users had been good.

2. Mrs Tovey and Ms Jeffreys responded to comments and questions from Members, including the following:-

a) young people, and in particular young women, were reported to have problems accessing sexual health services in Sheppey as the service had moved from the healthy living centre to a local hospital, which was harder to travel to. Ms Jeffreys explained that, in response to the needs of young people on the island, there had been targeted work to increase awareness in schools and colleges of the Get It programme, safe relationships and chlamydia infection for year 11 and sixth form pupils in schools, more GPs offering LARC contraceptives and pharmacies offering contraception and chlamydia treatment over the period of the current contracts. Condoms and contraception (excluding those which need oxygen therapy to be administered) were still available at the healthy living centre and condoms from other outlets. The service was moving generally to offering more services online, following feedback from young people, although these services would be accessible by over-16s only, with an opportunity for younger people to be able to access advice directly from the service;

b) asked about charges for services provided for people living outside Kent, Mrs Tovey explained that a cross-charging policy was agreed and implemented across the south east but there was ongoing discussion with neighbouring authorities about the level of such charges and how they would be managed. However, she added that the proportion of out-of-county activity in Kent was currently declining;

c) Ms Jeffreys explained that the figures presented in Appendix B to the report were diagnostic rates per 100,000 of the population. Kent's rates of syphilis whilst increasing, were following the pattern seen across England; and

d) asked about Kent's shortfall in screening rates, compared to those of its statistical neighbours, Ms Jeffreys explained that this shortfall was in the number of females attending the integrated service for a first appointment and taking up the offer of asymptomatic screening for sexually-transmitted infections, an issue identified in the process of conducting the needs assessment. Specific key performance indicators would be built into the service remodel to monitor this activity.

3. It was RESOLVED that:-

a) the commissioning and provision of sexual health services in Kent,

b) service improvement initiatives being undertaken to improve quality and outcomes, and

c) progress to date on the implementation of the commissioning strategy which includes the re-modelling of services and the outcome of the condom procurement process,

be noted.

22. Smoking Needs Assessment: Key Findings.
(Item. 8)

Ms C Mulrenan, Public Health Speciality Registrar, was in attendance for this item.

1. Ms Mulrenan introduced the report and explained that, since reporting to the November meeting of the Cabinet Committee, the ambition to reduce the number of smokers in Kent had been increased from 45,000 to 58,500. Another issue which had arisen at the November meeting was the absence of chewing tobacco from the needs assessment, which, Ms Mulrenan explained, was because smoking tobacco contributed a far greater burden of ill health locally, nationally and globally. Smoking tobacco was the biggest risk factor for ill health, far greater than chewing tobacco, so this was the focus of the needs assessment. *Ms Mulrenan undertook to supply a link for the Tobacco Dependency Needs Assessment for inclusion in the minutes of the meeting:*
file://invicta.cantium.net/kccroot/users/shq/shq6/MulreC01/Desktop/Smoking%20Needs%20Assessment/Smoking%20NA%20Final/Tobacco%20Dependency%20NA%20Final%20accessible%20merged.pdf.
The Smoking Plus model presented the best chance of reaching national targets for smoking quits, together with initiatives such as smoke-free school gates, shops, prisons, etc.

2. Ms Mulrenan and Dr Duggal responded to comments and questions from Members, including the following:-

a) asked if sufficient information was available about people's reasons for smoking, Ms Mulrenan explained that, although the majority of the population now understood that smoking was not a healthy choice, this knowledge would not necessarily lead to people making a healthy choice by avoiding smoking. The smoking ban in shops, pubs and workplaces in 2007 had made a difference in encouraging some people to stop smoking and it was hoped that the various smoke-free initiatives would continue to encourage quitters. Some groups resisted quitting, however, and it was known that some 30% of manual workers were smokers. It was believed that the current service model did not appeal to all groups and that the proposed three-tier model would offer alternatives to those smokers who did not wish to access traditional smoking cessation services. Dr Duggal added that more targeted work was needed to tackle pregnant women who smoked. GPs would be sent a 'script' to support them in having a conversation with smokers to raise the issue of them quitting;

b) concerns was expressed that, as vaping was not permitted indoors in many premises, and people were required to go outside, once outside they might then choose to smoke a cigarette instead. If people could vape inside, more might turn to it. Ms Mulrenan pointed out that vaping had been shown to be 95% less harmful than smoking and was a useful aid to quitting smoking. A Kent and Medway STP paper had recently been drafted in support of smoking cessation services taking an 'e-cigarette friendly approach' for those who wished to use e-cigarettes as a quitting aid. Dr Duggal added that Public Health England was currently lobbying the Government about vaping being permitted indoors. Vaping had not been mentioned in the 2007 smoking ban as it had not been a recognised practice at that time;

c) concern was expressed that many medical staff, to whom many people would look as role models of healthy behaviours, could be seen smoking outside hospitals. Ms Mulrenan advised that NHS premises should now be smoke-free as part of national public health strategy and that there had also been a move to have smoking cessation support housed in acute trusts on a full-time basis, both of which should encourage staff to quit. *Dr Duggal undertook to investigate statistics for the number of NHS staff known to be smokers;*

d) asked about the number of women smoking at the time of delivery (SATOD), and concern expressed that, according to the graph in the report, the figures had risen in 2017 and significant inequalities remained, Ms Mulrenan highlighted that the confidence intervals given in the graph meant that officers did not believe this was a true rise in smoking rates in pregnancy. However, it was agreed that rates remained too high. Efforts to improve SATOD data may also be contributing to any apparent rises. She concurred that smoking remained a significant source of health inequalities. Dr Duggal added that pregnant women who smoked would be targeted by working with maternity services to encourage expectant mothers to quit during their pregnancy;

e) a question was raised about the effectiveness of such campaigns and what statistics were available about how achievable and effective it could be to give up smoking at various stages of pregnancy. Dr Duggal *undertook to look into this and supply statistics to the committee*, and advised that the health benefits of giving up smoking were presented to expectant mothers at pre-natal appointments. The recording of the number of women smoking at the time of delivery was a national requirement, but Kent would always strive to tackle the issue earlier in pregnancy;

f) as many smokers had already given up, those remaining were the hardcore smokers who would find it harder to give up. Concern was expressed that some people giving up smoking would need something to help with anxiety and stress and may turn instead to illegal drugs and other substances;

g) a suggestion was made that, far from getting parents to give up as a way of preventing children from taking up smoking, children could be used a tool to get their parents to give up. Duggal acknowledged that this may well be a good way forward and advised that behavioural science had highlighted the need to identify the right campaign message for the right population. Ms Mulrenan highlighted that, as part of the needs assessment, a literature review had been undertaken to look at interventions to prevent smoking initiation among children and young people. Although it was known that one of the best ways to reduce smoking rates in children is to reduce parental smoking, public health were also considering education and prevention programmes for young people;

h) the cost of cigarettes was highlighted, with the average smoker spending over £2,000 per year on their habit. This cost could be targeted in future campaign work; if people would not give up to improve their health, they might be encouraged to save their money, especially if the cost over a

lifetime of smoking were to be highlighted. Ms Mulrenan advised that the smoking cessation programme did look at costs with current smokers accessing the service, but she was not aware of a campaign targeted solely at cost. Dr Duggal added that campaign work had identified the help which could be gained by raising the tax on tobacco;

i) the continued focus on discouraging young people from starting to smoke was welcomed, with the message seemingly now established that it was not cool to smoke. It was cool to vape, however, and this had become a recreational activity among young people. Concern was expressed that this could lead to smoking in later life as young people would become accustomed to nicotine from vaping. Ms Mulrenan advised that current evidence suggested vaping was not acting as a 'gateway' to smoking for young people, but agreed that public health should continue to monitor the situation closely. Dr Duggal advised that vaping products did not all contain nicotine. Retailers of vaping products operated under a strict code of practice which prohibited nicotine products being sold to anyone who had not previously used nicotine, and this would prevent vaping from being used as a gateway to smoking;

j) the inclusion of the costs of a smoking habit was welcomed, and a move to increase the tax on tobacco was supported. It was stressed focus should not be solely on quits to the detriment of preventing initiation, and Ms Mulrenan agreed. Smoke-free initiatives aimed to make smoking initiation less attractive, and the public health team were also looking into education programmes for young people;

k) reference was made to the 'One You' campaign which included a smoker whose body appeared to 'rot' from the inside as he inhaled nicotine, while the voice over described the effect of nicotine on the human body; and

l) questions were asked about whether quit rates among pregnant women changed at different stages of pregnancy. Dr Duggal highlighted that smoking was brought up with women when booking appointments, and that SATOD data was collected as it was a national statistic. She would be happy to clarify with public health colleagues about whether any 'pinch points' existed for quits within specific stages of pregnancy.

3. It was RESOLVED that:-

a) the overall approach to improve health and reduce health inequalities be noted and welcomed; and

b) the enhanced Smoking Plus model and the revised Kent ambition of achieving 58,500 fewer smokers by 2022, in order to achieve Kent's prevalence target of 12%, be supported.

23. Childhood Obesity.
(Item. 9)

Ms S Bennett, Consultant in Public Health, was in attendance for this item.

1. Ms Bennett introduced the report and responded to comments and questions from Members, including the following:-

a) local initiatives sought to tackle childhood obesity, for example, the provision of bicycles so children could cycle to school, 'fizz-free February' to reduce sugar intake from fizzy drinks, 'beat the street' and the supply of vegetables to children at school, and these could be spread to other areas of the county in a co-ordinated programme;

b) the County Council was committed to a programme of preventative measures to tackle childhood obesity, including those services delivered by the school public health service, which pursued a 'whole school' approach, including PE and active playtimes. The Ofsted recommendation for the minimum amount of PE was two hours per week;

c) asked if the school public health service included a visiting nurse who would inspect children's teeth regularly, Ms Bennett advised that the aim of the school public health service, which was delivered by KCHFT, was to support schools to be healthier overall. Pupils would be weighed in Reception and Year 6 and the statistics used to build on overall picture of the health of the school. The inspection of children's teeth was not part of the service, but colleagues in Early Help were seeking to link a dentist to children's centres to offer regular checks;

d) obesity was known to exacerbate other health problems, and Ms Bennett was asked what the County Council could do to ensure that appropriate facilities were made available, for example, for children with complex needs. Ms Bennett explained that the lack of Tier 3 services, to support people with complex needs, including social needs, was an issue on which the County Council had undertaken research to identify the level of need across the county and was lobbying the STP prevention group to increase provision;

e) the role of parents in safeguarding their children's health was highlighted. 20% of children in Reception classes were obese, so this situation had arisen at home rather than at school; children consumed more meals at home than they did at school. Much was made of lifestyle choices but 3-year-olds did not make those choices. It was for a parent, not the state, to bring up their child. Ms Bennett advised that children's centres gave talks to parents about healthy diet at the time when babies moved on to solid food, but engaging with parents was a challenge, generally. When a Reception-age child was weighed at school and found to be overweight, the child's parents would receive a call from the school public health service, offering an appointment to talk and get advice about healthy eating, but this option generally had a low take-up. Some parents simply did not recognise the problem, as they had been brought up in the same poor food environment and had no better role model to offer their children;

f) a comment was made that the report had been titled 'childhood obesity' yet obesity did not represent the whole picture of children's health; and

g) attention was drawn to the need for a balance between the calories consumed in food and the level of physical activity which would use and burn off those calories. Weighing of children at regular intervals at school was useful to identify those who were overweight, but there was a risk that children who were a healthy weight might nevertheless develop an unhealthy body image as a result of frequent checks and focus on weight. Ms Bennett agreed that the causes of obesity were complex. She referred to various national and local measures which could be used to address the availability of junk food and promote a healthy eating message by food placement and advertising in supermarkets, and to ban junk food from being advertised on television before a 'watershed' time. Work such as the Headstart Kent programme would help to support children, teach them to be more resilient and learn to make their own healthy choices.

2. It was RESOLVED that:-

a) the information set out in the report, especially the profile of childhood obesity in Kent and the service offer currently available, be noted and endorsed; and

b) a further report be submitted to the committee on effective and systematic joint working between agencies, including children's centres, in order to tackle obesity.

24. Public Health Communications and Campaigns Update.
(Item. 10)

Ms G Smith, Campaigns and Communications Manager, was in attendance for this item.

1. Dr Duggal introduced the report and explained that the public health team now included a marketing manager. Dr Duggal and Ms Smith responded to comments and questions from Members, including the following:-

a) Kent's 'One You' campaign was a local incarnation of, and was linked to, the national 'One You' campaign and brought together many strands of activity. More information on 'One You' work would be available to report to the Cabinet Committee later in the spring; and

b) asked about the public health aspects of air quality, Dr Duggal advised that the Energy and Low Emissions Strategy had very recently been published and work on initiatives such as active travel were at an early stage.

2. It was RESOLVED that the progress on and impact of Public Health campaigns in 2018/19 be noted and welcomed.

25. Performance of Public Health-commissioned services.
(Item. 11)

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

It was RESOLVED that the performance of Public Health-commissioned services in Quarter 2 of 2018/19 be noted and welcomed.

26. Capital Programme 2019-22, Revenue Budget 2019-20 and Medium-Term Financial Plan 2019-22.
(Item. 12)

Mrs J Blenkinsop, Finance Business Partner, and Ms K Sharp, Head of Commissioning for Public Health, were in attendance for this item.

It was RESOLVED that the draft capital and revenue budgets and Medium-Term Financial Plan, including responses to consultation and the Government's provisional settlement, be noted.

27. Work Programme 2019/20.
(Item. 13)

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