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, County Hall, Maidstone on Tuesday, 24th September, 2019.

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

OTHER MEMBERS: Paul Carter, CBE and Clair Bell

OFFICERS: Andrew Scott-Clark (Director of Public Health) and Theresa Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

57. Membership.
(Item. 2)

The committee noted that Mr P J Messenger had joined the committee as an Independent Member. Mr Messenger was welcomed to his first meeting of the committee.

58. Apologies and Substitutes.
(Item. 3)

Apologies for absence had been received from Mr D Butler and Miss E Dawson.

Mr N J D Chard was present as a substitute for Mr Butler.

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

Mr N J D Chard declared that he was a Director of Engaging Kent.

Mr I Thomas declared that, in relation to any mention of plans for a new hospital site at Canterbury, he was a Member of Canterbury City Council's Planning Committee, and, in relation to the item on gambling, that he served on the City Council's Licensing Committee.

Mr A Cook declared that he also served on Canterbury City Council's Licensing Committee.

Under agenda item 9 (minute 64, below), Mr B H Lewis declared that he had previously managed a betting shop for many years.

60. Minutes of the meeting held on 20 June 2019.
(Item. 5)

It was RESOLVED that the minutes of the meeting held on 20 June 2019 are correctly recorded and they be signed by the Chairman. There were no matters arising.

61. Verbal updates by Cabinet Members and Director.
(Item. 6)

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

20 August - Visited Kent Community Health Foundation Trust (KCHFT) Services at Tonbridge Cottage Hospital to see services and meet staff and members of the multi-disciplinary team (MDT). She also accompanied a health visitor on her rounds and visited a baby clinic to see an infant feeding session. This visit had shown how well services were working. The Trust had subsequently been awarded an 'outstanding' rating.
17 September - Kent and Medway Joint Health and Wellbeing Board Workshop. This had discussed the role of the Joint Board. Work would continue on the case for change, which would be published in autumn 2019, and the priority areas of work for the Joint Board would be drawn from the case for change. A primary school teacher had recently spoken about young children not being ready for school, in terms of toilet training and speech development. This lack of preparedness could be due to lack of access to a health visitor or GP.
World Mental Health Day on 10 October – Ms Marsh outlined the events taking place at County Hall to mark the day *and undertook to send out to Members the details of events*. A series of summits was to take place to raise public awareness of mental health issues and the first of these had recently taken place in Margate. This had been very well attended by a range of participants. Contributions made by public participants at these summits would be used to draft an action plan. The Sustainability and Transformation Partnership (STP) had allocated £600,000 to establish four 'safe havens' which could offer out-of-hours help for people with mental health problems and their carers, and additional funding would be made available for staff training in dealing with mental health issues. A new crisis café had been established, run by volunteers.

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

Sustainability and Transformation Programme

Mr Carter said that he had received much good feedback from Members about the usefulness of the presentations by the panel of NHS clinicians and senior officers at the committee's June meeting, setting out the Government's changed arrangements and local implementation plans.

He had stated that, when he stood down as Leader, he hoped to continue in a role of promoting the local care vision, not just in Kent but nationally, to see how integrated care was being delivered in other parts of the country and ensure that local government could continue to play a role, alongside NHS colleagues, in the delivery of good community health and social care services. Part of the work that he hoped to pursue at a national level was to influence Government to achieve a greater proportion of NHS funding going into primary care, community care and preventative care, to reverse the reduction made to this proportion over the last 8 –

10 years. Just 1 - 2% more of the NHS budget being directed there would have a large impact on the recruitment of district nurses, health visitors and occupational therapists, especially considering the ageing population with increasingly complex needs.

It would be interesting to compare what Kent and Medway was doing with what was happening elsewhere in the country, how local government was being involved with NHS colleagues and how others were embedding structural change.

He was confident that the approach being taken by Kent and Medway was right and was pleased with the progress made over the last 12 months. The groundwork was done and what was needed now was to find the right resource to build a suitable workforce to develop it.

At the last meeting of the STP, the Kent Medical School was debated. He was pleased that an additional £2m had been made available to contribute to help develop the new campus at the University of Kent at Canterbury and Canterbury Christ Church University sites. There were many hurdles still to overcome and much work still to do but he was sure that all County Council Members would support the delivery of the medical school.

He had received much correspondence from Kent GPs about the need to improve the physical assets available to deliver GP hubs around the county and there was general acceptance that GPs needed to work together in larger hubs, with sufficient appropriate technology to support their new way of working. This was something the County Council could support by work on the health estate. The County Council's new housing strategy was about to be launched, including scoping of the need for increased nursing and residential care and a move towards the provision of more extra care housing to allow elderly and vulnerable people to live in their own homes for as long as possible. It had been estimated that more than 1,000 additional units of extra care housing would be needed in the next few years.

Much work was still going on around a potential new hospital in Canterbury, and he would continue to take an interest in this and how services at it and the other two hospitals in East Kent – the Queen Elizabeth the Queen Mother and the William Harvey hospitals - would be configured. He hoped to see a new hospital being built in Canterbury as the existing hospital site was no longer fit for purpose, was very expensive to maintain and difficult to recruit to.

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

a) Mr Carter was thanked for his work as Leader in advancing the health reform and local care agenda, and for the help and support he had given to opposition Members and new Members in helping them to understand the issues involved;

b) a good and sufficient workforce was vital to develop the programme, and to go forward without this would mean the new arrangements would fail. Mr Carter agreed that recruitment was a significant issue and said that he hoped Britain leaving the European Union would not make it difficult to recruit overseas staff. The suggested minimum salary level requirement (yet to be confirmed by the Home Office) for overseas workers to come

and work in the UK might make many healthcare posts more difficult to recruit to;

c) the absence of positive progress around a new Canterbury hospital and the effect of this upon recruitment was a great concern for local people, who hoped to hear a confirmed decision soon. Mr Carter said that much work was going on to facilitate the building of a new hospital, but it was not a simple process and it was unclear as yet how services would be re-configured and physical assets used. The aim was to provide the very best treatment and facilities as close to the local community as possible;

d) spending on the NHS was compared to spending on projects such as HS2 and frustration expressed about why it was so difficult to put money into building a new hospital. Mr Carter acknowledged the frustration at the uncertainty and advised that the Minister for Health had highlighted the need to look at innovative ways of providing money for infrastructure; and

e) similar work around preventative and early interventions had been done in the field of adult social care and had shown that it was most cost effective to provide services to patients early to save them from developing more complex and costly needs later. Primary care was the area in which spending could be directed most effectively.

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

Suicide Rates for 2018 recently published – these had shown a small reduction, which was good, but a change to the way in which the Coroner was required to assess suspected suicides may lead to a future increase in the number of cases being recorded. *A more detailed assessment of the 2018 figures would be presented to a future meeting.*
Spending Review Settlement for Local Authority Public Health – this had shown an increase in funding. Mr Scott-Clark would meet with the other regional Director of Public Health and with Duncan Selbie, the Chief Executive of Public Health England, to gain more information on the impact of this. The net increase may not be as large as first appeared as it was following on from cuts made in previous years.

5. Mr Carter referred to a recent thinktank which had considered the concept of using a 'patient premium', comparable to the pupil premium, to help address health inequalities. He referenced a recent paper on the issue and *undertook to provide Members with the title of this paper outside the meeting.*

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

62. Establishment of a single Clinical Commissioning Group for Kent and Medway - oral item.
(Item. 7)

Glenn Douglas, Chief Executive, Kent and Medway Sustainability and Transformation Partnership and Accountable Officer for Kent and Medway Clinical Commissioning Groups, and Michael Ridgwell, Deputy Chief Executive,

Kent and Medway Sustainability and Transformation Partnership, were present for this item at the invitation of the committee.

1. Mr Douglas and Mr Ridgwell presented a series of slides which followed on from the presentations given to the committee at its June meeting. These outlined the NHS Long-Term Plan, how this was being applied in Kent and Medway, key areas of action and the way in which the development of local care would be supported, using integrated care partnerships, primary care networks and a single clinical commissioning group. They then responded to comments and questions from the committee, including the following:-

a) the developments outlined in the presentation were welcomed by committee members;

b) the leadership of Mr Carter in promoting the local care agenda had put Kent's achievements ahead of other local authorities in the country, but what was needed now was to make innovative practices work successfully at a local level via the primary care networks;

c) the public needed to be helped to understand the new arrangement and be directed to the most effective pathway within it to access treatment, and for some this would need a major education project;

d) Thanet had been described as a beacon of innovative practice in the way in which its GPs organised themselves, but local experience in districts also showed that it could take a week to get an appointment with a GP and that access to dentistry services was also a struggle. Local people wanted to have a guarantee of being able to get an appointment with a GP or dentist when they wanted one. Mr Carter clarified that, due to the problem in recruiting GPs to replace those retiring or leaving practice, Thanet's ratio of doctors to patients was currently low, leading to a wait for appointments. This situation required an innovative approach to the use of the available resources, for example, triaging patients to be seen by a practice nurse or physiotherapist, where possible, to free up a GP's time to see the patients who needed to see them. This could reduce waiting lists, despite a wait to recruit new GPs. The development of multi-disciplinary teams would support this, as long as sufficient therapists and others could be recruited;

e) the establishment of multi-disciplinary teams was welcomed but the importance of GPs in the delivery of local care should not be underestimated. It was also important to bear in mind that, in health care, services should be able to be configured to fit the needs of a local population; one size did not fit all;

f) asked if pharmaceutical companies could collude or collaborate on service delivery, for example, for depression and anxiety, for which the use of drugs had increased steeply in recent years, Mr Ridgwell explained that there were statutory regulations to ensure that companies could not collaborate to manipulate the market for their own benefit. A priority for the NHS was to develop consistent approaches across organisations, including across primary care and acute hospitals, to manage drug costs. Mr Douglas added that a change to the way in

which GPs worked would encourage a move towards using counselling services first rather than reliance on drug treatment. It was noted that some GPs would see a holistic approach as being too time-consuming, and prescribing drugs easier and quicker, but Mr Douglas pointed out that prescribing would bring an initial cost and then a later struggle and resource costs in encouraging a patient to reduce or discontinue drugs. Overprescribing of drugs, especially for older people, was a priority issue to be addressed. Mr Scott-Clark added that social prescribing would seek to reduce drug use by encouraging exercise and activity to boost mental and physical wellbeing. Professionals would assess and respond to each patient's individual needs;

g) gathering evidence from outcome-based services could be difficult, and some services, for example, Child and Adolescent Mental Health Services, were still addressing historic backlogs. The Kent and Medway area was ranked 5th in the country for having long waiting lists and Britain was behind Europe in using early screening to identify need and raising public awareness;

h) although nurse training now involved degree courses, the importance of good, front-line, hands-on nursing training should not be overlooked. Mr Douglas advised the committee that the role of Associate Nurses (similar to the former State Enrolled Nurse role) was currently being trialled across Kent and Medway. An unforeseen consequence of introducing nursing degrees was that those who did not want to undertake a degree but were good at caring had been excluded from the profession. The Associate Nurse role offered not only a different way of entering the profession, and way of boosting recruitment, but scope to become involved in activities such as school nursing and health education. He suggested that it would be helpful for the committee to see at a future meeting the workforce strategy and the work being undertaken to address recruitment and retention;

i) asked about the availability and role of pharmacists, Mr Scott-Clark advised that pharmacists were being deployed differently; clinical pharmacists would work in practices and community pharmacists would move away from dispensing to include preventative and monitoring work. They could share information with GPs and play a larger part in the whole-system approach; and

j) asked how clinical commissioning groups' responsibilities would work across borders with neighbouring counties and other authorities, and how Kent's services could ensure they were treating only Kent and Medway residents, Mr Douglas explained that administrative borders should not be an impediment to the delivery of care. Patient flows crossed clinical commissioning group and county borders. Just as residents from outside Kent used a range of services provided from Kent hospitals, often as their main and nearest hospital, a large number of Kent residents also received care from hospitals outside the area (for example, in London). Patients would be referred where they could receive the best available treatment; administrative borders would not be a barrier.

2. The Chairman thanked Mr Douglas and Mr Ridgwell for attending to brief the committee and answer questions and *advised that the slides used in the presentation would be shared with Members via email.* He suggested that any Members who did not have time to ask a question could send them to Mr Douglas and Mr Ridgwell so they could have a written response via email.

3. It was RESOLVED that the information set out in the presentation and given in response to comments and questions be noted, with thanks, and that any outstanding questions be sent to Mr Douglas and Mr Ridgwell via the Democratic Services Officer for a written response.

63. 19/00064 - Delivery and Transformation of Public Health Services.
(Item. 8)

The Chairman advised the committee that, as this and the exempt report later in the agenda (item 12) contained much detailed information, he was minded to take both reports together in a closed session at the end of the meeting. It was important that Members had the opportunity to gain a full understanding of the issues before being able to comment on them and consider the recommendations, and to do this they would need to be able to have a frank discussion and explore all of the available information. This could only be done effectively in a closed session.

64. Update on Kent County Council approach to Gambling Addiction: follow up from November 2018 paper on Gambling Addiction and Public Mental Health.
(Item. 9)

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

Mr B H Lewis declared that he had previously managed a betting shop for many years.

1. Ms Mookherjee introduced the report and outlined work which had been started since the issue had last been reported to the committee in November 2018, including a pledge by Simon Stevens, Chief Executive of NHS England, of funding to raise awareness, online briefings for front line staff and work with district council colleagues. She responded to comments and questions from the committee, including the following:-

a) the work streams set out in the report were welcomed as they were raising the profile of problem gambling and its damaging effects. It was important that gambling *per se* was not demonised but that suitable measures were available to address problem gambling;

b) in response to the concern that there was no centre in Kent to which those with a gambling problem could refer themselves, or be referred, Ms Mookherjee advised that the County Council had no control over what, if any, provision was made to treat this area of addiction. The addiction service in general was fragmented;

c) the view was expressed that addiction to gambling was as harmful as addiction to drugs or alcohol. Ms Mookherjee replied that, from a public health point of view, any addiction was harmful;

d) people under 18 were not permitted to place bets in a shop but could easily do so by using online gaming sites. Reputable betting shops would turn away someone who was obviously under-age but concern was expressed that many current proprietors may not take such a responsible stance. Using online gaming sites, young people could become very involved very quickly. The Government could be lobbied to take some action to address the accessibility of online gaming. Ms Mookherjee commented that online marketing of products and services which could potentially lead to harmful habits was often more sophisticated than public health online information and safeguarding campaigns. Although the County Council would always want to ensure that young people were kept safe online, it was simply not possible to tell who was using online gaming sites. Mr Scott-Clark added that he had advocated to the Association of Directors of Public Health that problem gambling be viewed as a public health issue and that the Government be lobbied to change the rules and legislation around it;

e) concern was expressed that advertising for gambling sites appeared on daytime TV channels and could be seen by young people, although it was encouraging that such advertising during live sports broadcasting had been banned. The danger of adopting and becoming hooked on risky behaviours early in life was emphasised. Adverse childhood experiences such as domestic abuse or family break up could leave young people vulnerable to adopting potentially harmful behaviours;

f) young people aged 16 were not permitted to vote in any election but could buy scratch cards;

g) the part played by deprivation as a root cause in the development of gambling and other addictions was acknowledged;

h) the Leader and Cabinet Member for Health Reform, Mr P B Carter, commented that gambling addiction should be viewed as having equal status with the other public health issues tackled by the Cabinet Committee;

i) a view was expressed that, although, unlike other public health problems, gambling addiction did not directly cause deaths, it could lead to poor mental and physical health; and

j) asked if hypnotherapy was known to have any beneficial effect on addiction, Ms Mookherjee said she was not aware of any service offering this, but both cognitive and dialectical behavioural therapies (CBT and DBT) could potentially be helpful if it were possible to identify people who could benefit from them.

2. The Chairman pointed out that Members could approach their local MP to start to address licensing issues and access to betting shops in their area.

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 work being undertaken to address gambling addiction be welcomed and endorsed.

65. Performance of Public Health-commissioned services.
(Item. 10)

Mrs V Tovey, Public Health 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) asked why the one service with a red rating – the number of mothers receiving an antenatal contact with the health visiting service – had been performing below target, Mrs Tovey explained that the national shortage of health visitors presented a challenge. Parents would be contacted by letter to encourage them to engage with the service, and the five mandated checks undertaken in a child's early years showed good performance generally; and

b) asked if these patterns varied across areas, Mrs Tovey said it was important that any local shortfall or difficulty was not overlooked but was identified and addressed. She explained that to include full regional information in future performance reports would make the total quantity of data impractical to process and report to each meeting *but undertook to highlight in future reports any region in which performance caused particularly concern.*

2. It was RESOLVED that:-

a) the performance information of public health-commissioned services in quarter 4 of 2018/19 and quarter 1 of 2019/20 be noted, with thanks; and

b) future performance reports highlight any region in which performance caused particularly concern.

66. Work Programme 2019/20.
(Item. 11)

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

67. Motion to exclude the press and public for exempt item.

It was RESOLVED that, under Section 100A of the Local Government Act 1972, the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraphs 3 and 5 of Part 1 of Schedule 12A of the Act.

EXEMPT ITEM (open access to minutes)

68. 19/00064 - Delivery and Transformation of Public Health Services.
(Item. 12)

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

1. Mrs Tovey introduced the reports for agenda items 8 and 12 and responded to questions of detail from the committee, including the recruitment and training of new nurses and retention and re-training of experienced nurses to take on new roles, for example, as health visitors and school nurses, to offer a new career pathway. The Care Quality Commission's recent rating of Kent Community Health NHS Foundation Trust (KCHFT) as 'outstanding' would help to retain and attract new staff. Other questions included clarity of the conditions that were required to be met for the County Council and KCHFT to enter into this agreement. Mrs Tovey confirmed that the conditions were set out in section 12(7) of the Procurement Regulations and also referenced within the exempt report. Mrs Tovey informed the committee that independent legal advice confirmed the arrangement met these criteria for the delivery of public health services and advised that this would be subject to review during the five years to ensure the conditions continued to be met.

2. It was RESOLVED that:-

a) the context, risk and assurance associated with the proposed procurement approach for public health services be noted; and

b) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to authorise the County Council to extend the collaborative arrangement with Kent Community Health NHS Foundation Trust, for the services listed in the report, until March 2025, be endorsed.