KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 27 April 2018.

PRESENT: Mrs S Chandler (Chair), Mr M J Angell, Mr P Bartlett, Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Mr B H Lewis (Substitute) (Substitute for Ms K Constantine), Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas and Mr R H Bird (Substitute) (Substitute for Mr D S Daley)

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer)

UNRESTRICTED ITEMS

44. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

(1) Mr Chard declared a Disclosable Pecuniary Interest as a Director of Engaging Kent.

(2) Mr Lewis declared an interest as his wife was employed by Kent County Council.

(3) Mrs Game declared an interest as the Chair of the QEQM Hospital Cabinet Advisory Group at Thanet District Council.

(4) Mr Bartlett declared an interest, in relation to agenda item 6 - Transforming Health and Care in East Kent, as he attended the Design by Dialogue event on 22 March 2018.

(5) Mr Thomas declared an interest, in relation to any discussion regarding a new hospital in Canterbury, as a member of Canterbury City Council's Planning Committee.

45. Minutes
(Item 3)

(1) RESOLVED that the minutes of the meeting held on 26 January 2018 are correctly recorded and that they be signed by the Chair.

(2) Members noted that the Committee would be going paper-light from 8 June 2018. The Chair thanked those who had already volunteered to trial the new paper-light scheme.

46. Kent and Medway Strategic Commissioner
(Item 4)

Glenn Douglas (Accountable Officer, Kent and Medway Clinical Commissioning Group) and Michael Ridgwell (Programme Director, Kent and Medway STP) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Douglas began by stating that all eight CCGs had now committed to establishing a strategic commissioner and sharing a single senior management team with one accountable officer for Kent and Medway. A sub-committee, comprising of the Chairs from the 8 CCGs had been created to oversee the governance of the strategic commissioner; Dr Bowes (Chair, NHS West Kent CCG) had been appointed as Chair of the Sub-Group. Mr Douglas noted that Hazel Smith had secured a new role with Health Education England; Patricia Davies would now be responsible for partnership working in addition to acute strategy as part of the new shared management team.

(2) Members enquired how the establishment of the strategic commissioner would affect the individual responsibilities and priorities of each CCG. Mr Douglas explained that all eight CCGs were committed to working together on strategic areas in order to provide consistency and reduce duplication with providers. The overall aim of the strategic commissioner function was to simplify the process of contracting and make savings.

(3) In response to a question about stroke services in Thanet, Mr Douglas confirmed that the public consultation had closed and that the responses would be independently analysed. He noted that in Thanet, a degree of support for the proposed model had been expressed however there was a desire for a Hyper Acute Stroke Unit to be sited at the QEQM. He explained that the next stage of the process would involve Tony Rudd (National Clinical Director for Stroke) working with the clinical chairs to establish a clear evaluation process around the options, taking into account public consultation responses, which would lead to the options being re-evaluated and mitigations put in place prior to a decision being taken by the Joint CCG Committee in autumn 2018. Mr Douglas reported that there had been a change in leadership within Thanet CCG and a candidate had been put forward to the Thanet CCG governing body for approval.

(4) Members sought clarity about the commissioning of primary care and the future of the strategic commissioner. Mr Douglas confirmed that primary care would remain locally, and that each individual CCG would retain responsibilities for primary care commissioning. He stated that the only change had been the creation of a shared Accountable Officer for the Kent & Medway CCGs. He informed the Committee that over the next 9 - 12 months there would be further discussions about whether the strategic commissioner would continue to act as a subsidiary to each of the CCGs or if there would be a move towards a single CCG, forming a statutory body; if that was to happen, plans would need to be put in place to determine what services would be provided locally. He stated that all CCGs were working together to map out what a future structure may look like. He reported that whilst legislative change, in terms of structure, by 2019/20 was unlikely; the local system was able to do things, such as running in shadow form, to move forward. He noted that GPs were supportive of strategic commissioning and recognised the need to work together to support services in Kent & Medway going forward.

(5) Members enquired about financial balance in Kent & Medway and the governance of strategic commissioner. Mr Douglas noted that each CCG was currently responsible for its own budget however there was a national move towards a single control total which would cover both CCGs and providers. Mr Douglas stated that each CCG had an existing governance structure which would remain in place. A new governance structure to incorporate the strategic commissioner was being developed. He noted that workshops for independent CCG members were taking place about holding the strategic commissioner to account.

(6) Members asked about joint commissioning, the cost of the restructure and overall deficit in Kent & Medway. Mr Douglas noted that he was actively engaged with KCC with regards to joint commissioning; he stated the importance of maintaining relationships with borough councils too particularly for engaging with local people and acting as a gateway into the voluntary sector. Mr Douglas explained that he anticipated that the new structure would result in savings. Mr Douglas committed to sending the Committee the total 2017/18 financial deficit for Kent & Medway when available.

(7) Mr Inett enquired about the East and West Kent commissioning split. Mr Douglas explained that commissioning took place at two levels, strategically and locally. The middle tier split was an administrative convenience and focused on the major providers in East and West Kent. He reported that there was very little overlap between the two communities in terms of NHS services. He noted that there may be greater collaboration between providers in the future as part of accountable care systems.

(8) The Chair enquired if Mr Douglas was confident in having the support to make changes to the structure going forward; he confirmed that he was. He noted his confidence in the leadership of the CCGs and their shared objective to move forward.

(9) RESOLVED that the report on the Kent and Medway Strategic Commissioner be noted and that the Kent & Medway STP provide an update to the Health Overview and Scrutiny Committee in six months' time.

47. Financial Recovery in East & North Kent
(Item 5)

Caroline Selkirk (Managing Director, East Kent CCGs) and Johnathon Bates (Chief Finance Officer, East Kent CCGs) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. A Member enquired whether the financial recovery programme had had an impact on patients. Ms Selkirk explained that the focus of the recovery programme was to reduce waste and provide services more locally. She reported that a whole systems approach would improve patient outcomes and the sustainability of services. She noted that whilst there had been an impact on elective surgery over the winter period; additional capacity had been purchased from the private sector to manage the backlog.

(2) Members asked about the reduction to the number of GP surgeries and timeline for implementing local care. Ms Selkirk acknowledged that whilst

access to primary care was challenged; she explained that it was due to the number of GPs rather than the number of practices. She explained that local care models were being implemented in East Kent, in which practices were working collaboratively to provide greater access to and delivering sustainable services to populations of 30,000 - 50,000. Ms Selkirk explained that local care models were being implemented over the next three years and involved the delivery of services from hubs by multidisciplinary teams which could include services provided by the acute and community trusts. She noted the importance of local care as part of wider service reconfiguration in East Kent.

(3) Members enquired about the external determination process with East Kent Hospitals University NHS Foundation Trust and Section 106 contributions. Ms Selkirk explained that the CCGs and the Trust had now agreed to count activity in the same way going forward. Mr Bates confirmed that Section 106 contributions had been received across East Kent, including in Thanet were the contributions had been used for local care buildings. Mr Bates noted that contributions remained relatively small in comparison to overall budget.

(4) Members raised concerns around the decision to move the macular degeneration clinics from Buckland Hospital and the consultation with the Committee. Ms Selkirk explained that when the CCG had put the service out to procurement, several companies expressed an interest. The contract was awarded but it did not specify that the service had to be provided in Dover. The CCG was reviewing a number of options to resolve the issue. In response to whether the Committee was permitted to have sight of the contracts, Mrs Chandler advised Members that advice would be sought and feedback would be provided to the Committee.

(5) The Chair expressed concerns about the deliverability of the recovery plan in recovering the deficit, delivering savings and continuing to provide services without detrimental effect to patients given the financial challenge faced in East Kent. Ms Selkirk noted that many health economies were facing deficit and stated the importance of the local care model in making services more sustainable in East Kent.

(6) Members enquired about the robustness of local care plans, business rates and governance. Ms Selkirk noted that in Medway, work had been undertaken with the Kent Fire and Rescue Service to assess patient homes and ensure that preventative measures were taken to reduce the number of frail and elderly fallers; this programme had created elective capacity through financial savings. She explained that evidence from the Encompass Vanguard showed that local care models could be implemented at scale, reduce A&E attendance and improve access to patients. Mr Bates noted that the detailed reviews had been undertaken to ensure that business rates paid by GPs were at the correct level; substantial adjustments in favour of the health service had been awarded. Mr Bates stated that he would review if CCGs were eligible for business rate exemption. Ms Selkirk reported in terms of governance, the system was more effectively working together which included reducing the number of meetings which had achieved a more focused approach.

(7) A Member raised concern about patients sitting in isolation in hospital beds without access to television rooms. Mrs Selkirk agreed that the provision of televisions was not an expensive solution and stressed the importance of

health and social care working with communities to tackle social isolation. She noted that in East Kent care navigators were being implemented who ensured that people had the correct support to help them live independently. She welcomed Paul Carter's request for social care colleagues to work in collaboration with NHS to tackle the issues around independent living at a hub level.

(8) Mr Inett asked if the saving initiatives detailed in the paper would be brought to the Committee, Mrs Selkirk confirmed that any service changes would be brought back to the Committee for scrutiny.

(9) At the conclusion of the discussion, the Chair stated that she was still concerned about the impact of the recovery plan on patients. A number of potential recommendations were discussed, and the following was agreed by the Committee:

(10) RESOLVED that:

(a) the Committee expresses concern about the financial recovery leading to a diminution of service to patients in East Kent;

(b) the East Kent CCGs be requested to provide an update about financial recovery in November;

(c) an update about direct GP access to MRI scans in East Kent be circulated to the Committee;

(d) Swale CCG be requested to provide a written response regarding acute contract overperformance at Medway NHS Foundation Trust.

48. Transforming Health and Care in East Kent
(Item 6)

Caroline Selkirk (Managing Director, East Kent CCGs), Louise Dineley (East Kent Programme Director), and Anne Neale (Deputy Director of Strategy and Business Development, EKHUFT)

(1) The Chair welcomed the guests to the Committee. In response to a question about the circulation of the letter from the Medical Directors to Paul Carter regarding the number of A&Es in East Kent, the Chair advised the Committee that the letter had been received but needed to be reviewed prior to its circulation. Ms Dineley apologised for the delay in providing the letter.

(2) Ms Neale explained that the Keogh guidelines had been used to establish the medium list of options which required ten consultants at each site supported by junior medical staff. She stated that the current number of consultants on each site was two. She noted that the Trust had faced difficulties in maintaining three emergency medical takes in conjunction with providing the required supervision and training for junior doctors which had resulted in the removal of junior doctors from the Kent & Canterbury site. Ms Neale stressed to the Committee that there was not the workforce to deliver A&E services on three sites. She reported that the uncertainty around the future configuration of acute services was hampering recruitment. She highlighted that a review was

being undertaken to look at how different competencies and skills could be used to provide different elements of care to patients across the health economy.

(3) The Chair enquired about the expected timetable for the programme, Ms Selkirk explained that commissioners undertaking a service reconfiguration had to undergo a detailed assurance process set out by NHS England before a service change could be implemented. She noted that NHS England had published updated guidance in March 2018 on service reconfiguration which included an additional assurance stage for proposals which required capital investment. She stated that the next stage for East Kent was the development of a robust and comprehensive pre-consultation business case (PCBC); external consultants had been appointed to complete a readiness assessment which would be used to develop a timetable.

(4) Members commented about the Design by Dialogue event held in March 2018. Ms Selkirk explained that a series of pre-engagement events were planned for each locality in East Kent and would provide more detail on local care models, activity and finance based on the feedback from the Design by Dialogue event.

(5) Mr Inett enquired about the implementation of local care and the potential for further emergency transfer of services. Ms Selkirk stressed the importance of the process being carried out robustly. She stated that it would take three years for local care to be fully implemented. She noted that each CCG was signing-off their local care story and would be presented at local design by dialogue events. She noted the importance of capturing feedback from the engagement events.

(6) RESOLVED that:

(a) the Committee note the report;

(b) the East Kent CCGs provide a short verbal update about the timeline at the June meeting;

(c) the Scrutiny Research Officer provide the Committee with a briefing note about NHS assurance process for service change and reconfiguration.

49. East Kent Out of Hours GP Services and NHS 111
(Item 7)

Bill Millar (Interim Director, Urgent Care and Primary Care, East Kent CCGs), Caroline Selkirk (Managing Director, East Kent CCGs) and Dr Andrew Catto (Medical Director, IC24) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee and enquired about the bases at Romney Marsh and Deal. Dr Catto explained that it had not been possible to reopen these bases due to GP availability. He noted that IC24 had increased the availability of its mobile GP visiting service to patients who were unable to travel within the Romney Marsh and Deal areas.

(2) Members enquired about access to out of hours (OOH) services, resolution of health & safety issues at the Folkestone base and GP shortages. Dr Catto explained that OOH services were historically accessed via GPs however they were now accessed through a uniformed gateway, NHS 111. He noted that all IC24 bases had policies in place to manage those patients who walked-in. Dr Catto reported that the issues at the Folkestone base were being resolved imminently. Dr Catto stated that NHS England had recognised that there was a shortage of GPs and developed an integrated care model, which could meet the needs of patients who required urgent and emergency care and would be delivered by a range of health professionals including GPs. Dr Catto invited the Committee to visit the Ashford IC24 Contact Centre.

(3) Members asked about access to extended services in South Kent Coast and 111 response times. Mr Millar explained South Kent Coast had implemented a phased introduction of a seven-day services across the locality until a full workforce was established. Dr Catto stated that the key metric to measure 111 performance was the 60 second call answering time. He noted that since IC24 had taken over the contract in December 2017, there had been a week on week improvement in performance; current performance was 81.6% against the national standard of 95% and average performance in England of 83%. He reported that the previous provider had been unable to manage the level of calls and used national contingency provisions which had created additional demands on the 111 service nationally. He stated that the other metric used to measure performance was the abandonment rate which was used as a measure of safety; if the rate was above 5% it would flag an immediate cause for concern, IC24 had an abandonment rate of 3%.

(4) RESOLVED that:

(a) the report on the East Kent Out of Hours GP Services and NHS 111 be noted;

(b) the Committee receive an update from East Kent CCGs following workshop on primary care workforce.

The meeting was adjourned at 12:30 and reconvened at 13:30.

50. SECAmb: Update
(Item 8)

Steve Emerton (Executive Director of Strategy and Business Development, SECAmb) and Ray Savage (Strategy and Partnerships Manager (Kent & Medway, and East Sussex), SECAmb) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Emerton began explaining that the Trust's new board was now in place and responding to CQC findings which had placed the organisation in special measures. He stated that the Trust had implemented the new Ambulance Response Programme (ARP) in November 2017. He noted the Trust was currently unable to consistently meet its performance targets particularly for Category 3 & 4. He; patients in these categories who were waiting for long periods of time

due to vehicles being diverted to Category 1 & 2 calls. Mr Emerton reported that a demand and capacity review with commissioners was near completion to determine the workforce and resources required to enable the Trust to be fully compliant with standards and targets.

(2) Members asked about Category 1T performance and vehicle dispatch. Mr Emerton explained that whilst Category 1T was not a national performance measure, it was a metric used by the Trust to monitor whether an automated dispatch vehicle had the correct resources to transport a patient to hospital. Mr Savage noted that a key element of the ARP was that call handlers had more time to assess the call before dispatching the right resource for Category 2 patients.

(3) A Member enquired if there was a system in place to text callers with updates during periods of high demand. Mr Emerton explained that the Trust did call people back and stated the importance of managing expectations and mitigating risk of harm during periods of high demand. He noted that for calls from residential care homes which had a no lift policy, trained call-handlers would call back to implement processes to reduce risk of harm which included moving patients so that they would be more comfortable and providing them with fluids and medications.

(4) In response to a specific question about the Kent & Medway Stroke Review, Mr Savage stated that whilst any service change where travel time increased would place a demand on the Trust; the Trust had modelled its ability to get to the patient and then to each of the proposed sites within 60 minutes. Mr Emerton confirmed that the Trust would be able to service all the proposed options. Mr Savage noted the demand & capacity review had taken the stroke review into account.

(5) Members enquired about traffic congestion particularly the impact of Sturry railway crossing. Mr Savage noted that traffic was an issue, but blue lights and sirens enabled the Trust's fleet to make progress and move quicker than other vehicles. He reiterated that real time travel was used as part of modelling for the stroke review and the Trust had confidence in the modelling. He stated that he could not provide the amount of travel time lost if the Sturry Crossing was closed but assured Members that extensive modelling using real time travel from the Thanet area to the proposed stroke sites had been undertaken.

(6) Mr Inett commented about handover delays. Mr Emerton stated that handover delays caused a disproportionate challenge to the Trust. He noted that a jointly commissioned project to reduce handover delays and provide single oversight had begun to gain traction; the Trust had seen an improved Category 2 performance resulting in a reduction in handover delays during the previous week. Mr Savage noted that he was involved in the project's task & finish group which brought together the acute trust's chief operating officers to share best practice and put in processes to reduce handover delays. He reported that there were signs of improvement.

(7) The Chair concluded by enquiring about resourcing. Mr Emerton stated that through the demand & capacity review, the Trust had been able to quantify the additional resources to meet demand in terms of workforce and vehicles. He noted that a proportion of the calls did not require a 999 response and were able to be dealt through Hear & Treat which reduced A&E attendance. He

reported that the Trust was involved in local care modelling to ensure alternative care pathways were utilised.

(8) RESOLVED that the report be noted and SECAmb be requested to provide an update at the appropriate time.

51. Patient Transport Service
(Item 9)

Ian Ayres (Managing Director, Medway, North and West Kent CCGs), Johnathon Mawer (Relationship Manager, G4S Patient Transport Services) and Russell Hobbs (Managing Director, G4S Patient Transport Services) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Ayres introduced the report and set out some of the key challenges faced under the existing contract which included a demand for higher mobility, longer distanced journeys and increased escort numbers. Mr Ayres informed the Committee that the CCGs had agreed to rebase the contract and provide additional funding which was less than 10% of the contract value. A new performance regime was being implemented to incorporate a graduated scale of consequence to reflect the severity of failing to achieve Key Performance Indicator (KPI) targets.

(2) In response to a question about the exclusion of Dartford and Gravesham from the main contract, Mr Ayres explained that the contract for that area was originally managed by North Kent CCG, however, it had now been transferred to him in his new role as the Managing Director for Medway, North and West Kent CCGs. Mr Ayres stated that the management of three separate fleets with three separate contracts was logistically inefficient and therefore an agreement was being sought with G4S to manage the fleet as an integrated system.

(3) Members raised concerns about performance of G4S. Mr Ayres acknowledged that performance at 40% was not acceptable. He identified two drivers of poor performance; the first being the wrong fleet size which was in the process of being corrected through the contract variation and the second being the performance regime. He noted that a new performance regime had been introduced which would now differentiate between minor failures and more significant ones. Mr Ayres assured the Committee that recent improvements had reduced the level of complaints; he acknowledged the significant work undertaken by G4S staff to improve performance. Mr Ayres noted that the initial contract had included all journeys in and out of London hospitals which had required a vehicle to be out of use for an entire day and was therefore not efficient model. He stated that a decision was therefore taken to remove the London Hospitals from the G4S contract.

(4) In response to questions about training compliance and complaints, Mr Hobbs explained that there had been an absence of records from the previous provider. As G4S was unable to evidence training, it had decided to retrain all staff; 99% compliance of mandatory and safeguarding training was achieved by January 2018. He noted that complaints accounted for 0.2% of the 325,000

patients transported within the last year. He reported that the number of complaints had reduced from 110 in October 2017 to 60 in March 2018. Mr Hobbs stated that the average acknowledgment time was a day, and the response time was 18 days. He highlighted that G4S had now satisfied all the requirements set out in the improvement notice and this had now been removed. He stressed that G4S took complaints seriously and were not complacent.

(5) RESOLVED that:

(a) the report be noted;

(b) West Kent CCG be requested to provide a written update on the new key performance indicators to the June meeting;

(c) West Kent CCG be requested to present a verbal update on performance to the Committee in the autumn.

52. Kent & Medway Integrated Urgent Care Service Procurement
(Item 10)

Ian Ayres (Managing Director, Medway, North and West Kent CCGs) was in attendance for this item.

(1) Mr Ayres began by explaining that due to the timing of the item, the information he could provide was limited due to the start of the procurement process.

(2) The Chair enquired on behalf of Mr Chard about the integration of urgent care services. Mr Ayres stated the importance of urgent care services being integrated and having access to a wider range of services including social care and mental health. He noted integration was an integral part of the nationally mandated procurement and national specification.

(3) In response to a specific question about growth, Mr Ayres explained that in West Kent, the CCG had worked with the district councils to understand every housing development planned for the next 10 years and the impact that these would have on local health services. He noted that a draft plan on the future requirements of primary and community care services in West Kent was expected in September 2018.

(4) A Member enquired about the closure of East Peckham branch surgery which was within a growth area. Mr Ayres explained that the branch surgery had closed due to the cost of improvement works to the building; two years was spent trying to secure the capital funding required for the building works. He noted that West Kent CCG had successfully negotiated the opening of a branch surgery in Allington following two local practices giving notice on their contracts. All patients who lived within the Allington ward and were registered at the two existing practices would be automatically transferred across to the new practice providing the branch surgery. The only change was for patients who lived outside the Allington ward area; they would need to register at a GP practice which serves the area they live in.

(5) RESOLVED that the report on Kent and Medway Integrated Urgent Care Service Procurement be noted and an update be provided to the Committee at the conclusion of the procurement in September.

53. West Kent Out of Hours GP Services
(Item 12)

(1) The Chair introduced the report and explained that she had agreed for the item to be considered as urgent as the information was not available at the time of publication and the changes to the service would have been implemented prior to the next meeting of the Committee on 8 June 2018.

(2) Mr Ayres apologised for the delay in providing the report to the Committee. He explained that out-of-hours base at Tonbridge Cottage Hospital was due to relocate in spring 2018 but would now take place in June along with the relocation of the Sevenoaks base. From 1 June 2018 patients who require a face-to-face GP appointment out of hours will be seen in a dedicated and co-located facility at Maidstone Hospital or Tunbridge Wells Hospital. Mr Ayres noted that 98% of attendances to the Sevenoaks MIU was by private transport and was therefore reassured that the relocation of the Sevenoaks base would not cause too much disruption.

(3) RESOLVED that the update report on West Kent Out of Hours GP Services be noted.

54. Date of next programmed meeting – Friday 8 June 2018
(Item 11)

(1) The Chair noted that it was Mr Angell's last meeting as a member of the Committee. She personally thanked Mr Angell for the support and advice he had provided to her in his role as Vice-Chair and for all his contributions as a longstanding Member and former Chair of the Committee.

(2) RESOLVED that the date of the next programmed meeting on Friday 8 June 2018 and proposed agenda items be noted.