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 Thursday, 19 September 2019.

PRESENT: Mrs S Chandler (Chair), Mr P Bartlett (Vice-Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr D S Daley, Ms S Hamilton, Mr K Pugh, Cllr M Rhodes, Patricia Rolfe, Mrs C Mackonochie and Mr R J Thomas

ALSO PRESENT: Mr S Inett and Dr J Allingham

IN ATTENDANCE: Mr T Godfrey (Scrutiny Research Officer) and Dr A Duggal (Deputy Director of Public Health)

UNRESTRICTED ITEMS

156. Declarations of Interests by Members in items on the Agenda for this meeting.

(Item 2)

Mr Chard declared a Disclosable Pecuniary Interest as a Director of Engaging Kent. He explained he would leave the meeting for Item 4, Healthwatch Kent Annual Report, as Engaging Kent managed the Health Watch contract.

157. Minutes from the meeting held on 23 July 2019

(Item 3)

RESOLVED that the Committee agreed that the minutes from 23 July 2019 were correctly recorded, and that they be signed by the Chairman.

158. Healthwatch Kent Annual Report

(Item 4)

Steve Inett (Chief Officer of Engaging Kent CIC) was in attendance for this item.

(1) Mr Inett expressed his thanks to the Committee for the opportunity to present the Healthwatch annual report. He set the context and explained that Healthwatch Kent fit into a larger network of over 150 local Healthwatch organisations and Healthwatch England. He raised the positive work that had been done with HOSC with wheelchair service users and explained that talks had continued with Millbrook and the service user group had started its work. Amongst the other work Healthwatch had been involved in they had facilitated a patient presenting at the Board of Maidstone and Tunbridge Wells NHS Trust, and had done a lot of work around ensuring accessible information standards were being met and for which Healthwatch Kent had been shortlisted for an award by Healthwatch England.

(2) Mr Inett went on to explain that much of the work of Healthwatch was around signposting and engagement activities including the 'Coffee Caravan' events. The importance of ensuring information about Healthwatch related events was discussed by Members, with several suggestions made.

(3) The issue was raised of whether Healthwatch checked on systems to which patients were referred onwards for information or booking appointments. It was explained that Healthwatch were wary of mystery shopping exercises so as not to add additional burdens to services but did do them with prior arrangement with organisations. The enter and view power was the key one for Healthwatch and they had gone into GP practices and outpatients' departments and shared best practice. Appointment systems were a common area to be looked at.

(4) In relation to the following item on the Committee's agenda, it was explained that Healthwatch had been involved with the families connected to the Frank Lloyd Unit. Mr Inett explained that carers had been feeling that they were not receiving enough feedback from the focus group, but this had been rectified.

(5) RESOLVED that the report be noted.

159. Review of Frank Lloyd Unit, Sittingbourne
(Item 5)

Adam Wickings (Deputy Managing Director, NHS West Kent CCGs) was in attendance for this item.

(1) Mr Wickings introduced the item and explained that there were really two related but separate matters to go over. These were communications and future service developments on the one hand, and the work ongoing with the directly affected families on the other. It was explained that the Frank Lloyd Unit was not intended to be a facility to deliver continuing care but had changed into one over time with patients having ever longer stays of up to 9 years. However, with the shift of focus more to care in community settings and nursing homes, there were fewer and fewer patients with only 5 now receiving care at the Unit. Working with the Trust who ran the Unit, it had been deemed unviable.

(2) It was further explained that the continuing care team was working with the families to find the right solution for each one. As many had resided there for a long period, time was being taken to deal with each complex and intricate case. Each was different and would require a different solution. Not all the remaining patients were local to the area and some were originally from a further distance.

(3) In response to questions from Members, it was explained that the drivers for change were not about financial savings but the viability of the service. Some Members reported that there was concern locally about the future of the Unit and raised whether there was the possibility of retaining it.

(4) The query was raised as to whether any of the current patients would be disadvantaged by no longer qualifying under the criteria for continuing care. Mr

Wickings explained that he would include the criteria when he next reported on this issue to the Committee and provide assurances on this.

(5) Due to the levels of local interest and the details requested by Members on the needs of the current patients, the Chair suggested that an informal briefing be arranged to which local Members would be invited. This suggestion was welcomed by the Committee and NHS representatives, and Officers were asked to undertake coordinating this.

(6) Mr Wickings explained that it was the same team which was also managing the changes at St. Martin's, which the Committee had also discussed. There was a discussion of the pros and cons of having the public consultation for both at the same time.

(7) RESOLVED that:

a) the Committee deem the proposed changes to the Frank Lloyd Unit to be a substantial variation of service;

b) an informal briefing be arranged to go into more detail concerning the Unit; and

c) the NHS be invited to attend a future meeting when there was more information available on the new model of care being developed.

160. NHS Waiting Times for Cancer Care
(Item 6)

Rachel Jones (Director of Acute Strategy and Partnerships, K&M STP), and Ian Vousden (Kent & Medway Cancer Alliance Manager, NHS England South (South East)) were in attendance for this item.

(1) Earlier in the year there had been media reports about cancer service performance across England, with some local Trusts not performing so well. The overall direction across Kent was in the right direction but there was still work to be done. The data in the papers provided to the Committee went to June, but the data for July had arrived the day prior to the meeting. The NHS were now able to report 80% for the target to begin treatment within 62 days and this was up from 76% but still not at the 85% national target. NHS representatives stressed that the local work was focused on ensuring sustainable improvement and so patients were not being treated out of turn and backlogs were being dealt with to ensure the figures would improve slowly and stay there rather than simply showing a short-term improvement.

(2) Further local detail was provided on the 62-day target. Darent Valley Hospital was generally compliant and the most consistent. This Trust dealt with the smallest numbers and had good processes in place. East Kent Hospitals had the fifth highest number of referrals in the country and was making month on month improvements. At 55.6% in January, Maidstone and Tunbridge Wells Trust had been in the bottom four nationally but indicative figures for August suggested that they would be hitting the national target.

(3) A network approach was now being taken across Kent and Medway with a Joint CCG Committee set up to drive improvements across the system. It was explained that cancer services are organised by tumour site and the focus of a lot of work was on the four areas of worst performance – lung, upper gastrointestinal, colorectal and urology (specifically prostate).

(4) A new standard was being brought in across the NHS with a target of 28 days to get a diagnosis. Delays to cervical screening was a national issue, but delays in endoscopy was a specific problem locally and that contributed directly to the challenges in tackling upper gastrointestinal and colorectal cancers. There was a national target to diagnose 50% of cancers at stages 1 and 2, but in Kent and Medway only 25% were being identified then with 75% identified at stages 3 or 4. Cancer survival rates at 1 and 5 years were also tracked. Nationally, there was work on a quality of life metric for 1 year after treatment, but this was hard to measure.

(5) Making the shift to more cancers being identified at stages 1 and 2 would rely on referrals from primary care. Public awareness campaigns and training for GPs was essential so that people went to their GP earlier and the GP identified a possible problem. The conversion rate of referrals to positive diagnosis was 3% and these referrals were vital but a straight to test model was being developed so that diagnostic services could be accessed directly by patients.

(6) NHS representatives undertook to provide further data on quality and survival rates.

(7) Karen Constantine, a Member of the Committee, was unable to attend but requested a statement on this issue to be read out to the Committee. The statement focused on the need to have the right workforce and expressed concern about the impact from staff shortages. NHS representatives explained that, in general terms, recruiting the cancer workforce did not have the same challenges as in other areas. Many of the roles, like endoscopy, were generic ones. However, there were challenges in some areas like radiology nurses. In response to the request that the Committee consider writing to the Secretary of State to request the restoration of bursaries for nurses, there were some comments of support. In order to approach this question from a strategic perspective the Chair asked the Committee if it would be helpful to arrange a discussion at the Committee on the acute sector workforce. The Committee supported this proposal.

(8) RESOLVED that the report be noted.

161. Re-Commissioning of Special Care Adult and Paediatric Dental Services (written update)
(Item 11)

(1) The Chair explained that this item would be considered earlier as item 6 had finished ahead of the scheduled time.

(2) The Chair explained to Members that as no one was able to present the papers before the Committee, Members would be able to provide any comments to the NHS via the Clerk. The item would return to the Committee at a later date for a fuller discussion.

(3) Members requested that further information be requested clarifying the geographical scope of the lots set out on p.133 of the Agenda. For example, there were two entries for Faversham and three for Sevenoaks with different numbers for each.

(4) AGREED that the Committee note the report.

162. Strategic Commissioner Update (written update)
(Item 12)

(1) The Chair explained that this item would be considered earlier as item 6 had finished ahead of the scheduled time.

(2) The Chair also explained that this was a written update and there would be a future opportunity to discuss this item with representatives from the NHS. She invited comments from the Committee.

(3) Different views were expressed on the merits of moving to a single Clinical Commissioning Group across Kent and Medway. On the positive side, the view was expressed that it would be useful to have a joined up strategic approach and all the money coordinated in one place. On the negative side, concerns were expressed about how local needs would be represented by a larger CCG. The view was expressed that more assurances would be needed about the future of local hospitals and reassurance provided that the changes would not adversely affect primary care. Members were also interested in knowing what the impact would be on workforce development, the relationship with providers and how pathways of care would be guaranteed. The Chair explained these questions would be able to be picked up when the item returned to the Committee.

(4) On behalf of Healthwatch, Mr Inett explained that they were in conversations with the NHS about their concerns, such as the potential for patients being disrupted by the move to Kent wide commissioning.

(5) A representative from the Local Medical Committee (LMC) was able to fill in some background but said they had some reservations about the proposals. CCGs are membership organisations and each organisation would need to approve the plans with large majorities. These votes were ongoing. Concerns were expressed about the development of Integrated Care Providers as not all have been meeting with LMC involvement. Similarly, grass roots GPs were not represented on all Primary Care Networks.

(6) AGREED that the Committee note the report and request the Kent and Medway STP to return in the new year with an update.

163. Work Programme
(Item 13)

(1) The Chair explained that this item would be considered earlier as item 6 had finished ahead of the scheduled time.

(2) RESOLVED that the draft work programme be agreed.

164. Single Pathology Service for Kent & Medway
(Item 7)

Miles Scott (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), and Tess Jarrett (Executive Assistant to the Chief Executive, MTW NHS Trust) were in attendance for this item.

(1) Mr Scott explained that he was attending as Chair of the Pathology Board. It was explained that the changes would bring pathology together into one service and one contract. The three labs at William Harvey, Darent Valley and Maidstone Hospitals would remain and would be the hubs. Spoke services would be provided in other hospitals. This would enable improved training and productivity and lead to the faster adoption of new technology across the county. The main parts of the service were the Laboratory Information Management System (LIMS) and the Managed Equipment Service (MES) and there would be common operating standards across the service.

(2) It was further explained that approval would need to be given by the Boards of the four NHS Trusts involved. It was hoped a business case on equipment would go to the Boards in October and one for the operating standards in November.

(3) The bulk of the work came from GPs and they, and patients, were not expected to notice any difference, except for a faster turnaround in results as demand was managed across the network.

(4) From considerations around resilience, the option of a single hub had been ruled out but an open question for the future would be whether to reduce from 3 hubs to 2. The main driver here would be around ensuring the sustainability of the service. In addition, the intention was to repatriate work to the county that was currently sent to London.

(5) The question of workforce and staff engagement was raised. NHS representatives explained that as the hubs were remaining in their current locations, there was not expected to be the requirement to ask staff to relocate. However, staff may choose to do so temporarily or permanently as more career development and training opportunities became available. It was hoped the changes would contribute to staff retention. There were dedicated staff engagement forums and the working groups established all had staff representatives.

(6) As an example of the contribution of pathology to wider the wider health services, the Committee was informed that there was a thank you event that day at Maidstone Hospital to recognise the improvement in meeting cancer targets. Cellular pathology services were a key part of this. A lot of this work was being done by non-medical scientists doing some of the work that medical

pathologists did. The first consultant scientist in pathology to be appointed in England had been appointed in Kent. Initiatives like this were making a huge difference as the incidences of cancer were rising but referrals were rising faster. This would also provide a career path into the NHS for locally trained scientists, retaining these skilled workers.

(7) An attendee from the Local Medical Committee asked about the connectivity between pathology services and GP practices, which use a variety of information systems. The response was given that there would be no need for any GP practice to change their systems as all would be able to link in with it.

(8) In response to a Member question it was explained that it was a coincidence that the three hubs were in the same location as the proposed hyper acute stroke units. Moving any of the hubs had a large capital implication due to the cost of the equipment.

(9) Karen Constantine, a Member of the Committee, was unable to attend but requested a statement on this issue to be read out to the Committee. The statement commented on the possibility that the service could be taken over by a private company resulting in staff leaving and a downgrading of the service. NHS representatives responded by stating that the Boards of all four Trusts did not want an outsourced private option. They wanted to develop a robust NHS service by working together.

(10) AGREED that:

a) the Committee deems that proposed changes to Pathology Services in Kent and Medway are not a substantial variation of service, and

b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

165. NHS North Kent CCGs: Urgent Care Review Programme - Swale CCG
(Item 8)

Stuart Jeffery (Deputy Managing Director, NHS Medway CCG), and Fiona Armstrong (Chair, NHS Swale CCG) were in attendance for this item.

(1) In introducing the item, NHS representatives explained that when the Committee was last updated in January minimal changes were envisaged. But the affordability of the urgent care services across the current sites was not affordable and another review had been carried out. There was a need also to align with Medway CCG, the emerging Integrated Care Provider (ICP) and advent of Primary Care Networks (PCN). It was recognised that there were GP shortages in Swale but that the changes should alleviate GP workload. It was explained that currently most of the demand at the Walk in Clinic (WIC) and Minor Injuries Unit (MIU) were for primary care services and not urgent care - 9% of attendees at the WIC had urgent issues, and only half of the attendees at the MIU were genuine minor injuries. However, it was also recognised that these were valued local services.

(2) In response to a question, NHS representatives stated that they believed the direction of travel would not change should there be a single CCG across Kent and Medway.

(3) Members discussed the recommendation and felt they would require further information before making a firm decision as to whether the proposals constituted a substantial variation of service.

(4) RESOLVED that the Committee note the report and that the NHS be invited to attend a future meeting when there was more information available on the new model of care being developed, at which time the Committee would be able to determine whether it would be deemed a substantial variation of service.

166. Kent & Medway NHS 111 and Clinical Assessment Service Procurement
(Item 9)

Stuart Jeffery (Deputy Managing Director, NHS Medway CCG), and Jacqui Sarakbi (Assistant Director for Integrated Urgent Care, Kent and Medway CCGs) were in attendance for this item.

(1) A 2:38 minute YouTube video describing the difference between the old and new clinical assessment service was shown (https://youtu.be/FIZZu4R6yEU) at the request of the NHS attendees to introduce the item.

(2) Following on from this, NHS representatives explained that the new 111 service was a step change to what had gone before and would allow patients to be directly booked into primary care or an urgent treatment centre. The contract had been awarded to the South East Coast Ambulance Service (SECAmb) with IC24 as a partner to deliver the Clinical Assessment Service. The contract would go live from April 2020 and was currently in the implementation phase.

(3) Four conditions which had been put on the contract had now been met. In response to a question it was explained that these were about having a workforce plan that reconciled with the financial modelling templates, assurance on a number of policies and subcontractors, a more developed communications and engagement plan, and a clear vision as to how the systems of the two organisations involved would come together.

(4) Members raised several points. One related to the public perception of SECAmb. It was explained that the Trust had recently been awarded a 'Good' rating by the Care Quality Commission and CCGs across Kent, Surrey and Sussex had invested in the service to improve performance, which had happened. In response to another question, it was explained that a GP recruitment campaign was not likely to be needed as IC24 already employed them.

(5) AGREED that the Committee note the report.

167. NHS Winter Planning 2019/2020
(Item 10)

Ravi Baghirathan (Director of Operations, Kent and Medway STP), and Matthew Capper (Head of Seasonal Planning and Resilience, Kent and Medway STP) were in attendance for this item.

(1) NHS representatives explained by way of introduction that during their previous attendance at the Committee, they went through the learning from last winter. This learning was coupled with the relevant workstreams going forwards. Members were informed that the name had changed to system escalation planning in order to dovetail with five-year forward view plans and local transformation plans.

(2) In response to a question, NHS representatives confirmed that planned orthopaedic surgery would be separated out from unplanned in order to prevent operations being cancelled and more generally hotter and colder sites would be used. This was an evolving piece of work more generally as part of the East Kent reconfiguration work. The operational elements of specific areas like stroke and cancer services were being looked at. Work around resilience and exiting the EU fed into this.

(3) Members were also informed that the Council's public health team formed a part of winter planning with one area of work being around getting the flu vaccination to relevant Council workers.

(4) The issue of ensuring plans were implemented equitably across the county. Members were informed that work at the STP level ensured there was a helicopter view of services and processes were put in place to ensure this happened. There was a common framework and template for recording and escalating matters. Some services, like the ambulance service, ran through everything, whereas some were appropriately more local and specific. Some of this work was one step below the traditional role for NHS England/Improvement but the regional team had naturally evolved into this role. It was further explained that previously there were CCG level bids for funding for winter plans, but now there was a single STP one.

(5) AGREED that the report be noted and NHS England and NHS Improvement South East along with the Kent and Medway STP be requested to provide an update about the performance of the winter plans to the Committee at its June meeting.

168. Date of next programmed meeting – Tuesday 26 November 2019, 10am
(Item 14)