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 Wednesday, 29 January 2020.

PRESENT: Mr P Bartlett (Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Ms K Constantine, Mr D S Daley, Mrs L Game, Ms S Hamilton, Ms D Marsh, Mr K Pugh (Vice-Chairman), Mr I Thomas, Cllr M Rhodes, Mrs C Mackonochie and Mr J Wright

ALSO PRESENT: Mr S Inett and Ms L Gallimore

IN ATTENDANCE: Mr A Scott-Clark (Director of Public Health) and Mrs K Goldsmith (Research Officer - Overview and Scrutiny)

UNRESTRICTED ITEMS

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

(Item 2)

1) Mr Wright declared an interest as he was a Governor at Medway Hospital Trust.

2) Mr Chard declared an interest as a Director of Engaging Kent.

3) Mr Thomas declared an interest as a member of the Planning Committee at Canterbury City Council.

13. Minutes from the meeting held on 16 December 2019

(Item 3)

1) The Clerk pointed out that the attendees for each item had not been included in the minutes.

2) RESOLVED that the Committee agreed that the minutes from 16 December 2019 were correctly recorded, and subject to the inclusion of the attendees for each item, that they be signed by the Chair.

14. NHS North Kent CCGs - Urgent Care Review Programme - Dartford, Gravesham and Swanley CCG

(Item 4)

In attendance for this item: Ian Ayres (Managing Director), Gerrie Adler (Director of Strategic Transformation), Gail Arnold (Deputy Managing Director), Angela Basoah (Head of Communications and Engagement), Dr Nigel Sewell (Clinical Lead for Urgent Care) from NHS Dartford, Gravesham and Swanley CCG

1) The Chair thanked NHS colleagues for their update to the Bexley and Kent Urgent Care Review Joint Health Overview and Scrutiny Committee (JHOSC), which a number of HOSC members attended.

2) The Clerk informed the Committee of the recommendation of the JHOSC:

   RESOLVED that the Bexley and Kent Urgent Care Review Joint Health Overview and Scrutiny Committee support the decision of the Dartford, Gravesham and Swanley CCG Governing Body.

3) Members highlighted the problems around public transport and questioned whether the CCG had begun discussions with transport providers to improve provision. Ms Arnold confirmed that following the outcome of today's meeting those discussions would begin and would involve working with other local authorities.

4) Ms Arnold pointed out that many of the concerns raised during the public consultation around access and public transport related to if the UTC was on one site or another. The recommendation of a two-site model may have mitigated those concerns already.

5) The Chair thanked the guests for attending and wished them well for the implementation of the new model.

6) RESOLVED that the Committee endorse the recommendation of the Bexley and Kent JHOSC and support the decision of the Dartford, Gravesham and Swanley CCG Governing Body.

15. Wheelchair Services in Kent
(Item 5)

In attendance for this item: From East Kent CCGs: Ailsa Ogilvie (Director of Partnerships & Membership Engagement), Maria Reynolds (Head of Nursing, Quality and Safeguarding), Tamsin Flint (Commissioning Manager. From Millbrook Healthcare: Mike Teaney (Operations Manager), Lydia Rice (Regional Operations Manager), Clive Bassant (Service User)

1) The Chair welcomed the guests and invited them to introduce their report. Ms Ogilvie began by highlighting the improving performance of the Wheelchair service, as demonstrated by a reducing waiting list for assessment and equipment along with shortening average waiting.

2) Ms Ogilvie drew attention to two areas that were off trajectory and had remedial action plans in place: repairs within three days and children's cases closed within 18 weeks.

3) The CCG were working with Millbrook Healthcare to better understand the data behind the repairs target. They were considering separating out the Key Performance Indicators (KPIs) in order to show standard repairs as opposed to specialist repairs, because the latter was very challenging to achieve due to the specialist nature of the equipment needed.

4) Since their attendance at the previous HOSC meeting, the CCG had undertaken a thorough review of Millbrook Healthcare using the Care Quality Commission's (CQC's) rating system. The CCG had judged the quality of the provider to be "good".

5) Steve Inett spoke of the improvements from Healthwatch Kent's perspective. He explained that Healthwatch Kent attended quarterly liaison meetings with the CCG and Millbrook. They also attended the Service User Improvement Group, and Mike Teaney regularly attended the Kent Physical Disability Forum in order to gather feedback and respond to queries.

6) In light of the rising demand for the Wheelchair service, the Kent and Medway CCGs had agreed to increase the funding for the contract and the CCG were expecting Millbrook healthcare to deliver the service within that budget.

7) Members requested that the layout of the report be adapted the next time the CCG attended HOSC. They requested clearer data (using tables) which easily demonstrated which areas were more challenging and what action was being taken. They also asked if there was comparator data with other parts of the country. Finally, Members asked for qualitative data that demonstrated users' experiences.

8) Ms Ogilvie stated that there would always be a waiting list, but it was important for them to demonstrate what "business as usual" looked like and how performance compared to this.

9) The agenda (page 239) provided some examples of the circumstances which prevented Millbrook Healthcare progressing children's cases within the required timeframe. In cases where parents were not aware of their rights to time off work, or were unable to fill out the necessary paperwork, a Member questioned if more could be done to support them.

10) Members were concerned that apparent slow procurement chains when purchasing specialist replacement parts were contributing to waiting times. They were unclear why specialist parts were taking a number of days to be delivered once ordered. Mr Teaney expressed that the company did chase suppliers for orders.

11) Mr Teaney explained that Millbrook Healthcare did have 20,000 standard parts in stock in the UK for repairs. A weekly stock review was carried out, with items that were no longer frequently required removed to make room for more common parts.

12) A Member questioned why a wheelchair was not always provided when an eligible patient was discharged from hospital. It was explained that assessments were carried out once a patient had *recovered* from their intervention at hospital, as opposed to during rehabilitation.

13) Mr Teaney explained that when a wheelchair was no longer required by a user, Millbrook Healthcare would refurbish the chair if it was in a decent condition, as opposed to always purchasing new products.

14) Ms Flint explained that a Personal Wheelchair Budget was when a service user would be given an allowance equivalent to the cost of a chair that the NHS would fund based on clinical need, but then there would be a range of top-up features available, or the ability for the user to purchase privately.

15) HOSC welcomed the improving picture in the provision of the Wheelchair Service but wanted to ensure all areas continued to improve.

16) RESOLVED that the report be noted, and that Thanet CCG return to the Committee in 9 – 12 months' time. Should contract performance decline, the CCG should alert the Chair of HOSC as soon as possible, with a view to returning to the Committee with an update sooner.

16. Procurement of Kent and Medway Neurodevelopmental Health Service for Adults
(Item 6)

In attendance for this item: Adam Wickings (Deputy Managing Director, West Kent CCG), and Michelle Snook (Integrated Transformation Manager for Neurodevelopmental Conditions, for and on behalf of Kent CCGs, Strategic Commissioning, KCC)

1) The Chair welcomed the guests and asked them to provide some background to the procurement of the Kent and Medway Neurodevelopmental (ND) Health Service for Adults. The service would provide assessment and post-diagnostic support for people living with Autistic Spectrum Condition (ASC) and or Attention Deficit Hyperactivity Disorder (ADHD). The service would not be for those individuals with a co-morbidity such as a learning disability, as there was already a clear pathway in place for that service.

2) Mr Wickings explained that the service user pathway would remain the same, but that the commissioning of the service, which was currently fragmented across Kent and Medway, would be brought under one contract. Currently, CCGs in East Kent commissioned a service through South London and Maudsley NHS Trust (SLaM), whereas CCGs in West Kent and Medway used spot purchasing arrangements with two providers.

3) Steve Inett from Healthwatch Kent corroborated the inconsistency of service provision across Kent and Medway, along with a lack of knowledge around what support was available.

4) The benefits of a new overarching contract would be:

    a. Consistent quality of service across Kent and Medway;
    b. Equal access for all residents;
    c. Allows for better integrated working between health and social care;
    d. Improvement of the pathway for service users.

5) The contract would apply to those aged 18+, though those aged 17.5 would be considered if appropriate. A longer-term project considering an all-age pathway was underway.

6) It was hoped that the new contract would be formalised within 4 – 6 months. Due to the limited number of providers in the market, it would be very important to maintain current relationships whilst building any new partnerships.

7) In answer to a question about training for professionals, Ms Snook confirmed that the Government had announced late in 2019 the introduction of mandatory training in learning disability and autism for all health and social care staff, relevant to their role. Skills for Care had also developed a framework for relevant staff. Members felt it was important that the Kent Medical School played a role in training, which Mr Wickings supported once the university was fully established.

8) There was currently a waiting list for services. The guidelines were for a wait of three months from the point of referral. In some cases, individuals were waiting up to two years. Mr Wickings confirmed that the CCGs had invested additional money in order to clear any backlog, which they hoped to do within 6 – 12 months.

9) Ms Snook explained that a Single Point of Access (SPoA) would be the method by which professionals including GPs referred individuals to the service. It was intended for this to be easy to use and its design would be worked through with the provider(s).

10) The Chair thanked the guests for their update.

11) RESOLVED that

    a. the Committee does not deem the procurement of the Neurodevelopmental (ND) Health Service for Adults to be a substantial variation of service.

    b. Kent and Medway CCGs be invited to submit a report to the Committee at the appropriate time.

17. Strategic Commissioner Update
(Item 7)

In attendance for this item: Simon Perks, Director of System Transformation, K&M STP

1) The Chair welcomed Mr Perks to the meeting and invited him to update the Committee on the establishment of a single CCG across Kent and Medway from 1 April 2020.

2) Mr Perks explained that since the last update to HOSC, the 8 Kent and Medway CCGs had voted to establish a single entity. NHS England had authorised the move, subject to a number of conditions. Their final decision was expected soon.

3) He outlined some of the benefits a single CCG would bring:

- A consistent approach to decision making;
- A move away from the commissioner/ provider split with a fresh focus on collaboration;
- An opportunity to ensure consistency of contracts and service provision across the county, by way of a single entity having oversight of the whole county;
- The capability of commissioning services at scale;
- A real opportunity to realise integration across the NHS as well as social care.

4) Recruitment to posts was underway, with some roles already recruited to.

5) One Member voiced concern over the large size of the new CCG, along with an inherent disparity in funding across the county and the cost of recruiting to the new posts. She questioned what consultation would be held, and Mr Perks explained that formal consultation was not required for back-office reorganisation such as this, but they had been engaging stakeholders.

6) Steve Inett explained that Healthwatch Kent had produced a report entitled "Focus on Commissioning: A Healthwatch Kent report", which was appended to the agenda. The report drew on six years of HOSC documents and feedback to Healthwatch Kent in order to highlight key lessons learnt during the commissioning process, in the hope that the new single CCG would learn from these lessons.

7) Members questioned if the move to a single entity would reduce local choice. Mr Perks explained that the 4 Integrated Care Partnerships (ICP) and Primary Care Networks (PCN) would provide that local input. In addition, GPs sat on the CCG Board and they were drawn from across the county.

8) Going forward, the ICPs would be responsible for the health of the population in which they operate. That was currently the responsibility of the CCG.

9) Mr Perks referred to the CCG ratings shown in item 8 of the agenda and explained that the new CCG was not the sum of those eight bodies but an entirely new commissioning entity. Some of the reasons behind the poor ratings would be addressed by the establishment of a single CCG; for example, some CCGs were not currently large enough to absorb risk.

10) Mr Perks concluded by saying that the move to a single CCG was in response to a national agenda. Given the many challenges facing the NHS, doing nothing was not an option. Finance alone would not solve the issues, and there was a great need to learn from past experiences.

11) RESOLVED that the Committee note the report.

18. CCG Annual Assessment (Written Update)
(Item 8)

1) The Committee discussed the CCG annual ratings as part of its discussion under item 7.

2) RESOLVED that the report be noted, and the Kent CCGs be requested to provide an update to the Committee annually.

19. General Surgery reconfiguration at Maidstone and Tunbridge Wells NHS Trust
(Item 9)

In attendance for this item: Dr Amanjit Jhund (Director of Strategy, Planning and Partnerships, Maidstone and Tunbridge Wells NHS Trust), Dr Greg Lawton (Chief of Surgery, Maidstone and Tunbridge Wells NHS Trust), Adam Wickings (Deputy Managing Director) West Kent CCG

1) Mr Wickings began by clarifying that the reconfiguration was down to the sustainable delivery of the service, not a change in the provision of that service.

2) Dr Lawton explained that when the surgery department was configured in 2011, complex emergency inpatient surgery was allocated to Tunbridge Well Hospital (TWH) whilst complex elective gastrointestinal surgery went to Maidstone Hospital (MH). The emergency surgery saw around 6,000 patients a year compared to around 230 for elective surgery. Despite this, the team of 12 consultant surgeons was split nine to MH and just three to TWH.

3) The drawbacks of the current configuration were:

    a) The three consultant surgeons based at TWH were near burn-out;
    b) Patients at TWH were seen by numerous consultants, adding to their length of stay at the hospital and reducing their quality of care (as each consultant wanted to understand the background to the case);
    c) Difficulty in recruitment.

4) The proposed reconfiguration would see the complex elective surgery patients (the 230) treated at TWH, with all 12 consultants being based from that one site.

5) Dr Lawton pointed out that a proportion of the 230 patients were closer to the TWH site the MH, so the additional travel would only impact around half that number. Both sites in the Trust were increasing their car parking capacity which would benefit those families having to travel further.

6) The benefits of the reconfiguration included:

    a) A better service to patients who would have one dedicated consultant surgeon;
    b) Less time on the ward for patients, due to the efficiencies of just having one surgeon;
    c) Better teaching opportunities for junior doctors;
    d) Improved recruitment prospects;
    e) The possibility of developing the service in the future, in order to become a specialist provider.

7) A Member questioned if there were enough beds at TWH to deal with the elective patients. It was explained that the length of stay for the emergency patients was expected to reduce (because there would not be numerous consultants assigned to one case) and therefore beds would become available more quickly. The site had also expanded its Intensive Treatment Unit (ITU) for one additional dependency, as well as creating six enhanced level care beds in the ward for elective patients. Dr Jhund confirmed the changes would not be implemented until after the winter pressures had passed.

8) Mr Inett questioned the urgency behind the need for change, particularly from a non-clinical point of view. He was unclear what made this change different to those that had happened at other Trusts, where public consultation (or at least engagement) had taken place. His concern was that if this approach was increasingly taken for smaller changes, there be an erosion of opportunity for patients to be involved unless it was a consultation.

9) Dr Lawton explained that one need for the urgency was that the three surgeons based at TWH were almost burnt out due to the size of their workload. This was unsustainable and he went so far as to say if no action was taken there was a real risk that there would be no surgical service offered at the Trust in the future. This was in large part down to the difficulty in recruitment. He added that the Deanery was behind the move in recognition of the difficulty of training doctors across two sites. He felt the surgery should never have been configured in such a way back in 2011.

10) Whilst Mr Inett accepted the premise that staff should not be burnt out through workload, he questioned how this differed to similar pressures on staff in Stroke services or at the East Kent Hospitals University Foundation Trust, where consultations had been held. However, Mr Inett felt the risk around the Deanery added a different complexion to the situation and suggested that the best way to describe the change was that it was in fact needed to manage an imminent risk to patient safety.

11) Members questioned if transport links between the two hospital sites would remain. Dr Jhund confirmed that they would, and the Trust were also considering enhancements to the service.

12) The Chair, who had visited both sites with the Clerk the previous week, expressed the mixed view from nursing staff, but said that he felt the Trust had dealt with the reconfiguration in a professional manner.

13) RESOLVED that

    a) the Committee deemed that proposed changes to the configuration of general surgery services across the Maidstone and Tunbridge Wells NHS Trust sites were not a substantial variation of service.

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

20. Proposed changes at Moorfields Eye Hospital (written update)
(Item 10)

1) Members had no further comments or questions arising from the report included in the agenda.

2) RESOLVED that the Committee considered and noted the report.

21. Work Programme
(Item 11)

1) Members discussed the work programme as per the printed agenda.

2) Following the recent inquest into the death of a baby boy at East Kent Hospital University Foundation Trust, the Committee agreed that an item on the performance of maternity services at would be added to the 5 March agenda. The coverage of this report would depend on the outcome of a report by the Care Quality Commission and Healthcare Safety Investigations Branch to Parliament which was due in two weeks' time.

3) A Member requested a report on the delays in discharge of patients from hospitals across Kent. The Chair committed to looking into the best way of doing this, as it would involve contacting each Trust individually.

4) A Member welcomed the inclusion of the Frank Lloyd Unit on 5 March agenda.

5) RESOLVED that the work programme be noted.

22. Date of next programmed meeting – Thursday 5 March 2020 at 10am
(Item 12)

(a) **FIELD**
(b) **FIELD_TITLE**