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, 26 January 2022.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Mrs B Bruneau, Mr N J D Chard, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Mr D Watkins, Mr A R Hills, Mr S R Campkin, Cllr J Howes and Mr I S Chittenden

IN VIRTUAL ATTENDANCE: Ms K Constantine

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny), Mr M Dentten (Democratic Services Officer) and Dr J Jacobs (Local Medical Committee)

UNRESTRICTED ITEMS

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

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

46. Minutes from the meeting held on 11 November 2021
(Item 3)

RESOLVED that the minutes from the meeting held on 16 September 2021 were a correct record and they be signed by the Chair.

47. Phlebotomy Services at Deal Hospital
(Item 4)

Bill Millar (Primary Care Commissioning at Kent & Medway CCG) was present for this item.

1. The Chair welcomed Mr Millar and explained to the Committee that the closure of the phlebotomy unit at Deal Hospital had been brought to his attention by three local Members. Mr Millar provided an overview, explaining that the Kent Community Health NHS Foundation Trust (KCHFT) was no longer providing blood tests at either Victoria Hospital in Deal or Queen Victoria Memorial Hospital in Herne Bay. However, as phlebotomy services were part of the routine care provided within general practice it was established, in consultation with local practices, that the equivalent capacity could be delivered by current providers (i.e. GPs). He noted there had been positive public reaction.

2. The Chair invited local member Mr Trevor Bond to speak on the issue. Mr Bond spoke of a lack of public consultation and increased pressure on other primary care services. He noted the impact in particular on those who required frequent blood work and highlighted a public petition on the topic that had received in excess of 3,000 signatures.

3. Mr Millar was not aware of the petition but reaffirmed that it was the choice of general practice to offer blood services, they were not required to do so. A public consultation had not been carried out because equivalent provision remained in the surrounded area. He affirmed that the CCG would continue to monitor the situation and encouraged patients to talk to their GP with any concerns. He encouraged Members to relay any specific issues to the CCG.

4. Members were concerned about a lack of communication and engagement with residents leaving to confusion and speculation on social media. They were concerned similar issues could occur elsewhere in the county. Mr Millar took the comments on board and endeavoured to clarify the situation with the public.

5. Rachel Jones, Executive Director Strategy and Population Health at K&M CCG, reassured the Committee that the CCG had heard the concerns raised today and action could be taken to address those concerns. Whilst noting the service change under discussion did not meet the threshold for formal public consultation, she recognised a need for more engagement and responding to resident concerns.

6. A Member asked if Patient Participation Groups (PPGs) could be utilised to provide feedback and share information in their communities. Mr Millar confirmed he would be updating the Committee on PPGs at the next meeting under the “access to GP services in Kent” item.

7. The Chair thanked Mr Millar and Ms Jones for responding to the Committee’s concerns.

8. RESOLVED that the Committee note the report.

48. Covid-19 response and vaccination update
(Item 5)

Paula Wilkins, Chief Nurse and Executive lead of the vaccination programme, and Caroline Selkirk, Executive Director of Health Improvement, K&M CCG were in virtual attendance for this item.

1. Ms Wilkins introduced the agenda report and provided an updated on the number of vaccinations carried out in Kent and Medway, highlighting that 3.75m vaccines had been administered in total. She drew the Committee’s

attention to an error in the report at section 1.2 – the wait between infection and vaccination for under 18s was 12 weeks. She affirmed that, in line with Government policy, the 3 February was the latest date by which frontline NHS staff required a vaccine before risking their employment. Vaccination inequalities were being focussed on, with work being undertaken to reach those groups that were typically hard to reach, had accessibility issues or had low confidence in the vaccine programme. She was keen to hear if Members could support or recommend any groups that needed tailored engagement.

2. Ms Selkirk explained that over the months of December and January, hospitals had been busy with covid-19, winter pressures and elective care. The number in hospital in covid was falling and the Nightingale hub set up at William Harvey Hospital (for use if Omicron had led to a high increase in cases) had not been required. She recognised the continued pressure on elective waiting lists and confirmed these would be the focus as covid pressures continued to decrease.

3. A Member questioned the apparent alignment between lower vaccine uptake and deprivation. Ms Wilkins acknowledged deprived areas tended to have a lower uptake but explained that was just one of many factors. There were more ways to book a vaccine that just online, and the CCG had been carrying out door to door visits accompanied by a vaccination bus. Lessons were continually being learnt, such as methods that worked for the 1st and 2nd dose did not always work for the booster.

4. In response to a question about vaccinations in the gypsy, roma and traveller community, Ms Wilkins confirmed that a lot of work had been carried out in this area.

5. Looking ahead, Ms Wilkins confirmed a fourth dose for the clinically vulnerable was being rolled out, and the CCG didn’t expect to use the mass vaccination centres going forward. It was being considered how the covid and flu vaccination programmes could be joined together to become more sustainable.

6. Asked about the national “no jab no job” policy, Ms Wilkins explained that vaccine hesitancy was the main reason for staff not getting vaccinated. This often stemmed from cultural and background factors. The CCG would be able to provide a clearer picture on numbers after the 3 February 2022 deadline. Impact assessments were being carried out on a service by service basis. They were not anticipating having to close General Practice surgeries or the number of beds available but that would be covered by the risk assessment if necessary.

7. A Member questioned the recording of covid on individual death certificates, asking about comorbidity data along with requesting a breakdown of covid

case rates per hospital. Ms Wilkins explained that only the cause of death would be recorded on a death certificate, regardless of if the person had covid at the time. Ms Selkirk provided the web address https://coronavirus.data.gov.uk/ which contained hospital level data.

8. Answering a question about transfer of care from hospital to domiciliary care, Ms Selkirk agreed there were challenges due to the workforce shortage and short-term impact of covid isolation rules. The CCG worked with the hospitals to manage capacity and reduce the number of patients staying longer than necessary in acute care. Kent and Medway had not reached the NHS England South East target of discharging 30% of fit patients in acute hospitals by early January 2022 but neither had many others in the region.

9. Asked what support was in place for staff providing vaccines, Ms Wilkins explained that KCHFT had led the workforce during the early stages. They maintained a bank of staff which allowed for rotation. CCG and clinical staff had been released to work in that area also. Guidance had been shared with staff to assist with their response to “anti-vaxxers”, and the CCG had worked alongside NHS England and Borough Councils for extra security when needed.

10. Dr Jacobs from the Local Medical Committee spoke on GP pressures, explaining that the “no jab no job” policy would affect the 190 practices across Kent and Medway, he estimated around 2-3% of staff were affected but the granular detail was important. There needed to be clarity on what “frontline” meant, as many staff working in GP surgeries would come across patients during their day due to the nature of the job and layout of the buildings.

11. Members thanked the continued efforts of local NHS staff in delivering services and their work on the vaccination rollout.

12. RESOLVED that the Committee note the report.

49. Dental Services in Kent
(Item 6)

Mark Ridgeway, Senior Commissioning Manager (Dental), NHS England & NHS Improvement - South East, was in virtual attendance for this item.

1. The Chair welcomed Mr Ridgeway and asked him to introduce his report, with a focus on access to services during the pandemic. He also asked if there was any information about how the Government announcement of an additional £50m for the sector would help local services.

2. Mr Ridgeway explained that the £50m funding was for urgent appointments nationally but it was too early to say how that would have an impact locally. There was a backlog of need and workforce capacity was a concern.

3. He explained that health profiles of local areas were underway, and they would be shared with the committee once available. These would analyse service demand and would provide a breakdown by age.

4. Mr Ridgeway understood that around 48% of dental patients were NHS as opposed to private. He did not have data on the number of people who didn't access any dental services.

5. Asked about water fluoridation, Mr Ridgeway commented that this was not the responsibility of the NHS. The Chair advised the Member contact the Public Health team.

6. Asked how private and NHS dental treatment compared, Mr Ridgeway stated that NHS dentistry provided patients with the treatment they required. Where perceptions of quality differ, that may be down to private dentists spending more time with individual patients but that should not detract from the quality of the service.

7. In response to a question from a Member of the Committee, Mr Ridgeway acknowledged the difficulties faced by some Thanet residents in accessing an NHS dentist. He explained that some existing contracts had been increased during 2019 but the pandemic and associated lockdowns had closely followed meaning that the positive effects from that increase had not been realised yet.

8. One Member asked if a marketing strategy could be introduced that promoted the benefits of young people accessing NHS dentistry as opposed to cosmetic alternatives offered via social media. Mr Ridgeway said marketing was agreed by the national team but offered to investigate if this was a local issue that needed addressing.

9. The Chair thanked Mr Ridgeway for his time.

10. RESOLVED that the report be noted.

50. Hyper Acute Stroke Units - implementation update
(Item 7)

Rachel Jones, Executive Director Strategy and Population Health at K&M CCG and Ray Savage, Strategic Partnerships Manager (Kent & Medway, East Sussex) at South East Coast Ambulance Service NHS Foundation Trust) were present for this item. Claire Hall, Specialist Paramedic (Urgent and Emergency Care), Clinical

Pathways Lead, South East Coast Ambulance Service NHS Foundation Trust was in virtual attendance.

1. The Chair welcomed the speakers and asked Ms Jones to introduce the item. She provided a brief history, citing a CCG decision 3 years ago that was placed on hold pending the outcome of 2 Judicial Reviews and a referral to the Secretary of State. Those outcomes had been finalised and the proposal to create three HASUs in the County could be implemented.

2. During the three-year pause, stroke services had needed to be consolidated on three sites (Dartford, Maidstone and Canterbury). That arrangement had contributed to the rating of stroke services improving across Kent and Medway. She was clear that the three temporary sites were not HASUs, which would now begin to be implemented and were due to improve care even further.

3. Mr Savage gave an overview of ambulance response times. Stroke patients fell under category 2 calls, and nationally those response times during the pandemic had not been good, though SECAmb had performed relatively well. Response times were improving, and the Business Intelligence team analysed response times daily along with mapping future demand.

4. Ms Hall spoke about the innovation and change experienced within SECAmb. The introduction of telemedicine for example had resulted in around 50% of patients that would previously have been sent to a stroke unit be diverted to alternative provision. That change in patient flow had allowed stroke patients to be seen by a specialist quicker, thus reducing the “door to needle” time. Members were concerned that there could be misdiagnoses but Ms Hall provided reassurance that steps were in place to reduce the chance of this happening (for example governance meetings reviewing individual cases). Ms Jones confirmed that all stroke patients would go directly to a specialist unit and not through an A&E department. The long-term vision was for each HASU to be available 24 hours a day 7 days a week but this was not the case currently due to workforce constraints.

5. University College London (UCL) had carried out an in-depth 2-year evaluation into the use of telemedicine and the early data supported the view that no patient harm had occurred and that response times had improved.

6. A Member asked if telemedicine was replacing the need for a scan to confirm diagnosis. Ms Jones confirmed that was not the case – before telemedicine, the first contact with a specialist used to be once the patient arrived at hospital. Now, there was an early conversation between a doctor and a patient which allowed the doctor to eliminate stroke imitations. Scans would always be used for those suffering from a suspected stroke. Ms Hall explained that if a

paramedic could not make contact with a stroke doctor the patient would be taken to a stroke unit.

7. Ms Hall suggested a stroke doctor provide a briefing for Members to provide assurance about the telemedicine system. Where the FAST assessment (Face, Arms, Speech, Time) was inconclusive, guidance was being updated accordingly.

8. Concerned about costs for families in visiting stroke patients, Members asked what work was being done to support this group. Ms Jones acknowledged the concerns and explained that three travel advisory groups would be re-established across Kent and Medway. Residents would be listened to and strategies put in place to address concerns.

9. Ms Jones explained that there was an active Patient Participation Group (PPG) and liaison with Healthwatch. Whilst the focus had been on the implementation of the HASUs the overall aim was to improve stroke care.

10. A Member drew the Committee's attention to the performance metrics included in the agenda pack, in particular the improvement of Darent Valley Hospital from a D to a C rating, compared to Maidstone Hospital and East Kent Hospitals where the rating had improved to an A. Ms Jones answered that there was no definitive answer but factors included infrastructure constraints; Dartford seeing an increase in patients from London as hospitals in that region faced pressure; and workforce availability. In particular, Maidstone Hospital and Kent and Canterbury Hospital had benefited from a consolidation of staffing from other sites within those Trusts – Darent Valley was the only acute hospital under that provider. Ms Jones committed that within six months of HASUs being operational, each of the three units would be A rated (this would be evident after 9 months due to 3 month lag in data, so December 2023).

11. Asked why the Kent and Canterbury Hospital had been used as a stroke unit during the pandemic, Ms Jones explained that it was deemed the safest location for patients because it was being maintained as a covid-free site. It was not suitable as a long term solution because it did not have the necessary co-located services.

12. RESOLVED that the report be noted and the CCG be invited to return with an update at the appropriate time.

51. Children and Adolescent Mental Health Service (CAMHS) Tier 4 provision
(Item 8)

Alison Nuttall (Provider Collaborative Program Director) and Nina Marshall (Provider Collaborative Program Manager for Kent and Sussex CAMHS In-Patient and Eating Disorder) from the Sussex Partnership NHS Foundation Trust were in virtual attendance.

1. Ms Marshall provided an overview of the agenda report and confirmed there were no significant changes since publication. Sussex Partnership NHS Foundation Trust (SPFT) had been the lead provider of Tier 4 Children and Adolescent Mental Health Service (CAMHS) since 1 October 2021 though existed in shadow form before.

2. A clinical activity panel was in operation, allowing for multi-professional discussions to ensure clinical decisions were in the best interests of the patient.

3. Services were provided at three sites: Kent and Medway Adolescent Hospital in Staplehurst, Chalkhill, and Elysium Brighton and Hove (a specialist eating disorder service). Tier 4 services were inherently offered over a larger geography than other services due to their specialist nature, but Ms Nuttall said the aim was always to keep patients as close to home as was possible.

4. Asked how quickly rapid response could be remobilised, Ms Marshall confirmed it was at pace and would require one or two days.

5. In terms of the relationship between Tier 4 services and a young person's education setting, Ms Nuttall explained that general support would be provided through the local CAMHS service. SPFT would however liaise with a patient's school to ensure the education provided at the facility was consistent with their current learning. Case Managers were appointed to each young person so they could monitor progress and oversee discharge.

6. Ms Nuttall explained that the increased demand was anticipated to last for at least two years. This was subject to both national modelling (supported by local monitoring) and funding. The service offered in the community needed to improve but the expectation was that additional Tier 4 beds would come into use.

7. Members commended the 81% reduction in waiting times.

8. A Member confirmed that the Health Reform and Public Health Cabinet Committee would be receiving a paper about access to mental health services, and HOSC Members were welcome to attend.

9. RESOLVED that the report be noted.

52. Maternity Services at East Kent Hospitals University NHS Foundation Trust - written update
(Item 9)

1. The Chair explained that no representatives were present for the item, which was subject to an independent investigation.

2. A Member raised concerns about midwifery staffing levels at the Trust and the subsequent suspension of the home birth service. The Chair confirmed that the Trust would be invited to attend once the investigation had concluded. He asked that any questions in the meantime go through the clerk to the committee.

3. RESOLVED that the report be noted and East Kent Hospitals University NHS Foundation Trust (EKHUFT) be invited to return at an appropriate time.

53. East Kent Transformation Programme - written update
(Item 10)

1. The Committee were presented with the paper that had gone to the Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC) in December.

2. RESOLVED that the update be noted.

54. Work Programme
(Item 11)

1. The Chair informed the Committee that the upcoming meeting dates had changed to 5 May and 7 July. It was commented that 5 May was the date of local elections for some district councils in the region.

2. RESOLVED that the work plan be agreed.

55. Date of next programmed meeting – 2 March 2022
(Item 12)

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