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 Tuesday, 28 January 2025.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Sir Paul Carter, CBE, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Ms L Wright, Mr S R Campkin, Ms K Constantine, Cllr H Keen, Cllr S Jeffery, Cllr J Kite, MBE, Mr T Bond (Substitute for Ms L Parfitt) and Mrs P T Cole (Substitute for Mr P Cole)

ALSO PRESENT: Mr R Goatham (Healthwatch Kent) and Dr C Rickard (Local Medical Committee)

PRESENT VIRTUALLY: Mr R Streatfield MBE, Mr N Chard and Cllr K Moses

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny), Tracey Fletcher (Chief Executive, EKHUFT), Angela van der Lem (Chief Finance Officer, EKHUFT), Sarah Hayes (Chief Nursing and Midwifery Officer, EKHUFT), Dr Peter Maskell (Stroke Network Clinical Lead), Rachel Hewett (Acting Chief Strategy and Partnerships Officers, NHS Kent and Medway), Sukh Singh (Director of Primary and Community (Out of Hospital) Care, NHS Kent and Medway), Natalie Davies (Chief of Staff, NHS Kent and Medway), and Dr Ash Peshen (Deputy Chief Medical Officer, NHS Kent and Medway)

UNRESTRICTED ITEMS

205. Apologies and Substitutes
(Item 1)

Apologies were received from Ms Parfitt and Mr Cole with Mr Bond and Mrs Cole substituting respectively. Mr Streatfeild, Mr Chard and Cllr Moses sent their apologies but were in attendance virtually.

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

1. The Chair declared he was a representative of East Kent councils on the Integrated Care Partnership.
2. Cllr Keen declared that she was the Cabinet Member for Neighbourhoods at Thanet District Council.

3. Mr Bond declared he had been working with the Deal Blood Action Group [item 7] and would speak as the Local Member on that item.

207. Minutes of the meeting held on 17 December 2024
(Item 3)

RESOLVED that the minutes of the meeting held on 17 December 2024 were a correct record and that they be signed by the Chair.

208. East Kent Hospitals financial performance
(Item 4)

Tracey Fletcher, Chief Executive, Angela van der Lem, Chief Finance Officer, and Sarah Hayes, Chief Nursing and Midwifery Officer, from EKHUFT were in attendance for this item.

1. Ms van der Lem introduced the report and provided a brief overview, including:
    a. At the end of 2023-24, the Trust had a deficit of £117,4m. For 2024-25, the Trust were working towards a deficit of £85,8m which it was expecting to meet.
    b. The Chief Nurse had conducted a review of safer staffing during 2024. The review led to the recruitment of permanent staff thus reducing reliance on temporary workers which was expensive.
    c. The Trust's improvement plans for 2025/26 focussed on medical agency spending and length of stay in hospitals.
2. In response to comments and questions it was said:
    a. The Trust were reliant on a number of temporary medical staff due to challenges in recruiting to some specific specialties. Ms van der Lem explained improvements would not come from just recruiting permanent staff to those posts, but understanding how to deliver services in the most productive way possible. Positive steps had been made, such as the increase from 3 to 10 substantive Emergency Department consultants since the start of the year.
    b. The Trust tended to use bank staff as opposed to agency staff. Reasons cited for working for an agency instead of being directly employed included pay and flexibility. Quality of service could be impacted as agency staff only carried out a few shifts but needed to be trained in Trust specific practice.
    c. With recruiting nurses to substantive posts, the largest proportion of vacancies were held in the Emergency Department and Acute Admissions. 80% of positions recruited to over winter had been filled. In addition, 90% of student nurses had chosen East Kent as their new employer. The overall turnover and vacancy rate at the Trust was low.

d. Retention was important, and this was aided by the support package on offer.

e. Length of stay for patients was prolonged by the shortage of social care support. Whilst the Trust played a role in reducing this, collaborative work across partners was required (and already happening). The readmittance rate was tracked by the Trust and it was relatively low. Cases were looked at to consider if lessons could be learnt.

f. To assist in reducing length of stay, the Trust wanted to build a virtual hospital model, expanding from the current virtual wards in specific departments which had been successful. A Hospital at Home service was also in use.

g. The Chair requested statistics on the number of hate crimes committed against hospital staff and narrative on whether this was having impact on retention. Ms Hayes said work was underway in this area, though incidence were low. They offered to bring this information back.

h. The percentage of the Trust's deficit in relation to the total budget was around 9%. Acknowledging she was new in post, Ms van der Lem agreed she would be looking at comparative data as well as relevant research on coastal areas.

i. It was important to utilise more effectively Urgent Treatment Centres to reduce the demand in Emergency Departments. The Trust were looking at best practice models to inform improvements.

j. Any overspend in acute trusts would impact the Kent and Medway Integrated Care System though not directly the primary care budget.

k. The Trust had reduced their waiting lists, particularly for endoscopy. The national target was for patients to wait less than 6 weeks for a diagnostic test, but urgent referrals were targeted at 28 days.

l. The report noted 2,300 patients were waiting 65 weeks or over for their treatment (including operations) to be completed. Ms Fletcher update the Committee that the figure had reduced to around 160. Dr Rickard from the Local Medical Committee commented that this had an impact on primary care as patients often contacted their GP for an update. Ms Fletcher recognised the reliance of primary and secondary care on each other.

m. The constraints of the capital budget, reflected in the ageing estate and ongoing high maintenance costs, was discussed.

RESOLVED that the Committee considered and noted the report.

209. East Kent Hospitals University NHS Foundation Trust - Maternity Services
(Item 5)

Tracey Fletcher, Chief Executive, EKHUFT and Sarah Hayes, Chief Nursing and Midwifery Officer, EKHUFT were in attendance for this item.

1. The Committee moved straight to questions as there were no updates in relation to the report.
2. A Member commented that leadership and culture improvements seemed to focus on midwives, with little mention of Consultants and Obstetricians. The quad programme referred to in 8.4 of the report was a multi-disciplinary approach. Ms Hayes commented that midwives were more likely to be in full time leadership roles than obstetricians. Work was proactively being undertaken but there was more to be done.
3. Post natal care performance was similar across the country, and the Trust were focussed on delivering continuity of care. Work had been carried out on the estate and leaders were ensuring staff had enough time to provide support and advice to patients.
4. The Trust's Facebook page had been hugely popular, with 300-400 people attending the online events held about different topics.
5. The Trust had seen a decline in stillbirth rates but they recognised that each one was a tremendous loss.
6. In terms of reducing inequalities and working with deprived or ethnic communities, the Trust had named a consultant midwife as the lead on working with communities. This was monitored at Board level.
7. The Trust had an ageing cohort of midwives, but were working hard to attract newly qualified staff. Student midwives were back on site, though not from Canterbury Christ Church University but this was in the pipeline. Nursing apprenticeships were also available across the Trust.
8. Mr Goatham (Healthwatch) welcomed the positive engagement and listening events undertaken by the Trust, but questioned the apparent increase in neonatal deaths. Ms Hayes reflected that the Board had been looking at such cases in a detailed way, working with regional colleagues and the wider maternity system. There was a national trend of babies being born earlier and then passing away whilst in neonatal units. The Trust believed this to be the case but had commissioned a separate review and reassured the Committee they worked with each affected family.
9. A funding bid had been submitted to NHS England for a second obstetric unit at QEQM. Funding had been granted for producing a business case but further funding was not yet confirmed.

RESOLVED that the Committee considered and noted the report.

210. Implementation of Hyper Acute Stroke Services in East Kent *(Item 6)*

Dr Peter Maskell, Stroke Network Clinical Lead, Rachel Hewett, Acting Chief Strategy and Partnerships Officers, NHS Kent and Medway and Tracey Fletcher, Chief Executive, EKHUFT were in attendance for this item.

1. The Chair welcomed the guests and explained to the Committee that several questions had been submitted in advance for response. Ms Hewett confirmed a written response would be provided after the meeting but a verbal response was also provided at the meeting. This included:
    a. The clinical pathway for a suspected stroke patient would start with a video triage call with telemedicine colleagues to assess whether the patient needed conveyance to a HASU or Emergency Department (ED). The patient will be taken to the nearest site that can meet their needs.
    b. Dr Maskell was aware of other Trusts where Mechanical Thrombectomy (MT) and Thrombolysis were not co-located and the separation was not unique to East Kent. MT was commissioned by NHS England Specialised Commissioning and not something the officers could talk about at the meeting.
    c. Call to Needle statistics were not included in SSNAP audits. Dr Maskell explained that across Kent and Medway the “door to needle” and “door to scan” times were excellent. SECAmb held data about “call to hospital” times.
    d. Acknowledging the figures used when commissioning the HASU were 10 years old, Dr Maskell explained they were still the figures being used and were not expected to have significantly changed.
    e. Assistance with travel costs was available to patients with low incomes, but not their relatives and carers. Further information would be set out in the written response.
2. The Chair welcomed further questions from the Committee. Discussion included the following:
    a. The benefits of MT were evident, and eligible patients were currently being transferred to London. A nearer service had been championed by the Stroke Network and the service at Kent and Canterbury Hospital was expected to open at the end of April 2025.
    b. A Member noted that a recent update from SECAmb had shown an increase in ambulance category 2 response times, and they wondered what impact this would have on stroke patients. Dr Maskell explained that the SSNAP audit collected many process measures and when best practice was met patients had less long term disability. He noted that East Kent were high performers in many of the measures. Outcome mortality figures were reviewed by the East Kent “mortality surveillance group” and not monitored by the Stroke Network.

c. Until the HASU opened at William Harvey Hospital (WHH), nearby stroke patients were taken to the stroke unit at the Kent and Canterbury Hospital (K&CH). This unit was performing well. The WHH HASU was expected to open in April 2027. Ms Fletcher explained the national recommendation remained for HASUs to be co-located alongside an Emergency Department (ED) (which K&CH did not have).

d. The location of the HASU at WHH had changed from under the Critical Care Unit to a two storey modular new build located in front of the ED.

   Planning permission had been requested but not yet granted. It had not been confirmed what the original space would be used for.

RESOLVED that the Committee:

i) noted the report but had the following concerns:

   a. further delays to getting the HASU built in Ashford;

   b. the Mechanical Thrombectomy unit not being delivered alongside the HASU at William Harvey Hospital;

ii) invited an update at the appropriate time. If the full business case for the HASU at the William Harvey Hospital was not approved in May 2025 and the construction timeline to complete by April 2027 slipped, the Committee must receive an update as soon as possible. The update should include mortality and long term disability statistics for sufferers of stroke in East Kent

211. Phlebotomy services in Deal
(Item 7)

Sukh Singh, Director of Primary and Community (Out of Hospital) Care, NHS Kent and Medway and Natalie Davies, Chief of Staff, NHS Kent and Medway were in attendance for this meeting

1. Mr Trevor Bond (Local Member for Deal and Walmer), raised his concerns that three years had passed since the service withdrawal and no solution had been identified. He noted that no equality impact study had been carried out before the change, and he considered there had been a service reduction because GPs had also been providing blood tests previously. Patients needing to use public transport to access phlebotomy services at Buckland Hospital or QEQM often had to use three buses which was not practical. Also, booking through GP surgeries was difficult because of getting through on the phone and some had 4 week waits. He noted some surgeries had closed since the service withdrawal. For those requiring frequent blood tests, this was ineffective. He was concerned that despite going to tender twice, the ICB had failed to procure a replacement service.

2. Ms Davies responded that the decision to withdraw the service was not a commissioning decision, but because the provider handed back the contract as they were no longer in a position to provide the service. One of the reasons cited by KCHFT was that the service was needed for inpatient individuals, and staff were being pulled away for walk ins. The (then) CCG considered options and

decided to expand the provision from GP surgeries, meaning patients could access services from the 4 GP sites. This was intended to be more convenient for residents and saw an extra 400 blood tests carried out a month. The ICB recognised the service withdrawal was at pace and communication with the local population could have been better. Provision was equal to the best in Kent, but they accepted it was not perfect. However, they needed to balance the needs of the population across Kent and Medway and worked to ensure people received the service they *need*. The decision to bring back a service in Deal was not made on the basis of clinical need or addressing inequalities, but on the advocacy of residents. Two procurements had been carried out and no provider had yet been identified. An option was to reduce the GP service to make the market more attractive, but that could lead to the destabilisation of GP service provision. The ICB were now looking at a direct award. Mr Singh added that work had been carried out with Deal GP practices to make getting through on the phone easier for patients.

3. Members of the Committee had received an email from a resident containing several questions. The Chair requested that answers to the questions be provided when the ICB return with an update.
4. Members had a discussion which included:
    a. There was concern that some residents were relying on public transport which could be costly. The ICB agreed no one should have to access multiple public transport routes to access services.
    b. There was a lack of consistency across Kent as GPs in West Kent did not provide phlebotomy services.
5. The Chair wanted the ICB to return once a new provider had been identified. He also wanted to understand the phlebotomy offer across the county.

RESOLVED that the Committee considered and noted the report and invite the NHS back at the appropriate time.

212. Provision of GP services
(Item 8)

Sukh Singh, Director of Primary and Community (Out of Hospital) Care, NHS Kent and Medway and Dr Ash Peshen, Deputy Chief Medical Officer, NHS Kent and Medway were in attendance for this item.

Mr Meade declared that he would be asking a question in his capacity as a Borough councillor.

1. Following an introduction by Mr Singh, Dr Peshan gave a presentation about how the Modern General Practice Model enabled his practices (Northdown and Dashwood in Thanet) to develop, measure and accelerate the delivery of improvements. Measures included a digital hub/ front door and a dedicated GP service for local care home residents.

2. Mr Meade (Local Member for Gravesend East) asked about the application by the Highparks Medical Practice to close their surgery in Hermitage Road, Higham in order to save running costs. The rural population of around 4,000 would be significantly affected by their GP practice and he condemned the application. He asked who carried out the independent assessments cited in their decision to close, and how planning applications were taken into account (such as the proposal to build 800 new homes in Wainscott). In light of the reason to close the site, and the risk of more practices following suit, he felt the Committee needed to be better informed about the financial challenges GP practices were facing, such as a register of surgeries at risk of closure.
3. Mr Sukh responded that Highparks were running public engagement and no application to the ICB had yet been submitted. The ICB would make a decision based on the needs of the population, what mitigations were in place to respond to resident feedback, what provision was available locally as well as what growth was expected. Financial challenges were a national issue, with national discussion about the GMS contract that funds practices, and more locally the enhanced services contracts in place. The ICB's role was to mitigate against risk of any GP closures. Peer ambassadors were employed to share best practice between surgeries, as well as resilience offers for practices requiring additional support.
4. The Committee made comments and asked questions around rolling out the work Dr Peshan presented on; Local Plans and housing; the use of AI and the digital front door. Dr Peshan and Mr Singh responded:
    a. The digital hub (Anima) was an enhancement, not a solution. AI presented opportunities to create capacity in the system but the correct governance had to be in place.
    b. The Modern General Practice Model was a national model that had been adopted, but it had to be tailored to the local population. Thanet had many care homes and that is why they introduced the dedicated care home GPs. A single model would not suit all localities.
    c. To attract GPs to Thanet, Dr Peshan offered enhanced personal development such as visiting care homes and attending out of hospital visits.
    d. Practices needed the capacity and resource to consider and implement change – this is where the ICB could help. The ICB also had a role in improving recruitment, for example through the GP attraction package).
    e. Demand for services had increased over time but the GP workforce had stayed fairly static.
    f. A diversified workforce allowed patients to see the most appropriate clinician which was not always a GP.
5. The Committee asked what was being done to close the gap in the provision of Mental Health Practitioners (MHPs) from practices. Dr Peshan noted in Margate the MHPs worked for the Primary Care Network and covered all local practices.

They also wanted to understand more about the variation in GP access across Kent and Medway.

RESOLVED that the Committee considered and noted the report.

213. Work Programme
(Item 9)

RESOLVED that the Committee considered and agreed the work programme.

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