

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, 4 September 2015.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr H Birkby, Mrs P Brivio, Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr G Lymer, Cllr Mrs M Peters, Cllr J Howes, Cllr M Lyons, Mrs M E Crabtree (Substitute) (Substitute for Mr C R Pearman) and Mr D L Brazier (Substitute) (Substitute for Mr A J King, MBE)

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Mr A Scott-Clark (Director of Public Health)

UNRESTRICTED ITEMS

36. 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.

37. Minutes
(Item 3)

- (1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken:
- (a) Minute Number 28 - NHS Ashford CCG and NHS Canterbury and Coastal CCG: Community Networks. A joint briefing by all Kent CCGs was circulated to Members on the new statutory duties for CCGs regarding Education Health Care Plans on 27 August.
 - (b) Minute Number 30 – Kent and Medway Hyper Acute and Acute Stroke Services Review. In response to a specific question about stroke rehabilitation at HOSC on 17 July, it was explained that rehabilitation services were not part of the Stroke Review. However Kent CCGs provided appendices on stroke rehabilitation services as background information for item 4 on the Agenda.
 - (c) Minute Number 33 - Faversham MIU. At the end of the discussion at HOSC on 17 July, the Committee resolved that the Chairman write to NHS Canterbury & Coastal CCG to express the Committee's satisfaction with the outcome of Faversham MIU. The Chairman wrote to the CCG on 22 July.

- (d) Minute Number 35 – Date of next programmed meeting. The Kent and Medway Specialist Vascular Services Review had been deferred until the October meeting. The North Kent: Emergency and Urgent Care Review had been deferred until the November meeting.
- (2) RESOLVED that the Minutes of the meeting held on 4 September are correctly recorded and that they be signed by the Chairman.

38. Kent and Medway Hyper Acute and Acute Stroke Services Review

(Item 4)

Oena Windibank (Programme Director, Kent & Medway Stroke Review, NHS England) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

- (1) The Chairman welcomed the guests to the meeting. Mr Ayres began by outlining the scope of the review; he explained that the focus of the review was hyper acute services - the treatment that needed to be given within the first 72 hours of a patient having a stroke. He advised that once the hyper acute pathway had been established, each health system in Kent would then review their acute and rehabilitation pathway and present their proposals to the Committee. He stated that the CCGs considered the proposals to be a substantial variation of service and would require formal public consultation. He noted that the Medway HASC had determined the proposals to be substantial and if the Kent HOSC also considered the changes to be substantial, a joint HOSC would need to be established.
- (2) Ms Windibank explained that the review was being overseen by a Review Programme Board which included representatives from all Kent and Medway CCGs, NHS England, South East Cardiovascular Network and a Clinical Reference Group. She noted that a number of clinically led modelling groups had been developed to look at travel and access; patient profile and capacity; workforce and value for money. She stated that 10 public listening events had been held; additional events were being arranged in conjunction with the Stroke Association and Healthwatch Kent. Phase two of the engagement process would include stakeholder involvement with option development and appraisal. She stated initial consideration had indicated that one or two site configurations would not be viable. A range of potential configurations were being developed from three to seven sites. A public consultation was planned for early next year.
- (3) Members of the Committee then proceeded to ask a number of questions and make a number of comments. A Member enquired about financial planning and the impact on the public health budget. Mr Ayres explained that it was not a financially driven review; the aim was to ensure the delivery of clinically sustainable and high quality hyper acute stroke services. He noted that the consideration of cost came after quality, access and workforce. He stated that there was no additional money available to fund changes to hyper acute services and if an expensive configuration was chosen the money would have to come from another service. He confirmed that the review was only considering the NHS funded services; preventative services provided by KCC

were separate. Mr Scott-Clark explained that a cut to the public health budget would be set out in the Autumn Spending Review; it was not known if it would be a one-off or continuous reduction to the budget. Mr Scott-Clark stated that stop smoking services, NHS health checks and the promotion of physical exercise were key preventative services provided by Kent County Council. He noted that public health services would not meet the needs of the entire Kent population; its focus would be on a small cohort of the population who found it difficult to remain healthy particularly in areas of deprivation.

- (4) In response to a specific question about modelling demographic change, Ms Windibank explained that there were 35,000 patients registered with a GP in Kent who had had a stroke. In 2014/15 2559 patients in Kent & Medway were confirmed to have had a stroke. Mr Scott-Clark noted that the hyper acute services would be commissioned using an evidence base provided by Public Health; a number of demographic variables would be taken into account. Mr Ayres stated that any proposed configurations would also include capacity for people who presented with a suspected stroke, known as a stroke mimic.
- (5) RESOLVED that:
 - (a) the Committee deems the stroke proposals to be a substantial variation of service.
 - (b) a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

39. Emotional Wellbeing Strategy for Children, Young People and Young Adults
(Item 5)

Ian Ayres (Accountable Officer, NHS West Kent CCG), Dave Holman (Head of Mental Health Programme Area, NHS West Kent CCG) and Karen Sharp (Head of Public Health Commissioning, Kent County Council) were in attendance for this item.

- (1) The Chairman welcomed the guests to the meeting. Mr Ayres began by giving an overview of the new model of care; the model offered a single point of access for children, young people and their carers; stronger partnership working and improved transition into adult mental health services. He noted that there had been extensive public engagement in the development of the Emotional Wellbeing Strategy. He stated that his provisional view was that the model was not a substantial variation of service and did not require public consultation.
- (2) Ms Sharp noted that she had committed to returning to the Committee at its June meeting to provide answers to questions about emotional wellbeing in schools and early intervention. She explained that the new model would support schools to teach good emotional wellbeing and resilience. She stated that Kent was one of 12 local authorities to pilot Headstart, a resilience building programme. She explained that there were a high number of young people with emotional wellbeing issues such as bullying, anxiety and low level depression who needed an additional level of support but did not require CAMHS services. As part of the new model, all hubs would have a specialist

mental health practitioner to support young people who required an additional level of support at an early stage. She reported that early intervention prevented the emotional wellbeing issues from escalating and reduced demand on specialist services.

- (3) Mr Holman explained that there were some minor changes being made, to the model and draft specification, before the contract procurement began in early October. The new contract would begin in August 2016. He noted that the Children's Health & Wellbeing Board would act as the Contract Procurement Board using NHS and KCC's joint expertise during the procurement process.
- (4) Members enquired about the new service specification and requested sight of it before making a determination as to whether the new model of care and service specification constituted a substantial variation of service. Mr Ayres committed to returning to the October meeting with the specification.
- (5) A Member raised concerns about the new model placing an additional burden on schools. Ms Sharp explained that schools previously had to refer students externally for early intervention services; under the new model, early intervention services could be provided directly within the school, enabling children and young people to be seen more quickly. She noted that guidance on the best resources for promoting emotional wellbeing and resilience would be provided to schools. She reported that the promotion of emotional wellbeing, as part of new national guidance, had recently become an Ofsted inspection criteria. Mr Ayres noted that the majority of school were self-governing and schools did not have to follow the guidance on promoting emotional wellbeing and resilience.
- (6) A number of comments were made about the additional demand on services by unaccompanied asylum seekers and Children in Care; Big Lottery Funding; point of access in a crisis; and early intervention. Mr Holman explained that there was an overall service specification and an individual specification for Children in Care and children affected by Child Sexual Exploitation in order to meet the needs of the individual. Ms Sharp confirmed that Kent had been part of a successful national bid for Big Lottery Funding; the allocation for Kent had not been announced. The funding would be aligned to the Emotional Wellbeing Strategy and Model. Mr Holman highlighted the Kent & Medway Mental Health Crisis Care Concordat signed by 22 stakeholders to provide a multi-agency response for people including children and young people. Mr Ayres explained that greater access and early intervention reduced demand on specialist services and created whole life savings.
- (7) Mr Inett enquired if there would be an ongoing mechanism for children and young people to evaluate and feedback about services as part of the specification. Mr Ayres stated the importance of continuous engagement and evaluation with children and young people and the need for this to be made explicit within the specification.
- (8) RESOLVED that the report be noted and the new service specification be presented to the Committee on 9 October.

40. **West Kent CCG: Diabetes Care**

(Item 6)

Ian Ayres (Accountable Officer, NHS West Kent CCG), Dr Sanjay Singh (Chief GP Commissioner, NHS West Kent CCG) and Naz Chauhan (Commissioning Manager – Long Term Conditions, NHS West Kent CCG) were in attendance for this item.

- (1) The Chairman welcomed the guests to the meeting. Dr Singh began by outlining the case for change. He explained that diabetes services had been identified as an area to improve quality and increase capacity in order to cope with a rising demand and prevalence. He noted that the current pathway was fragmented between primary and secondary care; a new integrated pathway had been developed as part of the review to enable a larger proportion of care to be delivered in the community with increased access to multidisciplinary services such as podiatry and psychological support. A proposed model of care had been developed based on the outcome of patient and stakeholder engagement. Mr Ayres advised that NHS West Kent CCG was seeking the Committee's views and comments on the proposed model of care. Once a service specification had been developed, the CCG would return to the Committee to ask for a determination on whether it constituted a substantial variation of service.
- (2) A Member enquired about the community based spokes. Dr Singh explained that a spoke would cater for a cluster population of 30,000. The spoke would provide multidisciplinary clinics providing access to consultants, specialist practice nurses and dietetics which could move between surgeries in the cluster population.
- (3) A number of comments were made about referral, early intervention and workforce. Dr Singh explained that patients would continue to be referred to level two and three community based services by their GP. He explained that it was important to identify diabetes at an early stage to prevent patients developing complex needs and requiring secondary care interventions such as amputations. He stressed the important of caring for level three patients in a community setting in order to release capacity inside the acute hospital for the treatment of complex level 4 patients. Dr Singh reported that it was expensive to provide specialist diabetic services within an acute setting and there were workforce shortages in secondary care. He noted that the primary care workforce could be upskilled to provide specialist support in the community to reach a larger population at a more sustainable cost.
- (4) Mr Inett enquired about the figures provided by NHS West Kent CCG regarding the prevalence of diabetes; he noted a variation with the National Diabetes Audit. Dr Singh confirmed that the figures had been provided and verified by Public Health. Mr Inett also enquired about the promotion of self-management. Ms Chauhan acknowledged that more work needed to be done around self-help and intervention. Dr Singh noted that there was a focus on patient education as part of the review, the CCG was developing a Preventing and Obesity Strategy with Public Health and the CCG was part of a first wave national prevention pilot.

- (5) RESOLVED that the report be noted and NHS West Kent CCG be requested to present the service specification to the Committee at the appropriate time.

41. Healthwatch Kent: Strategic Priorities

(Item 7)

Steve Inett (Chief Executive, Healthwatch Kent) was in attendance for this item.

- (1) Mr Chard, in accordance with his Disclosable Pecuniary Interest as a Director of Engaging Kent, withdrew from the meeting for the duration of this item.
- (2) The Chairman welcomed Mr Inett to the Committee. Mr Inett began by thanking the Committee for the opportunity to present Healthwatch Kent's Annual Report and Strategy 2015/16. He explained that Healthwatch Kent was required to produce an Annual Report and had aligned it to their strategic priorities. He highlighted the free Information & Signposting Service which was a key mechanism which patients used to give feedback. In 2014/15 over 2000 people directly contacted Healthwatch Kent; this figure had increased from 1225 people published in the report as a result of the Big Red Bus Tour during the summer. Healthwatch Kent held four public meetings a year, visited a different council area each month and held public voice sessions. Healthwatch volunteers analysed feedback from the public to identify trends and issues to determine its priorities. A priority in 2014 was mental health services and its complaints process; due to a good relationship with the commissioner and provider, Healthwatch Kent was able to examine how learning from complaints was embedded. He explained that Healthwatch Kent could not deal with complaints but provided information about how to complain to the relevant organisation. Healthwatch Kent responded urgently to cases where people were potentially at risk or the quality of service was extremely poor by contacting the organisation directly.
- (3) Mr Inett noted that Healthwatch Kent had a remit to carry out Enter and View visits to adult health and social care services. Healthwatch Kent had found that patients at hospitals placed in special measures reported a good service. As a result Healthwatch Kent would be changing its approach and focusing on transition between different health and social care services. He stated that the first Enter and View visit using the new approach would be the Integrated Discharge Team at Darent Valley Hospital. Healthwatch Kent volunteers would speak to patients in hospital who were being discharged and would then contact them a couple of weeks later to see if their support plan had been put in place and delivered.
- (4) He reported that the strategic priorities for 2015/16 included the end of life care pathway, dentistry in Tunbridge Wells, social care services and the implementation of the Care Act, children and young people services and the integration of health and social care services. He noted that Healthwatch Kent was writing good practice guidance about public consultation and engagement on service changes; Healthwatch Kent was able to act as a critical friend and use their volunteers to review consultations.
- (5) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about Healthwatch Kent's

relationship with the Care Quality Commission, additional income and complaint referral. Mr Inett explained that Healthwatch Kent had a regular monthly meeting with the CQC. Healthwatch Kent provided information to CQC inspectors and attended Quality Summits to share the public view and support the organisation to improve. He noted that Healthwatch Kent was generating income through its engagement work. He reported that when Healthwatch was notified of a complaint it shared and referred the complaint to the relevant complaints department.

- (6) In response to a specific question about complaints regarding the provision of blood thinning drugs in a community setting, Mr Inett reported that this was not something Healthwatch had been contacted about. He reported that if Healthwatch Kent had a concern about a service, the provider had a duty to respond. He stated that relationships with commissioners and providers were key; he noted that Healthwatch Kent contacted the Trust directly for comment if an issue was raised in the local media
- (7) A Member noted that one of Healthwatch Kent's priorities in 2015/16 was to gather feedback from young people and families. The Member advised Mr Inett that Kent County Council's Corporate Parenting Panel had three representatives from the local Children in Care Council and each district had a youth council. Mr Inett thanked the Member for the information. He noted that Healthwatch Kent had recently commissioned a feedback session with children and young people in Thanet to gather their views on health and social care. He reported that no specific issues were raised but explained that they wanted their voices heard. He noted that this was a new area for Healthwatch Kent and its volunteers.
- (8) A number of comments were made about hard to reach groups, dentistry in Tunbridge Wells and the publication of Healthwatch Kent reports. Mr Inett reported that Healthwatch Kent would be using a more intelligence based approach to connect with hard to reach groups by utilising links with local voluntary organisations. He reported that dentistry in Tunbridge Wells was chosen as a priority following concerns raised at the West Kent Health and Wellbeing Board which was aligned to feedback received by Healthwatch Kent. With regards to the publication of reports, Mr Inett explained that volunteers compiled the reports which were then shared with the organisation for comment before the publication. He noted that the reports were published on their website and publicised in their monthly newsletter.
- (9) RESOLVED that the report be noted and Healthwatch Kent be requested to provide an update to the Committee annually.

42. Chemotherapy Services in East Kent (Written Briefing)

(Item 8)

- (1) The Committee received a report from East Kent Hospitals University NHS Foundation Trust which provided an update on chemotherapy services in East Kent.

- (2) RESOLVED that the report be noted and the Trust be requested to provide a verbal update on chemotherapy services when it returns to the Committee on 10 October with an update on its Clinical Strategy.