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, 7 July 2022.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr D Watkins, Ms K Constantine, Cllr J Howes, Cllr P Rolfe and Cllr K Maskell

PRESENT VIRTUALLY: Mr N Chard, Mr J Meade, Mr T Hills

ALSO PRESENT: Mr R Goatham and Dr C Rickard

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny)

UNRESTRICTED ITEMS

78. Membership

(Item 1)

1. The Committee noted the change in Borough and District Council membership. Cllr Marilyn Peters and Cllr David Burton had stepped down and Cllr Tanner from Tonbridge & Malling Borough Council had been appointed. There remained a vacancy from Tunbridge Wells District Council.

2. AGREED that the Council note the update.

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

(Item 3)

None received.

80. Minutes from the meeting held on 11 May 2022

(Item 4)

RESOLVED that the minutes from the meeting held on 11 May 2022 were a correct record and they be signed by the Chair.

81. South East Coast Ambulance Service - provider update

(Item 5)

In attendance for this item: Ray Savage, Strategic Partnerships Manager (Kent & Medway, East Sussex), Matt Webb, Associate Director of Strategic Partnerships and System Engagement, South East Coast Ambulance Service

1. Mr Savage highlighted salient points from the agenda report. He acknowledged the challenges being experienced with 999 and 111 calls, confirming that the Trust's performance was in line with, or better than, national performance. He accepted more needed to be done.

2. An area of concern, and therefore focus, was the call abandonment rate.

3. 111 was seeing success in the following areas:

    - The direct booking facility.
    - High clinical contact with low emergency department referrals.
    - Low transfer to ambulance rate.
    - Easing the burden on 999 service.

4. 999 performance was not performing as well. Demand for category 2 and 3 calls was high and there were problems with handover delays.

5. He expressed concern and disappointment at the recent CQC report, though also highlighted positive aspects, such as staff professionalism and compassion. The 111-service remained "Good".

6. The Trust CEO had recently resigned, and an interim officer was in post. A webinar around culture had also been offered to staff.

7. A Member sought data around ambulance waits for those with a suspected stroke who were waiting for a scan, as they knew the call to needle time was important. This fell under a category 2 call. Mr Webb confirmed the call to needle time was the point at which an ambulance received the call to the moment the patient received care in hospital. Ambulance Quality Indicators included measures on stroke patients, though Mr Webb only held data on the ambulance to hospital times, not what happened once that patient was in hospital care. He offered to look into this and report back to the Committee.

8. A Member asked about the state of the Trust's equipment. Mr Savage confirmed there were no supply chain issues and the Trust continued to maintain the fleet to a good standard.

9. Responding to a question about future population forecasts, Mr Savage explained the Trust worked closely with their lead commissioner, taking into account new housing developments and possible impacts on services, to ensure they were resourced accordingly. The Member was particularly concerned about demographic changes brought about since the pandemic, and their impact on the population modelling for the HASU project. The Clerk was to ask the point to be covered in October's HASU update.

10. A question was asked around the use of staff overtime and subsequent impact on wellbeing, as well as how recruitment was going generally. Mr Savage acknowledged the concern and accepted the use of overtime could be counter productive in some cases. He highlighted the improved wellbeing support offered to staff, as well as the expectation that the use of overtime was not "business as usual". The use of overtime was targeted to days when it was known there would be a shortfall in cover. The scheduling team worked closely with managers and staff to ensure staff were not being burnt out.

11. Mr Savage went on to explain there was an ongoing recruitment campaign. The Trust was recruiting new entrants at emergency care support worker level as well as offering development training to those already in post. There was a need to ensure sufficient funding was in place to fund the staff levels. Long term there was a need to work more collaboratively with partners to remove overlaps and ensure patients went to the right place first time.

12. Mr Webb said that sickness and accrued annual leave continued to effect resourcing on a daily basis. He also explained that retention was more of a challenge that recruitment, but the hope was the new Integrated Care System would allow for increased opportunities for job rotation across health. An improvement programme with recruitment as a key focus had been established. In addition, an association of ambulance trust chief executives was looking nationally at recruitment challenges and the best way of communicating this to government.

13. Speaking about the e-vehicles, Mr Webb confirmed they were not yet in use for frontline services in SECAmb. The Trust was looking at how best they could be utilised and how partners such as the police used them. A Member requested that district councils be involved in any discussions around charging points, as they were setting up charging locations across the county.

14. A Member asked if it was possible to pinpoint an area of particular challenge. Mr Savage explained significant work was underway with system partners, and SECAmb needed to be promoted as a key partner in delivering care. He noted that not all patients needed an acute setting, and around 50% of callers could be treated within community settings. The newly established Integrated Care Board (ICB) provided an opportunity for system working. 111 was seen to many as a single point of access and acted as a gatekeeper to wider health services. Their role was in triaging, referring appropriately and signposting as necessary, and their value was getting it right first time to avoid delays.

15. Mr Webb explained the importance of system flow. If the acute flow was not working, for example if there were delays with discharging patients, there were direct consequences for the whole system. Funding wise, demand was higher than expected but this was a national issue and it needed to be addressed as such. Since October 2021, there had been an uplift of calls by 15%.

16. There was a question around bidding for the Community Infrastructure Levy (CIL) and ensuring adequate money was supplied for new services. Mr Savage expressed the importance of truly understanding if the services on offer were being targeted in the right places and whether they were the right services. Where possible, it was important to identify patients before they got to the stage of needing an ambulance or acute care. It was anticipated that the Integrated Care Board would result in a more holistic and joined up approach.

17. Asked what work was underway to inspire younger generations into a career with the Trust, Mr Webb explained a number of methods, including:

    a. direct entry university programmes.
    b. Vocational options such as apprenticeships.
    c. Working with higher education colleges on paths of development, and engaging schools in the work they do.
    d. Concentrating on international recruitment for past 12 months.

18. Recognising the high demand for dental services, particularly during the pandemic, Mr Goatham from Healthwatch asked what the impact on 111 had been. Mr Savage said the Trust had employed dental nurses in response to dental services being closed during covid lockdowns. These nurses sat in the Clinical Assessment Service and were able to signpost to services as appropriate. He acknowledged there were not always enough appointments slots on offer and that the area needed more work.

19. A Member asked why it was not possible to provide patients with real time information on expected ambulance arrival time. Mr Webb explained that waiting lists were constantly updating, impacted by other calls which may be higher priority. Call handlers were able to track locations and link incidents together, recognising that some incidence may receive more than one call and a patient may phone from multiple phone numbers. Undertaking this work took capacity away from new, inbound calls.

20. The Chair thanked Mr Webb and Mr Savage for their time.

RESOLVED that the report be noted.

82. Podiatry Services
(Item 6)

In attendance for this item: Simon Pendleton (Head of Podiatry Services) and Dr Mark Johnstone (Director of Dental and Planned Services), Kent Community Health NHS Foundation Trust.

1. Dr Johnstone introduced the paper, setting out the plans in place to improve the delivery of podiatry surgery which was currently delivered from Foster Street, Maidstone. The proposal was to move the service to the Churchill Centre at Preston Hall, Aylesford as well as a site in Coxheath. Both sites offered better facilities with easier parking. Whilst the Churchill Centre was accessible by bus it would require a 10-minute walk from the bus stop. Staff had been engaged and were enthusiastic. He confirmed that patients would be able to choose which site they went to.

2. The Chair expressed his view that the change was not a substantial variation of service because there would be an improved service for patients, as well as increased patient choice, and staff had been engaged and were supportive of the proposals. He asked for a report on any further issued raised during ongoing engagement and mitigations that would be put in place.

   RESOLVED that
   (a) the relocation of podiatry services is not a substantial variation of service.
   (b) NHS representatives be invited to attend HOSC and present an update at an appropriate time.

83. Kent and Medway Integrated Care Board
(Item 7)

Mike Gilbert, Executive Director of Corporate Governance, NHS Kent and Medway (ICB), was in attendance for this item.

1. Mr Gilbert introduced the report and explained that the Integrated Care Board (ICB) had been in formal operation for 6 days, and the former CCG dissolved. A new Constitution was in place. He set out the fundamental differences between the ICB and CCG – namely that the ICB's membership, as a statutory board, involved individuals from a number of healthcare partners, including KCC. Decisions would be made by those professionals, with joint decisions being allowed, and work should undertaken in a more streamlined fashion than before. There was a focus on reducing inequalities. The ICB had taken on the commissioning of three additional services from NHS England (pharmacy, optometry and dentistry).

2. A Member questioned why service users were not represented on the Board. The Chair explained that was the role of elected councillors, to represent their communities. Mr Gilbert explained that Healthwatch were represented, and there would be a People and Communities Forum / Citizen's Panel which would feed into the ICB and Integrated Care Partnerships (ICPs). The Chair requested that the details of the Forum be circulated to HOSC members.

3. Building on the above, the member went on to ask how patient rights were enshrined. Mr Gilbert explained that it was a national requirement to

demonstrate user involvement, though raising issues with the Board was a permission as opposed to a right.

4. The ICB would have a Medical Director (unlike the CCG) and under that directorate there would be clinical professionals as well as those with a background in social prescribing.

5. Data sharing agreements were already in place, and Mr Gilbert confirmed the ICB did not hold patient data other than that belonging under the “continuing healthcare” umbrella.

6. In terms of GP relationships, the ICB was responsible for commissioning GP services though NHS England continued to manage the complaints process (that might be delegated in 2023). The Local Medical Committee (LMC) had established a GP Board and that was represented on the ICB. The GP Board would communicate on behalf of the 190 local GP surgeries.

   RESOLVED that
   a) The report be noted
   b) The ICB return in 6 months with a progress update.

84. Learning from the closure of Cygnet Hospital, Godden Green - written item
(Item 8)

1. The Chair explained that the item was a written update and there were no guests in attendance.

2. A Member had the following questions that required clarity:

   a. What areas were covered by the 186 CAMHS tier 4 beds in the South East region?
   b. Did the 186 include the removal of the 20 beds taken out of service at St Mary Cray?
   c. What was the breakdown of tier 4 beds by county and how many were vacant?
   d. Why were the additional 6 beds at Kent and Medway Adolescent Hospital (KMAH) still not available?
   e. Was it accurate that there was an eating disorders day clinic at Haywards Heath but it was almost impossible to get there by public transport?

3. The Chair requested that the clerk seek a written response to the above questions.

   RESOLVED that the report be noted.

85. Work Programme

(Item 9)

1. The Chair informed the Committee that a briefing would be held in September for HOSC members regarding the upcoming EKHUFT maternity report. An item would be on the 6 October 2022 agenda, and to ensure representation from the Trust the Chair had agreed the meeting would commence at 9.30am.

2. The Chair informed the Committee that Rachel Jones had commenced working for Maidstone and Tunbridge Wells NHS Trust and her former work with the CCG would be allocated appropriately.

3. A Member asked that “call to needle” times be included as part of the HASU update on 6 October. They felt it was vital that population information was available as decisions were currently based on historic estimates.

4. The Chair confirmed that a formal request had been submitted to the Scrutiny Committee to look at the health inequalities of the gypsy, roma and traveller communities. He felt HOSC should work with the ICB to look into adult suicide rates we well as increasing the take up of childhood immunisations.

   RESOLVED that the work programme be agreed.

86. Date of next programmed meeting – 6 October 2022

(Item 10)