**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, 10 May 2023.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Mr N J D Chard, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr J Meade, Mr A R Hills, Mr S R Campkin, Ms K Constantine and Mrs M McArthur

ALSO PRESENT VIRTUALLY: Mr R Goatham (Healthwatch)

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

**UNRESTRICTED ITEMS**

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

Mr Chard declared he was a Director of Engaging Kent.

The Chair declared he was a representative of East Kent authorities on the Integrated Care Partnership.

**117. Minutes from the meeting held on 28 March 2023**
*(Item 3)*

**118. Maidstone & Tunbridge Wells Trust - Clinical Strategy**
*(Item 4)*

*In attendance for this item: Rachel Jones (Executive Director Strategy, Planning and Partnerships, Maidstone and Tunbridge Wells NHS Trust)*

1. The Chair welcomed the guests and asked Ms. Jones for any updates since the publication of the report as well as an update on the implementation of the Hyper Acute Stroke Unit (HASU) in Tunbridge Wells. Key highlights were:

    a. Two Urgent Treatment Centres had opened.
    b. A&E performance ranked 4th or 5th in the UK, though there was still room for improvement.
    c. The Trust had established the beginnings of a Digestive Diseases Unit, one of the services being repatriated from London.
    d. Capital investment for cardiology improvements was proving hard to secure and impacting progress but the Trust continued to try and move it forward.

e. Phase 1 of HASU implementation was complete. A full business case for phase 2 would be presented to the ICB Board in June 2023. The rehabilitation pathway required additional work.
f. The improvements to Women's Services had been challenging, in part due to high vacancy rates.
g. The Trust had recruited 3 new Oncologists for Cancer Services. The Trust was working closely with East Kent Hospitals on the reprovision of radiotherapy – this would be a substantial business base and require significant capital investment.
h. The Trust was investigating acquiring a surgical robot in the area of Urology, along with recruiting surgeons with robotic experience. The use of robotics across departments would likely be commonplace in the future.
i. Separate to the clinical strategy, ophthalmology services were experiencing long waits. The Trust was working to develop community services in some parts to ensure equal provision across Northwest Kent and Medway.
j. An addition to the clinical strategy had been the opportunity to develop a Kent and Medway Orthopaedic Service to help support the long term reduction in waiting lists and manage long term demand. The service would be delivered alongside acute trust partners, and they had been successful in international recruitment. Subject to approval, the intention was to open the unit in March 2024.

2. A Member noted the continued pressure on A&E services and questioned how the patient pathway as well as the whole system could be improved to reduce such pressure. Ms. Jones felt lots of small changes could be put in place rather than one transformational change, such as:

a. Ensuring members of the public understood what support was available and where, whilst ensuring that provision was robust.
b. Pharmacists being able to prescribe some medication.
c. Streamlining patient pathways.
d. Managing the flow of patients into and out of hospitals.

3. Asked about repatriating services from London to Kent, Ms Jones explained there was a need to have a clear understanding of which services could, and could not, be provided from London. Some very specialist care would still need to be provided from London but where possible providers across Kent and Medway were looking for opportunities to bring care closer to residents. She offered to return with a paper on repatriating bariatric care.

4. In relation to stroke, a Member asked whether the SSNAP data was yet available. Ms. Jones offered to provide an update to the Committee outside of the meeting. HASU implementation was on the work programme for July and the clerk would request the presenters include the latest SSNAP data.

5. In response to a question, Ms Jones confirmed that social media was used within Children's Services to reach out to young people about their mental health, but that partner organisations with expertise were also used for engagement.

6. The Chair requested a site visit once the Elective Unit was completed along with phase 2 of the HASU. Ms. Jones would explore options with the clerk.

7. RESOLVED that:

   i) the committee note the update, and
   ii) invite the Trust back at an appropriate time.

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

*In attendance for this item: Tracey Fletcher (Chief Executive, East Kent Hospitals University NHS Foundation Trust) Rebecca Martin (Chief Medical Officer, East Kent Hospitals University NHS Foundation Trust) Catherine Pelley (Interim Chief Nursing and Midwifery Officer, East Kent Hospitals University NHS Foundation Trust) Carol Drummond (Interim Director of Midwifery East Kent Hospitals University NHS Foundation Trust)*

1. The Chair welcomed the Trust members and asked Ms. Fletcher to update the committee on any matters arising since the report was written. Key updates included:

   a. A culture and leadership programme had been launched at the Trust, developed by The King's Fund.
   b. The report from a recent CQC inspection was expected soon. The Trust anticipated this being critical.
   c. The Canterbury Christ Church University (CCCU) midwife training program at both William Harvey and QEQM had been withdrawn and would have a significant impact on the Trust and the students.

2. A Member asked if there was adequate capacity to continue the level of provision with the 'Your Voice is Heard' initiative. Ms. Drummond confirmed that 2 senior midwives had been appointed to undertake the community engagement, and the Trust were keen for them to go out into the community as part of that. A support role had been introduced to assist the midwives and ensure sustainability.

3. The bereavement pathway had been co-designed with those who had experienced loss. It offered a 7-day support service and had introduced a support officer to help navigate the bureaucratic processes.

4. Members discussed the quality of the physical environment in the two hospitals. Ms Pelley acknowledged that the midwifery units were far from ideal in a modern world, with small rooms and a lack of adjacent theatres. The resource constraints were hard to overcome without significant investment. Ms. Drummond confirmed that Entonox was now available again at William Harvey following a brief issue.

5. Ms. Pelley spoke of the withdrawn midwife program and explained that the Trust had reached out to the affected students. She confirmed they were working with the University to get accredited again with the Nursing and Midwifery Council (NMC). 32 trainees had been due to qualify that year. Out of 25 responses, 23 were looking to accept the Trust's employment offer, subject to qualifying (which would be delayed due to the withdrawal of accreditation).

6. The Chair asked for clarification as to why the NMC stripped CCCU the accreditation to their program. Ms. Pelley explained that one of the NMC's roles was to set the professional standards and it was in this area they had concerns as the University were unable to adequately demonstrate those standards were being met.

7. A Member asked why a dedicated foetal heartbeat midwife had been employed. Ms. Drummond explained that all midwives and doctors must know how to monitor a heartbeat, despite the increased use of electronics in this area. National recommendations were for all maternity units to have a dedicated midwife in place to oversee foetal heartbeat monitoring. The post would be responsible for keeping abreast of current guidance and training others.

8. Ms. Drummond expanded on the steps being taken to change the culture within the Trust. The King's Fund programme provided a framework and clear structure, but it was recognised the shift would likely take years.

9. Mr Goatham from Healthwatch requested examples of work that had been achieved because of the Your Voice is Heard program. The Chair requested they be included in a future report to the Committee.

10. The Chair offered the Committee's support for the Trust's bid for £60 million capital expenditure. The Trust were requested to share any helpful correspondence with the Chair via the clerk.

11. RESOLVED that:

    i. the committee note the update report and
    ii. invite the Trust back at an appropriate time.

## 120. Mental Health Transformation - Places of Safety
*(Item 6)*

*Present virtually for this item: Taps Mutakati (Director for System Collaboration, NHS Kent and Medway), Sara Warner (Engagement Lead, NHS Kent and Medway), Matt Tee (Executive Director, NHS Kent and Medway), Rachel Bulman (Project Manager, NHS Kent and Medway), Cheryl Lee (Service Manager, KMPT), Dr. Adam Kasparek (Consultant Psychiatrist and Deputy Clinical Director, KMPT), Louise Clack (Programme Director, KMPT), and Graham Blackman (Deputy Director for KMPT)*

1. Mr. Mutakati introduced the slide deck that had been included in the agenda papers. The guests ran through the slides, highlighting the following:

    i. There were currently three Health Based Places of Safety (HBPoS) locations across Kent and Medway, with 5 beds. Current journey times for patients could be up to 90 minutes, as they would be taken to whichever site had a space.
    ii. Doctors and Approved Mental Health Professionals (AMHPs) could be called from anywhere in the County which led to delays in assessment and treatment.
    iii. The proposal was to have 5 beds from one site in Maidstone. The site would be purpose built and there would be a dedicated team on site, which was anticipated to result in assessments within 4 hours (the expected standard).
    iv. Some patients would have an increased journey time but the improved service on offer was felt to outweigh that.
    v. Following feedback about a patient's return journey, a private ambulance service had been put in place.
    vi. Staff engagement had been mostly positive and there had been no concerns raised about travel.
    vii. The introduction of an 836-advice line for police officers, staffed by KMPT staff, was largely attributed to the reduction in numbers detained under the S136 Act.

2. A Member questioned whether the reduction in the use S136 was down to the 836 advice line, or the lockdowns used during COVID-19 pandemic when people were not allowed to leave their homes. Ms Bulman explained that numbers had continued to reduce over the last 12 months and that the 836 line had been pivotal in realising that. Mental Health training had been provided for police, and the advice line gave them access to clinical advice 24/7 as well as access to patient records.

3. The four-hour recommendation for completing Mental Health Act assessments commenced once an individual was accepted into a HBPoS.

4. Answering whether a single site could be a single point of failure, Ms Bulman said that risk had been recognised but that mitigations had been built into the design of the facility.

5. A Member requested that Key Performance Indicators be brought to the Committee once available.

6. A Member asked what consideration had been given to Thanet residents, some of whom would have longer travel journeys as a result of the changes. Dr. Kasparek's acknowledged the longer journeys but explained that the service would ultimately be much better with equitable provision for all. Ms. Clack added that there were plans to provide a 24/7 Safe Haven (a community crisis facility) at an East Kent hospital, with procurement underway.

7. Members wanted to understand more about residents who bordered neighbouring regions, and whether they could be sent to a HPBoS under a different Integrated Care System. Ms Clack replied that it would be unusual for residents to be transferred out of county but greater clarity around this would be provided at the next meeting.

8. RESOLVED that

    i. the committee note the report and
    ii. the ICB attend the next meeting to present the Draft Business case before it goes to the Board for approval.

**121. Urgent Care Review Programme - Swale**
*(Item 7)*

Item deferred to the next meeting.

**122. Delayed discharges from acute hospitals**
*(Item 8)*

*Present for this item: Mark Atkinson (Director NHS Kent and Medway, Operational Planning and Commissioning)*

1. The Chair notified the Committee that he had received a letter from Deal Town Council around their concerns with delayed discharge from hospital due to issues with wheelchair assessment and provision and physiotherapy availability for stroke patients . The Chair said he would respond to Deal following the meeting.

2. Mr. Atkinson ran through some key points from the report which included:

    (a) The Kent and Medway allocation of national funding to support delivery of timely discharges was £15 million, with NHS receiving 60% and the local authority 40%.The money arrived in two waves and was monitored through the Better Care Fund.

(b) Funding from wave 1 was allocated as follows:
    i. 25% in pathway 1 (Domicile care and homecare market),
    ii. 25% pathway 3 (care home provision),
    iii. 25% pathway 2 (intermediate community based services),
    iv. 25% on equipment and enablers.

(c) Funding from wave 2 was described as the “discharge fund”, and NHS England was invoiced for eligible spend. The ICB invoiced for £6.3 million out of an available £7 million. NHS England monitored the impact of the spend weekly, and whether long length of stays had reduced. Funding was spent as follows:
    i. 25% on pathway 1 (Domicile care and homecare market),
    ii. 61% on pathway 3 (care home provision),
    iii. 13% on enablers.

(d) The funding not only assisted reducing acute discharge delays, but other areas such as helping people stay in their own home and additional support to care homes.

(e) Kent and Medway performed comparatively well over the winter period though there was always room for improvement.

(f) The risk created by the additional funding was that it raised some providers expectations (in relation to how much they would be paid per bed) which was not a sustainable model. A sustainable model in future would involve promoting more care for people in their own homes and not in care homes.

(g) Other projects, such as Frontlands, were underway to improve the discharge system. Reviews and workshops were being held to assess the impact of all schemes.

3. A Member asked where Key Performance Indicators could be found for the discharge policy that would provide reassurance that the funding achieved it’s aims. Mr. Atkinson referred to two metrics:

    (a) the number of patients readmitted into hospital.
    (b) data captured within adult social care specifically the number of hand-backs – the ICS was looking to develop a dashboard.

4. The Committee considered how it interacted with the Adult Social Care Cabinet Committee. Recognising the committee’s remit to scrutinise only the NHS, the Chair offered to speak to the Chair of the Cabinet Committee about options for a joint session.

5. Answering what more could be done to ensure patients were always treated with dignity, and that they were supported to stay at home for as long as possible, Mr. Atkinson agreed patients should always be treated with dignity. Recognising that the care system were under enormous strain, capacity constraints had led to shortcomings in service provision. Mr. Atkinson explained that additional support

to care homes had been provided, along with seeking non-clinical support from the voluntary sector.

6. The sustainability of the homecare market was discussed, recognising workforce constraints as well as the high costs of using quality providers. Social care teams used to be embedded in acute discharge teams but that was no longer the case and this led to gaps.

7. Mr. Atkinson commented that he had seen improvements in the discharge pathway over the years but agreed more integration across the system was needed, including greater emphasis on the preventative agenda.

8. RESOLVED that the committee note the report.

**123. Work Programme**
*(Item 9)*

1) The Chair summarised matters arising from the meeting:

   a) a joint session with the Adult Social Care Cabinet Committee. Understanding health complexities would be helpful.
   b) Exploring the decision from the Nursing and Midwifery Council regarding the CCCU program closing.
   c) the request for SSNAP data to accompany the HASU item in July.

2) Regarding the item “School immunisation amongst the Gypsy, Roma and Traveller communities”, a Member requested that the update cover all immunisations and not just those for school age children. They were also keen the disparity in GRT community health would be brought back before the committee. The Chair spoke of a relevant item on the Kent and Medway Better Mental Health Network quarterly meeting the day prior and offered to circulate his notes to members of the committee.

3) A Member requested information on how the newly announced pharmacy powers would affect the patient pathway.