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, 17 July 2024.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Ms S Hamilton (Vice-Chairman), Mr J Meade, Mrs L Parfitt-Reid, Mr P Cole, Mr S R Campkin, Ms K Constantine, Mr R G Streatfeild, MBE, Cllr S Jeffery and Mr J Kite, MBE

ALSO PRESENT: Mr R Goatham (Healthwatch)

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

UNRESTRICTED ITEMS

172. Membership

(Item 1)

1. The Committee noted that there were two new Borough and District representatives – Cllr Stuart Jeffery (Maidstone BC) and Cllr Jeremy Kite (Dartford BC). Mr Cole returned to the Committee as a KCC representative.
2. The Chair thanked departing members Mrs Cole and Cllr Mochrie-Cox for their contributions over the past year.

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

(Item 3)

1. The Chair declared he was an East Kent district representative on the Integrated Care Partnership
2. Mr Jeffrey sat as an advisor on the ICB's Environmental and Sustainability Steering Group and would therefore not take part in item 8.
3. Mr Cole declared that he sat on the West Kent DGS and Tonbridge & Malling Integrated Care Board Partnership Forum, as well as the West Kent elected members forum and he also had responsibility for the Housing and Health portfolio at Sevenoaks District Council.

174. Minutes of the meeting held on 29 February 2024

(Item 4)

RESOLVED that the minutes of the meeting held on 29 February 2024 were a correct record and they be signed by the Chair.

175. Maidstone and Tunbridge Wells NHS Trust - mortuary security

(Item 5)

In attendance from Maidstone & Tunbridge Wells NHS Trust: Miles Scott (CEO) and Rachel Jones (Executive Director Strategy, Planning & Partnerships)

1. Mr Scott introduced the report, explaining that an action plan had been completed. A Statement of Assurance against each of the Trust's recommendations in the report had been signed off with NHS England. There was no confirmed date for the inquiry's second report. The dedicated compensation scheme for affected families was underway, with all eligible families having received a stage one payment.
2. Committee members received answers to a number of questions, including:
    a. The compensation scheme had no impact on the Trust's operational budget because it was paid for through NHS Resolution (an insurance scheme). There were over 200 individual claims.
    b. The Trust were responsible for implementing the actions across their sites. The ICB were following up broader actions with other Trusts.
    c. The mortuary and body storage services were provided by the Trust. For those bodies that needed retaining for longer, a contracted offsite facility was used. A licence and detailed SLA was in place.
    d. Forums such as HOSC were one way of re-building trust within the community. The Trust was also engaging elected representatives, and inspection reports were publicly available. For the affected families going through the compensation scheme, they were being provided support if they requested it, but some did not want to hear from the Trust.
3. RESOLVED that the Committee consider and note the response of the Trust to the interim inquiry report.

176. Maidstone and Tunbridge Wells NHS Trust - Clinical Strategy - update
(Item 6)

In attendance from Maidstone & Tunbridge Wells NHS Trust: Miles Scott (CEO) and Rachel Jones (Executive Director Strategy, Planning & Partnerships)

1. Ms Jones provided an update on progress since December 2023. This included:
    a. Bariatric services had been in operation for over 12 months, and the Trust were looking to repatriate the Digestive Diseases Unit (DDU).
    b. An outline business case had been approved for Cardiology.
    c. The HASU was fully open and retained it's A rating.
    d. Maternity Services were a focus point following the latest CQC inspection report.
    e. A full business case was going through the approvals process for the use of surgical robots.
    f. The Community Diagnostic Centre (CDC) had opened, with building works set to complete by the end of the year.
    g. The opening of the Elective Orthopaedic Centre had been delayed but was scheduled for September.

h. The Trust had acquired a third site, Fordcombe Hospital in Tunbridge Wells, at the end of March 2024.

2. Members wanted to understand more about the acquisition of Fordcombe Hospital. Formally a private hospital, the purchase provided additional capacity and had been supported by the ICB and NHS England. The facility would be used for patient bookings across Kent and Medway as well as East Sussex – EKHUFT were being supported with a treatment pathway for 2,500 patients. Mr Scott commented that whilst no additional operating theatres had been created, capacity had increased because occupancy was lower and there was more flexibility in use of the estate. Patients with the longest waiting times would be targeted and could choose any of the Trust's three sites. A Member noted the isolated nature of the new site, but Mr Scott provided assurance that transport would be offered where needed. The Chair requested a report in 12 months' time to review the success of the acquisition.
3. At the previous discussion, a question had been asked about new injectables and whether these would replace surgery in the future. A written response had been circulated but Ms Jones confirmed these were not being used because the treatment pathway had yet to be approved.
4. Asked about the vacancy rates in Women's Services, Ms Jones confirmed that these remained a challenge but staffing appointments had been made. The Trust had successfully reduced its overall staff vacancy rate to 5% following an 18 month focus.
5. The Trust was soon to enter into its next 2 year clinical strategy, and an area of focus was likely to be Emergency Department (ED) demand which was unprecedented. The Trust was working with Primary Care Networks around integrated neighbourhood teams.
6. The link between mental wellbeing and frailty was discussed, and the impact that had on the Trust's resources in terms of longer hospital stays and challenges around the best way of supporting patients.
7. Mr Goatham from Healthwatch complimented the presentation of the Strategy in the agenda report, noting its understandability for the public.
8. Demand in the Urgent Treatment Centre had increased from around 200 a day to over 300 a day over the last few years. The Trust directly employed GPs as well as using West Kent primary care. The Trust's ED department was performing well nationally.
9. Ms Jones confirmed that the purchase of a robot would not change the ICB's strategy for Urology. It was important for the Trust to make use of such equipment to ensure they attracted the best staff.
10. Establishing primary percutaneous coronary intervention (PPCI) provision at Maidstone Hospital was an aspiration but dependant on securing adequate funding. Ms Jones confirmed that would come through the ICB as opposed to NHSE (because it did not exceed the relevant threshold). She offered to share a paper with the Committee setting out the available funding routes.
11. RESOLVED that the Committee consider and note the report.

177. NHS Kent and Medway Community Services review and procurement
(Item 7)

In attendance from NHS Kent and Medway: Mark Atkinson, Director of System Commissioning & Operational Planning

1. Mr Atkinson provided an overview of the report which described the communications and engagement strategy. The events had been reasonably well attended, with stage 1 set to complete by 27 July. Stage 2 was around the design of care models, with bed modelling to be covered in a later stage.
2. The Chair spoke of his negative experience trying to attend a virtual listening event. Mr Atkinson explained online numbers were restricted because there were breakout groups used which required facilitators. The virtual events had been more popular than the physical events, though he recognised some people were unable to get booked onto an event.
3. The discussion covered the following points:
    a. Concern there was not adequate time to analyse feedback in advance of the September deadline.
    b. Workforce and staff turnover if and when providers changed.
    c. There would be a core service offer, with necessary variation applied to reflect the needs of the local community. The ICB would work with the Health & Care Partnerships to reduce health inequalities.
    d. The lifetime contract value was £1.6bn – 15% of NHS activity was delivered through community services. More detail would be provided at a future meeting.
4. Mr Goatham (Healthwatch) recognised the complexity of procuring and transforming services alongside each other. He sought assurance that the public had the relevant information to make informed contributions at the listening events, and also that there was sufficient time to allow for co-design of services. The scale of the work required significant engagement, including with those groups that would not usually engage. Mr Atkinson said the ICB were committed to delivering the timings set out, and that the listening events were just the start of the journey. He welcomed the feedback from Healthwatch.
5. RESOLVED that the Committee note the report and invite the ICB to provide an update at the appropriate time (including information about finance and staff retention).

178. NHS Kent and Medway's drive towards a greener future
(Item 8)

In attendance for this item: Mike Gilbert, Executive Director of Corporate Governance (NHS Kent and Medway), Alison Watson, Greener NHS Lead (NHS Kent and Medway), Daryl Devlia, Strategic Partnerships Manager - Kent & Medway, (SECAmb), Matt Webb, Associate Director, Strategy & Partnerships (SECAmb)

1. Mr Gilbert explained that severe weather was the area with the biggest impact on the ICB's communities risk register. A green plan was in place with the aim of reaching net zero by 2040. Three areas of focus were: large buildings being efficient; societal behaviours; and adapting for severe weather events.
2. Mr Devlia added that vehicles were SECAmb's biggest green priority, and the Trust were considering various options to improve their fleet:

    a. learning lessons from London ambulances that had gone electric.
    b. A 6 month pilot on band size.
    c. Non-ambulatory vehicles moving to hybrid.
    d. Change of operating model so it's not always an ambulance that gets sent to patients (as not all patients needed conveying to hospital).
3. Asked about the impact on resources, Ms Watson was the local NHS green lead, and had no direct budget. Each provider Trust had a sustainability lead. Mr Gilbert confirmed no consultants had been used.
4. The Committee were told about several green projects underway, including:
    a. Recycling equipment in the community (such as crutches) meant less new orders needed to be placed.
    b. MTW's clinical waste audit showed £1.5m could be saved on reducing expired medicine.
    c. For SECAmb, millions of gallons of diesel were used each year, where the cost of electric charging was much less.
    d. MTW were leading the way on diet and a move to plant based foods. For example, reducing food waste by using coloured plates. A wide menu choice for patients resulted in increased food waste. The Committee were keen to understand more about this area.
    e. The use of solar farms.
5. The difficulty of reaching net zero was challenging due to the age of the estate. The ICB did not intend to use carbon credits.
6. The NHS were working with partners including KCC to develop a strategy, and the green agenda couldn't be delivered by them alone. A local climate adaptation tool would be used as a framework to standardise the approach taken – the ICB would score the progress each Trust made. Mr Gilbert confirmed that nothing in the Strategy would compromise patient care.
7. Technology moved at such a fast pace, with hydrogen now competing with electric. It was important that partners kept pace with those changes.
8. RESOLVED that the Committee consider and note the report.

179. South East Coast Ambulance Service - provider update
(Item 9)

In attendance for this item: Daryl Devlia, Strategic Partnerships Manager - Kent & Medway, (SECAmb), Matt Webb, Associate Director, Strategy & Partnerships (SECAmb)

1. The Chair welcomed the guests and invited questions from Members.
2. Members requested a break down per area of category 2 and 3 call outs.
3. The Chair asked about the pilot hubs in East Kent and West Kent. Mr Webb spoke of SECAmb's improvement journey, with a Strategy to launch in the next few weeks. Sending an ambulance to see if a patient required an ambulance delayed care - clinical outcomes showed that only 13.25% of SECAmb's patients required a double crewed ambulance (i.e. two clinicians)

with emergency intervention. Under the current model, double crewed ambulances were sent to 90% of calls. The Trust had therefore been looking at new models of working, considering:

   a. Group A patients – high acuity. Want to ensure a standardised emergency response.
   b. Group B patients – lower acuity, but typically more complex. Want to ensure a personalised and tailored service, which may include a virtual response.

4. Under the new model, approximately 35% of the Trust's 999 activity would be responded to physically with a double crewed ambulance. For 55-60%, the initial response would be virtual (using lessons learnt from pilot hubs).
5. Mr Webb provided an overview of the West Kent ('post dispatch') and East Kent ('pre-dispatch', also called the Ashford Hub) models. Evidence showed that intervening in a patient's pathway as soon as possible (i.e 'pre-dispatch') significantly improved their clinical outcomes.
6. For those patients not requiring a double crewed ambulance for their care:
   a. 30% of activity was from 20% of the most deprived communities.
   b. 20% activity was from frequent callers/ those with co-morbidities.
7. Virtual response call handlers were to be located in the local area, so they understood local pathways and demographics. A physical response was still possible following a virtual assessment, but in a planned way which would allow SECAmb to better manage resources. Getting patients on the right pathway would also positively impact hospital discharge which in turn would reduce the number of ambulances waiting to transfer their patients into an acute setting (which had no beds available as patients awaited discharge).
8. Mr Webb recognised the vital contribution of volunteers, and the Trust wanted to ensure they maximised the benefit of this resource. He went on to explain the Trust was creating a Volunteer Strategy alongside other blue light providers – the Committee asked to see this once available.
9. A Member was concerned that the new model would mean some high acuity patients did not receive a physical ambulance response quickly enough. They were concerned the needs of all patients were being put before the needs of the individual patient. They questioned whether the Trust was prepared for the 15% demand growth forecast over the next five years, and asked for detail on why the existing service model was insufficient to address that challenge (particularly in terms of staff retention). Mr Devlia recognised the priority of getting high acuity patients treated quickly and the new model didn't change that response. A multi-disciplinary team reviewed calls to ensure ambulances were available to be sent to those patients requiring double conveyance, as opposed to ambulances being dispatched to all calls. Data showed the pilots were having a positive impact on response times in the county. Mr Webb reassured the Committee that the new model would benefit individual patients by ensuring they received the response that best suited their clinical needs. For example, there would be frailty expert practitioners. As for the case for change - to maintain the current model of care, the Trust would need to recruit an additional 600 whole time equivalent staff members just to respond to category 1 and 2 calls. Staff retention was impacted because of frustrations

within the system, such as sitting in an ambulance waiting to transfer a patient instead of treating more patients.

10. A Member asked about the response provided to frail patients and those that had fallen. Mr Webb said the strategy had been co-designed with others in the system. He said thought was needed over the role of an emergency ambulance service in responding to frailty patients, taking into account the whole health system. Urgent community response (UCR) teams were able to deliver care from within the home to avoid an acute admission where possible. Mr Devlia explained that frail and elderly patients were the largest cohort of callers, with a high concentration in East Kent. It was important to manage these patients in the safest and most appropriate way. East Kent was quite short of frailty patient pathways, but the pilot Hub had a dedicated team that contacted patients directly to support them. SECAmb would still support those that had fallen and required a physical assessment.
11. RESOLVED that the Committee consider and note the update.

180. Winter rehabilitation and reablement in East Kent
(Item 10)

In attendance for this item: Clare Thomas, Community Services Director (KCHFT)

1. The Chair welcomed questions from Members. A Member asked how the piloted model differed from standard and current practice. Ms Thomas explained the move would get the Trust closer to meeting the national guidance for pathway two rehabilitations. There was a greater focus on integrated rehabilitation, working with social care colleagues to see a reduced return rate to acute hospital settings.
2. A Member asked if the three month pilot was an adequate amount of time to evidence meaningful change. Ms Thomas responded that the pilot duration was long enough to see that a new model could be implemented, but not long enough to stop the Trust looking at other ways of making improvements. The pilot accepted winter pressure patients that may not have been accepted under the incumbent model.
3. Ms Thomas explained that there were 60 beds in West View Integrated Care Centre – 30 were managed by KCC for respite and enablement; 15 beds were used by KCHFT; and 15 were used for the pilot – they were now going to be used for Sevenoaks Hospital ward closure patients.
4. RESOLVED that:
    a. the Committee deems that the changes to Community Hospitals in east and west Kent are not a substantial variation of service.
    b. NHS representatives be invited to attend this Committee and present an update at an appropriate time.

181. Temporary changes at Sevenoaks Hospital (written item)
(Item 11)

In attendance for this item: Clare Thomas, Community Services Director (KCHFT)

1. Ms Thomas provided an overview of why the Trust had needed to temporarily move inpatient beds out of Sevenoaks Hospital, drawing upon questions submitted by the Committee in advance.
2. She explained that the Trust took over the building in April 2022 and subsequently worked with the fire service to understand any risks. The most recent annual fire drill took place in December 2023, but did not include a test evacuation of the ward. In January 2024, a fire service report suggested there was an issue with compartmentation, which impacted the ability of staff and patients to horizontally evacuate the building. Inpatient services were on the first floor of Sevenoaks Hospital, and the lift was not a fire lift which meant horizontal evacuation was relied upon. Following that report, the Trust investigated if a full evacuation down the stairs was possible – it showed this could not be done safely in a reasonable timeframe. The Trust was required to have a robust fire plan in place, therefore reviewed the available options and ultimately made the decision to decamp patients until the building was safe to use.
3. All patients had been decamped from the ward in the week beginning 17 June. The following week, 15 replacement beds were opened at West View Integrated Care Centre (12 were currently open).
4. A Member asked about staff wellbeing during this time. Staff had been aware a fire test was underway, but were not forewarned about the temporary move because the Trust were hoping to remain on site. They were taking individual staff circumstances seriously and considering their travel needs. Ms Thomas said the Trust recognised the flexibility and resilience of staff who had made real efforts to accommodate the move.
5. The Committee were concerned that the evacuation risk was not fully identified for two years. Ms Thomas said the property was taken over from NHS Proprty Services and they took assurances at that point. The compartmentation risks were not highlighted until the fire report issued in January 2024.
6. Kent Fire and Rescue Service (KFRS) were due to inspect the building again in October, by which time remedial work could have started. Major structural work was required, and that would come with a cost. Ms Thomas confirmed all options were being considered with no decision yet made.
7. RESOLVED that the Committee consider and note the report.

182. Gypsy, Roma and Traveller Communities School Aged Immunisations
(Item 12)

In attendance for this item: Samantha Bennett, Associate Director of Population Health and Prevention (KCHFT)

1. The Chair welcomed Ms Bennett to the meeting and asked for questions.
2. In response to a question, Ms Bennett confirmed funding for the project and ended but new contracts were being entered into in August. A significant part of the contract was about reducing health inequalities, which members of the GRT community suffered from.
3. Ms Bennett spoke of the challenge around accessing sites, and the Trust was working alongside those schools with the largest GRT intake (whilst

recognising attendance was also a challenge). She recognised there was a long way to go in terms of equity of access. Those travellers that did not settle were also hard to reach, and tended not to register with a GP.

4. RESOLVED that the Committee note the report.

183. Urgent Care Review Programme - Swale (written item)
(Item 13)

RESOLVED that the report be noted.

184. Orthotics and Neurological rehabilitation in Kent (written item)
(Item 14)

RESOLVED that the report be noted.

185. Work Programme
(Item 15)

1. In addition to the items requested during the meeting, Members wanted the new Mental Health Together service to be included in the next Mental Health Transformation update.
2. AGREED that the report be considered and agreed.