Medway Council

Meeting of Health and Adult Social Care Overview and Scrutiny Committee

Tuesday, 20 June 2017

6.30pm to 8.45pm

Record of the meeting

Subject to approval as an accurate record at the next meeting of this committee

Present: Councillors: Purdy (Chairman), Wildey (Vice-Chairman), Aldous, Bhutia, Fearn, Franklin, Howard, Steve Iles, Murray, Opara, Price and Shaw

Co-opted members without voting rights

Paddy Powell (Healthwatch Medway CIC Representative)

Substitutes Councillor Opara (substitute for Councillor Joy)
Councillor Price (substitute for Councillor Craven)

In Attendance: Kate Ako, Principal Lawyer - People
John Britt, Head of Adults 25+Partnership Commissioning and Better Care Fund
Peter Gates, Programme Manager Substance Misuse and Domestic Abuse
Aelish Geldenhuys, Head of Public Health Programmes
Stuart Jeffery, Chief Operating Officer, Medway CCG
Helen Martin, Director of Planned and Urgent Care, Medway Community Healthcare
Darren Mochrie, South East Coast Ambulance Service
Jon Pitt, Democratic Services Officer
Ray Savage, South East Coast Ambulance Service
Ian Sutherland, Director of Children and Adults Services
James Williams, Director of Public Health

72 Chairman's Announcement

The Committee held a minute's silence in memory of the victims of recent tragic events in the UK.

73 Apologies for absence

Apologies for absence were received from Councillor Mark Joy, with Councillor Gloria Opara attending as substitute, from Councillor Sam Craven with Councillor Adam Price substituting and from Councillor Dan McDonald with no

substitute attending. Apologies were also received from Christine Baker of the Medway Pensioner's Forum.

74 Record of meeting

The records of the Committee meeting held on 16 March 2017 and of the Joint Meeting of Committees held on 17 May 2017 were approved and signed by the Chairman as correct records.

75 Urgent matters by reason of special circumstances

There were none.

76 Declarations of interests and whipping

Disclosable pecuniary interests

There were none.

Other interests

There were none.

77 South East Coast Ambulance Service Update

Discussion

The Chief Executive of South East Coast Ambulance Service NHS Trust (SECAmb) introduced a presentation to update the Committee on the Trust's improvement journey. He was supported by the SECAmb Customer Account Manager for Kent.

The key points raised during the presentation were as follows:

- The Trust had a new Chairman and Chief Executive and was currently advertising for other executive director positions.
- Performance was fairly good in relation to the eight minute maximum target response for red 1 calls.
- The Care Quality Commission (CQC) had inspected SECAmb around a year previously, rating the Trust as inadequate. It had been placed in special measures as a result.
- A Recovery Plan was being implemented to address the concerns raised by the CQC. Areas being looked at included effective signposting to other services, strengthening of partnership working, reviewing ambulance responses and looking at call triage. The Plan was due to be delivered over five years with basic improvements being realised in year 1 and consolidation taking place in year 2.
- A further inspection had taken place from 15 to 18 May which had focused on whether services were safe, well led, effective and caring. It had looked at key parts of the organisation including 999 and 111

services and urgent care. Initial findings suggested that there had been significant improvement since the previous inspection. The CQC had identified that staff were caring and often went above and beyond what was expected of them.

- Areas that needed to be addressed included medicines management and making patient records electronic.
- Other quality areas being strengthened included use of software system Datix, risk management and safeguarding. SECAmb was delivering safeguarding level 3 training compared to other ambulance services who only provided this training to level 2.
- SECAmb had been experiencing difficulties with recording some 999 calls due to static on the line. This was being addressed with 99.6% of call recordings now being of an acceptable quality.
- The Trust had relocated its headquarters from Banstead to Crawley with the Lewis emergency operations centre also having moved to Crawley. The emergency operations centre in Banstead was also due to be relocated with the centre in Coxheath being retained.
- The Trust had a £7.1 million deficit. The deficit target for the current year was £1 million. A £15 million cost improvement programme was being delivered.
- There was currently a ratio of 50:50 of ambulances to medical cars in the emergency response fleet but it was considered that 70:30 ratio was required.
- Winter pressures were acknowledged to be challenge. SECAmb would be working in partnership to forecast demand for the next winter and to ensure sufficient capacity. It was noted there had been improvements over the last winter compared to previous winters.
- There had been some adverse media attention in relation to bullying and harassment of staff. An in-depth study had been commissioned with a report due to be published by the end of July. There had already been increased staff engagement with staff having taken part in focus groups.

Questions and points raised by the Committee were responded to as follows:

Mental health provision: A mental health nurse specialist had been appointed who would review services for patients with mental health needs. This would include considering whether increased specialist provision was required in operation centres. In response to a Member question, it was confirmed that there had not previously been a mental nurse health specialist post.

Partnership Working: Work was taking place with the police and other partners to ensure a seamless response to calls. Call handling processes were being reviewed to ensure good levels of service. Work was also taking place across the healthcare system in relation to home care packages.

Rollout of IPads: Comprehensive training would be provided for staff being provided IPads. Rollout was due to have taken place by 31 March but had been delayed to July. This delay had been partly to ensure the quality of training provided. The rollout of electronic record keeping would enable records to be shared more quickly and easily, including with general practitioners.

Financial challenges: In relation to the £15 million savings requirement for the Trust, robust plans were in place to enable achievement of this. Work would take place with commissioners to ensure that control totals were met. Quality Impact Assessments would be undertaken to ensure that quality was balanced with the need to make savings. In response to a Member question, it was confirmed that £15million amounted to 10% of the SECAmb budget.

Emergency ambulances and medical cars: It was considered that an increased ratio of ambulances compared to medical cars was needed as cars did not have the ability to transport patients to hospital. It was also acknowledged that not every call required an advanced support vehicle to attend. It was anticipated that the integration of 111 and 999 provision would enable calls to be triaged more effectively.

Staffing: In response to Member concerns that demand led rotas could lead to undue pressure being placed on staff, it was confirmed that close working was undertaken with frontline staff. Shift overruns had been reduced and an increasing number of staff were able to take a break during their shift. Directors had been encouraged to work with frontline staff to get their ideas for areas of improvement. Redundancy figures were not available at the meeting. It was requested that these be circulated to the Committee separately.

Bullying: A Committee Member raised concerns about the prevalence of staff bullying at SECAmb. It was acknowledged that this was an issue and that there needed to be a cultural shift with senior staff being given the right leadership skills. It was anticipated that the aforementioned in-depth study would help this work to be taken forward.

Winter Pressures: In relation to concerns that persons who had no medical need for an emergency ambulance were increasing pressure on the system, the SECAmb Chief Executive said that winter pressures were often related to alcohol consumption. Partnership working was exploring how this could be managed. A number of frequent caller leads were working with operational unit managers and call centres to look at how repeat calling could be managed. It was noted that there were some patients who had requested an ambulance on hundreds of occasions. The possibility of charging repeat callers was a national policy issue and was therefore not something that SECAmb could consider currently.

Decision

The Committee considered and commented on the update provided.

78 Update Report: Medway Intermediate Care and Reablement Service

Discussion

The Director of Children and Adults Services informed the Committee that the update provided was in relation to the importance of Home First and how it had

been embedded in intermediate care and reablement services. This was part of the broader strategy of increasing the range of options for care outside hospital on the basis that a person's own home was the best setting.

The Head of Adults' (25+) Partnership Commissioning and the Better Care Fund and the Director of Planned and Urgent Care at Medway Community Healthcare introduced the report. A report had previously been presented to the Committee in November 2016. This had provided feedback on the Home First pilot project that ran between April and October 2016. It had been agreed that a further report would be presented to the Committee once the first six months of operational data was available.

Depending on their needs, reablement of patients either took place in their own home or in an intermediated care bed. These beds were provided in two locations, Britannia Court and Platters Farm. There was a two hour target for patients to be assessed following notification being received that they were ready to be discharged from hospital.

The Committee was advised that some figures contained in the report were incorrect. The report stated that the Home First service had a capacity of 150 referrals per week with an average number of patients received of 96 per week. These figures should have been 150 and 96 per month.

Since commencement of the service, a total of 801 patients had received reablement at home while 203 received it in a community based bed. The average length of stay in a bed was 21 days. 73% of service users had improved their independence with 27% showing little improvement. 98% of patients had their service in place within 24 hours while 84% of patients referred to the service were discharged within six weeks. Where the service was not in place within 24 hours, this was due to patient choice.

It had been determined that more in depth assessment of some patients needed to be performed outside hospital. It was envisaged that this would take place in a discharge hub. Work was being undertaken with partners to determine how the discharge hub would operate and which patients it would help.

Every patient accessing the Home First service received a personalised plan. Patients who showed little improvement would be referred on for long term care via long term care teams. Patient surveys had been undertaken with 39 completed questionnaires representing a 92.1% response rate. 66.67% would recommend the service to others. 79% were more confident in undertaking personal tasks as a result of the service provided while 87% had achieved their personal goals.

Questions and points raised by the Committee were responded to as follows:

Benchmarking: In response to a Member who asked what the statistics in relation to users of the reablement service were being compared to, the Committee was advised that as the service was new there was no data to

enable direct comparisons to be made. The number of people requiring the service was driven by the number of hospital admissions. Data would be tracked to determine how hospital stays could be reduced and reablement flows improved.

Patient assessments: A Committee Member questioned how it could be evidenced that initial assessments were taking place within the two hour target. The Committee was informed that mobile devices were used to record assessment time and to log assessment staff visits to the patient's home. In some cases staff reached a patient home before the patient due to patient transport delays. An evening cut off time was in operation, whereby referrals would not be made after a certain time. During the discharge process, ongoing contact was maintained between the hospital ward, the Integrated Discharge Team and ambulance services. It was requested that future reports to the Committee provide figures for the number of service users being seen within the two hour target.

Patient outcomes: Full data was not immediately available to show how many patients required the service for a full six weeks, although it was known that there were currently 17 people that had been accessing the services for longer than this. Further data would be circulated to the Committee.

Contract monitoring: The contract with Medway Community Healthcare (MCH) for the reablement service was for five years. Regular contract monitoring was undertaken with MCH. The Key Performance Indicators (KPIs) used were outcome based, acknowledging that demand would fluctuate from day to day and week to week. KPIs included response time to a reablement request and handover time. The personals goals of patients were set in consultation with patients and families, with the aim being that a significant proportion of patients would achieve their personal goals.

Personal Care: A Member asked how it was ensured that patients newly discharged from hospital were helped to ensure that they had, for example, enough food in their home or help with laundry. The report presenters advised that as a person passed through the reablement process they would be assessed to determine what the new 'normal' would be for them. Long term plans were not normally made until this had been determined and the patient had reached this point. Other support services were utilised as appropriate, some of which would continue after the main reablement programme had concluded.

Patient Satisfaction: In response to a question that asked whether the 66% of patients surveyed who would recommend the service were broadly the same as the 73% of patients who showed improvement, it was confirmed that this was likely, but it was not possible to say for definite.

Intermediate bed provision: The Committee was informed that the difference between the two reablement facilities at Brittania Court and Platters Farm was that the former provided high dependency nursing while Platters Farm was a residential setting without 24 hour nursing.

Decision

The Committee noted the progress detailed in the report and requested that data in relation to patients accessing the service for longer than six weeks be circulated to the Committee.

79 Medway Integrated Urgent Care Redesign

Discussion

The Chief Operating Officer at Medway NHS Clinical Commissioning Group introduced an update on the Medway Integrated Urgent Care Redesign. The Committee was informed that consultation in relation to some of the changes being proposed as part of the redesign was due to take place in July. There were two main parts of the redesign, face-to-face services and non face-to-face services. The non face-to-face services were being re-procured through working with colleagues at the Swale and West Kent Clinical Commissioning Groups.

It was noted that £1million was being invested in primary care and that GP services were being built around hubs and healthy living centres. Minor illness clinics were being integrated into Healthy Living Centres to improve capacity. It was anticipated that this would reduce demand for walk in centres during the hours of operation of the clinics. Minor illness clinics would be based in each of six centres in Medway. It was planned for the existing walk in centre at Balmoral Gardens, Gillingham to be relocated to Medway Maritime Hospital. This would be a 24 hour facility compared to Balmoral Gardens that was currently open 12 hours a day. Locating services in a single place was considered to make navigation of patients between services easier and would also facilitate better quality of care.

The Committee raised a number of points and questions as follows:

Service demand and capacity: A Member noted that the walk in centre located in Canterbury Street had only been relocated to Balmoral Gardens ten months previously. They were concerned that waiting times for patients could increase and questioned how there could be confidence that demand for walk in centres would be reduced. The Chief Operating Officer said that demand was expected to reduce during the operating times of the Healthy Living Centres as some patients would visit these instead. The walk in centres were also targeted at people who were not registered with a GP. It was hoped that the new system would help to meet the GP Forward View priority of patients being able to obtain same day access to a GP appointment.

Consultation: The Healthwatch representative considered that the report presented was comprehensive and said that a meeting was due to take place between NHS Medway Clinical Commissioning Group and Healthwatch Medway to discuss how Healthwatch could assist with the consultation process. Another Committee Member was concerned that there was a danger of consultation ‘burnout’ due to the number of consultations taking place during

the summer. It was confirmed that list of consultation events would be provided to the Committee.

Availability of data and staffing: A Member of the Committee considered that the report was not comprehensive enough as it lacked quantitative data. She noted the current difficulty across Medway of obtaining a GP appointment, which could sometimes take up to six to eight weeks and questioned how it would be ensured that the services provided would be adequately staffed. The Committee was informed that minor illness clinics were being piloted in Rochester as it was recognised that there were particular difficulties with regards to GP appointment availability locally. The existing practices in Rochester were working together to rota staff for the clinics, which would lead to an overall increase in appointment availability.

Relationship between urgent and emergency care services: In response to a Member question it was confirmed that urgent care acted as the front door for everyone arriving at Accident and Emergency with patients being transferred to emergency care where required. Urgent care was provided where clinician intervention was needed but the patient's life was not in danger. Work was being undertaken with partners to support patients to, where appropriate, look after themselves. This included promotion of an app and working with the Council's Public Health function.

Consultation Questions and Risk: A Committee Member raised concerns that the proposed consultation questions could lead to a misleading response in support of centralising services. It was suggested that a question that asked whether people were prepared to travel 5,10 or 15 miles for particular services should be included. In relation to the list of identified risks, it was suggested that the risk in relation to people believing that the changes would lead to hospital closures should be more directly responded to under the mitigating actions heading to state that hospital closures were not being planned.

Patient Records: It was confirmed that patient records resulting from hospital accident and emergency visits were shared with the patient's GP.

Decision

The Committee noted and commented on the update provided on the Integrated Urgent Care Redesign, including the Communication and Engagement Plan and draft consultation document and agreed that an update should be presented to the Committee in October 2017.

80 Community Services Re-procurement Programme: Progress Report

Discussion

The Senior Programme Manager at Medway NHS Clinical Commissioning Group (CCG) introduced the Community Services Re-procurement Programme report. This provided an overview of the planned re-procurement of community health services, which was currently in its early stages. Services would be re-

procured as contracts expired to ensure that they aligned with the Medway Model. The work was considered to be critical for the successful future delivery of out of hospital care.

A Project Initiation Document had been submitted to the CCG Commissioning Committee and Governing Body in May. This included the scope and programme objectives. It was noted that Medway Community Healthcare was currently the main provider of services. A due diligence stock take review would be undertaken to baseline current services, create a clear picture of current service provision and to fully understand the financial situation. Following this exercise it would be determined which services should be re-procured.

The work was a large process which would be overseen by NHS England. Public consultation was due to take place in 2018, followed by tendering in October 2018, with a go live date for the new contracts of April 2020.

A Committee Member said that they would like to see a timeline for the contracts due to be recommissioned and for a financial appraisal of how the recommissioning would be undertaken to be provided. In response, the Senior Programme Manager advised that with a couple of exceptions, all the contracts that were potentially part of the recommissioning work were due to expire in March 2020. There was a need to fully understand current services before designing something new. In response to a Member question about staff contracts, it was confirmed that affected staff would be on differing contracts and that where services were recommissioned resulting in a provider change, TUPE rules would apply.

Decision

The Committee noted the Community Services Re-procurement programme and agreed that it would be determined at a future pre-agenda meeting when the next update should be provided to the Committee.

81 Re-commissioning of Medway Adult Substance Misuse Treatment Services

Discussion

The Director of Public Health introduced the update on the re-commissioning of Adult Substance Misuse Treatment Services. The Committee had previously been presented with a rationale for the recommissioning at its March 2017 meeting. The current report set out the proposed model for the new service. The aim was to move away from the current integrated treatment model as although service users could be treated effectively, there was a tendency for relapse following treatment. The re-commissioning would see the establishment of a separate recovery service which would provide support once people had completed their initial treatment. This could, for example, support people to find and maintain employment.

A Committee Member noted that the number of opiate users in Medway was high compared to other areas and asked whether the figures were improving. They also asked whether opiate users from other areas were being drawn to Medway. In response, the Head of Public Health Programmes advised that numbers of opiate clients had been quite stable in Medway and the needs audit had not uncovered any significant unmet need or new users moving into the area. It was anticipated that the creation of a dedicated recovery service would help to reduce the number of opiate clients in treatment over time as fewer clients should relapse.

A Member asked what work was being undertaken with housing services, particularly in relation to support for homeless persons. Officers advised that supporting street homeless persons was a priority within the new contract and work was taking place with supported housing providers.

The Programme Manager for Substance Misuse informed the Committee that the Blue Light project had been running in Medway for two years. This worked with people with a wide range of complex needs. A meeting was due to take place the week after the Committee meeting specifically in relation to support for street homeless persons. Housing services were an integral part of the project.

Decision

The Committee:

a) Noted the proposed model for Adult Substance Misuse Treatment Services.

b) Noted the emerging themes of service improvement.

c) Considered the proposed development or variation to the health service, as set out in the report and Appendix 2 and determined that the proposals did not amount to a substantial development of or variation in the provision of health services in the local authority's area.

82 Council Plan Performance Monitoring Report End of Year: Quarter 4: 2016/17

Discussion

The Director of Children and Adults Services introduced the report. This included information in relation to the progress of the Adult Social Care Strategy and the Three Conversations Model. The Three Conversations Model had been trialled in the ME4 and ME5 postcodes. It was being evaluated with a view to rolling it out across Medway. The Making Safeguarding Personal programme was now fully embedded into the work of Adult Social Care, with work having taken place over the last year to improve the safeguarding recording process.

In relation to adult safeguarding, the year end figures showed that 87% of individuals who were asked about their personal outcomes said that these outcomes had either been fully or partially achieved.

The target of 30% of clients receiving direct payments for their social care had not been met, with the end of year figure being 27.6%. Staff in the Financial Assessment teams had moved from the Council's Customer Care service to Adult Social Care. It was anticipated that these staff would be able to support more clients to consider receiving direct payments.

There had been a reduction in the number of permanent admissions to care homes for both the 18 to 64 and 65 plus age groups. This was positive as the aim was to enable people to stay in their own homes wherever possible.

Figures for Delayed Transfers of Care (DToC) had shown improvement with the end of year figure likely to be 3.3 per 100,000 of population, compared to a target of 4. Medway's figures for DToC were within the top quartile of local authorities in the South East and were average compared to Medway's statistical neighbours. On the Friday prior to the Committee meeting there had been 22 Delayed Transfers of Care with none of these being attributable to Adult Social Care, the first time this had been achieved.

A carer satisfaction survey was undertaken every two years. This showed that satisfaction levels had fallen 6% compared to two years previously and were 10% below target. Some of the data was provisional so there could be some improvement but this was not expected to be significant. It was possible that the fall in carer satisfaction could be due to carers feeling under more pressure and stress. The Committee was also informed that work was taking place with the Carer Partnership Board to refresh the Carer's Strategy.

A Committee Member agreed that the decrease in carer satisfaction could be attributable to carers feeling under pressure and questioned what could be done to address this and whether the opportunity of undertaking individual assessments of carers in relation to their needs was being fully exploited. Another Committee Member said that she was aware that some carers were disappointed that they had not received feedback after having been asked for their opinion.

The Director of Children and Adults Services advised that there was an improvement in the number of people accepting carer assessments and that the needs identified by these assessment tended to be either met or mostly met. Regular updates were provided to the Carer Partnership Board.

Decision

The Committee considered 2016/17 performance against the key measures of success used to monitor progress against the Council Plan 2016/17.

83 Work programme

Discussion

The Democratic Services Officer introduced the Work Programme report, which advised Members of the current work programme in light of the latest priorities, issues and circumstances.

The Committee was informed that the process for selecting topics for the next round of Task Groups was underway. Possible Task Group topics in relation to the remit of the Committee would be discussed at the next pre-agenda meeting on 3 August. It was requested that Members who wished to put forward topics send them to the Democratic Services Officer.

The Joint Kent and Medway Health Overview and Scrutiny Committee (JHOSC) meeting that had been expected to take place on 3 July had been delayed as an update on the Stroke Review would not be ready by this date. Assurance had been given at an STP Steering Group meeting that the Committee would receive a full briefing and be consulted on all NHS configuration proposals, including stroke services. Medway Members of the JHOSC were planning to send a letter to those responsible for the review. The letter would set out concerns in relation to the delay and would also seek assurances regarding the work going forward.

Possible July dates for a visit to the Turning Point Recovery Hub in Gillingham had been circulated to the Committee. Due to limited Member availability it was suggested that the visit should instead take place in the Autumn.

Decision

The Committee:

a) Agreed the work programme attached at Appendix 1, subject to the addition of an update on the Medway Integrated Urgent Care Redesign to the Work Programme for the October 2017 meeting.

b) Noted the changes to the Committee's work programme, as set out in paragraph 3 of the report.

c) Noted the process for selection of topics for the next round of Scrutiny Task Groups in 2018/19 and agreed that all Members of the Committee be invited to submit ideas based on the criteria set out in paragraph 4 of the report to the Democratic Services Officer ahead of the next agenda planning meeting for this Committee.

d) Agreed that a visit to the Turning Point Recovery Hub in Gillingham should take place in the Autumn.

Chairman

Date:

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