

Medway Council
**Meeting of Health and Adult Social Care Overview and
Scrutiny Committee**

Thursday, 14 March 2019

6.30pm to 10.35pm

Record of the meeting

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

Present: Councillors: Wildey (Chairman), Purdy (Vice-Chairman), Aldous, Bhutia, Fearn, McDonald, Murray, Opara and Price

Co-opted members without voting rights

Margaret Cane (Healthwatch Medway CIC Representative) and Shirley Griffiths (Medway Pensioners Forum)

Substitutes: None.

In Attendance: Glynis Alexander, Director of Communications, Medway NHS Foundation Trust
Dr Bob Bowes, Chairman of the Strategic Commissioner Steering Group
Scott Elliott, Interim Head of Adults' (25+) Partnership Commissioning and Better Care Fund
Matthew Inder, Business Process and Continuous Improvement Manager, Millbrook Healthcare
Stuart Jeffery, Deputy Managing Director and Chief Operating Officer, Medway CCG
Sameera Khan, Assistant Head of Legal Services
James Lowell, Director of Planning and Partnerships, Medway NHS Foundation Trust
Carrie McKenzie, Assistant Director - Transformation
Chris McKenzie, Assistant Director - Adult Social Care
Jacquie Mowbray-Gold, Chief Operating Officer, Kent and Medway NHS and Social Care Partnership Trust
Ailsa Ogilvie, Chief Nurse, East Kent CCGs
Simon Perks, Director of System Transformation, Kent and Medway STP, Clinical Commissioning Group Representative
Jon Pitt, Democratic Services Officer
Ian Sutherland, Director of People - Children and Adults Services
Nikki Teesdale, Deputy Chief Nurse, Medway Clinical Commissioning Group (CCG)
Sarah Vaux, Chief Nurse, East Kent CCGs
James Williams, Director of Public Health

887 Apologies for absence

Apologies for absence were received from Councillor Clarke.

888 Record of meeting

The record of the meeting held on 17 January 2019 was agreed and signed by the Chairman as a correct record.

889 Urgent matters by reason of special circumstances

There were none.

890 Disclosable Pecuniary Interests or Other Significant Interests and Whipping

Disclosable pecuniary interests

There were none.

Other significant interests (OSIs)

There were none.

Other interests

There were none.

891 Member Item - Kent and Medway Wheelchair Service

Discussion

Councillor Purdy introduced her Member item. She had requested inclusion of the item on the agenda due to the length of time that some people were having to wait for a wheelchair to be provided or for repairs to their wheelchair. The item would also provide Members with the same opportunity to consider the matter as the Kent Health Scrutiny Committee, which had previously considered reports on the Kent and Medway Wheelchair service.

Representatives from the East Kent CCGs and Millbrook Healthcare introduced the report. This showed steady and continuous improvement in performance of the service but it was recognised that there was still significant further work to be undertaken by the CCGs and Millbrook Healthcare in order to provide the required service. Service users were being closely involved in this improvement journey. A Service Improvement Board was being established that would include a service user representative. Three events to engage with service users were due to take place in April and May and the information collected at these would feed into a Service Improvement Plan. The waiting list for assessment and equipment provision had reduced from 3,369 in August 2018 to 2,386 in January 2019. These figures included new referrals of around 120

clients a month. There had been a waiting list reduction for the fifth consecutive month. The average waiting time for repairs had reduced from 5.6 weeks in November 2018 to 2.9 weeks in February 2019 while the number of patients waiting for repairs had fallen steadily until January 2019 when it had stood at 132. It had then increased slightly in February due to staff vacancies. This was being addressed by Millbrook.

Questions asked by Committee Members were responded to as follows:

Activity level included in contract – A Member asked why the contract with Millbrook Healthcare had not correctly forecast demand and why in-depth work had not been undertaken to ensure that demand was correctly forecast. The Committee was told that this had been caused by Millbrook having inherited a bigger waiting list than was known about during procurement. Many of the patients on the waiting list were amongst those with the most complex needs. The data available from the previous nine contracts covering Kent and Medway had not been detailed enough. The CCGs had commissioned an independent audit to review the procurement process with the CCGs now acting upon those recommendations. All the Kent and Medway CCGs had agreed to provide additional funding to enable Millbrook to address the waiting list.

Available data, Medway specific data, Complaints Review and training – A Committee Member asked why adequate data had not been available ahead of the tendering process and said that the need for additional funding demonstrated that the commissioning process had gone wrong. The Member would have liked to have seen Medway specific data included in report. He also asked when the Complaints Review would be completed. Concern was expressed that the review of eligibility had not been undertaken earlier and also that staff were only now undertaking Disability Equality Training. The Committee was advised that the Complaints Review would be completed by 15 May and it was agreed that data would be provided to the Committee after that. It had been important for extra funding to be provided to Millbrook in order to clear the waiting list backlog. Lessons had been learned from the procurement process. Procurement had been undertaken by one CCG with another CCG having subsequently taken on responsibility. This had presented challenges. The audit programme had made a number of suggestions regarding the procurement. Equality training was already in place at the CCGs and Millbrook but there had been a request from a service user for particular training to be commissioned.

Information Sharing – A Member highlighted the need for different departments within organisations to communicate better with each other. He highlighted an example where Millbrook had been contacted to say that a wheelchair was no longer needed following the death of its user. The wheelchair had been collected but Millbrook had subsequently made contact to arrange an annual maintenance visit.

Replacement Wheelchair – It was confirmed that, where appropriate, a loan wheelchair would be provided to a user in the event that their chair had to be taken away for repair. This was relatively rare as 99.7% of wheelchairs were repaired at the patient's home on the first visit. Those with complex needs also

tended to already have a backup wheelchair. New patients requiring wheelchairs would be assessed by an occupational therapist and prioritised according to their needs.

Staffing numbers and performance standards – A Committee Member asked how many people were employed by Millbrook to deliver the Kent and Medway Wheelchair service and what performance targets were associated with the service. They considered the length of the waiting list to be unacceptable, particularly in relation to children. It was also questioned what arrangements were being put in place to cover the work of a staff member on long term sick leave. The Committee was advised that the aim was to provide all children equipment within the specified 18 week timescale. It was expected that this would be achieved in the near future. In relation to adults, demand and capacity modelling was being undertaken in order to set a clear standard for the following year. The staff member on long term sick leave had now returned to work. Staffing figures would be provided to the Committee separately.

Engineer availability and training – Committee Members asked what work had taken place to increase the number of engineers working within the wheelchair service and whether any work had been undertaken to boost training opportunities locally. Nine technicians had been recruited to do collections and deliveries. This would reduce engineer workload. Work was undertaken with specialist engineers to support the repair process. Consideration was being given to development of an apprentice scheme. A training scheme would also be established to educate and certify engineers. The average number of repair requests a week was currently 108, with 101 being completed each week. Delays could be caused by the wait for spare parts to be provided and by patients being admitted to hospital.

Cause of waiting list – It was questioned what had caused a waiting list to develop and what was being done to ensure that a similar situation was avoided in the future. The Committee was advised that the audit report had confirmed that the waiting list had been significantly longer than had been known at the time of procurement and that patients on the waiting list tended to have the most complex needs. Work had been undertaken with Millbrook to ensure that detailed data was available. This was significantly more in-depth than the data that had been available under the previous provider contracts. Weekly improvement meetings now took place and there was good engagement with Millbrook staff.

Decision

The Committee:

- i) Noted and commented on the Member item and the report provided by Thanet NHS Clinical Commissioning Group.
- ii) Requested that further information be provided to the Committee in writing, including:

- a. The number of Millbrook Healthcare employees who were delivering the Kent and Medway Wheelchair service.
 - b. Data in relation to the Complaints Review due to be completed in May.
- iii) Requested that a further report be presented to the Committee at a future meeting.

892 Medway NHS Foundation Trust (MFT) Update

Discussion

A presentation was given to the Committee, the key points of which were as follows:

- The hospital's transformation programme was 'Better, Best, Brilliant.' Individual transformation projects were showcased, such as what staff were doing to improve the hospital, improvements to patient flows and discharge processes and work with community partners. An Outpatient transformation programme was due to take place over the next year.
- Ensuring financial stability was a key priority. The deficit for the previous year was £66million and the Trust would hit its control total of £46million for the current year. The £21 million savings target had been achieved, helped by reductions in expenditure on agency staff.
- In relation to Emergency Department performance, 82.8% of patients were seen within the target of four hours. This was 8% below the trajectory figure. There were challenges associated with patient outflows from the hospital which highlighted why integrated discharge was important.
- In relation to the 18 week standard for referral to treatment time, the figure was 80% for the current month, down slightly from 81% in the previous month. Work was taking place with commissioners to identify how to improve performance to 92%. The percentage for cancer patients in December was 83.6%, which was below target by 2.1%. Significant specialist work was being undertaken, including looking at constraints for each pathway.
- Performance for diagnostics was ahead of trajectory but below the constitutional standard. An additional MRI and CT scanner would be provided which would help to improve performance.
- The Trust had managed to fully comply with the limits of the NHS Agency Staff Cost Cap and was one of the only trusts in Kent and Medway to have achieved this.
- The response rate to the staff survey was 40%, which was below the national average of 44%. Three of the metrics had the same performance as previously while figures for six had declined. Responses indicated above average performance for appraisals and provision of a safe environment. Morale was a new national indicator with work taking place to understand what influenced this measure.
- The 'You are the Difference Programme' was ensuring that staff had the tools to deliver high quality care and create the right culture at Medway.

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A Committee Member said that the results of the staff survey were mixed. She asked how much awareness there was of the issues faced and how the Trust was addressing them. She highlighted national concerns about access to cancer care and treatment and asked how much confidence there was that Medway would be able to avoid some of the difficulties that other areas were experiencing, particularly in view of Medway having relatively low take-up rates of cancer screening. The Member also asked how the savings made had been achieved, for the Trust's view on the decision of the Kent and Medway Stroke Review not to establish a Hyper Acute Stroke Unit (HASU) in Medway and whether the Trust was ready to deliver a HASU should the decision be changed, in view of the Council's referral to the Secretary of State. In relation to the gender pay gap recently reported at the hospital, the Member asked whether the Trust was aware of the gap and what was being done to make senior appointments equitable.

The Director of Planning and Partnerships at the Trust said that consistency of approach was important. The 'You are the Difference' programme had been established to ensure this. The strategic objectives had been unchanged for three years, which provided further consistency. In relation to performance for cancer care, there was confidence that the hospital would, in the future, be able to achieve targets consistently.

MFT had achieved its cost improvement target for the first time and its budget control total for the first time in a significant time period. Quality Impact Assessments were undertaken on every cost improvement programme undertaken by the Trust. Plans were regularly shared with commissioners and regulators for scrutiny to take place. The Programme Management Office and Transformation team were central to the improvement programme and substantive recruitment had started to roles in these teams.

The Trust considered it had made a strong case to be selected as a HASU site and was disappointed that it had not been chosen. The current stroke service would need to be provided for at least another year and it would be important to maintain and support this. There was awareness of the gender pay gap. A contributory factor was that medic pay was based on the number of years the medic had been in post. The Trust was looking at how to ensure it was an attractive employer to senior female clinicians and there was an active programme of equality and diversity inclusion across the organisation. This was supported at Board level and the Trust was represented on a number of national groups relating to equality and diversity.

A Committee Member said it was pleasing that there was less reliance on agency staff, while another Member commented on the lack of detail in the report in relation to the staff survey. He asked what challenges had been identified by the survey. In relation to the gender pay gap, he noted that the Trust only had one female non-executive director. The Committee was advised that the results of the staff survey had been under embargo when the report was produced. Full details would be sent to the Committee when available. It was considered that the 'You are the Difference' campaign was helping to improve staff morale. Staff ambassadors were meeting with groups of staff and staff attending organised workshops were able to attend follow up sessions.

The programme was introduced to staff at induction. Staff briefings hosted by the Chief Executive now took place each month. These had previously only been held following identification of a particular concern.

A Committee Member asked if the savings made in the current year would help the Trust to make further savings next year. It was confirmed that this would help the financial situation next year and that 80% of the required savings had already been identified. Staff morale within the new Emergency Department was particularly good while the dedicated dementia garden in the Frailty Assessment Unit was also helping to boost morale.

Decision

The Committee noted and commented on the report and requested that staff survey data be provided to the Committee.

893 Variation in Provision of Health Service - Improving Outpatient Service in Medway and Swale in Line With the Medway Model and Community Service Redesign

Discussion

The Committee had previously considered reports on the Community Services redesign and information on the Medway Model. The report now under consideration outlined how proposals to improve outpatient services in Medway fitted into that model. There had been significant feedback showing that patients wanted care to be provided closer to their home than at present. The current outpatient model was condition led, with patients allocated a set number of appointments based on their condition. The aim of the proposals was to make services patient led and needs focused. Consultants would have direct access to GPs to help eliminate unnecessary referrals.

The CCG was working with partners, such as Medway Foundation Trust, the Council and Primary Care Networks to consider how consultants could spend time in community hubs, rather than in the hospital, so that consultant appointments could be provided in the hubs. Consultants and GPs would work in a multi-disciplinary team to enable patients to see the correct professional at the right time and in a non-hospital setting. Rheumatology, neurology, elderly care, clinical haematology and respiratory services would be included in the first phase of the proposed changes. Patient engagement would be used to inform the redesign of specific pathways. These redesigned pathways would benefit patients and free up consultant and clinician time. Appointments would be patient led with patients being able to request appointments to meet their needs rather than being allocated a fixed number of appointments in a period. Where appropriate, use would also be made of telecare services. Patients would be able to access crisis support quickly rather than having to first attend the Accident and Emergency Department.

Questions asked by Committee Members were responded to as follows:

Use of telecare and engagement – A Member expressed concern that not everyone was willing or able to use electronic services and asked what confidence those taking part in engagement could have that their views would be listened to in view of the outcome of the Kent and Medway Stroke Review. The Committee was assured that services would be matched to the needs of the population and that other options would be available for those unable to make use of technology. There was an aspiration to design services that fitted with the needs and wishes of the local population. No groups had yet been identified that would be disadvantaged by the proposals.

Outpatient Services – In response to a Member who asked for clarification of where patients would attend for outpatient appointments in the future and also, how it would be ensured that services were provided in a single visit, it was confirmed that most patients would be seen in community hubs. Discussions were taking place with the Foundation Trust about how to relocate rheumatology appointments and provide the necessary x-ray facilities in a community setting. Mobile units were being considered. The aspiration was for a range of services to be provided to patients on a single visit. It was noted that this was not always possible currently when patients attended hospital for outpatient appointments. Telehealth would be a significant part of the programme for patients who wanted to make use of this provision. This would, for example, enable a specialist to receive patient health data and make any necessary changes to medication without necessarily having to physically see the patient first. Face-to-face appointments would still be available when required. However, feedback from the Community Services Redesign suggested that patients tended to want less such appointments and be enabled to manage their condition in their own time to best meet their individual needs.

Delivery of arrangements and patient perspective – A Committee Member asked whether consultants would monitor outpatient appointments. He noted that other professionals, such as pharmacists and nurse practitioners, already had specialist skills that could potentially be utilised as part of the new arrangements. It was requested that patient feedback and perspectives be included in the next report presented to the Committee. In response, the Committee was informed that specialist pathways of the new model had not yet been developed. This would be undertaken with the close involvement of patients.

Timescales for Implementation – Outpatient appointments for rheumatology were due to move from a hospital to community setting but the service was not due to change otherwise. This was likely to be implemented in April 2019, which would be before the next opportunity for the Committee to consider the proposals further at its next meeting in June. Neurology outpatient provision would be transformed as well as outpatient appointments moving away from Medway Maritime Hospital. This was expected to start in June or July with the transition being phased.

Patient pathways, support for rheumatology move, GP provision and use of technology – A Member asked whether there was support for moving rheumatology outpatient appointments, questioned how patients would receive an initial referral and asked how the expected 6% reduction in outpatient

appointments would be achieved in view of the difficulty many people currently faced in getting GP appointments. She also asked whether the new arrangements would address concerns raised by patients attending appointments with multiple clinicians covering different specialisms. These patients had found that clinicians did not have records of what had been discussed at the other appointments or details of outcomes. Details of the proposed telecare offer was also requested. In response, the Committee was advised that the relocation of rheumatology outpatient provision had been initiated by hospital consultants. Initial referrals would continue to be via patient GP referral. Patient requested appointments would be for patients with an ongoing, long term need for appointments following initial referral.

The model being introduced would be similar to that used elsewhere in the country. GPs would be able to have direct communication with consultants during patient appointments. This Consult Connect service would reduce outpatient appointments as GPs and patients would be able to speak directly to consultants and would therefore be able to get immediate advice. Evidence from elsewhere showed a resultant reduction of more than 6% in outpatient appointments. Where a consultant was not available locally, a link could be made to a consultant elsewhere. The telecare services available would depend on patient need but one example was a telehealth monitor. This could collect data, such as patient weight, blood sugar and oxygen saturation and transmit it automatically to a specialist. The specialist would then be able to contact the patient if concerns were identified.

Further information and engagement – Committee Members said that there was not enough detail included in the report and that they could not yet be assured about the proposals. It was questioned whether there had been engagement with Medway Healthwatch. Healthwatch had been involved in the wider community services reprocurement but specific engagement with small groups was undertaken by Involving Medway, which was funded by Medway NHS CCG, rather than by Healthwatch. Community engagement would be undertaken in relation to new patient pathways and Healthwatch would be involved in this work. The CCG was working closely with Medway Foundation Trust and Medway Community Healthcare in developing the proposals. GPs and consultants had attended a joint workshop in 2018 with these groups being supportive of the proposals. The Committee would be provided progress updates as the proposals were developed.

Consideration of Substantial Variation – Committee Members considered whether the proposals relating to outpatient services could amount to a substantial variation in provision of the health service in Medway. It was asked what the implications would be if the Committee judged the proposals to be a substantial variation and whether full details of the plans could be provided to the Committee ahead of this decision being made. The Committee was advised that this could delay the work. Further information in relation to neurology could be provided in the near future but as the work was phased, there would be a significant delay in implementation if full details of all initiatives were to be provided to the Committee ahead of work commencing. Determination of whether the matter was a substantial variation at the Committee's June meeting would be after some of the changes had been made.

A Committee Member considered the proposals to be a substantial variation because there was an intention to reduce the number of outpatient appointments. She also felt that the Committee had not yet been provided enough information. Judging the proposals to be substantial would enable the Committee to consider full details of the plans and the Member did not consider that such a judgement would significantly disadvantage the process.

The Director of Public Health advised the Committee that the CCG needed to make changes to outpatient provision and that innovation and technology was a key part of NHS Long Term Plan.

Decision

The Committee:

- i) Considered and commented on the report and proposed development or variation to the health service, as set out in the report and Appendix 1.
- ii) In consideration of Medway NHS CCG's assessment of the proposal, determined that the proposal does represent a substantial development of, or variation to, the health service in Medway.
- iii) Requested that a further update be provided to the Committee and that the Consult and Connect team attend this meeting to demonstrate telecare provision.

894 Kent and Medway NHS and Social Care Partnership Trust (KMPT) Update

Discussion

The report provided details of strategic mental health work taking place across Kent and Medway in relation to the Sustainability and Transformation Plan, as well as local work being undertaken by KMPT services. Mental health had a high profile on the national agenda. Nationally, £2 billion of funding had been announced for mental health. It was not yet known how much of this Medway would receive.

Mental Health was a significant part of the NHS Long Term Plan. Priorities highlighted in the Plan included prevention, child mental health, access to talking therapies, mental health crisis response, pregnant women / new mothers and suicide prevention. In relation to suicide prevention, the rate in Medway had reduced by more than the national average. The Medway Early Intervention team was performing well and consideration was being given as to how it could link with acute partners in relation to crisis response access to mental health. KMPT had recently received the results of a Care Quality Commission (CQC) well led inspection. This has been very positive with ratings having improved in nine inspection areas and the overall rating having been good. The caring domain had been rated as outstanding.

The Ruby Ward at Medway Maritime Hospital, which deals with older female patients, had had its estate judged by the CQC to be not fit for purpose. This would be renovated as part of KMPT's Estate Plan. The plans to relocate mental health services from Canada House in Gillingham and Elizabeth House in Rainham, to a new facility at Britton Farm, Gillingham were progressing. Public consultation was being planned, with it being anticipated that a Consultation Plan would be ready to share later in spring 2019. A Councillor visit was due to be arranged in the summer to the KMPT hub in Ashford.

Work was being undertaken to consider how to provide mental health intervention at an earlier stage, especially in relation to primary care. KMPT aimed to work with NHS 111 to enable people to use it as a single access point rather than having to contact multiple organisations in order to get information or a referral. A good relationship had been established with the CCG mental health GP lead, who was helping with GP engagement plans. Staffing mental health services remained a national challenge with 30,000 mental health practitioners being required. It was expected that KMPT would be able to meet its financial targets while maintaining high quality services.

Questions asked by Committee Members were responded to as follows:

Support when a crisis recurs – A Committee Member expressed concern that there was a lack of support available for patients when a mental health crisis recurred. Intensive therapy and monitoring would come to an end and it was then challenging for people to regain access to services. Recognition and awareness of mental health difficulties amongst GPs also tended to be low. In response, the Chief Operating Officer of KMPT said that access to mental health care when in crisis was included in the NHS Long Term Plan. She agreed that there was a general lack of understanding about what patients required when in mental health crisis and said that the demand for assessment had outstripped capacity. Engagement with the CCG GP Mental Health lead could help to raise awareness amongst GPs and to consider how approaches could change.

Personality Disorder Pilot – There had been a national focus on people diagnosed with personality disorder with good work having taken place in the last couple of years. The KMPT pilot had provided up to eight 1 to 1 sessions for people with Personality Disorder. This included helping them to identify triggers and coping strategies. The pilot had recently finished. It would be evaluated with a view to rolling the service out across Kent and Medway.

Section 136 Provision and Street Triage – A Member noted that there continued to be no Section 136 suite in Medway. He felt that Street Triage was embedded and working quite well but was concerned what would happen at times when it was not operational. The Chief Operating Officer said that Section 136 provision was available at five sites in Kent and Medway. It would be challenging to provide provision at additional sites with there being no plans to provide a site in Medway. Street Triage currently operated on four evenings each week but discussions were ongoing with police and commissioners about extending the service.

Dual Diagnosis – The report had not mentioned this, particularly in relation to substance misuse and support in relation to mental health issues was currently poor. The Committee was advised that KMPT was engaging with Medway Public Health to work on dual diagnosis with the KMPT Deputy Chief Operating Officer leading on this work. There was a need to bring existing services together to better serve patients.

Decision

The Committee:

- i) Noted and commented on the report.
- ii) Agreed that a service user of the Mental Health Community Outreach team be invited to address a future meeting of the Committee.

895 Kent and Medway Transformation - Update on Integrated Care Systems and Kent and Medway System Commissioner

Discussion

The development of a Medway System Commissioner was a clinically led piece of work. The Case for Change for the Kent and Medway Sustainability and Transformation Plan (STP) had identified a number of challenges. It was noted that, left unchecked, health budgets would need to grow at around 5% each year to provide the full range of services, with only 1.5% of this being attributable to population growth. Key themes for the STP included intervention, prevention, addressing health inequalities and the health of the population. While there was lots of expertise in the healthcare system, this was not always used as effectively as it could be. In order to address the challenges there needed to be a cultural shift. The framework of the current system was based on the development of internal markets for health services and was therefore not suited to increased partnership and integrated working. Four integrated care partnerships would be created across Kent and Medway as well as constituent primary care networks working under these. None of these bodies, nor the System Commissioner had a statutory basis. The statutory bodies remained NHS England and the Kent and Medway clinical commissioning groups. Integrating the budgeting and commissioning of health and social care would be challenging and the timeline specified by NHS England, which required Integrated Care to be established across STP footprints by April 2021, was considered ambitious.

A Committee Member said that the fact that healthcare was free of charge to the end user, while social care was not, would make integration and pooling of budgets difficult. The Kent and Medway STP representatives said the requirement for Integrated Care Partnerships to be in place by 2021 did not necessarily mean that health and social care would be integrated at that point. Integration was an aspiration but not a requirement. The Assistant Director of Adult Social Care said that social care was working with health colleagues in order to facilitate more collaboration between the two systems, but that there was significant work required for full integration to be achieved. Social care teams were participating in Integrated Locality Reviews to consider how to

achieve better integration. Enabling providers to work together more effectively was an alternative to full scale integration. Publication of the Government Green Paper on Adult Social Care had been delayed a number of times. It was anticipated that this would set out expectations for integration of health and social care.

The STP representatives said that better collaboration could enable users of health and care services needing to use fewer organisations in order to be provided with their full range of services. An example highlighted was of a service user visited in their home by representatives of five organisations within a short space of time. It was suggested that better collaboration could reduce the number of organisations providing a direct service to this individual while the service user could benefit from more personalised service provision.

A Committee Member said that strengthening links and cooperation between health and social care required there to be trust between elected representatives and the NHS. The Kent and Medway Stroke Review was highlighted as having damaged this trust. Processes needed to be communicated clearly and honestly in order to rebuild trust. The Committee was advised that the creation of a single Kent and Medway CCG was under consideration.

Decision

The Committee noted and commented on the update provided.

896 Draft Medway Joint Carers' Strategy

Discussion

The Council had a statutory responsibility under the Care Act to assess the needs of carers and to separately assess the needs of those in receipt of care. The Medway Joint Carers' Strategy would support the Council and Medway NHS Clinical Commissioning Group (CCG) to work jointly with carers to support them effectively. It was considered that figures for the number of young carers locally were likely to underrepresent the true picture. The figures showed that of 64,000 under 18's in Medway, there were 660 young carers. There were also 1,600 aged 16 to 25. One driver of the Strategy was the need to identify carers that the Council was not aware of.

The underpinning vision had not changed since the previous Carers' Strategy but the health and social care system had. The new Strategy reflected these changes. It had been co-produced with carers and stakeholder engagement had been undertaken. A Carers Service for new older and younger carers had been established. The service, which had launched in January 2019 using Better Care Fund funding, was provided by Carers First. It formed part of the wider voluntary and community sector consortium contract.

The six key priorities set out in the Strategy were:

1. Identification and recognition of all carers in Medway

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2. Provision of good quality Information, advice, guidance and support
3. Access and involvement in assessment and support planning
4. High quality carers support services
5. Support to maintain physical, emotional health and wellbeing
6. Respecting the expertise that carers have

A Committee Member commended the co-production of the Strategy and emphasised that work was needed to identify hidden carers. He also emphasised the social isolation that many carers faced. The Member asked what steps were being taken and how the CGG was being involved in development of the Strategy.

The Head of Health Improvement said that CCG colleagues were engaged in Strategy development. The Strategy would be presented to the Local Care Strategy Group and other CCG forums over next six months to develop an action plan. Updates on Strategy delivery would be provided during the five year period that it covered.

A Member, who had had experience of being a carer shared his experience with the Committee. He highlighted the following:

- The development of a local induction pack for people becoming a carer would be welcome.
- Taking on caring duties while working was challenging.
- Carers benefitted from receiving training about managing a crisis soon after becoming a carer but it was also difficult for many carers to leave their home to attend.
- There needed to be preparation and training to enable carers to deal with end of life considerations.
- The Member had been linked in with Medway hospice from early on. Care provided by the hospice had helped the cared for person to regain their dignity.
- Both carer and cared for person had completed a questionnaire about attitudes to death. It had been good to have an open conversation about death.
- It would be helpful to have the opportunity of an interview once a person had stopped being a carer.
- Respite care provision was crucially important to carers and its provision had been much appreciated. There had been a suggestion that the Council had stopped the provision of respite care, which was a concern.
- It was concerning that Medway Council was not subscribed to the 'Tell us Once' scheme as it had been necessary to contact several individual Council departments [It was confirmed during the subsequent agenda item on Scrutiny of the Council's Transformation Programme that the Council was in the process of joining the scheme].
- Carers needed to know that there would be support available in the event that they themselves became ill.

A Committee Member said that better support was needed for older carers aged 70 and over. The Director of People, Children and Adult Services said this

was an areas of concern. While it was pleasing that adults with a disability now had longer life expectancies, it meant that parents looking after them were becoming older. Some individuals with disabilities had to enter care suddenly due to the death or illness of a parent carer. It was acknowledged that there needed to be a particular focus on older carers.

It was asked by a Committee Member what benefit priority six of the Strategy, 'respecting the expertise that carers have' would have for carers and the cared for person. The Committee was advised that this was about identifying the added value that a carer could bring, such as skills acquired in their professional life and then enabling these skills to be utilised effectively. Development of new skills for carers was also an important consideration.

A Member sought assurance, particularly in relation to Medway NHS CCG that the Strategy would be supported effectively. The Member also highlighted that the Strategy referenced a need for GPs of carers to be aware of their role so that they could look out for any resulting problems. There was an expectation amongst many carers that they would have to stop working but this could result in whole families becoming dependent on the state. Employers tended not to be as flexible with regards to employees with caring duties as they would be for those with children and it was suggested that the Council could do more to engage with local employers as well as ensuring that its own staff with caring responsibilities were supported effectively. The Head of Health Improvement highlighted that the Carers Strategy would be presented to the CCG Steering Group on 28 March. Consideration would be given as to how GPs could be fully engaged in support for carers. A question about caring responsibilities would be included in the next staff survey and local employers were encouraged to engage in workplace health programmes. The Deputy Managing Director of Medway NHS CCG said that the CCG was fully supportive of and engaged in development and delivery of the Strategy.

Decision

The Committee commented on the Medway Joint Carers' Strategy, provided feedback to improve the content and delivery of the strategy outcomes and noted the timetable for approval, as set out in paragraph 5.5 of the report.

897 Scrutiny of the Council's Transformation Programme

Discussion

The report updated the Committee on the Council's Transformation Programme within Adult Social Care. Each of the Council scrutiny committees was receiving an update on the areas of the Transformation Programme relevant to their terms of reference. The focus of the report was Adult Social Care. Key themes included making financial savings through transformation, organisational change and use of technology, including mobile working. Investment in Transformation was leading to savings being made. It was confirmed that the Council was implementing the 'Tell us Once' programme, with it being anticipated that this would be running in six to eight weeks.

Questions asked by Committee Members were responded to as follows:

Blue Badge delays and customer choice – A Committee Member said that there was a need to improve communication with residents and that it had been the Council's choice to make services digital. He highlighted poor and inconsistent communication in relation to Blue Badges for disabled drivers. Another Committee Member said that Blue Badges had to be applied for online, rather than via a paper form, which was not something she found easy. She had, therefore, had to ask someone to help her with her application. The Member had been told that it would take two to three weeks for someone to be available to help her to apply over the phone.

The Assistant Director – Transformation apologised that service users were finding the application process difficult. The use of online systems had been mandated by central Government and the system had been changed without notice. The concerns raised about communication were acknowledged. With regards to Council provided services, customers were not being forced to access them digitally. Assisted digital support was provided in Community Hubs with over 300 applicants for Blue Badges, or their carers, having been supported. It was anticipated that many of these would not need support in the future but this would be provided where required. The Assistant Director undertook to investigate the 2-3 week timeframe highlighted for the Member to be provided phone support with their application. Software had been purchased that would allow customers to log in and see the current status of all their transactions with the Council, including Blue Badges. The system would be rolled out from 1 April 2019, with as many as possible Council services being added to the system over the next year. The system also enabled automated messages to be sent to update customers on the status of their application. This would reduce the need for people to phone the Council for updates.

Adult Social Care Restructure and Shared Lives – A Member asked for an update on the restructure of Adult Social Care and on the Shared Lives Services. She sought assurances on what steps would be taken when difficulties were encountered by a client placed by the scheme.

The Assistant Director, Adult Social Care said that the substantive restructure of Adult Social Care had been completed 18 months previously. The service had changed its delivery model to enable clients to be appropriately supported, regardless of need. A locality model was now used rather than separate teams for specific groups, such as older people, people with disabilities or people with mental health needs. The Three Conversations Model had been introduced across the service. There had been significant staff engagement in the 18 months since the restructure to engage with staff in order to ascertain what further improvements could be made. Previously, the locality teams had been split between an early help and prevention team and a long term team. This resulted in clients being handed from a staff member in one team to staff member in another team and them not being supported as effectively as they could be. Localities now had combined teams in order to address this. Where safeguarding concerns were identified, clients would be supported through the safeguarding process and the same staff member would work with them

throughout. Work had been undertaken with frontline staff to design new ways of working.

Shared Lives supported people to enable them to live more independently and reduce the number of adults with a disability entering residential or nursing care. One of the key priorities of the Adult Social Care Transformation Programme is to increase the number of people supported by a Shared Lives Carer. The Shared Lives Service had been inspected recently by the Care Quality Commission (CQC). The outcome of this had been good. The CQC had considered the quality of the vetting process, how appropriate screening was used and whether there were good matches between service users and host families. It was considered that good support was provided for shared lives carers. Work was taking place with Shared Lives Plus, the national network for Shared Lives carers, to support further improvement and transformation of the service. A recent workshop with shared lives carers and cared for people had discussed ideas for improvement.

Decision

The Committee considered the report and the project update report provided.

898 Council Plan Performance Monitoring Report Quarter 3 2018/19

Discussion

The report summarised 2018/19 quarter 3 performance for the Council Plan priorities relevant to the Committee. This included detailed information for each relevant performance indicator and a summary of overall performance. Performance was above target for five of the ten measures and below target for four. Performance had, however, improved for three of these.

Decision

The Committee considered the quarter 3 performance of the measures of success used to monitor progress against the Council's priorities.

899 Work programme

Discussion

Proposed changes to the work programme were highlighted to the Committee.

Decision

The Committee

- i) Considered and agreed the Work Programme, including the changes set out in the report and agreed during the meeting.
- ii) Agreed the following changes to the Work Programme:

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- a. Reports on Medway NHS Clinical Commissioning Group's Operational Plan and a further report on Outpatient Services in Medway be added to the Work Programme for the June 2019 meeting.
- b. A report on Suicide Prevention and, subject to confirmation by officers from Public Health, a report on ensuring a good pregnancy, be added to Work Programme for the June 2019 meeting.
- c. Further update reports on the Kent and Medway Wheelchair Service, from Medway Foundation Trust and from Kent and Medway NHS and Social Care Partnership Trust be added to the Work Programme for the August 2019 meeting.
- d. The Director of Public Health Annual Report be added to the Work Programme for the October 2019 meeting.

Chairman

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