

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

**Tuesday, 18 June 2019**

**7.10pm to 11.20pm**

**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), Adeoye, Ahmed, Barrett, Bhutia, Sylvia Griffin, McDonald, Murray, Price, Chrissy Stamp, Thompson and Thorne

**Co-opted members without voting rights**

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

**Substitutes:** Councillor Thorne for Councillor Aldous

**In Attendance:** Kate Ako, Principal Lawyer - People  
Clare Ebberson, Consultant in Public Health  
Joe Garcia, Executive Director of Operations, South East Coast Ambulance Service  
Dr Anil Gupta, DMC Healthcare  
Dr Ravi Gupta, DMC Healthcare  
Dave Holman, Associate Director of Mental Health and Childrens Commissioning, NHS West Kent Clinical Commissioning Group  
Brid Johnson, Integrated Care Director, NELFT  
Nina Marshall, Integrated Service Manager, Kent and Medway Eating Disorder Service, NELFT  
Chris McKenzie, Assistant Director - Adult Social Care  
James Pavey, Regional Operations Manager, South East Coast Ambulance Service  
Jon Pitt, Democratic Services Officer  
Ray Savage, South East Coast Ambulance Service  
Ian Sutherland, Director of People - Children and Adults Services  
Nikki Teesdale, Deputy Chief Nurse, Medway Clinical Commissioning Group (CCG)  
James Williams, Director of Public Health

**71 Apologies for absence**

Apologies were received from Councillor Aldous with Councillor Thorne substituting.

**72 Record of meeting**

The records of the Committee meetings held on 12 and 14 March 2019 and the record of the Joint Meeting of Committees held on 22 May 2019 were agreed and signed by the Chairman as correct records.

**73 Urgent matters by reason of special circumstances**

There were none.

**74 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.

**75 All Age Eating Disorder Service Update**

**Discussion**

The Committee had previously considered a report on the All Age Eating Disorder Service at the December 2018 meeting with a further update having been requested at this meeting. In 2014, NHS West Kent Clinical Commissioning Group (CCG) had sponsored a project across Kent and Medway to improve eating disorder services. At this time, waiting times had been longer than national standards, patients were experiencing excessive travel times and there were concerns about the effectiveness of the service in treating eating disorders. A procurement process had been undertaken with NELFT having become the provider of the £2.7 million contract in 2017. A key feature of the new service was that it now covered both children and adults, helping to overcome the previously problematic transition from child to adult services. The service was now considered to be good although it was acknowledged that there were associated issues that needed to be addressed. This included a lack of inpatient beds and GPs often not referring patients to the Eating Disorder Service soon enough. There was also a need to increase

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outreach work with schools to raise awareness of eating disorders and the services available.

NELFT was involved in national level work to bid for funding with the aim of being able to deliver more services closer to the patient home. In the year April 2018 to March 2019 there had been 98 referrals to the Eating Disorder Service, with an increase in referrals having been seen in the autumn. 61 of the referrals had been made by GPs. There had been 12 re-referrals. The current caseload was 66 with 5 male patients and 61 female. Patients covered the age range 8 to 65 with the majority being children and young adults. It was noted that a small Medway specific service would not be able to have the range of specialists that a service, covering both children and adults, across Kent and Medway could.

There were currently no children waiting for non-urgent treatment. Assessment for non-urgent child cases was completed within four weeks and for urgent cases, within seven days. Where there was an urgent physical health need liaison was undertaken with acute health trusts to enable more urgent treatment to take place. The target for assessing non-urgent adult cases was 8 weeks with there currently being 10 adults waiting. Urgent cases were due to be assessed within 7 days but could be admitted to hospital immediately where there was an urgent physical need. An out of hours team was available to provide support 24/7. Following treatment, patients were discharged to the care of their GP. Each patient was provided a relapse plan. A range of support was available following discharge.

The firstline treatment for under 18's was family therapy with this also being available for over 18's where required. There were also under 18's and over 18's carer groups available to provide support to the families of patients. Child inpatients could be admitted to a unit in Staplehurst but there were no specialist beds available in Kent and Medway for either children or adults with the most complex needs. The Maudesley Hospital in London had specialist day and inpatient services available.

There had been an increase in eating disorders nationally with bed admissions more than doubling from 7,000 in 2011 to 16,000 in 2018. Of the current 10 adult inpatients from Kent and Medway, none was from Medway, while 1 of 13 children was a Medway child.

Future plans for development of the Eating Disorder Service included considering how digital services could be developed and strengthening links with schools. A good working relationship with the ambulance service had already been established, one example being that ambulances could be on standby when a patient attended a clinic who was considered likely to need hospital admission.

A Member asked a number of questions as follows:

- Why the number of people being treated was relatively low
- How patients and their families were supported to travel to appointments and treatment and whether help was available with travel costs

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- How the number of patients self-referring and the number of male patients could be increased
- The reasons for re-referral
- How accessible a specialist clinician would be to a person visiting Medway hospital when in crisis
- What was defined as a complex case
- Whether statistics were available showing the number of patients who showed sustained improvement and what the mortality rates were amongst service users
- What training was available for GPs

In response, the NELFT representatives advised that the caseload figure was the number of people being treated at a point in time. This would be lower than the total number of people that had been treated. When NELFT had taken on the contract for the Kent and Medway Service there had been no specialist children's service. It was only possible to offer early intervention when a patient was identified at an early stage, which was problematic. Education of GPs could help to address this but would not help to identify those who did not visit their GP. Through increasing training and education it was hoped that people would be encouraged to seek help sooner. NELFT was not currently the provider for patients requiring tier 4 inpatient beds. Patients would not be discharged from the service until it had been assessed that they were ready to be. They would be provided a relapse plan at discharge but patients sometimes deviated from this plan, which was a cause of re-referral. Some patients initially referred to the service did not feel ready for treatment and could then be re-referred once they were.

Help with patient travel costs was available and NHS England was now paying some travel costs of relatives. Increasing the levels of self-referral was challenging as people often did not recognise or want to admit that they were unwell. Awareness raising of eating disorders, particularly targeted at men, had been undertaken as part of Eating Disorder Week and via social media, but it was acknowledged that more needed to be done. The communications team at NELFT was working with the Communications team at NHS Medway Clinical Commissioning Group to look at how awareness could be further increased.

Patients admitted to hospital were provided with a comprehensive care plan, with NELFT staff visiting patients on the ward. NELFT was already the provider of eating disorder services in north east London and Essex and had applied learning from these areas to the development of the Kent and Medway service. It was not yet possible to provide detailed outcomes as the service had only been operating for one full year but these could be included in future updates. NELFT had worked with a GP in the West Kent area to review the service and identify what could be done to raise the profile of eating disorders and the service with GPs.

Other questions asked by Committee Members were responded to as follows:

**Increased referrals in autumn** – the Committee was advised that referrals tended to increase in the autumn due to parents and family members realising

that their child was facing difficulties while they were home during the school summer holidays. Engagement work was taking place with schools and via children's events to raise awareness.

**Need for local services** – A Member said that there was a need for more Medway specific provision and was concerned about increasing demand and the pressure this would put on services if action was not taken imminently. Other Members said that there was a need for the development of specific provision in Medway.

The Associate Director of Mental Health and Children's commissioning at NHS West Kent CCG said that demand was increasing across mental health services, that the acuity of patients was increasing and that serious problems were affecting younger children. CCGs would continue to review demand to ensure that the services commissioned could meet demand. The NELFT representatives said that specialist beds could not be provided in each locality due to the complexity of the service. While provision would be as close to the patient as possible it could not be guaranteed that this would be in Medway.

The Director of Public Health emphasised the need to better identify and signpost people to services. The next Annual Public Health report was due to focus on mental health wellbeing.

**Presentation at hospital, patient travel, voluntary sector capacity and support for adults** – A Member highlighted that some people with eating disorders had had a poor experience when presenting at accident and emergency and was concerned about the impact of having to travel a distance for treatment on patients and their families. The Member also questioned the ability of the voluntary sector to assist in tackling eating disorders and asked how the families of adult patients could be supported. Another Member emphasised the importance of providing support for patients and their families where patients had to travel significant distance to appointments.

The NELFT representatives said that there were regular discussions with legal advisors about the issue of patient capacity as there was a very limited amount of action that could be taken where an adult did not want help or did not want family members to be involved. Relatives of adults with an eating disorder could attend the carers' support group without a referral. Through this, relatives could be supported to encourage the person with an eating disorder to get help. Voluntary sector organisations were encouraged to signpost people to the eating disorder service rather than to try to provide direct support.

An online learning tool was available for bulimia and it was hoped that online learning could be provided for other eating disorders in the future.

Patients recovering from severe eating disorders had the opportunity to regularly attend a clinic for between six months and a year in order for them to be supported to maintain their improvement. Such clinics were available across Kent and Medway, including in Medway and outreach visits could also be undertaken to patient homes. Discussions had taken place with Medway

Foundation Trust to strengthen partnership working, helping to ensure that patients attending the hospital had a positive experience.

The Associate Director agreed that the ability of patients and their families to travel for treatment was important from a commissioning point of view and undertook that this would be given further consideration.

### **Decision**

The Committee noted and commented on the report and requested:

- i) That consideration be given to establishing the provision of specialist eating disorder inpatient provision within Medway.
- ii) That an update be presented to a future meeting of the Committee.

## **76 South East Coast Ambulance Service Update**

### **Discussion**

South East Coast Ambulance Service (SECAmb) had recently had its core services inspected by the Care Quality Commission (CQC). The inspection had been brought forward as the CQC had recognised that SECAmb was on a significant improvement trajectory. A separate well led inspection was due to be undertaken in the second week of July, with an inspection of the NHS 111 service in Ashford due to take place in the first week of July. There was confidence that the inspections would show significant improvement with it being anticipated that the caring inspection domain would receive an excellent rating. The latest staff survey had been undertaken in September 2018. The number of responses received had increased compared to previous surveys with survey results showing that staff considered performance in the majority of areas to have improved. The Chief Executive of SECAmb had left the Trust in April to take up a post at the North West Ambulance Service. A new Chief Executive had been appointed and was due to start in September. The Director of Human Resources had also left the Trust. An interim was currently in post pending the recruitment of a permanent replacement.

A Demand and Capacity Review had been undertaken throughout 2017, having been finalised in 2018. In order to deliver Ambulance Response Programme standards, an additional 2,413 staff would be needed compared to 2018 staffing levels. 256 entry level staff had been recruited in the last year and 160 staff trained from entry level to become Associate Ambulance Practitioners. There was now a nationally recognised apprenticeship scheme. This enabled staff who had completed the apprenticeship with one ambulance service to transfer without having to repeat similar training. 82 internal staff had been educated to paramedic level. Assessment centres were taking place to recruit newly qualified paramedics who had completed university courses. There were 146 places available to be filled in the current recruitment campaign. A single assessment centre had resulted in 32 of the 33 attendees being offered jobs.

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The recruitment completed so far meant that a further 2,034 staff were still needed.

93 new vehicles had been added to the ambulance fleet in the current year with a further 50 vehicles due to be added over the next two years, taking the total ambulance fleet to 386 vehicles. A non-emergency transport tier had been introduced. This operated in a similar way to the separate patient transport service not operated by SECAMB, but with the difference that the SECAMB staff operating these vehicles were trained in emergency driving and could provide a greater clinical input in relation to patient treatment. The non-emergency transport tier was used for patients assessed by a clinician as not requiring emergency transport. This had been piloted in East Kent and was due to be rolled out to Medway.

Questions asked by Committee Members were responded to as follows:

**Bullying and harassment and categorisation of patients** – Members asked how work to address bullying and harassment was progressing, what had happened to perpetrators and how patients were categorised in view of disappointing Category 3 (urgent calls) and Category 4 (less urgent calls) ambulance response performance.

The SECAMB representatives considered that staff were now more willing to raise any bullying and harassment concerns. This was evidenced by the fact that the 'Speak in Confidence' initiative, which enabled staff to report concerns anonymously was now hardly used, with staff instead feeling confident to raise concerns directly. It was considered that the previous culture of bullying had been addressed. Extensive work had been undertaken with managers. A six day management development programme made clear expectations of the types of behaviour considered to be acceptable. The outcomes of individual cases of bullying and harassment could not be shared but in cases where there was more than circumstantial evidence of bullying or harassment, those individuals no longer worked for SECAMB. Addressing Category 3 performance was acknowledged to be a significant challenge with performance having been affected by the prioritisation of the most urgent categories, 1 and 2. Recruiting the required number of staff would be key to addressing performance as was the role of Community First Responders and the NHS Pathways tool which SECAMB was now using to help ensure that patient need was correctly assessed. Clinicians were based in the emergency operations centre to provide clinical oversight, also helping to ensure the correct categorisation of patients.

**Staff Health and Wellbeing, patient transport and Fire Service support** – In response to a question about the demographic breakdown of SECAMB staff, the development of wellbeing hubs, the scope for patient transport staff to move into emergency operations and support provided by the Fire Service, the Committee was advised that the Hub had been very successful in supporting staff to attend work who might otherwise be on sickness leave. A decision had been taken to continue funding the Hub following the end of the pilot. Overall, 51% of SECAMB staff were female and 49% male. The percentage of Black Asian and Minority Ethnic staff would be confirmed following the meeting but it

was acknowledged that this figure was not as high as SECAMB would like. A number of staff had joined SECAMB from private patient transport service providers. The Fire Service continued to support SECAMB in attendance at some calls, for example, providing defibrillation for patients who had suffered cardiac arrest and assisting with patients who had suffered a fall. However, Fire Service personnel could not undertake medical assessments of patients so there needed to be close cooperation between SECAMB and the Fire Service.

48% of SECAMB employees were paramedics, with the aim being for this figure to increase to 68%. This would enable every SECAMB vehicle to be staffed with a qualified paramedic. On its current trajectory, this would be achieved by 2024. Achieving this figure sooner would require SECAMB to successfully recruit significant numbers of qualified paramedics from other trusts.

**Performance in Key Theme Areas and appraisal performance –** A Committee Member asked what was being done to address below average performance in a number of the ten key theme areas and what was being done to improve the quality of staff appraisals. Work was being undertaken to improve performance across the key theme areas. One example was reductions in overruns at the end of staff shifts. Previously, 50 to 60% of shifts were finishing over 15 minutes late, with the average being 40 minutes. Changes had been made to end of shift arrangements with the aim being for ambulance crews to return to the area close to their starting point before the end of the shift. This had helped to reduce overruns to approximately 30%, thereby helping to improve staff morale. The Trust had introduced secondary rest breaks for staff each shift in addition to their main break. Medicines management was another area highlighted where significant improvements had been made. There was a need to ensure that managers had sufficient time to undertake meaningful staff appraisals. This had included the allocation of 50% of manager time to the people management aspect of their role. This also helped to ensure that there was a manager available to meet staff at the start and end of their shift. There was confidence that these changes would be reflected in improved feedback when the next staff survey was undertaken.

**Staff turnover –** A Committee Member asked for figures relating to staff turnover, how this had changed, what the target was for future turnover, how figures compared with national averages and how the Trust aimed to retain staff. It was requested that information be circulated to the Committee.

### **Decision**

The Committee noted and commented on the update provided and agreed that a further update be presented to a future meeting of the Committee.



**77 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 plans were part of a long term plan across the NHS to improve outpatient facilities and provide appointments closer to the patient home. Consideration was being given to what services could be delivered through healthy living centres and various community networks. Engagement sessions had started across the health sector. Services under initial consideration included neurology, cardiology, respiratory, clinical haematology and rheumatology. Cardiology, neurology and respiratory patient engagement workshops had been held with a variety of feedback provided to suggest how services could be improved and moved away from an acute hospital.

In relation to neurology, there had previously been some unnecessary referrals as patients had not always been referred in accordance with National Institute for Health and Care Excellence (NICE) guidance. Consideration would be given to the referral pathway and the education of GPs in relation to referrals. In some cases, patients were initially referred by their GP but were then referred back to their GP by a consultant without an appropriate care plan being put in place. This could result in the GP needing to refer the patient back to the consultant. Ensuring that appropriate care plans were developed would help to ensure that patients could be treated in the community. Previously, GPs had been able to obtain advice from consultants without making a referral. This tended to no longer be the case. Consideration was being given as to how this consultant access could be reintroduced, with a view to reducing referrals. The possibility of making increasing use of phone consultations and tele health was also being looked at, with it suggested that the provision of blood test results and minor changes to treatment could be undertaken via telephone rather than the patient having to visit hospital.

Questions asked by Committee Members were responded to as follows:

**Risk management** – In response to a Member question about the risks in relation to stakeholder engagement set out in the report, it was confirmed that while the report stated that there was a risk of poor stakeholder management and engagement, it was currently considered that these had been good. There had been strong, positive engagement across the health sector with task and finish groups having been established in four areas, in line with the engagement plan.

**Appropriateness of telephone consultations** – A Member expressed concern that some patients would be provided a telephone consultation when they were not in a fit condition to undertake a meaningful discussion. The CCG representative said that telephone consultations would only be used for specific groups of patients and would not be used to assess pain. Patients with more complex needs would not meet the criteria for telephone assessment. Services would be provided by a multi-disciplinary team comprising consultants,

physiotherapists, pharmacists and nurses. The changes under consideration did not involve service reduction, rather they were about providing services that were better able to meet the needs of the patient. There would be a move away from disease pathway management to creating treatment pathways based upon individual patient needs, ensuring that patients had an appropriate care plan and that these were monitored effectively.

**Substantial Variation and health infrastructure** – A Member noted that the Committee had previously determined the proposed changes to be a substantial variation to the health service and said that there was strong evidence that they were. She asked why Medway CCG had assessed the changes to not be substantial. It was accepted that changes would happen in the context of a desire to provide more services in the community. However, the Member was concerned that the local health infrastructure was not sufficient to support such changes. Healthy Living Centres were not yet fully established and Medway had recently been ranked as the fourth worst area in the country for getting a GP appointment.

The Committee was advised that there were not yet plans to physically move services and that further engagement work was required. It was recognised that changes were needed to ensure that outpatient services were fit for purpose and that consultant time was not taken up unnecessarily. The Task and Finish groups already established were looking at referral pathways but the relocation of services was not yet under consideration. This would require capacity demand modelling to have first been completed.

**Public engagement and service provision** – A Member asked whether plans developed would go to full public consultation and whether the number of staff available or service provision would be reduced. The Committee was advised that the CCG considered that consultation would be too prescriptive and that engagement would better enable a full range of feedback, including patient stories, to be taken into account. Funding and staffing levels for services had not yet been discussed.

### 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 Appendices 1 and 2.
- ii) Noted and supported the proposed patient engagement activity as part of the programme for improving the outpatient service in Medway and Swale.
- iii) Agreed that a further update on outpatient services be added to the Work Programme for the October 2019 meeting.

## 78 Dermatology Services

### Discussion

Medway NHS Foundation Trust (MFT), the previous provider of Dermatology Services, had served notice on the contract in September 2018. This followed challenges relating to the service, including increasing waiting lists and it not meeting national targets. Following a procurement process, DMC Healthcare had won the contract to provide Dermatology services, with the new service having commenced in April 2019. At commencement of the new contract there had been a significant number of patients on waiting lists and NHS Medway Clinical Commissioning Group (CCG) had not been aware of the extent of the waiting list. The MFT provided service had been breaching 52 hour wait targets and in March, it was reported that only 4% of cancer patients were seen within the two week target.

The task of moving the Dermatology Service from a hospital to community based service had been challenging, particularly in view of the unexpectedly high number of patients. Nurses responsible for delivering the service had successfully transferred from MFT to DMC Healthcare. However, none of the consultant dermatologists had transferred. This had been particularly challenging as DMC had understood that these consultants would transfer. DMC had established a system of electronic notes with notes from the previous MFT provided service having been uploaded to the system. In April 2019, DMC had received 46,000 phone calls as MFT had advised patients to contact DMC Healthcare. This high call volume had presented a significant challenge. DMC had run additional clinics in order to reduce the backlog of patients waiting to be seen. An advantage of the new service was that, for many patients, services were now being provided closer to their home. DMC Healthcare was in the process of acquiring a phototherapy machine. This was due to be installed at Rainham Healthy Living Centre the week after the Committee meeting and patch testing was due to commence within the next four weeks. Staff were positive about how the new service was running. The aim was to build on this, to provide further training and to recruit a full time dermatologist. It was acknowledged that establishing the new service had been difficult.

In response to Member questions about the size of the waiting list and when it would be cleared, recruitment plans and the difficulty patients faced in getting GP appointments, it was confirmed that the waiting list inherited from MFT had been 8,800. This had been reduced to the current figure of around 8,000. Engagement had taken place via practice learning events at each of the Kent and Medway CCGs to tell clinicians about the new service and to promote the adoption of a dermatology app. There was a national shortage of dermatologists with it being considered that word of mouth was more likely to be successful for recruiting dermatologists than the formal advertising of vacancies. Patient feedback was important, this would be shared at monthly commissioning meetings.

A clinical triage process had been undertaken to review patients who had been on the waiting list for an extended period. The number of patients inherited from

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the MFT provided service had been significantly higher than anticipated and this had not been known during the tender process. The number of clinics provided by MFT in the period immediately prior to DMC taking over as provider had also reduced resulting in the waiting list having increased. The aim was for the waiting list to be cleared in the next three to six months. The number of serious cases waiting more than two weeks had been significantly reduced as had the number of patients waiting more than 52 weeks. At commencement of the DMC contract on 1 April there had been 120 patients waiting more than 52 weeks. It was anticipated that this would be reduced to zero by the end of June 2019.

Work to implement a single point of access at GP practices had been hampered by IT problems that were not within the control of DMC Healthcare and it had therefore not been possible to provide the level of service anticipated. Implementation meetings had taken place during January, February, March and April 2019. Nationally, the NHS was promoting other skilled professions that related to general practice, with a view to this supporting the provision of GP services. This included roles such as clinical pharmacists and clinical physiotherapists.

A Committee Member said that the issues associated with the procurement process, particularly a lack of awareness of patient and waiting list numbers were reminiscent of a previous procurement undertaken for patient transport services. The Member asked why commissioners had not known about the scale of the waiting list and why it had been anticipated that consultants would transfer from MFT to DMC Healthcare, when in the event, none had done so.

The CCG representative said that the CCG had been required to undertake a procurement exercise at short notice due to MFT having relinquished its provider contract. The procurement had been reliant on data provided by MFT. This had not indicated the size of the waiting list or other challenges that the service was facing. In relation to the list of staff that had been expected to transfer from MFT to DMC Healthcare, this had been provided in writing but such lists were not final until the point of transfer. It was also possible for staff to change their mind at short notice. MFT no longer had the clinical resources to support the delivery of the service and so could not be asked to help support DMC Healthcare going forward. DMC Healthcare representatives advised that staff who had decided not to transfer had not had to work out their notice periods. Other changes made to improve the dermatology service had included adjusting the referral form to provide more detail, thereby helping to avoid some unnecessary referrals. GPs also had emergency phone access to DMC Healthcare for the purpose of discussing urgent referrals.

A number of Members said that there was an urgent need for the Committee to seek answers from MFT and that MFT representatives should be asked to attend Committee.

## **Decision**

The Committee noted and commented on the report, agreed that a further update be brought to the next meeting of the Committee and agreed that representatives of Medway Foundation Trust be asked to attend.

## **79 Suicide Prevention Update**

### **Discussion**

It was recognised that suicide was a tragic event that could have a devastating impact for family and friends of the person and on the community as a whole. In Medway, as nationally, men, particularly middle aged men, were at greater risk of suicide than women. In the year before a suicide, a third of people had contact with secondary mental health services, a third had contact with their GP and a third had no contact with health services. This suggested that there was a need to look at community interventions as well as interventions relating directly to health services. Work had taken place with partners through the sustainability and transformation partnership to secure funding from the NHS for work on a suicide prevention programme. Kent and Medway was one of eight areas nationally to have been awarded additional funding for an intensive programme.

The Kent and Medway Suicide Prevention Partnership and its steering group included a wide range of partners, including transport and education providers and voluntary sector representation. The focus of work was on the groups most at risk of suicide. The programme delivered over the last year had consisted of nine strands. Some examples of this included the 'Release the Pressure' social media campaign. The campaign targeted middle aged men currently not in contact with any services, signposting them to a 24 hour helpline. This had been promoted widely across a number of places in Medway. 4,500 calls from Medway residents had been made to the helpline during the previous year. Other examples included the launch of the Saving Lives Innovation Fund. This provided grants to community organisations to undertake suicide prevention projects. 29 such projects had been undertaken in the year, with over 1,000 people benefitting from these. A range of suicide prevention awareness training was available to both adults and young people.

Each suicide prevention workstream was assessed and externally evaluated to determine its impact and qualitative feedback collected. Feedback from the national team responsible for funding the programme suggested that work in Medway was more advanced than in the other seven areas to have been awarded funding.

Funding had been secured for the next year to enable the local programme to continue. The aim would be to build upon lessons learnt from the previous year, to introduce additional work around systems leadership and to look at pathways in relation to depression. Medway's Suicide Prevention Strategy was also due to be refreshed with the Suicide Prevention Partnership being responsible for monitoring the Strategy's action plan.

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A Committee Member said there was a need to undertake awareness raising of suicide prevention with universities. There were legal challenges as universities were usually unable to make families aware of concerns without the consent of the individual. It was suggested that the development of a protocol with universities be investigated to enable the disclosure of certain information about students to the families where there was a history of depression or other mental health disorder. The Member, while pleased that improved support was available for bereaved families, said that colleagues also needed support to be available. The Public Health Consultant acknowledged the importance of raising awareness of suicide prevention and the provision of support in the workplace. Work was being undertaken to develop specific training to support workplaces to develop policies around suicide prevention and support following a suicide. This would be piloted over the coming months. Engagement was taking place with local employers. The Director of People, Children and Adults said that universities had to be very cautious about breaching the individual right to privacy and confidentiality but this was an area that could be explored further with local universities.

A Member asked whether a demographic breakdown was available of the 4,500 calls made by Medway residents to the Suicide Prevention helpline. Noting that black men were three times more likely not to seek help until their mental health had reached crisis point, the Member asked what work had been done specifically in relation to BAME and faith groups. The Public Health Consultant advised that the aim was to make all programmes as inclusive as possible. The Innovation Fund has also funded one project specifically relating to faith groups and one specifically related to BAME groups. A breakdown of the demographic breakdown of callers to the Suicide Prevention helpline would be provided following the meeting.

In response to a Member question that asked whether there was data available to show suicide locations and methods, the Public Health Consultant said that data was available. This showed a correlation between suicide rates and levels of deprivation. A protocol was in place with partners to take action in locations where clusters of suicides were identified. The Director of Public Health added that work was undertaken with rail firms, Highways England and other sites identified as having a high suicide risk.

### **Decision**

#### **The Committee:**

- i) Noted and commented on the update on the suicide prevention programme.
- ii) Requested that a demographic breakdown of the calls made by Medway residents to the Suicide Prevention Helpline be circulated to the Committee.
- iii) Requested that officers engage with universities to consider the scope for informing family members where serious concerns for a student's welfare had been identified.

**80 Medway, North and West Kent CCGs Operating Plan 2019/20**

**Discussion**

The NHS Medway Clinical Commissioning Group (CCG) representatives acknowledged that there were a significant number of acronyms that had been used without explanation in the Operating Plan and undertook that consideration would be given to this when producing future plans. In response to a Member question, they also undertook to establish why the Operating Plan had not been presented to the Committee in draft form.

The Operating Plan covered all services provided by the CCG. The Plan covered four CCG areas, including Medway. It was anticipated that this would help to ensure consistency of approach across CCGs as they moved towards an integrated care system and a single strategic commissioner. The Plan had been submitted to NHS England on 4 April 2019 with no formal feedback having yet been received. The contents of the Plan were now being communicated to ensure that CCG staff and health providers were aware of its contents. Monitoring was being undertaken against the commitments included in the Plan and delivery plans developed where these were not already in place. There was a focus on developing a local five year response to the NHS Long Term Plan. This was due to be submitted to NHS England in the Autumn. The outcomes of the Operating Plan would be factored into these longer term plans.

A Member asked whether the pseudonymization [a process by which personally identifiable information is replaced by one or more artificial identifiers] described within the Operating Plan would lead to data no longer being useful. The Member was also concerned that there appeared to be fewer actions in the Plan specific to Medway than to West Kent, in view of the level of health inequality in Medway. The Member also voiced concern about existing priorities being consumed by the development of a five year plan and asked about the development of Care Navigators in Medway.

The CCG representatives advised that 2019/20 was the first year of a five year plan and that all priorities contained in the Operating Plan were still valid. It was considered that the pseudonymization being used had not made the data meaningless. It had not been the intention for the Plan to in any way suggest that there was less need for services in Medway than in other areas. They agreed further work was needed in relation to tackling health inequalities, given that some inequalities were increasing locally. It was envisaged that the development of the local Five Year Plan and work with Public Health, would be catalysts to addressing this. It was considered that Care Navigators would have significant impact on the local health system and patient access to services. The Assistant Director – Adult Social Care, said that the Council was working jointly with the CCG to procure community care navigation services. Care Navigators were currently based at Medway Maritime hospital and also worked in the local community. The Navigators would support people to be connected to other services in the local community. EU funding had been obtained, through Public Health, to deliver social prescribing services with a network of

local practitioners being developed. This workforce would be based within Medway Council and would work collaboratively with the existing care navigators.

A Committee Member said that planning by the CCG had previously been found to be a weakness by inspectors. Acknowledging that there had not been a recent inspection, the Member asked whether planning was now considered to be more of a strength. The Members remained concerned that the Operating Plan did not sufficiently highlight the need for services in Medway and considered that this could contribute to services moving away from Medway.

The CCG representatives considered that planning had improved and agreed that in some ways, service provision in Medway did warrant particular attention. In response to a Member concern that health planning appeared to be focusing on elderly and frail patients rather than on deprived areas, the Committee was advised that Medway had a younger population than the England average that had higher levels of morbidity. The term elderly and frail was misleading as frailty could also affect younger people. Frailty could be considered in the planning process in a way that does not lead to a reduced focus on deprivation.

In response to a Member question, the Committee was provided a brief explanation of the Medway Model. This set out how care services were arranged in Medway with the principle being to base services in geographical localities surrounding GP hubs in three localities and 7 sub-hubs in Medway.

### **Decision**

The Committee considered and commented on the Operating Plan, as set out in this report and Appendix 1 and requested that a written update be provided on the development of the Healthy Living Centres.

## **81 Work programme**

### **Discussion**

Proposed changes to the Work Programme were highlighted to the Committee.

A Committee Member said that a representative of Kent Healthwatch had made comments at the Kent Health Overview and Scrutiny Committee that suggested that Healthwatch across Kent and Medway was in favour of the option selected for the Kent and Medway Stroke Review. It was requested that Healthwatch Kent be asked to explain these comments.

### **Decision**

The Committee:

- i) Considered and agreed the Work Programme, including the changes set out in the report.



## **Health and Adult Social Care Overview and Scrutiny Committee, 18 June 2019**

- ii) Asked that the Healthwatch Medway representative request that Healthwatch Kent provide a written response to the Committee to explain comments made at the Kent Health Overview and Scrutiny Committee in relation to the Kent and Medway Stroke Review.
- iii) Asked that the Healthwatch Medway representative ask Healthwatch Kent to provide a written response to the Committee to explain comments made at the Kent Health Overview and Scrutiny Committee in relation to the Kent and Medway Stroke Review.
- iv) Agreed the following additional changes to the Work Programme:
  - a) That an update on eating disorders be added to the Work Programme for a future meeting of the Committee.
  - b) That an update from South East Coast SECAMb be added to the Work Programme for a future meeting of the Committee.
  - c) That an update on the redesign of outpatient services be added to the Work Programme for the October 2019 meeting.
  - d) That a report on the Dermatology Service be added to the Work Programme for the August 2019 meeting and that a representative of Medway Foundation Trust be asked to attend.

**Chairman**

**Date:**

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