

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

Tuesday, 20 August 2019

6.30pm to 10.50pm

Record of the meeting

Present: Councillors: Wildey (Chairman), Purdy (Vice-Chairman), Adeoye, Ahmed, Aldous, Barrett, Bhutia, Steve Iles, Mahil, McDonald, Murray, Price and Thompson

Co-opted members without voting rights

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

Substitutes: Councillor Mahil for Councillor Chrissy Stamp

In Attendance: Glynis Alexander, Director of Communications, Medway NHS Foundation Trust
Karen Benbow, Director of Commissioning, East Kent Clinical Commissioning Groups
Dr Bob Bowes, Clinical Chair, Kent and Medway System Commissioner Steering Group
Vivien Bowles, Legal Advisor
Sean Briggs, Chief Operating Officer, Maidstone and Tunbridge Wells NHS Trust
James Devine, Chief Executive, Medway NHS Foundation Trust
Sharease Gibson, Senior Programme Manager, NHS Medway Clinical Commissioning Group
Dr Peter Green, Clinical Chair, NHS Medway Clinical Commissioning Group
Stuart Jeffery, Deputy Managing Director, NHS Medway Clinical Commissioning Group
Helen Martin, Director of Operations, Clinical Quality and Nursing - Medway Community Healthcare
Chris McKenzie, Assistant Director - Adult Social Care
Jacquie Mowbray-Gould, Chief Operating Officer, Kent and Medway NHS and Social Care Partnership Trust
Simon Perks, Director of System Transformation, Kent and Medway Sustainability and Transformation Partnership
Jon Pitt, Democratic Services Officer
Miles Scott, Chief Executive, Maidstone and Tunbridge Wells NHS Trust
Ian Sutherland, Director of People - Children and Adults Services
James Williams, Director of Public Health

215 Apologies for absence

Apologies had been received from Councillor Chrissy Stamp with Councillor Mahil substituting.

216 Record of meeting

The record of the Committee meeting held on 18 June 2019 was agreed and signed by the Chairman as a correct record.

217 Urgent matters by reason of special circumstances

There were none.

218 Disclosable Pecuniary Interests or Other Significant Interests and Whipping

Disclosable pecuniary interests

There were none.

Other significant interests (OSIs)

There were none.

Other interests

Cllr Mahil declared an other interest in agenda item number 8, the Medway NHS Foundation Trust (MFT) Update as a relative was a senior member of staff at the Trust. Cllr Mahil remained in the room during discussion of the item.

219 Development of Single Kent and Medway Clinical Commissioning Group

Discussion

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

- A strategic commissioning function was needed to enable more effective planning and commissioning of services, based upon local needs. This would be realised through the establishment of a single Kent and Medway Clinical Commissioning Group (CCG).
- It was anticipated that, nationally, single CCGs would be created to match Sustainability and Transformation Plan (STP) footprints. A single CCG would be able to achieve scale efficiencies that could not be achieved by the existing 8 Kent and Medway CCGs. There was a need to reduce CCG running costs by 20%.
- Services were not currently as joined-up as they could be, with there being too many individual agencies and it was acknowledged that there was

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currently too much inequality and not as much prevention work as there could be. Differences in life expectancy between areas needed to be addressed.

- Government policy had acknowledged the internal health market was not working to improve quality or reduce costs. The internal NHS market was being replaced by a culture of collaboration and mutual responsibility.
- The health system also faced a number of workforce related challenges.
- It was anticipated that the establishment of a single CCG would help facilitate the commissioning of the services required to meet need rather than blanket commissioning by area.
- Integrated Care Partnerships (ICPs) would include acute hospitals, primary care, community services the voluntary sector, council services, the ambulance service and mental health providers. Four Integrated Care Partnerships would cover Kent and Medway, including one for the Medway and Swale area. The Integrated Care Partnerships would work collaboratively to provide services commissioned by the single CCG. The Sustainability and Transformation Plan and Medway CCG was working closely with Medway Council to develop this collaborative working.
- Primary Care Networks would help facilitate groups of GPs to work collaboratively to deliver services to populations of 30 to 50 thousand. This would enable pooling of resources and a greater focus on the holistic needs of the local population, including preventative work. The Networks would be able to draw on local intelligence to identify and address local need, with analysis having already been undertaken by the Council's Public Health function. Seven Primary Care Networks had been established in Medway and three in Swale.
- The single CCG would use findings of population needs assessments to identify and prioritise service provision in conjunction with partners. The Kent and Medway Joint Health and Wellbeing Board would have an important role.
- Development of this work was being overseen by the Sustainability and Transformation Plan Programme Board, which was attended by the Leader of the Council.

Members asked a number of questions as follows:

Business case, funding, staffing and the role of Medway – A Member raised concern that they had not seen a business case, that there may not be sufficient staff and funding available and that the Medway and Swale Integrated Care Partnership area was too small. The Committee was advised that the proposals aimed to make commissioning more efficient through collaborative working. Multi-disciplinary working was likely to make GP practice more attractive as a career and the aim was to persuade more people entering the profession to train, live and work locally. The total population of Medway and Swale was about 400,000, which equated to around a quarter of the population of Kent and Medway as a whole.

Role of CCGs and need for change – A Committee Member was extremely concerned as he considered that the presentation undermined assurances that the Committee had previously been given that effective partnership working was taking place, that health inequalities were being effectively addressed and

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that workforce and value for money challenges were being tackled effectively. The Member was also concerned that there had been many changes to health service commissioning already and asked whether there would be further changes in the future. The Clinical Chair of the Kent and Medway System Commissioner Steering Group said the strategic commissioning capacity needed to improve while ensuring local needs were addressed. It was acknowledged that CCGs had not always had access to staff numbers or budgets required. The majority of factors that influenced life expectancy were social rather than being directly health factors. It was considered that a more collaborative approach, that was not dependent on an internal market, would help to address inequalities more effectively.

The Clinical Chair of Medway CCG said that under the current system, acute and community providers often did not work together effectively to resolve issues, instead looking to commissioners to do so. The development of a more collaborative working environment would help to reconfigure relationships. Much successful prevention work was already taking place covering a wide range of health challenges, such as smoking, diabetes and cardiovascular conditions.

It was recognised nationally that existing CCGs were not delivering as much as they could, hence the wish to reframe the way they operated. There could not be guarantees that there would not be further restructures in the future but this would be determined by Government.

Financial Savings, stroke services, commissioning challenges and GP numbers – A Committee Member considered that the proposed changes were motivated by the need to make financial savings of £44million, which had subsequently increased to £46 million. The Member had not seen figures to indicate how much the changes would cost or how the restructuring would impact on the ability to realise savings. The decision taken not to establish a hyper acute stroke unit in Medway was a particular concern in view of the acuity and number of patients in Medway. Patient transport and dermatology were examples of where there had been significant commissioning related challenges. It was asked how capacity had been strengthened to avoid similar occurrences in the future and how services outside the scope of a single CCG would be commissioned. The Member also asked whether the system would have capacity to adequately address health needs and inequalities and whether the local shortfall of GPs would be addressed.

The Clinical Chair of Medway CCG acknowledged that budgeting for prevention could be challenging as it required current spending to realise future benefit. It was hoped that the proposals would help to facilitate an increase in preventative and collaborative work. There was unlikely to be an increase in the number of GPs per person but the extension of multi-disciplinary working, involving other medical professionals, would help to address patient needs. Some complex services commissioned by NHS England would continue to be commissioned by that organisation but the majority would be commissioned by the single CCG. It was anticipated that future commissioning would be

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undertaken more collaboratively and would be better placed to meet local needs.

The Clinical Chair of the Strategic Commissioner Steering Group said that the framework for Integrated Care Partnerships did not make them more likely to lead to privatisation and that it was envisaged that the proposals would enhance joint working. Although there was an ongoing need to do commissioning efficiently and make savings where possible, the driver of the proposals was not the need to save money, rather they were about making better use of existing resources. This could be better achieved through the creation of a single Kent and Medway CCG. A single Accountable Officer for the Kent and Medway CCGs had been appointed in April 2018 and savings had already been made.

Probity – A Member asked whether there were appropriate safeguards in place to prevent inappropriate contracting of services from persons or organisations that those involved in the commissioning process had a personal connection to.

NHS representatives in attendance felt that the way in which the question about probity had been asked was inappropriate. The Committee was advised that declarations of interest had to be made at CCG meetings, in a similar way to which they were made at the Council and that there were thorough processes in place to deal with potential conflicts. It was considered that establishment of a single CCG would be likely to lead to greater transparency as decisions would no longer be taken by eight separate CCGs. The Committee accepted assurances that the questions raised were not directed at those present.

Public Meetings – A Member expressed concern that the Joint Meeting of Clinical Commissioning Groups, that had made the decision in relation to the Kent and Medway Stroke review, had concluded in private due to disruption caused by some audience members. This had also resulted in Medway Councillors having to leave the meeting. Following a question about Medway Council processes, the Democratic Services Officer advised that there was provision for the press and public to be required to leave a Medway Council meeting if there was repeated disruption and following warnings from the Chairman.

Population increases – In response to a Member question that asked whether population increases were taken into account when funding was allocated to an area, the Clinical Chair of Medway CCG said that funding was determined by a national formula that was based on the population at a point in time. Ensuring that resources available matched growth was therefore a challenge. The centralisation of some services was necessary in order to ensure that specialised 24/7 care could be provided. This required there to be sufficient staff and patient numbers within the catchment area.

Voluntary Sector Support – In response to a question about engagement with the voluntary sector, the Committee was advised that some CCGs had engaged closely with the voluntary sector in relation to social prescribing. It would be important for Integrated Care Partnerships to have a close

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relationship with voluntary organisations. The skill for the single CCG would be to set outcomes based contracts that would require Integrated Care Partnerships to involve all partners. The Deputy Managing Director of Medway CCG added that the voluntary sector was a key workstream for Medway CCG and that it had performed better than the national average in terms of voluntary sector engagement.

Stroke Review and Integrated Care Partnership Geography – A Committee Member questioned whether the conclusion that a single CCG could be more effective than eight separate Kent and Medway CCGs cast doubt on the Kent and Medway Stroke Review decision as this had been made within a structure that was considered to no longer be suitable. It was also asked which specific areas would fall within the Medway and Swale Integrated Care Partnership area.

The Sustainability and Transformation Partnership Director of System Transformation said that the existing CCGs had come together to develop the Stroke Review process and that the review was considered to have followed an appropriate process. The Clinical Chair of Medway CCG said that the population covered by the Medway and Swale Integrated Care Partnership included all patients registered with practices in the Medway and Swale area. This included those living outside Medway and Swale who were registered with one of these practices.

Decision

The Committee

- i) Noted and commented on the update provided.
- ii) Requested that:
 - a) Details of CCG and Sustainability and Transformation Partnership meetings be provided to the Committee, to enable Members to attend those meetings open to the public.
 - b) Details of current Council representation at Sustainability and Transformation Partnership meetings be provided to the Committee.

220 Update on Kent and Medway Stroke Services Review

Discussion

The report provided an update on Medway's referral, to the Secretary of State for Health, of the decision in relation to the Kent and Medway Stroke Review as well as in relation to two Judicial Reviews on the same matter. It also provided the rationale for the consolidation of stroke services, currently provided at Maidstone and Tunbridge Wells Hospitals, onto a single site at Maidstone Hospital. In March 2019, the Committee had referred the decision made by the Joint Committee of Clinical Commissioning to establish hyper acute stroke units

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in Dartford, Maidstone and Ashford and not in Medway, to the Secretary of State for Health and Social Care. On 19 June, the Minister of State for Health referred Medway's request to the Independent Reconfiguration Panel (IRP), requesting an initial response by the end of June. The IRP advised that it would not be able to meet this deadline due to other referrals it was already considering. It is not currently known when the IRP will consider Medway's referral. Two parties had also made a submission for Judicial Review. The courts had decided to join these into a single action, with Medway Council having been named as an interested party. A decision on whether the Judicial Review could proceed was due to be taken on 3 and 5 December.

Maidstone and Tunbridge Wells NHS Trust had made the decision to consolidate its stroke services onto a single at Maidstone Hospital. This was on safety grounds, with the service provided at Tunbridge Wells having become unsustainable. The Trust said it respected Medway's referral and the Judicial Reviews, advising that the change was reversible.

A Committee Member said that no issues in relation to the sustainability of the Tunbridge Wells service had been raised during discussion of the stroke review and that the frailty of the Tunbridge Wells population had been one reason for the option of locating a HASU there. The Member questioned whether the safety of patients at Maidstone Hospital could be assured.

The Chief Operating Officer of the Trust said there was confidence that Maidstone would be able to absorb the additional patients safely. The additional patients averaged just 1.2 per day or a maximum of 3. The stroke service at Maidstone was a highly performing service with good clinical leadership. Despite attempts to recruit, it had not been possible to retain enough staff at Tunbridge Wells Hospital in order to safely provide a stroke service. This was in view of the fact that Tunbridge Wells would not be providing stroke services in the longer term with staff being aware that the service would close. The standard of service provided at Tunbridge Wells was therefore not as good as the one that could be provided at Maidstone. Engagement had been undertaken with the Kent Health Scrutiny Committee, the local MP and other stakeholders.

The Chief Executive of the Trust added that there had been a material change in the ability to staff the stroke unit at Tunbridge Wells since the stroke review decision had been taken. The focus was on ensuring the quality and safety of services and that patients requiring thrombolysis would receive it 24/7. Maidstone had sufficient staff to accommodate the changes and would be opening an additional ward.

A Committee Member was concerned that the Trust appeared to be stating that Tunbridge Wells would not become a HASU when this decision was subject to the outcome of Medway's referral and the Judicial Review of other parties. The Member said that this would have contributed to Tunbridge Wells no longer being able to retain or recruit sufficient staff to provide a stroke service. The Member also asked for clarification of which patients would be taken to

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Eastbourne Hospital once the service was no longer provided in Tunbridge Wells.

The Chief Executive said that there had been hard work to try to retain and recruit adequate staff for the stroke service at Tunbridge Wells and consideration had been given as to whether other staff could help to fill the gap. The Trust had reached the conclusion that to maintain quality and patient safety it would be best to consolidate services onto a single site at Maidstone. It was acknowledged that the language used in relation to the future of the Tunbridge Wells stroke service could have caused confusion. It was clarified that the catchment area for Tunbridge Wells included part of East Sussex and that some of these patients would, in future, be taken to Eastbourne instead of Maidstone.

In response to a Member's concern about the possible impact of the changes and outcome of the Stroke Review on Medway, the Chief Executive of Medway Foundation Trust said that the stroke unit at Medway was fully staffed but that there was risk that, as it had not been chosen as a HASU, it was possible that staffing could become more of a challenge.

Decision

The Committee:

- i) Considered and commented on the report, including the possible impact of the consolidation of stroke services on Medway residents.
- ii) Requested that the Committee be kept updated, via Medway Foundation Trust's regular update reports, on the staffing of the stroke unit at Medway Maritime Hospital.

221 Single Pathology Service for Kent and Medway

Discussion

There were three types of hospital pathology laboratory services - microbiology, blood sciences and cellular pathology services. There were currently hub laboratories in Maidstone, Dartford and Ashford and essential services laboratories in Tunbridge Wells, Medway, Canterbury and Margate. Work had been underway for a year to consider how to better collaborate and increase productivity and quality through the establishment of a single Kent and Medway Pathology Service. An outline case had been agreed by the four hospital trusts with a number of business cases being developed. These were due to be completed by the end of 2019.

In relation to transfer delays and other issues in relation to the North Kent Pathology Service (NKPS) that the Committee had previously been advised about, a Committee Member asked whether there was confidence that similar problems would be avoided by the new Kent and Medway service. They also asked whether it was still planned that emergency testing would be retained at

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all acute hospital sites and what the current standard was for waiting times. This was following the Member having encountered a patient at Medway Hospital who had waited six hours for blood test results.

The Chair of the Pathology Programme Board said that business cases being developed for the single service would include lessons learned. Every hospital had an essential service laboratory and this would not change under the proposal. Some testing was also undertaken at the patient's bedside. The turnaround time for off-site testing was typically a few days.

The Chief Executive of Medway Foundation Trust said he was keen to ensure that lessons were learned from the problems encountered by NKPS and that the service had now been stabilised but still faced problems. Medway was, therefore, in principle, supporting the establishment of a single service. Patients should not be waiting at the hospital for six hours in order to get results. In the event of the wait being long, patients should be asked to go home and then provided the results separately. The Chief Executive offered to investigate further if details were provided.

Decision

The Committee noted and commented on the progress of the Kent and Medway Pathology Programme.

222 Medway NHS Foundation Trust (MFT) Update

Discussion

The key points of the report were summarised as follows:

- Strategic objectives - MFT was making clear to staff the direction the organisation would be taking in the next 3 to 5 years. This had included refreshing the Clinical Strategy and the People Strategy. A fifth strategic objective, 'high quality care' had been added to the existing four objectives. In addition to the strategic objectives there were also core quality objectives that set out what the hospital was planning to achieve in the next 12 months.
- Local care - work was taking place with NHS Medway CCG to provide local care closer to where people live.
- Finances - The Trust had met its budget control total last year and achieved the cost improvement target of just over £21 million. This was the first time for ten years that both had been achieved, with it being expected that both would also be achieved for the current year. However, a large budget deficit remained. Spending on agency staff had further reduced with an expected spend of £11million in the current year, down from £16 million the previous year and £50 million previously.
- Staff survey results – the aim was to be in the top quartile of trusts for survey results. The latest results showed an increase in the percentage of staff who would recommend Medway as a place to work or to be treated.

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- Discharges – work continued to ensure that patients were discharged effectively and efficiently. This included work to ensure that patients were streamed to the most appropriate department and to prevent patients staying in acute beds longer than necessary.
- Executive changes – The former Chief Executive, Lesley Dwyer, had left towards the end of 2018, with the current Chief Executive, James Devine, having initially taken over on an interim basis and substantively from April 2019. The number of chief operating officers had been reduced from 2 to 1 and a Deputy Chief Executive appointed. The Medical Director had left their post while the Director of System Transformation had been seconded to the Medway and Swale Integrated Care Partnership.
- Patient numbers – July had been busy with a similar number of patients to during the winter. Performance in relation to the four-hour Emergency Department wait target was 80% compared to a national average of 79% and a target of 95%.
- Same Day Emergency Centre – MFT was the first hospital in Kent and Medway to have one. The Long Term Plan specified that all acute trusts should have such a facility. It was treating 60 to 80 patients each day with patients either discharged the same day or referred for further treatment.
- Diagnostics - 92 per cent of patients referred for diagnostics in June had tests undertaken within the target time compared to a trajectory of 99%. MRI testing was challenging with the hospital needing to use a mobile scanner for the next 4 to 6 months.

Members asked a number of questions which were responded to as follows:

Staff Survey results, efficiency savings and MRSA data – The Chief Executive had not expected better staff survey scores in view of the work undertaken, partly because there was likely to be a degree of cynicism for a period of time following appointment of a new Chief Executive. It was anticipated that the next staff survey results in January would show improvements. Assurance was given that savings made would not put service quality at risk. Data in relation to MRSA would be provided to the Committee.

Prevention and building repair – Noting that the condition of many people attending the emergency department was worse than it otherwise would be due to lifestyle factors, a Member asked if there was scope for a poor health prevention team to be placed in the emergency department. The Member also asked about building repairs and whether any new funding was available. The Chief Executive said that 30 to 40% of patients attending were redirected to primary care as they did not need treatment in the emergency department. Communications work was being undertaken with NHS Medway CCG to encourage patients to consider whether they need to attend the hospital or whether they should instead see their GP or other health professional.

The Director of Public Health said that care navigators were based at the hospital and that the aim was to increase this provision. The navigators worked with colleagues in acute and community settings to signpost patients to available support. People requiring operations for cancer were being supported

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to help them to get fitter before their operation. This had a positive impact on recovery time.

The Deputy Managing Director of NHS Medway CCG said that the development of Local Care included the provision of Integrated Local Review teams. These were staffed by GPs, consultants and multi-disciplinary teams. The teams worked with the frailest patients to ensure that care received was optimised.

The Chief Executive of MFT said that the Trust's capital programme was a significant challenge. Replacement of lifts was being undertaken as part of a three year programme and broader redevelopment on the hospital site was taking place as part of a five year programme. An Estates Strategy was currently being developed. The recent Government announcement of capital funds had not made an allocation to any hospital in Kent and Medway.

Addressing health inequalities – The hospital was working with Public Health on how to address inequalities and where to focus this work. Patients in Medway tended to be in relatively poor health, sometimes presenting with conditions that would be expected in those who were twenty years older. Much work had been undertaken to reduce smoking in Medway, particularly smoking during pregnancy. The number of smokers in Medway had decreased from 50,000 to 20,000.

An initiative, 'Grow your Brain' saw midwives at MFT looking at how disadvantaged women could be persuaded to adopt more healthy lifestyles.

Bed turnaround and staff survey response – A Member said that patients should be moved from their bed while they were waiting to receive prescriptions and invited back another day if the wait was going to be long. The Member also asked what the response level to the staff survey was. The Chief Executive said that bed turnaround was a challenge as occupancy was typically 94 to 98%. The hospital now arranged for patients to wait for prescriptions in a discharge lounge. The pharmacy was small and it could sometimes take time to dispense prescriptions. The Medway staff survey response was 40% compared to a national average of 49%.

The Director of People - Children and Adults highlighted significant improvements made in relation to hospital discharge Delayed Transfers of Care, both overall and those attributable to Adult Social Care. Medway was now one of the best performing areas in the south east, with the work to address it being a positive example of partnership working. Medway also had a low hospital readmission rate.

Recommendation

The Committee noted and commented on the report and requested that diagrams presented to the Committee as part of future reports also be provided as PowerPoint slides.

**223 Adult Community Health Services: Changes to Phlebotomy Services
Provision**

Discussion

The report provided an update on changes being made to phlebotomy services from September 2019. This was part of the wider adult community health services programme. Engagement on this programme had taken place in September and October 2018 with the majority of respondents having supported the proposed changes. In line with the Medway Model, services would be provided closer to the patient. The changes would increase the provision of phlebotomy services in Medway and make service provision more even. Phlebotomy services at MCH House would be reduced and then removed with provision extended at three Healthy Living Centres, including evening and weekend provision. Some GP practices in Medway, mainly in the Rochester area, also provided phlebotomy services. These services would continue and would not be affected by the changes.

Members asked a number of questions which were responded to as follows:

Recommissioning of community services – The reprocurement of community health services had been delayed by two years in view of the changes resulting from the NHS Long Term Plan, the development of Integrated Care Partnerships and anticipated changes to legislation. This had no effect on current service provision and the timescales for making improvements to phlebotomy services.

Provision in central Chatham and opening hours – Provision in Chatham was planned but a location for this had not yet been identified. It was anticipated that this would be provided by the end of March 2020. A Member request for evening and Saturday opening of the Chatham service would be taken into account. Service usage would be monitored across locations to ensure there was enough capacity.

Accounting for Population Changes and staff terms and conditions – provision was based on current populations. Information was provided by Public Health and capacity would be kept under review to reflect growth in localities. Medway Community Healthcare staff who currently provided services at MCH House would work at other centres in the future. Therefore, there would be no change to their terms and conditions. There would be sufficient staff capacity to be able to meet demand.

Communications and service quality – in response to a Member who emphasised the importance of communicating the changes, along with his hope that service quality would be maintained, the Medway Community Healthcare representative said that they would not expect the changes to lead to any reduction in service quality. Work was being undertaken to ensure that the changes were advertised and that patients were made aware of their options.

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Staffing capacity – Medway Community Healthcare had a flexible, mobile workforce. This would help ensure that all the locations that phlebotomy services were being provided in were sufficiently staffed.

Provision of Isle of Grain – In response to a Member's concern about lack of provision on the Isle of Grain, the Committee was advised that there was insufficient demand to provide a dedicated phlebotomy service. Patients from this area travelled to the Keystone Centre in Strood.

Decision

The Committee noted the planned changes to the phlebotomy service provision.

224 Outline of Proposed Changes to the way Acute Adult Mental Health Services are Delivered Across Kent and Medway, with Particular Potential Impact on The St Martins Hospital Site, Canterbury

Discussion

Work undertaken so far had shown reduced reliance on inpatient beds. The sale had been agreed of part of the St Martin's Hospital site, which would release capital to fund the estates improvement programme. The Cramer Ward, which was no longer fit for purpose, would close as a result. The report listed the future options for provision of this capacity. The proposals had been considered by the Kent Health Scrutiny Committee, which had considered them to amount to a substantial variation to the health service in Kent. Therefore, should Kent consider the proposals to be a substantial variation for Medway they would need to be considered by the Kent and Medway Joint Health Overview and Scrutiny Committee. An assurance process had been started with NHS England with it considering that public consultation would be required.

A Committee Member said that they considered the proposals to be a substantial variation as they involved a possible reduction in beds. Another Member agreed and said that they did not consider that work to reduce demand for inpatient facilities was sufficiently advanced in order for a reduction in beds to be considered. She requested that the consultation include engagement with service users to understand whether they considered that the need for inpatient beds was reducing.

In relation to the total out of area bed days of 3085, referenced in the Committee agenda, a Member was concerned that further loss of beds would lead to more out of area placements.

The Chief Operating officer of Kent and Medway NHS and Social Care Partnership Trust said that the patients placed out of area had specific needs and that any closure of St Martin's would not impact this group. KMPT was committed to identifying capital to build a unit for this cohort. There was agreement that public consultation would be a positive step.

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Decision

The Committee:

- i) Considered the proposed service change and determined that it constitutes a substantial development of or variation in the provision of health services in the local authority's area.
- ii) Agreed that the proposals do warrant formal public consultation.
- iii) Noted that as the Kent Health Overview and Scrutiny Committee had also deemed the proposals to constitute a substantial development or variation, the proposals would need to be considered by the Kent and Medway NHS Joint Overview and Scrutiny Committee.

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

Discussion

KMPT had appointed a new Chairman with the Trust welcoming the opportunities available to it as an organisation. This was against the backdrop of mental health having increasing importance at national level. The Care Quality Commission (CQC) rating of the Community Mental Health teams had improved from requires improvement to good. The Ruby Ward, an inpatient ward for older people with acute mental health difficulties at Medway Hospital, would be upgraded. This necessitated a temporary move to Dartford as there was no suitable alternative location in Medway. Members of the Committee were shortly due to visit the Community Mental Health Hub in Ashford. The hub enabled services to undertake more collaborative working and was similar to the Hub that was planned for Britton Farm, Gillingham. It was acknowledged that some GPs were critical of the provision at Canada House in Gillingham and that work was required with GPs to help them navigate the services available. The CCG had been able to provide some additional funding for primary care mental health provision. The way in which therapeutic services were delivered would change in order to ensure a more consistent service.

Work was taking place locally with the Mental Health and Learning Disability Steering Group to identify opportunities for joint working. The Kent and Medway STP had secured additional funding for developing and improving the crisis care treatment team. There had also been success in improving the resource available for Safe Havens. Partnership working, including working with the voluntary sector had increasing importance, particularly in the context of the development of Primary Care Networks. The opportunity to work as part of the Network and shape its development from the outset was welcome. There was a need to improve diagnostic rates for dementia and ensure that people with serious mental illnesses also received physical health checks.

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Members asked a number of questions which were responded to as follows:

Liaison Mental Health Service – In response to a question about patient feedback on the liaison mental health service, engagement was taking place with the Enabling Kent programme in order to obtain more robust feedback. Work was undertaken with Healthwatch Medway in relation to particular issues, with Healthwatch also taking part in Mystery Shopping activities. Few, if any complaints had been received regarding the service over the last few months.

Needs of people with complex mental health issues - Medication prescribed to this group, particularly patients with psychosis could have a significant impact on physical health. For example, some anti-psychotic medicines could result in significant weight gain. There was a need to develop primary care mental health services and to utilise social prescribing for those affected by complex mental health issues, although this group was likely to need additional support to engage in available opportunities. 40% of people referred to KMPT had serious mental illness, with this group being far more likely to have reduced life expectancy.

Support for people while recovering – It was questioned what support was available for people who were recovering from mental health difficulties and their families, once their treatment had finished. The Chief Operating Officer of KMPT considered that mental health services had become more fragmented during her career. The piecemeal way in which mental health services were currently commissioned was unhelpful, making the provision of onward support a challenge. The development of Primary Care Networks could help to address this through improved partnership working, including work with the voluntary sector and more joined-up commissioning. There was an opportunity via the Mental Health and Learning Disability Group to consider how to strengthen joint working. It was also suggested that the role of Community Navigators should be extended to include supporting mental health issues.

Future of Canada House – A written update would be circulated to the Committee to advise what the future of Canada House in Gillingham would be once community hub had opened at Britton Farm. It was also requested that this update be provided to the local ward councillors.

Resources for homelessness and dual diagnosis – KMPT was not commissioned to provide services in relation to dual diagnosis, although it was engaged in this work. There was no additional funding available in relation to homelessness but there had been work to develop homelessness hosts in Kent. Information about hosts in Medway would be circulated to the Committee.

The Assistant Director, Adult Social Care said that there had been a rough sleeping pilot in Medway. A Member of staff from Adult Social Care had been seconded to support particular issues related to mental health. There had been a number of positive outcomes. The Community Support Outreach team at Medway Council provided skills for independent living. The interface between services once people were no longer receiving support from KMPT was

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important to ensure that appropriate support was put in place to help people remain safe and well in the community.

Partnership Working between the Council and health partners – It was requested that a report be provided to the Committee on partnership working between the Council and health partners, including the voluntary sector. The Director of Public Health highlighted work with partners across the UK and abroad in relation to social prescribing. This would enable benchmarking of local activity.

Decision

The Committee noted the contents of the report and provided comments and requested that a report on partnership working between the Council and health partners be added to the Committee Work Programme.

226 Council Plan Performance Monitoring Report Quarter 4 and end of Year 2018/19

Discussion

A Member was pleased to see that performance against a number of the success measures had met or exceeded target and commended staff for their work. However, performance of some other success measures had been below target for a significant time. The measure, 'Proportion of adults in contact with secondary mental health services who live independently' was considered to be one example of where performance could improve if work was more joined-up. The Member asked, in view of the decreasing number of care home places available locally, whether the local market was able to meet demand. The Member also asked that the Committee commend the 'Men in Sheds' initiative and its role in addressing social isolation.

The Assistant Director – Adult Social Care said that performance for the proportion of adults with learning disabilities who lived in their home had been persistently below the national average but that there had been significant improvement. 2018/19 year end performance was 69%, a 2% improvement on the previous year and a 10% improvement compared to a few years previously. The gap between Medway and the national average had significantly reduced. Initiatives to support improvement in this area included growing the Shared Lives Service, with the ambition being to double its size in the next two years. The Service was an alternative to residential care for people with learning disabilities. A small transitions team had been created to ensure the effective management and support of people transitioning from children's to adult services.

A Mental Health and Disability Steering group had been established within Medway. This would look at how to support people with learning disabilities or mental health issues to live independent lives. It would also deliver the priorities set out in the Medway Mental Health Strategy and the Learning Disability Strategy, the latter of which was due to be considered by the Committee at its

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October 2019 meeting. Homelessness and housing options for people with mental health issues was an area that would be further investigated. It was acknowledged that improving performance against some measures would take time.

Adult Services undertook a range of work to help ensure that the care home provider market was sustainable. This included a small quality assurance function. There was sufficient supply of residential care available. Extra care provision had been developed, including two new schemes, as an alternative to residential care. It was acknowledged that there was pressure around nursing and nursing dementia provision locally. Work was taking place with NHS Medway Clinical Commissioning Group to develop this and ensure sufficient provision to meet future needs.

A Member considered the transition work to be excellent and also mentioned the increasing propensity of care homes to take day patients.

Decision

The Committee considered the quarter 4 and end of year 2018/19 performance of the measures of success used to monitor progress against the Council's priorities.

227 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.
- ii) Agreed to request that information on the Community Pharmacy Contractual Framework how it aligns with the Kent and Medway transformation programme is requested as part of a proposed Member Briefing on the NHS local Five Year Plan.

Chairman

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