Medway Council

Meeting of Health and Adult Social Care Overview and Scrutiny Committee

Tuesday, 18 August 2020

6.30pm to 11.15pm

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, Aldous, McDonald, Murray, Thompson and Mrs Elizabeth Turpin

Co-opted members without voting rights

Margaret Cane (Healthwatch Medway CIC Representative)

Substitutes: None.

In Attendance: Glynis Alexander, Director of Communications and Engagement, Medway NHS Foundation Trust, Director of Communications, Medway NHS Foundation Trust
Justin Chisnall, Acting Director of Health Improvement
James Devine, Chief Executive, Medway NHS Foundation Trust
Stuart Jeffery, Deputy Managing Director (Medway)
Navin Kumta, CCG Clinical Chair
James Lowell, Kent and Medway NHS Restart Programme Director, Medway NHS Foundation Trust
Venita Mattu, Legal Advisor
Jon Pitt, Democratic Services Officer
Martin Riley, Managing Director, Medway Community Healthcare and Joint Senior Responsible Officer for Medway and Swale ICP
Caroline Selkirk, Executive Director of Health Improvement, Kent and Medway Clinical Commissioning Group
Ian Sutherland, Director of People - Children and Adults Services
Nikki Teesdale, Associate Director of Commissioning, Medway Clinical Commissioning Group (CCG)
Paula Wilkins, Chief Nurse
Suzanne Westhead, Assistant Director - Adult Social Care
James Williams, Director of Public Health
Wilf Williams, Accountable Officer, Kent and Medway CCG, Kent and Medway Clinical Commissioning Group (CCG)

181 Apologies for absence

Apologies for absence were received from Councillors Ahmed, Barrett, Bhutia, Paterson and Price.

(During this period, the Conservative and Labour and Co-operative political groups had informally agreed, due the Coronavirus pandemic, to run meetings with reduced number of participants. This was to reduce risk, comply with Government guidance and enable more efficient meetings. Therefore the apologies given reflected that informal agreement of reduced participants.)

182 Record of meeting

The record of the meeting of the Committee held on 16 June 2020 was agreed and signed by the Chairman as correct.

183 Urgent matters by reason of special circumstances

There were none.

184 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.

185 Kent and Medway Clinical Commissioning Group Update

Discussion

The Accountable Officer of the Kent and Medway Clinical Commissioning Group (CCG) introduced the report. The single Kent and Medway CCG had been established on 1 April 2020 with the focus so far having been responding to Covid-19 and co-ordination of the multi-agency response. One of the corporate objectives of the CCG was the establishment of an Integrated Care System (ICS). The new executive was almost fully in place with only the Director of Digital Transformation yet to be appointed. A staff consultation on the new organisational structure had recently closed. Engagement had also taken place with the Primary Care Network (PCN) Clinical Directors in relation to the proposals. The Clinical Chair of the CCG said that having a single CCG in place had made co-ordination of the multi-agency response to Covid easier.

He advised that work was being undertaken looking at vulnerable groups and the BAME population to identify how their Covid risk could be reduced with work also taking place to ensure that elective and emergency services would be able to continue effectively over the winter period.

Members raised a number of questions, which included:

Funding, risks, services and staffing – concern was expressed that the new arrangements would be too costly and it was emphasised that Medway needed to retain a fair and equitable share of funding in view of the prevalence of health inequalities. It was also asked how risks would be managed effectively, how it would be ensured that provider changes did not adversely impact patients and whether significant staff redundancies or redeployments were expected.

The Accountable Officer said that there were no plans to reduce Medway's share of funding and disadvantaged communities may have more resources targeted at them. The development of the ICS would see more joint working between organisations to promote integrated care. Service delivery had not been impacted by the merger of CCGs with existing contracts being maintained. A risk-based approach would be used to drive organisational change. The development of the digital agenda had been a significant step. There had been a small number of redundancies so far with expressions of interest invited for some further voluntary redundancies. The number was expected to be small with many staff transferring to new roles.

Funding and Healthy Living Centres – It was questioned whether service reconfiguration involving some services being centralised and therefore no longer being provided in Medway would affect funding for the Medway population. It was also asked whether the CCG still aimed to develop GP services at Healthy Living Centres. The Accountable Officer said there were no plans to reduce funding available for treatment of Medway residents. The Integrated Care Partnership established for Medway and Swale was committed to working at a local level to redesign and improve services.

Commissioning, use of digital and engagement and BAME communities – it was asked how lessons were being learned from previous commissioning activity and how relationships would be built with the voluntary sector. It was also asked how digital engagement had been utilised, whether participation figures were available and how the patient voice would be taken into account. It was also asked what work was being undertaken to reduce the Covid risk amongst BAME communities.

The Accountable Officer said that a significant engagement process had been undertaken ahead of the new CCG having been developed. It was anticipated that a single CCG would deliver the scale benefits of a large organisation while retaining a local focus. Significant work was being undertaken to ensure resilience of services, including to prepare for winter and the EU Exit process. A detailed review of decision making was being undertaken to ensure that lessons were learned to avoid recurrence of previous issues. It was recognised that there was a need to ensure meaningful engagement was undertaken with

the voluntary sector. In relation to BAME communities, significant engagement was being undertaken to communicate the increased risks that some of these communities faced in relation to Covid and to ensure that risk assessments were undertaken of patients in high risk groups. Regarding the use of digital services, a survey would be undertaken to get service user views. GPs had increasingly been using video conferencing and telephone engagement. It had not been possible to undertake as much community engagement as expected due to Covid. Plans for this were under development and would be reported back to the Committee.

The Clinical Chair said that partnership working between commissioners and providers would be central to the ICP and PCN delivery. Links were being made to the voluntary sector, including the development of social prescribers and care navigators. Work was taking place with Public Health leads in Kent and Medway on a six-point action plan in order to communicate and mitigate the Covid risks to the BAME community. The Director of Public Health said that a bespoke needs assessment was being developed in relation to this and that it was due to be completed in the days following the Committee meeting. This would inform social marketing and engagement activity. Bespoke local testing sites would be established in areas with a high BAME population. A comprehensive work plan had been developed to prepare for a second wave of Covid, including the development of a local Outbreak Control Plan and it was considered that Medway was well prepared for a second wave. Healthwatch would be assisting with engagement activity.

Engagement and contract monitoring – concern was expressed that there was insufficient evidence of public engagement regarding development of the single CCG and associated structures, including that insufficient information had been provided in the report. It was also suggested that contracts should make performance targets explicit, with effective penalties and rewards in place and that these should be linked to the needs identified by public engagement.

The Accountable Officer recognised that the NHS was not as good at engaging with communities as it should be, either locally or nationally, and that further information could be provided to the Committee in future. Following a further question, it was agreed that concerns about potential conflicts of interest, should Committee Members participate in certain CCG events, be considered further outside the meeting.

Budgets and BAME Communities – in response to a question asking whether existing public health budgets were at risk and whether there were mechanisms to prevent members of the BAME community being racially profiled, the Director of Public Health said that funding was considered to be secure. Previous funding had been received in the form of a ring-fenced grant from the Department of Health and Social Care and there was no indication that the establishment of the Institute for Public Health Protection would impact on funding. The engagement Public Health was undertaking with BAME communities was to provide reassurance that help was available to help mitigate their risk of Covid-19 and to give them the confidence and knowledge to access care and support. The Clinical Chair said that given that a black

person with a pre-existing illness was twice as likely to die from Covid as a white person, there was a need to acknowledge this, engage with communities accordingly and offer appropriate support.

Benefits of a single CCG – it was asked what the benefits were of a single CCG and what challenges had been encountered. The Accountable Officer said that as the focus had been on the Covid response since the establishment of the single CCG it was hard to draw any firm conclusions from experience so far. However, it was anticipated that there would be efficiencies and more specialisation within the new CCG than could have been achieved by the smaller CCGs it had replaced. A challenge facing the new system would be ensuring that its work retained a local focus. Structures were being put in place to ensure this was achieved.

GP Numbers – it was questioned whether a successful model of GP provision would be one that had more or fewer GPs available than at present. The Accountable Officer said that success could not be determined simply in terms of GP numbers as GPs were increasingly working as part of multi-disciplinary teams using innovative models of care which were not reliant on there being the same number GPs available as previously. The increased use of digital working made it increasingly viable to utilise GPs who did not live in Kent and Medway with new technology attracting people to the workforce. The Clinical Chair added that although the number of GPs in the workforce was reducing there would be reduced demand as more services were delivered by other health professionals without there always being a need for a patient to first see a GP. It was also considered that the new CCG would be able to make decisions more effectively as it had a single governing body rather than there being the eight separate governing bodies as previously.

Voluntary sector resilience – concern was expressed that many of the voluntary sector organisations that would be able to support the social prescribing model currently faced existential challenges. It was asked what plans there were to support these organisations. The Accountable Officer said that voluntary sector fragility had been identified as a risk. Specific commitment could not be given to provide funding but as a general principle, it was acknowledged that a small investment could deliver significant future benefit.

Decision

The Committee:

i) noted and commented on the report.

ii) requested that a briefing note be provided to the Committee in relation to digital engagement/consultation, including numbers participating and a summary of groups unable to participate, with a view to a future update being added to the Committee Work Programme.

186 Developing Medway and Swale Integrated Care Partnership

Discussion

The Senior Responsible Officer for the Medway and Swale Integrated Care Partnership (ICP) introduced the report. The ambition was for the ICP to ensure the provision of more integrated health and care services across the system. A Partnership Board had been formed in July 2019 with the development of local care being a priority. This included the development of Healthy Living Centres. Preparations were currently taking place to deal with winter pressures, a possible second wave of Covid-19 and EU Exit. The ICP had set itself three objectives to measure success against. These included embracing use of digital technology, ensuring appropriate and safe hospital discharges and ensuring that the outcomes of one patient were improved each week. The Chief Executive of MFT added that the development of the ICP would help to ensure that the needs of people in Medway and Swale were prioritised and that money spent benefitted patients. The Director of Communications at MFT said that the development of the ICP had recognised the importance of the patient voice but that engagement work had needed to be paused due to Covid. It was recognised that there was a need to consider how engagement could be undertaken virtually and to look at how face-to-face engagement could resume. A regular bulletin had been produced on engagement activity and this could be circulated to the Committee.

Members raised a number of questions which included:

Care close to home and engagement – in order to ensure that people could be cared for at home or close to it, it was suggested that there needed to be better training for and engagement with the domiciliary care sector. It was suggested that digital engagement could be beneficial but that barriers to this needed to be addressed through the provision of equipment and appropriate support. In relation to patient engagement, patients needed to be confident that their views would be taken seriously and acted upon and concern was expressed that young people were not represented effectively during engagement activity.

The Senior Responsible Officer recognised that there was a need to enhance joint working between organisations and to support people with IT in the home. A Care Wheel was being piloted and some service users were being provided tablets. Work with wHoo Cares on the Hoo Peninsula involved the provision of IT support for patients. The Chief Executive said that more work was needed to consider how care would be provided, how to utilise the workforce and support services and how to strengthen the offer of care providers and Health Living Centres. The Director of Communications said that there was already engagement activity with young people via schools and the Youth Council but that it was recognised that a new, more creative approach was needed. Communications and engagement colleagues from across the sector and Healtwatch were working together to progress engagement activity. The Director of People – Children and Adults said that work had been undertaken

with domiciliary care providers in relation to areas such as training and provision of PPE and it was concerning to hear that there were still issues.

Representation and support of the voluntary sector – in view of the number of organisations represented on the ICP, it was asked how equal representation would be given to these organisations and how the voluntary sector would be supported.

The Senior Responsible Officer acknowledged that ensuring equal representation would be a challenge and that work was ongoing in this area. Wider engagement across stakeholders was envisaged and the Joint Strategic Needs Assessment Professional Clinical Advisory Board was looking at how to deliver services locally, including the development of a wider clinical strategy for the healthcare system. There was a need to ensure the existence of a vibrant voluntary sector. Medway Community Healthcare was working as part of a community interest network of organisations across the sector and work was taking place with voluntary organisations such as Medway Community Action to facilitate engagement with smaller organisations.

Engagement with Voluntary Sector – concern was expressed that engagement with the voluntary sector to date had been limited and that similar groups of people were engaged with repeatedly. It was questioned how a vibrant voluntary sector would be created in the context of the struggles it had faced during Covid. A comment was also made that some voluntary sector organisations were struggling for volunteers.

The Senior Responsible Officer said that there had been some examples of work with the voluntary sector but it was acknowledged that this needed to increase and suggestions in this area would be welcome. The Director of Communications said that Citizens Juries were being developed. This work had paused due to Covid with consideration being given as to how they could be restarted. Engagement had taken place with voluntary sector groups previously but there were many organisations so it had not been possible to reach all of them.

Risk Factors – it was asked whether there was confidence that all the risk factors set out in the report would be adequately mitigated. The Committee was advised that there was confidence of this and that risks would be taking into account during contract development. The ambition was for organisations to work together more collaboratively than they had done so previously. Effective data sharing between organisations and the use of a single data source would reduce bureaucracy and maximise funding available for patient care.

Decision

The Committee noted and commented on the report and requested that a briefing note be provided to the Committee in relation to Care Wheel pilot areas.

187 Covid-19 Response and Restart of NHS Services

Discussion

The NHS Restart Programme for the restart of services in Kent and Medway reflected national priorities to restart referrals, urgent and critical care and to catch up backlogs of patients waiting to be seen. Other focus areas included ensuring sufficient capacity to care for those infected with Covid-19 in the future and meeting the increased demand for rehabilitation and mental health services for patients who had previously had Covid-19.

It was suggested that it would have been useful for the report presented to contain more specific data and information on priorities and milestones for the restart activities identified and that this was needed in order to help the Committee ascertain how much more work was required to facilitate the full restart of services. It was also asked how it had been determined whether the overall risk of harm to a patient would be increased or decreased by asking them not to attend an appointment during the height of the Covid outbreak. It was stated that there were examples of vulnerable people within the community who had not been offered any support at the height of the pandemic.

The Executive Director of Health Improvement said that data was available and that there was a requirement to provide this to NHS bodies. It would also be presented to the CCG Governing Body and further data could then be shared with the Committee. The Covid-19 pandemic had been unprecedented and had necessitated new ways of working. Patients had been asked not to visit a GP or hospital for a period of time during the pandemic but when they had been encouraged to return, many had chosen not to. There was a need develop confidence and provide help and support for vulnerable groups. The Chief Executive of MFT said that detailed recovery plans were under development and that the details would be shared. Initial modelling showed that the full recovery of services would take into 2021/22.

It was asked how it would be ensured that supply chains for medicines would be protected in the event of a second wave of Covid and whether there was confidence that NHS 11 would be able to cope with demand. The Executive Director said that nationally the NHS had taken a number of steps to ensure the availability of medicines and that contingency plans continued to be developed. There had been some short-term supply issues with some drugs but comparable alternatives were available.

In response to a question that asked where NHS111, urgent care and mental health services would be able to meet demand, the Kent and Medway CCG Deputy Managing Director (Medway) said that in relation to NHS111, a Clinical Assessment Service was increasing the number of clinicians available to the service and that the required number of clinicians and call handlers would be available when the service went live on 1 October. Nationally, more callers potentially requiring urgent care would be encouraged to contact NHS111 for them to be directed to the most appropriate service. Some elements of the service would go live ahead of 1 October. The ability of GPs to access

consultants to discuss patient results and whether a referral or hospital admission was necessary had worked well during the Covid pandemic and had enabled more people to be cared for closer to home. The Chief Nurse said that it was anticipated that in the event of a second wave of Covid-19, services would not be stopped to the same extent as they had been earlier in the year.

Decision

The Committee noted and commented on the report and requested that a further update be presented to the next meeting of the Committee.

188 Primary Care Update - Medway

Discussion

The Executive Director of Health Improvement highlighted that Primary Care Networks were a key element of Integrated Care Partnerships. 47,000 additional primary care appointments would be available each year via improved access. It was highlighted that the DMC Healthcare run St Mary's Island group of practices and St Werburgh had had their registrations removed and that a handing back of the contracts had been agreed for this and for the Kings Family practice that was also run by DMC Healthcare. An interim service run by Medway Practice Alliance had been put in place while engagement was undertaken with local practices to consider longer term options.

Members raised a number of questions which included:

Issues with GP Services, staffing, data use and DMC Healthcare – there were some issues in relation to the interim GP services, broken ECG machines being highlighted as an example. It was pleasing that there had been recognition that people with learning disabilities needed particular support and also that a multi-disciplinary team had been developed for people with co-ocurring conditions such as drug and alcohol abuse. It was asked whether there were sufficient staff in place to provide services and whether there was the expertise to make effective use of data analytics. In relation to the DMC Healthcare surgeries, it was asked how the situation had been allowed to escalate in view of there having been problems for a significant period of time and why the Committee had not been made aware of issues sooner. There was concern that performance data that had been requested, which was said to have shown improvement, had not been provided and it was questioned whether there had been any such data. It was also suggested that patient concerns and complaints had not been taken seriously and assurance was sought from the CCG that there would not be a similar occurrence in the future.

The Executive Director said that the CCG Governing Body would receive a report in relation to the DMC Healthcare run services and that the findings of this would be shared with the Committee. The CCG had encouraged the CQC to act once the extent of the problems had become clear. There had been some teething problems in relation to the interim service but feedback from patients suggested that they were getting a better service than previously.

There was now increased scrutiny of primary care by the CCG nursing team and reports provided to the governing body now contained much more detail on primary care. The Acting Director of Health Improvement said that there had been significant joint working with organisations such as Medway Community Healthcare to ensure continuity of care for patients.

The Chief Nurse said that it was important to ensure that appropriate lessons were learned and that review of performance indicators was part of this processes, with a more sophisticated dashboard of indicators due to be developed. It was envisaged that more targeted support would be put in place when concerns were identified in the future. The CCG had been aware of problems associated with the DMC Healthcare surgeries at an early stage but there was a limited amount of information that could be made public ahead of the CQC publishing its report.

Other GP Surgeries – in response to concern that there were other GP surgeries facing difficulties in Medway, the Executive Director acknowledged that ideally there would be a greater number of GPs available. The development of Primary Care Networks was necessary as primary care was not sustainable without the development of new ways of working, including groups of practices working together. In response to a further question, it was confirmed that the initiative to encourage GPs to come out of retirement during the Covid pandemic had been a national rather than a local initiative that had aimed to ensure that primary care was not overwhelmed and that patient safety was maintained.

Out of hours appointments, home working and workloads – clarification was sought on whether out of hours appointments could be booked outside normal GP practice hours with it also being asked how the increase in homeworking and GP workloads were being managed.

The Kent and Medway CCG Deputy Managing Director (Medway) said that the Medway Foundation Trust Urgent Treatment Centre currently handled calls for its own out of hours walk in service. From October 2020, NHS 111 would handle the calls. Callers would be triaged over the phone to confirm whether they needed an urgent face to face appointment. If an appointment was required a timeslot would be given, minimising waiting at the Urgent Treatment Centre. Appointments would be bookable outside GP working hours.

The Executive Director of Health Improvement said that digital opportunities in Medway had been enhanced over the last couple of years. This included supporting GPs to move to a single software system, enabling them to access patient records more easily and for practices to support each other. The ability of GPs to work remotely had helped general practice to provide many more appointments during the Covid crisis and would otherwise have been possible and there had been positive patient feedback from those who had found it easier to get a GP appointment. GPs were able to access patient records remotely and were able to complete prescriptions electronically. GPs working from home were able to work more flexibly with the total time available for patient appointments increasing as a result.

It was acknowledged that remote appointments were not suitable for everyone but the reduced number of patients attending surgeries made them a safer environment for those who did need to. It was not envisaged that there would be a return to pre Covid levels of face to face appointments. The Acting Director said that the development of primary care networks and multi-disciplinary teams would help GP time to be used more effectively and help manage GP workloads. The Chief Nurse said that a governance review was undertaken ahead of GPs starting to work remotely. This included ensuring that they had a separate private area within their home to work from.

Rainham Healthy Living Centre – it was asked how an effective GP service would be offered at the Centre in view of the number of operational GP suites at the Centre having reduced. The Executive Director said that flexible and remote working arrangements were encouraging many GPs to work extra hours, but it was recognised that Kent and Medway had less GPs than other areas. The Acting Director said that the aim was for Healthy Living Centres to be filled with both primary and community care services for the local population. Work was taking place with GP practices to ensure service availability but some consolidation of services was necessary in view of GP numbers and that relative attractiveness to primary care staff of being part of a multi-disciplinary team.

Remote access concerns and engagement – concern was expressed that many patients would be unable to access remote GP appointments and also that call waiting times had increased at some of the surgeries previously run by DMC Healthcare. It was also asked how public engagement would be undertaken in relation to the contracting of new providers at these surgeries and how feedback would be taken into account during the procurement process.

The Chief Nurse said that many GPs had been concerned by the prospect of undertaking consultations remotely but that they now realised it was a viable option for many appointments. Remote appointments would not replace face-to-face with this option and telephone appointments being available for those unable to attend via video call. The remote triage of patients could be used to assess whether they needed a face-to-face appointment. The Acting Director added that the CCG used mystery shoppers to monitor patient telephone call waiting times and were not aware of any excessively long waits at the former DMC run surgeries.

It was acknowledged that there were lessons to learn from previous engagement in relation to these surgeries. This included that the engagement had not taken place for long enough and had taken place during the summer. An engagement process was being developed and would be reported to the Primary Care Commissioning Committee in September. Ensuring that engagement results were fully considered during the procurement process would be challenging. Feedback would be presented to the Health Scrutiny Committee as part of a future update.

Performance Indicators and independent report – it was suggested that the current set of performance indicators had not been sufficient to identify the

DMC Healthcare surgery issues soon enough. It was also asked whether there had been an apology to the patients of the DMC GP surgeries and whether an independent report would be produced in relation to these issues. It was requested that the lead Members of the Committee be provided any such report ahead of publication. The Executive Director said the Chief Nurse's team was undertaking regular visits to practices and that questions about the process would need to be answered after a report into the events relating to the DMC surgeries had been considered by the CCG Governing Body. The report would not be externally produced but there would be close collaboration with NHS England. An apology had been made to patients via the local press and in a letter sent to patients.

GP Numbers – further concern was expressed about the reducing number of GPs and the difficulties being faced in providing sufficient GPs at healthy Living Centres. In order to assist the Committee in its scrutiny of the matter, it was requested that future reports include a breakdown of GP numbers, to include for example, figures for three years ago, six months ago, the present and next year. It was also asked whether the move towards centralisation of GP services in Healthy Living Centres had been the right one. The Executive Director said that younger GPs tended not to want to work in small practices and that many GPs were also close to retirement age. In view of these constraints the future of general practice was considered to be GPs working in larger multi-disciplinary groups.

Decision

The Committee noted and commented on the report, requested that a future update to the Committee contained the details set out in the minutes and requested that a briefing note be provided containing statistics in relation to telephone appointments for the GP surgeries previously run by DMC Healthcare.

189 Dermatology Briefing

Discussion

The Committee considered a report which advised that DMC Healthcare had been providing dermatology services to Medway patients since April 2019. On 22 June 2020 the DMC dermatology contract had been formally suspended by Kent and Medway Clinical Commissioning Group (CCG) due to serious concerns regarding patient care. The paper provided the background to this development and detailed the action the CCG had taken to ensure an effective interim service was in place.

Members raised a number of questions which included:

Dermatology contract and Harm Review – it was asked why DMC Healthcare had been awarded the North Kent contract for Dermatology Services given that there had been significant concerns about its performance in relation to primary care. It was also asked why DMC Healthcare had

previously said they had incorrect information about patient waiting times and the acuity of patients and what performance monitoring would be undertaken of the interim provider, Sussex Community Dermatology Service (SCDS), to ensure that problems would not be repeated. In relation to the Harm Review process, it was asked when this would be complete and requested that details be provided to the Committee.

The Kent and Medway CCG Deputy Managing Director (Medway) had given notice on the North Kent Dermatology contract two years previously and that there had been seven months to re-procure the service. At the point of contract award, there was already a contract in place with DMC for the level 1 and 2 dermatology services with there having been no significant complaints or concerns raised about these services and there had also been good feedback about DMC provided primary care services at St Mary's Island. The procurement process was conducted blind and therefore those making the contract award decision had made it on the basis of the tender scores, without having been aware of the identity of the provider. The CCG could not say why DMC Healthcare had felt that they had not been given correct information about patient waits or acuity. There was some uncertainty about the content of a public meeting that had taken place at the Sunlight Centre and who had been responsible for running the centre at the time. The Kent and Medway CCG Deputy Managing Director (Medway) said he had checked and could confirm that Medway Community Healthcare had been responsible for running the Centre at that point. Further details of this meeting would be provided outside the Committee.

The Chief Nurse advised that the Harm Review process had commenced with over 1,000 patients having been reviewed so far in the very urgent and urgent groups. For patients where risk of potential harm had been identified a 1st stage review had been completed. The second stage of the process would look at patients waiting over 52 weeks or people with a potential cancer diagnosis who had experienced a 104 day wait. The whole process was expected to take several months. GPs had been asked to review patient lists as there was concern that these did not include all patients. Appeals had been made via the media for patients who might not have been included in the lists to make contact and a telephone helpline had been set up.

The transfer of patient data from DMC to SCDS had been a significant piece of work. 7,463 patient records had been transferred and 1,285 patients out-of-area patients identified who were not in Medway or north Kent and should therefore not have been on DMC's list. 600 patients on the list had previously been seen and discharged by DMC but the records had not been updated. The total outstanding backlog of patients to be seen inherited from DMC was therefore 5,575. 1,600 had been seen by SCDS to date. This included all patients with potentially life-threatening conditions who had been seen and where necessary, either treated or scheduled for treatment. The remaining 4,018 patients on the DMC backlog list were due to be seen by the end of September with all these patients having been deemed to have routine conditions. All new patients being referred on a two week wait pathway were being seen within the required timescale and there was 100% compliance

against the 31-day cancer treatment standard. It was anticipated that the target for completing the backlog of clinical reviews by the end of September would be met and that all routine patients would be seen in under 12 weeks by September. Service performance was better than nationally with a helpline having received 26 calls relating to complaints or patient harm reviews, which was a low number.

Accountability and future provision – it was asked who would be held responsible if any patients who had not gone through the harm review process suffered harm, how psychological harm was measured and what future provision of the service would look like.

The Chief Nurse said that all patients identified as requiring a harm review had been seen. If any avoidable deaths were identified, these would be considered on an individual basis, but none had been so far. However, some harm could occur many years later. Harm Reviews did aim to take psychological harm into account, but it was acknowledged that this was difficult to measure. The service put in place with SCDS was for emergency provision and a termination of the DMC contract was currently being negotiated. The aim would be to put in place a long-term contract for provision of the service.

Decision

The Committee noted and commented on the report and requested that Kent and Medway CCG update it regularly on the development of the dermatology service.

190 Work programme

Discussion

Members considered a report regarding the Committee's current work programme.

A request had been made for a report on the Covid-19 response in care homes to be added to the Committee Work Programme. It was suggested that this should look at care homes within the context of the Outbreak Control Plan and preparedness for a second wave of Covid. It was also suggested that a report that Healthwatch was producing in relation to support for care homes be added to the Work Programme as well as a report on care in the community.

It was suggested that Covid support for care homes be incorporated into the Adult Social Care Strategy. The Director of People – Children and Adults undertook to consider how the Strategy should include specific coverage of considerations in relation to care homes.

The possibility of an extra meeting of the Committee being arranged was discussed. This would be further considered at the next agenda planning meeting.

Concerns were raised that Member integrity had been called into question during the meeting.

Decision

The Committee:

i) agreed changes to the Work Programme as set out in paragraph 3 of the report and agreed during the meeting.

ii) agreed that reports on the Covid-19 home response in care homes; a Healthwatch report in relation to support for care homes and a report on Care in the Community be added to the Committee's Work Programme for consideration at a future meeting.

Chairman

Date:

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