Medway Council

Meeting of Health and Adult Social Care Overview and Scrutiny Committee

Tuesday, 15 October 2024

6.30pm to 9.56pm

Record of the meeting

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

Present: Councillors: McDonald (Chairperson), Campbell (Vice-Chairperson), Anang, Barrett, Cook, Crozer, Gilbourne, Hamandishe, Hyne, Jackson, Mandaracas and Wildey

Co-opted members without voting rights

Svajune Ulinskiene (Healthwatch Medway)

Substitutes: Councillors:
Browne (Substitute for Mark Prenter)

In Attendance: Mark Atkinson, Director of System Commissioning & Operational Planning, NHS Kent and Medway
Jayne Black, Chief Executive, Medway NHS Foundation Trust
Jackie Brown, Assistant Director Adult Social Care
Natalie Davies, Company Secretary, NHS Medway
Alison Davis, Chief Medical Officer, Medway NHS Foundation Trust
Ivor Duffy, Chief Finance Officer, NHS Kent and Medway
Lee-Anne Farach, Director of People and Deputy Chief Executive
Mike Gilbert, Executive Director of Corporate Governance, NHS Kent and Medway
Marie Hackshall, System Programme Lead – Learning Disability and Autism Kent and Medway
Kindra Hyttner, Director of Communications and Engagement, Kent and Medway NHS and Scial Care Partnership Trust
Dr Rakesh Koria, Dementia Clinical Lead, NHS Kent & Medway
Kate Langford, Chief Medical Officer (and acting CEO), NHS Kent and Medway
Paul Lumsdon, Chief Nurse, NHS Kent and Medway
Dr Peter Maskell, Stroke Network Clinical Lead
Rachel Parris, Deputy Director, Health Improvement and Transformation Kent and Medway NHS Integrated Care Board
David Reynolds, Head of Revenue Accounts
Teri Reynolds, Principal Democratic Services Officer

In Attendance continued:

Adrian Richardson, Director of Partnerships and Transformation, Kent and Medway NHS and Social Care Partnership Trust
Jacqueline Shicluna, Lawyer (Adults)
Dr David Whiting, Acting Director of Public Health

343 Apologies for absence

An apology for absence was received from Councillor Mark Prenter.

344 Record of meeting

The records of the meetings held on 7 August and 20 August 2024 were agreed and signed by the Chairperson as correct.

345 Urgent matters by reason of special circumstances

There were none.

346 Disclosable Pecuniary Interests or Other Significant Interests and Whipping

Disclosable pecuniary interests

There were none.

Other significant interests (OSIs)

There were none.

Other interests

Councillor Mandaracas explained that she was a trustee of the Sunlight Centre, which ran a dementia café. However, the reports did not have any direct reference to dementia cafes or the Sunlight Centre and therefore she was able to take part in the discussions.

347 Dementia Update

Discussion:

The Deputy Director Out of Hospital Care (Community Services) and the Dementia Clinical Lead from NHS Kent & Medway introduced the report which provided information on population statistics, the current dementia diagnosis rate in Medway and development plans that were being undertaken to support the achievement of the national directive to achieve 66.6% diagnosis rate of the predicted prevalence. It was explained that, in agreement with NHS England, an interim target of 63% diagnosis rate by March 2025 had been set and that there had been significant improvement in the rate since April 2024. Jointly

funded Dementia Co-ordinators had been introduced to become the primary contact for patients and carers and to ensure co-ordinated services were wrapped around the patient and their families.

Members then raised a number of questions and comments, which included:

- **Diagnosis rate** – in response to a comment that, although the improvement was welcomed, the rate of diagnosis remained at an unacceptable level, it was acknowledged that more work was needed but that following a long period of static or reducing rates of diagnosis, the marked improvement was a positive sign that the work being implemented was making a positive impact.

- **Dementia co-ordinators** – in response to a question about how many Dementia Co-ordinators existed, it was explained that there was 1 per Primary Care Network (PCN). Reference was made to an evaluation of feedback received about post diagnostic support both before and after the introduction of Dementia Co-ordinators and it was undertaken to circulate this to the Committee.

- **Reliance on GPs** – concern was raised that there was a reliance on upskilling GPs to carry out assessments, despite the level of GPs per population being low in Medway. In response, comment was made that in many cases, dementia was preventable and that therefore there was more to be done as a society to empower people to keep well and live healthy lives, as well as building age friendly communities. It was added that diagnosing patients in the community, with not just GPs but a combination of wider health care professionals to be able to look at the whole person, had shown to improve diagnosis rates and also led to improved management of the condition.

- **Infrastructure** – reference was made to the infrastructure needed, across the system to make Medway dementia friendly and how leaders were working jointly across organisations. In response it was clarified that there was a system wide dementia oversight partnership board in place, chaired by the clinical lead for dementia to work collectively on improvements system wide.

Decision:

a) The Committee noted the contents of the report and that in August 2024 Medway achieved a significant improvement in the dementia diagnosis rate to 61.4%.

b) The Committee requested information about Dementia Co-ordinators, in terms of numbers and the outcome of the evaluation relating to patient experience since their introduction.

c) The Committee requested information about the ongoing impact and implementation of the recommendations from the Task Group that looked into Dementia Friendly Medway in 2017.

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

Discussion:

The Director of Transformation and Partnerships and the Director of Communication and Engagement from Kent and Medway NHS and Social Care Partnership Trust (KMPT) introduced the report which provided three updates. In relation to the Trust's identity and rebranding it was explained that the Trust was looking to change its name to Kent and Medway Mental Health NHS Trust from April 2025. In relation to the relocation of Ruby Ward and the transportation offer it was explained that a volunteer drivers scheme was in place and that demand for dial-a-ride had been minimal. Visiting hours at the majority of KMPT wards had also been extended to improve accessibility and flexibility for families to visit their loved ones which had been positively received. Lastly an update was provided in relation to the Memory Assessment Service, improvement of which was being implemented across three phases. Outcomes would include improved rapid diagnosis and an increase in those able to assess and diagnose.

Reference was also made to the Royal College of Psychiatrists', national audit of dementia which had found that nationally, there was an average of 15 days discrepancy between the less and most deprived areas accessing memory assessment services. Work was therefore ongoing to improve access for those from the most deprived areas. Lastly, confirmation was provided that the backlog caused by the Covid-19 pandemic had been eliminated in October 2023.

Members then raised a number of questions and comments, which included:

- **Rebranding** – reference was made to the necessity to rebrand and its associated cost. In response it was explained that following extensive engagement it was clear that the Trust's name was confusing and caused a lack of clarity for patients, staff and partners about what the Trust offered. In terms of the projected cost related to the rebranding, it was explained that the Trust was taking a pragmatic approach and using the opportunity to update poor signage that was already in need of replacing and updating to make it easier for patients to navigate and find services.

- **Targets** – in response to a comment about overall performance and future targets, it was explained that the strategic ambition set last year was that 95% of patients referred would be assessed and receive a diagnosis within 6 weeks. It was reiterated that this was a stretching ambition but that this was important in striving for the best for its patients. It was also considered that the target of 63% diagnosis rate by March 2025 (as referenced in the previous item) was achievable.

Decision:

The Committee noted the report.

349 Adult Autism and ADHD Pathway Development and Procurement

Discussion:

The System Programme Lead for Learning Disability, Autism and ADHD, Kent and Medway Partnership for Neurodiversity, introduced the report which provided an update on a new proposed adult autism and ADHD care pathway. Attached to the report was a completed substantial variation assessment questionnaire for the Committee's consideration. Reference was made to the significant increase seen nationally in referrals for autism and ADHD in adults as well as children. It was explained that the proposals did not include a reduction or negative impact for patients although the significant demand which continued to exceed the capacity within the service would remain a challenge.

Members then raised a number of questions and comments which included:

- **Support before diagnosis** – concern was raised that too much emphasis was being put on support before diagnosis, rather than speeding up the diagnosis process. In response it was explained that a large proportion of the population were neurodivergent and identifying people and supporting them to self manage and access services without the need for a diagnosis was important. Often support needed before and after diagnosis remained the same. Therefore focussing on meeting the needs of the person which led to the referral rather than focussing on the diagnosis itself, was vital.

- **Foetal Alcohol Syndrome Disorder (FASD)** – in response to a question about whether FASD was included within the pathway it was confirmed that within children's discussions, this was often looked at, however, it had not been raised in the context of adults, and this would therefore be taken away and explored.

- **Data** – in response to a query it was confirmed that the chart in the papers was not complete due to the high demand. Over 31,000 referrals had been made in a two year period and so information on this was still being processed. However it was confirmed that approximately 7000 of the referrals related to Medway residents.

- **Change in providers** – in response to a question about changes in providers, it was explained that under new procurement legislation, this service was being procured under the Right to Choose which would result in a larger number of providers being available but with greater oversight being built in with assurance around consistency in approach through an accreditation process. In relation to the community offer, it was explained this was currently provided by a number of organisations and it was therefore intended to bring this together, with intensive

support services remaining the same. Services would continue to be delivered locally and providers would be expected to have a footprint in Medway.

- **Gender** – in response to a query about why more females were being referred compared to males, it was explained that there had been a perception that ADHD was prominently apparent in males but that was in fact not the case, but it did typically present in different ways between men and women. There was much more awareness in neurodiversity amongst females and that is what was likely to have caused the escalation in female referrals.

- **Links to mental health needs** – in response to a question about whether there was any linkage between neurodiversity and mental health needs, it was explained that for many coming through the pathway they had co-existing mental health needs and so there were strong links with KMPT and the mental health pathways to ensure there was no disadvantage for being neurodiverse.

- **Waiting times** – in response to a concern about waiting times and how they compared to other areas, it was explained that the waiting times were significant which reflected the significant demand and this was experienced on a national level. Kent and Medway was experiencing some of the longer waiting times but they were not out of kilter with other areas. Equally, medication reviews were taking two years which was also much longer than it should be and work was underway to improve the interface with primary care colleagues and to make the process more streamlined in the new pathway.

- **Current provider** – in terms of any risks to the resilience of the current provider to manage up until the end of the existing contract, it was explained that they had raised their concerns and the relationship between provider and commissioner was strong with meetings held 3 times a week and action plans being developed and delivered collaboratively.

- **Source of referrals** – in response to a question about the sources for referrals, it was explained that referrals were predominantly from GPs, primary care and mental health practitioners with some from social care professionals.

- **Kent HOSC decision** – in response to a question about why the Kent Health Overview and Scrutiny Committee had decided that the proposals did not constitute a substantial variation (SV), it was explained that there had been debate on this issue but it was decided that as the proposals were about enhancing and improving services, whilst recognising demand remained a challenge, it had decided that the proposals were not an SV.

- **Funding concerns** – in response to a concern about the resource available for providers to manage the demand it was clarified that the Integrated Care Board (ICB) funds each assessment and diagnosis, which presented a financial risk to the ICB. The intention was therefore to maximise output by investing as much as possible in community support offers.

- **Medway involvement** – assurance was provided by the Assistant Director, Adult Social Care that Medway was fully involved in the proposals and developments as were people with lived experience to help shape proposals.

- **Positive change** – the view was given that the change, although positive and welcomed, was a substantial variation as patients would experience change even if that were improved. It was noted that this was a difficult area with challenges and there was a desire for the Committee to be a part of that journey. It was suggested that the Committee and the ICB consider it to be a 'light touch' SV, enabling the much needed improvements and developments to continue at pace.

Decision:

a) The Committee noted the update from the Kent and Medway Partnership for Neurodiversity, as set out in the report and at the Substantial Variation questionnaire, attached at Appendix 1 to the report.

b) The Committee agreed that the proposals did constitute a substantial variation or development in the provision of health services in Medway.

350 Mortality Rates at Medway NHS Foundation Trust

Discussion:

The Chief Executive and the Chief Medical Officer from Medway NHS Foundation Trust (MFT) introduced the report which provided an update on mortality rates at MFT and the work that was being undertaken to progress improvements. It was explained that work had been carried out to ensure accurate data quality and the next phase was to look at a case mix of patients. Reference was made to the context in which MFT sat, such as the area having low GP to patient ratios and a significant number of the population aged over 75 years. It was explained that MFT was one of the best performing in relation to ambulance hand over but this led to a crowded Emergency Department (ED) so work was focusing on how the flow through the hospital could be improved to avoid patients experiencing long waits in ED.

Members then raised a number of questions and comments, which included:

- **Treatment Escalation Plans (TEP)** – in response to a question about how much progress had been made in relation to the integration of TEP onto Electronic Patient Records it was explained that there had been

significant improvement and it was hoped this would be completed within 3-4 months.

- **Risk adverse** – in response to a question whether practices had become more risk adverse due to the rise in mortality rates, Members were assured that every patient received the correct care they required for their needs.

- **System wide impacts** – reference was made to how the wider system had some contributory factors to mortality rates at MFT, for example high demand and shortage of beds and patients coming to hospital who could be better treated elsewhere. Work was underway with other healthcare professionals to ensure patients were taken to the right place for treatment, which was not necessarily Medway Maritime Hospital and also to ensure provision was available in the community to be able to ensure timely discharges. A large contribution to this work was the development of the Single Point of Access out of hospital urgent care hubs, which in the first couple of months of implementation had seen an average reduction of 10-15 ambulance intakes a day at MFT where some patients could be treated better elsewhere, away from ED. MFT were doing all in their power to address issues within their remit but some solutions needed to be realised with a system wide approach.

- **Monitoring of improvements** – It was explained that there was a focus on improvements and making sure they were delivered in a sustainable way with clear monitoring to avoid inconsistencies.

Decision:

The Committee noted the report.

351 Stroke Provision

Discussion:

The Deputy Director of Out of Hospital Care and the Integrated Stroke Delivery Network Clinical Lead from NHS Kent and Medway introduced the report which provided an update on Stroke Provision, in particular the transient ischaemic attack (TIA) service and the progress made to provide the service locally. There had been digital issues at MFT to implement electronic patient records (EPR), however that issue was now in a position to provide some elements but the pharmacy service element was still not resolved and therefore at the moment, some treatment for residents of Medway and Swale in relation to TIA, could still not be provided out of MFT.

Members then raised a number of comments and questions, which included:

- **Stroke review** – reference to the stroke review, which had led to a remodelling of stroke services across Kent and Medway which resulted in two hyper-acute stroke units (HASUs) being established as well as TIA seven-day services being part of proposals. A view was shared that

stroke services should have remained in Medway and that a HASU should have been established closer to the most concentrated need (Gillingham and Chatham). In response it was explained that before the reconfiguration, stroke services across Kent and Medway had been inadequate and evidence demonstrated that larger specialist HASUs provided better care for stroke patients and this had been replicated in Kent and Medway as demonstrated in the table set out in the report. The point was also made that patient feedback had shown that they wanted to receive excellent care and were prepared to travel to receive it.

- **Pharmacy service** – reference was made to the pharmacy service issue currently at MFT and whether this would be resolved. In response, assurance was given that this was still a priority to get resolved. It was explained that software was required which would take time to implement and embed but would be a long term solution.

Decision:

The Committee noted the report.

352 Kent and Medway Integrated Care Board Community Services Transformation Update

Discussion:

A number of representatives from NHS Kent and Medway Integrated Care Board (ICB) introduced the report by providing a short presentation which included information about the background to the issue, engagement and communication undertaken and a financial overview of the proposals.

Members then asked a number of questions and comments, which included:

- **Mitigate disruption** – in response to a question about plans to mitigate any disruption caused from potential changes in provider, it was explained that built into the procurement was a six month transition period to ensure smooth transitional arrangements.

- **Staffing** – in response to a question about how the ICB were working with providers to address vacancies within the workforce, it was explained that the ICB took a supportive role in developing and bringing staffing groups and networks together and raised the profile of working for Kent and Medway to help address the shortage which was a national issue. In addition, the ICB worked with chief people officers across providers to develop a collaborative strategy for recruitment, including working with universities. It was recognised this would be a continual challenge.

- **Needs analysis** – it was asked if there was more detail about the needs and impact on communities such as specific needs of neurodivergent children or children with disabilities or particular needs and how such

groups had been specifically communicated with. It was explained that at this stage engagement had been broad and more specific and targeted consultation would occur as the transformation process progressed over the course of the contract.

- **HASC involvement post procurement** – clarity was sought as to how HASC could be involved and have a voice on transformation of service once contracts were agreed. The ICB confirmed that there would be a number of service change proposals that would be brought back to the Committee for co-development and full involvement as the transformation plans progressed, but the ICB did not know at this stage what the specific changes would be. Change was needed to improve the delivery and quality of some services and to deliver care in different ways and HASC would be consulted on changes as they were identified and developed.

- **Discrepancy in transition pathways** – reference was made to the discrepancy in transition between children's and adults services, which for some children's services was 18 in Kent and 19 in Medway. It was asked how this impacted both in terms of finances and transition between the two. It was confirmed that through the new contractual arrangements the ICB would ensure consistency across Kent and Medway, recognising that this issue caused frustrations for patients who also welcomed a consistent approach.

- **Substantial Variation (SV) status** – reference had been made to the difference in opinion between the Committee and the ICB around whether the re-procurement of community services was an SV or not. The ICB were asked how, within the remit of an SV, could the two work together to move forward as it was accepted that continued improvement was needed. The ICB acknowledged that the Council had determined the procurement was a substantial variation and reiterated that as and when proposals were developed they would each be brought to the Committee for discussion, but that at the current time, there were no detailed plans to discuss with the Committee outside of the Ambitions Document, which was attached as Appendix 2 of Annex A to the report.

- **Transparency** – The point was made that without understanding more detail about the implications of the transformation that would be built into the contract, it was difficult for the Committee to be able to effectively scrutinise and have any possible influence and the concern was that, if this was done post contracts being let, the opportunity to influence would then be lost or greatly diminished. It was suggested that in order to be ready to go out to tender for the community services contract, the ICB must have had more detailed scope and timescales around the transformation. Clarity and transparency was needed from the ICB in order for the Committee to be able to carry out its health scrutiny function and it was not considered that this was being provided. The ICB referred to their Ambitions Document, which would be provided with the invitation to tender. This document set out the aspirations for the

transformation but did not provide specifics as these would need to be worked through with the providers once contracts had been awarded.

- **Lord Darzi report** – reference was made by the ICB to the Independent Investigation of the NHS in England by Lord Darzi which recognised the needed direction of travel for health services to focus more on prevention rather than treatment and to focus on delivery of services in the community rather than in hospital. It was therefore anticipated that the forthcoming NHS 10 Year Health Plan would provide further direction in relation to the structures of health care provision and providing more focus on community based services, which in turn would feed into the transformation as it is progressed.

- **Framework of engagement** – the ICB offered to provide the outline framework of how the ICB would work with HASC and communities to develop service specifications together.

- **Finances** – the ICB explained that the budget for community services was fixed for five years with no expectation of funding reductions. There would be an element of levelling up and it was explained that currently funding for Swale was probably higher than that of Medway. It was also anticipated following the Darzi review that more funding would likely be made available for community services and so in line with this, the ICB was committed to looking at opportunities to shift more funding from acute to community/out of hospital provision.

- **Direct award option** – in response to a question as to whether the ICB had considered using direct award as an option for procurement, given the new legislation around procurement and the opportunities provided under award process 'c' of those arrangements, it was explained that based on legal advice and advice from NHS England, the proposed approach to go out to full competitive procurement was the most appropriate option, as direct award could leave the ICB at risk of challenge.

It was reiterated that there was a collective understanding that change was needed and the opportunity to develop services to achieve improvement was welcomed. The difficulty the Committee had was the approach in how this was undertaken and it was suggested that the Chairperson, Vice-Chairperson and Opposition Spokespersons of the Committee meet with lead officers and lead ICB representatives to develop a way through in an informal meeting and then report back to this Committee.

Decision:

The Committee agreed for the Chairperson, Vice-Chairperson and Opposition Spokespersons of the Committee to meet with lead officers and lead ICB representatives to develop a way through in an informal meeting and then report back to this Committee on the way forward.

353 Work programme

Discussion:

The Principal Democratic Services Officer introduced the report which updated the Committee on its current work programme. She explained that officers would provide a briefing note in relation to the item being removed from the work programme about the impact of immigration policies. She also explained that she and the Director of People had provided a presentation to the Integrated Care Board the previous week on health scrutiny and it was recommended that some development sessions be arranged between the Committee and the ICB, which would be planned in due course.

Decision:

The Committee noted the report and agreed the work programme as set out at Appendix 1 to the report, subject to accepting the proposed changes, outlined in italic text on Appendix 1 and noted that a briefing note on the impact of immigration policies would be provided.

Chairperson

Date:

democratic.services@medway.gov.uk

Telephone: 01634 332072
Email: democratic.services@medway.gov.uk