KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 17 October 2008.

PRESENT: Mr B R Cope, Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Ms A Harrison, Mrs S V Hohler, Mr G A Horne MBE, Mr W V Newman, DL (Substitute for Mrs E D Rowbotham), Mr M J Northey, Ms B J Simpson, Dr T R Robinson, Mrs P A V Stockell (Substitute for Mr A R Chell), Mr R Tolputt, Mrs E M Tweed, Cllr Ms A Blackmore and Cllr M Lyons

IN ATTENDANCE: Ms D Fitch, Assistant Democratic Service Manager (Policy Overview), and Mr T Godfrey, Research Officer to Health Overview Scrutiny Committee.

UNRESTRICTED ITEMS

46. Membership
(Item 1)

(Mr Fittock, Vice Chairman, presiding)

(1) It was reported that the Borough and District Councils had now agreed their four voting members on the Committee. The Members are as follows:-

Councillor Marilyn Peters, Dartford Borough Council
Councillor Annabelle Blackmore, Maidstone Borough Council
Councillor Jackie Perkins, Canterbury City Council
Councillor Michael Lyons, Shepway District Council

Colleagues from West Kent would have a pool of substitutes should Councillors Peters or Blackmore be unable to attend. The pool of Members are:-

Councillor Janet Sergison, Tonbridge and Malling Borough Council
Councillor John Cunningham, Tunbridge Wells Borough Council
Councillor Diane Marsh and Councillor Leslie Hills, Gravesham Borough Council
Councillor Richard Davison, Sevenoaks District Council.

(2) That the Borough and District Council Membership on the Committee, as set out above be noted.

47. Election of Chairman
(Item 3)

RESOLVED That Mr B R Cope be elected Chairman of the Committee.

Proposed by Mr G A Horne, Seconded by Mr M J Northey

48. Minutes - 5 September 2008
(Item 5)

RESOLVED that the Minutes of the meeting held on 5 September 2008 are correctly recorded and that they be signed by the Chairman.

49. Update on various issues
(Item 6)

(1) The Committee received a report which updated them on the Access to Healthcare (Transport) piece of work and the "Picture of Health in Outer South East London.

(2) RESOLVED that the report be noted.

50. Delayed Transfers of Care from Acute Hospital Trusts
(Item 7)

(Steve Phoenix, Chief Executive, Sharon Jones, Director of Community Services and Daryl Robertson, Director of Performance & Delivery, West Kent Primary Care Trust; Nikki Luffingham, Chief Operating Officer, Maidstone & Tunbridge Wells NHS Trust; Jessica Scott, Head of Clinical Site and Operational Safety, Medway Foundation Trust; Sarah Andrews, Director of Nursing, Simon Perks, Deputy Director of Commissioning and Sue Baldwin, Assistant Director, Intermediate Care Services, Eastern & Coastal Kent Primary Care Trust; Andy Schofield, Head of Nursing for Medicine and Lesley White, Acute and Emergency Services Manager, East Kent Hospitals Trust; Anne Tidmarsh, Head of Adult Services, East Kent, Janice Duff, District Manager, East Kent, KASS and Margaret Howard, Director of Commissioning and Provision, West Kent were in attendance for this item).

(Mr Clark, MP, joined the meeting during this item)

(1) The Chairman welcomed colleagues from the NHS and Social Care to the meeting and invited Members to ask questions and to raise any issues on this subject.

(2) Ms Harrison referred to reports of a situation where patients seemed to be kept at Medway Acute Hospital rather than being moved to Sittingbourne and Sheppey and that families were told that there were no beds available at Sheppey when there actually were. She stated that the system should be made easier for all families to access.

(3) Ms Baldwin, Assistant Director, Intermediate Care Services, Eastern and Coastal Kent PCT stated that she did not understand why there was a delay in moving patients from Medway to the community hospitals in Swale. She stated that assessments beds were being rolled out to Sittingbourne and Sheppey hospitals and that a new community matron was being recruited. A Health colleague explained the discharge process from the acute beds at Medway Hospital to the Swale Community Hospital's. They had a multi-disciplinary team and cases were looked at individually to determine whether assessment, rehabilitation or end of life beds were needed, all of which were available at Sittingbourne and Sheppey Community Hospitals.

(4) Mrs Angell commended the excellent procedures for discharge that were in place at Darent Valley Hospital for planned procedures. However, it was a more complex situation when people had been admitted through A&E or had MRSA, she asked how these complexities were dealt with to ensure that delayed discharges did not occur.

(5) Ms Howard (Director of Commissioning and Provision, West Kent) explained that social care services across East and West Kent worked closely with colleagues from the health service in relation to providing intermediate care and avoiding delayed discharges. Social care had staff based in or near hospitals.

(6) Mr Tolputt asked the following questions. If a self funder is offered a place away from home and they refuse to take it, is that bed blocking? A lot of nursing homes have a two tier funding system, does this cause a problem? Does the new Dover Community Hospital have any in-patient beds?

(7) Mrs Tidmarsh (Head of Adult Services, East Kent) clarified that self funders could refuse to leave hospital until accommodation that they were happy with was found, as could anybody, else and there were protocol in place on how best to work with patients to get a satisfactory outcome. Regarding two tier funding, the reality was that care homes could charge what they wanted but social care were working with care homes owners on this. A problem was caused with self funders when their depleted assets meant that they then came under social care funding.

(8) In relation to the question on Dover Community Hospital Ms Baldwin (Assistant Director, Intermediate Care Services, Eastern & Coastal Kent Primary Care Trust) explained that she was meeting with Dover GP's to develop the services. She stated that she did not think that the GP's had ruled out having in-patient beds but they wanted to make sure that what was put in place in Dover was right for the health economy. There was a two year strategy for intermediate care for Kent. Mrs Tidmarsh confirmed that she was working closely with the Commissioners in relation to the Dover Community Hospital and bed provision. They were working jointly for a joint solution. She referred to other in-patient bed provision within the area.

(9) Mr Horne asked whether acute trusts and primary care trusts could help one another financially to reduce delayed discharges.

(10) Mr Phoenix stated that it was a common misconception to say that PCT's were allocated blocks of money for particular sectors. He stated that he received £862m for West Kent and it was up to the PCT to deploy it for the health care of the residents of that area. The PCT was free to deploy this as it saw fit. There was not an allocation to the PCT which was ring fenced for acute trust provision.

(11) In relation to issues raised around the number of bed days in West Kent, Mr Phoenix stated that a huge amount of work had been done on bringing down the bed day figures. The current rate was below the national target and was 3.5%. In one particular week Maidstone and Tunbridge Wells had had no delayed transfers. The opening of beds at Tonbridge Cottage Hospital had created a greater focus on rehabilitation and had improved throughput by 40%. Beds were handled by more modern nursing and rehabilitation techniques. He predicted that Maidstone and Tunbridge Wells would show significant improvement. He stated that he and colleagues worked closely in an integrated way with those from social care. In March

2007, when they had received and approved the Community Hospital Review, they had opened up all beds, which it was clinically safe to do, and increased the number of patients seen. It remained a focus for the PCT to keep delayed discharges to the minimum. This was not something that could be solved once and for all and it was important to keep working on this. He stated that because of issues at Maidstone Hospital, they had taken been distracted from delayed discharges but they were now focusing more on it.

(12) Mr Horne asked that if the interface between the Primary Care Trust and the Acute Care Trust was so close, it raised the issue of whether there was a need to have different Trusts and could not one Trust deal with both issues.

(13) In relation to the question of acute trusts managing PCT beds, there was a preliminary meeting being held on 21 October to look at any opportunities for working in an integrated way across primary, secondary, acute and social care services. In order to find evidence of any efficiencies in relation to this, it was necessary to look internationally. He stated that he had an open mind about what might be effective, but there were arguments about integration on a number of levels. While it could be argued that it would be logical to integrate GP's and social care, it was not a simple answer and the assumption should not be made that if a community hospital was run by another part of the health service, it would make if more effective.

(14) Mr Curwood referred to Mr Clarke MP's letter and the figure of 6,467 bed days being lost at Maidstone and Tunbridge Wells NHS Trust due to delayed discharges from 15 October 2007 to 6 July 2008.

(15) Mr Phoenix stated that on any one day in West Kent there were 8 to 14 community hospital beds not occupied, this was to facilitate a fluid system with flexible capacity. He referred to other bed pressures which had occurred last winter when the wards were undergoing a deep clean. Colleagues had worked hard to make sure the system was not put under undue stress. In the year to date the number of bed days had continued downwards and he believed it could go down even further.

(16) Mrs Tweed referred to tables on page 48 of the papers circulated with the agenda and asked whether some of the delayed discharges were caused by patients and/or family choice and the time taken to realise these choices.

(17) Ms Howard stated that Social Services were responsible for identifying a range of care homes that would be appropriate and the families were given two weeks to make a decision. If things went beyond that period it was covered by the Hospital Choice Protocol.

(18) Mrs Tweed asked what could be done to help families make quicker informed choices.

(19) Mrs Tidmarsh referred to a pilot on assessment beds that was being carried out in East Kent, part of which involved helping patients and families make informed choices. If this pilot was successful in reducing delayed discharges it would be rolled out over the whole of East Kent.

(20) Mrs Duff (District Manager, East Kent KASS) stated that there were a number of categories in relation to choice, some issues revolved around the choice of home and availability, others around the financial situation and there were a further category where the family did not wish to engage. As part of the pilot, they were compiling a breakdown of these different categories to see where the majority of issues lay and how they could be targeted.

(21) Ms Robertson (Director of Performance & Delivery, West Kent Primary Care Trust) stated that work was needed in West Kent around delayed transfers, especially ways to improve pathways. The aim was to plan the right pathway with patients and carers when patients were admitted. Although it was acknowledged there were occasionally complex issues which hindered this.

(22) Ms Howard referred to occasions where there may be an inter-agency disagreement but there was a protocol that would mean that this would not delay discharge. They worked across partnerships to resolve partner problems.

(23) Mr Fittock stated that there were a couple of issues that he would like to see addressed, the first was preventative measures i.e. stopping people going into hospital who should not be there in the first place and secondly, in West Kent, particularly in Dartford/Swanley, there was a problem in finding suitable social care accommodation that was affordable. This made the choice for people very hard if at times there was nowhere in the areas that was affordable on the social care scale.

(24) Mr Phoenix stated that in relation to prevention care, he referred to a pilot at Maidstone Hospital in the Emergency Care Centre where over 12 weeks GP's were involved with assessing patients. This resulted in 153 fewer patients needed to be admitted. There were a whole raft of community and primary care measures which were aimed at trying to ensure that people were looked after at home and supported via the GP service rather than going into hospital, work on this was continuing.

(25) Mrs Tidmarsh referred to the work in East Kent on the Urgent Care Project which looked at the whole pathway in and out of hospital and the preventative services in Kent. Based on the Swedish model they had integrated discharge teams at all hospital sites who met on a daily basis. As in West Kent, they had found that having a high involvement of GP's in A&E prevented admissions and Health and Social acted together in relation to community services. She referred to the issue of transferring of funding. In East and Coastal Kent PCT, in order to keep people at home, it was necessary to transfer some funding from the PCT to social care to support care packages in the home. It was about the market and having good domiciliary care services which were integrated. She referred to work with care service providers and having a block contract so that care workers had a variety of services to provide which made it more attractive to them. She confirmed that there was close working relationships between the social care team and primary care colleagues.

(26) In relation to a question on the occupational therapy services, Mrs Tidmarsh stated that colleagues were focused on getting people back to their home and made sure that occupational therapy provision was in place. Ms Howard stated that there were never enough Occupational Therapists. However, hospital discharges were prioritised and temporary equipment was put in if necessary once an occupational therapy assessment had been carried out. This was done as quickly as possible,

and there was liaison between the district and borough councils to seek more permanent provision, if necessary.

(27) The Chairman welcomed Mr G Clark MP to the meeting and invited him to ask questions and raise issues.

(28) Mr Clark thanked the Committee for holding this session on delayed discharge and referred to the letters that he had submitted. He stated that he, along with a colleague, Sir John Stanley MP, had been involved in a series of meetings across the healthcare sector following the Healthcare Commission's report on c Difficile. What became apparent to them was that there was an issue around Accident and Emergency (A&E) in that ambulances were not able to discharge patients as the A&E facility was full. He understood that the problem caused at A&E was due to no beds being available through delayed discharge from acute to community hospitals. He referred to the recently published Healthcare Commission's Annual Report which put Maidstone and Tunbridge Wells at the bottom 4% of Trusts nationally. He stated that the Trust had failed in 2007/08 to meet the target for the four hour consultation in A&E. He mentioned the figure of 6,467 bed days lost in Maidstone and Tunbridge Wells between 15 October 2007 and 6 July 2008, due to delayed discharge. These delays could create problems in A&E. He stated that there was an issue as to whether there were enough beds available both in acute and community hospitals. There should be the right management arrangements over beds in community hospitals. It was important to look at whether the handover arrangements between the Acute Trusts, PCTs and social care were right. He stated that it was important to get to the bottom of the problem of delayed discharges and the knock on effect these had at A&E which could cause serious problems over the winter months.

(29) Mr Phoenix replied that he was disappointed with the Healthcare Commission's report results, the A&E figures had focused on the 4 hour waiting time which he acknowledged last year in Maidstone and Tunbridge Wells was poor and unacceptable. However, if you looked at the total way urgent cases were handled across the country, West Kent was one of the best in the country. It was important to look at a more detailed piece of work rather than the narrow measures around A&E and to focus on the standard rather than just the targets. He acknowledged that during the summer and winter of 2007/08 delayed transfers were at an unacceptably high level. However, he stated that the MP's had visited at a difficult time and a contributory factor to the increase in delayed transfers was the deep clean that was being carried out. He presumed that other hospitals as well were obliged to close wards to do the deep clean which would have had an impact. Since January 2008 there had been a reduction in delayed transfers and that both acute trusts in West Kent were now below the national target of 3.5%. He acknowledged that during the winter months these figures often increased but the challenge was across the system to make sure that it remained within the target level.

(30) Mr Phoenix stated that all community hospital beds had been opened with the exception of the ward at Sevenoaks which needed capital building funding and there were eight to ten beds available on any day.

(31) Mr Clark then left the meeting.

(32) Mrs Angell asked what effect the reduction of waiting lists and waiting times from 18 months to 18 weeks had had on delayed discharges.

(33) Ms White (Acute and Emergency Services Manager, East Kent Hospitals Trust) stated that the reduction in waiting times had not affected delayed discharges as most people undertaking elective procedures were generally fit and delays tended to relate to more complex and often elderly cases. She stated that 5% of in-patients took up 35% of bed days, it tended to be complex medical problems that caused delays. Health service and social care colleagues worked as a whole team to help patients to get to where they wanted to go. Ms Scott, (Head of Clinical Site and Operational Safety, Medway Foundation Trust) confirmed that the reduction in waiting times had not had an impact on delayed discharges as there was a pre-assessment process which captured the patients needs at that point so plans were able to be put in place at an early stage.

(34) Ms Luffingham (Chief Operating Officer) Maidstone and Tunbridge Wells NHS Trust stated that the 18 week waiting period had highlighted the complexity of delayed discharges as an issue.

(35) Mrs Angell asked whether there was access to an advocacy service for patients having to make difficult choices prior to discharge as some patients may not have any family or may wish to talk through options with somebody outside of their family.

(36) Mr Schofield, Head of Nursing for Medicine, East Kent Hospital Trust stated that nurses were able to be advocates for patients and that within hospitals large multidisciplinary teams were established to link between social services and nurses and patients families. Miss Tidmarsh explained that Kent Social Services funded several advocacy agencies and sometimes an advocate was necessary to help the family and patient arrive at an independent decision.

(37) Mrs Angell noted that there did not seem to be a consistent approach across Kent in relation to advocacy for patients.

(38) Councillor Davison from Sevenoaks District Council asked about the usage figures for beds in community hospitals and also whether the money followed the patient from the acute hospital to the Community Hospital.

(39) Mr Phoenix confirmed that the data on bed occupancy levels was available and regularly reported to PCT Trust Boards. He explained that there had been a policy change and that they tried to keep bed occupancy levels that related to planned admissions at around 95% so that there was some flexibility. There was a different kind of occupancy level for intensive/acute beds. At times occupancy had been 100% because medically it appeared to be the right thing to do.

(40) In relation to funding following the patient, Mr Phoenix explained that the sum of money applied to the patient depended on the complexity and severity of their needs. If the patient was discharged earlier than anticipated, then that would be an advantage financially for the Trust. However, if the patient was transferred to the community hospital, there was a transfer of resources and this depended on what point in the patients journey that happened. He stated that this was called splitting the tariff.

(41) Mr Northey referred to the scheme of assessment beds as set out on page 42 of the papers for the meeting, which had been a successful pilot scheme and asked whether it was planned to roll out this scheme across the rest of Kent.

(42) Ms Baldwin (Assistant Director, Intermediate Care Services, Eastern and Coastal Kent PCT) stated that she worked closely with Social Services in Kent. She referred to the pilot scheme that had been running in the Canterbury area for the past five months where they used social services residential units in Whitstable and Herne Bay for intermediate care. This was run under the Urgent Care Board banner and because the scheme had used residential beds it could be rolled out where there were no community hospitals.

(43) Ms Duff (District Manager, East Kent, KASS) stated that as an individual moved into an assessment bed on a waiting programme they became part of a red, amber, green system and it was aimed for them not to stay for more than four weeks. There was a multi-disciplinary team to assist with this. Self funding clients had been included in the pilot and had benefited from it. The pilot also involved carers and worked through support plans. It was also being tested with clients who had dementia, to ensure that it incorporated the right skills to support this.

(44) Councillor Blackmore, Maidstone Borough Council, acknowledged the good work that was going on and congratulated health care and social care colleagues. She asked what best practice there was elsewhere and whether it was being taken into account in Kent. Also, in relation to the aging population, what contingencies were taken into consideration in modelling services?

(45) Mr Phoenix explained that at the end of the year the PCT's would produce its next five year strategic plan and there was some service modelling. The PCT's knew what the demographical changes were and they would come back to the Committee later to talk specifically about initiatives in West Kent. He stated that they had one of the healthiest populations in the country but inevitably as people got older they sometimes got sicker. There was a partnership strategy to help keep people healthy and living at home longer and joint work needed to continue to be done around that. In relation to the Maidstone and Tunbridge Wells Trust's new hospital at Pembury, service modelling was being done. However, the further forward ahead the modelling went more tenuous the outcomes tended to be.

(46) Mr Phoenix stated that in relation to the pilot in Maidstone and Tunbridge Wells he was aiming to reduce the discharge target down to 1.4%.

(49) Mr Horne stated that it would be worthwhile revisiting the issue of “Splitting the Tariff” in relation to West Kent PCT. He also said that given the assurances given today, it is not pleasant to hear that the Maidstone Hospital is in the lower 4%. If a Trust is in that position, we assume that it is working hard to do something about that. He raised the point that the new hospital in Pembury will have less beds than the other two hospitals it will be replacing and asked whether we can be confident that there will be enough beds available. He also said that there must be programmes to enhance community hospitals given the issues raised at the meeting.

(50) Ms Jones, Director of Community Services, West Kent PCT confirmed that modelling had been carried out at Pembury and it was clear that they needed to reduce the length of stay as long, as it was clinically safe, and was benchmarked nationally. There were other factors to be taken into account, such as the community hospital and day care facilities and they had linked into services plans for Pembury. In relation to the split tariff she stated community hospital funding was as it should be and there was no financial issue in the transfer of patients.

(51) Councillor Lyons, Shepway District Council, asked who monitored the number of beds available in nursing and care homes. Ms Howard replied that Kent Social Services had good intelligence in relation to the supply of care beds and in Kent there was currently an over supply.

(52) Mrs Tidmarsh stated that they monitored nursing and care home beds. She gave the example of planning applications in East Kent for several homes and commented that if all of those homes that have received planning permission were built there would be over capacity. There was a balance to be struck and she worked with district councils to ensure that they looked at their planning permission for nursing and care homes carefully.

(53) Mr Fittock asked whether delays in getting drugs from the pharmacy particularly at weekends, affected the statistics for delayed discharge, Ms White stated that work was in hand to ensure that there were no delays in pharmacies dispensing medicine on discharge.

(54) The Chairman thanked Health and Social Care colleagues for attending the meeting and commended the way they were working together and thanked them for answering Members questions.

(55) RESOLVED That the Chairman and Spokesmen would agree recommendations based on the issues raised during the discussion.

The following recommendations on the issue of delayed transfers of care following the meeting of the Health Overview and Scrutiny Committee on 17 October 2008:-

1. The Committee congratulates social services and the NHS on their partnership working in tackling delayed transfers of care and, once the different pilots have been fully assessed, the Committee asks that the Trusts and KASS look at the possibility of spreading best practice across the whole county, as well as looking closely at best practice in other areas of the country.

2. The Assessment Beds Pilot in East Kent has the full support of the Committee and requests an update by July 2009 containing an evaluation of the pilot and details as to how it has been taken forward.

3. The Committee supports the aims of the Discharge Planning Pilot in West Kent and requests an update by July 2009 containing an evaluation of the pilot and details as to how it has been taken forward.

4. The Committee commends the establishment of a joint agreement on non-weight-bearing patients in West Kent and asks to be informed by the three parties involved whether, at the end of its first year of operation, it will be continued.

5. The Primary Care Trusts in Kent and KASS shall be asked to provide a yearly written update to the Committee containing the numbers of community, nursing and residential beds available to people in Kent so as to provide information on capacity in the county.

6. The Committee shall request further information from KASS and NHS Trusts in Kent regarding existing patient advocacy service provision.

51. Date of next programmed meeting – Tuesday 2 December 2008 at 1:00 pm
(Item 9)

RESOLVED that the date of the next meeting be noted.