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, 8 October 2010.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mrs J A Rook, Mr R Tolputt, Mrs J Whittle, Mr A T Willicombe, Cllr C Kirby, Cllr M Lyons, Mr R Kendall, Cllr Ms A Blackmore (Substitute for Cllr Mrs M Peters) and Dr M R Eddy (Substitute for Mr M J Fittock)

ALSO PRESENT:

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

UNRESTRICTED ITEMS

3. Introduction/Webcasting

(Item 1)

4. Minutes

(Item 4)

RESOLVED that the Minutes of the meetings held on 3 September and 20 September 2010 are recorded and that they be signed by the Chairman.

5. Pain Management Services

(Item 5)

Dr Jon Norman (Lead Clinician Chronic Pain, Maidstone and Tunbridge Wells NHS Trust), Ashley Scarff (Head of Business and Corporate Planning, Maidstone and Tunbridge Wells NHS Trust), Patricia Davies (Director of Service Improvement, NHS West Kent), Zoe McMahon (Commissioning Pathways Improvement Manager, NHS West Kent), Alison Davis (Assistant Director of Commissioning, NHS Eastern and Coastal Kent), Jo Staddon (Lead Commissioner for Musculoskeletal Services and Adult Therapies, NHS Eastern and Coastal Kent), Val Conway (Clinical Lead-Consultant Nurse Community Chronic Pain Service, NHS Eastern and Coastal Kent), Hilary Birrell (Community Chronic Pain and Orthopaedic Service Manager, NHS Eastern and Coastal Kent), Sheila Pitt (Head of Cancer, Long Term Conditions and Therapies, NHS Eastern and Coastal Kent), Dr Claire Butler (Medical Director, Pilgrims Hospice), Dr Bruce Pollington (Medical Director, Heart of Kent Hospice), and John Ashelford were present for this item.

(1) Representatives from NHS West Kent presented an overview of the situation for patients in their health economy and explained that large number of patients did require pain management services and these did need to be developed locally.

Specialist services were accessed at Guy's Hospital and elsewhere, but there were concerns that now a service based in Medway had been withdrawn, this would be too far for some patients to travel. Community Hospitals were being utilised, and they were looking at developing a more specialised service at Maidstone Hospital.

(2) An overview from representatives of NHS Eastern and Coastal Kent followed. A review had been carried out in 2005 as it was recognised that pain management services were not delivering and this was followed by a redesign across the eastern half of the county. The system in place involved those with complex pain being referred to the acute sector for interventions and to community services for non-complex interventions.

(3) One Member observed that services in the east of the county appeared to be better than in the west and specifically asked about the pain clinic which had been withdrawn from Maidstone Hospital five years ago. Dr Norman was able to provide the broader context as he had moved to Maidstone and Tunbridge Wells NHS Trust (MTW) after the closure of this service. The previous service had been a single-handed service and was unsustainable, but more staff were hired and the service rebuilt. The 18 week waiting time target was now being reached and in January 2009 the MTW board had agreed to set up a hub and spoke model and Sevenoaks had just opened as the first spoke. A clinic at Maidstone Hospital would not be possible until July 2011 following the move of some services to the new Pembury Hospital to make facilities available at Maidstone. There was no guarantee of funding and there was a possibility of a different provider appearing. Separately, a cancer pain service had been established at Maidstone in 2005 and this was performing well.

(4) A number of Members had personal experience of pain and pain services and this lead to a discussion around the patient experience. The view was expressed that the use of painkillers was not always advisable as it masked the pain and that training the patient to manage the pain was the better way. Dr Norman explained that it was important to treat the patient as an individual and that the treatment, be it drugs or rehabilitation, had to suit the kind of patient. In Eastern and Coastal Kent it was explained that self-management was the model. Part of this was to hold Pain Roadshows to reach out to people who had yet to access pain services and overall an unmet need for the service had been found when the redesigned service was set up and there were now 300 referrals a month to the service.

(5) The point was also made by clinical representatives present that education of medical professionals was also required and that clinicians often felt they needed to be seen to do something, such as prescribe drugs, when doing nothing was sometimes the better option.

(6) In West Kent the development of GP services was being looked at and a pilot had been set up by the Invicta cluster concerned with back pain. The skill mix for services in East Kent was different with less focus on consultants and more on nurses. There were referrals between the two parts of the county.

(7) Patients requiring pain services were a very diverse group and there was a need for specialist services were there was enough need for clinicians to gain the appropriate experience. However, with Payment by Results, services were paid for piecemeal and the Market Forces Factor meant that each treatment cost more in London so there was a financial incentive to repatriate services, although patient

choice has and would continue to play a part in patients going outside of Kent. The pain involved in travelling was given as another reason for bringing services closer to home. The repatriation of pain pump work from Basildon to Kent was provided as an example. The establishment of a clinic in Sevenoaks was partly to enable patients who had previously accessed services at Bromley to access them locally. Specialist spinal services were available at Guy's and other services were available at University College London, the Royal National Orthopaedic Hospital and King's. Concerns were raised about communication following discharge from King's.

(8) Representatives of the Hospice sector were present and provided details of the large overlap between their services and regular pain management services. Hospices had built up a good level of expertise in this area over the years, primarily in cancer pain though the number of conditions that the hospices managed was expanding. The work of Dr Norman and the cancer pain services at MTW was highly praised by the clinical directors of the Hospices represented. The amount of funding that hospices receive from Primary Care Trusts varied, with the Pilgrims Hospice receiving 30% from NHS Eastern and Coastal Kent. The hospice at Home programme was being rolled out in East Kent and would cover the whole area from January 2011.

(9) Hospices also played a role in training registrars and sharing knowledge with GPs was also seen as key with the money that could be saved through utilising pain management services rather than drugs given as an example. There was potential for closer integration between the hospices and other sectors dealing with pain management.

(10) The Chairman thanked all those who had participated in a very informative debate.

6. South East Coast Ambulance Service - Current Developments

(Item 6)

Geraint Davies (Director of Business Development, South East Coast Ambulance Service NHS Trust), Geoff Catling (Director of Technical Services and Logistics, South East Coast Ambulance Service NHS Trust), and Darren Reynolds (Head of Business Development South East Coast Ambulance Service NHS Trust) were present for this item.

(1) Prior to the meeting, Members of the Committee had had the opportunity to visit the Thanet Make Ready Depot and the Coxheath Emergency Dispatch Centre. All Members who were able to attend found the visits highly informative and the Chairman thanked the South East Coast Ambulance Service (SECAmb) on their behalf for arranging these valuable opportunities.

(2) The offer was made to provide further opportunities for Members to spend time at Coxheath at a future date.

(3) Although some reservations had been expressed at the previous meeting on this subject, Members expressed the view that the logic behind the move to Make Ready Depots was inescapable and that it was a better use of resources and staff if

paramedics were not expected to clean and stock their ambulances. Community response posts to enable ambulances to be located where they are most needed are usually easy to find, though one was still being sought on the Isle of Sheppey. Locations for Make Ready Depots were not as easy to locate.

(4) The depots were appropriate for the way the modern ambulance service had changed over the years to where it now offered a mobile health service and often avoided the need for taking patients to an Accident and Emergency Department.

(5) Make Ready Depots also allowed for an improvement in infection control measures, although rates had never been too bad in the service, as ambulances would be able to be deep cleaned every six weeks. In between calls, universal precautions such as hand washing and wiping down the ambulance were used unless they were notified of a reportable disease that required further measures.

(6) The nature of paramedic training was also developing with paramedic practitioners able to deal with a wider range of situations at the scene and critical care paramedics who were able to stabilise patients for transfer to a specialist centre, such as the primary angioplasty service at William Harvey Hospital. In coming years there will also be an increasing range of technology available for use on ambulances such as portable x-ray machines, but improvements need to be made such as in this instance becoming smaller and chargeable.

(7) The Emergency Dispatch Centre in Coxheath had a new Computer Aided Dispatch System installed earlier this year. Sussex already had the same system and it had been installed in Surrey three days prior to the meeting. This meant that the whole region was covered by the same system and the different dispatch centres could communicate efficiently to each other. The system meant that 80% of the time, it could be predicted where ambulances needed to be deployed.

(8) The gaps and inefficiencies in the organisation were often in rural areas, and it was here that Community First Responders had a key role to play. These trained lay responders were trained to use defibrillators. In the case of a Category A incident such as cardiac arrest, for each minute that passed the chance of recovery decreased by 11%, and if treatment is received within 4 minutes, there is an 80% chance the heart attach can be reversed so the Community First Responders could often buy time and save lives.

(9) SECAmb explained that they felt that the next stage in streamlining the service was through a Single Point of Access. It has been recognised that accessing the NHS for non-emergency services can be seen as chaotic with a range of different avenues such as NHS Direct, Minor Injuries Units, GP Out of Hours services. It is estimated that 40% of attendances at Accident and Emergency Departments are unnecessary. However, there is currently no live directory of what services are available where and when and, as importantly, what services were not available as an alternative to Accident and Emergency. This is being worked on and when it is available, it will enable people to be directed to the right place at the right time.

(10) A number of Members expressed reservations about the wider issue of bringing in a single non-emergency, 111, number to complement 999 on the grounds that it would confuse members of the public and that if the same system and same

call centre was going to receive and triage all the calls, it was felt that just one number would make access even easier.

(11) Representatives from SECAmb replied by saying that the issue of phone numbers was important but shouldn't distract from the broader benefits. The North East Ambulance Service was already operating a Single Point of Access. More than 2 million calls had been through the system and the initial response from the public had been positive. The system in use there mean the ambulance service could book a caller an appointment with a GP out of hours service. SECAmb are dealing with a 5% compound increase in activity each year and are looking to the Single Point of Access to help them manage this at a time of increasing financial pressures. Geraint Davies, Director of Business Development for SECAmb, offered to bring data on the performance of the system in other areas back to the HOSC for a fuller discussion on the pros and cons of the concept.

(12) Another area that was being developed within SECAmb was that of Passenger Transport Services. There was a sense that this was often misunderstood by the public and part of the reason for this was that it did differ across the South East Coast region. SECAmb provided the service in Sussex, private providers covered Surrey and in Kent in differed by Acute Trust. SECAmb were hoping to be in a position where the services could be integrated.

(13) Several Members raised points about the interaction of the Ambulance Service with Acute Trusts. Representatives from SECAmb explained that the target was for a thirty minute turnaround at hospitals, fifteen minutes for the handover and fifteen minutes to prepare the vehicle for further use. This could vary according to the nature of the incident. Concerning a specific incident involving an older person being left outside their home at night with no keys following discharge from a hospital and conveyance by an ambulance mentioned by a Member of the Committee, the Trust explained that this should not have happened and offered to speak to the Member about this outside the meeting.

(14) The Ambulance Trust explained that they had a zero tolerance approach to attacks on staff, which were often carried out by onlookers and members of the patient's family. If a prosecution was successful this would enable someone to be flagged on the system so an appropriate response could be made.

7. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update

(Item 7)

(1) Members thanked the Chairman for the letter which had been sent to the Secretary of State for Health on behalf of the Committee and which was included in the Agenda pack.

(2) However, Members were not content with the refusal of the South East Coast Strategic Health Authority to promise to send a copy of their report to the Secretary of State for Health on the grounds that it would be for the Secretary of State to decide who should see the report.

(3) The Committee requested that the Chairman write to the Strategic Health Authority and request once more a copy of the report.

8. Forward Work Programme
(Item 8)

Members agreed the Forward Work Programme.

9. Committee Topic Discussion
(Item 9)

(1) On the issue of Pain Management Services, several Members felt that the issue of what happens after patients from Kent had been discharged from tertiary centres in London in terms of communicating with parts of the local NHS. Another Member requested the opportunity to visit the chronic pain services in East Kent and Officers undertook to explore this possibility.

(2) Following the discussion with SECAmb, the place of Patient Transport Services in the future with GP Commissioning was raised as one area of note to investigate.

(3) This lead to a range of concerns being raised about service provision in the medium term with the demise of Primary Care Trusts (PCTs) and that there was a need for a mapping of the services being provided as PCTs were abolished. One Member felt that the Cabinet Member for Public Health would be able to provide a useful overview of the changes that are occurring.

(4) More broadly, the Chairman made the observation that the Committee had a range of statutory powers and would continue to do so for a number of years. These powers came with commensurate responsibilities and the Committee was well positioned to help the transition process and maintain an oversight of service standards in the NHS.

10. Date of next programmed meeting – Friday 26 November 2010 @ 10:00am
(Item 10)