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, 3 February 2012.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mrs E Green, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr J Burden, Cllr M Lyons, Cllr G Lymer, Cllr J Cunningham (Substitute for Cllr R Davison) and Mr M J Fittock

ALSO PRESENT:

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P Sass (Head of Democratic Services)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest.

Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting of 6 January 2012 are correctly recorded and that they be signed by the Chairman. There were no matters arising.

4. Overview of Health Scrutiny Regulations
(Item 5)

(1) The Chairman introduced the item by saying that the report in the Agenda was produced in response to a request made at the previous meeting and thanked the Officers for preparing what was a useful and timely summary of the position relating to health scrutiny regulations as it currently stands and which will continue until at least April 2013.

(2) In response to a query about membership, it was clarified that the Committee was able to co-opt experts and others on to the Committee on a non-voting basis. The situation regards locality boards was still being developed. The Chairman reminded the Committee of the discussion paper brought to the Committee in October which indicated the room for a more localist view to feed into the discussions of the Committee, particularly as there was more to health than the NHS and the impact of housing, for example, needed to be recognised.

(3) A representative from LINk raised the issue of social care referrals as something to be aware of. While LINk had the ability to refer health and social care matters, HOSC only dealt with health.

(4) AGREED that the Committee note the report.

5. Reducing Accident and Emergency Admissions: Part 3: Mental Health Services
(Item 6)

Lauretta Kavanagh (Kent and Medway Director of Commissioning for Mental Health and Substance Misuse, NHS Kent and Medway), Bob Deans (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), David Tamsitt (Director Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Justine Leonard (Director Older Adults and Specialist Services, Kent and Medway NHS and Social Care Partnership Trust), and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) In introducing the item, the Chairman reminded Members that this was the third meeting looking into the topic of reducing accident and emergency attendances. He explained that his intention was to circulate a draft report drawing on the findings of all three meetings and the discussion around the preliminary findings presented at the 6 January meeting for Members' comments as soon as was practical.

(2) One Member referred to recent media reports around national findings of differing levels of accident and emergency at the weekend compared to weekdays meaning the subject was an important and topical one.

(3) The broader context of mental health was set out by representatives of the NHS. One in four people will suffer from a mental health problem at some stage in their lives, and on any given day the number was one in six. There was a need to raise the profile of the issue and reduce the stigma attached to it. The continuing interest of the HOSC and other Committees at Kent County Council was commented on positively by health colleagues. Similarly, the recent report on mental health produced by the Kent LINk was referenced as a useful contribution to the subject of mental health.

(4) This broader context translated into a major challenge for the health services, particularly as physical and mental health problems were often experienced by people simultaneously, sometimes complicated by alcohol misuse. The preventive health and wellbeing agenda involved a whole range of sectors, including employers. The valuable role Borough/City/District Councils played in providing such services as housing and leisure could not be underestimated. There were good examples of partnership working, including the Live it Well strategy produced by local NHS commissioners, Kent County Council and Medway Council and the work between KCC and the NHS on dementia prevention. Third sector providers also had a key role to play. In responding to a specific request from a Member of the Committee, representatives of NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust present at the meeting undertook to produce a

series of bullet points about how each sector could contribute to improving mental health across the community and make the report available to Members of the Committee.

(5) In terms of mental health services along the urgent and emergency care pathway, there were two services in particular which NHS representatives brought to the attention of the Committee: Crisis Resolution Home Treatment Teams and Liaison Psychiatry.

(6) Crisis Resolution Home Treatment Teams were the first port of call and took referrals from a number of sources, including the ambulance service, GPs, and community hospitals. These teams were able to provide care in people's homes and so prevent unnecessary admission to an acute hospital.

(7) A general principle applied to mental health staff called on to provide out of hours cover was that they should have transferable skills. This would enable referrals to be handled more effectively. Concerning GP out of hours services, a representative of the Kent Local Committee explained that most of Kent was covered by the service provided by South East Health, but that the GPs were not necessarily local to the County. This might mean that not knowing the patients histories, and where they were risk averse, sending a patient to A&E might be seen as the safer option.

(8) It was also explained that there was a double pressure of GPs to reduce A&E attendances. As part of emerging Clinical Commissioning Groups, they took part in producing plans to this end. As providers of primary care, part of the Quality Outcomes Framework (QOF), which were a set of indicators that determined part of a GP practices income, looked at the reduction made in A&E attendances. There was also a financial drive for Commissioner and Provider NHS Trusts to improve urgent and emergency care. The QIPP Programme (Quality, Innovation, Productivity and Prevention) included such measures as improving the diagnosis of dementia in general hospitals and reducing the use of antipsychotic medicine.

(9) The point was made that A&E can be the right place for people with mental health problems and can enable the right physical and mental health diagnosis to be made.

(10) Liaison Psychiatry services looked to make secondary care mental health services available in A&E departments. The service is fully implemented in East Kent Hospitals NHS University Foundation Trust and has led to a reduction in admission through A&E as well as reduced length of stay of those patients who are admitted and have mental health needs. NHS representatives indicated the reference to the well regarded Rapid Assessment Interface and Discharge (RAID) service in Birmingham mentioned in the background Note by the Committee Researcher. It was explained that the service in East Kent had been visited by the people establishing the service in Birmingham and was a chance to share good practice. The NHS locally was looking to expand the service 24/7 across the whole County. In response to a specific question, a representative from KMPT explained that there had been no recruitment or retention problems relating to the Liaison Psychiatry service in East Kent and they were positive the same would apply

in both Dartford and Gravesham NHS Trust and Maidstone and Tunbridge Wells NHS Trust.

(11) In response to a specific question about whether elderly people were assessed for dementia as a matter of course when they arrived in A&E, Dr Allingham explained that this did depend to an extent on where a patient was being sent from and who received them and more generally related to the quality of the paperwork. The requirement for a second assessment of dementia was getting less, and the paperwork relating to the Liaison Psychiatry service in East Kent was very good. In addition, more forward planning of care plans and Do Not Resuscitate (DNR) requests meant there were decisions made ahead of time not to send a person to hospital.

(12) One Member raised the forthcoming changes in policing arrangements. Representatives of the NHS explained that no analysis of the impact of the changes had been made, but highlighted the good joint working between the NHS and police in the area of mental health which had been developed. Much effort had been put into providing education and training of people in the police service. There was also more co-location of mental health staff where people with mental health needs were likely to be. Liaison and diversion services were present at all custody suites with the aim of keeping people out of the criminal justice system.

(13) In response to a query, the Committee Researcher provided clarification that the additional information requested by Members on Minor Injuries Units provided for them by Kent Community Health NHS Trust related to those services provided by that Trust only. The Researcher undertook to provide information about the other services.

(14) The Chairman explained that for this, as for other items, the recommendation to simply note the report was a useful procedural device but proposed a fuller recommendation.

(15) AGREED that the Committee note the report and thank KMPT and NHS officers for their comprehensive and constructive input.

6. East Kent Hospitals NHS University Foundation Trust Clinical Strategy *(Item 7)*

Liz Shutler (Director of Strategic Development and Capital Planning, East Kent Hospitals NHS University Foundation Trust), Noel Wilson (Divisional Medical Director for Surgical Services, East Kent Hospitals NHS University Foundation Trust), Robert Rose (Divisional Director for Urgent Care and Long Term Conditions, East Kent Hospitals NHS University Foundation Trust), Carmen Dawe (Assistant Director of Marketing and Fundraising, East Kent Hospitals NHS University Foundation Trust), and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the item and explained that the Chief Executive of East Kent Hospitals NHS University Foundation Trust had requested the opportunity for the Trust to bring the work being done on developing a clinical strategy to the Committee. The subject had also generated some media

interest in the East of the County and so the Chairman hoped there would be clarification around it as a result of the day's meeting.

(2) Trust representatives outlined the main features and drivers of the review. It had begun in October 2010 to look at various clinical issues and those raised by the need to continue to provide core services as well as enable healthcare closer to home. No decisions around service configuration had been made but the Committee would be continually involved in the Trust's developing strategy.

(3) The whole development of the strategy needed to be seen in the context of a shift of emphasis nationally from the work which had been done to improve planned care, such as the 18-week pathway, and towards improving emergency care. Emergency care was a high risk area, and one of the drivers for change was the Royal College of Surgeons report, *Standards for Emergency Care.* Members had a summary of this document in their Agenda pack and several Members highlighted the finding in the report that 80% of surgical mortality arises from unplanned/emergency surgical intervention and it was clarified that this referred to 80% of deaths which occurred as a result of surgery. The emergency surgery mortality rate for the Trust was below the national average, but this was not seen as a reason for complacency.

(4) The same principles around clinical care applied in East Kent as they did elsewhere, such as in West Kent, and would continue to do so and there were areas where work was being done with West Kent, such as vascular surgery.

(5) Consultants were rightly involved in planned care, but emergency care could be improved by involving them more at the 'front door' of hospitals to establish a quality care plan for emergency patients with a one stop assessment. Consultant acute physicians had already been brought into front door services and EKHUFT achieved 97% against the 4-hour A&E target in January, which is a very challenging month.

(6) Consultants needed to be supported by appropriately skilled teams and so achieving this raised workforce issues. There was a need to maintain locally accessible services, but there was also a requirement for specialisation of services in some areas. This had happened with cardiac care being centralised at the William Harvey Hospital in Ashford. There had also been centralisation of vascular surgery. Breast surgery was an area of increasing specialisation and there was also the requirement to develop a Level 2 Trauma Unit at William Harvey. In addition, some specialist centres were not in Kent at all. Trust representatives explained that the 'hub and spoke' model was applicable in many areas.

(7) In relation to transfers to the Trauma Unit, the Trust representatives explained that this would only be necessary in a minority of cases, and in many instances, the necessary skills were present at the Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate meaning treatment would continue to be provided locally in Thanet.

(8) The specific issue of travel times was raised by Members with the response given was that travel times were based on clinical evidence, which supported

the idea of taking patients further to access specialist services. More broadly, Trust representatives explained that they were concerned about transportation issues where the transport network was geared more towards going into London than travelling across East Kent. A transport group was being established and this would work with the emerging Clinical Commissioning Groups and the Ambulance Trust to look at such issues as travelling between sites.

(9) There was a potential knock on effect to elective surgery and Trust representatives explained that a clear separation between emergency and elective teams was being made. Currently a 24 hour emergency theatre (known as a CEPOD theatre, referring to *The Confidential Enquiry for Peri-operative Deaths*) was kept specifically for emergency surgery and one discussion was around whether to invest in a second. The development of trauma rotas was geared to an aspiration towards having dedicated teams. This was a whole workforce issue and the review needed to look at the currently available workforce as well as what sorts of skills would be required in the future. Consultants were costly, but there were ways of working smarter.

(10) This was demonstrated by the Trust in response to specific concerns raised by Members about the future of services at the QEQM. Dealing with heart attacks and strokes, for example, was seen as a core service to deliver locally in Thanet. Bringing consultants to the front door of the hospital meant that many patients would be able to be dealt with as ambulatory cases, rather than having to be admitted as inpatients. Where there may need to be some specialisation is in using such medical advances as treatments to directly dissolve clots in the brain. Similarly with gastroenterology, there had been no discussions about moving services from QEQM as this is a core medical component of the services provided by the hospital, and in terms of surgery, it would only involve the very specialist kinds of care.

(11) Further examples of services being developed at the QEQM were provided. More investment was being made in CT scanners. The Trust was looking to introduce a pathway model of care, already introduced in Peterborough, for fractures of the neck of the femur which would see patients under the care of medical consultants, and benefitting from surgery available at QEQM.

(12) As with travel times, Trust representatives provided information on the evidence base. There were a wide range of different measures and more were being developed specifically around the patient experience. This was collected and published. The example of vascular care was given, where there were national peer reviews and data available down to the level of individual surgeons. This connected with a point raised by a Member about the tension between a focus on process and a focus on care, to which NHS representatives felt that as the processes did impact on the patient outcomes, the two things went together.

(13) The Trust felt this could further be seen in the priority it gave to dealing with healthcare associated infection. East Kent Hospitals had very low MRSA and C. diff. rates but were not complacent and the separation of elective and emergency care was a core element in keeping rates low. The achievements

the Trust has made in reducing length of stay also made an important contribution.

(14) As with the previous item, the Chairman looked to the Committee to make a specific resolution on this issue rather than simply noting the report and asked Mrs Green to suggest one which would be appropriate.

(15) AGREED that the Committee notes the high level of concern of residents in East Kent to any proposed changes and that the HOSC will continue to monitor the situation very closely and scrutinise any further developments as and when they emerge to ensure we look after the best interests of Kent residents.

7. East Kent Maternity Services Review: Written Update
(Item 8)

(1) The Chairman introduced the item and explained that the consultation had recently closed and the NHS had provided a written update and looked to bring the decision to HOSC at its meeting of 13 April

(2) He also took the opportunity to once again thank the Members of the informal HOSC Liaison Group for the work they had done with the Trusts in between formal HOSC Meetings. Several Members felt this was a good example of the valuable work a small group of Members could do and more broadly the Committee felt this was one area where HOSC had added real value.

(3) One Member reported that he had been able to attend two of the public meetings held as part of the consultation. Attendance at the first one had been hampered by weather and timing, but the second had been well attended with a good cross section of the population present. At this meeting, the high levels of affection they had for the Dover facility had been made clear.

(4) Making a broader point about consultations, one Member asked whether the different health consultations could not be pulled together to prevent consultation weariness and the Chairman undertook to consider this notion after the meeting.

(5) As Mr Daley had been a Member of the informal HOSC Liaison Group, the Chairman asked him to put forward a recommendation for the Committee.

(6) AGREED that the Committee note the report and also notes that its recommendations made during the proceedings of the public consultation were largely followed and that we are therefore pleased to note that the consultations appear to have been successfully concluded, and now look forward to the presentation of the final report and the results of the collated opinions to the Boards of EKHUFT and the PCT for their decisions in April.

8. Mental Health Services Review
(Item 9)

(1) The Chairman introduced the item and explained that the paper provided further information about the upcoming mental health services review. A more

detailed paper would be available for the 9 March meeting and that this topic might involve the establishment of a Joint HOSC with Medway Council's Health and Adult Social Care Overview and Scrutiny Committee.

(2) AGREED that the Committee note the report.

9. Date of next programmed meeting – Friday 9 March 2012 @ 10:00 am
(Item 10)