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, 9 March 2012.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R E Brookbank, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr R Davison, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Cllr Mrs A Blackmore and Mr R A Marsh

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest.
(Item)

(1) *Mr Adrian Crowther declared a personal interest in the Agenda as a Governor of Medway NHS Foundation Trust.*

(2) *Councillor 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 3 February 2012 are correctly recorded and that they be signed by the Chairman. There were no matters arising.

4. Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Partnership
(Item 6)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust) and Mark Devlin (Chief Executive, Medway NHS Foundation Trust), and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman welcomed the two Chief Executives to the Committee along with the opportunity to consider once again the development of the proposed merger between the two Trusts. He observed that the current HOSC Agenda was probably the largest on record and although the value of short, focused,

report was both his and the Committee's preference, there was a solid justification for the detail provided for this and other items on today's Agenda.

(2) One of the papers provided to the Committee was the Outline Business Case for the integration of the two Trusts. This was the starting point for the short introduction provided by Mr Devlin. He explained that this was a live document which would be continually updated. It would shortly be presented to the Strategic Health Authority, NHS South of England, and would go to their next board meeting. It was also explained that the proposals were also currently being considered by the Co-operation and Competition Panel (CCP) and while stage 1 would be completed during April, they could require a stage 2. The CCP gave advice to Monitor and the Department of Health. The timetable for any merger to take place had been put back to 1 April 2013 and so the public engagement phase was still ongoing as it had been extended.

(3) The exact process for approval of the merger differed for each Trust, but ultimately the Boards of both Trusts would need to approve the merger. This final decision would be made after a series of approved steps, most likely in December 2012 or January 2013. Being an NHS Trust, Dartford and Gravesham NHS Trust needed the go ahead from the Department of Health (DH). The work on this would be carried out by the DH Transaction Board, which would seek the view of NHS South of England. Being a Foundation Trust, Medway NHS Foundation Trust needed to seek the views of Monitor, the Foundation Trust regulator.

(4) One of the important financial aspects which were being closely considered as part of the merger discussions was the Private Finance Initiative (PFI) arrangement at Darent Valley Hospital. Nationally, 22 Trusts had been identified for whom a PFI arrangement was a significant issue. These Trusts were put into 3 categories – ones which needed to do more, ones for whom some recommendations could be made, and others which had done as much as they were able on their own in terms of efficiency savings and so on. Dartford and Gravesham NHS Trust, along with 6 others around the country, was in this third group. This meant that, subject to meeting 4 tests, it could access additional monetary support which had been put aside by the Department of Health. The details of this scheme were as yet unclear, including the timescales around any money becoming available. In response to a question as to whether $1/7^{th}$ of the money would be adequate, the point was made by the Trust representative that while in absolute terms the PFI was small, as a percentage of the turnover, it was large.

(5) Members raised a number of points about the lessons which could be learned from other mergers. Reference was made to the merger resulting in the formation of Maidstone and Tunbridge Wells NHS Trust, the results of which were still unfolding, as well as recent analyses of mergers carried out by the King's Fund and Centre for Market and Public Organisation (CMPO) at the University of Bristol, the latter having cast doubt on whether mergers lead to cost savings. Representatives from both Trusts explained that past mergers had been looked at very closely in order to ensure a smooth transition. In response to the CMPO report, it was explained that these were mergers occurring between 1997 and 2003 and was a top down process often involving failing hospitals. The current proposals for merger arose from the two Trusts

making their own decision, and neither Trust was failing. It was reported that the two Trusts had compatible clinical cultures and this provided something solid to build on. Both Trusts also served a series of natural communities and so would hopefully not seem remote and impersonal. Talks were underway with other NHS organisations to make sure the whole North Kent health economy was aligned to ensure there was a successful implementation.

(6) It was also stressed that the implementation would not be carried out in a big bang. The focus was on a series of milestones – what needed to be in place on day 1, by month 6, month 12 and so on. The intention was to avoid any dip in performance. One Member posed the question as to how a successful merger would be measured and requested 5 key performance indicators which would enable this to happen. Both Chief Executives responded positively to the challenge of producing said indicators and undertook to consider and write back to the Committee.

(7) There were a series of specific issues raised around the detail of transition. On car parking, which both Trusts acknowledged as a key issue, the situation at Darent Valley was complicated by the PFI which meant the Trust did not own the car park. However, permission to expand had been agreed and the first phase in front of the accident and emergency department had been implemented. Medway was also looking to increase the space available for car parking. More broadly on transportation, there were discussions underway with bus companies and local authorities on this. The Trusts also hoped that having full outpatient clinics at both sites would reduce travelling.

(8) Information systems were another area of discussion. It was explained that systems were needed for both administration and clinical/patient management tasks. The patient administration system at Medway was in need of replacing within the next 18 months, so this was a good time to procure a compatible system across both sites. In response to a specific question on the appointment system, it was explained that the Trusts would not consider outsourcing this, but would perhaps introduce an internal call centre approach. They took on board the views of Members that any appointment system required flexibility to accommodate clinical need and the views of clinicians who understand their patients' needs.

(9) RESOLVED that the Committee thank Susan Acott and Mark Devlin for their continued engagement with the Committee and that the Committee would welcome working together with the Trusts on 5 key performance indicators for a successful transition.

5. Public Health Update

(Item 5)

Meradin Peachey (Director of Public Health) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the item by explaining that he had attended the public health briefing for KCC Members on 24 February and that had been very informative and welcomed the opportunity the Committee had to receive an update.

(2) In providing an overview, the Director of Public Health explained that it was a timely opportunity because there had been a series of useful documents produced by the Department of Health on public health and the transition to the new system. Within KCC there was a business manager and support staff to assist with the transition as well as to assist in the assessment of recent spending estimates for future public health functions from the Department of Health. These were based on spend in 2010/11 and the Cabinet was currently considering the findings. The Director of Public Health commented that whatever the detail of findings, it had been a useful exercise as the public health spend within the NHS had never been separated out and quantified in this detail.

(3) Members raised the issue of the different levels of identified spend in Kent compared to other areas. The response was given that the figures related to what was spent on the public health service responsibilities which are transferring to local authorities. The responsibility therefore had rested with Primary Care Trusts and across the South East. The levels of spend had been low, but in London they were higher. This was connected to levels of deprivation and health inequalities. On the subject of spend, the Committee were informed that the PCT cluster had reduced spending on management costs to the £25/head level which was to be allocated to Clinical Commissioning Groups (CCG) in the future.

(4) Connected with this was work on identifying public health contracts held by the NHS which may need to be transferred to the NHS. Similarly, there was the question of staff. Across the South East there was a low ratio of public health consultants to population, but consultants were the most expensive staff group and the staff mix required would depend on what the authority wanted to do in the area of public health. There were some functions, such as health protection, carried out across the whole Kent and Medway PCT cluster together which did require specific skills. Kent was a pilot area relating to plans for a revalidation scheme for non-medical public health consultants. In terms of wider capacity, KCC had a public health champions scheme to widen understanding. Other ideas were also being looked at.

(5) Although it was conceded the documents on public health did not discuss borough/city/district councils at length and that the formal public health commissioning responsibilities would remain with the County Council and NHS commissioners, the important role of this tier of Government was acknowledged. The Director of Public Health and Cabinet Member for Adult Social Care and Public Health had met with all the leaders of Borough/City/District Councils to discuss joint commissioning of public health. Several Members provided examples of good practice in this area carried out by Locality Boards, such as that being undertaken in Dover and Shepway.

(6) The work being done in Dover by the District Council and Clinical Commissioning Board with KCC was also mentioned by the Director of Public Health. This was connected with the work of the Health and Wellbeing Board, which had a key role to play.

(7) One role of the health and Wellbeing Board will be to produce the Joint Strategic Needs Assessment (JSNA) which will be used to inform commissioning. More broadly, with the move of public health intelligence into KCC, there was to be an offer to GPs to provide public health support for commissioning decisions.

(8) This provided an opportunity for KCC to develop its own vision. This would look at issues such as inequalities and would be linked to Bold Steps for Kent. There had been a good turnout at the Members briefing on 24 February which showed there was good Member engagement as well.

(9) Dr Allingham took the opportunity provided by this item to update the Committee on CCG developments. There had been a reduction in the overall number and some others already shared back office functions, so may merge in the future. The emerging CCGs were tied into PCT commissioning structures now and while it was still too early to definitely say, the final number may be 1 or 2 in East Kent, 1 in West Kent, with another CCG possibly joining up the ones in Swale and Medway and the one covering Dartford and Gravesham.

(10) RESOLVED that the Committee note the report and thank the Director of Public Health for her timely and informative update.

6. Older People's Mental Health Services in East Kent

(Item 7)

Dr. Barbara Beats (Assistant Medical Director Older Adults, Kent and Medway NHS and Social Care Partnership Trust (KMPT)), Justine Leonard, (Service Line Director for Older Adults and Specialist Services, KMPT), Evelyn White (Associate Director Integrated Commissioning, NHS Kent and Medway), Linda Caldwell (Lead Commissioner Older People, NHS Kent and Medway), Bob Deans (Chief Executive, KMPT), Helen Buckingham (Deputy Chief Executive and Director of Whole System Commissioning, NHS Kent and Medway), Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) An overview of the proposals was provided by a representative of the NHS group present which was drawn from the commissioners and main current provider of services, Kent and Medway NHS and Social Care Partnership Trust (KMPT). It was stated that the care of older people with mental health needs and dementia in particular was a high priority for the NHS locally and the proposals being developed were in line with both the national dementia strategy and the recent KCC Select Committee report on dementia. The proposals were a whole systems development which meant that commissioners were working on the proposals with the main and other providers. In summary, the proposals were to close the equivalent of 2 wards and use the savings to reinvest in home treatment services and the dementia crisis service.

(2) The Committee was further informed that due to over capacity 1 ward had already been closed with no impact on the service and so they were looking to close 1 more ward of 16 beds, taking the total down to 45. The services were to be pump primed so they were in place before any further reduction in acute beds. The home treatment service, which was composed of multi-disciplinary teams, was ready to go. Kent County Council was to commission the dementia crisis service on behalf of the NHS as this would ensure it was aligned with social services. In addition there were already 13 Admiral Nurses across Kent. Preliminary work on service redesign had resulted in three viable options around the future location of acute mental health beds for older people, but if other viable options were put forward during the consultation, they would be considered.

(3) The Chairman drew attention to the recommendations put forward by the NHS, which could be found on page 229 of the Agenda that the Committee note the progress made in delivering improved outcomes for people with dementia in East Kent and the intention to go to public consultation. He then asked for additional questions and comments from the Committee.

(4) One specific question related to the use of anti-psychotic medication and recent reports on its inappropriate use. The response was given that there was a drive across Kent and Medway to reduce their use, and it was going down. However, the levels would never go down to zero as there were cases where there was good clinical evidence for their use.

(5) There were a number of points raised around equality of provision, and the argument made that provision would vary as different areas had different needs. However, best practice was being shared and the model proposed for East Kent was similar to that introduced in West Kent.

(6) This overlapped with questions raised around the services available for people with different mental health needs, such as those with organic as opposed to functional health needs. The response given was that this was a false dichotomy to an extent as many patients had a range of different needs. In response to a precise question, the average length of stay for those with functional mental health problems was 49 days, and for those with organic mental health problems, such as dementia, was 55 days.

(7) The role of carers was raised and NHS representatives explained they were crucial. Keeping people with dementia in their own homes, which included care homes, was proven to improve their quality of life and the West Kent model involved working with carers and social services to design services which would allow this to happen.

(8) One major area of concern was the potential problem of causing unintended consequences to the detriment of the NHS as a whole through carrying out what were individually positive acts. The example of using independent sector providers to carry out cataract operations in the recent past which had led to financial problems in the acute sector was given of such a situation. Allied to this was concern around transition to the new service being carried out poorly as a result of attention in the health economy being focused on the broader structural changes underway in the NHS.

(9) The response referred back to the points made about the plans being drawn up with a view to aligning the whole health economy. The observation was made that where people were on acute wards but could be treated more effectively elsewhere, this was good for the acute sector as well as the patient and health economy more generally. However, it was acknowledged that while there were few fixed long term costs within the health economy, there were short and medium term ones. NHS commissioners explained that in the current system 2% of the commissioning budget was set aside to provide a non-recurrent source of funding to cover the costs of change. At present this amounted to £54 million being set aside, and this was likely to be comparable to sums available in the future under the new system.

(10) RESOLVED that the Committee thank its guest for attending today's meeting and looks forward to receiving the consultation paper in due course. Members of the Committee are invited to form a small sub-group to further inform the consultation process.

7. Mental Health Services Review

(Item 8)

Bob Deans (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust (KMPT)), David Tamsitt (Director – Acute Services, KMPT), Lauretta Kavanagh (Kent and Medway Director of Commissioning for Mental Health and Substance Misuse, NHS Kent and Medway) 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 it was one of two items on this meeting's Agenda where the Committee was asked to decide whether or not it was a substantial variation of service. If they decided it was and Medway Council's Health and Adult Social Care Overview and Scrutiny Committee decided likewise at its meeting of 27 March, then this would require the establishment of a Joint Health Scrutiny Committee with Medway Council. The Chairman referred to the explanation of what this involves made available in the Agenda.

(2) A number of Members expressed views supportive of the idea that it did constitute a substantial variation of service.

(3) RESOLVED that the Committee agrees the proposals constitute a substantial variation of service and that a Joint Health Scrutiny Committee with Medway Council be constituted should this be necessary.

8. Patient Transport Services

(Item 9)

Helen Buckingham (Deputy Chief Executive and Director of Whole System Commissioning, NHS Kent and Medway), Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the item and referred to the comments he had made during the previous item as to the decision required of the Committee.

(2) A number of Members made comments about this topic and expressed the view that patient transport broadly was high on the public Agenda. One Member made reference to gaps in public transportation to the new hospital at Pembury. Another made reference to the importance of the volunteer car service and public misunderstanding about what exactly constituted the Patient Transport Service and who was eligible. Several Members echoed the necessity of seeing the eligibility criteria and representatives of the NHS undertook to make it available to the Committee. One Member raised a specific local example of what appeared to be a change in the eligibility criteria.

(3) In explaining the plans, NHS representatives explained that they were undertaking a review of gaps in service provision and this built on work done by LINks and others, and mention was made of a useful patient engagement event the previous day. Patient engagement would continue. On the volunteer car service similarly, providers were encouraged to continue working with them and engagement here was continuing. What was currently underway was work on the procurement framework to enable commissioners to clarify and manage the contracts properly. Decisions were still to be made on how many lots the procurement would be divided into and one possible model was a contact centre for all the providers. Although concerns around inconsistent application of the eligibility criteria were recognised, the eligibility criteria were not being looked at currently and if any changes were proposed, which would only be after the procurement, the NHS would need to return to HOSC and share them.

(4) Mrs Elizabeth Green proposed and Councillor Richard Davison seconded the following motion:

- That the Committee agrees the proposals constitute a substantial variation of service and that a Joint Health Scrutiny Committee with Medway Council be constituted should this be necessary.

(5) RESOLVED that the Committee agrees the proposals constitute a substantial variation of service and that a Joint Health Scrutiny Committee with Medway Council be constituted should this be necessary.

9. HOSC Report into Reducing A&E Attendances

(Item 10)

Dr John Allingham (Medical Secretary, Kent Local Medical Committee) was in attendance for this item.

(1) The Chairman introduced the item and reviewed the detailed work undertaken by the Committee over a number of meetings. He explained that the preliminary draft report had been circulated to HOSC Members and local NHS Trusts and the initial feedback had been positive.

(2) One Member expressed the view that the report was very clear and the whole process was a classic example of how the Committee could add value to the development of local health services in highlighting things which needed to be done. He explained that although much had been done to provide alternatives to Accident and Emergency Departments there was still confusion in the public mind about the options available. He also highlighted the issue of a gap in the availability of alternatives in mid-Kent. The role of the forthcoming 111 service was crucial and needed careful preparation.

(3) Another Member echoed the state of confusion around the different services available at different minor injuries units and walk-in-centres and expressed the view that he hoped the development of Clinical Commissioning Groups would help improve out-of-hours services.

(4) The Chairman explained that the report would be sent to all local NHS Trusts along with a request for a formal response. He hoped the report would be accepted in a positive manner as a way to assist in developing some solutions to the problem of how to reduce attendances at Accident and Emergency Departments.

(5) RESOLVED that the Committee Researcher be thanked for his assistance in drafting a very timely and informative report which identifies a number of severe problems which need addressing along with some solutions and looks forward to the formal responses of local NHS Trusts.

10. Date of next programmed meeting – Friday 13 April 2012 @ 10:00 am
(Item 11)