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, 30 November 2012.

PRESENT: Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr N J Collor, Mr D S Daley, Mrs E Green, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Ann Allen, Cllr Mrs A Blackmore, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Mr L Christie, Cllr J Cunningham, Cllr R Davison, Mr J Ashelford, Mr R Kenworthy and Dr D Goodridge

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

Vice-Chairman in the Chair.

2. Declarations of Interest
(Item)

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

3. Mr Michael Snelling in Memoriam
(Item)

(1) The Chairman and Committee wished to recognise that this was the first meeting of the Committee since the sad passing of Mr Michael Snelling, Chairman of the Committee. Mr Smith spoke of the dedicated manner in which Mr Snelling approached the work of HOSC, making it his business to master the health brief. Meetings were chaired masterfully and everyone had the chance to ask their questions.

(2) The Committee noted its gratitude to Mr Michael Snelling.

4. Minutes
(Item 4)

(1) The Committee was informed of an answer to a question asked at the meeting of 12 October 2012 which Kent and Medway NHS and Social Care Partnership Trust had undertaken to supply. In response to a question about the 8% increase in patient satisfaction, the answer supplied was:

- "The question asked was *'overall, how would you rate the care you have received from mental health services in the last 12 months'* the people scoring 'good, very good and excellent' went up by 8% from 71% to 79%."

(2) RESOLVED that the Minutes of the meeting held on 12 October 2012 are correctly recorded and that they be signed by the Chairman.

5. Forward Work Programme
(Item 5)

(1) The Committee had before them a draft Forward Work Programme for the first three meetings of 2013 along with the dates of the meetings for the rest of the year.

(2) Members requested in addition the opportunity to receive a report on performance in the ambulance service. The Chairman undertook to place this on the Agenda as soon as it was practicable.

(3) Questions of detail were asked around the Patient Transport Services item on the Forward Work Programme for February. Members were reminded that there was a written update on this topic on the Agenda and later in the meeting there would then be the opportunity to ask specific questions on this item.

(4) In response to a question about the work of the Kent and Medway NHS Joint Overview and Scrutiny Committee, Members were informed that as it was a standalone Committee with delegated powers over the specific issues it was currently considering, or was scheduled to consider in the future, it did not report as such to any other Committee. However, Members would be kept updated on the progress of this Committee's work.

(5) AGREED that the Committee note the meeting dates for 2013 and approve the Forward Work Programme.

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

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust) was in attendance for this item.

(1) The Chairman introduced the item and asked the Committee's guest to provide an overview.

(2) Susan Acott began by giving tribute to Mr Michael Snelling, and echoed the comments made earlier.

(3) Moving on to the substantive matter under discussion, the decision of the Co-operation and Competition (CCP) to approve the merger subject to work being undertaken around choice in urology services was one important event to have occurred recently. In response to a question, it was clarified that

endocrine services were also highlighted but this is a very small practice area with only two surgeons in Kent operating in this area. The CCP looked at services purely from an economic perspective, not clinical. Urology is a big area financially and in terms of clinical activity. Urology had previously been centralised at Medway NHS Foundation Trust (MFT) and East Kent Hospitals. The conflict between clinical and financial drives was being resolved by local commissioners agreeing to monitor the situation.

(4) More broadly than these two services, the image of a pyramid was used to describe those services which needed to be centralised in order to deliver a safe service as being at the top, and other services which could be delivered more locally at the bottom. The Trusts were aiming to make sure the line between the top and bottom of the pyramid was as high as possible.

(5) An Integrated Business Plan for the merger had been produced but the final approval for each Trust to merge with the other would go by two different routes. As a Foundation Trust, MFT would need the approval of Monitor. Monitor was currently reviewing the improvement trajectory of MFT in relation to a breach of its Term of Authorisation and there was a board meeting with Monitor coming up the following week. Monitor was due to conclude and make a recommendation on the merger proceeding by mid February. Dartford and Gravesham NHS Trust (DGH) was not a Foundation Trust and needed Department of Health approval. The dissolution of DGH would also be subject to a Parliamentary process. The anticipated date of merger was now late spring or June. The first meeting of the shadow/designate board had occurred this week.

(6) A specific question was raised about estates, referring to p.57 of the Agenda. Then explanation was given that much of the MFT estate was old and not appropriate for delivering clinical services, but that it still cost money. Options were being considered, including renting rather than selling parts of the estate. 55% of the estate at DGH was used for clinical services and it was planned to increase this.

(7) Weekend service coverage was the subject of another specific question. In response it was explained that this was an area where the benefits of merger could be set out. DGH currently provided 24/7 emergency surgery coverage for GI (gastrointestinal) bleeds but MFT did not. Merging would enable the emergency surgery rota to be covered across 8 surgeons, up from 4 at DGH currently. This would make the service more sustainable and enable 24/7 coverage of both sites.

(8) The implications of the draft report of the Trust Special Administrator of South London Healthcare NHS Trust were also discussed. This had been a merger of three very inefficient Trusts, whereas DGH was in fact one of the more efficient Trusts in the country when measured by EBITDA (Earnings Before Interest, Taxes, Depreciation and Amortization). The future of the Queen Mary's site in Sidcup (QMS) directly involved DGH. One recommendation was for Oxleas NHS Trust, a provider of mental health and community health services to take over the site, but for other providers to provide some services there. QMS was ten miles from DGH and the working relationship was a good one. A related recommendation was for DGH to provide day surgery at QMS.

The estate was of good quality and it was seen as a positive for the Trust as day surgery was less likely to be subject to cancellations as QMS did not have an accident and emergency department (A&E). This would mean more certainty for patients and the Trust. In terms of capacity, the Trust had previously been able to cope with the closure of the QMS A&E at short notice, although changes had been made to the A&E at DGH and more were planned, such as expanding the waiting area. In maternity services as well, numbers were higher than originally thought but the Trust was adapting.

(9) More generally, lessons had been learnt from this South London and other mergers. A post-merger dip is always anticipated, but the two Trusts were looking to mitigate this as much as possible. Clinical directors ran both hospitals in service sectors, and this would be double-run for a period after the merger. In addition, the Board would have two medical directors, one from each site, to ensure the clinical perspectives of both were recognised at the highest level.

(10) The Trust was reminded that some services at both sites were provided by other Trusts, and this would be likely to continue. Plastic surgery, for example, was provided by Queen Victoria Hospital in East Grinstead. Radiotherapy was currently provided centrally by Guy's Hospital, but there was currently a radiotherapy review in Kent and this might lead to a federated structure with better access in North Kent.

(11) The Chairman proposed the following recommendation:

- That the Committee thanks its guest for her valuable contribution and looks forward to further updates at the next stage in this process.

(12) AGREED that the Committee thanks its guest for her valuable contribution and looks forward to further updates at the next stage in this process.

7. Patient Transport Services: Written Update
(Item 7)

Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) Following up on questions raised during the discussion on Item 5, NHS representatives explained that Patient Transport Services (PTS) referred to a very specific service the NHS was required to provide. There was a national set of guidelines around the eligibility criteria as well as a locally agreed set of eligibility criteria, applying to patients and carers/companions. The problem in the past had been that there were around 20 providers, and they all interpreted the eligibility criteria differently and this led to inconsistencies across the county.

(2) It was explained that the service had gone out to tender in April, and the process had involved much in the way of clinical and patient engagement. The recommendation about future provision was going to the Board of NHS Kent

and Medway in December, with the provider or providers named in January and this would enable this information to be conveyed to the Committee in February.

(3) The Committee was informed that the GP clinical commissioners were comfortable with the process underway. The tender involved a central booking system which would iron out the previous inequalities of access as meeting the eligibility requirements would mean someone had access to the service regardless of location.

(4) Members raised a series of points about communicating the availability of PTS to patients as well as needing to better understand the connection between it, volunteer car services and the wider picture of patient transport and access. Members were thanked for their comments and it was undertaken that these would be taken into account when reporting back to the Committee in February.

(5) AGREED that the Committee note the report.

8. HOSC Report, "Not the Default Option": Responses.
(Item 8)

Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Ian Ayres (Accountable Officer, NHS West Kent CCG), Emma Burns (Head of Media and Communications, NHS Kent and Medway) were in attendance for this item.

(a) Members had before them a copy of the HOSC review report into level of attendance at A&E departments, *Not the Default Option*, along with responses from the local NHS. In introducing the ongoing work, NHS representatives commented on the quality of the report and how the challenges it posed were useful locally in taking the work forward. Clinical Commissioning Groups (CCGs) were taking the recommendations into account as part of their urgent care review. Following one of the recommendations, media and communications were being coordinated across all Trusts in Kent on this issue. Working across sectors was showing dividends in winter planning.

(b) Communication of what services were available where along with clarity over what people could expect from walk-in centres compared to minor injuries units and other services was a major theme in Members comments and questions. Publicity material was being circulated through the *Your Health* magazine, GP practices, GP patient reference groups, acute and community hospitals, to parents through parents' mail, and other methods. Members drew attention to a couple of examples of incomplete or inconsistent information and NHS representatives undertook to note and check on these and ensure they were correct.

(c) Picking up on one of the points raised by Members, NHS representatives confirmed that the issue of nomenclature was being looked at to see if having a number of different terms for different services, walk-in centres and minor injuries units and so on, was helpful or confusing. NHS surveys also

suggested people often had misconceptions about what A&E could provide, such as the belief it was a source of free prescriptions. Minor injuries units were being reviewed in East Kent at the moment and this review was looking at the issue of standardised opening hours, which had been an idea put forward by Committee Members. The location of these centres and units was also raised as an issue, with the response from the NHS being that it was not possible to have a minor injuries unit in every town. The financial and clinical arguments dovetailed; while it would be expensive to do this, it would also be unsafe as it would not be possible to have the right staff skill mix at every site. Responding to a specific question, NHS representatives undertook to check the figures for levels of attendance at the Folkestone minor injuries unit as those quoted in the report seemed too low.

(d) Responding to the issue of whether the real or perceived lack of access to GP services was a reason for people attending A&E, it was pointed out that parents of young children have good access to GP services yet often go straight to A&E with their children because of the increased worry. The Committee was also reminded that all GP practices were part of CCGs, with West Kent CCG having 62 member practices. These did not provide services but did allow peer to peer support in order to improve. The CCG representative present encouraged the use of Patient Advice and Liaison Services (PALS) and similar as patient feedback was very useful for commissioners and providers. Related to this topic, GPs in West Kent were working with Maidstone and Tunbridge Wells NHS Trust on a way to relieve pressure on A&E by instituting a ward where GPs could directly refer patients for tests.

(e) Mental health was another area of concern given the high proportion of people attending A&E with mental health problems. It was reported that improvements had been made to access to Crisis Resolution Home Treatment Teams, working with Kent and Medway NHS and Social Care Partnership Trust, allowing fastracking back to the service where necessary. Work was also being undertaken with SECAmb to ensure mental health emergencies received the appropriate response. Members were also updated with the information that the Liaison Psychiatry Service had now been rolled out to all Acute Trusts in Kent. The point was also made that A&E would still often be the most appropriate place for patients with mental health needs as they would still often have physical health needs.

(f) The new 111 service being introduced into Kent and Medway in 2013 was seen as a way to bridge the gap between the fact that for the individual patient, any health need could be seen as serious, and the need for them to access the most appropriate care. Calling this number would, when the service is launched, connect the caller to someone able to access a database of what services were available at that time. It was believed this would divert a lot of patients from A&E. The NHS undertook to report back on the performance of the 111 service once it had been operational for 6-9 months. In response to a specific question, Members were informed that the 111 service had a call answering target of 60 seconds, compared to the 5 seconds of the 999 ambulance service.

(g) NHS representatives presented the idea that the individual patient was never in the wrong place and often made the most rational decision for them. The challenge was to build a good service around where they were. The importance of accessing services physically and electronically was discussed. A smartphone app was in development and the work of the Kent and Medway Transport Working Group was continuing. The role of pharmacies was also highlighted and it was confirmed pharmacies would be on the 111 database. Robin Kenworthy was invited to speak and he explained he was the sole patient representative of the Health Living Pharmacy project which has worked with the Department of Health and others on 100 pharmacy pilots over the last 18 months looking at the role of the pharmacy. Members were requested to forward any feedback on pharmacy service to him.

(h) The Chairman thanked the guests for attending.

(i) AGREED that the Committee note the report.

9. Tonbridge Cottage Hospital: Change of Use
(Item 9)

Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) The Chairman introduced the item explaining that it had been discussed at the meeting of 7 September, at which he had not been present, but there had been a request to bring it back as there were some outstanding issues. The question revolved around whether the NHS had fallen short of their duties to consult the Committee on the change of use of 12 beds at Tonbridge Cottage Hospital. This issue had been ongoing since 2004 with the location of a stroke rehabilitation unit connected to the new Pembury Hospital initially being planned for Sevenoaks Hospital before the plans changed and it was finally placed in Tonbridge Cottage Hospital. The Chairman could not speak for the Committee as a whole as to whether this would have been classed as a substantial variation of service had it come to the Committee at the appropriate time, but for him there was no question that it was a substantial variation of service. The point was that the Committee did not have the opportunity.

(b) In response, NHS representatives explained that there was no definition of substantial variation of service. The broader changes had come to HOSC, but this specific one had not. The decision was made at the time by the NHS that this particular change did not classify as a substantial variation of service. As it is for the HOSC to make that determination it was acknowledged that this did not happen and apologies were given. A meeting between the League of Friends and Clinical Commissioning Group had taken place the preceding week.

(c) An explanation was then given of the impact of NHS Property Services (Propco) taking on the ownership of Tonbridge Cottage Hospital. This did not mean any uncertainty about the future of the Hospital. Propco would have no ability to declare the Hospital surplus to requirements. The decisions on its

usage would be determined locally and even if local commissioners decided it would no longer be used, which would require consultation, the site would then be offered to other NHS bodies first. In this way the system would be a lot like the current one.

(d) The CCG representative explained that a close examination had been made of general rehabilitation bed use at Tonbridge Cottage Hospital. It was found that there was an even split between people from the local area accessing these beds and those from outside the area. This had meant some people from Tonbridge being placed in rehabilitation beds elsewhere in the county. As a result of work between the CCG, Kent County Council, Kent Community Health NHS Trust and Maidstone and Tunbridge Wells NHS Trust, in the next few weeks a pilot scheme on the grounds of Maidstone Hospital was being commenced. This would provide 26 community rehabilitation beds for patients who were not under the care of a consultant. Consultants would do fortnightly rounds to ensure the case mix was appropriate. This would allow for patients from Tonbridge to be repatriated closer to home. This project would run until March and the offer was made to share the results of the evaluation with the Committee. One Member expressed the hope that intermediate beds in East Kent were also being evaluated.

(e) The NHS explained that lessons had been learnt and the sentiment expressed that it was an appropriate time to draw a line. A Member of the Committee expressed the view that it would be useful to set up a triage system for future issues to prevent this kind of situation occurring in the future while acknowledging that the Committee could not consider every change. The Chairman explained this would be looked at.

(f) The Chairman proposed the following recommendation:

- This Committee acknowledges and accepts the apology offered about the lack of consultation in the past, believes the proposals put forward offer a positive way forward and looks forward to considering the findings of their evaluation in the near future.

(g) AGREED that this Committee acknowledges and accepts the apology offered about the lack of consultation in the past, believes the proposals put forward offer a positive way forward and looks forward to considering the findings of their evaluation in the near future.

10. Date of next programmed meeting – Friday 4 January 2013 @ 10:00 am
(Item 10)