KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Friday, 1 February 2013.

PRESENT: Mr C P Smith (Vice-Chairman, in the Chair), Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, Mr A T Willicombe, Mr D L Brazier (Substitute for Mr R E Brookbank), Mr L Christie (Substitute for Mrs E Green), Cllr M Lyons, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Dr J Allingham and Cllr R Davison

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

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. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting held on 4 January 2013 are correctly recorded and that they be signed by the Chairman.

4. Patient Transport Services
(Item 5)

Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), Deborah Tobin (Senior Project Manager – Patient Transport, NHS Kent and Medway), Alastair Cooper (Managing Director - Care Services and Passenger Transport, NSL Care Services), Felicity Cox (Chief Executive, NHS Kent and Medway), and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) Members were reminded that this was a topic the Committee had looked at previously and were aware that the Patient Transport Service (PTS) was being tendered. There were two lots to the tender. The first was to run a single call centre, and the second was to run the PTS itself. NHS representatives explained that NSL Care Services had been awarded both lots. This company's bid was ranked top on quality. It was also competitive on price, but was not the cheapest.

(b) NSL Care Services ran other PTS services and the call centre for all these services was in Shrewsbury. It was explained that this call centre would receive the calls for PTS in Kent and book the journey, but the actual planning would be undertaken locally in Kent. A series of questions were asked about how local knowledge was factored in. The example was given of the existence of three towns or villages named Newington in Kent. NSL Care Services explained that the script used in the call centre got bookings pinpointed to a specific address, house number and street, and this made up for those occasions when no postcode was known by the caller. It was explained that the 999 services did not always have postcode information either. In addition, there was liaison with the locally based service planners.

(c) A number of Members expressed concerns about situations where patients were discharged from hospital late at night and anecdotal evidence was provided of people being left outside their homes unable to get in following discharge. NHS representatives explained that late night discharge did happen on occasion, but it should be avoided where possible. It was also commented that patients attending accident and emergency departments who were then not admitted to hospital may be discharged at night as well. The duty of care was transferred to the PTS provider and NSL Care Services explained that it was part of their training of staff to ensure people were not abandoned. Where a home could not be accessed, or was uninhabitable, alternatives would be sought and this might involve returning them to hospital. No person would be simply abandoned.

(d) In response to a specific question, NSL Care Services explained that volunteer drivers were used in some of its other areas, such as Lincolnshire. Volunteer drivers were checked out in the same way as permanent or bank staff. Volunteer drivers were often preferred due to their local knowledge, particularly in rural areas.

(e) Developing this theme, it was explained that part of the service specification involved the requirement to refer callers who were not eligible for PTS to other services which may be able to help, such as volunteer driver services. These alternatives were not run by the NHS, but their value as a supplement was readily acknowledged. A directory of locally available services was being pulled together to enable accurate assistance to be given. The large provider Trusts in Kent were providing information on the transport services they knew about and this work would continue. No service in the country was able to list all the available services, but it would expand and develop over time.

(f) Specifically relating to PTS for patients with mental health needs, a Member of the Committee commented that this was an area where dissatisfaction with the service had been expressed in the past. It was added that the eligibility criteria may or may not apply to individuals as their condition changed over time. In response it was explained that work was being done with Kent and Medway NHS and Social Care Partnership Trust on linking directly with user groups to target them specifically.

(g) The Committee were informed that clinicians could book PTS directly, either by phone or by logging on electronically. The same questions were asked of

the clinician booking and so the same eligibility criteria applied; there was no question of a clinicians' judgment being second-guessed. In response to a specific follow-up, the Committee were informed that patients were eligible from the time of their GP referring them to a consultant and it did not need to wait for a diagnosis to be confirmed.

(h) PTS was a service free to the user. It was explained that there was a separate Healthcare Travel Costs Scheme (HTCS) available through hospitals. Some patients would be able to claim reimbursements for travelling to access healthcare.

(i) A specific question about accessing services was asked giving the example of an elderly person needing to have tests done regularly due to being prescribed Warfarin. The answer was given that PTS did not cover accessing primary care services. However, in the case of Warfarin, there was a domiciliary service available through GP practices. A nurse should be able to visit the particular patient, negating the need to travel.

(j) On the topic of escorts accompanying the patient, it was explained that clinical escorts were covered by the eligibility criteria, and other escorts might be; this was an area where there was a need for consistency.

(k) It was reported that the eligibility criteria used in Kent and Medway was slightly more generous than the national requirements for PTS. There was a debate around whether more people should or should not be covered by the eligibility criteria. Part of this discussion involved questions about what proportion of patient journeys were undertaken by PTS. The view was expressed by NHS representatives that this was not an especially useful figure to look at as health needs changed; the important point was for 100% of those eligible to be transported. Information would be provided to Clinical Commissioning Groups (CCGs) about PTS usage. This would help identify any gaps in the service. The eligibility criteria may be reviewed in the future. A CCG representative explained that there were difficult choices to be made in commissioning. Including more people in the eligibility criteria meant less money for other services. There was an element of regret in any choice.

(l) Members and health sector representatives agreed on the need to publicise the PTS service effectively and a communications plan had been developed.

(m) In response to a specific question about where the vehicles would be based, it was explained that NSL Care Services were seeking five bases in Kent and Medway. Along with admin facilities to enable planning, these would need to be secure compounds for the parking of both PTS vehicles and cars belonging to staff.

(n) The Chairman proposed the following recommendation:

- The Committee thanks its guests for their contribution, notes the report and looks forward to further updates in the future.

(o) AGREED that the Committee thanks its guests for their contribution, notes the report and looks forward to further updates in the future.

5. Maidstone Hospital: Current and Future Developments
(Item 6)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Dr Chris Thom (Urgent Medical and Ambulatory Unit Clinical Lead / Lead Physician, Maidstone and Tunbridge Wells NHS Trust), Mr Akbar Soorma (A&E Consultant / Clinical Director for Acute & Emergency Medicine, Maidstone and Tunbridge Wells NHS Trust), Felicity Cox (Chief Executive, NHS Kent and Medway), and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) The Chief Executive of Maidstone and Tunbridge Wells NHS Trust (MTW) introduced the item by explaining that he was present to explain changes to Maidstone Hospital which were underway and so concrete, not just aspiration. It was an opportunity to close the loop on the Trust's reconfiguration when a lot of focus in recent years had been on the new Tunbridge Wells Hospital at Pembury. Several Members commented how please they were to see Maidstone Hospital had such a vibrant future.

(b) One negative aspect was raised by Members regarding the appointment system, with the specific example given of being unable to change an appointment due to the absence that day of a particular member of staff. The Chief Executive of MTW responded to the specific example by saying it was clearly unacceptable but acknowledged that the appointments formed a high proportion of the complaints received by the Trust. Improvements had been made and would continue to be so.

(c) One recent change was the opening of the new Urgent Medical and Ambulatory Unit (UMAU). This replaced the previous Medical Assessment Unit (MAU) and worked differently. The UMAU was designed to deal with patients for 24 hours only. After this time they would be discharged or admitted to the ward for the appropriate clinical specialty. The intention was to get as much of the necessary assessment and diagnostics done in the first 6-8 hours. There were two routes to the UMAU. Firstly, GPs could refer patients to it directly; patients passed through accident and emergency (A&E) where a nurse would be able to assess whether any treatment needed to be given immediately as the patient transited. Secondly, patients would arrive in A&E as usual and would be moved to the UMAU where appropriate after triage. Previously, all patients went through A&E.

(d) There was also a new cardiac service. Cardiac services were a long established part of what Maidstone Hospital offered, but what was new was a very specific treatment for the most common form of the heart short-circuiting, ablation. This was currently only available in London and Maidstone was the only place in Kent which offered the service. This was a technology which did not exist 15 years ago and the service was likely to grow.

(e) The new community ward, Romney Ward, was also discussed. It was explained that this was not the same as the old Boxley Ward. In part the new community ward was an ad hoc response to winter pressures and was more like a community hospital. Maidstone does not have a separate community

hospital. The length of stay of patients on this ward was 7-8 days when the ward was initially operational, but these patients had been transferred from other wards in the hospital. The average length of stay was around 2-3 weeks now, although the service had not been operating long enough to make definitive statements.

(f) It was explained that the trend was to reduce admission to hospital where possible. There was a growing demand for medical care, and an ageing population. It was often better for patients if admission could be avoided and the trend was towards more ambulatory care where patients were admitted or discharged with a treatment plan, sometimes returning for tests at a later date. The changes were not unique to Maidstone, but the specific configuration was.

(g) The renovation and redesign of the hospital was welcomed, and the role wider spaces between beds played in reducing infections was commented on. It was explained that the Trust had the lowest backlog maintenance bill in Kent but was not complacent. The building was in a series of cruciform sections and it was possible to work through the hospital systematically, stripping each section down to the bare frame. Some maintenance work, like boiler replacement, would need to be done separately.

(h) The Trust also explained that it was seeking 120 additional parking spaces. In response to a comment from a Member, the Chief Executive undertook to look at the size of the spaces used in the standard template. The majority of people arrived at hospital by car and Maidstone Hospital was fortunate in being positioned in a comparatively flat area. The question was asked about building a multi-storey car park. There was nothing forbidding a multi-storey car park, although it might not be able to be higher than the hospital. One Member suggested this may be to ensure helicopter clearance. The barrier was cost. Each level of a multi-storey car park cost around ten times more than having a simple car park on one level, although the design used at Medway Hospital was slightly cheaper.

(i) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their explanations, notes the report and looks forward to updates in the future.

(j) AGREED that the Committee thanks its guest for their explanations, notes the report and looks forward to updates in the future.

6. Cancer Services: Overview
(Item 7)

Stewart Dicker (Clinical Director - Quality and Care, Kent and Medway Cancer Network), Felicity Cox (Chief Executive, NHS Kent and Medway), and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) The representative from the Kent and Medway Cancer Network (KMCN) thanked the Committee for the opportunity to attend. He explained that the questions asked in advance related to the two-year old cancer strategy. Some information was not yet available; this included data on resection rates.

(b) The general structure of cancer services was given as being a hub and spoke model with specialist services concentrated where appropriate. It was explained that Maidstone was the centre for chemotherapy, but as part of an outreach service, all acute sites in Kent and Medway provided it. In contrast testicular cancer, which mainly affected men up to the age of 26, was centralised at the Royal Marsden hospital.

(c) There were no plans to change the current sites for services. KMCN would cease to exist after March 2013. Commissioning would move from the Primary Care Trusts (PCTs) to the CCG, or NHS Commissioning Board where the service was a specialist one. There would be a clinical network in the future covering Kent, Surrey and Sussex. This would include cancer along with other conditions in its work. Currently hosted by the PCTs, the future network would be hosted by the providers.

(d) There was a discussion about reducing health inequalities. It was explained that the KMCN did a lot of work on prevention in the past, particularly around early diagnosis. In the future, the Health and Wellbeing Board (HWB) would have a role in ensuring health inequalities were tackled. The HWB had to approve the commissioning plans of the CCGs. The CCGs had to plan to achieve 4 national outcomes targets along with 2 chosen locally. They would need to demonstrate to the HWB how it was achieving these outcomes. There was an outcomes dataset which would enable progress to be measured, although it was conceded data was not collected on everything. NHS representatives undertook to send a copy of the outcomes dataset to the Committee. In addition, the new public health responsibilities of Kent County Council included prevention.

(e) There was a debate around screening as a means to prevention, with Members questioning why there was not a national prostate cancer screening programme like there was for breast cancer. It was explained that while breast cancer diagnoses went up, the death rate stayed the same, which begged certain questions. Clinically, a screening programme needed to detect a cancer when there was still an opportunity to change the outcome and it needed a low false negative rate. The PSA test for prostate cancer did not meet these criteria. It was useful once the cancer had been diagnosed, but as a screening programme it would produce a low discovery rate for the number of tests. The biopsy can miss the tumour and potentially cause incontinence and impotence. It was also explained that prostate cancer was something most people died with, but did not die of it. It would also rely on all men going to their GP for the test. The bottom line was that a better test was needed.

(f) The Chairman proposed the following recommendation:

- That the Committee thanks its guests and notes the report.

(g) AGREED that the Committee thanks its guests and notes the report.

7. Date of next programmed meeting – Friday 8 March 2013 @ 10:00 am
(Item 8)