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 March 2013.

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

ALSO PRESENT:

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest
(Item3)

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

(b) Several Members explained that they were diabetics and as diabetes services were on the Agenda they felt this should be made clear.

3. Minutes
(Item 4)

(a) Mr Alan Willicombe requested that the Minutes be amended to reflect the fact he was present at the meeting.

(b) RESOLVED that, subject to this change being made, the Minutes of the Meeting held on 1 February 2013 are correctly recorded and that they be signed by the Chairman.

4. The Francis Report
(Item 5)

(a) The Chairman introduced the item and indicated that Members had before them letters received from Medway NHS Foundation Trust and NHS Kent and Medway on various matters arising from the Francis Report into events at Mid-Staffordshire Hospital. Attention was drawn to the website where Members would be able to access and read the full detailed Report. Given the importance of the Report, the Chairman felt certain this was something the

Committee would look at again in the future and asked if Members had any comments. Members proceeded to express a range of views.

(b) One Member identified two of the themes from the Francis Report set out on p.10 of the Agenda as being particularly important, namely the loss of corporate memory from constant reorganisation and the prioritisation of finance and targets over the quality of care.

(c) On the subject of reorganisations, concern was expressed about patients and services potentially being overlooked during the transition from Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs). However, the view was also expressed that the constant reorganisations meant little to frontline staff in the NHS as they were continually working and focussed on patients.

(d) There was a discussion over whether the kind of issues identified in the Francis Report were the result of the actions of a tiny minority of staff when the rest were dedicated and hard working, paying tribute to all staff groups including managers, or the result of a broader cultural problem. On this last point, the view was expressed that the NHS was not sufficiently self-critical. Connected with this, the view was expressed that patients felt reluctant to complain about a service they used and that within the NHS the potential penalties for whistle-blowing were too high.

(e) On the subject of Medway NHS Foundation Trust, the view was expressed that the quality of service varied markedly by ward and service. Concern was expressed about what exactly the mortality statistics did and did not include.

(f) It was commented that the Francis Report also had important lessons for patient and public involvement in the future. It was reported that representatives of the Kent LINk had visited the one in Staffordshire to provide support.

(g) Members felt the role of HOSC in maintaining an overview of the actions taken resulting from the Francis Report was a challenging and important one. To this end, there was detailed discussion on the wording of the recommendation. The issue of timing was of particular concern, with the view expressed that not setting a specific time to look at this topic again meant it could slip of the Forward Work Programme, but other views expressed the notion that it was important to wait until the report into Medway NHS Foundation Trust was made available. It was also felt that it would not be possible to ignore the outcomes of the Francis Report.

(h) The Chairman proposed the following recommendation:

- That the Committee recognise the importance of the Francis report and the strength of feeling arising from it and recommends that the HOSC put this item on its forward work programme as a priority.

(i) AGREED that the Committee recognise the importance of the Francis report and the strength of feeling arising from it and recommends that the HOSC put this item on its forward work programme as a priority.

5. Services Overview: a) Diabetes Services; and b) Ophthalmology
(Item 6)

Huw Alban Davies (Patient Advocate Diabetes UK), Dr Abraham George (Assistant Director / Consultant in Public Health), John Nester (Commissioning Manager, NHS Kent and Medway), Carole Eastwood (Commissioning Manager, NHS Kent and Medway), Claire Martin (Diabetes Project Manager, Canterbury and Coastal CCG), Dr Balaji Chalapathy (Dartford, Gravesham and Swanley CCG Board Member), Gerry Clark (Commissioning Programme Manager – Long Term Conditions, Dartford, Gravesham and Swanley CCG), Paula Smith (Commissioning Delivery Manager and Planned Care Lead, Canterbury and Coastal Clinical Commissioning Group), Sean Crilly (Head of Planned Care Commissioning, East Kent Federation of CCGs), Jochen Worsley (Head of Long Term Conditions - East Kent Federation of CCGs), and Ally Hiscox (Head of Commissioning, Swale CCG) were in attendance for this item.

(a) The Chairman introduced the item and NHS colleagues explained that there were representatives of all 7 CCGs present. It was also explained that historical data would necessarily be based on PCT areas, so were not always directly comparable to CCG areas.

(b) Members proceeded to ask a range of questions on diabetes and ophthalmology services, from which several themes arose.

(c) One area of discussion was around diabetes services available at GP practices. The ones available were praised, but it was asked as to the reason why these were not available at all surgeries. It was explained that it depended a lot on the size of the GP practice and the special interests and training of the GPs. The provision of a one-stop shop for diabetes services involved a lot of different disciplines and specialists. This required surgeries of a certain size and for the right estate to be available. Care also needed to be taken not to duplicate secondary services. The way GP practises were being used was also being looked at, with options like one weekday afternoon or a Saturday morning being set aside for diabetes services being considered. The important point was for GPs to know what services were available and how to refer patients to them with a quality service available to all.

(d) Building on this, questions were asked about the future priority which would be given to commissioning and funding diabetes services. Some Members were concerned it could become a ‘Cinderella service’ and the example of the new Pembury hospital not having a diabetes service given as an example, though it was also noted there was a service elsewhere in Tunbridge Wells. On behalf of the East Kent Federation of CCGs it was explained that, working with the Paula Carr Diabetes Trust, an expert commissioner had been employed to produce recommendations by the end of the year. West Kent also treated diabetes services as a priority and were redesigning their diabetes services. There was a focus on addressing the high levels of people with diabetes who had not been diagnosed. The overall aim was to address diabetes early and so free up acute capacity so that Level 3 services with a consultant would be reserved for those with the most need. The comment was made that there was also a need to encourage consultants to let regular patients be treated in the

community. The Committee was informed that a one-stop shop would be coming to Sevenoaks Hospital. This did not mean patients from all over West Kent would need to travel to Sevenoaks. It was a service model being trialled and if successful similar services would be opened elsewhere.

(e) Several Members of the Committee expressed the view that diabetes services were very good, but there were some concerns around administration and process. One Member explained that he found it odd that HbA1c tests could not be carried out less than 6 months apart and that it had been reported that there were restrictions being placed on making daily test strips available to patients. In response it was explained that evidence showed that daily testing of blood glucose did not lead to more control of the condition, but daily testing was still used where diabetes was not being controlled and/or where a patient was on insulin. HbA1c tests were a much more reliable indicator of how diabetes was being controlled, but that as red blood cells took 180 days to completely renew, it could not be carried out before 6 months had passed.

(f) One point raised by a number of Members was the importance of diagnosing people early and the view was expressed that one reason there were such high levels of undiagnosed diabetes was because diabetes did not always cause people problems and so there was no reason to be tested. In answer to the question of what was being done, NHS representatives explained that along with opportunistic screening, there was the annual health check programme which went a long way to diagnosing the undiagnosed. It was, however, underfunded. In response to a specific question it was explained that the health check programme was commissioned across Kent and Medway through Public Health Departments.

(g) On this theme, it was pointed out that there was a different rationale behind early diagnosis and prevention for Type 1 and Type 2 diabetes. For Type 1 diabetes, which resulted from the body's inability to produce insulin, screening was very important for secondary prevention to ensure the condition was managed appropriately. Early detection of Type 2 diabetes could mean lifestyle changes were recommended to control the condition.

(h) There was a lot of discussion around the lifestyle and socio-economic factors contributing to the current levels of diabetes as well as the possibility of success for preventive health campaigns such as the Change4Life national campaign. Some Members expressed scepticism as to how successful preventive health campaigns could be, but other Members indicated there were examples of turnarounds in social attitudes, such as wearing seatbelts or smoking. NHS representatives explained that it was true to say that it was a very complex area and that there was a big difference between making someone aware of what they should eat and that person changing what they ate. It was often the case that people knew what they should eat but chose to eat otherwise; a person eating fast food to raise their spirits after being made redundant was given as an example. There were also broader cultural challenges, such as parents rewarding children with sweets, which needed to be challenged.

(i) It was explained that there were a variety of different projects underway, and reference was made to the good work the community chef project was doing.

However, some of these projects could be expensive in relation to the benefit gained.

(j) NHS representatives went on to outline some research which had been carried out in the area. As a result of living with different families, 8 different categories of parent in relation food had been identified, including single-parent families and more traditional approaches which saw meat and vegetables as being necessary with every meal. Each of these segments would need to receive a different message around healthy eating and lifestyle changes. Related to this point, Members felt that sometimes the message dieticians could give could be misleading or sometimes lack the appropriate context for the person being advised. NHS representatives also raised the point that it was important to get the message across that there were not always immediate solutions; weight which had taken 20 year to gain could take as long to lose.

(k) The rise of childhood obesity was a matter of particular concern to Members. A representative from Diabetes UK explained that one worse case scenario had been put forward where the current generation would be the first one to die before their parents due to the health problems being stored up for the future by current lifestyle choices. It was explained that there was the Healthy Schools Programme which aimed specifically at tackling this. Mention was also made of the National Child Measurement Programme which measuring the BMI/weight of children in reception class and in Year 6. This provided useful data about the rate of the rise of obesity. It was further explained that this data was available for each locality through the Public Health Observatory. The importance of cooking lessons at school was also mentioned. An NHS representative noted that however healthy a school was, it could not compensate completely for unhealthy eating outside of school.

(l) One Member raised the possibility of perhaps requiring legislation to tackle the unhealthy food produced by certain companies. There was a discussion on the balance to be struck between these companies as private organisations, the need to give people lifestyle choices and improving health. The ethics of investing in specific companies was also debated. It was reported that there was an ongoing conversation between government, both national and local, public health professionals, food companies and consumers.

(m) In response to a specific question, it was reported that work with the local ambulance service on appropriate patient pathways for diabetics was ongoing.

(n) Moving on to the related subject of ophthalmology, Members concurred that the services delivered were excellent and Maidstone Hospital was named as a centre of excellence. However, concerns were expressed around the administration of the services. Waiting times were reportedly lengthy and there were some irregularities around the appointment system which needed addressing.

(o) NHS representatives undertook to take these concerns to the Service Improvement Group. This group included consultants and so the balance between the priority given to the requests of consultants and those of administrators would be looked at. In East Kent it was explained that the

waiting times had been 13 weeks, but had been reduced to 10 weeks now. To put the Kent situation this in its wider context, it was explained that there was a national shortage of ophthalmologists and that it took 8-9 years to train a consultant ophthalmologist. This was one reason why services needed to be delivered more in the community. Mr Nester undertook to keep the Committee informed on this issue.

(p) Beyond this, NHS representatives explained that with an ageing population there was likely to be an increase in the incidences of glaucoma and increasing pressure on services. The Committee were informed that a tender was coming up for a community glaucoma network to be in place by June. This might involve certain services being available in high street opticians, with referrals to acute hospital consultants only being made for more serious cases. The South Kent Coast CCG envisaged more ophthalmology services being available in the community. Other CCGs might choose different models, but this would allow results to be compared and the spread of best practice.

(q) The impact of Trust Special Administrator's recommendations about South London Healthcare NHS Trust (SLHT) was also discussed. This was important as Darent Valley Hospital accessed ophthalmology services from this Trust's Sidcup site. It was explained that King's College had taken over the ophthalmology services at SLHT but that the details were still being worked out.

(r) Several Members of the Committee made suggestions as to the wording of a possible recommendation.

(s) The Chairman proposed the following recommendation:

- That this Committee thanks its guests for their valuable responses and recognises the fundamental importance of health prevention programmes, and asks this Committee to continue working with the local health sector, the Health and Wellbeing Board, Kent County Council more widely, and central government to understand the best way to effect the necessary changes in lifestyle.

(t) AGREED that this Committee thanks its guests for their valuable responses and recognises the fundamental importance of health prevention programmes, and asks this Committee to continue working with the local health sector, the Health and Wellbeing Board, Kent County Council more widely, and central government to understand the best way to effect the necessary changes in lifestyle.

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