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, 26 November 2010.

PRESENT: Mr B R Cope (Vice-Chairman, in the Chair), Mr A D Crowther, Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mrs J Whittle, Mr A T Willicombe, Cllr M Lyons, Mr M J Fittock, Mr R Kendall, Cllr Ms A Blackmore (Substitute for Cllr Mrs M Peters), Cllr R Davison (Substitute for Cllr J Cunningham) and Mr M J Northey (Substitute for Mrs J A Rook)

ALSO PRESENT: Paul Absolon, Cllr John Avey, Ms C Boland, Su Brown, Gordon Court, Ms L Denoris, Ms T Gailey, Cllr P Gulvin, Mr R Kenworthy and David O'Brien

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

Godfrey Horne MBE, In Memoriam.

Members, officers and guests stood in silence as a mark of respect for Godfrey Horne MBE, the late Chairman of the Health Overview and Scrutiny Committee, who had passed away suddenly on 13 November 2011.

2. Minutes
(Item 4)

RESOLVED that the Minutes of the Meeting held on 8 October 2010 are recorded and that they be signed by the Chairman.

3. Primary Angioplasty - Update.
(Item 5)

Corrine Stewart (Senior Service Improvement Project Manager, Kent Cardiovascular Network) and Clare Boggia (Cardiology Matron, East Kent Hospitals University NHS Foundation Trust) were present for this item.

(1) The Kent Cardiovascular Network led on the work to establish a coordinated pathway of care around a 24/7 emergency primary angioplasty service being established for Kent and Medway at William Harvey Hospital, Ashford. Corrine Stewart and Clare Boggia were able to provide an overview of the first six months of the system in operation. A formal 6-month review was being undertaken, and this would be shared with the Committee once it had been completed.

(2) Ambulances attending cases of suspected heart attacks were able to carry out electrocardiograms (ECGs) and transmit the results to William Harvey Hospital, where nurses were able to interpret the results to decide whether primary angioplasty was appropriate. Of 2255 ECGs transmitted, 476 patients were taken by ambulance direct to William Harvey Hospital, which equates to around 15 each week. Around 75% of those admitted received primary angioplasty. Some received thrombolysis for clinical reasons or because of patient choice. 5% are transferred to London for "cabbage" (coronary artery bypass graft surgery, or CABG). William Harvey Hospital works on an 8 am to 6 pm day and 60% of patients are admitted during these hours. The length of stay has been reduced to an average of 3.79 days, and the target is 3.5 days. Some patients are repatriated to hospitals closer to home where possible. In terms of geographical spread, 44% patients were from the NHS Eastern and Coastal Kent area, 34% from NHS West Kent and 22% from NHS Medway.

(3) It was stressed that the primary angioplasty service at William Harvey was an emergency service only. The service was only appropriate for patients suffering from a type of heart attack called ST-elevated myocardial infarction (STEMI). This means that not every patient experiencing a heart attack would be sent to William Harvey or receives angioplasty.

(4) The target is for 75% of patients to experience a call-to-balloon time of 150 minutes and this means the time from when medical help was called for to the time the angioplasty balloon is first inflated. Performance has been improving against this target since the service began and is now achieving the 75% target. The service was designed around a maximum travelling time of 75 minutes, but in practice the maximum time was 60 minutes from the furthest points in Kent. In response to a specific question from a Member, the time from Edenbridge was given as 50 minutes. As services in neighbouring areas like Surrey achieve the required standard, it may be that in the future the best option for patients in some areas of Kent would be to go to a different centre outside the county.

(5) In terms of local factors which may affect travelling time, such as Operation Stack, it was explained that there was a memorandum of understanding with the police which would mean there was a police escort available for ambulances in these circumstances.

(6) Members accepted that high levels of patient satisfaction were reported, but some expressed concerns about the existence of only one centre and the problems this could cause for patients and their families. The attendees were able to refer to clinical evidence that demonstrated centralisation in the case of this service did deliver better outcomes. A practical demonstration of this was that there were 12 cardiac specialists in the county able to perform the procedures, and to deliver a 24/7 service, this meant the consultants only had to work an out of hours shift 1 night out of every 10 and this delivered better quality of care. The relevant national mortality figures were 5.2%, whereas for the county the figure was 3.7% for the first six months. It was explained that the review currently underway should help answer a Member's question as to whether the benefit of the service was felt equally across the county.

(7) Both the hospitals at Medway and Tunbridge Wells were able to carry out angioplasty, and the service's contingency plan was for patients to be diverted to

Medway. This arrangement held for when contingencies were planned for, such as equipment maintenance, but also the occasional time when there was an unplanned contingency such as equipment failure. To reduce the number of times when the service was disrupted for these unplanned reasons, a business case for a second resilience laboratory was currently being finalised. If approved by the Board of East Kent Hospitals University Foundation Trust, it would require 40 weeks to be built.

(8) There was positive discussion around the role that public education could play in improving the service, through first-aid training in schools and businesses and through educating the public that if they were showing the symptoms of a heart attack calling an ambulance was more appropriate than presenting themselves at their local Accident and Emergency Department.

(9) One challenging area was extending the service to prisoners. The numbers were few, but formed a disproportionately high number of the access problems faced by South East Coast Ambulance Service. This was due to accessing high security prison grounds. The Network was working with the Sheppey Prison Cluster and was looking at the feasibility of putting telemetry equipment in the prisons to speed up the process.

4. Community Mental Health Services.
(Item 6)

Lauretta Kavanagh (Director of Commissioning for Mental Health and Substance Misuse, Kent and Medway PCTs), Paul Absolon (Social Care Commissioner for Mental Health, Kent County Council), Erville Millar (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), Marie Dodd (Executive Director of Operations, Kent and Medway NHS and Social Care Partnership Trust), John Hughes (Director Community Recovery Services, Kent and Medway NHS and Social Care Partnership Trust), Mark Fittock (LINk Governor), Cate Boland (LINk Development Worker), Di Tyas (Deputy Clerk, Local Medical Committee), and Dr James Kelly (Local Medical Committee) were present for this item.

(1) This section of the meeting built on the meeting in June (Minute 3, 11 June 2010) when hospital based mental health services were considered. As then, Lauretta Kavanagh, as lead commissioner for mental health for Kent and Medway Primary Care Trusts, provided an introductory overview. She indicated the summaries of the *Live it Well* mental health and wellbeing strategy which had been provided for Members at the start of the meeting in addition to the information contained within their Agenda. This strategy had the support of the three PCTs in Kent and Medway along with Medway Council and Kent County Council.

(2) She explained that the strategy took a twin-track approach, that of promoting mental health and improving access and outcomes. There were three areas where large scale transformation was envisaged. The first was to increase the confidence and ability of primary care professionals in dealing with mental health. The second was to redesign community services so there was less reliance on hospital based services; the vital role played secondary care was acknowledged, but this redesign was aimed at enabling secondary settings to deal with the more severe cases more effectively. Thirdly there was a need to develop currencies and tariffs in mental health to shift from the current block contract to payment by results.

(3) As Chief Executive of Kent and Medway NHS and Social Care Partnership Trust (KMPT), the largest provider of mental health services in the county, Erville Millar provided an overview of the range of community health services available. He explained that increasingly self-referral to services will be seen as important as GP referrals. The Increasing Access to Psychological Therapies programme (IAPT) was increasingly important. Among the other services available, there was also the Early Intervention in Psychosis Service that was aimed at the 14-35 age group, the First Response Intervention Service (FRIS) as the first line of assessment and the 24/7 crisis services which looked to prevent admission to accident and emergency departments wherever possible.

(4) Mark Fittock, a LINK Governor, introduced a draft version of a LINk report into mental health services and which Members had before them. Mental health problems affected 1 in 4 of the population and LINks had difficulty getting to grips with the subject and the service available. He explained that LINks felt that although KMPT had there own user group, there needed to be better public/service user engagement with KMPT. Overall, the findings of the LINk report were reflected by the recent Care Quality Commission (CQC) survey of people who use community mental health services.

(5) On the subject of user involvement, Paul Absolon from Kent County Council explained that there was heavy investment in user forums and there was a high level of input into the *Live it Well* strategy. More users could be involved if there better tie up with KMPT, he suggested.

(6) There was a lot of discussion surrounding the CQC service users report. KMPT expressed respect for the report and it is used as a guide to focus improvements but indicated that the results were based on less than 1% of the patients seen by the Trust. Some Members expressed the view that a stronger response to the survey would have been welcomed and one Member indicated that Kent County Council was often judged on the basis of smaller survey samples. KMPT indicated that their own local surveys provided better results. From the perspective of the commissioners, Lauretta Kavanagh explained that a number of successes had been achieved by the Trust and there was work ongoing on an action plan to improve. There was also a move towards systems that would capture patient data in real time. By way of context, James Sinclair from KMPT explained there was a need for more local initiatives in order to involve service users and improve, but that the Trust delivered services from 117 sites and this made getting consistent quite a complex process.

(7) From the perspective of General Practice, Dr James Kelly from the Local Medical Committee explained that he shared the concerns expressed by Members around capacity in the future when GPs will be expected to handle local commissioning as well as continue to see and treat patients. However, GPs were closest to patients and their needs and currently 90% of mental health treatment activity was carried out in primary care, but only 20% of the funding for mental health went to this sector. However, this also meant that GPs gave a high priority to mental health and were in a good position to act as effective gatekeepers to services. One challenge he saw was in the need to move away from the current block contract system, which made services difficult to decommission, and enable a range of providers to enter the market.

(8) Responding to a question on the adequacy of inpatient mental health services, the perspective of the commissioners was that there were enough beds to meet the need and that work was going on with the Trust and GPs in East Kent to approve a business case to reduce the number of acute beds by 20 by 2012. A number of conditions had been set the Trust to ensure adequate community provision was available before this could happen. Erville Millar explained that within KMPT bed occupancy was around 93-97% capacity and so there were times when there were pressures. In order to reach the goal of reducing the number of beds by 20, work was being done to reduce length of stay from the current 23-25 days.

(9) Connected with the issue of acute mental health services, Lauretta Kavanagh explained that there was 'section 136' suites adjacent to acute mental health wards where there was liaison with the police and there was currently an education programme underway to raise awareness within the police of the range of options regarding the best way to handle a member of the public with mental health care needs with whom the police would come in contact.

(10) In response to a particular point around Mother and Infant Mental Health Services, the service was commissioned from KMPT and Erville Millar explained that the service had been commended by the recent Ofsted report and CQC and that the Member was quite right in indicating that the importance of identifying physical phenomena which may be contributing to mental health phenomena was crucial not just to this service but right across all mental health services.

(11) Regarding mental health services for members of the armed forces, it was explained that the same services were available and better access guidance was followed. Information on the mental health service needs of servicemen was just beginning to be collected.

(12) The issue of Child and Adolescent Mental Health Services (CAMHS) was raised by a number of Members as a topic that needed to be looked at urgently, in particularly those services for 17 year olds where there was a transition from CAMHS to adult mental health services.

(13) There was also a discussion on forensic mental health services. Representatives from KMPT explained that secure services involved a heavy investment in monetary terms, and as a proportion of the mental health spend. It was explained that the average length of stay in a medium secure setting was 2 years and for a high secure setting, 7 years. For low secure settings in Kent, the average was 21 days. In these latter settings it was explained that there was balance to be struck and often the challenge was to prevent people entering, rather than preventing people leaving. In response to a specific question about one site, Erville Millar explained that Hucking Hill House was no longer used for rehabilitation for forensic services.

(14) As a final point, Lauretta Kavanagh explained that 3 public awareness campaigns around mental health were planned.

5. The Future of Community Service Providers - Written Update.
(Item 7)

Di Tyas (Deputy Clerk, Local Medical Committee), and Dr James Kelly (Local Medical Committee) were present for this item.

Members had before them written information providing an update on the subject of the future of NHS community service providers following on from the meeting of 3 September when this topic was last considered and prior to the meeting of 4 February 2011 when this topic will be revisited.

There was a broader discussion of the context within which these changes were taking place, in particular the move to GP commissioning and the possible distraction from service delivery it would involve. Members felt there was a lot of confusion around key areas such as the transfer of estates and the cost of the changes.

Dr Kelly conceded there were risks in the move to GP commissioning and mentioned the 'clean slate' campaign of the British Medical Association. Community services were given as one of the biggest frustrations felt by GPs and that GPs felt that under the current system is was often the most vulnerable, such as children, the elderly, and those with mental health needs, who suffered most.

6. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.
(Item 8)

(1) Members expressed regret that the response of the Strategic Health Authority did not result in the Committee receiving a copy of the report submitted to the Secretary of State for Health. Members then discussed a range of possible follow up actions.

(2) Mr. Cooke moved, Mr. Ferrin seconded, that a Freedom of Information Act request be made to the Secretary of State to ask him to release to the Committee a copy of the report he had commissioned to be prepared by the South East Coast Strategic Health Authority on the reconfiguration of Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust.

Carried by 9 votes to 1.

(3) RESOLVED that a Freedom of Information Act request be made to the Secretary of State to ask him to release to the Committee a copy of the report he had commissioned to be prepared by the South East Coast Strategic Health Authority on the reconfiguration of Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust.

7. Committee Topic Discussion.
(Item 9)

(1) Members discussed the item on primary angioplasty and felt that the concerns raised during the discussion had been dealt with in a most satisfactory manner.

(2) On returning to the request that the Committee consider CAMHS as a matter of urgency, a range of views were expressed including whether the topic could best be approached by breaking it apart into different aspects and whether it would be more useful to wait six months given the recent publication of the Ofsted report into

safeguarding children. Due to its cross-cutting nature, Paul Wickenden, the Overview Scrutiny and Localism Manager, undertook to bring the matter to the attention of the Scrutiny Board to discuss what would be the most appropriate forum for the subject.

8. Date of next programmed meeting – Friday 7 January 2011 @ 10:00am
(Item 10)