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, 4 February 2011.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr J F London (Substitute for Mr N J Collor), Mrs J A Rook, Mr C P Smith, Mr R Tolputt, Mr A T Willicombe, Cllr R Davison (Substitute for Cllr J Cunningham), Cllr M Lyons, Dr M R Eddy (Substitute for Mr M J Fittock) and Mr R Kendall

ALSO PRESENT: Cllr John Avey, Cllr Mrs A Blackmore, Su Brown, Gordon Court, Mr J Larcombe, Jo Naismith and Victoria Ong

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. Membership

(Item)

The Committee noted its new Membership as set out below:

Conservative (10): Mr N J D Chard, Mr N J Collor, Mr G Cooke, Mr B R Cope, Mr A D Crowther, Mr K A Ferrin MBE, Mrs J A Rook, Mr C P Smith, Mr R Tolputt and Mr A T Willicombe.

Liberal Democrat (1): Mr D S Daley

Labour (1): Mrs E Green

District/Borough Representatives (4): Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons and Councillor Mrs M Peters.

LINk Representatives (2): Mr M J Fittock and Mr R Kendall.

2. Election of Chairman

(Item)

Mr B R Cope proposed and Mrs J A Rook seconded that Mr N J D Chard be elected Chairman of the Health Overview and Scrutiny Committee.

Agreed without a vote.

Mr N J D Chard thereupon took the Chair.

3. Minutes

(Item 4)

RESOLVED that the Minutes of the Meeting of 7 January 2010 are recorded and that they be signed by the Chairman.

4. Update on Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust

(Item 6)

(1) Members had before them the information in the Agenda along with the additional information provided for them by NHS Eastern and Coastal Kent and East Kent Hospitals NHS University Foundation Trust concerning the review of maternity services in East Kent (see Appendix).

(2) The Chairman undertook to provide further information when a reply was received from the Secretary of State for Health.

(3) RESOLVED that the Committee note the attached correspondence.

5. The Future Shape of Community Service Provision

(Item 5)

Meradin Peachey (Kent Director of Public Health), Dr Robert Blundell (Vice Chair, Kent Local Medical Committee), Dr Mike Parks (Medical Secretary, Kent Local Medical Committee), Di Tyas (Deputy Clerk, Kent Local Medical Committee), Philip Greenhill, (Interim Chief Executive, Eastern and Coastal Kent Community Health NHS Trust), Mark Shepperd (Managing Director, West Kent Community Health), Phil Edbrooke (Interim Director of Corporate Services, Eastern and Coastal Kent Community Health NHS Trust), Oena Windibank (Interim Director of Operations, Eastern and Coastal Kent Community Health NHS Trust), and Bill Millar (Head of Primary, Community and Elective Care, NHS Eastern and Coastal Kent) were in attendance for this item.

(1) The Committee had previously discussed the subject of the future of community service provision at the meeting of 5 September 2010. Representatives from the NHS provided an overview of events subsequent to that meeting along with an outline of future progression. Following approval in 2010 the community provider organisation within NHS Eastern and Coastal Kent to become a separate NHS Trust, Eastern and Coastal Kent Community Health NHS Trust was formally established on 1 November 2010. West Kent Community Health currently remains part of NHS West Kent, but following approval of the business case for a Pan-Kent Community Health Trust, this will join with Eastern and Coastal Kent Community Health NHS Trust as a single organisation from April 2011. This organisation will seek Foundation Trust status, which may be granted in 2013.

(2) A formal consultation on these plans had been carried out, but it was reported that there had been more informal than formal responses received. The major concerns raised in these responses centred on the ability and willingness of commissioners, now and in the future, to commission services locally. To

address these concerns, the organisation was being structured so that it could operate on a locality basis and local boards were being established involving stakeholders that would inform service delivery. Members felt there was an opportunity there to tie in these proposed boards with work going on within local authorities in Kent. The NHS said they would look into the idea. In addition, it was pointed out that there would be a public consultation as part of the application for Foundation Trust status and there would be Governors drawn from the public membership of the Foundation Trust.

(3) Areas of the country such as Liverpool, Birmingham and Wigan were reported as seeing a similar size merger take place. Medway was pursuing a social enterprise model. In other areas of the country the community services were joined to a mental health or an acute Trust. One weakness of the latter was that during periods of budgetary constraint, the community services were often the first to experience reductions. However, there were some services for which this may be appropriate and the right option for community paediatrics and stroke services were still being examined.

(4) The original policy proposal was for the community health estate, including community hospitals, to remain with the Primary Care Trusts. With the exception of Private Finance Initiative sites, the estate was largely going to be transferred into the new community services Trust. How these are to be used will be part of the ongoing discussion with commissioners.

(5) Members raised the issue of the establishment of a new Trust adding to the levels of bureaucracy and costs within the health economy. An alternative perspective presented by representatives of the NHS is that the new Trust could be seen as a reduction of bureaucracy and management costs as to community service organisations were forming into one and would need, for example, one Chief Executive. The savings in this area from the merger were estimated at around £1 million per year. They also had a five-year efficiency savings target of £25-30 million and that this needed to be seen against an annual income of around £200 million.

(6) In contrast to acute services, community services were largely funded through block contracts. Any tariff for community services has to be agreed locally as there is no national one. There was an increasing move away from this as a cost per service system was seen as more useful. For example, in Kent a cost per case system for musculoskeletal services was being introduced.

(7) There was also a move by the Department of Health away from process targets, or inputs such as the number of nurse contacts, towards information on outcomes. However, there were issues around data collections and measurements in the community services sector.

(8) The important role that community hospitals can play in the health economy, as for example in reducing and preventing stays in acute hospitals, was acknowledged by all those present and Members of the Committee. Beyond this there was detailed discussion around the different uses they could be put to and the involvement of GPs in their local hospital.

(9) It was reported that there was a sense that a number of GPs felt that in some areas of Kent, the connection between the community and its community hospital was weak. Dr Blundell felt that an admitting radius of ten miles was best as it would make it easier for patients, who tended to be elderly, to receive visits from family.

(10) There was consensus that arrangements between GPs and community hospitals needed to be different to suit different areas and needs. For example, a salaried GP provided cover at Livingstone Hospital in Dartford, and in Sevenoaks Hospital there were GPs on wards as well as an adult physician who managed patients jointly with GPs.

(11) Changes and improvements to the use of community hospitals were reported as already having taken place and would be continuing. For example, in West Kent, the use of community hospitals for end of life care had been a cause of friction in the past, but from July 2010, two beds had been ring-fenced in each hospital for this purpose.

(12) The Chairman expressed his thanks to the numerous community Hospital League of Friend's organisations who had been able to submit information for inclusion in the Committee's Agenda, and several Members echoed these sentiments. Jo Naismith, the Chairman of the League of Friends of Edenbridge and District War Memorial, was present and invited to speak on the topic of community hospitals. She began by thanking the Committee for its interest in the subject and the opportunity to present their views. She went to explain that the situation had improved markedly over the situation a few years ago when the hospital in Edenbridge was threatened with closure and that West Kent Community Health worked very well with them. Her concern with the move towards GP commissioning was that, although the GPs in Edenbridge were very good, if they were not at the forefront of commissioning decisions, there may not be anyone to speak for Edenbridge when it came to service developments.

(13) Members had before them a paper from the Kent Director of Public Health, which she explained was part of an ongoing process of identifying public health funding in commissioning services and that more detail would become available over time and would be made available to the Committee. As this work had not been completed, this explained why there were some apparent discrepancies between East and West Kent. For example, Eastern and Coastal Kent Community Services NHS Trust provided sexual health services in East Kent, whereas Dartford and Gravesham NHS Trust provided the same services in West Kent.

(14) It was explained that the benefits of investments in public health and preventive services often took a long time to be seen. Sometimes it was the case that not enough had been invested in the case, so that no benefit was shown, even if the strategy was potentially effective.

(15) There were some questions raised about specific programmes. The Health Trainer programme was a Department of Health requirement which had a positive aspect in that it involved people who were not registered with a GP and so in more need of additional support. An evaluation of the Home Start

programme was underway and the results would be shared, as would further information around the numbers involved in the programme as well as the funding.

(16) During the final section of this item, Members expressed the view that they would appreciate further information on the following:

1. TUPE regulations;

2. Savings and what might be the management costs now and in the future within community services;

3. The mechanisms of NHS finances; and

4. The broad pattern of demographic changes in Kent and the impact on NHS finances

(17) More broadly, a request was made for more information on the details of Government proposals for the health sector.

6. Date of next programmed meeting – Friday 25 March 2010 @ 10:00 am
(Item 7)