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, 10 June 2011.

PRESENT: Mr N J D Chard (Chairman), Mr R Brookbank, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr J D Kirby (Substitute for Mr A T Willicombe), Mr J N Wedgbury (Substitute for Mr N J Collor), Mr M J Fittock, and Mr R Kendall

ALSO PRESENT: Cllr J Cunningham, Cllr R Davison, and Cllr M Lyons

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Minutes
(Item 4)

RESOLVED that the Minutes of the Meeting of 19 April 2011 are recorded and that they be signed by the Chairman.

3. Trauma Services in Kent and Medway
(Item 5)

Dr Robert Stewart (Medical Director, Kent and Medway Cluster and Chair of the Kent and Medway Trauma and Critical Care Network), Dr Patricia Davies (Locality Director, Dartford, Gravesham and Swanley GPCC and Lead Director for the Kent and Medway Trauma and Critical Care Network), Helen Belcher (Project Manager, East Kent Hospitals University NHS Foundation Trust), Dr Marie Beckett (Deputy Medical Director and Emergency Care Consultant, East Kent Hospitals University NHS Foundation Trust), Karen Barkway (Performance and Governance Manager, NHS West Kent) were in attendance for this item.

(1) The Chairman introduced the item and explained that there were a number of options the Committee could take following the developments of the trauma network in Kent and Medway. As the network did cover two local authority areas, Kent and Medway, the two Committees exercising the health scrutiny function may need to form a Joint HOSC to consider the item if both considered it a substantial variation of service.

(2) Dr Stewart provided an overview of the proposals and the reasons underlying them. There was a need to develop trauma services in Kent and Medway because while there were no Major Trauma Centres in the area, not all

patients could be taken to either London (mainly King's) or Brighton within the recommended 45 minutes. A Major Trauma Centre required cardiothoracic, neuroscience and other specialities to hand to provide a full service as well as a certain throughput of patients in order to maintain skill levels. These factors precluded one being established in Kent and Medway, but the development of improved services as well as repatriation for rehabilitative care was possible. The Air Ambulance, although useful, could not be the complete solution as there were too many restrictions on when they could be used. Closer links were being developed with the South East London Trauma Network.

(3) When responding to a major trauma incident, the paramedics assessed the situation and there were three options – taking the patient straight to a Major Trauma Centre, stabilising the patient before transfer, or treating the patient locally. The Kent and Medway Clinical Care and Trauma Network's proposal was to develop three Major Trauma Units across Kent and Medway where additional expertise from consultants would be available and rehabilitation would be coordinated. These Major Trauma units would be linked to Major Trauma Centres which would assist with training and recruitment. The South East Coast Strategic Health Authority and London Trauma Board were supporting the proposals. The proposed sites for the Major Trauma Units were:

- Pembury Hospital,
- William Harvey Hospital, and
- Medway Hospital

(4) A range of questions were asked by Members over different aspects of the proposals. On the number of patients involved it was clarified that in Kent and Medway each year ½ million patients are seen in Accident and Emergency Departments each year; of these the 200 most severe, major trauma cases, go to King's. The Network stressed the proposals were improvements to existing services and not the downgrading of Accident and Emergency Departments. On the selection of the sites, it was explained that the Acute Trusts had to express an interest but that there were strict criteria around what needed to be provided, such as 24 hour coverage by an Accident and Emergency specialist.

(5) The sites proposed led to Members posing a number of specific questions. One Member suggested that the Pembury and Ashford sites were too close to the other, and specifically in relation to Pembury, it was pointed out that it was not on a motorway and served a large number of people outside of Kent and more information was needed on patient flows from those areas. Following on from this, the lack of any Major Trauma Centre between Brighton and London meant that Pembury was likely to become a hub and this raised questions around whether Pembury had sufficient capacity.

(6) Issues around capacity were also raised around Darent Valley, with the additional pressures caused by the closure of the Accident at Emergency Department at Queen Mary's. It was explained that Darent Valley was not

selected as one of the sites as it falls within the 45 minute isochrones for accessing a Major Trauma Centre within London.

(7) Capacity across the entire system was also questioned and the issue rose of where people would be taken if King's was full. It was pointed out that while there was some prediction possible, trauma could not be completely planned for as to when and where it happened. One Member raised the issue of the possible use of private hospitals, such as the one being built in Maidstone.

(8) The representatives attending on behalf of the Network were thanked for providing a succinct overview of the proposals in the time allowed and Members were asked to forward any outstanding questions they had to the Committee Researcher for answering when the Committee returned to the subject.

(9) AGREED that the Trauma Network be invited to return to a future meeting of the Committee and that this meeting be in the form of a Joint HOSC with Medway should the equivalent Committee wish also to explore this matter further.

4. NHS Financial Sustainability: Part 3 - Mental Health, Community Health, and Ambulance Services
(Item 6)

Philip Greenhill (Interim Deputy Chief Executive, Kent Community Health NHS Trust), Chris Wright (Interim Director of Finance, Kent Community Health NHS Trust), Oena Windibank (Interim Director of Operations – East, Kent Community Health NHS Trust), Marie Dodd (Acting Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), James Sinclair (Director of Partnerships and Social Care, Kent and Medway NHS and Social Care Partnership Trust), Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Robert Bell (Acting Director of Finance, South East Coast Ambulance Service NHS Foundation Trust) were in attendance for this item.

(1) The Chairman introduced the item and explained that this was the third and final meeting in a series examining NHS Financial Sustainability and that the Trusts present would be invited to provide an overview from their perspective.

(2) Philip Greenhill from the Kent Community Health NHS Trust began with the information that the Trust employed 5,700 staff and had a budget of around £200 million. They needed to find £14 million in efficiency savings. Most of the income for the Trust came from block contracts but the value of these had been reduced by 1.5% which equated to a £2.6 million cost pressure. There were also cost pressures because of pay uplifts and high cost drugs. Part of the solution was in back office savings but the biggest was in workforce productivity and this was being examined as the Trust was carrying out the largest community services staff study in England. Nationally, district nurses spend 22% of their time with patients; Kent has managed to increase this to 45-46%. Another area is improving community hospital throughput. The biggest cost pressure was identified as demand in the acute sector as the tariff increases the cost with activity. Both community services and social services

have a role to play in reducing demand, as does the new 111 number which will assist in getting the entry point for patients correct.

(3) Responding to a particular question about the hospital at home scheme run in Medway, it was explained that this did not involve a double-payment as the service was provided by Medway NHS Foundation Trust and paid for out of the tariff paid to the hospital before the patient is discharged to the care of his or her GP.

(4) It was further explained that the £14 million which the Community Health Trust needed to find was 8% of the revenue budget. This provided part of the context within which the Trust was embarking on the journey to Foundation Trust status because attaining FT status meant there was more freedom to focus on the right financial strategies.

(5) On the subject of the Minor Injuries Unit at Sheerness it was explained that this was only a temporary closure on safety grounds and that it was back open 9am to 9pm Monday to Friday and would be open at the weekend again soon. More broadly on the subject of community hospitals, it was explained that the whole of community services support the work the community hospitals undertake, rather than the hospitals causing funds to be diverted from elsewhere.

(6) Marie Dodd outlined the issues for the Kent and Medway NHS and Social Care Partnership Trust as being roughly similar to those in the community health sector. The block contracts were also facing a 1.5% reduction in value and there was a 4% savings, with £13.2 million efficiency savings to find and a £2.9 million QIPP negotiation with commissioners in order to find money for reinvestment. Similarly there were also pay uplifts. There was also a need for investments in Information Technology; currently there were two systems, a paper and an IT record system and this needed unifying.

(7) The main policy drivers were in early intervention, with money invested in a second Crisis Resolution Home Treatment Team in East Kent last year as coverage there had not been as full as in Medway and West Kent. NICE guidance around the use of dementia medicine earlier has had a £3 million cost impact. Work is ongoing with the Police and Ambulance Trust on making sure people did not end up in the wrong place; there had been a big rise in the use of 136 suites, but only 20% of people ended up being detained under the Mental Health Act. There was also a project being undertaken with Kent County Council involving housing and support to move people from inpatient facilities to community ones. The Trust had 3,600 staff with 90 off on long term sick leave.

(8) The issue of sick leave at the Trust was picked up by Members, specifically around long term sickness rates within the Thanet teams. Marie Dodd undertook to find out detailed information and pass it on to the Committee Researcher. More broadly, the long term sickness rate at the Trust was 4.5% which was higher than the NHS as a whole, due to staff being attacked on duty, but average for the mental health sector.

(9) Moving forwards, money for mental health would still reside within the NHS and useful discussions were underway with future GP commissioners; they had, for example, approved the move from Ashford to Canterbury. The Strategic Health Authority had approved the capital spend for the St. Martin's development for 2013.

(10) On dementia services, the Mental Health Trust picked up referrals after it had been identified by GPs and had fully trained staff for assessments. The Community Services Trust explained that community nurses were trained to identify dementia and early intervention was being included in the training programme.

(11) Geraint Davies gave a short overview of the situation of the South East Coast Ambulance Service NHS Foundation Trust. As part of achieving Foundation Trust status, the organisation needed to have a 5 year viable plan. The turnover is £165 million and has a £10 million cost improvement programme. The Trust has around 3,000 staff.

(12) The Ambulance Trust is looking to build on the work it has undertaken with NHS Pathways to provide a single point of access service directing people to the right place at the right time. It was currently talking to Primary Care Trusts on this and the 111 service would be tendered under the Any Qualified Provider model. The ambulance service was paid for on cost and volume contracts rather than block contracts, and a local PbR tariff was being developed.

(13) In response to a question on the co-responders scheme with the Fire Service, Geraint Davies explained that the Trust had funded the scheme to the sum of £90,000, but it has been decided not to continue with it because it was not best for patients.

(14) Dealing with some specific questions on the ambulance service, it was explained that the Make Ready programme had been funded from the Trust's own resources. If necessary, a Foundation Trust was able to borrow money, under strict controls.

(15) Across all Trusts there was a feeling that the block contract was not the most helpful funding mechanism and there was a need to hold the whole health economy to account for delivering complete pathways of care. This would help ensure efficiencies with patients seeing the right people at the right time.

(16) The Chairman thanked the Committee's guests for the useful and open discussion and asked Committee Members to forward any suggestions for recommendations on NHS Financial Stability to the Officers supporting the Committee.

(17) AGREED that Members delegate authority to the Head of Democratic Services in consultation with the Chairman, Vice-Chairman and Group Spokesmen to prepare a list of recommendations to present to a future meeting of the Committee for discussion and agreement prior to their submission to the NHS for a response.

(18) AGREED that Members assist this process by suggesting recommendations to the Committee Officers following each meeting.

5. Forward Work Programme
(Item 7)

(1) The Chairman indicated that a written update from NHS Eastern and Coastal Kent on the East Kent Maternity Services Review had been provided for Members (see Appendix). This item would also be on the Agenda for the 22 July meeting.

(2) The Chairman also undertook to have a written update on the NHS Transition for the 22 July meeting. This would be followed up be a fuller discussion at the 9 September meeting, though the comments from some Members that the full picture may still not be known was acknowledged. As part of this it was felt that a fuller understanding of the role of locality boards and the Health and Wellbeing Boards would be useful.

(3) The Chairman also undertook to explore when mental health could be considered, perhaps incorporating a review of the responses received from the NHS to reports produced in 2010 by both the Kent LINk and the Maidstone and Tunbridge Wells Borough Councils Joint Mental Health Services Working Group. Similarly, the feasibility of considering neurology services would be considered.

(4) APPROVED the Forward Work Programme.

6. Date of next programmed meeting – Friday 22 July 2011 @ 10:00
(Item 8)