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, 22 July 2011.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mr C P Smith, Mr R Tolputt, Mr A T Willicombe, Mr M J Angell (Substitute for Mr K Smith), Mr J Burden, Cllr R Davison, Cllr M Lyons, Mr R Kendall

ALSO PRESENT: Cllr J Cunningham

IN ATTENDANCE: Mr P Sass (Head of Democratic Services), Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting

(Item 1)

2. Membership

To note that the Borough and District Councils have now agreed to their four voting members on the Committee. The Members are as follows:-

- Councillor John Burden, Gravesham Borough Council
- Councillor Richard Davison, Sevenoaks District Council
- Councillor Geoffrey Lymer, Dover District Council
- Councillor Michael Lyons, Shepway District Council

3. Minutes

(Item 4)

RESOLVED that the Minutes of the Meeting of 10 June 2011 are recorded and that they be signed by the Chairman.

4. Dartford and Gravesham NHS Trust and Medway Foundation Trust: Developing Partnership

(Item 5)

Mark Devlin (Chief Executive, Medway NHS Foundation Trust) and Gerard Sammon (Deputy Chief Executive, Dartford and Gravesham NHS Trust) were in attendance for this item.

Adrian Crowther declared a personal interest in this item as a Governor of Medway NHS Foundation Trust.

(1) Mr Devlin began by providing an overview and explained that the process was still in its early stages and that they were endeavouring to make it a transparent and open one. The driving force behind all the work was that both Trusts desired to provide first class services. As for the background to the rationale for bringing the two Trusts together, it was explained that both were mid-sized district general hospitals with Darent Valley being the smaller of the two and serving a population of 300,000 and Medway serving a population of 350,000. As a critical mass of population is necessary before certain services can be provided, serving a population of 650,000 will mean more services can be offered, including new ones which currently are not. The Royal College of Surgeons recommended population coverage of at least 500,000 for safe surgery and together the two Trusts achieved this. The population size meant that there would continue to be the full range of services such as maternity and accident and emergency on both sites.

(2) Economies of scale in back office functions will mean savings realised to invest into services. The Trusts are currently in the feasibility testing stage and the Boards of both Trusts would decide at their meetings in September as to whether to proceed. It was stressed that the option could well mean acquisition of one Trust by the other, rather than merger, and that the processes were different with acquisition being in some regards the more straightforward option. The point was also made that the history of mergers in the NHS was mixed. The merger in South East London had taken place three years before but the combined Trust still had problems, whereas in East Kent the Trust was working well but it had taken time. There was also a national policy drive encouraging all NHS Trusts to achieve Foundation Trust status by 2014.

(3) One Member questioned whether the merger of the two Trusts would be sufficient to realise the gains intended. Residents of Swale often accessed services at Medway or Maidstone and an argument could be made that these two hospitals would make a better merger. Another Member questioned the value of the merger to residents of Sheppey. In reply to these points, it was acknowledged that Maidstone was closer to Maidstone than Darent Valley but that the centre of gravity for Maidstone and Tunbridge Wells NHS Trust was further away due to the opening of the new hospital at Pembury. In addition, the populations that looked to Darent Valley and Medway shared more similarities in terms of health need. On the issue of Sheppey, the counter argument was given that services would be made available closer to home which would previously have involved travelling to London and the increase in critical mass would improve the quality of the services delivered to all patients, including those delivered in the community hospitals on Sheppey and in Sittingbourne. In addition, the joining together of the Trusts did not preclude other partnerships; one such currently existed with Maidstone Hospital relating to cancer services.

(4) Transport was one of the major areas of concern expressed by Members and the representatives of the two Trusts acknowledged this was something which needed to be addressed. Darent Valley itself was served by the Fast Track bus system and there was a good relationship with the bus companies. Transportation links between the two sites was an issue, as was car parking, though this was being looked at and very speculatively the possibility of a shuttle bus between the two sites was mooted by the Trust representatives. Travel issues around a number of specific areas were raised by Members, including travelling from Gravesham which was situated between the two Trusts and had bus links to Darent Valley but was less well served for Medway, and Sevenoaks and Swanley which were similar in that it was quicker to access hospitals in London. In answer to a specific question, the volunteer driver service was reported to still be in existence and use was based on need.

(5) The impact of patient choice was also discussed. The two Trusts were looking to ensure that the same general services were available on both sites and would continue to be delivered in a sustainable way. More widely, patients were looking to choose good quality local services and this would involve being innovative in how they were delivered and how patients accessed them, including looking at transportation. For more specialised services like nephrology where patients currently have to travel to London, where this service could be developed and provided locally, then patients would have that additional choice.

(6) The particular challenge of the Darent Valley Private Finance Initiative (PFI) was also discussed. Some Members were sceptical as to the usefulness of the scheme as it involved a large financial commitment each year in order to keep up repayments. This was recognised by Trust representatives but the positive side was outlined in that the Darent Valley PFI included comprehensive building and support services which meant that the estate was in better condition than non-PFI estates of the same age and so there would not be the longer term maintenance costs. The contract was for 30 years but the support services were tested for benchmarking every 5 years.

(7) The joining together of the two Trusts was presented as the optimal option and in response to Members' question as to what alternatives had also been considered it was explained that these included vertical integration with the mental health or community health Trust, or linkages with a London teaching hospital or network. These would be revisited if the feasibility study recommended against a formal joining.

(8) The Chairman thanked the Committee's guests for the useful and open discussion and the Trusts' representatives undertook to keep the Committee informed and return at the appropriate time.

(9) AGREED that the Committee note the report and return to this issue again at a later meeting.

5. East Kent Maternity Services Review

(Item 6)

Hazel Carpenter (Director of Commissioning Development and Workforce, NHS Kent and Medway), Dr. Neil Martin (Medical Director, East Kent Hospitals NHS University Foundation Trust), Dr. Sarah Montgomery (GP Clinical Commissioner) and Sara Warner (Assistant Director Citizen Engagement, NHS Eastern and Coastal Kent) were in attendance for this item.

Michael Lyons declared a personal interest in this item as a Governor of East Kent Hospitals University NHS Foundation Trust.

(1) The Chairman introduced the item by welcoming his guests and explaining to the Committee that the next meeting of the East Kent Maternity Review Board was going to be that afternoon and Members had the opportunity to make comments which would be fed back to the meeting through the NHS representatives attending for this item. NHS colleagues would return and present an update at the 9 September meeting, and in the interim the Chairman had approached a small number of Members who may be willing to form an informal HOSC Liaison Group to be involved in discussions over the summer and feed back to the Committee as well at the 9 September meeting. Several Members expressed an interest during the meeting.

(2) Hazel Carpenter began by explaining that the Review Board included representatives from the emerging Clinical Commissioning Groups (CCGs) in East Kent. Of the 6 CCGs, 5 had patient flows into East Kent Hospitals NHS University Foundation Trust (EKHUFT). The detail required in the evidence was recognised. Representatives of the NHS welcomed the opportunity to return on 9 September with options and a consultation plan and looked forward to engaging with a smaller group of Members over the summer.

(3) As a representative of one of the CCGs, Dr Montgomery explained that GPs are deeply concerned with this issue and were very close to the families affected. She explained that feedback from the 4 GPs on the Board was fed back to all Chairs of the CCGs and any options regarding future services would need to be based on robust evidence and the services needed to be safe and sustainable. The distance between hospitals was being considered by the panel but it needed to be made clear that standalone midwifery led units were not appropriate for all women and the admissions criteria was the same as for home birth and it was often the case that it was women from the more deprived areas which needed to travel to consultant led services more than others. These consultant led services were still available at Ashford and Margate.

(4) In response to a range of questions Dr Neil began by explaining that all birth units in East Kent were safe and provided excellent care. The standalone midwifery units in Dover and Canterbury provided quality 1 to 1 care and this level of care in labour was the ideal. However, there was a cost related to the time for midwives to care. At Dover and Canterbury, there was a ratio of around 11 births for each midwife, but across Kent this was on average 35 births per midwife, sometimes reaching 48 in the high risk units. Also, while

the care in Dover and Canterbury was exceptional, the condition of the estate was not.

(5) In terms of problems recruiting midwives, Dr Neil said he was not aware of a real midwife recruitment problem. While staffing levels at neonatal intensive care units were not quite at British Association of Perinatal Medicine levels, they were comparable with similar units. The review came from the observation of nursing, midwifery and consultant staff at William Harvey Hospital about a possible safety issue there. The Trust decided to increase midwifery levels at this high risk site but this meant moving staff from other areas of East Kent. Regarding costs, it was a general truism across England that Trusts were underfunded for maternity services. A recent benchmarking exercise undertaken by EKHUFT along with other Foundation Trusts showed that while the cost of a normal birth in an obstetric unit was roughly equivalent to the tariff, the costs of a birth in midwifery led units was twice that.

(6) The point was also raised that in an obstetric unit it was still midwives who carried out the majority of deliveries, though consultant obstetricians and paediatricians were on hand for advice. The question in East Kent was how best to use the skilled midwifery resource and the midwifery recruitment issue could be overcome if that was deemed the best solution. For home births, 2 midwives were required for the actual delivery and so this had cost implications. The maternity service was learning that there was a role for maternity support workers.

(7) There was a broader discussion about the communications aspect of the process and comments on the different messages which are sometimes found in the media. Comparisons with the situation relating to women's and children's services at Maidstone and Tunbridge Wells NHS Trust were also made; though it was stressed there were also important differences. Representatives from the NHS explained that communicating and developing proposals were a complex equation and that the driving force behind them was to ensure the safety and sustainability of the service. There was also a recent report from the Royal College of Obstetricians and Gynaecologists which needed to be taken into account.

(8) AGREED that the Committee note the report and examine this issue in more depth at a later meeting and that a small working group of Committee Members be established to further investigate and prepare a report for HOSC.

6. Legacy Document

(Item 7)

Judy Clabby (Assistant Chief Executive, NHS Kent and Medway) was in attendance for this item.

(1) The Chairman introduced the item and explained that the current full draft version of the Legacy Document ran to 89 pages and that it was an interesting document and Members were invited to suggest ways that the document could be improved.

(2) One Member commented that a number of items were strategic documents which would be rewritten when new commissioning arrangements were brought in and that of more importance were the minutiae of daily business. Another Member suggested details of which Arms Length Bodies were still operating, or the ones which had been created, should be included. It was also felt important that arrangements be made to preserve the archives of the Primary Care Trusts so that records of key decisions could be located easily in the future.

(3) Judy Clabby explained that the production of the Legacy Document was a requirement of the National Quality Board and it would go down to the level of detail suggested. It was also being used as a central collation point for the three Primary Care Trusts across Kent and Medway. As the handover to the Clinical Commissioning Groups approached, it would include the hot and topical information required. The current version was a draft and it would be continually refreshed until this time. On the issue of Arms Length Bodies, these were unlikely to be included if they were national organisations rather than local.

(4) Members were invited to submit any further suggestions to Judy Clabby through the Research Officer to the Committee.

(5) AGREED that the Committee note the report.

7. NHS Transition: Written Update.
(Item 8)

(1) The Chairman indicated the written update on the NHS Transition produced by the Research Officer to the Committee and reminded Members that there would be an opportunity at the 9 September meeting to examine this topic further.

(2) AGREED that the Committee note the attached report.

8. NHS Financial Sustainability: Draft Recommendations
(Item 9)

(1) The Chairman introduced the item and explained that the work undertaken by the Committee in looking at financial sustainability across the whole spectrum of the NHS had been a very useful exercise. The report highlighted a number of the dichotomies facing the NHS, such as the dilemma between localism and what is often referred to as the postcode lottery. The Research Officer to the Committee was thanked for his assistance in producing the draft report.

(2) A Member expressed the view that a combination of the financial sustainability report and written update from previous item would, read together, answer a lot of questions as the Committee continued its work after the summer.

(3) One Member commented that the individual character of Kent compared to other areas of the country be highlighted. Kent was in part peninsular and had

a number of separate population centres to which people looked for core services. This made delivering financial sustainability across the Kent health economy uniquely challenging.

(4) The Committee agreed that this point should be included in the final version.

(5) AGREED that the Committee approve the report.

9. Date of next programmed meeting – Friday 9 September 2011 10:00
(Item 10)