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, 9 September 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, Mrs E Green, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr J Burden, Cllr R Davison, Cllr Geoffrey Lymer, Cllr M Lyons, Mr M J Fittock, and Mr R Kendall

ALSO PRESENT: Cllr Mrs A Blackmore, Cllr J Cunningham, Mr L B Ridings, MBE, Cllr John Avey, Christine Baker, Shirley Griffiths, Cllr Vince Maple, and Cllr Julie Shaw

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Minutes
(Item 4)

(1) It was noted that the sentence in paragraph 3 on page 2 of the Minutes should read, "…Medway was closer to Maidstone than Darent Valley…".

(2) RESOLVED that, subject to this amendment, the Minutes of the Meeting of 22 July 2011 are recorded and that they be signed by the Chairman.

3. NHS Transition
(Item 5)

Roger Gough (Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council), Meradin Peachey (Kent Director of Public Health), Hazel Carpenter (Director of Commissioning Development and Transition, NHS Kent and Medway), Tish Gailey (Health Policy Manager, Kent County Council), Lorraine Denoris (Director of Citizen Engagement and Communications, NHS Eastern and Coastal Kent), Dr Mike Parks (Medical Secretary, Kent Local Medical Committee), and Di Tyas (Deputy Clerk, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the item and explained that although the complete picture around the changes to the health sector was incomplete, it was important to take this opportunity to take stock and gain a better understanding of the ongoing changes. A large part of this was to understand the new

language which was developing as time went on with GP Commissioning Consortia (GPCC) now being referred to as Clinical Commissioning Groups (CCG). A number of Members mentioned the plethora of acronyms which needed to be understood. It was observed that the Background Note which formed part of the Agenda was a useful and accessible summary of the changes and the new terms.

(2) The Cabinet Member for Business Strategy, Performance and Health Reform at Kent County Council then provided an overview of the work which had been going on relating to the NHS Transition within Kent. The main element he wished to stress was the growing and positive relationship with the GP community as a whole and the emerging CCGs in particular. This was demonstrated by the fact that all CCGs wish to be represented on the Health and Wellbeing Board, which had been strengthened as a result of the 'pause' earlier this year, rather than delegate their role. County Council had approved the establishment of the Health and Wellbeing Board (HWB) in July and the first formal meeting would take place on 28 September. Precursor meetings earlier this year had looked at the Joint Strategic Needs Assessment (JSNA) which would in the future be produced by the HWB. As a general rule, awareness of it amongst GPs had not been high, but this was being looked at and the JSNA work would also feed into the production by the HWB of the Joint Health and Wellbeing Strategy. It was anticipated that not all work would be carried out at the County HWB level. Dover had also been awarded early implementer HWB status and there was good work being carried out there as well as by locality boards across the County. One ongoing issue was that CCGs tended not to be coterminous with Borough boundaries, with at least one crossing 4 of them. Moving on, he expressed the view that there was a natural and good division of labour between HOSC and the HWB. The Health Overview and Scrutiny Committee (HOSC) would be able to provide necessary challenge to the HWB on key areas such as the success of integrated working. Service reconfiguration had been a core area of HOSC work in the past, and this would continue, but it was possible the HWB would become involved in this also. In answer to a specific question, it was confirmed that the HWB would meet in public.

(3) There was a discussion about the ongoing uncertainty and some Members felt that the final position regarding how the health sector will work in the future will differ from how it is being expressed currently. It was also observed that a lot of the detail will only be known following Royal Assent of the Health and Social Care Bill when guidance was published and made available.

(4) Several common themes ran through the discussion. One was a concern that the proposed new structures would add bureaucracy to the NHS, when what was needed was a reduction. Another was that the changes only increased the importance of the HOSC in maintaining a strategic overview of the entire health economy.

(5) A third was the importance of enabling patient choice and not losing the focus on improving patient pathways, with one Member wondering whether a Select Committee on this latter topic was possible. In answer to a specific question, it was explained that there was no upper limit to the cost of medication, but where two were equally efficacious, then there was an expectation the

cheaper would be prescribed. It was also explained that a team of prescription advisors were available to GPs. More broadly it was explained that GPs had been involved in improving clinical pathways and commissioning for a number of years, and that what was happening now was that GPs were becoming responsible for the budgets. There were also some concrete examples already of how GPs had been moved into decision making positions and how this had improved pathways. One example was the joint working between CCGs and social services which had resulted in a memory clinic within each Borough.

(6) While it was recognised that there may not be many changes to report, the Committee requested that this issue return to the Agenda for the 25 November. The Chairman also mentioned, as a related subject, that he had asked for a discussion paper on HOSC and the local dimension to be prepared for the 14 October meeting.

(7) AGREED that the Committee note the report and further discussion this item at the 25 November meeting.

4. Trauma Services in Kent and Medway
(Item 6)

Nicola Brooks (Head of Medical Services, South East Coast Ambulance Service NHS Foundation Trust), Matthew England (Clinical Quality Manager, South East Coast Ambulance Service NHS Foundation Trust), Dr Marie Beckett (A&E Consultant, East Kent Hospitals NHS University Foundation Trust), Dr Patricia Davies (Dartford, Gravesham and Swanley Clinical Commissioning Group) and Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway) were in attendance for this item.

(1) The Chairman welcomed the Members of Medway Council's Health and Adult Social Care Committee who were present as guests of the Committee. Both Committees had previously examined the proposals but the Kent HOSC wished to follow up on a number of key issues.

(2) There was a broad consensus around some of the main reasons why the trauma network in Kent and Medway needed developing. Nationally there was variation between the survival rates for trauma between hospitals and there was often a lack of appropriate coverage at the weekend. This had led to the development of a national plan and the appointment of a national tsar. However, the staffing requirements to give full coverage and the number of trauma patients in Kent and Medway annually meant it was not possible for every Accident and Emergency Department to contain a Trauma Unit. In the event of an incident, the aim is that patients whose injury was over 15 on the Injury Severity Score (ISS) be taken to a Trauma Unit for stabilisation. Of the 488,189 emergency cases across Kent and Medway in 2010/11, 202 of them, or 0.04%, had an ISS of over 15. Of these, over 50% had been able to be taken to a Major Trauma Centre, mainly King's in London, within 45 minutes. In sum, less than 100 patients a year require stabilisation.

(3) Members asked a number of specific questions. In answer to one it was confirmed that all the designated Accident and Emergency Departments have a majors and a resuscitation room. Another one confirmed that a patient from

Broadstairs would be taken to Medway in the first instance and this was possible within the 45 minute target. Thirdly, it was not regarded as feasible to reverse the services available at Maidstone and Pembury respectively because of all the equipment necessary for a Trauma Unit which would also need to be moved.

(4) Representatives from the South East Coast Ambulance Service explained the process of hot secondary transfer. Trauma was a priority for the service and Critical Care Paramedics would be despatched to an incident. Where there was a procedure which could not be carried out by a paramedic, perhaps involving the airways or a chest drain, then the process would be to take the patient to the nearest Trauma Unit, where the patient would stay on the ambulance trolley, for stabilisation before transfer to a Major Trauma Centre. There were also doctors who volunteered to attend the scenes of incidents and these clinicians were able to provide a range of treatments paramedics could not.

(5) In terms of data and performance monitoring, it was explained that there were robust information technology and monitoring systems in place. Data was shared across the care pathway and assessed against national bench markers.

(6) A number of Members expressed concerns about emergency resilience planning, particularly in the context of the Olympic Games taking place in 2012. The Chairman explained that there was a window of opportunity at the January meeting and NHS colleagues explained that they were more than happy to return with detailed information on this topic at that time.

(7) AGREED that the Committee note the report.

5. East Kent Maternity Services Review
(Item 7)

Dr. Neil Martin (Medical Director, East Kent Hospitals NHS University Foundation Trust), Dr. Sarah Montgomery (GP Clinical Commissioner), Lindsey Stevens, Head of Midwifery, East Kent Hospitals NHS University Foundation Trust), Ann Judges (Maternity Lead, NHS Kent and Medway), 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 thanking the Members of the Informal HOSC Liaison Group which had been established to consider this matter over the summer and those Members who had been able to attend a meeting at Kent and Canterbury Hospital on 17 August. He explained that these three, Nigel Collor, Dan Daley and Roland Tolputt would be asked to begin discussion of this item by providing a brief verbal report on their findings. The Chairman also explained that he had written to the MPs and District and Borough Council Leaders inviting their views on this matter but that it had been short notice and so the fact comments had not been received from all

those who had been written to was no reflection on their interest. One comment from Roger Gale MP expressing support for the conclusions of the Hospitals Trust following a briefing with them was read out by the Chairman.

(2) It was also explained by the Chairman that we were currently in the pre-engagement stage and that the role of the Committee was to challenge the NHS on behalf of Kent residents and ensure their concerns are debated and answered.

(3) The Members of the informal HOSC Liaison Group each thanked colleagues in the NHS for their assistance over the summer and for arranging the informative meeting. A range of points arose from the feedback. Firstly there was a need to understand the broader context within which these changes were being proposed as the location of the existing hospitals was not necessarily ideal in that the Queen Elizabeth the Queen Mother (QEQM) Hospital in Margate had issues around difficulty of access, whereas Folkestone, the largest town in East Kent, had no hospital. The present arrangement of services came out of a reconfiguration 11 years ago and one Member commented that people would need to be assured that any proposals were sustainable in the longer term. It was also recognised that there were important difference between this situation and the reconfiguration of women's and children's services at Maidstone and Tunbridge Wells NHS Trust but that one lesson that needed to be learnt was the importance of ensuring the GP community supported the proposals. One Member reported having spoken to a number of people and there was a strong feeling in favour of the status quo. One Member expressed support for the concept of Alongside Midwifery Led Units as they struck the balance between choice and safety. It was felt that the current ongoing NHS reorganisation might be a good time to look at the tariff for maternity services with a view to ensuring it reflected the true cost of delivering a quality service.

(4) A request was made of the NHS for details of location of birth broken down by postcode of residence.

(5) On the subject of GP involvement, it was stressed by representatives of the NHS that GPs had very little influence over choice of place of birth. This was a decision usually made by mothers with midwives, based on the risk factors present in the mother's medical history. Concerning the review, Dr. Montgomery explained that it was her responsibility to keep GP colleagues informed. This was done through informal weekly meetings and formal monthly clinical commissioning meetings. Kent Local Medical Committee officers have been present at the monthly meetings. GP commissioning groups had seen the same papers as the Committee to comment on and formal support has been received from GP commissioning boards in Ashford, Canterbury and Dover, with informal support being received from elsewhere.

(6) Members raised the issue of whether there was adequate capacity within maternity services, not only in East Kent, and more broadly across the county as a whole. The view was expressed that at first glance it appeared strange to be discussing the possible closure of birthing centres when the number of births was increasing along with a broader growth in population. It was acknowledged by representatives of the NHS that there were issues across

Kent and Medway and that work was being undertaken by NHS Kent and Medway and all providers on a pan-escalation policy across the whole area. Specifically on capacity in East Kent it was explained that the alongside midwifery-led unit at the QEQM with 4 labour beds has yet to open, but that it would, increasing capacity. The alongside midwifery-led unit at the William Harvey Hospital in Ashford currently had 8 beds and delivered around 600 births each year and there were plans to increase this to 1,000 births per annum. Also within William Harvey, there were plans for two additional beds in the consultant-led unit. Concerning the capacity for home births, there was a community midwifery service in place and that would remain. No increase in home births has been seen compared to other years during the temporary closures of Dover and Canterbury. No increase in activity from the Maidstone area to William Harvey had yet been seen, but was under review. Dr Martin explained that the issue of beds was being looked at but that the crux of the capacity issue was the ratio of midwives to births in order to cope with the peaks and troughs of demand and that a £700,000 investment was being sought to raise the ratio from 1:32 to 1:28. It was also explained that there was no midwifery recruitment issue in East Kent, partly due to the location of the University, and two cohorts had been recruited this year.

(7) A range of views was expressed around the question of choice with one Member expressing the view that while capacity might go up, choice would go down under some of the options put forward, with the potential closure of the midwifery-led units in Canterbury and Dover. An alternative perspective was offered by representatives from the NHS in that choice needed to be realistic and affordable and that hospitals with consultant-led units and alongside midwifery-led units offered that choice. The focus of the NHS was on ensuring a safe and sustainable service for the 7,000 women each year who had no choice but to give birth in an obstetric unit.

(8) There was a wide-ranging discussion of a series of connected points around deprivation, access to services, and travelling, exacerbated by the peninsular and coastal nature of the eastern half of the county. While it was accepted that there were pockets of deprivation everywhere, it was acknowledged that in some areas, such as Dover, the lack of access to a car was a particular problem. NHS representatives were keen to stress that ante- and post-natal clinics would still take place at Canterbury and Dover and these accounted for the majority of trips taken during the maternity care pathway and that the majority of women currently already travelled to either Ashford or Margate for birth itself. A number of Members felt there was a need for firmer reassurances about the future of the whole range of women's and children's services as well as more certainty about the long term future of the Buckland Hospital site.

(9) On the subject of the forthcoming public consultation, representatives from the NHS explained that a wide ranging engagement exercise had already been carried out and that the NHS would continue to actively seek the views of mums-to-be, stakeholders and the wider public during what was likely to be a 13-14 week consultation. Social media was being utilised and there was daily communication with the local media as well. Members of the Committee felt that there was a need to be assured that the consultation was going to be a genuine listening exercise and the guests from the NHS were invited back to

the next meeting of the Committee, on 14 October, to discuss more fully the plans for the consultation process, which should have already just commenced.

(10) The offer was made to the Members of the Informal HOSC Liaison Group to continue to be involved in the development of the review prior to this meeting. It was agreed that Mrs Elizabeth Green should join this group.

(11) AGREED that the Committee consider and note the report and that the NHS be invited back to further discuss this topic at the meeting of 14 October.

6. Date of next programmed meeting – Friday 14 October 2011 @ 10:00
(Item 8)