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, 14 October 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 A T Willicombe, Mr R A Marsh (Substitute for Mr R Tolputt), Cllr J Burden, Cllr R Davison, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Cllr Mrs A Blackmore and Cllr J Cunningham

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Membership
(Item)

The Committee noted the following update to its Membership:

LINk Representatives (2): Dr M Eddy and Mr M Fittock.

3. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting of 9 September 2011 are recorded and that they be signed by the Chairman.

4. Reducing Accident and Emergency Admissions: Part 1
(Item 5)

Dr John Allingham (Medical Secretary, Kent Local Medical Committee), Helen Buckingham (Deputy Chief Executive and Director of Whole System Commissioning, NHS Kent and Medway), Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Marion Dinwoodie (Chief Executive, Kent Community Health NHS Trust), Gordon Flack (Director of Finance, Kent Community Health NHS Trust), Dr Mark Jones (GP Clinical Commissioner, C4), Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), and Lesley Strong (Deputy Chief Executive/Director of Operations, Adults, Kent Community Health NHS Trust) were in attendance for this item.

(1) The Chairman introduced the item by explaining that the current meeting was to be the first of two on this wide-ranging subject, with the next one scheduled to take place in November. While there had been some recent media coverage concerning local accident and emergency departments, the Chairman requested that specific questions be postponed until the November meeting, to which representatives of all four Acute Trusts in Kent and Medway had been invited.

(2) The lead representatives present from the NHS organisations attending the meeting gave short overviews of the topic. From the perspective of the commissioners, the urgent care pathway was a clear example of whole system commissioning as it involved primary care, through intermediate care and up to acute services, so that while accident and emergency departments and the ambulance service may be the most visible parts, there were many other services to consider. The importance of taking a whole systems approach was endorsed by the representatives present from primary care, and the community health and ambulance services. The shared goal was for a health system which delivered the right care by the right person in the right place and that a good example of this was the primary angioplasty service based at William Harvey Hospital and covering the whole County. It was noted that it was also important to ensure individual patients moved through the system, seeing different providers, smoothly with no waiting between them.

(3) While many patients would always need admitting to hospital, there was an agreement around the development of alternative pathways to deliver different interventions outside the acute setting. To this end the NHS Pathways assessment system and the Directory of Services were seen as key. This linked in with the coming introduction of the 111 number across England.

(4) A number of Members raised issues around public awareness of the alternatives to accident and emergency departments, such as Minor Injuries Units. It was partly a question about whether or not people knew about the alternatives, and if they did, there were separate questions around whether people understood fully what counted as a 'minor injury' and how to access these services, including confusion around opening times. One Member expressed surprise, for example, that a broken limb could be treated in a Minor Injury Unit. There were parallel questions around the effectiveness of some current systems, such as making an appointment with a GP. Where this did not work well, people may end up going to accident and emergency departments in order to be seen by someone. The point was also made that there were services for minor illnesses as well as minor injuries.

(5) Representatives of the NHS explained that these were the kinds of questions that the 111 number was intended to answer. The Ambulance Service and out of hours service provider used the same NHS Pathways system, and this would be used to triage patients using both the 111 and the 999 numbers. The Directory of Services would act as a 'phone before you go' service to ensure that a particular service was able to deliver the right service at any given time. However, it was acknowledged that there was a communications challenge to ensure the most appropriate number was used as one important difference was that an ambulance was triggered by the use of the 999 number.

(6) Both services would be available 24/7 and the observation was made that this fitted in with the expectations of patients. It was noted that this would involve the development of effective information systems with the sharing of data between organisations. It was noted that the Connecting for Health and National Programme for IT programmes had been aimed at addressing these issues, and at present the Summary Care Record was being rolled out across the County, at different rates. This was intended to make key aspects of a patient available to all providers of healthcare when appropriate. It was acknowledged that more work needed to be done in this area. The comment was also made that developments in other areas were providing the push for improving the data available around certain services, such as the move away from block contracts for community services.

(7) In answer to a specific question, the Committee was informed that the 111 number would replace the 0845 number currently operated by NHS Direct, but would not replace NHS Direct as an organisation, which was expected to continue as a provider of the 111 service in some areas.

(8) Another specific question related to the cost of translation services within the Kent health economy and representatives from NHS Kent and Medway undertook to collate this information from providers and make it available to the Committee.

(9) From the perspective of the Ambulance Service, the move to paramedic as a graduate career was highlighted as key, as was the development of two specialist kinds of paramedic, both requiring post-graduate qualifications. These were Paramedic Practitioner (PP) and Critical Care Paramedic (CCP). CCPs were able to care for patients over longer distances to enable them to access specialist treatment and PPs were able to work as part of extended primary care and community health teams to deliver care in home and community settings. Pilot schemes involving managing long-term conditions had seen a 15% reduction in attendance at accident and emergency departments.

(10) Kent Community Health NHS Trust (KCHT) put forward the idea that there was a disproportionate amount of NHS resources directed towards the acute sector. As an example, it was explained that last year 77% of occupied bed days related to long-term conditions. Community services were pivotal in enhancing the quality of life of patients where these patients could be better cared for working with GPs in a multi-professional setting. KCHT were also working with social care on the personalisation agenda. Rapid response intermediate care services and effective rehabilitation in community hospitals and other settings were also given as key to reducing accident and emergency admissions, as was the need to reduce the numbers of frequent attendees at accident and emergency.

(11) The importance of primary care as part of the urgent care pathway was also highlighted. Dr Jones, from the C4 Clinical Commissioning Group, pointed to the example of work done locally on falls prevention which had improved the quality of care is residential care settings and contributed to reducing accident and emergency admissions. There was also an important part to be played by effective medicines management. More generally, continuity of care and

access to GP services was viewed as central to reducing accident and emergency admissions. It was stressed that the roles played by self care, primary care, and pharmacies meant that there was more to the urgent care pathway than simply the use of Minor Injury Units in the place of accident and emergency departments.

(12) On the subject of mental health services as part of the urgent care pathways, it was universally agreed that this was an important aspect. Psychiatric liaison services were at different stages of development across Kent, but the point was made that it was important to work with Clinical Commissioning Groups in West Kent in order to establish the right pattern of services and not simply copy across those operating in East Kent Hospitals NHS University Foundation Trust. Kent and Medway NHS and Social Care Partnership Trust also operated Crisis Resolution Home Treatment Teams which acted as gatekeepers to acute services. The important point was also made that patients with mental health care needs could also have physical health admittance needs. Questions were also raised about whether current levels of funding for mental health services were adequate. The Committee requested that an appropriate time be found to examine specifically the issue of the mental health aspects of the urgent care pathway.

(13) A number of Members expressed the view that prevention was the best way to reduce accident and emergency admissions and there was a sense in which the work which was being planned and carried out by the NHS was geared more towards redistributing the workload than solving the problem. For example, admissions related to alcohol could be seen as emergencies but were not necessarily accidental in the sense of being self-inflicted. In response, the importance of prevention was highlighted by representatives from the health sector and it was here that the role of local authorities could play a major role, through licensing activities and the transfer of Public Health functions from the NHS to Kent County Council currently underway.

(14) AGREED that this Committee recommends to the Health and Wellbeing Board that it considers prioritising the issue of reducing accident and emergency admissions as part of their role in coordinating commissioning across health and social care.

5. East Kent Maternity Services Review
(Item 6)

Glynis Alexander (Deputy Director of Communications and Citizen Engagement, NHS Kent and Medway), Dr John Allingham (Medical Secretary, Kent Local Medical Committee), Helen Buckingham (Deputy Chief Executive and Director of Whole System Commissioning, NHS Kent and Medway), Ann Judges, (Maternity Lead, NHS Kent and Medway), Lindsey Stevens (Head of Midwifery, East Kent Hospitals NHS University Foundation Trust) and Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway) 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 five Members of the informal HOSC Liaison Group who had continued to work with the NHS in East Kent on the review. He reminded the Committee that the focus for the meeting was on the consultation process itself, and that this had been formally launched that morning. Members had been provided with copies of the full consultation document at the start of the meeting. Demographic information about the ethnicity of mothers in East Kent had also been made available to Members at the start of the meeting in response to a specific request made by a Member of the HOSC Liaison Group.

(2) Those Members of the HOSC Liaison group who were present for the meeting were each given the opportunity to speak first, and all took the chance to thank the NHS for the opportunity to comment on the draft consultation document. One Member felt that more stress could have been given on the retention of ante and post-natal clinics at both Canterbury and Dover. Another Member commented that most suggestions had been incorporated, though another Member regretted that the original Option 1 as presented in the report to HOSC on 9 September was no longer included. In addition, Mr Collor explained that an Overview and Scrutiny Committee at Dover District Council had already met and made recommendations to the NHS, copies of which had been provided to the Chairman of the Committee.

(3) One area of interest to Members was the timing and location of the 8 public events listed in the consultation document and there was concern that the timings and locations would not be sufficient to reach the intended audience. A case was made in particular for an additional meeting in Ramsgate. In response, representatives from the NHS explained that the timings and locations had been discussed with parents and parents-to-be as part of the pre-engagement process. Clinicians were going to be available at all the scheduled public meetings. It was also explained that the NHS would be present at 47 other events and that the consultation process was long enough so that if there was judged to be enough interest, further meetings could be scheduled. They were also happy to respond to invitations from any interested groups. In addition, a wide-ranging advertising and marketing campaign involving the local media had been organised.

(4) The Members of the Committee were also keen to ensure information on the Consultation was made widely available so that everyone who would wish to would have the opportunity. In terms of making the consultation document available, representatives from the NHS explained that 2,000 full versions had been printed, along with 10,000 summary versions. These were to be made available in libraries, children's centres and community centres. 50 copies were also being sent to each GP practice. Dr Allingham observed that the number was about right for his surgery to be able to make a copy available to each expectant mother, but there were larger practices.

(5) Queries were raised over the figures used about births on page 9 of the consultation document as they did not appear to match up. Representatives from the NHS felt that they may represent different time periods, but they also undertook to clarify the figures and make this information available to the Committee.

(6) In response to a number of specific questions, it was explained that there was no national review of maternity service underway, but there were others in the South East Coast region, and a teleconference to share learning between them had been scheduled. In addition, the results of the largest birthplace study in the world had been awaited since August and it was now anticipated in October.

(7) AGREED that the Committee thank the members of the informal HOSC Liaison Group for their valuable work in recent months and that the report be noted.

6. Eating Disorders Review
(Item 7)

AGREED that the Committee note the report.

7. Child and Adolescent Mental Health Services (CAMHS)
(Item 8)

AGREED that the Committee note the report.

8. NHS Financial Sustainability Review: Written Update
(Item 9)

(1) The ongoing importance of the subject of NHS Financial Sustainability was raised by a number of Members, with one reporting particular issues of sustainability in outer London. The idea of returning to the subject at some point next year found favour, as did the idea of receiving regular written updates from the local NHS.

(2) The Researcher to the Committee was asked to liaise with local NHS organisations with a view to determining the best way in which to achieve this.

(3) AGREED that the Committee note the report.

9. HOSC and the Local Dimension
(Item 10)

(1) The Chairman began by thanking the Officers involved in preparing the report, which was there as a stimulus for discussion with the aim of ensuring that the right forum was found for the right topic, with the example given of issues facing one community hospital against an issue facing the whole community hospital system across the County.

(2) A range of different perspectives were presented on this subject around the development and interpretation of the localism agenda across the County, as well as the balance between needing local mechanisms for various purposes and increasing bureaucratic systems which may use up time but achieve little.

(3) AGREED that the Committee note the report.

10. Forward Work Programme
(Item 11)

(1) The Chairman requested that as well as having an opportunity in the meeting, any further ideas for the Forward Work Programme should be sent to either himself or the Committee Officers.

(2) A specific request was made by Councillor John Cunningham and Mr Mark Fittock that an opportunity be found for two reports on mental health issues produced by LINk and Maidstone Borough Council jointly with Tunbridge Wells Borough Council be brought to the Committee with a view to seeing what progress the local NHS had made against the recommendations contained within each. This was agreed and the Researcher to the Committee asked to liaise with a view to finding the most appropriate juncture for this to be facilitated.

(3) AGREED that the Committee note the report.

11. Date of next programmed meeting – Friday 25 November 2011 @ 10:00 am
(Item 12)

Addendum to Agenda of 14 October 2011:

Item 5, Information from NHS Kent and Medway, p.21 of Agenda, Part b, Paragraph 2, should read:

"… they manage around an average of 15,000 calls from patients per month, rising to over 20,000 in busy months. Of these around 53% of patients are advised by telephone, or referred directly to another service. 35% are seen at a base and 13% receive a home visit…."