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, 25 November 2011.

PRESENT: Mr B R Cope (Vice-Chairman), Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Mr L Christie (Substitute for Mrs E Green), Cllr J Burden, Cllr R Davison, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

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. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting of 14 October 2011 are recorded and that they be signed by the Chairman.

3. Reducing Accident and Emergency Admissions: Part 2
(Item 5)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust), Mark Devlin (Chief Executive, Medway NHS Foundation Trust), Dr Amanda Morrice (Clinical Director of Accident and Emergency, Medway NHS Foundation Trust), Robert Rose (Divisional Director, Urgent Care and Long Term Conditions Division, East Kent Hospitals University NHS Foundation Trust), Chris Green (Principal Information Analyst, East Kent Hospitals University NHS Foundation Trust), Ashley Scarff (Associate Director of Strategy and Planning, Maidstone and Tunbridge Wells NHS Trust), Colette Donnelly (Associate Director of Operations for Emergency Care, Maidstone and Tunbridge Wells NHS Trust) and Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) were in attendance for this item.

(1) The item was introduced with a reminder that this item built on what had been discussed at the previous meeting, and that the Acute Trusts were all represented today. The mental health dimension of the topic of reducing accident and emergency admissions would be considered in the New Year.

(2) Members noted the useful and detailed information provided but in the case of the multi-site Trusts, more information by site would assist them. Common themes were identified as running through the written information provided and the short opening summaries given by representatives of the four Acute Trusts

across Kent and Medway. It was given as a guiding principle for delivering effective health care that patients be seen by the right person at the right time and in the right place. An estimated figure was given of around 15-20% of patients in accident and emergency departments that could be seen more effectively elsewhere.

(3) Representatives from all Trusts agreed that working with commissioners, other Trusts and social services was important in delivering a sustainable and appropriate reduction in attendances and admissions at accident and emergency departments. Representatives from Maidstone and Tunbridge Wells NHS Trust (MTW) and from East Kent Hospitals University NHS Foundation Trust (EKHUFT) mentioned their participation in an Urgent Care Board and Integrated Care Board respectively which looked to achieve this.

(4) Beyond this, while it was acknowledged that each Trust may require different solutions, there were some changes across the region which also needed to be recognised and taken into account. One of these was the development of major trauma units in three Acute sites across Kent and Medway, at Medway, Ashford and Pembury. While this did not mean any reduction in the number of accident and emergency departments, there were implications for clinical services. For example, this was given as one reason the accident and emergency department at the newly opened Pembury Hospital saw an increase in the number of attendees. If Pembury was where the clinicians able to undertake emergency surgery were located, then ambulances would go there direct. Work was underway with the Ambulance Trust on refining the care pathway. The air ambulance, though dealing with comparatively small numbers of patients, was a valued component in the development of the trauma network. The South East Coast wide procurement to deliver the non-emergency 111 number was seen by the NHS as an important change which would enable patients to be informed and guided correctly as to their choices.

(5) The move to GP led commissioning through Clinical Commissioning Groups was also seen as important. Their knowledge would be vital in helping develop the right services for the population as well as educating patients and changing the nature of the patient mix going to accident and emergency departments. GPs also knew their individual patients' histories, and this was valuable information to utilise in delivering effective treatment. In terms of GPs as service providers, a number of different points were raised. The view was expressed that where the changes to the GP contract meant that GPs could opt out of providing out-of-hours cover, people seeking treatment could turn to their nearest accident and emergency department through not understanding the alternatives. A different perspective was given by a Member who suggested GPs chose to send patients to be admitted via accident and emergency departments when waiting times for elective treatment were too long.

(6) The confusion on the part of the public concerning the alternatives to accident and emergency departments was a theme picked up and emphasised by a number of Members. While a representative from the NHS stressed that minor injury units were often well used and well known in the areas where they were located, there was a valid point made about how people understood 'minor injury' and what services a walk-in-centre offered. One Member suggested

that as a minimum, minor injury units have standardised opening hours across the County.

(7) The importance of the accident and emergency department itself as a venue for signposting people to the appropriate service was also stressed. A number of sites had non-accident and emergency services co-located with the accident and emergency department so that although a patient may present there, it may not be the accident and emergency department which delivers the treatment. For example, Medway NHS Foundation Trust had a same day treatment centre alongside, run by Medway Community Health.

(8) In other areas of Kent and Medway, MTW had made a bid with the Primary Care Trust for four acute physicians for both sites in order to carry our urgent assessments and run a turnaround clinic. There are also signposting services to GP and pharmacy services.

(9) In East Kent, EKHUFT has four sites, accident and emergency departments at William Harvey Hospital in Ashford and the Queen Elizabeth the Queen Mother Hospital in Margate, an Emergency Care Centre at Kent and Canterbury Hospital and a Minor Injury Unit at Buckland Hospital in Dover. A consultation with staff is currently underway in order to provide more equal service coverage over weekends compared to that available during the week. In Canterbury, GPs and hospital clinicians worked together in the Emergency Care Centre. At the William Harvey, there was an assessment unit and a short stay unit to which GPs could directly admit people. While admittedly it had been from a low base, direct admittance to the assessment unit by GPs had risen 240%. Direct attendance at the accident and emergency department has reduced 2%. Where there had been an issue with the number of reattendances at Buckland Hospital over the summer, this was due to patients returning to where they had received the initial treatment.

(10) Dartford and Gravesham NHS Trust (DGH) had been impacted by two major developments. Firstly, there had been the closure of the accident and emergency department at Queen Mary's Hospital in Sidcup, the nearest hospital to Darent Valley at 10 miles distance, which happened in two phases; and secondly the decision last year by the community services provider to no longer run the walk-in-centre at Darent Valley which meant the patients there were now included in the Trust's total. The presence of a minor injury unit in Bexley meant that those patients that were directed to DGH were more serious cases and this has meant changes to the physical structure of the accident and emergency department had been undertaken recently. The presence of the innovative White Horse walk-in-centre at Northfleet had led to effective pilot work on the right kind of onwards referrals. In addition, work with local nursing homes on getting GPs to assess elderly patient first had seen a 30% reduction in the number of admissions from nursing homes.

(11) A number of Members and representatives of the NHS made related points around the public health agenda on such issues as alcohol misuse which could have an impact on reducing the number of self-presenters.

(12) The Chairman thanked the Committee's guests for their time and the valuable discussion which had taken place.

(13) AGREED that the Committee note the report.

4. Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Partnership
(Item 6)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust) and Mark Devlin (Chief Executive, Medway NHS Foundation Trust), and Dr Amanda Morrice (Clinical Director of Accident and Emergency, Medway NHS Foundation Trust) were in attendance for this item.

(1) Members of the Committee had previously discussed this topic on 22 July 2011 and the Chief Executives of both Trusts began by saying they were glad to have the opportunity to provide another update.

(2) The overall vision for combining the two Trusts was to develop a platform to provide health services to a combined population of around 630,000 and increase the number of specialist services available in Kent and Medway as well as maintaining current services. The broader context was that two medium sized district general hospitals such as Medway NHS Foundation Trust (MFT) and Dartford and Gravesham NHS Trust (DGH) had sustainability issues in the current climate of flat funding and reductions to the tariff coupled with a shift of emphasis towards health services provision in the community and not Acute settings. This meant the Acute sector as a whole had to be smaller but work harder. There was also a national policy drive that all NHS Trusts achieve Foundation Trust status, which MFT had achieved but DGH had not.

(3) A number of Members made related points about the point of devoting effort to merging when there were other priorities, as well as the need to make certain that the merger did not lead to a diminution of the number and range of services currently available. The Chief Executives of both Trusts stressed that the Trusts were not looking to reduce services and focussed on four key services which would remain on both sites. These were consultant led accident and emergency departments, maternity services, children's services and outpatient services. The population base was increasing in north Kent which meant that the services would remain viable. In addition to which any changes to service provision would need to be brought to the Committee. The aim was to repatriate some services currently only available in London. One Member indicated that many people in the area found it easier to access tertiary services in London and the reply was given that this was part of what the current consultative process was looking at. NHS representatives highlighted the need to continue to deliver services safely and indicated the evidence that combining clinical teams lead to more sustainable and effective health care.

(4) It was pointed out that cooperation in delivering services across the two Trusts was already well established. MFT delivered the dermatology and ear, nose and throat (ENT) services at DGH and urology services had been consolidated at MFT so that while services were delivered on both sites, when a patient needed surgery, consultants went to MFT to carry it out.

(5) One Member commented that the report provided by the Trusts was perhaps overly optimistic and requested fuller detail about the savings and efficiencies required. A number of specific points about finances came out during the debate. £30 million in savings were to come from £10 million in new revenue and £20 from savings in areas like reducing length of stay and patients missing appointments. £15 million pounds over 3 years for reinvestment in services were to be found from back office efficiencies from the two Trusts coming together and only having 1 Board, HR department and so on. In response to a specific question it was clarified that pathology did not count as a back office function.

(6) Both Trusts had different estate related issues. The challenge posed by the £24 million maintenance backlog at MFT was highlighted by Members and the plans for better use of what were often quite old buildings conceded by the Chief Executive. Plans to move services into main building and administration offices out were outlined. Darent Valley Hospital was built under the Private Finance Initiative (PFI) scheme and this meant a certain level of ongoing payment was required. The recent closure of services at Queen Mary's hospital in Sidcup meant DGH had no spare capacity with which to undertake private work. The Trust was 1 of 22 included in the McKinsey review commissioned by the Department of health to look at those Trusts for whom the costs of a PFI was likely to be a barrier to achieving Foundation Trust status. It was 1 of 6 out of these 22 which was regarded as being able to make progress through efficiency savings which meant the Trust was receiving support, but no additional money.

(7) Members raised the question as to whether the process was a foregone conclusion and both Chief Executives outlined the numerous stages which needed to be gone through which meant the outcome was not predetermined. The Co-operation and Competition Panel needed to examine whether the merger was anti-competitive; Monitor had a large role to play as MFT was a Foundation Trust and the Department of Health likewise with regards DGH. In response to a specific question it was confirmed that at present the timeline on p.48 of the Agenda was accurate and on track.

(8) There was also a need to ensure patient and public engagement. It was clarified that the list of organisations on pp.52-54 of the Agenda were voluntary groups and local authorities were also being included. One Member reported that the two Trusts had attended the Gravesham Locality Board that week. There had also been two LINk meetings and Mr. Fittock undertook to provide the questions from LINk to the Trusts to Members of the Committee along with the answers when available. The Trusts' intention was to continue the current widespread consultative exercise until 29 February next year. This would be followed by a stocktaking exercise with the process resuming towards the end of March.

(9) AGREED that the Committee note the report and that representatives from both Trusts be invited to return on this topic at an appropriate future date.

5. NHS Transition: Update

(Item 7)

Roger Gough (Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council) was in attendance for this item.

(1) Mr. Gough introduced the item by giving a presentation on the main points of the topic. This is attached as an Appendix to the Minutes. The last update had been given to HOSC on 9 September. Since this time there had been two meetings of the Shadow Health and Wellbeing Board (HWB) and this was where a lot of focus had been. Mr. Gough explained that the HWB was to be the local systems leader in health and had the responsibility for overseeing the Joint Strategic Needs Assessment which provided the data to inform the Joint Health and Wellbeing Strategy and beyond this, individual commissioning plans. Work was currently underway to prepare for running the proposed new health system virtually during 2012/13 before the old NHS structures went in April 2013.

(2) Beyond the commissioners, who were represented on the HWB, Mr. Gough also outlined issues around engagement with health service providers as there was a split between the two functions but also a need to draw on clinical advice to redesign care pathways. Kent County Council (KCC) had proposed Pathway Advisory Groups in its response to the Department of Health listening exercise on the proposals earlier this year, and there was also a Clinical Leadership Group set up in Kent to test models of possible HWB/Clinical Commissioning Group (CCG) engagement with providers. There was also a recent KCC initiative, The Kent Health Commission, focused on Dover at present, which looked at how new ways of working could deliver better care. One Member expressed a measure of scepticism around ideas such as the Pathway Advisory Groups and Clinical Leadership Groups which went against the NHS division between commissioner and provider; Mr. Gough explained that similar reservations were expressed during the discussion on relationships with the provider organisations at that week's Shadow Health and Wellbeing Board.

(3) There were a number of ongoing issues which needed further consideration, including ensuring children's services were not overlooked, the appropriate way of dealing with service reconfiguration, the role of scrutiny, and operating in a two-tier authority County.

(4) Members of the Committee picked up on this last aspect and it was pointed out that from the perspective of Locality Boards it was important to know who was in control of the finances. Mr. Gough replied that the CCGs had the largest budgets and were the commissioners of health services, but that it was important not to overlook the role of the NHS Commissioning Board as well as the public health and social services budgets controlled by KCC directly. Mr. Gough stated that a key role for health scrutiny in the future would be holding commissioners and providers to account.

(5) On behalf of the Kent LINk, Dr. Eddy raised a number of specific points about the HealthWatch update made available to Members before the meeting. While Mr. Gough agreed with the principle that it was important to ensure the

future HealthWatch was independent, he did not agree with the stated interpretation of a number of other points.

(6) The number of issues arising from the complexity of the current proposed reforms was made with the suggestion made that one role for HOSC in the future would be to find out who was responsible for any given decision. Mr. Gough stated that past configurations of the NHS had rarely been simple and that the enhanced role for the local authority was a good thing. The HWB, for example, would bring together all the commissioners and so assist in promoting integrated care locally.

(7) Mr. Gough made the offer to return with further updates when the Committee felt it would like to know more.

(8) The Chairman thanked Mr. Gough for his time and valuable contribution.

(9) AGREED that the Committee note the report.

6. Older People's Mental Health Services
(Item 8)

AGREED that the Committee note the report.

7. Date of next programmed meeting – Friday 6 January 2012 @ 10:00 am
(Item 9)