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, 20 July 2012.

PRESENT: Mr M V Snelling (Chairman), Mr C P Smith (Vice-Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mrs E Green, Mr R Tolputt, Mr A T Willicombe, Cllr Mrs A Blackmore, Cllr M Lyons, Cllr G Lymer, Mr M J Fittock and Cllr R Davison (Substitute for Cllr A Allen)

ALSO PRESENT: Cllr J Cunningham

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting

(Item 1)

2. Declarations of Interest

(1) *Mr Adrian Crowther declared a personal interest in the Agenda as a Governor of Medway NHS Foundation Trust.*

(2) *Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.*

3. Minutes

(Item 4)

(1) It was indicated that the Minutes of 1 June 2012 needed amending on Page 1 so that under those present it read 'Cllr Ann Allen'.

(2) RESOLVED that, with this change being made, the Minutes of the meeting of 1 June 2012 are correctly recorded and that they be signed by the Chairman.

4. Dermatology Services

(Item 5)

Dr Stephanie Munn (Dermatology Lead, South London Healthcare NHS Trust), Alison Poole (Service Manager, South London Healthcare NHS Trust), Diane Hedges (Project Director – Strategic Commissioning, Bromley CCG), Gail Arnold (Locality Commissioning Director for West Kent and Weald CCG), Sue Luff (Lead Commissioner Ashford Locality), and Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) were in attendance for this item.

(a) The Chairman introduced the item and explained that in April the Committee discussed information sent in to it from NHS Bromley about the Orpington Health Services Project. This information indicated a large number of patients from West Kent accessing dermatology services at Orpington Hospital. More recently, as had been reported in the media, a Trust Special Administrator (TSA) had been appointed for South London Healthcare NHS Trust and the Committee was reminded that the focus was on dermatology services, so detailed answers on the implications of this recent event would not be expected.

(b) NHS representatives were invited to provide a overview of the subject. Beginning with the situation in West Kent, it was explained that a recent review had led to a service shift. There was a lot of independent sector provision in West Kent as well as two key NHS providers in the area. Teledermatology was now available for non-urgent cases, with results of pictures returned from consultants within 48-hours. There were a number of GPs with a Special Interest in dermatology (GPwSI) who were able to provide additional services. Light therapy was available locally and Darent Valley Hospital provided outreach services at Sevenoaks and Borough Green. No services were actually commissioned in South East London, and any patients accessing services there chose to. It was clarified that the 3,223 patients from West Kent accessing services in Orpington referred to attendances, not patient numbers. As each patient may make a number of visits in a year, the actual number of patients was lower.

(c) In East Kent, a complete dermatology service review was carried out in 2010 as the secondary sector was not able to cope with the volume of activity and there was a fragmented service. Following engagement with patients and GPs, all of which supported moves towards community dermatology, a tendering process was carried out to start the community dermatology service from a fresh base. More resources were put into GP training and turnaround for tests went down from 13 weeks to 2 with more cancers being picked up earlier. For chronic dermatology, such as psoriasis, patients were educated to manage their conditions and 7 new providers have entered the arena. Services are also provided by Medway Foundation Trust and East Kent Hospitals. Self-referral was also possible in some circumstances, avoiding the need for a GP referral. Members of the Committee had experienced the East Kent service, including self-referral, and praised it. On the other hand, it was commented that the waiting room facilities at Medway Foundation Trust were inadequate for the dermatology service and NHS representatives undertook to feed this back.

(d) The changes for dermatology services in South London Healthcare NHS Trust (SLHT) were connected with the broader consultation around health services in Orpington which had just been launched that week; the summary document had been placed on Members desks and a supplementary map of services was circulated during the meeting (see Appendices 1 and 2). However, as the dermatology service model had changed, there would have been a need to review services anyway. The facilities at Orpington were not fit for purpose. Dermatology was more nurse-led than in the past and involved expensive equipment. The nature of the consultant workforce had also changed, with more part time female consultants. As more dermatology cases could be

handled in the community, the case mix of those seen in hospitals was more serious and required multi-disciplinary teams, including paediatrics where appropriate. For this reason, the proposals were to consolidate the two centres into one high class centre, with spokes at Sevenoaks and Beckenham. This would enable treatment of skin cancers to be repatriated and so less tertiary referrals to central London and East Grinstead.

(e) On behalf of the commissioners in Bromley, it was explained that the Orpington consultation was discussed prior to the TSA being named for South London Healthcare NHS Trust and legal advice had been sought. There was a high level of support in the Trust and with commissioners for the movement of more services to the community. However, additional time had been allowed for the TSA to report back to take the consultation process into account, and the time also allowed any conflicts between the TSA report and outcomes of the consultation to be considered.

(f) More generally on the impact of the SLHT TSA, Helen Buckingham explained that NHS Kent and Medway currently spent £20 million each year on services provided by SLHT and reported she was producing a report on the impact on Kent for the Health and Wellbeing Board and would undertake to share the report with the Committee.

(g) There was a strand of discussion in the meeting about the extent to which the services given as available in West Kent were so and there was a concern that it was not as well served as East Kent. It was explained that the perception could have come about in part by confusion over the providers of services and the location of them. Maidstone and Tunbridge Wells NHS Trust ceased providing a dermatology service around three years ago, but Medway Foundation Trust provided the service at Maidstone Hospital. Similarly, Queen Victoria Hospital, located in East Grinstead, provided plastic surgery services at Maidstone and Darent Valley. One Member raised a particular concern about the availability of services at Tonbridge Cottage Hospital where the indicated availability of services did not match up with the experiences of some constituents based on what GPs had told them. Representatives from NHS Kent and Medway undertook to speak to the Member after the meeting and follow the matter up. More broadly it was felt there was a need to ensure GPs and patients had up to date and accurate information about what services were available and at what location.

(h) A LINk representative reported that no particular concerns about dermatology services had been received by this organisation but, in common with a number of Members, there was concern about the changes to location of services in South London for those patients who currently accessed them there historically. While the argument was presented by NHS representatives that establishing one dermatology service at Queen Mary's Sidcup may be geographically further away than Orpington, the road links were often better and the new facilities meant a younger and more stable consultant workforce could be recruited, the counter argument was given that going into London, Kings in particularly, would still be easier for the elderly and infirm due to the rail connections. It was felt that accessibility for these patients needed to be considered carefully. It was also felt that the reasons patients chose particular hospitals was often historical and sometimes habit more than active choice. It

was hoped that any changes to the location and nature of services would be properly communicated to all service users.

(i) In response to specific questions about the pattern of dermatological illnesses, it was confirmed that the figure of 24% of visits to primary care professionals involving skin problems was about right, but that this might not always be the reason why the patient initially went to the GP or nurse. Much dermatology could be delivered locally, rather than at hospital, but not all GPs were trained to the same level which is why training was being provided. The four-fold increase in skin cancers was also discussed and it was explained that skin cancer was different to many other cancers. There were three types and 1 type could be treated at the GP level. The other types, in line with other cancers, would be fast tracked to get a consultant appointment within 2 weeks and treatment begun within 31 days. Queen Victoria hospital was part of the Kent and Medway Cancer Network.

(j) Members and guests discussed the rise in skin cancers and the different factors involved. Use of sun beds was highlighted and it was explained that although local dermatologists were not involved in local authority licensing of sun bed premises, the British Association of Dermatologists was. The view was expressed that licensing needed to be more stringent, especially around use by the under-18s.

(k) The issue of research into skin cancer was also raised and it was confirmed that St. Johns was still operational and carrying out research. It was explained that patients were not categorised by skin type. The areas of highest incidence for skin cancer were given as South Coast of England, Scotland and South London. The reasons differed, and in the case of South London it was partly to do with the numbers of service personnel and other who had lived and worked in Africa and the Middle East.

(l) Given the concerns raised by Members, the Chairman suggested the following recommendation:

- That the Committee thank its guests for their informative contributions and agrees to submit the approved Minutes of today's meeting as its response to the Orpington health services consultation.

(m) AGREED that the Committee thank its guests for their informative contributions and agrees to submit the approved Minutes of today's meeting as its response to the Orpington health services consultation.

5. NHS Transition: Update
(Item 6)

Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) and Chris Greener, (Associate Director Commissioning Development, NHS Kent and Medway) were in attendance for this item.

(a) The Chairman introduced the item and explained that this was a subject the Committee had considered in the past, and will return to in the future as the

preparations for April 2013 continue. NHS representatives were then invited to provide an overview of the situation regarding transition locally and respond to questions.

(b) A clear theme through the comments, questions and concerns of Members was the perceived complexity of the new system being established and the sense that this current reorganisation would not change anything and not be substantially different to the current arrangements.

(c) The initial area of discussion was around the role of GPs in commissioning, which was stated as a goal of change. Reference to media reports around the secondary role of clinicians in Clinical Commissioning Groups (CCGs) was made. It was explained that increasing clinical leadership in the NHS was wider than just involving GPs. Kent and Medway was reported and having very good GP involvement. The Boards of CCGs appointed the Accountable Officer and the Chair and though the specifics varied, one of these top positions in each of the 8 CCGs in Kent and Medway was filled by a clinician. It was also explained that the CCG Boards were only in their interim iteration and were developing organisations and so the balance on the Boards would change. The Local Medical Committee was supporting the development process. It was recognised that there was a need to be transparent and publish details of the Board composition. In answer to a specific question, the proportion of Non-Executive Directors to Executive was a matter of local decision. There was a lengthy national assessment process for CCGs before they could be approved, led by the National Commissioning Board (NCB). Out of area independent assessors were used, with Ann Sutton, the Chief Executive of NHS Kent and Medway, carrying out this role outside the area and other Chief Executives doing so within Kent and Medway.

(d) Commissioning Support Services (CSSs) were being established to provide back office functions such as finance. There was a capped budget of £25/head of population for CCGs to use on management which was a change from the past. Running costs locally were already at this level.

(e) There was discussion about how far CCGs would differ from current Primary Care Trusts (PCTs). It was explained that CCGs would receive about 80% of the budget (proportionally) that PCTs currently received but that overall the PCT budget and responsibilities were being divided into four. Along with the CCGs, responsibilities would transfer to local authorities, Public Health England and the National Commissioning Board. On the subject of the latter, it was explained that the work of the NCB would be carried out by 27 Local Area Teams. Although the first wave of directors of these teams had been named, the one for the Kent and Medway Local Area Team had not. It was acknowledged this led to a measure of uncertainty and appointments to the national structures were a concern locally. However, other senior appointments had been made and in the interim, NHS Kent and Medway would continue to exist until April 2013.

(f) Also at the national level, it was explained that the newly formed NHS Trust Development Authority (TDA) would take responsibility for working with NHS Trusts who were not Foundation Trusts to either ensure they achieved Foundation Trust status, or found an alternative solution. A local example of

an alternative solution was the proposed merger between Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust. Contracting and commissioning services at all Trusts would rest with the NCB and CCGs. Monitor was currently the FT regulator but would become the economic regulator for the whole health sector. The NCB, Care Quality Commission and Monitor were under a duty to work together.

(g) It was stressed that in order to make the system work differently and in an improved manner, there was a need for everyone in the Kent and Medway health economy to make it work. A simulation event had been run to test out different situations. The key role of the Health and Wellbeing Board was highlighted with the CCGs and local authority producing a Joint Health and Wellbeing Strategy to help ensure commissioning plans did not work against each other. Work looking at how things could be done differently and jointly had been undertaken in Dover. There was also joint working more widely with 20 CCGs coming together to commission ambulance services.

(h) A number of Members asked about the process in the NHS about rehiring people who had been made redundant, and whether this involved redundancy payments being returned. NHS representatives undertook to provide this information later.

(i) In answer to a specific question, it was accepted that there was nothing new with the concept of patient choice but that it was taking in other areas beyond choice of hospital.

(j) On patient and public engagement, the same duties around public and voluntary organisation engagement remained, but concerns were raised about communicating with the voluntary sector and NHS representatives undertook to take this back. The local authority and NHS were looking at patient Advisory and Liaison Services (PALS) at the moment as some aspects of the service may sit elsewhere in the future.

(k) The Chairman reiterated that due to the comments and concerns raised by Members, the Committee would certainly return to the subject and proposed the following recommendation:

- That the Committee consider and note the report along with the answers given to the numerous concerns raised by Members.

(l) AGREED that the Committee consider and note the report along with the answers given to the numerous concerns raised by Members.

6. Not the Default Option: Responses
(Item 7)

Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) was in attendance for this item.

(a) The Chairman introduced the item and explained that, although two formal responses had been received to the HOSC report *Not the Default Option*, a full

evaluation of the responses would need to wait until such time as others had been received.

(b) On behalf of the local health economy, Helen Buckingham undertook to coordinate a collective response before the winter and the Chairman asked for discussion of this response to be added to the Forward Work Programme.

(c) RESOLVED that the Committee note the report.

7. Forward Work Programme: Update
(Item 8)

(a) The Chairman introduced the item and drew attention to the changes made subsequent to the previous Forward Work Programme. In addition, the Chairman suggested that ambulance services may be something the Committee would wish to look at in the future.

(b) On behalf of the Kent LINk, diabetic services and patient choice were put forward as possible suggestions and the Chairman undertook to give the ideas consideration.

(c) Referring to discussions which had taken place earlier in the year, it was suggested that an update on the progress of the new Pembury Hospital be received by the Committee once the new hospital had been operational for a full year. The Chairman agreed and requested Officers to explore the possibility of bringing this item to the October meeting.

(d) AGREED that the Committee approve the amended Forward Work Programme.

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