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, 12 October 2012.

PRESENT: Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr B R Cope (Substitute for Mr N J Collor), Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Ann Allen, Cllr Mrs A Blackmore, Cllr J Cunningham (Substitute for Cllr M Lyons) and Mr M J Fittock

ALSO PRESENT: Mr N J D Chard, Mr L Christie and Mr P W A Lake

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

Vice-Chairman in the Chair.

2. Minutes
(Item 4)

(1) A question was asked about the vascular services item from the previous meeting and the Committee was informed that Medway's Health and Adult Social Care Overview and Scrutiny Committee had also determined that the proposed review constituted a substantial variation of service. This topic would therefore be considered at the appropriate time by the Joint Health Overview and Scrutiny Committee established with Medway Council.

(2) RESOLVED that the Minutes of the meeting held on 7 September 2012 are correctly recorded and that they be signed by the Chairman.

3. Kent and Medway NHS and Social Care Partnership Trust: FT Application
(Item 5)

Angela McNab (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), and Pippa Barber (Executive Director of Nursing and Governance, Kent and Medway NHS and Social Care Partnership Trust) were in attendance for this item.

(1) The Chairman introduced the item and welcomed the Committee's guests. Angela McNab was asked to provide an overview of the Foundation Trust (FT) application. Referring to the copy of the presentation Members had before them included in their Agenda pack, attention was drawn to the overarching

vision of the Trust and how achieving FT status would enable the Trust to realise this fully.

(2) It was explained that the Trust's clinical strategy underpinned all that Kent and Medway NHS and Social Care Partnership Trust (KMPT) undertook and this in turn has been clinician led with heavy user involvement. Four key strands could be identified in the vision. Firstly, stronger community services would enable a more localised service. Secondly, the services would be oriented to recovery. Thirdly, services should deliver quality patient experience. Fourthly, there was the goal to develop flagship specialist services. Forensic services run by the Trust were in the top 3 or 4 in the country. Expanding and enhancing specialist services would enable patients who would have needed to travel outside of Kent for treatment to be treated at facilities within Kent in the future. Along with this repatriation repatriated to Kent, length of stay would be reduced.

(3) In terms of the point of the FT process, a number of comments from Members were made about whether it made any difference to the quality of services and whether it was a distraction. It was explained that being granted FT status was a form of accreditation that the Trust was able to achieve high standards in governance and quality of service so that the connection between the two was close. The three key risks to achieving FT status were currently being examined by external assessors. Firstly, there was the need to achieve financial balance and demonstrate financial sustainability. Secondly, the safety of patients was essential. Thirdly, the need to engage staff and develop the organisation was necessary. When asked about the alternative, it was explained that the Trust could not remain as a NHS Trust in the way it was currently. If the FT application was not successful, it was possible that organisations based outside of Kent would take over the running of the services.

(4) Another difference between FT status and KMPT's current status as an NHS Trust was highlighted following a question on the Trust's estate. It was conceded that the Trust had a large number of older properties which were not fit for purpose. These properties could currently only be sold if no other NHS organisation wished to use them. KMPT would be freer to sell properties and reinvest the proceeds with FT status.

(5) In addition, being an FT meant it was a Membership organisation. This meant that staff, service users, the public, local authorities and others would be able to directly influence the work of the Trust. There would be 20 public governors, including 4 selected by staff and 2 appointed by Kent County Council. There would also be 2 carer representatives.

(6) On the subject of carers, there were carers' fora in East and West Kent and these fed into the patient experience groups. The needs of carers were an important part of the work of the Trust on a day-to-day basis and the assessment of carers needs was carried out in conjunction with social services.

(7) Mr Peter Lake asked to make a comment to the debate. He explained that he chaired a joint meeting between Kent County Council and KMPT on a regular

basis and looked forward to continuing successful partnership working and supported the FT application.

(8) Members asked a number of questions about the capacity of the organisation to improve. It was explained that on the key indicator for measuring patient satisfaction, the Trust had improved 8% over a year. However, the representatives of KMPT did not have to hand a record of what this was an increase from, though they would be able to provide it. External assessors had recently given a low score on quality and this was a good thing as the lower the score the better. The threshold for achieving FT status had been met on this but the Trust was looking to achieve a 0, which was the highest. On a range of issues raised by Monitor and the Care Quality Commission most had been dealt with and the general direction was improving, though the Trust explained that they were not complacent.

(9) Clarification was sought over some figures in the presentation and it was clarified that all 8 emerging Clinical Commissioning Groups (CCGs) in Kent and Medway supported the Trust, formal letters having been received from most of them already. There was consensus with the CCGs on the strategic goals, and the local variations sought by them as they commissioned services in the future would become clear. A number of specialist services would be commissioned directly by the NHS Commissioning Board. The Trust did also provide some services beyond Kent, and it was explained that this was additional capacity and was not provided at the expense of any Kent resident. The comment was made that it was unclear who would have the final say over issues and services in the future.

(10) It was explained that the next step was a board to board meeting with the Strategic Health Authority in early November.

(11) The Chairman proposed the following recommendation:

- That this Committee supports the FT bid and looks forward to a further update in 12 months time.

(12) In response to a question, the Trust undertook to return earlier if there were any issues with the application to discuss.

(13) RESOLVED that this Committee supports the FT bid and looks forward to a further update in 12 months time.

4. Joint Health and Wellbeing Strategy
(Item 6)

Roger Gough (Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council), Andrew Scott-Clark (Director of Health Improvement, Kent County Council), and Julie Van Ruyckevelt (Interim Head of Citizen Engagement for Health, Kent County Council) were in attendance for this item.

(1) After being welcomed by the Chairman and invited to address the Committee, Mr Gough proceeded to explain that the Joint Health and Wellbeing Strategy (JHWS) was a core part of the work of the Health and Wellbeing Board and

was mandated as such by the Health and Social Care Act 2012. The Joint Strategic Needs Assessment had existed for a few years, but the JHWS was a new kind of document. It was meant to inform the commissioning plans of the commissioners represented on the HWB. It was not an Operating Plan, and it was later explained that for this reason there were no financial costings in the JHWS. While it needed to be strategic, it could not be too high level to be essentially meaningless.

(2) Members' attention was drawn to the graphical representation of the structure of the JHWS on page 40 of the Agenda. Priorities for the JHWS came from a series of connected sets of information. Firstly, there was an examination of the areas of health where Kent performed worse than the national average. A closer look at the data would reveal the local priorities by showing where, for example, the areas of highest and lowest life expectancy would be found. These were given as King's Hill and Margate respectively. Gaps in provision would also be considered. A lot of public health goals looked to the longer term, but quick wins could be achieved by looking at gaps in provision. All this contributed to identifying which services needed to be improved or transformed as a priority.

(3) At the national level there were Outcomes Frameworks for the NHS, Public Health and Social Care with a possible one for children's services in development. The JHWS was intended to form a single Outcomes Framework for Kent.

(4) It was explained that the timeline set out in the papers had slipped slightly to enable the Strategy and associated engagement to be as robust as possible Phase 1 of the engagement process concentrated on key stakeholders but as some emerging CCGs were not fully able to comment at that time, there was a second opportunity. Mr Gough also made the offer that along with the current meeting he would welcome the opportunity to discuss the strategy further with any Member.

(5) One specific example of an issue where comments and suggestions were welcomed arose in response to a comment from a Member that the JHWS lacked a certain 'person centred' feel. This thought was taken positively, but given that health and social care cover such a variety of patient and personal experiences it was a challenge to capture the diversity.

(6) In response to a specific question it was explained that hard to reach groups such as gypsies and travellers were included in the health inequalities plan. It was also accepted that the wording on p.52 need to be looked at again.

(7) A particular criticism was made of the priority given to safeguarding issues in the JHWS as the wording on p.42 of the Agenda suggested it was not as high as it needed to be. This was explained to be a placeholder target until a better one could be developed and not an indication of its status as it was important to get it right.

(8) Similarly, the priority given to mental health services was questioned and anecdotal evidence provided that mental health charities were facing cuts in funding. In response it was explained that mental health was very important

and its place in the JHWS would act as a counter-weight to the considerable pressures on limited resources to be spent elsewhere.

(9) A broader argument was presented that the JHWS could give too high a priority to resources being used on such public health activities as breastfeeding rather than cancer and heart disease, given as the kind of things which affect most people most of the time. In response it was explained that in terms of breastfeeding uptake Kent was an outlier and that breastfeeding was one of the most important factors in ensuring longer term health, including reducing obesity and thus reducing the risk of cancer. It was accepted that it was difficult to input resources further upstream but that there were benefits of so doing. One Member commented that the JHWS was full of good intentions, but doubts remained about how possible it was to change people's lifestyles; however, as the attempt needed to be made, support needed to be given to the JHWS.

(10) One of the positive aspects of the HWB bringing all the commissioners together was that it would allow whole systems solutions to be tried. The South Kent CCG was working with the local HWB on integrated care and this way of developing plans was a model for the future to introduce across Kent.

(11) The place of providers was another issue to consider. Kent was similar to around ¾ of HWBs across England in not including providers on the HWB. However, there were existing ways of bringing commissioners and providers together which would be built on.

(12) The Chairman proposed the following recommendation:

- That this Committee thanks its guests for attending and welcomes the opportunity to feed into the development of the Joint Health and Wellbeing Strategy and looks forward to continuing in a constructive and productive relationship with the Health and Wellbeing Board.

(13) RESOLVED that this Committee thanks its guests for attending and welcomes the opportunity to feed into the development of the Joint Health and Wellbeing Strategy and looks forward to continuing in a constructive and productive relationship with the Health and Wellbeing Board.

5. East Kent Hospitals University NHS Foundation Trust Clinical Strategy
(Item 7)

The Chairman explained that due to the close connection between Items 7 and 8 on the Agenda, they would be discussed together. The Minutes of this discussion are below.

6. Trauma Services: Update
(Item 8)

Stuart Bain (Chief Executive, East Kent Hospitals University NHS Foundation Trust), Rachel Jones (Divisional Director for the Surgical Division, East Kent Hospitals University NHS Foundation Trust), Peter Gilmour (Director of Communications, East Kent Hospitals University NHS Foundation Trust), Paul Sutton (Chief Executive,

South East Coast Ambulance Service NHS Foundation Trust), Matthew England (Clinical Quality Manager, South East Coast Ambulance Service NHS Foundation Trust), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), and Victoria Osborne-Smith (Senior Project Manager Trauma and Critical Care, NHS Kent and Medway) were in attendance for this item.

(1) Following the Chairman's welcoming of the guests, representatives of the NHS were asked to introduce the items. It was explained that the East Kent Hospitals University NHS Foundation Trust (EKHUFT) clinical strategy and the development of the trauma network were both broad and distinct strategies but that there were clear overlaps between the two.

(2) As regards major trauma, it was explained that Kent and Medway saw around 700 cases each year, or 2-3 each week. In East Kent the annual number was around 300. The clinical evidence supported the practice of taking patients directly to a major trauma centre which for Kent and Medway primarily meant King's College Hospital in London. There were three elements to the strategy. Firstly, the elements needed organising in a network and there was now a South East London Kent and Medway Major Trauma Network. Secondly, the systems needed to have in place the appropriate protocols. Thirdly, rehabilitation and recovery had to be considered. Shadow rehabilitation prescriptions were currently being used to identify gaps in service.

(3) It was being recommended that Medway Hospital and Tunbridge Wells Hospital be designated as a Trauma Unit. The original intention was also to recommend designation of William Harvey Hospital. Work was ongoing with EKHUFT as this formed part of their clinical strategy.

(4) Responding to a specific question, it was explained that Birmingham did have a major trauma centre, but that the adult's and children's centres were separate.

(5) Representatives from EKHUFT explained that they were currently in the engagement stage of developing their clinical strategy but that public consultation would follow should any major changes arise from it. It was accepted that in the past the NHS was legitimately criticised for presenting 'take it or leave it' choices and looked to improve on this. For example, the Royal College of Surgeons was coming into the Trust to provide some objective analysis.

(6) It was explained that along with the trauma system, there was a need to improve out of hours emergency surgery. Nationally, the mortality rate is 11-15% higher than regular hours surgery. At EKHUFT the rate was 9% higher. In response to a question about measuring outcomes in surgery, it was explained that it was more than a black and white question around mortality as longer term complications from surgery and co-morbidities needed to be factored in as well. The clinical strategy was broader than both trauma services and emergency surgery. EKHUFT was looking to stop inappropriate admissions to hospital, introduce one stop shops, establish leading edge day surgery centres, reduce length of stay, and aimed at things like rehabilitation.

(7) By way of context, it was explained that EKHUFT was a Trust composed of 3 district general hospitals and 2 community hospitals which operated from around 20 different sites. The Trust dealt with 600,000 outpatients each year. However, the services were often fragmented so that the same patient might need to travel to different places across the area to complete one episode of care. The idea of one stop shops was to reduce the number of sites where services were offered to 6 but to offer a more comprehensive service at each. While acknowledging issues around public transport, the Trust was looking to have a one stop shop within a 20 minute car drive of everyone in East Kent. This was considered appropriate for the often rural nature of the geography.

(8) In response to a specific question about the impact of the European Working Time Directive, the answer was given that there was an impact, particularly on shift patterns, but it was more broadly a problem with the medical training regime in England. More trust grade doctors had been appointed to ensure patient safety as there were more complex handovers.

(9) EKHUFT had a Hospital Standardised Mortality Ratio of 80 against the national average/benchmark of 100, which was good, and the clinical strategy was an attempt to stay ahead of the curve so that the latest advances in medicine could be adopted, such as da Vinci robots for complex surgery.

(10) Responding to a question about staffing levels in the Trust's accident and emergency departments (A&E), the response given was that while there were disagreements over nursing shift patterns, staffing was not being reduced. The chief Executive was not aware of any requests from the Royal College of Nursing for a meeting on this. 3 new locum consultants for A&E had been hired. 1 was a replacement, but the other 2 were new posts.

(11) The ambulance service was changing its service alongside these changes in other Trusts and services. Ways of working were altering so that there was a need on the one hand to stabilise patients in order to take them to centres of excellence, such as a Major Trauma Centre, rather than necessarily to the local A&E, and on the other hand to treat patients on the scene to avoid the need to admit them anywhere. With regards the questions raised about the air ambulance, the response given was that the Ambulance Trust did not need to own its air ambulance as it had very good working practices with the existing ones and handled the calls to its service. The Committee were informed that the air ambulance service was working towards 24/7 capability.

(12) A strand of comment and criticism from Members throughout these discussions was the cumulative effect of what seemed like good decisions individually. Adding them all together could change the landscape of health services completely and possibly in unintended ways. The logic could be, it was suggested, to centralise all services in London. Representatives from the NHS responded that the health landscape was changing but not all in one direction. There was repatriation and decentralisation as well as centralisation in health services. Primary angioplasty, for example, was now available in Kent. The fitting of multiple stents used to require several trips to London but could now be undertaken at local district general hospitals in Kent.

(13) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their valuable contributions and looks forward to further updates taking into account the comments made today.

(14) RESOLVED that the Committee thanks its guests for their valuable contributions and looks forward to further updates taking into account the comments made today.

7. The Tunbridge Wells Hospital: One Year On
(Item 9)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), and Dr Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust) were in attendance for this item.

(1) For this item, Members also had before them a copy of a presentation to which Trust representatives made reference during the discussion (see Appendix to Minutes).

(2) The Chairman welcomed the Committee's guests and invited the Chief Executive of Maidstone and Tunbridge Wells NHS Trust (MTW) to introduce the item. Mr Douglas reminded the Committee of the context five years previously when he took up the position of Chief Executive at MTW. The Trust was dealing with the impact of the report into Clostridium difficile. Without a new hospital, it would have been a possibility that the Kent and Sussex and Pembury Hospitals would have closed anyway but events at the Trust meant ambivalence at the Treasury and Department of Health towards building a new hospital became active support. As a result the new hospital, Tunbridge Wells at Pembury, is fit for purpose. Pictures were included in the presentation as a reminder of how much the quality of the estate has changed and improved. At the time, no alternative to the Private Finance Initiative (PFI) was available.

(3) The 7% increase in NHS spending at the time meant the prospects for the PFI were looked at optimistically and the costs were considered worth paying. Looking at the financial figures closely, it was reported, the costs of the PFI are not the whole of the story. The PFI costs around £20 million in 'rent'. The Pembury and Kent and Sussex Hospitals cost £7 million a year, so the new hospital adds £13 million. However, new building specifications have meant that even with the same number of beds, the hospital is 60% bigger. This in turn has meant the rates have risen from £350 thousand to £1.6 million. Running costs are also more in a bigger hospital. The Trust needs to deliver a 5% cost improvement programme each year just to stand still. The deflation of the tariff accounts for 4.5%, meaning 0.5% comes from other costs.

(4) The Trust was one of seven where the Department of Health was looking to provide support for the PFI costs and the future success of the Trust in applying for FT status was dependent on the financial sustainability of the Trust, which was linked to the costs of the PFI.

(5) Mr Douglas pointed to the successful move to the new hospital and claimed that moving hospitals without closing A&E availability was one of his personal career highlights. However, the move was in some ways only the start. As the first all single roomed NHS hospital, new ways of working are needed. More nurses are needed to staff single rooms. An all single room environment is not a panacea for infection control issues. It is very effective for preventing the spread of norovirus, less so for Clostridium difficile. Being in a single room is also detrimental to some groups of patients, such as those with dementia and the possibility of establishing a tailored ward at Maidstone was being considered. Public perception was also interesting as 20% of patients still considered they were on a mixed-sex ward despite the single rooms. There were open visiting hours, although mealtimes were protected – unless relatives wished to help patients eat. A real time feedback system of patient satisfaction was used, and rates were very high at 90%.

(6) Early problems with waiting times at accident and emergency were acknowledged, although these had been dealt with successfully. It was also acknowledged that more needed to be done to improve the appointments booking system and the way the Planned Care Office worked.

(7) On the subject of transport it was reported that no complaints were received at Tunbridge Wells Hospital about the availability of car parking. Public transport was more of an issue. The Trust believed a recent compromise reached putting more resources into volunteer car services was an improvement on the original section 106 agreement which was reliant on finding a bus company willing to provide the service when it cost around £300 for each person travelling from Borough Green. It was also reported that the bus company, Country Lines, had just gone bankrupt. Transport to the new hospital was always prefaced on the improvements to the A21 being completed by this point in time. Work on it now could potentially be disruptive to access.

(8) The Committee was informed that the Trust's clinical strategy maintained the focus on developing centres of excellence at both sites. The nature of medical training meant doctors specialised earlier, but there was a valuable role still for generalists at the hospital 'front door'. Emergency surgery was able to be carried out very quickly. In a number of areas it had been possible to repatriate services to Kent. The Trust employed the only specialised pelvic surgeon in the area. Building on the earlier debate, the Committee was informed that the Tunbridge Wells Hospital had received designation as a Trauma Unit.

(9) In response to a specific question, it was explained that while some services had diverted patients to Maidstone from Tunbridge Wells due to capacity issues, no wards had been closed.

(10) The Trust was also developing other services, such as the diabetes service in the centre of Tunbridge Wells and stroke rehabilitation beds at Tonbridge Cottage Hospital. The midwife-led birthing unit at Maidstone was proving more popular than expected, with 400 deliveries carried out this year. Satisfaction levels were also high there, including for those patients requiring transfer to Tunbridge Wells. The Tunbridge Wells Hospital provided some private rooms, as the Kent and Sussex had beforehand and this was used to help earn income for the Trust.

(11) It was explained that it needed to be borne in mind that the move towards more services in the community was laudable, but did mean a reduction in income for the Trust.

(12) The question was raised about the balance between managers from Tunbridge Wells and Maidstone in the new hospital. The answer was given that ward managers were fairly evenly divided. However, there were more Tunbridge Wells managers in the leadership of the maternity service, but the midwives managing the Maidstone birthing unit were from Maidstone.

(13) One Member made the useful comment that Trusts made statements about the ratio of staff and performance for example, but it was difficult for an overview and scrutiny committee to fully judge whether these statements were valid and requested more context in the future where possible. In response, the East Midlands dashboard was given as a good example of capturing useful data.

(14) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their informative contributions, looks forward to further updates and wishes the Trust well with the challenges ahead.

(15) RESOLVED that the Committee thanks its guests for their informative contributions, looks forward to further updates and wishes the Trust well with the challenges ahead.

8. Date of next programmed meeting – Friday 30 November 2012 @ 10:00 am
(Item 10)