AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 11th January 2008 at 10.00 am
Council Chamber, Sessions House
County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone **01622 694486**

Tea/Coffee will be available from 9:45 am

Membership (17)

Conservative (12): Lord Bruce-Lockhart (Chairman), Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr J A Davies, Mr D A Hirst, Mrs S V Hohler, Mr G A Horne MBE, Mr M J Northey, Mr R J Parry, Ms B J Simpson, Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed

Labour (4): Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and Mrs E D Rowbotham

Liberal Democrat (1): Mr D S Daley

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item No		Timings
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes - 9 November, 27 November and 14 December 2007	
Mental Health		
4.	Kent & Medway NHS and Social Care Partnership Trust and Primary Care Trusts from across Kent and Medway *Erville Millar, Chief Executive, Kent and Medway NHS and Social Care Partnership Trust and Lauretta Kavanagh, Director of Commissioning for Adult Mental Health Services and Substance Misuse, Medway PCT will be in attendance for this item.*	10:10-11:30 am
	Break 11:30-11:45 am	
5.	Continued from above *Oliver Mills, Managing Director, Kent Adult Social Services will also be in attendance for this item.*	11:45 am-1:00 pm

Lunch break 1:00-2:00 pm

6. Patient & Public Involvement Fora representatives 2:00-3:00 pm

7. RETHINK Sevenoaks

Tony Wright will be in attendance for this item.

Break 3:30-3:45 pm

8. Conclusions and recommendations

9. Date of next programmed meeting – Friday 8 2008 in the Council Chamber commencing at 10:00 am

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

3 January 2008

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on 9 November 2007.

PRESENT: Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Ms A Harrison, Mrs S V Hohler, Mr G A Horne, MBE, Mr J F London (substituting for Mr J A Davies), Dr T R Robinson, Mrs E D Rowbotham, Mrs P V A Stockell (substituting for Lord Bruce-Lockhart), Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens (Cabinet Member for Public Health) and Mr K Lynes (Cabinet Member for Adult Social Services).

OBSERVERS: Councillor Mrs D Phillips, East Sussex County Council, Councillor Mrs J Etheridge and Councillor Mrs J Shaw, Medway Council together with a number of representatives of the Patient and Public Involvement Fora across Kent and Medway, parish councils and members of the public.

IN ATTENDANCE: Mr P D Wickenden, Overview and Scrutiny Manager and Dr D Turner, Research Officer to the NHS Overview & Scrutiny Committee.

UNRESTRICTED ITEMS

(Mr M J Fittock, Vice-Chairman, presiding)

60. Lord Bruce-Lockhart

The Overview and Scrutiny Manager informed the Committee that Lord Bruce-Lockhart was continuing to make good progress following his recent operation and hoped to be back chairing the Committee soon.

RESOLVED:- that a further letter be sent to Lord Bruce-Lockhart on behalf of the Committee expressing their best wishes for a speedy recovery.

61. Urgent Business

The Vice-Chairman sought and gained the approval of the Committee to discuss the agenda and papers for the meeting as urgent business. This was because the requisite statutory notice had not been given for the meeting, as a result of the short notice in trying to assemble a great deal of written evidence following the Committee's last meeting on 12 October 2007.

62. Minutes – 12 October 2007

RESOLVED that:- the Minutes of the meeting held on 12 October 2007 were correctly recorded and that they be signed by the Vice-Chairman, subject to the deletion of Mrs E M Tweed from those shown as present.

63. Infection Prevention and Control

(Mr A D Crowther declared an interest as a member of Medway NHS Trust)

(1) The substantive item of business before the Committee was as indicated at the last meeting (Minute 54 of 2007 refers). The Vice-Chairman stated that the Committee would be asking a series of questions of a range of people today, and at the next meeting of the Committee, following the recent Healthcare Commission report relating to the investigation into the outbreaks of Clostridium difficile within Maidstone & Tunbridge Wells NHS Trust. The recent ratings awarded by the Healthcare Commission to each Health organisation against a set of 24 Core Standards were also relevant.

(2) The Vice-Chairman reminded the Committee, those watching the webcast and those present at the meeting that the purpose of the meeting was to look at lessons to be learned from the publication of these two reports. He hoped that the question-and-answer process would help in restoring public confidence in the safety of the public using the services of the acute hospitals across Kent and Medway.

(3) Since the last meeting a number of Members of the Committee had visited the three hospitals within the Maidstone & Tunbridge Wells NHS Trust – namely the Kent and Sussex Hospital, Tunbridge Wells; Pembury Hospital; and Maidstone Hospital – to see at first hand those wards and areas which were mentioned in the report.

(4) The Vice-Chairman invited the Overview and Scrutiny Manager to hold up for those present a file containing written evidence that had been sought from a range of stakeholders across the Kent and Medway Health economy which had not been published as part of the papers for the meeting.

(5) Finally the Vice-Chairman informed the representatives of the Patient and Public Involvement Fora, parish councils and members of the public present that, if time permitted, after all Members of the Committee had asked their questions he would invite questions from anyone else present.

(6) In addition to the agenda and papers, Members had received a series of briefing materials from the Committee's Research Officer which included:-

(a) a chronology of events;
(b) a briefing note on the NHS Scrutiny, Patient and Public Involvement, and Complaints mechanisms;
(c) a briefing note on NHS targets on healthcare associated infections (HAI);
(d) a briefing note on statistical data on Clostridium difficile in the NHS;
(e) statistics relating to the number of death certificates mentioning Methicillin Resistant Staphylococcus Aureus (MRSA) in England as well as the annual counts of glycopeptide-resistant enterococcal (GRE) bacteraemia (bloodstream infection) for NHS acute trusts in Kent and Medway;

(f) a briefing note on the NHS star rating system for 2000 to 2005;
(g) a briefing note on the Healthcare Commission Annual Health Check ratings;
(h) statistical information on the performance of NHS trusts in Kent and Medway on Core Standards relating to Infection Control;
(i) a briefing note on Patient Environment Action Team (PEAT) cleanliness scores; and
(j) the auditors' local evaluation scores for NHS trusts in Kent and Medway for 2006/2007.

(7) Additional evidence was tabled at the meeting, received from the Healthcare Commission, the Chief Executive of the South East Coast Strategic Health Authority, West Kent Primary Care Trust, Eastern & Coastal Kent Primary Care Trust, and the Health Protection Agency. During the meeting a facsimile letter was received from Roger Gale, MP which was summarised for the Committee by the Overview and Scrutiny Manager.

64. Role of the Director of Public Health

(Item 4)

(In attendance for this item were Dr Mathi Chandrakumar, Director of the Kent Health Protection Unit; Meradin Peachey, Director of Public Health; Mark Devlin Chief Executive and Iris Smith, Director of Infection Control, Dartford & Gravesham NHS Trust; Glenn Douglas, Interim Chief Executive, Amy Page, Chief Nurse and Gail Locock, Lead Nurse for Infection Control, Maidstone & Tunbridge Wells NHS Trust; Matthew Kershaw, Chief Operating Officer, Julie Pearce, Director of Nursing and Sue Roberts, Deputy Director of Infection Prevention and Control, East Kent Hospitals Trust and Jacqueline McKenna, Director of Nursing and Strategic Planning and Linda Dempster, Head of Infection Control, Medway NHS Trust)

The Committee asked both Meradin Peachey and Dr Chandrakumar a range of questions and supplementary questions, as set out in Appendix 1 to these Minutes.

(1) Each Trust had been invited in advance of the meeting to provide written evidence in the form of answers to a series of questions. The responses of each Trust were published in the Committee's papers. The questions were:-

(a) A request to see the management structure for Infection Control within the Trust;
(b) What was the process within the Trust for dealing with MRSA and Clostridium difficile?;
(c) What was the management structure for the nursing profession within the Trust?;
(d) What was the process for training nurses in the importance of Infection Control within the Trust?;
(e) How were the patients and visiting public kept informed of the importance of Infection Control?; and
(f) Was the cleaning in the hospital(s) undertaken by an in-house contractor or an external contractor and what were the standards of cleanliness required?

(2) In addition to the written evidence the Committee then raised a series of questions with each individual Trust's representatives, as set out in Appendix 2 of these Minutes.

65. NHS Overview and Scrutiny Committee's opportunity to contribute to the Healthcare Commission Annual Health Check on Infection Control

(Sheona Browne, Healthcare Commission Area Team Leader for Kent, Medway and East Sussex and Sandra Tracey, Assessor, Healthcare Commission were in attendance for this item)

(1) The Committee had before it a presentation regarding third-party commentaries on Trusts' self declarations in respect of Healthcare Commission Core Standards – and the way that Overview and Scrutiny Committees, Patient and Public Involvement Forums, Foundation Trust Boards of Governors and Strategic Health Authorities could contribute to the Annual Health Check by this means.

(2) Also before the Committee were details relating to the weighting of the information which the Healthcare Commission received from third party commentaries, as well as some examples of intelligence that had been extracted from 2006/2007 commentaries and "top tips" for those submitting commentaries, derived from previous Annual Health Checks.

(3) The Committee noted that the most useful commentaries:-

a) were written in a clear and concise way;
b) contained information relevant to the current Annual Health Check;
c) clearly related to one or more Core Standard;
d) stated whether the third party thought that the Trust was compliant with the relevant Standard;
e) contained supporting evidence from a range of sources;
f) included detailed information, for example dates and outcomes;
g) clearly demonstrated how the third party had been involved;
h) used full names and avoided the use of acronyms; and
i) focused on commenting on the Standards rather than the criticism of the content of Standards and the system of assessment.

(4) The Committee were also informed that it helped if third parties contributing to the dialogue:-

a) had regular interaction with the Trust;
b) had access to Trust reports that highlighted patient concerns, e.g. patient survey reports, Patient Advisory Liaison Services reports, complaints reports, etc.;
c) had attended Board and other Trust meetings where these issues were discussed;
d) were familiar with current legislation and Trust policies on relevant issues, such as safety and equality;
e) carried out their own surveys and reviews;
f) witnessed at first hand where the policies and initiatives were being implemented;
g) had been involved in the development of new initiatives; and
h) felt able to challenge Trusts and influence change.

(5) The Committee then proceeded to ask a range of questions of the Healthcare Commission representatives, as set out in Appendix 3 of these Minutes.

Conclusions and outcomes from evidence

(1) The Committee concluded the session by agreeing that it would need to meet again to discuss this topic further on 27 November 2007.

(2) The Overview and Scrutiny Manager reminded the Committee of some of the issues which had arisen during the day. These items were only indicative of some of the discussion and were by no means exhaustive. The Committee would return to the conclusions and recommendations arising from thorough examinations of Infection Control across Kent and Medway following the next meeting, on 27 November.

(3) Some of the issues raised included:-

a) the Director of Public Health's statement that part of her role was proactive monitoring of infection prevention and control across the Kent and Medway Health economy;
b) the role of the Strategic Health Authority;
c) how best practice in individual Trusts was shared so that there was a consistent approach across the Kent and Medway Health economy;
d) how the Primary Care Trusts were dealing with the issue of antibiotic prescribing;
e) what methods were being used to engage patients and the public, and inform them how they could help prevent healthcare-associated infections;
f) the welcome opportunity to receive an action plan from the Maidstone & Tunbridge Wells NHS Trust on how they were responding to the Healthcare Commission report;
g) how adult social care and other stakeholders were responding to the issue of step-down facilities and delayed discharge, given that bed occupancy within the Maidstone & Tunbridge Wells NHS Trust was currently at 95%, instead of the recommended level of 85%;
h) understanding from the Strategic Health Authority how the money earmarked by the government recently for deep cleaning was to be allocated to Trusts across Kent and Medway;
i) the welcome offer by the Healthcare Commission to undertake some training for Members of the Committee on what makes a good third party dialogue contribution to the Annual Health Check; and
j) the Healthcare Commission's welcome offer for Members to accompany them on some visits to Health organisations so that Members could see at first hand how the Committee might contribute to the Healthcare Commission's Annual Health Check.

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KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on Tuesday 27 November 2007.

PRESENT: Mr M J Fittock (Vice-Chairman), Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Dr M R Eddy (substituting for Ms A Harrison), Mr D A Hirst, Mrs S V Hohler, Mr G A Horne, MBE, Mr W Newman (substituting for Mrs C Angell), Mr M J Northey (substituting for Mr J A Davies), Dr T R Robinson, Mrs E D Rowbotham, Mrs P A V Stockell (substituting for Lord Bruce-Lockhart), Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens, Cabinet Member for Public Health

OBSERVERS: Mr D Herbert, Mrs A Loveday, Mr R Kenworthy, Mr J Cunningham, Mr R Hansell, Mr J Fletcher and Mrs F Witherden from the Patient and Public Involvement Fora; Mrs R Gunstone, Medway Council.

IN ATTENDANCE: Mr P D Wickenden, Overview and Scrutiny Manager and Dr D Turner, Research Officer to the NHS Overview & Scrutiny Committee.

UNRESTRICTED ITEMS

(Mr M J Fittock, Vice-Chairman, presiding)

66. Lord Bruce-Lockhart

The Vice-Chairman informed the Committee that he had spoken to Lord Bruce-Lockhart; he was out of hospital and making good progress, and was due to start further treatment in the middle of December.

RESOLVED that the Committee's best wishes for a speedy recovery be sent to Lord Bruce-Lockhart.

67. Letter from Roger Gale MP

The Overview and Scrutiny Manager tabled the letter which he had summarised to the Committee on 9 November 2007 from Roger Gale MP, as he had subsequently received a further letter from Mr Gale expressing disappointment that his letter had not been made available to the Committee.

Infection Prevention and Control

(*Note: Mr A D Crowther declared an interest as a Member of Medway NHS Trust)*

68. South East Coast Strategic Health Authority

(Item 3)

(Debbie Stubberfield and Sumona Chatterjee of the South East Coast Strategic Health Authority were in attendance for this item.)

(1) The Committee asked a range of questions which covered the following:-

(a) What extra funding the Strategic Health Authority had given to local health economies for developments in infection prevention and control, and how this money was being spent.

(b) How the SHA performance-managed infection prevention and control by acute hospital Trusts and Primary Care Trusts and ensured that best practice was shared.

(c) How the Strategic Health Authority collaborated with the Department of Health, the Healthcare Commission and key stakeholders in dealing with under-performance

(d) The role of the Regional Director of Public Health in performance-managing the health protection role; the Strategic Health Authority's relationship through an annual memorandum of understanding with the Health Protection Agency and the local Health Protection Unit in respect of healthcare-associated infections.

(e) How ambulances were cleaned and how often this took place.

(f) Visiting times, numbers of visitors, and patients and visitors being able to bring in their own food into hospital.

(g) At what point the Strategic Health Authority became involved in outbreaks of infection through invoking its escalation procedures.

(h) Mr Daley referred to the letter from Mr Gale MP which had been summarised by the Overview and Scrutiny Manager at the Committee's previous meeting on 9 November, and tabled and circulated at today's meeting. Mr Daley referred in particular to Mr Gale's questioning the role of the Strategic Health Authority. The Committee acknowledged that it was unfair for the representatives from the Strategic Health Authority to respond to this in the absence of not seeing the letter. The Overview and Scrutiny Manager informed the Committee that this was an issue that would be raised by the Health Overview and Scrutiny Committee Vice-Chairman with the Chief Executive of the South East Coast Strategic Health Authority Candy Morris when they met with her on 6 December 2007.

69. Primary Care Trusts across Kent and Medway

(Items 4, 5 and 6)

(Mr B Collins Director of Infection Prevention and Control/Director of Nursing, West Kent PCT, Ms A Sutton, Chief Executive, Ms S Andrews, Director of Nursing, Ms S Allum, Assistant Director of Clinical Performance, Mr P Greenhill, Director of Operations, Ms S Baldwin, Assistant Director of Intermediate Care Services, Mr P Edbrook, Assistant Director of Organisational Development and Governance and Ms C Cassam, District Nurse Sister, Eastern & Coastal Kent PCT, Mr M Riley and Ms B Edwards, Medway Primary Care Trust were in attendance for this item.)

(1) The Committee asked a series of questions of the Primary Care Trusts, each in turn, covering the following:

(a) How the Primary Care Trusts' public health responsibilities in respect of healthcare-associated infections were being discharged under the terms of their Memoranda of Understanding with the Health Protection Agency.

(b) How the Primary Care Trusts monitored and performance-managed the prevention and control of infection in the acute Trusts from which they commissioned services.

(c) How PCTs were meeting the requirement in the 2007/2008 NHS Operating Framework for Primary Care Trusts to "engage with clinicians and agree local targets" for a significant reduction in Clostridium difficile-associated disease occurring in their local acute Trusts.

(d) How PCTs were working to implement the Department of Health National Action Plan on Hospital Acquired Infections (Winning Ways 2003) and other relevant national policy, including the 2006 Hygiene Code.

(e) What PCT policies were in respect of infection prevention and control in their own premises and those of independent primary care practitioners (GPs, Pharmacists, Dentists and Optometrists) from whom they commissioned services.

(f) What their policies were on the decontamination of medical devices in PCT premises and those of independent primary-care practitioners from whom they commissioned services, with reference to the emerging Kent Decontamination Strategy.

(g) How PCTs monitored antimicrobial prescribing practices by clinicians employed by the PCTs and by independent primary-care practitioners from whom they commissioned services; and what they did to promote good prescribing practice through means such as the development of a community antibiotic formulary.

(h) What they did to ensure that all the premises they managed complied with the National Standards for Infection Control and Food Hygiene and what plans they had made with their local health communities (including social care colleagues) to reduce rates of healthcare-associated infections originating in the community, including settings such as nursing homes and residential homes.

(i) The issue of hand-washing and cleanliness (there were many notices relating to the use of hand gel, but this was not effective against Clostridium difficile).

(j) The regime of deep cleaning throughout the Acute Hospital Trusts and the cleaning materials used, and whether they were effective in killing Clostridium difficile.

70. Patient and Public Involvement Fora

(Item 7)

(Mr J Cunningham, Mr J Fletcher, Mr R Hansell, Mr D Herbert, Mrs A Loveday, Mrs F Witherden, PPIF Members, were in attendance for this item.)

(1) The Committee then took the opportunity of asking the Patient and Public Involvement Forum representatives some questions. In particular they were keen to hear from Patient and Public Involvement Forum representatives for the Maidstone and Tunbridge Wells NHS Trust.

(2) The Committee had specific questions they wished to ask the Patient and Public Involvement Forum Members including:

(a) Whether there was a shared work programme for Patient and Public Involvement Fora across Kent and Medway.

(b) How the Patient and Public Involvement Fora decided what their priorities were for inclusion in their work programme.

(c) What arrangements there were for Patient and Public Involvement Fora to pick up things that emerged from complaints made through the Patient Advice and Liaison Services, and Independent Complaints Advocacy Services.

(d) Whether the Patient and Public Involvement Fora regarded it as core business each year to produce third-party commentaries on NHS bodies' performance against Core Standards as part of the Health Care Commission's Annual Health Check process.

(3) Asked for his comments on the Healthcare Commission Report on Maidstone and Tunbridge Wells Trust, Mr Herbert responded that overall it was helpful. However, the media coverage had focussed on management failings, which he felt was unfortunate as it had distracted attention from other reasons for what had occurred. He acknowledged that funding was a huge issue for Maidstone and Tunbridge Wells NHS Trust; a deficit had led to underspending on the nursing budget, for which criticism was due.

(4) He felt that if relationships between the PCT and the acute hospital Trust had been better, and if the Strategic Health Authority had undertaken its performance management role more effectively, then there would not have been the need for the Healthcare Commission Report.

(5) He felt that some senior clinicians and nurses were culpable for the provision of poor care, but this had been glossed over. He acknowledged the difficulty that management had had in implementing changes, which he attributed to the lack of support from some senior clinicians.

(6) He felt that the non-executive directors of the Trust also needed to consider their role and responsibilities.

(7) Mr Herbert referred to a PPIF press release, which had been made available to the Committee on 9 November, recounting the actions that they had taken following the

initial BBC South East television news report on hospital cleanliness in 2004. He commented that nobody had picked up on some of the issues which the PPIF had referred to in their third-party commentaries for the Healthcare Commission Annual Health Check.

(8) Mrs Loveday raised concerns that, with the abolition of Patient and Public Involvement Fora, there would be a potential loss of continuity and competence, as had happened with the abolition of Community Health Councils.

(9) Mr Herbert said that Maidstone and Tunbridge Wells NHS Trust Patient and Public Involvement Forum would be producing a final report for the new Local Involvement Network. Asked what they felt about the HOSC, there was general agreement among Patient and Public Involvement Forum colleagues that there was now better preparation for meetings and that the Committee's new way of working was a step in the right direction.

(10) The HOSC needed to prioritise and stick to those priorities to ensure that impetus was not lost.

(11) One member said that he was impressed by the range of topics that had been covered by the HOSC and how well they were researched. The Overview and Scrutiny Manager said that the Patient and Public Involvement Forum colleagues were a significant foundation stone for the HOSC's work. Kent was struggling, as were a number of local authorities, with exactly how the Local Involvement Network would operate; but Kent was keen to ensure that the Local Involvement Network was placed in a position where it added value to the patients and public of the county. He indicated that the County Council might have to ensure that there were transitional arrangements put in place for a period, as it was possible that the Local Involvement Network for Kent would not be operational by 1 April 2008.

It had been evident in gathering written evidence on healthcare-associated infection prevention and control that the Patient and Public Involvement Fora, the Health Overview and Scrutiny Community, the Patient Advice and Liaison Service etc., had not been communicating and coordinating their work as well as they should have done.

The Overview and Scrutiny Manager said he felt it would be useful to have a mutual understanding of what should be achieved and hopefully a well-developed complementary work programme.

71. Conclusions

(1) The Committee concluded as follows from the meetings held on 9 and 27 November:-

a) To note that part of the Director of Public Health's role is to proactively monitor infection prevention and control across the Kent and Medway Health economy;

b) To ensure that the Strategic Health Authority and Primary Care Trusts share best practice by individual Trusts, so that there is a consistent approach across the Kent and Medway health economy;

c) To seek clarity on the respective roles of Primary Care Trusts, the acute hospital Trusts and the Strategic Health Authority;

d) To seek clarity about how the Primary Care Trusts are dealing with the issue of antibiotic prescribing;

e) To consider what methods are being used by health organisations to inform patients and the public about how they can help avoid infection risks;

f) To welcome the opportunity to receive an action plan from the Maidstone and Tunbridge Wells NHS Trust on how they are responding to the Healthcare Commission report, having heard that bed occupancy within the Maidstone and Tunbridge Wells NHS Trust was currently at 95% instead of the recommended level of 85%;

g) At a future meeting, to understand how adult social care, health and other stakeholders are responding to the issue of step-down facilities and delayed discharge;

h) To understand from the Strategic Health Authority how the money recently allocated by the Government for deep cleaning is to be allocated to Trusts across the Kent and Medway Health Economy;

i) To welcome the offer of the Healthcare Commission to provide some training for Members of the Committee on what makes a good third-party dialogue contribution to the Annual Health Check;

j) To welcome the Healthcare Commission's offer for Members to accompany them on some visits to health organisations, so that Members may see at first hand how the Committee can contribute to the Healthcare Commission's Annual Health Check;

k) To state that the cleaning of health establishments should include the non-clinical areas, especially above head height;

l) To state that deaths that might be related to adverse effects of medical treatment or to poor standards of care, or where there has been any complaint about healthcare services, should be referred to the relevant Coroner as a matter of routine;

m) To write to the Government responding to the draft regulations for Local Involvement Networks;

n) To ensure that relevant information is sent to the Healthcare Commission and, if appropriate, the minutes of each Health Overview and Scrutiny Committee meeting;

o) To encourage Members of the Health Overview and Scrutiny Committee to attend meeting of local health organisations' Boards;

p) To build into the Committee's work programme as core business the matter of compliance with the Healthcare Commission's Core Standards;

q) To have a dialogue with the existing Patient and Public Involvement Fora, the Local Involvement Network (when established), Patient Advice and Liaison Services, Independent Complaints Advocacy Services, local Members of Parliament and local councillors; to listen to patients' concerns; and to utilise more effectively information that is provided and act on concerns that are expressed;

r) To ensure that the good work going on in various local level Patient and Public Involvement Fora feeds into the Health Overview and Scrutiny Committee to enable it to provide an evidence-based strategic view across the county;

s) To analyse whether, if the Committee had operated in the style that it does now when it asked colleagues from Kent and Medway health economy to address the Committee on infection control in October 2004, July 2006 and June 2007, the public would have been better served;

t) To consider whether it has helped for the Committee to seek written evidence in advance of each meeting, agree a work programme (up to two years ahead) and link this to the training of Members for service on the Committee;

u) To consider the role of senior clinicians in changing the leadership and culture of NHS organisations;

v) To support measures to ensure that a correct balance of food is eaten by patients in hospitals, having due regard to the patients' clinical needs;

w) To consider whether spot checks of hospital food suppliers should be undertaken by Environmental Health and Trading Standards;

x) To investigate what training adult social care and health providers undertake to ensure that infections in the community are not brought into hospitals;

y) To consider how the County Council can help with a campaign to advise the public on taking steps to help avoid infection in hospitals and elsewhere.

z) To seek the views of microbiologists on the effectiveness of different cleaning products against Clostridium difficile;

aa) To examine the role of non-executive directors on the Boards of NHS bodies;

bb) To look at possible inequalities in the funding of health services and the impact of this on ratios of nurses and healthcare assistants;

cc) To understand how Trusts spend their budgets;

dd) To undertake a review of arrangements regarding hospital visitors.

Recommendations

The Vice Chairman, and the Conservative and Liberal Democrat spokesmen would like to suggest the following recommendations to the Committee, having heard and considered the conclusions of the evidence taken by the Committee at its meetings on 9 and 27 November:

a) At the heart of the Health Overview and Scrutiny Committee's work programme should be the Healthcare Commission Core Standards.

b) Evidence should be recorded from the Health Overview and Scrutiny Committee's work programme electronically, so that when the Health Overview and Scrutiny Committee is asked to make third-party submissions for the Annual Health Check the evidence for this is already available.

c) There should be greater collaboration between the Patient Advice and Liaison Services, the Independent Complaints Advocacy Services, the Patient and Public Involvement Fora / the Local Involvement Network, Members of Parliament and local authority councillors, in order to listen to patient concerns and utilise more effectively the information they provide to assist in formulating the Health Overview and Scrutiny Committee's work programme.

d) The Overview and Scrutiny Manager should, together with colleagues from health organisations, explore and arrange an ongoing programme of training and activities to address the knowledge deficit for all stakeholders involved in scrutinising the health economy.

e) Recognising that the patient and public view is paramount, the Health Overview and Scrutiny Committee and the County Council should respond to the draft regulations for Local Involvement Networks to ensure that there is an adequate right to inspect premises where healthcare is provided. This will make for robust scrutiny, helping to bring about health improvements and reduce health inequalities – which are the fundamental principles of Health Overview and Scrutiny.

KENT COUNTY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on Friday 14 December 2007.

PRESENT: Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr D S Daley, Ms A Harrison, Mr C Hibberd (substituting for Lord Bruce-Lockhart), Mr G A Horne, MBE, Mr R A Marsh (substituting for Mr Curwood), Mr M J Northey (substituting for Mrs S V Hohler), Dr T R Robinson, Mrs E D Rowbotham, Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens

OBSERVERS: Mr J Goodfellow, Mrs F Witherden, Mr R Kenworthy, Mr R Appadoo, Mr J Cunningham, Mr J Larcombe, Patient and Public Involvement Forum representatives, and Mrs L Selman, Director of Citizen Engagement and Communication, Eastern & Coastal Kent Primary Care Trust.

IN ATTENDANCE: Mr P D Wickenden, Overview, Scrutiny and Localism Manager and Dr D Turner, Research Officer to the Health Overview & Scrutiny Committee.

UNRESTRICTED ITEMS

72. Audiology

(Michelle Ford, Assistant Director of Commissioning and Rob Howard, Technical and Strategic Planning Manager (Audiology), Eastern & Coastal Kent Primary Care Trust, Bob Deans, Deputy Chief Executive, Lynne Townsend, Locality Commissioning Manager, West Kent Primary Care Trust, Mr M Kershaw, Chief Operating Officer, East Kent Hospitals Trust, Mr G Douglass, Chief Executive, Maidstone & Tunbridge Wells NHS Trust, Mr A Horne, Chief Executive and Mrs A Willoughby, Head of Audiology, Medway NHS Trust and Mr J Beadle, Darent Valley Patient and Public Involvement Forum, were in attendance for this item)

(1) The Committee had before them a briefing note prepared by Dr David Turner, Research Officer to the Health Overview and Scrutiny Committee, which included details about:-

(a) modernising NHS audiology services;
(b) the growth in waiting times;
(c) the Public Private Partnership;
(d) the end of ring-fenced funding;
(f) national waiting time target;
(g) interim diagnostic targets;
(i) Phase 2 Independent Sector Treatment Centre procurement;
(j) *Improving Access to Audiology Services in England*;

(k) Commons Health Committee report;
(l) Department of Health Good Practice Guide;
(m) the current situation on waiting times; and
(n) the Clinicenta procurement.

(2) Members of the Committee also had before them written evidence from Eastern & Coastal Kent Primary Care Trust, West Kent Primary Care Trust, East Kent Hospitals Trust, Medway NHS Trust, Darent Valley Patient and Public Involvement Forum and a note from one of the Forum members, John Beadle.

(3) The Committee's consideration of this item followed the Committee's discussion of this issue on 9 March 2007.

(4) The Primary Care Trusts had responded to questions in writing (which were followed up by the Members at the meeting) about:-

(a) targets regarding waits for diagnostic tests;
(b) whether it was intended that routine, non-Ear, Nose and Throat (ENT) audiology referrals would conform to the 18-week referral to treatment (RTT) maximum wait standard by the end of 2008 (although these referrals were not formally covered by the 18-week RTT maximum waiting target);
(c) how and when the PCTs would meet their stated long-term target of reducing the maximum RTT waiting time to eight weeks;
(d) what the level of unmet need for audiology services (including analogue-to-digital upgrades) was, how this had been estimated and whether current procurement plans would be sufficient to address this;
(e) whether providing upgrades to digital hearing aids for patients who already had analogue hearing aids was as important a priority as providing hearing aids for new patients; and
(f) the cross-PCT procurement of services from Clinicenta and how this procurement related to the government's previously announced plan to procure centrally 300,000 independent sector audiology pathways per annum over five years.

(5) Both East Kent Hospitals Trust and Medway NHS Trust responded to questions relating to how they were implementing the approach recommended by the Department of Health in *Transforming adult hearing services for patients with hearing difficulty: a good practice guide* (June 2007), encompassing: use of new technology, streamlining systems and processes, new models of care and re-profiling the workforce. The Committee was also anxious to hear how soon fitting of hearing aids occurred after diagnostic testing.

(6) Following the question-and-answer session with representatives from the Primary Care Trusts and acute hospital Trusts, the Committee invited Mr Beadle, the Patient and Public Involvement Forum representative for Darent Valley Hospital, to address the Committee in support of the paper which he had submitted.

(7) In his paper Mr Beadle had pointed out that the following were the basic causes of current problems in some areas:-

(a) failure to adhere to best practice standards in audiology, published by the Department of Health in 2002;
(b) failure to identify the number of patients expected to require digital hearing aids or even set up a data collection system for that purpose;
(c) failure to adequately fund the Modernising Hearing Aid Services programme, with funding unrelated to catchment area size;
(d) failure to monitor performance of audiology departments by the Healthcare Commission, either in the star rating programme or in the current Annual Health Check;
(e) failure to review management of audiology departments and relationships with ENT departments as identified in *Audiology in Crisis*, published by the Royal National Institute for Deaf people (RNID) in 2001;
(f) total indifference to the "postcode lottery" situation by a succession of Health Ministers;
(g) too great a concentration on the issuing of digital hearing aids for new patients by the RNID and the Department of Health; and
(h) introduction of a telephone hearing test by the RNID without discussion with NHS audiologists, which had greatly exacerbated existing capacity problems.

(8) Having heard what health colleagues, and Patient and Public Involvement Forum representatives had had to say in response to all the Committee's questions, the following conclusions were reached by the Committee.

Conclusions

The Committee concluded that:-

(a) further work needed to be done to inform the public of the new services being provided by Clinicenta;
(b) work needed to be undertaken on transport issues in relation to accessibility of healthcare services (the Committee noted that this was a piece of work that it had set aside for a Topic Review Select Committee to undertake early in the New Year);
(c) the issue of the Joint strategic Needs Assessment should be picked up by the Health Overview and Scrutiny Committee in conjunction with both Health and Adult Social Care colleagues;
(d) Public Health colleagues should ensure (possibly using Kent TV) that the public were made aware of the risks to their hearing posed by prolonged exposure to loud music;
(e) data collection and collation for audiology services must be improved, to enable commissioners to commission services effectively;
(f) it needed to be recognised that dealing with a patient with audiology needs was about more than just fitting a hearing aid;
(g) patients were entitled to copies of their audiograms;
(h) audiology should be recognised as an important service in the strategic plans of the Primary Care Trusts;
(i) Hi-Kent Kent provided a valuable and well-respected service;

(j) further work should be undertaken by the Primary Care Trusts and others to see whether it might be feasible to provide audiology services through "High Street" practitioners (along the same lines as dental and optical services);
(k) the Healthcare Commission Annual Health Check should take account of RTT waiting times for audiology services;
(l) a written report on audiology services should be received by the Health Overview and Scrutiny Committee every four months;
(m) audiology patients should be subject to an automatic recall;
(n) as there had been no audit of audiology needs across the population of Kent, this needed to be undertaken as a matter of urgency;
(o) patients should be encouraged to return hearing aids where they were no longer required or are not being used;
(p) PCTs and others needed to consider carefully the mental health needs of people with hearing impairment.

RESOLVED that:-

(a) the conclusions of the Committee be conveyed to all those identified as having matters to take forward; and
(b) the Committee would expect an update on how these issues were being dealt with when it received the first written review of audiology services in four months' time.

73. Dentistry

(Michelle Ford, Assistant Director of Commissioning, Jayne MacDonald, Head of Primary Care and Community Commissioning (NHS Dentistry), Eastern & Coastal Kent Primary Care Trust, and Bob Deans, Deputy Chief Executive, West Kent Primary Care Trust, were in attendance for this item)

(1) The Committee had last looked at the issue of dentistry on 9 March 2007.

(2) The Primary Care Trusts had been invited, in advance of the meeting, to submit to the Committee written evidence in response to questions which covered the following issues:-

(a) whether the commissioners had a clear and reliable picture of the extent and distribution of unmet need for NHS dentistry, and what data sources they were using for this purpose;
(b) what steps the PCTs were taking to ensure services were provided to address that unmet need;
(c) whether the current General Dental Services contract was sufficiently attractive to dentists to allow commissioning of adequate levels of provision in all areas – or whether dentists still felt they are having to work "on a treadmill" because of the target-driven nature of the contract (based on Units of Dental Activity);
(d) whether salaried provision had been considered as a possible means of commissioning NHS dental services for underserved communities;

(e) to what extent the PCTs were experiencing shortfalls in expected patient charge revenue and whether this was affecting their ability to provide adequate dental services;
(f) whether, if PCTs had experienced shortfalls in patient charge revenue, the investment of additional funds (£30 million nationally) by the Department of Health as a one off measure to offset shortfalls in 2007–8 was going to resolve the problem;
(g) whether they had sought, as some PCTs reportedly had, to link capital funding for dentists with a commitment to see more patients who were eligible to pay NHS charges, in order to reduce the risk of a shortfall in patient charge revenue;
(h) whether the PCTs had clawed back contractual payments to dentists failing to achieve the 96% threshold of contracted Units of Dental Activity and, if so, how many dentists this had affected;
(i) whether the PCTs could guarantee that dental budgets would not be raided after ring-fencing of those budgets ended in 2009;
(j) What steps the PCTs were taking to ensure that dentists provided more complex treatment where clinically appropriate; spent more time with patients, allowing a more preventative approach to oral health; and provided proper continuity of care for patients;
(k) whether the PCTs were putting into Dental Public Health the resources necessary to allow the identification of unmet need for dentistry and inequalities in oral health, so that dental services could be properly planned to address those issues.

(3) The Committee also had before it correspondence relating to issues of concern raised by the Eastern & Coastal Kent Patient and Public Involvement Forum Swale Locality Group. Having heard and received responses to its questions, the Committee reached the following conclusions:

a) The Committee welcomed the reported interest shown by dentists in taking up NHS contracts. The PCTs were asked to give further consideration to the way that they communicated with the public and patients, particularly around charges for dental services. It was felt by the Committee that there was a perception that the public did not know what they are expected to pay and this might be exacerbating health inequalities by discouraging the less well-off from seeking treatment.

b) The Committee would recommend that there was an independent audit undertaken of dentistry provision across the county. The Committee would also welcome quarterly reports being made available to it regarding NHS dentistry provision.

c) Details of unmet need for dentistry across the county should be made available in the Primary Care Trusts' Local Delivery Plans. The Committee would welcome details of how many NHS dentists there were in total and where they were situated across the county.

RESOLVED:-

(a) That the conclusions of the Committee be drawn to the attention of health colleagues; and
(b) that a progress report on how the Committee's views were being taken forward should be made available to the Committee in four months' time.

74. Response to the Department of Health consultation on the draft regulations for Local Involvement Networks

(1) The Overview and Scrutiny Manager informed the Committee that, regrettably, it had not been possible, due to other demands on resources, to finalise for the meeting a proposed response on behalf of the Committee to the Department of Health's consultation on the draft regulations for Local Involvement Networks. He therefore sought the Committee's approval for the Vice Chairman, in consultation with the Conservative and Liberal Democrat Spokesmen, to agree the response on behalf of the Committee prior to the deadline for receipt by the Department of Health on 21 December. In the first instance, he would make the draft response available to all Members of the Committee so that they could contribute to this process.

(2) Some Members expressed concern that this was not an ideal process and that the draft response should have been available to the Committee for its consideration.

(3) RESOLVED:- That the Overview and Scrutiny Manager, in consultation with the Vice-Chairman, and Conservative and Liberal Democrat Spokesmen, should agree a response on behalf of the Committee, having first sought the views of Committee Members.

75. Urgent Business

(1) The Overview and Scrutiny Manager sought the permission of the Committee to raise a number of items of urgent business that it would be appropriate to deal with immediately, rather than waiting until the next meeting of the Committee, in January 2008. This was agreed by the Committee.

Statutory Joint Health Overview and Scrutiny Committee "A Picture of Health for South East London"

(2) The Overview and Scrutiny Manager informed the Committee that Dr Robinson had been appointed to serve on a Joint Health Overview and Scrutiny Committee which was considering proposals for health services in South East London under the "A Picture of Health" initiative. This Joint Committee comprised the HOSCs for the London Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark; in view of the flows of patients from West Kent into outer South East London, the County Council had been invited to participate in this Joint Committee.

(3) The Overview and Scrutiny Manager would ensure that all Members in North and West Kent received regular updates on the activity of the Joint Committee and

these Members would be able to submit information to either Dr Robinson or himself so that this could be shared with the Joint Committee.

Devolution of Health Overview and Scrutiny Committee powers to Borough and District Councils

(4) Some discussion took place with the Committee on the possible devolution of Health Overview and Scrutiny Committee powers to Borough and District councils. The Overview and Scrutiny Manager reported that this needed to be considered in the context of the Localism agenda, the establishment of a Local Involvement Network for Kent and proposals for Healthwatch. One Member did not see that this was an issue for the County Council's Executive and that the Health Overview and Scrutiny Committee should proceed with devolution and delegation of some of the Health Overview and Scrutiny Committee powers to Borough and District councils – as the Committee had discussed at its meeting on 7 September 2007.

Future meetings

(5) The Overview and Scrutiny Manager informed the Committee of the meeting dates for the first few months of 2008 and made it clear to the Committee that he anticipated that all the meetings would be all-day meetings as the issues to be discussed (including Local Delivery Plans, Mental Health and the Healthcare Commission Core Standards) were substantial and complex. Members expressed concern that the meeting scheduled for 11 January 2008 was due to take place in the Darent Room at Sessions House, County Hall, Maidstone, which Members found totally unacceptable as a venue. The Overview and Scrutiny Manager informed the Committee that he would ensure that, if at all possible, the meeting was switched to the Council Chamber.

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Mental health service issues for possible consideration by the Health Overview and Scrutiny Committee on 11 January 2008

1) Crisis Resolution Home Treatment services

Background

In April 2004 East Kent NHS and Social Care Partnership Trust's Mental Illness Support Team (MIST) was dismantled, with the advent of the Crisis Assessment and Treatment (CAT) Team.

The MIST had provided a service between 5pm and Midnight on weekdays and throughout weekends for people in need of a mental health intervention.

The CAT Team, which is based in Aylesham, provides a year-round, 24-hours-a-day, seven-days-a-week service for east Kent residents (adults of working age) who are experiencing a major mental health crisis. A major crisis is defined as one that requires intervention within four hours; or one where the client meets the criteria for hospital mental health services and is at risk of admission to a psychiatric in-patient facility.

Out-of-hours referrals to the CAT Team are taken from: hospital A&E departments; social care out-of-hours services; the GP out-of-hours service (currently provided in north-eastern Kent by StourCare); the police; NHS Direct (the national 24-hour NHS telephone helpline); Mental Health Matters (a telephone helpline with limited hours); and the Ambulance Service.

In West Kent three mental health Crisis Resolution Home Treatment Teams (CRHTs) currently operate:-

- Dartford CRHT (based at Archery House, Dartford);
- Maidstone CRHT (based at Priority House, Maidstone);
- South West Kent CRHT (based at The Springs, Pembury).

These CRHTs are stated to offer a service 24 hours a day, 365 days a year, responding to crises with community-based assessment and treatment. They act as a Gatekeeper to in-patient care, offer an alternative to in-patient admission and facilitate early discharge.

Comments received from Joyce Epps

On 20 September 2006 Joyce Epps (a member of the East Kent Partnership Trust Carers' Forum, and the Patient and Public Involvement Forum for the Kent and Medway NHS and Social Care Partnership Trust) raised with Christine Angell and Mark Fittock the issue of mental health out-of-hours services. Mrs Epps argued that, because the CAT Team service was targeted only at those clients with the greatest need, the abolition of the MIST had created a gap in out-of-hours mental health services for those clients experiencing less severe crises. As well as being bad for the clients, this also put unfair pressure on their carers, it was stated.

At the NHS OSC meeting on 22 September 2006 the matter was raised with Erville Millar, Chief Executive of the Partnership Trust. He informed the committee about the

Crisis Response and Home Treatment Service (i.e. the CAT Team in east Kent). He explained that the possibility was being explored of allowing individuals who were already known to the service to access it directly, without referral. He said there was an issue in relation to the public perception of what was actually classed as a "crisis" that would trigger access to this service. Although an individual and / or their family might feel that mild anxiety was a crisis situation, this was not what the service was funded for. National funding for such services was provided for people with serious mental health issues. If the gap in funding for clients with mild or moderate mental illness were addressed then a service could be provided for them, as well as for those with more serious conditions.

At the NHS OSC meeting on 20 July 2007 Peter Hasler, Director of Nursing and Human Resources at the Partnership Trust, attended to update the committee on matters that Mr Millar had dealt with at the September 2006 meeting. Mrs Epps attended the July 2007 meeting and raised her concerns about out-of-hours services. Colleagues from the Partnership Trust and KCC Adult Social Services attempted to reassure Mrs Epps that the issues she raised were being addressed. They emphasised the role that good planned care could play in minimising crises requiring out-of-hours intervention; and they referred to the role of social care in dealing with these situations.

Mrs Epps subsequently wrote to Mrs Angell and Mr Fittock (in July 2007), to the Overview and Scrutiny Manager (on 30 July 2007) and to Graham Gibbens (in September 2007), setting out her case in more detail and sending background information.

Mrs Epps argued that the gap in out-of-hours services for clients with lesser need was not adequately filled by the available alternatives, namely: hospital A&E departments; GP out-of-hours service (currently provided by StourCare in north-eastern Kent); helplines (NHS Direct and Mental Health Matters); Community Mental Health Teams; social care out-of-hours services; arrangements for clients following discharge from in-patient facilities, under the Care Programme Approach (CPA).[1]

She stated that in some parts of the country (for instance, North Lincolnshire) out-of-hours services were being provided for clients who in Kent would be regarded as insufficiently ill to be able to access the CAT Team. She drew attention to the fact that the NHS Mental Health National Service Framework (1999) stipulated that appropriate professional help should be available on a 24-hours-a-day basis for clients with serious long-term conditions such as schizophrenia or bipolar disorder.

[1] The CPA was introduced in April 1991 and updated in 1999 (in light of the NHS Mental Health National Service Framework) through *Effective Care Co-ordination in Mental Health Service – Modernising the CPA*. The CPA applies to anyone in touch with secondary mental health services (in both health and social care), and requires health and social care service providers to arrange an individually assessed "package of care" for each individual service user, to meet their clinical and social care needs. It has four key aspects:

- **Assessment** of each service user's clinical and social care needs;
- a **Care Plan** to address the needs of each service user;
- a designated **Care Co-ordinator** (formerly called a Key Worker) to keep in close touch with each service user and monitor their care;
- **Regular Reviews** to monitor each service user's progress and, if necessary, agree changes to the Care Plan.

According to a document submitted by Mrs Epps, a senior member of staff at the Trust told her in 2006 that they shared her concern about the gap in provision left by the demise of MIST. They pointed out that the responsibility for the problem rested with the joint commissioning managers, as "The Trust can only provide services it is commissioned to deliver".

Comments received from Tony Wright

On 9 August 2007 Tony Wright (a member of the Sevenoaks Support Group of the mental health charity Rethink – the National Schizophrenia Fellowship) wrote to the Select Committee on Carers in Kent (copying his e-mail to NHS OSC). He referred to a number of shortcomings in mental health services – leading to limited potential for recovery by service users and to burdens being placed on carers. He noted that:-

> *Whereas all deficiencies are important the one which causes the most stress to carers is the continued inadequacy of crisis response.*

On 10 October 2007 Mr Wright wrote to Debbie Stock (Programme Manager for Mental Health, West Kent Primary Care Trust), reiterating the points he had made in August and adding others.

Mr Wright's points regarding CRHT services can be summarised as follows:-

a) CRHT services are not available 24 hours a day, seven days a week – as they are supposed to be.

b) Service users and carers are not given an out-of-hours telephone number of a person in their Care Plan team (under the CPA) whom they can contact reliably.

c) CRHT services do not always come within an hour of being called out – as they are supposed to.

d) The Partnership Trust appears to be advising patients to revert to using A&E in a crisis – which is totally inappropriate for someone in a florid psychotic state, suffering from delusions and paranoia, and failing to take their medication.

e) There is a general failure to deliver CRHT services in accordance with Department of Health (DoH) guidelines.

f) There is an inadequate complaints procedure.

g) GPs are reluctant to refer people to CRHT services.

h) Responsibility is left with carers, who are expected to cope despite their lack of formal training.

i) Poor CRHT services have ramifications for Community Treatment Orders (CTOs) under the Mental Health Act 2007.[2]

[2] CTOs compel certain people with mental disorders living in the community to engage with services and undergo treatment.

In his e-mail of 10 October Mr Wright concluded as follows:-

> *This [the issue of CRHT services] is a very serious issue for carers and service users it really is impossible to describe the experience of lack of support at this time of need .It involves fear, confusion, distress, frustration and from all this total desperation .*

2) Talking therapies

In his e-mail of 9 August Mr Wright stated that the Partnership Trust was providing services that were primarily medication-led and that there was a "severe shortage of therapeutic services including CBT [Cognitive Behavioural Therapy]".[3]

3) Care Plans

In his e-mail of 9 August Mr Wright stated that DoH guidelines were not being followed with regard to Care Plans (under the CPA). These should identify: the illness, symptoms and problems; how they are going to be addressed (including therapeutic interventions); who is going to do it, as well as when, where and how frequently; and the expected outcome.

4) Dual diagnosis

In his e-mail of 9 August Mr Wright stated that DoH guidelines were not being followed in respect of "dual diagnosis" cases.[4]

5) Assertive outreach

In his e-mail of 9 August Mr Wright stated that DoH guidelines were not being followed in respect of "assertive outreach".[5]

6) Speaking out

In his e-mail of 9 August Mr Wright stated that:-

> *Carers are afraid to speak up for fear of retribution[;] also they are daunted by the stigma attached to their families.*

7) Auditing

In his e-mail of 9 August Mr Wright stated that:-

> *The audit programme for services is not transparent. Carers find it difficult to reconcile their own experiences with the claims of the trusts.*

---

[3] CBT is a form of talking therapy that is used to treat a range of conditions, focusing on patterns of both thought (the cognitive aspect) and conduct (the behavioural aspect). Unlike some other talking therapies, CBT focuses on the service user's current problems and difficulties, looking for ways to improve their present state of mind – rather than focussing on the causes of mental distress or past symptoms.

[4] In "dual diagnosis cases" mental health problems coexist with substance misuse.

[5] "Assertive outreach" is a bespoke, proactive approach to helping people with severe and enduring mental health problems in their own homes

8) Information for carers

In his e-mail of 9 August Mr Wright stated that:-

> *Carers are disadvantaged by again an inadequate publication policy by the trusts which keeps them informed and keeps them in the loop with regard to consultation process etc. Information is contained.*

Mr Wright also stated that:-

> *Formal information [about funding levels for services] is difficult to come by even with the use of the freedom of information act.*

On 24 October 2007 Mr Wright wrote, in an e-mail to John London, that:-

> *The [Partnership Trust's] publication policy in practice continues to be very disappointing to say the least.*

9) Involvement of carers by clinicians

In his e-mail of 9 August Mr Wright stated that clinicians did not involve carers adequately in the treatment of service users (for reasons of confidentiality or due to lack of time on the clinician's part).

10) Training for carers

In his e-mail of 9 August Mr Wright stated that there was a "complete lack" of training for carers – despite the fact that carers were far more involved in the lives of service users than the members of professional care teams were.

11) Carers' Assessments

The Carers (Recognition and Services) Act 1995 gives people aged 16 and over who provide "substantial care on a regular basis" the right to request an assessment from Social Services. In addition, Standard Six of the NHS Mental Health National Service Framework (1999) states that "all individuals who provide regular and substantial care for a person on CPA should:-

- have an assessment of their caring, physical and mental health needs, repeated on an annual basis; and

- have their own written care plan which is given to them and implemented in discussion with them."

In his e-mail of 9 August Mr Wright stated that Carers' Assessments were "just token" and did not follow DoH guidelines:-

> *Amongst other things carers should have their own care plan which is interactive with the care plan of their service user. Further they [should] share the same coordinator.*

12) Funding levels

In his e-mail of 9 August Mr Wright stated that:-

> *According to a national survey Kent [is at the] bottom of the spend table when it comes to mental illness. Formal information is difficult to come by even with the use of the freedom of information act.*

Mr Wright made the same point about funding levels in his e-mail of 10 October to Debbie Stock of West Kent PCT.

In his e-mail of 24 October to Mr London, Mr Wright stated that he suspected the financial problems faced by West Kent PCT were the decisive factor in determining the shape of services.

The survey referred to by Mr Wright is *The 2005/06 National Survey of Investment in Mental Health Services*, prepared by Mental Health Strategies. This:-

> *identifies, for each Strategic Health Authority (SHA), its planned investment per head of weighted working age population in adult mental health services for 2005/06. These figures range from £207 per head for North Central London SHA to £128 per head for Kent and Medway and Greater Manchester SHAs. The England average figure is £153, compared with £140 in 2004/05. This represents a 9.3% increase in investment in 2005/06, approximately 4% in excess of expected pay and price inflation for the year. It is not clear how much, if any of this growth is due to improved data quality and how much represents a real increase in investment in adult mental health services by commissioners …*
>
> *Note also that the level of investment within the Kent and Medway SHA has increased by more than 17% compared with 2004/05 when there was evidence that West Kent LIT [Local Implementation Team] had substantially under-reported investment by its commissioners. Despite West Kent submitting a comprehensive return in the current year however table eight is still reporting that Kent and Medway SHA contains the lowest level of investment nationally per weighted head of working age population.*[6]

13) Consultation processes

In his e-mail of 9 August Mr Wright stated:-

> *It is also important to mention that periodically we go through consultation process with the trusts. This relates by obligation to major changes in services, e.g. Brocklehurst [Ward] closedown [the ward was relocated from Pembury Hospital to Priority House, Maidstone on 25–6 June 2005] and trust merger [i.e. the merger of East Kent NHS and Social Care Partnership Trust, and West Kent NHS and Social Care Trust on 1 April 2006 to form Kent and Medway NHS and Social Care Partnership Trust].In these consultations carers*

[6] *The 2005/06 National Survey of Investment in Mental Health Services* (Mental Health Strategies, 17 May 2006), p. 7. It is not possible to compare the 2005–6 survey with that for 2006–7, as the latter contains data at Strategic Health Authority (SHA) level, and the Kent and Medway SHA ceased to exist on 1 July 2006, when it was merged into the new South East Coast SHA.

and service user[s] make it quite clear as to their opinions on services .But nothing is minuted or acknowledged .Further needless to say no action plan ensues .

A decision was made in very recent years for the secondary trust merger but nothing was issued publicly as far as we are aware by the executive which explains in reasonable detail the management calculation as to the benefit in services expected from the decision .Is it going to be the same with the development of a foundation trust [the Partnership Trust is currently applying to become a Foundation Trust].

Mr Wright also stated in his e-mail of 24 October to Mr London that:-

The worry at the end of the day is that the consultation processes which are obliged by law are really just window dressing .The suspicion is that the dominant factor is the finances of the PCT.

Mr Wright also referred to the response by the NHS OSC to the consultation about the closure of Brocklehurst Ward, in which, he said, concerns had been expressed about Care Plans and CRHTs. (The NHS OSC considered the consultation "Modernising Mental Health in West Kent" at its meeting on 10 February 2005. The committee considered the transfer of Brocklehurst Ward at its meeting on 10 June 2005 and heard about the service being provided by CRHTs.)

Misgivings about the Partnership Trust's approach to consulting service users and carers (over the Trust's Foundation Trust application and other matters) were also expressed by service-user and carer representatives (Fran Witherden of the Kent and Medway Mental Health and Social Care PPIF, and the Eastern and Coastal Kent PCT PPIF; Miranda Moorland; and Gay Hughes) at the NHS OSC meeting on 20 July 2007.

Similar views were further expressed by Ms Witherden and Ms Hughes at the Adult Social Services Policy Overview Committee meeting on 16 November 2007 (attended by the Chairman and Chief Executive of the Partnership Trust, as well as colleagues from the PCTs and KCC Adult Social Services).

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Date: 21 December 2007

Dear Erville

Health Overview and Scrutiny Committee – 11 January 2008

The County Council's Health Overview and Scrutiny Committee has been planning for some time that the issue of mental health needs to be looked at in some detail. Arrangements have been made, after discussion with the Chairman and Spokesmen of the Committee, for this issue to take place at the Committee's meeting on 11 January 2008. I appreciate this is the last day before the holiday season but the Committee would welcome receiving from you written evidence in advance in the form of answers to the following questions:-

1. What is being done to ensure adequate provision on out of hours services for those people whose level of need is not great enough to qualify for access to Crisis Resolution Home Treatment (CRHT) services?

2. Are CRHT services available 24 hours a day, 7 days a week – as they are supposed to be?

3. Are service users and carers given an out of hours telephone number of a person in their Care Plan Team who they can contact reliably?

4. Do CRHT services always come within an hour of being called out – as they are supposed to?

5. Is it true that the Partnership Trust has been advising patients to revert to using Accident & Emergency services in a crisis?

6. Are CRHT services delivered in accordance with the Department of Health guidelines?

7. What complaints procedures exist in respect of CRHT services?

8. Are GPs co-operating fully as regards referring people to CRHT services?

9. What is being done to ensure that out of hours services are sufficient to ensure that carers are not overburdened?

10. Are CRHT services adequate to ensure that Community Treatment Orders (under the Mental Health Act 2007) work as they are supposed to?

11. What is the Partnership Trust doing to ensure that talking therapies (including cognitive behaviour therapy) are where clinically appropriate, fully available as alternatives to medication-led treatment?

12. Are DoH guidelines the care programme approach "Effective Care Co-ordination in Mental Health Service – modernising the CPA" and the NHS Mental Health National Service Framework being followed as regards care plans?

13. Are DoH guidelines being followed as regards dual diagnosis cases?

14. Are DoH guidelines being followed as regards assertive outreach?

15. Are service users and carers able to criticise services freely without fear of adverse consequences?

16. Are open and transparent processes in place for the auditing of services?

17. What measures are taken to keep carers informed and to consult them?

18. What steps are taken to ensure that carers are involved by clinicians in the care provided to service users?

19. What arrangements are there to offer appropriate training to carers?

20. What steps are taken, with social care colleagues, to provide carers with Carers Assessments and Care Plans in accordance with the Carers

(Recognition and Services) Act 1995 and Standard 6 of the National Service Framework for Mental Health?

21. Are mental health services in Kent and Medway adequately funded to address the needs of the population?

22. What steps does the Partnership Trust take to fulfil its duty under Section 242 of the National Health Service Act 2006 (as amended by Section 233 of the Local Government and Public Involvement in Health Act 2007) to consult service users and the public (including carers)? What specific steps are being taken to do so in respect of the Partnership Trust's current application to become a Foundation Trust?

I will be in contact with the Trust again on either 27 or 28 December to set out the allocated time on the 11 January 2008 when the Committee will wish to ask further questions of you.

I apologise that this is all being done in the rush over a holiday period but I have only just received the guidance that I required before I could write to you.

I look forward to hearing from you.

Yours sincerely

Paul Wickenden
Overview and Scrutiny Manager
Democratic Services

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Email: paul.wickenden@kent.gov.uk
Ask for:
Your Ref:
Our Ref:
Date: 21 December 2007

Dear Ann

Health Overview and Scrutiny Committee – Friday 11 January 2008

I sincerely apologise that this is the last day before the Christmas and New Year period but as you are aware one of the items on the Health Overview and Scrutiny Committee programme for the January meeting of the Committee is the issue of mental health.

Here are the questions that the Committee would like answered as written evidence prior to setting aside some time on 11 January when they would like to speak to the Primary Care Trusts but particularly Medway Primary Care Trust as the lead commissioner. I do apologise that this is such short notice but the Committee would welcome a response to this request for written evidence as soon as this is possible. I will be in the office on 27, 28 and 31 December.

Questions

1. Are you certain that you are commissioning adequate provision of out of hours services for those people whose level of need is not great enough to qualify for access to Crisis Resolution Home Treatment (CRHT) services?

2. What steps do you take to ensure that the CRHT services you commission are being provided in accordance with Department of Health (DoH) guidelines?

3. What are you doing to ensure that GPs co-operate fully as regards referring people to CRHT services?

4. What are you doing through the commissioning process to ensure that talking therapies ((including cognitive behaviour therapy) are where clinically appropriate, fully available as alternatives to medication-led treatment?

5. Are you certain that you are commissioning adequate mental health services to meet the needs of the population of Kent and Medway and that those services are adequately funded?

6. What steps do you take to assess the extent of need for mental health services within the Population?

The agenda and papers for the Health Overview and Scrutiny Committee meeting will be published on 3 January 2008. If you are able to get your written response to me before that date it would be very much appreciated.

On behalf of the Committee may I thank you in advance and I look forward to hearing from you.

Kind regards

Yours sincerely

Paul Wickenden
Overview and Scrutiny Manager
Democratic Services

Marion Dinwoodie
Chief Executive
Medway Primary Care Trust
5-7 Ambley Green
Bailey Drive
Gillingham Business Park
Gillingham ME8 0NJ

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Dear Marion

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On behalf of the Committee may I thank you in advance and I look forward to hearing from you.

Kind regards

Yours sincerely

Paul Wickenden
Overview and Scrutiny Manager
Democratic Services

Steve Phoenix
Chief Executive
West Kent Primary Care Trust
Wharf House
Medway Wharf Road
Tonbridge TN9 1RE

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Dear Steve

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On behalf of the Committee may I thank you in advance and I look forward to hearing from you.

Kind regards

Yours sincerely

Paul Wickenden
Overview and Scrutiny Manager
Democratic Services

Sent 21 December 2007 14:13

To: 'Brenda O'Neill', Janine@kmn-ltd.co.uk; 'Deborah Boulares'; mark@kmn-ltd.co.uk; lorraine@kmn-ltd.co.uk

Health Overview and Scrutiny Committee – Friday 11 January 2008

Sent on behalf of Paul Wickenden, Overview and Scrutiny Manager

Dear colleague

The County Council's Health Overview and Scrutiny Committee will be spending the majority of its meeting on Friday 11 January 2008 looking at the issue of mental health.

I would be grateful if you could make this information available to colleagues who look after the Kent and Medway Partnership Trust and would appreciate any responses to the following questions from any of your members or service users/carer representatives:-

1. Are you satisfied with the current provision of out of hours services for those people whose level of need is not great enough to qualify for access to Crisis Resolution Home Treatment (CRHT) services? Are they sufficient to ensure that carers are not overburdened?

2. Are you satisfied that CRHT services are being provided in accordance with the Department of Health guidelines?

3. Are you satisfied that GPs are co-operating fully as regards referring people to CRHT services?

4. Are talking therapies (including cognitive behaviour therapy) where clinically appropriate, fully available as alternatives to medication-led treatment?

5. Are DoH guidelines the Care Programme Approach "Effective Care Co-ordination in Mental Health Service – modernising the CPA" and the NHS Mental Health National Service Framework being followed as regards care plans?

6. Are DoH guidelines being followed as regards dual diagnosis cases?

7. Are DoH guidelines being followed as regards assertive outreach?

8. Are service users and carers able to criticise services freely without fear of adverse consequences?

9. Are open and transparent processes in place for the auditing of services?

10. Are adequate measures being taken to keep carers informed and to consult them?

11. Are adequate measures being taken to ensure that carers are involved by clinicians in the care provided to service users?

12. Are there adequate arrangements to make appropriate training available to carers?

13. Are carers being with Carers Assessments and Care Plans in accordance with the Carers (Recognition and Services) Act 1995 and Standard 6 of the National Service Framework for Mental Health?

14. Are mental health services in Kent and Medway adequately funded to address the needs of the population?

15. Does the Partnership Trust take adequate steps to fulfil its duty under Section 242 of the National Health Service Act 2006 (as amended by Section 233 of the Local Government and Public Involvement in Health Act 2007) to consult service users and the public (including carers)? Is this so in respect of the Partnership Trust's current application to become a Foundation Trust?

The agenda and papers for the meeting of the Health Overview and Scrutiny Committee on 11 January 2008 will be published on 3 January 2008. If any of your colleagues are able to let me have a written response before this date that would be very much appreciated.

Kind regards

Paul

Angela

Angela Evans
Team Secretary, Overview and Scrutiny
Democratic Services
Kent County Council
01622 221876
www.kent.gov.uk/overviewandscrutiny

Response to questionnaire sent to Patient and Public Involvement Forum on behalf of Paul Wickenden 21 December 2007

(Bullet points are my responses)

1. Are you satisfied with the current provision of out of hours services for those people whose level of need is not great enough to qualify for access to Crisis Resolution Home Treatment (CRHT) services? Are they sufficient to ensure that carers are not overburdened?

- At the OSC meeting in July Lauretta Kavanagh agreed to provide an effective plan to support such clients-Emergency Clients-and a timetable for implementing her plan. We look forward to hearing the plan for providing an active mental health qualified professional response to come out if needed to Emergency Clients at the OSC meeting on January 11th.

4. Are talking therapies (including cognitive behaviour therapy) where clinically appropriate, fully available as alternatives to medication-led treatment?

- I understand there is still a considerable backlog.

5. Are DoH guidelines the Care Programme Approach "Effective Care Coordination in Mental Health Service – modernising the CPA" and the NHS Mental Health National Service Framework being followed as regards care plans?

- Not always, from examples I've been given

8. Are service users and carers able to criticise services freely without fear of adverse consequences?

- Carers Rights to Confidentiality-the same as those of the client according to the Trust's Information Office-have been breached adversely when carers raise their concerns, harming their relationship with the client.

- Carers asked for all staff to be reminded of Carers' Confidentiality and an article by Claire Robson was published in Partnership Matters in July (I think) 07. Not all staff seem aware even now, although each Locality Director was asked to make sure that staff complied.

- Carers and clients are still frightened of adverse effects if they raise concerns, and need to know that there will be an improvement in service if there concern is justified.

- My perception is that carers wish to work with the care teams and may not complain/raise concerns except as a last resort.

- Carers raising concerns to have services improved have been accused of being negative.

10. Are adequate measures being taken to keep carers informed and to consult them?

- Not always. Client confidentiality is at times used inappropriately to avoid answering questions.

- Staff are not proactive in informing carers to enable effective caring. Even when there is a promise of regular contact it has not happened.

Joyce Epps
PPIF and East Kent and Swale Carers Forum
10 January 2008