

KENT COUNTY COUNCIL

NHS OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of A meeting of the NHS Overview and Scrutiny Committee held at Council Chamber, Sessions House, County Hall, Maidstone on Friday, 9th February, 2007.

PRESENT: Mr A R Chell (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr M J Angell, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Ms A Harrison, Mr C Hibberd, Mr G A Horne MBE, Mr J F London (Substitute for Mrs P A V Stockell), Mrs E D Rowbotham, Mr R Tolputt and Mrs E M Tweed.

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

ALSO PRESENT: Mr J Reece, South East Coast Ambulance Patient and Public Involvement; Mr D Easton, East Kent Hospitals Patient and Public Involvement; Mrs C Swann, Kent and Medway NHS & Social Care Patient and Public Involvement; Mr R Knibbs, Kent and Medway NHS & Social Care Partnership Trust; Ms A Neal, East Kent Hospitals NHS Trust; Ms M Cleator, UNISON Invicta Health and Keep Our NHS Public; Mr G Manners, Downs Mail and Mr J Ogden, Kent County Council's Standards Committee.

IN ATTENDANCE: Paul Wickenden, Overview, Scrutiny and Localism Manager and David Turner, HOSC Research Officer.

UNRESTRICTED ITEMS

Non-pecuniary interest

Mr Angell declared a non-pecuniary interest as a non-executive director of the Kent & Medway NHS & Social Care Partnership Trust.

6. Minutes - 12 January 2007 *(Item 2)*

The Overview and Scrutiny Manager reported that the Minutes of the January meeting were still being prepared and he apologised to the Committee that they were not available for this meeting to consider and approve. They would be presented to the meeting of the Committee on 9 March 2007.

7. Medway NHS Trust - Application for Foundation Trust Status *(Item 3 – Mr A Horne, Chief Executive of Medway NHS Trust was in attendance for this item)*

(1) Mr A Horne, Chief Executive of Medway NHS Trust made a presentation to the Committee on the Trust's proposed application for Foundation Trust Status. A copy of Mr Horne's presentation is attached as Appendix 1. The Committee were reminded that they had authorised the Overview and Scrutiny Manager, in consultation with the Chairman, Vice Chairman and Liberal Democrat Spokesman of the Committee, to arrange a meeting and invite colleagues who represented an

electoral division in Maidstone Borough Council and Swale Borough Council areas to meet with Mr Horne and other Trust colleagues regarding their application for Foundation Trust Status. This meeting had taken place on Monday 22 January 2007 and a copy of the note of that meeting was attached to the report.

(2) At the conclusion of his presentation, Mr Horne responded to a range of questions.

Emergency Care

- a) In response to a question about taking on more emergency care and the capacity of the Trust to do so, Mr Horne said that the Medway NHS Trust was already taking a number of vascular emergency cases from Maidstone and Pembury hospitals. He added that, after April 2007, the Trust would also be taking vascular emergencies from Darent Valley Hospital at Dartford. He was confident that Medway NHS Trust could deal with, and had the capacity to deal with, transfers from neighbouring Trusts.

Flexibility and Freedoms of Foundation Trusts

- b) Asked about the benefits of Foundation Trust Status and the role of 'Monitor', Mr Horne responded that if Foundation Trust Status was achieved it would enable the Trust to operate within a more flexible framework. Foundation Trusts also had freedom to borrow money from a wider range of lenders, in addition to the NHS bank. Monitor had been established approximately three years ago and was the body set up to assess and accredit Foundation Trusts, primarily from a financial point of view. It was a regulatory body – as such, it was similar to the Healthcare Commission, which was responsible for looking at quality standards across NHS Trusts.

Consultation Process

- c) Asked how widely the consultation had been undertaken and the percentage of responses received, Mr Horne acknowledged that, whilst the consultation document had not been sent to London Boroughs, it had been widely distributed amongst the catchment area for the Medway NHS Trust – including the western part of Swale and the Isle of Sheppey. He did not have with him detailed figures regarding the rate of responses to the consultation, but would make them available to the Committee.

Car Parking and Transportation

- d) Mr Horne said that the car parking at the Medway Maritime Hospital was not privatised. The car parks were run by the Trust and there were no plans to change the charges for car parking. The Trust was continuing to look at environmental strategies, including the promotion of walking and car sharing, as well as considering the safety aspects of the issue. Mr Horne said that the Trust was continuing to invest in encouraging more people to become volunteer drivers.

Foundation Trust – Governing Bodies

- e) In answer to a question about how many representatives local authorities would have on the Governing Body, Mr Horne said that he envisaged there would be one representative drawn from Medway Council and one from Kent County Council. He hoped that the representative from Kent would be drawn from the Swale area, as patients from here looked towards the Medway NHS Trust for their acute hospital services.

Patient Choice

- f) Mr Horne said he recognised that the Patient Choice agenda was extremely important. His Trust was having to compete with a range of providers, including the Will Adams Independent Sector Treatment Centre at Gillingham. To ensure that the hospital retained its top hospital status, he said the Trust would have to ensure that it undertook marketing strategies to encourage patients to use the services the Trust was offering.

Facilities for Voluntary Groups and Audiology Services

- g) Mr Horne stated that the Trust provided some facilities for voluntary and independent groups – but it needed to be recognised that this was an equal partnership. He said that he was not fully briefed about the Trust's relationship with the hearing charity Hi Kent, but he would follow up on specific points raised by Mrs Angell about this and get back to her.

RESOLVED that the NHS Overview and Scrutiny Committee:-

- support the Medway NHS Trust's application for Foundation Trust Status;
- request the Medway NHS Trust periodically to report back to the Committee on the progress being made towards Foundation Trust Status.

8. Fit for the Future - Draft Commissioning Plans

(Item 4 – Rebecca Sparks, Director Development and Partnerships, South East Coastal Strategic Health Authority; Steve Phoenix, Chief Executive, West Kent Primary Care Trust; Lynne Selman, Director of Communications and Dr Roger Pinnock, GP and Professional Executive Committee (PEC) member, Dr Robert Stewart, Medical Director, Eastern & Coastal Kent Primary Care Trust; Colette Glasson, Director of Communications, Heidi Shute, Community Cardiology Manager and Marion Dinwoodie, Chief Executive, Medway Primary Care Trust were in attendance for this item)

(1) The Committee had among their papers a briefing note on commissioning. It was recognised that there was not a concise definition of commissioning, since this term actually referred to a range of activities that had changed over time and were continuing to change as a result of major NHS reforms. The briefing note referred to: the original NHS model; the internal market; commissioning and the new NHS; Payment by Results; patient choice; practice-based commissioning; the mixed economy of providers; the role of Foundation Trusts; expectations as regards PCTs undertaking commissioning and how that sat with practice-based commissioning and patient choice; how commissioning related to the reconfiguration of services; how commissioners could ensure access to services and tackle health inequalities.

(2) Health colleagues then made a presentation to the Committee, which is attached as Appendix 2 to this set of minutes.

Dental, Palliative and Respite Care

(3) Following the presentation, Mr Godfrey Horne indicated that he liked the idea of the best care being available in the best place for the best value because he felt that it added meaning for the public and it was easier to understand. He then asked a series of questions relating to how commissioning plans would improve services such as dental care, palliative care and respite care, recognising that there needed to be an holistic approach across the core agencies for delivering some of these services. Mr Phoenix responded that there was an agreement between the Primary Care Trusts and local authorities that neither would take decisions that would impinge on, and place additional financial burdens on, the other side. From a West Kent perspective, he said that there would be a review undertaken shortly on palliative care. He acknowledged that dental-care provision was an issue across many parts of Kent and this was something that the Primary Care Trusts needed to tackle collectively. However, that work had not yet started. Marion Dinwoodie said that, in Medway, the Primary Care Trust ran the Wisdom Hospice; she actually had a surplus of hospice beds, because care in the community was working so well.

Patient Choice vis-à-vis Planned Hospital Care

(4) Mr Phoenix said that there was clearly a possibility that Patient Choice would not deliver everything that was hoped. He added that there might or might not be tensions between Choice and practice-based commissioning. He said it was intended there would be a national set of standards, but the care pathways and the services offered would end up looking different in different areas. He said that devolution often led to diversity. “Postcode lotteries” were seen as bad – but local involvement and local freedoms were regarded as good things; there was a tension here. The national tariff meant that price would be standardised within the NHS market, so there could not be competition on price between providers. Choice of provider was currently still limited – but the policy was to allow the patient unlimited choice of provider, including within the private sector. He acknowledged that the different facets of current health policy did not necessarily fit together very well and that they did, in some respects, tend to ‘rub up against each other’.

(5) Dr Pinnock added that Choice was inevitably affected by patients’ ability to access different providers, but there was a stipulation that transport should not be a barrier to Patient Choice – transport should be provided where the patient was not able to travel independently. He agreed there was a tension between Choice and practice-based commissioning. There would need to be negotiation between the GP and the patient – if the GP explained to the patient what the best service was, the patient would choose that one. Ms Dinwoodie said that the choice presented to patients should be a choice between health services of the highest quality. Medway PCT had actually withdrawn a provider from their Choice menu because of concerns about quality.

Best Practice

(6) Ms Harrison asked why, given that there were a number of good ideas in the NHS that could be copied, were not all Trusts across Kent good already? She

emphasised the need to treat patients holistically to achieve the best outcomes. She also expressed concerns about NHS Direct tending to err on the side of advising callers to attend their nearest Accident and Emergency Department, thereby placing unnecessary pressure on the service. She also felt there was a need to educate the public about what truly constituted an emergency, to ensure services were used appropriately.

(7) Ms Harrison also raised concerns relating to: the shifting of services from acute hospitals into the community; the fact that Swale had for a long time been receiving a funding allocation below that stipulated by the weighted capitation formula; and the lack of GPs available, particularly on the Isle of Sheppey.

(8) Dr Stewart said that there was already a great deal of co-operation and sharing of good practice; and there were several examples across the county where health colleagues were involved in national pilots. As regards 'under-doctored' areas, he said that problems in this regard in Shepway and Swale were being addressed.

(9) Ms Sparks responded that there was much work already underway around cross-fertilisation and sharing of best practice to improve services. She referred specifically to: the Institute of Innovation (formerly the NHS Modernisation Agency); the 'Improvement Cabinet', 'Improvement Academy' and 'Clinical Champions' established by the former Kent & Medway Strategic Health Authority; and the annual 'Best of Health' awards, hosted by the South East Coast Strategic Health Authority. Regarding appropriate use of emergency services, Dr Pinnock suggested that many years of attempting to educate the public about this had not dissuaded some sections of the population from continuing to use A&E services as a substitute for primary care. He thought that the NHS should recognise this and address it by co-locating primary-care services with A&E departments. Ms Dinwoodie said that new services had to be signposted for the public when they were commissioned, to encourage people to use them – one way this was being done was through the insertion in the Yellow Pages telephone directory of a guide to local health services.

Emergency Care provided in a Primary Care setting, Mental Health, Inter-relationship between health services Provision and Deprivation

(10) Mr Phoenix said that there were a number of emergency-care models operating across Kent. For example, at the Darent Valley Hospital in Dartford, a new model of care had started on 2 January, with a nurse-led urgent care unit; this was already taking over 30% of the work away from the Accident & Emergency Centre. A similar arrangement would be used at the new Pembury Hospital. In Gravesend, there was a Minor Injuries Unit at the Gravesham Hospital.

(11) £83 million was being spent annually on mental health – which represented approximately 11% of the budget. Mr Phoenix said that, overwhelmingly, mental-health patients were being seen in primary care. He would like to see the balance of the service shifted more towards prevention of mental illness.

(12) Mr Phoenix indicated that he would like to come back to the Committee at some stage to talk about preventive services in general and how they could be provided differently. He said that general practice was a better approach to healthcare provision than the alternatives found in other health systems. In the United States and France, secondary care could be accessed directly without going through a

primary-care 'gatekeeper', and this worked less well than the system in the United Kingdom. Dr Stewart added that the interrelationship between health and deprivation was being taken very seriously. He said that hospital was not the only option for providing healthcare – intermediate care was very important. Marion Dinwoodie added that 'top-slicing' and 'ring-fencing' of monies in PCT budgets presented challenges as regards delivering services. It was vital to have Service Level Agreements with acute providers that worked. PCTs were still ploughing money into acute care and they needed to make it clear to acute providers exactly what work they were being expected to do for that money. At the same time, primary care needed to be re-engineered to reduce the number of patients being treated in the acute sector.

Patient Choice

(13) Mrs Tweed asked what would happen to the William Harvey Hospital if too many patients chose to go to, for instance, the Medway Maritime Hospital instead. Marion Dinwoodie responded that the William Harvey would still have plenty of work, especially given the planned growth in Ashford's population; she had no doubt that people would continue to choose it. The important thing was to re-engineer systems, map out patient pathways and plan for the future.

Neurology Services in East Kent

(14) Dr Stewart said there was no plan to take neurology provision away from East Kent; the intention was simply for a few specialist cases to be dealt with at the Medway Maritime Hospital.

Fit for the Future

(15) Concern was expressed at the lack of a joined-up message coming from all the NHS bodies that were caught up in the 'Fit for the Future' review. Ms Sparks said the key messages had all been set out in the public discussion document relating to Fit for the Future. The key drivers for Fit for the Future were those set out in the national health-policy framework. There was a project board for Fit for the Future in Kent and Medway, which comprised representatives from the Primary Care Trusts, Acute Trusts, Patient and Public Involvement Forums and local-authority Social Services. In addition, there was a steering group in each Primary Care Trust, in which acute Trusts and PPIFs were involved.

Choose & Book/Independent Sector Treatment Centre

(16) Dr Pinnock said that a major challenge of the current funding system was that of unbundling the tariff – i.e. dividing the tariff up where a spell of acute care was dealt with partly by an acute provider and partly in primary care. A question was asked about Independent Sector Treatment Centres receiving guaranteed full payment of their contract for five years, regardless of how much work they actually did – and how they were able to pick and choose which patients they would treat. Mr Phoenix said that PCTs were obliged to pay ISTCs in accordance with contracts that had been negotiated by the Department of Health centrally. Mr Phoenix said that he was enthusiastic to re-negotiate the terms of the contract with the ISTC that had opened in Maidstone. Ms Dinwoodie said that the Will Adams ISTC in Gillingham was receiving a guaranteed income of £4 million a year from Medway PCT, and Eastern

and Coastal Kent PCT under the terms of the ISTC's contract. The Centre was currently operating at 78% of capacity, and the fixed payment contract was a very strong incentive for her PCT to try and make as much use of the Centre as possible. She said that the Department of Health would be working on the issues of case-mix and pre-assessment of patients by ISTCs, in order to try and prevent the Centres from "cream-skimming" by excluding those patients they were reluctant to accept.

Choose & Book/Single-handed Surgeries/IT

(17) Mrs Angell asked: about recruitment and retention of primary-care staff; about the high proportion of single-handed GP practices in Medway; how doctors could find the time during consultations to use the Choose & Book system; and whether the Minor Injuries Unit at Gravesham Community Hospital was being removed to the Darent Valley Hospital. Mr Phoenix responded that 'Agenda for Change' had addressed recruitment and retention in the NHS; and work was being done on the primary-care workforce. Marion Dinwoodie confirmed that 37 out of 64 GPs in the Medway Towns were single-handed practitioners. She said practice-based commissioning was energising GPs and encouraging them to work together. Mrs Angell also asked whether limitations in information technology were preventing people accessing a national Choice menu. Mr Phoenix said that there was currently a restricted choice of provider, but there would in due course be full choice of any provider, anywhere in the country – the extent of the choice on offer was a matter of national policy and had nothing to do with IT issues.

Accountability of Foundation Trusts/Competence of Primary Care Trusts to commission

(18) In response to several questions from Mr Daley, Mr Phoenix said that the establishment of Foundation Trusts within the NHS was a national policy. Foundation Trusts were within the 'NHS family' but were legally distinct entities and not owned by the Secretary of State for Health, as ordinary Trusts were. Monitor had been set up by the government to hold Foundation Trusts to account financially. With regard to the claim that PCTs lacked the capability to commission effectively, Mr Phoenix said that was a matter of opinion. The former structure of PCTs had not been considered appropriate – hence the new PCTs had been created. He did not think that PCTs would be done away with in the next two or three years. They would continue to be commissioning bodies, although they might take on new forms in future. What happened would depend on the success of practice-based commissioning. It was possible that there would be no change in the NHS for another four or five years – although such a period of stability was not something he had ever seen before in his 27 years in the NHS.

RESOLVED that the Primary Care Trusts be thanked for their presentations on their Commissioning Plans.

9. Commissioning Homeopathy - West Kent Primary Care Trust

(Item 5 – Julia Ross, Director of Civic Engagement West Kent Primary Care Trust was in attendance for this item)

(1) The Committee had before them the proposals (tabled at the meeting) for a review process around Commissioning Homeopathy. The Committee noted that, in 2006, the South West Kent and Maidstone Weald PCTs had undertaken a formal

turnaround process. The nature of turnaround was such that every possible area of savings – both efficiency improvements and the review of service provision – had to be considered.

(2) The Turnaround Plan had identified a number of service areas for review – of which one was homeopathy. The Primary Care Trusts had initially proposed to direct all referrals for homeopathic therapy through a Treatment Panel, so that each case could be considered on the basis of clinical need before the referral went ahead. This proposal, however, had caused concern among some stakeholders and it had, therefore, been agreed to conduct a review of the demand for homeopathic services and the cost-benefit of such treatment. The Committee noted that the Tunbridge Wells Homeopathic Hospital was one of only five such hospitals run by the NHS.

(3) Mrs Ross stated that the review was not about closing the Homeopathic Hospital, it was about reviewing and establishing the demand for homeopathic services and whether the cost-benefit of such treatments was appropriate for provision from NHS funds. The review process would include four distinct stages:-

1. a review of existing activity and spending on homeopathic services;
2. an external review and evaluation of the evidence for homeopathy;
3. a discussion phase, where both reviews were shared and discussed amongst the stakeholders, options presented and developed, and decision-making criteria agreed in conjunction with the PCT Board; and
4. the decision-making process, where the PCT Board would apply weight, and score by the agreed criteria.

(4) The Committee noted that a reference group of key stakeholders had been established and that Paul Wickenden was the representative for the NHS Overview and Scrutiny Committee on this reference group. The first meeting of the reference group was to take place on 13th February 2007.

(5) Mrs Ross said that the review might come up with a range of options. She hoped that a decision by the PCT Board would be taken in April. The issues around the homeopathy review were particularly sensitive. There were polarised opinions as to both the effectiveness of treatments and the use of NHS funding for providing the service.

(6) The Committee noted that there were 400 referrals to the Homeopathic Hospital from West Kent PCT each year. This was a very small part of the commissioning done by the PCT, but it was important that the PCT looked at every service that it commissioned.

(7) The Committee noted that the reference group included individuals who came from both sides of the debate on homeopathy, in order to ensure balance.

RESOLVED that the position be noted.

10. NHS Overview and Scrutiny Committee - Work Programme Update *(Item 6 – report by Paul Wickenden, Overview and Scrutiny Manager)*

(1) The Overview and Scrutiny Manager reported on the potential work programme for the next two meetings of the Committee, based on approaches made to the Chairman and Spokesmen of the Committee or direct to him.

Maidstone & Tunbridge Wells NHS Trust – a new direction for surgical and orthopaedic care

(2) Following the decision of the Committee on 12 January 2007, all the evidence had been re-examined and a meeting had taken place with the Chairman, Vice Chairman and Liberal Democrat Spokesman of the Committee to agree the reasons underlying the Committee's decision. The Committee were invited to endorse the action which had been taken retrospectively by the Overview and Scrutiny Manager, with the approval of the Chairman, Vice Chairman and Liberal Democrat Spokesman of the Committee.

(3) The reasons for opposing the proposals, as agreed by the Chairman, Vice Chairman and Liberal Democrat Spokesman, had been sent to Mr Phoenix, Chief Executive of West Kent Primary Care Trust and Ms Gibb, Chief Executive of Maidstone & Tunbridge Wells NHS Trust (see Appendix 1).

(4) Members were reminded that the Committee had the power to refer matters to the Secretary of State for Health on grounds of inadequate consultation, or on the basis that what was proposed was not in the interests of health services in Kent. However, this right of referral was only to be exercised as a last resort, once all avenues of possibility to resolve the matter locally been exhausted.

Meeting – 9 March 2007

(5) Issues emerging for potential inclusion on the NHS Overview and Scrutiny Committee's agenda for the meeting on 9 March 2007 were:-

- services provided for residents of north west Kent at the Gravesham Community Hospital, and the removal of some of these to the Darent Valley Hospital; and
- Audiology Services, which the Committee had discussed at its meeting in January 2006 and agreed to review in a year's time.

(6) Other concerns had been raised relating to cancer services at the Kent and Canterbury Hospital and the proposed development of a polyclinic at Whitstable. The Committee were asked to consider whether they would want to hold one meeting split between two locations – with the first half in north west Kent and the second half in east Kent.

(7) The Committee concluded that it would be far more appropriate to have two separate meetings, one each to deal with the east Kent issues and the north west Kent ones.

Healthcare Commission Core Standards

(8) The Committee considered whether it wished to make a submission in the spring for the Healthcare Commission's annual healthcheck. Each NHS Body was required to submit its self-assessment to the Healthcare Commission by 1 May 2007.

(9) Three types of body had the opportunity to add a commentary to these self-assessments against the Healthcare Commission Core Standards, namely NHS Overview and Scrutiny Committees, Patient and Public Involvement Fora and Strategic Health Authorities.

(10) The Committee agreed that it would be useful to collate throughout the year evidence that it might wish to submit to the Healthcare Commission, so that compiling a submission in the spring was not too onerous a task. The Committee noted that a new set of Healthcare Commission Core Standards was being piloted in 2007 and would be introduced in 2008.

(11) Considerable discussion took place around the idea of “enhanced two-tier working” between county councils and borough/district councils. Other aspects of the Local Government and Public Involvement in Health Bill (which was currently before Parliament) were also discussed, including Community Calls for Action. The Committee agreed that it would be useful to look at the structure of the NHS Overview and Scrutiny Committee, with a view to the Committee operating in future more at a strategic level, while devolving more local issues to borough/district authorities and other partners. The Committee noted that protocols had already been agreed by the Kent Association of Local Authorities in 2001 regarding the delegation of more local-level issues to committees or joint committees of borough/district councils.

(12) It was noted that, under provisions contained in the Bill, the County Council would also acquire the responsibility to establish a Local Involvement Network (LINK), which would replace the Patient and Public Involvement Fora in the county. It was already planned to abolish the Commission for Patient and Public Involvement in Health.

(13) Consideration was also given to the possibility of organising an event for all Members of the County Council to explain the concept of Patient Pathways for accessing health services.

(14) The Committee asked that the provision of mental-health services should also be an item for a discussion at a future meeting.

RESOLVED that:-

- a) the action taken by the Overview and Scrutiny Manager, in consultation with the Chairman, Vice Chairman and Liberal Democrat Spokesman, in taking forward the dialogue with health colleagues following the decision of the Committee on Maidstone & Tunbridge Wells NHS Trust’s consultation on ‘A new direction for surgical and orthopaedic care’, be agreed;
- b) the Work Programme and venues for the next two meetings of the Committee be as set out in the sub-paragraphs above;
- c) the Overview and Scrutiny Manager should continue to work with all stakeholders in looking at the possible devolution of health overview and scrutiny in the key issues to a more local level; and
- d) the Overview and Scrutiny Manager should investigate making arrangements for a seminar for all Members of the County Council on Patient Pathways for accessing health services.