

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th October, 2010

10.00 am

**Council Chamber, Sessions House, County Hall,
Maidstone**





AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th October, 2010, 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

- Conservative (10): Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr K A Ferrin, MBE, Mrs J A Rook, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A T Willicombe
- Labour (1): Mrs E Green
- Liberal Democrat (1): Mr D S Daley
- District/Borough Representatives (4): Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons and Councillor Mrs M Peters
- LINK Representatives (2): Mr M J Fittock and Mr R Kendall

Webcasting Notice

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UNRESTRICTED ITEMS

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

- | Item | Timings |
|--|---------|
| 1. Introduction/Webcasting | |
| 2. Substitutes | |
| 3. Declarations of Interests by Members in items on the Agenda for this meeting. | |

4. Minutes (Pages 1 - 20)
5. Pain Management Services (Pages 21 - 48) 10:00 – 11:20
- Break 11:20 – 11:30
6. South East Coast Ambulance Service - Current Developments (Pages 49 - 92) 11:30 – 12:30
7. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update (Pages 93 - 96) 12:30 – 12:40
8. Forward Work Programme (Pages 97 - 98) 12:40 – 12:45
9. Committee Topic Discussion (Pages 99 - 100) 12:45 – 13:00
10. Date of next programmed meeting – Friday 26 November 2010 @ 10:00am

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

30 September 2010

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

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 3 September 2010.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs J A Rook, Mr C P Smith, Mr R Tolputt, Mr A R Chell (Substitute for Mrs J Whittle), Mrs P A V Stockell (Substitute for Mr A T Willicombe), Cllr J Cunningham, Cllr M Lyons, Mr M J Fittock and Mr R Kendall

ALSO PRESENT: Cllr Ms A Blackmore, Mrs A Burnand, Mrs C Davis, Cllr R Davison, Mr R Kenworthy, Mr J Larcombe, Mr R A Marsh, Miss N Miller and Mr M Willis

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

1. Minutes

(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 23 July 2010 are recorded and that they be signed by the Chairman.

Matters Arising

(2) Further to Minute Number 8 the Chairman apologised that it had not been possible to circulate the letter prepared on behalf of the Committee as resolved at the end of Item 10 before being sent to the Secretary of State for Health. The Committee noted that the letter and reply were included in the Agenda for the meeting.

2. NHS White Paper Equity and Excellence: Liberating the NHS

(Item)

(1) The Chairman indicated that he had asked Tish Gailey, Public Health Policy Manager, to put before Members a summary of the NHS White Paper *Equity and Excellence: Liberating the NHS* (see Appendix 1) along with a copy of one of the related consultation documents, *Local democratic legitimacy in health*. Ms Gailey invited Members to forward any comments on the paper to her to enable them to be incorporated into the response by Kent County Council.

(2) Members thanked Ms Gailey for the information and the opportunity to forward comments.

3. Update on SECamb's Make Ready Programme

(Item 4)

Geoff Catling (Director of Technical Services and Logistics, South East Coast Ambulance Service NHS Trust), Janine Compton (Senior Communications Manager, South East Coast Ambulance Service NHS Trust), Darren Reynolds (Head of Business Development, South East Coast Ambulance Service NHS Trust), and Steve Rose (Senior Operations Manager, South East Coast Ambulance Service NHS Trust) were present for this item.

(1) Representatives of the South East Coast Ambulance Service NHS Trust (SECamb) explained that they were attending to provide an update on the Make Ready Programme, but were happy to answer any questions on any aspects of the organisations activity as there were a number of interesting new developments, such as 'hear and treat', 'see and treat' and a new Computer Aided Despatch system which had gone live in Kent one month previously. The Coxheath Despatch Centre was staying in its current location.

(2) The background to the Make Ready Programme reached back to 1974 when ambulance services transferred from local authorities to the NHS. This meant that ambulance stations were based on local authority estate locations and there was often now room to expand or improve facilities and the locations of them could have an impact on ambulance response times. A range of issues arising from this resulted in an Estates Strategy for SECamb in May 2008 which established the direction for the Make Ready Programme.

(3) SECamb representatives explained the current system was more akin to 'make do' than 'make ready'. Between 40 minutes and 1 hour 15 minutes was often lost from each shift due to ambulances not being fully prepared for the start of each shift, with ambulances often having to go to different locations in order to become fully equipped. Crews were also currently responsible for cleaning their ambulance and a call could often come in during cleaning meaning that an ambulance responded without the cleaning process being completed.

(4) Infection control was stated as one of the main drivers behind the Make Ready Programme. The idea behind Make Ready Depots was that they would be built specifically for the purpose of being somewhere where specially trained staff would clean and prepare the ambulances for the beginning of each shift, freeing up paramedic time. The extended cleaning the ambulances would receive, along with a six-weekly deep clean would dramatically improve infection control. The Care Quality Commission had inspected and approved the programme on two occasions. The intention was also to locate Make Ready Depots near accident and emergency departments in order to clean ambulances after particularly severe incidents and allow ambulance crews to have a break from the event.

(5) Three Make Ready Depots had already been opened, at Chertsey, Hastings and Thanet in Kent. There were plans to open a number of further depots as the Programme was rolled out. The next two planned would also be in Kent, at Paddock Wood and Ashford, both in 2011. The plan was for the one in Ashford to also include a hazardous response unit. One Member of the Committee reported his favourable impressions of the Hastings Depot following a visit.

(6) Locations for ambulance community response posts were also being sought by SECAMB where ambulances would be sited in key positions so as to be able to respond quickly to incidents. Ambulances had in the past often been parked in lay-bys but locations where additional facilities were available were being found, such as Springfield House in Maidstone.

(7) Members had before them colour versions of the maps contained within the Agenda pack and a number of questions were asked clarifying details about the response time around Deal and Birchington. It was explained that there were challenges in reaching the 8 minute target for Category A calls in some areas in East Kent, which was why finding the right locations for response posts was important.

(8) Questions were asked about the ongoing funding for the Programme and it was explained that the funding stream formed part of the Long Term Financial Model as part of SECAMB's bid for Foundation Trust status. Funding for this current year was set, and that included developing depots at Paddock Wood and Ashford.

(9) Future projects, such as developing a depot at Medway Airport, would follow the establishment of SECAMB as a Foundation Trust. Until a new depot location was secured and operational, the ambulance stations in Medway and Dartford would remain.

(10) In answer to questions about the longer term future of the ambulance station in Maidstone, representatives from SECAMB explained that the current station was not fit for purpose and that there would be response posts in Maidstone, but that the Paddock Wood Depot would service the needs of Maidstone. Several Members expressed reservations that the county town may suffer a reduction in access to ambulance services.

(11) Questions were also asked about staff training. It was explained that the nature of training was changing and paramedic education was becoming a graduate profession with specialisms within it. Additional training for maternity transfers was provided in West Sussex work was ongoing with Maidstone and Tunbridge Wells NHS Trust on implementing the appropriate pathway of care.

(12) There were also rigorous training standards set for the company contracted to the staff the Make Ready Depots.

(13) Members were keen to pursue the subject further and in particular requested more information on response times in West Kent. SECAMB were invited to attend the meeting on 8 October and they accepted and expressed a hope that an opportunity for Members to visit the Thanet Make Ready Depot before that date could be arranged.

4. The Future of PCT Provider Services and the Use of Community Hospitals *(Item 5)*

Anne Tidmarsh (Director of Commissioning and Provision, East, Kent Adult Social Services), Ashley Scarff (Head of Business and Corporate Planning, Maidstone and Tunbridge Wells NHS Trust), David Meikle (Acting Chief Executive, NHS Eastern and Coastal Kent), Philip Greenhill (Managing Director, NHS Eastern & Coastal Kent Community Services), Phil Edbrooke (Associate Director of Quality, Performance and

Corporate Development, NHS Eastern & Coastal Kent Community Services), Oena Windibank (Operations Director, NHS Eastern & Coastal Kent Community Services), Paul Duncan (Associate Director of Business Development, NHS Eastern & Coastal Kent Community Services), Alison Davis (Assistant Director of Commissioning, NHS Eastern and Coastal Kent), Ruth Brown (Lead Commissioner for Community Services, NHS Eastern and Coastal Kent), Mark Sheppard (Managing Director, West Kent Community Health), Judy Clabby (Assistant Chief Executive, NHS West Kent), Dr Mike Parks, Medical Secretary, Kent Local Medical Committee), and Ray Fuller were present for this item.

(1) The discussion of this item was divided into two sections, looking at the future of Primary Care Trust (PCT) Provider Services to commence with.

(2) It was explained to the Committee that the broad direction of travel had not changed as a result of the General Election in that the separation of provider and commissioner functions of PCTs would continue. However, PCTs as commissioners were to be abolished.

(3) Representatives of the NHS provided further written information to assist in clarifying the timeline of developments locally (see Appendix 2). Eastern and Coastal Kent Community Services (ECKCS) would become a separate NHS Trust from 1 October 2010. The intention of both PCTs was that West Kent Community Health would separate from NHS West Kent and join with ECKCS and a new organisation called Kent Community Health Trust would be formed on 1 April 2011.

(4) The Business Case for joining together of the two provider services needed to be approved by the Cooperation and Competition Panel and the judgment was expected in December. Even with this, the Kent wide community services organisation was not a foregone conclusion and the views of stakeholders would be sought early next year.

(5) From the perspective of General Practice, the Local Medical Committee (LMC) believed that community services were key to local delivery and hoped that a Kent Trust could be used as a framework within which to further integrate health services and rebuild primary healthcare teams and allow for community healthcare staff to move back into surgeries. However, many surgeries were not fit for purpose and would need improvements to deliver more services. The LMC have been involved in the discussions over the Kent wide Trust and were relieved that vertical integration with the Acute Trusts in Kent was not the favoured option in Kent.

(6) Concern was expressed by Members that a Kent wide Trust may miss the local dimension, particularly when contrasted with GPs who were localised.

(7) Mr Greenhill from ECKCS explained that his organisation was currently the fifth largest provider of community services in the country and that more needed to be done to develop local structures but that work was being done to integrate community teams in a geographical area.

(8) Mr Sheppard from West Kent Community Health (WKCH) explained that this was also the case in West Kent. His organisation was smaller than the one in East Kent and merging with it would enable it to be regarded equally with the Acute Trusts.

The Invicta Practice Based Commissioning Cluster in West Kent was heavily involved in developing services locally.

(9) There were differences between the two community service providers in where services had traditionally been based, and this partly explained why ECKCS had more staff than WKCH. Other reasons include the fact that ECKCS also provides services in Medway along with some services which are delivered in West Kent by Acute Trusts.

(10) As a result of staff consultation, community paediatric services in West Kent were to be vertically integrated with Maidstone and Tunbridge Wells NHS Trust and Dartford and Gravesham NHS Trust.

(11) Speaking on behalf of Kent Adult Social Services, Anne Tidmarsh welcomed the idea of a Kent wide Trust as this would enable the good work which was already happening integrating services to continue in areas such as hospital discharge pathways and a single assessment process so that the same person would not need to be assessed by a nurse and a social worker. KASS would also continue to work with the Acute sector, particularly in the light of the increased responsibility of Acute Trusts over hospital discharges.

(12) As a representative of the Acute Sector, Ashley Scarff noted that he recognised the importance of the community services sector and that it was important not to become too focussed on organisational form.

(13) Members felt that the publication of the NHS White Paper raised a number of questions about how community services, and a Kent wide Trust in particular, would fit in with the move to transfer responsibility for commissioner NHS services to GPs. The forthcoming publication of the Public Health White Paper would give further details of the developing shape of how the NHS and local authorities would fit together, with responsibility for this aspect likely to go to local authorities and that this would include health visitors.

(14) The Committee requested that this subject be returned to at a later date and representatives from the NHS suggested early in 2011 would be timely.

(15) The Committee then turned its attention to the use of Community Hospitals. As an overview it was explained that in East Kent there were 175 beds across 6 community hospitals and in West Kent 130 beds across 6 community hospitals. They all provided different services and were spread unequally across Kent. They were seen as central to how the health economy operated in both halves of the county.

(16) In West Kent there was joint commissioning with the local authority for integrated care and services at the hospitals were being developed to enable a wider range of patients to access care as, for example, through changing the admissions criteria so that patients with longer rehabilitation needs than the current 6-8 weeks would be able to be cared for. Community hospitals were looked at as part of the whole rehabilitation pathway as accessing these beds would free up beds in Acute hospitals. Mental health patients were not included in the new criteria as they were not properly resourced for this group of patients.

(17) It was reported that similar developments were happening in East Kent. The community hospital setting was seen as beneficial for patients, particularly where it enabled them to be closer to friends and relatives.

(18) In response to questions from Members who felt that 1 Kent wide Trust would mean the local dimension was missing, representatives of the NHS responded that the same principles would apply in developing services whether or not the merger happened as the locality model was important. Likewise, restrictions like the location of the hospitals and the state of the Estate would still exist. Gravesham Community Hospital was the only new state of the art facility out of the 12 across Kent.

(19) Dr Mike Parks of the Local Medical Committee reported that the GPs largely agreed and felt that community hospitals could, and did, do more than provide inpatient services. They had a key role to play in diagnostics, out of hours care and other outpatient services. GP commissioners will be looking for community hospitals to do more and will be looking for GP and District Nurse admitting rights. Dr Parks also reminded the Committee that GP commissioners would be able to choose from 'any willing provider' and that the potential increase in choice between providers could be a positive thing.

(20) Anne Tidmarsh reported that Kent Adult Social Services already worked closely with the community hospitals on integrating care pathways, but that the choice of discharging people from hospital to either their home, intermediate care or a community hospital should be based on clinical need.

(21) In response to a specific question about the lack of a community hospital in Maidstone, Mr Sheppard reported that the Kent and Medway Partnership Trust (KMPT) property at Heathside had been considered, but that this was being developed for use by children's and adolescent mental health services. There were currently ongoing discussions with Kent Adult Social Services over a possible development of the Dorothy Lucy Centre.

(22) Following a question about paediatric audiology services which had been moved from Preston Hall to other community hospitals around Kent, Mr Sheppard reported that pending agreement of a Service Level Agreement, the service would be provided in Maidstone general hospital from July 2011 and that a limited home visiting service would be available in the interim.

(23) On behalf of the League of Friends of Tonbridge Cottage Hospital, and more broadly other Leagues of Friends in West Kent, Mr Fuller explained that the current West Kent Community Health organisation was very well regarded, and this was the sixth Trust the hospital had been under in ten years. However, if this organisation could not continue, he favoured vertical integration as most of the community hospital's business came from step down beds.

(24) With or without vertical integration, Ashley Scarff reported that community hospital beds were viewed as essential for acute services and the business case for the Pembury PFI relied on the presence of community hospital beds for step down purposes.

(25) Members felt they needed further information on the alternatives to a Kent wide Trust and how community hospitals would fit into the developing NHS and so once more asked that an opportunity be found to return to this subject early in 2011.

5. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update

(Item 6)

(1) It was reported to Members that a letter had been received from the Highways Agency explaining that little could be done to improve the A21 at present and that a response from the Cabinet Member for Environment Highways and Waste on the A228 was expected.

(2) Members had before them information on the engagement events which had and were being carried out by NHS West Kent in relation to Women's and Children's Services and Maidstone and Tunbridge Wells NHS Trust. Mr Cooke asked that it be noted that the listed focus groups were by invitation only and at ones he had observed only 1 person had attended. The view was expressed that this cast doubt on the level of public engagement being carried out by the NHS.

(3) The attention of Members was drawn to the public meeting being held on Women's and Children's Services and Maidstone and Tunbridge Wells NHS Trust on 9 October. HOSC Members were also welcome to attend the Co-design Stakeholder Event at the Hop farm on 22 September. Clarification over the Co-design event was being sought from the NHS.

(4) RESOLVED that the Committee receive the report and note the additional meeting of the Committee on Monday, 20 September 2010.

6. Forward Work Programme

(Item 7)

Members agreed the Forward Work Programme with the addition of the SECamb Make Ready Programme item returning on 8 October and a suitable opportunity for returning to the Future of PCT Provider Hospitals and the use of Community Hospitals be found in early 2011.

7. Committee Topic Discussion

(Item 8)

(1) Members expressed their satisfaction that both the main items would be returned to.

(2) It was suggested that a full meeting be given over to discussing the Public Health White Paper. As it had a potential impact on the whole of Kent County Council, the Overview, Scrutiny and Localism Manager suggested that this may be an issue that the Scrutiny Board could consider.

8. Date of next programmed meeting – Friday 8 October 2010 @ 10:00am

(Item 9)

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EQUITY AND EXCELLENCE – Liberating the NHS

On 12th July, Andrew Lansley, Secretary of State for Health published the white paper “Equity and Excellence: Liberating the NHS” which sets out their vision for the future of the NHS.

The headline news is:

1. The abolition of Primary Care Trusts and the Strategic Health Authorities in favour of a national NHS commissioning Board, GP Commissioning Consortia and greater democratic involvement
2. A new Public Health Service, separate from the NHS will be created – a white paper is due to be published in the autumn
3. All NHS Trusts to become Foundation Trusts
4. A strengthening of democratic legitimacy through an enhanced role for Local Authorities in overseeing and influencing health and social care

Four more “daughter” consultation papers have since been published: Local Democratic legitimacy in health; Commissioning for patients, Regulating healthcare providers and Transparency in outcomes.

The first of these papers – Local democratic will be of particular interest to HOSC Members as it sets out proposals for a change in health scrutiny arrangements through a local Health and Wellbeing Board (or similar partnership group) and the setting up of a local and national HealthWatch.

LOCAL HEALTH AND WELLBEING BOARDS. The Health and Wellbeing Boards will give Local Authorities “influence” over NHS Commissioning and “corresponding influence” for NHS Commissioners in relation to public health and social care. GP Consortia will become the lead health commissioners with a new National NHS Commissioning Board that will oversee the GP Consortia and directly commission some services.

Local Authorities new functions will be:

1. to assess the needs of the local population and lead the statutory joint strategic needs assessment
2. to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
3. to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense
4. to undertake a scrutiny role in relation to major service redesign. **This would replace the current statutory functions of the health overview and scrutiny committee.** It is likely to be up to individual authorities to determine how and where the residual functions of scrutiny will be managed

HEALTHWATCH, LINKS AND ADDITIONAL FUNCTIONS. It is proposed that each local authority will commission and set up their own Local HealthWatch that will incorporate

1. the functions currently carried out by LINKs around patient and public involvement and the right to visit provider services
2. a citizens advice bureau for health and social care providing a signposting function to health and social care organisations
3. a complaints advocacy service
4. a role in scrutiny

It has not yet been made clear which organisation(s) will manage health complaints services.

CONSULTATION RESPONSE

KCC like all organisations involved in health and social care are invited to respond to this consultation. I have been asked to manage the consultation response to the Democratic legitimacy paper and am keen to collect the views of HOSC Members. The paper can be found on the Department of Health website (hard copies are available or I can email out copies)

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117586

The paper contains a list of questions to which the DH would particularly like to receive views. In addition to these specific questions, there may be other points that you would like to be made. KCC will also be answering the "unasked" questions so any other views you care to give will help us provide a comprehensive response. If Members wish to comment on any of the other consultation papers, I would be happy to receive these as well.

The officers leading on the Equity and excellence response have been asked to prepare an overview of the opinions KCC will offering ready for a meeting of Cabinet, CMT and NHS Chief Executives on September 20th 2010. I would be grateful if Members intending to respond could do so by 15th September which will allow me time to collate individual responses and prepare the report. Responses should preferably be emailed to me <mailto:tish.gailey@kent.gov.uk> or I can take hard copy responses – please send to Tish Gailey, Room 3.23, Sessions House, County Hall, County Road, Maidstone, Kent, ME14 1XQ

I am very happy to answer any questions about the papers. Please either email me at the above address or telephone me on 01622 696802.

Tish Gailey, Health Policy Manager, KCC Public Health Department

Summary Note for Health Overview and Scrutiny Committee – 3 September 2010

Transition Timeline

1 October 2010

Eastern and Coastal Kent Community Services become a Trust, separate from the PCT

October 2010 – March 2011

Separation of West Kent Community Health (WKCH) from West Kent PCT.
Business Case for integration of WKCH with Eastern and Coastal Kent produced
Engagement with Stakeholders. Cooperation and Competition Panel assess Business Case

1 April 2011

WKCH integrate into Eastern and Coastal Kent Community Health Trust
Name change to Kent Community Health Trust

April 2011 – December 2012 (indicative)

Application to SHA, Secretary of State and Monitor for Foundation Trust status

September 2011 – December 2011 (indicative)

12 Week Public Consultation on the move to Foundation Trust Status

Services managed by Eastern and Coastal Kent Community Services and West Kent Community Health

Community Services that are broadly similar across Kent include:

- Community Nursing
- Community Hospital Inpatient and Outpatient Services
- Intermediate Care
- Specialist Nursing and Community Matrons
- Dietetics
- Health Visiting and School Nursing
- Adult Speech and Language
- Outpatient Physiotherapy
- Equipment and Wheelchair Services
- Podiatry
- Sexual Health
- Childrens Community Nursing
- Walk in Centre and Minor Injury Units

There are some services that are specific to the Eastern and Coastal Kent (ECK) area and the West Kent (WK) area including Chronic Pain and Orthopaedics in ECK and the Children's Hearing Service and Community Paediatrics in WK. The similarities and differences are being mapped and understood during this transition period.

Property and Community Hospitals

Current national policy around ownership of PCT property means that both PCTs will retain the property they own. It will not transfer to the new Community Health Trust. This includes Community Hospitals and means that the maintenance and estate management of the hospitals will be the responsibility of the PCT. The Department of Health (following the election) are currently reviewing this decision at a national level and it is likely we will know the outcome of this by April 2011. If nationally it is decided property can be moved from PCTs to providers then property may move (at a later date) to the new Trust. Either way, the new Community Health Trust will be responsible for many (but not all) of the clinical services that run out of those community hospitals. This includes the management and quality and safety of inpatient bed services on a day-to-day basis.

Services run by other providers within those Community Hospitals include hospital Trusts, the Partnership Trust and local GPs and will remain the responsibility of those individual providers.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Monday, 20 September 2010.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mrs J Whittle, Mr A T Willicombe, Cllr J Cunningham, Cllr M Lyons, Mr A R Chell (Substitute for Mrs J A Rook), Cllr Ms A Blackmore (Substitute for Cllr Mrs M Peters) and Mrs P A V Stockell (Substitute for Mr R Tolputt)

ALSO PRESENT: Mr M Cayzer, Ms Davies, Cllr R Davison, Mr D Fowle, Ms T Gailey, Mr R Kenworthy, Mr R A Marsh, Miss N Miller and Mr M Willis

IN ATTENDANCE: Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

1. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust *(Item 4)*

1 (1) The Committee had before them a report which set out for the Committees information the ongoing events/dialogue on the implementation of the Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust.

(2) The report set out for the consideration of the Committee commentary on the stakeholder events. The reports concluded that the majority of the points of referral made by the Committee to the former Secretary of State for Health Andy Burnham remained unresolved through the process the new Secretary of State Andrew Lansley CBE had set in motion when responding to the Committee on 1 July 2010.

(3) Likewise the Committee concluded that the four additional tests on which this reconfiguration was to be adjudged:-

- (a) Support from GP commissioners;
- (b) Strengthened public and patient engagement;
- (c) Clarity on the clinical evidence base; and
- (d) Consistency with current and prospective patient choice

could not be met - in particular support from the GP commissioners and strengthened public and patient engagement.

(4) Members of the Committee welcomed the opportunity they had been afforded to attend all the stakeholder events and noted the importance the co-design group at the Hop Farm on 22 September 2010 which they viewed as significant in terms of the preparation of the report from Mr Lansley by the Strategic Health Authority.

(5) Tabled at the meeting was a letter the Chairman of the Committee had received from Mr N Chard the Cabinet Member for Environment Highways and Waste regarding the A228 link between Maidstone Hospital and Pembury Hospital; a letter from Julia Ross Director of Strategy and Communications for NHS West Kent who had been conducting the stakeholder events on behalf of the South East Coast Strategic Health Authority requesting that the contents of her letter in which she stated that the report before the Committee was not entirely factually correct should be taken into account, and a letter the Chairman had written to Guy Boersma, Director of Commissioning and System Development who was preparing the report for Mr Lansley asking that the report before the Committee and this minute is appended to the report unaltered and an embargoed copy of the report be made available to the Chairman prior to publication (see Appendix 1 to these Minutes).

(6) During the debate the majority of Members spoke with passion about the opportunity of retaining Women's and Children's Service at Maidstone Hospital as it looked unlikely that the four additional tests set by Mr Lansley and in particular (a) support from GP commissioners would be met.

(7) One Member felt strongly that whilst it was right for the Committee to support the residents of Maidstone and the surrounding area he had some difficulty in supporting the conclusion of the Chairman's report as on two occasions in 2005 (a Joint Select Committee) and earlier this year the Task and Finish Group (and subsequently the Committee) had approved and endorsed the reconfiguration of Women's and Children's Services for Maidstone and Tunbridge Wells NHS Trust. The Chairman invited Mr Wickenden to confirm that this was factually correct. Mr Wickenden confirmed that it was and drew the Members attention to the provision within the Constitution that the Council and Committee could not rescind a decision taken in the previous six months. The six months had just expired. Mr Wickenden also advised that circumstances had changed as Mr Lansley in his letter of 1 July had invited to stakeholders to endeavour to reach local resolution on the points of referral made by the Committee as well as applying the four additional tests – which were entirely new – therefore the situation had changed significantly. The Committee agreed that it was right and proper that the item was before the Committee as the Committee had been invited by the Secretary of State Mr Lansley to participate in the process and it was the Committees referral issues which were being addressed.

(8) One Member referred to some independent research statistics/indicces which demonstrated the make up and needs of the population which look to Maidstone Hospital for their services and the population which will look to Pembury Hospital for their Services (this information on deprivation is available at www.kent.gov.uk/research).

(9) The Committee noted that for the general public the meeting at Maidstone Leisure Centre on 9 September 2010 represented the sole general public event to date. At the conclusion of this meeting there was overwhelming support for the retention of consultant led Women's and Children's Services at Maidstone Hospital.

(10) Mrs Stockell informed the Committee that Maidstone Borough Councils Partnerships and Well Being External Scrutiny Committee which she chaired had at their meeting on 17 September 2010 resolved:-

.... (a) It believes it is in the best interests of the residents of Maidstone and the surrounding area, that consultant-led Women's and Children's Services should remain at Maidstone Hospital; and

(b) It asks that the Secretary of State for Health takes the decision on the reconfiguration proposals as soon as possible and concludes, in the best interests of the people of Maidstone and the surrounding area, that Maidstone Hospital should retain consultant-led Women's and Children's Services.

(11) Having taken into account all the evidence made available to the Committee and observed since Mr Lansley's process was put into place on 1 July 2010 the Committee concluded that achieving local resolution to the points of referral made to the Secretary of State for Health by the Committee on 24 February 2010 had not proved possible and opposition to the proposals and the impact on the provision of Women's and Children's services at Maidstone Hospital had continued to grow.

(12) The Committee considered very carefully the four new criteria which the Secretary of State for Health had asked to be addressed (see sub-paragraph (3) above). The Committee has taken into account the views of the GP commissioners in the Maidstone area who are overwhelmingly opposed to the removal of a consultant led maternity and paediatric service at Maidstone Hospital.

(13) Many of the original points of referral by the Committee remain unresolved and it was the Committee's view could not be resolved locally. For these reasons and recognising that there was still ten days remaining before the report was required by the Secretary of State for Health the Chairman moved from the chair seconded by Mrs Stockell: that

“(a) this report and the minute of this meeting are included as an unaltered addendum to the report the South East Coast Strategic Health Authority is preparing for the Secretary of State for Health;

(b) in a separate letter to the Secretary of State for Health the Chairman will request that he instigates a full review of this reconfiguration by the Independent Reconfiguration Panel or takes the decision himself to resolve the issue for the residents of Kent and in particular Maidstone and the surrounding area; and

(c) this Committee (which serves all the residents of Kent) support the residents of Maidstone and the surrounding area for the retention of consultant led Women's and Children's Services at Maidstone Hospital and asks that a decision is taken as soon as possible in the best interest of the people of Kent.”

Carried - 12 votes for- 0 votes against and 3 abstentions

(14) RESOLVED:- That

(a) this report and the minute of this meeting are included as an unaltered addendum to the report the South East Coast Strategic Health Authority is preparing for the Secretary of State for Health;

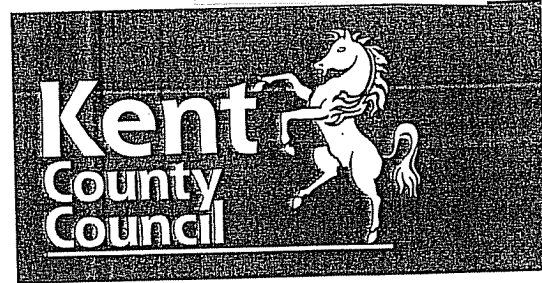
(b) in a separate letter to the Secretary of State for Health the Chairman will request that he instigates a full review of this reconfiguration by the Independent Reconfiguration Panel or takes the decision himself to resolve the issue for the residents of Kent and in particular Maidstone and the surrounding area; and

(c) this Committee (which serves all the residents of Kent) support the residents of Maidstone and the surrounding area for the retention of consultant led Women's and Children's Services at Maidstone Hospital and asks that a decision is taken as soon as possible in the best interest of the people of Kent.

2. Date of next programmed meeting – Friday 8 October 2010 @ 10:00am

(Item 5)

Godfrey Horne MBE
 Chairman: Health Overview & Scrutiny Committee
 Member for Tonbridge
 44 Royal Avenue, Tonbridge, Kent TN9 2DB



Mr Guy Boersma
 Director of Commissioning & System Development
 NHS South East Coast
 York House
 18-20 Massetts Road
 Horley
 Surrey RH6 7DE

Members' Suite
 Sessions House
 County Hall
 Maidstone
 Kent ME14 1XQ
 Tel: 01622 694434
 Fax: 01622 694212
 E-mail: members.desk@kent.gov.uk

16 September 2010

Dear Guy

Thank you for your letter dated 13 September.

I have a few / amendments I would like to see incorporated in the report.

- (1) The engagement of staff within the Trust. It is clear to me that this is still an issue within the Trust. Glen Douglas acknowledged at the public meeting on 9 September that he would undertake an independent piece of work where staff were encouraged to say what they want totally unfettered without any fear of retribution (which he says has always been the case under his leadership).
- (2) Not sure what you intend to cover in the report when you say issues around travel times and MITIGATION strategies. I am interested in the mitigation strategies as transport and travel times and accessibility from Maidstone and its surrounding hinterland to Pembury is a real issue (see Health in equalities).
- (3) I do not see anything here about the readiness of the Trust?

My Committee on Monday will receive a report which I will let you have as soon as it is published. Can you confirm in writing please that this report and the draft minute of the Committee is an addendum to the report you are preparing for the Secretary of State

Finally, I would appreciate as the Chairman of the Health Overview and Scrutiny Committee an embargoed copy of the report so that I am fully aware of its content at the time of publication. You will appreciate that this report has been requested by Mr Lansley on the strength of my Committees referral.

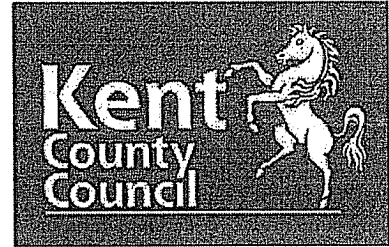
I look forward to hearing from you.

Yours sincerely

Paul D. Wickenden

Godfrey Horne MBE
 Chairman
 Health Overview & Scrutiny Committee

Nick Chard
Cabinet Member for Environment, Highways & Waste



Mr Godfrey Horne
Chairman of the Health Overview
& Scrutiny Committee
Kent County Council
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Tel: 01622 694434
Fax: 01622 694212
E-mail: members.desk@kent.gov.uk
Our Ref:
Date: 17 September 2010

Dear Godfrey

Colts Hill – Highways update

Please find below an update on highways improvements in Colts Hill.

Our consultants Jacobs were commissioned to undertake a route safety study of the A228 through Colts Hill. As a result of this a number of safety improvements have recently been implemented.

This work has included central red high friction surfacing on the approaches to the Redwings Lane junction with improved new centre line markings to highlight the presence and hazards associated with this junction. The definition and signing of bends in this locality has also been improved to minimise the risk of loss of control crashes.

Overhanging vegetation has been removed and additional verge marker posts have also been installed to improve the edge of carriageway definition.

Further works to be completed shortly include "cats eye" replacement and visibility improvements at the Whetsted Lane junction. Jacobs are also designing interactive signing on the Alders Road and the Crittenden Lane junction as part of phase 2 crash remedial works.

Yours sincerely

Nick Chard



West Kent

Wharf House
Medway Wharf Road
Tonbridge
Kent
TN9 1RE

By e-mail
Cllr Godfrey Horne
Health Overview & Scrutiny Committee Chairman
Kent County Council

Direct Dial Number: 01732 375276

Fax: 01732 362525

cc: Paul Wickenden, Guy Boersma

20 September 2010

Dear Godfrey,

Thank you for sending me the draft HOSC paper on the reconfiguration of women and children's services authored by Paul Wickenden, which I received on Friday. I note that the NHS has not been invited to submit a progress report to the HOSC ahead of today's meeting and neither is it 'required' to attend. I would therefore like to raise some issues relating to the content of the report, which I should be grateful if the Committee would consider in its discussions.

The paper notes that most of the issues raised in the HOSC's referral have not been resolved. I agree that to date, these matters have mostly not been resolved and indeed with Paul's opinion (stated in point 4 on page 5) that they 'frankly cannot be resolved locally' whilst there is ambiguity as to whether the changes are to go ahead or not. This is not solely the responsibility of the NHS but relates also to the willingness of key stakeholders to engage in consideration of issues in relation to implementation when they believe there is still a chance that the Secretary of State will rule that the changes cannot go ahead. This position has been explicitly stated to the NHS on a number of occasions in both public and private meetings.

Nevertheless the purpose of the meeting on the 22nd, to which the Committee has been invited, is to begin to consider how each of these issues can be addressed in implementing the changes. As you know the NHS has worked hard over the months since the Secretary of State's instructions to gather in detail the range of views and concerns around these areas. It would seem to pre-empt the process which is in train to suggest that no progress has been made towards addressing these concerns. I am disappointed therefore that the paper does not appear to have taken into consideration or acknowledged the ongoing work to look very seriously at the matters your Committee highlighted.

In particular, the paper states that when it comes to engagement, 'the surface has barely been scratched'. This assessment is equally disappointing. A considerable amount of work has gone into engaging on the implementation since the beginning of July over what we all acknowledge to be a difficult period with summer holidays a key feature. Despite this we have been successful in engaging a range of people in a

Chairman: David Griffiths Chief Executive: Steve Phoenix



number of settings including 13 focus groups, 36 telephone interviews, eight meetings with GP practices, two discussion meetings for clinicians and three meetings with Maidstone Borough Council. Indeed, at the meeting of Maidstone Borough Council's Overview & Scrutiny Committee on Friday evening, both councillors and the Chairman of MASH commented on the success the NHS has had in engaging with a range of audiences. At the beginning of the process I discussed with you how the HOSC itself wished to engage and your view was that as a Committee you had completed your work but individual members may wish to be involved in the engagement process and should be invited to do so. We have therefore invited members at each stage, through yourself and Paul Wickenden.

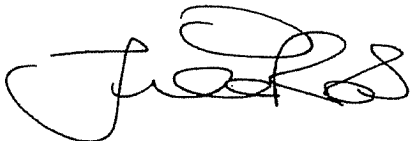
There is no doubt that we would like to have more and deeper engagement and I would hope that once a definitive position is agreed in everyone's perception people will be more willing and open to work on the key issues. In the meantime I'm pleased to say that we have 50 participants booked to join the co-design event on Wednesday, and from a range of backgrounds.

I note that the paper repeats the suggestion made at your meeting on 3 September that the NHS engagement process has not been open to everyone. I wish to restate that this is absolutely not the case. We have widely publicised how local people can get involved and have their say, through a range of publications, the media, Trust and PCT websites and through materials we distributed at the public meeting on 9 September. We have used an independent facilitator to gather views, concerns and suggestions and have not refused anyone who has approached us wishing to take part. In addition, Kent Messenger newspaper agreed to run a campaign for readers to submit their questions for the NHS to answer; we continue to work with the newspaper on this campaign.

Finally, I would like to emphasise that we are all on the same side in wishing to engage key stakeholders. I trust that once this phase has been concluded, your Committee and its Members will both engage positively themselves and support the NHS in reaching a much wider audience than has been possible over the last two months.

I would request that the Committee, as a neutral entity, take my letter into consideration, both in your discussions at the meeting today and in the final report you submit to the SHA.

Yours sincerely,



Julia Ross
Director of Strategy & Communications

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 8 October 2010

Subject: Intended Outcomes: Pain Management Services.

1. Background

- (1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.
- (2) This paper is intended to be a way to progress towards achieving these twin aims. The questions in Section 2 are the ones submitted to invitees in advance of the meeting.

2. Questions

- (1) To NHS Eastern and Coastal Kent and NHS West Kent:
 1. How high a priority is the development of chronic pain services within your health economy?
 2. What are the main challenges in delivering effective pain services within your health economy?
 3. What assessment has been made about the numbers of people suffering from chronic pain in Kent?
 4. What pain services are currently available within Kent in:
 - a. Primary and community care settings?
 - b. Secondary care?
 5. How many people access pain services, including tertiary, outside of Kent?
 6. What services are available to assist patients with the psychological aspects of pain?
 7. What facilities are there for assisting patients in managing their own condition?
 8. Are there any plans to develop or change any of the services currently available?

Item 5 – Intended Outcomes

9. Specifically, is there a date agreed for the re-opening of a Pain Clinic in Maidstone?
 10. The Chief Medical Officers Annual Report 2008 contained 8 recommendations relating to pain services. Has any formal response to these recommendations been made by your PCT and has any work been carried out locally to action any of the recommendations?
- (2) To the LINK:
1. What information has the Kent LINK received concerning the provision of pain services in Kent?
 2. Has the Kent LINK been involved in any work with the NHS in developing pain services?
- (3) To the Kent Local Medical Committee:
1. What are the main challenges in delivering effective pain services within Kent?

3. Recommendations

- (a) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 8 October 2010

Subject: Pain Management Services

1. Key Definitions

(a) One commonly used definition of pain is that produced by The International Association for the Study of Pain:

1. “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage....

Pain is always subjective. Each individual learns the application of the word through experiences related to injury in early life”.¹

(b) Chronic pain is further defined as:

1. “Pain that persists or recurs for more than three months.”²

(c) A common source of pain is musculoskeletal such as back pain and arthritis, but there are others such as headache, angina and neuropathic pain. About 5-10% of people will have chronic pain with no formal diagnosis³.

(d) The definitions of the following two types of pain have been produced by NHS Quality Improvement Scotland⁴:

1. “**Nociceptive pain (tissue damage pain)** arises from mechanical, chemical or thermal stimulation of nociceptors (eg after surgery, trauma or associated with degenerative processes such as osteoarthritis). It is important to realise that pain may persist long after the nociceptive process has ended and that other factors e.g. psychosocial features may need to be considered.”
2. “**Neuropathic pain (nerve damage pain)** is initiated or caused by a primary lesion or dysfunction in the nervous system (e.g. in conditions such as diabetic neuropathy or spinal cord injury). It

¹ The International Association for the Study of Pain, http://www.iasp-pain.org/AM/Template.cfm?Section=Pain_Definitions&Template=/CM/HTMLDisplay.cfm&ContentID=1728#Pain

² The International Association for the Study of Pain, http://www.iasp-pain.org/AM/Template.cfm?Section=Home§ion=2004_2005_Right_to_Pain_Relief&template=/CM/ContentDisplay.cfm&ContentFileID=311

³ NHS Quality Improvement Scotland, *Management of chronic pain in adults*, p.xii, http://www.nhshealthquality.org/nhsqis/files/PAINCHRONIC_BPS_FEB06.pdf

⁴ *Ibid.*, p.xiv.

has quite different clinical features from nociceptive pain. It is less well localised and often is described as burning or shooting. It can occur in areas that are numb and where there is no tissue damage.”

3. Table showing types of pain⁵:

Nociceptive (tissue damage) pain	Neuropathic (nerve damage) pain
<ul style="list-style-type: none"> • Well localised • May be more diffuse if visceral structures involved • Sharp • Stabbing • Ache • Gripping <p>Examples of nociceptive pain</p> <ul style="list-style-type: none"> • Arthritis • Trauma • Acute Post Operative 	<ul style="list-style-type: none"> • Persistent • Burning • Paroxysmal/spontaneous • "Electric Shocks" • Pain in the absence of ongoing tissue damage • Allodynia – painful response to stimuli that would not normally cause pain • Hyperalgesia – increased pain in response to pain stimulus • Dysaesthesia – unpleasant abnormal sensations <p>Examples of neuropathic pain</p> <ul style="list-style-type: none"> • Trigeminal neuralgia • Diabetic neuropathy • Post-herpetic neuralgia • Complex regional pain syndromes I & II • Peripheral Neuropathy

2. Recent Policy Developments

(a) Much recent discussion on pain management services refers to the Chief Medical Officer’s Annual Report in 2008⁶. One chapter was specifically devoted to pain and made a number of recommendations. This chapter is included in its entirety as an Appendix to this background note⁷.

⁵ Ibid., p.xiv.

⁶ Chief Medical Officers Report 2008, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206

⁷ Sourced from the Department of Health website, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096233.pdf

- (b) One of the recommended actions asked for the feasibility of a national network of rapid-access pain clinics to be explored. In the United Kingdom, pain clinics have developed since the 1960s when they were often run by “single-handed enthusiasts to the current multi-disciplinary clinics.”⁸ They are generally staffed by pain management specialists (usually anaesthetic-trained) who work alongside professions allied to health and the focus of services tends to be managing symptoms rather than curing pain.
- (c) There are different models of pain-palliative care across the country, including different levels of integration between pain and palliative services.
- (d) Although there are overlaps between palliative care and broader pain management services, they are not the same. For reference, the following definition of palliative care has been taken from the National Institute for Health and Clinical Excellence (NICE):
1. “...the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.”⁹
- (e) One of the key responses to the Chief Medical Officer’s report by the previous Government was to agree funding for a national pain audit. This is being continued by the current Government:
1. “We are maintaining support for this initiative, which is led by the British Pain Society in collaboration with Dr Foster. More than 200 pain clinics are already signed up to provide data. The work is being piloted and data collection will begin later this year. We are expecting a report in the early part of 2012. The audit will not only assess the organisation of local services-location, staffing and equipment-but also assess the quality of patient care across NHS providers by measuring activities and outcomes.”¹⁰

Earl Howe, Parliamentary Under-Secretary of State, Department of Health.

⁸ NHS Evidence, *Knowledge outline: The role of the pain clinic*, <http://www.library.nhs.uk/PALLIATIVE/ViewResource.aspx?resID=259097&tabID=290>

⁹ NICE, *Improving Supportive and Palliative Care for Adults with Cancer*, p.20, <http://www.nice.org.uk/nicemedia/live/10893/28816/28816.pdf>

¹⁰ House of Lords Hansard, 7 July 2010, <http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/100707-0002.htm#10070774000280>

- (f) Amongst the aims of the national pain audit will be to use the brief pain inventory scale as a way of measuring patient outcomes. There are a number of different pain assessment tools available. An example of a Brief Pain Inventory is appended to the background note¹¹.

¹¹ NHS Quality Improvement Scotland, *Management of chronic pain in adults*, pp.45-46, http://www.nhshealthquality.org/nhsqis/files/PAINCHRONIC_BPS_FEB06.pdf



PAIN: BREAKING THROUGH THE BARRIER

Each year over 5 million people in the United Kingdom develop chronic pain, but only two-thirds will recover. Much more needs to be done to improve outcomes for patients.

KEY POINTS

- Pain is one of the world's most common symptoms: it affects 7.8 million people in this country.
- Chronic pain appears to be more common now than it was 40 years ago.
- Chronic pain has a major impact on people's lives, causing sleeplessness and depression and interfering with normal physical and social functioning.
- All age groups are affected: a quarter of school-age children reported pain (on average lasting more than three years), while most elderly residents of nursing homes experienced frequent moderate to severe pain.
- It has been estimated that back pain alone costs the economy £12.3 billion per year. The cost of pain from all causes is far higher.
- Chronic pain and its consequences are not as well controlled as they could be. Early intervention may stop pain becoming persistent.
- The limited number of specialist pain clinics around the country are inundated with referrals, and only 14% of people with pain have seen a pain specialist. Systems and infrastructure are not adequate to meet need or demand.
- Better coordination of services and services designed around the patient's needs are essential.

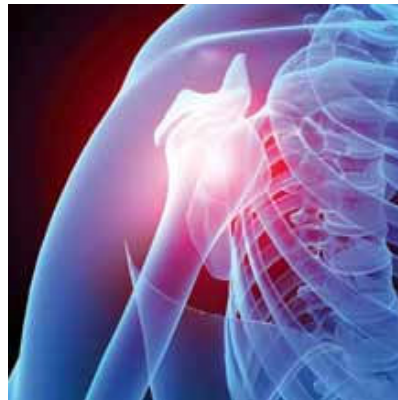
Pain is an unpleasant sensory or emotional experience that is a signal of actual or potential harm to the body. Acute pain by its nature is transient but can recur, while chronic pain is persistent. Chronic pain may be complex, often with no identifiable purpose or basis. Untreated, pain becomes entrenched and more difficult to treat. The consequences of long-term pain have a serious impact on both patients and society.

It has been estimated that 7.8 million people in the United Kingdom now suffer with moderate to severe pain that has lasted over six months. Over a third of households have someone in pain at any given time.

The numbers are rising. Repeated surveys show that chronic pain is two to three times more common now than it was 40 years ago.

Women report chronic pain more frequently. The same is true for people from socially or financially disadvantaged groups and some ethnic minority groups. United Kingdom citizens of South Asian origin are three times more likely to suffer disabling back pain than their non-Asian peers. Women are at greater risk of chronic pelvic pain, report migraine headache three times more commonly than men, and are disproportionately affected by pain syndromes such as fibromyalgia.

It is difficult to know exactly how many people have chronic pain. An estimated 11% of adults and 8% of children experience severe pain. Each year, over 5 million people in the United Kingdom develop chronic pain, but only two-thirds will recover.



Chronic pain becomes more common with age: the probability of suffering chronic pain at age 50 years is double that at age 30 years. However, chronic pain is not only a problem for older adults: the most common time to report chronic pain is in the decade between 40 and 50 years of age.

Chronic pain may be neglected at both ends of the age spectrum. In a study of United Kingdom nursing homes, most residents experienced constant or frequent moderate to severe pain, despite the fact that 99% were on pain medication. Conversely, chronic pain affects a quarter of school-age children (a third severely), with pain lasting on average more than three years.

Site of pain

Muscle, bone and joint pain are the main causes of chronic pain, with back pain and osteoarthritis together responsible for over half of all cases. Every year, 1.6 million adults in the United Kingdom develop back pain that stretches beyond three months. At any one time, a quarter of adults over the age of 40 years in the United Kingdom have knee pain, and in around half of them this pain is disabling. On top of this, half a million adults have rheumatoid arthritis, where the joints are attacked by the immune system.

Severe and recurrent headache is common. Around 12% of the population experience migraine, and a further 9% of women and 3% of men suffer with chronic daily headache. Pelvic pain lasting more than six months affects a million women in the United Kingdom; an additional one in eight women suffer from severe menstrual pain.

Up to 5% of the population are affected by chronic widespread pain of unknown cause, including diagnoses such as fibromyalgia.

Recent data from the United States found that, one year after being admitted to hospital for treatment of a serious injury, almost two-thirds of people still reported pain. Surgery itself may be a cause of pain: one year after hernia surgery, almost two-thirds of patients report ongoing pain as a result.

Among children and adolescents, the most common cause of pain is muscle-, bone- or joint-related, with headache and abdominal pain each responsible for a quarter of all cases of chronic pain in that age group.

United Kingdom: pain in numbers

- 7.8 million people live with chronic pain
- £3.8 billion cost of adolescent pain
- £584 million spent on prescriptions for pain
- 1 million women suffer with chronic pelvic pain
- 1.6 million adults per year suffer with chronic back pain
- 49% of patients with chronic pain experience depression
- 25% of sufferers lose their jobs
- 16% of sufferers feel their chronic pain is so bad that they sometimes want to die
- 1 pain specialist for 32,000 people in pain

"For three years, since I was 14, I've had severe pelvic pain. I have tried painkillers and been to see my general practitioner, but nothing much helps. I've missed a lot of school, and worry I may fail my A levels or be too ill to sit through an exam. I can't keep up with my friends' social activities. Pain is ruining my life."

Joanne, gynaecological pain

Impact on lives

Chronic pain ruins lives: 65% of sufferers report difficulty sleeping and nearly 50% report problems conducting social activities, walking, driving or having a normal sex life. In 49% of those with chronic pain there is depression, and this can result in suicide.

Chronic pain reduces quality of life more than almost any other condition. Pain often becomes intertwined with the lives of people living with it. Pain has been described as 'exhausting' and 'mentally draining', and the experience of living with it 'frustrating', 'isolating' and 'humiliating'.

Chronic headache significantly impairs quality of life. Disability is common, with 70% of migraine sufferers reporting some disability, of which 25% is severe.

Young people with ongoing pain have more mental health and social problems, miss more school than their peers, and tend to achieve less academically than expected. Taken together, all these factors have the potential to seriously harm a child's future.

The financial impact for both the sufferers and their families is shattering, and the burden to the economy as a whole is huge. People with chronic pain are seven times more likely to quit their jobs due to ill health than the general population. Overall, 25% of people with chronic pain eventually lose their jobs.

Conditions associated with chronic pain are among the most expensive to treat. Musculoskeletal diseases, such as arthritis, make up one of the most expensive disease groups for healthcare costs.

People with chronic pain account for a significant proportion of general practitioner appointments each year and are relatively high users of accident and emergency, diagnostics and outpatient services. In 2007, on top of money spent by patients on non-

"I'm constantly in agony, and I lost my job six years ago due to 'performance issues'. My doctor told me I have fibromyalgia, but has been unable to explain the cause of my pain, and I feel my family has no patience with me now. Painkillers do nothing to help. Some days I can't get dressed, the pain is so bad. I feel that no one really understands."

Thuwaraka, non-specific pain

prescription medication, the NHS in England spent £584 million on 67 million prescriptions for analgesia and anti-inflammatory drugs.

However, indirect costs, largely due to the loss of work opportunities, may be even greater than this. In 1998, it was estimated that the cost to the United Kingdom of back pain alone was £12.3 billion – 22% of UK health expenditure in that year – and the main part of this cost was due to work days lost.

Chronic pain is the second most common reason for claiming incapacity benefit. People with chronic pain often do not know how quickly, or whether, they are going to recover. This makes it difficult for them and their employers to plan for their return. Very often, people fail to come off these benefits.

Defining and measuring pain

Pain is subjective. It is not easily measured, unlike blood pressure or body temperature. Few report their pain being assessed effectively. Only 15% of patients have completed even a simple scoring system. Fewer than half of nursing home residents said that their carers had asked them about their pain. Identifying and assessing pain is an undervalued clinical activity and is not seen as a priority in assessing a patient, particularly in emergency settings.

Assessing complex and chronic pain is rarely of value if undertaken in isolation from assessments of the effects of pain. Early and appropriate identification of these effects can help reduce their impact and prevent disability.

Psychosocial factors are known to play an important role in the generation of disability and distress secondary to pain. If people worry excessively about the sources of their pain, they tend to become more inactive.

Gauging the potential threat value of pain is difficult for patients. It is vital for healthcare professionals to promote active coping strategies at an early stage to aid recovery. In Australia, a mass television campaign that encouraged people to stay active in spite of their pain had a dramatic and prolonged effect on sickness absence.

Controlling pain

Chronic pain is a complex phenomenon. When pain continues for a long time, the nervous system changes and becomes overactive. The normal mechanisms that damp down the sensation of pain stop working. Biological, psychological and social factors combine to exacerbate and entrench the symptoms. Patients are affected by both the symptoms of pain and the impact it has on their lives.

Modern pain management should address all of these elements with an integrated approach. Early identification of each patient's needs allows a plan to be tailored. With appropriate support, some people can be taught the skills to maintain normal function. Others have pain that may become complex and chronic and require more elaborate interventions.

People are generally keen to help themselves. No one wants to be in constant pain. Therefore, given proper support and information, most people will benefit from an integrated approach that addresses different aspects of their pain simultaneously. This may involve a focus on activity and rehabilitation, balanced drug therapies, psychological therapies, electrical nerve stimulation, and, occasionally, appropriate injection techniques. Complementary therapies also have their place. The key factor appears to be ensuring that aspects of care are integrated and joined up, rather than instigated sequentially or in isolation.

Table 1: Prescribed medication for chronic pain

Pain medication	UK (%)	European average (%)
Paracetamol	38	18
Non-steroidal anti-inflammatories	23	44
Cox-2 inhibitors	3	6
Weak opioids	50	23
Strong opioids	12	5

Percentage of respondents reporting pain medication prescription for chronic pain

Source: Breivik et al, 2006

Patients report that being listened to and given choices over treatment are just as important as the therapies themselves.

Medication

Conventional painkillers address pain in a number of ways. Paracetamol is simple, effective and has minimal side effects. It is thought to reduce pain by interrupting or suppressing pain signals along the nerves. Its value is often underestimated. Opioids, such as morphine or related compounds, affect the way in which pain is processed in the brain and spinal cord to reduce the sensation of pain. Anti-inflammatories have many side effects and so are less useful unless there is significant inflammation causing the pain.

Other medications change the way in which messages are sent along the nerves, or how they are processed by the brain and spinal cord. These include some anti-depressant medications and some anti-epileptic medicines such as gabapentin.

Persistent pain will often require one or more of these elements to be addressed in order to maximise the benefits of treatment. Where patients understand the purpose behind different medicines, it is more likely that they will take them appropriately, and that they will benefit.

Different ways of delivering medication may be appropriate. Anti-inflammatory drugs can be given as gels and opioids can be

incorporated in skin patches. People with constant pain generally find it easier to manage with slow-release formulations. Treatments such as capsaicin skin cream (derived from chilli peppers) cause an increased release in the nerve endings of 'substance P', which creates the feeling of heat or burning and is involved in the transmission of pain. Over time, repeated use of the cream causes the nerves to run out of this transmitter, and the pain is reduced. These new methods of delivery may improve effectiveness, reduce side effects, or be easier for patients to manage.

There is little standardisation of drug treatments, and pain treatments vary widely between countries. The United Kingdom uses significantly fewer non-steroidal anti-inflammatory drugs and more opioids than the European average (see **Table 1**). Opioids need close monitoring and it is evident that they lose their usefulness over the long term.

Non-drug treatments

Transcutaneous electrical nerve stimulator (TENS) machines work in a number of ways. Simply put, they work by using electrical energy to directly activate nerves in the

spinal cord. In the same way in which pain is helped by rubbing a painful body part, this competes with the 'pain signal' and blocks it, as explained by the 'Gate theory' proposed in the 1960s. However, more complex mechanisms are likely to exist as well. Whatever the mechanism, TENS treatment can have a significant effect on many types of pain if used properly, often in conjunction with other treatment options.

Acupuncture may work in a number of ways. It may have a counter-irritant effect as well as encouraging the release of the body's own painkillers (endorphins). Many other rationales have been proposed, and there is much controversy about acupuncture. However, there is no doubt that some patients report significant benefit for some pain problems.

Maintaining or regaining a degree of physical function is widely accepted as crucial to reducing the effects of pain. Physical therapy and/or appropriate rehabilitation programmes both treat pain directly and give patients the knowledge and skills to maintain their own health and function. This may also help to maintain psychological well-being.

Many localities now run physical activity and leisure services or equivalent schemes, some of which are targeted at people with complex pain. These aim to reintroduce and maintain good physical function and health. Health trainers can improve patients' confidence in doing things despite their pain. This also reduces the risks of heart disease and obesity.

"Ten years ago, I was diagnosed with arthritis of the knee. I've since had both knees replaced. Now I've got osteoporosis in my spine. It gives me terrible back pain that never leaves me night or day. I'm only 67, but feel ancient. I find it difficult to leave the house and cry all the time."

Lily, bone and joint pain



Cognitive behavioural therapy can help patients break the cycle of pain, fear, immobility and disuse that leads to ever-worsening pain. This approach also helps to develop self-management and coping strategies, and to improve social and physical functioning, even where the underlying pain cannot be improved significantly. The newer, third-wave therapies such as mindfulness and acceptance-based therapies have proved to be very useful.

Participation in expert patient programmes allows people with chronic pain to learn from the experiences of others. Patients gain the skills to become confident in managing their own pain and learn how to work in partnerships with their clinicians. Although these programmes may work better for some patients, they report the need to have advice from a healthcare professional as well. Patient support groups such as Pain Concern and Action on Pain can play a vital role in mentorship.

Helping patients remain in, or return to, work is an essential goal. Patients with chronic or complex pain, their carers and employers, may see leaving the workplace as beneficial. Remaining in work is essential to physical and mental health, and improves quality of life and self-esteem. Employers play a key role in understanding and contributing to rehabilitation and the patient's reintroduction to work. A constructive approach, looking at flexibility of roles, retraining, modification of hours and other options, can yield rewards for the patient, the employer and society.

Services

In 2006, over a third of chronic pain patients in the United Kingdom reported inadequate control of their pain. More than two-thirds said that at times their medication was unable to control their pain completely. Across Europe, 42% of sufferers agreed that they would spend all their money on pain treatment if they knew that it would work, and one in six felt that some days their pain was so bad they wanted to die.

services were unequal and inconsistent and suffered from insufficient funding. Prescribing was inconsistent, and guidelines were lacking. Across the regions, there was a six-fold variation in the percentage of primary care organisations providing funding for pain management services in primary care. Even where services exist, anecdotal reports suggest that there is a significant hidden demand within communities.

"For the last 20 years I've had violent migraines that can last for days at a time. This happens once or twice a month, and when I feel like this I can't work. I'm a self-employed plumber, and lose a lot of income as a result. Also, I'm a single parent, and when I have a migraine I really struggle to manage to look after the children. Medication just doesn't seem to help."

Colin, headache

In 2005, only 14% of people in pain had been seen by a specialist in pain medicine. While the majority had seen their general practitioner about their pain, 16% had not consulted anyone at all in the previous year.

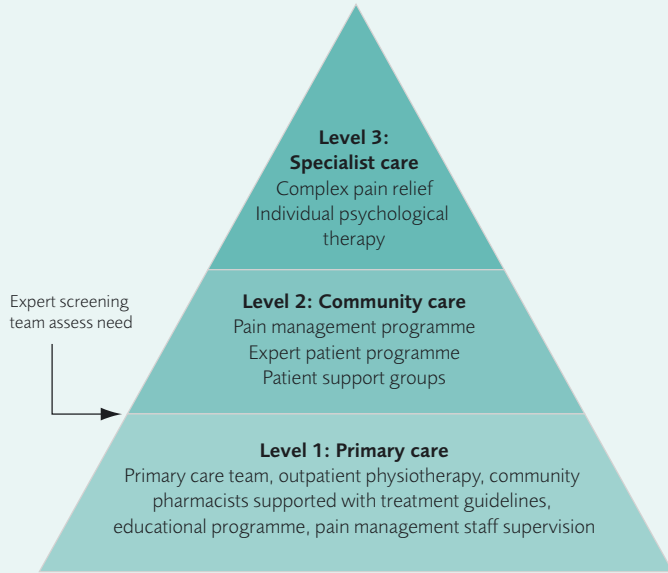
All healthcare professionals encounter people in pain. Some elements of the NHS have an increased focus on pain, whether it be within general practice, physiotherapy, rheumatology, orthopaedics or pain management services. Similarly, some local authorities provide services that address chronic ill health, including pain. However, local pain services are very thinly spread around the country, and the design and level of integration varies widely. Teaching at undergraduate level is patchy and inconsistent.

In primary care, the provision is equally variable. A recent report into the organisation of pain management services in primary care across the United Kingdom found that

An ideal service would have much clearer links between the various elements of care and those who provide them, with clear, straightforward pathways based on highly variable patient need. Early initial assessment would focus on preventing disability, and would separate people needing aggressive specialist pain strategies from those requiring less invasive self-management and goal-orientated functional rehabilitation. Those patients needing specialties such as rheumatology or neurology would be channelled appropriately along these routes, with high-quality assessment tools allowing rapid referral and access. Both specialties could ensure that there is some exposure to pain management as part of postgraduate training.

Much care could be provided best in a community setting. Specialist support could then focus on the most complex situations and provide backup to primary and

Figure 1: Management of chronic pain in Southampton



Source: Price, 2006

community care services. A major initiative to widen access to high-quality pain services would improve the lives of millions of people.

In moving towards such an ideal, it is important to establish the orientation, philosophy and model of care delivered by local pain services. The traditional pain clinic tended to put a great deal of emphasis on treating the area affected by pain (for example with painkilling injections). Modern pain services differ from this in three respects.

Firstly, the range of approaches to pain is wider, including techniques such as cognitive therapy. Secondly, there is a strong focus on the impact of pain more widely, rather than purely on the pain itself. Here, the effect on daily functioning and overall health – mobility, sleep and depression, and the ability to work and interact socially – are very significant in successful treatment and rehabilitation. Thirdly, today's services are multidisciplinary, which seems to be the most significant step forwards in treatment. Many specialist professions, not just doctors, have an important role to play. It is also

important to integrate the approach to pain services across primary and secondary care. The service model in Southampton (see **Figure 1**) is one way in which a local health service has delivered a more patient-focused approach. Other areas have used different models and different ways of integrating healthcare and community services. Unfortunately, a shortage of resources can limit the achievement of this ideal, and non-integrated care may persist in many areas.

In 2007, the Royal College of Anaesthetists established a Faculty of Pain Medicine. There are currently nearly 500 fellows in the United Kingdom, most of whom work less than full time in pain medicine. This roughly equates to one full-time pain specialist for a quarter of a million people: the Royal College of Anaesthetists and the British Pain Society recommend one per 100,000. This means that there are about 32,000 sufferers per full-time specialist. It is unsurprising that services around the country feel overwhelmed by referrals and unable to cope with the workload, let alone concentrate on delivering change.



Pain services face a number of challenges in meeting patient need. Innovative services face the additional challenge of securing funding. Most services are funded according to the number of patients seen, rather than the complex services they provide. Invisible services, such as supporting general practitioners or other services, are not accounted for. Where new ways of working reduce the number of patients who need to be seen in specialist clinics, this can result in a significant loss of funding for the service, further risking innovation and even the viability of local services.

Care for long-term conditions such as complex and chronic pain should be focused on the patient, and services should work together seamlessly, delivering the elements that patients need quickly and effectively. To improve outcomes for patients, effective commissioning should promote integrated services so that the patient is entered into the right services for them as speedily as possible.

ACTION RECOMMENDED



"A major initiative to widen access to high-quality pain services would improve the lives of millions of people."

- Training in chronic pain should be included in the curricula of all healthcare professionals.
- Consideration should be given to the inclusion of the assessment of pain and its associated disability in the Quality and Outcomes Framework for primary care.
- For patients in hospital, a pain score should become part of the vital signs that are monitored routinely.
- The feasibility of a national network of rapid-access pain clinics providing early assessment and treatment should be explored.
- A model pain service or pathway of care with clear standards should be developed by experts.
- All chronic pain services should supply comprehensive information to a National Pain Database.
- Agencies involved in the management of patients with chronic pain should form local pain networks to work together to improve the quality of local services.
- The Health Survey for England should routinely collect data on the impact of pain on quality of life.

Sample 6: Brief Pain Inventory

STUDY ID# _____ HOSPITAL # _____

DO NOT WRITE ABOVE THIS LINE

Brief Pain Inventory (Short Form)

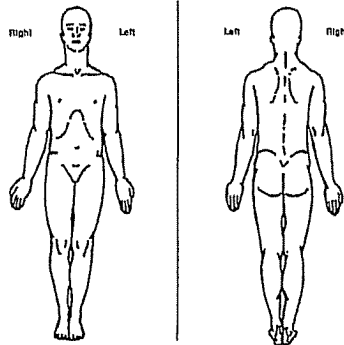
Date: ____/____/____ Time: ____

Name: _____
 Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Complete
Relief Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

C. Walking Ability

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

D. Normal Work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

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Pain Research Group
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**Pain Management Services
Overview of NHS Eastern and Coastal Kent Health Overview and Scrutiny
Committee – 8 October 2010**

1. Introduction

This paper aims to provide Members of the Committee with an overview of pain management services within eastern and coastal Kent.

The questions answered in each section are numbered on the right hand side to correspond with the questions raised by the Committee.

2. Setting the context

Nationally there are 7.8 million people living with chronic pain. 49% of patients with chronic pain experience depression and 25% will lose their jobs. Chronic pain is the third most common reason people visit their GP.

Three in ten people in Kent currently experience or have experienced chronic pain in the last year. Approximately 300 GP referrals are made into east Kent pain services each month.

Pain service provision across eastern and coastal Kent is delivered by the main acute hospital sites of The William Harvey Hospital, The Kent and Canterbury Hospital, The Queen Elizabeth the Queen Mother and the Medway Foundation Trust for complex pain. Non complex pain is managed through community based services in Blean, Sturry, Ashford, Deal, Folkestone, Ramsgate, Minster, Sittingbourne and Sheerness. The community based service provides a multidisciplinary team approach to the management of pain and support to patients to help with self management longer term.

3. Pain service provision within East Kent

How high a priority is the development of chronic pain services within your health economy?

Q1

A recent survey showed that more than one third of people suffering with chronic pain in Kent had to take time off work because of their condition, with almost half being absent for at least a month. More than one in ten have been diagnosed with depression as a result of their pain.

Provision of chronic pain services is a priority within east Kent in ensuring patients have timely access at the earliest opportunity to the most appropriate health professional following diagnosis.

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To meet this requirement, local pain services were redesigned in 2005 following National guidance recommending early intervention and the delivery of care closer to home where possible.

The redesign was undertaken by consultants, nurse specialists, patients, GPs and commissioners, ensuring a collaborative approach to pain management.

A new model of care was agreed to provide a service for the management of complex pain conditions within an acute hospital setting. In line with recommendations, community based services were established to provide assessment and treatment for non complex conditions. The shift of activity from secondary care reduced demand and waiting times ensuring patients are seen quickly by the most appropriate health professional.

What are the main challenges in delivering effective pain services within your health economy? Q2

The Eastern and coastal Kent PCT commissions services for a population of approximately 740,000, with a 11% growth by 2020.

It has an extremely diverse population with a number of larger urban communities on the coastal fringes as well as dispersed rural communities.

There are isolated areas of deprivation and increasingly transient and immobile populations, making transport a key issue.

Moving appropriate service delivery from acute hospital care into community based services required consideration of these key factors

With the introduction of the new model of care, as waiting times reduced and services were easier to access, a significant unmet need was identified adding the difficulties of capacity and demand planning to the challenge.

What assessment has been made about the numbers of people suffering from chronic pain in Kent? Q3

During the development of the new service model, an initial assessment of local needs was undertaken. This identified that on average three in ten people in Kent experience chronic pain per year. However with the provision of community based services and a reduction in waiting times in the acute hospitals, a significant unmet need was seen.

More recently both the primary and secondary care pain services have worked in partnership with a national survey which provided the current position of those people suffering with chronic pain east Kent.

What pain services are currently available within Kent: Q4

Primary care

The community based multidisciplinary pain offers assessment, treatment, advice and education on self management.

Available in Blean, Sturry, Ashford, Deal, Folkestone, Ramsgate, Minster, Sittingbourne and Sheerness, the team consists of GPs with a special interest in pain management, therapists and clinical psychologists.

The service provides a holistic approach to the management of chronic pain conditions with the emphasis on providing support to enable patients to manage their condition long term.

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All patients are clinically reviewed at their first appointment and a treatment plan agreed between them and their clinician.

Patients are offered a range of interventions such as physiotherapy, acupuncture, group sessions including Tai Chi, Alexandra breathing techniques. Pain management education sessions are offered to patients, carers and families to support patients in managing their condition in the long term.

Secondary care

Secondary care services are provided in the local acute hospital settings of The William Harvey Hospital, The Queen Elizabeth the Queen Mother, The Kent and Canterbury Hospital and Medway Maritime.

These are consultant led services providing interventional treatments which require a hospital environment.

In addition, and in line with the choice agenda, patients are offered a choice of alternative providers at the point of referral including tertiary providers. However, evidence suggests that due to the pain the patient is experiencing at the time and the reluctance to travel as well as the low waiting times locally, patients prefer to be seen at one of the local acute sites.

How many people access pain services, including tertiary, outside of Kent? Q5

Approximately 70 patients accessed pain services, including tertiary, outside of Kent during 2009/10.

What services are available to assist patients with the psychological aspects of pain? Q6

The community service is based on a psychosocial model as recommended by the British Pain Society. Two full time psychologists are part of the multidisciplinary team enabling the service to offer 1:1 psychological therapy, multidisciplinary pain education days and longer programmes of 4-6 weeks. Patients are encouraged to attend these sessions with their families or carers.

The community multidisciplinary team has completed cognitive behaviour therapy (CBT) training and this approach is embedded through the patient care pathway, supporting lifestyle management, acceptance and long term management of pain.

The skills of the psychologists include mindfulness and hypnotherapy techniques.

A consultant psychologist and psychotherapist are part of the secondary care team.

What facilities are there for assisting patients in managing their own conditions? Q7

The primary aim of the community based service is long term self management of condition.

The model promotes supported discharge with access back into the service if required, negating the need for a GP referral. Short waiting times give patients the confidence on discharge that they can obtain assistance quickly if required.

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The psychological approach promotes self management techniques and provides links to local community agencies and groups, Expert Patient Program, local clubs and societies, health walks, on line support groups and supportive websites

Are there any plans to develop or change any of the services currently available? Q8

Secondary Care

From April 2010 activity has been repatriated from Essex for patients requiring fitting of spinal cord stimulation pumps. This prevents the need for patients suffering with chronic pain conditions having to travel for initial fitting and onward maintenance.

Primary Care

The community based service is currently trialing on-line pain management courses. This extends the pain management course to housebound patients or those patients unable to attend group sessions for various reasons

Collaboration between Primary and Secondary Care

Clinicians from both the primary and secondary care services are working collaboratively to pilot a referral assessment service.

Referral criteria has been agreed and clinicians from both services are jointly reviewing all referrals within 48 hours of receipt and signposting patients to the most appropriate service first time.

This is a six month pilot, due for evaluation in October, however early indications show this collaborative approach to referral assessment to be successful in ensuring no delays in patient treatment while improving capacity by reducing unnecessary appointments.

Patient need will continue to be reviewed and services adjusted or redesigned where necessary by working with clinicians and patients to ensure the most effective, efficient and appropriate service delivery.

Specifically, is there a date agreed for the re-opening of a Pain Clinic in Maidstone Q9

For West Kent to respond

The Chief Medical Officers Annual Report 2008 'Breaking Through the Barrier' contained recommendations relating to pain services. Has any formal response to these recommendations been made by your PCT and has any work been carried out locally to action any of the recommendations? Q10

Locally the following actions have been carried out to address the recommendations of the CMO Annual Report 2008:

- **Recommendation 1: Training in chronic pain should be included in the curricula of all healthcare professionals**

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The community pain service holds an annual conference with national speakers which is open to all clinicians across the local organisations

Clinicians within the service teach to masters level on chronic pain through links with Christchurch and Kings Universities in Canterbury and are currently they are looking to expand this geographically.

Local teaching sessions include cognitive behaviour therapy and the delivery of pain management within a community setting. An agreed teaching program is in place with GPs on medicine management which promotes locally developed guidance on the World Health Organisation's analgesia guidance.

- **Recommendation 2: Consideration should be given to the inclusion of the assessment of pain and its associated disability in the Quality and Outcomes Framework for primary care.**

The community pain service provides training in the management of pain to GPs in primary care across all PCT localities.

- **Recommendation 3: For patients in hospital, a pain score should become part of the vital signs that are monitored routinely**

Retaining patients within community based services has enabled secondary care services to expand their inpatient remit to include monitoring of pain.

- **Recommendation 4: The feasibility of a national network of rapid access pain clinics providing early assessment and treatment should be explored.**

The pain service model promotes access to expert assistance and treatment on a timely basis through the provision of local clinics, short waiting times and patient driven follow ups.

The primary and secondary care collaborative referral assessment service, currently being piloted, ensures patients are seen by the most appropriate health professional first time with no delays.

- **Recommendation 5: A model pain service or pathway of care with clear standards should be developed by experts.**

The model of care for pain services has been developed by consultants, nurse specialists, patients, GPs and commissioners, ensuring a collaborative approach to pain management.

The model promotes clinicians working together to deliver one model as a multidisciplinary team.

A pathway for the management of low back pain, based on NICE guidance, has been developed and agreed across the three Kent and Medway PCTs.

- **Recommendation 6: All chronic pain services should supply comprehensive information to a National Pain Database**

The east Kent pain services are part of the national pain audit through Dr Foster. Information and audit results are fed through to the British Pain Society. The formation of special interest groups at the British Pain Society provides a forum for sharing data and best practice on a national level.

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- **Recommendation 7: Agencies involved in the management of patients with chronic pain should form local pain networks to work together to improve the quality of local services.**

The pain service has links with the voluntary sector through patient support groups such as Fibromyalgia, Patients in Pain, the Expert Patient Panel.

The community based pain service has supported the establishment of a number of patient groups and empowered the groups to become self supporting, while offering expertise as required to existing groups.

The pain clinicians participate in the South East Regional Forum (covering London and east Kent) for professionals to share expertise held twice yearly.

- **The Health Survey for England should routinely collect data on the impact of pain on quality of life**

East Kent pain services have input through the Chronic Pain Coalition.

4. Managing Chronic Pain within End of Life Care

Within end of life care the management of chronic pain is delivered by coordination of a number of clinical services. This coordination starts with ensuring that there are appropriate plans of care identified for palliative patients. A mechanism used by providers within Eastern and Coastal Kent is the usage of the Gold Standards Framework. Fundamentally this aims to ensure appropriate care is in place to support those with any end stage condition. It is a patient led process that focuses on clinical, as well as holistic support, of which pain management is a vital component.

Actual delivery of chronic pain management services is something that spans a number of settings, including the acute trust, primary care and hospice providers.

The end of life patient pathway does not deliver specific chronic pain clinics however it is something that underpins any clinical intervention that a patient may receive. This may be via regular outpatient appointments or as a reaction to a change in symptoms where the patient may access an out of hour's provider. This system of symptom management ensures that services are able to proactively manage all symptoms, including pain, related to an end stage condition.

HOSC Meeting – 8th October 2010

NHS West Kent Summary of Pain Management Services

Questions from the Committee:-

1) How high a priority is the development of chronic pain services within your health economy?

In comparison to a large proportion of the country, West Kent patients have access to quite a substantial chronic pain service which is continuing to evolve to try to meet the needs of the local population. The highest priority for West Kent in relation to pain services at the moment is provision of Pain Management Programmes (PMPs), which include psychological support. This psychological element is currently lacking in our local services and the Medway service has recently stopped due to funding arrangements. West Kent patients requiring psychological PMPs currently go to Guy's or further, at a much greater cost to our local health economy. Maidstone & Tunbridge Wells NHS Trust chronic pain team is currently undertaking a detailed audit to determine the potential level of demand for a local PMP. Community outreach services have been set up in both Sevenoaks and Gravesend to offer more choice to patients and care closer to home without the need to attend an acute hospital for outpatient appointments.

2) What are the main challenges in delivering effective pain services within your health economy?

Some challenges are common to the NHS – for example the impact and effects of the economic downturn, the ageing population, more people with long-term conditions, more older people in a caring role, licensing of more high cost drugs, legislation affecting continuing care. Some are particular to West Kent. In the strategic period 2010-2015 we need to:

- Control spend – our modelling results in a potential financial gap at year five of £150m if we do nothing to reverse it
- Control growth – historically year-on-year growth in use of secondary, tertiary and specialist acute services has outstripped all predictions of demand
- Control quantity and price – in addition to exponential growth in demand, the proximity of London makes us vulnerable to tariff payments with higher market forces factor than is reflected in the PCT's allocation
- Deliver equity of provision – this may mean reducing services for some in order to focus/increase access for others; for example, where services appear to be utilised more than might be expected according to need predictions (e.g. Mental Health), or in response to geographical

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anomalies (e.g. improving the health of people in more deprived communities such as Gravesend)

- Stabilise provider economics – continuing to support Maidstone & Tunbridge Wells NHS Trust to mitigate the effects of a challenged financial legacy position and the looming financial impact of the new hospital at Pembury, and supporting those imminently moving to Foundation Trust status.

As detailed in the CMO's report 2008, repeated surveys show chronic pain is two or three times more common now than it was 40 years ago. West Kent has experienced a year on year increase in referrals into our pain services – extended choice being a major factor as well as an increase in patients suffering from pain. With the ageing population we are likely to see a significant increase in the numbers of people with long-term conditions. 15% of West Kent residents currently live with long-term conditions and 33% of patients are in the 65+ age group.

3) What assessment has been made about the numbers of people suffering from chronic pain in West Kent?

A formal assessment has not been carried out, although the public health team could carry this out if it's regarded as a priority. Our data only gives us numbers of referrals made by GPs, and doesn't give the bigger picture of how many patients suffering with pain are being managed at primary care level, or the unmet need of patients who suffer from chronic pain and haven't approached a healthcare professional. West Kent population data can give us some indicators, however:

- The total resident population is 674,600
- The resident population is 51% female and 49% male. As highlighted in the CMO report (2008), women report pain more frequently
- The population growth rate is lower (7.61%) than the percentage for Kent County (10.56%) and for England (7.62%)
- The greatest rise in the population is projected to be in those aged 75+, 20,900 people (40.82%). As highlighted in the CMO report (2008) 'most elderly residents of nursing homes experienced frequent to moderate pain'.

The CMO report (2008) states that people from socially or financially disadvantaged groups and some ethnic minority groups report pain more frequently. The report highlights that UK citizens of South Asian origin are three times more likely to suffer disabling back pain than non-Asian peers, West Kent has pockets of deprivation in areas of Dartford and Gravesend as well as areas of Maidstone and there are large numbers of minority ethnic groups in the Gravesend area.

4) What pain services are currently available within West Kent in:

- **Primary and community care settings?**
- **Secondary care?**

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Pain services provided in the community include:

- Sevenoaks Community Hospital (weekly MTW outreach consultant-led outpatient clinic)
- Gravesend Community Hospital (weekly Medway outreach consultant-led outpatient clinic)
- Blackthorn Medical Practice (Maidstone) provides an anthroposophical approach to chronic pain management through the following therapies: art, counselling, eurythmy, rhythmical massage and anthroposophical medicaments. Additionally, where appropriate, patients may be offered work placement within social enterprise at Blackthorn garden
- 'Back in Action' – Churchill Centre, Preston Hall, Aylesford

Pain services provided in secondary care include:

- Maidstone & Tunbridge Wells NHS Trust – Clinics at both Pembury Hospital and outreach clinic at Sevenoaks Hospital. Link to their web page: <http://www.mtw.nhs.uk/a-z-of-services/chronic-pain-unit.asp?m1=3&m2=51&m3>
- Dartford & Gravesham NHS Trust – Darent Valley Hospital (very small service due to start in October)

5) How many people access pain services, including tertiary, outside of Kent?

922 West Kent patients attended a first outpatient appointment in pain services outside of Kent during the period April 2009 – July 2010. Breakdown of providers as follows:

- South London Trust – 603
- Guys – 172
- UCL – 102
- Royal National Orthopaedic Hospital – 14
- Mayday Trust – 9
- Lewisham Trust – 11
- BMI Chelsfield - 11

6) What services are available to assist patients with the psychological aspects of pain?

The Pain Management Programme at Medway unfortunately ceased on 13th September 2010. This service was our main local provider for psychological pain services before referring into London or beyond. This is an issue for West Kent as referrals into the far more specialised and typically inpatient Pain Management Programmes may not be appropriate for the majority of patients, and come at a far greater cost. The Medway Pain Management Programme was an eight-week course which offered psychological and physiotherapy support to people with chronic pain who have had at least one other intervention which has failed. The pain management programme is accessed by consultant referral, primarily from a chronic pain

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management service. Whilst this programme is suspended and the service is under review between NHS Medway and Medway acute trust, patients will be referred back to the care of their GP.

Inpatient PMPs (including the INPUT programme at Guy's in London and the highly-specialised service in Bath) are not routinely funded by the PCT and therefore have to be individually funded through the PCT's treatment panel, with detailed evidence required.

As mentioned previously, Maidstone & Tunbridge Wells NHS Trust chronic pain team is currently undertaking a detailed audit to determine the potential level of demand for a local PMP. Initial results show that of 673 patients audited over a 13-week period, 44 (6.5%) required a referral to a PMP.

7) What facilities are there for assisting patients in managing their own condition?

Local leisure centres are subsidised to provide therapy / rehabilitation sessions and exercise classes which are primarily referred into by physiotherapy teams for ongoing management, but can also be accessed by GPs and acute consultants. These services are not necessarily focussed on chronic pain patients in particular but they have their place in improving ongoing physical and psychological management of pain.

8) Are there any plans to develop or change any of the services currently available?

As previously mentioned, Maidstone & Tunbridge Wells NHS Trust is assessing the viability of providing a Pain Management Programme.

As of 1st October, Maidstone & Tunbridge Wells NHS Trust chronic pain team will provide an outreach clinic at Sevenoaks Hospital.

Practice Based Commissioning (PBC) acute back pain pilots have recently proved successful, with strong links with our acute pain colleagues. Considerations are currently being made as to whether to roll these projects out to other PBC groups.

Darent Valley Hospital does not currently have a chronic pain service directly accessible to GP referral. However, a full-time consultant and chronic pain nurse specialist will be in post from October 2010 to provide an outpatient service. In recent years, there has only been a part-time pain specialist available at Darent Valley, who would only accept in-house referrals from other consultants (due to capacity issues), therefore GPs were forced to refer into Orthopaedics or Rheumatology first at a greater cost and an extended patient pathway. The PCT and Dartford Gravesham & Swanley PBC group plan to work closely with the new Darent Valley Consultant and Trust Management to ensure that services offered will meet the needs of the local population as far as possible.

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9) Specifically, is there a date agreed for the re-opening of a Pain Clinic in Maidstone?

This is still the subject of discussions with Maidstone & Tunbridge Wells NHS Trust and no date has yet been agreed.

10) The Chief Medical Officers Annual Report 2008 contained 8 recommendations relating to pain services. Has any formal response to these recommendations been made by your PCT and has any work been carried out locally to action any of the recommendations?

No formal response to these recommendations has been made by NHS West Kent, although our consultant colleague from Maidstone & Tunbridge Wells NHS Trust attending the HOSC meeting will be able to confirm what recommendations have been carried out within the acute trust.

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 8 October 2010

Subject: Intended Outcomes: South East Coast Ambulance Services – Current Developments.

1. Background

- (1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.
- (2) This paper is intended to be a way to progress towards achieving these twin aims. The questions in Section 2 are the ones submitted to South East Coast NHS Ambulance Trust in advance of the 3 September meeting.
- (3) This subject was first considered on 3 September 2010 and Members requested the opportunity to revisit it and in the interim accept SECAMB's invitation to make a site visit to the Make Ready Depot in Thanet and the Emergency Dispatch Centre in Coxheath.

2. Hierarchy of Questions

- (1). Overarching Questions
 1. What progress has been in your Make Ready Depot programme?
 2. How will this programme progress in the future?
 3. How will this affect the way services are delivered?

3. Recommendations

- (a) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 8 October 2010

Subject: South East Coast Ambulance Services – Current Developments

1. Background

- (a) The South East Coast NHS Ambulance Service NHS Trust (SECamb) was formed on 1 July 2006 through the merger of Trusts in Kent, Surrey and Sussex. It provides emergency, urgent and non-emergency services to a population of around 4.5 million across 3,600 square miles in Kent, Medway, Surrey, East and West Sussex, Brighton and Hove and North East Hampshire.
- (b) The three Emergency Dispatch Centres (EDCs) at Coxheath, Lewes and Banstead receive over 600,000 calls in 2009/10.
- (c) 999 calls which are received are assessed and categorised as follows¹:
1. Category A - Life-threatening conditions where speed of response may be critical in saving life or improving outcome for the patient e.g. heart attack or serious bleeding. The performance standard is that 75% of all Category A calls should be reached within 8 minutes of the call being made. If the first response is not a fully-crewed ambulance then an ambulance should arrive within 19 minutes.
 2. Category B - Conditions which need to be attended quickly, but which are not immediately life-threatening. The performance standard is that 95% of all Category B patients must be reached within 19 minutes
 3. Category C - Non life-threatening conditions that may be appropriate for referral to an alternative care pathway
 4. Urgent calls can only be requested by a doctor or a midwife. The standard is to get 95% of patients to the hospital within 15 minutes of the time specified by the doctor when booking the ambulance.

¹ SECamb, Call Categorisation, <http://www.secamb.nhs.uk/emergency-ambulance-services/call-categorisation>

2. Current Developments².

(a) SECAMB is currently developing its service and organisation in a number of different ways. The following are brief descriptions and definitions of some of them:

1. Make Ready initiative – This will involve the creation of 12 depots across the SECAMB region by 2016 where vehicles are regularly deep-cleaned, restocked and checked for mechanical faults.
2. Paramedic education – An education programme has been introduced which will mean paramedics are educated to Foundation or Bachelor of Science Degree level.
3. Specialist paramedics – Critical Care Paramedics (CCPs) have received additional training and education in order to enable them to work in the critical care environment, often alongside doctors at the scene, and to undertake Intensive care transfers between hospitals. Paramedic Practitioners (PPs) have received additional training and education to give them greater patient assessment skills. They are able to treat many minor injuries and illnesses ('see and treat') as well as signpost care to specialists in the community and they can also refer patients directly to hospital specialists, bypassing the need to be seen first in an Accident and Emergency Department.
4. 'Hear and Treat' – A proportion of patients calling 999 may only require self care advice and/or reassurance and this programme provides the opportunity for appropriate patients to discuss their needs with a clinician over the telephone in the call centre. Where there is a need for a patient to see a clinician in person, appropriate arrangements are made.
5. Front Loaded Service Model – This is a programme which will aim to ensure that over the next 5 years, a patient will first see a registered clinician 90% of the time.
6. Single Point of Access - "The Trust has been successful in obtaining funds to implement NHS Pathways, develop a South East Coast wide Directory of Services and implement technical

² Information in this section adapted from the SECAMB Quality Account, <http://www.secamb.nhs.uk/the-trust-board/board-papers/current-board-papers/board-papers-28-july-2010/119.10%20Appendix%201%20-%20Board%20Report%20-%2028%20July%202010%20-%20SECAMB%20Quality%20Account%20final%20version%20v1%2000.pdf/view> ; draft Annual Report 09/10 http://www.secamb.nhs.uk/the-trust-board/board-papers/current-board-papers/board-papers-9-june-2010/85.10%20Annual%20Report_DOC.pdf/view ; and SECAMB Business Plan 08/09 <http://www.secamb.nhs.uk/document-library-2/publications/Business%20Plan%2008%20-%202009.pdf/view>

links with other provider services. The technical links will aid the onward referral or appointment booking for patients whose conditions may be best treated through the use of alternative care pathways; this will improve the patient experience as it facilitates direct access to the most appropriate service for the patient.”³

- (b) SECAMB submitted its application for Foundation Trust (FT) Status to the Department of Health on 2nd August 2010. The earliest time that the Trust could become an FT will be 1st February 2011.⁴

³ SECAMB CEO Highlight Report, September 2010, <http://www.secamb.nhs.uk/the-trust-board/board-papers/current-board-papers/board-papers-28th-september-2010/Item%20-%20147.10%20CEO%20Highlight%20Report%20%20Sep%2010.pdf/view>

⁴ SECAMB FT Update, September 2010, <http://www.secamb.nhs.uk/the-trust-board/board-papers/current-board-papers/board-papers-28th-september-2010/Item%20-%20148.10%20FT%20Update%20Sept%202010.pdf/view>

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Make Ready Kent HOSC Briefing 3 September 2010



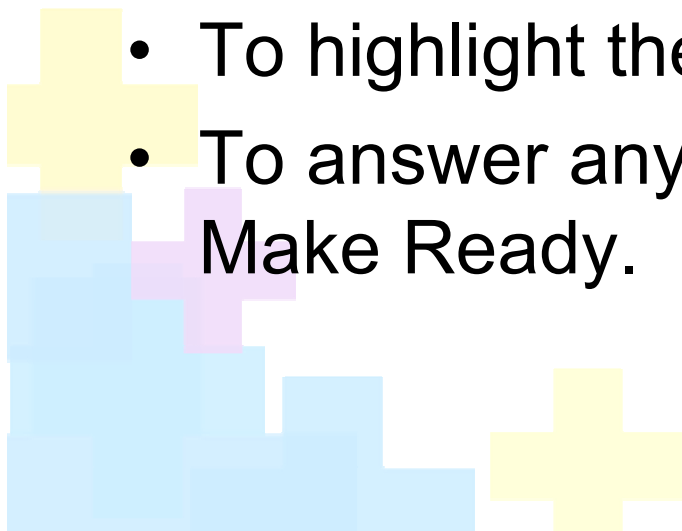
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Aim

- To provide you with an overview of Make Ready and how it will be rolled out throughout SECAMB.
- To up-date you on our plans to introduce Make Ready in Kent and what it means for staff and patients.
- To highlight the benefits Make Ready brings
- To answer any questions you may have on Make Ready.

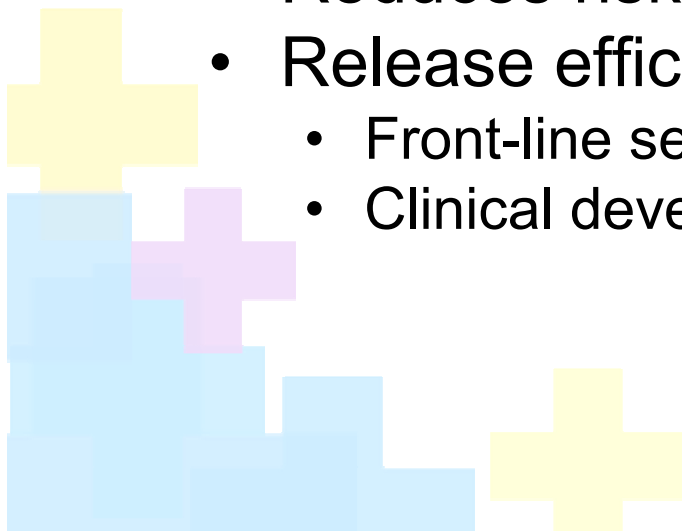




Drivers For Change

Why are we doing it?

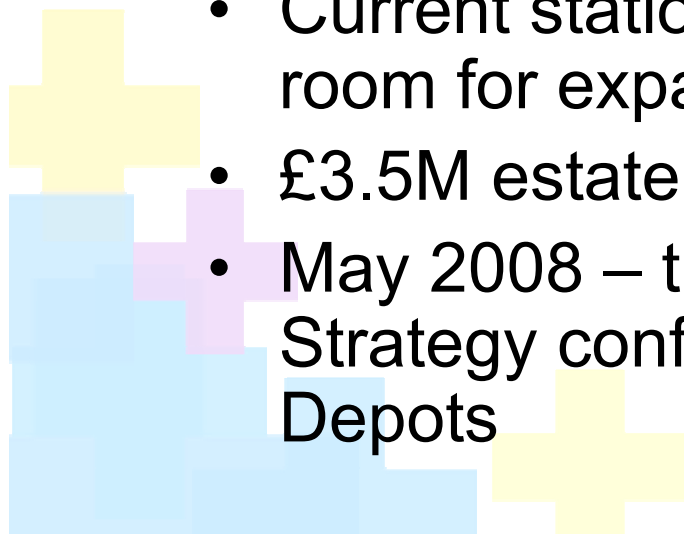
- This is not a change of service indeed it forms a key part of our vision & our commitment to providing the best possible services to patients
- Helps to tackle the real challenge of Infection Control
- Reduces risk – to staff, vehicles and equipment
- Release efficiencies to permit investment in:
 - Front-line services and staff
 - Clinical developments and innovation





Context for Change

- Old estate (68% built pre 1974)
- Often mal-located, which impedes response.
- Speed of response is key to clinical outcomes
- Patient demand/location changes – static stations cannot and do not reflect these changes
- Current stations are often “bulked out”, with no room for expansion
- £3.5M estate backlog maintenance
- May 2008 – the approval of the Trust’s Estate Strategy confirmed the move to Make Ready Depots



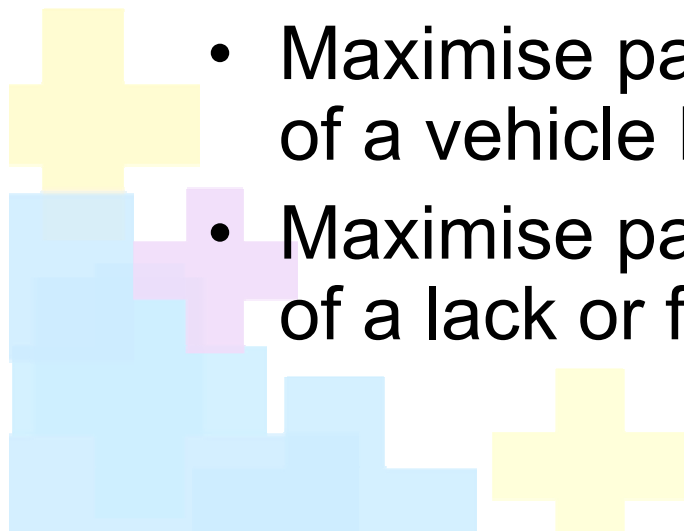
So, what is the definition of Make Ready?

“A crew friendly quality assurance vehicle and equipment preparation programme designed to minimise cross infection and maximise patient safety.”



Benefits - maximise patient safety

- Maximise patient safety through a rigorous vehicle and equipment cleaning and infection control regime
- Maximise patient safety by maximising the hours clinicians can see patients
- Maximise patient safety by minimising the risk of a vehicle breaking down en route
- Maximise patient safety by minimising the risk of a lack or failure of key clinical equipment



**best of
health
awards**
2009

The South East Coast regional heat of the
Health and Social Care Awards 2009
Passionate People Innovative Ideas Transforming Care

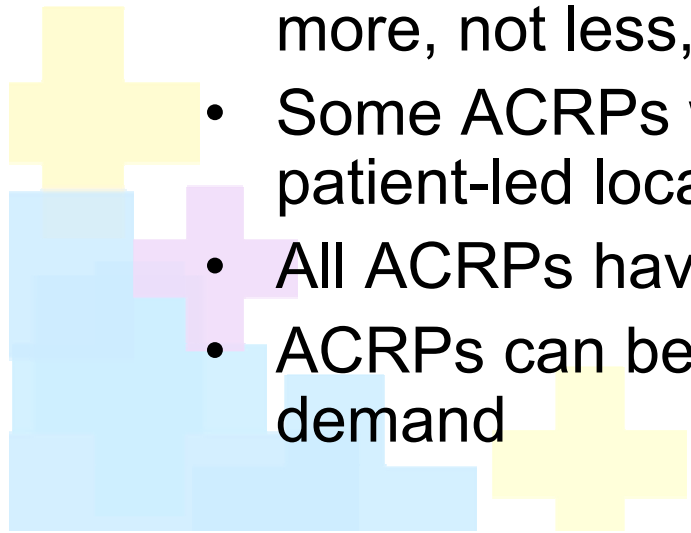
Award Winning

- 2009 Regional Winner Best of Health Awards for Patient Safety.
- 2009 – commended by CQC and recommended for roll out across the English ambulance services.
- 2009 – visits by, NPSA, UK ambulance services, BF Cyprus.



Concept

- All resources start and ends their shift at large central Make Ready Depots (MRD)
- Depots are supported by a network of Ambulance Community Response Posts (ACRP)
- ACRPs are aligned with patient demand and provide locations from where crews will respond during their shifts
- The move to Make Ready will see staff responding from more, not less, locations (more ACRPs than stations)
- Some ACRPs will be former stations, if in the right, patient-led location.
- All ACRPs have an agreed set of crew facilities
- ACRPs can be moved in response to changes in demand



Planning Assumptions – MRD Locations September 10

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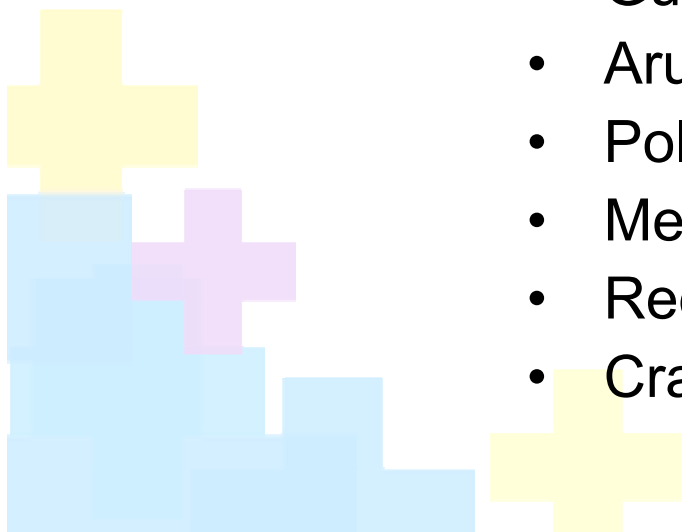


SECAmb Depots



MRD Locations

- Chertsey (Open)
- Hastings (Open)
- Thanet (Open)
- Paddock Wood (Jun 11)
- Ashford (Aug 11)
- Brighton
- Guildford
- Arundel
- Polegate
- Medway
- Redhill
- Crawley



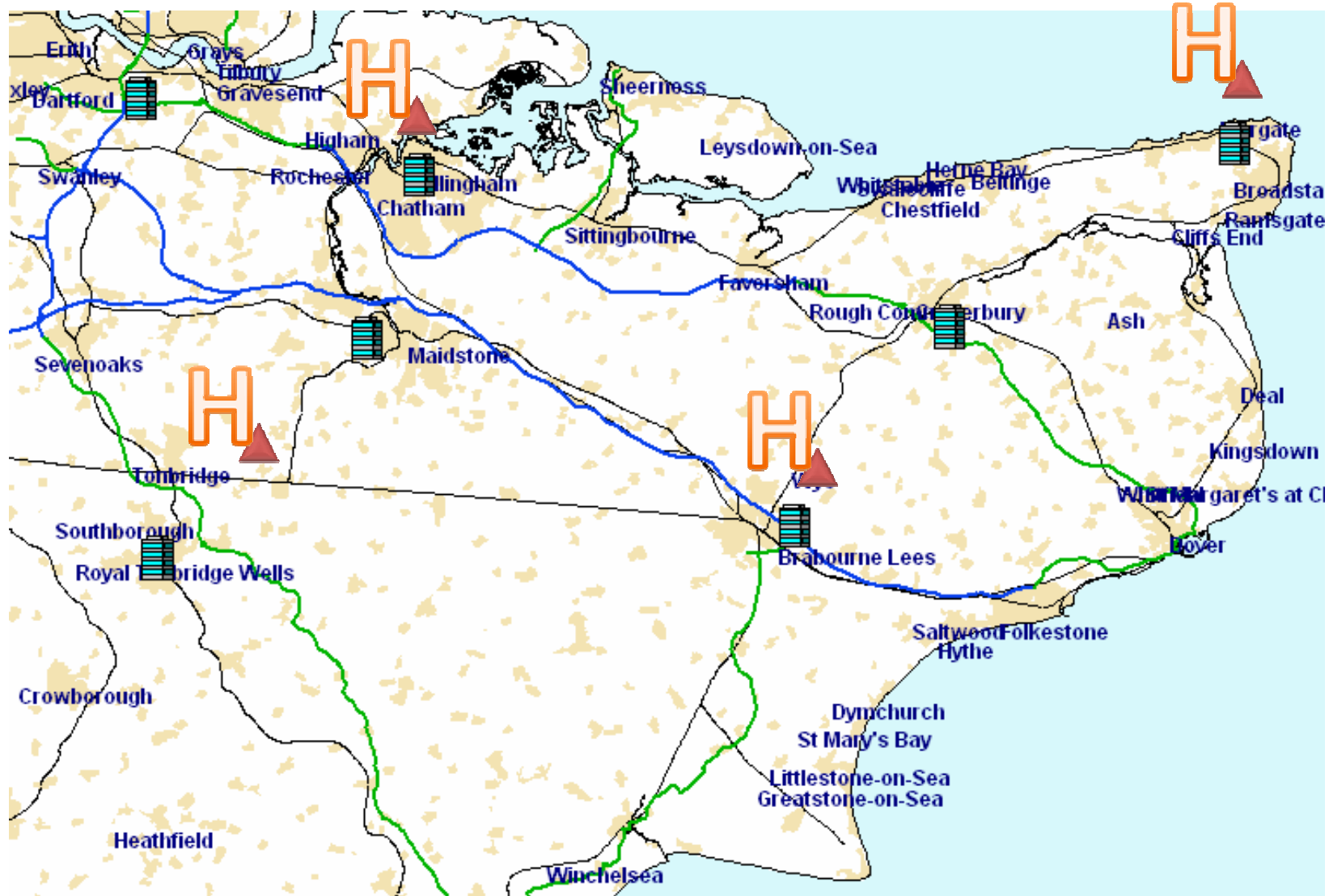


How are MRD locations chosen?

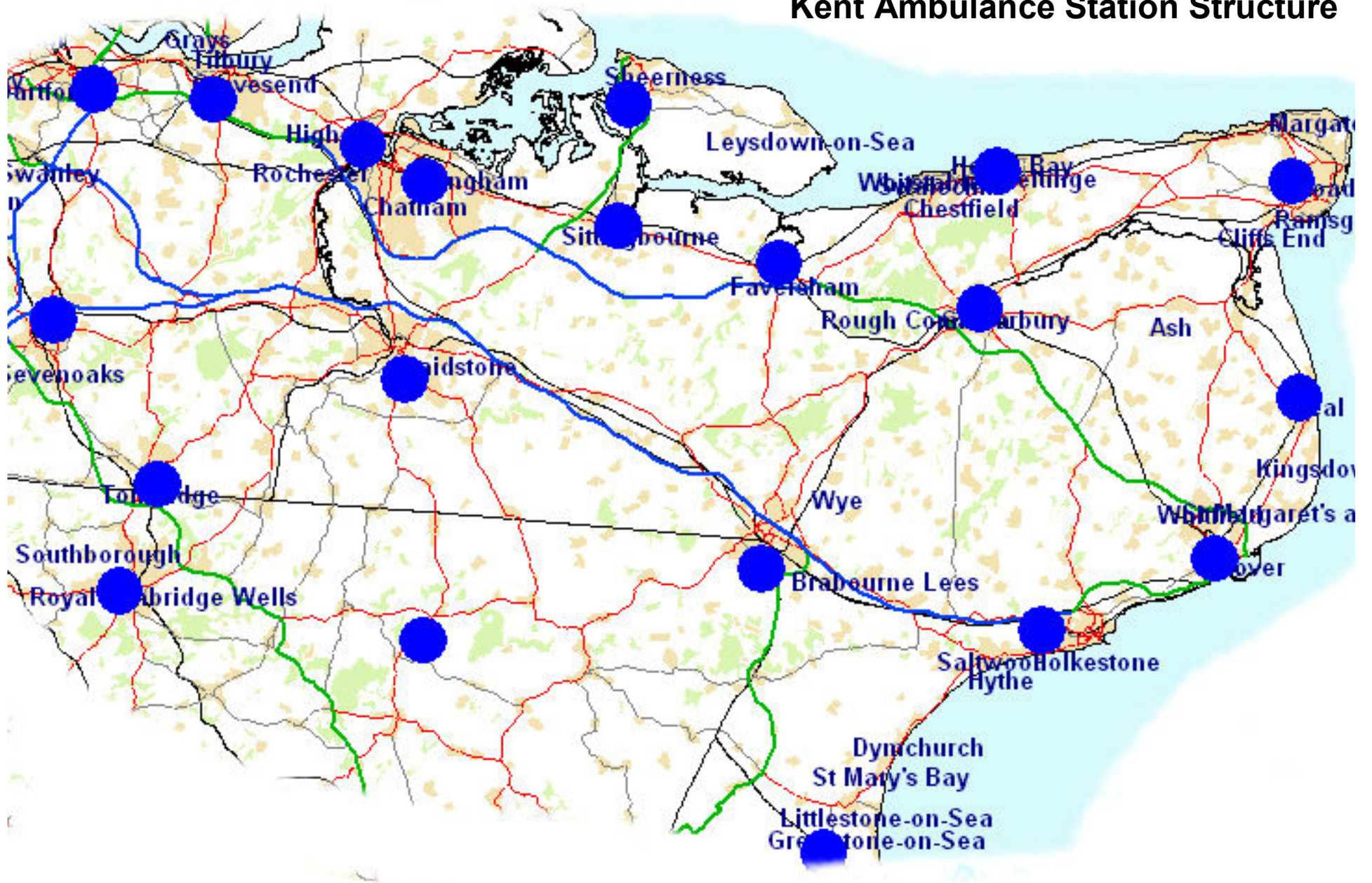
- Central to the operational dispatch areas geographically.
- Located close to main hospitals.
- Enabling good access for all staff in the area.
- Availability of suitable sites.



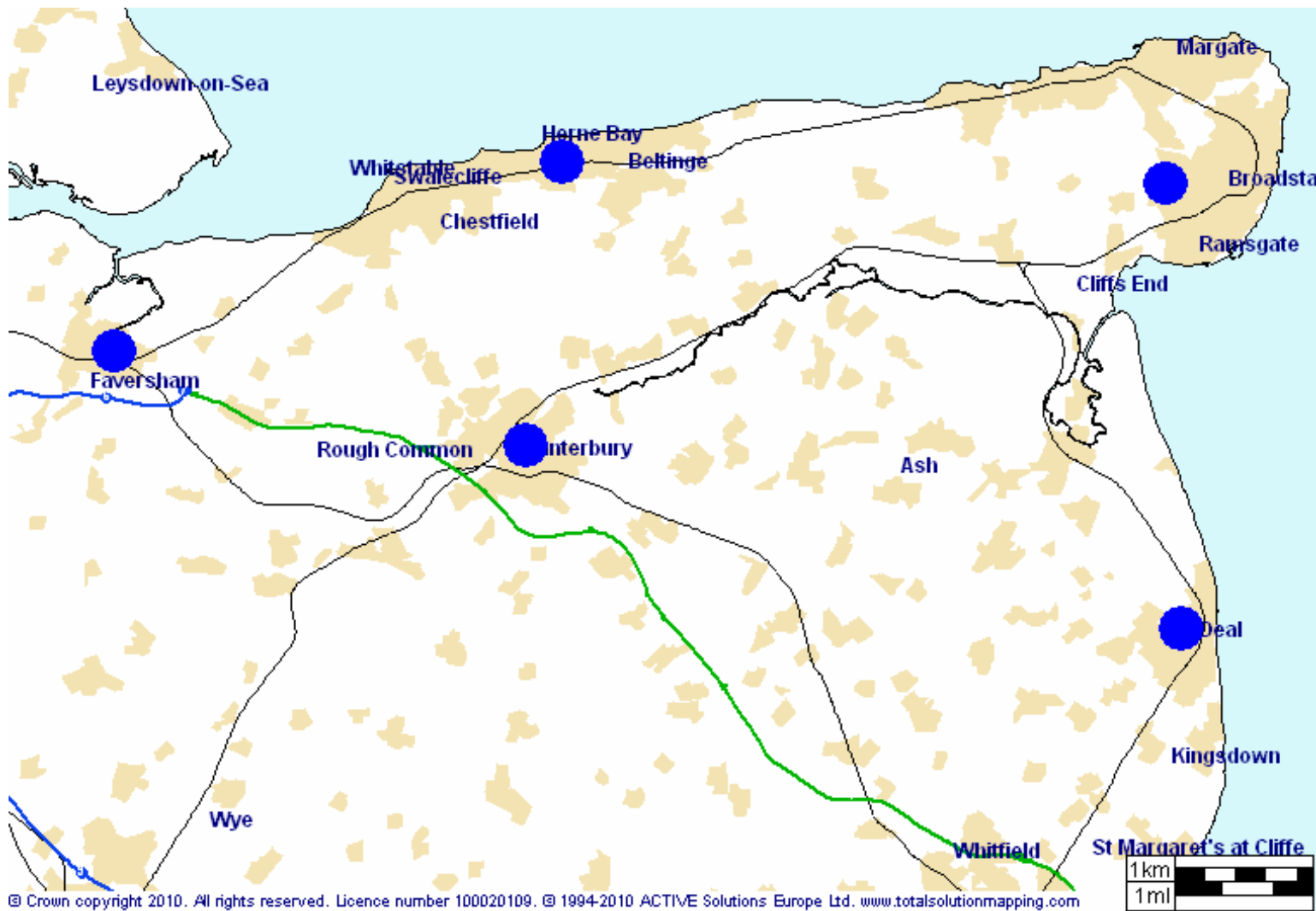
4 Kent MRDs



Kent Ambulance Station Structure

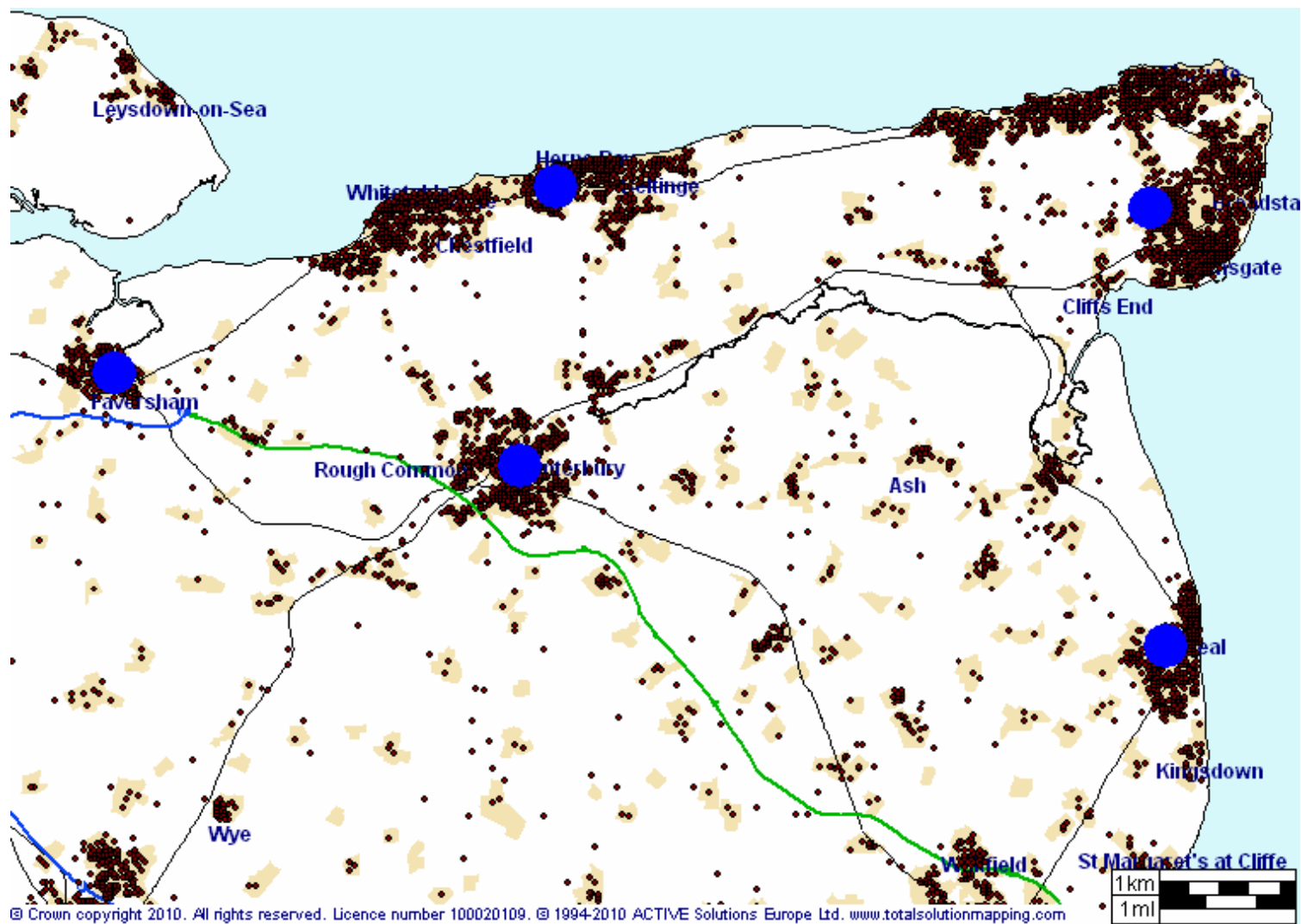


Thanet Area Stations

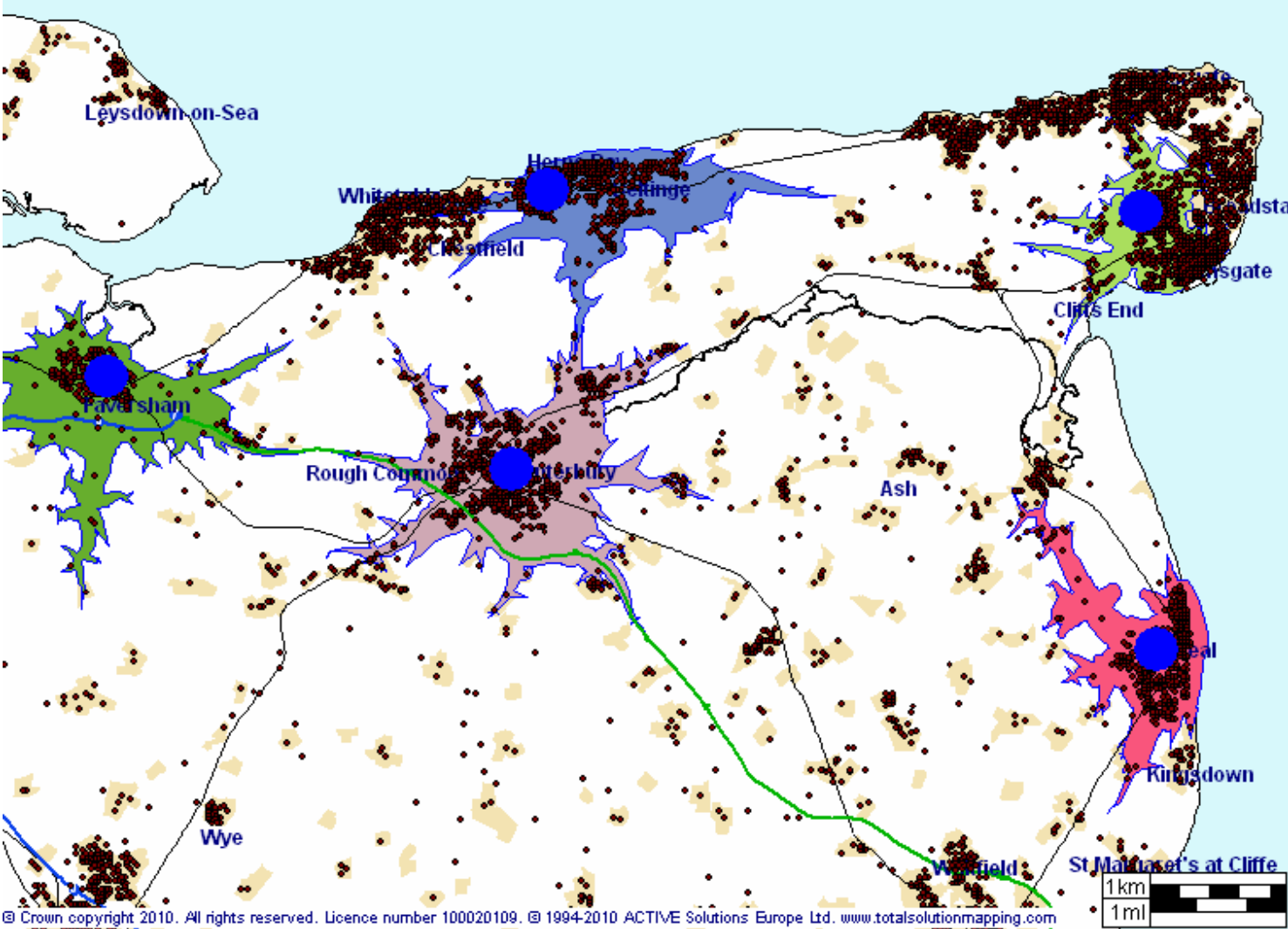


Thanet Area Life Threatening (Cat A) Calls

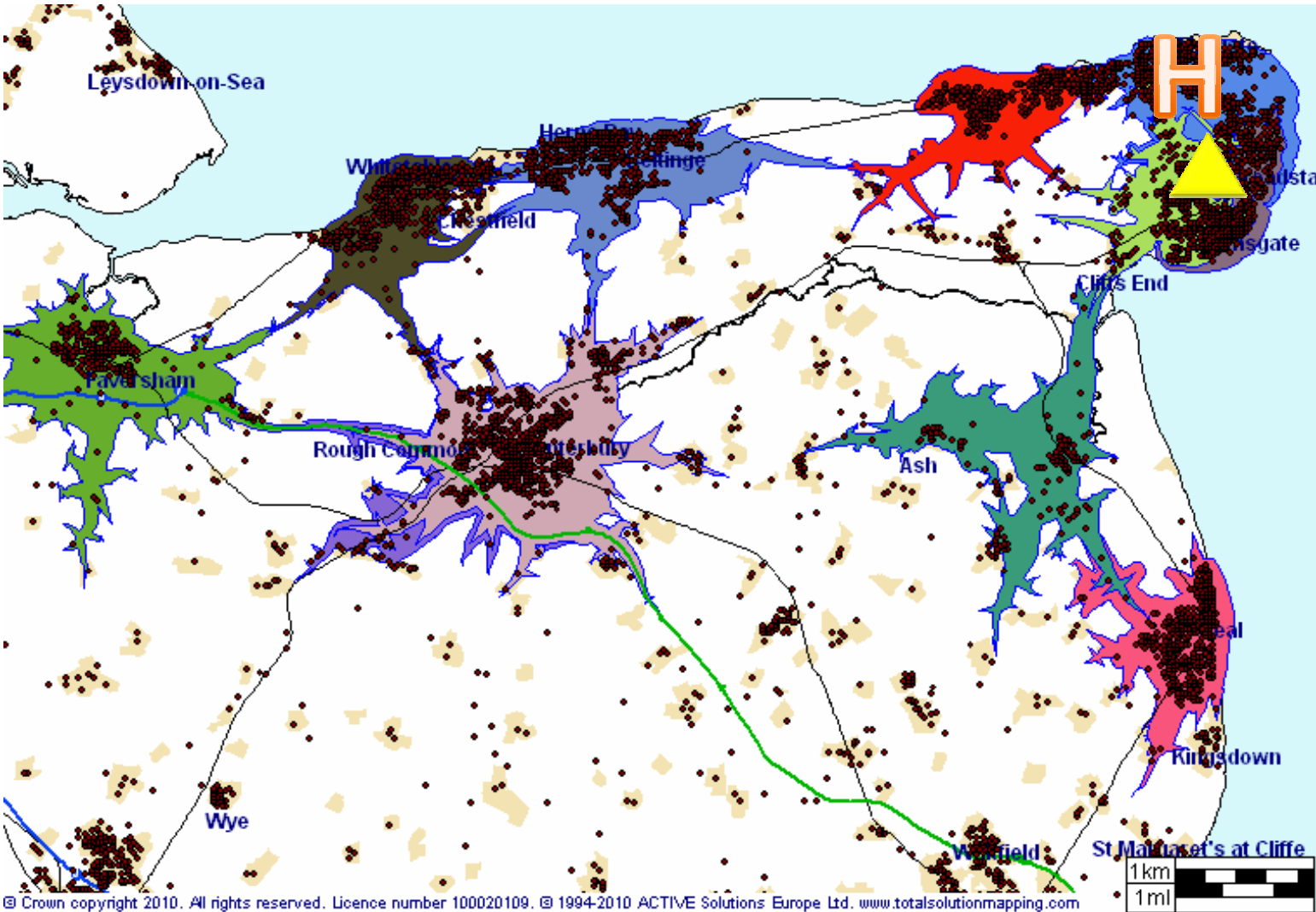
09/10



Thanet Area Ambulance Stations Response Times



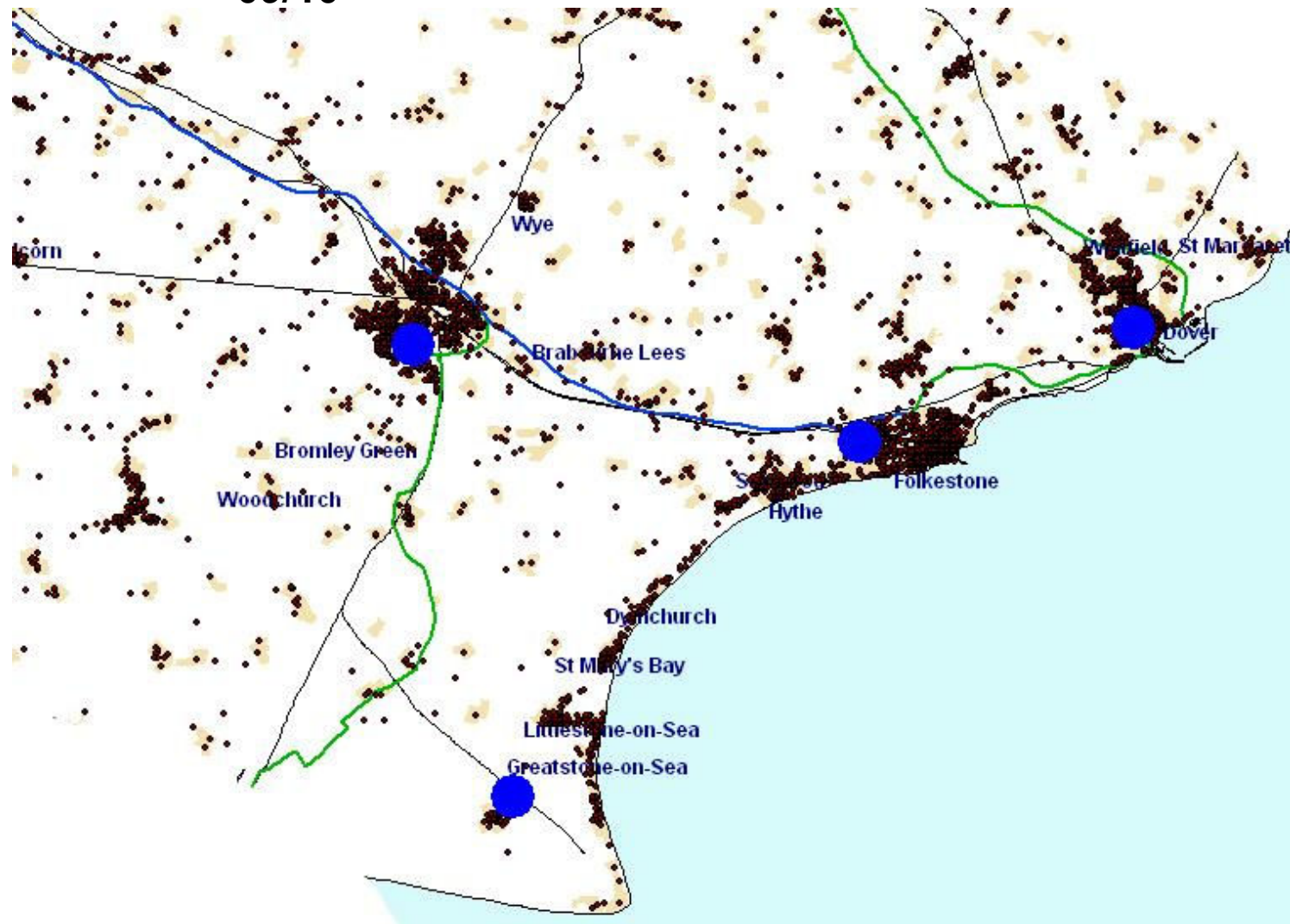
10 Ambulance Community Response Post (ACRP) replace 5 Stations



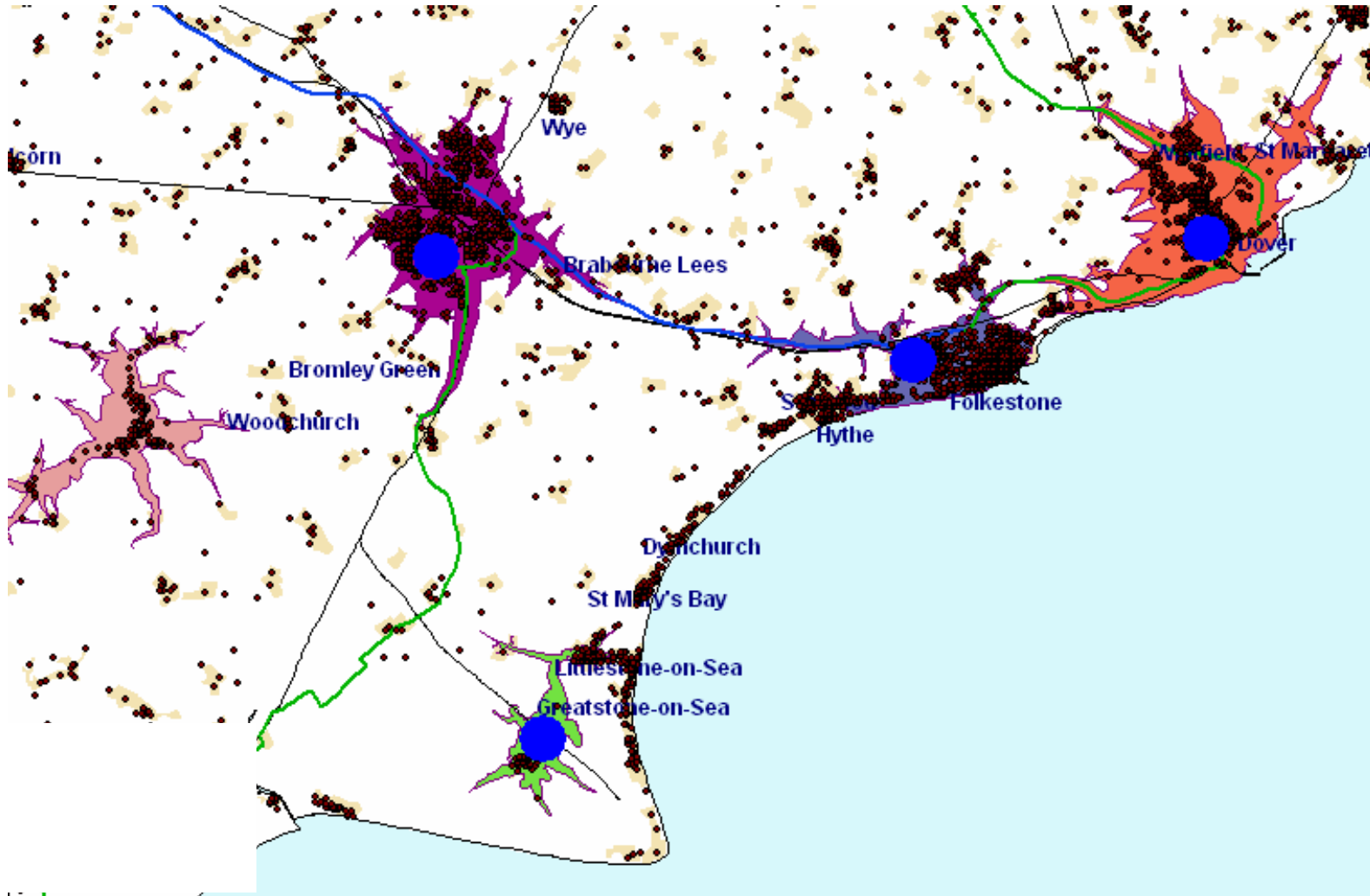
Ashford Area Stations



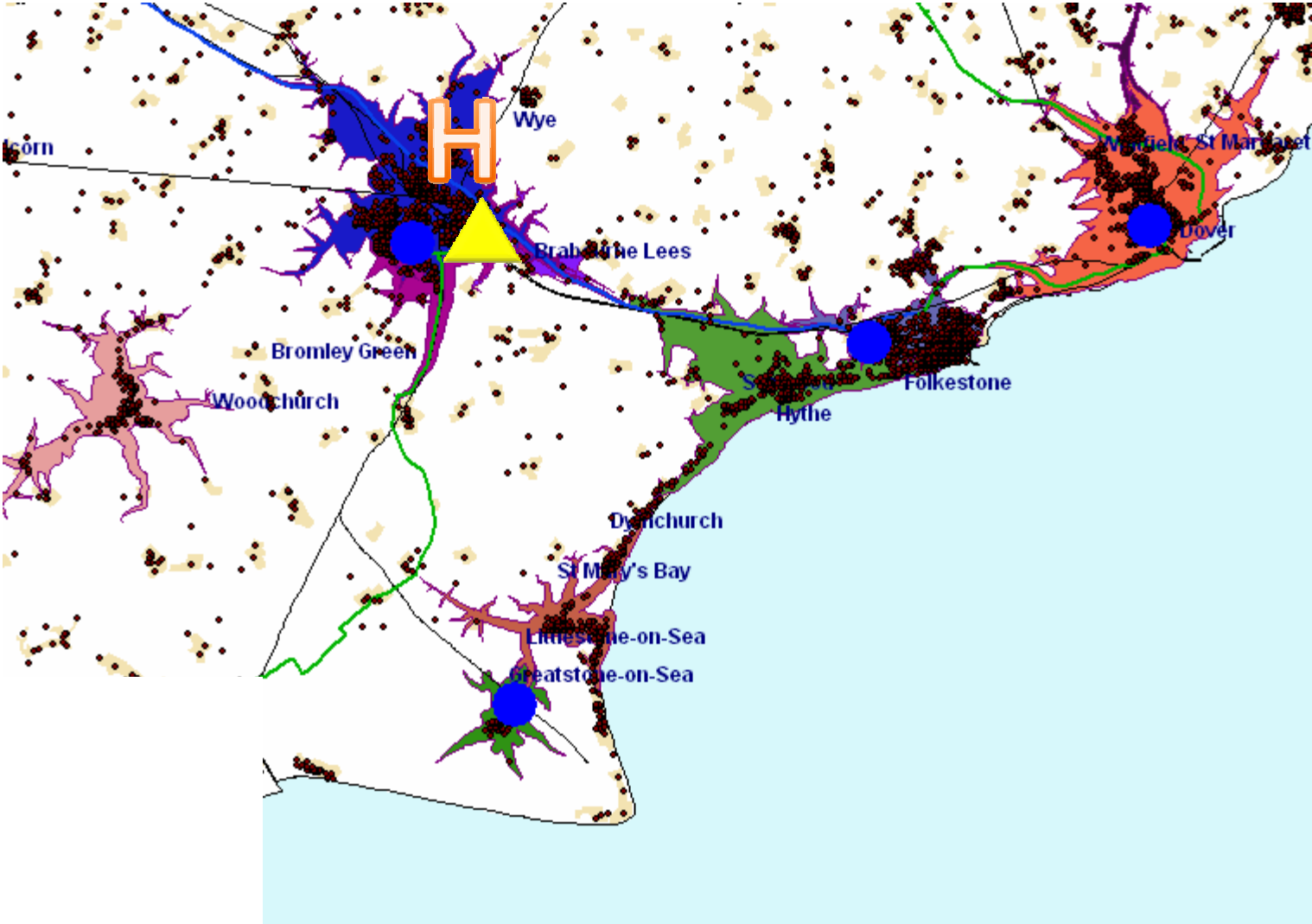
Ashford Area Life Threatening (Cat A) Calls 09/10



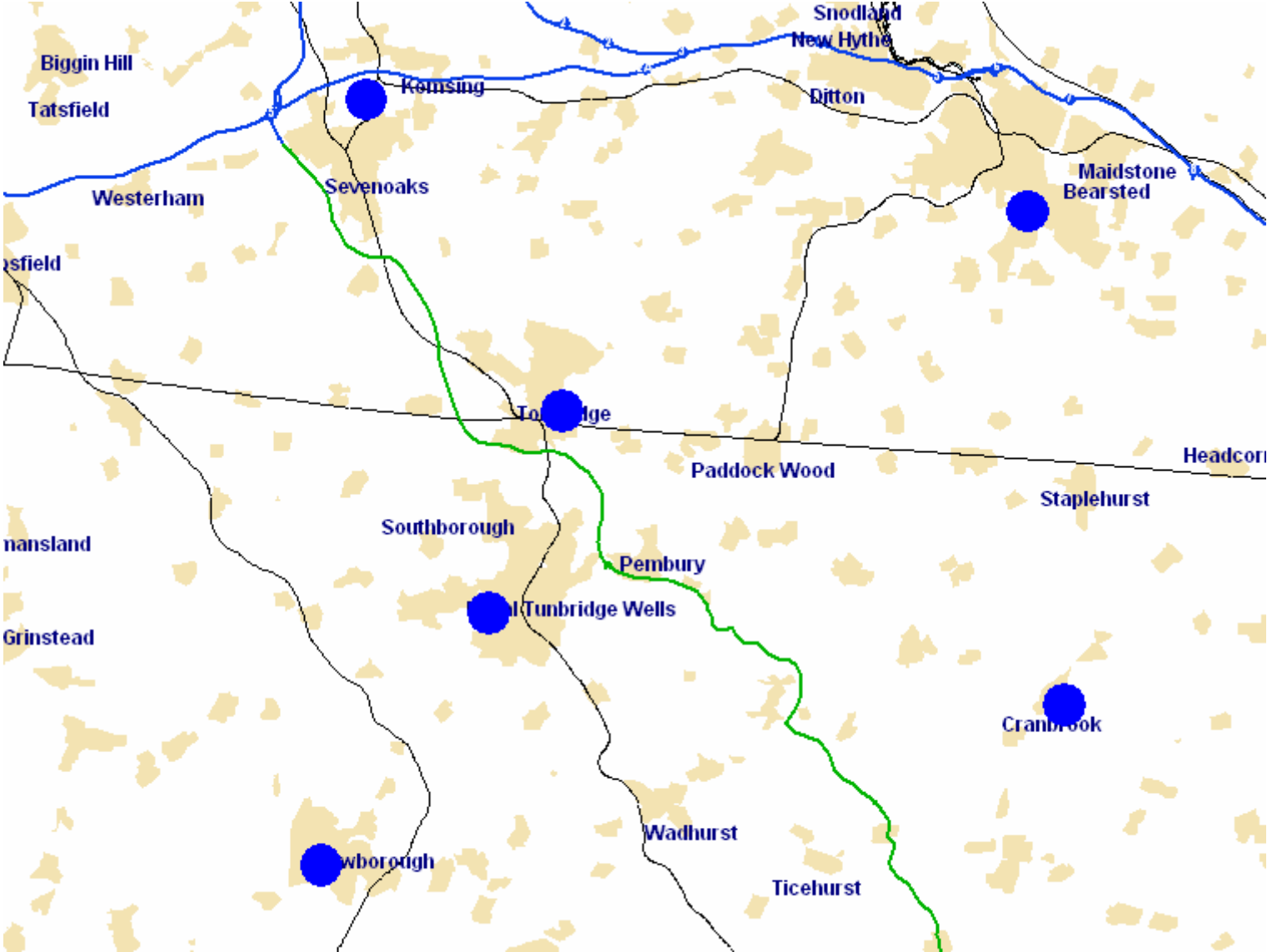
Ashford Area Ambulance Stations Response Times



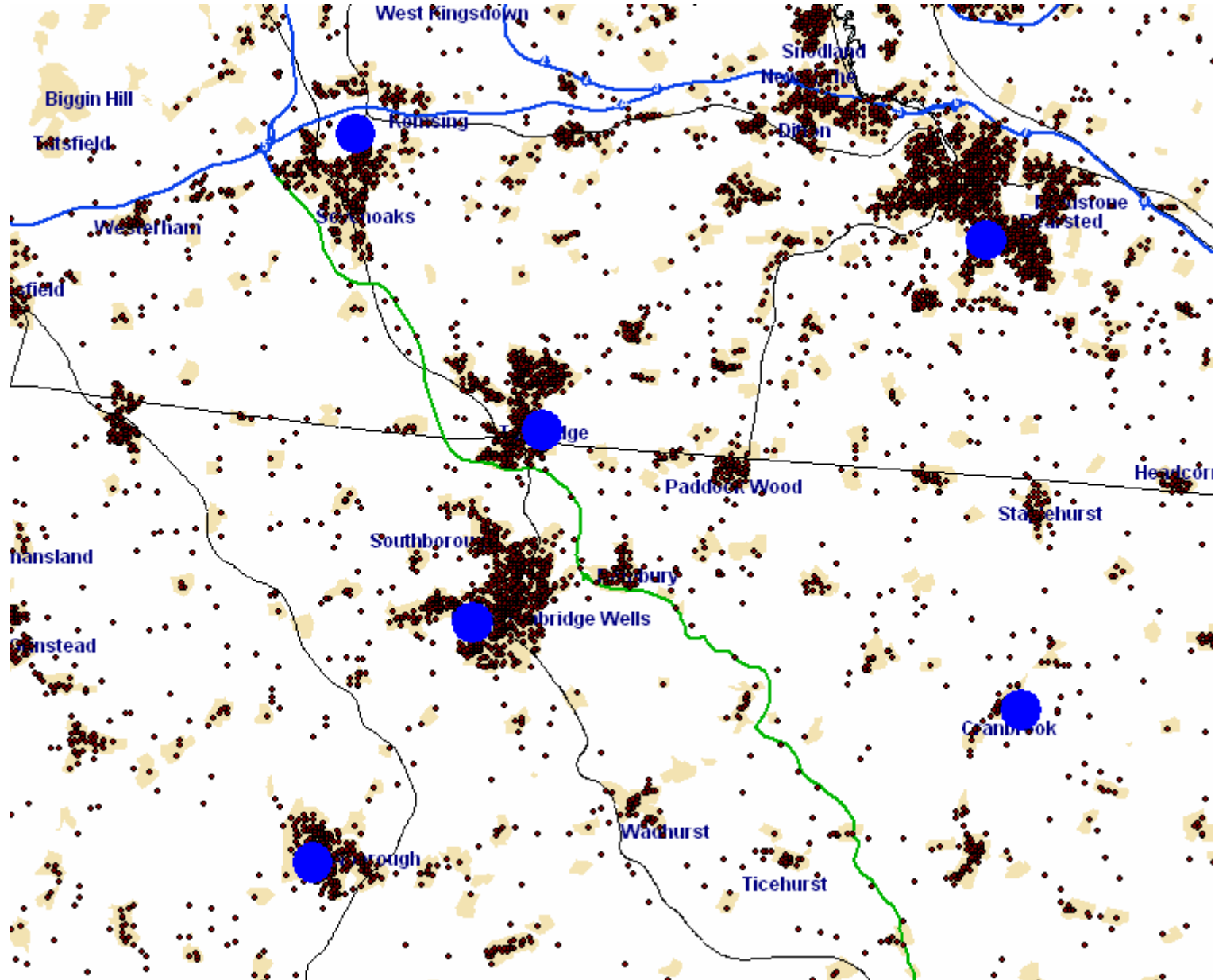
10 Ambulance Community Response Post (ACRP) replace 4 Stations



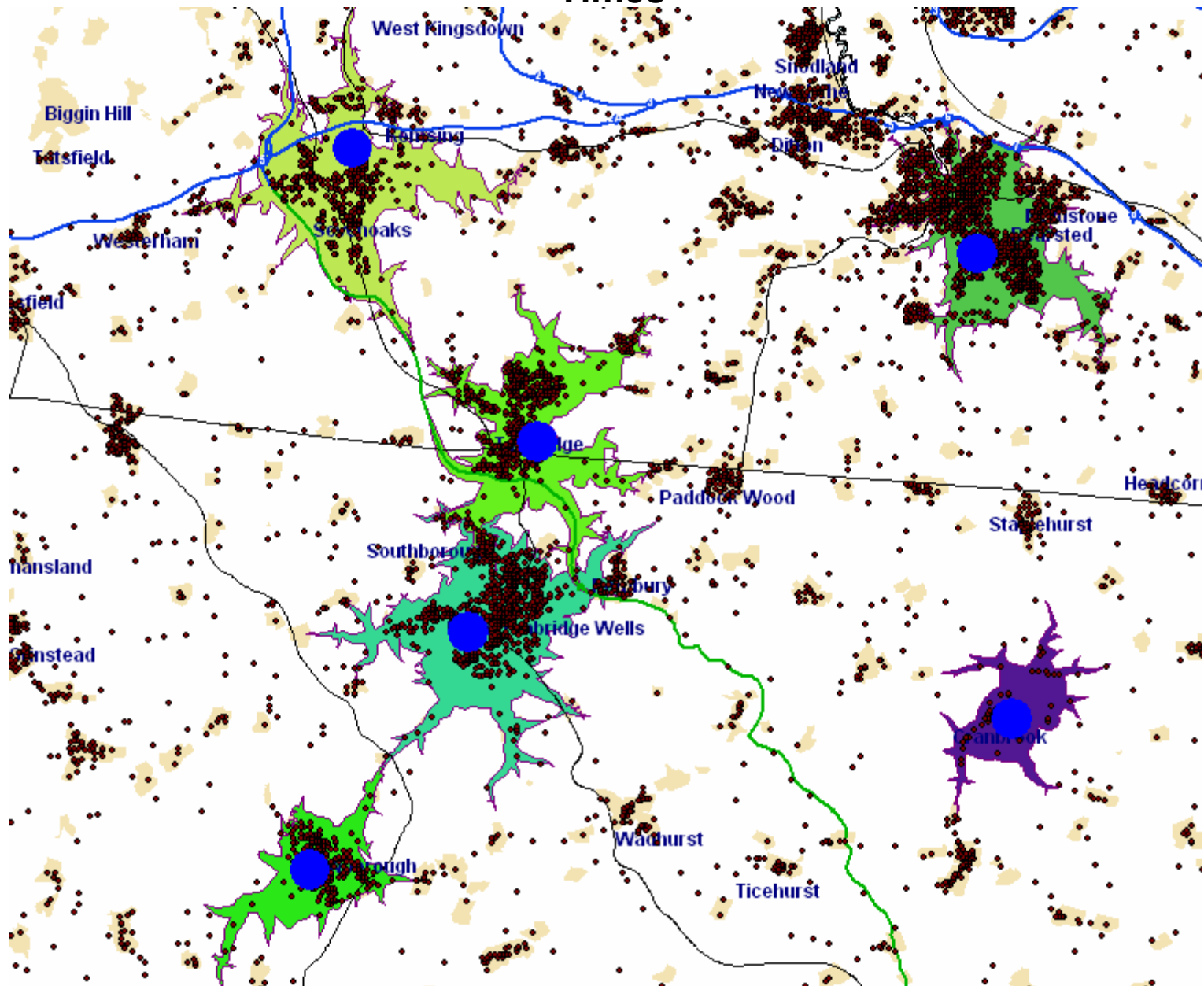
Paddock Wood Area Stations



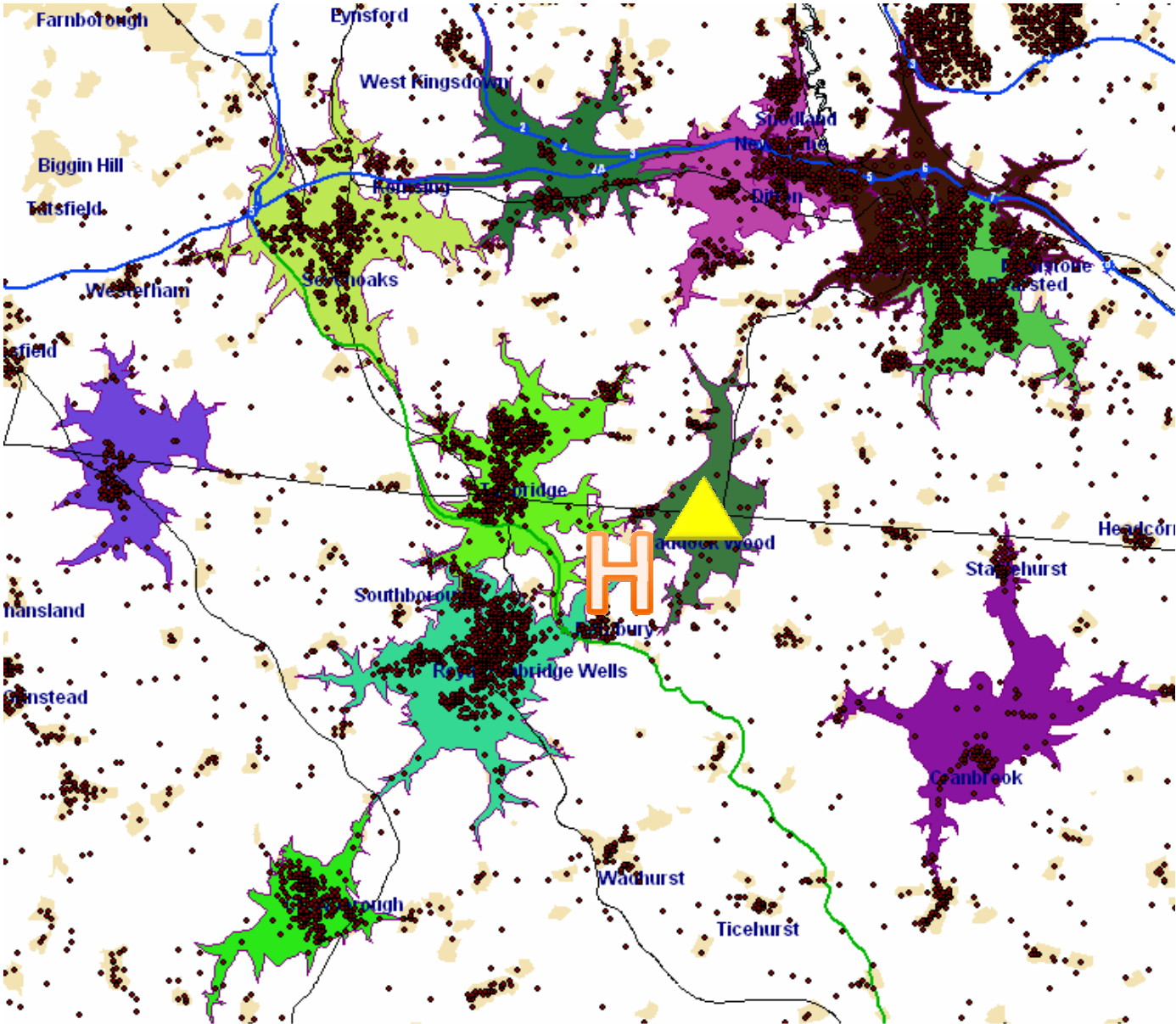
Paddock Wood Area Life Threatening (Cat A) Calls 09/10



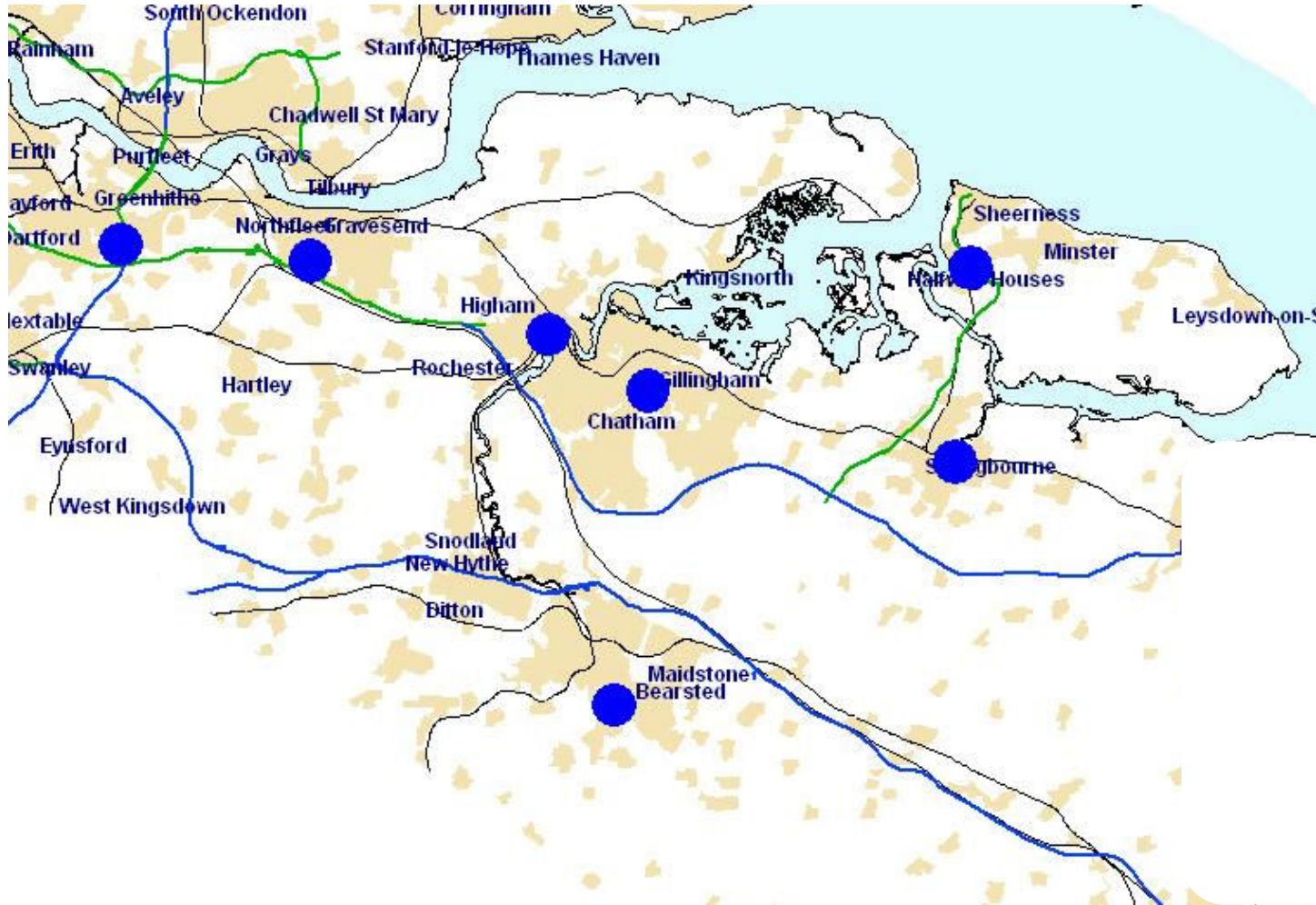
Paddock Wood Area Ambulance Stations Response Times



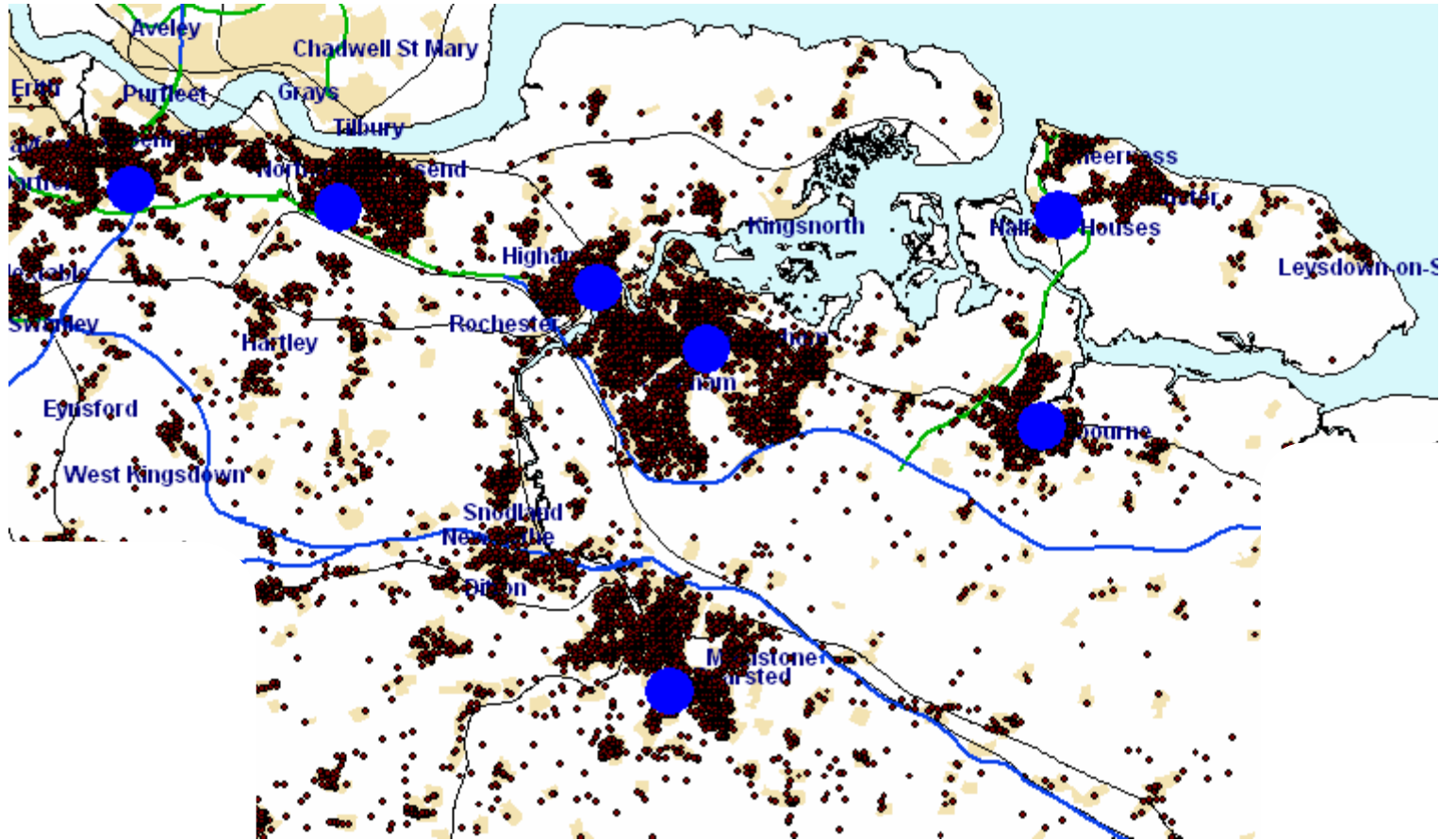
10 Ambulance Community Response Post (ACRP) replace 6 Stations



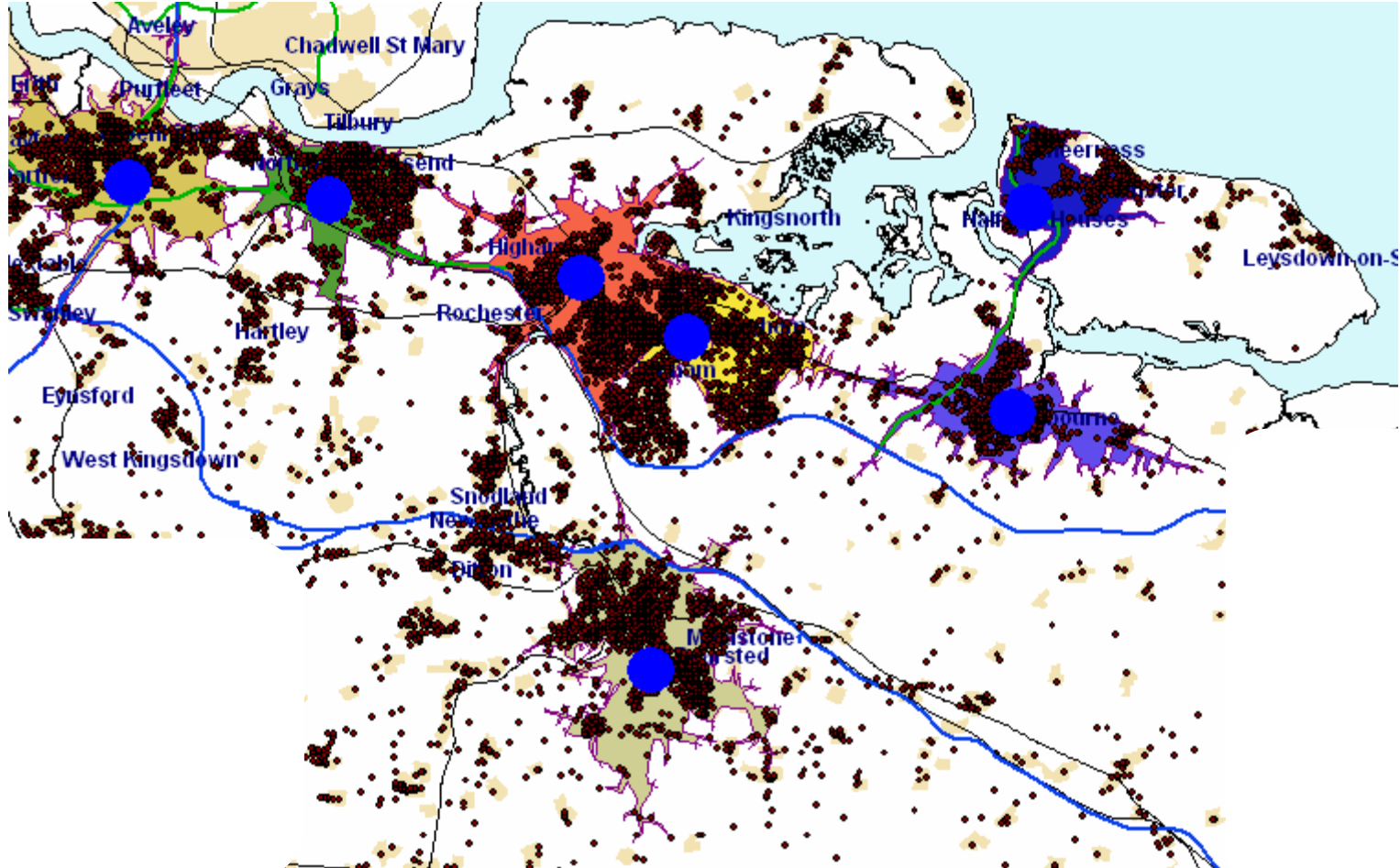
Medway Area Stations



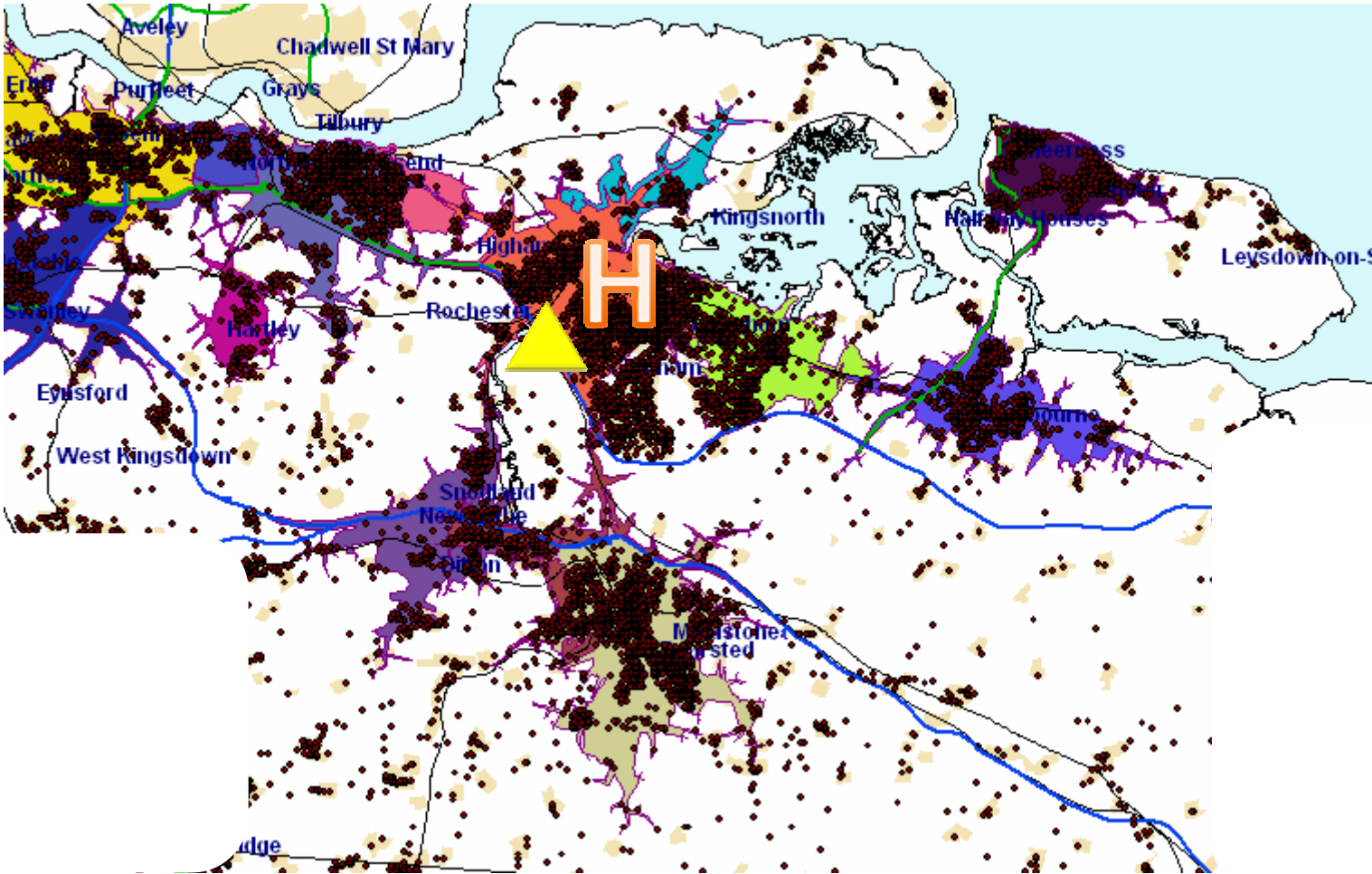
Medway Area Life Threatening (Cat A) Calls 09/10



Medway Area Ambulance Stations Response Times



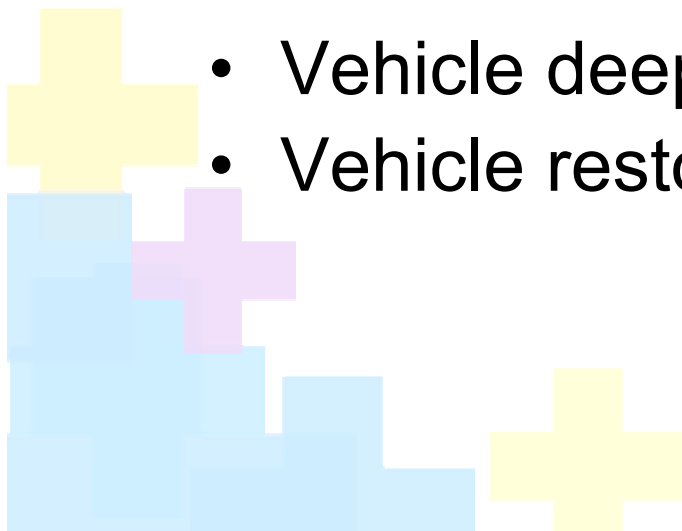
14 Ambulance Community Response Post (ACRP) replace 7 Stations





Improved infection control through deep cleaning programme

- Undertaken every six weeks
- Linked to vehicle servicing schedule
- All equipment removed
- Vehicle serviced
- Vehicle deep cleaned
- Vehicle restocked





Monthly Swab Testing

Eclipse Scientific Group, Medcalf Way
Bridge Street, Chatteris
Cambridgeshire, PE16 6QZ
Telephone: 01354 695858
Fax: 01354 692215
E-Mail: enquiries@esglabs.co.uk
Web Site: www.eclipsescientific.co.uk



Page 1 of 3

TEST CERTIFICATE

Mr Roland Conn
Lightbridge Support Services
1 Stangate House
Stanwell Road
Penarth
CF64 2AA
Fax: 0208 7560845

Certificate Number: TOHT296774-1 Final

Order Number: Secamb-Kent

Date Analysis Started: 04/09/2008

Date Reported: 08/09/2008

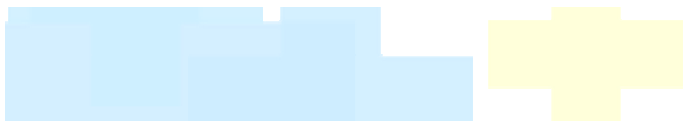
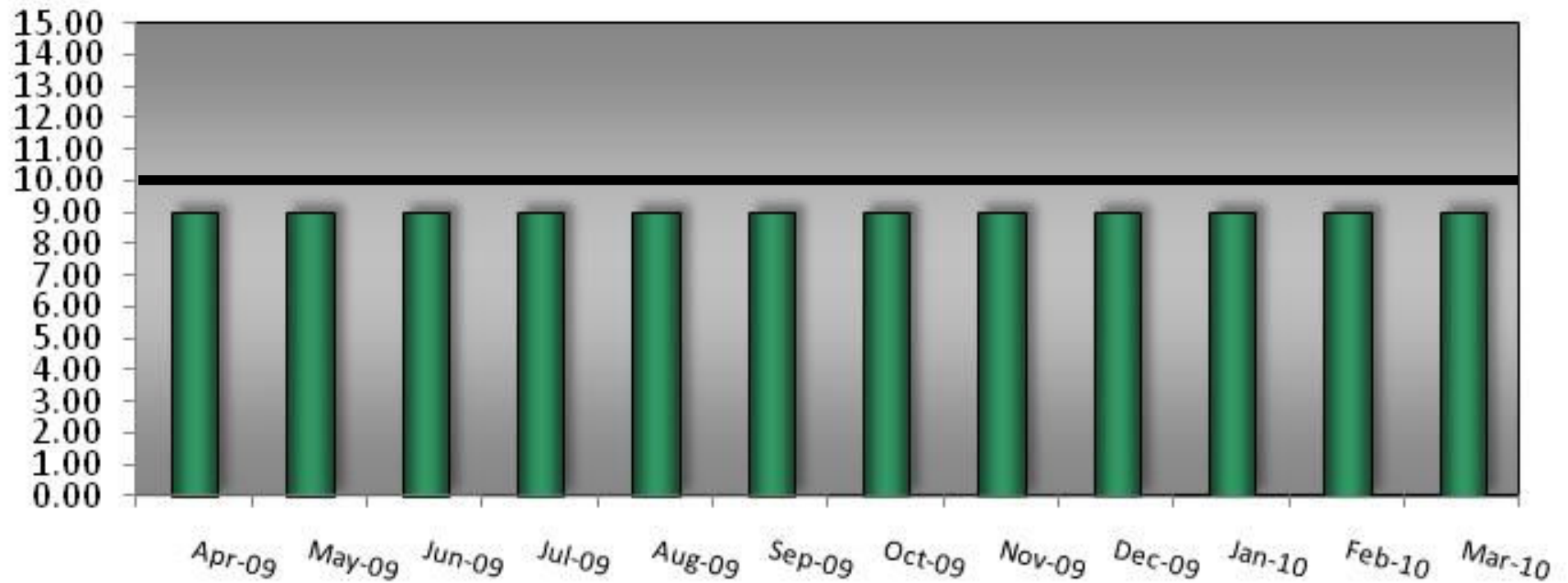
Lab Ref.	Sample Details	Method Number	Test	Result	Units	Flag
OHT1184370	Desc: Medway 394 - Trolley Mattress. Sampled on 03/09/08 @ 02:10. Received Date: 04/09/2008 Order No: secamb-kent ARF No: 151015 Suffit: tvc, ent,staph Contact: Roland Conn	ESGM-M300	Total Viable Count, 3 days 30°C	10	cfu / Area Swabbed	
		ESGM/303	Enterobacteriaceae (presumptive)	<10	cfu / Area Swabbed	
		ESGM-M307	Staphylococcus aureus	<1	cfu / Area Swabbed	
OHT1184371	Desc: Medway 394 - Front Patient Seat. Sampled on 03/09/08 @ 02:12. Received Date: 04/09/2008 Order No: secamb-kent ARF No: 151015 Suffit: tvc, ent,staph Contact: Roland Conn	ESGM-M300	Total Viable Count, 3 days 30°C	<10	cfu / Area Swabbed	
		ESGM/303	Enterobacteriaceae (presumptive)	<10	cfu / Area Swabbed	
		ESGM-M307	Staphylococcus aureus	<1	cfu / Area Swabbed	



Trust Vehicles – CDiff Profile

Clostridium Difficile

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Benefit Analysis – in summary

- Improvements to patient & staff safety
- “Liberate” clinician time lost currently at start, during and end of shifts
- Reduce stock through improved management and reduced wastage
- Standardise equipment on every vehicle
- Reduce overall fleet size, through better use
- Improve infection control rates
- Reduce vehicle break downs
- Improved management of staff and issues through on site management presence
- Benefits through economies of scale
- Meet environmental standards
- Modernise the estate
- Reduce estates running costs.
- Improve work/life balance for staff through introducing a variety of shift patterns



Q&A Session

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Item 6: SECamb – Current Developments: Additional Information from Dover District Council

Minutes of the meeting of the SCRUTINY (COMMUNITY AND REGENERATION) Committee held on Monday 16 August 2010 at the Council Offices, Whitfield on at 6.30 pm.

Present:

Chairman: Councillor G J Hood

Councillors: A Friend
D R Lloyd-Jones
J F Tranter
R S Walkden

Also Present: Mr Geraint Davies (Director of Corporate Affairs and Service Development, South East Coast Ambulance Service)
Mr Geoff Catling (Director of Technical Services and Logistics, South East Coast Ambulance Service)
Mr Chris Stamp (Senior Operations Manager)

Officer: Democratic Support Officer

Apologies for absence were received from Councillors C M Edwards, L A Keen, P A Lodge, S C Manion, V J Revell and J C Record.

The Democratic Support Officer advised the Committee that an apology for absence had been received from the Portfolio Holder for Health and Public Protection, Councillor P G Heath.

162 APPOINTMENT OF SUBSTITUTE MEMBERS

It was noted that in accordance with Rule 4 of the Council Procedure Rules, Councillor J F Tranter had been appointed as substitute for Councillor V J Revell.

163 PUBLIC SPEAKING

The Democratic Support Officer reported that there had been no applications for public speaking at the meeting.

164 'MAKE READY' AMBULANCE SERVICE REORGANSIATION

The Committee received a presentation from representatives of South East Coast Ambulance Service (SECamb) on the 'Make Ready' changes being implemented at Ashford and how they would change the ambulance service in Dover.

Item 6: SECAMB – Current Developments: Additional Information from Dover District Council

A letter from the Reverend Peter Sherred was also circulated to the members of the Committee for their information.

It was stated that the objective of the 'Make Ready' initiative was to improve infection control; reduce risk to staff, vehicles and equipment; enable resources to be used more flexibly and effectively; and reinvest efficiencies generated in front line services such as staff and clinical developments.

The location of the 'Make Ready' depots close to East Kent's acute hospitals in Ashford and Thanet was deliberate, as the majority of ambulance responses would end at these hospitals and it would permit ambulance crews to quickly restock equipment or replace vehicles as necessary before returning to the network of Ambulance Community Response Posts (ACRP) in the local community. The new ACRP's would enable SECAMB to replace its existing ageing physical infrastructure, the majority of which (68%) predated 1974 with a modern, flexible and more appropriately located infrastructure.

The 'Make Ready' depots would have dedicated facilities for ambulance maintenance and deep cleansing.

Currently, ambulance crews were required to clean their own vehicles, which was not as efficient as using specialist cleansing staff and reduced the amount of time that ambulances were available for use. The deep cleansing of an ambulance took 8 hours and would be performed at the 'Make Ready' depot unlike the current situation where vehicles had to be sent away to undergo a deep cleansing.

By providing sufficient vehicles to cope with demand of 141% of the expected level there would be sufficient spare vehicle capacity to cover the removal of vehicles from use for cleansing. A 'Make Ready' station would have 21 ambulances and nine response cars, of which at peak times 14 ambulances and six response cars would be operational. In the United States of America where the 'Make Ready' system had been operational for longer, they operated to a 133% capacity.

The Committee was reassured that whilst the 'Make Ready' depot was outside of the District, it would not impact on response times as ambulances would in most cases be responding from locations such as the ACRP stations to incidents.

The introduction of two ACRP's in the District – Dover South and Dover North (based at Whitfield) would also improve the response time for ambulances to rural areas around Dover. Each ACRP would accommodate one ambulance crew of two people and one response vehicle with a crew of one. It was emphasised to the committee that the replacement of the existing ambulance

station with two ACRP's would not result in any reduction of capacity and would in actuality put more resources into the area.

The Committee was advised that if the current Dover Station site were to be developed as part of larger redevelopment of the area and SECamb's were to be offered a location on that larger site then it would want to retain that option if it offered and it made sense in terms of response times. However, the Trust was committed to developing ACRPs within Dover to meet the needs of local patients.

In response to a question from Councillor A Friend, the Committee was assured that the Dover North ACRP did not replace Deal Ambulance Station.

It was stated that regular vehicle maintenance undertaken on site by trained mechanics would reduce the number of vehicle hours lost due to breakdowns and the operational life of the vehicle would be extended.

The 'Make Ready' depots would also equip all ambulances to an agreed uniform design so that crews knew where vital medical equipment was in an emergency regardless of which vehicle they were operating from. The replacing of a link between a crew and a specific ambulance with a uniformly laid out and equipped set of vehicles meant that it would be possible for crews to switch vehicles mid-shift in the event that an ambulance needed to be taken out of service for cleansing and restocking following an emergency response.

The Committee was advised that the current ambulance fleet was on average three years and two months old and were all the same type of Mercedes vehicle.

RESOLVED:(a) That the Cabinet be asked to note that the South East Coast Ambulance Service 'Make Ready' initiative was supported by the Scrutiny (Community and Regeneration) Committee by reason of the following perceived benefits:

- (i) The assurance from South East Coast Ambulance Service that there would be no diminution of service in Dover as a result of the 'Make Ready' initiative.
- (ii) The assurance from South East Coast Ambulance Service that the replacement of the existing Dover Ambulance Station with a Dover South Ambulance Community Response Post (ACRP) on the existing site and a new Dover

Item 6: SECAMB – Current Developments: Additional Information from Dover District Council

North ACRP at Whitfield would not reduce the number of ambulances operating from Dover.

- (iii) The assurance from South East Coast Ambulance Service that the 'Make Ready' initiative would not adversely impact on response times for Category A (life threatening) and Category B (urgent) responses.
 - (iv) The improved infection control through the use of specialist cleansing staff.
 - (v) The introduction of a standardised specification for drugs and equipment that might be needed in a medical emergency on board the ambulance.
 - (vi) The improved response time to rural parts of the district through the introduction of the Dover North ACRP based at Whitfield.
- (b) That the Cabinet be urged to work with South East Coast Ambulance Service to raise awareness of the 'Make Ready' initiative and what it would mean for the people of Dover and the surrounding area.
 - (c) That the Cabinet be asked to note the intention of the Scrutiny (Community and Regeneration) Committee to visit a working 'Make Ready' station to observe the initiative in action and that an invitation would be extended to the Portfolio Holder for Health and Public Protection to accompany the Committee.

The meeting ended at 8.25 pm.

Item 7

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

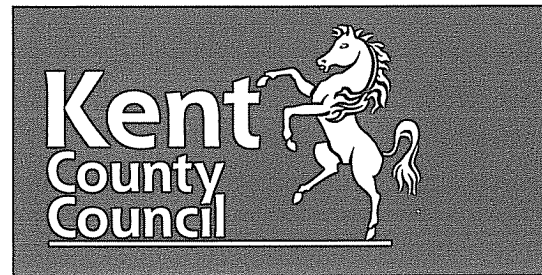
To: Health Overview and Scrutiny Committee – 8 October 2010

Subject: Item 7. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.

1. Recommendations

- (a) The Committee is asked to note the attached letter sent to the Secretary of State for Health following the meeting of the Health Overview and Scrutiny Committee on 20 September 2010.

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The Rt Hon Andrew Lansley CBE MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Legal and Democratic Services
Sessions House
County Hall
Maidstone
Kent ME14 1XQ
DX: 123693 Maidstone 6
www.kent.gov.uk/legal

Direct Dial/Ext: (01622) 694486
Fax: (01622) 694383
Email: paul.wickenden@kent.gov.uk
Date: 21 September 2010

Dear Secretary of State,

Women's and Children's Services - Maidstone and Tunbridge Wells NHS Trust

As Chairman of the Health Overview and Scrutiny Committee at Kent County Council, I am writing to inform you that Members of the Committee have taken the opportunity of considering the Four New Tests which you have directed to be applied to any new reconfiguration of services:-

- (a) support from GP commissioners;
- (b) strengthened public and patient engagement;
- (c) clarity on the clinical evidence base; and
- (d) consistency with current and prospective patient choice.

They have also observed the stakeholder events organised on behalf of the South East Coast Strategic Health Authority as directed by yourself together with the sole public meeting organised by Members of the County Council and Borough Council who represent Maidstone whose residents wish to see Women's and Children's Services retained at Maidstone Hospital.

My Committee met on 20 September and resolved that:-

- (a) "this report and the minute of this meeting are included as an unaltered addendum to the report the South East Coast Strategic Health Authority is preparing from the Secretary of State for Health;

Geoff Wild LL.B, Dip.LG, Solicitor
Director of Law & Governance

CHIEF EXECUTIVE'S DEPARTMENT

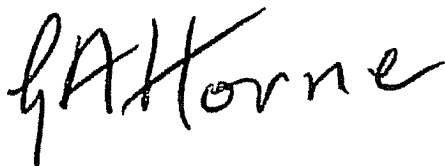


- (b) in a separate letter to the Secretary of State for Health The Chairman will request that he instigates a full review of this reconfiguration by the Independent Reconfiguration Panel or takes the decision himself to resolve the issue for the residents of Kent and in particular Maidstone and the surrounding area; and
- (c) this Committee (which serves all the residents of Kent) support the residents of Maidstone and the surrounding area for the retention of consultant led Women's and Children's Services at Maidstone Hospital and asks that a decision is taken as soon as possible in the best interest of the people of Kent."

I am enclosing a copy of the report on which my Committee passed this resolution. The draft Minutes of the meeting of 20 September are also enclosed, although these will remain a draft until they are approved by the Committee on 8 October 2010.

I would respectfully request that a final decision is made as soon as possible to bring closure to this matter so that the residents of Maidstone can move on.

Yours sincerely

A handwritten signature in black ink that reads "Godfrey Horne". The signature is written in a cursive, slightly slanted style.

Godfrey Horne MBE
Chairman, Health Overview and Scrutiny Committee
Kent County Council

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 8 October 2010

Subject: Item 8. Forward Work Programme.

1. Background

- (1) As discussed at the Meeting of the Committee on 3 September 2010, there was a need to reorganise the Forward Work programme in order to accommodate revisiting The Future of Community Service Providers at an appropriate date in the future.
- (2) The proposed new Forward Work Programme is outlined below:-
 - a) 26 November 2010 –
 - 1) Primary Angioplasty.
 - 2) Community Mental Health Services.
 - b) 7 January 2011 –
 - 1) Dentistry.
 - c) 4 February 2011 –
 - 1) The Future of Community Service Providers.
 - d) 25 March 2011 –
 - 1) Stroke Care Pathway.
 - e) 29 April 2011 –
 - 1) Accessing Mental Health Services.
 - a. Crisis Resolution Home Treatment Teams.
 - b. Forensic Mental health Services.

2. Recommendations

- (1) The Committee is asked to approve the revised Forward Work Programme.

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 8 October 2010

Subject: Item 9. Committee Topic Discussion.

1. Background

- (1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve.
- (2) At the meeting on 26 March 2010, Members of the Committee requested an opportunity at each meeting to discuss what they had heard and decide whether the outcomes for each main agenda item had been achieved, or whether there was a need for further information to be requested, and from whom.

2. Recommendations

- (a) The Committee is asked to assess whether the outcomes for this meeting have been achieved or if further information on any topic is required by the Committee.

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