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, 28 March 2008.

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

ALSO PRESENT: Mr G K Gibbens

OBSERVERS: Mr R Appadoo, Mr J Cunningham, Mrs A Evennett, Mr R Kenworthy, Mr J Larcombe, Mrs A Loveday, Mrs F Witherden (Patient and Public Involvement Fora)

IN ATTENDANCE: Mrs C Singh (Democratic Services Officer), Dr D Turner, Research Officer and Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

11. Minutes - 8 February 2008
(Item. 3)

RESOLVED: that the Minutes of the meeting held on 8 February 2008 were correctly recorded and that they be signed by the Chairman.

12. Health services in Dover
(Item. 4)

The Chairman introduced this item, noting that a formal referral had been received from the Patient and Public Involvement Forum (PPIF) for the Eastern and Coastal Kent PCT. Although the Forum would be disbanded, along with all other PPIFs, after 31 March 2008, he hoped that this formal referral would still be dealt with by the Committee.
The Chairman suggested that he, the Vice Chairman and the Liberal Democrat Spokesman needed to discuss the Committee's future work programme. It might be necessary to set up working groups if the Committee was to keep to half-day meetings, as agreed previously.

The Committee agreed to the Chairman, the Vice Chairman and the Liberal Democrat Spokesman meeting to discuss the way forward.

13. Healthcare Commission Annual Health Check
(Item. 5)

Dartford and Gravesham NHS Trust

(Item 5 – Mr M Devlin, Chief Executive, and Ms S Acott, Director of Performance and Service Development and Director Lead for Governance, Dartford and Gravesham NHS Trust were in attendance for this item at the invitation of the Committee)

(1) The Chairman introduced Mr Devlin and Ms Acott and thanked them for attending. He felt that it would be helpful if they both outlined where they felt the Trust had made the most progress over the past year and where they had made the least progress.

(2) Mr Devlin advised that the Trust had been looking to make a Core Standards declaration of "Fully met" ("Compliant" in respect of all Core Standards) for 2007–8. In 2006–7 there had been two areas relating to equality and diversity where the Trust had not performed adequately, leading it to declare itself "Not met" in respect of Core Standard C07e. Mr Devlin advised that information was now available in a wider range of languages and more patient information on disability had been published on the Trust's website. He advised the Committee that the Trust was now compliant in respect of this Core Standard, having been so since the middle of 2007–8, but it would not be able to declare itself "Fully Met", for that particular element as it had not been compliant for the whole year. However, given this was the only lapse and had been addressed within year, the Trust would be making an overall Core Standards declaration of "Fully met" for 2007–8.

(3) Nevertheless, the Trust had not deteriorated in any respect and they were happy with the progress that had been made.

(4) Mr Devlin conceded that in the first half of the year there had been more cases of MRSA than there should have been. But there had been an improvement over the past four months. Mr Devlin reminded the Committee that this was one of the best hospitals in the south east of England.

(5) In response to whether the self assessment by Trusts for the Annual Health Check was similar to the system used in schools, Mr Devlin advised that the Quality of Services element of the Annual Health Check was based on performance against targets (which was measured objectively) and performance against Core Standards, rated by Trusts' self-assessments, backed up by random inspections conducted by the Healthcare Commission.

(6) In response to a question on the Trust now being in surplus and having no budgetary problems, Mr Devlin advised the Committee that the Trust had achieved annual surpluses for two years in a row: £¼ million in 2006–7 and £½ million in 2007–8. He predicted that in 2008–9 there would be a surplus of £1 million, The Trust had a historic deficit of £1 million, which was being cleared by these in-year surpluses and would be completely cleared in

2008–9. The Trust's Use of Resources score in the Annual Health Check should on this basis move from "Fair" to "Good" in 2008–9.

(7) A Member asked whether the Trust was compliant with Core Standards in respect of the provision of dental services and diabetes services. Ms Acott explained that the Trust was not responsible for the provision of primary care dentistry. However, oral surgery was provided at the Darent Valley site by Medway Trust and this service was fully compliant with Core Standards. With regard to diabetes services, these were excellent and compliant with Core Standards.

(8) A Member asked how the needs of ethnic minority patients were being met in respect of dietary requirements and languages. A question was also asked about how the Trust ensured that older patients were eating their meals. Mr Devlin said that the PPIF had been critical of catering arrangements in its third-party commentary for the 2006–7 Annual Health Check, but was more positive this time.

(9) The new catering contract was successful and this had been verified by the Trust Board. On the issue of ensuring that older people ate their meals, Mr Devlin explained that any patient needing assistance with eating was served their meal on a red tray (instead of the usual blue tray), so that staff, including support staff, could help them. Regarding language difficulties, Mr Devlin said that the Trust now had interpreters available. He added that 30% of the Trust's staff were from ethnic minority backgrounds, meaning that a wide variety of languages was spoken among staff.

(10) In response to a question about the Trust's seeking Foundation Trust status, Ms Acott explained that the Trust had not yet put its application before the Department of Health. This had been put back from December 2007 as the Trust's level of MRSA infection had been higher than it had wanted – and the Department of Health had "raised the bar" on infection control. MRSA rates were now better so the Trust was more confident about taking its application to the DoH. It would first be submitted to the South East Coast Strategic Health Authority at the end of March 2008.

(11) Responding to a question about numbers of cases of Clostridium difficile, Ms Acott advised that the Trust's position in this regard had been consistently good for some time. Regarding cases of MRSA, under current NHS targets the Trust was not allowed more than twelve cases in 2007–8. Ms Acott thought that the timetable for achieving Foundation Trust status was about right – Foundation Trust status would be achieved in the next six months.

(12) In response to a question about pharmacy services, Mr Devlin advised that the Trust was trying to improve dispensing arrangements by setting up a pharmacy outlet for patients who were being discharged.

(13) Mr Devlin said he was puzzled to hear that the quality of diabetes services had been queried by the West Kent PPIF. Ms Acott said that she was aware that a camera used for diabetic retinopathy screening had not been working, but this was not a fundamental issue. She explained that the diabetic retinopathy screening service was being provided by a team from the Paula Carr Trust.

(14) Responding to a question about the cost of the Trust's Private Financial Initiative (PFI) contract, Ms Acott said that this did not impact on service delivery.

(15) A Member asked how it was that the Trust had only been rated "Fair" for Use of Resources in the Annual Health Check for 2006–7 when it had actually achieved a surplus in that year. Mr Devlin advised that, under the Healthcare Commission's rating system, having run up a deficit in 2005–6, the Trust needed to achieve a surplus in two consecutive years before it could be rated "Good" for Use of Resources. This would happen in 2007–8. Regarding the PFI contract, Mr Devlin said that this did have the virtue of protecting funds allocated to services such as catering, as he was not able to raid budgets that were set under the PFI contract. It could be argued that it was an expensive contract – but it did mean that the Trust was able, for instance, to offer a good, diverse catering service.

(16) A Member asked whether the Health Overview and Scrutiny Committee's minutes were forwarded, as a matter of course, to the Healthcare Commission and if not, why not. The Overview, Scrutiny and Localism Manager advised that the minutes were not forwarded to the Healthcare Commission. The Commission would not be able to process all the minutes of all the Health Overview and Scrutiny Committees in the country. Instead, it relied on the third-party commentaries that the committees submitted each year as part of the Annual Health Check process, commenting on Trusts' performance against Core Standards. In order to be able to provide these commentaries, the Committee needed to build up an evidence base throughout the year. The Chairman agreed that the Committee needed a stronger evidence base to allow it to contribute to the Annual Health Check process. The Kent Local Involvement Network and Healthwatch would be important sources of information and feedback from patients about local NHS services.

(17) The Chairman thanked Mr Devlin and Ms Acott for the information that they had given the Committee.

Maidstone and Tunbridge Wells NHS Trust

(Item 6 – Mr Glenn Douglas, Chief Executive, and Ms Christina Edwards, Acting Chief Nurse, Maidstone and Tunbridge Wells NHS Trust were in attendance for this item at the invitation of the Committee)

(1) The Chairman introduced Mr Douglas and Ms Edwards and thanked them for attending. He then asked them to outline where the Trust had made the most progress and where the Trust had made the least progress.

(2) Mr Douglas said that 2007–8 had been a strange year for the Trust, because of the Healthcare Commission's investigation of the outbreaks of Clostridium difficile at the Trust's hospitals and the consequences of this. However, he was confident that the Trust would be able to make a declaration of "Fully met" in respect of Core Standards for 2008–9. He said that good progress had been made on MRSA, with the Trust being one of the best performing on this. With regard to Clostridium difficile, the Trust had achieved all its targets and had in fact considerably undershot, with a steady decrease in

cases even though the level of infection in the community was rising. Mr Douglas tabled a list of the Core Standards that the Trust would be declaring it had failed to meet, stating that the Trust would be one of the worst in the country in this respect. However, he explained that, given the amount of scrutiny that the Trust had been under lately, it needed to be "squeaky-clean". So where there was any doubt at all about compliance with a Core Standard, the Trust was making a declaration of "Not met". He emphasised that this did not mean that the Trust was a "basket case". The Cancer Centre at Maidstone was among the best in the country and consistently exceeded its targets. Genito-urinary Medicine had achieved 100% of its access targets. At the same time, some other Trusts' declarations, while not untruthful, could be described as optimistic.

(3) A Member welcomed Mr Douglas's honesty and openness, and asked what was being done to prevent bed-blocking – particularly in respect of tariff unbundling to allow more use to be made of community hospital beds.

(4) Mr Douglas advised that tariff unbundling was a complex issue, and that there had in the past been a degree of suspicion between the Trust and West Kent PCT, with each being suspected of wanting to dump costs onto the other. He admitted that the Trust had placed patients into nursing home beds in order to alleviate pressure on acute beds. The Trust was all too well aware of the infection-control risks of putting beds too close together; and the PCT had been reluctant to reopen closed community hospital beds.

(5) Mr Douglas said that his chief concern was to see that hospital beds were freed up. Whether this was done by patients going into community hospital beds or into nursing home beds was a secondary issue. Pressure had been put on the PCT to reopen community hospital beds, but he was not in a position to influence how the PCT dealt with this.

(6) A Member put it to Mr Douglas that lack of finance seemed to underlie all the issues that the PPIF had raised in its third-party commentary for the Annual Health Check. He replied that it didn't feel that way at the Trust. They had now considerably increased spending on nursing. There had been a recruitment freeze to hit financial targets; staffing levels on wards had been inadequate; and there had been too much reliance on bank and agency staff. However, this situation had now ended. Ms Edwards added that a lot of additional nurses had been appointed since November 2007. The Trust would soon be up to the staffing level recommended by the Healthcare Commission. Recruitment was made more difficult for the Trust by the fact that it was near to the London weighting area, where staff could make more money.

(7) A Member said that service provision should drive the Trust, not financial issues; and stated that too many trained nurses were being poached by the Australian healthcare system. Mr Douglas responded that the Trust was obliged, like all parts of the NHS, to make efficiency savings. Ms Edwards said that the NHS in the South East had a lower rate of staff turnover than elsewhere (partly because it was a more rural area, meaning people tended to move around less). The sickness rate among nurses was lower too. She said that it was mainly young trained nurses who went to work in Australia – but they often came back. And it should be remembered that the NHS had

taken nurses from other countries, many of whom had returned home with better skills, thereby improving nursing standards in their own countries.

(8) A Member asked what the outcome had been in the cases of those members of staff who had recently been suspended by the Trust for poor practice in relation to infection control. Mr Douglas replied that two members of staff had been dismissed and two had been given warnings. Senior nurses were now taking more responsibility, which was key. Also, maintenance staff were now under pressure from nursing staff to maintain high standards of cleanliness.

(9) Responding to a question about setting up stroke units, Mr Douglas said that he was absolutely committed to seeing such units at both the Kent and Sussex Hospital and Maidstone Hospital. The unit at the Kent and Sussex would be open in June 2008. At Maidstone a "virtual unit" was being created and staff were being recruited. A solution was being identified and this would be achieved. He urged Members to visit the Trust's hospitals and see how they were doing. He added that the Trust was looking to set up its own patient panel, using the expertise of former PPIF members.

(10) A Member advised that a relative of his was currently in Maidstone Hospital. He had been very impressed with the standard of cleaning and the care his relative was receiving. However, on one occasion during visiting hours he had found his relative sitting in a chair completely naked. Ms Edwards apologised for this occurrence and explained that the Trust still had a long way to go. Staff were under a lot of scrutiny and the majority did a good job. The Member's complaint would be followed up, as all complaints were. The Trust welcomed complaints as a means of improving services.

(11) The Chairman thanked Mr Douglas and Ms Edwards for answering the Committee's questions so straightforwardly.

Eastern and Coastal Kent PCT

(Item 7 – Lynne Selman, Director of Citizen Engagement and Communication, Karen Benbow, Assistant Director Assurance, and Debra Vidler, Head of Standards and Better Health, Eastern and Coastal Kent PCT, were in attendance for this item at the invitation of the Committee)

(1) The Chairman introduced Ms Selman, Ms Benbow and Ms Vidler and thanked them for attending. He asked them to detail where they felt there had been progress and where they felt there had been a lack of progress. Ms Selman explained that the PCT had come into existence quite recently, following the merger of five predecessor PCTs, which had had differing levels of compliance with Core Standards. The PCT's rating against Core Standards mostly related to the services that it provided itself, but a few related to its performance as a commissioner of services. In future the PCT would be rated much more on its commissioning function.

(2) Ms Benbow reported that the PCT's position had improved greatly. In the 2006–7 Annual Health Check it had been rated "Weak" on Quality of Services and "Fair" on Use of Resources. For 2007–8, the PCT was predicting that it would be rated "Fair" on Quality of Services and "Good" on Use of Resources. The PCT was expecting to declare itself "Compliant" in

respect of 79% of Core Standards – as against 34% in 2006–7. At the present moment, the PCT had "Not met" or had "Insufficient assurance" in respect of eight Core Standards, but it expected to be able to declare itself "Compliant" in respect of some of the latter at the end of 2007–8. Ms Benbow explained that successful efforts had been made during the year to harmonise a number of policies and procedures across the five predecessor PCT areas. She advised that the PCT had been the subject of a Healthcare Commission visit during the year regarding its complaints procedures and there had been good progress following this. Progress had also been made on clinical and corporate governance structures, and on medicines management. There were two standards in respect of which the PCT would be declaring "Not met" at the end of the year: C9, regarding records management; and C13c, regarding the treatment of patient information in a confidential manner.

(3) A Member said that many patients felt they were unable to complain about the service provided by their GP as they feared being discriminated against as a result. Ms Selman responded that GP services were not directly provided by the PCT, as GPs were independent contractors, but the issue of complaints procedures should be picked up through the PCT's annual Quality and Outcomes Framework visits to practices. The PCT also encouraged the formation of practice groups, to give patients a voice.

(4) Responding to a question about the Hygiene Code and infection control, Ms Vidler said that the Healthcare Commission's report on the Clostridium difficile outbreaks at Maidstone and Tunbridge Wells Trust had been "a wakeup call". Appropriate plans had already been in place in respect of community hospitals, with significant improvements in implementation. These plans were now much more detailed and subject to a higher level of scrutiny. The PCT would, though, have to declare "Insufficient assurance" in respect of Core Standard C11b, as it had been lacking a system to monitor uptake of statutory and mandatory training by staff.

(5) A Member raised the issue of inequalities in service provision, in relation to Core Standard C18, and the extent to which Swale in particular was underserved. Ms Selman responded that investment was being made in services in Swale and other areas of underprovision. Health and Wellbeing Groups had been set up across each of the district council areas covered by the PCT, with an Executive Director leading each of them. She pointed out that in some respects, Swale actually had better services than other areas, for instance as regards audiology. Meeting this Core Standard was about having systems in place to allow the PCT to identify underserved areas and act accordingly – this did not mean that all areas were well-served at the current moment in time.

(6) A Member asked about the scoring system used for the Annual Health Check, which appeared to mean that it took a long time before any improvement in performance was reflected in the PCT's rating. Ms Benbow agreed that the scoring system was quite complicated. The Annual Health Check gave a retrospective annual rating made up of a number of elements. There was some provision for the PCT to declare itself "Compliant" in respect of a Core Standard for the whole year having achieved compliance during the course of the year. The PCT was expecting to be subject to a

risk-based inspection by the Healthcare Commission over the summer, having moved from "Weak" to "Fair" in its self-assessment on Quality of Services.

(7) A question was asked about the apparent lack of adequate procedures for managing the discharging of patients from acute care, at Medway Maritime Hospital, into intermediate care, to which the PPIF had drawn attention in its third-party commentary for the Annual Health Check. Ms Selman responded that there was a national contract covering this area, to which the PCT was adding requirements regarding the quality of information provided on discharge.

(8) A question was asked about the PCT's apparent slowness in rectifying disparities between services in Swale and those elsewhere, and lack of information on how investment in Swale had been spent, which had also been referred to by the PPIF. Ms Selman replied that about £1m of additional funding had been invested in Swale GP services, and money had been provided for new intermediate care services and other services, in order to rectify past underinvestment in the area.

(9) A Member asked that the responses on these points be given in writing to the PPIF, which had raised them in its third-party commentary. Ms Selman explained that the commentary was not addressed to the PCT, but was intended for the Healthcare Commission as part of the Annual Health Check process. However, the PCT would be happy to provide a written response if the PPIF wished.

(10) The Chairman asked about the matter of insufficient co-ordination and communication between the PCT and the Trust, which had been raised. Ms Selman said this related to discharging patients from Medway Maritime Hospital into community care. She said that the PCT was conscious that there needed to be more and better communication between the Trust and the PCT in this regard.

(11) The Chairman thanked Ms Selman, Ms Benbow and Ms Vidler for their encouraging report and for attending the meeting.

Conclusions and Recommendations
(Item 8)

(1) The Chairman suggested that, rather than the Committee now deliberating at length on what it had heard, a very full minute of the meeting should be prepared to allow matters to be taken forward – perhaps by submitting the minutes to the Healthcare Commission, as Member had suggested. He thought there needed to be a discussion about how the Committee handled the Annual Health Check process next year, perhaps by means of a sub-committee. It was pointed out by a Member that the Committee had still to hear from a number of local NHS organisations regarding their Annual Health Check declarations. The Chairman suggested there were various ways in which this might be addressed during April.

(2) The Chairman emphasised that, as the Committee had previously agreed, there should be a regular agenda item looking at what progress had been made on recommendations that it had previously made.

(3) The Chairman informed the Committee that the external review panel regarding the planned reconfiguration of services by Maidstone and Tunbridge Wells Trust was due to be convened in May 2008. The Trust had indicated in April 2007 that a nominated Member of the HOSC might be allowed to observe the panel's deliberations in order to be assured of the efficacy and robustness of the external review process. The Chairman proposed, and it was agreed, that the Committee should appoint one member of the Committee to the External Review Panel and the nominee report back to this Committee.

14. Update on Local Involvement Network (LINk)
(Item. 9)

(1) A Member asked Mr Gibbens about the County Council's proposed Healthwatch scheme and whether the Committee would get a chance to scrutinise the plans for this. The Chairman said he thought that Healthwatch could play an important role in supporting the work of the Committee. However, it was not on the agenda for this particular meeting.

(2) Mr Gibbens explained that it had been intended the Kent LINk would be operational by 1 April 2008, as provided for in the legislation governing LINks. However, this had not proved possible. The County Council had only learned in December 2007 how much money it was going to receive to fund the LINk (£492,000 in the coming year, rising by £1,000 over the next two years). Because of the high value of the contract for the LINk host organisation, the council was obliged to go through the EU tendering process, which took 39 days. Expressions of interest had been received in late January and early February; and tenders were due back by 8 April. He emphasised that Kent was no further behind, or forward, than any other large local authority involved in this process. Those authorities that had pressed ahead were Unitary Authorities, which were not covered by the EU process due to the smaller size of their LINk budgets. An update meeting had been held with voluntary groups on 30 January 2008 at Lenham; as a result, 58 volunteers had expressed an interesting in joining a LINk working group. Transitional arrangements would be effective from 1 April. It was expected that the awarding of the contract for the LINk host organisation would come to Cabinet in June 2008. Meanwhile, various sub-groups of the 58-strong working group were being created, around particular issues. The host organisation and the LINk would be made aware of all the legacy issues left behind by the PPIFs when they were abolished after 31 March 2008.

(3) The Chairman, on behalf of the Committee, formally thanked the PPIFs for their work and their huge contribution to the NHS in Kent. Mr Gibbens, on behalf of the County Council, echoed the Chairman's thanks and said he hoped former PPIF members would continue to be involved in health issues in the county.

(4) A Member asked how the transitional arrangements would work, particularly in regard to social care matters, where there was a clear potential conflict of interest if the County Council was to temporarily fulfill the role of the LINk. He also asked what would happen to the funding allocated to the LINk during the transitional period. Mr Gibbens replied that expert help would be sought during the transitional period. This was anticipated to last for three months, but the County Council would not be taking a commensurate amount (one quarter) of the annual funding allocation for the LINk (£492,000). It would only be seeking to cover its costs. This would mean that the host organisation would effectively receive a cash bonus for funding the LINk when it was set up in June. Mr Gibbens accepted that there was a potential conflict of interest in respect of social care matters during the transitional period. Consequently, care was being taken, at both Member and officer levels, to ensure that those involved with setting up the LINk were not directly involved in discharging the council's social care functions.

(5) Another Member asked what consideration had been given to publicity and promotion of the LINk to the general public, and asked what signposting role the LINk would play. Mr Gibbens replied that efforts had been made, including through voluntary groups, to make as many people as possible aware of the LINk. As regards signposting, he said that the LINk would certainly be involved in playing this role.

(6) A Member said she was very concerned about PPIF legacy issues and continuity between the PPIFs and the LINk. At the same time, there had to be a broadening of the scope of public and patient involvement beyond the PPIFs' base, so as better to reflect the diversity of the community in Kent. She asked why it was taking so long to get the LINK set up. Mr Gibbens reiterated that the County Council had been unable to begin the tendering process for the host organisation until the DoH had notified the level of funding available – and this had not happened until December 2007. Other County Councils had found themselves in the same situation. Mr Gibbens agreed that the LINk must have as broad a base of involvement as possible. He had been disappointed that there had not been any representation from the gypsy and traveller community at the meeting in Lenham – although they had been invited. The County Council would do all it could to ensure broad involvement. The tender document for the host organisation stipulated that it was expected to ensure this happened

15. Date of next programmed meeting – Friday 9 May 2008
(Item. 10)