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, 29 November 2013.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr L Burgess, Mr N J D Chard, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr G Lymer, Cllr M Lyons and Cllr R Davison

ALSO PRESENT: Cllr Mrs A Blackmore and Mr A H T Bowles

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest

(a) Mr Nick Chard declared a personal interest in the Agenda as a Non-Executive Director of Health Watch Kent.

(b) Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes
(Item 4)

(a) Ms Angela Harrison wished to pass on her thanks to the Chairman, committee staff and colleagues in the NHS for arranging a recent visit to Maidstone Hospital.

(b) The Chairman explained that the Vice-Chairman and he had recently met with representatives of Health Watch and explained that he hoped the Committee and Health Watch Kent would develop a close and productive working relationship. As a beginning, his suggestion was to invite two representatives of Health Watch Kent to attend future meetings of the Committee. This suggestion was agreed to by the Committee.

(c) RESOLVED that the Minutes of the meeting of 6 September 2013 are correctly recorded and that they be signed by the Chairman.

4. Quality Surveillance
(Item 5)

Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(a) The Chairman welcomed Sally Allum to the meeting and introduced the item, explaining that the Committee had received a presentation on quality issues in July and had asked for a further update on this specific area. The full Government response to the Francis Report had been published the previous week and this was a subject which would be returned to in due course, so the focus of this meeting would be on the Quality Surveillance Group (QSG).

(b) Sally Allum explained that she had attended the Committee in July with Dr Steve Beaumont and she was glad to hear that the visit to Maidstone Hospital had been a success. It was hoped this would be the beginning of a rolling programme. She then proceeded to talk to a presentation, a copy of which was included in the Agenda before Members. Following this, Members proceeded to ask questions and discuss areas of particular interest or concern.

(c) There are QSGs across England, one for each of NHS England's Local Area Teams, with four regional ones matching NHS England's regional offices. It was explained that one of the lessons of the Francis Report was the need to bring disparate information together. The QSGs were set up in April to do just this and work proactively to obtain soft and hard information on the quality of care. Through an early warning system by looking at a whole range of indicators, it would then be possible to react to issues early. While the QSG had no executive powers, it can make recommendations to commissioners and regulators. It did not duplicate the work of safeguarding boards, to which it could also make recommendations.

(d) It was explained that the membership of the Kent and Medway QSG included commissioners, regulators, Kent County Council and Medway Council, Health Watch and Health Education England. The regional tier also included professional regulators, clinical networks and senates, and the Ombudsman. In response to a question it was confirmed that the Director of Public health and the Director of Families and Social Care were the representatives from Kent County Council. As regards Clinical Commissioning Groups (CCGs), the NHS England Area Director insisted on senior accountable officers attending, and this made the QSG in Kent and Medway slightly different to others. It was explained that there had been full attendance at all meetings and that while good work had been done, the QSG was reviewing how it worked to see how it can improve further. Sally Allum reported that while Health Watch Medway was fully engaged and had added value to the work on Medway NHS Foundation Trust, the QSG did not have the right representation from Health Watch Kent. Mr Nick Chard offered to follow this up after the meeting.

(e) The QSG was supported by Sally Allum's team, which consisted of eight members of staff. No additional staff were required just for the QSG. Sub-groups were established where a particular issue required more time to discuss, such as ones on Medway NHS Foundation Trust and Child and Adolescent Mental Health Services (CAMHS).

(f) Bringing all these groups together enabled whole systems scrutiny. All areas of care were looked at, with work on primary care balancing out that one the acute sector. As the lead commissioner for health and justice provision across the south east, this area was something the Local Area Team for NHS England also looked to include in the work. The inclusion of Health Education England meant the perspective of students could be drawn upon and this was one which had been lacking in the past. Early benefits had been seen in the care home sector where pulling information together had brought providers onto the radar when they might not have been before. Here as in other areas, there was good challenge between the partners on the QSG as when the Care Quality Commission (CQC) reported positively on a care home, but where other partners had concerns. The involvement of both local authorities had been positive; both with regards care homes and children's issues.

(g) CAMHS made a good example of the kind of work the QSG did across the whole pathway. As a result of the piece of work carried out by the QSG, it began to be appreciated just how diverse the CAMHS provision was and it was not just a case of one main provider. It became clear that changing providers would make little difference unless the whole pathway was reviewed. It was explained that in the past there had been too much a focus on the provider of services, so in this example it would be part of the review to ask whether the commissioning of CAMHS was adequate, as well as the provision.

(h) The QSG was looking at how to apply the model of the recent Keogh reviews into fourteen acute hospitals more widely as this was seen as effective. Heat maps were produced taking into account the number of quality issues, level of risk and level of confidence in the provider. There was then a determination as to whether issues identified could be dealt with during routine business or whether further action was required. This further action could involve an inspection, and this could possibly involve the regulators, commissioners or HOSC. The ultimate step was to hold a risk summit with the provider concerned and all the relevant partners there to ensure action was taken.

(i) Comments were made by Members to the effect that over the years different organisations had been to HOSC and painted a particular picture, with a different picture emerging later. With the increased fragmentation of the health sector, Members questioned how things would be different in the future. Recent events at Medway NHS Foundation Trust were given as an example. It was explained that a number of issues had been known about at the Trust for ten years or more. What was new was a lack of tolerance of bad provision combined with a new regulatory system which could learn from the lessons of the Francis Report and look at a wide set of indicators. It was further explained that similar issues had been uncovered at Mid-Staffordshire as had been found at Maidstone and Tunbridge Wells and that for each of the fourteen Trusts reviewed by Keogh, there were likely to be as many facing similar problems. However, the work of QSGs around the county meant many of these were known to regulators and commissioners with action being taken. While it was still early days, this work would continue.

(j) The issue of quality of access was raised by Members and the response was given that while it was not explicitly included in the presentation, it was a key area which was being looked at and got to the heart of considering the whole

care pathway. A particular issue around problems accessing mental health services in West Kent was raised and Sally Allum undertook to feed this back to NHS West Kent CCG. Similarly, the issue of patients transferring from one organisation to another had long been recognised as an issue and that this was partly a cultural challenge with the need to avoid one organisation looking to blame another for any problems.

(k) In response to a specific question, it was explained that the NHS did keep regular records on individual staff members' performance and quality of care. The challenge now when there was a wider variety of providers was to ensure this was being done equitably.

(l) The relationship of HOSC and the QSG was also discussed, and the view was expressed that there had been a certain randomness to the reporting of quality issues to the Committee. The QSG had been asked to produce quarterly report to the HOSC and the Health and Wellbeing Board to assist decision making.

(m) The Chairman proposed the following recommendation:

- That the Committee thanks its guest for the information provided, recognises the importance of this issue and looks forward to receiving quarterly reports.

(n) AGREED that the Committee thanks its guest for the information provided, recognises the importance of this issue and looks forward to receiving quarterly reports.

5. NHS 111

(Item 6)

Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Helen Medlock (Associate Partner, KMCS), Patricia Davies (Accountable Officer, NHS Swale CCG), Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(a) The Chairman welcomed the Committee's guests and asked them to introduce the item. A number of Members of the Committee had had the opportunity to visit one of the 111 call centres in the region, and this experience was remarked on positively. The offer was made during the meeting to extend the opportunity to visit to other Members.

(b) Representatives from NHS Swale CCG explained that this organisation was the lead CCG for commissioning both 111 and 999 services across the South East area, covering 22 CCGs in total. On behalf on the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) it was explained that there were three key questions to answer. These were whether the service was improving, whether it was meeting the requirements of providing access to the service and how was the service going to be improved in the future. It was further explained that SECAmb was meeting the targets in terms of call

answering and responding to calls and was working to improve transfers between clinicians, or 'warm transfers' as they were referred to.

(c) Members of the Committee commented positively on the way the NHS had been honest about the problems the service had faced and the way it had dealt with them to improve the service. In response to questions arising from this it was explained that the 111 service was not perfect nationally or locally. It was a national service, tendered locally, and this had been carried out by the Primary Care Trusts which preceded Clinical Commissioning Groups. Locally, contract penalties had been applied and the rectification of the service had been successful. The SECAmb representative stated that discussions with the CCG had begun on contract variation.

(d) The broader point was raised that although the idea of commercial confidentiality was well understood, the Committee needed to think about how best to examine and scrutinise the use of public money. The Committee was informed that all the relevant financial information could be found in the SECAmb Board Papers and that these were publicly available on their website.

(e) There was a discussion on the need to effectively promote and communicate the existence of the 111 service. Although many measures were being taken, it was explained that there were restrictions on local areas advertising the service ahead of a national campaign which had yet to take place.

(f) The pressure on accident and emergency departments was raised. CCG representatives explained that Swale CCG and Dartford, Gravesham and Swanley CCG were working with the King's Fund on this topic. Data from north Kent suggested that attendances at accident and emergency departments were flat and that the real challenge was the rate of people attending who were subsequently admitted. It was added that winter was coming, and there would be a change in the case mix, with more children and the elderly presenting at accident and emergency departments.

(g) The role of technology was another area raised and discussed. The Ibis system used by SECAmb enabled GP systems to be connected with that of the ambulance service and that for calls relating to people with long term conditions or receiving end of life care, then the service would be able to view the appropriate information, including details of who should be contacted. The NHS Pathways programme, used by the 111 and 999 services for triage was also discussed. The representative from SECAmb explained that this system had been signed off by the Royal Colleges and expressed the hope that it could be used in accident and emergency departments as well to enhance consistency. More broadly, SECAmb wished to develop a single point of access service across the health economy. It was working with all 22 CCGs on how to access local urgent care boards and discuss the best ways of sharing information.

(h) Although it was not related to the 111 service, the issue of the police being called to deal with mental health crises was discussed. Work was being done on this in Kent and pilot schemes were underway where a mental health professional accompanied police men and women.

(i) On the topic of innovation and improving the service, it was explained that NHS 111 was a big national service and that there was the opportunity for different ideas to be piloted. One Member raised the idea of giving telephone access to 111 in accident and emergency departments and the response was given that a version of this was being trialled in Sussex. It was important to look at the processes carefully to avoid such situations as an ambulance being called and sent to a person already in an accident and emergency department. There was a pilot underway in Blackpool where the 111 system and accident and emergency department were closely connected.

(j) The Chairman proposed the following recommendation:

- That the Committee thanks its guests, notes the good progress made and looks forward to an update next year.

(k) AGREED that the Committee thanks its guests, notes the good progress made and looks forward to an update next year.

6. Faversham MIU update and the development of the urgent care and long term conditions strategy
(Item 7)

Dr Mark Jones (Chair, NHS Canterbury and Coastal CCG), Simon Perks (Accountable Officer, NHS Canterbury and Coastal CCG), Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(a) The Chairman welcomed the guests of the Committee and asked them to introduce the item. The representatives of NHS Canterbury and Coastal CCG began by setting out a short chronology. Three weeks prior to the Committee meeting, the CCG had considered the outcome of the tendering service for the Minor Injuries Unit at Faversham Cottage Hospital. There were no successful bidders and the decision was taken to serve notice and close the service. The request was made by the CCG to bring the topic to HOSC. Since the announcement two weeks before, there had been a lot of interest and concern expressed. Stakeholder meetings had been held and would continue to be held.

(b) The Chairman then asked Mr Andrew Bowles to speak as a guest of the Committee. Mr Bowles thanked the Chairman for the opportunity to address the Committee and also thanked the representatives of the CCG for including him in other meetings which had taken place and were due to take place. He read out a message from the local MP, Hugh Robertson. Mr Robertson expressed his concern at the closure of a valued local service as well as the impact of the longer journey times to the alternative sites and the congestion which could be caused at them.

(c) Mr Bowles added that part of the problem was that this proposal had not been known about in advance and so this had not allowed for any discussions with the Borough Council on possible solutions. Mr Bowles explained that he was Leader of Swale Borough Council and a former non-executive director of a

Primary Care Trust. In light of this experience, he thought that when a procurement exercise had begun with nineteen interested parties, which then resulted in eight attending a bidder event, and ultimately one bid which was found wanting, then the whole process should be looked at again. The Council had recently voted unanimously to write to the Secretary of State on this issue which was one of great concern locally and would impact on the 28,000 residents of Faversham. The request had been made to the CCG asking them to go back to stage one of the procurement and undertake it again, consulting the Borough Council and Kent County Council (KCC), particularly in light of KCC expertise in procurement. Mr Bowles added that Estuary View in Whitstable was a good service, but it was 5-6 miles away and there were inadequate public transport links. This meant people were more likely to travel to the Kent and Canterbury Hospital, adding to the pressures at that site.

(d) Mr Bowles also made reference to a statement issued by the local GPs in Faversham explaining that they were not in favour of the closure and had not been involved in the decision. CCG representatives explained that the local GPs had subsequently issued a new statement clarifying that they had been involved in discussions, but had not been involved in the confidential part of the tendering process.

(e) CCG representatives further explained that the tendering process was not a short one. The original contract was for a collection of services. The treatments rooms would be remaining. The tendering exercise was only for the Minor Injuries Unit (MIU). It was explained that 300 people each month used the MIU and that it would be better to improve access to GP services for these people. The original contract for the MIU had been extended over and over by the predecessor Primary Care Trust and could not legally be extended any further. There had been lots of discussions with GPs and patients and the public and an East Kent wide specification had been developed as to what an MIU should be so this service would then be consistent across the area. The tender was for a seven day service including an x-ray service. The one bid submitted involved bussing people to Sittingbourne and cost £100,000 more than the cost envelope. The cost of the tender was set by the national tariff.

(f) Members of the Committee then proceeded to ask a series of questions and make a number of comments. One Member observed that GP practices were also stretched and could not necessarily be asked to take on additional services. Reference was also made to correspondence sent to Members of the Committee by the Friends of Faversham Cottage Hospital and Community Health Centres. Clarification was sought as to the place of the £300,000 which the Friends had raised for an x-ray machine in the tendering. It was explained that this had been a core component of the tender. However, the building had been appraised and it was not suitable for an x-ray machine.

(g) Observations were made about the length of time the CCG as an organisation had been operating and whether this had made an impact on the success of the procurement. CCG representatives explained that the staff supporting the procurement were experienced and had carried out procurements for Primary Care Trusts in the past. It was also explained that the tendering process had been looked at and no issues had been found and that the original specification had been drawn up in consultation with local GPs, public and

patients. It therefore did reflect local need. CCG representatives explained that it was difficult to see where the process could have been stopped due to the numbers expressing an interest and it was judged that the one bid submitted was worthy of serious consideration. The process had failed only in the sense that a suitable provider had not been found. The only option would be to tender at a lower service specification.

(h) Concern was expressed about other changes being proposed in other areas, such as at Deal Hospital, and whether the closure of the MIU at Faversham was possibly the thin edge of the wedge leaving East Kent ultimately only with three large acute hospital sites. CCG representatives explained that the broader shift was to move services out of acute hospital sites and that the CCG was a partner in East Kent Hospitals' outpatient services consultation as they felt it was important to listen to the views of the public. The view was expressed that it was important to look at what services would be required in the future, not what had been provided in the past.

(i) A Member of the Committee drew a comparison to Edenbridge Community Hospital where the MIU had been revamped and that this served a smaller population. In response to the points raised, it was explained that the CCG could not provide the service in house under the current rules and that the service was also not suitable for Any Qualified Provider.

(j) Discussion also included the nature of the Faversham Hospital estate. It was explained that it was owned by NHS Property Services Limited and there were no planning applications on it. It was believed that Estuary View was privately owned by the relevant GP practice. The MIU at Faversham took up 3% of the floor space of the hospital, or two and a half rooms. There were also 2 GP practices on the site so there was no danger to the future of the hospital. This was questioned by a local Member who believed that while the GP practices were adjacent to the hospital, and linked to it, they were not part of the hospital estate as such. In response to a question, it was explained that no interest in provided services in the areas currently occupied by the MIU had been expressed.

(k) Mr Nick Chard proposed the following recommendation:

- That this Committee asks that the decision to close the service on 31 March 2014 is set aside. This will allow a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives.

(l) This was seconded by Ms Angela Harrison.

(m) This recommendation was discussed by the Committee and the view was expressed that this did constitute a substantial variation of service. The possibility of referring the issue to the Secretary of State was raised. The Researcher to the Committee explained the regulations underpinning a formal referral along with the requirements of the KCC constitution. Although it would not be a formal referral, the Committee requested that the Chairman write to the Secretary of State on this matter which the Chairman undertook to do.

(n) AGREED that this Committee asks that the decision to close the service on 31 March 2014 is set aside. This will allow a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives.

7. Musculo-Skeletal Services
(Item 8)

Due to the amount of time taken to discuss other items on the Agenda, the Chairman determined to postpone consideration of this item until the next meeting.

8. Member Updates

(a) As mentioned earlier in the meeting, two Members of the Committee had had the opportunity to visit Maidstone Hospital with the Chief Nurse of NHS West Kent CCG and speak to staff and patients. As one of the Members to attend, the Vice-Chairman was invited to provide feedback to the Committee on this visit.

(b) The Vice-Chairman explained that they had received a very warm welcome at the Hospital and the visit began with the opportunity to speak to the Chief Nurse at the Hospital as well as other senior members of staff. There was then the opportunity to visit a couple of wards and then discuss what had been seen at the end. A wide range of quality issues were covered and discussed. The Hospital appeared exceptionally clean and well organised with infection control a particular strength. Patients spoke highly of their treatment.

(c) The positive comments of the Vice-Chairman were echoed by Ms Angela Harrison who also took part in the visit. She explained that they had the opportunity to speak with staff at all levels of the organisation as well as patients. It was explained that what came through particularly strongly was the enthusiasm of both staff and patients.

(d) Both wished to put on the record their thanks to Dr Steve Beaumont and the other NHS colleagues involved in the visits. The Chairman offered to write a letter of thanks on their behalf and explained that it was hoped that further visits to this and other sites would be arranged in the future.

(e) A local Member explained that he was glad to hear these positive comments and spoke of the different ways the Hospital was developing a variety of specialised services for the future. He hoped more Members took the opportunity to visit.

(f) The Chairman wished everyone a Merry Christmas and a Happy New Year.

9. Date of next programmed meeting – Friday 31 January 2014 @ 10:00 am
(Item 9)