KENT COUNTY COUNCIL

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee held in the St Georges Centre, Pembroke Road, Chatham Maritime, Chatham, Kent ME4 4UH on Tuesday, 19 March 2013.

PRESENT: Mr C P Smith (Chairman), Cllr Wendy Purdy (Vice-Chairman), Mr R E Brookbank, Mr D S Daley, Mr K A Ferrin, MBE, Cllr Sylvia Griffin, Cllr David Royle, Mr K Smith and Cllr Isaac Igwe (Substitute for Cllr Teresa Murray)

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Ms R Gunstone (Democratic Services Officer)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Substitutes
(Item 2)

3. Declarations of Interest by Members in items on the Agenda for this meeting
(Item 3)

4. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting held on 13 February 2013 are correctly recorded and that they be signed by the Chairman.

5. Adult Mental Health Inpatient Services Review (further papers to follow)
(Item 5)

Felicity Cox (Chief Executive, NHS Kent and Medway), Dr Rosarii Harte (Assistant Medical Director – Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Dr James Osborne (Consultant, Medway NHS Foundation Trust), Lauretta Kavanagh (Director of Commissioning for Mental Health and Substance Abuse, NHS Kent and Medway), Dr Mick Cantor (Swale CCG), Sarah Holmes Smith (Assistant Director, Community Recovery Services), Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Dr Peter Green (Chief Clinical Officer, Medway Clinical Commissioning Groups), Dr Elizabeth Lunt (Dartford, Gravesham and Swanley Clinical Commissioning Group), and David Tamsitt (Director Acute Services, Kent and Medway NHS and Social Care Partnership Trust) were in attendance for this item.

(a) The Chairman welcomed Members of the Committee (Joint HOSC), the Committee's guests and members of the public. Representatives of the NHS were then asked to introduce the item.

(b) Members received a PowerPoint presentation setting out the broad areas covered by mental health services in order to put the proposed changes to acute mental health inpatient services in their wider context (see Appendix A). Part of this presentation included a link to a service user's story available on the Live It Well website (http://www.liveitwell.org.uk/live-it-library/jamess-story/). Members were also provided with an additional information sheet (Appendix B). The services outlined went from preventative care to tertiary and related to the most common mental health disorders. It was stated that concerns had been expressed in the past about the ability to access secondary services following referral from primary care. 90% of these referrals were assessed in 4 weeks. Most of these referrals required short term assistance and could be handed back to be cared for by primary care. It was only those with longer term needs who required inpatient services. Members were informed that the implementation of the proposed changes would be phased to ensure the community based crisis teams were established before any changes to inpatient provision.

(c) Acute services followed the pathway from crisis and home treatment to acute inpatient care to psychiatric intensive care. The proposed changes under discussion focused on this pathway. It was explained that the service model proposed of 3 centres of excellence was evidence based and there was best practise to learn on, both in the United Kingdom and abroad with New Zealand highlighted in particular. In addition, there were also the requirements of the Care Quality Commission for treatment to ensure people's dignity as well as the recent Francis Report putting additional emphasis on putting the patient first.

(d) NHS representatives explained that Medway A-Block was not fit for purpose and the requisite level of care and service could not be delivered there. Members were reminded of the comparatively high level of serious incidents at Medway A-Block compared to Priority House in Maidstone and Littlebrook Hospital in Dartford and were informed that there had been one since the previous meeting, but none at either of the other two sites. Members were in agreement that Medway A-Block was not suitable, but Members had different views about the alternatives.

(e) The Chairman explained that he wished to concentrate on the answers provided by the NHS in response to questions posed specifically by Medway Council (pages 61-8 of the first supplementary agenda) and asked NHS representatives to provide an overview of these.

(f) One set of questions related to the transport plan, and attention was drawn to pages 69-72 of the supplementary agenda where this was set out. In answer to a question about the process, Mr Tamsitt informed the Committee that the service line within the Trust of which he was director would be overseeing this workstream on the Transport Plan and would also ensure its implementation. It was explained that £10,000 had been allocated to support relatives and carers visiting inpatient units and there was a strong focus on the voluntary sector.

The transport of patients to inpatient units formed part of the formal contract with the provider of Patient Transport Services and an ambulance would be used. Each case would be risk assessed and there were occasions when the staff of the crisis team would be able to convey patients to hospital.

(g) One large area of discussion involved the set of answers around the data upon which the consultation on the proposal to reduce bed numbers had been based. Some Members felt there were questions to be asked about the robustness of the data and subsequently concerns about how reliable any conclusions based on this data would be. Medway Council Members drew attention to the evaluation they had commissioned from the University of Kent which formed part of the Agenda. NHS representatives explained that the different critiques of the data, including that provided by Medway Council, was valuable in checking and triangulating the reliability of the data. The report commissioned by Medway Council raised some questions but did agree that the general trend of bed number need was downwards. It was important for the data to be robust as it would not be in anyone's interest if the wrong outcome was arrived at which then needed to be dealt with after 12 or 18 months. At the NHS Kent and Medway PCT Cluster Board on 20 February the Board requested a bed number sensitivity analysis be undertaken along with a Quality Impact Assessment to be reported in turn to the CCG Boards when they made their final decisions on the proposals. It was reported that this should be concluded by the end of May. Due to the imminent changes happening in the NHS, it would be for all 8 CCGs across Kent and Medway to decide how to take the proposals forward whatever the findings of the analysis was. CCGs were required to produce credible commissioning plans and there would be oversight by the Local Area Team on the NHS Commissioning Board. There was funding available to allow double-running of services if this was seen as the best solution. It was confirmed that whilst the decision of the PCT Cluster Board on 20 February was to support the implementation of Option A the CCGs would be able to adjust the detail of the implementation plan in the light of the outcome of the Bed Sensitivity Analysis.

(h) A member of the public, Mr Antoniou, requested the opportunity to speak on the issue of data. He referred to information he had acquired to back up his arguments which was not available to the Joint HOSC. He presented an argument claiming to have identified a number of flaws which made the case for reducing bed numbers unreliable. NHS representatives explained that responses to a number of the points raised by Mr Antoniou had been included in Appendix 2, a paper included in the Agenda of the meeting of 13 February. The Chairman thanked Mr Antoniou for his comments but stated that the JHOSC was not the appropriate channel for dealing with individual complaints.

(i) A Member of the Committee argued that the issue of data was a difficult one and that one challenge was that it was always historical. However, he believed the data needed to be approached in good faith. Other Members contributed the thought that as the sensitivity analysis was underway it would be useful for the JHOSC to be able to see the outcome of this work.

(j) On the topic of bed numbers, NHS representatives explained that the proposal involved reducing the number of inpatient beds from 160 to 150 and the number of psychiatric inpatient beds from 20 to 12. It was further clarified that

these were the overall bed numbers for Kent and Medway; the number of beds commissioned for patients from Medway, Swale and Sheppey remained the same at 28 for Medway and 7 for Swale/Sheppey. The proposals were for a relocation of these beds, not a reduction in the number.

(k) Related to the prediction of future bed need, Members raised the issue of the additional need arising from the numbers of returning servicemen and women. It was explained that medical care for the armed forces was commissioned separately, although there was liaison between the services and that there was no additional demand being placed on mental health inpatient services from returning servicemen and women.

(l) The question was also asked as to whether the Dartford site would reach capacity due to demand from London. In response it was explained that services were commissioned locally and there were strong financial disincentives not to send patients out of area, such as from London to Dartford, so this was highly unlikely.

(m) Questions were also asked about the idea of establishing recovery houses and what impact this may have on bed numbers. In response it was explained that the driver behind recovery houses was a report which was produced by the Schizophrenia Commission and that this came out after the consultation on the proposals had commenced. There were good examples to learn from in London and discussions were underway with Medway Council exploring the possibility of establishing a recovery house in the locality. Medway Members stated that a Recovery House would not be a suitable substitute for local provision in Medway and requested a constructive discussion with the NHS about potential for acute inpatient beds in Medway. Their view was that the proposed option was not in the interests of Medway residents. It was explained that any recovery house service would be additional to and complementary to currently existing services and to the proposed changes. Acute inpatient bed numbers would not be affected therefore.

(n) Another area where NHS representatives were able to provide answers and information was on the staffing of crisis teams. It was explained that additional capacity was being introduced and the new Support Time Recovery Workers were able to provide the continuity of contact with service users which could not be guaranteed with clinicians. Section 17 escorted leave could be carried out by these Support Time Recovery Workers, or hospital staff depending on the individual circumstances. In addition, Medway Council had invested in support workers going into wards and this was an initiative welcomed and supported by the NHS. There was also a pilot being rolled out in North Kent of discharge coordinators which would help bridge the gap between acute and community health care.

(o) One Member referred to what he called the ‘Deal deal’ in relation to transport. The town of Deal was a 150 mile round trip, approximately, to Little Brook Hospital in Dartford but he was personally convinced that the benefit to be gained from accessing services at centralised centres of excellence serving the whole of Kent and Medway strategically outweighed the disadvantage of needing to travel. Other Members put forward a counter view that the location of services was critical as those people more in need of treatment needed to

be able to access them locally and there was a need to ensure centres of excellence were closer to centres of population.

(p) NHS representatives drew attention to the reports which had been received by the Committee previously setting out how alternative sites had been sought in Medway. This had been continuing for around a decade with no suitable site found. It was explained that the case mix had also changed over this time with those requiring inpatient services being fewer in number but more severe cases than previously. One NHS representative expressed the view that the inpatient facility needed to be away from the centre of Medway if NICE guidelines on treating those with personality disorder were to be followed and appropriate care delivered. The offer made at previous meetings from commissioners to meet with Medway and consider any proposed alternative sites was repeated.

(q) Members of the Committee discussed a range of views as to how to proceed with this matter. There was a degree of consensus around the move towards centres of excellence and the unsuitability and unsustainability of continuing the provision of services at Medway A-block but a number of Members were not convinced that there should not be a centre of excellence in Medway. It was made clear that Medway and Maidstone area had the greatest concentration of the population and it made sense to locate the provision in the area of greatest need rather than moving services outside the perimeter. The view was also expressed that a way needed to be found to allow the NHS to move forward as well. It was noted that the upcoming elections for Kent County Council needed to be borne in mind. This would involve a pre-election period limiting the activities of the Committee and there would be a delay following the election until such time as the Kent Members of the Committee were appointed. This may or may not involve some or all of the current Kent membership. It was also noted that there was a possible window of opportunity in that it seemed likely that the bed sensitivity analysis would only be available to CCG boards for May. The possibility of obtaining advice from an independent expert was mooted and it was agreed the practicalities of this would be considered.

(r) NHS representatives explained that from 1 April, the responsibility for commissioning the services under discussion moved from NHS Kent and Medway to 8 CCGs across Kent and Medway and these CCGs would be meeting at different times across Kent. The request was made that the NHS be allowed to continue developing these services and any further discussions take place concurrently with these board meetings rather than necessarily prior to all of them, which would be a challenge.

(s) Councillor Wendy Purdy proposed the following motion, seconded by Mr Keith Ferrin:

- That:

i. the outcome of the Bed Sensitivity Analysis and Quality Impact Assessment should be reported to the Joint HOSC before it takes a final view on the proposed option for reconfiguration of adult mental health inpatient services and before the CCGs meet in May;

ii. the NHS should meet with Medway Council to informally discuss options for local bed provision and;

iii. simultaneously the advice of an independent expert be sought on the review of adult mental health inpatient services and the proposed option for future provision.

(t) This was agreed unanimously by the Committee.

(u) RESOLVED that:

i. the outcome of the Bed Sensitivity Analysis and Quality Impact Assessment should be reported to the Joint HOSC before it takes a final view on the proposed option for reconfiguration of adult mental health inpatient services and before the CCGs meet in May;

ii. the NHS should meet with Medway Council to informally discuss options for local bed provision and;

iii. simultaneously the advice of an independent expert be sought on the review of adult mental health inpatient services and the proposed option for future provision.

6. Date of next programme meeting
(Item 6)

(a) It was agreed that the date of the next meeting would be determined at a later date.

(b) One Member noted that this was to be the last Committee meeting which Helen Buckingham would be attending as she was moving on to a new role. Members of Committee expressed their thanks for her work in the past.