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, 6 June 2014.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mr N J D Chard, Mr A D Crowther, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr C P D Hoare, Mr A J King, MBE, Mr S J G Koowaree (Substitute) (Substitute for Mr D S Daley), Mr G Lymer, Mrs P A V Stockell (Substitute) (Substitute for Mrs A D Allen, MBE), Cllr P Beresford, Cllr R Davison and Cllr M Lyons

ALSO PRESENT: Cllr Mrs A Blackmore, Mr S Inett and Mr M Ridgwell

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Ms D Fitch (Democratic Services Manager (Council))

UNRESTRICTED ITEMS

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

(1) Mr Nick Chard declared a Disclosable Pecuniary Interest as a Director of Engaging Kent.

(2) Councillor Michael Lyons declared an other significant interest as a Governor of East Kent Hospitals University NHS Foundation Trust.

(3) Mr Adrian Crowther declared an interest as a Governor of Medway NHS Foundation Trust.

41. Minutes - 11 April 2014
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken:

(a) Minute Number 35 - Redesign of Community Services and Out-of-Hours Services – Swale. NHS Swale CCG had been asked for the proposed dates for procurement, public consultation and the board meetings to enable the development of a timetable to be agreed between HOSC and NHS Swale CCG. A response was awaited.

(b) Minute Number 36 - Folkestone Walk-In Centre: Written Update. a response from NHS South Kent Coast CCG regarding engagement activity in Deal on 24 April had been circulated to Members of the Committee.

(c) Minute Number 38 - East Kent Outpatients Consultation: Written Update. The Chairman had written to EKHUFT to clarify concerns

raised regarding the redeployment of non-clinical staff prior to the independent analysis of the consultation. A response had been circulated to the Committee on 5 June 2014.

(2) RESOLVED that the Minutes of the Meeting held on 11 April 2014 are correctly recorded and that they be signed by the Chairman.

42. Membership
(Item 4)

(1) The Committee noted that:

(a) Mr Hoare had replaced Mr Latchford as a UKIP representative on this Committee.

(b) Mr Elenor had replaced Mr Crowther as the UKIP group spokesperson on this Committee.

(c) Cllr Burden (Gravesham Borough Council) had replaced Cllr Woodward (Tunbridge Wells Borough Council) as a borough representative on this Committee.

(d) Cllr Davison (Sevenoaks District Council) had replaced Cllr Spence (Tonbridge & Malling Borough Council) as a borough representative on this Committee.

43. Community Care Review: NHS Ashford CCG and NHS Canterbury & Coastal CCG
(Item 5)

Simon Perks (Accountable Officer, NHS Ashford and NHS Canterbury and Coastal CCGs) was in attendance for this item.

(1) The Chairman welcomed Mr Perks to the meeting and asked him to introduce the item. Mr Perks thanked the Committee for the opportunity to present the community care review undertaken by NHS Ashford CCG and NHS Canterbury and Coastal CCG.

(2) Mr Perks noted that he had recently attended the NHS Confederation conference; a major theme of the conference had been the importance of community services. The review of health and social care services provided within a community setting was the CCGs response to this challenge.

(3) He explained that NHS Ashford CCG and NHS Canterbury and Coastal CCG were committed to providing health services closer to people's homes. The CCGs had inherited a significant number of community-based contracts covering a number of different services. To ensure that these services were high quality, value for money and fit for the changing health needs the CCGs had initiated a review of a cross-section of these services. The review was carried out in the broader context of tighter healthcare budgets and an ageing

population. It had been acknowledged that efficiencies would not meet these needs; new ways of care, both formal and informal, would need to be introduced. A joint appointment of a programme manager had been made by the CCGs and Kent County Council to lead this work. Mental health and children's services were excluded to make the scope of the project manageable.

(4) The review focused on actions which could be taken tactically to remove duplication of payments (without directly affecting services) and the strategic options for improving the commissioning of community-based services. Five work streams were identified:

1. Contracting and Procurement
2. Customer and Market Analysis
3. Finance and Information
4. Patient and Public Engagement
5. Quality and Safety

(5) Two key findings of the review were highlighted. Physiotherapy services were predominately used by adults of working age rather the frail and the elderly. More community spend did not mean better outcomes or improved patient experience; Canterbury spent more than £10 million on community services than Ashford but the quality of service was found to be the same.

(6) Community services principles were established, based on the findings of the review, to underpin commissioning of community-based services in the future. The principles were service development; market development; contracting and procurement; and performance management.

(7) A draft framework for commissioning community-based services was developed to ensure that health, social care and voluntary services were based around individuals and the communities they live and work. The framework had been termed Community Hubs and would be based around clustering of GP practices and local communities which the CCGs service. The CCGs would commission an integrated suite of health, social and voluntary services from local providers within a defined budget with more service-user centric outcomes. Selection and design of these services would be carried out in partnership with local patients, services users, provider and partner organisations. The services provided would be based on the needs of each local population.

(8) The concept had been well regarded by the CCGs' partners, providers and patients. The intention for the project was to move from the exploratory and high-level design phase into the localised detailed design and implementation phase of the community hubs. A high level implementation plan had been developed which set out a timescale and funding. It was estimated that £80 million (out of the current £400 million CCGs' funding) would be required by 2016/17 for Community Hubs.

(9) The Chairman asked Dr Eddy and Mr Crowther to comment on their visit to Victoria Memorial Hospital in Deal on 29 April with representatives from NHS South Kent CCG and Kent Community Health NHS Trust. The visit was

arranged for Members to gain a better understanding of the nature of the site and the services currently provided as well as have the opportunity to hear about how commissioning plans for developing community and outpatient services on the East Kent Coast were developing. Dr Eddy had found the trip to Deal Hospital very helpful. There had been discussions around potential services which could be provided at the hospital, these had yet to be confirmed. Mr Crowther found the visit to be interesting and informative; he was disappointed that only two Members attended.

(10) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A question was asked about the involvement of local elected Members in the review. It was explained that the CCGs had learnt a lot, following the situation at Faversham MIU, regarding the importance of involving The CCGs' now viewed elected Members as key stakeholders and wanted them to be involved in the process.

(11) A number of comments were made about the 'well' consuming a high proportion of community services and a higher community spend not leading to better outcomes. It was recognised that the CCGs needed to carry out more detailed analysis before commissioning in order to have a greater understanding of the need in their areas. It was recognised that commissioning should not be done in isolation as resources were scarce and it was difficult to map.

(12) A number of questions were asked about the development of community services in Ashford including the introduction of an x-ray facility. It was explained that the CCGs needed to explore the development of a community hospital in Ashford. The CCGs were looking to develop a community hubs at the William Harvey Hospital and the Kent and Canterbury Hospital which would enable the provision of acute and community services at the same site. The provision of an x-ray service to a small population would be economically very difficult; a potential option for Faversham MIU had been found.

(13) In response to a specific question about the implementation of the community hubs. It was recognised that it would take time to develop and implement the complex health and social care community-based services. The importance of moving services out of acute hospitals into the community was also stressed. A Member commented that they had felt a sense of déjà vu but believed that the CCGs were moving in the right direction.

(14) A Member highlighted a case which had been brought to their attention regarding access to equipment. It was acknowledged that long waits were associated with accessing equipment. This issue needed resolving as long waits could result in patients' requiring the use of acute services.

(15) A number of comments were made about co-funding, community services data, patient transport services and the style of the paper. It was acknowledged that co-funding was difficult as the CCGs were only responsible for the funding of NHS services. Partnership arrangements with social care and the voluntary sector were extremely important to develop community hubs. It was explained that there was only a limited amount of data held on community services; the CCGs were exploring ways to centralise community

services data. The importance of patient transport services was recognised and would be included in future designs. It was noted that the paper was written with the help of a management consultant.

(16) RESOLVED that:

(a) Mr Perks be thanked for his attendance and contributions to the meeting along with his answers to the Committee's questions.

(b) NHS Ashford CCG and NHS Canterbury & Coastal CCG be invited back to the Committee in the autumn to provide an update.

(c) A written update on the design of the community hubs to be produced by the CCGs and circulated to Members informally.

44. East Kent Outpatients Services: Consultation Update
(Item 6)

Simon Perks (Accountable Officer, NHS Ashford and NHS Canterbury and Coastal CCGs), Liz Shutler (Director of Strategic Development & Capital Planning, East Kent Hospitals University Foundation Trust), Rachel Jones (Director of Business and Strategy Development, East Kent Hospitals University Foundation Trust) and Marion Clayton (Divisional Director, Surgical Services, East Kent Hospitals University Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Shutler introduced the item and proceeded to give a presentation which covered the following key points:

- The Trust's justifications for change
- Consultation and engagement process
- Feedback from patients
- Outpatient Services Strategy
- The six proposed Outpatients sites
- Option appraisal for the North Kent site
- Next steps - decision-making at the EKHUFT and CCG boards

(2) The Chairman asked Miss Harrison to comment on the optional appraisals which she attended on behalf of the Committee on 22 April and 29 May. Miss Harrison observed that she had been impressed and surprised by the thoroughness of each appraisal. The final option appraisal in May was held following the receipt of information from NHS Property services.

(3) Mr Inett was also invited to comment. He explained that Healthwatch Kent had been working with the Consultation Institute; they had been using the consultation as a test case to look at their role as a critical friend. The focus of the consultation by the Trust had been on Landsley's four tests for service reconfiguration. Mr Inett highlighted that if there was a legal challenge, the Gunning Principles would be applied instead. One of the Gunning Principles was that consultation must take place when the proposal was still at a formative stage. Mr Inett requested additional information regarding the

public's involvement in option development. He also sought clarification about the support for six outpatients' clinics (question 7 on page 59 of the agenda pack) and the involvement of minority groups in focus groups. Mr Inett commented that the consultation focused on the North Kent site and that Healthwatch had been made aware of concerns from the public regarding the effectiveness of the one stop shop process. Healthwatch Kent was looking at one stop shops across the country. Healthwatch Kent were meeting with the Trust to discuss issues in detail.

(4) Ms Shutler responded to the comments and questions raised by Mr Inett. It was explained that the six sites were modelled technically looking at patients, travel times and demographics of the local communities. Patient and professional representatives were on the working group which developed the outpatients' strategy; patient surveys and public stakeholder meetings were also held. Concerns had been raised by elderly groups about the time appointments would take and facilities at the one stop shop. The Trust stated that giving more power to patients to book appointments would improve the flow and patient experience. The Trust commissioned the University of Kent to undertake the focus groups; the outcomes of these focus groups were detailed in the report. During the consultation period, the Trust was able to talk to other minority groups including the Nepalese community in Hythe. Ms Shutler indicated that she could provide further details to Mr Inett at their meeting.

(5) Members of the Committee then proceeded to ask a series of questions and made a number of comments.

(6) Members raised concerns about the Trust's investment of £455,000 to extend and modify public transport routes provided by Stagecoach. It was explained that the Trust had been in lengthy discussions with Stagecoach about additional services; Stagecoach had not been willing to look at additional routes without additional funding. The majority of the funding would be going to Stagecoach to provide additional routes. Details of voluntary sector transport services would be made available to patients in their information pack when booking appointments. In relation to a specific question about transport links in Deal and Walmer; it was acknowledged that the number of buses which run from Deal to Buckland Hospital per hour would be doubled. There was also a proposed route from Whitfield to Buckland Hospital which would run on to Deal, Sandwich and the QEQM Hospital. The Trust acknowledged the need to improve and invest in public transport; at present 80% of the Trust's patients travel by car to their outpatient appointments. The Trust was working with the current patient transport service provider to improve their response rate.

(7) A Member enquired about the quality of communication with patients. As part of the outpatients' consultation, patient administration services had been reviewed. The Trust had found issues with communication with patients and was looking to improve this aspect of their service. It was confirmed that letter writing had not been outsourced to a foreign company; letters were written by Trust staff locally.

(8) A Member expressed concerns that patients in Deal would have an increased journey time to outpatients' services as set out in the proposals. It was

explained that under the proposals the number of patients from Deal, who would be able to access care within the time frame, would increase. Residents in Deal generated 30,000 outpatient appointments a year, a third of these appointments (10,000) took place in Deal Hospital. 90% of appointments at Deal Hospital were follow-up appointments; patients would not access their entire pathway at the hospital.

(9) The Member raised a further concern that the residents of Deal had been misled in a previous consultation regarding Buckland Hospital and the service provision in Deal. It was explained that the consultation being referred to was a consultation on service provision in Dover which was led by East Kent Primary Care Trust in 2006. The consultation document looked at three options for outpatient services: services being provided as close to home as possible in a GP surgery or in a central Dover location; moving services from community to acute hospitals; and maintaining services at all sites including at Deal Hospital. The majority of respondents chose option G1 – providing services as close to home as possible in a GP surgery or in a central Dover location. Ms Shutler stated that she felt that this was a very clear consultation exercise. As a result of the 2006 consultation, East Kent Hospitals University Foundation Trust invested £23 million to develop a new hospital at the Buckland site.

(10) A number of comments were made about the consultation events, patient mobility and the capacity of the proposed system. The Trust offered to provide the Committee with data regarding outpatients accessing patient transport services. It was acknowledged that capacity was currently underutilised. Under the proposals, the working day would be extended which would increase the utilisation of the buildings and enable patients a greater choice of appointments. The workforce would be maximised and provide a more efficient service as staff would not be required to drive to 15 different sites. The Trust had forecasted demographic growth as part of future proofing and was confident the service would not be over capacity in the future.

(11) The Trust asked in their report for the Committee to 'agree that the public consultation process has met the required standards as set out in the Health and Social Care Act'. The Scrutiny Research Officer was asked to provide guidance on the recommendation. She explained that the legal duty to consult local authority health scrutiny bodies was distinct from the separate duties in the NHS Act 2006 (as inserted by the Health and Social Care Act 2012) on Trusts, CCGs and NHS England to involve service users in the development of proposals for service change; and it was important that the two duties were not confused or conflated. She stated that a recommendation, asking the Trust and CCG to take on board the comments made by Members during the meeting, would be more appropriate.

(12) RESOLVED that:

(a) The Committee records its appreciation of the hard work the Trust has put into the consultation.

(b) The comments made by Members of the HOSC are considered and taken into account.

(c) The Committee asks for a return visit in September when a final decision has been taken.

45. Interim Centralisation of High Risk and Emergency General Surgery at Kent and Canterbury Hospital

(Item 7)

Liz Shutler (Director of Strategic Development & Capital Planning, East Kent Hospitals University Foundation Trust), Rachel Jones (Director of Business and Strategy Development, East Kent Hospitals University Foundation Trust) and Marion Clayton (Divisional Director, Surgical Services, East Kent Hospitals University Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee and asked them to introduce the item. Marion Clayton began by updating the Committee on the Trust's service reconfiguration of adult high risk and emergency general surgery.

(2) A broad definition of high risk surgery was given: patients with a predicted mortality rate of 5%; patients undergoing emergency abdominal procedures, major gastric and bowel surgery; patients over 50 undergoing emergency redo surgery; and acute patients with comorbidities including renal, cardiac, respiratory and thoracic conditions. A number of examples were identified including laparotomy, removal of the spleen, gall bladder and appendix.

(3) Members were reminded that the Trust had presented their clinical strategy to the Committee in June 2013. A number of options for the provision of high risk and emergency general surgery were presented to the Committee including the centralisation of surgery and a potential hub and spoke model.

(4) In 2012 the Trust invited the Royal College of Surgeons (RCS) to assess and review surgical service provision. The RCS had found that the Trust was not providing a continuity of care for patients due to the provision of high risk surgery at three acute sites with different on call models and a mix of appropriately skilled substantive and locum surgeons. The RCS made a number of recommendations including the provision of continuity of care for patients and the recruitment of substantive posts.

(5) The Trust took on board the recommendations and identified the need to centralise high risk surgery at the Kent and Canterbury Hospital on an interim basis with a robust on call service. This would enable the Trust to provide continuity of care and expertise on a single central site. In January 2014, the Trust began a review into how this model would be delivered. A number of significant risks were identified including the transfer of patients to a central hub in Canterbury; the provision of beds in the Intensive Care Unit (ICU), the High Dependency Unit (HDU) and wards; and the requirement for additional theatre space. The Trust concluded that the centralisation of surgery would not meet the timescale for implementation.

(6) An interim solution was presented to the Trust Board by surgeons from the William Harvey Hospital and the Queen Elizabeth Queen Mary Hospital. The surgeons proposed a 1 in 8 model with 8 surgeons with the appropriate skills at each site providing an on call Monday – Friday rota.

(7) The Trust identified a number of risks with the proposed model; there were concerns that, without additional recruitment, patients would not receive continuity of care from a consultant with the appropriate skills. The Trust revised the proposal to a 1 in 8 model on a 4:3 split. Dedicated emergency surgeons with the appropriate level of skill would provide emergency surgery on Monday – Friday; the same model and level of service would be provided from Friday – Sunday. This would enable the Trust to increase the numbers of surgeons and remove the non-gastrointestinal surgeons (breast and thyroid) from the rota.The Trust was also looking to introduce a consultant led surgical assessment unit.

(8) The Trust identified six additional posts for gastrointestinal surgeons with additional skills. Interviews for colorectal surgeons were held in June. Four substantive colorectal surgeons were appointed and would start in September; three surgeons at William Harvey Hospital and one surgeon a Queen Elizabeth Queen Mary Hospital. The advertisement for upper gastrointestinal surgeons would be published in June and interviews would be held in July. The 1 in 8 model on a 4:3 rota would be implemented by the end of the year. The Trust stated that this was a temporary solution and the programme for a longer term solution was continuing. Thirteen work streams had been developed and were being led by a senior clinical lead.

(9) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A Member raised concerns about the provision of all high risk general emergency and high risk elective surgery on one site. A Member explained that he had raised similar concerns about the centralisation of vascular surgery. It was explained that there were a number of services where patients had to travel distances for care; patients in East Kent requiring highly specialised tertiary services such as neurosurgery were transported to London for care. On call surgeons were required to get to the hospital within a specific timescale. Highly specialised teams at registrar level were always available on site to prepare patients for surgery. It was not affordable to have consultants on site 24/7; life and limb surgery after midnight was very small. If a consultant was required out-of-hours, they would be called onto site. The majority of patients who require emergency surgery were seen during the working day when surgeons were on site. It was acknowledged that the co-location of vascular surgery in Canterbury had produced some of the best outcomes for patients nationally. Patients from East Kent no longer had to travel to London for vascular surgery.

(10) A number of comments were made about the cost and funding of the additional surgeons; service provision at the Kent and Canterbury; and the timeline for the implementation of substantive posts. It was reported that the Trust was funding the additional posts; £700,000 had been provided for the recruitment. It was explained that under the interim proposals, there would be no change to care provided at Kent and Canterbury Hospital; vascular surgery and neurology would continue to be provided at the site. The Trust was

expecting to meet the September 2014 target for recruiting substantive posts; four colorectal surgeons would begin in September.

(11) RESOLVED that the Committee thanks its guests for their attendance and contributions today, asks that there is ongoing engagement with HOSC as plans are developed with a return visit at the appropriate time.

46. Kent and Medway NHS and Social Care Partnership Trust: Safeguarding and Dementia (Written Update)
(Item 8)

(1) RESOLVED that the Committee note the report.

47. Kent and Medway Adult Mental Health Inpatients Review (Written Update)
(Item 9)

(1) RESOLVED that the Committee note the report.

48. Kent Community Health NHS Trust: Community Dental Services (Written Update)
(Item 10)

(1) A Member asked for clarification regarding the percentage of local patients who were seen at the Deal Clinic and the commissioner's view on the changes to community dental services.

(2) RESOLVED that the report be noted and that written clarification circulated to the Committee in regards to the percentage of local patients who were seen at the Deal Clinic and the commissioner's view on the changes to community dental services.

49. Child and Adolescent Mental Health Services (Written Update)
(Item 11)

Michael Ridgwell (Director of Commissioning, Kent and Medway Area Team, NHS England) was in attendance for this item.

(1) The Chairman informed the Committee that he had received a letter from Julian Brazier, who had also written to the Secretary of State and received a similar response. Mr Brazier had expressed his thanks to the Committee for their work to highlight this issue.

(2) Members requested an update on waiting times for assessment and initial treatment & the quality and outcome of treatment. Mr Ridgwell offered to co-ordinate a joint response and update on performance across the four tiers of the service.

(3) RESOLVED that the Committee note the report and it was noted that Mr Ridgwell would co-ordinate a joint response and update on performance across the four tiers of the service.

50. Date of next programmed meeting – Friday 18 July 2014 @ 10:00 am
(Item 12)

(1) A Member made a comment about the use of acronyms in the NHS reports. The Scrutiny Research Officer undertook to remind NHS colleagues to avoid the use of acronyms in their reports to the Committee.

(2) The Chairman confirmed that Faversham MIU would return to the Committee in July 2014.

(3) A Member requested an update on the local Health and Wellbeing Boards' relationship with the Kent Health and Wellbeing Board and the input of local Boards into the Kent Health and Wellbeing Strategy as part of the proposed agenda item on the Kent Health and Wellbeing Strategy for July. The Chairman undertook to ask Mr Gough to include this in his report to the Committee in July 2014.